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Medical-care issues that can kill your personal-injury case

Don't let defendants try to use malpractice as a shield to defeat your case

Personal-injury cases almost always involve medical issues, and there are many traps for the unwary, particularly when the quality of the medical care is at issue.

Virtually without exception, any injury case with substantial damages will become entangled with medical issues. There will always be issues of how to maximize the economic damages, usually dependent on numerous, sophisticated medical analyses. If medical malfeasance is even colorable, it will be necessary to protect the noneconomic damages from being decimated by: (1) MICRA; and (2) Proposition 51, which is (mis)interpreted in the *Henry* case (*Henry v. Sup. Ct.* (2008) 160 Cal.App.4th 440) and usually (mis)characterized by the defense.

Of course, the PI defendants often will point to medical defendants or medical empty chairs to avoid blame altogether. At other times, you will be enticed to add medical wrongdoers to your case.

You should generally quash these impulses to add medical defendants. It often behooves you to avoid having medical defendants, particularly if they are MICRA-qualifying medical defendants. However, it takes substantial prospective analysis and planning to avoid creating viable empty chairs, being forced into a MICRA situation unnecessarily, and to avoid medical causation arguments that may obviate totally the personal-injury claim (e.g., as a superseding cause).

At other times, however, the facts will be such that the case will fail unless it is primarily a medical malpractice case. This usually occurs when there is weak liability or weak damage availability against the PI defendants (e.g., an automobile accident with no insurance coverage for the PI defendant).

Making these decisions early in your handling of the case is essential to avoiding litigation catastrophes. The best decisions require an ability to recognize the potential liability issues and having knowledge of how to protect and strengthen the personal injury liability aspects of the case as necessary and appropriate. It also requires knowledge of multiple areas of law to enable you to maximize and protect your case's damages.

Liability issues

There are innumerable ways that health-care providers become a part of a PI case. As to becoming potential defendants, there are two common scenarios.

First, the PI defendant may attempt to blame a provider treating the plaintiff before the incident for a prior health condition. Our firm recently had a case where a 40-year-old man with a preexisting heart condition had a cardiac arrest while playing basketball in a health-fitness facility. As often occurs, the defense in that case pointed at the previously-treating cardiologist for inappropriately treating the heart condition.

Second, and far more commonly, PI defendants seek to place blame on subsequent treating medical providers (treaters). Almost all instances of serious injury require medical care; whenever possible, the original-wrongdoing PI defendants will seek to attach blame to the subsequent providers.

The shrewd PI defense counsel often will claim that prior or subsequent medical care has broken the chain of causation. This is particularly true when the medical condition precedes the personal-injury tort. It also occurs when, arguably, there is egregious care, which the PI defendants will seek to portray as a supervening cause.

It is in your and your client's best interest to avoid making claims against these prior or subsequent treating medical providers. Shrewd PI defense attorneys may use a plaintiff's claims against these defendants, and even a plaintiff's complaint that includes medical claims, to argue the extreme or obvious nature of the malpractice, using the complaint's advocacy language to assert the case was sufficiently egregious to be a supervening cause.

It will typically seem appealing to pursue claims against apparently wrongdoing medical practitioners. However, there are numerous advantages to refraining from doing so. Besides avoiding the harsh effects of MICRA and Prop 51, these advantages include: (1) avoiding multiple defense experts on liability and causation; (2) having greater ability to use the inculpated and more subsequent medical practitioners to undermine the PI defendants' liability theories and support plaintiff's theories; and (3) having as your opponents less medically-sophisticated defense attorneys, and thereby more poorly prepared defense medical experts.

The decision on whether to bring in medical defendants requires early strategic planning. Even if you forego doing so, defense counsel may always cross-claim or merely point to the empty chair. Early decision-making on your part not only will enable you to propound effective discovery to limit defense counsel's ability to lay blame on the medical providers, but will also enable you to obtain more favorable testimony from the medical providers.

Protecting and strengthening your liability case

There are numerous methodologies available to strengthen the liability case against PI defendants and to minimize the strength of the case against potential medical defendants.

See Heimberg, Next Page

Journal of Consumer Attorneys Associations for Southern California
ADVOCATE
March 2014 Issue

First, use the natural tendencies of prior and subsequent treaters to defend themselves to strengthen your case. There is little doubt you can persuade potential medical defendants whom you have *not* named to save face or cover their backsides while minimizing the wrongdoing and undermine causation regarding their own conduct.

