AIR COMMAND AND STAFF COLLEGE

STUDENT REPORT

GUIDELINES FOR INVESTIGATING MALPRACTICE CLAIMS - A CLAIMS OFFICER'S PERSPECTIVE.

MAJOR BRADFORD C. VASSEY 84-2670

"insights into tomorrow"

84 07 23 100

DISCLAIMER

The views and conclusions expressed in this document are those of the author. They are not intended and should not be thought to represent official ideas, attitudes, or policies of any agency of the United States Government. The author has not had special access to official information or ideas and has employed only open-source material available to any writer on this subject.

This document is the property of the United States Government. It is available for distribution to the general public. A loan copy of the document may be obtained from the Air University Interlibrary Loan Service (AUL/LDEX, Maxwell AFB, Alabama, 36112) or the Defense Technical Information Center. Request must include the author's name and complete title of the study.

This document may be reproduced for use in other research reports or educational pursuits contingent upon the following stipulations:

-- Reproduction rights do not extend to any copyrighted material that may be contained in the research report.

-- All reproduced copies must contain the following credit line: "Reprinted by permission of the Air Command and Staff College."

-- All reproduced copies must contain the name(s) of the report's author(s).

-- If format modification is necessary to better serve the user's needs, adjustments may be made to this report--this authorization does not extend to copyrighted information or material. The following statement must accompany the modified document: "Adapted from Air Command and Staff Research Report (number) entitled (title) by (author) ."

-- This notice must be included with any reproduced or adapted portions of this document.

REPORT NUMBER 84-2670

TITLE GUIDELINES FOR INVESTIGATING MALPRACTICE CLAIMS - A CLAIMS OFFICER'S PERSPECTIVE.

AUTHOR(S) MAJOR BRADFORD C. VASSEY, USAF

FACULTY ADVISOR MAJOR ROBERT W. DADE, ACSC/EDCC

SPONSOR MAJOR MARK MAGNESS, LMDC/JA

Submitted to the faculty in partial fulfillment of requirements for graduation.

AIR COMMAND AND STAFF COLLEGE

AIR UNIVERSITY

MAXWELL AFB, AL 36112

UNCLASSIFIED

SECURITY CLASSIFICATION OF THIS PAGE *(When Data Entered)*

REPORT DOCUMENTATION PAGE		READ INSTRUCTIONS BEFORE COMPLETING FORM
1. REPORT NUMBER 84-2670	2. GOVT ACCESSION NO.	3. RECIPIENT'S CATALOG NUMBER
4. TITLE *(and Subtitle)* GUIDELINES FOR INVESTIGATING MALPRACTICE CLAIMS - A CLAIMS OFFICER'S PERSPECTIVE		5. TYPE OF REPORT & PERIOD COVERED 6. PERFORMING ORG. REPORT NUMBER
7. AUTHOR(s) Bradford C. Vassey, Major, USAF, [redacted]		8. CONTRACT OR GRANT NUMBER(s)
9. PERFORMING ORGANIZATION NAME AND ADDRESS ACSC/EDCC, MAXWELL AFB AL 36112		10. PROGRAM ELEMENT, PROJECT, TASK AREA & WORK UNIT NUMBERS
11. CONTROLLING OFFICE NAME AND ADDRESS ACSC/EDCC, MAXWELL AFB AL 36112		12. REPORT DATE APRIL 1984 13. NUMBER OF PAGES 42
14. MONITORING AGENCY NAME & ADDRESS*(if different from Controlling Office)*		15. SECURITY CLASS. *(of this report)* UNCLASSIFIED 15a. DECLASSIFICATION DOWNGRADING SCHEDULE

16. DISTRIBUTION STATEMENT *(of this Report)*

STATEMENT "A"

17. DISTRIBUTION STATEMENT *(of the abstract entered in Block 20, if different from Report)*

18. SUPPLEMENTARY NOTES

19. KEY WORDS *(Continue on reverse side if necessary and identify by block number)*

20. ABSTRACT *(Continue on reverse side if necessary and identify by block number)*

A brief guideline for the new Claims Officer on how to investigate medical malpractice claims. From the vantage point of a former base Claims Officer, it provides a practical description of the investigation process, including tips on interviewing physicians and preparing the 7-point memorandum. It contains frequent references to actual claims investigated by the author.

DD FORM 1 JAN 73 1473 EDITION OF 1 NOV 65 IS OBSOLETE

UNCLASSIFIED

SECURITY CLASSIFICATION OF THIS PAGE *(When Data Entered)*

PREFACE

The purpose of this paper is to make some practical suggestions which are helpful to the new base Claims Officer investigating medical malpractice claims submitted under the Federal Tort Claims Act (28:2674). It is intended to be used as a handout to students attending the Claims and Tort Litigation Course at Maxwell AFB, but could just as well be used by new Claims Officers who have not attended the course. As the title implies, the focus is on providing a practical tool for the base Claims Officer, rather than on developing another work to insure compliance with existing directives and policies. Therefore, these guidelines should be used in conjunction with existing material on the subject provided by higher headquarters. Since the author has been exposed to the claims business, some of the material presented will unintentionally duplicate material presented in various official formats. However, since the exposure has not been great, some of the material may not be entirely consistent with official publications on the subject. Therefore, the reader is urged to apply good judgement in following these guidelines. On the other hand, it is hoped that the limited exposure of the author to medical malpractice will not impede some fresh approaches to the problem of investigating malpractice claims.

