Produced under an educational grant from Medtronic Vascular.

Endovascular Fellow TODAY

May 2008

A supplement to *Endovascular Today*

Understanding Malpractice Litigation

How to protect yourself and your practice in today's legal environment.

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A Primer on Malpractice Litigation

Understanding medical malpractice law is important in every vascular surgery practice.

BY O. WILLIAM BROWN, MD, JD

It has been said that the only things that are certain in life are death and taxes. I would add a third certainty; if a physician practices medicine long enough in the US, he will be named in a medical malpractice suit. Accordingly, in view of this eventuality, it is important for vascular surgeons to understand the basic components, process, and defenses that constitute the backbone of any medical malpractice suit. A vascular surgeon would never enter the operating room without a complete understanding of the indications and the technical aspects of the procedure that was about to be performed. So too the vascular surgeon should never enter into a legal proceeding without a firm understanding of what is about to transpire. I will review some of the basic tenets of medical malpractice law as they exist in the US today. State statutes may differ, but the basic concepts remain constant.

There are four prongs to any medical malpractice suit: duty, breach of duty, proximate cause, and damages. All four of these must be present if a medical malpractice suit is to be successfully filed. *Duty* is most often established by proving that a physician-patient relationship existed. *Breach of duty* most often refers to a breach of the standard of care. *Proximate cause* basically means that the negligence of the physician was the cause of the patient's damages. Finally, the patient must show that he sustained *damages*.

PHYSICIAN-PATIENT RELATIONSHIP

A physician-patient relationship may be established in one of several ways. If the patient is seen by the physician in his office, or is seen in the hospital as a consult, clearly, a relationship has been established. Similarly, if a physician is called by his resident or by a nurse regarding a patient in the emergency room, a relationship will most often be deemed to have been established. A relationship may sometimes be assumed to exist by a simple comment made by a physician in a social setting. If a vascular surgeon, after being questioned by a fellow party guest concerning leg swelling, states that the swelling is probably not significant, he may be deemed to have established a physician-patient relationship. Accordingly, if the person in question subsequently develops a pulmonary embolism and dies, the physician may be held liable. It should be stressed that whether the physician has charged or been paid for his services is unimportant in determining if a physician-patient relationship exists.

A physician-patient relationship may be terminated in one of three ways. First, the patient can dismiss the physician. Second, the physician may withdraw from giving care, but only after providing the patient with sufficient notice. Finally, if the patient's medical problem has been resolved, the physician-patient relationship no longer exists.

STANDARD OF CARE

The standard of care may be established in one of five ways. Most often, it is established by an expert witness. The definition of a "medical expert" varies from state to state. In some states, any physician may give "expert" testimony in any type of medical malpractice case. In other states, the qualification of the expert is more narrowly tapered. In Michigan, if the defendant is board certified, the experts must be board certified in the same specialty. The standard of care may also be established by the defendant. This occurs when the defendant admits that he has violated the standard of care. The third method is known by the Latin phrase *res ipsa loquitur*, or *it speaks for itself*. An example of the use of *res ipsa loquitur* to establish the standard of care would be leaving a sponge in the abdomen of a patient following a laparotomy. The fourth method of establishing the standard of care is by the plaintiff if he is a medical expert. The final method is by citing the common knowledge doctrine. An example of this would be performing extensive x-ray evaluations on a woman who is in the first few weeks of her pregnancy. Even a layperson knows that x-ray use early in pregnancy can produce birth defects.

The standard of care applied to physicians is a national standard. That is, a physician from the small city of Munising, Michigan, is held to the same standard of care as a physician in Boston. Location becomes a consideration only when hospital equipment is an issue. A physician cannot be held liable for not obtaining a 128-slice CT scan on a patient if the hospital does not have such a scanner.

INFORMED CONSENT

The statement "risks and benefits discussed with the patient" does not constitute informed consent. Any note attempting to establish informed consent must contain at least five basic components: diagnosis, treatment plan, risks and benefits, treatment alternatives, and prognosis with and without treatment. In addition, the physician must tell the patient anything that could affect his decision whether or not to proceed with the treatment. Moreover, obtaining informed consent is a nondelegable duty, which means that the informed consent for a procedure must be obtained by the physician performing the procedure and not the resident or physician assistant who is helping the physician with the procedure. Lastly, a signed operative consent form does not constitute informed consent. In truth, the only purpose of the operative consent form is to protect the physician from liability for civil or criminal battery. This is particularly important when one considers that malpractice insurance will not cover monetary verdicts, which result from a civil battery suit.

MALPRACTICE DEFENSES

There are several medical malpractice defenses. The first is that the physician acted in a manner consistent with a reasonably prudent physician. A second defense is that the damages were a result of an error in judgment and not negligence. A third defense is "assumption of the risk." An example of this would be if a patient was told not to run after having a hip replacement and then decided to participate in a marathon, whereby the hip became dislocated. Contributory negligence is a fourth defense. An example of this would be if a patient was told to stop smoking after a femoropopliteal bypass and continued to smoke three packages of cigarettes per day. Let us assume the graft occludes. Even if the surgeon placing the graft were found to be negligent, many states would reduce the award by the percentage that the patient contributed to the graft's occlusion by continuing to smoke cigarettes.

GENERAL CONSIDERATIONS

In most states, there is a Good Samaritan statute. This statute covers physicians who provide medical care in an emergency situation to patients whom they have no duty to treat. The classic example of a Good Samaritan is a physician who stops at the side of the road to help an accident victim. However, in many states, the Good Samaritan statute has been extended to cover acts that occur within the hospital. For example, if a vascular surgeon is called emergently by an orthopedic surgeon to assist in the repair of a popliteal artery injured during a total knee replacement, the vascular surgeon can refuse to see the patient as long as he is not on call. If the surgeon does choose to help the orthopedic surgeon and treat this patient, the vascular surgeon, under the Good Samaritan statute, cannot be held liable for ordinary negligence. The vascular surgeon can only be held liable for willful or wanton acts, that is, acts that are intentionally negligent. It is therefore important for all vascular surgeons to be familiar with the Good Samaritan statute in the state in which they practice. Although statutes of limitation vary from state to state, it is important to remember that there is no statute of limitation for fraudulent concealment. Therefore, it is imperative that the patient and the patient's family be informed of any significant occurrence in the operating room.

