Practical Strategies for Defense in Malpractice Lawsuit: A Case Illustration

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Abstract- This report describes an unprecedented malpractice litigation on a neurology case. A young woman developed multiple complications after a simple hysterectomy: pan-peritonitis, post-op deep coma with hypotension, generalized anasarca, hyponatremia, hemolysis, cerebral hypoxia and renal shutdown requiring dialysis and multiple-unit blood transfusions. She survived 43 days in Neuro-ICU, and was transferred to a regular ward where she developed status epileticus lasting for 17 hours. On examination, she had cortical blindness, which the plaintiff believed it was caused by prolonged seizures but actually hypoperfusion/hypoxia of the brain did it. Plaintiff's attorneys jumped to a lawsuit for $80+ millions, accusing defendant for failure to stop her seizures. They took the plaintiff to Honolulu and San Diego to confirm brain injury. Results: On the top of calcarine infarct, she has pseudoseizures or malingering. To inflate the claim for compensation, they cleverly included three guardians ad litem as co-plaintiffs who live in U.S. Mainland. The first court battle was denied at Guam Superior Court on the ground of exceeding one year of Statute of Limitation. Cunningly they manipulated clinical course to stretch the date of discovery of damages in order to move the statute of limitation within one year of filing to the court. They then went on to Guam Supreme Court, where it was struck down. Unconvinced, they went on all the way to the Federal Ninth Circuit Court in California where again it upheld the original decision. The plaintiff lost and never reached the trial court.

After two years' legal combat, I have learned hard way defense strategies: (1) Practice defensive medicine, to keep informed consent and tracks of timing of diagnosis and treatment; (2) Avoid factors that may provoke dissatisfaction, anger, or frustration on outcome of treatment; (3) Keep ledger of ambulance chasers and good defense lawyers; (4) Never surrender at the notification from court; (5) Settle out of court, if this can be done reasonably to save time and stress; (6) Keep cool and study carefully the allegations; (7) Consultation with experts in the area involved; (8) Set up trust fund for children; (9) Buy liability insurance and take CME in medicolegal classes.

Key Words: Status epilepticus, Pseudoseizures, Hypoperfusion, Plaintiff, Guardian ad litem, Statute of limitation, Ambulance chaser

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Malpractice litigation, hitherto unheard of on Guam, began to prevail on practicing physicians during the past two decades. Like ten-foot-tall sea hags, fretted by tiny defenseless islanders for centuries, the 'ambulance chasers' on island and off-island have overwhelmed Guam in recent history. In one instance just past, I was almost swept away by the torrents of legal maneuvering forces into the Pacific Ocean, were my able attorney had not come to my rescue.

This is a painful journey of my legal entanglement, in a protracted and expensive malpractice lawsuit. As an ordinary practicing physician, having devoted to help people suffering from incurable neurological diseases in this Western Pacific Isolate, I did not have primer in medico-legal aspects of practice. I was not prepared at all. Here I describe in detail my personal experience in going through the ordeal of this nuisance litigation. The story includes the anatomy of the case, the motives of plaintiffs, clever legal maneuvering and tactics in sneak attacks, and their appeals to Guam Supreme Court and the Federal Circuit Court of Appeal. I hope this writing provides some useful insight in self-defense. (This is a true story, but the characters are fictitious)

King Henry VI, "The first thing to do is to kill all lawyers".

Shakespeare 1965: New York. Cambridge Univ. Press[1].

BACKGROUND

After WW II, U.S. Navy took over control of Guam in 1945. President Truman signed the Organic Act in 1951, relinquishing U.S. Navy control of the government to the civilian hands. Americanization of Guam began - education, health care, banking, and civilian business outside of military compound. With setting up of Immigration & Naturalization Services in 1962, influx of outsiders - Caucasians as well as Orientals, population rapidly mushroomed. Vietnam War debacle in 1974 had brought in more immigrants and Guam rapidly moved into economic boom on one hand, but also became the transport center of drugs from Southeast Asia into US Mainland in 1970s and 1980s.

The establishment of Guam Legislature and the Judiciary System by the civilian government had introduced cumbersome official procedures and red tapes. Naturally the numbers of lawyers and legal personnel had skyrocketed over the years, outnumbering the physicians in a population of 150,000 by year 2000.

Health care system of guam. The ancient Chamorro resorted to folk healers and witchcraft until 1898 when U.S. Navy took control of Guam. The Surgeon General of U.S. Navy reported to the Secretary of Navy on the health condition of the 'La Drone Island' (Island of Thieves) that it was infested with 'hereditary paralysis' and 'syphilis'. In 1901, Navy established a hospital compound in Agana. The postwar health care for the islanders was solely provided free by the Naval Hospital. After relocating to Oka, Tamuning in 1949, the civilian part of the compound was dedicated to war casualties as the 'Guam Memorial Hospital' (GMH). In 1956, a new 100-bed hospital was built over the Oka Cliff line. Later in 1959, additional building was built for Public Health. GMH then had a total capacity of 250 beds, ran by the Government of Guam. GMH accommodated NINDS research on Amyotrophic Lateral Sclerosis/Parkinsonism-Dementia Complex (ALS/PDC) since 1959. It was stricken by financial foes, lack of well-trained medical providers, and equipment. No CT scanner was available until 1982 when NINDS donated a used one. It took 4 years to replace a 4th generation Picker whole body scanner in 1987. Under AMA, GMH received conditional certificate by Joint Commission on Accreditation of Hospitals (JCAH) in 1982, but has never regained it to this date.

