dri™ The Voice of the Defense Bar

The MedLaw Update

The newsletter of the Medical Liability and Health Care Law Committee

8/10/2018

Volume 23 Issue 2

Committee Leadership

In This Issue

Leadership Note

Letter from the Chair

By J. Richard Moore

Our committee has a strong network of leadership in organizing our publications, hosting seminars and other educational presentations, and development and implementation of strategies to attract new members and improve on the services that our committee and DRI provide. I am proud be a part of such a talented, enthusiastic, active committee.

One of my favorite aspects of community involvement is personal fellowship with other members. Because we are busy working in our diverse geographical locations, opportunities to spend time in the same room with other members do not arise often enough. I would like to highlight three such opportunities that are coming up between now and the end of 2018.

First, in just a few weeks, our committee is presenting a one-day workshop titled **Striking Back Against The Reptile In Medical Malpractice And Long-Term Care Cases**. The "reptile theory" is an increasingly well-known strategy employed by plaintiffs to divert a jury's attention from the rigorous standard of care and proof requirements of malpractice claims and to inject a punitive element into negligence cases. Helmed by Program Co-Chairs Minton Meyer, our committee's resident reptile expert, and Laura Eschelman, DRI's 2017 Program Chair of the Year award winner, the workshop will feature jury trial specialists and interactive presentations designed to demonstrate how the reptile approach works, illustrate why it works, and explore legal strategies and trial tactics to overcome it. The workshop will be held on June 11, 2018, at the Gleacher Center in Chicago.

On September 13–14, 2018, our committee will present our annual **Nursing Home and ALF Litigation Seminar** at the Sheraton New Orleans Hotel in New Orleans, LA. It is always a challenge to develop a program for this seminar that tracks industry trends, highlights new approaches employed by plaintiffs in long-term care litigation, and appeals both to practitioners who are new to nursing home cases and those who have been in the battle for years. This year, our steering committee, under the leadership of Program Chair Peter Winterbourne and Vice Chair Caroline Berdzick, has developed a strong program. Presentations include fractures in the elderly population, how to respond to "active shooter" situations, natural disasters and similar scenarios that affect long-term care facilities, and defending cases involving dementia and its impact on a resident's overall health. We will also host a Women and the Law luncheon on September 13, 2018, and a committee business meeting will be held at the conclusion of the day on September 13. All are invited to participate in the business meeting, in which the gamut of activities and opportunities our committee provides are discussed. This will be our first time in New Orleans for this seminar, so we are looking forward to enjoying local cuisine and attractions.

Finally, the **DRI 2018 Annual Meeting** will be held at the Marriott Marquis in San Francisco on October 17–21, 2018. Our committee will hold a meeting on Thursday, October 18, 2018, at 3:30 p.m. The meeting will include both a substantive business meeting and an educational component. Committee member Laura Eschelman and insurance professional Laurie Schaffer will discuss effective communications and case management between outside counsel and insurance claims professionals. San Francisco is of course a spectacular location, and the Annual Meeting provides the opportunity to visit with our own committee members as well as members and leaders in other substantive law committees and parts of the organization.

These opportunities are significant for the educational benefits they provide to our members. For me, just as important as the education is the opportunity to gather face-to-face with other members and leaders, to woodshed in person ideas for improving what we offer our members, and to socialize with peers that face the same kinds of professional pressures, challenges and rewards that I do. I look forward to seeing you in Chicago, New Orleans and/or San Francisco this year!

J. Richard Moore is a shareholder with BleekeDillonCrandall in Indianapolis, Indiana. His practice focuses on the defense of professional liability claims against physicians, nurses, long-term care providers, architects, engineers, and attorneys; advising businesses and insurers regarding large property losses, catastrophic casualty claims, complex insurance coverage questions, fraud and bad faith; and assistance in the resolution of a variety of business and

commercial disputes before litigation where possible, and through trial where necessary. Richard is licensed in Indiana, Alabama and Tennessee, and has also assisted in the assessment and handling of matters in Arkansas, Illinois, Ohio, West Virginia, Missouri, Mississippi and Georgia. Richard is an active member of DRI, having served as Program Chair for the 2011 and 2012 DRI Nursing Home/ALF Litigation Seminars, and as Program Chair for the DRI Sexual Torts Seminar. He currently serves as Chair of the DRI Medical Liability and Health Care Law Committee.

Feature Articles

Deflating Plaintiffs' Use of the Hippocratic Oath in Medical Negligence Cases

By Matthew Moriarty

Lawyers representing plaintiffs in medical negligence cases often ask doctors about their having taken the Hippocratic Oath. They want to gain a simple concession from the physician that they swore to uphold the principle of "primum non nocere," which means "first do no harm." Here is a typical exchange:

> Q: As part of your job, is one of your ultimate goals when you have a patient who comes into the emergency room, to keep them safe from harm?
>
> Yes.
>
> Q. And you take an oath to do that, right -- do no harm?
>
> A. That is correct. That's the Hippocratic Oath.

The concept that an oath can give rise to a duty, in and of itself, is not the problem. The problem with this line of questions is how plaintiffs try to elevate doing "no harm" to either the primary duty, or to some form of strict liability.

