Kentucky Association of Healthcare Facilities
Kentucky Center for Assisted Living
November 11, 2021

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I. Overview of Recent Changes in the Law

A. Patient's Rights Suits

i. **KRS 216.515 – Rights of residents; duties of facilities; actions**

(1) Right to be informed of all available services at a facility
(2) Right to be informed of Resident's rights and responsibilities
(3) Right to be informed of service charges; right to file complaints re charges
(4) Limits on bases for transfer or discharge from facility
(5) Right to freely voice grievances or recommend changes
(6) ***Right to be free of mental, physical abuse;*** free from chemical and physical restraints (except by MD Order)
(7) Confidential medical and personal records
(8) Right to manage personal funds; accounting when facility manages funds
(9) Private spousal visits; right to live together, unless contraindicated
(10) Residents not required to perform services
(11) Right to private communications
(12) Right to personal clothing
(13) Right to leave the premises, go outdoors, not be detained
(14) Permitted to engage in social, religious and community groups
(15) Right to visual privacy in multibed rooms, tub, shower and toilet

(16) Right to choice of physician
(17) Right to guardian to advocate rights, if adjudicated disabled
(18) Right to consideration, respect, dignity and privacy
(19) Right to be fully informed, or have family or guardian fully informed, of resident's medical condition (unless medically contraindicated)
(20) Right to be suitably dressed and assisted with hygiene and grooming
(21) Right to telephone access
(22) Right to immediate family or guardian notification of accident, illness, absence, or "anything unusual"
(23) Right to private meetings with inspectors from Cabinet for Health and Family Services
(24) Right to access facility inspection reports
(25) All enumerated rights apply unless medically contraindicated and documented by a physician
(26) ***Cause of action for violation of these enumerated rights; includes actual and punitive damages; recovery of attorney's fees, costs***; Facilities that prevail may recover attorney's fees.

ii. KRS 216.520 – Supplementation of resident's rights

(1) Long-term care facilities to post rights conspicuously
(2) Facility to implement mechanism for resident and family/guardian to participate in care
(3) Facility to establish written procedures for submitting and resolving complaints, recommendations
(4) Facility to provide appropriate staff training to implement resident's rights
(5) Facility to maintain a copy of most recent inspection

iii. Case law

(1) Overstreet v. Facility. (479 SW3d 69 (Ky. 2015))

a. Five year statute of limitations for all patient's rights suits, except KRS 216.515(6)

"For the most part, *these legislative provisions are designed to enhance the quality of living conditions for nursing home residents. They authorize court action as needed to compel compliance with statutory protections designed for the benefit and enjoyment of residents during their lifetimes.* There is nothing to be gained in a posthumous action, for example, to vindicate the resident's right to a telephone or to wear her own clothing."

b. *One year statute applies to (6), as this is a personal injury claim*;

"Subsection (6) encompasses, in the context of a nursing home environment, the traditional common law duty to avoid negligently or intentionally injuring another person."

c. No claims under this statute, except claims for personal injury or property damage, continue after resident's death

Court reasoned that since these claims are to be brought by the "resident or his guardian," they must be brought during the resident's lifetime.

2. ***Jennings v. Facility,*** 2016-CA-001823-MR (Ky.App. 2018) – After the death of a resident in 2009, the Estate brought claims against the facility alleging negligence, medical negligence, corporate negligence, wrongful death, and violations of the long-term Resident's Rights Act, KRS 216.515. The jury found against the facility and awarded the Estate $4M in Pain and Suffering; Infringement of the right to be free from chemical and physical restraints $500K; Failure to treat the resident with consideration, respect and dignity $2M; Failure to inform the family of resident's medical condition $500K; Failure to maintain hygiene and grooming $1.5M; Punitive damages $9.5M (Total $18M).

Reversed. New Trial Granted.

Overstreet specifically held that 'actions otherwise brought to enforce rights created exclusively by KRS 216.515 must be brought by the "resident or his guardian" pursuant to KRS 216.515(26) and therefore do not survive the resident's death.'

"The KRS 216.515 Resident's Rights claims of the Estate were improperly submitted to the jury, as those claims ceased to exist upon the resident's death."