It was inconceivable and foolish that I, with my training and experience, would work for this inadequately equipped, understaffed, poorly managed, and money-in-the-hole hospital and get rotten professionally. But in reality I became a jungle doctor in this isolated tropical island thousands of miles away from the mainstream of medicine. I worked half time for GMH and the other half for NINDS research in order to keep up with my training at Mayo and experience with neuro-epidemiology. So I had to perform family practice in addition to basic neu-

rology and research. I became skillful in giving a first aid, splintering fractured arm or leg, or suturing lacerations of trauma cases, head injury from falling coconut or out of moving pick-up trucks. I could even find out that the ethnicity of a victim's assailant by inspecting the injury. I was the only neurologist who could determine brain death of patients in the ICU. I also took care of advanced ALS patients with dysphagia or respiratory failures. I saw many bed-ridden PDC patients with extensive decubitus sores in the sacrum, scapula, both hips and feet with foul smelling juice seeping out constantly. Some were infected with maggots in the undermined edge of sores or ants crawling all over the body in shabby shacks. I sought all kinds of remedies, Western and Oriental, trying to contain the sores in vain, because pressure deprived blood supply and the failing autonomic nervous system crippled body's ability to repair. High protein diet, heat lump, and proteolytic ointment applications did not help either. I learned that fairly effective remedy called Betadine-sugar paste, which was readily available at GMH. Sugar pickles the necrotic tissue and Betadine solution disinfects.

As the officer-in-charge of NINDS, I followed through countless PDC patients. I was able to complete the description of the natural history, which was published in the Handbook of Clinical Neurology in 1986. In addition I began to see Alzheimer's disease and vascular dementia on the rise. I single-handedly continued to monitor the occurrence of ALS/PDC and treat them free of charge at my clinic from 1983 to 1990 when a National Institute of Aging (NIA) grant was awarded to Mayo Clinic to reactivate research on Guam for next five years. The result was no way nearer to the solution of the century-old Guam mystery. However, it was clear that ALS was disappearing from Guam. I reported this in the 35th Japanese Neurological Society Meeting in Nagoya in May 1995. On the other hand, it is sad to see "ambulance chasers" prosper and flourish on Guam in recent years.

This was the story of a jungle neurologist on permanent exile to Guam.

Malpractice lawsuit on Guam. Back in 1960s there were a handful of lawyers on Guam who dealt with immigrations and business transaction. Malpractice litigation was literally unheard of until influx of immigrants and progressive changes in socioeconomic environment. In 1970s, a young lawyer from Oregon tied up with local Atty. L. 'handled' a multi-million real estate inheritance a wealthy Chinese-Filipino businessman left behind. This man allegedly wrote a will to each woman who lived separately in Guam, Manila, Hong Kong and California to receive his estate. It turned out that each one claimed she was his legitimate wife and was entitled to inheritance. Grueling legal battle made these two lawyers pocketed more than 85% of estate and the Oregonian vanished from Guam, according to local newspaper. By 1990, the lawyers already outnumbered the physicians. The malpractice lawsuit against health providers and hospitals has become one of the most significant constraints affecting the health care system of this island. In 1996, Guam legislature passed a law on the Statue of limitation of one year for recovery of damages and mandatory arbitration before litigation in the court.

The judiciary system of Guam patters after California, called English system, which is different from Taiwan, Japan or Europe, which applies Continental system. The process includes:

Step 1. Accusation by plaintiff to the local court;
Step 2. Arbitration by plaintiff and defense attorneys and a neutral third party. If no settlement out of court, then go to
Step 3. Jury trial. The court appoints jurors by random selection.
Step 4. Appeal courts-local Supreme Court and federal circuit court.

Here I describe my encounter with unprecedented multimillion-dollar malpractice lawsuit by a Filipino plaintiff, filled by two notorious prosecution lawyers from Hawaii.

CASE MATERIAL

On 12/24/96, I received a Superior Court of Guam

Order (CV1607-96) to answer an accusation by a Filipino patient for "negligence" in treating her "status epilepticus", which was caused by complications from abdominal surgery. It was in essence asking for a jury trial. The plaintiffs were: (1) the patient's sister, Victoria S. Custodio, individually and as Guardian Ad Litem for Teresita S. Custodio, an invalid, and Benjamin A. Custodio, an invalid father of patient, and (2) her mother, Estrella Hernandez, individually and as the Guardian Ad Litem for the invalid daughter, Teresita S. Custodio and her invalid husband, Benjamin A. Custodio.

The plaintiff Victoria was one of duly appointed Guardians Ad Litem for sister, Teresita and Benjamin, invalid father of Teresita. They all lived in Guam. Plaintiff Estrella Hernandez who lived in San Diego, was other duly appointed Guardian Ad Litem for both Teresitra and Benjamin. The plaintiff's attorney claimed Teresita was so sick that she could not represent herself.

The plaintiff's attorney accusation (CV1607-96) wrote:

On 2/7/94, a hysterectomy was performed on plaintiff at GMH. Following said operation, it was discovered that her bowel had been perforated. Surgery to repair the bowel was performed on or about the early morning of 2/13/94 at GMH.

Due to complications from these operations, she began to experience multisystem failure, and was admitted to the ICU to undergo further procedures. (Defense's note: She in fact went into prolonged coma from septic shocks and hypoperfusion of the brain, which required hyperalimentation, multi-unit transfusions and hemodialysis.)

In mid-March, her health had improved and she was transferred to a regular ward. On or about 3/27/94, she began to have continuous grand mal seizures. Defendant Chen was contacted for the first time to perform a neurological consultation. Chen ordered additional anticonvulsant but did agree to take over the care. The medication he ordered was insufficient to stop the seizures, which continued unabated.

On several occasions later that day, GMH personnel informed me about the unabated seizures. Instead of returning to GMH, he simply telephoned orders for further medication. However, the additional medication did not stop the seizure activity.

The following day, on 3/28/94, Chen returned to GMH and was finally able to stop the seizures, which had continued unabated for approximately 17 hours. As a result of the length of the seizure activity, Chen discovered that the plaintiff suffered severe and irreversible brain damage, including cortical blindness.