These "oath" questions are sometimes bundled within a longer sequence of "reptile" questions. (The so-called Reptile Theory, borne by the book *Reptile: The 2009 Manual of the Plaintiff's Revolution* by Don Keenan and David Ball, has been analyzed extensively elsewhere, including in DRI's *For The Defense* magazine. *See*, *e.g.*, John Crawford & Benjamin Johnson, "Strategies for Responding to Reptile Theory Questions," For The Defense, Dec. 2015; Bryan Stanton, "Proven Strategies to Outsmart the Reptile Theory," For The Defense, Dec. 2017; and Mike Bassett and Sadie Horner, "Just What Is the 'Reptile' and How Do I Combat Against It?" For The Defense, Mar. 2017.) The strength of the plaintiffs' Hippocratic Oath approach, like most "reptile" sequences, is based first on the doctor giving a simple "yes" answer when asked to agree that he or she took that oath, and second, that safety and doing "no harm" is their primary duty. The plaintiffs are looking for simple sound bites they can later display to a jury. Conceding these points can usually be avoided, however, because the Hippocratic Oath questions are built upon a complete myth; contrary to common belief, medical oaths do not contain such a statement of primary duty.

A Short History of Medical Oaths

The Hippocratic Oath is the earliest known expression of medical ethics in the western world. Like many ancient texts, its origins are unclear and its evolution extensive. It is named after Hippocrates, a Greek physician who reportedly lived from approximately 450–370 B.C.E. But modern scholars are quite certain he did not personally write the oath, asserting the view that it was written by a Pythagorean sect after studying what is known as the Hippocratic corpus, a collection of some sixty ancient Greek medical works associated with the teachings of Hippocrates. The authors of the corpus are also unknown.

To make the history even more convoluted, the original Greek version would not have been translated directly into English. It would have been translated first into Latin and then, centuries later, English, French, etc. Thus, there are several different translations of the original Hippocratic Oath. Subtle differences in translation of the ancient Greek, like subtle changes in the language of a statute, could be meaningful. Translations of the oldest known version can be found in scholarly articles and on the internet. *See*, *e.g.*, Brian Hurwitz and Ruth Richardson, *Swearing to Care: The Resurgence of Medical Oaths*, BMJ 315:1671–74 (1997); Peter Tyson, *The Hippocratic Oath Today* (2001), *available at* NOVA http://www.pbs.org/wgbh/nova/body/hippocrat-

ic-oath-today.html; and AAPS http://www.aapsonline.org/ethics/oaths.htm. Unquestionably, as an ancient text, its origins arouse debate among historians and the oath has evolved in various ways over the last 2,000 years; different people, generations and religions have had their say about its content.

In its original "Ionic" Greek, the Hippocratic Oath requires the nascent doctor to swear, by a number of healing Greek gods, to uphold certain ethical standards, including confidentiality and not performing abortions or euthanasia. The duty of care language says: "I will use treatment to help the sick according to my ability and judgment, but never with a view to injury or wrongdoing." And "… I will abstain from all intentional wrongdoing and harm,…." *See, e.g.*, version posted on Wikipedia (last visited Mar. 18, 2018). The invocation of deities in the Hippocratic oath was the enforcement mechanism; there would be cosmic consequences to breaking the oath.

There are a number of other oaths or prayers that developed over the centuries: the Osteopathic Oath, the Declaration of Geneva's Physician's Oath, the Prayer and Oath of Maimonides. The Declaration of Geneva says: "The health of my patient will be my first consideration." The Prayer of Maimonides was written in the twelfth century and does not contain primary duty language. Nor does its shorter cousin, the Oath of Maimonides. A more "modern" version, which still bears the name Hippocratic oath, was penned in 1964 by a medical dean named Louis Lasagna. Like the original, it does not contain a primary duty of patient safety.

Avoidance of harm is never, in any oath, elevated to a priority higher than is attempting to help. *See, e.g.*, Robert Shmerling, MD, *First, Do No Harm*, Harvard Health Blog (2015), posted at https://www.health.harvard.edu/blog/first-do-no-harm-201510138421.

The Rise of the Myth

The phrase "primum non nocere" does not appear in the original Hippocratic Oath. One good reason is that the phrase "primum non nocere" is Latin, not Greek. The phrase does not even appear in Greek in the Hippocratic corpus, the supposed foundation documents for the oath. The closest the corpus comes is: "The physician must … have two special objects in view with regard to disease, namely, to do good or to do no harm." This avoidance of harm, sometimes referred to as non-maleficence, does appear in various medical oaths. But many medical historians believe this was an admonition against overtreatment, not a general statement of duty. And it has never been expressed as the primary duty.

The origin of the specific phrase "first do no harm" in association with a medical oath, whether in English or Latin, is controversial. The research about the origins of the phrase in association with medicine is too extensive to repeat here. (For discussion of the origin of the phrase, see Daniel Sokol, *First Do No Harm Revisited*, BMJ 347 (2013); Cedric Smith, MD, Origin and *Uses of Primum Non Nocere--Above All, Do No Harm!*, J. Clin. Pharmacol., Apr. 2005, at 45(4):371–77.; and Wikipedia.) Suffice it to say it did not originate with Hippocrates, Galen or Pare', as theorized by a few. Smith's paper notes that the phrase barely appears in print in association with medicine until after the 1960s. Cedric Smith, MD, *Origin and Uses of Primum Non Nocere--Above All, Do No Harm!*, J. Clin. Pharmacol., Apr. 2005, at 45(4):371–77. The phrase "primum non nocere" probably crept into the discussion in the 1600s or 1800s. The historical literature points to either the Englishman Worthington Hooker in the 1600s, a French physician, Auguste Francois Chomel, in the early 1800s, and then, in about 1860, by either Dr. Thomas Inman or Dr. Thomas Sydenham. But the exact phrase still never appears in any medical oath found in the literature. And the concept of non-maleficence is not the same as primum non-nocere.