MEDICAL MALPRACTICE INSURANCE TYPES

There are basically two types of medical malpractice insurance: occurrence and claims made. Occurrence type of insurance covers any lawsuits that arise when the surgeon was covered by the occurrence policy. For example, assume that a surgeon purchases an occurrence policy for the year 2008 and then discontinues the policy. Even if the lawsuit is filed in 2010, if the event in question occurred in 2008, the policy is still deemed to be in force. However, if the same surgeon purchased a claims-made policy for 2008, and the lawsuit is filed in 2010, the surgeon is not covered by that policy. He would be covered only for claims filed in 2008, no matter when the event in question occurred. Although claims-made insurance is less expensive for the first few years, after several years, the price for claims-made insurance closely approaches that for occurrence insurance. Finally, if a surgeon selects claims-made insurance and then leaves town or stops practicing, the surgeon will need to purchase what is referred to as *tail coverage*, which will cover the surgeon for all future years even though the surgeon no longer has active malpractice insurance.

CONCLUSION

It is important that vascular surgeons understand the basic components of a medical malpractice suit. It is only with this understanding that the surgeon can provide appropriate assistance to his defense attorney. It is important to remember that no matter how many books they read or how many depositions they take, attorneys can never know as much about vascular surgery as a vascular surgeon. Accordingly, it is imperative that the defendant be an active participant in the lawsuit if he is to prevail in today's legal system. ❐

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Medical Malpractice Litigation Roundtable

Our panel of attorneys responds to a variety of medical malpractice questions submitted by members of *Endovascular Today*'s Editorial Advisory Board.

PANEL

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The information contained in this article is intended for informational purposes only. It is not intended as legal advice or to serve as a substitute for a consultation with an experienced attorney or risk management professional. The laws of the reader's particular state and particular situation may affect the information contained herein. Readers should consult a risk management professional and/or an attorney regarding their specific needs.

An 80-year-old patient requires abdominal aortic aneurysm repair. Due to elevated risk factors, the physician recommends endovascular aneurysm repair using an endograft. The patient is notified of the risks of the procedure, and the patient seems alert and coherent and agrees to proceed. Does the patient's age alone require the physician to obtain consent from a younger member of the family?

Ms. Rode: Not necessarily. If the patient appears competent and presumably came to the visit alone and unassisted, the patient is probably competent to sign the form. In this situation, you may consider sending the patient home with the consent form, enabling him to seek advice from family and/or his primary care physician. Another recommendation is that you should also document the informed consent discussion in the medical record (ie, "Patient was informed of risks, alternatives, and complications; was given the opportunity to read, sign, and ask questions. Patient had no questions and/or patient's questions were answered.")

Dr. Brown: Although good in theory, the practicality of sending the form home with the patient is that patients will lose or forget to return the form. If the surgeon proceeds without the form, he will be subject to increased liability. If he refuses to proceed without the form, he will most likely upset the patient and the family. In addition, this question demonstrates a common misunderstanding. One must differentiate between informed consent and a consent form. The statement "risks and benefits discussed with the patient" generally does not constitute informed consent. Any note attempting to establish informed consent must contain at least five basic components: diagnosis, treatment plan, risks and benefits, treatment alternatives, and prognosis with and without treatment. In addition, the

physician must tell the patient anything that could affect his decision whether or not to proceed with the treatment.

What other considerations should a physician consider that could challenge the validity of the consent?

Ms. Rode: Does the patient wear glasses? When was consent signed? (ie, how many days were there before the procedure, allowing the patient to think about it, seek advice of his family and primary care physician?). Was the patient given the opportunity to ask questions after the informed consent discussion and reading of the consent form, in which he is fully informed of the risks, alternatives, and complications? It is vital to document that this discussion took place. The old adage in medical malpractice litigation is, "If it's not documented, it didn't happen." Trying to convince a jury later that you are absolutely certain that you informed the patient of the risks is very difficult if there is no mention in your notes of having done so.

How extensive does the informed consent form need to be? I have been told that hospital consent forms do not really mean much.

Dr. Brown: Hospital consent forms do not constitute informed consent, they simply protect against a claim for battery (for unauthorized touching of another person). I have never seen a hospital consent form that outlines alternative treatment modalities or discusses expected results of nonintervention.

Ms. Rode: Hospital consent forms can be proof that a conversation took place, and that is vitally important. However, what we see more frequently are subsurgical specialties having their own consent forms, in addition to the hospital consent form, and these forms are presented in the office at the visit prior to the day of the procedure. The consent form can be tailored to the procedure, but it can still be general enough to cover the more common risks associated with the procedure in general terms. The informed consent conversation can also include the lesser-seen risks, and that's where the documentation comes in. It is important to remember that a physician can testify to his "usual custom and practice" regarding informed consent discussions that can encompass a lengthy and detailed conversation, which is reflected in a one-line note in the chart.

Should I develop separate, procedure-specific consent forms for each of the procedures I perform (eg, a separate form for abdominal aortic aneurysm intervention, a carotid intervention, a superficial femoral artery [SFA] stent, or an angioplasty, etc.)?

Ms. Rode: You can do so if the separate procedures carry significantly different risks and complications. What's important is that a form is signed after the patient has been fully informed, given sufficient time to ask questions, and that the conversation is documented, and at least one consent form is signed.

"Hospital consent forms do not constitute informed consent, they simply protect against a claim for battery . . ."

When a patient gives consent for a procedure and doesn't mention his family, should we contact the family after surgery to let them know it went well? I have had some instances in which the family was livid that I didn't let them know what was going on. If I should be telling the patient's family, does this collide with my duty of confidentiality under HIPPA?

Dr. Brown: If the patient comes to the office or is seen in the preoperative holding area with a family member or significant other present, it may be assumed that the [HIPPA] privilege has been waived. If not, it is best to ask the patient if there are any restrictions on which family members may be notified about the patient's condition.

Are we obligated to tell patients that some peripheral stenting is not approved by the FDA even though it is done very commonly?

Ms. Rode: Requirements regarding the disclosure of off-label uses likely vary by state. In Pennsylvania, a physician is under no obligation to advise a patient of the FDA status of a medical device (eg, Southard v. Temple Univ. Hosp., 781 A.2d 101 [Pa. 2001]). The law in your state may vary and on this important topic, and you should consult with local counsel.

I use many products off-label and outside of the Instructions for Use (IFU). I always notify the patients and family of this and note that the patient may be at increased risk of short- and long-term adverse events as a result of this. If adverse events do occur, what is my liability?

Dr. Brown: This will usually fall under the "standard of care" discussion. If what you do falls under the accepted "standard of care," it should not expose the surgeon to increased liability.

Mr. McChesney: The standard of care will usually be determined via expert testimony, so your liability for use of an off-label product may devolve into a battle of the experts regarding what is customary practice for endovascular specialists performing the procedure in question. (See "Monitoring Expert Testimony" on page 12.)

Ms. Rode: However, you should be prepared for the added sex appeal of the "investigatory/guinea pig" spin that the plaintiff's counsel will use to inflate the verdict/settlement value of a case involving off-label products. Insurance carriers take that factor very seriously in evaluating cases involving off-label devices, institutional review board protocol, etc.

