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Committee Leadership

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In This Issue

Leadership Note

Letter from the Chair

By J. Richard Moore

Reflection on what 2018 has brought us, and anticipating what we might see in 2019, are natural inclinations as we close out another year. We continue to live in tumultuous times nationally and internationally. As I write this letter, there are ongoing riots in France stemming from fuel prices, uncertainty over completion of Brexit, and broad disputes between the United States and historical international allies over trade agreements and tariffs. Here at home, we have a much-discussed divide concerning domestic political ideology that seems to be widening, and an executive administration that is increasingly under the law enforcement microscope. The Chinese curse about living in interesting times certainly seems apt in these cold days of the waning year.

Along the same lines, while the holidays are intended to be times of frivolity and mirth, they can also induce stress and depression. Particularly in times of economic uncertainty, our celebrations of faith, friends and family may resonate with ambivalence. Our culture tells us that we are supposed to have lives that are full and bountiful, and when we sense—specifically we lawyers, with our trained critical eye that is never more cutting that when focused inward—that what we have is wanting in some way, it can be challenging to recognize that our blessings, more often than not, vastly outweigh our deficits.

What, you may be asking, do these melancholy thoughts have to do with DRI, and with the Medical Liability and Health Care Law Committee? Well, I'll tell you: while DRI involvement is certainly an opportunity for business and professional development, and while it is the preeminent resource for continuing legal education in the world, it is also a safeharbor for talented lawyers to develop strong interstate relationships. Those relationships are of course professional, but at their best they are also personal. And as much business as I have developed over my 15+ (that's as specific as I'll get) years of DRI involvement, the bedrock benefit of continuing DRI involvement for me has been the persistence of those cherished friendships.

With that background, I would like to report that 2018 for our committee has been a year of resounding success, and 2019 promises to be even greater. We kicked the year off with our first-ever webinar, "Avoiding Claims of Negligent Hiring, Supervision, or Retention in Hospital Abuse Cases," which was presented on February 15, 2018. Our excellent 2018 Medical Liability and Health Care Law seminar, led by Jodi Terranova, vice chair Erika Amarante, and marketing coordinator Andrew DeSimone was held in San Diego from February 28 to March 2, 2018. On June 13, 2018, our committee presented a one-day workshop titled "Striking Back Against the Reptile in Medical Malpractice and Long-Term Care Cases," which was helmed by Program Co-Chairs Minton Meyer and Laura Eschelman. On September 13 and 14, 2018, our committee hosted our annual Nursing Home and ALF Litigation Seminar, held for the first time in New Orleans. We also presented a substantive education session during our business meeting at this year's Annual Meeting in San Francisco on October 17, 2018, again led by Laura Eschelman. Along the way, our committee members published several pieces in our dedicated issue of *For The Defense* in May, and contributed to an number of additional DRI publications throughout the year. Not bad for one committee.

Next year, we already have on the docket our Medical Liability and Health Care Law Seminar in Nashville on March 19–21, 2019. It will be a year of firsts for that seminar: We have not been to Nashville before, and we are also including an add-on, limited enrollment session the day before the main stage seminar on expert witness preparation. Program Chair Erika Amarante and Vice Chair Andrew DiSimone have developed a sterling program, and marketing coordinator Meg Yanacek is currently spearheading our registration efforts. In addition, planning is well under way for our Nursing Home and ALF Litigation seminar in Chicago in the fall. Program Chair Caroline Berdzick and Vice Chair Drew Graham are well ahead of the curve in planning a cutting-edge agenda for that seminar. We are also working to develop at least one additional webinar, and other educational and publications opportunities for our members.

I am gratified to be able to work with these talented people, and with a raft of other highly credentialed lawyers, who volunteer their time to get our committee work done. At times when I lose focus or confidence due the press of business or the uncertainties that are attendant to an active litigation practice, I remind myself that I am involved with such a creative and motivated leadership team. That involvement is its own reward.

