

Chapter 53

Countersuits by Health Care Providers

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Recent years have seen a precipitous increase in the incidence of medical malpractice litigation. This increase has taken the form of a dramatic rise in the number of suits filed and in the size of judgments and settlements. Although many of the suits filed have some legitimate basis, physicians and their insurance carriers have noted a rise in the number of actions filed that lack substantial merit. To counteract these nonmeritorious claims, physicians have sought recourse through countersuits.

Physician countersuits have been conspicuously, although not uniformly, unsuccessful. Countersuits for abuse of process, malicious prosecution, intentional infliction of emotional distress, defamation, barratry, and negligence have been consistently rejected by the courts for numerous reasons.

POLICY CONSIDERATIONS

State and federal courts must weigh a number of opposing public policy issues when deciding whether to permit countersuits. On one hand, courts have recognized a policy favoring protection of individuals from unjustified and oppressive litigation. On the other hand, courts have sought to protect the public interest by providing injured parties with free and open access to the courts. Successful countersuits are thought to exert a chilling effect on injured persons who would seek legal redress.

When an individual with a meritorious claim is faced with the possibility of a countersuit, many legal scholars and members of the judiciary believe that the potential plaintiff's right of access to the courts is threatened. In this situation the nation's legal system for redress of wrongs would be threatened with failing to protect the rights of the individual, and many meritorious claims for damages would not be pursued. The end result could well be to leave the injured party without adequate remedy. On the whole, courts have given far greater weight to preserving the peace by favoring free access to the courts. This policy choice renders it extremely difficult for wrongfully sued physicians and others to seek an effective remedy via countersuits.

Most physician countersuits are brought against the physician's former patient (plaintiff in the original medical malpractice action) and the patient's attorney. As the countersuit

litigation progresses, the focus usually shifts from the former patient to the attorney. This shift occurs because the patient frequently raises the defense that he or she relied on legal advice from the attorney regarding the merits of the case. As a practical matter, because most unsuccessful medical malpractice plaintiffs have limited resources, a judgment against a former patient is rarely collectible. The patient's attorney, however, is frequently covered by a legal malpractice liability policy; thus a judgment against a defendant attorney, if covered in the policy, usually is paid. The attorney's insurance carrier may be more willing and able to settle than the insured. The attorney's defense is weaker than that of the former client. The attorney usually can claim only that, before initiating the medical malpractice action, he or she relied on information from the client. The attorney will then claim that such information was inaccurate and led to an unjustified medical malpractice action. Another defense is that the attorney acted reasonably, obtained the advice of medical experts, and relied on their advice before filing suit.

MALICIOUS PROSECUTION

The tort of malicious prosecution has its origin in English common law. It developed as a remedy against persons who unjustifiably initiated a criminal proceeding. Modern English law has not extended this tort to allow redress against persons wrongfully instituting a civil action. A minority of jurisdictions in the United States follow that conservative approach. However, the majority of jurisdictions in the United States currently permit suits based on malicious prosecution if someone wrongfully initiated a civil lawsuit.

The moving party in a malicious prosecution suit must prove facts that satisfy the four elements of the cause of action: (1) Initial suit was terminated in favor of the plaintiff, (2) it was brought without reasonable or probable cause, (3) it was actuated by malice, and (4) the counterclaimant suffered a "special grievance." A physician countersuit based on malicious prosecution can be instituted only after the medical malpractice action has been terminated; it cannot be instituted while the medical malpractice action is still pending. A formal, favorable determination of the malpractice suit for the physician defendant must come first.