"Your chances [of being sued] can be reduced with good communication with the patient, appropriate documentation, and good follow-up care . . ."

Given the different types of endografts used in endovascular repair, is the physician expected to relate complications of a specific device, or just those of endovascular repair in general?

Ms. Rode: If the specific risks associated with a particular device are recognized in the medical literature and acknowledged to have significant incidence rate, then the patient should be informed. For instance, if there is a procedure in which two devices may be used, and the devices carry different risks, the patient needs to be informed of the risks associated with both devices and consent to it (eg, in hip-replacement cases or other cases in which the choice of two devices is determined intraoperatively, the patient needs to know that device selection will take place during the procedure, and—if the risk associated with each device differs—the risks associated with each device).

Does a poor outcome alone indicate malpractice? Both surgical and endovascular repairs run risks of morbidity and complications. What determines when a procedure that goes badly is malpractice or simply a risk of the procedure?

Ms. Rode: Bad results do not mean bad medicine, and they do not always translate into a lawsuit. Unfortunately, however, bad results do often translate into lawsuits, even if they occurred under the best care. The chance of a bad result turning into a lawsuit sometimes cannot be avoided, but your chances can be reduced with good communication with the patient, appropriate documentation, and good follow-up care, especially when a complication occurs. Don't run and hide from the patient or problem. Don't let residents deal with the patient and family. Address complications and treat them appropriately.

In a malpractice suit, is every physician held to the same standard of excellence? Is a specialist 3 years out of fellowship working in a community hospital held to the same standard as the top specialist at a teaching hospital?

Dr. Brown: The standard of care is a national standard and is unaffected by the age or experience of the physician or the location of the event.

Ms. Rode: Although your state may hold to a different standard, in most states, a physician is held to that standard of care practiced by physicians in similar circumstances. A board-certified physician is held to the same standard as other board-certified physicians, whether he has practiced for 3 years or 30.

Assume that an endovascular specialist who has a great deal of experience performing interventions in one vessel bed has a poor outcome in another vessel bed in which he or she has very little experience (eg, a physician with great experience placing iliac stents has a poor outcome while placing a stent in the SFA). If the skills required to treat the two vessels are essentially the same, will the physician's inexperience in the particular vessel bed be grounds for liability?

Ms. Rode: Although inexperience performing an intervention in a particular vessel is not immediate grounds for liability, this would make for great cross-examination material for the plaintiff's attorney. The defendant may be criticized for treating a patient he "couldn't handle," or was not experienced enough to treat. In Pennsylvania, it will be up to the jury to determine whether the defendant is qualified to do the SFA intervention based on his training and experience with iliac stents, that endovascular specialists perform both procedures routinely, and that the unfortunate outcome in this case was the result of patient anatomy, disease morphology, or simply a risk associated with the procedure (which presumably the defendant included in the informed consent discussion and form).

Dr. Brown: To avoid such a claim, it is always best to inform the patient of your degree of experience with any procedure that you are going to perform prior to the procedure.

Can a defendant to a malpractice action shift blame for a poor outcome to the patient's own disease process, comorbidities, compliance with medical management, and behavior modification? For instance, if the patient has extensive vascular disease but refuses to quit smoking, the benefits from any intervention are likely to be fleeting. Can this be raised as a defense to a claim for malpractice if the outcome is unsatisfactory?

Dr. Brown: The legal theory in torts is that you "take the plaintiff as you find him." You can't blame preoperative comorbidities for a patient's postoperative results. However, if the plaintiff's conduct (as opposed to his anatomy, etc.) contributed to his injuries, the court may find that the patient was guilty of contributory negligence. Such a finding will likely not result in a defense verdict but often reduces the amount of the patient's ultimate award.

Ms. Rode: These issues can be raised by the defense experts, as they go to the issue of causation (eg, did the defendant's negligence cause the alleged damage, or was it caused by the plaintiff's refusal to stop smoking?). However, these issues are not "affirmative defenses" in the pleadings, which means you will not prevail without going to trial on this issue. But you also need to be mindful that the plaintiff can and will counter that the comorbidities may have precluded the defendant from performing the procedure in the first place.

In endovascular aortic aneurysm repair, frequent follow-up with the patient is usually required to monitor the ongoing safety of the device and ensure that the aneurysm is not growing and that the device has not migrated. What is my liability if the patient does not return for follow-up visits and a complication arises?

Ms. Rode: The patient's failure to comply with postprocedural visits is not likely to keep the physician from being sued. However, "Document, document, document." This is a great defense to a lawsuit and can be relied on by the defense expert. It is also a very powerful tool at plaintiff's deposition, trial testimony, and mediation. I suggest the following: The follow-up appointment schedule should be part of written instructions signed by the patient or family member prior to the procedure. Require the patient to provide a preferred phone number and mailing address on this signed form. If the patient is a no-show or cancels an appointment, document that in the chart. If the patient calls to cancel the appointment, be sure your staff instructs the patient regarding the importance of the follow-up visit and then includes this in the chart: "Patient was reminded about importance of postprocedural follow-up and urged to reschedule." Lines in a chart that back up the testimony of your staff may prevent the plaintiff's counsel from accepting the case and filing suit. A registered letter can also be a very effective defense.

We had a lung cancer case in Philadelphia in which the jury returned a defense verdict in favor of the doctor because the patient's lack of compliance and follow-up were incredibly well-documented in the patient's chart, including multiple telephone calls, letters, and finally a certified letter begging the patient to come back for follow-up of a lung lesion. Despite this documentation, the plaintiff still brought the suit, although several plaintiffs' lawyers turned the case down before the plaintiff found one who would file the ultimately unsuccessful suit.

"Honest interaction and communication about an adverse outcome can be done without an 'I'm sorry' or 'I'm at fault.' "

If a procedure goes badly, is there any recommendation on how best to interact with the patient's family? Are my apologies, offers of regret, or sympathy going to be used against me in a subsequent lawsuit to establish malpractice?

Dr. Brown: In some states, expressions of apology or sorrow cannot be used in court as an admission of guilt and are therefore excluded as evidence. As always, confirm with local counsel the status of the law in your jurisdiction.