These treaters will help identify issues and already will be friendly with prior or more subsequent treaters. Such treaters are generally from the same institution or are in some way aligned with the caregivers at which the PI defendants are pointing. For example, a cardiologist who works primarily at a particular hospital will almost invariably be glad to help defend an emergency room doctor, ICU doctor, or nurses from the same institution. As a bonus, you will get the opportunity to see just how easy medical-malpractice defense attorneys have it.

Next, you can take advantage of the relative lack of sophistication, particularly medical sophistication, of the PI defense attorneys compared to med-mal defense attorneys. You can further this advantage by consulting with experienced plaintiff med-mal attorneys or even friendly med-mal defense attorneys. They will be able to spot the issues for you, obtain superior medical experts, and likely be familiar with any opposing experts that the PI defendants eventually designate. They can enable you to prepare your own medical experts more effectively.

More importantly, early on they can help you analyze the strengths and weaknesses of your medical case versus your personal-injury case. This assistance can range from analyzing medical records to identifying the proper subsequent treaters and type of medical experts with whom you will need to consult. Furthermore, they can assist you in propounding discovery that will allow you to better prepare your rebuttals to the cross-claims/empty-chair allegations by the PI defendants or, alternatively, to support a summary judgment motion you can bring to have the case thrown out against the medical defendants. Additionally, they can help you convey complex medical issues to the jury.

Protecting and enhancing damages in a PI case: *Henry* issues

Whether or not medical wrongdoers are actually named, if they are even remotely subject to liability claims, the PI defendants almost certainly will attempt to point in their direction. The primary reason for doing so, even against unnamed defendants, stems from the effects of Proposition 51 as interpreted by *Henry*.

According to the defense interpretation, this case stands for the propositions that: (1) fault will be allocated between the initial personal injury tortfeasor and the subsequent medical malpractice tortfeasor; and (2) noneconomic damages will be apportioned according to that allocation of fault.

So applied, *Henry* has two potentially devastating effects on your client's damages. First, this could be a serious reduction of the noneconomic damages by the percentage of fault attributable to the implicated health-care providers. Second, that allocated amount will be zero to your client if the medical wrongdoers are not in the case, and reduced by MICRA to $250,000 if they are.

For example, imagine a situation in which a jury awarded $5 million in noneconomic damages for a catastrophic, life-altering injury, such as quadriplegia. Further assume that the jury allocated 80 percent fault to a MICRA-qualifying medical defendant. In that situation, the damages would be reduced to one-quarter of what the jury awarded, even if the medical defendants are in the case (less if they are not). The PI defendant would be responsible for only $1 million of the noneconomic damages (20 percent of the $5 million), and the $4 million for which the medical defendant was responsible would be cut to $250,000 by operation of law.

Fortunately, the *Henry* holding and its application, and therefore its adverse effects, are far from clear. Although its superficial holding reiterates the requirement of Civil Code section 1431.2 that there be several rather than joint liability for noneconomic damages (meaning each defendant is liable for noneconomic damages only to the degree of that defendant's fault), *Henry* provides more questions than answers.

The *Henry* "holding" seems mostly an evidentiary rule, allowing evidence of fault of the subsequent medical tortfeasor to be introduced. However, the entire concept of allocation of fault to the subsequent medical wrongdoer is based on a rarely existing distinction. Proper preparation should permit avoiding application of *Henry*, or at least will minimize its harm in most situations.

The problem with the *Henry* analysis is that it is based on two constructs that are extremely dubious in the real world. First, the ruling speaks with a "forked tongue." It simultaneously states there can be allocation of fault (and therefore damages) to the subsequent medical provider while recognizing the well-established law that clearly indicates 100 percent of the fault is attributable to the original tortfeasor so long as the chain of causation from the original tortfeasor's act is unbroken. Second, all allocation is based upon the rare and suspect premise of clearly divisible components of the injury.