The inclusion of evidence offered to prove the Estate's Resident's Rights claims was so intermixed and comingled with the evidence that supported the Estate's claim of negligence that the evidence became inseparable on the issues of liability (both standard of care and causation) and damages. This improper evidence of proof offered on the Estate's negligence and punitive damages claims, creating verdicts which were not separable post-trial…."

3. ***Facility v. Techau,*** *605 S.W.3d 60 (2020)* – Claim of negligence causing personal injury and Resident's Rights violations. Resident was deceased.

The issues on appeal included a claim for punitive damages, which was upheld, and a claim for attorney's fees, which was reversed.

The attorney's fees were awarded pursuant to KRS 216.515(26), the Resident's Rights statute. Since these claims did not survive the death of the resident, there was no statutory basis for an award of attorney's fees. The court held that it was error to instruct the jury as to the Resident's Rights claims and it was error to award attorney fees, as these claims had expired upon the death of the resident.

* Key points
  * KRS 216.515 does not extend the statute of limitations for personal injury or wrongful death claims.
  * Patient Rights suits do not continue after the death of the patient.
  * The inclusion of evidence regarding alleged patient rights violations in a wrongful death action may constitute prejudicial error.
  * There is no basis for attorney fee awards after the death of the resident.

B. Arbitration Clauses

i. 84 FR 34718 Medicare and Medicaid Programs; Revision of Requirements for Long-Term Care Facilities: Arbitration Agreements (July 18, 2019)

Federal Register :: Medicare and Medicaid Programs; Revision of Requirements for Long-Term Care Facilities: Arbitration Agreements

ii. 42 CFR 483.70(n) 42 CFR § 483.70 - Administration. | CFR | US Law | LII / Legal Information Institute (cornell.edu)

(n) ***Binding arbitration agreements.*** If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section.

(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign

the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.

(2) The facility must ensure that:

(i) *The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands;*

(ii) *The resident or his or her representative acknowledges that he or she understands the agreement;*

(iii) *The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and*

(iv) *The agreement provides for the selection of a venue that is convenient to both parties.*

iii. ***Facility v. Clark, 137 S.Ct. 1421 (2017)***

Facts: Two cases were before the U.S. Supreme Court asserting claims for wrongful death, personal injuries, and violations of Kentucky's Long Term Care Facilities Act. The facility asserted that these claims were subject to an arbitration clause. The cases were on appeal from the Kentucky Supreme Court, which had held that a document granting Power of Attorney must have a "clear statement" that the principal (i.e., the resident) intended to grant the POA authority to waive the resident's constitutional right to a jury trial.

The United States Supreme Court held: The Kentucky Supreme Court's clear-statement rule violated the Federal Arbitration Act by singling out arbitration agreements for disfavored treatment (as opposed to other contracts). "The FAA, which makes arbitration agreements, 'valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract,' 9 USC Section 2, establishes an equal-treatment principle: A court may invalidate an arbitration agreement based on 'generally applicable contract defenses,' but not on legal rules that 'apply only to arbitration or that derive their meaning from the fact that an agreement to arbitrate is at issue."

The Court also looked to the language of the underlying POA (Wellner, not Clark) and sent the case back to the Kentucky Supreme Court to determine whether a grant of authority to "in my name, place and stead, to … institute legal proceedings and make contracts of every nature in relation to both real and personal property" was a sufficient grant of authority to allow the POA to enter into the arbitration agreement for the resident.

Note: Ultimately, the Kentucky Supreme Court held that the language of the Wellner POA was not sufficient authority to execute an arbitration agreement.

iv. ***Facility v. Alexander, 530 SW3d 919 (Ky.App. 2017):***

Citing *Ping v. Beverly Enterprises, Inc*. 376 S.W.3d 581 (Ky. 2012), "*Finally, the wrongful death claimants would not be bound by the decedent's arbitration agreement, even if one existed, because their statutorily distinct claim does not derive from any claim on behalf of the decedent, and they therefore do not succeed to the decedent's dispute resolution agreements*…."

"Under *Ping*, nothing precludes those beneficiaries from entering into arbitration agreements."

In *Marmet*, each family member signed the arbitration agreement on behalf of the decedent, and was thus a party to it. As a result, the Supreme Court 'enforced the bargain of the parties to arbitrate.' In contrast, no wrongful-death beneficiary signed the Agreement here – it was only Mr. Nichols himself. Thus, Mr. Nichols' wrongful death beneficiaries never struck the bargain that the family members in *Marmet* did."