I'd like to add a few quick words of thanks. First to Jonathan Blakley, who has served for several years as our publications chair. Jonathan has been phenomenally organized and on top of things. He is moving on to other leadership positions and passing his torch to Justin Hardin. Jonathan, thank you so much for your hard work on behalf of our committee.

Second, to Jeremy Falcone, who has served for several years as our membership chair. Under Jeremy's watch, the membership of our committee has continued to rise. Brigette Foley is our new membership chair, and Jeremy will continue to be involved in seminar planning leadership. Jeremy, thanks for leaving our membership substantially larger than it was when you started in the position.

Finally, thanks to our Committee Vice Chair Barclay Wong. Barclay has been much more of a Dick Cheney than a Spiro Agnew in his Vice Chair role. He is actively involved in seminar planning and committee leadership decisions, and I rely regularly on his trusted advice and counsel. Barclay, many thanks.

Here's to 2018 in the rearview mirror, and to 2019 through the windshield. Like it or not, we live in interesting times.

Feature Articles

How Reptile Theory Is Used in Rule 30(b)(6) Depositions in Medical Malpractice / LTC / ALF Litigation

By Laura D. Eschleman and Michael A. Gross


Lawsuits involving medical malpractice, long term care and assisted living facilities are rife for the use of the Reptile theory. As Keenan and Ball state themselves with respect to medical negligence cases, "*[r]emember that errors and mistakes don't motivate verdicts (especially med mal verdicts); patient-safety-rule violations do*." Keenan and Ball, Reptile, The 2009 Manual of the Plaintiff's Revolution, p. 243 (emphasis supplied). As most attorneys who defend medical negligence cases are aware, jurors can forgive physician judgment if the judgment turns out to thoughtful but wrong. The Reptile theory seeks to erode physician judgment and the standard of care and instead insert rigid absolute safety rules.

With respect to the 30(b)(6) designee for a hospital or nursing home defendant, Reptile plaintiffs' attorneys attempt in deposition to: (1) establish that a safety rule exists that protects not only the plaintiff but also the jurors; (2) prompt the designee to admit that an employee, agent or the entity itself violated the rule, putting both plaintiff and the jurors in danger; and (3) admit that people and companies should be responsible for their actions, allowing the jury to keep its community safe by punishing the dangerous defendant.

The Reptile plaintiffs' attorney will begin with seemingly simple safety rules, and then narrow the questions until they apply them to the facts of the particular case. With respect to 30(b)(6) depositions in medical negligence actions, Keenan and Ball provide a guideline for the safety rules:

> For hospital cases, an important rule source is the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). They do not merely provide rules; they provide rules about how the rules (policies and procedures) must be written. JCAHO requires that every hospital policy and procedure be described specifically and clearly, that examples be provided, and that there is repetitive in-service training to ensure that hospital personnel know them.
>
> There are also medical staff bylaws, policies, and procedures; general hospital policies and procedures; and policies and procedures governing every medical treatment and procedure in the hospital.
>
> Every one constitutes a patient-safety rule.

Keenan and Ball, Reptile, *The 2009 Manual of the Plaintiff's Revolution*, pp. 243–44.

The way plaintiffs' lawyers make the Reptile theory effective is when they ask a 30(b)(6) deponent very broad and seemingly common sense type questions about patient safety. Then once the deponent agrees that, for example, "hospitals should not needlessly endanger patients," and "hospitals have rules in place for patient safety," and "if an employee violates a patient safety rule, that can cause harm to patients," they have the 30(b)(6) deponent cornered when later trapped by the violation of the patient safety rule

in the actual case. The Reptile theory seeks to avoid the application of specific facts to specific cases and the applicable standard of care, and rather seeks to apply absolutes in the form of safety rules. Once the deponent is trapped, it is actually the deponent who goes into survival mode, not the jury. Bill Kanasky, "Debunking and Redefining the Plaintiff Reptile Theory," DRI *For The Defense*, April 2014. Once the deponent goes into fight or flight mode, he or she either fights and becomes argumentative, or defensive, which we know is ineffective, or flights and becomes submissive and agrees to everything the Reptile plaintiffs' attorney needs from the deponent. Worse yet is the deponent who may try to go back and clarify previous answers, or explain why the broad safety rule to which he or she just agreed does not apply in the present case. The contradictory and hypocritical testimony will quickly lead to the often incurable dislike and distrust of the defense deponent by the jury. *Id.* These strategies work because Reptile plaintiffs' attorneys have stopped focusing on juror sympathy for the severity of a plaintiff's injuries and have begun focusing on "bad" defendant conduct.