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That favorable determination generally need not be a jury verdict for the physician but may be a voluntary dismissal by the patient or an involuntary dismissal by the court.¹ To serve as a basis for a malicious prosecution action, the malpractice action must not have been terminated solely on procedural grounds:

*The mere fact that the party complained against has prevailed in underlying action [sic] does not itself constitute favorable termination, though such fact is an ingredient of favorable termination, but such termination must further reflect on his innocence of alleged wrongful conduct; if termination does not relate to merits, reflecting on neither innocence of nor responsibility for alleged misconduct, termination is not favorable in the sense it would support a subsequent action for malicious prosecution.*²

The most difficult element for a physician to establish in a malicious prosecution action is lack of probable cause. Mere failure of a patient to prevail in a medical malpractice action does not by itself indicate lack of probable cause. Courts realize that the complex legal issues and fact patterns surrounding medical malpractice litigation contain substantial uncertainties. In many such cases questions of liability and damages are not resolved until the trial. Therefore a physician must show that the former patient's attorney had no reasonable basis for an ordinarily prudent person to believe that there was merit to the case. It is usually difficult to prove this element because courts give attorneys a great degree of latitude in pursuing malpractice actions. Courts are even more understanding concerning the early stages of litigation before discovery has progressed. Some courts have liberalized this element by holding that an attorney's failure to investigate and conduct reasonable discovery supports a finding of lack of probable cause.

Malice traditionally implies a motive of ill will. As with the element of lack of probable cause, a showing of malice on the part of the patient or attorney may prove to be an insurmountable barrier. Because of this extreme difficulty, some courts have liberalized the malice requirement. These courts will find that malice is present if there is a lack of a reasonable belief in the likelihood that the malpractice action will be successful. Where that suit was begun primarily for a purpose other than adjudication of a reasonably valid claim, malice may be inferred.

The states are divided concerning the damage element. In the majority of jurisdictions that recognize the tort of malicious prosecution, only proving "special injury" can satisfy the damage element. This requirement is based on the historical origin of malicious prosecution suits. They arose as a redress for the initiation and prosecution of an unwarranted criminal action. Those jurisdictions recognizing the special injury rule require a showing of (1) arrest or imprisonment of the physician, (2) seizure of property, or (3) injury different from that ordinarily sustained by malpractice defendants. Special damages do not include the costs of the physician's defense, increased liability insurance premiums, or injury to the physician's standing in the community. Rather, special damages are those in the nature of business losses. If the physician cannot prove that he or

she has lost patients, for example, as a direct result of the groundless malpractice suit, the special damages requirement is not met. The occurrence of one or more of the three types of special injuries is quite rare. To date, no special damages have been awarded in a malicious prosecution suit based on a prior medical malpractice suit in such a jurisdiction. As a result, there has been a complete lack of success in prosecuting the tort of malicious prosecution in those states requiring a showing of special damages.

A number of states that recognize the tort of malicious prosecution, however, require only that the physician demonstrate some injury to establish the damage element. This element may include the attorney's fees incurred to defend the prior medical malpractice action. Other possible damages include the physician's mental anguish, loss of reputation in the community, decreased patient flow, and loss of income. Even an increase in liability insurance premiums caused by the prior medical malpractice claim could be sufficient to meet the damage requirement.

At least two malicious prosecution judgments for physicians have been upheld on appeal. In 1980 an intermediate appellate court in Tennessee allowed a malicious prosecution judgment.³ During prosecution of the medical malpractice action, it was determined that the attorney continued to press the case without his client's consent.

The patient's attorney also made allegations in his original complaint that were not predicated on information provided by the client; they were fabricated by the attorney. Finally, the plaintiff lost the case and the plaintiff's attorney filed a groundless appeal—again without his client's consent. The key finding was that continued prosecution of a medical malpractice suit, without the plaintiff's authorization, constituted clear-cut evidence of lack of probable cause.

The Kentucky Supreme Court decided a second malicious prosecution action in favor of a physician in 1981.⁴ In that case the patient plaintiff had sustained an orthopedic injury before being diagnosed and treated by the defendant physicians. The element of lack of probable cause was established by the fact that the attorney filed a malpractice suit with full knowledge that the plaintiff had suffered the injury before the defendants assumed the plaintiff's care.