How predominant is the use of medical oaths to begin with? There are several interesting studies worthy of consideration. In 1970 Crawshaw published his study about the predominance of medical oaths. Ralph Crawshaw, MD, *The Contemporary Use of Medical Oaths*, Journal of Chronic Disease 145–50 (Vol. 23, 1970). Building on an earlier work by Irish, he polled 97 medical school deans about whether and what oaths were used by their classes of 1969. He disseminated three oaths: the original (from a 1947 Encyclopedia Britannica translation), the "modern" version used at Ohio State University in 1957, and the Declaration of Geneva. Eighty five schools replied. Seven (8 percent) used no oath, while 78 (92 percent) did. The original Hippocratic Oath was used by 14 (17 percent), the modernized version by 24 (29 percent) and the Declaration of Geneva by 20 (24 percent). Other oaths were used by 25 (30 percent). He did not get into any detail about the use, or absence, of "primum non nocere" or non-maleficence.

In 1989 Crawshaw and colleagues followed up on his earlier work on polled 126 American medical schools. Of those, 119 replied. *See* Ralph Crawshaw, MD, Letter to the Editor, *Is Alive and Well In North America*, BMJ 309:952 (1994). They reported the use of the oath of Geneva (33), the classic Hippocratic oath (three), a modified Hippocratic

oath (67), the prayer of Maimonides (four), a covenant (one), other oaths (eight), an unknown oath (one), and no oath (two).

There is even a study about the contents of various oaths used. In 2000, Kao and colleagues published their study of the subject. Audiey Kao, MD, PhD and Kayhan Parsi, PhD, *Content Analyses of Oaths Administered at U.S. Medical Schools in 2000*, Acad. Med., Sept. 2004, at 79(9):882–87. They obtained the oath, if one existed, from every one of the 141 accredited medical schools in the United States, and then analyzed them. There were 122 allopathic schools, and 19 osteopathic. All 19 osteopathic schools used the osteopathic oath. Less than half (49.2 percent) of all U.S. allopathic schools administered the Hippocratic Oath or a modified version of it. Almost one quarter (24.6 percent) of the allopathic schools' oaths had been written by medical students or others at the school. Eighteen schools offered more than one oath option to their medical students. The content of the oaths varied in many key respects, such as whether abortion or euthanasia was a covered subject. As to the key subject about which we are concerned—a statement of primary duty—Kao and his co-authors concluded that: "... fewer explicitly characterized the need for non-maleficence or the "first do no harm" principle (24 percent)." Kao's article did not identify any oaths using primum non-nocere, and in that quote improperly conflate such a primary duty with non-maleficence.

It can be argued that the Hippocratic Oath has been superseded by modern ethical codes, such as that of the AMA's *Code of Medical Ethics*. But it is understandable that doctors are asked to take a short, supposedly ancient oath at entry into medical school, as opposed to reading the statement of a voluntary, modern organization like the AMA. It adds to the grandeur or solemnity of the occasion.

Why This Matters in Tort Cases

While all versions of medical oath have some duty element to them, the scope of that duty is a critical issue in medical negligence cases. What duties the plaintiff extracts from the witness should not be inconsistent with American tort law, and should accurately be based on an oath actually administered at a medical school, American or otherwise.

By putting "do no harm" "first," the Plaintiff is suggesting a duty inconsistent with American tort law. It smacks of absolute liability if harm occurs. The original Hippocratic oath is more in keeping with American tort law in two respects. First, by emphasizing "ability and judgment," it is comparable to modern expressions of the standard of care, which emphasize reasonableness in comparison with peer expectations. Second, by using the phrase "never with a view to injury," the original oath injects the distinction between negligence and intentional conduct, a notion emphasized in the later passages quoted above, about abstaining from intentional harm.

It would be impossible to practice medicine if one obsessed in the first instance about avoiding harm. Patients seeking medical care are often already in some peril. The diagnostic and treatment process always entails some risk, as does doing nothing at all. The practice of medicine is—to some degree—the art of weighing and balancing risk versus reward.

While avoiding harm is a laudable goal, it is completely unrealistic in medical practice, and an unattainable goal of medical ethics. In Smith's words: "... as many ethicists and physicians have pointed out, merely avoiding harm does not meet the challenges of promoting positive actions to improve health, cure disease, and alleviate suffering." Cedric Smith, MD, *Origin and Uses of Primum Non Nocere--Above All, Do No Harm!*, J. Clin. Pharmacol., Apr. 2005, at 45(4):371–77; citing Lasagna, Shelton and Rogers.

Further, Daniel Sokol, a barrister in London, points out that what constitutes "harm" is by no means always clear, because medical decisions are always a balance of risk versus benefit, some of which are subjective value judgments. He suggests that a more accurate formulation of the principle would be "first do no net harm." *See* Daniel Sokol, *First Do No Harm Revisited*, BMJ 347, f6426 (2013).

Preparing the Physician Witness

How can we prepare witnesses to deal with this line of questions?

First, counsel should find out in the preparation sessions whether the witness even knows which oath he or she took. Were they told the origins of their oath, or its title? Do they remember the content, and whether it contained the phrase so often quoted? The plaintiff's whole approach might be cut off early if the doctor does not know what oath he or she took, and what duties it contained.

