



‘GOOD FAITH’ STATUTE CAN LEAD TO BAD RESULTS

Amended law causes extensive litigation, dismissal of meritorious cases

By **CHRISTOPHER D. BERNARD**

A medical malpractice lawsuit that lacks merit is a disaster for all concerned parties. Health care providers who are sued are forced to deal with unnecessary expense and embarrassment. Plaintiffs must relive a difficult experience and expend time and money, only to be disappointed in the result. Plaintiffs’ lawyers and insurance companies waste time and money that could be better spent on other matters. Everyone has an interest in having procedures in place to ensure that medical malpractice cases are properly investigated and evaluated before they reach the courthouse.

Requiring a good faith basis for filing a medical malpractice claim, as mandated by Connecticut General Statutes §52-190a, is a useful tool in achieving this

result. Unfortunately, changes made to that statute during the last wave of tort reform legislation have led to an avalanche of litigation and some unintended and undesirable results.

The good faith requirement, first enacted in 1986 as part of extensive tort reform legislation, required that the attorney or party filing a medical malpractice case undertake a reasonable investigation to determine whether there is a basis for a good faith belief that there was negligence in the care of the plaintiff. The statute required that the attorney or plaintiff attach a certificate attesting to this good faith basis for filing the action. The validity of that certificate could only be challenged after the completion of discovery, something that essentially never occurred.

In 2005, the statute was amended to address concerns, real or imagined, that the good faith certificate was being abused. Public Act 05-275 required a letter from a “similar health care provider,” as defined in Connecticut General Statutes §52-184c, be attached to the original complaint as evidence of the requisite good faith investigation. The failure to obtain and file the required written opinion became grounds for dismissal of the action.

The clear purpose of the new law was to more effectively screen out the bad cases, without impeding access to the courts for claimants truly injured by medical negligence. Reference to §52-184c was designed to ensure that before an action was filed, a potential plaintiff would have an opinion from an expert who would be qualified to testify in court that the defendant was negligent.

Despite this laudable intention, an imperfectly worded statute and some creative lawyering on behalf of defense counsel has led to dozens, if not hundreds, of motions to dismiss inundating our judiciary in just the past few years. According to a staff member in the appellate system, this has been the most frequent issue raised in civil appeals in the past year. Presently, there are at least nine cases dealing with expert opinion letters pending on appeal.

Egregious Example

The most troubling aspect of this new litigation is that it has closed the courthouse doors to some claimants with meritorious claims. The most egregious example is a case decided in the Appellate Court last year that is now before the Supreme Court. In *Bennett v. New*

Milford Hospital, 117 Conn. App. 535 (2009), the plaintiff was treated in the emergency department by Dr. Frederick Lohse following a car accident and sent home with undiagnosed fractures in his spine and leg. Dr. Lohse was trained as a general surgeon, practiced in the specialty area of emergency medicine, and was not board certified in any specialty.

The plaintiff’s attorney conducted a pre-suit investigation and, as required by §52-190a, attached a certificate of good faith along with a letter from an expert containing an opinion that there was medical negligence in the treatment of the plaintiff by Dr. Lohse. The expert was a trauma surgeon, board certified in general surgery and surgical critical care, who, according to the affidavit cited by the Appellate Court, practices regularly in the emergency department of a Level 1 trauma center, teaches as a professor of emergency medicine, serves on a number of emergency department committees, and publishes in the field of emergency medicine. After reviewing the expert’s qualifications, the Appellate Court, in something of an understatement, acknowledged that the expert “may be quali-



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fied to testify at trial” on the standard of care applicable to Dr. Lohse. Nevertheless, the dismissal was affirmed.

The Appellate Court noted the incongruity of its holding that a plaintiff who could prove his case at trial cannot get the case into court. The Court stated that it felt constrained to reach this result, which thwarted both the intent of the statute and of our public policy of allowing access to the courts, because of a very narrow and flawed interpretation of §52-184c. The Court relied upon subsection (c) of §52-184c as controlling the determination of a qualified similar health care provider. That subsection applies to defendants who are either: 1) board certified, 2) trained and experienced in a specialty, or 3) hold themselves out as specialists in a particular specialty. Dr. Lohse does fall under this subsection as a physician who holds himself out as a specialist in emergency medicine. But Dr. Lohse, who is not board certified, would also fall within the definition of subsection (b) of §52-184c, which applies to defendants who are 1) not board certified, 2) not trained or experienced in a medical specialty, or 3) do not hold themselves out as specialists. The expert retained by the plaintiff in *Bennett* would clearly qualify as a similar health care provider under subsection (b).

Bizarre Result

The application of subsection (c) to this defendant requires an opinion letter from an expert who is 1) trained and experienced in the same specialty, and 2) board certified in that specialty. Applying those requirements to the *Bennett* facts means that the plaintiff’s expert must be board certified even though the defendant was not.

This leads to the bizarre result that if the plaintiff’s expert had precisely the same education, training, experience, and qualifications as Dr. Lohse, he could not qualify as a similar health care provider for the purpose of supplying the necessary good faith opinion letter. Indeed, Dr. Lohse himself would not be qualified to issue the requisite opinion letter as to his own care of the plaintiff.

Hopefully, the Supreme Court will fix this anomaly when it decides *Bennett*, so that the valid policy objectives underlying the good faith statute can be realized without depriving real victims of medical malpractice of a remedy. In the meantime, prospective plaintiffs are left in a very difficult predicament. It can be very difficult prior to filing an action to even discover the identity of all of the potentially negligent health care providers, let alone

their precise training and experience. While there is still an open question as to whether dismissal of an action is mandatory under the statute, or merely discretionary, the potential exists that a plaintiff who has conducted a good faith inquiry, and obtained a written opinion from an expert qualified to testify at trial, will be locked out of the courthouse with no ability to amend a perceived defect in the opinion letter.

The ambiguities in the good faith statute and its judicial interpretations do not end with the definition of a similar health care provider. There are presently cases on appeal in which plaintiffs’ actions have been dismissed raising a number of important issues. How much detail is required in an opinion letter? Is an expert opinion letter required in an informed consent case? If an expert in his or her own practice treats the condition at issue, can that expert offer an opinion as to a defendant in a different specialty caring for that condition, and under those circumstances what is required to be alleged in the complaint? The courts can expect the large volume of litigation over this statute to continue until these issues are resolved and plaintiffs are given clear guidance as to precisely what is required to institute a medical malpractice action. ■