While the Medical Law Consultant (MLC) and the headquarters staff attorney (JACC) play important roles in investigating malpractice claims, the base Claims Officer is the key actor in the process, and it is this individual to whom these guidelines are directed. Subsequent to Chapters One and Two, the chronology used in these guidelines follows closely the sequence used to investigate a malpractice claim; beginning with a discussion on how to find out about hospital incidents,

CONTINUED

and ending with how to write the memorandum opinion. Chapter One covers background information on a sample of 73 claims filed at Lackland AFB over a five-year period beginning in 1978. Data from this sample is referred to repeatedly throughout the paper. Chapter Two deals with the subject of malpractice claims involving hospital machinery and equipment. The final chapter includes a summary and a discussion of some major shortcomings in the claims process that the new Claims Officer should be aware of.

TABLE OF CONTENTS

ABOUT THE AUTHOR

Before coming to ACSC the author spent one year as Claims Officer at the Lackland Law Center. During this period he investigated approximately 25 medical malpractice claims filed at Lackland for medical treatment rendered at Wilford Hall Medical Center (WHMC). He received a Bachelor of Science degree from the University of South Carolina in 1967 and Juris Doctor degree from the University of North Carolina in 1973. In addition to the United States Court of Military Appeals, he is licensed to practice law before the Supreme Courts of North Carolina and Texas. Previous Judge Advocate (JAG) assignments include Charleston AFB, Lindsey AS (SJA), and Lackland AFB.

Chapter One

BACKGROUND

In order to provide a useful framework for discussion, information was gathered from 73 malpractice claims arising over a five-year period at the Air Force's largest hospital - Wilford Hall Medical Center (WHMC) - and will be constantly referred to in this paper. This information consisted of 21 separate facts extracted from each claim and grouped under four broad categories involving the nature of the claim, status of the claimant, data on the claim, and processing time of the claim.(See Appendix A) Since the existing data system for claims - CAMP- does not track most of the information used, it had to be manually extracted from each claim file. This sample of 73 claims files represents the number of completed files available locally from 1978-1982, but because some files were retired or are being used in litigation, it does not represent the total number of malpractice claims filed during the period. These total claims figures are as follows:

(a) Year Filed	(b) Number Filed	(c) Number Paid	(d) Amount Paid($)	(e) Number in Litigation
1978	22	5	385,809	4
1979	17	5	976,500	4
1980	14	1	10,000	3
1981	25	4	1,465,000	6
1982	24	2	14,500	2

Since all of the 1982 claims have not been finalized, there will likely be a substantial increase in the numbers shown in columns c, d, and e for that year. It is interesting to note that a single claim accounted for the vast majority of the money paid in 1978, 1979, and 1981. $250,000 was paid on one claim in 1978; $650,000 in 1979; and $1.3 million in 1981. Besides paying a disproportionately large sum of money each year on a single claim involving serious injury, both the number of claims paid and the number of claims resulting in litigation remain consistently low in relation to the number of claims filed each year.

Chapter Two

CLAIMS INVOLVING MEDICAL EQUIPMENT

The 1981 claim referred to in Chapter One which resulted in a $1.3 million settlement is an excellent example of a claim involving defective hospital equipment. In this case, the brain of a newborn girl was severely damaged when she received a transfusion of grossly overheated blood. The blood was ov eated due to a defective thermostat in a blood warming machine (hemokinetother The government was probably liable because a supervisor knew of the defect, allowed the machine to remain in service. (20:475)

The Claims Officer must insure that any medical equipment involved in an injury to a patient is immediately identified and isolated. If this is not done, particularly if the machine is in short supply, it may be used again on another patient before it is repaired. For example, the blood warmer causing injury to the newborn was not identified with certainty until the malpractice claim was filed months after the incident, and may have been reused many times before it was repaired. The Claims Officer must also insure that all maintenance records, operating manuals, and supply documents pertaining to the machine are likewise identified and isolated. Maintenance records are useful not only to identify a possible defect in the machine, but also to see if required periodic and preventive maintenance was performed. Operating manuals can be used to compare the operator's actual use of the equipment with the operational guidance recommended by the manufacturer. In this regard, it is highly beneficial for the Claims Officer to view the machine in operation, and to take photographs during

the operation. Since persons reviewing the claim ordinarily do not have access to the machine, photographs are extremely valuable to help understand how the machine works. The more the Claims Officer understands the technical aspects of the machine in question, the better off the government will be. Supply documents, such as purchase orders or requisitions, might also be useful to determine if a particular component of the machine has had a history of repairs or replacement. The maintenance, operations, and supply records on the machine in question are critically important to determine whether the injury was caused by a defect in the machine or due to operator negligence.

If it is determined that the injury was caused by a defect in the machine, the government may be totally or partially indemnified by the manufacturer. However, before discovery is taken, the plaintiff may not know whether the injury was caused by a defect in the machine or by operator negligence; therefore, the manufacturer will routinely be joined as co-defendent with the government in the original complaint. When this occurs, the Claims Officer should be very cautious in dealing with the plaintiff who may informally solicit protected information ostensibly for use against the manufacturer, while in reality it will be used against the government. Once a claim against the government is filed, regardless of the number of co-defendents involved, information in government hands should be disclosed to the plaintiff only as required by the Federal Rules of Civil Procedure. (25:26-36)

Chapter Three

SOURCES OF INFORMATION

Obviously, a malpractice investigation cannot begin until the Claims Officer learns of the incident causing the injury. If the incident occurs at a Medical Center, the MLC is one of the best sources of information. To learn of incidents occurring at other large facilities, such as regional hospitals, the Claims Officer should work closely with hospital officials including the Vice Commander, Chief of Services, and Administrator. At smaller facilities, such as base clinics, the clinic Commander may be the best source of information. The hospital Inspector General (IG) should always be consulted because the incident may have also been the basis of an IG complaint, and if so, the IG report should be appended to the claim file. While the IG report contains a wealth of information about the incident, because of the chance of bias, the Claims Officer should always conduct an independent investigation. Another fertile source of information concerning potential malpractice claims is the Risk Management Committee. This committee usually meets monthly and is attended by key staff and division chiefs. Ordinarily, details of malpractice cases are not discussed at committee meetings, but nevertheless, an alert Claims Officer will often learn about incidents meriting further investigation.