In summary, these two cases indicate that the difficult burden of establishing lack of probable cause can be met. These courts upheld judgments for physicians in situations in which an attorney prosecuted a suit without the client's consent and in which an attorney recklessly or knowingly maintained suit against a wholly blameless physician.

Since 1981, continuing inroads have been made by appellate courts in furthering the liability of the tort of malicious prosecution. In 1982 the Kentucky Supreme Court reversed a directed verdict for the defendant and returned the case to the trial court level for rehearing.⁵ In 1983 the Kansas Supreme Court reversed a summary judgment for the defendant and returned the case to the state court level for retrial.⁶ In 1985 a California intermediate appellate court partially sustained a physician's victory on appeal but remanded the case to the trial court for a new trial.⁷ Finally, in 1986 a California intermediate appellate court reversed a summary judgment for the defendant and returned the

case to the state court level for retrial on its merits.⁸ Although none of these state appellate court decisions represents a complete victory on the merits by the physician plaintiff, each certainly indicates a recognition on the part of the appellate courts that malicious prosecution is a viable tort and should be afforded respect at both the trial and the appellate court levels.

An opinion in a California Supreme Court case rendered in 1989 dramatically increased the burden of proving a malicious prosecution action.⁹ Before this ruling, the attorney who filed the prior medical malpractice action had to fulfill a two-part test to establish that the action was brought with probable cause. First, he or she had to have a subjective belief that the claim merited litigation; second, that belief had to be satisfied by an objective standard of legal tenability.

The California Supreme Court, in a unanimous decision, ruled that the two-part test was invalid. The court stated that the only standard to be applied was that of objectivity, and if the prior attorney could show that objective tenable evidence supported the prior malpractice claim, his or her subjective beliefs at that time were unimportant in establishing a basis for proper probable cause.

Also, in the same case the court indicated that the party bringing the action for malicious prosecution could not introduce into evidence opinion testimony of expert witnesses as to whether a reasonable attorney could conclude that the claims advanced in the prior action were tenable. The Supreme Court felt that the objective tenability of the prior action was a matter to be determined solely by the present trial judge.

In essence this important California case greatly increased the burden of a physician wishing to prove lack of probable cause in a prior medical malpractice action. It also greatly reduced the defensive burden of the prior attorney in establishing that he or she brought the prior action with necessary probable cause.

Since 1985 a rather interesting development has occurred at the trial court level involving a variation of the tort of malicious prosecution. As previously discussed, the typical defendants in a physician countersuit based on this theory of liability are the original patient plaintiff in the prior medical malpractice action and his or her attorney. Several recent trial court cases, which have not reached the appellate level, have named the prior plaintiff's expert medical witness as a co-defendant in the physician's subsequent suit for malicious prosecution, based on a conspiracy theory of liability.

Conspiracy is a legal theory of liability usually applicable in criminal actions. A conspiracy occurs when two or more individuals agree to carry out an illegal act. Many jurisdictions permit a conspiracy theory of liability to be pleaded in a civil action. The theory of liability for including the expert medical witness in the malicious prosecution lawsuit is that he or she participated in the prior medical malpractice action by providing expert medical witness advice while knowing that the medical malpractice suit had no merit. In many jurisdictions a co-conspirator, such as a participating expert medical witness, would be jointly

and severally liable for all damages along with the other co-conspirators (the former patient and his or her attorney).

This new basis of liability for nonmeritorious expert medical witness participation in medical malpractice suits is likely to make physicians much more cautious to avoid participating in obviously nonmeritorious litigation. Cases of this type should deter many medical expert "hired guns" from participating in those cases in which there is no reasonable basis for believing that medical errors were committed by the treating defendant physician.

ABUSE OF PROCESS

Abuse of process is a cause of action frequently employed by physicians after what is perceived as an unjustified medical malpractice action. The elements of this cause of action include unauthorized use of an otherwise legal process, existence of an ulterior purpose in bringing the original malpractice suit, and damages sustained by the physician defendant as a result of the abuse of process.