A Reptile plaintiff's attorney will begin with easy to understand safety rules that will make the unprepared 30(b)(6) deponent agree with ease. Of course hospitals should not needlessly endanger its patients, the deponent will think! A jury would think badly of me as the representative of the hospital if I did not agree with that! A Reptile plaintiff's attorney wants the rule to be an absolute, with no room for an answer like "it depends." There are, of course, real safety rules that meet this standard: "It is never okay for a surgeon to operate while under the influence of alcohol or drugs when he or she is so inebriated that he or she cannot cut in a straight line." But cases with these extremes usually do not get to corporate depositions because good defense lawyers know that there will be an early admission of liability or settlement. When a 30(b)(6) deposition is taken in a medical liability or long-term care case, Reptile plaintiffs' attorneys will have to work to establish the absolute safety rules.

The Reptile theory works, not because it awakens the Reptilian brain of the jurors, but because a defense witness becomes trapped by agreeing to a safety rule, which then creates a clear contradiction between the rule and the defendant's conduct in the actual case. *Id.* This can be a devastating contradiction, because as all seasoned trial attorneys know, trials are entirely about perception. Once the defendant's witness is on the stand and it appears the defendant broke a safety rule with respect to the plaintiff, that behavioral inconsistency has a powerful effect on jurors' decision making; as on the other hand, behavior consistency is highly correlated with honesty and truthfulness. *Id.* The Reptile plaintiffs' attorney therefore seeks to create and fuel the inconsistency perception. *Id.*

It is no longer acceptable in a post-Reptile world to advise defense deponents to keep answers as short as possible, answering "yes," "no," "I don't know," or "I don't recall." It is also ill advised to counsel your deponent not to volunteer information beyond the question that has been asked. Rather, we want to include all information that speaks the entire truth and pushes the defense narrative forward. We must provide specialized deposition preparation. We must pivot to speak the defense narrative. We must speak the whole truth. And, we must distinguish the particularized care from the broad and absolute Reptile theory theme.

We need new rules. The most basic rule to slash back at the Reptile theory is to never say yes. This is a dead end. Reptile theory questions are designed to allow the Reptile plaintiffs' attorney to testify, with the 30(b)(6) deponent answering "yes" to all of the questions that push the case forward for the plaintiff. Even if the defense deponent has no choice but to agree with the question asked, the deponent should at least complete the response with a complete sentence. If a Reptile plaintiffs' attorney insists on a "yes or no answer," prepare your witness to begin answers with a "Well, it depends. I cannot give a yes or no answer to that question. Would you like me to explain why?"

In medical negligence cases, the jury must determine if the defendant acted within the standard or care, or, as a reasonably prudent physician considering surrounding facts and circumstances. The Reptile plaintiffs' attorney seeks to replace the sometimes undefined reasonableness standard for the clear cut absolute safety rule. Any time the safety rule can be undercut, it should be. The key is for the 30(b)(6) deponent to know the defense narrative and push it forward by speaking the truth at all times.

Finally, advise your deponent to refrain from answering damages questions. The Reptile plaintiffs' attorney will ask whether a person who causes damage by refusing to obey a safety rule should "pay" for that damage. It is hard for the 30(b)(6) deponent to say no to that question, so refrain from saying it. Instead, a deponent should let the Reptile plaintiffs' lawyer know that the question sounds like one that should be answered by lawyers.

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matters in 28 states. Laura has tried several medical malpractice cases to successful jury verdict in multiple states. In addition, Laura represents healthcare providers in Medicare, Medicaid, quality improvement organization and private health insurance company audits and administrative actions. Laura is the current Co-Chair of DRI's Striking Back Against the Reptile in Medical Malpractice and Long-Term Care Cases Seminar and was the Program Chair for the DRI Medical Liability & Health Care Law Committee's 2017 Seminar, for which she received DRI's Albert H. Parnell Outstanding Program Chair Award.

