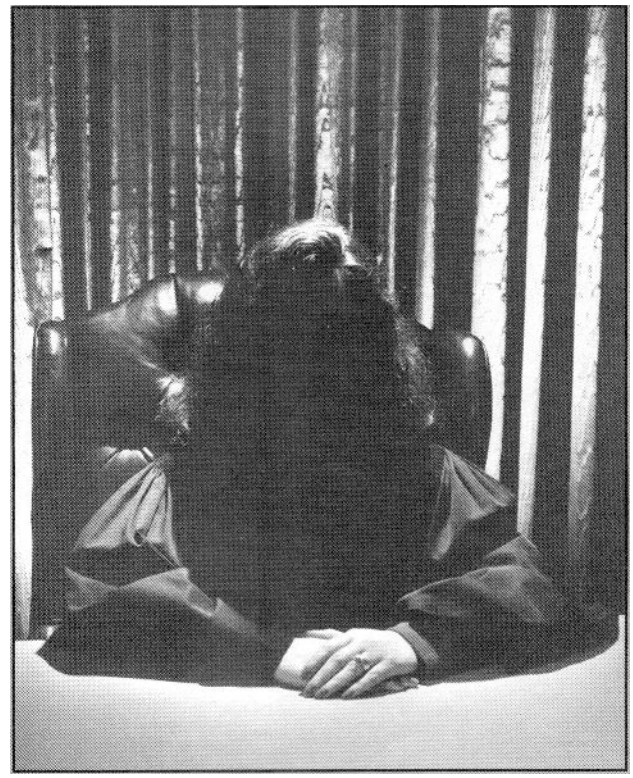
ADVOCATE

Consumer Attorneys Association of Los Angeles

March 1995



Judicial Appointments

page 12

Medical Malpractice Litigation

page 14

Civil Discovery and Self-Incrimination

page 24

Damages in Wrongful Death Cases

page 28

Medical Malpractice Litigation, Case Preparation and Trial

by Howard A. Kapp

Every attorney who has faithfully followed jury verdicts is aware that the vast majority of medical malpractice trials end in a defense verdict. Nonetheless, many otherwise intelligent and capable plaintiffs' attorneys feel qualified to handle an occasional medical negligence claim. This is not surprising: many plaintiff's attorneys are confident in their skills, developed over years of experience, and feel—quite correctly—that the legal knowledge unique to medical malpractice is rather minimal, easily accessible and quite comprehensible to any attorney handling personal injury cases.

It is manifestly true that the specialized legal knowledge unique to medical malpractice law is easily understood and finite; after all, medical malpractice is simply a variant of the tort of negligence (*Flowers v. Torrance Memorial Hospital* 8 Cal.4th 992, 35 Cal.Rptr.2d 685 (1994)) and the structure of medical malpractice litigation, from filing through trial, is essentially identical to handling a garden variety automobile accident case. Indeed, the pamphlet-size discussion of medical malpractice in any of several widely-available treatises would probably adequately acquaint counsel with a working outline of the law specific to malpractice. See, e.g., Levy, Golden & Sacks, *3 California Torts* (Matthew Bender), Chapter 31. It is not difficult to become generally familiar with the finite number of rules which constitute MICRA, such as the limitation on general damages or restrictions on attorney fees, which are largely mechanical. (The one very difficult conceptional area in MICRA litigation is the statute of limitation. *Code of Civil Procedure* §340.5[1])

The Issues Are Usually Different

In real life, medical malpractice cases raise entirely different issues than the usual vehicle accident or trip-and-fall case. In most injury cases, for example, the factual issues involve the relative credibility of the parties (e.g., "who ran the red light?"); in medical malpractice cases, it is rare that the parties have significant, case-deciding factual disputes. In medical malpractice cases, factual disputes are relatively rare; indeed, the relevant events are usually contemporaneously documented by the defendant.

The core issue in malpractice cases is usually not, as in so many other forms of litigation, "what happened," but the expert *interpretation* of the events and facts indisputably documented (or not documented) in the medical record. Malpractice cases almost always focus on issues rarely present in non-malpractice injury litigation: the officially objective, but actually quite contestable, issue of adherence to the legal fiction of a "standard of practice" (i.e., negligence) and, quite often, complex issues of actual causation. Indeed, these issues predominate in medical malpractice litigation almost to the exclusion of everything else.[2]

The Pre-Trial Preparation is Radically Different

The elusive, and expert-related, issues which predominate in malpractice cases involve an entirely different pre-trial approach than those in other forms of tort litigation.