Unlike the tort of malicious prosecution, abuse of process does not require proof of prior favorable determination or lack of probable cause. The principal difficulty faced when prosecuting this cause of action is proof of an ulterior purpose. To establish this element, the physician must demonstrate that the original use of legal process in bringing the medical malpractice action, although justified initially, was later perverted and that the process itself was employed for a purpose not contemplated by the law.

Note that institution of a meritless lawsuit is not sufficient by itself to state a cause of action for abuse of process. Physicians sometimes allege that the original, groundless medical malpractice suit was brought merely to coerce a nuisance settlement. However, a majority of courts have rejected this argument as insufficient to fulfill the requirement of an improper ulterior purpose.

In 1980 the Nevada Supreme Court upheld a countersuit based on an abuse of process.¹⁰ In that case the defendant physician was alleged to have been negligent in the treatment of bed sores that the patient developed while under the physician's care. A thorough review of the facts indicated that there was absolutely no basis for initiating or prosecuting the medical malpractice action. Shortly before trial, the patient's attorney attempted to settle for the nominal sum of \$750. The physician refused to settle. The case was tried without the plaintiff's attorney having retained an expert witness, and the plaintiff lost the malpractice case.

The Nevada Supreme Court found that the plaintiff's attorney had used an alleged claim of malpractice solely for the ulterior purpose of coercing a nuisance settlement. His offer to settle for \$750, his failure to investigate the facts properly before filing suit, and the absence of essential expert testimony at trial supported a case for abuse of process. Although this court recognized the threat of litigation to coerce a settlement as satisfying the ulterior purpose element, it is unlikely that other jurisdictions will expand on this holding because of the great weight that courts place on the public policy of providing injured parties free and open access to the courts.

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DEFAMATION

The tort of defamation can be committed when an oral or written false statement is made to a third party about another person and is damaging to that person's reputation and good name. Countersuits based on the tort of defamation rely on the principle that an unfounded suit attacks the professional reputation of the defendant physician.

Defamation has not proven effective as a cause of action on which to base a countersuit because of an underlying privilege covering oral and written statements made in the course of judicial proceedings. That privilege immunizes patients and their attorneys from liability for any reasonable communication made in the course of a lawsuit. The purpose of this privilege is to permit the free expression of facts and opinions necessary to decide the merits of a lawsuit. The threat of defamation lawsuits would have a chilling effect on access to the courts and on honest testimony and would be contrary to the public interest in the free and independent operation of the courts.

However, in a 1963 countersuit based on defamation, a California intermediate appellate court ruled in favor of the physician.¹¹ On the other hand, the fact pattern in this case was unusual *and subsequent decisions have criticized the court's ruling*. In the original medical malpractice action the defendant physician was charged with negligent diagnosis and treatment of a child, resulting in the child's death. A local reporter contacted the office of the plaintiff's attorney for information. That attorney reiterated his formal allegations and added additional, unsubstantiated charges. Those charges were incorporated into a subsequent newspaper article. The defendant physician read that article and contacted the newspaper, demanding that the false allegations be formally retracted in a subsequent article. A newspaper official contacted the attorney who had made the original allegations and asked if the facts set forth in the article were true. The attorney assured the newspaper official that they were true and later supported his claims with formal, written correspondence with the newspaper.

The physician sued for defamation and prevailed at trial. The judgment was upheld on appeal because the attorney's statements to the newspaper were not made in pursuit of the underlying malpractice litigation. The wrongfulness of the attorney's false statements was compounded by his failure to retract them when the newspaper contacted him to substantiate his allegations. Defamation may be a viable form of action in countersuits in which erroneous statements are made outside of usual judicial proceedings. In such circumstances the privilege covering judicial proceedings will not protect an attorney or a patient who makes false statements that are injurious to a physician.