For example, the original oath swears to several Greek gods like Apollo and Panacea, and then generally "all the gods and goddesses." That is not exactly in step with modern religious thought. It is pretty unlikely that a modern physician took an oath swearing to a group of Greek gods and goddesses. As a stand-alone point it may not be effective, but a thoroughly prepared witness could keep it in mind as an example of how the original oath has changed and is not in step with modern American thought.

And American juries are unlikely to subconsciously enforce an oath which relies on a smorgasbord of gods.

Next, the vast majority of articles about defending against the reptile theory emphasize that witnesses, whenever possible, should avoid agreeing with absolute statements. For example, the lawyer may ask "do you agree that safety is your first priority when you see a patient?" The uninitiated witness may say "yes," because they are scared to appear foolish by disagreeing with such a basic statement. But the well-prepared witness might say: "no, I do not agree. My duty is to make a reasonable assessment and disposition based on the information available." Or they may say that safety is a relative term; everything they do, or do not do for patients, involves risk of harm. By doing so the witness removes or reduces the power of the plaintiff's intended individual sound bite and, thus, reduces or eliminates the power of a chain of them. It disrupts the plaintiff's lawyer's flow and devolves the questioning into abstract, historic or philosophical debate, far removed from the facts of the case.

Here is a hypothetical example of how it could play out in a medical negligence case:

Q: Did you take the Hippocratic Oath?

A: I am not sure if I did.

Q: Doesn't every medical student take it?

A: No, there are many different oaths.

(in the case of someone who did take it....)

A: I am not sure if I took the original or a modernized version of it. (or "not the original one, no.")

Q: And regardless of which oath you took, did it say your first duty is to do no harm?

A: Do you mean the original Hippocratic Oath, or the modern version?

Q: The one you took to become a doctor.

A: I do not remember the exact language of that oath. That was ten years ago.

Q: Regardless of what oath you took, would you agree that your first duty is to do no harm?

A: No. First of all, that is not what the original oath says and I am not aware of any medical oath that makes that our first duty. (Or no, my duty is defined by Ohio law, not an ancient Greek text which has been changed repeatedly in the last 2,000 years.)

Clearly the plaintiff's lawyer is not getting where he or she wants to be.

The more modern versions of the oath often caution the physician to avoid the "twin traps of overtreatment and therapeutic nihilism." (Therapeutic nihilism is a contention that it is impossible to cure people of their condition through treatment. It is connected to the idea that many so-called cures do more harm than good, and that one should instead encourage the body to heal itself.) In a case in which the plaintiff's lawyer is advocating the usual more of everything —more tests and more treatment—the "overtreatment" issue may come in handy, such as the doctor being prepared to convey the thought that—"you know that oath you asked me about? It says not to overtreat, and I thought ordering every conceivable test may be just that."

It also has to be considered that oaths taken by medical students have no connection to medical licensure, unlike the oaths lawyers must take. Of what value is an oath that has no legal or deistic enforcement mechanism? Could one argue that, as an improper statement of the duty of care under state tort law, the Hippocratic Oath question should not even be permitted in evidence? Is it worth filing a motion in limine to exclude one misleading question about medical oaths? Probably not, but if Plaintiff's counsel does not get their sound bites at deposition, they may skip the questions at trial. Regardless, well-prepared witnesses will not be perpetuating the myths of the Hippocratic Oath.

Matthew Moriarty is a trial lawyer in the Cleveland office of Tucker Ellis LLP. His practice focuses on representing companies in products liability and pharmaceutical defense and representing hospitals in professional liability cases. Board certified as a civil trial lawyer by the National Board of Trial Advocacy, he has tried over 50 jury cases to verdict in state and federal courts, and he is a trained mediator. Matt received his law degree from Case Western Reserve University School of Law and his undergraduate degree from Georgetown University.

Defending Total Hip Arthroplasty: Control vs. No Control

By Greg Forney

Resulting leg length inequality from total hip arthroplasty surgery is one of the single most litigated types of orthopedic surgery in the United States. Leg Length Discrepancy After Total Hip Arthroplasty: A Review of Literature, Desai, Dramis, Board, Curr. Rev. Musculoskelet Med. (2013) 6: 336–41. Despite technical advances in digital imaging as well as various intra-operative attempts at measurements designed to preserve leg length symmetry, creating a leg which is either too long or too short as a result of performing total hip replacement remains a known risk of the surgery. This article explores the concept of describing the known risk of Leg Length Inequality "LLI" within the conceptual frame work of control vs. no control. More specifically, what surgical techniques cannot predict or prevent LLI and how this equates to an inability of a surgeon to control LLI outcome.

A recent trial illustrates the concept. An orthopedic surgeon performed a primary total hip arthroplasty ("THA"). Following surgery, the patient had complaints that her operative leg felt longer than her non-operative leg. Despite attempts at physical therapy to strengthen the joint and surrounding supporting muscles, the patient bitterly complained about ongoing pain. The patient's post-operative symptoms were more consistent with her pre-existing degenerative joint disease of her back as well as companion hip disease of her non-operative leg. Plaintiff eventually sought a second opinion about revision surgery. After the patient agreed to have the second surgery performed, with knowledge that there was a known risk of LLI, the patient again experienced noticeable LLI. On post-operative day 1, the patient experienced a hypotensive episode which was diagnosed by brain MRI showing water shed findings of stroke. The plaintiff sued the orthopedic surgeon who performed her primary THA claiming that, had that primary surgery been performed correctly and not created such a significant LLI, the patient would not have been forced to undergo a second revision surgery that resulted in post-operative stroke.

