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THE DEVELOPMENT OF PROFESSIONAL STANDARDS FOR PHYSICIAN EXPERT WITNESSES IN
MEDICAL MALPRACTICE LITIGATION IN THE UNITED STATES

John M. Luce*

Abstract

The development of professional standards for physician expert witnesses in medical malpractice litigation in the United States has resulted primarily from the efforts of mainstream medicine to improve its performance and the efforts of governments and courts to enhance the qualification of physician experts, if not regulate them externally. At the state level, these efforts to enhance physician experts' qualifications have led to rules requiring that physician experts share the same school of practice, practice specialty, and practice, if not the same practice locality, as those they testify for or against. At the federal level, physician experts' qualifications have been enhanced by the Federal Rules of Evidence and the requirement, articulated in *Kumho Tire Co. Ltd. v. Carmichael*, that experts testify to empirically supported opinions and employ the same standards of professional practice that they use in evaluating medical research and in diagnosing and treating patients. Recently, the American Medical Association and many specialty organizations have added to their codes of ethics explicit standards for the professional conduct of members who serve as expert witnesses. The same organizations have urged states to include the testimony of physician experts in their definitions of what constitutes medical practice, and some states also have taken this position.

These actions should advance the *Kumho Tire* requirement that physician experts testify with the same intellectual rigor that they employ in their practices. Professional standards may be further advanced through the education and certification of physician expert witnesses.

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Introduction

In the landmark case of *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, the United States Supreme Court held that trial courts must be “gatekeepers” and ensure that proffered scientific

evidence was legally relevant and scientifically valid.¹ In interpreting this requirement, the Court in *Kumho Tire Company v. Carmichael* held that *Daubert's* gatekeeping obligation applies not only to scientific testimony but to the testimony of all expert witnesses.² Justice Breyer, writing for the Court, stated that, "The objective of that requirement is to make certain that an expert, whether basing testimony on professional studies or personal experience, employs in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field."³ In keeping with this opinion, physicians who serve as expert witnesses in areas such as epidemiology and pharmacology are expected to draw from laboratory and clinical investigations with the same exactness they would use to evaluate their own research and that of their colleagues. Similarly, physicians who testify in cases involving alleged medical malpractice should call on the same professional standards they use with patients in appraising the performance of other physicians in their discipline.

Although the idea that physician expert testimony should be based on professional standards may seem self-evident today, it is a relatively new governing principle in medical malpractice litigation in the United States (U.S).⁴ Indeed, mainstream or so-called "allopathic" physicians had few professional standards to call on when competing and testifying against non-allopathic practitioners early in the eighteenth and nineteenth centuries. As the medical profession became organized, local and state allopathic medical societies and the American Medical Association (AMA) sought to marginalize non-allopathic practitioners, generate funds and provide expert witnesses for physician defendants, influence states to oversee and license

¹ *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 593 (1993).

² *Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 152 (1999).

³ *Id.*

⁴ R. Sonny Bal, *The Expert Witness in Medical Malpractice Litigation*, 476 CLIN. ORTHOP. RELAT. RES., 383, 384 2009.

medical practice, and promulgate ethical codes to enhance and distinguish physician performance. More recently, the AMA and many medical specialty organizations have added to their codes of ethics standards for the professional conduct of members who serve as expert witnesses in medical malpractice litigation. These organizations also have urged states to include the testimony of physician experts in their definitions of what constitutes medical practice. In doing so, they have attempted to institutionalize the principle of “intellectual rigor” articulated by Justice Breyer in *Kumho Tire*.⁵

In this article, I explore the development of professional standards for physician expert witnesses in medical malpractice litigation in the U.S. Part I provides the background history and legal context that frame the modern debate over professional standards. It begins by discussing the early history of the medical profession and of physician expert witnesses and the efforts of states to impose expert witness qualifications such as scope of practice and locality through statutes and case law. Part I then examines the application of case law and the Federal Rules of Evidence regarding expert testimony, along with court decisions relevant to the immunity of physician experts. Part II discusses recent medical board actions regarding physician experts. Part III covers the recent development of expert witness standards within the AMA and specialty organizations and evaluates the benefits and limitations of these standards. Part IV explores how these standards might be refined to allow the training and certification of physician experts.

I. BACKGROUND AND LEGAL CONTEXT

⁵ *Kumho*, *supra* note 2, at 152.