Subsequent to the diagnosis of her brain damage, Chen accepted primary care for her follow-up medical treatment. On several occasions, Chen was confronted by further "status epilepticus" (actually a partial seizures), and failed to prevent or stop the seizures in a medically significant or reasonable period of time, causing further brain damage. (False accusation)

Defendant Chen's conduct constitutes professional malpractice and negligence, falling below the applicable standard of care for medical treatment.

As a legal and proximate result of defendant's negligence, Plaintiffs Victoria and Estrella are entitled to compensation on behalf of Teresita's for past and future medical expenses, past and future wage loss, other out-of-pocket expenses, pain and suffering, severe emotional distress and mental anguish, the loss of future enjoyment of life, and other special and general damages allowed by law in the amount of $25 million dollars or in such amount as is proven at trial.

As a legal and proximate result of defendant's negligence, Plaintiff Victoria has been required to provide 24 hour care for patient and has sustained additional injuries and damages, and is thus entitled to compensation for past and future medical expenses, past and future wage loss, other out-of-pocket expenses, pain and suffering, severe emotional distress and mental anguish, the loss of future enjoyment of life, the loss of consortium, society, companionship and affection, and other special and general damage allowed by law in the amount of $10 million dollars, or in such amount as is proven at trial.

As a legal and proximate result of defendants' negligence, Plaintiff Estrella has sustained injuries and damages, and is thus entitled to compensation for past and future medical expenses, past and future wage loss, other out-of-pocket expenses, pain and suffering, severe emo-

tional distress and mental anguish, the loss of future enjoyment of life, the loss of consortium, society, companionship and affection, and other special and general damages allowed by law in the amount of $10 million dollars each, or in such amount as is proven at trial.

As a legal and proximate result of defendants' negligence, Plaintiffs Victoria and Estrella are entitled to compensation on behalf of Benjamin (patient's father) for past and future medical expenses, past and future wage loss, other out-of-pocket expenses, pain and suffering, severe emotional distress and mental anguish, the loss of future enjoyment of life, the loss of consortium, society, companionship and affection, and other special and general damages allowed by law in the amount of $10 million dollars, or in such amount as is proven at trial.

Defendant Chen's conduct is so grossly negligent, reckless, and devoid of any consideration for the rights and safety of Plaintiffs, that Plaintiffs are entitled to an award of punitive damages against defendants in the amount of to be proven at trial. (Exaggeration)

Wherefore, plaintiffs pray for relief against defendants, jointly and severally, as follows:

1. Special and general damages in the amount of $25 million for Plaintiffs Victoria and Estrella on behalf of Teresita;
2. Punitive damages in the amount of $25 million for Plaintiffs Victoria and Estrella on behalf of Teresita;
3. Special and general damages in the amount of $10 million for Plaintiff Victoria individually;
4. Special and general damages in the amount of $10 million for plaintiff Estrella individually;
5. Special and general damages in the amount of $10 million for Plaintiffs Estrella and Victoria on behalf of Benjamin;
6. Costs and attorneys' fees incurred in the litigation; prejudgment and postjudgment interest; and any additional and further relief deemed just and appropriate under the circumstances.

Dated: 12/01/96. Signed by three Attorneys for plaintiffs.

This was filed almost two years after the plaintiff had already filed a suit against her gynecologist on Jan. 1995 (CV207-95), who performed a simple hysterectomy and allegedly caused her peritonitis on February 1994. With the help of two Hawaiian 'ambulance chasers', and a Canadian neurologist as an expert witness, her lawyers filed a similar suit against me. It was about the plaintiff's hypoxic encephalopathy secondary to a month long post-op coma, multisystem failures and cerebral hypoperfusion causing prolonged seizures. They accused me of wrongdoing that I could not stop her prolonged status epilepticus and brain damage.

What an accusation! My lawyer told me this was unprecedented suing for $80 million plus cost and attorneys' fees, and so on. He told me that accusation was nothing but a gross distortion of the fact and threats to dip into a deep pocket.

The followings are my rebuttals:

1. Why should I assume the responsibility of the outcome of a laparatomy and prolonged coma from peritonitis? Consultant provides only suggestions and advice in regard to the treatment of the complication.
2. How could the plaintiff's lawyers dare list every 0.5 living relatives living on Guam and overseas as co-plaintiffs for individual claims?
3. Why do her parents who reside in California need compensation and support? At their age and 'invalid' state, they must have received welfare and food stamps, as well as medical assistance, such as 'MediCal', paid by the US Government. I am sure when they applied for governmental assistance, they had to claim they had no family to support them, or having no income or ability to earn a living - a common practice of the immigrants to this country. So it is a flaw in including them as dependents.
4. How could the lawyer list claims for compensation not only for bodily damages but also for all imaginable psychological and sociological 'sufferings', past, present and future, by every guardian? $80 millions plus litigation fees and interests, which may outlast their life? What a convenient tactic to inflate the malpractice claims.
5. The accusations were gross exaggeration and distortion of the fact, which can be contested in court.

6. The wording of accusation is nothing but threats. The tactics they used were (1) Intimidation of the defendant to settle out of court; (2) Doctor had deeper pocket to go; (3) Strong back-up by an expert witness, a neurologist and good friend of plaintiff; and (4) To take advantage of no capping in the malpractice award by the jury in this country.

Discovery phase I

Attorney Gary Hull was our long time acquaintance and trusted lawyer. He informed me that the case had been going on for over one year against gynecologist who performed total hysterectomy, which unfortunately complicated with peritonitis. Atty. Hull's opinion was that my case could win through, but it might be an expensive, protracted legal battle, needing an off-island expert witness later when the case comes to an arbitration, as required by Guam law.