While the concept of "control vs. no control" of the surgical techniques and outcome may seem obvious, it was used effectively in the defense of an orthopedic surgeon and deserves discussion given its apparent effect in producing a unanimous verdict for the orthopedic surgeon. There is nothing particularly difficult about this concept which is easily demonstrable by using an Exhibit which creates a side by side comparison of operative tasks which are in the control of the surgeon as compared to the uncontrollable facets of performing the surgery or in producing a precise LLI outcome. Some explanation of the medicine is helpful in understanding this simple yet effective defense to a claim of negligence against an orthopedic surgeon.

State of the art digitized plain films obtained pre-operatively may more accurately permit measurements of the anatomy via "Templating." Historically, an orthopedic surgeon would obtain a silver nitrate film which could be placed on a view box. The physician would then make ballpark calculations called "Templating" about the patient's unique anatomy. The problem with such calculations is that a hip film, regardless of using new or old technology to obtain the images, is subject to numerous inaccuracies.

A hip film is typically not to scale such that an orthopedic surgeon must revise any measurements based on the crude conversion that the image is approximately 120 percent of the true anatomical size of the hip structure. The size and weight of the patient also alter the mathematical conversion of the image size to the actual anatomical size of the hip joint. Patients are typically in pain which alters their stance. A patient who has a painful hip may favor weight bearing on the non-operative leg which produces a tilted image of the hip anatomy (See Figure A). A patient in pain may also rotate one hip slightly away from the opposing hip such that one hip joint is in a slightly different imaging plane than the opposing hip. This gives the inaccurate and misleading impression that there is a LLI when, in reality, is caused solely by the patient rotating one hip away from the plane of the other hip. As a result of tilting and rotating the hip joints, an orthopedic surgeon can be grossly misled into believing that there is a pre-operative leg length inequality (most likely a leg shortening due to the degeneration of the joint). More importantly, the factors of inaccurate scale, tilt, and rotation of the hips leads to the technological limitation of not being able to precisely measure the anatomy in a way which would help predict or prevent a LLI based on pre-operative selection of the type or size of artificial components which an orthopedic surgeon may use to complete the THA. Currently, the state of the art is that pre-operative measurements or "templating" only provide a general ballpark estimate of the patient's native anatomy such that he can discuss the case with the

onsite component provider to ensure accurate selection of a correct hip kit which contains a sufficient range of different size and type components for use during surgery.

With the advent of digitized plain films of the hip anatomy, surgeons can now implement computer programs which will model and predict which specific component parts might best create a stable, pain free hip joint. This can be very powerful evidence. In a recent trial, the components used by the defendant surgeon were compared with computerized modeling of which hip components would create a stable, pain free hip. Remarkably, the surgeon's selection based on non-computerized pre-operative templating and reliance upon judgment and experience produced an almost mirror image of the computer model image. As one might imagine, the fact that the actual work of the surgeon could be overlain on a computer image that allegedly demonstrates the correct component parts very persuasive demonstrative evidence for a jury. This has the effect of a "hand in glove" effect which was very powerful in convincing the jurors to unanimously vote for the surgeon.

The primary goal of THA is creating a pain free hip joint which will not dislocate. As discussed below, LLI is a lesser goal as a new hip which produces pain or easily dislocates typically constitutes surgical failure.

Medical literature describes how surgeons have attempted to preserve leg length as a subordinate priority to establishing a pain free non-dislocatable hip, through intraoperative measuring techniques. These techniques include the use of pins and sutures placed at anatomical hallmarks, marking surgical drapes across the operative and non-operative leg, feeling for bony ankle prominences, and other crude, imprecise measurement techniques. Some medical literature opines that preoperative measurement via templating is important to outcome despite its lack of precision. Without exception, each of these intra-operative attempts at measurement has been demonstrated to have high rates of imprecision. Preoperative Planning For Primary Total Hip Arthroplasty, Gonzalez Della Valle, Padgett, Salvati, J Am Acad. Orthop. Surg 2005; 13: 455–62. Much of the imprecision can be attributed to the fact that a THA requires a physician to mix and match a series of component parts of various size and length to accomplish three major goals. First, relief of the patient's pain by replacing a degenerative bony structure and socket with artificial components. Second, use of these artificial components to create a hip joint that will not readily dislocate. A dislocatable hip is essentially a failure as it is the quickest route for the patient's return to the operating room. Third, there is a concern to attempt to ensure leg length equality which takes a subordinate position to the first two goals for obvious reasons. The failure to create a stable non-dislocatable hip could result in unpredictable dislocation in ways that create extreme danger of future injury in performing such simple tasks as walking, driving, bending, or stooping.

The problem in accomplishing these goals is that much of the success of the hip surgery depends on the surgeon's judgment and feel of how the component parts fit together to create a new hip. After removing the degenerative ball, neck, and socket, creation of the hole to place a femoral stem is accomplished through a series of reamers. The depth and size of these reamers is determined by the surgeon's judgment and feel on when a reamer sufficiently removes the soft inner portion of the femoral bone but does not begin to remove necessary calcaneal bone which provides stability for the femur. Physicians are provided with a wide variety of trial femoral stems to test which stem size properly fits. Once the stem is placed, the surgeons can then select a wide variety of neck lengths to accommodate the cup and ball selection. These various component parts can result in changing leg length as well as lateralization of the hip joint which can be both beneficial and detrimental to overall leg length equality but may be absolutely essential to create proper tissue tension and the primary goal of creating a pain free non-dislocatable hip.