Mr. McChesney: A number of states have enacted legislation that precludes the introduction of apologies into evidence in trials for malpractice, in order to encourage doctors to apologize without worrying about its effect in future litigation. The Institute of Medicine found that where such legislation exists or the practice is followed, fewer lawsuits were filed.[1]

Ms. Rode: Many specialties and institutional providers are going the route of apologies or sit-downs with patients and families after adverse outcomes. Some are even having patients sign mediation agreements prior to treatment. If your state allows the introduction of apologies into evidence and the apology is not made in a confidential setting (ie, mediation), it could become

evidence used against you later. However, honest interaction and communication about an adverse outcome can be done without an "I'm sorry" or "I'm at fault." Direct communication with the family and patient about a poor outcome and the course of treatment is usually the best avenue to take. When patients are not "kept in the loop," or feel that their physician is putting his head in the sand after an unanticipated outcome, it only serves to inflame their emotions and motivate a lawsuit. It can also impede settlement and inflate the settlement value for the plaintiff.

Sometimes the sales representatives for the device companies are the ones who determine the aneurysm or aorta size, or they are asked to confirm the physician's own sizing estimate. If the sales representative incorrectly estimates the size, and the patient's aneurysm subsequently ruptures, what would be the respective liability of the representative, his or her employer, and the treating physician? Would his actions constitute the practice of medicine without a license?

Dr. Brown: The sales representative would likely have no liability. The physician is responsible for measuring these grafts, although often the sales representatives do help with the sizing information. Sales representatives are a resource but are quick to explain that they are not physicians, and the final decision regarding the placement of an endograft is the sole responsibility of the treating physician.

What constitutes an expert witness?

Dr. Brown: In general, unless there is a specific state statute addressing this issue, the judge is allowed to determine if a physician is an appropriate medical expert for the case at hand.

Ms. Rode: Each state has its own standard to judge who can testify as an expert witness; some are codified by statute, whereas others are based on a standard set forth in case law. Here is a sample of the statute in Pennsylvania: "To be qualified to give expert medical testimony at a medical malpractice trial, the expert must possess sufficient education, training, knowledge, and experience to provide credible, competent testimony." Also, under other provisions of the code, the "physician must possess an unrestricted medical license in any state, have been engaged in active clinical practice or teaching within the previous 5 years, be familiar with applicable standards for care at issue, and have practical experience in the same subspecialty as the defendant doctor, or be board certified by the same or similar approved board as the defendant doctor." (The Pennsylvania courts have interpreted this last phrase to mean that a podiatrist cannot testify against an orthopedic surgeon if the injury occurs to the foot, etc.) The court can waive the subspecialty requirement if the defendant provided care for a condition that is not within the defendant's specialty. Courts can also find that the expert "possesses sufficient training, experience, and knowledge to provide testimony as a result of active involvement in or full-time teaching of medicine in the applicable subspecialty."

If I testify as an expert witness, what liabilities does this place me under? If an expert knowingly testifies falsely, what are the ramifications? What if the expert testifies incorrectly but is merely negligent in doing so?

Ms. Rode: First, whenever you testify, your sworn testimony is now part of the public record and preserved. If you are sued or testify as an expert again, your testimony in one trial can be used to cross-examine you in another. There are companies that maintain expert testimony in databanks, and attorneys contract with these companies across the country to obtain prior testimony. Some medical societies (including the SVS) are self-policing physicians who testify as experts.

Editor's Note: See accompanying article on Monitoring Expert Testimony, page 12, for more details on societal sanctions for inaccurate testimony.

Presume that a patient has an AAA with a short neck and does not meet the criteria for endovascular repair. Therefore, I modify the device to fit his aneurysm. Can I be sued, and if so what can I do to avoid a lawsuit or protect myself?

Dr. Brown: Clearly, you could be sued, but this would most likely fall under an informed consent issue. If you discussed your plan with the patient and his family prior to proceeding with the operation and then documented your discussion, you will have afforded yourself a significant defense.

Mr. McChesney: If the modified device were to fail subsequent to the procedure, this would also fall under the "standard of care" analysis, in which experts for both sides can argue as to what a reasonably prudent surgeon would do under similar circumstances (eg, was there an approved device available that did not require modification? Was there another treatment alternative?) ❐

1. Kohn LT, Corrigan JM, Donaldson MS, eds. To Err Is Human: Building a Safer Health System. Washington, DC. The National Academies Press; 2000.

LITIGATION TERMS AND DEFINITIONS

ARBITRATION

Most jurisdictions provide for arbitration by the parties, either as a mandatory step or as an option. Arbitrations are often required if the amount of damages requested is below a particular threshold (eg, in Pennsylvania, any case in which the amount of damages requested is below $50,000 must first go to arbitration). Arbitrations are proceedings held outside of the regular court system without the presence of a judge. A panel (usually composed of attorneys) hears the evidence and renders a verdict. In most jurisdictions, arbitration verdicts are not binding; if either party is dissatisfied with the verdict, he or she may file an appeal and receive a new trial presided by a judge, with liability determined by a jury. Many litigants like arbitrations because they are far less costly than a trial, are usually appealable, and can be used to convince a reluctant party to settle.

ANSWER

The document prepared by the defendant (or the defendant's attorney) to respond to the allegations contained in the plaintiff's complaint (see complaint). Generally, the defendant is required to admit or deny all factual allegations contained in the complaint but is not required to address conclusions of law.

COMPLAINT

A document that is filed with a court to commence a legal action. Most states require the plaintiff to provide detailed and numbered allegations of all facts required to support the plaintiff's claims along with all theories upon which the plaintiff alleges liability (informed consent, negligence, etc.).

DEPOSITION

A pretrial discovery proceeding in which any party can obtain the sworn testimony of any other party or witness. These are recorded via written transcription, video, or both, and can be used to cross-examine a witness at the time of a trial. Unlike trial testimony (which requires that all questions be relevant) most courts only restrict the scope of depositions to those matters "reasonably calculated to lead to discovery of admissible evidence." Hence, they often take all day and can seem like open-ended fishing expeditions with little connection to the basis of the lawsuit.

DISCOVERY

The process of obtaining information from each of the respective parties to the litigation prior to the trial.

INTERROGATORIES

Written questions directed to another party during the discovery phase. These questions must be answered within a specified period of time. Like deposition testimony, answers to interrogatories can be introduced as evidence at the time of a trial.

MEDITATION

Some jurisdictions require the parties to engage in mediation shortly after the pleadings have been filed. A court-appointed mediator will attempt to settle the case prior to either discovery or trial by providing the opinion of a neutral third party and advising each party of the weaknesses of their respective position. Because the mediator's role is to settle the case, they rarely—if ever—will tell a party that they have very little chance of prevailing at trial and try to convince both parties to give up something to achieve an amicable resolution.

MOTIONS

Motions are merely requests to the judge to do something. They can be filed before, during, and after a trial. Generally, the parties will file their pretrial motions and argue their position at a hearing before the judge, who then issues an order. The most common pretrial motions are Discovery Motions, Motion in Limine, and Motion for Summary Judgment.