In auto accident litigation, for example, the best, and necessary, pre-trial work-up requires the prompt evaluation and reconstruction of events, with or without an expert. This can be done through a variety of devices, including statements of alleged witnesses, obtaining photographs and property damage estimates, confirming financial responsibility, and the gathering of (usually friendly) medical reports.

Moreover, the plaintiff's attorney has the advantage on these matters: usually, that attorney is the first professional involved in the process. The defense usually has little information on the

[1] This statute is full of traps for the unwary, consistently interpreted adversely to the malpractice victim and differently than other statutes of limitation, and is an area ripe for the inexperienced lawyer to commit malpractice. This statute can lead to bizarre and unbelievably cruel results.

[2] The major exception to this rule is informed consent. "We underline the limited and essentially subsidiary role of expert testimony in informed consent litigation. As we cautioned in *Cobbs, supra*, a rule that filters the scope of patient disclosure entirely through the standards of the medical community "'arrogate[s] the decision [of what to disclose] . . . to the physician alone.'" [Citation.] We explicitly rejected such an absolute rule as inimical to the rationale and objectives of the informed consent doctrine; we reaffirm that position." *Arato v. Avedon* 5 Cal.4th 1172, 1191, 23 Cal.Rptr.2d 131 (1993).

plaintiff's background. Indeed, in many non-malpractice tort cases, formal discovery appears to be very much a one-sided affair. The auto plaintiff's lawyer generally expects to learn little from discovery. The defense lawyer, to the contrary, may spend much time and effort securing documentation regarding the plaintiff. The deposition of the auto accident plaintiff is almost always a critical event.

In malpractice cases, with the usually sympathetic (i.e. clearly injured) plaintiff, the usual agreement as to the facts themselves and the focus on expert-only issues, the plaintiff's deposition is largely a non-event. For this reason, many malpractice defense firms send their most junior lawyers to plaintiffs' depositions. This is especially true since the defendant has the benefit of knowing the plaintiff's relevant medical history and condition better than, and long before, the plaintiff-patient's malpractice lawyer.

Indeed, the most intimate details of the plaintiff's life and personality are commonly well-known to the defendant physician; the malpractice defendant probably knows more about the plaintiff before the case even starts than the defense lawyer in an accident case could ever hope to know about the accident case plaintiff. Indeed, even the defendant's deposition, which is a much more critical event in malpractice litigation, is quite predictable (assuming that you understand the medicine involved) and the focus is on formally filling in the historical gaps for your experts and getting the defendant to commit to a single account of the case.

Paper discovery in medical malpractice is largely worthless. Since the critical issues usually involve the ultimate opinions of (supposedly) still-unselected experts, even the most probing, specially-drafted interrogatories can be answered in any of several one-size-fits-all ways which will make the question and answer unusable at trial. While the opinions of the defense experts (and the defendant itself) are plainly discoverable (*see, e.g.*, Weil & Brown, *California Practice Guide/Civil Procedure Before Trial*, ¶8:984 *et seq.*), the actual answers are usually little more than boilerplate.

Paper discovery in malpractice litigation is largely prologue to the designation of experts stage.

The Importance of Experts in Malpractice Litigation

One cannot overemphasize that medical malpractice cases are won or lost on the selection and use of appropriate experts. It is, unfortunately, the weak spot for many plaintiff's attorneys.

Standard of practice and causation issues in malpractice litigation are issues strictly for expert testimony; indeed, the trial court will so instruct the jury. BAJI 6.30. This stands in dramatic contrast to non-malpractice litigation. Since, for example, the rules of the road are well-known to virtually every potential juror and, in almost every case, explicitly defined by law, it would be inconceivable for an expert in an automobile accident case, for example, to offer testimony that it was not negligent for a driver to drive 90 mph while repeatedly changing lanes in an occupied school zone; such testimony would probably be disallowed by the court. Even if it were permitted, no lay juror would be fooled. In malpractice terms, however, equivalent testimony is given routinely.