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Opioid Overdoses: From Crisis to Litigation

By Christine L. Stanley

Every day, more than 115 people in the United States die from an opioid overdose. CDC/NCHS, National Vital Statistics System, Mortality. CDC Wonder, Atlanta, GA: US Department of Health and Human Services, CDC; 2017. https://wonder.cdc.gov. The misuse of and addiction to opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—affects public health as well as social and economic welfare. In 2017, more than 72,000 people in the US died of drug overdoses; more than were ever killed by guns, car crashes or HIV/AIDS in a single year in the US. The Centers for Disease Control and Prevention estimates that the total "economic burden" of prescription opioid misuse in the United States is $78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement. Florence CS, Zhou C, Luo F, Xu L. The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013. *Med Care*. 2016; 54(10):901-906. doi:10.1097/MLR.0000000000000625.

Opioid overdoses increased 30 percent from July 2016 through September 2017 in 52 areas in 45 states. Vivolo-Kantor, AM, Seth, P, Gladden, RM, *et al.* Vital Signs: Trends in Emergency Department Visits for Suspected Opioid Overdoses—United States, July 2016–September 2017. Centers for Disease Control and Prevention. The Midwestern region saw opioid overdoses increase 70 percent from July 2016 through September 2017. *Id*. Opioid overdoses in large cities increase by 54 percent in 16 states. *Id*.

This national issue has become a public health crisis with devastating consequences, including the rise of neonatal abstinence syndrome due to opioid use and misuse during pregnancy, and the spread of infectious diseases including HIV and hepatitis C.

There have been a number initiatives put forth by the U.S. Department of Health and Human Services, pharmaceutical companies, states, localities, physicians and many others. This past April, at the National Rx Drug Abuse and Heroin Summit, National Institutes of Health Director, Francis S. Collins, M.D., Ph.D., announced the launch of the HEAL (Helping to End Addiction Long-term) Initiative; an aggressive, trans-agency effort to speed scientific solutions to stem the national opioid public health crisis.

More recently, on October 24, 2018, President Donald Trump signed the Support for Patients and Communities Act into law. This bipartisan legislation passed the House of Representatives by a vote of 396-14 in June and the Senate by a vote of 99–1 in September.

Ten key provisions of the legislation include:

- STOP Act – to stop illegal drugs, including fentanyl, at the border;
- Support for the research and fast track of new non-addictive painkillers;

- Allows the FDA to require prescription opioids to be packaged in 3 or 7 day supply blister packs;
- Extends support for Medicaid patients seeking treatment from 15 to 30 days, covering all substance abuse disorders;
- TREAT Act – permanently allows more medical professionals to treat people in recovery to prevent relapse and overdoses;
- Improves state prescription drug monitoring programs to prevent "doctor shopping";
- More behavioral and mental health providers;
- Support for comprehensive opioid recovery centers;
- Help for babies born in opioid withdrawal and for mothers with opioid use disorders;
- More early intervention with vulnerable children who have experienced trauma.

Separately, in March, the FY2018 Omnibus Appropriations bill included $4.7 billion to fight the opioid crisis, and in September, the FY2019 Health and Human Services Appropriations bill included $3.8 billion. The idea behind the Support for Patients and Communities Act, and similar legislation, is to help states and communities better address the opioid crisis. Critics of these laws approve of the motive, but insist that these measures are not sufficient, and that more funding is needed to reverse the epidemic.[1]

Optimistically, with so many collaborations and legislative efforts, the future looks brighter. But what about those individuals, counties and states that have already suffered the ultimate consequence of opioid addiction? Who is to take responsibility for all of those who have died?

