

FSL Frank Spector Law, LLC

A BALTIMORE MALPRACTICE ATTORNEY'S GUIDE

Maryland Birth Injury and Medical Malpractice Claims

What Baltimore Families Need to Know About Proof, Deadlines, and Who Pays

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Foreword

A Maryland birth injury claim is a medical malpractice claim, brought for a child and a family, that rests on one finding: care during labor and delivery fell below the accepted standard, and that shortfall caused lasting harm. It is built from the same pieces as any other malpractice claim, and it adds a question the others seldom carry, which is what a child will need over a lifetime. *Maryland Birth Injury and Medical Malpractice Claims* sets out those pieces in the order a Baltimore family meets them.

Each piece has a name and a measure. The standard of care is the measure of what a doctor should have done, drawn from nationally recognized guidelines. The certificate of qualified expert, which Maryland generally requires, is a signed statement from another doctor, with that doctor's report attached, that the standard was not met. The filing deadline is a clock. Three years from the injury is the working count Frank Spector gives an adult, a child's clock runs far longer, and the Maryland statute, not the working rule, governs. The medical record is the evidence, and in a delivery the baby strips that trace a heart rate through labor can show when an injury occurs. Insurance decides what a recovery can be in practice. Damages divide into economic losses, which Frank describes as not limited, and non-economic losses, which the statute caps (section 3-2A-09, which also limits past medical expenses to amounts paid or owed). The book uses each of these terms the same way every time it appears.

Frank Spector has spent more than thirty-five years in the law in Baltimore, and he practices medical malpractice law. He is the founder of Frank Spector Law and, by his own account, is licensed throughout Maryland and in Washington, DC. A fourth-generation Baltimorean, he attended the McDonogh School, studied at Duke University, and earned his law degree with honors at the University of Baltimore School of Law, where he later served as an adjunct professor for two or three years. Super Lawyers has recognized his work. He names birth injury as the hardest work he handles.

The chapters were adapted from three recorded episodes of his podcast, Baltimore Malpractice with Frank Spector, which is available on Apple Podcasts and Spotify. The founder interview, the first episode, supplies his account of how he came to this work and how he handles a first call. The second episode is the recording behind the chapters on cross-claims and on defendants who blame one another.

The opening chapters draw the claim itself. Chapters 1 and 2 separate a bad outcome from malpractice and show how a negligence case is assembled, and Chapter 3 explains what makes a birth injury case different from a surgery or diagnosis case. Chapters 8 through 11 then take the working parts one at a time: the medical record and how experts reconstruct a delivery, shoulder dystocia and Erb's palsy, the certificate, and the deadline.

Around that center, the other chapters widen the view. Chapter 4 covers the surgery, anesthesia and missed-diagnosis calls that fill the rest of a malpractice practice. Chapters 5 through 7 follow a family from its first steps to the first conversation with a lawyer, and Chapter 6 takes on the myths. Chapters 12 through 14 follow the claim to the parties named, the insurance behind them and the recovery Maryland allows. Chapters 15 through 18 show how a case becomes a story a jury can follow, what defendants file against one another, and who decides whether a case settles. The last two chapters take up accountability, what families ask for beyond money, and the distance that technology and hospitalists place between doctor and patient.

Three chapters meet the questions families bring first. Chapter 5 answers what to do now: write down what you remember, get the medical records, and speak with a lawyer before speaking with the hospital. Chapter 11 answers how long a family has, the question that can end a claim before anyone reads the records. Chapter 14 answers what a family can recover, and where Maryland draws its lines.

Frank is plain about limits. He says a bad outcome is not always malpractice, that a very small share of the people who call become cases, and that when he cannot help he tells the caller why. On a first call he can often say there is no case. When there may be one, the investigation takes months before he can say so. And the decision to settle belongs to the client, not to him.

Read this before the first meeting with a lawyer, and bring your questions. Understanding a Maryland birth injury claim does not undo what happened to a child. It lets a family decide what comes next with the facts in hand.

About the Author



Frank Spector, founder of Frank Spector Law

Frank Spector is a Baltimore trial lawyer who represents patients and families harmed by medical mistakes, including families bringing a Maryland birth injury claim, and the founder of Frank Spector Law. His practice covers surgical complications, anesthesia errors, misdiagnosis and failure to diagnose, and birth injury, which he calls the toughest work he does. He has practiced for more than thirty-five years, and he is licensed throughout Maryland and in Washington, DC.

He is a third-generation lawyer, with a grandfather, a father, and a mother in the law, and a fourth-generation Baltimorean. He attended the McDonogh School from first grade through twelfth, studied political science at Duke University, and graduated with honors from the University of Baltimore School of Law, where he met his wife, who sat next to him on the first day of class. He first learned the law of personal injury there, in a torts course, and had seen it practiced at home.

After law school Frank joined a Baltimore firm, where a mentor he describes as probably one of the best trial lawyers in Baltimore taught him how to try a case. As a young lawyer he took on a medical malpractice case, found that he liked medicine, and stayed with the work. He later opened his own firm. He is Baltimore based, with a practice centered on Baltimore City, Baltimore County, Harford County, and Howard County, and substantial experience in Montgomery County, Prince George's County, and the District. The firm's Baltimore office is listed online.

Frank also teaches. He served as an adjunct professor at his law school for two or three years, leading a trial advocacy course on how to build a case from the beginning and an externship seminar on practicing law in the real world. He has lectured on trial advocacy and on professional

ethics, in Maryland and on nationwide platforms, and keeps current through continuing legal education. His peers have named him to Super Lawyers, a recognition he values because it comes from other lawyers.

That background is the reason for this book. Frank explains Maryland medical malpractice law on Baltimore Malpractice with Frank Spector, the podcast where the conversations behind these chapters were recorded, and on his YouTube channel, TikTok, and Instagram. His reasoning is plain. If a family calls after a deadline has passed, there is nothing he can do, so the rules should be known before anyone needs them.

He describes the firm's mission as guiding families through a process that feels like a foreign country, listening first, and telling people the truth about their case, including when the answer is that there is no case. Families who want to talk through what happened can contact the firm, and the message goes to Frank himself.

Introduction

If you are reading this book, something happened in a hospital or a doctor's office, and your life, or your child's, was turned upside down. Maybe it was last week. Maybe it was years ago and you are only now ready to ask what went wrong. You are carrying questions, and in thirty-five years of practice in Baltimore I have heard a lot of them. Was it a mistake, or did something simply go badly? Is there a case? How long do I have? Who is responsible, and who pays?

I can't turn back the hands of time, and I wish that I could. What I can offer is a calm hand and the truth about how a Maryland claim works. A lawsuit is like going into a foreign country. You do not speak the language, and you do not know where to go. This book is meant to be your guide, so that you have a map before you ever sit down with a lawyer.

The spine is simple. A bad outcome is not always malpractice. A claim rests on the standard of care, which is what we call the measure of what a doctor should have done, and on a second doctor willing to say it was not met. It rests on the medical record, which is the Bible of a case. It generally needs a certificate of qualified expert, and it has to be filed on time. Then come the questions of who is named, what insurance sits behind each name, what a family can recover and what Maryland limits. Last, who decides whether a case settles. The answer to that one is the client, and I say so plainly.

Birth injury runs through the book because those are the toughest cases for me to handle. A moment of joy becomes a disaster, and I never lose sight of that. I also write about surgery, anesthesia and missed diagnoses, because those are calls I hear too.

Here is what this book is not. It is not legal advice, and it is not a promise about any case. Every case turns on its own records, and a lawyer has to read them before anyone can say what a case is. Let's manage your expectations from the first page: a very small share of the callers I hear from become cases, and I will explain why. Every legal term is defined the moment it appears.

You do not have to read in order. Start with the chapter closest to the question that brought you here, and come back to the rest when you are ready.

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CHAPTER ONE

When a Bad Outcome Is Medical Malpractice, and When It Is Not

When a family calls me, there is a question underneath all the others, and it usually comes out as some version of this: was what happened to us a mistake? It is a fair question. The law answers it in a particular way, and the answer is not yes every time something goes badly in a hospital.

I tell everybody like it is. I use the term straight talk for that, and this chapter is straight talk about the line between a result nobody wanted and a medical malpractice case. A lot of people want to know where that line sits and what it means for the call they are about to make.

We will take it in order. First comes the yardstick the law uses, what we call the standard of care. Then the place of risk in every birth and every operation. Then the second question, whether any shortfall caused the injury. After that comes vocabulary, because malpractice, negligence, neglect and abuse get used as though they were different claims, and one of those words leads some people to decide they have no case. The chapter ends with a communication gap I see between patients and the healthcare system, and with how I try to set expectations from the first conversation.

> ***“the idea that you have a bad outcome or something bad happens to you doesn’t necessarily mean there’s medical malpractice.”***
>
> — FRANK SPECTOR, ON THE DIFFERENCE BETWEEN A BAD OUTCOME AND MALPRACTICE

A bad result is a fact about the outcome, not a finding about the care

The size of a harm tells you how much was lost. It does not tell you why. Everything else in this chapter rests on that, so let me put it as plainly as I can: a patient can be badly hurt, and the care that came before the hurt can still have been the care a doctor is expected to give.

Maryland’s statute gives the injury its own definition. The law defines a “medical injury” as injury arising or resulting from the rendering or failure to render health care (Maryland Courts and Judicial Proceedings section 3-2A-01(g)). That is the wording of the statute, not mine. It tells you where an injury came from. Whether anyone was at fault is a separate question, and it is the one this chapter is about.

Let's suppose two people leave an operating room with the same kind of injury. In the first case the care followed the guidelines and the injury came from a risk of the operation. In the second the care fell below the guidelines and that failure caused the injury. The first is a bad outcome. The second is what we call medical malpractice. Nothing about the injury itself separates them. What separates them is what the care looked like and whether it caused the harm.

So I do not treat a result as an answer. The result is where I start asking, and the questions I ask come from the standard of care.

The standard of care in plain words

The term that we use is the standard of care. What that means is that there are *"nationally recognized guidelines of what doctors should do and shouldn't do."* Those guidelines are the yardstick. A lawyer like me measures the care against them, and not against how the result turned out.

The most important element of the case is the one I just named. As I put it, *"The most important thing that we have to prove is we have to prove something called a violation of the standard of care."* Those of us who do this for a living know what the phrase means, and it rolls off our tongues. A family has no reason to know it, which is why I define it before I use it.

How is it proved? Through other doctors. We have other doctors come into court who know what the standards of care are and who are able to tell the jury how those standards were violated or not adhered to. The work begins well before a courtroom. I consult with a practicing doctor who is familiar with the standards of care and the medical literature and who has lots of experience. That doctor's job is to say whether the doctor we are bringing a lawsuit against fell below the standards of care.

Then comes the part families find hard to hear. If we are unable to get a doctor to say that what the other doctor did was wrong, we can't move forward on a case. A family's belief that something went wrong deserves a hearing. It cannot stand in for a doctor who knows the guidelines and has reviewed what was done. Chapter 10 explains the signed certificate that Maryland generally requires from that doctor, and Chapter 2 builds the negligence case on the standard itself.

Risk comes with every birth and every operation

The other question that comes up right away is about risk. Here is how I answer it: *"there are risks to every birth, there are risks to every surgery."* A lot of people have surgery, whether that is elective surgery or emergency surgery, and a mother going into labor faces the risks of a birth. Risk is part of the care before anyone is hurt.

I have to be careful about what follows from that. Someone who has an injury from a risk has been hurt, and I will not shrink that. But just because someone has an injury from a risk doesn't necessarily mean that it is medical malpractice. Like I said, we have to go back to the standard of care.

Let's suppose a person has an operation, and one of the risks of that operation happens to them. The injury is real. Is it malpractice? Not by itself. The question I go back to is the same one I always go back to: did the care meet the standard? If it did, an injury from a risk does not become malpractice just because it hurt. If it did not, we are having a different conversation, and the next section is about what that conversation requires.

Falling short is half the case: the departure also has to cause the injury

There are two questions in these cases. Did the care fall below the standard? And did that departure cause this injury? Like I said, the first is the standard of care. The second is a separate question. As I explain it, *"we have to prove that that violation or breach of the standard of care caused the injury in question."*

Both questions take work. In a birth injury case I go through the medical records with a fine tooth comb and build timelines of when things happened. Everything is charted: when a nurse comes in, when a nurse goes out, when a doctor comes in, when a doctor goes out. One of the records that helps is the baby monitor strip from labor, which can show when an injury occurs, whether that is because of a delay in delivery or sometime earlier. When the injury occurred matters to the second question. Chapter 8 and Chapter 9 take those records apart.

Then we consult with practicing obstetricians or other specialists who go through the records alongside us. Together we look at whether the standards of care were met, whether any violation caused injury, and how severe and how permanent the injuries are. It takes a lot of work on the front end. It takes months of investigation before we are able to tell someone that they have a case.

That does not mean every answer takes months. A caller who reaches me speaks to me directly, and I can often tell that person early on that I don't see a case. Confirming that a case exists is the slow work.

Malpractice, negligence, neglect and abuse describe one claim

A lot of people describe this subject with different names: medical negligence, medical malpractice, medical neglect, medical abuse. I keep using the term malpractice, and the others mean the same thing. As I say it, *"A lot of people use all these terms to mean the same thing."* A medical

accident and a medical mistake belong on that list too.

I hear the confusion on the phone. Callers tell me they don't want to bring a medical malpractice case, but they do want to bring a medical negligence case. I explain that they are one and the same. I like to talk about a case by its ingredients, and I can tell you that *"It's the same ingredients that go in to a case, no matter what you call it."* That matters, because a person should know that the label does not change what has to be proved.

Malpractice is the word that causes trouble. Here is how I describe the problem: the word malpractice sometimes makes people think *"my doctor did something on purpose or they did it with the intent to hurt me."* Then they tell themselves they will never be able to prove that, and so they decide that they don't have a case. They believe malpractice means something different than negligence does.

It doesn't. Medical malpractice and medical negligence mean the same thing, and the most important element to prove is a violation of the standard of care. A person who decides on the strength of a single word that they have no case has been misled by that word. The facts come first, and the label does not change them.

The gap between what a patient expected and what happened

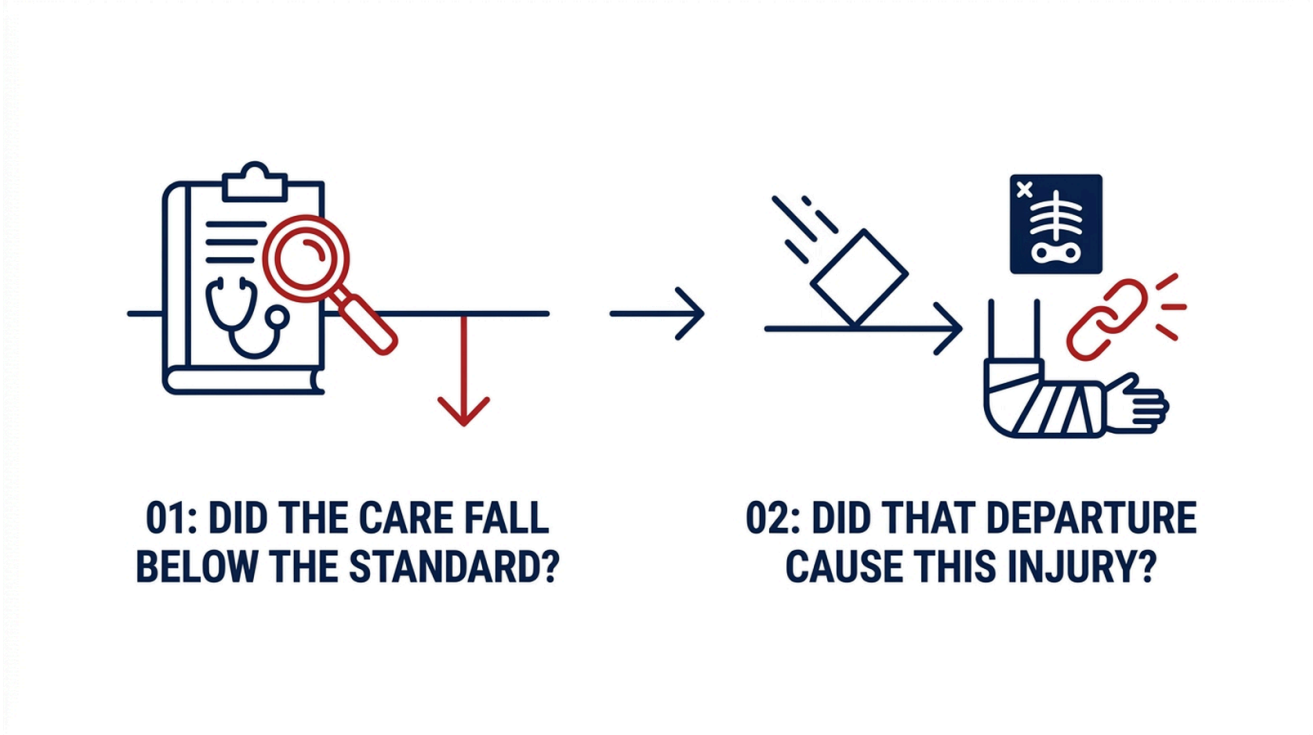
A lot of my clients are very upset to learn that the outcome they have after surgery isn't what they expected. I hear it around neurosurgery, where a lot of people get spinal fusions or neck fusions, which are very complicated operations that people get frequently, especially as they age. There are a lot of complications around those operations, and a lot of miscommunication too.

What I see is *"a communication problem between the healthcare system and the patient."* In my view, the patient has not been grounded in what to expect and in what the outcome should be. I am describing a gap in communication. I am not calling it malpractice. A gap between what a person expected and what happened is a good reason to start asking questions, and it is not an answer to them. The answer comes from the two questions in this chapter.

That is why expectations come up at the start of a case. After thirty-five years of this work, here is how I put it: *"at the beginning, you have to make sure that the expectations are aligned."* I tell everybody like it is. I explain what the process looks like, how long it will take, what the potential outcomes are and what the decision points will be. I tell my clients, *"let's manage our expectations."*

Let's suppose a family leaves a first conversation believing that a bad result and a winning case are the same thing. They could be set up for a harder disappointment later. So I say the other half out loud. Whether it is a medical malpractice case or a birth injury case, I think the common mis-

take is not managing expectations. I can't turn back the hands of time. I wish that I could. What I can do is give a family an honest account of what the law asks, and the first honest thing to say is that a bad outcome does not settle the matter either way.



The two questions that decide a malpractice case

Common Questions

Does a bad medical outcome mean malpractice? No, not necessarily. A bad result tells you what happened to the patient, not whether the care met the standard of care. Medical care carries risk, and an injury from a risk is not automatically malpractice. Two questions decide it: did the care fall below the nationally recognized guidelines, and did that departure cause this injury? A bad outcome alone answers neither one.

What is the standard of care in a medical malpractice case? It is the set of nationally recognized guidelines for what doctors should and shouldn't do. A case starts when a doctor's care fell below them. I prove that through other doctors who know the standards and can tell a jury how they were violated. As I put it, *"If we are unable to get a doctor to say that what the other doctor did was wrong, well, we can't move forward on a case."*

Is medical negligence the same as medical malpractice? Yes. Malpractice, negligence, neglect and abuse are terms people use for the same thing, and the same ingredients go into the case whichever one you choose. Some callers tell me they want a negligence case but not a mal-

practice case. I explain that, as I put it, *"they're all one and the same."* What I have to prove first is a violation of the standard of care.

Does malpractice mean the doctor meant to hurt me? No. The word can make people think a doctor acted on purpose, and that thought leads some of them to decide they cannot prove it and have no case. But malpractice and negligence mean the same thing, and the most important element I have to prove is a violation of the standard of care. A person should not give up on a claim because of what a word sounds like.

Why are patients surprised when surgery does not turn out as they expected? To me it is a communication problem between the healthcare system and the patient. A lot of my clients are upset to learn the outcome after surgery isn't what they expected, and I see it with complicated operations like spinal and neck fusions. The patient was not grounded in what to expect. That gap is a reason to ask questions, and it is not an answer.

Chapter Reflection

A result can be terrible and the care can still have met the guidelines. The care can also fall short and still not be what caused the harm. Both are true, and that is why the outcome alone never settles whether a family has a claim. The family needs two answers, one about the standard and one about cause, and neither is visible from the result alone. Chapter 2 starts with the first answer, the guidelines themselves, and shows how a negligence case is built on them.

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CHAPTER TWO

The Rules of the Road for Doctors: How a Negligence Case Is Built

People call me and say they do not want to bring a medical malpractice case, they want to bring a medical negligence case. I explain that the two are one and the same, and so are medical neglect and medical mistake. A lot of people use these words to mean the same thing, and whichever one you pick, the same ingredients go into the case.

The word malpractice can cause one particular kind of trouble. It leads some people to think a doctor must have done something on purpose, with the intent to hurt them. Because they do not think they could prove that, they decide they have no case. I want families to know the words mean the same thing, so that a label does not talk anyone out of making a call.

I like to explain a case by its ingredients. This chapter takes them in the order I put them together: the rules a doctor is expected to follow, and the doctor who reviews the records or the films and says whether those rules were broken. Then comes a defense that comes up a lot, which is that the doctor was only using judgment. It closes with how I came to learn all of this as a young lawyer. Chapter 1 draws the line between a bad outcome and malpractice, and Chapter 10 returns to the certificate a reviewing doctor signs. Here the subject is the measuring stick itself, and what it takes to hold a doctor up against it.

> ***"if a doctor doesn't follow those rules of the road, he or she doesn't get the benefit of saying, well, I was using my judgment."***
>
> — FRANK SPECTOR, ON JUDGMENT CALLS AND THE STANDARD OF CARE

The rules of the road, borrowed from driving

Start with a car. We all drive, so we all know there are rules of the road. We can look in the Maryland laws and find them: you are not supposed to speed, and you are supposed to stop at a red light. Now let's suppose a driver goes through a stop sign, or does not yield to traffic, and hits your car and injures you. Most of us know what that means. It means negligence, because that other driver did not follow the rules of the road.

Medical negligence works the same way. *"Doctors have to follow the rules of the road."* For a doctor, those rules are what I call nationally recognized standards, the guidelines for what a doctor should and should not do. What we call a violation of the standard of care is a doctor stepping outside them. I sometimes call these standards laws, because the word may be easier to picture when you are thinking about how a doctor is supposed to act in a given situation.

For those of us who do this for a living, the phrase "standard of care" rolls off the tongue. A lot of people outside the profession have had no reason to hear it, which is why I reach for the driving comparison. The most important thing we have to prove, as I see it, is that violation. So what goes into a medical negligence case first and foremost is showing that the doctor did not follow the rules of the road.

A radiologist, an X-ray and what a reviewing doctor does

Let's suppose the case involves a radiologist. That is the name for the doctor who reads films: X-rays, CT scans and MRIs. Let's suppose that doctor looks at an X-ray and does not see something that looked suspicious. Or the doctor does see something suspicious and decides there is nothing wrong at all. Either way, the film held something the guidelines say a radiologist should catch, and it was missed or waved off. A doctor who does that has broken the rules of the road, and that is where a medical negligence case begins.

The lawyer is not the one who decides whether a film was misread. The way we prove it further is to consult another doctor, and in this example another radiologist, someone familiar with these rules of the road. In a case like that, the first thing we do is gather the medical films ourselves. Then we have them reviewed by a practicing radiologist. These are practicing doctors who consult with us, and I describe them this way: *"They're familiar with the standards of care. They're familiar with all the literature, and they have lots of experience."*

Their job is to look at the films and tell us whether what was seen on the X-ray was good or bad. If the answer is yes, this was medical negligence, that doctor did not do what he or she was supposed to do, that is how the case begins. Sometimes the reviewing doctor comes back with a different answer, and that answer deserves its own section.

A judgment call has to stay inside the standard

The term judgment call comes up a lot in medical negligence cases, and you can see why. The doctor being sued is going to want to say there is a recognized standard, I followed that standard, and within that standard there is what we call judgment.

Go back to the radiologist. Let's suppose the doctor saw something suspicious and called the film totally fine. After being sued, the doctor says it was a judgment call, that it was very close. If I had called it cancer or some other big problem, the doctor explains, I would have put the patient through lots of procedures, maybe surgery, maybe biopsies where needles have to be placed into someone's body. And if it is not cancer, I have subjected that person to something they should not have to go through. So I have to use my judgment before I say something is a problem.

Now, that can be a very effective defense, because many people hear it and think, well, everyone can use their judgment, or everybody can have their own way of looking at something. I understand why it lands. But we have to be very clear that we are not talking about a judgment call. We are talking about establishing what the standards of care are, what the rules of the road are. Judgment is real, but it lives inside the standard. A doctor who steps outside the standard cannot fix that afterward by calling the departure a judgment. *"That's not the way the law works."*

Judgment calls do exist, and I do not say otherwise. There are other areas of cases where they come in, and many times I have to say to my clients, look, this can be a gray area, this can be a judgment call. What I want to be clear about is that medical negligence and a judgment call are not one and the same.

The reviewing radiologist is where that line gets drawn. Sometimes the doctor we consult says yes, this was medical negligence. Sometimes the answer comes back that this was a very hard call. We know now, in hindsight, that it was cancer, but looking at the film at the time, the reviewing doctor may tell us it was a judgment call. That is how we prove the difference between a negligence case and a judgment case: hindsight tells us the outcome, and the reviewer has to tell us what could be seen when the film was read. In a misdiagnosis there are hard calls, and sometimes we cannot prove that what the doctor did was wrong. I take that seriously, because when we bring a lawsuit it has to stand on an excellent foundation.

The case has to start with a doctor willing to say it was wrong

Everything above depends on one person who is not a lawyer. Without a doctor who is willing to say the care was wrong, the case stops there.

In Maryland that doctor has to be a practicing doctor in the area of medicine the case involves, and the doctor also has to be willing to sign what is called a certificate of qualified expert. It sounds like a tongue twister. What it means is a signed certificate that spells out what the standards of care are and how the doctor we are bringing a lawsuit against violated them. It is generally required, and Chapter 10 takes it apart. For now, what matters is where it sits in the case.

A lot of lawyers get a bad name for just bringing lawsuits. But having the power to bring a lawsuit does not mean I can do whatever I want. The certificate is one of the reasons. I understand the certificate to go with the lawsuit. The law itself, in Maryland Courts and Judicial Proceedings section 3-2A-04(b), allows it to be filed with the complaint or within 90 days after it. Either way, what it means to me is *"some doctor has done a quality control inspection of this case"* and has said this is a meritorious case. That doctor is also willing to come into court, raise a hand and stand behind the opinion. I think it is an excellent safeguard.

A mistake that sounds obvious does not let us skip this step. A lot of people think that if a doctor operated on the wrong side, the case is automatic and there are no procedures to go through. That is not the way it works. Even then another doctor has to review the medical records and be willing to sign the certificate. The wrong side does let us state an obvious error, and that has a lot of jury appeal. But to get there, we still follow the procedures of a negligence case.

How a young lawyer learned to read a medical case

I did not start out in medical malpractice. I grew up in a household where the practice area was personal injury, mostly around auto accident cases, and in law school a good professor taught us torts, which is the legal term for anything that involves a personal injury. That gave me a foundation. Medical malpractice came to me a different way.

I was a young lawyer working at a law firm, and I was exploring whether there were other practice areas that might interest me. Medical malpractice was not my practice area at all. A medical malpractice case was in the office, and my boss at the time asked me if I wanted to take it on. In those days the cases were not as expensive as they are now, so a young lawyer like myself could take one on. I did. *"I didn't really know what I was doing at that time. I had some good mentorship, but I took that case on."*

That is where it started. I found it was something I liked. *"I really do like medicine. I like the whole science of it."* I am grateful to the mentor who let me have that experience, and it is what set the whole career off, thirty-five years of it now. I think of that first case as where my own education in the rules of the road for doctors began.

I was lucky to have great mentors along the way. After law school I went to work at a law firm, and I had probably one of the best trial lawyers in Baltimore as my mentor. He showed me the nuts and bolts and how to be a trial lawyer. I think having a mentor may not be as common for young lawyers as it used to be. I still put a case together by the ingredients in this chapter: the rules of the road first, and a practicing doctor to say whether they were followed.



A reading room desk with imaging films and a lightbox

Common Questions

What does standard of care mean in a Maryland malpractice case? It is the set of guidelines for what doctors should and should not do, and a case starts by showing a doctor did not follow them. I use driving to explain it: a driver who runs a red light broke the rules of the road, and a doctor can break theirs. As I put it, *"there are nationally recognized guidelines of what doctors should do and shouldn't do."* A reviewing doctor is who tells us whether they were followed.

Is medical negligence different from medical malpractice? No. The two terms mean the same thing, and so do medical mistake and medical neglect. I hear from people who say they want a negligence case and not a malpractice case, and I tell them *"they're all one and the same."* The same ingredients go into the case no matter which word you use, so the word you pick should not decide whether you call.

Who decides whether a doctor broke the standard of care? Another doctor does, not the lawyer. We consult a practicing doctor in the same field, such as a practicing radiologist for an X-ray case, who is familiar with the standards of care and the literature. If the answer is that the doctor did something wrong, we can go forward. In Maryland that doctor also has to be willing to sign a certificate of qualified expert, which is generally required.