Unfortunately, many attorneys don't understand that finding a doctor willing to testify to these issues doesn't prove anything: the defense lawyer has ready access to a profession filled with potential experts, usually well-known to the defendant himself or herself, who are anxious to do virtually anything to defend their noble profession against the plaintiffs' malpractice bar. These doctors, while they will rarely admit it, see the plaintiffs' malpractice bar as the modern equivalent of massing hordes of greedy mouthpieces cynically making a living by harassing already overburdened, over-regulated, premium-gouged, life-saving, colleagues. They deeply resent this "interference" from lawyers. This feeling is, in many cases, a deeply held belief in the medical community. Whether these beliefs and feelings are rational or correct is beyond the scope of this article; knowing that they exist is critical, however.

This anti-lawsuit environment in the medical industry leads to basic axioms of the selection of experts in malpractice litigation that should never be ignored.

First, no matter how ridiculous the medical defense is in a real life context, the defendant can always find some appropriately credentialed

Medical Malpractice . . . cont. on page 16

Howard Kapp is a member of the Consumer Attorneys Association of Los Angeles. His practice is based in Beverly Hills.

colleague who will be willing to aggressively defend the defendant's actions, even to the point of deliberate perjury. It is undeniable that there are plenty of well-credentialed doctors who will support all sorts of quackery, thievery and downright stupidity on the part of their colleagues. On direct examination in particular, their testimony may appear to be essentially perfect for the defense; of course, that doesn't change the fact that it may be a pack of lies.

Second, the defense lawyer always has the advantage in focusing on the "right" specialist: after all, the defendant may be a real dummy, but he or she can easily assist counsel to identify, and connect to, at the very least, the right sub-specialist. The superior qualifications of the defense experts may be, in and of itself, enough to defeat many valid malpractice claims.

Third, no matter how good your case really is, it is frequently difficult to find the right doctor for your case. There is an incredible variety of reasons for potential experts to exercise their right to refuse to get involved, regardless of the merits of the case. For example, the defendant may be well known or even held in awe in the universe of potential experts. In other cases, a potential expert may be concerned about criticizing a particular procedure, even though it is quite controversial or even arguably quackery. The reasons are endless.

Fourth, since the defense can pick and choose its experts from among a number of well-qualified doctors, the plaintiff's attorney must be very careful in picking the absolute best expert.

Fifth, the plaintiff's attorney must always remember that the rules of evidence do not permit the direct introduction of "learned treatises" by which one could establish, for example, what was taught, or is being taught, in medical schools or residency programs, or what was the actual state of knowledge at a given time. *Evidence Code* §721. As long as the defense expert is willing to swear that he or she didn't "read, consider or rely" upon such materials,[3] the defense can and will block the introduction of such terribly useful material which might have, at least, provided the jury with an objective basis of truth. This is truly the battle of the experts *as trial witnesses*, the truth notwithstanding.

The supposed availability of commercial "expert referral" services is of little help in real-life medical malpractice trials. First, competent defense counsel invariably focus, at the expert's deposition, on how the expert and lawyer connected in the first instance. (This is important in dealing with any expert, as it may demonstrate bias.) An admission that the expert allowed his or her name to be on a list of available experts, or that the expert may even have applied to be on the list, instantly allows the defense to exploit the theme that the witness is a professional witness. Second, since such services, at least in medical malpractice cases, are invariably useful only to plaintiffs, the expert will be attacked as having a pro-plaintiff bias. (Considering that the usual theme of a good plaintiff's medical malpractice attack on the defense experts is a pro-doctor bias, this can effectively neutralize the plaintiff's entire case.) Third, there is usually no economical way to personally subjectively evaluate the expert candidate, who may be located in a remote city.

Further difficulty in selecting an expert can be, and frequently is, encountered in the details. One expert may, for example, be willing to testify that the defendant's conduct was pure quackery, but that same expert may not support the case on causation grounds. Moreover, many experts, because of the very nature of their specialty and training, are incapable of conveying damages. The very natures of their specialties literally require that they suppress some aspects of humanity just to function year after year in their

[3] Of course, one would think that, at least asserted ignorance of, at least, what the "leading authorities" said on this point would be impeaching; unfortunately, the law rewards feigned or real ignorance by virtue of Section 721.

specialty. Consider the oncologist: how does he or she cope with the daily routine of telling patients, face-to-face, that they have a potentially fatal case of cancer? How do they cope, year after year, with the reality that they habitually attend the saddest of all human events, the death of a patient? Is this expert capable of forcefully conveying emotional damage information?