DISCOVERY MOTIONS

These seek to either compel another party to comply with a request for discovery or prohibit a party from obtaining such information. If a party fails to respond to discovery requests, the court may grant a Motion to Compel, providing that such discovery must be answered within a particular timeframe, or face further sanctions such as preclusion of evidence at trial.

MOTION IN LIMINE

This pretrial motion seeks to prevent a party from introducing certain evidence at trial. This motion is particularly useful for eliminating any damaging and irrelevant evidence prior to trial so the jury never hears it.

MOTION FOR SUMMARY JUDGMENT

This motion seeks to have the judge decide the litigation in favor of either the defendant or plaintiff as a matter of law. This requires that the judge assume all disputed facts to be in favor of the nonmoving party, yet still hold that the moving party should prevail on the law.

NOTICE OF DEPOSITION

The process to compel the deposition of any party to the litigation and also the process by which opposing parties are notified of nonparty depositions.

PERSONAL JURISDICTION

Refers to the concept that the court of a given state can exercise any authority over the defendant. In order for a court to exercise jurisdiction, the defendant must be subject to the jurisdictional reach of the court. The Supreme Court of the US has held the requirements of due process limit the exercise of personal jurisdiction over nonresidents of a state, subject to certain exceptions. In order for a nonresident defendant to be subject to personal jurisdiction in the court of another state, the defendant must have a sufficient level of personal or business contacts with the state in which the court sits that the defendant could "reasonably expect" to be sued there. These contacts are referred to as "minimum contacts." A physician who lives in Pennsylvania but sometimes practices in New Jersey will likely be deemed to have minimum contacts for New Jersey courts to assert jurisdiction over the physician. Similarly, merely running advertisements in another state can sometimes be sufficient contact for a court to assert jurisdiction.

PLEADINGS

The complaint, answer(s), crossclaim(s), and any third-party complaints constitute the pleadings.

PROCESS SERVERS

City officials or persons employed by an attorney who serve a subpoena.

REQUEST FOR PRODUCTION OF DOCUMENTS

A pretrial request directed to a party to produce certain documents responsive to the request. These can be very burdensome ("All documents pertaining to your treatment of Alice Smith," etc.). Failure to produce all documents can prove troublesome if either the defendant later wishes to introduce a document that was not produced but would prove helpful, or the opposing side discovers the existence of a document that should have been produced and was not, giving the impression of a cover-up.

SUBPOENA

A writ or order directed to a nonparty requiring their appearance at a particular time and place to testify as a witness.

SUBPOENA DUCES TECUM

An order for a nonparty to appear at a deposition and produce business records listed in the subpoena for copying. Generally, any party complying with a subpoena for business records can merely provide the requesting party with the documents prior to the date of the deposition without need to attend. Most courts also permit a reasonable fee for the retrieval and reproduction of the documents.

SUMMONS

Also known as a writ of summon. An order to appear in a court of law.

THIRD-PARTY COMPLAINT

The document used by the defendant to add another party to the litigation whom the defendant believes is culpable (in whole or in part) for the plaintiff's injuries.

VENUE

Where the case will be tried. For cases tried in state courts, venue refers to the county (eg, Cook County, Illinois); for cases tried in federal court, venue refers to the district (eg, US District Court for the Southern District of New York). Venue is a concept distinct from jurisdiction, which focuses on the authority of a court to hear a particular case. Venue often revolves around concepts of fairness to the parties. Some recent malpractice reforms have addressed the practice of "forum shopping" by requiring a plaintiff to file lawsuits in the county where the malpractice occurred, instead of a more plaintiff-friendly venue nearby. ❐

Monitoring Expert Testimony

The Society for Vascular Surgery provides litigants with a new tool for combating inaccurate expert testimony.

BY CRAIG McCHESNEY, JD

You've just been sued for malpractice. When looking over the complaint, you read that the plaintiff (the party who filed the lawsuit) claims that 1 year ago, you failed to save his leg, the arteries of which were chronically occluded after years of smoking, diabetes, and obesity. You recall the case; you spent hours trying to revascularize the patient's occluded superficial femoral and popliteal arteries, but to no avail. You were unable to restore blood flow to the patient's foot. When surgical bypass was ruled out, the patient was referred for an amputation. The patient is now claiming that you were negligent and that your negligence was the proximate cause of his amputation. To add to your misery, you learn that another vascular surgeon is testifying on behalf of the plaintiff and is being well paid to testify against you. You eventually receive the report prepared by this surgeon who

"So, 12 people who have no medical background will need to assess which expert is accurately testifying regarding the state of endovascular therapy . . ."

TABLE 1. SUMMARY OF SVS GUIDELINES FOR TESTIMONY BY VASCULAR SURGEONS SERVING AS EXPERT WITNESSES IN LITIGATION

A vascular surgeon expert witness is required to abide by the following:

1. Be an impartial educator for the court.
2. Testify to the practice behavior of a "prudent vascular surgeon" and provide any different viewpoints that may exist within the field.
3. Identify as such any personal opinions that vary significantly from generally accepted vascular surgical practice.
4. Correctly "represent the full standard of vascular surgery care and shall with reasonable accuracy state whether a particular action was clearly within, clearly outside of, or close to the margins of the standard of vascular surgery care."
5. Not be evasive for the purpose of favoring one litigant over another, and answer all properly framed questions pertaining to his opinions relevant to the litigation.
6. Have sufficient knowledge of and experience in the specific subject of his or her written or oral testimony. Ideally, the witness should hold current hospital privileges to perform those procedures that are the subject of the testimony.
7. Review all pertinent available medical information regarding the patient whose care is the subject of the testimony before rendering an opinion about the appropriateness of the medical or surgical management of the patient.
8. Be very familiar with "prior and current concepts of standard vascular surgical practices before giving testimony or providing a written opinion about such practice standards. Ideally, the witness should be able to demonstrate evidence of continuing medical education relevant to the subject matter of the case."
9. Not accepting a contingency fee for providing expert medical opinion services.

THE SVS's PROCEDURE FOR PROCESSING CHARGES

Any active member or senior member in good standing may prefer charges alleging that a member is failing to maintain good professional standing or has violated the SVS Code of Ethics. Such charges may be made against any class of member, including suspended members. All charges shall be in writing and shall specify the basis therefore. Members wishing to initiate charges should send a letter to the SVS's legal counsel, spelling out in detail the medical issues involved and the testimony of the vascular surgeon whom they believe to have been unprofessional or unethical. The description should refer to the specific elements of the Code of Ethics or Expert Witness Guidelines that have been violated and should cite specific pages of the relevant transcripts supporting those charges. The full text of any relevant transcript should also be submitted with the charge. In order to comply with HIPAA requirements, any medical records that have not been made public through litigation should be depersonalized; however, any records that have been admitted as evidence in a trial and which are now matters of public record need not be depersonalized. ❐

claims that you "breached the standard of care" by failing to do—or not do—what this "expert" claims you should have done. While reading the report, you come to a slow boil, as this expert claims that your actions were inconsistent with what a reasonably prudent vascular specialist would do under similar circumstances.