What if the doctor says it was a judgment call? It depends on what the reviewing doctor tells us. Judgment is real inside the standard, and I tell clients *"this can be a gray area."* But a judgment call is not the same as negligence, and a doctor who steps outside the standard cannot rely on it. Sometimes the reviewer says it was a very hard call, judged by what could be seen at the time and not by hindsight.

Chapter Reflection

A bad result in a hospital is a fact. A violation of the standard of care is a finding, and a finding takes a doctor who practices the same medicine and is willing to say so, in a signed certificate and in a courtroom. Judgment has its place, and that place ends where the standard begins. The next chapter takes these same rules of the road into a delivery room, where the signs that something is going wrong are subtle, and a lawyer has to piece together what I describe as a thousand-piece jigsaw puzzle.

03

CHAPTER THREE

What a Birth Injury Case Is, and Why It Is Different From Other Malpractice Cases

Of all the malpractice cases a lawyer like me can take, birth injury cases are the toughest for me to handle. A family goes to the hospital looking forward to a moment of joy, and something goes wrong.

When I talk with families about this, I use the term straight talk. It means I tell everybody like it is, and that starts with a plain answer to a question a lot of people have never had answered: what exactly is a birth injury case?

This chapter gives that answer in my own words. It covers the definition I work from, what I have seen a permanently injured child's life can involve, and why these cases are built differently from the surgery and diagnosis cases that follow in Chapter 4. The records, the deadlines and the people named in a lawsuit each get a chapter of their own later on (Chapters 8, 11 and 12), so here I stay with the basic question of what a birth injury case is.

> ***"there are so many warning signs that happen during birth that get ignored or blown off or not recognized."***
>
> — FRANK SPECTOR, ON WHAT A BIRTH INJURY CASE IS

Where a moment of joy turns into a disaster

When I describe the work I do, I start with the cases that call me most often. By far the most frequent call I get has to do with a surgical complication. Anesthesia errors, misdiagnosis and failure to diagnose are part of what I see too, and Chapter 4 walks through all of them. Birth injury sits apart from those. I put it this way: *"These are the toughest cases, at least for me, to handle because you're dealing with something where parents' life is turned upside down. A moment of joy and anticipation of joy becomes something that's a disaster."*

It is sad even for me to talk about, and I have been at this a long time. My own start in medical malpractice came when I was a young lawyer at a law firm. Medical malpractice was not my practice area at all. I was exploring whether some other practice area might interest me, and a med-

ical malpractice case was in the office. My boss asked whether I wanted to take it on. In those days these cases were not as expensive to bring as they are now, so a young lawyer like me could take one. I had some good mentorship, though what I knew about the work then was thin.

That case is where it started. I found it was something I liked. I do like medicine, and I like the whole science of it, and I am still grateful to the mentor who allowed me to have that experience.

The delay in delivery at the center of a birth injury case

I was introduced to a birth injury case as a young lawyer, and a lot of people still do not know what one is. So let me give you the definition I work from. Here is how I explain a birth injury case: *"It's a delay in delivery. It's the failure to deliver a baby early enough before the baby suffers permanent brain damage."*

The weight of that definition sits on two words, early enough. In many of the cases I have, a birth injury case is about timing, about whether a baby was delivered soon enough.

Let's suppose a lawyer brings a lawsuit in a birth injury case. The allegation is that the doctor and the nurse did not deliver the baby early enough, and that the baby was deprived of oxygen. Now that baby has permanent cerebral palsy or brain damage. That is the shape of the claim as I frame it: a delivery that came too late, a baby short of oxygen, and an injury that does not go away. Who gets named in a suit like that, and how responsibility is divided among them, are questions for Chapters 12 and 16.

Three ways a warning sign gets lost during birth

Birth is full of signals, and in the cases I take, many of them were missed. Some were seen and set aside. Some were waved off. Some were never recognized as signs at all.

To understand what a sign looks like, it helps to know what a mother sees in the room. When a mom goes into labor, belts are put around her stomach. One measures the contractions and the other measures the baby's heart rate, and that, in my words, is *"the signal from the baby, whether our baby's doing well or not well inside mom."*

The record of that signal is what we call the baby monitor strips, or just the baby strips. In my view they are the biggest piece of evidence we can use, because they can show when an injury occurs, whether it came from a delay in delivery or from something sometime earlier. How an expert reads them, line by line, is the subject of Chapter 8.

None of this means that every hard labor is malpractice. Chapter 1 covered this: there are risks to every birth, and an injury from one of those risks does not by itself mean medical malpractice. We go back to the standard of care, which is the term we use for the nationally recognized guidelines about what doctors should and should not do. Then we have to prove that a breach of that standard caused the injury in question.

The life that follows a permanent injury

In many of the cases I have, the child is permanently brain damaged. I tell families what that can mean in plain words. The child *"may not walk or talk, may not be able to feed himself or herself, may not be able to see or hear, may be in a wheelchair, maybe bedbound for the rest of your child's life."* I ask people to imagine the emotion that goes into that, and to imagine how devastated a family is.

Fear of the cost belongs in that picture too. Many of my clients who have children like this need *"24-hour medical care, nursing care. That's very expensive."* In my observation, with modern medicine, children who have these severe brain injuries are living a lot longer than they did when I started practicing law thirty-five years ago, and I see that as one reason the costs are so large.

I cannot turn back the hands of time. I wish that I could. What I tell my clients is that I can't change what happened, but I can make sure we hold the system accountable. Chapter 14 takes up what a family can recover, and Chapter 19 takes up accountability.

A child's injury lasts a lifetime, and Maryland treats the time to file for a child differently from the time for an adult. I think the time limits for children in Maryland are very generous, and I tell people that many states do not have Maryland's long limit for children, and many have very restrictive limits. That matters in birth injury cases. The law itself, which is not my working rule, is written in Maryland Courts and Judicial Proceedings section 5-109. Subsection (a) says an action for damages for an injury arising out of a health care provider's professional services must be filed within the earlier of five years of the time the injury was committed or three years of the date the injury was discovered. Subsections (b) and (c) of the same section set when those periods begin to run for a young child. Because the date depends on the particular child, a lawyer has to confirm it. I take up deadlines in Chapter 11.

A thousand-piece jigsaw puzzle: how the pieces come together

A birth injury case is different from a typical malpractice case because of the level of detail it takes to see the subtle signs that something was not going right. Compare it with a surgery case: *"It's not going to be something like in a surgery case where you can say, well, the doctor cut the*

wrong organ or the doctor cut an artery, and it's very clear and obvious. In birth injury cases, there are very subtle signs that maybe something is not going right."

The way we handle that is that *"we put together this, I'll call it, a thousand-piece jigsaw puzzle."* Each piece has to come from somewhere, and I look for them in three places.

Step one is the interview. I spend a lot of time in that first conversation, and it is a two-way street. I ask a lot about the labor, a lot about the prenatal care, a lot about what happened afterwards and a lot about what the child is like. The family asks me questions too, and we get all the information down.

Step two is the medical records. I go through them with a fine-tooth comb and build timelines of when things happened. By looking at those records, we can tell whether a delay in delivery caused brain damage or cerebral palsy.

Then we consult with medical doctors, practicing obstetricians or other specialists who go through the records together with us. They help determine whether the standards of care were met, whether a violation of those standards caused injury, and how severe and how permanent that injury is.

All of that takes a lot of work on the front end. It takes months of investigation before we can tell someone whether they have a case, and it is all in the preparation beforehand. On a first call I can often tell someone that there is no case. Confirming that there is one is slower.



What a birth injury case is built on

A subspecialty that not many lawyers handle

Birth injury is a very specialized area inside medical malpractice. I describe it as *"a subspecialty of medical malpractice that not a lot of lawyers deal with."* The same point comes through in another way: *"Not too many lawyers who do medical malpractice even do birth injury cases. There are so many factors that have to go into it."*

The level of detail is the reason. A lawyer like me who takes a birth injury case is taking on the whole puzzle: the interview, the timelines drawn from the records, and the opinions of consulting doctors. That is what sets these cases apart from the cases in the next chapter.

Common Questions

What is a birth injury case? I define the kind of birth injury case I was introduced to, and often see, as a delay in delivery: a baby not delivered early enough, deprived of oxygen, and left with permanent cerebral palsy or brain damage. Other birth injuries turn on other things, which Chapter 9 covers. Not every difficult birth qualifies. There are risks to every birth, so a lawyer has to prove that a breach of the standard of care caused the injury.

How is a birth injury case different from other medical malpractice cases? The difference is the level of detail. In a surgery case the error can be clear, like a cut organ. In a birth injury case the signs that something was going wrong are subtle, so the work is gathering many small facts from the interview, the records and consulting doctors. I compare it to a thousand-piece jigsaw puzzle. Many malpractice lawyers do not take birth injury cases at all.

How long does a family have to file a birth injury lawsuit in Maryland? A child gets far more time than an adult, which is why time limits matter so much in birth injury cases. Maryland Courts and Judicial Proceedings section 5-109 sets the limits for health care malpractice claims and delays the start of the clock for a young child. A lawyer has to confirm the date for a particular child. For an adult, the rule I use is three years from the date of the injury.

How does a lawyer find out whether a birth injury case exists? It starts with a long personal interview about the labor, the prenatal care and what happened afterwards. Next comes a careful read of the medical records, with timelines built from them. Then practicing obstetricians or other specialists review the records with us to say whether the standard of care was met and whether a violation caused the injury. On a first call I can often tell someone there is no case, but confirming one takes months of investigation.

Chapter Reflection

Much of this chapter comes back to timing. In many of the cases I have, a baby needed to be delivered sooner, and the signs were there during the birth to be read. A family's life is turned upside down when they are missed, and it stays that way for as long as the child lives. The next chapter turns to the calls that reach me most often: the surgical mistake, the anesthesia error and the diagnosis someone dismissed as nothing.

04

CHAPTER FOUR

The Medical Mistakes That Reach a Baltimore Malpractice Lawyer Most: Surgery, Anesthesia, and Missed Diagnoses

When families first call me, a lot of them are carrying one picture in their heads: something going wrong on an operating table. That picture covers part of what I see, but only part. A medical malpractice lawyer like me runs the gamut, and the calls range from an operation that did not go as planned and an anesthesia error to a doctor who told someone a suspicious lump was nothing, only for months to go by.

This chapter takes those situations one group at a time. It starts with surgical complications and the kind of error we call wrong side surgery. It moves to anesthesia, then to misdiagnosis and what we call failure to diagnose. It also covers neck and spine fusions, which are complicated operations that more people undergo as they age, and a question that sits underneath many of the calls I take: if the mistake looks obvious, does the case become easy? It does not, and I will explain why.

One caution before the list. Everything I say here about what comes up most comes from my own calls, the ones that reach a Baltimore lawyer, and not from a statewide count of anything. A caller who has had a bad experience in one of these categories does not automatically have a case. Chapter 1 draws the line between a bad outcome and malpractice, and Chapter 2 explains how a negligence case is built. Here I want to show you what these situations look like when a family describes them.

> ***"So I would say surgical mistakes by far are the biggest volume of calls that I get."***
>
> — FRANK SPECTOR, ON THE CALLS HE RECEIVES MOST OFTEN

The kinds of calls a Baltimore malpractice lawyer hears

Start with a plain fact about modern medicine. *"A lot of people have surgery, whether that's elective surgery or emergency surgery."* Some operations are planned well ahead, and some happen in a hurry. Either way, an operation is a place where a lot can go wrong, and that is where many of my calls begin.

When I look for the reason, I come back to how often these operations happen. The ones I hear about are hip replacements, knee replacements, gallbladder operations and heart surgeries. Those are everyday procedures, and my reasoning is that with that level of frequency you can expect a matching level of surgical mistakes. I offer that as my own reasoning about my own calls, not as a measurement.

Surgery is not the only place families call from. Like I said, a lawyer like me runs the gamut. Misdiagnosis is another big area, failure to diagnose is a close relative of it, and I see a lot of cases involving neurosurgery. Each has its own section below.

Many of the people on the other end of those calls are angry and confused. Some of them had a good relationship with their doctor right up to the surgery, then something bad happened, and they did not see the doctor again. They want to get it off their chest, so I let them tell their story. When a call does not turn into a case, the reason is one of two. *"Either we tell the potential client that there is no malpractice here. We don't think the doctors did anything wrong."* Or the injury is not enough to substantiate a case, because a person who was hurt and then got well does not have much of a case to bring, given how expensive a case is to bring. Chapter 6 takes up that part in full.

Surgical complications and wrong-side surgery

The group I hear about most often starts with what I call a surgical complication. Sometimes that means a surgery that gets called *"botched, which means the surgery didn't go as planned."* By itself that word does not tell a lawyer whether anyone did anything wrong. That question belongs to the standard of care, which Chapter 2 describes.

Then there is what we call wrong side surgery. I will give you the example I give, because it is easy to picture and the facts are plain. *"There was supposed to be an operation on the left knee, and the nurse put a mark on the wrong knee and no one checked it."* Walk through it one beat at a time. The operation was meant for the left knee. A nurse put a mark on a knee, and the mark went on the wrong one. No one checked it. The patient was then operated on in the other knee, the one that was not supposed to be operated on. That is wrong side surgery.

I describe it as something that comes up a lot. In my words, *"Sometimes there's a situation called wrong side surgery that happens a lot."*

Two facts carry that example: the wrong mark and the missing check. Later in this chapter I will explain why even a mistake this plain still has to pass through the same safeguards as any other case.

Anesthesia errors and serious injury

Surgery brings a second group of calls with it. In my words, *"with surgery, there's also complications with anesthesia."* And I do not soften what I have seen: *"Unfortunately I've had serious cases where people have been very seriously injured because of anesthesia error."*

I will not describe the medicine behind an anesthesia error here, because I want to stay with what I can say from my own work. What I can say is where it sits. It belongs with the surgical group, because the injury comes with an operation, and it is part of why surgery fills so much of my calls. An anesthesia injury is measured the way any other claim is measured, against the standard of care in Chapter 2, and the certificate that Chapter 10 describes generally applies.

When someone has been seriously hurt this way, I cannot turn back the hands of time. I wish that I could. What I found over my career is that I can provide at least some measure of comfort to people whose lives have been turned upside down, and that I can make sure we hold the system accountable. *"People really want accountability."* They understand that mistakes happen. That does not mean they are willing to let one go.

Misdiagnosis and failure to diagnose, side by side

Misdiagnosis is the second big area I hear about. A person goes in to see a doctor, complaining of something. The doctor says, well, it's nothing, don't worry about it. Then, in the words I use for it, *"months and months go by, and all of a sudden it is something really major and really bad."* In my own calls I find that a lot in cancer, where the first complaint was something suspicious on the skin or a suspicious lump.

Failure to diagnose is a close relative. A person goes in with symptoms, and *"the doctor thinks it's one thing and doesn't really have an open mind when it actually was something else."* The patient had a proper disease or a proper condition, and it went undiagnosed. I see that quite a bit. Put the two side by side and both are cases where something was missed.

I have to be careful here, because I would be misleading you if I stopped at the cancer examples. *"Not every case is medical malpractice. Not every misdiagnosis is always medical malpractice."* Some doctors face a hard call, and I put it plainly: *"sometimes in a misdiagnosis situation, we can't prove that what the doctor did was wrong."* A missed diagnosis may feel like proof to a family, and in my practice it is where the questions start, not where they end. Chapter 2 explains the difference between a judgment call and a departure from the standard of care, with an example from radiology.

Neck and spine fusions, and the gap between outcome and expectation

We have a lot of cases involving neurosurgery. A lot of people are getting spinal fusions or neck fusions. These are very complicated operations, and people get them frequently, especially as they age. In my experience there are a lot of complications around them, and there is a lot of miscommunication about them too.

What I see most clearly is this. *"A lot of my clients are very upset to learn that the outcome that they have after surgery isn't what they expected."* What I am seeing is *"a communication problem between the healthcare system and the patient, in really grounding the patient into what the expectations are, what the outcomes should be."*

Let me be just as clear about what it does not mean. A result that differs from what a patient expected is not malpractice by that fact alone. In my words, *"most of the time, things that happen to people, bad outcomes are not medical malpractice at all."* So when a caller tells me about a fusion that left them in a different place than they had been promised, I tell them where I come down. I tell everybody like it is. I use the term straight talk. In my work, the strategy for any case begins with making sure the expectations are aligned. I also put it this way: *"we are telling most people why the healthcare system did the right thing by them and why they don't have a case."* Sometimes they are disappointed to hear it, and I would rather say it plainly than leave a caller guessing.

An obvious mistake still passes through the same safeguards

Go back to the wrong knee. Here is the question I hear underneath that story. *"A lot of people think, well, just because my doctor operated on the wrong side, that's automatic. I don't have to go through any of these procedures. It's going to be an easy case."* My answer is short. *"But that's not the way that it works."*

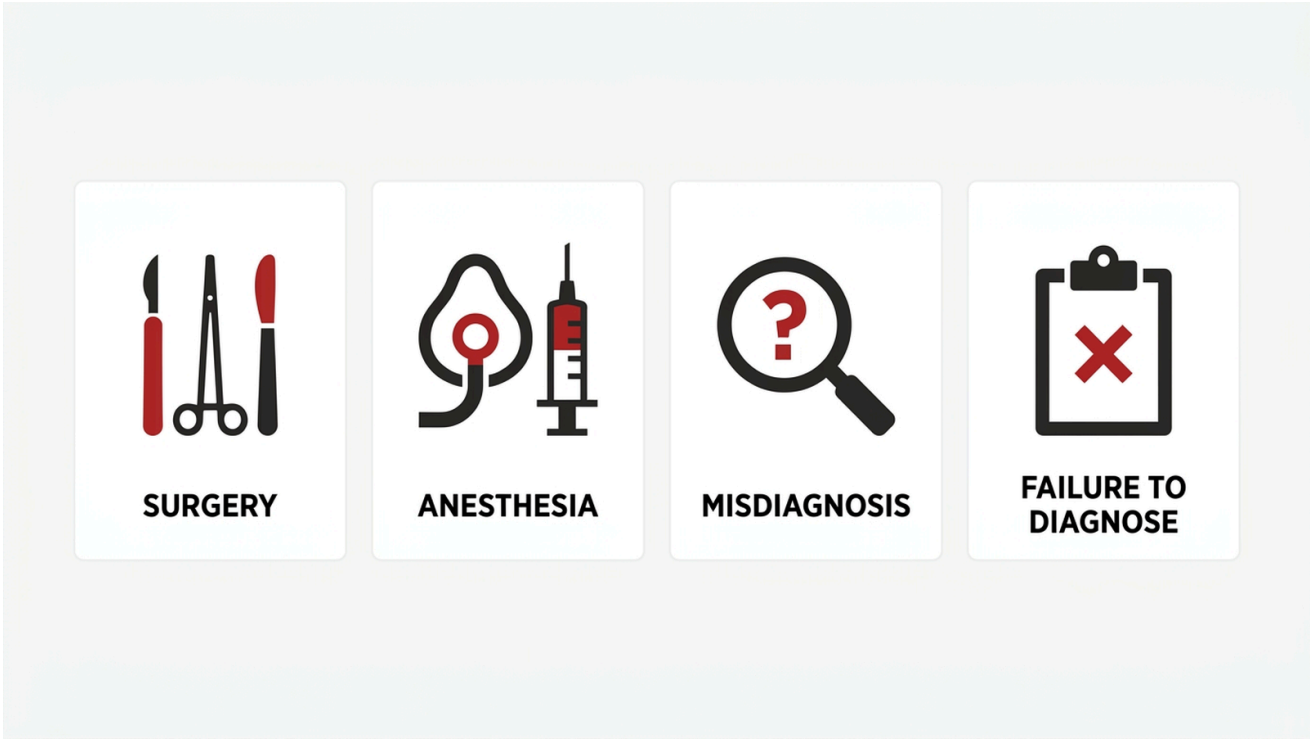
It does work this way. Even for a wrong knee, *"even though it sounds obvious, you still have to go through the safeguards of getting another doctor to review the medical records."* That doctor must be willing to sign a certificate of qualified expert and to come into court and say that this was medical malpractice. Chapter 10 covers the certificate in full. That reviewing doctor must also be a practicing doctor. *"They have to be practicing. They can't devote their whole lives to testifying in cases."*

The law behind this is written down, and it is the law, not my words. Under Maryland Courts and Judicial Proceedings section 3-2A-04, unless the sole issue in the claim is lack of informed consent, a claim is dismissed, without prejudice, if the claimant fails to file a certificate of a qualified expert within 90 days from the date of the complaint. The certificate must attest to a departure

from the standards of care and that the departure is the proximate cause of the alleged injury, which is the legal way of saying it caused the injury. The attorney files it with a report of the attesting expert attached. The statute also allows limited extensions of that deadline, and it limits an attesting expert to no more than 25 percent of the expert's professional activities devoted to testimony in personal injury claims during the 12 months before the claim was first filed.

What, then, does an obvious error buy? Not a shortcut. What it allows us to do is state an obvious error, and *"that has a lot of jury appeal."* When someone has surgery on the wrong knee, I expect the case would probably settle, because it is so open and obvious. But to get to that point, we still follow all of the laws and procedures that apply to any malpractice or negligence case.

A practical safeguard sits beside those rules, and it has nothing to do with court rules. Lawyers like me take cases on what we call contingency, which means we don't get paid unless we win. A malpractice case is enormously expensive to bring, and if we lose, we lose what we put in. A lawyer who builds flimsy cases is not going to be in business long.



The kinds of medical mistakes families call about

Common Questions

What kind of medical malpractice case gets the most calls from Baltimore families? For my practice, it is surgery. I can only speak to the calls that reach me, and I have no statewide count to offer. By far the most frequent type of case that reaches me has to do with a surgical compli-

cation, and I say that only about my own calls. Misdiagnosis, failure to diagnose and neurosurgery are other big areas, and anesthesia errors sit alongside the surgical group.

What is wrong-side surgery? It is what we call an operation performed on the wrong side of the body. My example is a left knee scheduled for surgery, where a nurse marked the wrong knee and no one checked it, so the patient was operated on in the other knee. Even a case that plain has to be built the usual way, which Chapters 2 and 10 describe.

What is the difference between misdiagnosis and failure to diagnose? They are close relatives. In a misdiagnosis, a patient raises a concern, such as something suspicious on the skin or a lump, and the doctor says it is nothing. Failure to diagnose, which I call *"a sort of a first cousin to that,"* is when a patient comes in with symptoms and the doctor settles on one explanation without an open mind. Either can be malpractice, but not every one is.

If a doctor operated on the wrong side, is the case automatic? No. A lot of people expect a wrong-side error to be an easy case, and it does not work that way. The same safeguards apply: another doctor reviews the records, a certificate of qualified expert is signed, and that doctor is willing to testify in court. What an obvious error does give us is jury appeal, and I expect a case like that would probably settle.

Is a disappointing result after spinal or neck surgery medical malpractice? Not by that fact alone. A lot of my clients are upset to learn the outcome is not what they expected, and I see a communication problem between the healthcare system and the patient about what to expect. The measure I use is the standard of care, which Chapter 1 explains, and a result that differs from expectations does not by itself show a departure from it.

Chapter Reflection

A family on the phone gives me a story, and the story usually arrives with a name attached: a botched surgery, a wrong knee, a doctor who said it was nothing. The name is where the call begins, and it is not where the case begins. The case begins with what the doctor did, measured against the standard of care, and it moves forward when another doctor is willing to put a signature to the claim and say so in court. That holds for a knee marked wrong and for an outcome after a fusion that a patient did not expect. I cannot turn back the hands of time, and I wish that I could. What I can do is explain how it works and tell a family the truth when the answer is no. Birth injury, which not a lot of lawyers handle, puts the same questions to a very different set of records, and Chapter 5 begins with what a family can do first.

05

CHAPTER FIVE

The First Steps a Baltimore Family Can Take After a Suspected Birth Injury

Birth injury is the part of my work that is hardest on me. In my own words, *"these are the toughest cases, at least for me, to handle because you're dealing with something where parents' life is turned upside down."* A family arrives at the hospital with a moment of joy and the anticipation of joy, and what follows can be a disaster. Everything in this chapter starts from that point: what a family can do once they begin to suspect it happened to them.

I tell everybody like it is, what I call straight talk, so here is the plan. There are three steps, and each of them is within reach. Write down what you remember. Get your medical records. Speak with a lawyer before you speak with the hospital. None of the three needs a law degree, and none of them requires you to decide whether you have a case. Whether a bad outcome counts as medical malpractice at all is the subject of Chapter 1, and what makes a birth injury case what it is, I explain in Chapter 3.

Before the steps, though, I want to start with a feeling, because many mothers who call me bring it into the call itself. It is the one thing I like to address right up front.

> ***"I tell them, I said, you didn't do anything wrong. You went to the doctor, you kept your appointments. You did what you were supposed to do."***
>
> — FRANK SPECTOR, ON WHAT HE SAYS TO MOTHERS ON THE FIRST CALL

What I say first to a mother who feels guilty

"Many mothers who call me, they feel guilty. They feel like they did something to cause this problem in their child." And the feeling follows them to the phone. A mother may expect that if she calls a lawyer, then the lawyer, the hospital and the lawyers for the other side will turn the blame around and aim it at her, and that she will hang up feeling worse than she did when she dialed.

Why begin there, in a chapter about steps? Well, because the fear is about the call itself, and a fear like that can stop a person before step one.

I am also careful about what I promise. *"Now I can't change the way people feel, but I want to provide them some comfort and to have that conversation."* A feeling like guilt does not leave because a lawyer says so, and I will not pretend it does. What I can do is make sure the conversation offers some comfort. I want a mother to know that she should speak to a lawyer, and that a lawyer like myself is not going to judge her or tell her it is her fault, because it is not.

The rest of that first conversation is a lot of listening. The lesson I took from my early years in practice is that what people are looking for is *"someone to guide them with a calm hand."* I do not talk over people. I let them tell their story, and I let them tell me everything they want to get off their chest. A lot of times they want to vent. Many of the people who call have been hurt by the medical system, and some of them feel ignored by it. They are mad and they are confused, and part of my job is giving them the space to say so.

Step one: write down who was there and what happened

Let's suppose a mother now believes that something happened to her child during the birth. The first step needs nothing but a pen and some time. She should put it on paper while it is fresh, and this is how I put it to families: *"I'm not asking you to keep a journal while you're delivering, but if you now believe that something happened to your child, while it's fresh in your mind, take very good notes about what happened, when it happened, who was there, the names of the doctors, the names of the nurses, while that is fresh in your mind."*

Notice how little that asks. A mother is not being asked to reconstruct a medical chart or to work out what went wrong. She is asked for five plain things: what happened, when it happened, who was there, and the names of the doctors and the nurses. The instruction even starts with belief, not proof. It says "if you now believe." You do not need to be sure of anything to begin.

The reason for the timing is built into the instruction itself, and I repeat it because it is the point: do it while it is fresh in your mind.

The hospital charts the times and the actions, down to *"when the nurse comes in, when a nurse comes out, when a doctor comes in, when a doctor comes out."* The chart is the hospital's account. Your notes are your own account, in your own words, and they do not need to look like a chart.

Those notes also give you something to bring to the first real conversation with a lawyer. When we sit down, I am going to ask you a lot about the labor, a lot about your prenatal care, a lot about what happened afterwards, and a lot about what your child is like. It is a two-way street, and you will have questions for me too. That interview, and the investigation behind it, are the subject of Chapter 7.

Step two: get your records through the health portal

The second step is easier than it used to be, and I am glad to say so. *"It's not like it used to be, where medical records were in paper format and they had to be requested in paper format, and it took weeks and months to get medical records. Those days are gone."* Now we have health portals through which patients can get their records. So the instruction is short: get your medical records through your health portal as soon as possible.

Why does a lawyer care so much about those records? Because I have called the medical record the Bible in a medical malpractice case. Chapter 8 returns to that image. The record holds the nursing notes, the doctor notes, the lab results, the X-ray results and the MRI results. As I see it, whatever is in that record is the core basis for the case, and I have said that the medical record is a lawyer's friend. How experts read a record, and what a delivery looks like on paper, are the subjects of Chapter 8. For now, the step is only to get it.

Maryland law speaks to the request as well, and what follows is the law, not me. Under Maryland Health-General section 4-309, if a health care provider knowingly refuses to disclose a medical record within a reasonable time but no more than 21 working days after the date a person in interest requests the disclosure, the health care provider is liable for actual damages. The same section also says a health care provider may not refuse to disclose a medical record on the request of a person in interest because that person failed to pay for health care the provider rendered.

Put the portal and the statute side by side and the picture is plain enough. The records are the core of a case, getting them is faster than it was, and the law sets a limit on a knowing refusal.

Step three: do not handle the hospital and the doctors on your own

The third step is the one I call the most important. *"Do not try to talk to the hospital and doctors on your own."* That covers talking about the case, trying to settle it, and trying to do it yourself. *"You have to speak with an experienced medical malpractice lawyer."* The reason is short. *"Because the hospitals and doctors have people that do this every single day. You need somebody as an advocate on your side."*

Now, what that instruction is, and what it is not. It is not a rule against settlement. I'm a big proponent of negotiating and trying to resolve a case out of court, so nobody should read the third step as a warning against settling. It is a warning against doing the negotiating alone, across the table from the people who, in my words, *"do this every single day,"* when this may be the first time you have faced anything like it.