In the past, individual plaintiffs suffering from addiction and prosecutors have always targeted pharmaceutical manufacturers, including opioid distributors and pharmacy retailers. *Civil Litigation and the Opioid Epidemic: The Role of Courts in a National Health Crisis*, The Journal of Law, Medicine & Ethics, 46 (2018): 354. But now, state and local governments are also targeting pharmaceutical manufacturers, distributors, retailers.

As of February 2018, more than 700 states, counties, and cities had filed suit against pharmaceutical companies, with the numbers increasing weekly. United States Judicial Panel on Multidistrict Litigation, MDL Statistics Report- Distribution of Pending MDL Dockets by Actions Pending (Washington, DC 2018), available at http://www.jpml.uscourts.gov/sites/jpml/files/Pending_MDL_Dockets_By_Actions_Pending-January-16-2018.pdf . See also, C. Ghose, "Cardinal Health now Facing More than 350 Opioid Lawsuits," Columbus Business First, February 13, 2018. Twenty-six states, including Alabama, Alaska, Arizona, Delaware, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, South Carolina, Washington, and West Virginia along with hundreds of cities and counties, have sued. *Civil Litigation and the Opioid Epidemic: The Role of Courts in a National Health Crisis*, The Journal of Law, Medicine & Ethics, 46 (2018): 355. Further, 41 state attorneys general were working together in an investigation targeting manufacturers and distributors. *Id.*

A typical example of a filing by a locality is the suit filed by Summit County, Ohio. The County alleges that it has spent $66 million since 2012 on ramifications of the opioid crisis and is seeking to recoup that loss. *Id.* Like personal injury, repeat-player law firms are aggressively recruiting clients on a contingency basis and contributing to the rising number of cases. *Id.* Furthermore, local governments are afraid that financial settlements to states may not result in money to local communities. *Id.* For example, financial payouts by tobacco companies to federal and state governments were often not directed to particular localities. *Id.*

Some causes of action include: public nuisance (does this interfere with rights that are held in common by the general public including public health and safety), negligence, unjust enrichment, violations of state consumer protection, racketeering, and Medicaid fraud. There are even five class actions against drug makers including allegations that the opioid crisis has caused insurance premiums to rise for those not suffering from the addiction.

Some interesting questions brought to the courts include the following: do plaintiffs have an individual right of action derived from distributors' duties under federal and state law to "monitor, detect, investigate, refuse and report suspicious orders of prescription opioids"? At least one federal court has said most likely no, *McKesson Corporation v. Todd Hembree*, Case. No 17-CV-323-TCK-FHM (N.D. Okla,

[1] The opioid crisis has compelled the editors of Yale University's *Journal of Law Medicine & Ethics* to dedicate an entire symposium and summer issue to Opioids, Law & Ethics. The issue is said to be the first of its kind to bring together faculty and students from the law school, medical school and school of public health to explore the crisis from many different angles and to collaborate on research and analysis. For more information please review the *Journal of Law, Medicine & Ethics*, 46 (2018).

2017). Another is whether a reasonably prudent pharmacy would have recognized these high-risk prescriptions and refused to fill such orders, as filed by the Cherokee Nation against McKesson Corp 2017. NO. CV – 2017-203 (Dist. Ct. of the Cherokee Nation 2017).

The defense for many of the companies has been that the plaintiff cannot prove that he or she is the proximate cause of the injury; that given the complex chain of opioid delivery, there is no way to apportion fault, especially if the plaintiff was prescribed the drug by a physician (and, arguably, causation is even more remote if the plaintiff was not prescribed the drug at all).

This summer, more than 700 opioid-related cases were consolidated into multidistrict litigation ("MDL") before Judge Dan Polster in the northern district of Ohio, pursuant to 28 U.S.C. §1407. Judge Polster stated that the "federal and state governments punted on legislative solutions," and advocated for global settlements rather than litigating to answer legal questions in order to solve the *ongoing* opioid crisis; "Everyone shares some of the responsibility, and no one has done enough to abate it…."

Now that the Support for Patients and Communities Act has passed, it will be interesting to see whether Judge Polster continues to encourage settlement or whether he feels that the law is sufficient to address the crisis and returns back to a traditional litigation model in the MDL.

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