For example, the oncologist who is willing to testify that the defendant was a complete idiot for initiating chemotherapy may have difficulty conveying the necessary sense of physical and emotional damage to the jury, since the expert's unique perspective may be that that course of "therapy" was not as bad as other forms of therapy used in this area. Orthopedists, no matter how they deny it, are trained to accept that patients will always have some temporary pain associated with injury, and to focus on the long-term recovery of function and reduction of pain. Thus, while the defendant's treatment may have delayed recovery, with serious real-life consequences for the patient, some orthopedists just can't be used effectively to present the damages to a jury.

The "Over Qualified" Plaintiff's Expert--Part 1

Conventional wisdom is that, all other factors being equal, the best expert will be the best qualified in his or her field. While this is true for the defense in a medical malpractice context, the defense may argue that the plaintiff's expert is so expert in the relevant field that the expert is "over-qualified."

From the juror's perspective, the relevant standard of practice *appears to be* a *minimum* standard. BAJI 6.00. In cases where the plaintiff's expert is especially well-qualified, the defense may argue that the plaintiff's expert is over-qualified, that is, the expert is unfamiliar with the *minimum* acceptable standard in the community. The defense will claim that the expert's knowledge and skills are so far beyond the usual, garden-variety medical community doctors that the expert doesn't know what's going on in the community.

This can be a real-life problem. In medical malpractice litigation, the plaintiff's physician-expert commonly will, and should, offer opinions on both causation and standard of care issues within the scope of his or her specialty.[4] Moreover, the standard of care and causation can be closely intertwined both factually, legally and medically. For example, an obstetrician might testify that the defendant *negligently* delayed a necessary Caesarian section and that that delay *caused* a catastrophic loss of oxygen to the baby's brain (anoxia). The obstetrician may offer related testimony that the baby's brain was not injured *in utero* or prior to the asser-

[4] As a practical matter, it is difficult to restrict a designated expert testimony to only causation or only standard of practice. Moreover, the designation on its face may subject the plaintiff's attorney to a protective order, or a motion *in limine*, to avoid the use of "redundant" experts in the same medical specialty. Finally, since each expert should review the same material, this practice can be prohibitively expensive.

tively negligent conduct. In such cases, the issues of negligence and causation become inseparable.[5]

Thus, on direct examination, it is critical to establish both that *the expert has the necessary qualifications to discuss the issues and that the expert is familiar, in practical terms that the jury can relate to, with community standards and practices.* While the expert's teaching the specialty to interns and residents can be vehicle for relating this knowledge to the jury (i.e., the expert is teaching standard of practice medicine), it can also become a trap. Be sure to relate this concern to the expert and

Medical Malpractice . . . cont. on page 18

[5] By contrast, there are many cases where the standard of care issues are quite distinct from the causation issues. Typically, these involve assertedly sub-standard care by a primary care physician causing, or aggravating, an injury within the peculiar knowledge of a medical specialty.

determine areas of possible testimony on this seemingly mundane topic. Also, be careful to focus on the precise standard of care issues involved; it may well be that the procedure at issue was one that it is well established and not esoteric. (If the defense argues that the procedure was esoteric, consider that the defendant was negligent in failing to refer the patient to a properly qualified specialist. BAJI 6.04.)

The "Over Qualified" Plaintiff's Expert--Part 2

As HMO's, PPO's, capitation[6] and other managed care insurance plans become more common, the defense bar, in a rather cynical twist, has been arguing that there is a "different" (i.e., lower) standard of care for physicians in those contexts than those in conventional fee-for-service practice, which, in turn, is less than that in a university setting.

While the sales departments of these insurers would vigorously deny that they offer an inferior level of medicine, the sales department is not in court. They would never admit that their institutional focus on cost-saving would actually place patients at extra risk even though that is exactly what the defense lawyer is arguing in court. Indeed, the defense lawyer, in a strange irony, builds a defense on demeaning his or her own clients. Even as plaintiff's counsel, I have felt compassion for a defendant physician when defense counsel argues that his or her client is permitted to, and does, practice sub-standard medicine.