A second reason belongs to later chapters, though a sentence of it fits here. A malpractice case runs on rules and deadlines. In my words, *"you must have an experienced medical malpractice lawyer who knows the rules and will file things on time."* The certificate that has to come with a case is the subject of Chapter 10, and the clock a family is working against is the subject of Chapter 11.

Taken together, I tell families that doing the three things puts them in a much better position than skipping them. Step one costs a pen. Step two is a request through your portal. Step three is the call, which is why I began with guilt.

What peace of mind can mean for a family

Families sometimes want to know what all of this is for, and I give them an honest answer. I cannot turn back the hands of time, and I wish that I could. *"Money sometimes just seems to be such a sort of a bittersweet or a hollow thing to talk about with people."* What I can do, as I found over my career, is provide *"at least some measure of comfort to people who've had this happen to them and their lives turned upside down."*

What does compensation do, then? In my experience, *"compensation allows people to kind of put their lives back together."* Let's suppose that because of an injury a family needs therapies and other medical treatments that their insurance does not cover. Medical costs keep going up, and as I see it, so many people are being wiped out and having to file for bankruptcy because of them. That is the setting in which a family hopes to have the resources to meet those needs.

The peace of mind I mean is concrete. It is *"giving them the peace of mind to know that they have the financial resources to be able to have their child at home versus having to be in some kind of institution."* In my view, and I say it as my own opinion, those institutions are not great. If I can help a family reach that point, I get a lot of satisfaction from it.

None of this is a lottery. As I tell it, *"Nobody who has ever called me in 35 years has said to me, Hey Frank, I got great news."* What families understand is that they will need money to pay for things that insurance and disability payments do not cover.

When I talk about compensation that way, families understand that I am not judging them. *"I'm not thinking that they're here for all the money."* I know it from dealing with my clients for thirty-five years, not from my own life.



The three first steps after a suspected birth injury

Common Questions

What should I do first if I think my baby was hurt during birth? Three things, in order. Write down what happened, when it happened, who was there, and the names of the doctors and nurses, while it is fresh in your mind. Get your medical records through your health portal as soon as possible. Then speak with an experienced medical malpractice lawyer before you try to deal with the hospital or the doctors yourself. I call that last step the most important of the three.

Can I get my medical records through a health portal after a delivery? Yes, and it is a lot faster than it used to be. Waiting weeks and months for paper copies, *"those days are gone."* Get your records through your health portal as soon as possible. If a provider knowingly refuses to release a record, Maryland Health-General section 4-309 sets a limit of 21 working days after a person in interest requests it and makes the provider liable for actual damages.

Should I talk to the hospital myself before I call a lawyer? No. I tell families not to try to talk to the hospital and the doctors on their own, and not to try to settle a case or handle it themselves. The hospital and the doctors have people who handle this work daily, and you need *"an advocate on your side."* I'm a big proponent of negotiating, but I want an experienced lawyer in the room when it happens.

Will a lawyer blame me for what happened to my baby? I will not, and I say so. Many mothers who call me feel guilty and fear being blamed, so I address it at the start of the first call. I want them to understand that, in my words, they should not feel that a lawyer like myself is going to judge them. I cannot change how a mother feels, but I can offer some comfort and give her the space to tell me everything she wants to tell me.

Do I need to know whether I have a case before I start writing things down? No. The first step begins with belief, not proof: *"if you now believe that something happened to your child."* On a first call I can often tell a caller there is no malpractice or not enough injury. Confirming that there is a case is different. It takes a lot of work on the front end, and months of investigation, before a lawyer can tell a family whether they have one.

Chapter Reflection

Set the three steps side by side and they share one feature. None of them asks a family to be a lawyer, a doctor or a judge of their own case. A pen, a health portal and a phone call are all it takes, and the person holding them may still be carrying the guilt I started this chapter with. That is where I begin, because that feeling should not be the reason a mother does not make the call. What she can expect after the call is an honest matter too, and I will tell her straight: a very small share of the people who call me become cases. Chapter 6 looks at why that is, and at the checks the system builds in before a case is allowed to go forward.

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CHAPTER SIX

Why Most Calls Never Become Cases: Myths About Malpractice Lawyers and the Checks Built Into the System

Before I explain how a malpractice case gets built, I want to clear away an idea that a lot of people carry with them when they call a lawyer. You have heard the names people use for us: that we are in it just for the money, that we make up cases that have no merit, that a lawyer like me hates doctors and wants to hold them accountable for everything. That picture of my profession hits a nerve with me, and I want you to have the accurate information instead.

The picture is wrong on two grounds, one ethical and one practical. The ethical ground covers the rules that bind a lawyer and the checks Maryland places between a bad outcome and a lawsuit. The practical ground covers what these cases cost and why a lawyer who files flimsy ones does not stay in business.

From there the chapter turns to the phone calls themselves: what I tell the people who call me, why I explain my reasons, and where the idea of the "suing type" came from. Chapter 1 drew the line between a bad outcome and malpractice. This chapter is about the machinery that holds that line in place.

> ***"So we are rejecting the vast majority of cases. Why? Either we tell the potential client that there is no malpractice here. We don't think the doctors did anything wrong."***
>
> — FRANK SPECTOR, ON THE CASES HE TURNS DOWN

The biggest misconception about lawyers like me

A lot of people have heard the same things about my profession, and one of them sits at the top of the list. I have put it this way: *"one of the biggest misconceptions is that lawyers like myself, we don't like doctors, we hate doctors."* The picture goes on to say that we are just trying to hold doctors accountable for everything, and that we are in it for the money.

I want to say plainly that none of that holds up. *"It's not true. There's some ethical reasons why it's not true, and there's some real-world practical reasons why that's not true."* Those two kinds of reasons are the spine of this chapter, and I will take them one at a time.

I also like to clear up the misconceptions people have about lawyers, because I think they are unfair. This one in particular matters to me, and the reason is short: *"I want people to know the accurate information."*

Ethics and the checks built into a malpractice case

Start with ethics. A lot of people roll their eyes when a lawyer says that word. Lawyers are bound by ethics anyway, and the lawyers I know and deal with take that professional responsibility seriously. *"We're officers of the court. We can't bring cases that don't have merit."*

The word that matters here is what we call meritorious. A meritorious case has a real basis. Its opposite is a frivolous one, and a lot of people throw the phrase frivolous lawsuit around without knowing it is a legal term for a case that has no merit. The way I describe the safeguards is this: *"The medical malpractice system has checks and balances in it to make sure that cases are what we call meritorious."*

The first check is another doctor. Before a malpractice case can go forward, a practicing doctor who is familiar with the standards of care and the medical literature has to review the medical records. That doctor also has to be willing to come into court and say that what was done was wrong. The doctor also signs what we call a certificate of qualified expert, a signed statement that the doctor has reviewed the records, practices in the area of medicine involved, and is familiar with the standards of care. A malpractice case generally cannot go forward without it, and the statute sets the window for filing it.

People often assume an expert can be bought. *"People think, you just pay an expert and they'll say anything. There are safeguards."* One safeguard is who the expert can be: a doctor who is still practicing, and one who cannot devote a whole career to testifying in cases.

The statute behind this is the law, and it should be read as the law and not as my opinion. Under Maryland Courts and Judicial Proceedings section 3-2A-04, unless the only issue in a claim is lack of informed consent, a claim shall be dismissed, without prejudice, if the claimant fails to file, within the time the statute sets, a certificate of a qualified expert attesting to a departure from the standards of care and that the departure was the proximate cause of the alleged injury. The certificate is filed with a report of the attesting expert attached. The same section provides that a party may not serve as a party's own expert, and that an expert who attests may not have devoted more than twenty-five percent of professional activities to activities that directly involve testimony in personal injury claims during the twelve months before the claim was first filed. Chapter 10 takes the certificate apart step by step.

The certificate works as a quality control step, because a doctor has looked over the case first. It also cuts in a direction families should understand. If we cannot get a doctor to say the other doctor did something wrong, we cannot move forward on the case.

The second check is a judge. At any time, the other side or a judge can question whether a case is legitimate. The rules that guide Maryland courts, what we call the rules of civil procedure, include what are called bad faith lawsuits. As I describe those rules, when there is a question about whether a case was brought in bad faith, *"the system has safeguards, like I keep saying, for a judge to say, no, this case is not legitimate."*

That is why, on ethics and on the rules, I call the picture of lawyers like me unfounded.

The practical reason a lawyer cannot afford flimsy cases

The practical ground may persuade a skeptic faster than any rule. A medical malpractice case is enormously expensive to bring. Lawyers like me take these cases on what is called contingency, which means we do not get paid unless we win. If we lose, the money that went into the case is gone.

Let's suppose a lawyer puts together a case only because he thinks there is money in it. He has to spend a great deal of money on that case, and the other side is very smart. The defense lawyers are among the smartest I have ever come across. Put those two facts together and the result is easy to see: a lawyer who puts together flimsy cases and has to spend all that money is not going to be in business that long. As a practical matter, the cases are too expensive for it to work any other way.

It was different when I started. As a young lawyer, a malpractice case came into the office where I worked, and my boss offered it to me. In those days the cases were not as expensive as they are now, so a young lawyer like me could take one on, and I did, with some good mentorship. I found that it was work I liked, and that was where my career in this area started. Today the cost is a fact a lawyer in this work has to face before anything else.

Turning callers away, and what I tell them

Baltimore is a small place for the lawyers who do this work. We call it Smalltimore. I think all medical malpractice lawyers have the same experience, because *"we all share each other's information. We're not necessarily friendly, but we're colleagues."*

That shared experience says the same thing about the callers. A caller gets one of two answers. Either there is no malpractice, and we do not think the doctors did anything wrong. Or there is not enough injury to support a case. A person who was injured and then got well does not have much of a case to bring, because of how expensive a case is.

A bad outcome is not the same thing as malpractice, and most of the time a bad outcome is not medical malpractice at all. Some calls are hard, too. Sometimes, in a misdiagnosis situation, we cannot prove that what the doctor did was wrong.

Let's suppose the call is about an X-ray that a doctor read as normal. We gather the films ourselves and have a radiologist who consults with us review them. Sometimes the answer is yes, this was medical negligence, and the doctor did not do what he or she was supposed to do. Sometimes it comes back as a judgment call, a very hard call to make. We know now in hindsight that it was cancer, but looking at it at the time, the doctor may tell us it was a judgment call. That is how I describe proving the difference between a medical negligence case and a judgment. And because of it, *"we have a responsibility that when we bring a lawsuit, that we have to make sure that that case stands on an excellent foundation."*

When the answer is no, I tell the caller why. I think of that as a service, as funny as that may sound. We are telling most people why the healthcare system did the right thing by them and why they do not have a case. Sometimes they are disappointed to hear it.

The most gratifying response I get comes from callers I cannot help. Some of them say, *"I wish I had a case, but you're the only lawyer who took the time to listen to me and to explain it."* In my experience, a person who calls a lot of lawyers mostly gets no clarity about why a lawyer does not want the case. They call one after another and have no sense of the reason. When I finally explain it, there is a sense of relief, because *"at least they can close the door on that chapter and go on with their lives, even if they can't bring a lawsuit."*

Some callers have a problem that has nothing to do with medical malpractice. They were hurt at work, or they want to file for disability, or they have an employment issue. When I have someone to send them to, I do that. *"That's not what I do, but here's somebody that I can send you to that can help you."*

Where the idea of the suing type comes from

A lot of people arrive believing something they heard long before they called me. As I see it, much of it traces back to what we call tort reform. Insurance companies and the associations that speak for them put a great deal of money into tort reform, in Maryland and across the country. In

my view these are insurance companies that want access to justice narrowed or closed. *"They don't want people bringing lawsuits."* Social media lets them take that message straight to the public.

The McDonald's hot coffee case is the example many people know. People hear that someone said the coffee was hot and spilled it, and they stop there. I am not going to retry that case here, but when you look at it in detail, I believe the evidence showed that McDonald's was much more responsible and more liable than people think. *"Nobody wants to go behind those headlines."* And so here come lawyers who want to sue for anything and get money for anything. I think those messages resonate with people.

Clients who call me sometimes tell me, *"I'm not the suing type."* Others say they have not sued anybody before. They say it almost to pre-empt something, I think because they believe some of these misconceptions themselves. I think the main reason the message has spread is that these organizations have the funds and the ability to get it out.

The lottery idea belongs to the same story, and I have called it bad press and propaganda. In all my years of taking these calls, nobody has phoned me with great news. What they understand is that they will need money to pay for what insurance does not cover and what disability payments do not cover. That is a conversation about care, and a lottery has nothing to do with it.

Doctors are not my enemy

Here is the part I most want a family to hear, so I will say it plainly: *"I love doctors, I don't hate doctors, I have doctors who are my friends."* They understand what I do.

That first malpractice case did more than start a career. I found that I liked the medicine itself: I like the whole science of it. I'm a big proponent of innovation. I'm a big proponent of robotic surgery, and of anything that can help people.

I will not pretend that all lawyers abide by ethics, because there are lawyers who do not, as in any other profession. What I can speak to is what I see: *"my experience is the people that I associate with and deal with, we all feel very strongly about all the things that I just said."*

My target is the system, and the accountability a family is owed. I do not say that lightly, because a person's relationship with their doctor is one of the most trusted relationships they have. You are putting your life in their hands. When a mistake happens, here is how I see it: *"I think the only way that we can get that accountability is to bring a lawsuit."*

None of the checks in this chapter makes the mistakes themselves go away. Speaking from where I sit, *"I'm not seeing that there's been much of a change in the frequency of medical mistakes."* That is why the checks matter to me. A case that clears them has already been looked at by a practicing doctor, and that is the kind of case I want to bring.



Why most calls do not become cases

Common Questions

Can a lawyer file a malpractice lawsuit against any doctor? No. A lawyer cannot file one against just anybody for anything. Another doctor has to review the medical records, be a practicing doctor familiar with the standards of care, and be willing to come into court and say that what was done was wrong. I think of that as a safeguard, because *"just because we can doesn't mean that we should."* Chapter 10 covers the certificate in detail.

Why do malpractice lawyers turn down so many cases? Most bad outcomes are not malpractice. A lawyer turns a case down when the doctors did not do anything wrong, or when there is not enough injury to justify a case that is so expensive to bring. Not every case is medical malpractice, and not every misdiagnosis is. A case has to stand on a solid foundation before it is filed.

Why is a malpractice case so expensive for a lawyer to take on? A malpractice case is enormously expensive to bring, and lawyers like me take these cases on what is called contingency, which means we do not get paid unless we win. A lawyer who loses a case loses the money that went into it. The expense falls on the lawyer, and the defense lawyers on the other side are smart.

What is a frivolous lawsuit in a malpractice case? A frivolous lawsuit is a legal term for a case that has no merit. A lot of people throw the phrase around, but a malpractice case has checks and balances meant to make sure the case is what we call meritorious. A practicing doctor has to sign a certificate of qualified expert, and the other side or a judge can question whether a case was brought in bad faith.

How soon will a lawyer tell me whether I have a case? A no can often come on the first call, and a yes takes months. Callers want to know, *"do I have something or I don't?"* Confirming a case takes months of investigation: going through the medical records with a fine tooth comb, building the timelines, and consulting with doctors who review them for the standards of care.

Chapter Reflection

Put the pieces side by side and the picture of a lawyer hunting for doctors to sue does not hold. Ethics bind me. A practicing doctor has to put a signature on the case. A judge can say a case is not legitimate. The cost of a weak case lands on the lawyer who brings it. A bad outcome is not enough, and a case needs a foundation before anyone files it.

Those same checks are the reason my answer to most callers is no, and the reason I explain it. A no from a careful lawyer carries information, and sometimes the information is that the healthcare system did right by you. For the callers who clear these gates, the work is only beginning. What the first conversation with your lawyer looks like, and the investigation behind it, is where the checks in this chapter first go to work, and it is where Chapter 7 begins.

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CHAPTER SEVEN

What to Expect From Your Lawyer: The First Conversation and the Investigation Behind It

A person who calls a medical malpractice lawyer for the first time is usually in the worst stretch of their life. Their lives have been turned upside down, and they are asking me to help with a big problem. They tend to arrive with strong feelings and very little idea of how the law works. What they need from that first conversation is not a speech. They need someone to guide them with a calm hand.

This chapter walks through that conversation from my side of the desk. It covers how I describe my job, why I spend the first call listening, and why a caller reaches me directly. It then follows the work that happens after the call: the interview, the records and the review by practicing doctors. That work takes months before I can tell anyone whether there is a case. It also covers what I say when the answer is no, and where I can and cannot help.

Everything here describes how I work, and each case is different. The medical records get a chapter of their own, and you will find them in Chapter 8.

> ***"going into a lawsuit is just like going into a foreign country, and you don't speak the legal terms, and you're not sure how the process works"***
>
> — FRANK SPECTOR, ON BEING A CLIENT'S GUIDE

The lawyer as a client's guide and the roadmap people ask for

The core mission of my practice is to help people in a time of crisis and to treat them with dignity. Part of that is making sure the process I am about to take you through is explained. Many people may not have been through a process like this. Think of anyone who has gone on a trip and hired *"a tour guide because we don't know the language and we don't know where to go."* A lawsuit is a trip of that kind, with its own terms and its own map, and the person setting out is often doing it for the first time.

Being the guide has a specific meaning. I explain what the process looks like, how long it is going to take, what the potential outcomes are, what the decision points will be for you and what your own involvement is. A lot of people find comfort in that, because *"people just want a roadmap."* They want to know how this is going to go. The responsibility of a lawyer like me is to provide a calm hand to someone facing something traumatic and uncertain, someone who does not know how the law works.

A guide is not a decision-maker. I would not call myself a problem solver, because that word takes away the client's ability to decide things on their own case. I value my client's input because it is their case, not mine. Whether to file a lawsuit is the client's choice. If I believe a case can move forward, I say so, and then the decision belongs to the client. Many strategy decisions, such as how to word a brief, are lawyer decisions, and I bounce ideas off the client along the way. The client also decides whether to settle, and Chapter 18 returns to that.

Listening first: letting a caller tell the story in their own words

The first conversation is mostly listening, and I spend a lot of time on it. I let people tell me everything they want to get off their chest. A lot of the time they want to vent. As I put it, *"I don't talk over people, I let them tell their story."*

There is usually a reason they need to. They have been hurt by the medical system, and in many cases they have been ignored by it. A patient may have been having a good relationship with a doctor, then something bad happens and the doctor is never seen again. That person is mad and confused. Giving them the space to say so is part of the job, and I count it as a core part of my mission.

Listening is also the groundwork of the case. The practice of law comes down to understanding how to interact with people, and listening is something I pride myself on. It is not a matter of being the smartest lawyer in the world. The work starts with that first interview: hearing the client's story without interrupting and letting them tell it in their own words from beginning to end. People tell you a lot that way, and it is information you are probably going to need.

Medicine has the same principle. In the part of a visit called the history, the doctor talks to the patient. In my view, that is one of the lost things in medicine, because doctors do not want to spend much time on it anymore. Older doctors will tell you that the more you listen to the patient, the more the patient will tell you about what is wrong. I use that same principle in the interview stage.

Speaking to the lawyer directly, without layers of intake

When you call me as a new client, you reach me. Many callers are surprised. Some say they never thought they would speak to a lawyer, and some ask whether I am a real lawyer or one of the AI voice assistants. I tell them I am a real lawyer. *"You get to speak to the lawyer that you wanted to speak to,"* and I want you to know you are important. I also want to explain the system to you with thirty-five years of experience behind the explanation.

Here is the alternative. A caller may reach an intake person first, and the call then works its way up to the lawyer's desk. That can take weeks or months, and the caller is told only then that there is no case. *"I shortcut that process."*

Let's suppose the caller has only a lunch break in which to phone a lawyer. Their lives have been turned upside down by medical malpractice, and they still have family, work and other responsibilities. They want to know whether they have something or not. On that first call I can often tell a caller when there is no case. Confirming that there is one takes longer, and the next section explains why. Answering a caller quickly is a point of pride for me, and I think people deserve it.

One caution, as of when I recorded this. After hours I use an AI virtual assistant, because many reception services no longer have live staff around the clock and I want to be sure you are talking to someone. It has been well trained, and it is not a person.

What happens between the first call and a lawsuit

After the call comes the work that decides whether there is a lawsuit at all. In a birth injury matter it runs in three steps.

Step one is the interview. In my experience a lot of lawyers no longer spend enough time on it, and I spend a great deal. I talk with you personally and ask many questions, and you ask me many questions. The conversation runs in both directions until all the information is down. For a birth injury I ask about the labor, about the prenatal care, about what happened afterwards and about what your child is like. At the beginning I also make sure the client's expectations and mine are lined up, and I keep the client informed regularly about how the case is going.

Step two is the records. A lawyer has to go through the medical records with a fine tooth comb and build timelines of when things happened. In my words, by going through the records we can tell whether a delay in delivery caused brain damage or cerebral palsy. How an expert reconstructs a delivery from those pages is the subject of Chapter 8.

Step three is the review by doctors. We consult with practicing obstetricians, or with other specialists who are able to work with us. They go through the records together with us to determine whether the standards of care were met, whether any violation of them caused injury, and how severe and permanent the injuries are. The standard of care is what we call the nationally recognized guidelines for what doctors should and should not do. Chapter 2 explains it in detail.

"So it takes a lot of work on the front end." It takes months of investigation before I am able to tell someone whether they have a case. Confirming a case takes the interview, the records and the doctors' review.

When the answer is no, and the reason that still matters

I represent clients from all walks of life. People used to find lawyers through referrals, and I think that has changed. A great deal of information is out there and a lot of people do research, so callers come from everywhere. I am grateful for it, because I get to help so many different people.

I cannot help most of them. A very small share of the people who call me become cases, so most callers hear a no from me. Either I tell the caller that there is no malpractice here because I do not think the doctors did anything wrong, or there is not enough injury to support a case. Someone who was hurt and got well has little to bring, because of how expensive a case is. Chapter 6 takes up why so many calls end this way.

What keeps me going is the satisfaction of a thank-you, even at the end of a case. I hear it from people I cannot help, too. I tell them why, and the answer I treasure most is a caller telling me they are disappointed there is no case, and then thanking me for being the one lawyer who took the time to listen and explain. A lot of callers have phoned one lawyer after another without learning why none of them would take the case. When I finally explain it, there is a sense of relief. They can close the door on that chapter and go on with their lives, even if they cannot bring a lawsuit.

I have the training and the information, and if I can give that to someone and give them some clarity, I find that satisfying. Sometimes people are disappointed to hear it, and I understand why. There is satisfaction in that for both sets of clients, the ones whose cases go forward and the ones whose cases do not.

Cases across Maryland and the District, and referrals for problems outside my work

A lot of people ask whether a Baltimore lawyer can help them if they live somewhere else. That is a common question when clients call. Most people with a legal issue are more used to speaking with someone in their own area. They do not think a lawyer like myself who is Baltimore based can help them if they live, let's say, in Montgomery County or DC. What I tell them is *"I have a license to practice all over Maryland and in DC."*

My practice is based in Baltimore City, Baltimore County, Harford County and Howard County, and the surrounding counties. I also have a lot of experience in Montgomery County and Prince George's County, which are suburbs of Washington, DC, and in the District itself. Where I happen to sit does not decide whether I can help. People in other parts of the state or in DC should not doubt that I can.

People also call me about problems outside medical malpractice. Maybe they were hurt at work, or they want to file for disability, or they have an employment issue. When I can, and when I have the right person, I send them there. I tell them it is not what I do, and here is somebody who can help. I went to law school with a lot of people who now practice in Baltimore in divorce, employment and hurt-on-the-job matters. I can offer those resources because *"many people don't know who to call."* They trust my suggestion because they have called me, and I think of it as having almost vetted those lawyers myself. Talking to everybody, even if I cannot help them, is part of the service I give back to the legal community.



The three stages of a first conversation and investigation

Common Questions

What happens during the first call with a medical malpractice lawyer? Mostly the lawyer listens. I let you tell the story in your own words from beginning to end, and I ask a lot of questions in return. In a birth injury matter I ask about the labor, the prenatal care, what happened afterwards and what your child is like. As I describe it, *"It's a two-way street."* I do that interview personally, before any of the records work begins.

How long does it take to find out whether I have a medical malpractice case? A confirmed case takes months, though I can often tell a caller early that there is no case. The months go to the interview, a careful read of the medical records and review by practicing doctors. Each case is different, so the time varies.

Will I speak to the lawyer or to an intake person? With me, you speak to the lawyer. *"When you call as a new client, you speak to me directly."* Many callers are surprised, and I do it to shortcut the weeks or months it can take when a call travels up through intake. After hours, as of when I recorded this, an AI virtual assistant answers so that you are talking to someone.

Can a Baltimore malpractice lawyer take a case outside Baltimore? Yes, in my practice. I am licensed throughout Maryland and in the District of Columbia, and I take cases in both. My concentration is in Baltimore and the surrounding counties, with a lot of experience in the

Washington suburbs. Where you live is not the test, because *"it's not just geographically driven."*

What if the lawyer cannot take my case? Then I explain why, so the caller has a clear reason and can close that door. If the problem is outside medical malpractice, I refer people to lawyers I trust when I can. I tell them plainly that it is not what I do, and I point them to somebody who can help.

Chapter Reflection

A first conversation with a lawyer should leave a caller holding a map, whether the answer is yes, no or not yet. The map shows who does the work, in what order, who decides what, and how many months can pass before anyone is able to say a case exists. Even a no arrives with its reason, and the reason is worth as much to the caller as the answer. That is what I try to give people in the first call: an honest account of where they stand and what comes next. For the families whose cases go further, what comes next is paper. Chapter 8 opens the medical record and reads it page by page.

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CHAPTER EIGHT

The Medical Record Is the Bible: How Experts Reconstruct a Delivery

A family brings me what they remember of a delivery. I want to hear all of it, and Chapter 7 describes how I listen. But memory is one witness, and a malpractice case needs more than one. The other witness is the medical record, the written account of a hospital stay as the nurses and doctors charted it.

A lawsuit over a delivery is a reconstruction. I was not in the delivery room, and the jurors who decide a case were not there either. What exists is what got written down, so the work is to read it closely enough to say what happened, in what order, and whether the standards of care were met.

This chapter follows that work from the first reading of the chart to the last. It covers the notes, the times, the baby monitor strips, the practicing doctors who read the record with us, and the records written after a child is born. All of it is work on the front end of a case, and it takes months.

> ***"the medical records are really the Bible in a medical malpractice case because medical records have everything in there."***
>
> — FRANK SPECTOR, ON THE MEDICAL RECORD

Where the record sits in the order of the work

I start with a person, not a chart. I consider myself a pretty smart guy, but *"a lot of it is in the groundwork."* The groundwork begins with the first interview, where I let a client tell the story in their own words from beginning to end. Medicine has the same idea in what doctors call the history, which means talking to the patient. Older doctors will tell you that *"the more you listen to the patient, the more the patient will tell you what's wrong."* I use that same principle in the interview stage.

The record comes next. Let's suppose a family has called me about a delivery they believe went wrong, and their child now has cerebral palsy. Step one is a long conversation that runs both ways. I ask about the labor, the prenatal care, what happened afterward, and what the child is like. Step two is the chart. Then comes a consultation with doctors, which I take up below.

What do I mean by the chart? I mean the nursing notes and the doctor's notes, the lab results, the X-ray results and the MRI results. In my words, *"anything that's in that medical record is really the core basis for a medical malpractice case."* That puts a duty on the lawyer: *"It's incumbent upon the lawyer to make sure they are intimately familiar with that medical record."*

I call the record a friend for a reason. *"That medical record is your friend."* It *"has all the things that you're going to need in order to not only know the medicine, but to be able to put your fingertips on the things that you need."* A lawyer has to learn the medicine from the page, and then be able to find the one entry that matters when the case calls for it.

Getting hold of the chart is easier than it used to be. Medical records once existed in paper format, had to be requested on paper, and took weeks and months to arrive. Today, in my words, *"we have health portals where everyone has access to their medical records."* Maryland law also speaks to a provider that holds back a record. Under Health-General section 4-309(a), a health care provider who knowingly refuses to disclose a medical record within a reasonable time, but no more than 21 working days after a person in interest requests the disclosure, is liable for actual damages. That is the statute speaking, not me.

Charted times and the timeline built from them

A hospital record carries a quality that makes a reconstruction possible: it carries times. I describe the charting this way. *"Everything is charted, all the times, all the actions when the nurse comes in, when a nurse comes out, when a doctor comes in, when a doctor comes out."* Each of those entries is a point on a clock. Put enough of them in order and you can see when a nurse came in, when a doctor left, and what was written at each point.

The lawyer cannot ask the clock on the wall what time it was. The times in the chart are how the lawyer gets one. To prove a case, *"you have to go through the medical records very, very carefully."* The doctors who consult with us do the same, because an expert has to become intimately involved with the medical records. The record is the Bible of the case, and that is why it gets read so carefully.

The next move is to build chronologies. A chronology is the events in the order they happened, laid out so that anyone can see when things happened. That means going through the records line by line and making a timeline for each stretch of the stay.

The notes are one source for that work, since the timeline starts from the doctor's notes and the rest of the chart. A second source exists, and I treat it as the more important one. It comes next.

Baby strips: the belts, the heart rate, and the timing of an injury

If you have been through labor in a hospital, you will remember the belts. When a mother goes into labor, belts are put around her stomach. *"One measures the contractions and one measures the baby's heart rate."* What those belts record is what we call the baby monitor strips, or the baby strips.