When the Claims Officer learns of an incident involving a potential claim, the investigation can be started while the facts are still fresh in mind. How far to proceed before a claim is actually filed depends upon the risk of liability to the government. If the risk is substantial, the investigation should

proceed as if a claim had already been filed. If the risk is slight, it is still a good idea to keep a summary of the incident, along with names and addresses of the personnel involved and their immediate plans. When an investigation is delayed, not only do memories fade, but the personnel involved may no longer be readily available due to transfer or separation from the service. The claims interview becomes much more difficult when the subject has transferred, and sometimes impossible when the subject has been discharged. Occasionally, the discharged physician will refuse to cooperate in the investigation, and as a practical matter there is little that can be done to compel cooperation. When this happens, the Claims Officer should remind the physician that the claim is against the United States instead of the individual physician, and that a subpoena can and will be issued if necessary to secure testimony at trial.

Chapter Four

MEDICAL RECORDS

As soon as an incident occurs which will likely lead to a malpractice claim, the Claims Officer should request that the medical records on the injured party be promptly secured. Prior to an incident, most medical facilities provide little records security, and a record will sometimes disappear or be altered in some manner before it is secured. The first place the Claims Officer should look for a missing record is with the patient who, believing that he owns the record, sometimes borrows it to take to his attorney. In this event, the patient should be informed that the medical record belongs to the government, and that the claim will not be processed until it is returned. Missing records can be fatal to the government's case. For example, in one case, an anesthesiologist at WHMC removed his notes from the chart covering a critical period while the claimant was in the Intensive Care Unit following surgery, and he stubbornly refused either to return them or to provide a statement concerning his treatment of the patient. Shortly thereafter, the anesthesiologist was discharged from the service, and the government eventually had to settle the case due to lack of complete medical records. It is obviously very difficult to defend against a claim of malpractice if a written record of the treatment rendered cannot be produced.

Alteration of entries in the record occurs less frequently, but when it does happen it usually serves to flag treatment problems which otherwise might not have been recognized by the claimant as significant. This also can be devastating to the government's case. For instance, in the blood warmer case, critical

temperature readings of the blood were obliterated by someone with access to the record. The plaintiff quite naturally assumed that the true temperatures were obliterated to protect against damaging disclosure, as was probably the case. The obliteration became an important factor in the decision to settle the case before trial.

Besides securing inpatient and outpatient records maintained in the central records section, individual clinics should always be checked for separate records maintained on the patient treated there. Once the complete record has been secured, enough information can be obtained from it to begin the investigation, and in no event should the investigation be delayed awaiting copies ordered from the records section. To avoid unnecessary work, the three copies of the record required by the Claims Officer should not be ordered until the claim is filed. In a busy hospital, obtaining adequate copies of medical records is often one of the most difficult tasks in the investigation, and if more than three copies are needed, they should be made by the Claims Officer. In the WHMC sample, an average of 1.3 months elapsed from the date copies of the record were ordered by the Claims Officer until they were received. (See Appendix B1) This unacceptable response time underscores the need for constant follow-up after copies have been requested.

Obtaining copies of records that are readable and organized in proper sequence often presents a more serious problem for the Claims Officer. Illegible copies are the result of either the poor quality of the original entry or a problem with the copying process. Physicians need to be constantly reminded of the importance of entering legible notes in the chart, and records personnel need to be periodically reminded of the importance of making copies of the highest quality possible. At WHMC, physicians were strongly encouraged to use a name stamp instead of their handwritten signature at the end of an entry in the

patient's record. Illegible entries are of little use to anyone who must review the record.

A related problem concerns the organization of the medical record. Since the original record is often not properly organized in accordance with AFR 168-4, Chapter 12, the copies furnished to the Claims Officer will be similarly disorganized. Even though the Claims Officer is not responsible for proper maintenance of medical records, experience has shown that it is easier to organize the record in proper sequence rather than returning it to the records section to accomplish this task. While reorganization of the record entails a lot of work for the Claims Officer, an improperly organized record is one of the most frequent criticisms voiced by other personnel reviewing the claim.

Chapter Five

STANDARD FORM 95

Once the medical record has been ordered, the claim form (Standard Form 95) should be scrutinized for accuracy and completeness. Occasionally, the claim must be returned to the claimant to correct obvious defects, such as failing to claim a sum certain, or to sign the claim form. Of the 73 claims comprising the WHMC sample, only seven were returned to the claimant for correction. (See Appendix B2) Another common defect is the failure of the claimant to cite the specific basis for the malpractice. For example, in the aftermath of the extensive publicity surrounding the malpractice trial of an Air Force surgeon in Milwaukee, a claim was received citing absolutely no grounds for malpractice. The claimant, however, alleged that since the same surgeon was involved in his case, malpractice must have been committed! The court may impose the sanction of dismissal when the information provided in connection with the claim is inadequate for the Air Force to exercise its administrative power in resolving the claim. (3:30) However, the investigation should proceed as far as possible without delay pending receipt of any additional information requested from the claimant. Some offices have developed form letters addressed to the claimant acknowledging receipt of the claim, and at the same time requesting that corrections be made or that additional information be provided.