"Any claims asserted for negligence, medical negligence, corporate negligence, and violation of a nursing home resident's statutory rights were subject to the arbitration agreement, as noted by the circuit court, which are not an issue on appeal in this case."

Again, we find nothing in the Kindred decisions that would overturn the analysis set out by the Sixth Circuit in the Nichols decision above as concerns the viability of *Ping*, which correctly details the current law in Kentucky that wrongful death beneficiaries are not bound by agreements executed by a decedent.

v. ***Facility v. Richardson, 581 SW2d 590 (Ky.App. 2019)***

Reaffirmed that an arbitration agreement executed by a POA could not bind the beneficiaries of a wrongful death action, as they were not part of the original agreement.

The personal injury and statutory claims that belonged to the resident and to which the estate succeeded must be submitted to arbitration.

KRS 417.050 provides that a written agreement to submit any existing controversy to arbitration between the parties 'is valid, enforceable, and irrevocable, save upon such grounds as exist at law for the revocation of any contract. The Federal Arbitration Act (FAA) contains the identical provision. 9 USC Section 2.

The Kentucky Supreme Court reiterated its original conclusion that with respect to the powers [granted by the POA] to 'demand, sue for, collect, recover, and receive all … demands whatsoever' and 'to institute legal proceedings' ***the POA only confers the authority to bind existing claims to arbitration***. The facility arbitration agreement was not executed in the context of a lawsuit, but rather on the admission of a resident to the facility and, therefore, did not confer the authority to sign the arbitration agreement. Similarly, the power to make contracts 'in relation to real and personal property' did not confer the power to execute a ***pre-dispute arbitration agreement***, because it did not relate to the principal's property rights."

vi. Facility v. Roark, 2020 WL 70886083 (2020)

Trial court denied facility's Motion to Compel Arbitration. Person holding POA for Resident signed admission papers, including a voluntary arbitration agreement, without properly designated "POA" after his signature. There were lines on the form that designated the capacity of the signator, including a line for the "Legal Representative," but this was not the line the Person holding the POA signed.

The trial court held, and the Kentucky Court of Appeals affirmed, (even though public policy under both state and federal law favors arbitration), "… general public policy does not overcome the requirement under Kentucky contract law that an agent must denote his representative capacity to bind the principal to the contract."

Key Points

* 42 CFR 483.70(n)

* Wrongful death beneficiaries are not parties to the arbitration agreement and, therefore, not bound by the arbitration agreement

* If the wrongful death beneficiary agreed to arbitration, the arbitration agreement will be enforced (with respect to that beneficiary).

* A POA can only bind the resident or the resident's representative to an arbitration agreement, if the POA signs as "POA."

* The language of the POA must confer the ability to bind the resident to future disputes, not just disputes that exist at the time the POA is signed.

* Court relies heavily on jury protections guarded by Kentucky Constitution.

D. Privilege and Confidentiality of post-event review materials

i. Federal Nursing Home Reform Act (1987)/ Federal Quality Assurance Privilege

Requires the establishment of an internal quality assurance committee. Extends privilege to the "records of such committee."

42 USC § 1392r(b)(1)(B) and 42 CFR § 483.75(h), "A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of sch committee with the requirements to of this subparagraph."

ii. ***Facility v. Wilson and McGuire, 612 S.W.3d 811 (Ky. 2020)*** – Writ of Prohibition to protect evidence

Case was defended by Craig Johnson, Esq., James N. Martin, Esq. of Steptoe & Johnson.

Plaintiff sought by interrogatories, "… all surveys, mock survey visits, documents, reports, and tools including quarterly site visits and all focused/follow up visits, applicable to the residency of patient and 6 months before which memorialize facility's evaluation and monitoring of the facility's compliance with mandatory regulations, policies and procedures, and care given to the residents." AND "… all documents reflecting or reviewing clinical outcomes in the facility during the residency of patient including Dashboard and Clinical Outcomes Reports (COR) and QI/QM Reports and Flags." AND "… all documentation or reports from any consultant or management personnel hired to evaluate the adequacy of care rendered to residents at the facility anytime during residency"

a. ***Federal Quality Assurance Privilege (FQAP) of the Federal Nursing Home Reform Act does not only protect a quality assurance committee's own documents such as*** **minutes, internal working papers, or statements of conclusions*; instead, a case-by-case approach applies allowing a trail court to determine how a***

document was generated, why it was generated, and by whom it was generated before determining if the FQAP applies to the document.