That is where the timeline gets its most important entries. In my words, *"the more important way that you do that is what we call the baby monitor strips."* The notes record what people did and what they wrote down. The strips come from the monitor, and I give them more weight.

I go further. The strips are *"the biggest piece of evidence that we can use."* The reason is what they can show. A strip can show when an injury occurs, whether the cause was a delay in delivery or something that happened earlier. That bears on the question I put to the records in a birth injury case: whether a delay in delivery caused brain damage or cerebral palsy. A record that can show when an injury occurred speaks to that question directly.

A strip showing when an injury occurred is not the same as a finding that someone broke the standards of care. Deciding that is the work of the next step. How a strip read in one particular case is told in Chapter 17.

Practicing obstetricians who read the chart with us

After the interview and the first full reading of the chart, we bring in medical doctors. These are practicing obstetricians, or other specialists, and they work with us. The task I give them is *"to go through the medical records together with us and to determine whether the standards of care were met, whether those violations of the standard of care caused injury and the severity and permanency of those injuries."*

That sentence holds three questions. The first is whether the standards of care were met. The standard of care is the term that we use for nationally recognized guidelines of what doctors should do and shouldn't do. The second is whether a violation of those guidelines caused the injury. The third is how severe and how permanent the injury is. A lawyer reads the chart and keeps the timeline. The doctors are the ones who work through those three questions with us.

This is why a case takes time. On a first call, I can often tell a caller there is no case, and Chapter 6 explains why. Confirming that there is a case is another matter, and it takes months.

Doing that work on the front end matters, and the beginning is also when expectations get set. A sound strategy, as I see it, means having a good idea of what the case is about and a good idea of what the client's expectations are. Lawyer and client have to start from the same expectations.

In practice, that means rolling up your sleeves and doing a lot of hard work.

The records written after the delivery, and the planner who reads them

Nobody can undo a delivery, and the delivery records look backward. The records written afterward look forward, and they answer a different question, which is what a child's life is going to need.

For that question, I put the weight on a different set of pages. In my words, *"the records that matter the most are the records that happen afterwards."* Many of these children go to specialists, and in Baltimore one of them is the Kennedy Krieger Institute. Its records show the diagnosis and the therapies a child needs, such as occupational therapy and speech therapy. They also answer questions like these: *"Do they need to have specialized equipment? Do they need to have care in the home?"* All of these records help me build a case.

With that information, we consult a specialized expert called a life care planner. A life care planner is someone who is able to *"project out into the future all the medical care and all the services that a baby who has cerebral palsy is going to need for the rest of his or her life."* How that projection becomes a figure a jury hears is the subject of Chapter 14.



A timeline from the start of the record to the delivery

Common Questions

Why are medical records so important in a medical malpractice case?

The record is the core basis of the case. It holds the nursing notes, the doctor's notes, and the lab, X-ray and MRI results, and the lawyer has to be intimately familiar with all of it. A lawyer who is will find, in my words, *"all those little things in the medical record"* that the case is going to need. The record lets a lawyer learn the medicine and then find the exact entry that matters.

What do baby monitor strips show during labor?

During labor, belts around the mother's stomach measure contractions and the baby's heart rate. That heart rate is the baby's own signal about how it is doing inside the mother. The record of those readings, what we call the baby strips, can show when an injury occurs, whether from a delay in delivery or from something earlier. I count them as the biggest piece of evidence we can use in these cases.

How do lawyers decide whether a delay in delivery caused brain damage?

We read the medical records closely, build the timelines, and then have practicing obstetricians or other specialists go through the chart with us. In my words, by looking at the records we can tell whether a delay in delivery caused brain damage or cerebral palsy, and the doctors help decide whether the standards of care were met. It is slow work, because *"it's all in the preparation beforehand."*

What records matter after a child is born with a birth injury?

The records from the specialists who treat the child. In Baltimore, *"we have the Kennedy Krieger Institute, which specializes in dealing with children who have these types of injuries."* Those records show the diagnosis, the therapies, any specialized equipment, and whether the child needs care in the home. A life care planner then uses that information to project the care a child will need in the future.

Chapter Reflection

This chapter rests on one habit: read what was written before deciding what it means. The chart holds the times. The strips hold the baby's signal. The doctors who go through both with us are how a lawyer learns whether the standards of care were met. The listening comes first and the record comes next, and a case needs both. In the next chapter I take that same reading into a different kind of delivery, one where a baby gets stuck during the birth process, and ask what the records show there.

09

CHAPTER NINE

Shoulder Dystocia and Erb’s Palsy: What the Delivery Records Show

Two medical terms sit at the center of this chapter. One is shoulder dystocia. The other is Erb's palsy. A lot of people want to know what those words mean, and they deserve a plain answer before anything else. Shoulder dystocia is what we call a baby getting stuck during the birth process. Erb's palsy is a nerve injury to the baby's arm. It can leave the arm weak or paralyzed, and in the worst cases the paralysis is permanent.

These are cases I know well. I have had so much experience with them that I am probably one of the lawyers who has done the most of them in my career. The last chapter made the point that the medical records are the Bible in a malpractice case, and a delivery is no different.

When I want to know what happened to a baby who got stuck, the delivery records are where I start. The records that come afterward tell me what the child needs. This chapter follows that order. I will walk you through the two things I look at first, what it tells me when a maneuver is missing, and why you do not pull on a baby's head. Then I will say what Erb's palsy is in plain words, and I will tell you about a phone call from a former client.

> ***"I hadn't heard from that client in twenty years. I knew who she was immediately."***
>
> — FRANK SPECTOR, ON A FORMER CLIENT WHO CALLED HIM

A baby stuck during birth, and what the law asks about it

A baby who gets stuck during the birth process, what we call shoulder dystocia, is a moment inside a delivery, and the doctors in the room are trained for it. The doctors who are trained to get a baby unstuck are trained to do certain maneuvers. A maneuver, as I use the word here, is one of the specific moves a doctor is taught to make to free the baby.

A baby getting stuck is not the same thing as malpractice. A bad outcome does not necessarily mean medical malpractice. Every birth carries risks, and an injury that comes from a risk is not automatically malpractice.

The law asks a different question. The term we use is the standard of care, which means the nationally recognized guidelines of what doctors should do and shouldn't do. We prove malpractice by having other doctors come into court who know what the standards of care are and can tell the jury how those standards were violated or not adhered to. Then we have to prove that the breach of the standard of care caused the injury in question. Chapter 2 builds that idea out in full. Here I only need its shape, because everything I look for in a delivery record is a way of asking that question.

Reading the baby's weight first and the maneuvers second

Here is the order I read a delivery record in. The records will show whether or not the baby is big, because a larger baby is more likely to get stuck. So the first thing we look at is what the baby weighed.

The second thing is what the doctors did once the baby was stuck. As I put it, *"The doctors who are trained to get a baby unstuck are trained to do certain maneuvers. These are nationally recognized maneuvers to get a baby unstuck, and they have to be done in a very calm, cool, non-panic way."*

The weight and the maneuvers answer two different questions. A big baby may help explain why a baby got stuck. Whether the doctors then did what they were trained to do is another matter, and the second thing I look at is how I get to it.

Let's suppose a family brings me the records from a delivery where the baby got stuck. I go to the weight first. Then I read what was done. A delivery is charted, the times and the actions, when a nurse comes in and when she goes out, when a doctor comes in and when he goes out. By looking at the medical records, I can tell whether the doctors performed these recognized maneuvers in a way that would get the baby unstuck, so that you don't cause the Erb's palsy. Chapter 8 describes how an expert builds the timeline from those entries, and I will not repeat it here.

Pulling on a baby's head, and what a missing maneuver tells me

Now let's suppose the records show that the maneuvers were not done properly, or were not done at all. What does that tell me? In my view, it means the doctor did the thing you don't want to do. *"You don't want to pull on that baby's head to get that baby out. Because if you pull on the baby's head to do that, you're going to cause terrible, terrible damage."*

Notice the words I chose. In my view. That is a reading, and a reading is where a question starts. I can read a chart, but a lawyer does not decide on his own whether the standard of care was met. So we consult with doctors who are practicing obstetricians, or other specialists, who go through the records together with us. They determine whether the standards of care were met, whether any violation of them caused the injury, and the severity and permanency of the injury.

All of that takes a lot of work on the front end. I can often tell a caller on the first conversation that there is no case. Telling someone that there is one is different, and it takes months of investigation before we are able to say so.

The chart has another side. As I said earlier in this chapter, every birth carries risks, and an injury from a risk does not necessarily mean medical malpractice.

Erb's palsy in plain words

Erb's palsy is a specific type of birth injury, and it is the injury those maneuvers are meant to avoid. It is a nerve injury to the baby's arm. It can leave the arm weak or paralyzed, and in the worst cases the paralysis is permanent. The recognized steps are done in a calm way so that you don't cause it.

How serious it is for a particular child, and whether it lasts, are questions for the doctors who go through the records with me, because severity and permanency are part of what they determine. A definition cannot answer them. A child's records can.

Putting the delivery chart together with the injury gives me three questions to carry to those doctors. What did the baby weigh? Were the recognized maneuvers done, and done properly? And if they were not, did that cause the injury this child has? The first two I can read from the chart. The third takes the practicing doctors, and it takes time.

The records that follow the child

The delivery records are one set. A second set comes afterward, and it is the set that matters most.

Many of these children go to specialists. In Baltimore we have the Kennedy Krieger Institute, which specializes in dealing with children who have these types of injuries. Those records tell me the diagnosis, and they tell me the therapies the child needs, occupational therapy and speech therapy among them. I read them to see whether the child needs specialized equipment, and whether the child needs care in the home.

All of these records are important because they help me build a case. With that information I consult a specialized expert we call a life care planner, someone who can take it and project out into the future the medical care and the services a child with a lasting injury, as in cerebral palsy, is going to need. Chapter 14 shows what that projection becomes when a case is valued.

A phone call from a former client

I want to tell you about a client. I represented her when she was a baby, and she had Erb's palsy. Several months ago I heard from her. She called to tell me that, because of what I was able to do for her, she was able to go to college, she was able to get a good job, and she had a child of her own. I don't know whether she found me on the internet or heard me on the radio. She wanted to check in and let me know that everything with her was all right.

It choked me up. *"I really got emotional about that."* After the call I had to stop for a moment, because, as I put it, *"I really had to take a moment to pause because that was so meaningful."*

Even after all that time, I knew who was calling. *"You remember all your clients."* I don't know why memory works that way. What I thought was *"good job Frank. I helped somebody and they really appreciate it."* It was a surprise, and a wonderful one.

Families who call me about a birth injury have had their lives turned upside down. A call like this one tells me something else, that what I did for a baby was still part of her life twenty years later.



A desk phone beside a lamp

Common Questions

What is shoulder dystocia? Shoulder dystocia is what we call a baby getting stuck during the birth process. A larger baby is more likely to get stuck, so the first thing I look at in the delivery records is what the baby weighed. The second thing is what the doctors did to get the baby unstuck. The weight may help explain how it happened, but it does not tell me whether anyone made a mistake.

What is Erb's palsy, and is it permanent? Erb's palsy is a nerve injury to a baby's arm. It can leave the arm weak or paralyzed, and in the worst cases the paralysis is permanent. Whether a particular child's injury lasts is a question for the doctors I consult, because part of their job is to determine the severity and permanency of the injury once they have gone through the records with me.

What do delivery records show after a shoulder dystocia birth? Two things come first. The records show whether the baby was big, and they show whether the doctors performed the nationally recognized maneuvers for getting a baby unstuck and whether those maneuvers were done properly. When the records show they were not done properly, or not done at all, that is where my questions begin. Practicing doctors then tell me whether the standard of care was met.

Does a baby getting stuck during delivery mean the doctor committed malpractice? No. A bad outcome does not necessarily mean medical malpractice, because there are risks to a birth just as there are to a surgery. An injury from one of those risks is not necessarily malpractice. The questions are whether the doctors followed the standard of care, the nationally recognized guidelines for what doctors should and shouldn't do, and whether a breach of it caused the injury.

What records matter after a child has a birth injury? The records from the specialists who see the child afterward. Many of these children go to specialists, and in Baltimore that can mean the Kennedy Krieger Institute. Those records show the diagnosis, the therapies, and whether the child needs specialized equipment or care in the home. I use them to build the case, and for a child with a lasting injury, as in cerebral palsy, to work with a life care planner.

Chapter Reflection

A delivery chart can tell me that a baby was big, whether the recognized maneuvers appear, and where a question begins. It cannot tell a court what a doctor should have done. That takes another doctor, one who knows the standards of care and puts a signature to the opinion, and the case generally cannot go forward without it. Who signs, and what exactly they are signing, is where Chapter 10 begins.

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CHAPTER TEN

The Certificate of Qualified Expert: Maryland's Safeguard Against Weak Claims

A lot of people give medical malpractice a bad name, and the reputation lands on lawyers like me. Here is the belief as I hear it put: *"They say, well, a lawyer like myself can just file anything, they can put anything in court. That's not true."* Maryland does not work that way, and the reason is a document with an awkward name.

That document is the certificate of qualified expert. In plain terms, another doctor has to review the medical records and put a signature behind the claim that the care fell short, and that it caused the injury. Without it, a malpractice case generally does not move. This chapter takes that one safeguard apart: why a lawyer cannot just file whatever he or she likes, what the certificate says, who is allowed to sign it, what the Maryland statute says about its timing, and what happens when the paperwork is late or wrong.

Like I keep saying, the medical malpractice system has checks and balances built into it, and Chapter 6 introduced several of them. This chapter looks closely at one. Where this chapter describes what the law requires, I label it as the statute. Where it describes how I see the certificate, I say so.

> ***"And it gives people the comfort to know that the system is going to work, that there are safeguards, and that lawyers just can't file lawsuits against anybody for anything. Because just because we can doesn't mean that we should."***
>
> — FRANK SPECTOR, ON THE CERTIFICATE OF QUALIFIED EXPERT

What stops a lawyer from filing just anything

Start with the question behind the belief: can a lawyer put any complaint in front of a court and see what happens? In Maryland malpractice cases the answer is no, and the check does not come from the lawyer's conscience alone. As I put it, *"We have to have another doctor look at the*

medical records, be familiar with the literature, be a practicing doctor to be able to come into court and to say that what was done was wrong."

Let's suppose a lawyer has a hunch that a hospital did something wrong. The family is hurting, and the lawyer believes them. But the lawyer cannot find a single practicing doctor who will look at those records and say the care fell below the standard. Without that doctor, we cannot move forward on a case. The hunch stops there. A strong feeling about a case is not a substitute for a doctor's review of it.

Before that doctor can come to court, there is a step in between. The doctor has to be willing to sign what we call a certificate of qualified expert. It is a detailed document, and I say more about its contents in the next section. For now, the point is that a doctor has to review the records and sign it, and that the certificate is filed with the lawsuit or within the window the statute allows (Courts and Judicial Proceedings section 3-2A-04(b)). I put it flatly: *"A medical malpractice case can't go forward without it."*

I need to add one qualification, because the law does. The statute that sets the requirement, Maryland Courts and Judicial Proceedings section 3-2A-04(b), begins with an exception: it applies unless the sole issue in the claim is lack of informed consent. So the accurate version is that the certificate is generally required. A claim built only on informed consent is the exception the statute names.

Ethics matter here too, and I take them seriously. We're officers of the court, and as I say it, *"We can't bring cases that don't have merit."* A lot of people throw the word frivolous around. It is a legal term, and it describes a case without any merit. The certificate is one of several checks aimed at that problem, and it is the one that puts a second doctor's name on the question, filed with the lawsuit or within the window the statute allows.

What the certificate says and who is allowed to sign it

I describe the certificate as a very detailed document that the doctor signs. The doctor is saying that he or she reviewed all of the medical records, practices the kind of medicine that matters in the case, and is familiar with the standards of care and with the medical literature. A lot of people want to know what that standard of care means. It is what we call the nationally recognized guidelines of what doctors should and should not do. In my description, the certificate is specific about two things: what those standards are, and how the doctor being sued departed from them.

The statute puts the content in its own words. Under Courts and Judicial Proceedings section 3-2A-04(b)(1), the certificate attests to a departure from standards of care, and that the departure is the proximate cause of the alleged injury. Proximate cause is the legal phrase. The plain-lan-

guage version, in my words, is that we have to prove that the violation of the standard of care caused the injury in question. The statute also directs that the attorney file the certificate with a report of the attesting expert attached, and that discovery is available as to the basis of the certificate (section 3-2A-04(b)(3)). In other words, the other side is entitled to look behind the signature.

Who counts as a qualified expert is spelled out as well. These are statements of the statute, not of me. Under section 3-2A-02(c)(2), for a claim filed on or after January 1, 2005, the expert must have had clinical experience, provided consultation relating to clinical practice, or taught medicine in the defendant's specialty or a related field of health care, or in the field in which the defendant provided care or treatment to the plaintiff, within 5 years of the date of the alleged act or omission that gave rise to the claim. Where the defendant holds a specialty credential from a certifying board, the expert generally must hold a matching credential in the same or a related specialty. The statute lists two situations where that matching requirement does not apply: when the defendant was treating the plaintiff for something unrelated to the area of the defendant's credential, and when the expert taught medicine in the defendant's specialty or a related field.

The statute also says who cannot sign. Under section 3-2A-04(b)(7), a party may not serve as the party's own expert, and the certificate may not be signed by a party, by an employee or partner of a party, or by an employee or stockholder of a professional corporation of which the party is a stockholder.

What I tell people about these doctors comes from the same place. *"These are practicing doctors, they have to meet very strict guidelines under Maryland law."* They have to be practicing, and they cannot make a career out of testifying. The statute supplies the measuring stick for that last point. Section 3-2A-04(b)(4) says the health care provider who attests may not have devoted more than 25% of the expert's professional activities to activities that directly involve testimony in personal injury claims during the 12 months before the claim was first filed.

This is why I push back on one idea in particular. People think you can pay an expert and the expert will say anything, and I push back on that because there are safeguards. A doctor who signs a certificate has to fit the statute's description, and the signature is attached to a report the other side can examine.

In a birth injury case, the doctors we consult are practicing obstetricians or other specialists. They go through the medical records together with us and help determine whether the standards of care were met.

What the statute says about timing

Now to the deadlines. The details in this section are the statute speaking, and I cite the section each time so you can read it for yourself.

The statute sets the clock for the certificate at 90 days. Under Courts and Judicial Proceedings section 3-2A-04(b)(1)(i), a claim or action filed after July 1, 1986 shall be dismissed, without prejudice, if the claimant or plaintiff fails to file the certificate of a qualified expert with the Director within 90 days from the date of the complaint. The Director, in the statute's own definition, is the Director of the Health Care Alternative Dispute Resolution Office (section 3-2A-01(d)). The claimant must also serve a copy of the certificate on all the other parties or their attorneys of record.

The statute then makes room for narrow relief. If the limitations period for the claim has expired, and the failure to file the certificate was neither willful nor the result of gross negligence, the panel chairman or the court shall grant an extension of no more than 90 days (section 3-2A-04(b)(1)(ii)). Section 3-2A-04(b)(5) adds that an extension of the time allowed for filing the certificate shall be granted for good cause shown.

The certificate is not only a plaintiff's obligation. Section 3-2A-04(b)(2)(i) provides that a claim may be adjudicated in favor of the claimant on the issue of liability if the defendant disputes liability and fails to file a certificate of its own, attesting either to compliance with standards of care or that any departure was not the proximate cause of the injury, within 120 days from the date the claimant served the plaintiff's certificate. If the defendant does not dispute liability, no defendant's certificate is required (section 3-2A-04(b)(2)(ii)).

The deadline for the lawsuit itself is a separate subject, and Chapter 11 takes it up. What I want you to hold onto here is that the certificate has its own clock, and the clock is written into the law. As I say it, *"We are bound by rules. And rules tell us certain deadlines when things have to be submitted into court."* A lawyer like me has to know both clocks and meet both.

A quality-control inspection of the case

The name itself is a mouthful. As I put it, *"That sounds like a lot, tongue twister."* What it means is that a doctor has to be willing to put in writing, very specifically, what the standards of care are and how the doctor we are bringing the lawsuit against violated them.

I think of it as a safeguard. It means another doctor has inspected the case for quality and said the case has merit. Meritorious is the word we use for a case with merit. It is the opposite of frivolous. The doctor is not only willing to sign. As I describe it, *"They're willing to raise their hand in*

court and to swear that what they are about to say is the truth and nothing but the truth, and this is their opinion, and they stand by it." The certificate is a signed document with the expert's report attached. The oath comes later, when the doctor testifies in court.

I have said it plainly: "*The certificate of qualified expert, I think, is an excellent safeguard.*" The safeguard matters to families too. In my words, it "*gives people the comfort to know that the system is going to work, that there are safeguards, and that lawyers just can't file lawsuits against anybody for anything.*"

That comfort has a practical side. Another physician outside my office has looked at the records, practices in the kind of medicine that is relevant to the case, and is prepared to put a name to the conclusion. And if we cannot find a doctor willing to do that, the case does not go forward.

When the certificate is late or wrong, and the case that still needs one

The rules on timing are strict, so here is a hypothetical. Let's suppose you have the greatest case, and you file your lawsuit too late, say on the first day after the deadline. You could have the greatest case in the world, but it is thrown out because it was not filed on time. The certificate works the same way. "*You could have the greatest doctor, the best doctor, the biggest expert, the only expert in this area of medicine. But if you file it too late or you don't file it properly, you might as well just throw it in the trash because it's going to be worthless.*"

As I see it, you must have an experienced medical malpractice lawyer who knows the rules and will file things on time. "*Because if things are even one minute late, it's like they're a hundred years later.*" That is my warning in practical terms.

The statute does contain some narrow relief. These are the law's words, and I report them as they are written. Dismissal for a missing certificate is without prejudice under section 3-2A-04(b)(1)(i). Beyond the extensions in the last section, section 3-2A-04(b)(4)(iv) says that if a court dismisses a claim or action because a qualified expert failed to comply with the requirements of that subsection, then unless there is a showing of bad faith, a party may refile the same claim before the later of two dates: the expiration of the applicable period of limitation, or 120 days after the date of the dismissal. Subparagraph (v) adds that a claim may be refiled this way only once.

Each of those provisions has conditions written into it: an expired limitations period together with a failure that was neither willful nor grossly negligent, no showing of bad faith, a single refiling. Even so, these are narrow exceptions, and the safest course is a certificate filed correctly and on time.

The certificate also applies to the cases that seem easy. A lot of people assume that a wrong-site surgery is automatic. Many of them figure that a surgeon who operated on the wrong side means the procedures can be skipped. But that is not how it works. If a case involves a wrong knee, even though it sounds obvious, we still have to get another doctor to review the medical records. The wrong knee does let us state an obvious error, which has a lot of jury appeal, and as I see it a case like that is probably going to settle out of court because it is so open. To get to that point, we still have to follow all of the laws and procedures of a medical negligence case in Maryland, and the certificate is one of them.



How a certificate of qualified expert moves a case forward

Common Questions

What is a certificate of qualified expert in a Maryland malpractice case? It is a signed certificate in which a qualified doctor attests that the care departed from the standards of care and that the departure caused the alleged injury, with the expert's report attached (Courts and Judicial Proceedings section 3-2A-04(b)). I describe it as a detailed document showing the doctor reviewed the records and knows the standards and the literature. It is generally required, except where informed consent is the only issue.

Who can sign a certificate of qualified expert in Maryland? Under the statute, the signer must have recent experience in the defendant's specialty or a related field, and a matching specialty credential when the defendant holds one, with stated exceptions (section 3-2A-02(c)(2)). A par-

ty, or a party's employee or partner, cannot sign (section 3-2A-04(b)(7)). In my own summary, these doctors have to be practicing and cannot devote their whole lives to testifying. The statute caps testimony work at 25% of professional activities in the prior 12 months.

How long does a family have to file the certificate in Maryland? Under the statute, a claim is dismissed without prejudice if the certificate is not filed within 90 days from the date of the complaint (section 3-2A-04(b)(1)). An extension of up to 90 days is available only if the limitations period has expired and the failure was neither willful nor grossly negligent; a separate provision allows one for good cause shown (section 3-2A-04(b)(5)). Confirm the dates for a particular claim with a lawyer.

Does a wrong-site surgery case still need a certificate of qualified expert? Yes. A wrong-knee case may sound open and shut, but *"You have to have the same procedures that go into it."* Another doctor reviews the medical records, signs the certificate, and is willing to come to court and say it was malpractice. The obvious error carries a lot of jury appeal, and the safeguards still come first.

Chapter Reflection

A family can get a good deal of comfort from this chapter, and a good deal of caution. The comfort is that in a Maryland malpractice case, a practicing doctor outside my office reviews the records and signs a certificate that the statute describes in detail, filed with the lawsuit or within the window the statute allows. The caution is that the safeguard has a clock and a form, and a case with a strong expert can still be undone by paperwork filed late or filed wrong. Both things are true at once. The next chapter turns to the larger clock, the time a family has to bring the lawsuit at all.

CHAPTER ELEVEN

11

How Long a Maryland Family Has to File a Malpractice Claim

Every chapter before this one has been about what it takes to prove a case: the standard of care, the medical records, the doctor who signs the certificate. This chapter is about a rule that can end a case before anyone gets the chance to prove a thing. It has nothing to do with medicine. It has to do with a date, and a family that misses the date loses the case no matter what the records show.

I will give you the rule the way I give it to the families who call me, and then I will show you where it comes from. Along the way I will explain why one phrase in the Maryland rule, "knew or should have known," makes lawyers who handle these cases reach for a simpler count. I will set out what the Maryland statute says, labeled as the law and not as my opinion. And I will explain why a child's deadline is a different question from an adult's, one a family should never settle alone.

Before you hold on to any number in this chapter, hold on to the idea of a deadline. The numbers depend on facts: when the injury was committed, who was hurt, how old that person was at the time. I cannot see those facts from the page. A lawyer who has your records can.

> ***"Because if you call me when it's too late, there's nothing I can do to help you."***
>
> — FRANK SPECTOR, ON THE FILING DEADLINE

A strong case filed one day late is a lost case

A lot of people picture a lawsuit as a fight over what happened in the operating room or the delivery room. Before that fight can begin, there is a rule about when it is allowed to begin, and it is the rule I most want every family to know.

Let's suppose you have the greatest case in the world, with the best doctor behind it. Let's suppose you file your lawsuit on the first day after the third year in Maryland. Nothing about the medicine has changed overnight, and none of it matters. In my words, *"You could have the greatest case in the world, but it's going to be thrown out. It's over because you didn't file it on time."*

A lot of people also ask what "filed" even means. It means that a lawyer prepares a document called a complaint and brings it to the court. It used to mean carrying paper to the clerk's office. Now it is all done online. Once the case is filed, that is how the litigation starts, and the date of that filing is what the deadline measures.

We are bound by rules, and *"rules tell us certain deadlines when things have to be submitted into court."* The lawsuit has a deadline. The certificate of qualified expert has a deadline of its own, since it is filed with the lawsuit or within the window the statute allows (Courts and Judicial Proceedings section 3-2A-04(b)), and Chapter 10 covered that clock. This chapter is about the larger one, the time a family has to bring the lawsuit at all. Both are the reason I say, *"So you must have an experienced medical malpractice lawyer who knows the rules and will file things on time."*

The count I give adults: three years from the injury

The general rule, the way I state it: in Maryland, an adult has three years from the date the malpractice happened to bring a lawsuit. That is the number most callers need, because most of the people who call me are adults.

The rules around that number get more complicated, and I will come to them. When they do, I fall back on a count that is easy to explain and hard to get wrong. *"So the rule that I use is three years from the date that the malpractice was committed upon you."* It is also the conservative way to count. In my words, *"That's the most conservative and that is the time that we tell our clients."*

The consequence of missing it is spelled out in the plainest terms I know. *"You must bring a lawsuit within three years, or else you can't bring it again."* There is no second try.

I will say it the simple way once more, because simple is where a family should begin: *"You have three years in Maryland to bring a lawsuit. That is the most simplified way to express it."* Notice the last words. I call it the most simplified way, which tells you there is more underneath it. A simple rule is a place to start counting. It is not a substitute for someone looking at your dates.

Knew or should have known: where the clock becomes a guess

Underneath the simple rule sits what we call discovery. As I describe it, Maryland law gives a person three years from the date that person knew or should have known that medical malpractice was committed upon them. It sounds fair. Then you try to use it.

Let's suppose a family learns long after the care that something went wrong. When did they know? And the harder question: when should they have known? The first asks what was in their minds. The second asks about a person who was not told, and there is no calendar date that answers it. The difficulty is real. *"That's very confusing. It's very confusing for those of you watching, and it's very confusing for lawyers who do this."* The question sits at the center of the whole rule: when does that clock start running?

I wish the law were clearer, and I have said so: *"Maryland law is very confusing, and I wish they would change it."* Until it does, I do what lawyers who handle these cases do. We use a much more defined time, three years from the date of the injury, and we give that date to clients instead of leaving them to guess at what they should have known.

What section 5-109 says about the earlier of two dates

This part is the statute speaking, not me. I cite each piece so that a family can read it for themselves.