In addition to administrative defects, the Claims Officer should be alert for affirmative defenses revealed on the claim form. The most common affirmative defenses are based on the statute of limitations and on the status of the

party filing the claim. A claim filed more than two years after it accrues is barred by the statute of limitations. (27:240) Under the Feres doctrine, a claim based on an injury sustained "incident to service", is also barred. (9:135) This doctrine operates to bar suits by service members who are victims of malpractice. Also, when death is involved, the status of the party filing the wrongful death claim must comply with state law in order to be cognizable. The wrongful death statute of the state where the injury occurred must be consulted to determine the necessary and proper party or parties to file the claim. For example, some statutes may require that all injured parties be joined in the complaint, while others may permit one injured party to sue on behalf of all injured parties. 27 of the 73 claims sampled at WHMC revealed an affirmative defense on the claim form. (See Appendix B3) The existence of an affirmative defense simply creates another issue in the case to be investigated by the Claims Officer. It does not excuse an investigation on the merits because there is always a danger that the government will lose on the affirmative defense, and the case will then proceed to trial.

Chapter Six

CLAIMANT PROFILE

The status of the claimant is important to determining eligibility to file a malpractice claim. It is also interesting to look at the status of the claimant from the point of view of attempting to understand the motivation behind the claim. Analysis of the status of patients filing malpractice claims at WHMC suggests that a significant percentage of claims filed are unfounded and unmeritorious. If one draws a profile of the typical claimant at WHMC, it might include either an elderly dependent wife suffering from cancer or a premature infant with brain damage. Nearly two-thirds of the claims in the WHMC sample involved either patients over 40 or infants. (See Appendix B4) Also, about one-half of the total number of claimants suffered from serious chronic illness such as cancer or heart disease before they were admitted to the hospital. (See Appendix B5) These patients had a poor prognosis to begin with. Since high risk patients filed most of the malpractice claims, one wonders if the filing of the claim was more of a reaction to the disease itself, rather than the result of malpractice rendered. Regardless of the claimant's underlying motivation, every claim must be investigated as though it were meritorious. Sometimes the investigation will disclose a basis for negligence unknown to, and not even considered by, the claimant. When this happens, there is a strong tendency to deny the claim on the theory that the government has no obligation to perfect the claim for the claimant. If the claim is denied under these circumstances, the Claims Officer runs the risk that the claimant will subsequently learn of the unclaimed

negligence and use it against the government at trial. Therefore, whether the Claims Officer recommends approval or denial, the important point is to insure that the unclaimed negligence is as thoroughly investigated and reported as the claimed negligence, in order that the approval authority may make an informed decision.

Regarding other common characteristics of claimants, 43 out of the 73 claims sampled involved dependents; 17 involved retirees; and 13 were submitted by active duty personnel. Only about 10% of the claims involved either active duty or retired officers and their dependents. (See Appendix B6) One wonders whether the ratio of officers to enlisted personnel submitting malpractice claims is the same as the ratio of officers to enlisted personnel receiving medical treatment or whether there is an inverse correlation between the income level of the patient and the propensity to file a malpractice claim. It is also interesting to note that claimants who hire lawyers appear to be more successful. Only 12 of the 73 claims from WHCM were filed without a lawyer's assistance, and only one of the 12 filed pro se was paid. In the one claim filed pro se which was paid, the claimant accepted a settlement of at least $10,000 less than the government was prepared to pay in the case. Although claimants represented by lawyers are more successful than those without legal representation, attorney's fees can be astronomical. For example, attorney's fees in the blood warmer case totaled $325,000, and the case was settled before trial! Attorney's fees are limited by law to 25% of any judgement rendered by the court, or to 20% of any settlement agreed to by the parties. (29:2674)

Chapter Seven

INTERVIEWING THE PHYSICIAN

The claims investigation begins with a review of the medical record, and at least two reference works will be necessary to understand it. The first is a good medical dictionary. The second is a medical textbook, such as Gray's Attorney's Textbook of Medicine, for preliminary research on the medical issues involved. Once the medical issues are understood, medical journals can be used for more advanced research. The Claims Officer should never undertake to interview the physician without a good understanding of the medical issues involved, and without preparing questions in advance. Many physicians have little patience for lawyers who do not do their homework.

The interview with the physician can be done either in person or in writing. Claims Officers are encouraged to conduct the interview in person and prepare a written summary. Since a summary of the interview is the work product prepared by an attorney in anticipation of litigation, it is protected from discovery. (24:26) However, in many instances, particularly when the physician has left the area, it would be more convenient to request a written statement. The request should be accompanied by specific questions from the Claims Officer, and therefore, the written response by the physician to the questions should also be considered protected work product. (23:862) Moreover, a written statement by the physician tends to be more complete and accurate than a written summary prepared by the Claims Officer. The Claims Officer may find it useful to conduct a preliminary interview in person, and follow it with a detailed written interview. In the

WHMC sample, the Claims Officer obtained 175 separate written statements from physicians and prepared 140 separate physician interview summaries. Either way, the key to a successful interview is detailed advance preparation.

The purpose of the local interview is to obtain facts, and an opinion as to the quality of the treatment provided is ordinarily left to an outside physician chosen by the MLC. The theory is that a physician from a different hospital will be more likely to conduct an impartial and unbiased review of the case. However, in an appropriate case, the Claims Officer should consider an expert review by a physician from the same facility where the incident occurred, or even by a physician from a civilian institution. These alternatives should be considered when the physician available to the MLC does not have sufficient expertise to render an authoritative opinion. It is not difficult to locate the leading civilian or military experts in a particular field of medicine, and their opinions are extremely valuable and carry considerable weight. If a civilian expert is selected to review the case, and funds have not been arranged, make sure the civilian expert realizes there will be no remuneration for his services. In most cases, however, medical review by the "expert" selected by the MLC is entirely satisfactory.