The major point of this discussion is to illustrate the notion that there is no precise mathematical methodology that can be employed by a surgeon pre-operatively or intra-operatively which guarantees leg length equality. A surgeon engages in trial and error with various component parts. A surgeon will test a series of less expensive disposable trial components. A trial hip will then be positioned through a series of provocative ranges of motion in order to test the ability to dislocate the hip, assess tissue tension, and make a crude attempt to assess leg length equality. The physician aggressively moving the hip through a test range of motion realigns the hips on the operating table. Even slight realignment of the hips can result in any attempts at intra-operative marking or measurement to be rendered useless as the patient is no longer in their original pre-operative position when measurements were taken. Moreover, to attempt to measure leg length equality in a patient who is anesthetized and paralyzed is extremely problematic. The patient is non-weight bearing. The tissue had been immobilized. How the hip joint and leg length will feel to a weight bearing patient post-operatively is truly unknowable. This is why physicians have post-operative

discussions with the patient about the distinction between actual, anatomic leg length discrepancies versus apparent leg length discrepancy-the way the leg feels to the patient.

Post-operatively, it is a common phenomenon for patients to feel that the new leg is not the same length as the non-operative leg. Surgeons will counsel their patients that the disease process of the hip took months and years to create while the repair took only 45 to 75 minutes. The creation of a "new normal" requires the patient to undergo physical therapy as the body needs to relearn proprioception of the new hip joint as well as strengthen muscles weakened or dysfunctional due to the prolonged misuse/disuse of the deteriorated joint.

As demonstrated by this description of the intra-operative process of surgery, there is no precise was to measure leg length. Fortunately, most patients who are diligent in completing physical therapy find that, despite having a lack of true symmetry between the operative and non-operative leg, they find the disparity to be tolerable. There is a body of literature which indicates that most individuals are born with LLI. Military personnel and marathon runners have been documented as having leg length discrepancies of up to a half inch that are asymptomatic. Patients tolerate LLI even though they may never experience degenerative changes of the joint.

Informed Consent

My home State of Missouri has recently adopted a prohibition about admitting evidence about the surgeon's informed consent discussion with the patient in which the patient is pre-operatively told that LLI is a known risk of the procedure. For most of my colleagues nationally, this is not new law as Missouri seems to have been one of the later States to adopt the notion that informed risk discussions with the patient may not be used as a "defense" to the claim (unless the patient specifically asserts a cause of action for lack of informed consent). Despite the apparent prohibition against introducing evidence of the specific informed consent discussion, it is admissible to state that LLI is a known risk of the procedure. Some success may result from asking a plaintiff generically if they discussed the surgery with the physician prior to the operation but not requesting details of the discussion. This allows the jury to understand that there was some type of discussion pre-operatively while not violating the evidentiary prohibition about discussing the details of the informed consent discussion. Not surprisingly, by allowing a generic question that proves some discussion occurred, the jury will hopefully infer that it was about risks associated with the surgery.

Knowing that informed consent discussions cannot be used as an effective defense to the claim leads to the concept of "control vs. non-control." By simply creating a side by side list of factors which are in the control of the orthopedic surgeon versus other factors which are not in control of the surgeon is effective, demonstrative evidence to help the jury understand that the resulting LLI outcome is not within the control of the surgeon. For example, on the "control" list, such things as selection of components, approximate assessment of tissue tension, assessment of the ability to dislocate the artificial hip, and the surgical approach/technique are all concepts within a surgeon's control. By comparison, on the "no control" ledger, such items as inability to precisely measure leg length pre-operatively, inability to precisely measure intra-operatively, inability to precisely measure tissue tension (a hallmark of establishing a stable non-dislocatable hip joint), inability to precisely measure or test leg length discrepancy intra-operatively, and the inability to control how the patient's body position intra-operatively will help a jury understand why LLI remains a known risk and complication of THA.

Finally, in addition to these causation arguments relating to control versus no control, it is imperative to note that the American Academy of Orthopedic Surgeons has repeatedly concluded that there is no bright line test to determine whether a surgeon has met the standard of care based on experiencing LLI as a surgical outcome. In fact, the AAOS has repeatedly sanctioned plaintiff's experts for stating under oath that a given amount of LLI following THA is evidence of negligence. The AAOS maintains a compendium of reports discussing the facts and circumstances upon which an orthopedic expert has been sanctioned for attempting to opine that there is some bright line measurement of LLI which constitutes negligence. The reader is encouraged to consult with the AAOS and request research reflecting the various AAOS decisions reprimanding its members for these unethical non-evidence based opinions. Armed with the knowledge that AAOS will sanction an expert for attempting to equate LLI with negligence, it is recommended that deposition questions be tailored in an attempt to force the expert to concede there is some specific amount of LLI that constitutes negligence. The AAOS decisions can then be used for impeachment.

Greg Forney has been actively practicing since 1988 and a member shareholder of Shaffer Lombardo Shurin since 1994. He has extensive experience in malpractice defense

for a wide variety of medical disciplines and institutions. Mr. Forney is also involved in the handling of complex commercial cases on behalf of individuals and businesses involving a wide variety of business related issues. His representation of clients spans both rural and urban venues in Kansas, Missouri and Iowa.