You know that your actions were the same as what your peers would do and that this expert—and not you—is the one who is inconsistent with what other prudent endovascular specialists are doing. What can you do? Obviously, you are going to need to get an attorney. In addition, you (or your malpractice carrier) will also need to hire an expert to testify on your behalf, someone who will testify that your actions were in accordance with what any reasonably prudent endovascular specialist would do. But, where will that get you?

There will then be contradictory testimony from two endovascular specialists that will result in the "battle of the experts." This means that a jury of people from various educational backgrounds and professions will need to decide which medical expert is more credible. You can be fairly sure that the chance of having an endovascular specialist in the jury pool is slim (even if one were in the jury pool, he would be from the same city and likely know you, and therefore excluded). So, 12 people who have no medical background will need to assess which expert is accurately testifying regarding the state of endovascular therapy for treating peripheral vascular disease in a patient with these particular comorbidities. Depending on the sympathies of the jury, you'd probably have a better chance of winning a coin toss.

SOCIETAL ASSISTANCE

Some medical societies have looked at this scenario and have begun to fight back by requiring that their members' depositions and court testimonies be subject to review by the society. If the member is testifying falsely, or contrary to the accepted practice of the members of that society, that physician is subject to disciplinary action, including ejection from the society. In 2004, the Society for Vascular Surgery (SVS) adopted Guidelines for Testimony by Vascular Surgeons Serving as Expert Witnesses in Litigation, which are summarized in Table 1. Surgeons who believe another SVS member has violated these guidelines can report offenders to the society's legal counsel. The above sidebar outlines the procedure for processing charges for ethical violations. Once an SVS member makes such charges, the Professional Conduct Committee will then review the charges and take further action as warranted.

This remedy may only help you after the damage has been inflicted and the jury has rendered its verdict. At a minimum, however, by acting after your case is over, you may spare the next surgeon who would otherwise be on the receiving end of dubious expert testimony. Any expert who is ejected from their medical society because the society's peers deemed that he or she had previously provided testimony that was "outside of the margins of the standard of vascular surgery care" would be unable to credibly testify again because the cross examination on the grounds for the expert's ejection from the society would be devastating to the expert's credibility.

Finally, the SVS only recently adopted these standards, and their impact may take some time to materialize. As more surgeons learn of these standards and report offenders, the mere threat of such a proceeding may make the plaintiff's expert in your case think twice about providing testimony that is contrary to the accepted practice of a reasonably prudent vascular surgeon. ❐

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Litigation Preparation: Before You've Been Sued…

Five steps you can take today to protect yourself and your practice against a lawsuit.

BY ADAM B. KRAFCZEK, JR, ESQ, AND CHARLES M. O'DONNELL, ESQ

Just as the title applies to sports, it applies equally to your medical practice in today's litigious society. The fact is, if you encounter life-altering periprocedural complications, which most interventionists will at some point in their career, you risk a lawsuit. Unfortunately, you do not necessarily have to be negligent or at fault to get sued. Once you are served with legal process (ie, a Complaint, which is the first document typically filed in a lawsuit by a plaintiff), even if the suit has no merit, you can easily spend tens of thousands of dollars proving your innocence. The good news is that there are a few simple steps that you can take now to protect yourself and your practice.

STEP 1: CONSULT A LAWYER

Find and consult a competent attorney with whom you are comfortable, and ensure that he or she specializes in areas such as medical malpractice and corporate law. These issues require specialized expertise, and it is not advisable to consult your friend who specializes, for example, in probate law. Act now, because if you wait until after you are sued or are threatened with a suit, it may be too late. You cannot turn back the hands of time to change the corporate structure of your practice, your malpractice insurance coverage, your informed consent procedures, or your medical records. Your personal counsel can be vital to you and your practice during litigation.

STEP 2: EVALUATE YOUR PRACTICE

How is your medical practice structured? Who organized it and when, and why was the practice structured in that particular way? Are you at risk personally, in the event that you are singled out in a lawsuit? What is your exposure for acts of your employees or coworkers? These are questions you need to address with your attorney today. Whether you are a solo practitioner, or are involved in a large medical practice or a corporate structure (eg, partnership, corporation, limited liability corporation, or limited liability partnership), each practice structure provides different forms of protection. The laws that apply to corporate structures are constantly changing and often vary slightly from state to state. Consult your lawyer to ensure that your practice is legally established in the way that best suits your individual needs.

"… if you encounter life-altering periprocedural complications, which most interventionists will at some point in their career, you risk a lawsuit."

STEP 3: ASSESS YOUR INSURANCE

When was the last time you reviewed your malpractice insurance for both your practice and yourself? How much coverage is enough, particularly in light of issues concerning joint and several liability? Are you well-versed in the laws in your jurisdiction that govern joint and several liability? Do you have excess coverage, and is it really necessary? Chances are, you may not know the answers to these questions. If not, consult your lawyer and a reputable professional liability insurance broker.

STEP 4: REVISIT YOUR INFORMED CONSENT

Have you carefully read your informed consent, and is it written in layman's terms? What are the procedures for obtaining your patient's informed consent? Informed consent typically plays a role in every lawsuit, with the plaintiff alleging that it was inadequate, and the defendant asserting the informed consent as part of the defense. It is imperative that you review your current informed consent, practice, policies, and procedures with your attorney. Discuss whether it is advisable to have different types of informed consent documents, policies, and procedures depending on the type of patient, his or

her background, his or her occupation, and the level of risk involved.

"Unless you have previously been involved in a legal proceeding, you cannot fully appreciate the value of notes or the records of events and/or patient consultations . . ."

STEP 5: REVIEW YOUR RECORD KEEPING

How adept are you at keeping patient records? In this case, records do not strictly pertain to those medical in nature. Records can also refer to notes detailing conversations with your patients in which you have recorded questions they ask and your answers, consultations in which you advise the patient of procedural risks, and follow-up examinations, as well as your routine medical office practices. In the event that you are sued, expect a subpoena for all medical records relating to the patient in question, and then some. Unless you have previously been involved in a legal proceeding, you cannot fully appreciate the value of notes or the records of events and/or patient consultations that are documented at that time. This is one of the best forms of evidence you can present to a jury to demonstrate your actions, as opposed to your verbal testimony that you allegedly did or did not do something based solely on your recollection of events that have often occurred a year ago or more. If the testimony is strictly verbal, it is going to be your word against the plaintiff's, and your fate rests with a jury of your peers (or perhaps your patient's) to judge credibility. On the other hand, if the evidence is written contemporaneously with the issue at hand, it will be compelling. The rule of thumb is to document and to document well.