The *Henry* court recognized that "[t]raditional California tort law holds a tortfeasor liable not only for the victim's original personal injuries but also for any aggravation caused by subsequent medical treatment, provided the injured party exercised reasonable care in obtaining the medical treatment." (*Henry*, 160 Cal.App.4th at 445.) It cited the seminal California Supreme Court case, *Ash v. Mortensen* (1944) 24 Cal.2d 654: "It is settled that where one who has suffered personal injuries by reasons of the tortious act of another exercises due care in securing the services of a doctor and his injuries are aggravated by the negligence of such doctor, the law regards the act of the original wrongdoer as a proximate cause of the damages flowing from the subsequent negligent medical treatment and holds him liable therefore." (*Henry*, 160 Cal.App.4th at 450-51.) "The original

See Heimberg, Next Page

Journal of Consumer Attorneys Associations for Southern California
ADVOCATE
March 2014 Issue

tortfeasor's liability for enhanced injury suffered during medical treatment is not limited to additional harm caused by negligence. If death resulted from a risk inherent in the medical treatment reasonably required to cure the injuries caused by the accident, [the original tortfeasors] would be liable irrespective of whether such treatment was rendered in a proper or negligent manner." (*Id.* at n. 6.) Moreover, "the chain of causation set in motion by the original tort remains unbroken" whether the additional harm results from the negligence of doctors or hospitals or from a risk inherent in the necessary medical care. (*Ibid.*)

Henry's superficially frightening (for plaintiffs) holding has two gaping holes through which plaintiffs should be able to drive their liability Mack trucks. First, 100 percent of fault is attributable to the original tortfeasor. Even if fault is "allocated" to a subsequent tortfeasor, that does not obviate or reduce the 100 percent fault of the original tortfeasor. The *Henry* court recognized its ruling was rooted solely in the fact that section 1431.2 was intended to "remedy the inequity resulting from holding a party bearing only a fraction of the fault financially responsible for the entirety of damages." (*Id.* at 458-59.) This notion has little application to an original tortfeasor who is responsible for all the harm, and the *Henry* court conceded that, even in the situation before it, the original personal-injury tortfeasor was responsible for the damages attributable to the allegedly negligent subsequent medical treatment. (*Id.* at n. 9.)

Second, by its terms, the holding in *Henry* applies to only a very limited situation, and one which is more imaginary than ever real. It applies only when the aggravation of the injury "can in fact be divided by causation into distinct component parts . . . [then] liability for each indivisible component part should be considered separately . . . [and] is properly apportioned." (*Id.* at 455.)

To the extent this ever occurs, it has no relevance to the overwhelming preponderance of the cases. As the court conceded, there is joint liability and responsibility, and therefore no "indivisible component" when the harm results from a risk inherent in the treatment, whether or not negligent, particularly when the treatment was necessary. Rare is the complication not known to occur during any significant procedure; it is often not an acceptable complication, which may make its occurrence negligent but would not make it susceptible to *Henry* allocation.

Henry similarly would not apply where the negligence simply failed to fix a problem created by the original tortfeasor. That is, if the harm would have occurred had no treatment been given, it would make little sense to apply any allocation of fault. Indeed, it seems completely absurd that the original tortfeasor could better escape responsibility when the plaintiff sought subsequent medical care than when no care was sought at all, if pursuing subsequent medical care was reasonable (as it invariably will be held to be for any significant injury).

Furthermore, the *Henry* court concedes that its holding is inapplicable in situations where liability is not based on comparative fault, because there is nothing to compare. This includes claims ranging from vicarious liability, conspiracy, to violation of a statute by the original tortfeasor, to strict liability. (*Id.*, at 457-58; see also *Marina Emergency Medical Group*, *supra*, 184 Cal.App.4th at 440.)

Henry's requirement that the subsequent injury be separate and divisible from the prior PI injury creates two scenarios you can use to your advantage. The first scenario involves a looming empty chair from a subsequent provider not being named as a defendant. In that circumstance, the unnamed provider will almost certainly say the subsequent injury is not separate from the injury the PI defendant caused. This undermines *Henry*'s application and would likely preclude the PI defendants from pursuing a cross-claim against the subsequent provider.

Under the second scenario, if a subsequent provider is named as a defendant, the PI defendant must testify not only that the subsequent provider was negligent, but also that the subsequent provider's negligence was completely causative of a separate, divisible injury. If you have economic damages to justify pursuing the claim against the subsequent provider, this situation could be extremely advantageous because your case against the subsequent provider is handed to you on a silver platter.

Successfully combatting *Henry* consists of understanding *Henry*'s limitations and propounding the proper discovery and obtaining the proper experts to obviate its narrow holding. If the case goes to trial, these efforts should be followed with properly briefing the court on *Henry*'s limited holdings and related matters.