Maryland Courts and Judicial Proceedings section 5-109(a) says that an action for damages for an injury arising out of the rendering of, or failure to render, professional services by a health care provider shall be filed within the earlier of two periods: five years of the time the injury was committed, or three years of the date the injury was discovered. The word in the statute is "discovered." The phrase "knew or should have known" is how I describe that discovery part.

Now let me put dates into it. What follows is arithmetic on the statute's words, not another statement from the statute. Let's suppose the injury is discovered the day it is committed. Both periods begin together, and the three-year period ends first. Now let's suppose the injury is discovered later. The three years from discovery start later, but the five years from the injury have been running since the injury itself. Because the statute says "the earlier of," the period that ends first is the one that counts.

Count three years from the date of the injury and you land on or before the end of either period. That is why I call my count conservative, and it is why I give it to clients.

The statute adds one more place to the picture. Section 5-109(d) says that filing a claim with the Health Care Alternative Dispute Resolution Office in accordance with section 3-2A-04 is deemed the filing of an action for this purpose. Section 3-2A-04(a)(1)(i) provides that a person having a claim against a health care provider for damage due to a medical injury shall file the claim with the Director of that office. I describe filing as a complaint brought to a court. The statute names this office as well, which is one more reason the person doing the filing needs to know the rules.

Nothing in the statute hands a family a date. A lawyer's job is to put real dates into it.

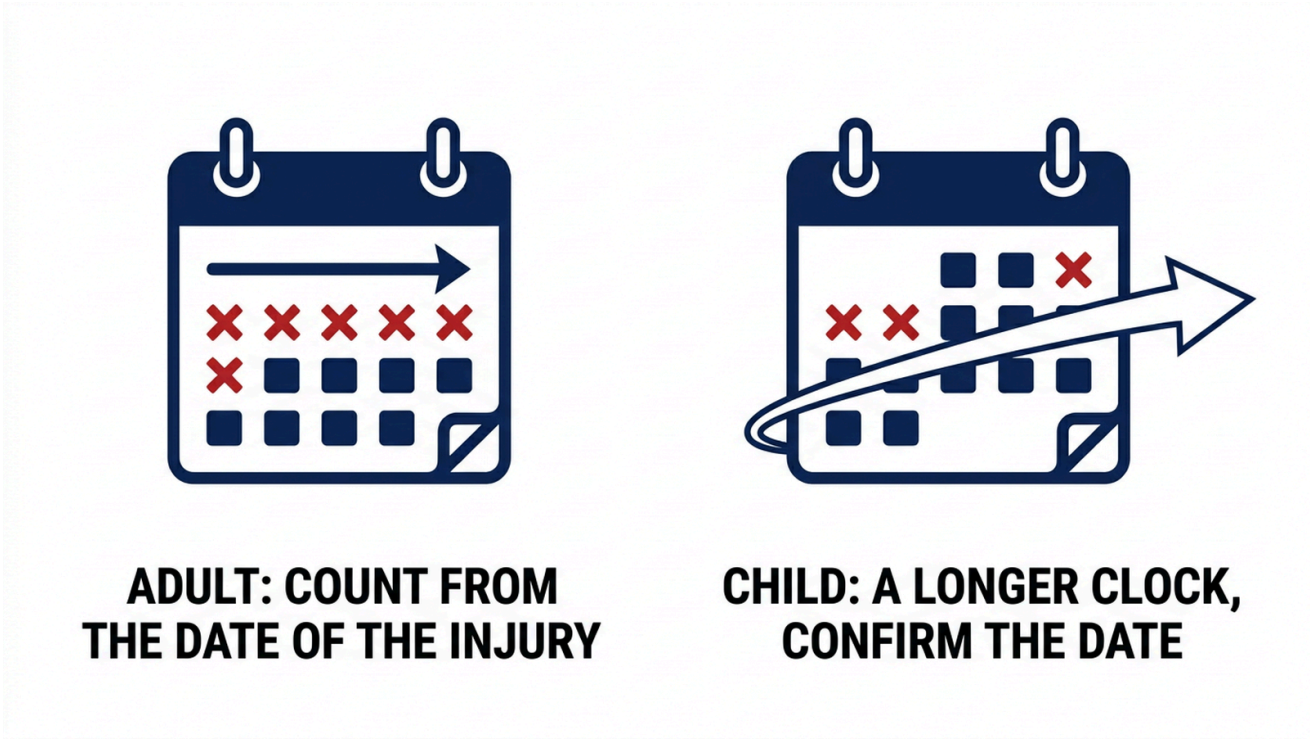
A child's clock runs longer, and a lawyer still confirms the date

Three years is the rule for an adult. Maryland treats children differently, and the difference is large. In my view Maryland has a very generous time limit for children, and I tell people that this is not true everywhere: *"Many states have very restrictive time limits."* A child in Maryland gets far more time than an adult.

That matters most in birth injury cases, because the person who was hurt is a child.

The statute is where the rules for children live, and they live in more than one place. Section 5-109(b) provides that for a claimant who was young enough at the time the injury was committed, the periods in subsection (a) begin later than the injury, and subsection (c) sets a different later starting point for a few specific kinds of injury. The date for a given child comes from reading those provisions against the child's age when the injury was committed.

For that reason I will not put a single age in this book and ask you to plan around it. The statute's text for a child is more complicated than for an adult, and a lawyer has to confirm the date for the particular child, so I do not hand one over. If your child was hurt at birth, take the question to a lawyer now, and let that lawyer confirm the date for your child. A longer clock is still a clock.



How the filing clock differs for an adult and a child

Making podcasts and videos so the deadline is not a surprise

If you get nothing else out of this chapter, take one idea: *"You don't have forever to bring a lawsuit."* That is the whole point of a statute of limitations, which is a time limit set by law.

Many people have never been told that. *"Most people do not know what the legal options are."* Some do not know the time limit exists. Others have a misunderstanding of it, because they *"look it up on the internet and the information that you get is not always accurate."* Given how confusing the rule is even to lawyers, I understand how that happens.

There is no reason a family should know how these rules come about. *"In our state capital, Annapolis, that's where laws are made."* The time limits are made there, along with the amount of money a lawsuit can bring and what it takes to get a medical doctor behind a case. All of it is Maryland law, and people don't know about those rules.

I make podcasts and put videos on YouTube, TikTok and Instagram. I want families to learn the rule before they need it. My reason is *"to give you the information that you need to know to protect your rights."* I put it as plainly as I can: client education is extremely important, and I am fortunate to have the platforms to do it. A family that has heard about the deadline before the worst times of their lives arrive has one less surprise waiting.

Common Questions

How long do I have to file a medical malpractice lawsuit in Maryland?

For an adult, the rule I use is three years from the date of the injury. That is the conservative count, and it is the one I give clients. The statute, Maryland Courts and Judicial Proceedings section 5-109, sets the limit at the earlier of five years from the injury or three years from discovery. A child's deadline comes from separate provisions, so a lawyer has to confirm that date.

What does "knew or should have known" mean for the Maryland malpractice deadline?

It is the discovery part of the rule, which I describe as three years from the date a person knew or should have known that malpractice was committed upon them. The trouble is the second half, because what a person should have known is not a date on a calendar. *"That gets very confusing even for lawyers."* So I count from the date of the injury. The statute's own word is "discovered."

How long does a child have to file a birth injury lawsuit in Maryland?

A child gets far more time than an adult. In my view Maryland's limits for children are very generous compared with many other states. The statute has its own provisions for a young child, and the date depends on how old the child was when the injury was committed. I never give a family one age to plan around. A lawyer should confirm the date for that child.

What happens if a malpractice lawsuit is filed one day late in Maryland?

The case is thrown out, however strong it is. Nothing else matters once the date has passed. The best doctor and the strongest records do not change that. The certificate of qualified expert has a clock of its own, which Chapter 10 covers, so a lawyer has to meet more than one date.

Can I trust what I read online about the filing deadline?

Treat it as a place to start, not a place to stop. People have misconceptions about the deadline, and what they find online is not always accurate. The Maryland rule has two periods and a discovery question inside it, and it confuses lawyers too. Have a lawyer count the dates for your facts.

Chapter Reflection

A family can do very little about what happened in a delivery room or an operating room, and a lot about the calendar. Count early. Count from the injury. Have a lawyer check the count, and have the lawyer confirm a child's date before anyone relies on it. The date comes first, and the names come second: a complaint filed on time still has to carry the right ones, and who belongs on it is the subject of Chapter 12.

CHAPTER TWELVE

12

Who Gets Named in a Maryland Malpractice Lawsuit

The easy picture of a malpractice lawsuit has two names in it, the doctor and the hospital. It is a natural place for a family to start, and in a Maryland case the list of people on the other side can be longer than that. A family has no way of seeing the longer list from the outside.

A lawsuit begins with a document that names the people being sued, and I have to get those names right before I file it. Deciding who belongs on that document takes research into who was involved in the care and which companies those people worked for. That work comes first, during the months of investigation it takes before anyone can say whether a case exists.

This chapter covers what it means to file in court, who typically ends up as a defendant in a birth injury case, why an employer shows up beside an employee, and what happens when a name is missing from the lawsuit. Chapter 13 takes up the insurance behind these names, and Chapter 16 explains the claims the defendants can file against each other.

> ***"you have to bring a lawsuit against all the relevant parties."***
>
> — FRANK SPECTOR, ON WHO HAS TO BE NAMED

A complaint is the document that starts a lawsuit

A lot of people want to know what it even means for a case to be filed in court. By the time a case reaches that point, it has been worked up: the first interview, the medical records, and the doctors who review them, all covered in Chapters 7 through 10. Filing means that a lawyer like me prepares a document called a complaint and brings it to the court. It used to be that you carried it on paper to the clerk's office. Now *"we do everything online."* Once the complaint is filed, that is how litigation starts.

I describe litigation as a battle. When a lawsuit begins, each party is trying to do the best it can for its client. There may have been settlement negotiations before, and maybe some friendly conversations, but once a case is in litigation, all bets are off. Two legal terms come along with it. The person who brings a lawsuit is called the plaintiff, and the person being sued is called the defendant. I try not to use too many legal terms, but I slip, so I want those two out in the open before they appear again in this chapter.

The complaint is also the document where the defendants get named. As Chapter 10 explained, the certificate of qualified expert is filed with the lawsuit or within the window the statute allows (Courts and Judicial Proceedings section 3-2A-04(b)). The names have to be right before any of it goes to the court, which is why this chapter spends its time on them.

Behind the doctor stands a corporate practice

Let's suppose a delivery goes badly and a family asks who is responsible. The easy answer has two names in it, Dr. Jones and the hospital, and the lawsuit would be against those two entities. It is not as simple as that.

Why is that? Well, first of all, a doctor is usually part of a corporate practice. Let's say Dr. Jones works under the name Babies Inc., or Babies LLC. It could be one doctor under that name, or it could be a large practice. Either way, the doctor works under that corporate entity, and I have to make sure I am setting up the right corporate entities to be sued. So a lawyer like me does the due diligence, and I bring the lawsuit against the doctor and against the doctor's corporate entity.

A patient cannot see any of this from the bedside. I put it this way: *"a patient doesn't know all the different corporate entities that a hospital has or a doctor is a part of."* The emergency room is a good example. *"The doctors who treat you in the emergency room, they actually are part of a separate corporation. Now you have no idea about that."*

The same holds more broadly. *"There are so many entities out there, corporate entities that we don't know anything about."* That is why the sorting falls to the lawyer and not to the family.

The hospital, the nurse and the corporate entities behind them

The next name is the hospital. I bring a lawsuit against the hospital, and maybe against corporate entities within the hospital as well.

Then there is the nursing staff. Maybe a nurse was involved in the care. If so, I bring the lawsuit against the nurse. And just as a doctor can be part of a practice, maybe the nurse is part of a corporate entity that I have to discover. Finding that out is my job, and I do it before a case is filed.

Put those pieces together for a birth injury case and this is the typical list. It starts with the doctor and the doctor's corporate practice, because many doctors are part of one. It moves to the hospital. It may add corporate entities within the hospital, and it may add the nurse. Each of those is a separate name on the complaint. I describe the work in these words: *"it's a very complicated situation to make sure all the parties are correctly part of the lawsuit."*

An employee's mistake belongs to the employer too

A second reason a facility belongs in a case comes from a rule most of us know from work. Those of you who have worked for a company will recognize it: when an employee makes a mistake, the employer is responsible.

Let's suppose a nurse's mistake is part of what went wrong in a hospital. The nurse is named as a defendant, and the facility is named as well. In my words, *"an employee's actions go back to the employer."* The nurse is responsible, and the facility is responsible too, because the facility answers for that nurse's actions. Both belong in the lawsuit.

The rule has a wrinkle, and I raised it earlier. Many doctors work for a separate corporation. The emergency room doctors in the example above are one case. So for a doctor, the question of who the employer is has to be answered by research, and that research is part of what a lawyer does before the complaint goes in.

Proper insurance and the search for the policies behind each name

Why go to all this trouble? Because we have to make sure that there is proper insurance. *"Every one of these different entities may carry different policies of insurance."* The job is to find the most insurance that we possibly can. If a birth injury case is successful, it can result in a monetary recovery, and we have to be able to find the insurance that will satisfy it.

That is where the hospital comes back in. In a birth injury case there can be several layers of insurance, and *"we need to make sure that we have adequate insurance coverage to pursue a claim."* Each entity may carry its own policy, so finding the names is how I find the policies.

Chapter 13 explains how coverage shapes a case. The point here is narrower: each name on the complaint is a possible source of coverage, and the research that produces the names comes before the filing.

A name left off the complaint, and the lawsuit within the lawsuit

This is what can happen when a name is missing. Let's suppose I bring a lawsuit against the doctor and no one else. The doctor says, wait a minute, I am not responsible, but even if I am, the hospital is responsible too. That hospital has not been made part of the lawsuit, because I have only sued the doctor.

The doctor's lawyers can bring a lawsuit to bring the hospital in. That is called a third-party defendant, and it is a lawsuit within the suit: the doctor saying that it is not my fault, but even if it is, somebody else is responsible too. Now remember who did what. I brought the lawsuit against the doctor. The doctor brought a lawsuit against the hospital. I have not connected those dots, and the doctor's lawsuit does not connect them for me. *"I have to take some affirmative action."* So I have to, what we call, amend my lawsuit. I change it and add in the hospital. Once I do that, everything is put together properly.

These litigation tools are meant for lawyers with a lot of experience, because they get very complicated. That is why a family needs an experienced medical malpractice lawyer for this part of a case.

To sum up the point for anyone on the plaintiff's side: with third-party defendants, you have to make sure you are bringing all the parties into your lawsuit, because if you don't, *"you may be out of luck."* Chapter 16 covers cross-claims, counterclaims and third-party defendants in full. The lesson for this chapter sits at the front end of a case. The names go on the complaint, and the research that finds them comes first.



Four parties that can be named in a malpractice lawsuit

Common Questions

What does it mean to file a medical malpractice lawsuit in Maryland? It means a lawyer prepares a document called a complaint and brings it to the court. That used to happen on paper at the clerk's office, and now it is done online. Filing the complaint is how litigation starts, and it comes after the case has been worked up. Because the complaint names the defendants, the research into who was involved has to happen before it goes in.

Can I sue just the doctor and the hospital in a Maryland malpractice case? Usually that is not enough. A doctor is usually part of a corporate practice, so the practice gets named along with the doctor. The hospital gets named, maybe corporate entities within it, and maybe a nurse. About Dr. Jones and the hospital, I say it plainly: *"It's not as simple as that."* The research comes first, to find the right entities.

Who gets named in a birth injury lawsuit? A typical birth injury case starts with the doctor and the doctor's corporate practice. It moves to the hospital and maybe corporate entities within the hospital. If a nurse was involved, the nurse is named too, and the nurse may belong to a corporate entity that I have to discover. Which names belong depends on the research into who was involved and who they worked for.

Can a hospital be sued for a nurse's mistake? Yes. The nurse is responsible, and the facility is also responsible. The way I put it, *"the employer is responsible for the negligence of their employees."* So in a lawsuit over a nurse's mistake, the nurse is named as a defendant and the facility is named as well. The facility answers for what its nurse did.

What happens if a party is left out of a malpractice lawsuit? It can be serious for the plaintiff. If I sue only the doctor, the doctor's lawyers can bring the hospital in as a third-party defendant. That does not connect the hospital to my lawsuit, though. As the plaintiff's lawyer, I still have to take affirmative action, amend my complaint and add the hospital. Doing that work before filing is the safer course.

Chapter Reflection

A family sees a doctor, a nurse and a hospital. The record and the research around it show what stood behind them: a practice behind the doctor, a facility behind the nurse, and corporate entities that a patient had no way of knowing about. An employer answers for an employee, which is why the names come in pairs. Chapter 13 follows each of those names to the insurance behind it. For now the point is the order of the work: the research comes first, and the complaint comes after it.

13

CHAPTER THIRTEEN

Insurance Coverage and Why It Shapes a Malpractice Case

The chapters before this one deal mostly with proof. What the standard of care is, how a medical record is read, who signs the certificate of qualified expert, how long a family has to file, and who ends up named in the lawsuit. Those questions decide whether a doctor or a hospital did something wrong.

A second question sits right beside them. Let's suppose a lawyer proves that a doctor fell below the standard of care. That is a finding about what happened in a delivery room or an operating room. It is not money. A family whose child is going to need care for the rest of the child's life needs something more than a finding, and whether anything stands behind the people at fault is a question about insurance.

Nothing a lawyer does undoes the injury, and I wish it could. What I can do is give a family straight talk about whether a case has the resources behind it to help. This chapter covers why people picture the wrong source of money, how a birth injury case can rest on several layers of coverage, how the amount of insurance changes what a doctor is willing to risk at trial, and why we look for all of the coverage before telling a family what to expect. Chapter 12 explains who gets named in a lawsuit, and this chapter explains one reason that list matters. Chapter 14 turns to what a family can recover and what Maryland limits.

> ***"insurance is everything because you have to have adequate insurance to be able to tell your client that you have a meaningful chance of a recovery."***
>
> — FRANK SPECTOR, ON INSURANCE COVERAGE

Insurance decides what a case can become

Much of the work in the earlier chapters answers questions about the past. Did the care meet the nationally recognized guidelines? Did a departure from them cause the injury? Is there a practicing doctor willing to say so in writing and in court? Insurance answers a different kind of question, which is what can be done about it.

A lawyer who tells a family there is a case is also telling them that something stands behind the people at fault. That something is coverage. Without it, a finding that a doctor fell below the standard of care is a finding that cannot pay for a single hour of nursing or a single therapy session.

The word adequate carries the weight, and it does not mean the same thing from one family to the next. A malpractice case is worth something different each time, because each client has different needs. Some are more injured than others. Some need more medical care or more medications, and some have lost a job or the chance of one. So adequacy is measured against the client.

That is also why a lawyer like me cannot treat the lawsuit as a way of making a point and nothing more. I have said that going after a doctor who has no insurance, or inadequate insurance, is not realistic, and the reason is easy to state: *"there's not going to be any money for my client."*

Picturing a rich doctor and the money a lawsuit can reach

A lot of people picture a malpractice case as a claim against one wealthy person. *"People think, well, doctors are rich, I could just go get the money from a doctor."* I understand why the picture is common, but it does not match these cases. In my words, *"most of these cases go beyond what even any doctor would have in their personal assets."*

To see why, start with what a family faces after a serious birth injury. Many of my clients with a child like that need round-the-clock medical and nursing care, and that is very expensive. Children with severe brain injuries are also living a lot longer than they did when I started practicing law, thirty-five years ago, and so the costs are enormous. A family in that position is frightened of those costs, and you can imagine how fearful a family is of those costs.

What the money can mean, as I see it, is peace of mind. It can mean a family knows they have the financial resources to keep their child at home instead of in an institution, and the institutions are not great. In thirty-five years, nobody who called me has said they had great news because they were injured and were going to get a whole lot of money. They understand that they will need money to supplement what their insurance does not cover and what disability payments do not cover.

The size of that need is the work of a specialized expert called a life care planner, who projects the therapies, the medications and the nursing care a person is going to need for the rest of life. Chapter 14 shows how that projection becomes a number a jury sees. For this chapter, the point is simpler. When I decide which names belong on a lawsuit, proper insurance is part of the reason.

A birth injury case can rest on several layers of coverage

Here is where a lawyer's due diligence starts to look complicated from the outside. A patient does not know all of the different corporate entities that a hospital or a doctor is part of. If you go to the emergency room, the doctors who treat you there are part of a separate corporation, and you have no idea about that.

Let's suppose a mother delivers with Dr. Jones. A doctor is usually part of what we call a corporate practice, so Dr. Jones may operate under a company I will call Babies Inc. That is one entity beside the doctor. Maybe a nurse was involved in the care, and the nurse may be part of a corporate entity too, one I have to discover. Then there is the hospital, and there may be corporate entities inside the hospital as well. A lawyer brings the lawsuit against the doctor and the doctor's corporate entity, then against the nurse, and then against the hospital and its corporate entity. The law also holds an employer responsible when an employee makes a mistake, with the caveat that a lot of doctors work for a separate corporation and not for the hospital.

Why does this matter for insurance? Because we have to make sure there is proper insurance, and each of these entities may carry a different policy. A lawyer who names only one of them may be looking at only one of the policies.

In birth injury cases, the layers can go further. There could be several layers of insurance, with more than one company insuring the hospital. In my words, we need to make sure we have adequate insurance coverage, and that is part of why a hospital is named, alongside the rule that an employer answers for an employee's mistake.

None of this is visible to a family in a hospital room. It is the reason a medical malpractice lawyer does the research on the entities before the lawsuit is filed, so the right parties and the right policies are in the case. Chapter 12 walks through the naming. The point to hold onto here is that each name on the lawsuit may bring its own coverage with it.

A doctor with a finite policy thinks hard about trial

Insurance does not only decide whether a case can be brought. It shapes what happens after the case is filed. In my words, *"The amount of insurance does dictate settlement."*

Let's suppose a doctor has only a finite amount of insurance, and the damages in the case far exceed it. Sit in the doctor's chair for a moment. That doctor is probably going to think long and hard about going to trial, and is going to want to resolve the case, because *"they don't want to expose themselves to getting a judgment against them over the amount of insurance."* It is hard

to collect money from a doctor personally, but a court can still enter a judgment against an individual doctor, and no doctor welcomes that possibility. The gap between the policy and the damages is a form of pressure, and it pushes a case toward the negotiating table.

Whether a case can be resolved out of court is one thing the insurance helps decide. A trial puts the case in front of jurors, and the outcome is uncertain. *"The trial you think you're going to try is not the trial that happens before you."* A negotiated result leaves much more control with the people at the table. Once a case is settled, it is final. Even a jury win is not the end, because the other side can appeal, and an appeal can take years to work through the court system.

None of this makes a settlement certain. I have to be honest about that, because sometimes *"the doctors and the hospitals and insurance companies are adamant and they want to go forward."* The amount of insurance moves the conversation, and it does not end it. Like I keep saying, I tell my clients, let's manage our expectations. And whether to accept any number is the client's decision. If I bring a number to a client and the client does not think it is fair, the client has the right to say no thank you. Chapter 18 returns to who decides.

Looking for all of the coverage before promising a family anything

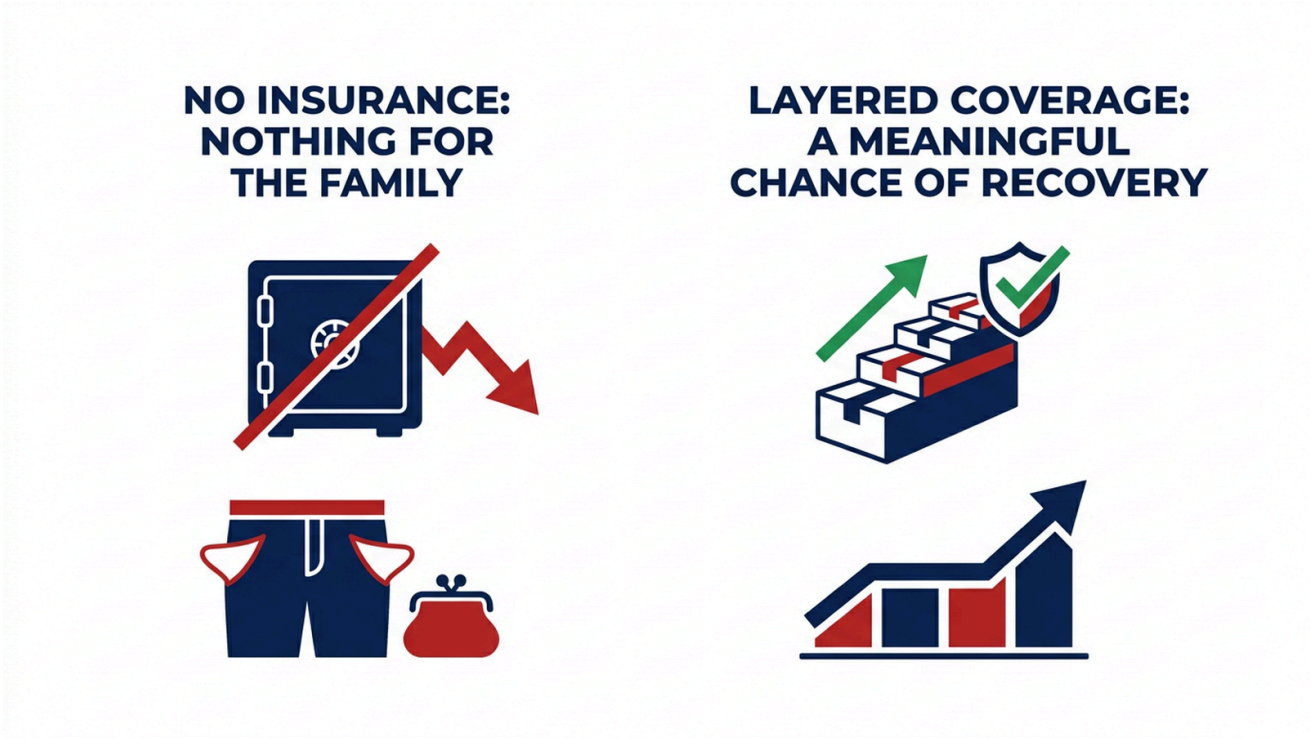
Because coverage shapes so much, the investigation has to include it. *"We need to find the most insurance that we possibly can,"* because a birth injury case that succeeds can result in a recovery that can be significant, and the insurance has to be there to satisfy it. In a birth injury case, that means investigating all of the coverage so we can maximize the recovery for the family.

That search sits inside the larger investigation described earlier in this book. With some callers, I can tell on a first conversation that there is no case. With the ones I look into, it takes months of investigation before we can tell someone whether they have one, and coverage is one of the things we need to understand along the way.

A second reason coverage matters to a lawyer is that a malpractice case is enormously expensive to bring. Lawyers like me take cases on what's called contingency, which means we do not get paid unless we win. If we lose a case, the money we advanced is gone. That is part of why not every caller becomes a case: either there is no malpractice, or there is not enough injury to substantiate a case, given how expensive a case is. And in a case against a hospital, I need adequate insurance coverage behind the claim before I can pursue it.

This is where straight talk matters. I tell everybody like it is. If the coverage is not there, a family deserves to hear that plainly, along with the reason, and a no from a lawyer who took the time to explain it gives people something useful. If the coverage is there, the family can hear that too,

with the same honesty about what comes next. A family whose life has been turned upside down is owed that answer before anything else.



Why a claim needs insurance coverage behind it

Common Questions

Can you sue a doctor who has no insurance?

You can file the lawsuit, but it is not realistic. A case against a doctor with no insurance or inadequate insurance runs into one plain problem, which is that nothing is there to pay the family. Proving the doctor fell short of the standard of care does not change that. Before I take a case, the coverage behind the doctor has to be weighed alongside the proof.

Can a doctor be held personally responsible beyond their insurance?

A court can enter a judgment against an individual doctor, even though collecting money from a doctor personally is hard. A doctor whose coverage is smaller than the damages in the case has a reason to think hard about a trial, since *"nobody wants to have a judgment hanging over their head."* That risk is one reason such a doctor often wants to resolve a case.

Can more than one insurance company be involved in a birth injury case?

Yes. In birth injury cases, as I put it, *"There could be different layers of insurance, multiple companies that insure the hospital."* The doctor, the doctor's practice, a nurse and the hospital may each have their own entity, and each entity may carry its own policy. That is why the investigation looks at all of the coverage.

Does health insurance pay for round-the-clock nursing care for an injured child?

It does not, and I have found that to be so. As I have said, *"Insurance doesn't cover 24 hour nursing care."* Many of my clients with a seriously injured child need that care, and it is very expensive. Money from a lawsuit is meant to cover what insurance and disability payments do not, and a life care planner projects what that need will be over the child's life.

Chapter Reflection

Proof and coverage are two separate gates, and a family has to get through both. The first gate asks whether someone fell below the standard of care. The second asks whether anything stands behind that someone to pay for what a child or a parent is going to need, and a case can stall at the second gate. That is the straight talk a family should hear at the start. Once a lawyer has found the coverage, the question becomes what the law allows a family to recover from it, and which part of that Maryland limits. That is the subject of Chapter 14.

14

CHAPTER FOURTEEN

What a Family Can Recover, and What Maryland Limits

A lot of people ask me what a case is worth, and I understand why. A family that has been hurt by the medical system wants to know where all of this leads. The answer is that it depends on the person. Each case is worth something different, because we evaluate each client on what that client needs, what care lies ahead, and what has been lost.

