In a series of ten articles, Jayme Vaccaro shares her strategies for successful resolution of medical malpractice claims. Article number three focuses on co-defendants.

Ten Strategies for Successfully Resolving a Medical Malpractice Claim

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From never being afraid to try a case – any case – to knowing what ultimately motivates the plaintiff, thinking outside the box and creativity can be a mantra for successfully resolving medical malpractice claims. Getting caught up in pretty file syndrome and rote processes without considering the intangibles of a case can sabotage a good outcome. Missing the elephant in the room and leaving all the power with the plaintiff attorney without realizing how, when and why we surrendered is unacceptable. Take back that authority and explore 10 ways to resolve your medical malpractice claims through these time tested strategies.

Strategy Number Three:

Always know where your codefendants lie and wait; friend or foe

In malpractice actions, the codefendants attempt to avoid pointing fingers at one another. Defendants strive to maintain a unified defense. The theory is once you start attacking your codefendant you make the case for the plaintiff. This can result in letting the plaintiff attorney sit back and have the jury sort out the exposure between the codefendants. Even better, robust finger pointing can lead to a jury finding all the defendants liable.

Knowing the strengths and weaknesses of your codefendant(s) can facilitate a more favorable resolution. While understanding
how to effectively deal with the plaintiff attorney is important, working with a codefendant can be just as challenging and if done successfully, render more acceptable outcomes. A major factor with a codefendant is 1 allocation and 2 apportionment. If codefendants disagree on how much each party contributes to the eventual settlement it can tear them apart. This friction can also increase the value of the settlement for the plaintiff as he enjoys the discord.

Take the codefendant that has a large policy limit vs. the codefendant that has lower limits. Even if the lower limit defendant has the lion share of the exposure, many times the plaintiff attorney will take their limit and pursue the remaining codefendant with the larger limits. Why? It’s much easier to go after the larger limits than go into the personal assets of the other codefendant. Also, most plaintiff attorneys don’t like a reputation of bankrupting physicians or medical groups. Taking the easier target, the large self-insured defendant for example, streamlines the process and ruffles fewer feathers; that is if you are not the codefendant with the large limits.

In addition to 3 policy limit tensions, consider the other types of business relationships that may exist between the individual physicians, their groups and the hospital where the incident took place. For example:

- The codefendant that is in contract renewal with their codefendant hospital;
- Your codefendant is a 4 general partnership and due to how they are legally formed, all the partners are individually exposed in the event of a mega verdict;
- The codefendant medical group is incorporated where the physicians are shareholder employees. The entity is exposed through the labor code for excess losses.
- A codefendant that has experienced an adverse verdict and is apprehensive about trials;
- Your codefendant is a hospital system that is experiencing negative publicity or is risk adverse and wants the case to just go away.

Knowing more than the facts of the case can help you navigate the business and political agenda of the codefendants to your client’s advantage.

Example A
A physician and his group are named in a case involving the failure to diagnose a spinal abscess. There are three other codefendant physicians and their groups named. Throughout the litigation, one attorney

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1 The dollar amount of the settlement or verdict assigned to each of the codefendants.
2 The percentage of the settlement or verdict assigned to each of the codefendants.
3 $1 million per occurrence and $3 million per year is standard policy limits for physicians in California
4 Partners share in both the income and the financial responsibility for losses.
5 California labor Code 2802 requires employers to reimburse their employees for “necessary expenditures or losses incurred by the employee” while performing his or her job duties.
represented the co-defendants. At the end, just prior to the first settlement conference, separate counsel is assigned to the FIVE codefendants—three physicians—two groups.

- What are you thinking if you are the claims person for our physician and his group?
- How do you play your hand with your codefendants?

When codefendants suddenly get separate counsel, there is usually a conflict between them and as a codefendant you strategize accordingly. The pressure this may create for the conflicted codefendant(s) could reduce your share. Many of us have had the opposite result and were left the last man standing only to pay more at settlement.

In our example, the conflicted codefendants paid three times more than the non-conflicted codefendant. The reason being a good temperature was taken on their “panic” as well as effective dealing with the plaintiff attorney (global demand so the plaintiff wanted the matter settled at the same time and he did not care who contributed what). Taking these factors in, the non-conflicted codefendant achieved the best outcome.