As to discovery, it is worthwhile to force finger-pointing early through form and special interrogatories. If there has been no cross-claim by the original tortfeasor, early discovery can be powerful. If the original tortfeasor answers with true finger-pointing, it will make it easy to get the subsequently alleged wrongdoing treaters and any treaters thereafter on your side. If the original tortfeasor avoids finger-pointing, it should allow a successful summary judgment motion on your part to eliminate the medical defendants. If they oppose the summary judgment, at the worst, you have a true battle between defendants.

If there has been a cross-claim against health-care providers, discovery can enable you to eliminate the cross-defendants from the case. Specifically, if the PI lawyers do not set forth the basis for their affirmative defense, there should be an opportunity to invite a summary judgment motion from the medical defendants while at the same time befriending them. Even if the summary judgment motion does not prevail, it will permit a nominal settlement with the medical defendants. If that is granted by the court, and good faith is upheld (as it almost certainly will be), this will prevent the non-settling original tortfeasor from utilizing the benefits of *Henry*, even if they otherwise could have shown a distinct injury caused by the subsequent

See Heimberg, Next Page

Journal of Consumer Attorneys Associations for Southern California
ADVOCATE
March 2014 Issue

tortfeasor. This is because non-settling defendants cannot use Proposition 51 to reduce their non-economic damages. (*Wilson v. John Crane, Inc.* (2000) 81 Cal.App.4th 847; *Espinoza v. Machonga* (1992) 9 Cal.App.4th 268, 275.

Seek testimony from treaters

It is also worthwhile to seek expert testimony, particularly that of the implicated and subsequent treaters, on the necessity of the medical procedures utilized. Both the experts and vast literature will support almost any complication as a known (even if unacceptable) risk of the procedure. Similarly, treaters, even subsequent to the alleged medical wrongdoing, will almost always be willing and able to testify that the injury cannot "be divided by causation into distinct component parts." These tactics together should generally obviate any attempt at a *Henry* damages' reduction.

If by the time of trial there has been a cross-complaint or the specter of the empty chair still looms large, we suggest a trial brief be submitted on the *Henry* issues. This brief should explain the limited application of *Henry*. It must also explain this is an affirmative defense and that the defendant has burden of proving this is a distinct additional injury. This burden is one the defendants rarely will be able to meet.

The brief to the court should also address a problem likely to arise at trial. The CACI verdict form question allocating fault includes a "total" of fault at 100 percent. You must explain to the court that 100 percent total is not meaningful when the original tortfeasor is liable for 100 percent of the harm, even if the subsequent tortfeasor also is liable for some harm. If the court is hesitant to modify the verdict form because of inherent antipathy towards altering anything CACI, point out that CACI 3929, "Subsequent Medical Treatment," provides that the original tortfeasor is "responsible for any additional harm resulting from the acts of others in providing aid…even if those acts were negligently performed." Point out this was cited favorably by *Henry*.

Further, proper preparation for the deposition of the original tortfeasor's experts will go far in eliminating a *Henry* allocation. It is rare for a defense expert to testify willingly that a result does not occur but for negligence or that the injuries are related. At worst, they have handed you the medical defendants on a platter.

The bottom line is you need to convince the court of the truth of the *Henry* holding. First, it is primarily an evidentiary rule and not an instruction to allocate damages except in the most limited of circumstances. Further, there's no reason to believe that such circumstances exist in your case.

Avoiding MICRA

There are many reasons to avoid MICRA besides the obvious cap on non-economic damages. Not as reviled, but perhaps even more problematic, is the abrogation of the collateral source rule set forth in Civil Code setion 3333.1, and the right of the defendant to demand installment payments for verdicts over $50,000 in future damages and have any remainder revert back to the defendants in the event of the injured party's death as set forth in Code of Civil Procedure section 667.7. It is also much more difficult to get punitive damages under MICRA, and there is a ridiculously low fee structure, severely limiting the attorney's fees on the already extremely limited recovery.

MICRA only becomes important when a MICRA-qualified defendant is indeed brought into the case. Pre-existing knowledge of the methods and likelihood of avoiding the application of MICRA is intimately entwined with one's decision regarding whether to bring suspected medical wrongdoers into the PI case.

Consider the following general approach to arguing the non-applicability of MICRA: First, MICRA does not completely abrogate the common law for medical cases. Rather, MICRA was a legislative compromise setting forth limited statutory exceptions to the common law. It protects only limited wrongdoers ("health-care providers") and limited wrongs ("professional negligence"), both of which are statutorily defined and case-limited.

