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Medical malpractice: Handling birth trauma cases

Birth trauma cases are the most difficult and expensive that plaintiffs' medical malpractice lawyers undertake. Multiple experts (often as many as eight or nine) are required. Defense lawyers assigned to these cases invariably are the "cream of the crop." An entire body of "medical" literature has been generated over the past 20-plus years for the sole purpose of exculpating doctors from liability. Litigation costs average well over $100,000, and frequently exceed $200,000.

Birth injury cases also present plaintiff lawyers with the opportunity to help those malpractice victims who, as a group, are most in need – brain-damaged children and their families. The events giving rise to liability typically occur over a short period of time and are emotionally compelling. The revisionist literature does not hold up under careful scrutiny. Economic damages, expressed in present value dollars, generally range from the mid-seven figures to the low-eight figures. On several levels, these cases represent the ultimate challenge for plaintiffs' medical malpractice lawyers.

Case screening

Because of the devastating emotional cost to the family and enormous financial cost to the attorney of mis-selecting a birth trauma case, careful screening is essential. Screening begins with the initial client intake. The attorney or staff member performing the initial screening should, in a stepwise fashion, obtain the following information:

- When was the child born;
- Where (hospital, city, state) was the child born;
- Names of the delivery health-care provider and pre-natal provider(s);
- Apgar scores, if known;
- How long did the child remain hospitalized at birth;
- How long did the pregnancy go;
- Were there any problems noted prenatally;
- Mode of delivery;
- Length of labor;
- Any problems noted during labor;
- Has the child had seizures;
- How does the child's development compare with siblings, if any;
- Any family history of developmental, cognitive, motor or neurological problems;
- Has any health-care provider told the family the cause of the child's problems;
- Has the family been told that the child will have permanent problems; and
- What, if anything, does the family think might have been done wrong that caused the child's problem.

Assuming that the initial intake provides a basis for going further, the next step is to schedule an appointment with the child's parent(s). The parents should be requested to bring with them any medical records or documents relating to the case that are already in their possession. At the time of the initial meeting, authorizations to obtain medical records should be signed. At a minimum, the following medical records need to be obtained in connection with the initial case evaluation:

- All pre-natal records;
- The mother's complete hospital records for the admission that included labor and delivery;
- The fetal monitor strips (if these are not requested specifically, they will not be forwarded, since they are customarily kept separately from the medical chart);
- All hospital outpatient records for the mother during the pregnancy in question, along with the monitor strips, if any, pertaining to those visits;
- The baby's complete newborn admission hospital chart; and
- A "representative" sampling of the child's medical records after discharge from the hospital.

The next step is for plaintiffs' counsel to personally review all the medical records obtained. While a legal nurse consultant can be a very valuable resource in helping the attorney to navigate his/her way through the medical records and understand the significance of what is or is not there, there is no substitute for the lawyer's own review. Failing to familiarize himself/herself with the medical records places plaintiffs' counsel at a significant disadvantage when making initial contact with prospective experts and, subsequently, when discussing those experts' opinions regarding the case.

Before deciding to move forward on a birth trauma case, the lawyer should obtain credible favorable opinions from well-qualified experts on liability and causation. While an obstetrician may be able to express some opinions regarding causation, it is necessary at the outset of the case, to retain experts who will specifically address causation. For initial review purposes, this expert would most likely be a pediatric neurologist or neonatologist. Even if the negligence appears to be egregious, plaintiffs counsel could be making a very expensive mistake by not solidifying expert's support for causation before filing the case.

Theories of liability

Liability may be based upon events that occur during one or more of the following time frames: Pre-natal; Intrapartum; or Neonatal.

A partial list of issues arising during each timeframe is set forth below.

***Pre-natal*:**

- Failure to properly screen for genetic defects;

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• Failure to properly calculate due date;
• Failure to diagnose and/or treat gestational diabetes;
• Failure to diagnose and/or treat properly pregnancy-induced hypertension;
• Failure to timely order/perform/interpret fetal ultrasounds;
• Failure to timely offer expanded AFP screening;
• Failure to timely offer/recommend amniocentesis;
• Failure to work up size disproportionate to date;
• Failure to diagnose interuterine growth retardation (IUGR);
• Inappropriate recommendation of vaginal birth after Caesarean (VBAC);
• Failure to properly manage post dates of pregnancy;
• Improper management of breech presentation;
• Improper management of twins/multiple gestation pregnancy.

***Intrapartum*:**
• Failure to timely diagnose fetal distress;
• Failure to timely offer/perform Caesarean section;
• Failure to administer timely Group B Strep prophylaxis;
• Failure to monitor properly during VBAC;
• Improperly starting/failure to discontinue Pitocin;
• Failure to suspect/diagnose uterine hyperstimulation;
• Failure to appreciate/act on sinusoidal heart rate pattern;
• Failure to properly manage prolonged second stage of labor;
• Failure to properly manage shoulder dystocia;
• Improper use of vacuum extractor;
• Improper use of forceps;
• Failure to follow nursing chain of command;
• Improper management of umbilical cord prolapse;
• Improper management of placental abruption;
• Improper management of breech presentation;
• Failure to timely assemble neonatal resuscitation team.

***Neonatal*:**
• Failure to properly resuscitate in delivery room;
• Failure to monitor;
• Failure to oxygenate/ventilate;
• Failure to timely transfuse;
• Esophageal intubation;
• Failure to timely obtain arterial blood gas;
• Failure to timely obtain CBC.