1. The plaintiff's lawyer was a notorious 'ambulance chaser' on Guam whom I had the first encounter back in 1972 when I was an ER staff at GMH. He wanted me to write a report of a rare-end collision victim and demanded I exaggerate the extent of injury, so that he can collect more from insurance company. (Fresh from graduation, he was literally an ambulance chaser!) He hired two more 'chasers' from Honolulu. They tactfully twisted and exaggerated the fact. They conveniently fabricated the clinical course and the outcome that I was totally responsible for it.
2. Statute of limitation for action to recover damages was one year from the date of discovery of damage[2]. it was beyond one year when they filed.
3. For the next four months, I reviewed over 4,000-page documents including the plaintiff's voluminous medical records at GMH, the off-island medical referral reports, the depositions of all related physicians and nurses, diary of plaintiff after discharge from GMH, and medical certificate from her primary physicians. I meticulously plotted graphics and charts of her clinical events so that I could present her case at Arbitration Board, mandated by Guam law. I consulted with neurology experts whom I have acquainted with over the years from ALS/PDC Research. They were professors of neurology from UC San Diego, Mount Sinai School of Medicine, University of Hawaii, and Mayo Clinic. As I concluded from my own intensive review, the brain injury (cerebral hypoperfusion, prolonged seizures and resultant cortical blindness) had begun long before I was called in for consultation to control plaintiff's status epilepticus.
4. Dr. X, a well-known disruptive physician at GMH, was Plaintiff's family friend, and had closely monitored her entire hospital and outpatient course. He wrote a 48-page inflammatory 'expert witness report' to the plaintiff's attorney to initiate this suit[5]. It was a year and ten months after the plaintiff filed a suit against her gynecologist whom was accused of causing dreadful peritonitis after a total hysterectomy on February 1994.
5. Her recurrent 'seizures' after her dismissal from the GMH Skilled Nursing Facility (SNF) was actually categorized by the experts in UCSD as 'pseudo seizure', which was a polite way of saying malingering. While under the care of the plaintiff's witness and primary care physician, she kept coming back to my clinic with computerized medical records.
6. Plaintiff secretly prepared to sue me by going to Honolulu and San Diego. During this period, she intermittently visited my clinic, asking for certificate of disability to apply for social security benefit and local governmental assistance. Actually she was gathering evidences of damages from surgery. I naively accepted her sister's computerized progress notes and took them as honest observations. Later I discovered that it was a ploy, coached by her attorney and Dr. X to provide evidence of seizure activities after discharge from GMH, in order to extend the statute of limitations of one year from the date of discovery of injury.
7. My attorney decided to file a dismissal petition, instead of surrendering to a jury trial, to the Superior Court on January 7, 1997. He knew there was a Recovery Rule on Guam, which stipulates a statute of limitation of one year from the discovery of permanent damage[2-4].

Clever Legal Maneuvering. Atty. Hull informed me that the plaintiff's lawyers filed an amendment on January 17, 1997 requesting for arbitration as required by Guam Public Law. (It was stupid for them of not knowing arbitration law exists on Guam) They also modified the accusation of negligence to extend into her outpatient period after discharge from GMH Skilled Nursing Facility. Again, this was a malicious legal maneuver. Atty. Hull assured me that things were under control. His strategy was to file for dismissal of the case on the ground that the statute of limitation of one year from the discovery of damage had expired long time ago.

On January 6, 1997, Atty. Hull discovered that the plaintiff went to Honolulu for diagnosis and treatment on January 1995. He received records Drs. R. Taniguchi, neurosurgeon, J. E. Liu, neurologist, and J. G. Camara, ophthalmologist, dated January 8, 1995. This was the very date of discovery of damage; if the court did not accept the day I informed them of cortical blindness on March 30, 1994. These experts all agreed that the plaintiff was a case of brain hypoperfusion during protracted post-op. complications, and she had eventually stroked out, resulting in cortical blindness and status epilepticus. I searched for evidence that she stroked out before I was called in to stop the seizures. Oh, lo and behold, the plaintiff's CT scan taken 16 hours before I came in showed definite evidence of cerebral infarct, i.e. hypoperfusion of the brain, in the occipital lobes.

On March 6, 1997, my attorney sent me four documents he obtained as the exhibits at Dr. Sison's deposition. One from Sison was a certification of plaintiff's permanent disability dated 10/12/94. One was a reply letter from Dr. Evelyn Tecoma of UCSD Epilepsy Center for consultation dated 12/17/96. The third was a report from Dr. Mark Kritchevski of the Neuro-behavioral Center dated 2/19/97. They had slightly different diagnosis on visual problem - instead of Anton's syndrome, they called it Balint's syndrome, which is characterized by (1) cortical or psychic paralysis of visual fixation; (2) Optic ataxia - unsteady eye movement; (3) Disturbance in visual attention with preservation of spontaneous and reflex eye movement. In addition, plaintiff showed true seizures, pseudoseizures, and significant functional overlay on both mental and neurologic examinations. Dr. Kritchevski commented that were it not for neuroimaging tests, he would suspect that the patient had entirely or predominantly functional illness. These reports indicated: (1) Date of discovery of brain damage was as early as 10/12/94; (2) If she was truly faking her seizures and visual symptoms, she must have been coached to do so. When I examined her eyes, her eyes kept moving around. She must have fooled ophthalmologists in Hawaii and San Diego. They thought she had Balint syndrome, which can be easily imitated or faked.