After completion of the investigation, the Claims Officer should send the file and medical record, accompanied by a detailed factual summary raising the issues involved, to the MLC for medicolegal review. Some MLC's also require a brief summary of local law on the issues raised by the facts. The average time for medicolegal review on the WHMC sample was 3.34 months. Therefore, constant follow-up by the Claims Officer is recommended. Although occasionally the medicolegal review does not contain a discussion of all the issues raised by the Claims Officer, generally the quality is excellent, and the Claims Officer should heed the advice and recommendations contained therein.

Chapter Eight

7-POINT MEMORANDUM

The 7-point memorandum should be started immediately upon receipt of the medicolegal review. Basically, it contains a discussion of the facts, law, and a recommended disposition of the claim. If the facts are set out in detail in the medicolegal review, they need to be repeated in the memorandum only to the extent necessary to raise and discuss the issues in the case. In the event of a difference of opinion between the MLC and the Claims Officer, the Claims Officer's judgement on the facts will be given more weight, because he is in the best position to know the facts. After setting out the facts, the state law on medical malpractice is briefed. The legal research of the Claims Officer should always be saved, because many of the cases can be cited in future memorandums. Although the MLC will usually attempt to cite state law derived from works such as Medical Malpractice by Louisell and Williams, the Claims Officer should always do individualized research using the Federal Reporters and cite only the cases which are most on point. The Claims Officer's opinion and recommendation should flow naturally from the discussion of the facts and law. The strong tendency to take a "fighting stance" should be avoided in a losing case. If exposure is great, the Claims Officer should recommend settlement. Settlement of a meritorious claim by the Air Force will most likely be for an amount substantially less than settlement by the U.S. Attorney, or than by losing a law suit in federal court. On the other hand, in a close case, the best policy is probably to recommend denial. In determining whether to

recommend payment or denial, the Claims Officer must put aside personal feelings, and do what is best for the Air Force. For instance, because malpractice cases often involve very unfortunate personal circumstances, it is easy to feel sorry for the claimant and to let feelings of sympathy cloud professional judgement. Sometimes the tendency to feel sorry for the claimant is compounded by sympathy for the physician involved who might also rather have the government settle the claim administratively, rather than having to undergo the trauma and publicity of a trial. However, the Claims Officer must not allow personal feelings towards the claimant or the physician to interfere with his determination of liability.

One last point on the 7-point memo: be brief and to the point. It is not necessary to write a book. Time should be spent uncovering the facts rather than writing a law review article. Zero in on the critical issues and concentrate on the discussion of those issues.

Chapter Nine

DAMAGES

Once settlement is recommended, the Claims Officer should recommend a settlement amount. The calculation and discussion of damages is often the weakest part of the claims investigation. It usually consists solely of finding the verdict expectancy in a similar case from the Personal Injury Valuation Handbook (PIVH), Verdict Research, Inc., and adjusting this figure for local differences and inflation. Even though verdict expectancies in the PIVH are based on actual cases, many plaintiff's attorneys distrust this method of calculating damages. Since each malpractice case is different, their mistrust is well-founded if the PIVH is used as the exclusive basis for calculating damages. In addition to using the PIVH to calculate damages, the Claims Officer must also independently analyze each element of damages in every case.

Analysis of the elements of damages in every malpractice case involves three phases: identification of the elements recognized by law; proof of the existence of damages under each element recognized; and measuring the extent of damages under each element. In each phase, the law of the state where the injury occurred is controlling. (10:1047)

The first phase involving identification of the elements of damages is normally routine because most courts recognize standard elements in medical malpractice cases. The elements commonly recognized are past and future medical expenses, past and future pain and suffering, and loss or dimunition of earning capacity. (7:621) In addition to these standard elements, courts in

recent cases have recognized such additional elements as the loss of enjoyment of life, deprivation of normal life expectancy, and loss of consortium. (16:283)

Once the elements of damages have been identified, the Claims Officer must determine whether there is any evidence of damages under these elements. It goes almost without saying that damages must be proven by competent evidence, and will not be based on mere speculation. (8:621) In the face of uncertain prognosis and conflicting evidence, the phase of proving the existence of damages is often very difficult. In proving damages, the Claims Officer must first determine whether the claimant has been or will be reimbursed for damages from collateral sources. Such reimbursement is quite common in medical malpractice claims under the FTCA because many claimants receive benefits for the injury from other federal sources, such as medical care and disability pensions. Under the collateral source rule, compensation for the loss received by the claimant from a collateral source, wholy independent from the wrong-doer, cannot be set up by the latter in mitigation or reduction in damages. (30:99) In the typical case of the military dependent filing a malpractice claim, the claimant will most often have received medical treatment free of charge at a government medical facility, and will also receive additional free treatment if needed in the future. In this event, there is strong support for the proposition that the USAF, sued under the FTCA, should not have to pay damages that will be paid under some other federal program - this would amount to double compensation. (2:49) Accordingly, in the case involving a serviceman injured outside the scope of his military duties, a 40% disability pension and the cost of government medical care, were both deducted from an award made under the FTCA. (11:355)

Once the existence of damages has been established, the Claims Officer must then determine the amount recommended for payment. In this regard, each element of damages should be priced out separately. Annuity tables may be used to calculate the present value of future medical expenses and diminished earning capacity. For example, again in the blood warmer case, the claimant proved that $1,814,959 would be needed for medical expenses over the 27-year life expectancy of the injured infant. The annuity tables provided the present amount ($87,650) which compounded annually at 2% (9% return less 7% inflation) for 27 years would yield $1,814,959. Also, with evidence of expected future earnings over the average adult work life, the annuity tables were used in a similar fashion to compute the present value of diminished earning capacity. Pain and suffering are obviously more subjective, but these elements still must be analyzed in light of the seriousness of the injuries.