Identifying the defendants and coverage

It is particularly important in birth injury cases to identify and name all appropriate defendants, since individual defendants frequently lack sufficient insurance coverage to compensate the plaintiff's damages. For example, a physician may have been acting as an employee of a medical group at the time he/she provided negligent medical care. In some cases, the individual doctor and the group are covered by separate policies. In other cases, although both individual and group are covered under a single policy, the policy limit applies separately to each.

Interrogatories should be sent to the defendant hospital as quickly as possible, requesting identification by name and last known address of each person who provided care to mother and baby from the time of admission through the time of delivery. If there are potential issues regarding the adequacy of neonatal care, the same interrogatories should be asked as to the neonatal personnel during any portion of the neonatal hospitalization where the quality of care is in question.

All hospital and/or nursing policies and procedures that might be relevant should be obtained. Typically, there will be an index of the policies and procedures for labor and delivery. The index can be requested initially, and then a follow-up request for production should be sent requesting the specific policies and procedures that appear relevant. In some cases, there is a need to establish whether the hospital had a policy or procedure in place on a particular issue. In that event, the hospital should be requested to produce the specific policy or procedure in question, as well as the index.

The form interrogatories 4.0 series (insurance coverage) should be served early on as to each defendant. Identifying insurance coverage is important to know whether the coverage is adequate. In addition, knowing the level at which excess coverage kicks in may be important in formulating settlement strategy.

Experts

All birth injury cases are multiple (five or more) expert cases. The types of experts needed vary depending upon the facts of the particular case. Since causation is usually disputed vigorously (see below), it is not uncommon to have as many as five experts from different specialties testifying regarding causation. The types of experts typically retained in birth trauma cases include some or all of the following:
• Obstetrician;
• Maternal/fetal medicine specialist/perinatologist;
• Labor and delivery nurse;
• Neonatologist;
• Neonatal nurse;
• Pediatric neurologist;
• Neuroradiologist;
• Placental pathologist;
• Neuropsychologist;
• Physical medicine/rehabilitation specialist;
• Life care planner; and
• Economist

Overcoming the causation defenses

The defendants invariably take the position that the baby's brain injury was due to undetectable events that preceded the onset of labor, and that nothing the defendants did, or failed to do, affected the outcome. The obstetrical literature has been systematically rewritten since the early 1980s for the express purpose of shielding obstetricians from liability. Much of the literature has little or no scientific validity. The most recent publication that the defense relies on was published in 2003 by the American College of Obstetrics and Gynecologists with the joinder of the American Academy of Pediatrics titled *Neonatal Encephalopathy and Cerebral Palsy, Defining the Pathogenesis and Pathophysiology* (hereinafter "2003 ACOG Task Force Report"). The report sets forth, in dogmatic fashion, criteria which are *required* in order to define an

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acute intrapartum hypoxic event sufficient to cause cerebral palsy. By defining four *essential* criteria that must be satisfied before an intrapartum hypoxic event can even be considered as a cause of cerebral palsy, the 2003 ACOG Task Force Report clearly seeks to minimize the number of birth injury cases in which the plaintiff will be able to meet his/her burden of proof on causation. In virtually every case, one or more defense experts will testify that the 2003 ACOG Task Force Report is "reliable authority" regarding the relationship between intrapartum events and cerebral palsy, thereby opening the door for defense counsel to cross-examine the plaintiffs' experts at length regarding the report pursuant to California Evidence Code section 721(b)(3). In order to counter this potentially devastating defense, plaintiffs' counsel must be thoroughly familiar with the entirety of the 2003 ACOG Task Force Report, including the cited references, and must make sure that plaintiffs' experts are prepared for cross-examination based on the report.

For a comprehensive discussion regarding causation issues, please see *Overcoming the Latest Causation Defenses in Birth Injury Cases*, by Kenneth M. Sigelman, J.D., M.D., previously published by CAALA in The Advocate, Volume 31, Number 4, April 2004.

Developing the damages case

The key disputed issues as to damages in birth injury cases are the following:

(1) The extent of medical, nursing and therapeutic care, particularly the level of attendant care, that will be required over the child's lifetime; and

(2) The child's life expectancy.

In every birth injury case, the plaintiff must present a life care plan that is complete, realistic and understandable by the jury. The defense will typically counter with a life care plan that costs far less than the plaintiffs' plan because (1) a significant portion of the attendant care burden is assigned to the parents, (2) the level of attendant care is inadequate (for example, non-licensed attendants cannot administer medication), and (3) the defense experts, relying upon largely outdated literature, will project an extremely shortened life expectancy. The plaintiffs' experts can cite more recent literature, including Plioplys, *Survival Rates of Children with Severe Neurologic Disabilities: A Review,* Seminars in Pediatric Neurology, Volume 10, Number 2 (2003), pages 120-129 and Plioplys, et al., *Survival Rates Among Children with Severe Neurologic Disabilities,* Southern Medical Journal, Volume 91, Number 2 (1998), pages 161-172 to prove a significantly longer life expectancy than that suggested by the defense.