b. ***"… documents created by or at the behest of a quality assurance committee for quality assurance purposes of the committee will likely be protected by the FQAP***. Further, ***documents that otherwise would have been generated instead by an outside source at the behest of the committee will also likely be protected.*** Put simply, if a document is generated for the express purpose of aiding the committee in its work, then it will likely be privileged.

c. Documents generated outside of the committee and for purposes unrelated to the committee are not protected by the FQAP merely because the committee reviews the documents during the course of its work…. This is true even if those documents are used in creating privileged quality assurance documents. Documents kept in the facility's ordinary course of business or that are kept as a part of a patient's medical records are not privileged. If documents are required to be generated pursuant to other legal requirements, those documents are not privileged.

d. A "case by case approach" - The documents actually protected in Wilson included, "chart audits," "compliance rounds," and a summary of statistical data.

The factors a court is to consider when determining whether a document falls within the Federal Quality Assurance Privilege include:

Clearly protects QAPI, "minutes, internal working papers, or statements of conclusions."

Cannot "'funnel' documents through QAPI in an attempt to confer privilege on otherwise unprivileged records."

Documents generated outside the committee for purposes unrelated to the committee are not protected by the FQAP because the committee reviews the documents during the course of its work," even if the documents are used in creating privileged quality assurance documents."

"Documents kept in the facility's ordinary course of business" are not privileged.

Documents "kept as a part of a patient's medical record are not privileged."
"Documents [that] are required to be generated pursuant to other legal requirements" are not privileged.

However, "The FHNRA requires a nursing facility's quality assurance committee 'to identify issues with respect to which quality assessment and assurance activities are necessary' and 'develop and implement appropriate plans of action to correct identified quality deficiencies.' 42 USCA 1396r(b)(1)(B). If documents are created for the purposes outlined int eh statute at the behest of the committee, even if generated by someone who is not a member of the committee, said documents will likely be protected by the FQAP."

iii. KRS 311.377 (Amended July 14, 2018)

(2) At all times in performing a designated professional review function, the proceedings, records, opinions, conclusions, and recommendations of any committee, board, commission, medical staff, professional standards review organization, or other entity, as referred to in subsection (1) of this section, shall be confidential and privileged and shall not be subject to discovery, subpoena, or introduction into evidence, in any civil action in any court, including but not limited to medical malpractice actions, actions arising out of review of credentials or retrospective review and evaluation as referred to in subsection (1) of this section, and actions by an applicant for or grantee of staff privileges as referred to in subsection (1) of this section, or in any administrative proceeding before any board, body, or committee, whether federal, state, county, or city, except as specifically provided with regard to the board in KRS 311.605(2). The confidentiality and privilege protections of this subsection shall only be available to a person or entity that attests to participating in a patient safety and quality improvement initiative, including the program established by the Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. secs. 299b-21 to 299b-26. This subsection shall not apply to any proceedings or matters governed exclusively by federal law or federal regulation.

Thoughts on How To Prepare a Witness for Deposition

Please consider this advice to be a "point of view;" I hope you find it worth your consideration. I have had the good fortune to practice with and to practice opposite many very talented attorneys; if there is any good advice on these pages, the credit goes to them. As a senior attorney once told me, "Don't worry. Your fellow lawyers will teach you how to practice law. You won't like it when they do, but you will learn."

A. The goal of a deposition is to say what you mean to say.

The best place to start is by confronting the single most stressful element of this process for the witness – the other lawyer. In my experience, the most common concern among witnesses is that they will be tricked, coerced, or just led into saying something they do not mean and did not intend to say. Of course, this can happen; it happens frequently.

Setting the goal for the witness to express herself clearly helps the deponent focus on remaining accurate and in control. It is considerably easier to reach the goal of saying what you intend to say, once you identify that clear expression is the goal. When the deponent reaches *fluency* in the subject matter of his or her testimony, then there is a stopping point to deposition preparation that inspires confidence.

It is not really helpful to practice questions and answers with a witness; instead, it is better to talk about the facts of the case and to develop the process of expressing these facts accurately.