A. Early History of the Medical Profession and Physician Expert Witnesses in the United States

American tort law is part of the English common law that was adapted for use by the colonies before the U.S. was created. The 1767 case of *Slater v. Baker and Stapleton* established that physicians should be held to the standards of other members of their profession in the United Kingdom.⁶ In this case, according to Faden and Beauchamp, Drs. Baker and Stapleton were asked by Slater to remove the bandages from his fractured leg. Instead of removing the bandages, and over Slater's objections, they fractured the leg again and placed it in an experimental device to achieve better alignment. Slater claimed that Drs. Baker and Stapleton breached the contract they had made with him by practicing "ignorantly and unskillfully" and without his consent. He produced physician experts who testified both that the device was not commonly used in medical practice and that Drs. Baker and Stapleton did not operate with necessary skill.⁷ The court held the defendants liable under Slater's contract theory; although it did not rule on the issue of their operating without consent, which was not considered an area of negligence at the time, the court included obtaining consent as a customary part of medical practice that was subject to a contractual relationship between physicians and patients.⁸

In both England and the U.S., actions such as the one against Drs. Baker and Stapleton came to be dealt with not as contract violations but as torts, which were categorized under the heading of private wrongs in Blackstone's *Commentaries*, the English text used by most lawyers in the two countries.⁹ Indeed, had malpractice continued to be regarded as a contract violation

⁶ 95 Eng. Rep. 860, 2 Wilks. K.B. 359 (1767)

⁷ RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 116 (1986).

⁸ *Id.* at 117.

⁹ KENNETH ALLEN DE VILLE, MEDICAL MALPRACTICE IN NINETEENTH-CENTURY AMERICA: ORIGINS AND LEGACY 6 (1990).

by the courts, and had physicians pushed for that interpretation, they might have contracted with patients for limited liability regarding the results of their interventions.¹⁰ However, U.S. physicians neither wanted to be classified with plumbers, carpenters, and other non-professionals nor considered the equals of their patients. Instead, they argued that they occupied a superior position by virtue of their knowledge and skill and urged that they be judged on their efforts and not their outcomes.¹¹ Mohr believes that “that ideological position served the physicians’ professionalizing agenda well and helped them obtain the licensing laws they sought. But it cost them dearly, both literally and metaphorically, on the malpractice front because malpractice remained a tort: vague, flexible, easily manipulated, and easy to initiate.”¹²

Although trial court malpractice cases were undocumented in the colonies and the early American republic, only seven appellate malpractice decisions were recorded from 1790-1840, when the U.S. population grew from approximately 4,000,000 to 17,000,000.¹³ Assuming a ratio of trial cases to appellate decisions of 1:100, malpractice cases in this country must have been rare. Injured plaintiffs could seek a remedy with the special legal action, or writ of trespass, on the case. The scope of trespass included damages sustained as a result of breach of duty, which was called negligence or carelessness. Defendant physicians were required to exercise ordinary diligence and skill and were held to the standards of ordinary members of their profession.¹⁴ Expert witnesses established these standards, as they do today.

¹⁰ James C. Mohr, *American Medical Malpractice Litigation in Historical Perspective*, 283 JAMA 1731, 1736 (2000).

¹¹ *Id.* at 1736.

¹² *Id.*

¹³ DE VILLE, *supra* note 9, at 3.

¹⁴ *Id.* at 6.

Medical malpractice litigation increased dramatically around 1840. Between that year and 1850, when the U.S. population increased from 17,000,000 to 50,000,000, appellate malpractice decisions jumped from seven to ninety three, presumably reflecting more trial court activity.¹⁵ Mohr attributes this increase to several factors, including a sharp decline in religious fatalism and a rise in perfectionism, which made people “less willing than earlier generations to accept physical afflictions as acts of divine providence,” and “a revolution of rising expectations in the medical arena, fed by aggressive and flamboyant medical advertising.”¹⁶ But the most important reason was “the advent of what has been labeled *marketplace professionalism*, a phenomenon unique to the United States at that point in Western history, and one of the most dramatic ways in which professional development in the United States differed from older European patterns.”¹⁷

Throughout Europe and the United Kingdom, the learned professions had evolved over centuries under the explicit sanction of whoever governed their societies. In the U.S., however, the few statutes previously enacted at a state level to regulate physicians and other professionals were repealed early in the nineteenth century, and by 1840 “each profession had to shift for itself,” according to Mohr.¹⁸ Professional training was minimal and conducted primarily in proprietary institutions where students apprenticed with established practitioners, and almost anyone could call himself a physician—or a minister or a lawyer, for that matter.¹⁹ Physicians considered mainstream today were confronted with a wide variety of often

¹⁵ *Id.* at 3.

¹⁶ Mohr, *supra* note 10, at 1732.