Maryland divides the money into two kinds. One is what we call economic damages, the losses a calculator can reach, which I describe as not limited, with one statutory limit on past medical expenses that I set out below. The other is what we call non-economic damages, the kind people shorthand as pain and suffering, and that is the kind Maryland caps. This chapter covers both, shows how a lifetime of care becomes a figure a jury can follow, and names the family members who can bring a claim when a loved one has died.

First, though, I want to say what the money is for. Nothing a lawyer does can turn back time, and I wish it could. What compensation can do is help a family put a life back together after it has been turned upside down, and the numbers are easier to follow once that purpose is clear.

> ***"Nobody's talking about medical malpractice cases winning a lottery."***
>
> — FRANK SPECTOR, ON WHAT COMPENSATION IS AND IS NOT

What compensation replaces when a life is turned upside down

Let me start with what compensation does. It lets people put their lives back together, especially when those lives have been turned upside down, like I keep saying. The easiest way to see it is to walk through an ordinary day.

Think about your own morning. You get up, brush your teeth, wash your face, put on your clothes, make breakfast and coffee, and get in your car. Many of us take that for granted, and I do too. These are what we call our activities of daily living: getting up, getting dressed, getting in your car, going shopping, going on vacation. Let's suppose it became a struggle just to get out of bed, to get downstairs, or to drive. What would that do to your life? Could you hold a job? Could you go to the food store?

Now let's suppose the job goes. Maybe you cannot work anymore, or you are so disabled that no job is open to you, or you are fired because you can no longer do the work. Let's suppose you also need speech therapy, occupational therapy, regular visits with doctors and specialists, and expensive medications, and some of those therapies and treatments are not covered by your insurance. In my view insurance does not cover much of this anymore.

Medical care costs keep climbing, and in my observation they have become unaffordable, so that many people are wiped out by medical costs and end up filing for bankruptcy. So what I tell my clients is that the compensation is going to allow them, hopefully, to have these things in their lives.

Now let's suppose it is worse. The person you live with cannot take care of you because it is too much. They have to help you walk, and they have to bathe you, because you cannot stand in a shower. You may need a nurse or an aide to come into your home for eight hours a day, ten, twelve, or around the clock. Many of my clients need twenty-four-hour care, and it is massively expensive. Insurance, I have found, does not cover around-the-clock nursing care.

I will say that money can seem *"a bittersweet or a hollow thing to talk about with people."* No lawyer can change what happened. What I can tell a client is that we will hold the system accountable, and Chapter 19 takes up what accountability means to the families who ask for it.

The lottery nobody is playing, and what the money gives a family instead

People sometimes roll their eyes and say it is all about the money, as though something is wrong with that, and I understand the reaction. The families who call me have had their lives turned upside down. Still, the picture some people hold of a malpractice case as a windfall is bad press, and in my view it is propaganda that has been put out there.

Thirty-five years of phone calls have taught me this. In all those years, no one has phoned to say that medical malpractice hurt them and that they expect to receive a lot of money. What my clients understand is that they now have to find money to pay for the things they need, to supplement what their insurance does not cover or what disability payments do not cover.

That gives them *"the freedom, the peace of mind"* to know the money will be there to make the quality of their lives as good as it can be. It is how I talk to a client about compensation, and when I do, they understand that I do not judge them. I do not think they are here for all the money. A lottery mentality is *"the farthest thing from my mind,"* and I know that from dealing with my clients for thirty-five years and seeing what it is like.

Take a family with a severely brain-injured child. Many of my clients who have children like this need 24-hour medical care and nursing care, and that is very expensive. The most rewarding thing I can offer is peace of mind: the knowledge that the family has the financial resources to have the child at home, as opposed to some kind of institution. In my view those institutions are not great. A lot of satisfaction comes from helping a family reach that point.

How a life care planner turns a child's needs into a number

The question I hear next is how anyone puts a figure on years of care that have not happened yet. We do it through a specific type of expert called a life care planner. This is someone with the experience and knowledge to determine what each person needs, and to put together what is called a life care plan: the therapies, the medications, the nursing care, and everything else that person will need for the rest of life.

The plan starts with records, and the ones that matter most are the ones created afterwards. Many of these children go to specialists, and their charts tell me the diagnosis and the therapies the child needs, such as occupational therapy and speech therapy. Does the child need specialized equipment? Does the child need care in the home? Chapter 8 covers how the delivery records are read. These later records feed the damages side of the case, and I take that information to the life care planner, who can project out into the future the medical care and services a child with cerebral palsy is going to need.

For each item the planner gives me a number. What does it cost? Sometimes it is a fixed cost and sometimes it is an hourly cost. Then the planner tells me how long the person needs it. From there the method is arithmetic. We work out what it costs to provide the care for one year, and then we multiply that by the amount of time we project the person will live.

Let's suppose someone needs a hundred thousand dollars of medical care per year and is projected to live twenty-five years. We take a hundred thousand, multiply it by twenty-five, and that gives us the number we present to the jury. That is arithmetic, offered only to show the method. It is not a prediction of what any case is worth.

Children with severe brain injuries are living a lot longer than they did when I started practicing law, which means more years in the multiplication, and the costs are enormous. A medical negligence case is worth different amounts for different people because each client is different. Some are more injured than others, some need more medical care or more medications, and some need a job replaced or have lost job opportunity. So we have to evaluate each case on its own.

Economic damages: the losses a calculator can reach

Maryland law allows a claim for what we call economic damages. These are the things that can be calculated: medical bills, both past and future, job loss, past or future, and any future medical care the person will need. The way I phrase it, *"you can take a calculator and you can actually come to a number."* Past losses have already happened. Future losses are the ones the records and the experts project, and the life care plan in the last section is how future care gets its number.

Those are what we call economic damages. In my description they are *"not limited,"* and, as I put it, and they are *"decided case by case."* Each case is different, so the figure is built from that client's own bills, that client's own work history, and that client's own projected care. The limit that applies to pain and suffering, which comes next, is a separate matter.

The law does address one economic item. Maryland Courts and Judicial Proceedings section 3-2A-09 says that a verdict for past medical expenses is limited to two amounts: the past medical expenses paid by or on behalf of the plaintiff, and the past medical expenses incurred but not paid, for which the plaintiff or another person on the plaintiff's behalf is obligated to pay. That is the statute speaking, not me.

Non-economic damages and the limit Maryland sets

The other kind is what we call non-economic damages, and pain and suffering is the shorthand people use. Maryland is one of the states that limit the amount of these damages, and a number of states are going in the same direction. The statute defines non-economic damages, in a claim for personal injury, as pain, suffering, inconvenience, physical impairment, disfigurement, loss of consortium, or other nonpecuniary injury. That definition is in Maryland Courts and Judicial Proceedings section 3-2A-01.

For claims against health care providers, the limit itself is in section 3-2A-09. The statute sets a fixed dollar ceiling on non-economic damages, and it raises that ceiling by a set amount each January 1, so the figure that governs one family's claim depends on the date the cause of action arose. A lawyer has to work that figure out from the facts of the case, and this book prints no dollar amount because the number moves. The ceiling applies in the aggregate to all claims for personal injury and wrongful death that arise from the same medical injury, regardless of the number of claims, claimants, plaintiffs, beneficiaries, or defendants. In a jury trial, the jury may not be informed of the limit, and if the jury awards more, the court reduces the amount to conform to it.

Those are the words of the law. Here is my own view, and it is only mine. To me the limit is too restrictive. *"I wish we didn't have those damages."* I call them arbitrary numbers, ones the Maryland legislature put in place, and in my view they no longer fit cases the way they should, because people are suffering a lot and the limits are restrictive.

Who can bring a wrongful death claim in Maryland

A wrongful death claim is the claim a family brings when a medical mistake ends in a death. The statute states the basic rule in Maryland Courts and Judicial Proceedings section 3-902: an action may be maintained against a person whose wrongful act causes the death of another.

The harder question is who in a family can bring it. States differ on this point, and in Maryland only certain family members can. As I explain it, it has to be the spouse of the person who died, the children, or the parents. They are the only ones who can bring a medical malpractice wrongful death case, *"not a brother, not a sister, not an aunt, or an uncle."* Let's suppose a family has lost someone. The spouse, the children, and the parents hold the claim, and in the ordinary case a sibling does not. The statute's fallback for a dependent relative comes next.

The statute says the same thing in its own terms, with a fallback I want you to know about. Section 3-904(a) provides that an action shall be for the benefit of the wife, husband, parent, and child of the deceased person, with narrow exceptions the statute spells out. Section 3-904(b) adds that if no one qualifies under subsection (a), the action is for the benefit of any person related to the deceased by blood or marriage who was substantially dependent upon the deceased. Section 3-904(f) adds that only one action lies in respect to the death of a person.

A wrongful death claim has non-economic damages of its own. Section 3-2A-01 defines them, in a wrongful death claim, as mental anguish, emotional pain and suffering, loss of society, companionship, comfort, protection, care, marital care, parental care, filial care, attention, advice, counsel, training, guidance, or education. Section 3-2A-09 sets a rule for this situation too: when a wrongful death action has two or more claimants or beneficiaries, the total non-economic damages for all of the actions may not exceed 125% of the ordinary limit. That is the law, and a lawyer has to read it against the facts of each family.



A therapy room set up for a child's care

Common Questions

What can a family recover in a Maryland medical malpractice case?

Maryland recognizes two kinds of money damages. Economic damages are the losses a calculator can reach, such as medical bills and job loss, past and future. In my description they are not limited and are decided case by case, though the statute limits the past medical expense verdict to amounts paid or owed. Non-economic damages, or pain and suffering, are the kind Maryland caps. Each case is different.

Does Maryland put a cap on pain and suffering damages?

Yes, for non-economic damages. Under Maryland Courts and Judicial Proceedings section 3-2A-09, a fixed ceiling applies to claims against health care providers, raised by a set amount each January 1, and the jury is not told about it. To me the limit is too restrictive, and in my words, *"They don't really pertain to cases anymore the way that they should."* Economic damages stand outside it.

What does a life care planner do in a birth injury case?

A life care planner is a specialized expert who works out what a person will need for the rest of life, including therapies, medications, and nursing care. The planner prices each item and tells me how long it is needed. We calculate the cost for one year and multiply by the years we project. In my words, the planner can *"project out into the future"* the care a child will need.

How much is a medical malpractice case worth in Maryland?

It depends on the client, because a case is worth something different each time. We evaluate each person on what that person needs, what future medical care is required, and what has been lost in job opportunity. Everybody's different, and a figure that fits one family says little about the next.

Who can file a wrongful death claim after a medical mistake in Maryland?

The spouse, the children, and the parents of the person who died. Under Maryland Courts and Judicial Proceedings section 3-904, the action is for the benefit of the wife, husband, parent, and child, and if none of them exists, a blood or marriage relative who was substantially dependent on the person who died. As I explain it, a brother, a sister, an aunt, or an uncle is not on the list.

Chapter Reflection

Strip the dollar signs away and this chapter is about an ordinary morning: getting up, getting dressed, getting to work, and having someone who can help when a person cannot. That is what the money replaces. Maryland lets the calculator run on the losses it can count, puts its own ceiling on the losses it cannot, and decides which relatives may speak for a person who has died. A lawyer's job is to say plainly which is which. Even then, a number on a page has to reach a jury, and numbers do not carry themselves there. The next chapter turns to the story a case tells, the theme a lawyer builds around it, and the facts that do not help.

CHAPTER FIFTEEN

15

Building the Story of a Case: Themes, Bad Facts, and a Lawyer's Strategy

A lawsuit is a story that someone has to be able to tell. Before I can tell it to a jury, I have to know it myself: what happened, who was involved, and what it has cost a family. This chapter is about how I build that story. Most of what is in it I learned as a young lawyer, from the work and from the people who taught me.

When people ask what my strategy is, they tend to expect something clever. What I tell them is that it is mostly groundwork. It starts with a first interview where I listen, it moves to the medical records, and at each stage it checks that my client and I expect the same things from the case. Chapter 7 describes that first conversation and Chapter 8 describes the records. Here I want to show what ties those steps together, which is a story and a theme, and why a story only holds up when it is honest about its weak points.

Some of what follows is my opinion, and I will say so when it is. One idea in particular I picked up early in my career, and it carries a responsibility: a lawyer has to tell the client about it. It has a plain name, and it comes next.

> ***"One of the things that I learned as a young lawyer is something that we call a bad fact. Every case has a bad fact."***
>
> — FRANK SPECTOR, ON BAD FACTS

Groundwork before brilliance: how a strategy gets started

You might expect a malpractice lawyer to win by being clever. I learned something different. In my words, *"it's not so much that you have to be the smartest lawyer in the world."* A lot of what matters, as I see it, is the groundwork, and I build it one step at a time.

The first step is the interview. A client tells me the story in their own words, from beginning to end, and I try not to interrupt, because the information I am probably going to need comes out in that telling. The second step is the medical records, which I have called the Bible of a malpractice case and which a lawyer has to know intimately. The work behind those steps takes months of investigation before I can tell someone whether they have a case, though on a first call I can often tell a caller there is none. The way I say it, *"it's all in the preparation beforehand."*

Running through all of it is a check on expectations. A strategy, as I see it, means having a good idea of what the case is about and a good idea of what the client expects, and the two have to line up at the beginning and again at each step of the investigation. I don't count that as an extra. It is part of rolling up my sleeves and doing the hard work.

A story and a theme, from the first conversation

While I am interviewing a client, I am already thinking about what the case will look like when it is told. In my words, *"what I'm trying to develop is a story, a theme. Because people connect with stories and they connect with themes. All of us do."*

Think about what happens when someone starts a sentence with "Let me tell you a story." *"Our ears perk up and we become interested."* That is true of all of us, and I take it seriously when I build a case.

Step one is listening. I can't develop a story without hearing one, so the interview comes first and the theme follows from it. After that the job is to use the records and any other information I collect to *"fill in the gaps of that story or to fill in the pieces of that story."* The facts do not stay a pile. They are what the story is made of.

What a bad fact is, and why it comes back at trial

What we call a bad fact is something someone did that you wish they hadn't. The way I put it, *"there's something that somebody did that you wish they didn't. And it's on both sides."* The lawyer who represents the doctor has bad facts too, things that lawyer wishes the doctor had not said or done.

The lesson I took from that is that you cannot ignore one. In my words, *"you can't ignore a bad fact. A bad fact is gonna come back, it's gonna be there throughout the whole case."* It does not go away because nobody brings it up. It stays in the case from beginning to end, and at trial it is something we will hear at the start.

The other side gets to make its case too, and Maryland gives it a defense that I will only touch on here, called contributory negligence. Maryland is one of a small handful of states that has it. As I explain the rule, if a jury finds that a patient contributed to the negligence even a little bit, the patient can lose the entire case. Let's suppose a doctor's lawyer says the patient did not show up to appointments or did not take the medicines the patient was told to take. That is raised as a defense, not as a claim against the patient, and Chapter 16 takes up the difference. I have said that in a malpractice case the defense is probably not going to press it, because it does not want the jury to think it is blaming the patient for something that was its own responsibility.

Telling a client the hard part, including the gray areas

This is where the term stops being vocabulary and becomes a duty. If I feel a bad fact is so serious that I don't think it would be a responsible decision to continue with the case, I believe I have a responsibility to tell that to my client. Even though I think I'm smart, *"I'm not gonna be able to lawyer it away."* Telling them is a strategy *"that only a lawyer can do because we really only know the significance of that."*

Telling is not deciding. Whether to file a lawsuit is the client's choice, and no one forces it. When I think a case is one we can move forward on, I say so, and I add that the decision is theirs. Chapter 18 returns to who decides.

The same honesty applies to the gray areas. Chapter 2 explains what a judgment call is and where the law draws the line around it. What I add here is how it sounds to a client. Many times I have to say to my clients that a question in their case is a gray area, a judgment call, and that plain answer is part of telling them the truth about the case.

Each witness and each step should move the story along

Once a case has a story and a theme, the strategy is mostly a matter of staying inside them. The way I put it, *"the overall strategy is to make sure that we are staying within the story and the theme that I talked about."* That applies to the people who testify and to the smaller work in between. In my words, each witness matters for the same reason: *"every time we're doing something in a case, we're trying to advance that story."*

A lot of that work belongs to the lawyer. Many of the decisions about the strategy of a case, such as how to file something, how to write a brief and how to word it, are a lawyer's decisions. I bounce strategic ideas off my clients, and I make sure they hear from me on a regular basis about how the case is going, but *"it really is the purview of the lawyer."*

I will leave the rest as a belief and not a promise. If you stay within the story, I think you are going to be more successful than not.

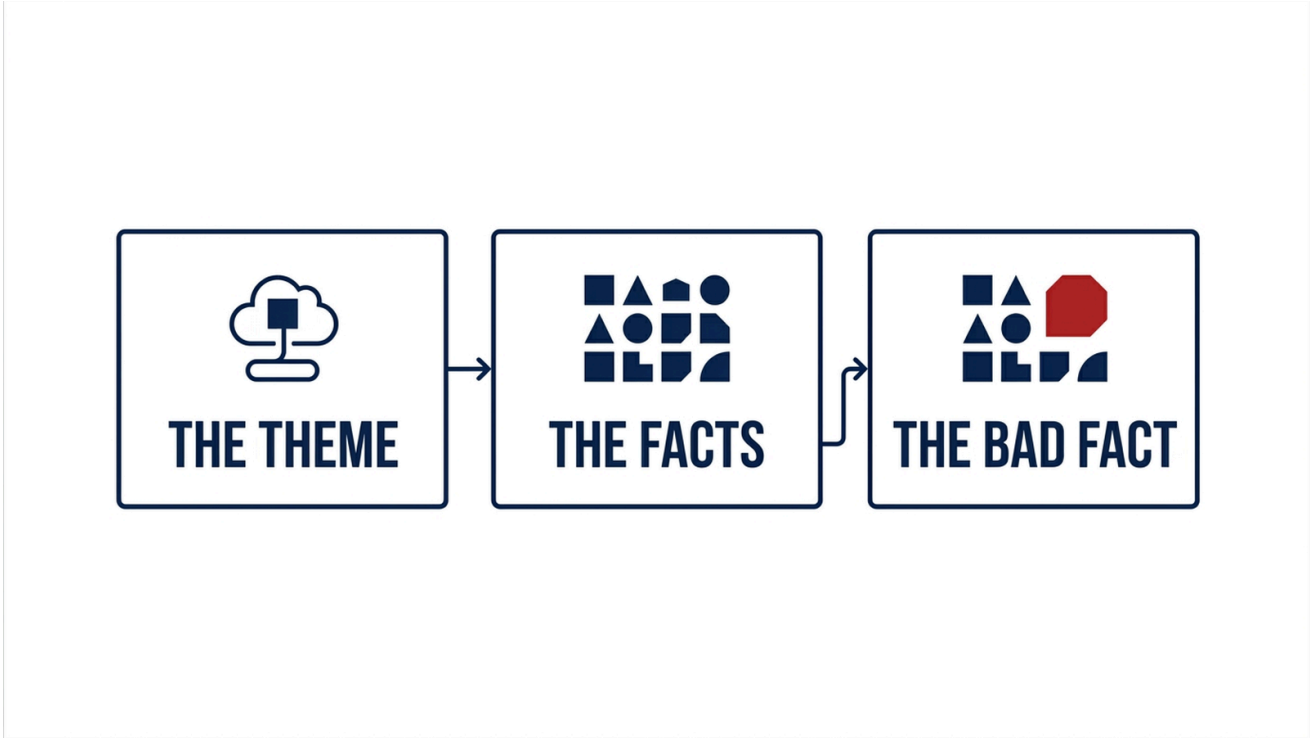
A mentor, a frightening start and what I pass on

I did not come to any of this alone. As I said in Chapter 2, I have had great mentors along the way, and I think young lawyers who have mentors may not be as common as they used to be. After law school I had probably one of the best trial lawyers in Baltimore as my mentor. He showed me how to be a trial lawyer, including *"how to take control of a courtroom, how to present yourself to a jury,"* and a good deal that was just intangibles.

That gave me a basis to launch my own law firm. I had an entrepreneurial spirit, and I wanted to do things the way I wanted to do them and provide the services I wanted to provide. *"It's scary when you're a young person starting out your own law firm."* You do not know whether you will be successful, and there are a lot of lawyers out there. I had confidence in myself, and my wife had confidence in me. She was a big supporter then and she has been ever since.

What I figured was simple: *"if I just do the right thing and I do the right work and I hold myself with integrity, that things would work out."* Slowly but surely, they did.

Part of what I try to do now is pass that on. When I taught at my law school as an adjunct professor, I talked with students about what practice is like in the real world, how to manage yourself in a firm, how to decide on a practice area, how to meet people. *"I was able to get that from a mentor and I was able to pass that along to students."*



The theme, the facts and the bad fact

Common Questions

What is a bad fact in a lawsuit? A bad fact is something someone did that you wish they hadn't, and it exists on both sides of a case. A lawyer cannot ignore one, because as I put it, *"It's gonna come back to haunt you at the end."* In my view the lawyer's job is to know it is there and to deal with it directly, starting with the client.

Should a lawyer tell a client about a weak point in the case? Yes, if it is serious. When a bad fact is so serious that continuing would not be a responsible decision, *"I believe you have a responsibility to tell that to your client."* A weak point does not disappear because nobody mentions it, and a lawyer cannot talk it away. What the client does with that information is the client's choice, because the decision to file belongs to them.

What does a lawyer mean by the theme of a case? It is the story the lawyer builds the case around. I start developing it at the first interview, and I say it plainly: *"I'm thinking of a theme from the first time I'm talking to the client."* Step one is still listening. After that I use the information I gather, from the client and from the records, to fill in that story.

Why do trial lawyers think of themselves as storytellers? Because, as I see it, the work is storytelling and persuasion. I put it this way: *"I think trial lawyers are a special breed because we're storytellers."* People connect with stories and themes, which is why I try to find the story and the theme of a case at the start and keep each witness and each step inside it.

Chapter Reflection

The whole chapter serves one story. The groundwork gives it facts, the theme gives it a shape, and each witness and each step is there to move it forward. The bad fact is the part that tests the lawyer, because it stays with the case, and the lawyer's part is to tell the client what it is. Chapter 16 follows the story into the stretch of a lawsuit where defendants who may have stood together begin pointing at one another. A bad fact that nobody mentions is still in the case.

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CHAPTER SIXTEEN

Cross-Claims, Counterclaims, and Third-Party Defendants Explained

A lot of people want to know what it even means to say a case has been "filed in court." The answer is shorter than they expect, and it opens the door to the part of a malpractice case where the vocabulary turns strange. Once the complaint is filed, the case is in litigation, and litigation is a battle. The lawyers on each side do the best they can for their clients, and the tools they reach for have names that mean little to anyone outside a courtroom: cross-claims, counterclaims, third-party defendants.

This chapter explains each one the way I would explain it to a family sitting across the desk from me. A cross-claim is what we call a lawsuit within the suit, brought by one defendant against another. A counterclaim runs the other way, from a defendant back at the patient. A third-party defendant is someone a defendant pulls into the case who was not named at the start. Of the three, the cross-claim is the one I like to see, because the defendants are then pointing at each other. A counterclaim almost never happens, and the third-party claim is a reminder to bring every party into the case.

I will also be plain about what these tools do not do. Finger-pointing between a doctor and a hospital can help a family's case, and it does not decide it. Chapter 12 covered who gets named in a Maryland malpractice lawsuit, and this chapter picks up after the names are on the page. Chapter 17 follows one case where a doctor and a nurse blamed each other.

> ***"Now actually from a plaintiff's point of view, me as the plaintiff's lawyer, I actually like when that happens because now they're going to start pointing the fingers at each other. That makes my job a lot easier."***
>
> — FRANK SPECTOR, ON CROSS-CLAIMS

What filing a complaint sets in motion

By the time a case reaches the courthouse, the work behind it has been done: the medical records reviewed, the timelines built, the doctors consulted. Filing is the next step. The plaintiff's lawyer prepares a document called a complaint and brings it to the court. It used to be that you

carried the paper to the clerk's office. Now we do everything online. Once the case is filed, that is how litigation starts.

The person who brings a lawsuit is called the plaintiff, and the person being sued is called the defendant. I try not to use too many legal terms, but sometimes I slip, so I want that definition out of the way. In this chapter the family is the plaintiff, and everyone named in the complaint is a defendant.

The corporate world makes the picture more complicated than it looks. It is not as simple as suing Dr. Jones and the hospital. Why is that? Well, first of all, a doctor is usually part of a corporate practice, operating under something like Babies Inc. or Babies LLC. That practice could be one doctor or a large group. A nurse may belong to a corporate entity that I have to discover. So I bring the lawsuit against the doctor and the doctor's corporate entity, against the nurse where a nurse is involved, and against the hospital and the hospital's corporate entity. The plaintiff's lawyer has to do that due diligence, because the lawsuit is only as complete as the list of parties in it.

The reason it matters is insurance. Each of those entities may carry a different policy, and I need to find the most insurance I possibly can, because a successful birth injury case can result in a large monetary recovery and the coverage has to be there to meet it. Chapter 13 takes up insurance on its own.

Once everyone is in the case, the defendants have their own lawyers, and their lawyers do not necessarily see the case the same way. That is where the new vocabulary begins.

A lawsuit inside the lawsuit: how a cross-claim works

Let's suppose I bring a lawsuit against a doctor, the doctor's practice and the hospital in a birth injury case. The allegation is that the doctor and the nurse did not deliver the baby early enough, and that the baby was deprived of oxygen. Doctors do get to go home and take call, which means they are at home, and if there is a problem with one of their patients the nurse is supposed to call. So in a case like this, the doctor is usually either not in the room or at home, and the nurse is the one coming in again and again to check on the patient.

Let's suppose the nurse calls the doctor and says she is looking at the baby strips, the machine that shows how the baby is doing, and things do not look so good. Let's suppose the nurse says, "Doctor, I think there's something wrong here," and the doctor answers, "Tell me the information over the phone." The doctor decides everything is okay. Let's suppose there are several calls like that. Then, God forbid, the worst happens and the baby is permanently injured.

When the lawsuit is brought, there is going to be finger-pointing, and it sounds like this. The doctor says the nurse did not give all of that information in a way that raised any concern, and did not explain it properly. The nurse says she told the doctor everything, and she told the doctor she thought there was a problem. Now you have a finger-pointing situation.

How does that show up in a piece of litigation? Well, that is what we call a cross-claim. The doctor and the hospital are represented by two different lawyers. The doctor's side wants to say that the nurse gave the wrong information, so the fault belongs to the nurse and the hospital. A defendant can only say that in the lawsuit by filing a cross-claim, which is a court document, what we call a pleading. In it, the doctor brings a lawsuit within the suit, against the hospital, over what the nurse said. If the jury returns a verdict against the doctor, the doctor is asking to shift that responsibility onto the nurse.

A plaintiff's lawyer has reason to welcome that. Once defendants start pointing at each other, I can bring that out in front of the jury, and they are fighting among themselves. In my words, *"That makes my job a lot easier."*

Now I have to be honest about how often it happens. Cross-claims are very rare. Many times the doctor, the nurse and the hospital stand together. In my words, *"Many times the doctor and the nurse and the hospital will stand as a united front."* They do not file cross-claims against each other.

There is one situation where defendants do sometimes file a cross-claim, and it is a technical one. It has to do with what happens if there is a money judgment: who is responsible for it, and what portion or percentage each defendant is going to contribute. That is beyond the scope of this book. It has nothing to do with the underlying case, because it concerns something that happens afterward.

Counterclaims, and what a jury would think of a doctor suing a patient

The second tool runs in the opposite direction. A counterclaim is what we call a claim a defendant brings back against the plaintiff, meaning the patient, and not against the lawyer. Let's suppose I bring a lawsuit as the plaintiff's lawyer against a doctor, and the doctor believes the patient did something wrong. The doctor can answer with a counterclaim. In effect it says: I did not do anything wrong, and not only that, you are the one who did something wrong.

In medical malpractice and birth injury cases, counterclaims rarely, if ever, happen. I have been doing this work for thirty-five years, and *"I can't think of the last time, if any time, a counterclaim was filed in any of my medical malpractice cases or birth injury cases."*

Why is that? Well, think about it as a matter of tactics. A doctor who brings a lawsuit against his or her own patient has to ask how the jury will react. Jurors, to my mind, are not going to like it at all. They are going to think the doctor is taking advantage of somebody, blaming somebody, and refusing to take accountability. A hospital does not want to be seen picking on a person who has been horribly injured, and that is especially true in a birth injury case. So even a defendant who believes there is some counterclaim to bring does not often bring it.

Holding back a counterclaim does not mean a defendant gives up the argument. Another place exists to make it.

Contributory negligence belongs in the defense, not in a counterclaim

A defendant can raise defenses to protect itself without filing a counterclaim, and the clearest example in Maryland is contributory negligence. Maryland is one of a small handful of states that still has this rule. In practice, it works like this. If you are the plaintiff and you bring a lawsuit, and you prove the doctor was negligent, the jury can still find that you contributed to the negligence yourself. *"Even if you prove that the doctor was negligent, if the jury finds that you contributed to the negligence yourself, even a little bit, and we call it 1%, you can lose the entire case."*

Let me show how the defense would put it. The doctor says you were contributorily negligent, meaning you were also negligent, because you did not show up to your appointments, or you did not follow the test the doctor asked you to get, or you did not take the vitamins or medicines the doctor told you to take. Therefore, the doctor says, it is your fault. The distinction fits in one line: *"You wouldn't bring that in a counterclaim, but you can bring that as a defense."* The accusation is the same. The vehicle is different.