Discovery phase II

Analyzing the case, the following evidence-based facts were discovered:

1. Inpatient Clinical Course. A young woman with menorrhagia had a simple hysterectomy, which post-operatively complicated with peritonitis. The condition turned sour after extensive 'clean-up' laparatomy by another surgeon and ended up in prolonged coma, septic shock, respiratory distress, and multisystem failures. In fact, she had severe low serum osmolality from hemodilution, hyponatremia, metabolic acidosis and generalized anasarca, which her surgeon and consultants ignored. She was under intensive care for 33 days requiring multidisciplinary consultants. It included life-saving measures such as Dopamine drips to combat shock, ventilator and, chest tubes insertion, hemodialysis, multiple blood transfusions for G-I bleeding, hyperalimentation, and intravenous infusion of mega dose 4th generations antibiotics. It is well known that the prolonged use of closed-control ventilator in a patient with profound shock from multisystem failure will end-up in a 'ventilator brain' - softening of the brain. This in turn compromises the posterior cerebral artery circulation to the occipital lobe of a patient in a prolonged supine position, thus resulting in occipital cortex infarct. During this critical stage in ICU, neurological consultation was never called. As a result, she developed hypoperfusion syndrome, which passed unnoticed until she began status epilepticus after she was transferred out of ICU. It was her 44th days in hospital when I was called in to help. It took

17 hours to stop the seizures. Two days later on March 30, 1994, the patient and her sister were notified that she had cortical blindness as the result of stroke and seizures. She slowly recovered from a moribund state. She was then transferred to SNF on April 18, 1994 and discharged on May 13, 1994. During this period at SNF, her friend neurologist, Dr. X took over the case and discontinued the anticonvulsant. As a rule of hospital procedure, the doctor-patient relationship ended when she was discharged to SNF, or when the other physician took over treatment.

2. Outpatient Clinical Course. The plaintiff's primary physician referred to my clinic on May 16, 1994, two days after discharge from SNU. In her return clinic visits, she always wore large dark sunglasses and described various kinds of scintillating scotomata. I was impressed by her knowledge of the syndrome of cortical blindness as well as her ability to exaggerate her description. She then began to complain bizarre seizure activity, for which I had to put her back to anticonvulsants. Strangely, the heavier the dosage, the more "seizures" she described. An EEG was negative for seizures. But some cortical activity over the occipital lobes was noted to respond from photic stimulations. She revisited three months later on October 14, 1994 and again on November 26, 1994. In fact she was already preparing to sue me and went to Honolulu for further consultation with various experts on January 1995. On March 25, 1995 she was readmitted to GMH under her primary physician's care for more seizures. I was not consulted. Then on April 2, 1995 she suddenly showed up again with dark glasses, and right in front of my receiving nurse, she had a bizarre seizure, which was grossly hysterical. Her last visit was on May 2, 1995, still having bizarre visual symptoms and seizures, she claimed. Her sister, a co-plaintiff, turned in long lists of meticulously recorded clinical events in computer printouts to be included in her medical records from June 1994 to March 1996. I believed it as a genuine description of her condition, but it turned out to be a trap to make-belief that I am still responsible for her cortical blindness and subsequent seizure disorder. On November 22, 1996, Dr. X, who apparently had been advising her all along, referred her to UCSD Epilepsy Center. Each time when she went off-island for consultations, I, as her sole treating physician as they claimed, was not informed. I was innocently, or stupidly, tried to help her all along by Hippocratic oath. In this case, it was evident that (1) The doctor-patient relationship ended on August 1994; (2) Honolulu consultation on January 1995 confirmed she had cortical blindness but mentally not incompetent; and (3) San Diego consultation confirmed she had had pseudoseisure, not genuine epilepsy, and was malingering.
3. She also sued GMHP, her insurance carrier, and had collected $800,000; assistant surgeon for hysterectomy who settled for $25,000; and her primary doctor who referred her to the gynecologist and settled for $10,000. For the accused gynecologist, they sued for $25 million. For my case, the ambulance chasers cleverly created three more ad litem plaintiffs legally invalid family members whom the plaintiff allegedly obliged to support and demanded $10 million for each, and $50 million for the damage - a total of record $80 millions, plus cost and attorneys' fees in the litigation!
4. A close friend of the plaintiff. Dr. X wrote 48 pages of "expert witness"[6] for this lawsuit. He is a Canadian neurologist who wrote a hit research paper in 1964 and then spent 12 years in Micronesia. In 1983, he landed on Guam when the NINDS research center on Guam had just announced its closure. He took a VA job first, but got interested in ALS/PDC research. So I introduced him to my friends at NINDS. Quickly, he became an instant expert on AL/PDC. After several years, he was fired from VA. GMH then hired him as medical staff in 1986. He was non-compliant to medical staff's bylaws where he was known as an impaired, disruptive physician.

Then in 1991, Dr. Leonard Kurland of Mayo Clinic, the principal investigator to reactivate ALS/PDC research at University of Guam, hired him (by mistake, he told me in 1994) as the regional research director. University of Guam (UOG) received $330,000 per year for next 5 years from National Institute of Aging (NIA). Dr. X also received local appropriation from Guam Legislature to be added to

the research coffer. Unfortunately he could not carry out the required research protocols and wanted to keep the local appropriation for his own use. During the International Symposium held at Okura Hotel on 2/1992, he invited a local anti-federal activist to denounce the ALS/PDC research. He then moved out UOG lab without resignation, but tied up himself with Univ. of British Columbia team. He shipped out without NIA approval a number of valuable research specimens to Canada and England at the expense of Guam research budgets. On April 1994, he was formerly fired. In anger, he accused UOG of conspiracy and discrimination and asked the Guam 23rd legislature for an oversight hearing[6]. On October 3, 1995. It transpired that, in his preoccupied ideation that nobody but him could conduct medical research on Guam, and I was in his way all along. He turned to this lawsuit in apparent personal vendetta or revenge for his research setbacks.

5. Plaintiff's tactics. Summarized here are four vicious and deceitful legal maneuvers: (1) To add weight on plaintiff' claims, her lawyers created three 'invalid' guardians ad litem on November 23, 1994; (2) The plaintiff singled me out among half a dozen treating physicians as solely responsible for plaintiff's damage, and filled the suit separately at a later date, because her expert witness' 48-page report came in late; (3) Knowing the statue of limitation was long over, the plaintiff maintained that the date of discovery of the damages was on February 1996 after the report from Dr. X. This was of course a lie. In fact, I personally informed her sister, Victoria on March 30, 1994, and again did the consultants in Honolulu on January 1995; (4) To stop the clock of one-year statue of limitation, the plaintiff argued that she was mentally 'insane' which could make the commencement of litigation tolled. Actually the plaintiff was very smart to fake and exaggerate her symptoms.