Example B
The case involves a catastrophic injury with high medical and loss of earning damages. Your codefendant is a physician and his group. The group is an “asset-rich-intentionally-underinsured-mega-entity.” It also happens to be a general partnership. The codefendant physician is refusing to consent thereby putting great pressure on you, a large self-insured program to settle the case.

How can you put pressure as a codefendant in such a scenario? Is the entity concerned given they are exposed with their low limits, assets and legal make-up? As a general partnership, the partnership is exposed as well as all individual partners. Is the one physician keeping his partnership hostage exercising the right to control the consent over the settlement decision?

Physicians and groups continue to maintain lower limits not withstanding their assets or legal make-up. Plaintiff attorneys may not go after a physician or group’s assets, especially if there is an easier dip into a codefendant’s larger policy limits. The plaintiff may opt to go after the defendant’s hospital or healthcare system. As the codefendant with more to lose (if you are the hospital or even a doctor with significantly higher limits), getting your codefendant’s in agreement to contribute their fair share is crucial to not being the deep pocket.

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6 A court ordered or voluntary meeting among the parties of a lawsuit to reach a settlement. These are often used to learn more about each other’s positions.
Large systems/programs continue to have larger limits. Adjusting their deep pocket outcomes is increasingly important to stay financially healthy. This is especially true when facing a strategically underinsured, legally vulnerable codefendant. All bets were placed on the plaintiff taking low limits, not pursuing assets and a deep pocket. There is a belief among physicians and defense attorneys that you do not want to stand out among codefendants with higher policy limits. Hospitals and health systems have high limits to protect their assets and their employees and stakeholders. As a result, entities need to strategically consider their alternatives. Use of indemnity agreements, bylaws of hospitals that increase minimum limits and other pre-litigation measures also may assist in having your codefendant contribute their fair share. Medical groups can consider partners waiving their right to consent through their partnership agreement.

While your codefendant strategized long before the case, you need to step up your game as you attempt a more acceptable apportionment among you’re codefendants. This is a combination of placing safeguards in place prior to litigation but once in litigation, using all the tools in your tool box and considering the intangibles is a key consideration.

Word to the wise, if the business relationship is valued, negative interactions during the claim need not develop and threaten the relationship. Building collaborative relationships with your potential codefendants well in advance of an incident should be an objective. After all in the end it will come down to people sitting across the table from one another. Above all in the heat of the negotiations they must be professional and respectful. For example, if you and your codefendants disagree on apportionment but you do agree the case should be settled and for how much, then settle the case. Take your differences on apportionment to a separate arbitrator or mediator. Let someone else be the bad guy.

Before closing consider this checklist:
1. Know your codefendants legal structure
2. Learn about your codefendants insurance coverage
3. Think through the economic and political implications for your codefendants and your client
4. Learn about your codefendants’ settlement philosophy
5. Above all remain professional and respectful, long-term relationships matter to you and your clients

In the end, while a case may not go as planned, you can work to raise awareness of the need to redefine the allocation/apportionment found in a claim. Many would say these tensions are best dealt with not

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7 Indemnity agreement is another term for hold harmless, where a party to a contract agrees to make the other party financially whole in the event of a legal action.
8 Details the means and methods by which the organized medical staff governs its members. Insurance requirements are typically defined by the hospital’s governing board of directors.
in the heat of a medical malpractice claim but in the board room: long before and certainly after the claim is resolved. Doing your home-work with insight and perception, while being mindful of the short-term and long-term implications to the business relationship is the best approach to working with codefendants.

Visit next time for strategy #3:

**Use your tools: from \(^9\)high/lows to \(^{10}\)bifurcation.**

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\(^9\) An agreement with the plaintiff where they are assured a minimum payment if they lose and a maximum payment if they win at trial. The tactic reduces financial exposure for both sides.

\(^{10}\) The question of negligence is separated from the damages portion of the lawsuit. For example pleading to negligence and going to trial over damages only.
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Summary

Jayme Taormina Vaccaro has worked in the Risk and Claims field in Healthcare Professional Liability for 24 years. She represents physicians, large groups, allied health providers and hospitals in multispecialty medical malpractice claims. She is a Director of Professional Liability Claims with Sedgwick, Inc. Prior to joining Sedgwick, she served as Vice President of Integrated Risk and Claims with MedAmerica Mutual Risk Retention Group and Assistant Vice President of Claims with TDC.

Training and education

Jayme received her law degree from Lewis & Clark Law School in Portland, Oregon and her undergraduate degree from Cal State. She lives in Lafayette, California.