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

antagonistic practitioners, including hydropaths and homeopaths, who called the mainstream physicians “allopaths,” after the Greek prefix *allos*, meaning different, because they allegedly treated only symptoms and not the disharmony caused by underlying disease.²⁰ The non-allopathic physicians, who today are referred to as complementary and alternative (CAM) practitioners by mainstream physicians, competed aggressively with allopaths in the medical marketplace. Mohr notes that lawyers also had to compete in their own professional marketplace, and “suits for medical malpractice, a previously arcane and quiescent branch of the law, suddenly emerged as a tempting new growth area for lawyers. American courts encouraged the trend by relaxing the rigid standards for initiating civil procedures of all sorts, including medical malpractice.”²¹

The explosion of medical malpractice suits that resulted from these developments was accompanied by the entrenchment of expert witnesses in the U.S. malpractice system. The injuries claimed by plaintiffs—injuries related to amputations and other orthopedic procedures for the most part—were often apparent to juries and not challenged by defendants, so causation rarely was an issue.²² In fact, most of the disagreement among witnesses derived from problems in determining what constituted the standard of care.²³ These problems in determination stemmed in part from the fact that allopathic medicine was in its technological infancy, so that physicians approached each patient differently and without the benefit of commonly accepted textbooks, let alone the practice guidelines available today. This did not prevent allopathic physicians from claiming that their often unique style of practice was

²⁰ JAMES C. WHARTON, NATURE CURES: THE HISTORY OF ALTERNATIVE MEDICINE IN AMERICA 18 (2004).

²¹ Mohr, *supra* note 10, at 1732.

²² DE VILLE, *supra* note 9, at 32.

²³ *Id.* at 50.

ordinary, however, or from attacking other allopaths with whom they competed. At the same time, mainstream physicians were competing with CAM practitioners in the courts as well as the marketplace, as experts from various schools argued that their activities constituted the dominant standard of care.²⁴

In this contentious environment, a number of allopathic physicians banded together at the local and state levels to create medical societies dedicated to improving the educational and practice standards of their fledgling profession and to offsetting the influence of CAM practitioners through state licensing and other mechanisms.²⁵ Although these societies usually contained only a minority of the areas' physicians, the physicians who were organized could gain unprecedented political influence.²⁶ In 1846, state society representatives met in Chicago and created the AMA to further the goals pursued in the states at a national level.²⁷ Although the AMA was also a minority group at the time and remains one today, it has long been recognized as the voice of organized medicine. Supported by member dues and contributions from industry, the AMA has exercised its voice in political lobbying, education and training, and medical publications, the best known of which is the Journal of the American Medical Association (JAMA).

²⁴ *Id.* at 51.

²⁵ PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY 44 (1982).

²⁶ *Id.*

²⁷ *Id.* at 90.

Shortly after its inception, the AMA published its first *Code of Medical Ethics*, the hallmark of its emergence as a professional society.²⁸ The 1847 code was adapted largely from Thomas Percival's *Medical Ethics*, which was first published in England in 1803.²⁹ The British and American codes both emphasized the authority of the physician in society, even though this was an aspiration and not an accomplishment in the U.S. at that time. The codes also contained lists of physicians' virtues, appeals to them to act benevolently toward patients, suggestions about the proper etiquette toward other members of the profession, and warnings not to cooperate with non-members.³⁰ However, the codes did not mention patients as autonomous agents from whom informed consent should be obtained before performing procedures because these concepts had not been accepted in either country. In fact, patient autonomy was not mentioned in the AMA *Code of Ethics* until 1981.³¹

Although the original AMA *Code of Medical Ethics* did not specifically address the issue of physician expert witnesses, its emphasis on professional etiquette discouraged its members from testifying against one another. Furthermore, as mainstream physicians increasingly identified themselves as such and worked together at local, state, and national levels, they depended more and more on their colleagues to share patients with them and testify on their behalf in malpractice suits.³² In turn, some larger medical societies, including those in New York, Cleveland, and Chicago, began to make malpractice defense a direct service, organizing

²⁸ AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION, 1847 www.ama-assn.org/resources/doc/ethics/1947_code.pdf (last accessed July 22, 2013).

²⁹ THOMAS PERCIVAL, MEDICAL ETHICS; OR A CODE OF INSTITUTES AND PRECEPTS, ADAPTED TO THE PROFESSIONAL CONDUCT OF PHYSICIANS AND SURGEONS (Nabu Press, 2010) (1803).

³⁰ FADEN & BEAUCHAMP, *supra* note 7, at 72.

³¹ *Id.* at 96.