Sexual Misconduct: Balancing the Victim's Rights with Those of the Accused

By Ashley Cleek

Sex with clients. As lawyers, we all know (or should know) of the ethical dangers associated with such conduct. The attorney/client relationship is a fiduciary one "in which the lawyer occupies the highest position of trust and confidence." *See, e.g.*, Tenn. Sup. Ct. R. 8, RPC 1.7, cmt. 12 (2013). Because of this fiduciary duty, "[a] sexual relationship between a lawyer and client can involve unfair exploitation of the lawyer's fiduciary role and thereby violate the lawyer's basic obligation not to use the trust of the client to the client's disadvantage." *Id.* at cmt. 12a. Such concerns, however, are obviously not limited to the legal profession. All too frequently in today's culture we see headlines about individuals who have engaged in inappropriate sexual conduct with persons over whom they hold a position of authority: prison guards and inmates, teachers and students, politicians and interns, just to name a few. Unfortunately, such conduct can also occur in the context of what is supposed to be a therapeutic relationship. As a result, many states have passed legislation creating civil causes of action that benefit victims of psychotherapeutic sexual exploitation. Minnesota and Wisconsin took the lead in 1986, and the Minnesota statute was essentially duplicated by California in 1987 and Illinois in 1989. *See* Minn. Stat. Ann. §604.201; Wis. Stat. Ann. §895.441; Cal. Civ. Code §43.93; Ill. Comp. Stat. Ann. Ch. 740 §140/2. *See* Minn. Stat. Ann. §604.201; Wis. Stat. Ann. §895.441; Cal. Civ. Code §43.93; Ill. Comp. Stat. Ann. Ch. 740 §140/2.

In 1995, the Tennessee legislature followed suit by passing the Therapist Sexual Misconduct Victims Compensation Act, which like its predecessors in other states, contains some notable limitations on discovery. *Id.* at §29-26-207. It provides that the victim's sexual history is not admissible except to prove that the sexual conduct occurred prior to the provision of therapy, and the only discoverable evidence of the victim's sexual history is that which may be relevant in determining the timing of the sexual relationship between the parties. *Id.* Such discovery limitations in these types of actions raise a number of important issues for litigators, and many courts have been called upon to determine the proper scope of the "victim shield" provisions contained in these statutes. As explained in one commentary, "[a]ll of the states that have passed psychotherapist sexual exploitation statutes included a victim shield provision that deems prior sexual history irrelevant for purposes of both discovery and admission at trial." *See* Linda Jorgenson, *et al.*, The Furor Over Psychotherapist-Patient Sexual Contact: New Solutions to an Old Problem, 32 Wm. & Mary L. Rev. 645, 713 (1991).

> *Nevertheless, when assessing the extent of damages, the court may appropriately elicit the victim's sexual history.* If the victim alleges damage to sexual function, the court in fairness must allow the defendant to inquire about the victim's sexual history. *Furthermore, the need to evaluate the possibility that personality disorders predating the sexual abuse caused certain symptoms may also justify inquiry into the plaintiff's sexual history.*

Id. (emphasis added).

Relevance of Sexual History

Many aspects of a victim's sexual history, including sexual encounters with other partners, may arguably be relevant in such actions. For example, by seeking damages based upon alleged sexual misconduct, it may be argued that the victim has placed his or her pre-existing physical and emotional condition at issue. In addition, a defendant may not be able to fully assess the extent of the plaintiff's alleged injuries without exploring his or her pre-existing condition, which may include certain elements of that person's sexual history. In this regard, the plaintiff's sexual history, as well as any sexual encounters with others during the same timeframe as his or her relationship with the defendant, may be relevant to the damages that were allegedly sustained as a result of the defendant's conduct. Likewise, if during the time period that patient was seeing the defendant, he

or she engaged in numerous sexual encounters with other individuals and/or reported being raped or sexually abused by others on multiple occasions, this information would also be relevant to the cause of the victim's alleged injuries. For these reasons, the defense may argue that in fairness, they should be permitted to undertake discovery that could provide a basis to challenge the plaintiff's proof on causation and damages.

One decision from California is particularly instructive on this issue. In *Patricia C. v. Mark D.*, 16 Cal. Rptr. 2d 71, 72 (Cal. Ct. App. 1993), the patient brought an action for medical malpractice, emotional distress, and "injury to future sexual relationships" on the basis that her psychologist had allegedly seduced her into having multiple sexual encounters with him. At the outset of trial, the plaintiff moved to exclude evidence of her sexual contact with persons other than the defendant and evidence of her employment as a topless dancer. *Id.* The trial judge concluded, however, that "the challenged evidence was essential to a fair trial on the issue of damages—*i.e.*, whether Patricia's current mental condition was attributable to Mark's alleged conduct or to her pre-treatment psycho-sexual history." *Id.* at 73. Thus, "[d]efense counsel argued to the jury that Patricia should not be believed because her extensive history of psychiatric disorder and treatment demonstrated she was psychotic, delusional and vengeful, and even if the allegations of sexual conduct were true[,] there was no damage because Patricia had already been psychotic." *Id.*

On appeal, the California Court of Appeals initially noted that the evidence in dispute was not admitted to prove the absence of any injury to the plaintiff. *Id.* Rather, "Mark's position was that Patricia's injury was not caused by any conduct on his part, but by experience or conduct which occurred in her life prior to the commencement of the psychologist-patient relationship." *Id.* Because the issue of proximate cause of Patricia's injury was in dispute, the challenged evidence was admitted on that issue. *Id.* The Court then noted that in 1987, the legislature had created a new cause of action for sexual contact by a psychotherapist with a patient, and

> [i]n such actions, the cause of a plaintiff's mental condition—*i.e.*, the extent to which injury resulted from sexual contact—is more likely to be legitimately disputed, since the plaintiff will likely have had some emotional disorder that predated the sexual contact and led to psychotherapy in the first place.