Non-expert testimony regarding damages is at least as important as the testimony of the experts. While family members are often compelling witnesses in recounting the difficulties of caring for a disabled child and the ongoing adaptations that the entire family has to make, non-family members who are well-acquainted with the family situation (family friends, clergy, teachers, therapists, etc.) may carry greater weight with the jury because they are not interested parties. With regard to presenting a teacher or therapist as a witness, plaintiffs' counsel must consider the fact that, inevitably, teachers and therapists who work with disabled children tend to think positively, sometimes to the point of painting an unrealistically rosy picture. The school and/or therapy records should be reviewed carefully, so that plaintiffs' counsel will have a sense of how the testimony is likely to go before deposing or calling as a trial witness a teacher or therapist. With regard to therapists, an additional problem that must be considered is a possible relationship between the therapist and the defendant health-care provider.

As with any catastrophic injury case, demonstrative evidence is critically important in proving damages. "Day in the Life" video footage should be prepared so as to illustrate specific points raised in the testimony of expert and/or non-expert witnesses. Photographs and/or video footage of items in the life care plan (special equipment, residential facilities, etc.) should be used whenever possible in order to help the jury understand fully the purpose and importance of each item.

Settlement strategies

Settlement strategies in birth injury cases often turn on the relative apportionment of liability among physician and/or midwife, and hospital, and to the respective insurance coverage. In a typical case, liability may be stronger as to the health-care provider (usually physician, but possibly midwife) who was managing the labor and delivery, but whose insurance coverage is inadequate to cover his/her proportionate care of the damages. Accordingly, it is imperative that (1) all of the details of coverage be elicited during discovery as stated above, (2) the liability case as to the hospital/labor and delivery nurse be worked up meticulously for more than simply "chain of command" issues, and (3) neonatal resuscitation issues also be explored carefully.

Where appropriate, a policy limit demand should be served on all individual physician and/or midwife defendants at the earliest opportunity. However, this should only be done after plaintiffs' counsel has determined how to deal with the "empty chair" at trial.

Finally, since structured settlements are a part of the settlement of most birth injury cases, plaintiffs' counsel should retain his/her own structured settlement consultant before entering into meaningful settlement negotiations.

Motions in limine

Two key motions in limine are (1) to preclude evidence of potential benefits to be paid by Medi-Care, Medi-Cal, the Regional Center and other sources which are not within exceptions to the collateral source rule set forth in Civil Code section 3333.1, and (2) to preclude the testimony of an annuitist.

Kenneth M. Sigelman, J.D., M.D. is the founder of Kenneth M. Sigelman & Associates in San Diego. The firm represents plaintiffs in catastrophic medical malpractice and personal injury cases.

The motions in limine cited above are attached to this document.

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SUPERIOR COURT OF CALIFORNIA

COUNTY OF

_____, By and Through His Guardian Ad Litem, _____; and _____,	) CASE NO.) General Civil
Plaintiffs,	) **PLAINTIFFS' MOTION *IN LIMINE* PRECLUDING EVIDENCE RE REGIONAL CENTER BENEFITS, MEDI-CAL BENEFITS, OR ANY OTHER COLLATERAL SOURCE**
v.	
_____, M.D., et. al.,	
Defendants.	) **[NO. OF]**
_____	) Trial Date:) Complaint Filed:

TO: THE ABOVE-ENTITLED HONORABLE COURT AND TO ALL PARTIES AND THEIR ATTORNEYS OF RECORD:

Plaintiffs _____, By and Through His Guardian Ad Litem, _____; and _____ hereby seek an Order *in Limine* precluding any reference by Defendants, their attorneys, or any witness called by the defense, to the payment of any of Plaintiff _____'s past or future expenses by the California Department of Health Services through the Medi-Cal program ("Medi-Cal"); by the Regional Center of _____County ("RC"); by California Children's Services ("CCS"), by any public school district, or by any other collateral source not specifically mentioned in Code of Civil Procedure section 3333.1, pursuant to the Collateral Source Rule.

I.

INTRODUCTION

It is anticipated that the defendants will attempt to present evidence at trial of various services and non-monetary benefits which have been provided to Plaintiff _____ in the past, or may be provided to him in the future, by various "collateral sources," and that the defense will claim that the "Collateral Source Rule" has been completely abrogated in medical negligence cases by Civil Code section 3333.1. However, as will be shown below, only a limited exception to the Collateral Source Rule is created by Civil Code section 3333.1, and that section is inapplicable to Medi-Cal benefits, RC benefits, CCS benefits, services provided through the public school system, or any other collateral source non specifically identified in section 3333.1.

II.

THE COLLATERAL SOURCE RULE AND CCP § 3333.1

Any reference to the past, present, or future provision of services, without cost, to Plaintiff through Medi-Cal, RC, and/or any other collateral source, should be excluded at the time of trial pursuant to the Collateral Source Rule. This rule provides that "if an injured party received some compensation for his injuries from a source wholly independent of the tortfeasor, such payment should not be deducted from the damages which the Plaintiff would otherwise collect from the tortfeasor." *Hrnjak v. Graymar, Inc.* (1971) 4 Cal.3d 725, 729. The California Supreme Court has repeatedly held that California remains a firm proponent of this rule (*Id*. at p. 729; *Acosta v. Southern Cal.Rapid Transit District* (1970) 2 Cal.3d 19; *Helfend v. Southern California Rapid Transit District* (1970) 2 Cal.3d 1). Thus, in the absence of some exception to the Collateral Source Rule, evidence of collateral benefits, such as those provided to Plaintiff _____ through Medi-Cal or RC, may not be introduced at trial.

In medical negligence actions, Civil Code section 3333.1 creates a limited exception to the Collateral Source Rule. It provides, in pertinent part:

> (a) In the event the defendant so elects, in an action for personal injury against a health care provider based upon professional negligence, he may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the personal injury pursuant to the United States Social Security Act, any state or federal income disability or worker's compensation act, any health, sickness or

> income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental or other health care services. . . .