NEGLIGENCE

The law of negligence requires that individuals do not subject other persons to unreasonable risks of harm. A countersuit based on negligence alleges that the patient's attorney was negligent in unreasonably bringing an unfounded lawsuit against the physician. However, under negligence law the plaintiff must prove that the defendant owed him

a duty. No physician has succeeded with a countersuit based on negligence and prevailed at the appellate level.

Courts have consistently held that an attorney owes no duty to a party, other than his or her client, unless that party was intended to benefit from the attorney's actions. In the usual medical malpractice action an attorney owes a duty to the client (the patient) to zealously represent him or her and to prosecute the claim. Requiring a concurrent duty to a physician not to file an unjustified suit would create a conflict of interest between attorney and client, denying the latter a right to effective counsel and free access to the courts.

INTENTIONAL TORTS

Intentional torts alleged by physicians in their countersuits against plaintiffs and their attorneys from a prior medical malpractice action include invasion of privacy, intentional infliction of emotional distress, and barratry (persistent incitement of lawsuits). Although the courts have, in dictum, lauded the application of these causes of actions as being novel and innovative, they have consistently rejected them.

CONSTITUTIONAL MANDATE

Some jurisdictions do not recognize the common law countersuits. Innovative attorneys in those states have attempted to create new theories of liability to permit physicians to bring successful countersuits. In other states in which there are major stumbling blocks to countersuits, attorneys have sought to establish such novel theories.

For example, Illinois courts require proof of a "special injury" to prove malicious prosecution. This requirement effectively prevents physicians from winning a countersuit of this nature. However, the Illinois Constitution specifically provides that "every person shall find a certain remedy in the laws for all injuries and wrongs which he receives to his person, privacy, property, or reputation. He shall obtain justice by law, freely, completely, and promptly."

An attorney representing a radiologist who was sued unsuccessfully seized on this wording and attempted to fashion a new cause of action based on constitutional mandate. He argued that, because Illinois case law required a showing of special injury, physicians were precluded from successfully bringing a malicious prosecution action. Therefore any wrongs suffered from unjustified malpractice suits had no remedy. This attorney argued that the Illinois Constitution gives a broad remedial right to such plaintiffs who are unable to obtain remedies by more conventional common law causes of action.

An intermediate appellate court in Illinois found that the pertinent section of the Illinois Constitution was merely a philosophical expression and not a mandate for a legal remedy.¹² The court ruled that, as long as some remedy for the alleged wrong exists, this constitutional section does not mandate recognition of any new remedy. It so held in spite of the fact that a physician wrongfully sued is effectively precluded from countersuing. Because the common law remedy of malicious prosecution technically is

available to him or her, the courts will not create a new cause of action based on constitutional mandate.

PRIMA FACIE TORT

A form of countersuit recently relied on by creative attorneys attempting to carve out a new countersuit cause of action is the prima facie tort. The elements of this tort are intentional infliction of harm, without excuse or justification, by an otherwise lawful act, causing special damages to the physician.

Innovative attorneys had to resort to this cause of action because of the clear failure of the more conventional causes of action. Charges that the patient's attorney was negligent in failing to ascertain the merits of the case before filing suit have been summarily dismissed because the patient's attorney is not considered to have a duty of care to an adverse party—the physician. As for claims based on the attorney's breach of the attorney's oath not to bring frivolous suits, courts generally consider that private citizens are not proper parties to enforce such oaths and that any disciplinary action must come from the organized bar. Charges of barratry (i.e., the practice by an attorney of habitually pursuing groundless judicial proceedings) have been dismissed on the ground that barratry is a criminal offense with only a public remedy, not a private one.¹³ Casting about for some means of avoiding the strictures of these closely defined causes of action, attorneys in three recent malpractice countersuits have laid before the courts a more novel form of action—the prima facie tort. Although in all three instances the physicians ultimately lost, the cases point the way for possible future physician countersuits.