Id. at 75 (emphasis in original).

The Court recognized that an absolute bar on discovery of a victim's sexual history may be justified in a typical sexual harassment, assault, or battery case, in which there is no special likelihood of preexisting emotional disorder, in order to protect victims from intrusion into their private lives. *Id.* On the other hand, in actions for psychotherapist-patient sexual contact, a countervailing consideration—the special likelihood of preexisting emotional disorder and the potential relevance of sexual history to the disorder—warrants discretionary admissibility where the sexual history is relevant and its probative value outweighs its prejudicial effect. *Id.* Therefore, the trial court's ruling was affirmed. In conclusion, the Court observed that

> [d]efense counsel was careful to present the bare minimum necessary to support the theories that Patricia was delusional and had not been injured by the alleged sexual contact. This was simply not a case where the focus of trial was deflected from the question of psychotherapist-patient sexual contact to an attack on the plaintiff's moral character.

Id. at 77.

The rationale utilized by the California Court of Appeals seems to strike an appropriate balance between the statutory protection against unwarranted intrusion into victims' personal affairs and the defendant's right to adequately defend the causation and damages aspects of such cases. Moreover, the California Court's focus was on the admissibility of such evidence rather than the much more lenient standard that usually applies to discovery.

The Defendant's Constitutional Right to Present a Defense

Many "rape shield laws," which are generally much more specific and comprehensive than the sexual misconduct statutes discussed hereinabove, do not prohibit the discovery or admissibility of a victim's sexual history under any and all circumstances. For example, in *State v. Brown*, 29 S.W.3d 427, 429 (Tenn. 2000), the Tennessee Supreme Court accepted review to address the "overlapping application" of the Rape Shield Law and the defendant's constitutional right to present a defense. The Court explained that "Rule 412 is designed to recognize that intrusions into the irrelevant sexual history of a complaining witness are not only prejudicial and embarrassing but also discourage many complainants from reporting sexual crimes." *Id.* (citing *State v. Sheline*, 955 S.W.2d 42, 44–45 (Tenn. 1997)). On the other hand, the Court also observed that sometimes a defendant can only have a fair trial if the introduction of such evidence is permitted. *Id.* (citing Tenn. R. Evid. 412, Advisory Comm'n Cmts.). "Moreover, the constitutional right to present a defense has been held

to 'trump' a number of other state and federal rules of procedure and evidence, including rape shield statutes." *Id.* (citations omitted).

> The facts of each case must be considered carefully to determine whether the constitutional right to present a defense has been violated by the exclusion of evidence. Generally, the analysis should consider whether: (1) the excluded evidence is critical to the defense; (2) the evidence bears sufficient indicia of reliability; and (3) the interest supporting exclusion of the evidence is substantially important.

Id. at 433–34 (citing *Chambers v. Mississippi*, 410 U.S. 284, 298–301 (1973)).

Based upon these considerations, the Court reversed the judgment of the appellate court and remanded the case for a new trial because the excluded evidence of the alleged victim's sexual history could have enabled the defendant to "rebut or explain scientific or medical evidence." *Id.* at 429. Specifically, the Court found that the defendant's constitutional right to present a defense had been violated because "[e]xcluding the proffered evidence essentially deprived Brown of an opportunity to present to the jury critical evidence of an alternative explanation" for the complainant's injury. *Id.* at 436.

Conclusion

The States that have taken legislative action on this subject should be commended for creating a statutory cause of action that specifically addresses the problem of sexual misconduct by those who provide therapy to vulnerable individuals suffering from mental, emotional, or substance abuse problems and those who may be experiencing marital or family difficulties. In those states, victims of such misconduct are now often afforded the benefit of a longer statute of limitations and expanded categories of available damages. However, trial courts must ensure that the defendant's rights are not violated in the process of enforcing the victim shield provisions contained in these statutes.

The fact that there are relatively few appellate decisions addressing these causes of action might lead one to conclude that sexual misconduct by therapists is a rare or at least infrequent occurrence. Conversely, it may be due to the reluctance of victims to come forward or simply a lack of awareness on the part of trial lawyers that such a statutory cause of action exists in many jurisdictions. In any event, it is likely that many trial and appellate courts will eventually be called upon to consider the scope of discovery limitations in such cases and the propriety of those restrictions based upon the impact that they may have on the defendant's constitutional rights.

A member of his firm's medical malpractice group, Ashley Cleek has focused his practice on representing physicians and hospitals in both state and federal cases in Memphis, Jackson, Nashville and throughout Tennessee. He also has significant appellate experience, handling numerous cases before the Tennessee Court of Appeals, Tennessee Supreme Court, and the United States Court of Appeals for the Sixth Circuit. Mr. Cleek joined Rainey Kizer following graduation from the University of Tennessee College of Law, where he was awarded Certificates of Excellence for extraordinary achievement in the areas of criminal law and workers' compensation law. Prior to law school, he attended the University of Tennessee at Martin, where he earned a Bachelor of Science degree with high honors while majoring in biology and chemistry.