Fortunately, there is a solution to this problem: when the defendant physician takes the stand, ask. No self-respecting physician is going to testify that his employer's special concern with cost containment effects his or her delivery of health care. No doctor is going to admit that he or she deliberately practices a lower standard of medicine.

Even so, the argument is made. It will commonly be expressed by defense experts to create the fiction of a lower standard than that which the defense expert may practice. Defense counsel will focus on archaic irrelevant boilerplate in the jury instruction on standard of practice ("similar circumstances," "similar locality"). In one case, this author confronted a vigorously argued claim that plaintiff's expert, a Harvard-trained physician who practiced in a conventional fee-for-service context in the Encino area, didn't know the standard of practice for a capitated patient in a lower income area.

It is important for plaintiff's counsel to carefully explore these really fictitious practice distinctions with the standard of care expert before taking the stand. Care should be taken to emphasize that the standard of care is a pure legal fiction which is essentially identical wherever the care is provided or how

[6] Capitation is the fairly new, but widely spread, practice of an insurer's contracting with a group of primary care physicians (or specialty groups) to provide all relevant medical care to a pre-defined insured population, regardless of the actual amount of usage. Of course, this provides a direct monetary incentive—i.e., a conflict of interest—for the physician to do as little as possible.

the doctor is compensated. The doctors attend the same schools, take the same boards, obtain the same license, have the same prescription pads, and read the same periodicals; even in the unusual case, every physician has access to a telephone and the telephone number of the closest medical center. The shabbiness of a neighborhood or the method of payment may effect the attractiveness of the doctor's office or even the doctor's bedside manner; it should have no effect on the standard of care, which is a legal fiction and not a medical concept. This standard, except in the most cutting edge matters where specialized equipment may not be available on an emergency basis, is the same in Beverly Hills as it is in outlying or poorer areas.

It is also fair to question this odd argument on public policy grounds: defense counsel is asking the jury to ratify the rather nasty notion that, unknown to the patients, their doctors are expected, and permitted, to practice sub-standard medicine. From the standpoint of the medical consumer, this is fraud; from a policy perspective, it is an attempt to gain secret license to discriminate against patients who are poor or are "foolish" enough to purchase that health care plan.

The Defendant As Expert

In the defendant's deposition, it is critical that plaintiff's counsel make a clear record that the defendant is not being offered as an "expert." Unless the defense unequivocally stipulates that the defendant physician is not yet being offered as an expert, it is vital to make a record that the defendant is not testifying as an expert. This can be done easily by directly asking opinion questions as well as for disclosure of communications between the defendant and his counsel with regard to the case. This will certainly invoke objections on the grounds of attorney-client privilege and/or work product; the making of those objections is effectively an admission that the defendant is not being offered as an expert.

It is not uncommon for the defendant to designate him- or herself as a (invariably redundant) defense expert in an effort to create an imbalance in the number of experts. (The Code explicitly requires that a party who intends to offer expert testimony must be formally designated. *Code of Civil Procedure* §2034(a)(1).) This practice, it seems, was more prevalent in the past.

Recent case law, however, clearly establishes that a defendant who self-designates is exposed to an additional "expert" deposition and that the fact of designation leads to a waiver of the attorney-client privilege and work product protection. *See County of Los Angeles v. Superior Court (Martinez)* 224 Cal.App.3d 1446, 274 Cal.Rptr. 712 (1990). As discussed above, the defendant who refused to answer on the grounds of these privileges in his or her "first" deposition cannot claim that that deposition doubled as an "expert" deposition.

Medical Malpractice . . . cont. on page 20

The minute the defendant self-designates, a deposition notice should be sent, together with a cover letter specifically citing this case and indicating that plaintiff's counsel expects to take an objection-free deposition, including a review of any correspondence between counsel and the defendant-physician. Furthermore, since the defendant's own opinion testimony might be highly relevant to your experts, insist that the defendant's deposition go first. If defense counsel insists on some fictitious "priority," remind defense counsel that your experts may change their opinions after they read the defendant's deposition, which may not, in view of the limited time to trial, be made available to the experts in time. This practice, in my experience, usually results in the wise and prompt withdrawal of the defendant from the defense expert list.