Second, MICRA is an affirmative defense. The defendant claiming MICRA protection has the burden of proving that (1) it is indeed a MICRA-qualified defendant; and (2) its wrongdoing is MICRA-protected conduct. A defendant does not receive the benefits of MICRA just because the case sounds in medical malpractice.

To qualify as a MICRA defendant, the "health-care provider" must be licensed or certified under various sections of the Business and Professions Code or the Health and Safety Code. This does not include most clerical staff, unlicensed or uncertified personnel (even if holding themselves out as licensed or certified), or various outsource personnel. Nor does it cover entities that employ health-care providers, although they may gain such protection through that employment if the only claim against the entity is one of vicarious liability. (*Lathrop v. Healthcare Partners* (2004) 114 Cal App.4th 1412.)

Otherwise extending MICRA protection to entities that employ healthcare providers is absurd, as shown by the fact that doing so would provide MICRA protection to pharmaceutical companies, drug stores, insurance companies and even my law firm. Such claims have been rejected since the enactment of MICRA. (See, e.g., *Frederick v. Calvio Pharmaceutical* (1979) 89 Cal.App.3d 49.)

Furthermore, if you can bring in a defendant HMO rather than merely its physicians or nurses, no MICRA protection applies. Civil Code section 3428, subdivision (c) and its legislative history clearly indicate the Legislature's specific contrary intent that, without qualification, health-care service plans and managed-care entities are not "health-care providers" within MICRA and get no MICRA protection for their wrongdoings as HMOs.

It is important to note the broad statutory definition of a health-care service plan. It includes "any person who

See Heimberg, Next Page

Journal of Consumer Attorneys Associations for Southern California
ADVOCATE
March 2014 Issue

undertakes to arrange for the provision of health-care services . . . in return for a prepaid or periodic charge." (Health & Saf.Code, § 1345, subd.(f).) Moreover, the burden is on the defendant claiming MICRA to prove it is exempt from any limitations under these statutes, including the exemption from MICRA. (See Health & Saf. Code, §1343.3.)

To avoid the application of MICRA, the HMO, managed-care entity, or medical business must have wrongdoing other than vicarious liability. This generally can be found readily through various statutes and case law setting forth non-delegable duties of such entities. These legal bases include the doctrine of non-delegable duties for public licensees. (See *California Assoc. of Health Facilities v. Dept. of Health Services* (1997) 16 Cal.4th 284 [addressing non-delegability of obligations under a personal health services contract]; see also, e.g., *Newman Co., Inc. v. Nero* (1973) 31 Cal.App.3d 490, 495.) Statutory duties of health-care service plans and managed-care entities are set forth in Health and Safety Code section 1367, *et seq.*, and 28 California Code of Regulations section 1300.80, *et seq.*

In order to obtain MICRA protection, a MICRA-qualifying health-care provider must also show that the wrongful conduct falls within the ambit of MICRA. There are two primary tests for determining whether the challenged conduct is within MICRA's purview. The first is statutory, specifically asking whether the conduct falls "within the scope of services for which the provider is licensed." (Civ.Code, § 3333.2, subd. (c)(2).) The case law arguably adds another restriction, namely that the professional negligence be "mere" negligence and not more egregious or intentional conduct.

One can avoid the application of MICRA under the first test by finding causes of action that fall outside the scope of licensed services. Such claims include: (1) fraud, ranging from defrauding the patient to performing ghost surgery; (2) stealing from the patient during medical care (e.g., stealing eggs in fertility clinics, stealing cell lines, etc. (see, e.g., *Moore v. Regents of Univ. of California* (1990) 51 Cal.3d 120); and (3) decisions a provider makes for economic gain rather than for the medical benefit of the patient, including all unrevealed economic conflicts of interest (e.g., research with economic benefits such as a pharmaceutical drug trial, flat-fee payments for obstetric care resulting in inadequate care, declining known necessary interventions, inappropriately discharging or transferring a patient for economic reasons, providing inadequate staffing levels for economic reasons, or ratcheting down care using lower level providers for economic reasons).

This theory also supports excluding "ordinary" (non-medical) negligence committed by MICRA-qualifying defendants. The majority of cases (but not all) have held that mundane, universal activities, such as dropping a patient from a gurney, are properly characterized as having occurred outside the scope of services for which the health-provider was licensed. (See, e.g., *Gopaul v. Herrick Memorial Hosp.* (1974) 38 Cal.App.3d 1002; *Andrea N. v. Laurelwood Convalescent Hosp.* (1993) 18 Cal.App.4th 1698.)