Once the settlement value has been determined, the Claims Officer should recommend the method of payment. For example, when the settlement amount is large, it is often advantageous to structure a settlement so that payments are made at regular intervals in the future, instead of in one lump sum. By structuring the settlement, the government saves considerable interest which would be earned by the injured party in a lump sum settlement. A structured settlement also results in considerable savings because future payments are made in cheaper dollars due to inflation. One popular way to structure a settlement is to set up a revertionary trust. The trust is initially funded by an amount expected to produce enough income to cover medical expenses and other compensation, and typically gives the trustee the power to invade the corpus to cover deficiencies. The advantage of a trust is that the corpus is returned to the treasury upon termination of the trust, so the government

actually pays only for the use of the money. Another advantage is that the trustee will insure that payments are made only for the purpose intended, i.e., for medical expenses. Although attorney's fees are the same in a structured settlement as a lump sum settlement, most plaintiff's attorneys will try to get as much of the settlement up front as possible.

Chapter Ten

STANDARD OF CARE

The vast majority of medical malpractice cases turn on the facts, not the law. This is not to say that the law is unimportant, but rather to re-emphasize the importance of timely fact finding. The law can be researched anytime, while the facts are often fleeting. About 95% o the Claims Officer's time should be spent investigating the facts, and about 5% spent on researching the law and writing the 7-point memorandum. Nevertheless, a brief discussion of the law might be helpful in directing the individualized research of the Claims Officer.

Since medical malpractice is a tort, it is not surprising that the same formula used to analyze negligence cases in tort law is used in malpractice cases. Thus it has been said that:

> A prima facie case of medical malpractice must normally consist of evidence which establishes the applicable standard of care, demonstrates that the standard has been violated, and develops a causal relationship between the violation and the harm complained of... (13:947)

and that:

> A malpractice action does not lie unless the physician violates a duty of care owed the patient nor, even, then unless the physician's breach of duty proximately causes the injury complained of by the patient...(12:692)

In every case, the claimant must establish the existence of a duty owed by the doctor, breach of that duty, and damages proximately caused by the breach. The duty attaches whenever a physician undertakes to render care to another,

thereby creating a professional relationship with a corresponding duty of care to the recipient. (31:8) The question of when the doctor/patient relationship is entered into arises in civilian hospitals in the context of determining whether a physician/patient relationship was in fact established. This issue is not so common in military cases because the military patient has the statutory right to receive treatment in military facilities. (26:1074) The issue in a military treatment facility is usually not whether a physician/patient relationship has been established, but whether the treatment rendered measured up to professional standards. Therefore, little time needs to be devoted to the concept of duty.

Although the proximate cause issue appears much more frequently in malpractice cases than the duty issue, a great deal of discussion is not required on this issue either, primarily for two reasons. First, even though the determination of proximate cause is often more difficult in malpractice cases because the patient is ordinarily sick or injured prior to receiving treatment, the concept and terminology of proximate cause are the same in malpractice cases as in general tort law. Second, experience has shown that once negligence has been proven in malpractice cases, many courts are prone to bootstrap proximate cause in order to find in favor of the suffering claimant.

Since the issue of damages has already been discussed, the only issue remaining is the standard of care required of the physician, and this issue needs to be discussed in greater detail. In looking at the standard of care employed in the state where the injury occurred, it might be helpful to think of a continuum with the "locality rule" at one end, and the "medical community rule" at the opposite end. The "locality rule" imparts a geographic standard for malpractice by holding that physicians and surgeons are not negligent if

they exercise that degree of care and skill which is usually possessed and exercised by practitioners of their profession in the same locality or community. (6:918) The primary question arising in the application of the "locality rule" is whether or not the treatment provided is customary in the same or similar locality where the physician practices. One controversial feature of the "locality rule" is that physicans are held to differing standards of professional competence depending on the location of their practices. For example, a physician with a small general practice in a rural area would not be held to the same high standard of care as the physician working in a large metropolitan medical center. Regardless of the emphasis on custom and geography, the "locality rule" is still the rule used in the majority of jurisdictions to establish the standard of care used in malpractice cases. (32:43)

At the opposite end of the spectrum is the "medical community rule" which imposes a standard of care derived from the medical community at large, rather than from an insular segment of the community based on geographical boundaries. This rule assumes that there is a body of knowledge and skill extant in the profession as a whole that individual physicians must master, regardless of the location of their practice. Most of the time this rule would impose a higher standard of care than the "locality rule". The most apparent use of the "medical community rule" occurs in the field of medical specialization where various specialists are held to a national standard of care. For example, specialists in obstetrics and gynecology are nationally licensed after taking nationwide examinations and are held to a higher standard of care than general practitioners in similar cases. (18:123)

A number of niches have been carved out in between the extremes in the standards of care imposed by the "locality rule" and the "medical community rule".

A court which prefers a broader standard typically rejects the "locality rule" by saying in effect that although custom is one factor to be considered in determining whether a physician exercised due care, conformity to custom is not in itself the exercise of care as a matter of law. (15:283) After rejecting the "locality rule" as parochial, the court might lay down a very general standard such as to require a physician to exercise that degree of care which a reasonable and prudent person in the same profession would have exercised in the same or similar circumstances. (17:808) The courts have also broadened the "locality rule" by combining it with various external criteria. For example, the "locality rule" has been modified by references to the teachings of medical colleges (5:918), the state of the medical profession (1:369), and the advances in the medical profession (19:1342). Further departures from the "locality rule" have been made by reference to discrete subgroups within the overall medical community. Thus, courts have measured physicians' competence against the competence level of a "substantial segment of the medical community" (22:989), or even by a "respectable minority" of the community. (14:897) Other modifications to the "locality rule" would require consideration of any written standards published by the medical community itself (4:149) and the resources available in the local community. (20:1342) Thus, it would seem reasonable to hold physicians to any written standards which were self-imposed, such as local hospital by-laws and operating procedures, or even to external standards of various health organizations and accreditation agencies. In measuring a physician's competence, it would also be reasonable to consider the medical facilities and equipment available to work with.