In this case, Plaintiff _____ has never received and will never be eligible to receive any "amounts payable as a benefit" pursuant to any federal income disability or worker's compensation act, since he has never worked, and all parties agree that this neurologically devastated child will never be able to work. He has never received, and will never be eligible to receive any private income-disability insurance benefits, or benefits through any accident insurance policy that provides health benefits or income-disability coverage. He has never been a party to "any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental or other health care services." Thus, the only benefits Plaintiff _____ is ever likely to receive to which Civil Code section 3333.1 applies would be social security disability benefits.

III.

JUDICIAL INTERPRETATION OF § 3333.1

More than twenty years ago, *Brown v. Stewart* (1982) 129 Cal.App.3d 331, addressed a number of arguments offered by the defense in hopes of obtaining a determination that Civil Code section 3333.1 applies far more broadly than the literal wording of the statute suggests. The *Brown* court specifically addressed the question of whether Civil Code section 3333.1 is applicable to Medi-Cal benefits, and held that it is not. The same reasoning applies to such "collateral sources" as Medi-Cal benefits, CCS benefits, RC benefits, and services that may be provided by the public school system.

First, the *Brown* defendants contended that Medi-Cal benefits fall within section 3333.1 because they constitute an "amount payable as a benefit to the plaintiff as a result of the personal injury pursuant to the United States Social Security Act." The *Brown* court rejected that argument, even though it recognized that the Medi-Cal program receives some federal financial support pursuant to Title XIX of the Social Security Act. The *Brown* court explained:

> "[P]ayments to recipients under the Medi-Cal program are not 'any amount payable as a benefit to the plaintiff pursuant to the United States Social Security Act.' First, the funds provided are paid to the State of California, to be administered as part of its program of providing medical care for the needy. To qualify for such financial assistance, the state must qualify by compliance with requirements of the federal law. Second, Medi-Cal payments are made directly to the medical service providers upon proof of rendition of health care services to an eligible Medi-Cal beneficiary. In a technical sense, a benefit is conferred upon the Medi-Cal recipient by the receipt of medical services but the thrust of the statutory language is directed to sums payable to the plaintiff.

Thus, the *Brown* decision makes it clear that the provisions of Civil Code section 3333.1(a) pertaining to "amounts payable as a benefit to the plaintiff" by Social Security apply only where those benefits are in the form of money paid directly to the recipient. *Id*. at p. 343. Identical considerations apply to the question of whether section 3333.1 is applicable to services provided through RC, CCS services, the public school system, and, indeed, to any collateral source which pays for services, but does not provide monetary benefits. Thus, even though the Security Act may provide funds which are utilized by the CCS and RC programs, the services provided by or through those programs are not "any amount payable as a benefit pursuant to the United States Social Security Act." The *Brown* defendants argued "that the direct payment to health care providers under Medi-Cal is of no significance as private health care plans such as Blue Cross, Blue Shield, and the Foundation Health Plan of _____ also pay directly according to an agreed upon schedule." The *Brown* court rejected this argument as well, pointing out that "such private plans are specifically identified in the second contract providers clause of subdivision (a) of section 3333.1."

Next, the *Brown* defendants argued that the State of California and/or the county constituted "organizations" which make payments to health care providers pursuant to a contract or agreement to provide health care services. Again, the *Brown* court found that the defendants' "suggested statutory interpretation is unsound." (*Id*. at p. 339.) The *Brown* court concluded that the term 'contract' in section 3333.1 refers to "an express, bilateral contract between the payor and the recipient of services," and that there is no such contract between State of California and Medi-Cal recipients. Similarly, there is no "express, bilateral contract" between CCS, RC, any

public school system, or any other collateral source which provides or is likely to provide services to Plaintiff _____.

Even in the absence of the *Brown* case, the basic, well-established rules of statutory construction demonstrate that § 3333.1 cannot properly be interpreted as simply abrogating the Collateral Source Rule; it simply does not say that. If there is no ambiguity in the language of the statute, then the courts are to "presume the lawmakers meant what they said, and the plain meaning of the language governs." *(Allen v. Sully-Miller Contracting Co.* (2002) 28 Cal.4th 222, 227.) Where the words of a statute are clear, the courts may not add to or alter them to accomplish a purpose that does not appear of the face of the statute or f rom its legislative history. (*Robert F. Kennedy Medical Center v. Belshee* (1996) 13 Cal.4th 748, 756.) As the California Supreme Court has pointed out, *Sierra Club v. State Bd. of Forestry* (1994) 7 Cal.4th 1215, at page1230, under the maxim of statutory construction *expressio unius est exclusio alterius*, if exceptions to a general rule are specified in a statute, the courts may not imply additional exceptions unless there is a clear legislative intent to the contrary. The interpretation of section 3333.1 urged by the defense abrogates these basic rules.

IV.

EVIDENCE OF MEDI-CAL AND REGIONAL CENTER BENEFITS WOULD RESULT IN A DOUBLE REDUCTION OF PLAINTIFF'S COMPENSATION

In *Brown*, the court pointed out that Welfare & Institutions Code section 14124.71 et seq., specifically authorizes Medi-Cal to recover against third party tortfeasors either by lien or by a direct action. Additionally, the Social Security Act, 42 U.S.C.A. section 1396a(25) also requires states in the Medicaid program to seek reimbursement for Medicaid payments from third party tortfeasors. Thus, a finding that section 3333.1 is applicable to Medi-Cal benefits "would create a direct conflict with the statutory recoupment sections." (*Id*. at p. 340.)