A corollary to the goal of "saying what one means to say" is that the questions do not matter, only the answers matter. The witness is the only knowledgeable person in the room; she should be empowered to offer the facts in her possession, rather than to have information extracted by opposing counsel. All legal cases start with a bad outcome, so there is no reason to hide from the fact of it, and someone in that deposition is going to tell the story – either the witness or the Plaintiff's lawyer; it will sound much better coming from the witness.

The defense attorney, who has read the records, the relevant laws and regulations, and heard the testimony of the other witnesses, can help provide the deponent truthful information to which other witnesses have testified and can direct the witness to the medical records and regulations that pertain to her care. When a witness is familiar with the context in which her care occurred, she will be fluent with the facts of her testimony and why these facts are important to the case. With this understanding, the witness has tools to prevent her testimony from being taken out of context.

B. Good witnesses are made, not born. Listen to your lawyer.

If you are in a position of Counsel or Risk Manager or Claims Manager for a facility, I would encourage you to encourage your attorneys to prepare. Set an expectation of the information you want your attorney to cover with the witnesses – including medical records, other relevant testimony, and any relevant facility policy or regulation. An attorney should start with a reasonable fluency of the medical records; of course, detail will be filled in as the investigation continues, but by the time of depositions the attorney should understand *and have a response for* the pivotal events that will become the themes of the Plaintiff's case. There may be one central event, or there may be multiple events that Plaintiff's counsel is investigating. With your help and that of the witnesses, the attorney should be able to locate and understand the medical records that surround each of these events, including the meanings of lab tests; the effects of the medications the patient was taking; and the anticipated routines of care. Similarly, as the Plaintiff's themes recur in depositions, later deponents should be advised as to the issues Plaintiff's counsel is exploring – *even if the later witness has no direct knowledge of these events*. A witness who is unprepared on an issue of the case will be a fruitful source of half-truths and partial information. Each witness should understand all the major issues in the case, and how those issues may arise when it is her turn.

There are two pieces of common bad advice. First, when an attorney tells the witness to "not speak," "keep your answers short;" "don't elaborate;" and "don't volunteer anything," then he is using very generalized terms to restrict the witness' ability to convey the facts. *How is any witness supposed to follow this advice when commanded to appear for deposition and sworn to tell the truth?* Telling the witness not to speak is advice that sounds very good advice in a conference room, but it almost never works in a deposition. Many good lawyers will disagree with me on this point, but as a general matter to tell a deponent to not speak is just stressful for the witness and ineffective. The whole purpose of a deposition is to hear what the witness has to say, so this is advice that the witness will be compelled by the circumstances to ignore.

The goal is not for the witness to be silent, but instead for the witness to say what she means to say. To a lawyer, "Yes," means 100% "Yes;" "No," means 100% "No." Phrases like "Yes, but …," "No, but …," and "No, because …" can be very helpful to empower the witness *to make distinctions*. To successfully defend a case, the witness will have to escape "always" and "never," so it just makes sense to teach them how to distinguish the situation of providing care to the Plaintiff's patient from the more routine circumstances that are the basis for the policies and regulations upon which Plaintiff's counsel will rely.

A poorly informed witness is a dangerous witness. When asked about care generally, care providers will always talk about the ideal circumstance; they will completely lay out the

general reason behind the general rule. If there is some theme of Plaintiff's case that is entirely outside the knowledge of the witness, then it is far better to talk with the witness about the event; to confirm that she does not know anything about it; and to explore what she would say when asked about this event, even though she knows nothing about it. The Plaintiff's lawyer will ask the witness about every criticism of the care, every family complaint, every relevant regulation, even if the witness was not present and knows nothing about the care at issue. So, prepare the witness for questions about which they know nothing – "This event happened, but you weren't there when it happened, right?" "How does that event compare to the routines of care with which you are familiar?" "If you are asked about a departure from routine, what will you say?"

If the witness is prepared, the witness' answers will change from "You are supposed to do it this way," to "I don't know; I wasn't there. It depends on the circumstances."