This overview is meant only to provide a framework from which to begin individualized research in the appropriate jurisdiction. In determining the

scope of the legal research, the Claims Officer should remember that malpractice cases usually turn on the facts instead of the law.

Chapter Eleven

SUMMARY

Using claims data on 73 claims filed at WHMC as a backdrop, this paper has taken the new Claims Officer through the process of investigating medical malpractice claims, beginning with the identification of an incident which might result in a claim, and ending with the drafting of the 7-point memorandum. It was not meant to be all-inclusive because there are other works on the subject, but rather to be a handy guide hitting upon the high points in the claims investigation process.

After laying a foundation using a sample of 73 malpractice claims from WHMC during 1978-1982, the paper began with a short discussion of cases involving defective medical equipment. This subject was chosen because a great deal is not written on cases involving defective hospital equipment, and such cases could be more prevalent in the future as the operation and maintenance of hospital machinery becomes increasingly more complex. Next, the paper discussed how to identify incidents and injuries which could result in malpractice claims. Here, the importance of timely identification of potential claims was stressed. Next, the paper discussed the critical role of the medical records in a malpractice claim, and the devastating impact that missing or unreadable records have on the government's case. After medical records, the paper went into some common defects and defenses that an alert Claims Officer may find on the face of the claim form. Next, the paper discussed some similarities and common characteristics of claimants that were present in the WHMC sample. The purpose of this discussion was

not to deride claimants, but to help the Claims Officer understand the motives of some claimants and to be aware of both the mental and physical status of persons who file malpractice claims. The next area involved the extremely important job of interviewing the physician involved in a malpractice claim. The keys to doing this job well are advance preparation and selecting the interview method that best fits the situation. Next, the importance of brevity and objectivity was stressed in drafting the 7-point memorandum. The issue of damages was discussed next in some detail due to the weakness of this area in many claims investigations. The paper dealt not only with the important area of proving damages in malpractice cases, but also in the equally important area of structuring damage awards once proven. The last area covered in the paper gave a brief analysis of the law in medical malpractice cases, emphasizing the standard of care used by the courts to determine liability. The purpose of this last section was to give the Claims Officer a flavor of the language and legal rules used by the courts in adjudicating complex malpractice cases. From this analysis as a starting point, the Claims Officer should be better prepared to do the detailed individual research required in each case.

Before concluding, it is appropriate to point out several deficiencies in the claims program that the new Claims Officer should be aware of, and perhaps, overcome. The first deficiency involves manpower and is divided into two parts. The first part involves the process currently used by manpower officials to calculate authorized manning levels for the claims function. Basically, manpower authorizations required to perform the malpractice investigations are computed in the same manner as authorizations required to perform routine claims investigations. In other words, the same workload factors are used in computing authorizations for all types of claims investigations. Medical malpractice claims are sufficiently unique both in terms of substance and the

investigation time involved, that they should be categorized separately in the process of computing manpower authorizations. The second manpower issue seen as a deficiency in the claims program is the unspoken, but common, practice of assigning the most junior attorney in the legal office as Claims Officer. Just in terms of management of Air Force resources, not to mention the morale connection, the claims branch is one of the most important, if not the most important, branch in the legal office. With the present emphasis on fraud, waste, and abuse of government resources, it is difficult to imagine how the Staff Judge Advocate can consider filling the Claims Officer position with inexperienced personnel.

A second weakness in the claims program that a new Claims Officer should be aware of involves the lack of specialized training in medical malpractice for Claims Officers. Presently, most Claims Officers receive only limited training in malpractice cases at JASOC (Judge Advocate Staff Officer Course), and at the Claims and Tort Litigation Course offered by the JAG school at Maxwell AFB. This training is adequate for a Claims Officer at bases processing only a limited number of malpractice claims, but is not adequate for the Claims Officer at a base processing a significant number of malpractice cases. Therefore, as a minimum, Claims Officers supporting either a USAF Medical Center or a regional hospital should receive additional specialized training in malpractice cases. The training proposed would not be as comprehensive as currently provided to prospective MLC's, but would be more comprehensive than afforded in either of the courses stated above. In support of additional training, it is important to re-emphasize that the Claims Officer, and not the MLC, is responsible for investigating malpractice claims. On many occasions the MLC is so preoccupied with other internal hospital matters that the Claims Officer may find it difficult to get the indepth advice needed on a particular malpractice case.

The last pitfall for the new Claims Officer to be aware of concerns the process by which claims are settled. Due to the high amounts claimed in malpractice cases, settlements are usually negotiated by JACC or Justice Department attorneys. Although the Claims Officer is the person who is most familiar with the facts and circumstances of the case, he is rarely involved in the settlement negotiation process. It confounds reason that the person who is most familiar with the case is left out of the negotiating process. Not only is the Claims Officer the person most familiar with the facts in the case, but he is also the only person in a position to evaluate intangible factors, such as witness demeanor, which often have a great impact on the merits of a case. Moreover, the Claims Officer usually is quite familiar with the claimant's attorney, and is in the best position to evaluate the strength of the claimant's determination on certain issues, particularly on the amount of damages demanded by the claimant. Headquarters attorneys are not in as good of a position as the Claims Officer to evaluate the claimant's demands, and to negotiate a favorable settlement for the government. Because of his proximity to the case, a properly trained Claims Officer is in the best position to negotiate and structure a settlement which is most advantageous to the government.