Assuming that the defendant refuses to submit to a free-wheeling expert deposition, a motion in limine should be prepared to preclude the defendant from sneaking "non-expert" "opinions" or "impressions" into his or her testimony under any of a variety of guises. Such testimony from any non-designated physician is totally improper (*Province v. Center for Women's Health* 20 Cal.App.4d 1673, 1681-1684, 25 Cal.Rptr.2d 667 (1993).) Indeed, one should have a limiting instruction prepared in anticipation that the defendant, as will almost always happen, testifies to his or her opinions through the proverbial back door (e.g., such as the defendant's account of what risks and benefits of the proposed surgery were allegedly related to plaintiff).[7]

[7] "Defendant(s) _____ will now be calling Dr. _____ as a witness on [their] behalf. Prior to this trial, the parties were required to, and did, formally notify each other of the persons who they intended to call as expert witnesses. Such a designation had legal consequences and involved certain specific legal rights and obligations. As was [their] right, the defense did not elect to designate Dr. _____ as an expert. You are not to speculate as to why the defense made this election.

"Accordingly, Dr. _____ will be testifying solely as a witness to facts and not as an expert. By the virtue of [his][her] being a physician, it is expected that Dr. _____ will offer testimony to show why certain things were done, or not done, and particularly as to Dr. _____'s beliefs as to certain medical theories, state of the art knowledge, modes of treatment, standards of care and so forth. You are instructed that such testimony is only admissible to show why actions were taken, or not taken, and not as proof that such medical theories, state of the art knowledge, modes of treatment, standards of care were, in fact, true.

"You are hereby instructed that you are not to consider Dr. _____'s testimony as expert testimony in the field of _____ or to weigh, or consider [his][her] testimony in evaluating the opinions of the experts who have testified, or will testify, on behalf of the parties. Such testimony is only admissible for the purpose of setting forth the observations of the witness, what [he][she] did, and why."

Built-In Jury Bias

There is no doubt whatsoever that the jury pool has been deliberately infected by an onslaught of negative propaganda generated by the organized medical establishment, the insurance industry and politicians ready to use trial lawyers as a foil for everything that has gone wrong since the Flood. Whatever the reality, there is no doubt that jurors, as a whole, are generally willing to give the healing arts community the "benefit of the doubt," despite the fact that that is directly contrary to the spirit and letter of the standardized instruction on burden of proof.

After all, in spite of all the potential problem areas in relating to lay jurors (i.e., their significantly higher incomes, their enormous egos, etc.), doctors are generally genuinely good people, dedicated to doing good and helping others. Besides, they have years of training in bedside manner and are generally a favored class in our society (unlike, for example, us).

While capable medical malpractice plaintiffs' attorneys try to confront this directly in *voir dire* and are usually

given fairly free rein to do so, the plain fact is that potential jurors are not stupid and, if they want to sit on a given case, will deny their bias. After all, committing oneself to a position of bias will not only get you instantly dismissed from the jury; it is not politically correct.

Interestingly, there is, in my experience, a growing number of potential jurors who no longer consider the harboring of such bias shameful; I find it increasingly common that a good number of honest potential jurors will openly admit to pro-doctor bias. While that is genuinely good and will lead to dismissal for cause, these admissions are almost always blurted out in front of the entire prospective panel, usually with an explanation that will warm defense counsel's heart.

The "Known Complication" Defense, Res Ipsa Loquitur and the Informed Consent Rule

It is axiomatic that many medical procedures have inherent (unavoidable) risks associated with them. Every potential juror knows that to be true.

One of the last lines of defense available to a malpracticing physician is that the horrific outcome was a "known risk" of the procedure. In any given case, that claim can be offered as an excuse for the most inexcusable neglect or can be the absolute truth. It is, once again, primarily an area for expert testimony.

It is literally true that many bizarre and negligently-caused injuries are "known" or even "reported in the literature;" doctors have been known to remove the wrong leg, drop anesthetized patients or otherwise cause all sorts of unnecessary havoc. The medical literature is replete with anecdotal case reports of the bizarre; of course, these are understood, by the doctors, as being so rare that they are worthy of interest in much the same way the public is interested in sightings of Elvis.

The real question is not whether the risk was "known," but whether it was "generally accepted" or "unavoidable." Don't let the defense expert confuse the issue by this misuse of language.