Precisely the same reasoning applies to RC. RC is statutorily required to undertake funding of benefits only as a funding source of last resort. See Welfare & Institutions Code section 4659. Only very rarely do the Regional Centers wind up actually funding the services they are required to provide by statute. This is because there are almost always either public or private resources that will provide such funding, thereby effectively eliminating the need for RC

funding. One "big ticket" item that the regional center may facilitate is custodial placement in either a group home or a skilled nursing facility. When that occurs, the regional centers customarily obtain the funding for such placements by attaching the beneficiary's Supplemental Security Income ("SSI") (if he is receiving it) and by having Medi-Cal pay for whatever the beneficiary's SSI benefits do not. However, for the reasons set forth in *Brown*, any RC benefits likely to be actually paid by Medi-Cal are inadmissible. Moreover, pursuant to the provisions of California Welfare and Institutions Code section 4659(a)(2), RC is *required* to pursue recovery for benefits it provides from "private entities" to the maximum extent they are allowable for the cost of services, aid, insurance, or medical assistance to the [beneficiary]." The scope of this provision has recently been addressed by an Administrative Law Judge in his decision relating to the issue of whether a special needs trust constitutes such a "private entity" thereby allowing the corpus of the trust to be attacked by the RC to pay for benefits provided to the beneficiary of the trust.

The Administrative Law Judge in *Artopoeus v. Tri-Counties Regional Center* concluded that, even in the case of a special needs trust, the corpus of the trust was a "private entity" within the meaning of section 465(a)(2). Therefore, the regional center was permitted to seek reimbursement from the trust for benefits it provided.

Accordingly, if Medi-Cal benefits or RC benefits were deemed admissible pursuant to Civil Code section 3333.1, a "double-dip" would effectively be taken from Plaintiff's recovery. The first subtraction would be made by the jury which, upon introduction of the collateral source evidence, would presumably not award those sums as damages to the Plaintiff. See, *American Bank & Trust Co. v. Community Hosp.* (1984) 36 Cal.3d 359, 204 Cal.Rptr. 671, 683 P.2d 670. The second subtraction would occur when Medi-Cal, CCS, and RC subsequently pursued reimbursement. Such a "double-dip" would improperly and unjustly deprive Plaintiff of damages he is legally entitled to recover.

V.

THE DEFENDANTS SEEK TO HAVE THE TAXPAYERS PAY FOR THE CONSEQUENCES OF THEIR NEGLIGENT CONDUCT

When Defendants argue that benefits are available to Plaintiff from various sources "for free," it should be remembered that the funds expended by Medi-Cal, the Regional Center, the public school systems, and CCS do not come out of thin air; they are tax dollars. In suggesting that section 3333.1 should apply to Medi-Cal benefits and RC benefits, Defendants essentially suggest that the damages suffered by the Plaintiff as the result of the Defendants' negligence should be paid by the taxpayers rather than by the Defendants. In that regard, the *Brown* court stated that in enacting section 3333.1, "we do not perceive it was the intent of the legislature to bail out doctors and other health providers by the use of public funds."

VI.

CONCLUSION

Based upon the above, Plaintiffs respectfully request that the Defendants, their attorneys, and all witnesses called by the defense, be prohibited from making any reference to the past or future payment of any of Plaintiff's expenses by either the California Department of Health Services through the Medi-Cal program, the Regional Center of _____ County, California Children's Services, the public school system, or any other collateral source not specifically mentioned in Code of Civil Procedure section 3333.1, pursuant to the Collateral Source Rule.

Dated: KENNETH M. SIGELMAN & ASSOCIATES

By_____
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SUPERIOR COURT FOR THE STATE OF CALIFORNIA

FOR THE COUNTY OF

_____, an Incompetent Person, by and through his Guardian ad Litem, _____,	)	CASE NO.
Plaintiff,	)	**PLAINTIFF'S MOTION *IN LIMINE* PRECLUDING TESTIMONY OF DEFENSE EXPERT _____; DECLARATION OF KENNETH M. SIGELMAN [NO. OF]**
v.	)	
_____, M.D., et al.,	)	
Defendants.	)	**TRIAL DATE:** **TIME:** **DEPT:** **JUDGE:**
_____	)	

TO THE ABOVE-ENTITLED HONORABLE COURT, AND TO THE DEFENDANTS AND THEIR ATTORNEYS OF RECORD:

Plaintiff hereby moves the Court for an Order *in Limine* precluding the testimony of defense expert _____, an annuity salesman, on the grounds that _____'s proposed testimony, which involves the cost of an annuity for Plaintiff, does not constitute proper expert testimony, is irrelevant to any issue properly before the jury in this case, and thus lacks probative value, but would create a substantial danger of undue prejudice, of confusing the issues, and of misleading the jury.

I.

FACTS

This case involves a young man who suffered serious, permanent brain damage as the result of the Defendants' mismanagement of his diabetes at the time he underwent eye surgery at_____ Hospital on April 9, 1999. On November 17, 2000, all parties served their designations of expert witnesses. Each of the Defendants designated _____ as a retained expert.