The talkative witness exists, and he or she frequently declines to listen to the attorney. This can't be changed; talkers will talk. When an attorney meets with a talkative witness, the attorney should embrace that characteristic and *work on affecting the witness' judgment of the relevant facts.* When a patient has a bad outcome, care providers can be harshly judgmental of their coworkers. It is good advice to help the witness develop empathy for the provider at the front-line of the case, and to help the witness understand the circumstances in which these events occurred. This approach will put your case in as good a position as the facts will allow, and when the witness talks, his or her judgments will be tempered by an understanding of the circumstances faced by their coworker.

The question that will be presented to the jury is whether your facility's care was "reasonable under the circumstances." It is fair to review medical records, policies, and testimony so as to teach the witness the circumstances.

The second frequent bad advice is to restrict the knowledge of the witness to only her charting. This is a judgment call, but attorneys rely upon it too heavily. When a witness is very minimally involved; has entries in the record that are of lesser importance; and knows nothing about any central issue of the case, then Yes, limit the witness' document review to that which she will need to know.

However, if a witness has had any involvement; authored any relevant record; has made a statement to a family member that is at issue – anything that could be important to the Plaintiff's case, then the correct answer is to inform the witness of what happened before, during, and after her involvement. The witness will be asked in deposition what he reviewed to prepare and having reviewed the records of other providers rarely exposes them to questions about the care of other providers; the witness is not an expert, is not there to express opinions, and so knowledge of the relevant events does not open the witness to expressing opinions about the care of another. It is the opposite; correct information helps the witness avoid expressing incorrect judgments about the care of others. The witness can know what happened before and after his care, and his lawyer

still can direct him not to comment on the care of others. A defense lawyer, however, cannot prevent a witness from explaining the importance of a policy, regulation or standard; a witness who knows nothing of the facts can be asked to comment on policy, so it is important for every witness to understand the issues in the case.

Other than when the lawyer restricts the knowledge of the witness, the single best predictor of how a witness will do in deposition is how well the witness engages with the lawyer, and how well the lawyer engages with the witness. The lawyer cannot know what it is like to be on the front lines of patient care, so a good lawyer will listen and can be influenced in her own judgments by the proposed testimony of the witness. Good lawyers are adaptable to change and, when confronted with a fact that does not fit her theory, a good lawyer will modify her theory to trust the witness and to reconcile any questions she may have between the events that this witness knows, and the events the lawyer has learned from others. A good lawyer will explore the witness' comments to reconcile her understanding between this witness and others, as opposed to instructing the witness that the witness is incorrect. If the lawyer cannot reconcile her concerns, *then* she will question whether the witness' understanding is correct. A witness may change in their own understanding of the events when informed of additional facts, but the witness must never be asked to change her proposed testimony.

If we start with the idea that health care providers have answered a calling to be at the bedside, then it is most likely that the care provider acted in good faith and with a reasonable understanding of the patient's condition. Providers are to be believed.

C. "When in doubt, tell the truth. It will confound your enemies and astound your friends." – Mark Twain

A good lawyer will guide the witness, the facility, and the case toward the truth. It is unacceptable under the attorney's ethical rules to ask a witness to change his or her testimony. It also does not work. Every single time a witness deviates from her own understanding of the events (on either side of the case), the witness' testimony becomes irreconcilable with the testimony of others and the known circumstances of care. Credibility is lost.

When preparing for a deposition, it is acceptable for a defense lawyer to inquire as to the basis of a witness' understanding; in other words, "to question the witness." If the witness' testimony is internally consistent, however, it is not acceptable to ask the witness to conform his testimony to that of the other witnesses. I have on a hundred occasions been uncomfortable with a witness' deposition testimony only to later learn that his or her testimony is the most important fact in the facility's favor. Most of the time, when I don't believe a care-provider witness, it is because of something about the routines, or the circumstances, or the health care perspective I do not understand.

At the end of the day, the lawyer needs from the witness only one thing – credibility. The deponent should be reassured that her desire to tell the truth, and the facility's desire to have the truth told are one in the same.

D. Forgive the patient; forgive yourself.

Appropriately, most care providers do not blame themselves for a bad outcome, and they are now required to submit to an attorney's questioning, because of events in which they were doing their best or were only minimally involved. From the most involved witness to the least, every witness is thinking about themselves. For every witness, the deposition process pricks every work-related nerve it can prick; they all want to know:

"Why do I have to do this?"
"Am I in trouble?"
"What happens if I 'mess up' in deposition?"
"I don't need this job."
"Is my license in jeopardy?"
"That family is ungrateful."
"I did my best for that patient, and this is the thanks I get," and so on.