Prima facie tort is a remedy of fairly recent origin; it grew out of an opinion delivered in 1904 by Supreme Court Justice Oliver Wendell Holmes in a case involving a conspiracy among several Wisconsin newspapers to draw away the advertising customers of a rival paper. In appealing their conviction the defendants pointed out that their stratagems had been, strictly speaking, perfectly legal and that they were really being tried for their motives. They argued that motive alone is not a proper line of inquiry for the court. Justice Holmes disagreed, holding that even lawful conduct can become unlawful when done maliciously and that such conduct becomes actionable even when it does not fit into the mold of an existing cause of action.¹⁴

Out of these general principles there eventually grew the specific cause of action known as *prima facie tort*. Unlike malicious prosecution, abuse of process, or the other torts described earlier, prima facie tort has not been accepted or even introduced in all jurisdictions. Ohio, New York, Georgia, Missouri, and Minnesota have recognized the tort by name, whereas Massachusetts recognizes the principle without the label. Oregon, on the other hand, once enforced the action but has since discarded it.

No appellate court has thus far upheld a countersuit judgment based on a prima facie tort theory. The reason generally stated is that prima facie tort should not be used to circumvent the requirements of a traditional tort remedy, such as malicious prosecution. The courts stress

the need for open access to the judicial system and state that the prima facie tort should not become a catch-all alternative for every countersuit that cannot stand on its own. Appellate courts have refused to accept prima facie tort when relief technically is available under traditional theories of liability.

APPEALS RESULTS

Approximately 30 physician countersuits have been decided by appellate courts in recent years. In nearly all of these suits the courts have ruled against countersuing physicians and in favor of medical malpractice plaintiffs and their attorneys. At least four appellate decisions have favored physicians who brought countersuits. Specifically there have been at least two successful appeals of malicious prosecution actions, one successful appeal of an abuse of process action, and one successful appeal of a defamation action.

CONCLUSION

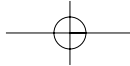
Although the absolute number of medical malpractice claims has increased dramatically in recent years, there has been no concomitant increase in the number of successful physician countersuits. Because the courts recognize the strong public policy interest in ensuring that injured parties have free and open access to the judicial system, they are extremely reluctant to allow countersuits because it is believed that countersuits would have a chilling effect on a party's ability to seek legal redress. Despite the application of many innovative and novel causes of action, physician countersuits have been and will probably continue to be conspicuously, although not uniformly, unsuccessful.

Endnotes

1. *Raine v. Drasin*, 621 S.W. 2d 895 (Ky. 1981).
2. *Lackner v. La Croix*, 25 Cal. 3d 747, 159 Cal. Rptr. 693, 602 P. 2d 393 (1979).
3. *Peerman v. Sidcaine*, 605 S.W. 2d 242 (Tenn. App. 1980).
4. *Supra* note 1.
5. *Mahaffey v. McMahon*, 630 S.W. 2d 68 (Ky. 1982).
6. *Nelson v. Miller*, 233 Kan. 122, 660 P. 2d 1361 (1983).
7. *Etheredge v. Emmons*, No. A014929 (Cal. App. 1985).
8. *Williams v. Coombs*, 179 Cal. App. 3d 626 (1986).
9. *Sheldon Appel Co. v. Albert & Olier*, 47 Cal. 3d 863 (765 P. 2d 498) (1989).
10. *Bull v. McCuskey*, 615 P. 2d 957 (Nev. 1980).
11. *Hanley v. Lund*, 32 Cal. Rptr. 733 (1963).
12. *Berlin v. Nathan*, 381 N.E. 2d 1367 (1978).
13. *Moiel v. Sandlin*, 571 S.W. 2d 567 (Tex. Civ. App. 1978).
14. *Aikins v. Wisconsin*, 195 U.S. 194 (1904).

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