A. Declarations of Defense Counsel Regarding _____'s Proposed Testimony.

Counsel for defendants _____, M.D. and _____ stated in his declaration accompanying their designation of expert witnesses (Exhibit 1) that:

> _____ is an annuitist and designs structured settlements. _____ is expected to testify on the issue of monetary damages and issues relating to life expectancy. Upon due notice, _____ will be sufficiently familiar with this action to submit to a meaningful deposition.

Counsel for Defendants _____, M.D. and _____, M.D., a Professional Corporation stated in her declaration accompanying _____'s designation of expert witnesses (Exhibit 2) that:

> "_____ is an annuitist and designs structured settlements. _____ will be called to testify in regard to the issues of monetary damages and issues related to life expectancy and further will respond to issues raised by experts designated by the plaintiff. _____ will be sufficiently familiar with the pending action to submit to a meaningful oral deposition concerning the specific testimony, including any opinion and its basis, that he is expected to give at trial."

Counsel for Defendant _____ stated in her declaration accompanying the hospital's designation of expert witnesses (Exhibit 3) that:

> _____ is an expert in the area of structured settlements. _____ is expected to testify with regard to Plaintiff's ability to obtain his claimed damages through a structured settlement. I have not personally spoken with this expert, but understand from counsel for co-defendant that _____ has agreed to testify at trial and upon due notice, will be sufficiently familiar with the action to submit to a meaningful deposition.

B. _____'s Deposition

Upon receipt of the Defendants' designations of experts, Plaintiff served notice of _____'s deposition on November 30, 2000. (Exhibit 4.) That deposition notice requested that _____ produce at his deposition, among other things:

(1) All documents or writings of any kind or nature, as described in the California Evidence Code section 250, supplied to him by any party, including but not limited to correspondence, instructions, memoranda, deposition summaries, depositions, pleadings and medical records or charts of any kind regarding Plaintiff _____;

(2) All original reports, notes, documents, diagrams, or writings of any kind, as described in Evidence Code section 250, prepared during the course of his consideration of the subject matter;

(3) Copies of all articles, studies, and/or research considered, and/or relied upon in arriving at his opinion and/or in preparing his report in this matter; and

(4) His curriculum vitae.

_____ was not produced for his deposition on the date for which the deposition was originally noticed. Defense counsel ultimately agreed to produce _____ for his deposition on March 28, 2001, whereupon plaintiff served an Amended Notice of Taking Deposition of _____ and Request for Production of Documents and Things

(Exhibit 5) requesting that _____ produce exactly the same materials as had been requested in the original notice of his deposition.

On March 28, 2001, _____'s deposition took place. He testified that his formal education consists of a bachelor's degree in teaching and general education which he obtained in 1972. He has no other formal education. He does not purport to be an economist, an accountant, an actuary or an underwriter. He has never had any kind of academic appointment, never authored any publications in his field, and has never done any kind of research in his field. He does have a "life and disability" license from the State of California, which allows him to sell life and disability insurance and annuities. The requirement for obtaining that license was completion of a three (3) day course which consisted of an explanation of "life products, annuity products, disability products" and training regarding the ethics of sales. Since 1980 _____ has run _____, an insurance brokerage of which he is the president. _____ limits its business to providing annuities to personal injury plaintiffs; all of its income comes from the commissions it obtains from the insurance companies who sell the annuities to those personal injury plaintiffs. He has testified at trial as an expert witness once.

_____'s involvement in the present case began when he was contacted by defense counsel and asked to provide some "annuity quotes." He was then provided with some records by defense counsel which he forwarded to various insurance companies to find out what "rated age" each of them would assign to _____. _____ did not bring those records with him to his deposition (although they were requested in the request for production served with the notices of _____'s deposition) and he could not recall what those records consisted of. Additionally, _____ could not remember the names of most of the insurance companies he sent the records to. He testified that he had records that would reflect that information, but he did not bring those records with him to his deposition. He further testified that he thought that there were twenty two of them.

_____ then received faxes from the life insurance companies whose medical underwriters had established a life expectancy for plaintiff, stating the "rated age" each of those companies had assigned to plaintiff, but no other information. He did not bring those faxes with him to his deposition, and could not recall what most of the faxes said. All he could recall about them was that the company who had given plaintiff the highest rated age was _____, and it had given him a rated age of 58. _____ communicated that information to defense counsel, and denied doing any other work on the case (other than attending two voluntary settlement conferences) up until his deposition. He denied having any conversations with any defense attorneys at any time regarding the subjects they would like him to address at the time of trial.

_____ testified that as an annuitist, the only things he is qualified to testify about would be what it would cost to buy a certain stream of payments for a male or female with a certain "rated age", or, conversely, what payments could be obtained for a male or female with a certain "rated age" given a certain amount of money with which to buy an annuity. The way he learns the cost of an annuity, once an insurance company has provided a "rated age" for a particular plaintiff, is by consulting a computer disc provided to him by each of the insurance companies with whom he does business. There is nothing else that he does in order to learn the cost of an annuity. The quotes he gets from these insurance companies are good for only seven days.

_____ initially stated that other than stating that plaintiff's "rated age" from _____ was 58, he has no other opinions which he plans to express in this case. There were no other topics which he had discussed with defense counsel, no notes or reports which he had prepared, and nothing else he had been asked to do.

_____ did also testify that if an annuity had been purchased from _____ for plaintiff as of the date of _____'s deposition, for each $1,000 per

month to be paid out to _____ for the remainder of his life, the annuity would cost $130,174.94. This price quote would be good for seven days – i.e., it will no longer be good as of the date this motion is heard.

