Notable Grand Rounds

of the

Michael & Marian Ilitch
Department of Surgery

Wayne State University
School of Medicine

Detroit, Michigan, USA

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PRACTICING MEDICINE UNDER THE SHADOW OF LITIGATION

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About Notable Grand Rounds

These assembled papers are edited transcripts of didactic lectures given by mainly senior residents, but also some distinguished attending and guests, at the Grand Rounds of the Michael and Marian Ilitch Department of Surgery at the Wayne State University School of Medicine.

Every week, approximately 50 faculty attending surgeons and surgical residents meet to conduct postmortems on cases that did not go well. That “Mortality and Morbidity” conference is followed immediately by Grand Rounds.

This collection is not intended as a scholarly journal, but in a significant way it is a peer reviewed publication by virtue of the fact that every presentation is examined in great detail by those 50 or so surgeons.

It serves to honor the presenters for their effort, to potentially serve as first draft for an article for submission to a medical journal, to let residents and potential residents see the high standard achieved by their peers and expected of them, and by no means least, to contribute to better patient care.

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Practicing Medicine Under the Shadow of Litigation

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Editor's Note: This paper is an abridged version of the authors' presentation at Surgical Grand Rounds of the Michael and Marian Ilitch Department of Surgery, Wayne State University School of Medicine.

Author Note. The perspectives summarized here draw on decades of Michigan malpractice defense on behalf of physicians and hospitals, including trial experience across multiple specialties. Our goal is not to turn clinicians into lawyers, but to help good doctors practice—and, when necessary, defend—good medicine.

Introduction

Physicians enter practice to care for patients, not to defend lawsuits. Yet across a career, most will face a malpractice claim—sometimes more than one—regardless of how conscientious or skilled their care has been. What propels claims is rarely a tidy "black-and-white" definition of negligence. Rather, lawsuits arise at the intersection of adverse outcomes, perceived opacity, and a civil justice system that translates alleged wrongs into money damages. Understanding that ecosystem—and your place in it—helps you protect patients, yourself, and your professional standing.

The Business of Medical Malpractice

Medical malpractice is a business. Plaintiffs' attorneys generally work on contingency, advancing costs and recovering fees only when cash is obtained by settlement or verdict. That structure lowers the barrier to entry for would-be plaintiffs: a phone call, an intake, acquisition of records, and—if the file looks promising—the retention of an expert. Advertising amplifies the pipeline; in many markets, high-visibility firms field voluminous daily inquiries, triaging for cases with revenue potential. The patient's initial impetus is often emotional and informational:

"Something went wrong, and no one explained why." When patients or families leave a hospital without a clear account of what happened and why, the probability of that first phone call goes up.

Damages, Caps, and the National Practitioner Data Bank

In Michigan, noneconomic damages (pain and suffering) are capped at two statutory tiers; economic damages (wages, services, life-care costs) are uncapped and often drive case valuation. Birth-injury claims exemplify the dynamic: projected lifetime care costs can swell to tens of millions, making such cases especially attractive to the plaintiffs' bar. Defense counsel and insurers therefore focus early on realistic exposure, sometimes pressing to settle even where the medicine is defensible. For named clinicians, a settlement can mean reporting to the National Practitioner Data Bank, with potential implications for credentialing and insurability. This is where self-advocacy matters: if you are named, make your voice heard on strategy, experts, and the advisability of settlement versus trial. Juries often want to believe the treating physician—if the physician shows up prepared, credible, and human.

A special note on "gross negligence": in extraordinary circumstances, plaintiffs may argue that caps do not apply and that personal exposure can exceed policy limits. While such scenarios are uncommon, they underscore the practical value of robust limits (e.g., $500,000 to $1,000,000 per claim) and clear communication with your carrier about consent-to-settle provisions.

What "Standard of Care" Really Means—and Why Experts Rule the Gate

The "standard of care" is what a reasonably prudent physician in your specialty would (or would not) do under the same or similar circumstances. That is inherently contextual; multiple reasonable approaches can coexist. Michigan law requires that plaintiffs file an affidavit of merit from a same-specialty physician (e.g., a board-certified general surgeon criticizing a board-certified general surgeon) who, at the time of the alleged negligence and during the prior year, dedicated the majority of professional time to practicing in that specialty. The defense must answer with an affidavit of meritorious defense—often from a parallel expert. The duel of experts frames the case; your credibility and clarity complete it.

Where do experts come from? Plaintiffs frequently shop nationally—sometimes via public directories in which experts openly advertise and post fee schedules. Defense teams tend to avoid "frequent flyers" prone to inconsistent testimony and prefer well-credentialed, practicing specialists with scholarly engagement and reputational ballast. Jurors also notice geography and relationship: a respected local voice can carry persuasive weight, while overly cozy personal ties can raise bias concerns. If you know a superb, independent colleague—especially someone with relevant publications—tell your lawyer. Your suggestions often improve the defense's options.