The mother lode for the other theory of conduct beyond the MICRA's purview – conduct constituting more than "mere negligence" – can be found in the body of elder-abuse cases. Indeed, the separate, non-MICRA claim for elder abuse was based on the fact that the acts prescribed by the elder abuse statute constituted culpability greater than "professional negligence." (*Delaney v. Baker* (1999) 20 Cal.4th 23.) Otherwise stated, "health-care providers are not exempt from liability for reckless neglect simply because the cause of action arises from the rendition of health services," according to another elder-abuse case. (*Mack v. Soung* (2000) 80 Cal.App.4th 966, 97.) Yet another elder-abuse case found that MICRA was not applicable for reckless, oppressive, fraudulent or malicious conduct. (*Guardian North Bay, Inc. v. Sup. Ct.* (2001) 94 Cal.App.4th 963.)

By the same token, intentional torts are generally seen to be outside the scope of MICRA. Battery clearly is now considered beyond MICRA's ambit. (See *Perry v. Shaw* (2001) 88 Cal.App.4th 658.)

If you are stuck in a situation where MICRA is held to apply, there are numerous ways to take the bite out of MICRA, though the details are largely beyond the scope of this article. There are, for example, numerous ways to limit the admission of collateral sources even under MICRA; numerous ways to multiply the $250,000 cap in appropriate cases; and ways to strongly discourage and limit the use of periodic payments.

Maximizing economic damages

If the PI defendant believes it will get a significant proportion of the fault attributed to the medical defendants, or if a medical defendant is joined, the defense may engage in tactics designed to decrease economic damages, even at the risk of raising non-economic damages. There are numerous methods to combat such attempts.

These methods are noteworthy not only because they increase the value of medical claims across the board, but also because they allow for better evaluation of potential cases against medical defendants. In *Henry* scenarios, for example, if a subsequent provider is named as a defendant, you may have the opportunity to use *Henry* to your advantage by having the PI defendant help build your case against the subsequent provider. MICRA will likely apply to limit non-economic damages, so you have to be realistic and confident about the economic-damages potentially recoverable from the medical defendant.

Commonly, the defendants will argue for an unreasonably short life expectancy, whereas in straight personal injury cases, a defendant will be hesitant to pronounce so boldly that they did not merely maim a child or young adult but have effectively killed them in short order. In medical malpractice cases, this presents an imprimatur of truth because the jury usually is not allowed to know of the cap and the attempted shifting away from economic damages. However, if there is a non-MICRA qualified defendant that will receive a large proportion of the blame, defendants rarely will be so brazen as to claim they caused early death.

See Heimberg, Next Page

Journal of Consumer Attorneys Associations for Southern California
ADVOCATE
March 2014 Issue

There are numerous ways to combat such shortened life-expectancy arguments. These include recognizing and arguing the victim's actual non-vegetative condition, motions precluding life-expectancy testimony or foregoing the right to periodicize future damages, and combatting new, voguish defense statistical arguments using medical statisticians as experts.

There are also numerous methods for demonstrating the increased needs of severely injured people. For example, paraplegics often require minimal medical care during their younger years; however, as their age increases, the normal aging of the shoulders increases and is accelerated because of the greater wear caused by one's arms serving as both arms and legs. When that occurs, a paraplegic effectively becomes a quadriplegic, requiring attendant care 16 to 24 hours per day.

Similarly, although the average (with emphasis on *average*) medical expert sets forth what is medically necessary, they usually are reporting their experience as to what the insurance has traditionally reimbursed, rather than what is needed to make a plaintiff whole. Looking at the care Christopher Reeve received or that is available for the seriously injured at places like Abilities Expo, strongly supports the need for extensive (and costly) devices, therapies, and treatments available to the seriously injured if there are sufficient funds. There are also numerous ways to explain to a jury why a far cheaper 24-hour live-in adult or CNA is simply not adequate for a severely injured person and why hourly care is needed. Moreover, often more costly LVN care is required by law.

The more effective your damages' experts, the easier it is to present persuasive evidence of these greater needs and life expectancy. Such testimony usually is simply beyond the scope of most nurse life-care planners. There are, however, experts in rehabilitative medicine and in resources for the severely injured that are far more persuasive. Some are particularly adept at explaining how the increased care not only is necessary but also is intimately tied to life expectancy.

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