_____ has no expertise regarding the safety of annuities as opposed to other investment vehicles. He has no opinion regarding the amount that would have to be invested in any kind of United States government securities to get the same payments to the plaintiff. He has no opinion regarding the relationship between the concept of present cash value and the cost of annuities.

II.

_____'S "OPINION" REGARDING PLAINTIFF'S LIFE EXPECTANCY, AND ANY MENTION OF PLAINTIFF'S 'RATED AGE', SHOULD BE EXCLUDED

At the time of his deposition, _____ testified that he has formulated an opinion in this case regarding plaintiff's life expectancy, which was: "There are two life expectancies for _____. One would be that of a healthy 35-year old male. The other would be a life expectancy, as supplied by _____, of a 58-year-old man." In order to determine the life expectancy for a healthy 35 year old male, _____ merely looked at a chart prepared by the United States Bureau of Health and Life Statistics.

Apart from his erroneous assumption as to Plaintiff's age (_____ is actually 30 years old), _____'s testimony makes it clear that he has no expertise with respect to the life expectancy of the plaintiff, or anyone else. He does not claim to have any special education or training that would make him competent to render an opinion regarding life expectancies. He did not formulate any expert opinion of his own , he simply read a figure out of a table, and read a fax sent to him by some unknown underwriter at _____ stating an "age rating" based upon unknown information, calculated in an unknown manner, by an unidentified person.

Based on this information, _____ should not be permitted to testify that _____'s life expectancy has been shortened by 28 years, nor should he be permitted to testify that some unspecified person at an insurance company has decided that plaintiff's life expectancy has been shortened by 28 years. Any such information would be inadmissible hearsay which is not subject to any exception to the hearsay rule. It lacks foundation, since there is no available information regarding what that rated age is based on, the identity of the person who originally came up with that figure, or how it was arrived at. Moreover, allowing testimony regarding the rated age of 58, under circumstances where this differs from the opinions of the medical experts regarding plaintiff's life expectancy, creates a danger of confusing the issues and misleading the jury, while the probative value of such information is low; any such testimony should therefore be excluded pursuant to Evidence Code section 352. Finally, defendants are apparently planning to have their medical experts testify regarding life expectancy. Thus, allowing additional testimony from this defense witness regarding life expectancy would be cumulative.

For all of these reasons, _____ should be precluded from expressing any opinions regarding plaintiff's life expectancy, or from mentioning to the jury the fax he received from _____ stating that plaintiff's "rated age" is 58, or the faxes he received from any other insurance company giving a "rated age" for plaintiff.

III.

_____ SHOULD BE PRECLUDED FROM MAKING ANY COMMENTS REGARDING THE OPINIONS OF EXPERTS DESIGNATED BY PLAINTIFF

Counsel for Dr. _____, in her declaration, stated that _____'s expected testimony includes his response "to issues raised by experts designated by plaintiff." However, any such "response" should be precluded at the time of trial. First of all, _____ was not provided by defense counsel with any of the depositions of any of plaintiffs' experts; and was

not provided with the "Summary of the Analysis of the Economic Losses Sustained by _____" prepared by plaintiff's economist, _____, although _____'s deposition was taken by the defense over a month prior to _____'s deposition, and the transcript has been available since March 5, 2001. (Declaration of _____, par. 8.) Moreover, _____ stated that he was not prepared at the time of his deposition to express any opinions about any issues raised by any of the experts designated by the plaintiff. He should therefore be precluded from expressing any such opinions at the time of trial pursuant to Kennemur vs. State of California, (1982) 133 Cal.App.3d 907.

IV.

_____ SHOULD BE PRECLUDED FROM TESTIFYING REGARDING THE COST OF AN ANNUITY

_____'s testified at his deposition that after providing _____ with some unidentified materials regarding plaintiff, and after receiving a fax back from_____ assigning plaintiff a "rated age" of 58, he looked up the cost of an annuity from that insurance company for plaintiff on a computer disc provided to him by _____. Apparently, the defense plans to call_____ testify as an expert what an annuity would cost at the time of trial, based on his having looked up this information a computer disc. Any such testimony should be precluded, for several reasons.

First, any such testimony is irrelevant to any issue properly before the jury. Defendants apparently wish to suggest that it is somehow relevant to the question of the present cash value of _____'s future lost earnings and future care needs. However, annuities have nothing to do with present cash value. It should therefore be precluded pursuant to Evidence Code Section 350.

The law relating to present cash value is set forth in BAJI 14.70 (1996 Rev.):

An [award for] [finding of] future economic loss must be only for

its present cash value.

> Present cash value is the present sum of money which, together with the investment return thereon when invested so as to yield the highest rate of return consistent with reasonable security, will pay the equivalent of lost future benefits at the times, in the amounts, and for the period that you find such future benefits would have been received.
>
> The present cash value will, of course, be less than the amount you find to be the loss of such future benefits.
>
> [In the event you have occasion to determine the present cash value of future constant annual economic losses, there is handed to you a table the correctness of which the court takes judicial notice and from which you can determine the present cash value of such losses by following the instructions printed thereon.]

Second, _____'s testifying that he has contacted an insurance company which has informed him what it would charge for an annuity is not proper opinion testimony.

Third, any such testimony is clearly prejudicial to plaintiff, as is the inference which defendants hope the jury will make, which is that the cost of annuity can be used in place of present cash value to measure Plaintiff's future damages. Such an approach is clearly contrary to applicable law as set forth in BAJI 14.70.