Recurrent Allegations and Illustrative Patterns

Certain themes recur across surgical claims:

- **Known complications framed as negligence.** Consent discussions and documentation matter because jurors intuitively grasp that accepted risks are not proof of substandard care. Yet plaintiffs' experts will argue that even a known risk was avoidable here. This is where your reasoning and contemporaneous notes are vital.
- **Wrong-site or wrong-procedure events.** Busy ORs and cascading schedule pressures erode verification rituals. Never delegate final identity, site, and procedure confirmation; "trust but verify" with your own eyes and voice, every time.

- **Misdiagnosis or delay in diagnosis across fragmented care.** When many services are involved, responsibility can diffuse. Juries resist "not my lane" defenses. If you are on a case and the clinical trajectory is stalling, document your concern and your recommendation—even when another service "owns" the problem.

One memorable matter began as suspected appendicitis in a young woman and ended with the unintended removal of an ovary, later followed by a prompt return to obtain the appendix. The central dispute became not "Was the surgeon evil or inept?" but damages—specifically, the monetary cost of future fertility assistance. The case ultimately resolved confidentially within the health system. Precision, humility, and prompt, plain-language communication with the patient and family were indispensable.

Documentation in the EMR Era: Your Best Friend, Your Worst Witness

Electronic records improve continuity but create traps. Copy-and-paste progress notes invite cross-examination: identical exams for days, mismatched vitals, and templated language undermine the assertion that you personally assessed the patient. Jurors will hear, "If the nurses documented a drop in blood pressure, why does the your note on day 4 parrot the note you wrote on day 1, word-for-word?" Practical fixes include documenting the pre-op conversation on the day of surgery, explicitly noting "see prior note; today's changes are…" and ensuring that critical data (e.g., vital signs) match nursing flowsheets. And remember: the person whose name sits under the note gets named in the suit.

The Litigation Lifecycle in Michigan

Michigan's tort-reform architecture front-loads expert scrutiny and provides an early "cooling-off" window:

- **Notice of Intent (NOI).** Before suing, plaintiffs must serve a detailed NOI on all potential defendants, laying out facts, alleged breaches by each specialty, and causation theory. The NOI triggers roughly six months of waiting before a complaint can be filed. Use that time: alert risk management immediately, engage with assigned counsel, and help assemble the medical and scientific story.
- **Complaint and Affidavits.** The complaint must be filed with an affidavit of merit; the defense answers with an affidavit of meritorious defense. Discovery then opens. Plaintiffs are deposed first; named clinicians follow, carefully prepared. Expert depositions often determine whether the matter settles or tries.
- **Limitations Periods.** Generally two years from the date of alleged malpractice (with NOI tolling). Wrongful-death matters follow a savings provision: two years from appointment of the estate's personal representative, capped at five years from the malpractice date.

Insurance Dynamics, Consent to Settle, and Choosing Counsel

Your carrier pays defense costs and, absent a consent-to-settle clause, often controls settlement. That can place your interests (e.g., avoiding a National Practitioner Data Bank hit) at tension with institutional risk management. Stay engaged. Communicate directly with your claims representative about experts, trial posture, and the consequences of settlement for your credentials. Many institutions will honor a physician's request for specific defense counsel, especially where there is prior experience and trust. Ask.

Preventive Medicine for Litigation Risk

Several habits lower the likelihood of becoming a target—and strengthen your defense if sued.

- **Communicate early, plainly, and often.** Patients and families chiefly seek lawyers when they feel ignored, confused, or misled. A few more minutes at the bedside, an honest

explanation after a complication, and a clear articulation of roles in a multi-service admission go further than any script. Availability and follow-up convey respect.

- **Own the verification steps.** Identity, site, procedure, and consent are yours to confirm, aloud, every time. In the OR crunch, shortcuts invite indefensible outcomes.
- **Document what matters—today.** Avoid boilerplate repetition. Record the encounter that jurors will later imagine: that you were there, you examined, you thought, you decided, and you explained.
- **Be a citizen in the care team.** If the plan stalls and your clinical radar pings, say so in the chart and to colleagues. Juries reward physicians who notice and advocate rather than retreat behind service lines. Conversely, resist the temptation to disparage prior clinicians; "expertizing" your community in the clinic note tends to boomerang.
- **Be your own best advocate if named.** Bring literature, suggest experts, prepare relentlessly, and present yourself to jurors as you do to patients: clear, candid, and calm. Most cases never reach verdict—and those that do are winnable when the medicine is sound and the physician is credible.

Conclusion

Malpractice litigation reflects how our civil system prices adverse medical events and unmet expectations. You cannot eliminate that reality, but you can navigate it. Communicate like a teacher, document like a scientist, verify like a pilot, collaborate like a colleague, and advocate like a professional whose name and reputation matter—because they do. Do these things consistently and, should a claim arise, you will be ready to meet it with facts, empathy, and poise.

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