Whether we, as lawyers and employers, respect these emotions will be immediately apparent to the person who is about to be deposed. These feelings start to fade when the witness feels in control of her testimony, and when she understands that her employer and her lawyer both value her honesty. From there, it is important to acknowledge and address the witness' self-concerns.

When the care provider testifies, she is educating the family - just like she educates at the bedside. This is important; families process grief best when they know the truth, so testifying is a function of providing care. Even when the witness' truthful testimony does not validate the Plaintiff's lawyer's criticisms or help them win the lawsuit, it helps a family heal to know that their loved one experienced thoughtful care.

Since relaying the facts of good care puts the health care provider in a position opposite Plaintiff's counsel, the witness usually will benefit from acknowledging that it is she, and not the Plaintiff's lawyer, who has an emotional attachment to the patient. A Plaintiff's lawyer always steps into the room as the patient's "advocate." This does not mean, however, that the lawyer ever met the patient, or talked with the patient, or cleaned or bathed the patient. A lawyer will use the provider's emotion to pull her toward his way of thinking and will use any guilt the witness may feel to encourage her to take full responsibility and unapologetic self-blame for the patient's bad outcome. The witness needs to understand that everyone else in the room is acting objectively. When preparing, it helps to acknowledge up front that the provider had a bond with the patient, and to use this bond to empower the deponent to advocate for her own care. The bond between provider and patient should never be a vulnerability for the witness; it should be a source of strength.

The deponent must forgive the patient for putting her through these questions, and she must forgive herself for any issues that arose during her care. The witness should know how to resolve doubts in her own favor. When there are care issues, these issues are to be discussed dispassionately, objectively, professionally, and in context.

E. Talk about the patient.

Plaintiff's lawyers want to talk about the rules. They may throw in an inflammatory fact or two, but mostly the deposition will be about the regulations, policies, and practices that the care provider is to follow. These "rules" include physician's orders; facility policies; CMS regulations; the "themes" that the Plaintiff's lawyer believes she can prove through her expert witnesses; "standard of care" testimony from other witnesses; and especially the standards the deponent sets for herself.

Several years ago, Plaintiff's lawyers developed and publicized a way of questioning a medical witness that they refer to as "The Reptile Theory." The series of questions goes like this:

Attorney: "In the course of providing care, you are expected to follow facility policy; is that correct?"
Witness: "Yes."

Attorney: "And you are familiar with your facility's policy on X; correct?"
Witness: "Yes."

Attorney: "And what is that policy?"
Witness: "The policy is to do X"

Attorney: "Why is it important to do X? What does facility teach you is the reason for the rule for X?"
Witness: "X is how we keep the patient safe." (or protect the patient, or keep track of the patient's blood pressure, or keep track of how much the patient is eating, or prevent decubitis, etc.)

Attorney: "And it is important to do X, because bad things can happen if you don't do X."
Witness: "Yes."

Attorney: "You would agree with me that X is a reasonable thing to do." "You would agree with me that X is the required standard of care."
Witness: "Yes."

Attorney: "And you would agree with me that anyone who did not do X would be in violation of the standard of reasonable care; right?"
Witness: Wait - What? How did we get here? Still says, "Yes."

Attorney: "And you would agree with me that if a care provider did not do X, she could put the patient in danger of [insert reason for X here – falling, skin breakdown, etc.]?"
Witness: This is a nightmare, but the witness still says, "Yes."

Attorney: "You did not properly X, did you?"
Witness Ask me anything you want, I'll answer it your way.

This is a very effective, circular pathway. Plaintiff's lawyers have all learned to do this when deposing a witness. Please take note of all the emotional alarms it triggers in the witness.

The answer to the Reptile Theory is to remember that health care providers have professional judgment; they are not expected to blindly follow every policy, nor does every violation of policy result in a bad patient outcome. There are no "rules" of providing patient care; there is only the exercise of judgment.

In almost every case, we have at least the good faith of the health care provider as a starting point. There is never an intention to cause harm to the patient; there is never an intention to have a lapse in attention or judgment. The deponent arrived at work that morning with the intention of helping the patient, and something happened along the way that had many, many factors underlying its cause.