Although taking these and other defensive measures today will not guarantee you a "win" in the event you are one day faced with a lawsuit, it will certainly better position you, your practice, and your case. ❐

Litigation Preparation: After You've Been Sued…

Five steps you should take to protect yourself after you have been named in a lawsuit.

BY CRAIG McCHESNEY, JD

Once you have been sued, your ability to increase your malpractice insurance, restructure your corporate arrangements, or even shelter personal assets is limited. In fact, once the alleged malpractice occurs, it is usually too late to take many effective pre-emptive steps toward minimizing your exposure. There are, however, several things you should be doing to ensure a successful outcome and reduce future malpractice premiums.

STEP 1: RETAIN YOUR OWN LAWYER

Yes, your malpractice carrier will appoint a lawyer to act on your behalf, and yes, that lawyer's fees will paid by the carrier. So, why incur the additional expense of hiring your own lawyer when you already have one that doesn't cost you anything? Because you have more riding on the outcome of this case than either your insurance company or the lawyer they have hired.

Over the past decade, insurance companies have applied similar measures to both doctors and the defense attorneys hired to defend them. They have curtailed increases (or sometimes reduced) to the hourly rate paid to the attorneys, while scrupulously auditing legal bills to remove charges they deemed unnecessary such as "legal research" or "conference between attorneys." They have similarly decreed preset limits for many tasks, such as motions, pleadings, and review of records. If they deem the time for any task to be too high, they often unilaterally cut the fee, regardless of the amount of time the defense attorney spent on the task in question. The result has been that some insurance defense firms are filled with attorneys who are overworked, underpaid, and constrained by the insurance companies from providing a zealous and aggressive defense. The law firm's desire for more revenue in this environment has lead to a dramatic increase in the amount of billable hours required of their associates and partners. As a result, the defense attorney's order of priorities may become skewed, with an

". . . you have more riding on the outcome of this case than either your insurance company or the lawyer they have hired."

emphasis on following the insurance companies' rules regarding billing codes and status reports (to ensure proper levels of reserves on each case), performing those tasks that provide the easiest billable hour return, with the result obtained in a particular case coming in a distant third. The average plaintiff's lawyer is not constrained by such considerations. They normally take 33% to 40% of any verdict, but do not get paid unless there is a recovery. Once they accept a case, their only goal is to maximize their recovery. Accordingly, the attorney on the other side of the table from you is usually more motivated to get a large verdict than your insurance defense attorney is to ensure that there is no verdict. If they see a potential for a large verdict, they will throw all possible resources at the case, while your defense attorney is left asking the insurance company for permission to conduct one day's worth of legal research on a salient part of the defense. Unless you get proactive, this is the system that will be defending your case.

By hiring a personal attorney (with a background in litigation), you will have an advocate, familiar with the litigation process, who is interested solely in obtaining the best result for you, without regard to the insurance company's budget or interests. As soon as the suit has been filed, your personal attorney should insist on meeting with you and the attorney hired by the insurance company to plan the defense strategy, identify and interview key witnesses, and select the expert witnesses who should review your case and possibly testify on your behalf. You and your attorney should both insist on being copied on the peri-

odic status reports prepared by your defense attorney for the insurance adjuster, which summarizes deposition testimony and provides the legal opinion regarding your potential liability and the amount of exposure. Some insurance companies will allow you to choose your defense attorney, letting you have the representation you want without having to pay extra. This is often negotiated in advance at the time you obtain your policy, but is worth exploring at any time in the litigation process.

From the standpoint of the insurance defense attorney, the knowledge that another attorney is looking over his or her shoulder will likely result in better representation for you. At best, lawyers with a sense of professional pride will want to demonstrate to any colleague that they are providing the best possible care. At worst, no lawyer wants to be the subject of a legal malpractice case, which an involved personal attorney would be uniquely able to establish.

Finally, your personal attorney will also be able to ensure that all of your rights under your insurance contract are honored, including obtaining the best expert to testify on your behalf, and exercising as much control as possible over the decision to try or settle your case.

STEP 2: STAY ON TOP OF DISCOVERY

The discovery phase of the litigation usually begins with the filing of the Answer to the Complaint, and lasts for a predetermined length of time set by the court. Although courts will frequently grant a motion to extend a discovery deadline, neither you nor your attorney should count on that. If you have complied with all discovery deadlines and the opposition has not, you may gain an advantage later (for instance, if the other side needs more time and you oppose their motion to extend the deadlines).

The primary tools used in discovery are written interrogatories, requests to produce documents, and depositions. You, or someone at your office, should keep an eye toward complying with these requests, and ensuring that your answers are accurate and complete. If you make a misstatement in your discovery answers, you can usually amend those answers, but you should expect the plaintiff's attorney to highlight any inaccurate (and uncorrected) information at time of trial in an effort to establish a cover-up.

STEP 3: ACTIVELY PARTICIPATE IN THE EXPERT REPORTS (YOURS AND THEIRS)

No single aspect of your case is as important as the expert reports prepared by the two sides (or multiple sides in the frequent case of multiple defendants). Your liability will likely hinge on the experts' testimony and how credible each is to be perceived by the jury. You can greatly assist in this effort by providing your attorneys with names and contact information of experts who you believe possess the expertise to properly evaluate the standard of care that should have been exercised and your actions.

In addition, you should thoroughly review the expert reports of the plaintiff and any co-defendants and be familiar with their allegations of negligence against you and any other medical personnel. You are the expert and can provide your attorneys with invaluable insight that will assist them in their cross examination of the other experts who may be testifying against you. Anything that you can do to discredit these experts, such as providing text book quotes or published data that contradicts their assertions will assist your case tremendously.

STEP 4: PREPARE FOR YOUR DEPOSITION

Your deposition will be used by the plaintiff extensively in their preparation for trial. You should fully expect that they will go through every page to find any contradiction between your testimony and any written records, or the testimony of other witnesses. Therefore, you need to prepare for this deposition with the knowledge that it will be the major tool used to cross examine you at trial. The plaintiff's attorney will attempt to use any changes between your deposition testimony and your court room testimony to discredit you (ie, "Were you lying then or are you lying now?").

To prepare for your deposition, you should review all of the pre-, post-, and perioperative notes and records. These may jog your memory regarding some aspect of the case that you might otherwise have misstated.

You will also need to meet with your attorney prior to your deposition. He or she will provide you with the ground rules regarding your testimony.