Now, a patient who delayed care or missed an appointment may well wonder about that rule. So let me give the practical side. In theory, your case could be over if you delayed care. But the defense in a medical malpractice case does not want the jury to think it is blaming you for something that should have been its own responsibility. Because of that, the idea of the defense blaming the patient is probably not going to happen. The answer I give families is practical: *"The practical answer really is it doesn't come up that often in medical malpractice cases."*

Bringing the hospital in: third-party defendants and the amended complaint

The last tool is a little bit complicated. It is called a third-party defendant. What does that mean? Let's suppose I bring a lawsuit against the doctor, and only the doctor. The doctor says, wait a minute, hold on. Responsibility is not mine, but even if I am responsible, the hospital is responsi-

ble too. The hospital has not been made part of the lawsuit, because I have sued only the doctor.

The doctor's lawyers can then bring a lawsuit to pull in the hospital, and that is what we call a third-party claim, with the hospital as the third-party defendant. Once again it is a lawsuit within a lawsuit. It says: it is not my fault, but even if it is my fault, somebody else is responsible too.

I hope I am not making this too complicated, so let me go slowly, because this is the part where a family's lawyer has work to do. I brought my lawsuit against the doctor. Now the doctor has brought a separate lawsuit against the hospital. But I have not connected those dots. I have not sued the hospital, and the doctor suing the hospital does not mean that I, as the plaintiff, have done so. *"I have to take some affirmative action, so I actually have to, what we call, amend my lawsuit."* That means I change my complaint and add the hospital. Once I do that, everything is put together properly.

The stakes are plain. If you represent the plaintiff, you have to bring all the parties into your lawsuit, because *"if you don't, you may be out of luck."* That is why I did all that due diligence on the corporate entities at the start, and why Chapter 12 matters as much as this one.

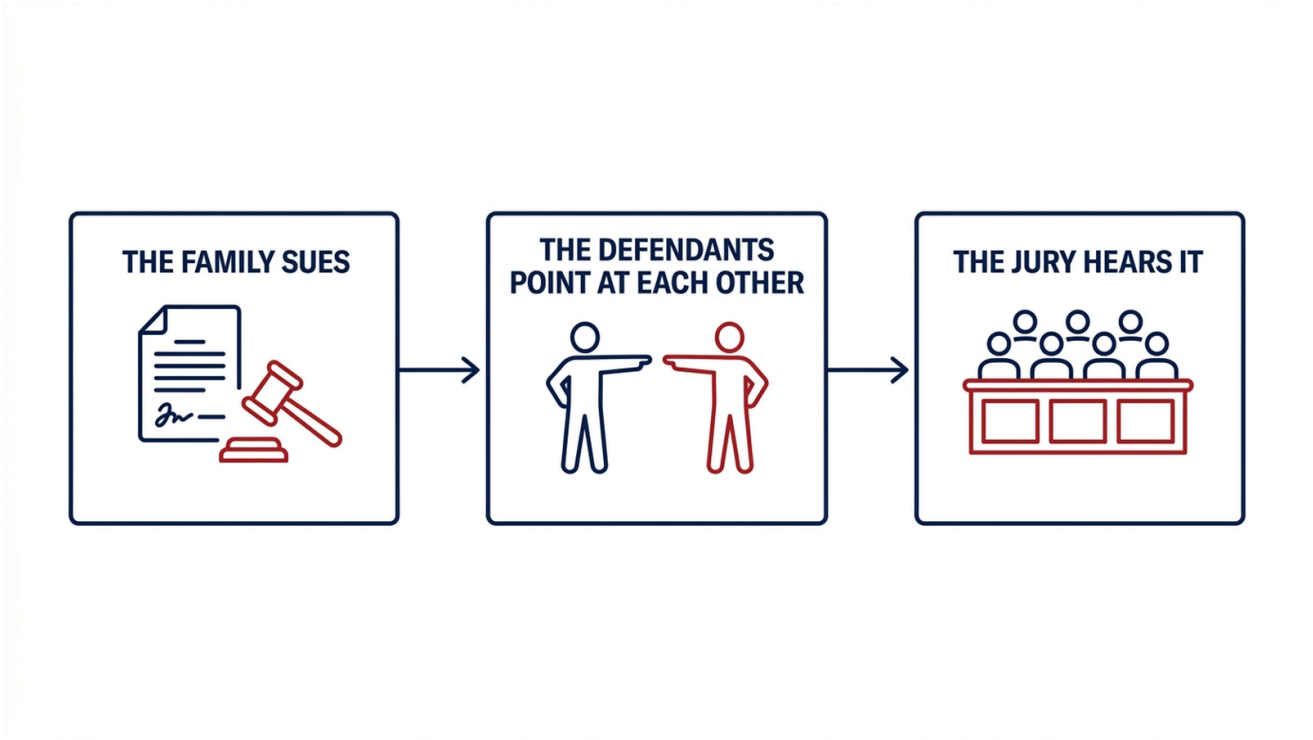
Litigation tools like these are meant for lawyers who have a lot of experience, because it gets very complicated. As noted at the start of this chapter, the parties in litigation are each trying to win. We may have had settlement negotiations, and maybe some friendly conversations. Now all bets are off. When a case goes into litigation, there are many tools at the disposal of the plaintiffs, and the defendants have them too.

What finger-pointing does and does not tell a family

The common mistake about all of this is easy to make. A family hears that the doctor and the hospital are blaming each other, and the natural conclusion is that a jury will certainly vote for the plaintiff and there is nothing to worry about. That is a common mistake, because that is not how it works. Even with finger-pointing, we have to present the evidence and we have to tell the story. And *"even in cases of finger pointing, jurors have come back and voted for the doctor and the hospital."* They did not find in favor of the plaintiff.

So I tell all my clients, *"Let's manage our expectations."* Finger-pointing does not mean we are going to win, and it does not mean we are going to get a large settlement. Sometimes the doctors, the hospitals and the insurance companies are adamant, and they want to go forward.

Finger-pointing still has value, and I have seen it work in the right case. In one birth injury case I was involved in, a doctor's insistence on blaming a nurse put the family in a stronger position in settlement talks, and Chapter 17 tells that case.



How a lawsuit moves from filing to the jury

Common Questions

What is a cross-claim in a medical malpractice lawsuit?

A cross-claim is a lawsuit within the suit, filed by one defendant against another defendant in the same case. Let's suppose a doctor says a nurse passed along bad information. The doctor's lawyer files a court document called a pleading, asking that responsibility shift to the nurse and the hospital if the jury finds against the doctor. In my work, cross-claims are very rare, because defendants often present a united front.

Can a doctor countersue a patient in a malpractice case?

A doctor can file what we call a counterclaim against the patient, but in medical malpractice and birth injury cases it rarely, if ever, happens. The reason is tactics. A jury is unlikely to react well to a doctor suing an injured patient, and, in my words, *"They're not going to want to look like the big bad guy."* A defendant can still raise the patient's own conduct, but as a defense instead.

What is a third-party defendant, and why would a lawyer amend a lawsuit?

A third-party defendant is someone a defendant pulls into the case who was not named by the plaintiff. Let's suppose I sue only the doctor, and the doctor's lawyers bring the hospital in. That does not make the hospital a defendant in my lawsuit. I have to amend my complaint, which is what we call changing it, and add the hospital, so everything is connected properly.

Can missing appointments end a Maryland malpractice case?

In theory, yes. Maryland is one of a small handful of states with contributory negligence, which means a jury that finds the patient even a little at fault can end the case. In practice, the defense does not want the jury to think it is blaming the patient for something that was its own responsibility, so it probably does not happen often.

Does finger-pointing between defendants mean the family will win?

No. Finger-pointing can help, and it does not decide the case. Even with defendants blaming each other, the plaintiff still has to present the evidence and tell the story, and jurors have voted for the doctor and the hospital in cases like that. I tell my clients that we have to manage our expectations. Sometimes the doctors, hospitals and insurance companies are adamant and want to go forward.

Chapter Reflection

Finger-pointing between defendants is welcome when it arrives, and no family should plan around receiving it. Cross-claims are rare, defendants often stand together, and a counterclaim rarely, if ever, appears. Contributory negligence is the rule in the chapter that can end a case over a patient's own fault, and, in my experience, it does not come up that often in malpractice cases. A third-party claim can leave a family out of luck if the lawyer does not amend the complaint and bring the new party in. None of these tools carries a case by itself. The evidence still has to be presented, the story still has to be told, and the right parties still have to be in the lawsuit before any of it can count. Chapter 17 puts a doctor and a nurse in exactly that position, pointing at each other, and shows what that looked like in one case.

CHAPTER SEVENTEEN

When the Doctor and the Nurse Blame Each Other: One Case and What Families Should Expect

The last chapter gave you the vocabulary: cross-claims, counterclaims, and third-party defendants. Words like those mean little until you watch people use them, so this chapter follows one case that I was involved in. I tell it without names or identifying details. The family, the hospital, and the people who worked there stay out of the telling, because the case teaches what it teaches without them.

At the center are two people. One is a nurse watching a mother in labor, and the other is a doctor who is at home and on call. What passed between them, and what each of them said about the other once a family brought a lawsuit, shaped how the case was negotiated. It is not an easy case to tell, even for me, because it ends with a child who is permanently injured.

I tell it for three reasons. It shows what finger-pointing looks like from the inside. It shows what that finger-pointing did to a settlement. And it ends on a mistake I see families make, one I would rather name now than let you find out later.

> ***"Well, it wasn't fine. It was the beginnings of a disaster. And what was happening was the baby was being deprived of oxygen."***
>
> — FRANK SPECTOR, ON ONE DELIVERY-ROOM CASE

A new nurse, a doctor on call, and a second concern many hours later

In the typical situation, the doctor is either not in the room or at home, and the nurse is the one coming in to check on the patient. Doctors do get to go home. They take call, which means they are home, and if one of their patients has a problem, the nurse is supposed to phone. That was the arrangement in this case.

The nurse was new and fairly inexperienced. At some point she saw something on the baby monitor that she thought was a problem, and she called the doctor and asked him to come in. He did. A nurse has to be careful about how often she asks. Doctors do not like to come in all the time, especially when a mother is in early labor, and a doctor who is called in again and again can cause a lot of friction in the way the two of them communicate.

The doctor looked at what had worried her and said it was nothing, just early labor. Then he went home.

Many hours later, the nurse expressed another concern. Pay attention to how the first visit colored the second call. The way I tell it, the doctor had already come in once and judged that what she saw was not a big problem, so he did not think she was seeing anything concerning this time. He did not come in. He told her it was fine.

Chapter 8 covers this: everything is charted, all the times and all the actions, including when the nurse comes in and goes out and when the doctor does. A sequence like this one, a first visit, a departure, and a second concern many hours later, is the kind of thing those timelines exist to lay out.

The heart rate that climbed, and what happens when a baby runs out of gas

What was happening to the baby, as I explain it, was that the baby was being deprived of oxygen. The reason we knew is the baby strips.

If you have been in labor, or in the room with someone who was, you remember the belts. One goes around the stomach and measures the contractions. The other measures the baby's heart rate and draws the little squiggly lines that go up and down. Those are what we call the baby strips, and the lines mean something. Nurses and doctors have to read them. Chapter 8 shows how an expert reads them against the rest of the chart.

To explain what a baby in distress does: the baby communicates. *"The baby says, Hey, pay attention to me. I'm not doing so great in here."* As I explain it, the heart rate goes way up, because the baby is working harder while it is deprived of oxygen. That engine, if you will, can go only so far. When the baby runs out of gas, with nothing left in the tank, the heart rate drops, and the baby is in serious trouble.

That is what happened here, as I tell the case. The baby was born with terrible, permanent brain damage and did not walk or talk or see or hear. In a birth injury case the strips are the biggest piece of evidence I can use, because they can show when an injury occurs, whether it came from a delay in delivery or from something earlier.

I do not tell this part easily. *"I've done this for so many years, but I never lose sight. It really gets me because I can see just how much the joy of a birth has been ruined by things that were preventable."* Birth injury cases are the toughest ones, at least for me, to handle, because a family's life is turned upside down at the moment they expected joy.

Two accounts of the same call: the nurse's and the doctor's

You can imagine how much finger-pointing there was in a case like this. Picture the nurse saying, *"I told you there was a problem. You didn't come in."* The doctor's answer, as I picture it, went to her experience: *"You don't have a lot of experience. You called me in for nothing. I really didn't trust that you knew what you were talking about."*

Each of them pointed at the other. The nurse said she had raised the alarm and been ignored. The doctor said she had called him in once for nothing, so he had no reason to believe her the second time.

I should say that this was not the usual picture. Cross-claims are very rare, and in many cases the doctor, the nurse, and the hospital stand together. Chapter 16 explains what we call a cross-claim, the formal way one defendant points at another inside the lawsuit. What I follow here is the finger-pointing itself, and what it did to the negotiation.

From where I sit as the plaintiff's lawyer, a defense that turns on itself works in my favor, and more so if I can get the defendants to do it in front of a jury, because then they are fighting among themselves.

None of this comes from disliking doctors. I have doctors who are friends of mine, and I do not hate doctors. My concern is accountability, and the system that has to answer for what happened.

What the blaming did to the settlement talks

The finger-pointing put the case in a very good settlement posture. In our negotiations we kept telling the other side that we were going to present the case to a jury, that the finger-pointing they were doing would inflame that jury, and that it could be very dangerous for them. The doctor would not back off. He was adamant that he was going to keep pointing at the nurse.

With that degree of finger-pointing, we were able to make a settlement higher than we had anticipated. Negotiating and trying to resolve a case out of court is something I favor, and a case like this one shows why. A trial puts your case before jurors, and you do not know what they will do. The trial you picture is not always the trial you get. Negotiating leaves you with much more control. Once a case is settled it is final and done, while even a jury win can be appealed, and an appeal can take years and years.

The decision whether to settle, and for how much, belongs to the client. I say so right up front. Chapter 18 takes up settlement, mediation, and trial in full.

I describe a result like this one as bittersweet. *"I wish this baby was never born this way."* I wish the parents had never had to call me. But my job is to make sure that the child is adequately compensated for the rest of his or her life and gets all the care that child needs.

The assumption that finger-pointing wins the case, and where it breaks

The common mistake is this. A family sees cross-claims and blame going back and forth between the defendants and concludes that a jury is certain to vote for the plaintiff, so there is nothing to worry about. That is a mistake because it is not how it works.

Even in cases of finger-pointing, jurors have come back and voted for the doctor and the hospital, and not found in favor of the plaintiff. The plaintiff's lawyer still has to present the evidence and tell the story, and blame between defendants does not tell it for us. Chapter 15 is about building that story, and finger-pointing is one fact inside it, not a substitute for it.

It does not even mean a large settlement. Though we advocate for large settlements, there are times when the doctors, the hospitals, and the insurance companies are adamant, and they want to go forward. The settlement in the case I described is a report of what happened there. It is not a forecast for yours.

Managing expectations before the investigation begins

The mistake that sits underneath the first one is not managing expectations, and the time to start is the first conversation. I tell my clients not to assume that finger-pointing means we are going to win, or that it even means a large settlement. At the beginning, the expectations have to be aligned, mine and the client's.

A lawsuit is like going into a foreign country. You do not speak the language, so you need a guide, and what people want is a roadmap. I explain what the process looks like, how long it is going to take, what the potential outcomes are, what the decision points will be, and what your involvement is.

That includes the answer to the first question, which is whether there is a case at all. Sometimes, on a first call, I can tell a caller there is no case. When there may be one, it takes months of investigation before I can say.

It also includes the facts that hurt. A case has a bad fact, something somebody did that you wish they had not, and it exists on both sides. A bad fact does not go away. It comes back at the end, and if one is serious enough that continuing may not be a responsible decision, I believe a lawyer

has a responsibility to tell the client. Chapter 15 takes up bad facts. For this chapter, the point is that an expectation has to include them too.

Nobody can undo what happened to this child, and I wish somebody could. What I can do is hold the system accountable. *"Accountability is a big deal for a lot of my clients."* They know that mistakes happen, and they are not willing to just let it go. Money is part of that, though I know it can feel like a hollow thing to talk about. A family that understands from the first day what a lawsuit can and cannot do is a family that can decide well when the hard moments arrive.



A hospital hallway at night

Common Questions

Why do a doctor and a nurse blame each other after a birth injury? In the case I tell here, the blame grew out of what passed between them during the labor. The nurse's position was that she told the doctor there was a problem and he did not come in. The doctor's position was that she lacked experience and had called him in for nothing. That is finger-pointing, and Chapter 16 explains what we call a cross-claim, the formal version of it inside a lawsuit.

Will a jury side with the family when the defendants blame each other? Not necessarily. Jurors have found for the doctor and the hospital in cases with finger-pointing, so I tell families not to count on it. What carries a case is the evidence and the story a lawyer tells with it. In my

words, *"we have to present the evidence, we have to tell the story."* Blame between defendants can help that story along, but it does not replace it.

Can finger-pointing between defendants raise a settlement? In the case I handled, it did. We told the other side in negotiations that we would present the case to a jury, that the finger-pointing would inflame that jury, and that it could be very dangerous for them. The doctor would not back off, and *"we were able to make a settlement higher than we had anticipated."* That describes one case. It does not forecast another.

How should a family manage expectations in a birth injury case? Start by asking your lawyer to explain the process, how long it will take, what outcomes are possible, and where the decisions fall to you. Blame between defendants does not promise a win or a large settlement. Sometimes, on a first call, I can tell a caller there is no case. When there may be one, it takes months of investigation before I can say.

Chapter Reflection

Blame between a doctor and a nurse tells a family something about the people on the other side. It can move a negotiation, as it did in the case I have told. It cannot tell a family what a jury will do. What carries a case is the evidence and the story, and what a family can set from the first day is what it expects. One question remains, and it belongs to the family: when an offer arrives, who decides what happens next? Chapter 18 answers it.

CHAPTER EIGHTEEN

18

Who Decides: Settlement, Mediation, and Trial

People come to a medical malpractice lawyer when their lives have often been turned upside down, and many of them assume that once the case is in a lawyer's hands, they will have no control and no say over how it ends.

That picture is wrong, and I correct it at the start. Some decisions in a case belong to the client and some belong to me. Whether to file a lawsuit is the client's choice. Whether to settle, and for how much, is the client's choice too. The strategy, and how to file and word what goes to the court, is mine. This chapter draws that line, explains what mediation is and what a client can do inside one, sets out why I lean toward resolving a case without a trial, describes what happens when that does not work, and ends with how I measure success.

Behind all of it is how I understand the job. What people want from a lawyer, as I have come to see it, is someone to guide them with a calm hand. They assume I know the rules, because I went to law school. But they are not looking for a problem solver, a word I avoid because it takes away their ability to make decisions for themselves in their own case.

> ***"I have an expression that says a good settlement beats a great trial all the time."***
>
> — FRANK SPECTOR, ON SETTLEMENT AND TRIAL

Whether to file and whether to settle belong to the client

A lot of people are surprised by how much decision making a client has. Nobody forces a person to file a lawsuit. If I feel a case is one we can move forward on, I tell the client that, and then I say the decision is theirs. *"You tell us yes or no."*

The second decision is the one I treat as a hard and fast rule, and I tell clients about it right up front. Whether to settle a case, and for how much money, is totally up to the client. *"I cannot and will not make that decision for you."* I may come to a client with a number that I believe is fair. If the client does not think it is fair, the client can say no. That answer is theirs to give.

I say it early because of what I have seen people assume. They think that at the end of the case they will have no say over the outcome. Hearing at the beginning that they do gives them a lot of comfort.

A second reason is that going into a lawsuit is like going into a foreign country. You do not speak the language, you do not know where to go, and you need somebody to guide you, the way a tour guide does for a traveler. So I explain what the process looks like, how long it is going to take, what the potential outcomes are, what the decision points will be for you, and what your involvement is. People want a roadmap, and the settlement decision is one of the marked stops on it.

Strategy, briefs and wording belong to the lawyer

Many of the other decisions in a case are lawyer decisions. They are decisions about the strategy of the case: how to file something, how to write a brief, how to word it. Those calls are mine to make.

That does not mean I work in a closed room. I do bounce strategic ideas off my clients, and I make sure they hear from me on a regular basis about how the case is progressing. But the strategy is the purview of the lawyer, and I keep it there. The line comes down to whose case it is, and the work reflects that from the first interview. I let the client tell the story in their own words, from beginning to end, without interrupting, because they will tell me a lot of the information I am going to need. At the beginning of a case I also make sure my client's expectations and mine are aligned. The client's input matters to me because it is their case, not mine. I represent them, and the arrangement does not run the other way.

Mediation: a neutral person, an offer, and the right to say no

Many cases now go to some form of mediation, and I think virtually all of them do. Mediation is what we call alternative dispute resolution. The judges want the parties to get together with a mediator, who is neutral and has no stake in the case, and to see whether the parties can resolve it out of court.

Let's suppose we are at a mediation, and the other side comes up with a number to settle the case. I look at it and I think it is fair. You do not. You say to me, Frank, no thanks, I do not want it, I would rather end the mediation and go to trial. That is your right. The mediation ends, and the case moves toward trial.

I tell clients about this before a mediation begins. As I understand it, this is not a favor I hand out, and it is not even a matter of discretion among lawyers. It is in our rules. Even so, I make a point of explaining it, because *"I think that is very empowering to people to know that they have a say*

in the outcome."

Control, finality, and the limits of a jury verdict

I lean hard toward negotiating and trying to resolve a case out of court, for two reasons.

The first is control. When you go to trial, the trial you expect to try is not the trial that happens. You are putting your case in front of jurors, the outcome is uncertain, and you do not know what a jury is going to do. You are leaving the decision in the hands of other people. When you negotiate a case, you keep much more control over where it ends up.

The second is finality. I believe every case deserves an attempt to resolve it, because *"once the case is settled, it's over, it's final, it's done."* A jury win does not carry that certainty. The other side can appeal, and an appeal can take years and years to move through the court system.

That is what I mean when I say a good settlement beats a great trial. Trials do happen. My point is that a settlement the client considers good puts the control and the ending in the client's hands, and a verdict, even a favorable one, hands both to a jury and then possibly to an appeals court. If the case cannot be resolved, or the client says no, we move on to trial.

What pushes a settlement offer up, and when negotiation ends

Several things shape an offer before the client ever has to say yes or no. One is insurance, which I take up in Chapter 13. The amount of insurance does dictate settlement. Let's suppose the damages in a case far exceed what a particular doctor's insurance covers. That doctor is probably going to think long and hard about going to trial and is going to want to resolve the case, because a judgment can be entered against an individual doctor, and nobody wants a judgment hanging over his head.

Another is the way the defendants behave toward each other. In the case I walk through in Chapter 17, the doctor was adamant about blaming the nurse, and we kept telling the other side in negotiation that we would present that finger-pointing to the jury. We were able to reach a settlement higher than we had anticipated. Finger-pointing can help a negotiation, but it is not a promise of a win or of a large settlement. I tell all my clients that we should manage our expectations. Sometimes, even though we advocate for large settlements, the doctors, the hospitals and the insurance companies are adamant and want to go forward.

Negotiation also has an end. We may have had settlement negotiations, and maybe even some friendly conversations, but once a case goes into litigation, *"now all bets are off."* Litigation is a battle, and all the parties are trying to do the best they can for their clients. If the case cannot be

resolved, or the client says no, we move on to trial.

Success is the client's reaction, not my record

I measure success by the client's reaction. *"Success is really defined by the client's reaction."* Did they feel it was a success? I have won more cases than I have lost, and I have lost cases. *"Any lawyer tells you they've never lost a case, I'd like to meet that person."*

It would be easy to say that success is a large settlement or a large verdict. That is not how I see it. Going through a trial is an arduous journey, and I want the client to feel afterward that the experience was worth it. For that reason, I hold that success has to be *"more client-centric than Frank Spector-centric."*

I have seen what that looks like when a case did not go our way. Clients have said to me, *"At least you fought for me."*



What the client decides and what the lawyer decides

Common Questions

Can my lawyer settle my medical malpractice case without my approval?

No, not in my practice. Whether to settle and for how much belongs to the client, and I tell clients so right up front. I put it this way: *"If I come to you with a number, even if I think it's fair, if you don't think it's fair, you have a right to say, Frank, no, thank you."* If you turn the offer down, we go forward toward trial.

What is mediation in a medical malpractice case?

Mediation is what we call alternative dispute resolution. The judges want the parties to meet with a mediator, *"somebody who's neutral, that doesn't have any stake in the case,"* and see whether the case can be resolved out of court. Many cases go through it, and I think virtually all of them. If an offer comes up that you reject, you can end the mediation.

Can I walk away from a mediation if I do not like the offer?

Yes. If the other side comes up with a number I think is fair and you do not, you can tell me you want to end the mediation and go to trial. I explain that to clients before the mediation starts, and, as I understand it, it is in our rules. Walking away does not close the case. It moves the case toward trial.

Why do lawyers push settlement instead of trial?

For me it comes down to control and finality. A trial leaves the outcome with a jury, and you cannot know what it will do. A settlement ends the case. A jury win may not, because *"Even if you win a jury trial, it's not over because the other side can appeal."* An appeal can take years. The decision to settle still stays with you.

Does the amount of insurance affect whether a case settles?

Yes. *"The amount of insurance does dictate settlement."* If the damages in a case far exceed what a doctor's insurance covers, that doctor is probably going to think long and hard about going to trial, because nobody wants a judgment over his head. Chapter 13 covers insurance and why it shapes the whole case.

Chapter Reflection

Everything in this chapter turns on a single question: whose life does the outcome land on? It lands on the client, so the client holds the two decisions that matter most, whether to file and whether to accept an offer, and I hold the craft of getting the case there. A good settlement beats

a great trial because it lets the client end the case on terms they chose. When the client says no, the case goes to trial, and that choice is theirs to make. A number, though, is only part of what a family brings to a lawsuit. The next chapter takes up the rest of what they are asking for.

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CHAPTER NINETEEN

Accountability, Apologies, and What Families Are Asking For

A lot of people assume that a call to a medical malpractice lawyer is a call about money. It is, in my experience, a call about something larger, and the money is only one piece of it. Families come to me after a surgery went wrong, a diagnosis was missed, or a delivery ended in a disaster. What they carry with them is hurt, confusion, and the sense that a relationship they trusted with their lives has gone quiet.

This chapter is about that part of the work, the part that does not fit in a damages calculation. It covers the two things a firm like mine tries to do, what families mean when they ask for accountability, the apology that clients sometimes ask about at the end of a case, and what it means to be a real person on the other end of the phone in a world of call centers and billing departments. It also covers what compensation can do for a family and what it cannot.

One limit comes before we start: nothing a lawyer does can turn back the hands of time. Chapters 11 through 14 cover the deadlines, the parties, the insurance, and the recovery a Maryland family can pursue. This chapter is about what sits underneath all of that.

> ***"They want some validation that the healthcare system let them down."***
>
> — FRANK SPECTOR, ON WHAT CLIENTS WANT

Holding the industry accountable and treating people with dignity

When I describe what Frank Spector Law is for, the answer comes in two parts. In my words, *"We're trying to accomplish two things. We're trying to accomplish holding the medical industry accountable for their mistakes."*

I do not say that lightly. A person's relationship with a doctor is one of the most trusted relationships in a life, because a patient is putting their life in that doctor's hands. Patients need their doctors to do things they cannot do for themselves, and not many people can do those things. That is why the next observation carries weight with me: *"For some reason, accountability still seems to be a stumbling block in the medical industry."*

The second thing is dignity. As I said at the start, there are two parts, and this one is about how a person is treated while they are in crisis. My core mission is to help people in a time of crisis, to treat them with dignity, and to do my best to make sure the process I take them through is explained.

A lawsuit is like going to a foreign country. You do not speak the language and you do not know where to go. Those of us who have gone on a trip hire a tour guide for exactly that reason. A person walking into a lawsuit may not speak the legal terms and may not have been through a process like it, so my job is to be the guide. I explain what the process looks like, how long it is going to take, what the potential outcomes are, what the decision points will be, and what the client's own involvement is. A lot of people just want a roadmap, and I think a roadmap gives them comfort.

Recognition from the system that failed them

Accountability is a big deal to a lot of the families I represent. Their lives have been turned upside down, and they are looking for something a check cannot give them. They are looking for the medical industry to recognize what happened. Unfortunately, in my view they do not get that in most cases.

I try to be careful about what families are and are not saying. They are not saying that mistakes do not happen. Families know that mistakes happen. What I hear is that knowing it does not mean they are willing to let it go.

So I tell my clients the truth about what I can offer. I cannot change what happened, and I wish that I could. What I can do is make sure we hold the system accountable. By the system I mean the medical industry and the way it answers for its mistakes.

That distinction matters because one of the biggest misconceptions I run into is that lawyers like me hate doctors. I say it plainly: I love doctors, I do not hate them, and several of them are my friends. The doctors in my life understand what I do. Chapter 6 takes up the myths about malpractice lawyers and the checks built into the system.