³² STARR, *supra* note 26, at 111.

common defense funds and providing expert witnesses. Starr notes that “the Massachusetts Medical Society began handling malpractice suits in 1908. During the next ten years, it supported accused physicians in all but three of the ninety-four cases it received. Only twelve of these ninety-one cases went to trial, all but one resulting in victory for the doctor.”³³

Although collecting funds and using them to defend physicians may have forestalled some malpractice litigation, enhanced medical professionalism in the U.S. might have had the ironic effect of increasing litigation.³⁴ As allopathic physicians emphasized their differences with CAM practitioners, standardized their education and training, and promulgated their medical techniques through publications such as JAMA, they helped create a standard of care against which their practices could be compared by patients and plaintiff attorneys.³⁵ Furthermore, as they became organized and developed common defense strategies, physicians provided a stimulus for the medical malpractice insurance industry that emerged in the late 19th century. Medical society membership became attractive, if not obligatory, because society members could obtain insurance at low rates, whereas non-members often could not afford insurance. The medical societies grew in turn, thereby creating a larger insurance market. And while insurance benefitted physicians by helping them avoid the personal bankruptcy risk they had faced since the 1840s, it is also produced a situation in which they were worth being sued.³⁶

B. State Regulation of Medicine and Physician Expert Witnesses

³³ *Id.*

³⁴ Mohr, *supra* note 10, at 1734.

³⁵ *Id.*

³⁶ *Id.* at 1735.

1. State Licensing

Although some overlap exists between states and the federal government in areas such as the prescribing of controlled substances, the primary responsibility and authority in licensing and regulating physician practice rests with the states, each of which, along with the District of Columbia, has passed a medical practice act.³⁷ Most of these statutes are general, leaving the specifics of licensing and regulation to regulatory bodies and administrative boards. Among their other activities, these bodies and boards usually clarify what constitutes medical practice in a particular state. Most of them have not indicated whether physician expert testimony in malpractice suits should be considered a part of practice. If they did so, physician experts could be disciplined if the boards and bodies determined that the experts' testimony did not meet professional standards.³⁸

State licensing and regulatory statutes and the bodies and boards that enforce them were developed in the latter half of the nineteenth century in the U.S. largely in response to pressure from state medical societies and the AMA.³⁹ These organizations saw licensing as a means of requiring that physicians obtain their medical education from exemplary medical schools, not the poorly provisioned proprietary institutions that were commonplace at the time. Licensing also was a way of distinguishing certain mainstream physicians, most of whom were members of medical organizations, both from poorly trained allopaths and from CAM practitioners.⁴⁰ Although state medical societies and the AMA urged allopathic physicians not

³⁷ Fred L. Cohen, *The Expert Medical Witness in Legal Perspective*, 25 J. LEGAL MED. 185, 192 (2004).

³⁸ *Id.*

³⁹ STARR, *supra* note 26, at 102.

⁴⁰ *Id.*

to associate with their non-allopathic counterparts, covering both groups under a single license often was pursued to raise overall standards. Eventually, however, the allopaths sought an exclusive license that would separate their profession from those of other practitioners.⁴¹

Although these efforts led rapidly to rigorous licensing in some states, in others it did not. Missouri, for example, passed an initial law in 1874 requiring only that a physician register a degree from a legally chartered medical school with a county clerk. As Starr observes, “since lax incorporation laws permitted anyone to start a medical school merely by applying for a charter, Missouri soon had more medical colleges than anyone could keep track of.”⁴² Eventually, however, the state passed a definitive medical practice act that established medical school standards and empowered Missouri’s board of health to act as medical examiners.⁴³ Other states took similar actions, which were often opposed by physicians with inferior training. In the 1888 case of *Dent v. West Virginia*, the U.S. Supreme Court ruled against one such physician whose license was denied by the State Board of Health. The Court agreed that, like any citizen, a physician had a right to follow any lawful calling, but the state could protect society by imposing conditions for the right’s exercise.⁴⁴ *Dent* provided the springboard from which state licensing schemes emerged.

a. Rules Regarding the Same Practice Locality

As medical licensing became more widespread in the U.S., having a current license became one of two minimum requirements for physician experts testifying on standard of care

⁴¹ *Id.*

⁴² *Id.* at 104.