APPENDICES

Appendix A

DATA CATEGORIES

Category 1 - Nature of the claim.
This category includes the claimant's specific allegation of malpractice; the organ or body part involved in the malpractice allegation; the hospital service providing treatment to the claimant; and the status of the person providing the treatment forming the basis of the claim, i.e., doctor, nurse, orderly.

Category 2 - Status of the claimant.
This category includes the age of the claimant; the pre-existing health of the claimant; and the military status of the claimant, i.e. active, retired, dependent.

Category 3 - Claims data.
This category includes the amount of the claim; the date of the incident of malpractice; the date that the claim was signed by the claimant and received by the SJA; whether or not the claimant was represented by an attorney; and whether or not an administrative defect or a legal defense was revealed on the face of the claim form (SF 95).

Category 4 - Claims processing times.
This category includes the date the medical records were ordered by the Claims Officer; the number of physicians interviewed by the Claims Officer and the date of each interview; the date that the claims file was forwarded to the MLC; the number of physicians interviewed by the MLC and the date of each interview; the date of the medicolegal review; the recommendation of liability by the SJA and the date the 7-point memorandum was forwarded to JACC; the recommendation of liability by JACC and the date the recommendation was made; and whether suit was filed when the claim was denied.

CONTINUED

Appendix B

DATA FROM 73 MEDICAL MALPRACTICE CLAIMS FILED AT
WILFORD HALL MEDICAL CENTER FROM 1978 TO 1982

1. Data relating to the lengthy delay encountered in receiving copies of medical records from the hospital.
   There is no requirement to record the dates that medical records were requested and the dates they were received; however, these dates were ascertained from informal notes existing in 26 of the 73 claims files available for examination.

2. Data relating to defects commonly found in completing the claims form (SF 95).
   Of the seven claims forms returned to the claimant due to defective completion, three required additional information supporting the basis of the claim; one required the signature of the claimant; one required completion on the correct claim form; and two required completion of age of the claimant and date of the claim.

3. Data relating to claims in which an affirmative defense was revealed on the face of the claim form.
   Of the 27 claims in which an affirmative defense was raised, 15 claims were subject to a statute of limitation defense; 5 were subject to a Feres defense; 5 were subject to both a statute of limitation and a Feres defense; and 2 were subject to dismissal due to submission by improper parties.

4. Data regarding the age of the claimants.
   Out of the 73 claims examined, 31 were submitted by patients over 40 years of age, and 10 were submitted on behalf of newborn infants.

5. Data relating to the nature of the claimant's underlying pre-existing illness.
   Of the 37 claims involving patients suffering from long-term illness, 15 suffered from some form of cancer, and seven suffered from circulatory problems.

6. Data relating to the officer or enlisted status of the person filing the claim.
   Eight out of the 73 claims examined were submitted by officers or officers' dependents, while the remainder were submitted by enlisted personnel and their dependents.

BIBLIOGRAPHY

Cases

1. Brandon v. Art Centre Hospital, 366 F. 2d 369(1966).

2. Brooks v. United States, 337 U.S. 49(1948), Kubrick v. United States, 444 U.S. 111(1979), Elliot v. United States, 329 F. Supp. 621(1971).

3. Cummings v. United States, 449 F. Supp. 40(1978).

4. Darling v. Charleston Community Memorial Hospital, 200 N.E. 2d 149(1964).

5. Davis v. Duplantis, 448 F. 2d 918(1971).

6. Davis v. Duplantis, 448 F. 2d 918(1971), Down v. American Employee's Insurance Company, 423 F. 2d 1160(1970).

7. Elliot v. United States, 329 F. Supp. 621(1971).

8. Elliot v. United States, 329 F. Supp. 621(1971), Treuman v. United States, 180 F. Supp. 172(1960).

9. Feres v. United States, 340 U.S. 135(1950).

10. Foskey v. United States, 490 F. Supp. 1047(1949).

11. Hale v. United States, 416 F. 2d 355(1969).

12. Johnson v. United States, 547 F. 2d 692(1976).

13. Kasberg v. Washington Hospital Center, Inc., 394 F. 2d 947(1968).

14. Leech v. Bralliar, 275 F. Supp. 897(1967).

15. McNeil v. United States, 519 F. Supp. 283(1981).

16. McNeil v. United States, 519 F. Supp. 283(1981), Rogers v. Okin, 478 F. Supp. 1342(1979).

17. Morgan v. Sheppard, 188 N.E. 2d 808.

18. Robbins v. Footer, 553 F. 2d 123(1977).

19. Rogers v. Okin, 478 F. Supp. 1342(1979).

CONTINUED

20. Rogers v. Okin, 478 F. Supp. 1342(1979).

21. Sheppherd v. McGinnis, 131 N.W. 2d 475(1964).

22. Soles v. United States, 522 F. Supp. 989(1981).

23. Sprague v. Director, 688 F. 2d 862(1982).

Statutes

24. Fed. Rules Cov. Proc., Rule 26(b)(3), 28 U.S.C.A.

25. Fed. Rules Cov. Proc., Rules 26-37, 28 U.S.C.A.

26. 10 U.S.C.A. §1074.

27. 28 U.S.C.A. §2401(b).

28. 28 U.S.C.A. §2674.

29. 28 U.S.C.A. §2678.

Other Sources

30. 25 C.J.S. Damages §91(1).

31. King, Joseph H., The Law of Medical Malpractice, St. Paul, Minn.: West Publishing Co., 1977.

32. King, Joseph J., The Law of Medical Malpractice, St. Paul, Minn.: West Publishing Co., 1977.

INDEX