STEP 5: ATTEND THE TRIAL

A jury will likely be evaluating whether you are liable or not for the plaintiff's damages. Occasionally, it may be a judge or an arbitration panel. The jurors are not medical specialists, and often they may make their decision based on whether they like you, feel sympathy for the plaintiff, or how well they like the attorneys representing the respective parties. Attending the entire trial will let the jurors get to observe you, and see how much this case means to you. ❐

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Protecting Your Assets From Malpractice Claims

Three mechanisms can prevent malpractice creditors from seizing your assets.

BY GIDEON ROTHSCHILD, ESQ, AND DANIEL S. RUBIN, ESQ

All signs indicate that the prevalence of litigation against physicians for malpractice is in a continuing upward spiral across the US. Although some malpractice claims are meritorious, far too many are not. In such an atmosphere, even the most skilled and diligent physicians are subject to an unacceptable level of risk. Aggravating this problem for physicians is the fact that even in those instances in which liability for malpractice might be clear, the extent of the injury (and the dollar amount of the damages) often remains subjective and can therefore be grossly inflated by an overzealous judge or jury.

Thankfully, the old adage that to be forewarned is to be forearmed still rings true, at least for those physicians who take heed before the onset of litigation. This article will demonstrate specific steps physicians can take to safeguard assets from future malpractice (and other) claims. Moreover, these steps can supplement and in some instances even replace professional liability insurance. Such steps are often referred to under the umbrella term *asset protection planning*.

TRANSFERS TO OTHERS

One of the most basic techniques used in asset protection planning is simply transferring assets to one's spouse or to (or in trust for) one's children or other family members. Although generally protective, such transfers involve surrendering (1) all rights to control the transferred assets, and (2) any certainty that the transferor can continue to enjoy the benefits of the transferred assets. Transferring assets to one's spouse also subjects the owner to the possibility of losing assets as a result of divorce. Additionally, such transfers (for less-than-adequate consideration) have sometimes been held to be subject to attachment by the transferor's creditors where the transferor earned most or all of the family's income. Using a legal fiction known as a *constructive trust*, the courts have sometimes held that the transferee spouse is merely holding the property as a trustee for the benefit of the transferor spouse, thus permitting a creditor to attach the transferred assets. Finally, to the extent that the transfer is later deemed a *fraudulent conveyance*, the transfer will be unwound by the courts and the transferred property will be paid over to the transferor's creditors.

". . . these steps can supplement and in some instances even replace professional liability insurance."

Other traditional planning techniques include the use of the homestead exemption, the use of exemptions for life insurance and annuities, and holding property with one's spouse as tenants by the entireties. Each of these techniques, however, is limited in its protectiveness and varies from state to state; the details are beyond the scope of this article.

LIMITED PARTNERSHIPS AND LIMITED LIABILITY COMPANIES

Transferring assets to a limited partnership or limited liability company is another fairly common asset protection technique. Under this technique, the owner of the property contributes it to a limited partnership in which he or she is the general partner, wherein other family members (including the transferor) are named as limited partners. As the general partner, the transferor retains control over the assets in a fiduciary capacity for the benefit of all of the partners. At the same time, the assets are generally secure from the claims of the creditors of any individual partner because the assets are owned by the entity, rather than by the individual partner. Under what is known as the *charging order protection*, a creditor of a limited partner is generally only entitled to attach the interest of the limited partner in the partnership, and thereby receives distribu-

tions only if and when distributions are made. Of course, if the general partner of the limited partnership is a family member, he or she is unlikely to make any such distributions until after the debtor partner has successfully settled the creditor's claim, which itself provides the debtor partner with the necessary leverage to do so.

". . . physicians should ideally structure their affairs . . . before the patient who ultimately becomes a plaintiff ever walks through their office door."

In addition to the asset protection benefits that a limited partnership can provide, it can also prove beneficial for more traditional estate planning purposes such as saving estate and gift taxes. For example, if a parent is the general partner and transfers a limited partner's interest in a limited partnership to his or her children, the value of the transferred interest will likely be entitled to a discount from the value of the underlying assets of the entity because the transferred interest is (1) noncontrolling and (2) has no public market. Moreover, because the parent, as general partner, retains total management control over the assets held within the entity (albeit in a fiduciary capacity for the benefit of all the partners), the oft-cited fear of a child obtaining access to substantial sums of money immediately upon attaining majority (as would be the case with a Uniform Gifts to Minors Account or a Uniform Transfers to Minors Account), is not an issue.

THE OFFSHORE ASSET PROTECTION TRUST

Where the liability risk warrants additional protection (at additional cost and complexity), and where the physician desires to retain an interest in the property, the partnership technique can be married to an offshore asset protection trust. As implied by its name, such a trust takes advantage of the law of certain select foreign jurisdictions. These jurisdictions have enacted legislation aimed at attracting trust business by protecting the trust fund from creditor claims, even where the person who established the trust is also a beneficiary thereof. The trust must generally be established offshore because the law of most of the US posits that where a person establishes a domestic trust, and is also a beneficiary of that trust, the trust fund is available to that person's creditors to the full extent of his or her beneficial interest. This principle of domestic trust law holds true even where the trust was established at a time when no creditors existed and even if the future potential for such creditors was wholly unforeseeable at that time. Although four states have enacted legislation enabling such creditor protection for self-settled trusts, significant uncertainty remains as to their effectiveness.

Interestingly, the term *offshore trust* is somewhat of a misnomer in this context. Although an asset protection trust must provide that it is to be governed by the law of an offshore jurisdiction in order to receive the benefits of the asset protection trust, the assets of the trust can actually remain in the US. To avoid losing control over the property, the trust can be combined with a limited partnership wherein the physician is the general partner retaining a 1% interest and the trust receives a 99% limited partnership interest. If the trust only holds a limited partner's interest in the limited partnership, the trustee has no "day-to-day" authority over the transferred assets in any event. Instead, the general partner maintains control over the partnership investments until such time that an actual transfer of the partnership's assets offshore may be warranted due to a more imminent threat.

THE PROBLEM OF FRAUDULENT CONVEYANCES

The transfer of assets in anticipation of a creditor problem might be deemed a fraudulent conveyance under the law of most states. Accordingly, asset protection planning must be sensitive to avoid circumstances in which the transfer of property appears to have occurred with the intent to hinder, delay, or defraud creditors. Certainly, no transfers can be made that would have the effect (after consideration is given to any pending or threatened litigation) of rendering the transferor insolvent. Under all other circumstances, the issue boils down to how little time elapsed between the time of the transfer and the time of the subsequent creditor's claim. It is therefore imperative that asset protection planning is undertaken as far in advance of a potential creditor claim as possible—physicians should ideally structure their affairs for asset protection before the patient who ultimately becomes a plaintiff ever walks through their office door. Given proper planning, asset protection can be an achievable goal. ■

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