The apology families ask for and seldom receive

Let's say I am in a car accident and I hit somebody, and it was my fault. I know what I would do. *"I would get up and I would get out of my car and I would say, I'm sorry, this is on me. I did this."* We see a lot of accountability in our daily lives. All of us make mistakes, and when we do we say we are sorry.

Then I look at the medical profession, and the picture changes. *"In the medical profession, they don't do that."* I will not guess at the reasons. I can tell you what I have seen. I believe the only way to get accountability from the medical industry is to bring a lawsuit.

Even then, an apology is a different matter from accountability. Sometimes, at the end of a case, a client will ask me, *"Do you think we can get an apology? Do you think we can just have them say I'm sorry?"* I give the answer I believe is true. I tell the client I do not know, and I do not think so. In my thirty-five years of practice it has not happened much.

I cannot promise a family what the other side will say. What I can do is give a true answer when a family asks, and keep working toward the accountability a lawsuit can bring.

A real person on the phone, with compassion and integrity

The dignity I mentioned shows up in small ways first. The idea of customer service, of being treated with dignity wherever you go, seems to me to have been lost. A lot of people cannot get to see anybody anymore. Contact runs by phone and through call centers. People are dealing with insurance issues that seem to have no end, and they are billed for things they cannot make sense of. The frustration is real, and the whole experience feels impersonal.

So I want people to know this about me: *"I'm a real life person. I'm not an AI robot and I'm here to help them."*

When a new client calls Frank Spector Law, the rule is plain. A new client speaks to me directly, and Chapter 7 describes why. A caller who goes through an intake person may wait weeks or months for the question to reach a lawyer's desk, and then be told there is no case. I shortcut that process. The people who call have had their lives turned upside down by a medical mistake, and they still have family, work, and all the other responsibilities. Maybe they only have a lunch break to call. They want to know whether they have something or they do not, and I can answer that. As of this writing, I also use an AI phone assistant for calls that come in after hours, because many reception agencies no longer have live service around the clock, and I say so openly. I make sure that someone answers.

If you ask me for one sentence about what I stand for, it is this: *"I stand for compassion and integrity."*

In practice, compassion starts with listening. *"I spend a lot of time listening. I don't talk over people, I let them tell their story."* A lot of the people who call me have been hurt and ignored by the medical system. A patient has a good relationship with a doctor, something bad happens, and that doctor is gone from their life. They are angry and confused, and a lot of times they want to vent. Part of my mission is to give them the space to do it.

Compassion also means reassuring the mothers who call after a birth injury, many of whom feel guilty. They worry that a lawyer will blame them. I tell them they did not do anything wrong, that they went to the doctor and kept their appointments. I cannot change the way a person feels, but I want to give them some comfort in that conversation.

It covers the callers I cannot help as well. I talk with a lot of people whose situations do not make a case, and I tell them why. Many of them have called one lawyer after another without learning the reason. When I finally explain it, there is a sense of relief. Some of them tell me they wish they had a case, but that I am the only lawyer who took the time to listen and explain. That integrity is part of the job, and I find it satisfying, because I have the training and the information, and giving it to someone gives them clarity.

What keeps me going

A call from a former client, which I describe in Chapter 9, is part of what keeps me going. She had been a baby when I represented her, and hearing that she was all right meant a great deal to me.

That call is part of the answer when people ask what motivates me. The rest is what I see around me. There has not been much of a change, in my view, in how often medical mistakes happen. I see them getting more and more. *"I wish they would go down, but they are not."* People need help, and their lives have been changed forever. *"And what motivates me is being able to just help a person."*

I measure success the same way. It is not my definition that counts. *"The success is dictated by the client."* A thank-you at the end of a case means a lot to me. I have lost cases, and I have had clients in those cases tell me, *"At least you fought for me."* My hope is that the client feels the arduous journey of a lawsuit was worth it. It is not about me. It is about the client.

What compensation can do, and what it cannot

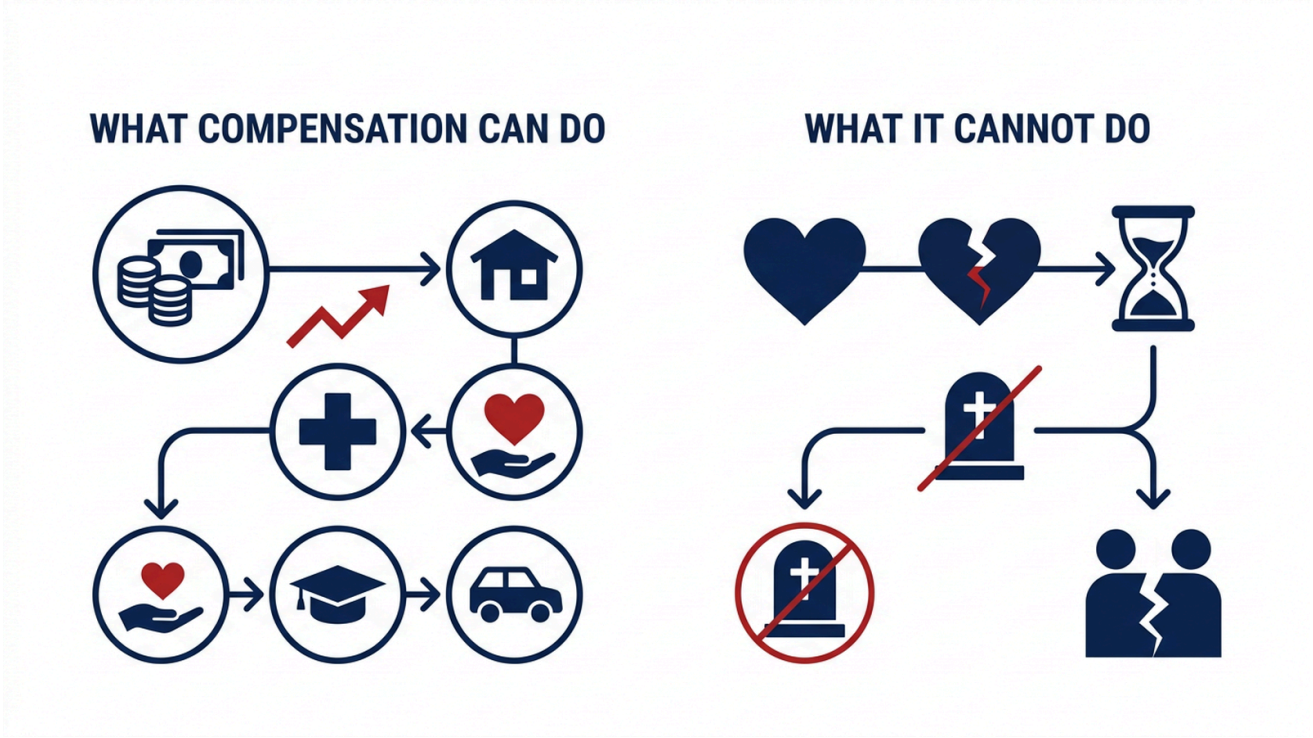
None of this means money is beside the point. Compensation is the power a medical malpractice lawyer has, and we talk a lot about it with families. I also know how it can sound, because talking about money with a family in this position can feel empty.

The honest framing starts with what I wish I could say: that I never wanted this family to be one of my cases, and that I cannot make it not have happened. Compensation does not undo an injury, and it cannot promise that anyone will say they are sorry.

What it can do is help people put their lives back together. Let's suppose you could no longer do what an ordinary morning asks of you, getting up, getting dressed, getting in your car, going shopping, going on vacation. Let's suppose you were in pain all the time, could not do your job anymore, and were fired. Let's suppose you needed therapies and other medical treatments that your insurance did not cover. Medical care costs keep going up, and, as I have seen it, so many people are being wiped out and forced into bankruptcy because of medical costs. Insurance, as I have seen it, does not cover 24-hour nursing care. Compensation can supplement what insurance and disability payments do not cover, and it gives a family the peace of mind to know the money is there to make life as good as it can be. Chapter 14 covers what a Maryland family can recover and what Maryland limits.

That is also why I reject the lottery picture. In thirty-five years, nobody who called me has phoned with great news. When I explain it this way, my clients understand that I am not judging them, and that I do not think they are there for all the money.

The bittersweet feeling comes back to me most in the cases where the result is good. In the delivery-room case I describe in Chapter 17, the settlement came out higher than we had anticipated, and I still call it bittersweet. *"I wish the parents never had to call me."* My job in a case like that is to make sure the child is adequately compensated for the rest of their life and gets all the care that child needs.



What compensation can and cannot do

Common Questions

Can a malpractice lawsuit make a doctor or hospital apologize? A lawsuit can bring accountability, but an apology is a different matter, and I cannot promise one. Clients sometimes ask me at the end of a case whether they can get one. My answer to them has been, *"I don't know. I don't think so."* In my thirty-five years of practice it has not happened much. I believe a lawsuit is the only way to get accountability from the medical industry.

What do families mean when they ask for accountability after a medical mistake? They mean recognition from the system. Families understand that mistakes happen, and, in my view, *"they understand that mistakes happen, but that doesn't mean that they are willing to just let it go."* They are asking the system to acknowledge what it did. That is a large part of why accountability is a big deal to a lot of my clients, and why money alone does not settle it for them.

Will a lawyer answer my call about a possible medical malpractice case? At Frank Spector Law, a new client speaks to me directly, and there are not many middle people on the line. *"Many clients say to me, my gosh, I never thought I would speak to a lawyer."* I do it because I want you to know you are important. As of this writing, for calls after hours I use an AI phone assistant, and I say so plainly, so that someone answers.

Is a medical malpractice lawsuit about winning the lottery? No. That picture is bad press and propaganda, and nobody who has called me has phoned with great news. The families I work with expect to need money for things that insurance and disability payments do not cover, and compensation gives them peace of mind that it will be there. Nothing turns back the hands of time, but compensation can help with the cost of care.

Why would a malpractice lawyer tell me I do not have a case? Most callers do not have a case, and I think they deserve the reason. Many of them have phoned lawyer after lawyer without getting clarity. When I finally explain it, there is a sense of relief, because at least they can close the door on that chapter and go on with their lives, even without a lawsuit. That clarity is a service in itself.

Chapter Reflection

A lot of families who call me are asking for more than a check. They want a person who listens, a system that answers for its mistakes, and an honest word about what a lawsuit can and cannot give back. Nothing turns back the hands of time, and in thirty-five years of practice an apology has not come often. What I can do is stay a real person through the process while the family de-

cides what comes next. Chapter 20 turns to the distance between patients and doctors: the technology, the hospitalists, and the gap that opens when the person across the desk is no longer the doctor you knew.

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CHAPTER TWENTY

Technology, Hospitalists, and the Distance Between Doctors and Patients

A reminder call about tomorrow's appointment. A form sent out ahead of the visit. A doctor who walks into the exam room carrying a laptop. Technology came into the medical system in small ways first, and a lot of people never stopped to notice. I have practiced for thirty-five years, long enough to remember when a visit looked different, and I think the change deserves a plain look.

I come to this subject as a lawyer who likes medicine. I like the science of it, and I am all for innovation. I use technology in my own practice, and later in this chapter I will tell you how. What worries me is something else: the distance that opens up between a patient and the people caring for that patient, and what I think that distance costs in mistakes.

Everything here is my opinion, drawn from my work and from what the people who call me tell me. It is not a study, and I do not offer it as one. I take it in six steps: where technology already sits in medicine, why programming has limits, what the laptop and the hospitalist change, what I think juries are telling the medical profession, where human safeguards still belong, and how I use these tools myself.

> ***"However, medicine is still a human-to-human interaction. And the further that we get away from that human interaction, I think it's going to be fraught with more medical mistakes."***
>
> — FRANK SPECTOR, ON TECHNOLOGY AND MEDICINE

Robotic surgery, reminder calls and forms: where technology already sits in medicine

Everybody is talking about AI, and the questions come fast. Are we going to have robots delivering babies? Robots doing surgery? Before I answer, it helps to separate what exists from what people picture.

Robotic surgery exists. We already have it, and *"those are controlled by doctors almost like a video game simulator."* A doctor sits at the controls. As of this writing, what does not exist is a robot that operates on its own. *"Do we have standalone robots that are performing surgery? We*

don't. Could we? Sure." I can see that coming in the future, and I say so as someone who is a proponent of robotic surgery.

A lot of people miss that AI is already part of their lives, and they do not recognize it. The forms that get sent out and the automated calls that remind us about appointments are how AI is beginning to appear in our medical system.

None of this bothers me by itself. We should have every technological advance we can get. What I watch is how far a patient ends up from a human being once the advances arrive.

Programming has limits, and a self-driving truck shows where

My worry starts with a plain fact about machines. A computer or a robot does what it was programmed to do. I am all for innovation, and I mean that. But *"those robots are not infallible. They can make mistakes. It has to do with programming."*

The picture I keep in mind is the self-driving truck. It is a machine doing work a person used to do, and *"they crash into cars because it's not programmed for every situation."* I apply the same limit to medicine, and I call it my opinion. If medicine were put only in the hands of a computer or a robot, I would expect the mistakes to follow, because the machine can meet only the situations it was programmed for.

The further medicine moves from people dealing directly with people, the more I expect those mistakes: *"I think it's going to be fraught with more medical mistakes."* That is a judgment from thirty-five years of this work, and I hold it as a judgment, not a finding.

Laptops, hospitalists and the doctor you used to know

I think everybody is experiencing this, and I am experiencing it too: *"We're becoming less and less connected to our doctor." "Our doctor comes in now with a laptop. That wasn't always the way it was."*

One piece of this stands out to me. *"The most important part that doctors don't want to spend a lot of time on anymore is called the history, which means talking to the patient."* Older doctors will tell you that the more they listen, the more the patient tells them about what is wrong. I use the same principle in my own work. A case begins when I let a client tell the story in their own words, from beginning to end, without interrupting. Chapter 7 describes that first conversation.

Now follow the patient into the hospital. *"Many times our own doctor doesn't even admit us to the hospital."* What we meet instead is *"somebody called a hospitalist, a hospital employee who's taking the role of a doctor that we had the relationship with."* To my mind the relationship between patient and doctor is going to suffer.

I hear what that distance feels like from the people who call me. Their lives have been turned upside down, and many of them feel ignored by the medical system. A person has a surgery after a good relationship with the doctor, then something bad happens, and the doctor is never seen again. They do not know why. They are mad and confused, and they need to get it off their chest. I am describing what clients tell me, not laying down a rule about every hospital stay.

It reaches past the hospital. The idea of customer service, of being treated with dignity wherever you go, is lost, I believe. You do not get to see anybody anymore. Everything runs through phone calls and call centers, insurance problems never end, and bills arrive for things nobody explained. Things have become so impersonal. Chapter 19 takes up what families are asking for in the end.

What I think enormous verdicts tell the medical profession

Some verdicts against the medical profession are enormous, and people ask me why a jury would do that. My answer is an opinion, and I give it as one.

The less connected people are to their doctor personally, the more distant they become. *"The more detached they become, the more angry they become. They can't see a human being."* My view is that people who feel detached from the system, and angry at it, hold real power once they sit as jurors. And I do not think they use it carelessly.

Now, I have talked with jurors, and what I have found is this: *"Jurors like to do the right thing. My experience in talking to jurors is they take the duty seriously."* When a jury sends out one of those *"monster verdicts,"* I read it as a message to the medical profession: *"We don't want to be treated like a robot. We want a human to human interaction."* That is how I read it.

The medical industry ought to take note, in my view. In my opinion the verdicts are going to keep growing, because people grow more frustrated and angry with a system they cannot see a person in. Chapter 18 looks at who decides a case, from settlement to trial.

Innovation with a human at the controls: prescriptions, pharmacies and false security

None of this makes me an opponent of technology. *"I'm a big proponent of innovation. I'm a big proponent of robotic surgery."* I am a proponent of anything that can help people, and there is one place where I hope technology helps a great deal.

Medical mistakes, in my experience, are not coming down. I see little change in how often they happen, and what I see is more of them, with *"many more prescription errors, many pharmacy errors."* Those are mistakes that should not happen, and I hope technology can eliminate them for the good of everybody.

Here is where I see the danger. *"I think that when people rely on technology, they have a false sense of security that the computer and that the technology is going to catch all mistakes."*

Let's suppose a prescription reaches a pharmacy. Someone has to confirm that the drug is the right drug for that person. Someone has to confirm the dosage, and someone has to look at the interactions between the drugs. *"Can all of that be programmed into AI? I guess. I'm not the right person to ask that."* Saying what can be programmed is outside my field, and I would not pretend otherwise. What I can tell you is where I stand until the answer is clear: *"Until we get to a point where we can say we can rely on this technology, we have to have human beings be at the controls to make sure the safeguards are in place."*

The tools I use myself: edited videos and an after-hours AI assistant

I would be a poor critic of technology if I did not tell you how I use it. Those of you who know me see my videos on TikTok, YouTube and Instagram. I am using a lot of AI techniques to make sure those videos are edited properly, and that they are entertaining in a way that keeps you interested in the information.

The information is the point. Most people do not know what their legal options are, and they have no idea how these laws are made. The laws are made in our state capital, Annapolis: the time limits, the amount of money a person can get in a lawsuit, the steps a lawyer must take to bring in a medical doctor. People do not know about those at all. That is why I make videos and a podcast, to give you the information you need to protect your rights. *"I have to go to my audience in the way that they want that information presented to them,"* and the tools help me do that. And *"if you call me when it's too late, there's nothing I can do to help you."*

As of this writing, I also use an AI-assisted phone system, and I say so plainly. If you call after hours, many reception agencies no longer have live service around the clock, and I want to be sure you are talking to someone. *"Yes, it is an AI virtual assistant."* The one I use has been very well trained and very well programmed, so *"it's almost like talking to a real person, but it's not."* It lets me respond in a world that runs twenty-four hours a day, seven days a week.

The assistant is for the hours when a live person is not answering. It is not who I am. *"I'm a real life person. I'm not an AI robot."* Clients tell me they never expected to reach a lawyer at all. Some ask whether I am a lawyer at all or one of the AI voice assistants, and I tell them I am a real lawyer. A new client who calls me speaks to me, and I want them to know they are important. I use these tools, I tell you which ones, and I want you to know that the lawyer you reach is a real one.



A closed laptop on an exam-room desk

Common Questions

Is AI going to replace doctors and surgeons?

Not as things stand. Robotic surgery exists, but doctors control it, and, as of this writing, a robot that operates entirely on its own does not exist. I can see one arriving in the future. AI already shows up in appointment reminder calls and in the forms patients are sent. My concern is not the technology itself. It is how far patients end up from a human being as it spreads.

What is a hospitalist, and how is that different from your own doctor?

As I describe it, a hospitalist is a hospital employee who takes the role of the doctor a patient already knows. Many times a patient's own doctor does not admit that patient to the hospital at all. That is how I see it from the patient's side, and I think it strains the relationship between patient and doctor. It is my opinion about the relationship, not a claim about any one hospital.

Why do juries return such large verdicts in medical malpractice cases?

I can only give you my opinion. People who feel detached from the medical system grow angry with it, and some of them later hold the power of a juror. *"They're not doing it irresponsibly."* I read an enormous verdict as jurors sending a message to the medical profession about being treated like a robot. Chapter 18 covers who decides a case, from settlement to trial.

Do medical malpractice lawyers use AI?

I do, in two ways, and I say so. AI techniques help me edit the videos I put on YouTube, TikTok and Instagram so they hold a viewer's interest. As of this writing, after hours an AI virtual assistant answers my phone, because many reception services no longer offer live answering around the clock. A new client who calls me speaks to a real lawyer, and I say that on purpose.

Can technology reduce medical mistakes?

I hope so. *"What I hope is that the technology will be able to reduce medical mistakes."* My condition is that people stay in place as safeguards, at a pharmacy for example, where someone checks the drug, the dosage and the interactions. *"We have to balance innovation with still the human safeguards."* Until technology can be relied on, I want a human being at the controls.

Chapter Reflection

This chapter holds two beliefs, and I think they belong together. Technology can help, and I want the help. Fewer prescription and pharmacy mistakes would be good for everybody. But a patient who meets a laptop in the exam room and a hospitalist where the family doctor used to be feels the distance, and my opinion, after thirty-five years, is that the distance costs the medical profession something. Medicine will keep changing, and I will keep using the tools that help me reach people. I will also keep saying that a family deserves to deal with a person who listens. The conclusion that follows draws the whole book together.

Frequently Asked Questions

How do I know whether I have a medical malpractice case in Maryland?

You cannot tell from the result alone. Most bad outcomes are not malpractice at all. A case needs care that fell below the nationally recognized guidelines and a departure that caused the injury, and another doctor has to be willing to say so. On a first call I can often tell someone there is no case. When there may be one, it takes months of investigation before I can say.

What are the stages of a Maryland malpractice case, from the first call to the end?

It starts with a long interview where you tell the story in your own words. Next I go through the medical records, build timelines, and have practicing doctors review them. A doctor signs a certificate of qualified expert, which is generally required. Then I file a complaint naming every party that belongs, and litigation begins. Virtually all cases, I think, go through mediation, and the decision to settle is yours.

What deadlines can end a Maryland malpractice claim?

Two clocks run, and missing either can end a strong case. For an adult I count three years from the injury, the conservative rule I give clients. The statute, section 5-109, sets the earlier of five years from the injury or three years from discovery, and a child gets far more time. The certificate has its own clock. As I put it, *"if things are even one minute late, it's like they're a hundred years later."*

What does a lawyer look for before taking a malpractice case?

A departure from the standard of care that caused the injury, a practicing doctor willing to sign the certificate, enough injury to justify an expensive case, and enough insurance. On that last one, there has to be enough insurance behind the case for me to tell a client plainly that there is a meaningful chance of a recovery. When one of these is missing, I tell the caller why.

Why does a malpractice case need an experienced malpractice lawyer?

The deadlines are unforgiving and the litigation tools are complicated. A party left out of the complaint can leave a family out of luck, and those tools are meant for lawyers with a lot of experience. The lawyer has to know the rules and file things on time. The research on who to name comes before the complaint.

Which decisions in my case are mine and which are my lawyer's?

Whether to file and whether to settle, and for how much, are yours. Strategy, briefs and wording are mine, though I bounce strategic ideas off my clients and keep them updated. As I put it, *"It's their choice whether to file a lawsuit or not."* I say this up front: if I bring you a number I think is fair and you do not, you can tell me no and we go to trial.

Do malpractice lawyers dislike doctors?

No, and I think that is the biggest misconception about lawyers like me. I do not hate doctors, and I have doctors who are my friends. Ethics bind me, a practicing doctor has to sign off, and a lawyer who files weak cases goes out of business. Most callers hear from me that the healthcare system did the right thing by them and that they do not have a case.

Does a Baltimore malpractice lawyer handle only birth injury cases?

No. Birth injury runs through this book because, in my words, these are *"the toughest cases, at least for me, to handle."* The calls I hear most often are about surgical complications, and I also take anesthesia errors, misdiagnosis, failure to diagnose and neurosurgery cases, such as spinal and neck fusions. Not a lot of lawyers handle birth injury.

What can a lawsuit do for a family, and what can it not do?

A lawsuit can bring compensation and accountability. It cannot undo what happened, and I tell clients so. Compensation can help a family pay for care, therapies and lost work that insurance does not cover. An apology is different. I cannot promise one, and in thirty-five years it has not happened much.

What if I am not the suing type?

Callers tell me *"I'm not the suing type"*, and I understand it. I believe that feeling comes largely from a message pushed by organizations with money behind them, insurance companies among them, that want to narrow access to justice. A malpractice case is not a lawsuit against anybody for anything. A doctor has to sign a certificate, and I turn away most of the people who call.

Conclusion

Twenty chapters come down to one idea. A claim has to stand on things other people can check. A second doctor has to put a signature behind the statement that the standard of care was not met. The medical record has to show what happened and when. A filing deadline can end a claim before anyone reads the records, and the insurance behind each name decides what a recovery can look like in practice. That is why the work is in the groundwork, and why it takes months before I can tell a family whether there is a case.

The Foreword said a birth injury claim rests on one finding: that care fell below the standard and caused lasting harm. Everything since has been about how that finding gets made and what Maryland lets a family recover once it is made. A bad outcome is not always malpractice. A very small share of the people who call me become cases, and when I cannot help, I tell them why. Even when there is a case, I cannot promise how it ends, so I ask every client to manage expectations.

Families come to me wanting more than the rules can give. They want what happened to be acknowledged, and they want the system held accountable. I believe the only way to get accountability from the medical industry is to bring a lawsuit. I cannot promise an apology. I can't turn back the hands of time, and I wish that I could. What I can do is listen first and tell you the truth about what I see. Whether to bring a lawsuit, and whether to settle, are your decisions. I will not make them for you.

A lawsuit is like going into a foreign country, and I hope this book has worked as your map. When you are ready to talk, contact the firm.

Final Takeaways

1. **A bad result is not a finding.** A patient can be badly hurt and the care can still have met the standard, so the outcome alone never tells you whether you have a claim.
2. **Many birth injury cases turn on timing.** The warning signs during a birth get ignored, blown off or not recognized, and the question is whether the baby needed to be delivered sooner.
3. **Most callers hear no, and the no carries information.** I reject the vast majority of cases, because a weak case costs the lawyer who brings it and a bad outcome is not enough.
4. **Read the record before deciding what it means.** The charted times and the baby strips, reviewed with practicing doctors, are how I learn whether the standard of care was met.
5. **Another doctor has to sign first.** A case generally cannot go forward in Maryland without a certificate of qualified expert, and one filed late or wrong can undo a strong case.
6. **Count from the injury.** I give adults three years from the date of the injury, the conservative count, and a child's date is one a lawyer should confirm.
7. **Proof and coverage are two separate gates.** Someone has to have fallen below the standard of care, and something has to stand behind that someone to pay for what a family will need.
8. **I say Maryland limits pain and suffering but not the losses a calculator can reach.** Economic damages are not limited, as I see it. The statute, section 3-2A-09, sets a ceiling on non-economic damages that rises each January 1 and limits past medical expenses to amounts paid or owed.
9. **Your life, your two big decisions.** The client decides whether to file and whether to accept an offer, and I believe a good settlement beats a great trial.
10. **Families want more than a check.** They want what happened acknowledged and some validation that the system let them down, and in my thirty-five years an apology has not come often.

Appendix: Legal Sources and Official Resources

This book is built from Frank Spector's own words about how Maryland medical malpractice and birth injury cases work. The sources below are the statutes and official resources the chapters cite. The statutes are the law and not my opinion, so where a chapter quotes one, read it as the law and check the current text before you rely on it.

Maryland Statutes

- **Maryland Courts and Judicial Proceedings section 3-2A-01** - the definitions of a medical injury, of the Director of the Health Care Alternative Dispute Resolution Office, and of non-economic damages in personal injury and wrongful death claims. Chapters 1, 10 and 14. Courts and Judicial Proceedings section 3-2A-01
- **Maryland Courts and Judicial Proceedings section 3-2A-02** - who counts as a qualified expert, including the requirement that the expert have clinical, consulting or teaching experience in the defendant's specialty or a related field within five years of the act, with stated exceptions. Chapter 10. Courts and Judicial Proceedings section 3-2A-02
- **Maryland Courts and Judicial Proceedings section 3-2A-04** - the certificate of qualified expert, its 90-day clock, the limited extensions, and the dismissal without prejudice when it is not filed. Chapters 4, 6, 10 and 11. Courts and Judicial Proceedings section 3-2A-04
- **Maryland Courts and Judicial Proceedings section 3-2A-09** - the limit on past medical expenses and the ceiling on non-economic damages in claims against health care providers. Chapter 14. Courts and Judicial Proceedings section 3-2A-09
- **Maryland Courts and Judicial Proceedings section 5-109** - the filing limit for health care malpractice claims and the later start of the clock for a child. Chapters 3 and 11. Courts and Judicial Proceedings section 5-109
- **Maryland Courts and Judicial Proceedings section 3-902** - the basic rule for a wrongful death action. Chapter 14. Courts and Judicial Proceedings section 3-902
- **Maryland Courts and Judicial Proceedings section 3-904** - who the wrongful death action is for: the spouse, the parent and the child of the person who died, with a fallback to a relative by blood or marriage who was substantially dependent on the person who died. Chapter 14. Courts and Judicial Proceedings section 3-904

- **Maryland Health-General section 4-309** - the time a provider has to release a medical record once it is requested. Chapters 5 and 8. Health-General section 4-309

Institutions

- **Kennedy Krieger Institute** - the Baltimore institution that treats children with these types of injuries, whose records show the diagnosis and the therapies a child needs. Chapters 8 and 9. Kennedy Krieger Institute

Methodology

The book comes from Frank Spector's recorded conversations about medical malpractice and birth injury. Where a chapter quotes him, the words are in quotation marks. Where a chapter states what the law says, the wording was checked against the Maryland General Assembly's published text of the statute. A statute is only as good as its current version, and the rules change, so a lawyer should confirm the exact deadlines and limits for your family before you act on any of them.

Legal Notice

This book offers general information only. It is not legal advice, and neither reading it nor acting on it creates an attorney-client relationship with Frank Spector or Frank Spector Law. Each case turns on its own facts and the law changes, so the Maryland law described here is current as of October 2026. Results in earlier matters do not predict the outcome of any other matter. Talk to a licensed Maryland attorney about your own situation before you act.

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