Dr. X's fateful deposition. As part of discovery process, on 3/8/97, my attorney arranged to depose the plaintiff's witness. The discovery deposition found:

1. In the 48-page 'expert' report to plaintiff's attorney on November 1996, he accused me of negligence and substandard treatment, etc. It was inflammatory and so 'convincing' that Plaintiff's lawyers were confident they had the case[6]. It was discovered that he was not only an impaired physician at GMH, but also disruptive researcher at UOG.
2. Dr. Tecoma of UCSD suspected the Balint syndrome and pseudoseizures on the top of visual seizures. She recommended perimetry and neurobehavioral consultation.
3. Dr. Kritchevski of the neurobehavioral Clinic, UCSD, reported on February 27, 1997 a major depression and "significant functional overlay" in both mental and neurological examinations, meaning that she had a possible hysteria or malingering.
4. When Dr. X was asked about Kritchevski's report, he was furious, face turned red, wielded his fists and yelled: "I am not aware of the report. (He was lying). This is the most irresponsible report I have ever seen for a professor to write such a conclusion. I am just appalled. It is totally absurd and irresponsible. I will go after him".
5. Dr. Camara of Honolulu Eye Clinic reported on January 1995 was correct. He suspected functional overlay on visual disturbances. The electroretinogram and pattern shift visual evoked potential were normal. So was the EEG here at my clinic; she had fairly good response from photic stimulations, meaning that her visual cortex was not bad. While she visited my clinic from February 1995 to February 1996, she always put on dense sunglasses and was reluctant to remove them for my examination on the ground that she was photophobic! After an examination, she showed a 'searching nystagmos of the miners'. This was not a real Balint's syndrome. I also saw her seizures at the clinic. They were really bizarre, focal or partial seizures in front of my nurse.
6. After grueling questions by my skillful attorney on the details of alleged mismanagement, he did not know plaintiff's body weight and proper dosage of anticonvulsants. Nor did he know supplement medications other than Dilantin. All he could answer was standard 1000mg Dilantin IV loading followed by 5mg/kg/day as maintenance dose in an otherwise healthy epileptic. He continued to accuse me of 'substandard treatment' that resulted in her cortical

blindness, without knowing that in any severe brain-injured case, no amount of anticonvulsants could stop the seizures - just like the cases with post-cardiac arrest cerebral hypoxia or purulent meningitis, or severe cerebral contusions, it is impossible to stop seizures. He could not even tell the difference between cerebral infarcts and hypoxic encephalopathy, or the adverse effects of prolonged metabolic acidosis, renal failure, hemolysis and hypoperfusion, hyponatremia, brain edema, and prolonged use of most potent fourth generation antibiotics and so on. With a body weight of only 42 kg on March 16, 1994, the dosage of 500 mg ordered by Dr. Basilio plus 200 mg by me were adequate. He categorically admitted that he could not do better if he was called in to treat her and I did nothing substandard or wrong in treating her that day. Incidentally. Dr. X was on hospital back-up call that day when I was not available that morning.

7. At the conclusion of deposition, Dr. X approached me in red-shot faces and wanted to shake hand with me. My attorney intercepted, telling him: " Doctor, if you has something to say to him, you should say it in front of me." He then said: " I had no intention to hurt you, Dr. Chen. It was for neurological science's shake." implying that it was an exercise in critical care in neurology. Atty. Hull smiled and said: "Dr. X was our best defense witness."

A shot in my arm. The following week on March 14, 1997, Dr. Taniguchi decided to help me defend all the way. He cautioned me: (1) Dr. X was 'passionate' with the patient, just like he did for ASL/PDC patients. At the trial, the jury may quickly pick it up and sympathize on the plaintiff; (2) It was wise to insist that the plaintiff had cortical blindness, rather than watershed zone infarct or anoxia in hypocampus or cerebellar deep folia. When blood pressure drops, these areas receive insufficient blood supply, resulting in ischemia. It would make no difference when it comes to a witness stand; (3) The conclusion was to emphasize on her pre-seizure status where she had already infarcted occipital lobes; and (4) The reports from UCSD were correct and on our favor.

Two weeks later, Dr. Perl arrived from New York. He found that, in addition to an acute dilutional hyponatremia, septic shock during exploratory laparatomy for peritonitis on February 13, 1994, she continued to have hypotension despite of continuous Dopamine IV drips for over one month, which resulted in peripheral vasospasms. This in turn led to the prolonged hypoperfusion of the brain and renal shut down. The critical condition persisted even after she was moved out of ICU while continued to have hemodialysis. The status epilepticus on March 27, 1994 was only the symptom of cerebral insult. This was proved by the daily vital sign charting and the CT scan of her head at 1:35 PM the day before, which indicated hypodensity over the right parieto-occipital lobe. It was exactly 16 hours before I arrived to take care of the convulsions! Dr. Perl was kind to offer to be my defense witness. Atty. Hull tape-recorded his statement and asked to present in HNL in June if the arbitration takes place.

Prof. Wiederholt of UCSD told me on 4/16/97, that Dr. Kritchevski's diagnosis of 'pseudoseizures' was actually a gross malingering. Drs. Kritchevski and Tecoma were his Department Staff. When he reviewed the CT scans taken on 3/16/95, the day before I was called in for consultation, he confirmed that there was occipital infarct prior to my arrival. He smiled and assured me that there was no case that I was responsible for her brain damage.

Renewed allegation. On March 21, 1997, two weeks after his fateful deposition, Dr. X wrote two-page notarized affidavit to plaintiff's attorneys[7]. It literally repeated his malicious accusations and adding my treatment for her subsequent seizures on Feb. 1995 up to February 1996 was also negligent resulting in additional injury and I failed to treat her pseudoseizure and functional problems properly. In fact, he took over the case on 4/96 and referred her to UCSD.