Fourth, there is a substantial danger that the introduction of such evidence could confuse the issues and mislead the jury. As discussed above, the cost of annuity is not relevant to the issues before the jury. Allowing evidence of the cost of an annuity to be presented can only suggest to the jury that they should be taking it into account in some manner – thus substantially confusing any issues properly before them. Again, the evidence should be precluded pursuant to

Evidence Code Section 352.

V.

CONCLUSION

For all of the reasons stated above, it is apparent that there is no part of's proposed testimony which is admissible. His testimony should therefore be excluded in its entirety.

DATED:

Respectfully submitted,

KENNETH M. SIGELMAN & ASSOCIATES

By_____
KENNETH M. SIGELMAN
PENELOPE A. PHILLIPS
Attorneys for Plaintiff

DECLARATION OF KENNETH M. SIGELMAN

I, Kenneth M. Sigelman, declare:

1. I am an attorney licensed to practice before all of the courts of the State of California. I have personal knowledge of all of the facts set forth in this declaration, and if called upon as a witness, I could and would competently testify to them.

2. Attached hereto as Exhibit 1 is a true and correct copy of the First Designation of Expert Witnesses by Defendants _____, M.D. and _____.

3. Attached hereto as Exhibit 2 is a true and correct copy of the Expert List of Defendants _____, M.D. and _____, a Professional Corporation.

4. Attached hereto as Exhibit 3 is a true and correct copy of Defendant _____ First Designation of Expert Witnesses.

5. On November 30, 2000, plaintiffs served defendants with notice of the deposition of _____. A true and correct copy of that notice of deposition is attached as Exhibit 4.

6. On March 21, 2001 plaintiffs served an amended notice of_____'s deposition. A true and correct copy of that notice is attached as Exhibit 5.

7. I have reviewed a rough ASCII transcript of the deposition of _____ taken on March 28, 2001. _____ testified to the following: his formal education consists of a bachelor's degree in teaching and general education which he obtained in 1972. He has no other formal education. He does not purport to be an economist, an accountant, an actuary or an underwriter. He has never had any kind of academic appointment, never had any publications in his field, and has never done any kind of research in his field. He does have a "life and disability" license from the State of California, which allows him to sell life and disability insurance and annuities. The requirement for obtaining that license was completion of a three (3) day course which consisted of an explanation of "life products, annuity products, disability

products" and training regarding the ethics of sales. Since 1980 _____ has run _____, an insurance brokerage of which he is the president. _____ limits its business to providing annuities to personal injury plaintiffs; all of its income comes from the commissions it obtains from the insurance companies who sell the annuities to those personal injury plaintiffs. He has testified at trial as an expert witness once. _____'s involvement in the present case began when he was contacted by defense counsel and asked to provide some "annuity quotes." He was then provided with some records by defense counsel which he forwarded to various insurance companies to find out what "rated age" each of them would assign to _____. _____ did not bring those records with him to his deposition (although they were requested in the request for production served with the notices of _____'s deposition) and he could not recall what those records consisted of. Additionally, _____ could not remember the names of most of the insurance companies he sent the records to. He testified that he had records that would reflect that information, but he did not bring those records with him to his deposition. He did testify that he thought that there were twenty two of them. He then received faxes from the life insurance companies whose medical underwriters had established a life expectancy for plaintiff, stating the "rated age" each of those companies had assigned to plaintiff, but no other information. He did not bring those faxes with him to his deposition. He could not recall what most of the faxes said; indeed, all he could recall about them was that the company who had given plaintiff the highest rated age was _____, and it had given him a rated age of 58. He communicated that information to defense counsel, and denied doing any other work on the case (other than attending two voluntary settlement conferences) up until his deposition. He denied having any conversations with any defense attorneys at any time regarding the subjects they would like him to address at the time of trial. _____ testified that as an annuitist, the only things he is qualified to testify about would be what it would cost to buy a certain stream of payments for a

male or female with a certain "rated age", or, conversely, what payments could be obtained for a male or female with a certain "rated age" given a certain amount of money with which to buy an annuity. The way he learns the cost of an annuity, once an insurance company has provided a "rated age" for a particular plaintiff, is by consulting a computer disc provided to him by each of the insurance companies with whom he does business. There is nothing else that he does in order to learn the cost of an annuity. The quotes he gets from these insurance companies are good for only seven days. _____ initially stated that other than stating that plaintiff's "rated age" from _____ was 58, he has no other opinions which he plans to express in this case. There were no other topics which he had discussed with defense counsel, no notes or reports which he had prepared, and nothing else he had been asked to do. However, _____ did also testify that if an annuity had been purchased from _____ for plaintiff as of the date of _____'s deposition, for each $1,000 per month to be paid out to _____ for the remainder of his life, the annuity would cost $130,174.94. This price quote would be good for seven days – i.e., it will no longer be good as of the date this motion is heard. _____ has no expertise regarding the safety of annuities as opposed to other investment vehicles. He has no opinion regarding the amount that would have to be invested in any kind of United States government securities to get the same payments to the plaintiff. He has no opinion regarding the relationship between the concept of present cash value and the cost of annuities.

8. The deposition of plaintiff's expert economist, _____, was taken by the defense on February 28, 2001, over a month prior to _____'s deposition, and the transcript has been available since March 5, 2001.

I declare under penalty of perjury that all of the foregoing is true and correct.

Executed this 30th day of March, 2001 at San Diego, California.

_____
KENNETH M. SIGELMAN, Declarant