When asked what the rule is, the answer is "It depends." It depends upon the circumstances. There is no "rule" to providing care; there is only professional judgment.

The old health care provider maxim of "If it wasn't charted, it wasn't done" is a complete myth. It is a way that providers teach other providers that charting is important, but it is not objectively true. Deficits in documentation are not equal to deficits in care. Care can be proved through witness testimony and other surrounding events. Even without documentation, witness testimony can be reinforced by the internal consistency of the narrative. Of course, when charting by exception, "If it wasn't charted, the patient's assessment was normal."

Health care providers are trained observers; they see the patient's skin color; they are inherently aware of the patient's respiratory rate; they know what distress looks like; and they are aware of neurologically intact responses – like speech, eye movement, and reaching for objects. A patient-provider relationship is interactive; when the provider is surprised, the reasons usually trace back to the appearance of the patient or the provider's interactions with the patient. Sometimes, sudden, unexpected changes occur.

Good lawyers explore the patient's appearance and interactions, put words to what the bedside provider observed, and help the provider explore the reasons that her professional care judgment was exercised. A good witness will talk about what she saw, what she heard, what she said, what was said to her, and what was done; you can see through her eyes, and hear through her ears, just as you want the jury to do. These observations are the "circumstances" of care, and the question is always, "Was the care reasonable under the circumstances?"

F. Talk about the circumstances.

A good defense is presented when the jury can walk in the shoes of the bedside providers. When the jury understands what the witness saw; what she heard; what was said to her; what she did; and the factors that influenced her exercise of judgment. When the jury can walk a mile in the witness' shoes, then they are at their most likely to empathize with the witness. Anything less than living through the witness is just reciting facts, and the jury is rarely persuaded.

Physician's orders; facility policies; CMS regulations; expert and provider testimony about what "should be done" are not the standard of reasonable care. All these things are "evidence" of what may have been reasonable under the circumstances faced by the care provider. Until CMS can tell a provider what to do for a specific patient in a specific bed at a specific time, the question of what is reasonable under the circumstances always will be an evaluation of the provider's professional judgment.

If the jury doesn't understand the circumstances of care, they will not understand any basis for exercising judgment outside of the "rule."

G. The truth, the whole truth, and nothing, but the truth.

A "half-truth" is a statement that is objectively true, but it is false when placed in context. In health care litigation, the words "always" and "never" are my triggers that a half-truth is coming, because these words ignore professional judgment, and they ignore the infinite circumstances of providing care. The Reptile Theory is entirely dependent upon "always" and "never" statements; it thrives by turning evidence of a rule into the rule, itself. These are half-truths, because in health care, reasonable judgments depend upon the circumstances of care.

Plaintiff's lawyers always will question the least knowledgeable witness about the most important issues.

To evade the reptile, dig deeper than the reptile. Get to "the whole truth." What did the provider know? How was the patient when last seen? What factors influenced the provider's decisions? Put words to these factors and help the provider say what she

already knows to be true – that her intentions were good and her care was appropriate. She did not intend for the patient to come to harm; the care that was provided followed the provider's best judgment at the time.

There is one last point – what to do with the bad fact? First and foremost, the lawyer should understand the context in which the bad fact arose, and whether the bad fact caused or contributed to the bad outcome. There are errors in every patient's care. There is absent documentation in every patient's care. Not every error results in harm, and most often, the patient's overall health condition provides more of an explanation for the bad outcome than does any single bad fact. The witness will have to testify truthfully to the bad fact, but when she does, her judgments of her own care need to be tempered with situational awareness, self-forgiveness, and understanding. In the end, the witness' credibility is more important than any fact in any case; without a believable witness, the facility will lose the case every time.

Providing care to the elderly means that some patients will die in your facility, some will fall, some will have skin breakdown, some will develop infections, because there is an inescapable statistical occurrence of these events. These events happen outside of long-term care, and they happen in long-term care. Diligent care can minimize their occurrence, but these events are part of the human experience and cannot be completely avoided. When a bad outcome happens at your facility, then develop a plan of defense that best supports the honest testimony of the bedside care provider; inform all witness of the relevant facts; and empower the witnesses to testify objectively and professionally.

At that point, the provider will be fluent with the facts, and she will be prepared to say what she means to say.