The defense, in attempting to argue the "known/accepted" complication defense, puts itself on the horns of a dilemma. After all, it is ultimately the patient, and not the doctor, who has to decide what risks are "acceptable" or not. *Arato v. Avedon* 5 Cal.4th 1172, 1191, 23 Cal.Rptr.2d 131 (1993); see, generally, *Cobbs v. Grant* 8 Cal.3d 229, 104 Cal.Rptr. 505 (1972) (lead case). The fact that a particular risk may be known to a physician or an expert does not necessarily imply that it is known to the patient. The defendant physician, of course, has a universally-accepted duty to inform the patient, before the procedure, of the inherent risks of the procedure. *Id.* Assuming that the plaintiff has preserved the issue of informed consent, this obligates the defense to come forward with evidence that the plaintiff was informed of these so-called risks. *See Cobbs*, esp. at 245. If, in the proper case, the odds of a particularly unhappy outcome from this

Medical Malpractice . . . cont. on page 22

procedure were extremely rare, the defendant may have neglected to inform plaintiff of this.

Moreover, if the defense asserts that the risk fell within that narrow range of risks which were "acceptable" but rare enough that the defendant was not obliged to disclose it for informed consent purposes, that evidence of rarity may be admissible to establish a *res ipsa loquitur* claim. *See* discussion in *Hale v. Venuto* 137 Cal.App.3d 910, 918-919, 187 Cal.Rptr. 357 (1982).

Biased Jury Instructions

A careful review of the standard medical malpractice jury instructions (BAJI 6.00 et seq.) shows some rather unexpected bonuses for the defense.

BAJI 6.00 ("Duty of Physician") unfortunately uses the term "best judgment" in a context which falsely implies that the defendant is somehow immune to malpractice liability if he or she used his or her "best judgment," even though it was totally wrong or based on ignorance. This critical instruction, which has been used for generations, is poorly drafted and misleading. Unfortunately, some jurors see this out-of-context reference as defining the "standard of practice" as relating to "good faith" rather than to objective negligence (which it is; see *Flowers v. Torrance Memorial Hospital* 8 Cal.4th 992, 35 Cal.Rptr.2d 685 (1994)). Since it is generally not appropriate or wise to argue, in most cases, that the defendant physician was acting indifferently to the needs of the patient or in bad faith, the plaintiff's evidence simply won't meet this erroneous standard.

BAJI 6.02 ("Medical Perfection Not Required") can, and probably is, viewed by many jurors as a virtual direction to find for the defendant, unless the plaintiff can show some level of intent to harm, ill will or moral culpability. It doesn't say that but, like so many unnecessary or redundant instructions, this instruction can, in the hands of lay jurors, cause mischief. There is, of course, no similar instruction in auto accident litigation; it would be interesting to see the outcome to an appeal based on the unthinking, knee-jerk reading of this patently argumentative and unnecessary instruction.

BAJI 6.04 ("Alternative Methods of Diagnosis or Treatment") in the hands of a capable and cynical defense lawyer can easily lead to a virtually automatic defense verdict. The instruction really refers to the not uncommon situation where current medical knowledge allows for several acceptable alternative forms of treatment. For example, in treating an acute heart attack, the attending cardiologist may elect a "clot-busting" medication or angioplasty. Either choice may be acceptable, although the methods are radically different and have different risks.

However, some jurors, with some careful prodding from defense counsel, may believe that this seemingly mundane instruction requires that they vote for the defense if the defense and plaintiff experts disagree on the appropriate course of treatment. Incredibly, some jurors may be led to believe that the mere fact that the experts disagree is itself evidence of the existence of alternative methods of treatment! A careful practitioner should object to the instruction *unless there is testimony that the relevant medical community recognizes alternative forms of treatment and that the form of treatment provided by the defendant is one form that is generally considered acceptable.* Without such testimony, this instruction should not be given.[8]

Conclusion

Medical malpractice litigation is, in reality, quite different from other forms of tort litigation. While the law is theoretically quite similar in both areas, the approach is quite different and the real issues can be entirely different. The malpractice trial lawyer's instincts should be quite different. The wise general tort practitioner should carefully consider the implications and differences of handling a medical malpractice case and make his or her approach accordingly. ■

[8] Strangely, there is no apparent authority on this.