This additional affidavit was intended to (1) abrogate his admission at deposition of no wrongdoing on my part in his deposition, (2) provide a basis to extend my responsibility beyond the plaintiff's hospitalization in case the court agrees no negligence, and (3) push forward the date of discovery of damage to February 1996.

It was tantamount to a perjury under oath. What a slick psychopath with split personality! What a cunning legal maneuver by the ambulance chasers!

My friends, doctors and attorneys told me that I could sue Dr. X for defamation and collect all my loss in terms of attorney's fee and clinic practice, because I had all solid evidence that he was an impaired or disruptive physician. A professor from UCSD once wrote: "He was the epitome of ruthless person who had blatantly, for his personal gain, abused the trust in him by patients, research subjects, and colleagues. In so doing, he had inflicted serious and permanent physical and psychological harm. He had violated all ethical and moral standards expected of a physician and researcher. In my 40 years as a physician and researcher I have encountered my share of bad apples. None was as rotten as he".

Landmark decision

At 11:30 a.m. April 29, 1997, Atty. Hull informed me that he received Judge Manibusan's Decision and Order. It threw the case out of court on the grounds that 1. The statute of limitation of ONE year from the date of discovery of injury has expired: 2. Plaintiff was not insane, and 3. The doctrines of continuous treatment and continuum of negligent treatment do not apply in this case; The Judge on 6/05/97 wrote an amendment on the decision and then the final judgment in favor of the defendant on 8/26/97. IT WAS A MONUMENTAL DECISION - the first ever in malpractice litigation on Guam. It was a 38-pages document with detailed analysis and discussions based on facts and on precedent U.S. courts decisions. It pointed out that the plaintiff was trying to deceive the court in presenting her erroneous conclusion in setting the date of discovery as late as February 1996, the date she ceased to see me[8-11].

I thought five months' ordeal was finally over. I had been under tremendous stress going through the self-analysis of what I had done wrong that the plaintiff's lawyer sought to make a fortune out of me. On many occasions, I was discouraged and deeply depressed. My performance as the neurologist had waned. The ordeal had overturned my self-confidence and stirred up a self-doubt from the deepest foundation of my conscience. It seemed that my forty years' specialty practice, continuing medical education in advanced neurological science, and strife for higher professionalism and decency were all futile and worthless.

Appeal to the Supreme Court of Guam

Unconvinced by the Superior Court's decision, the plaintiff appealed on 9/12/97 to the Supreme Court of Guam. It was within 30 days of judgment as required by law. My attorney had to ask an off-island specialist in appellate court to write an appellee's brief on December 31, 1997[12].

Meanwhile the ambulance chasers repeatedly contacted my attorney for settlement out of court. The appeal was actually another legal maneuver and continuing tactic of intimidation by the plaintiff. I flatly refused and determined to fight on.

The plaintiff's contention was that:

(1) The tort of one-year statute of limitation should be nullified because she was mentally 'insane' which stopped the clock the moment she was diagnosed 'insane'. Cunningly citing California law precedents, her lawyer insisted that the court was obliged to extend the statue of limitations, for there was no Guam Law defining it on actual case basis.
(2) The date of discovery was not March 29, 1994, nor January 1995 when Honolulu experts told them, because of being "insane".
(3) After returning from Honolulu, the plaintiff continued to see me for control of her seizure, (although there was 5 months' interruption), physician-patient relationship is legally still binding until February 1996 when her clinic visit was terminated. Therefore the date of discovery should be February 1996.

My attorney had to ask an off-island specialist in appellate court to write an appellee's brief on December 31, 1997.

The rebuttals were:

1. The date of discovery in bodily injury was clearly not later than January 1995. The plaintiff's attorneys tried to fool the court by stretching her outpatient visits as continuation of problems from her hospital days.
2. Dr. X could not tell the difference between genuine seizure, psychogenic seizure, and myoclonic seizures. That was why he kept telling the plaintiff continued to

have 'status epilepticus' extending into 1996.
3. He discontinued Dilantin on April 1994 while she was in SNF and thus he had ever since been her private physician. This was the exact reason why I did not follow up her. After discharge from SNF, the plaintiff developed several seizures on February 1995 for which she was admitted briefly because Dr. X discontinued her anticonvulsant. Strangely Dr. Sison referred her to my clinic after dismissal from the hospital, although he knew Dr. X was following her. Probably. Dr. Sison did not trust Dr. X.
4. On June 15, 1994, the plaintiff asked for EEG tracing done on 6/11/94 without explanation, and then, late on December 1994, without informing me, she took off to HNL for further opinion. HNL was the home base of plaintiff's ambulance drivers
5. The HNL visit confirmed she had cortical blindness and visual hallucination, but could not confirm that status epilepticus on March 27, 1994 was the cause.

I attended the hearing by three Supreme Court Judges on Judge Manibusan's summary dismissal of the case on January 18, 1998. Each side was allowed fifteen minutes for arguments. My attorney very succinctly presented evidence that an appellant who could malinger was NOT insane, as that was the opinion of several US mainland expert consultants. The three judges asked no questions. Appellants' attorney spent over 25 minutes in argument, and when he was asked by one of the Judges the legal bases for malpractice litigation to continue on a la carte indefinitely whenever a new damage was discovered, he was shaky and unable to answer. My attorney, however, cautioned me that there was a remote possibility that the plaintiff might appeal to the 9th circuit court in San Francisco.

Supreme Court's Decision on February 17, 1998, affirmed the Superior Court's decision[12,13]. Yes, we won, and the case was closed. My attorney congratulated me and said that this affirmed the landmark decision in the history of Guam malpractice litigation.

In a 38-page Opinion, the Supreme Court ruled and affirmed the Trial Court's grant of summary judgment to defendant:

1. Guam Code Annotated #11404 applies to tolling provision only those who are insane and not to anyone who is mentally incompetent but not insane.
2. The fact that a guardian ad litem was appointed for plaintiff does not conclusively establish that she was incompetent.
3. Even if the court holds that she is "insane" under the statue, her insanity did not exist at the time the cause of action accrued.
4. The appointment of a guardian ad litem ended any tolling of the statute of limitations.
5. Even if Guam has a discovery rule for its medical malpractice statute of limitation, plaintiffs failed to timely file this action.
6. The continuing relationship rule has not been adopted in Guam. Even it does exist, it does not extend the statute of limitations in this case, because the plaintiffs were not relying totally on the defendant after June of 1994 and defendant did not provide continuous treatment for Teresita.
7. Exception for continuous negligent treatment, which causes continuing damage, has not been adopted in Guam and, even if it does exist, it would not toll the statue of limitation under the fact of this case.

Appeal to the Ninth Circuit Court

As expected, on 4/17/98, the ambulance chasers filed another appeal to the 9th Circuit Court of Appeal in San Francisco[14]. The mentality of the ambulance chasers was that they did not trust the judicial system of Guam. It entitled: "Petition for Writ of Certiorari", a legal term no body can understand, but for sure I had to spend more money in my defense. With the help of an Oregon attorney specialized in argument at appellate court, a response to the petition for Writ of Certiorari was received on 6/98. The Ninth Circuit Court response upheld Guam Supreme Court's decision[14].

The 9th Circuit Court's conclusions were:

1. Guam Supreme Court had the authority to interpret Guam Statute.
2. Plaintiff was not insane and Guam statue of limitation was not tolled by her physical incompetence.
3. The Guam Supreme Court correctly applied the Discovery Rule.

Yes, I won again and it was final!

There was no professional experience more exasperating than for a physician to be involved in an unjust lawsuit against his professionalism. My attorney congratulated on me that it was all over. Well, I would like to believe it, for I was still shaking. Thank God that I have endured the ordeal. The total legal expenditure was $60,000. Many of my colleagues and mentors who had gone through the ordeals of malpractice lawsuits agreed with King Henry VI of medieval England, "The first thing we do, lets kill all the lawyers"[1].

Dr. X's setback in Deposition and Legislative oversight hearing, and loss in this lawsuit made him overtly attack UOG research center. The president of UOG wrote a letter to him stating that if he continues to write derogatory letters and interfere with UOG research activity, he was prepared to take a legal action. We have never heard from Dr. X again. A Chinese proverb says, "A mad dog frets beating".

DISCUSSION

I have endured the ordeal of this legal entanglement that lasted almost two years. I have no idea how long it would take if I lost this first battle. I have given serious thoughts about the ramifications of malpractice in general and myself in medical practice. My profession is supposed to be one of the most admired and respected with a noble mission to help sick people in need, but often ended up as a victim of predators.

Prolonged entanglement of malpractice like this case has inflicted tremendous emotional stress on the defendant. Unless insurance company will devote to comprehensive defense strategy, it is a pain and suffering, mental anguish, loss of income as well as life-long saving if defeated in the trial. Enjoyment of life or commitment to community welfare as a physician will no doubt be affected while going through arbitration and trial court. Litigation amply sets forth more constraints on the health providers and in the long-run restricts attempts to national health care system reform.

There are many questions that no one seems to know the answer. Who would protect physicians? How about Individual practitioner to go to law school? The local medical association is usually powerless. How about the National Medical Practice Board to gear up enforcement of professional discipline, instead of policing by greedy lawyers? How good or competent is the jury system? They are selected randomly from the community, who are no necessarily knowledgeable in medicine and ethics. What happened to the Tort Reform introduced by the Congress years ago? Who would police the lawyers? It is inconceivable that a good lawyer would go after their bad apples. The problem, which never goes away, is that any malpractice lawsuit, whatever the outcome, is not only expensive but also threats to physician's professional integrity[15]. Not to mention personal adversity, which no body wants[16,17].

A reputable law professor claimed he has long supported a no-fault medical malpractice compensation remedy and drafted such a remedy to the New York State Special Advisory Committee on Medical Malpractice in 1976. What happened to that proposal? What would happen if the lawyers, and physicians alike, were paid by hourly fees, not by a third or more of the award by the jury? The trouble is that the legislators are lawyers, and there is no 'conflict of interest' in their dictionary. This is a never-ending game of predator and prey[18].

CONCLUSION

Once in my life time, I have learned important and useful lessons:

(1) Practice defensive medicine. Remember that when treating a seriously ill patient, always keep in mind of possible future malpractice litigation when things turn sour. Documents in terms of diagnosis, timing of diagnosis and treatment, and informed consent for any procedures must be done properly;
(2) Avoid factors that may provoke dissatisfaction, anger, or frustration on the outcome of the illness;
(3) "Know thy enemy" is an indispensable rule, which may require research and private detective;
(4) Keep ledger of ambulance chasers and good defense attorneys, and all malpractice litigation in the Medical Society files;
(5) Never be intimidated and surrender at the notification from the court. Remember the accusation is nothing but allegations, which can be contested or a threat in

order to force defendant to settle out of court;

(6) Keep cool, study the allegation thoroughly, and search for defense tactics before surrender. Understand that there will be long, painful process of 'discovery' of the facts, which involves depositions and consultations with experts in the field;

(7) Prepare defense budgets, which may run astronomical;

(8) Set up trust fund for children in case the lawsuit is lost. Otherwise, the life-long saving can be wiped out;

(9) Maintain a list of all "ambulance Chasers" at professional organizations as warning for the practitioners;

(10) Buy professional liability insurance. Though expensive, it will save time in preparing for defense. Unfortunately, it was not available on Guam. Lastly;

(11) Medical school should adopt a curriculum in medicolegal education or CME in medicolegal classes by Medical Society.

ACKNOWLEDGEMENT

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