⁴³ *Id.*

⁴⁴ *Dent v. West Virginia*, 129 U.S. 114, 122 (1988).

issues, the other being involvement in current practice.⁴⁵ In the first two-thirds of the nineteenth century, physician defendants argued that their care should be measured against that of ordinary practitioners in the area in which they practiced. Courts were sympathetic to this position, and trial judges instructed juries that rural practitioners should not be required to possess the same skills as their urban counterparts.⁴⁶ This notion, which became known as the locality rule, was unknown in English common law and was unsupported by any state appellate decision until 1870. Nevertheless, judges often used it in instructing juries, and even without being instructed, juries were sympathetic to the plight of rural practitioners.⁴⁷

The locality rule was applied in the 1870 case of *Teft v. Wilcox*, in which the Kansas Supreme Court accepted the differences between rural and urban practice.⁴⁸ In the 1872 case of *Smothers v. Hanks*, the Iowa Supreme Court highlighted these differences and noted that it “is doubtless true that the standard of ordinary skill may vary even in the same state, according to the greater or lesser opportunities afforded the locality for observation and practice.”⁴⁹ And in the 1880 case of *Small v. Howard*, the Massachusetts Supreme Court upheld a trial court’s jury instruction that a physician was “bound to possess the skill only which physicians and surgeons of ordinary ability and skill, practicing in similar localities . . . ordinarily possess.”⁵⁰

Under the strictest form of the locality rule, a patient was required to prove that a physician violated the standard of care in the specific community in which he practiced. This

⁴⁵ Rickee N. Arntz, *Competency of Medical Expert Witnesses: Standards and Qualifications*, 24 CREIGHTON LAW REV. 1359, 1367 (1991).

⁴⁶ DE VILLE, *supra* note 9, 55.

⁴⁷ *Id.* at 56.

⁴⁸ *Teft v. Wilcox*, 6 Kan. 46 63, 64 (1870).

⁴⁹ *Smothers v. Hanks*, 34 Iowa 286 (1872), cited by DE VILLE, *supra* note 9, 212.

⁵⁰ *Small v. Howard*, 128 Mass. 131, 136 (1880), cited by DE VILLE, *supra* note 9, 212.

standard could only be established by physician experts practicing in the same community, and in the small communities in which the locality rule was most often applied, physicians other than the physician being sued were few in number and invariably unwilling to testify.⁵¹ Another offshoot of the locality rule was increased physician involvement in local and state medical societies, whose members were even more hesitant to testify against one another than they were against non-members because of their closer association with them. Thus, during the years of its wide use, the locality rule contributed to medical professionalization by inducing physicians to organize, not only to improve the profession but also for their own defense.⁵²

The physicians' penchant to organize eventually eroded the influence of the locality rule in many ways, however. As medical societies, the AMA, and state regulatory boards and bodies improved medical training in the late nineteenth century and eventually imposed continuing education requirements on practitioners, judges and juries became increasingly unwilling to accept the notion that rural and urban practice were—or should be—distinguishable.⁵³ At the same time, public awareness of medical technologies such as radiology, pharmaceuticals, and new surgical techniques in the early twentieth century led rural and suburban residents to demand such technologies for their own communities and to resent local physicians who did not respond to that demand.

By the 1970s, many states abandoned the locality rule in favor of national-based standards. Some states adopted a resource-based standard that acknowledges that some rural

⁵¹ Michelle Huckaby Lewis, et al., *The Locality Rule and the Physician's Dilemma: Local Medical Practices vs the National Standard of Care*, 297, JAMA 2633, 2634 (2007).

⁵² STARR, *supra* note 26, at 111.

⁵³ Lewis, *supra* note 51, at 2634.

physicians may not have access to the technology available in urban centers.⁵⁴ In the case of *Hall v. Hilbrun*, for example, the Mississippi Supreme Court specifically limited the reach of a national standard to a physician's care and skill but preserved the locality rule in the use of facilities and equipment.⁵⁵ Courts in other states, such as Tennessee, allowed the use of the locality rule to exclude the testimony of physician experts who were unfamiliar with local practice, or to determine what the applicable standard of care should be rather than who was qualified to testify about it.⁵⁶ In the 1970 case of *McCay v. Mitchell*, the trial court excluded the testimony of the plaintiff's expert witness, who was licensed to practice in Pennsylvania. The Tennessee Court of Appeals upheld the exclusion, and the Tennessee legislature subsequently enacted a statute requiring that physician experts be licensed in Tennessee or a contiguous state.⁵⁷

Although the locality rule persists in some form in twenty-one states, by 2007, twenty-nine states and the District of Columbia had adopted a national standard.⁵⁸ Further adoption seems inevitable because most judges and members of juries, who may be patients themselves, seem hesitant to accept anything that might appear inferior to a national standard in their own communities. By the same token, they appear increasingly willing to have those standards testified to by experts from other parts of the country that may have no relationship in those communities but represent the cutting edge of health care. Lewis and colleagues take the position that

⁵⁴ *Id.*

⁵⁵ *Hall v. Hilbrun*, 466 So 2d 856, 872 (Miss 1985).

⁵⁶ Arntz, *supra* note 45, at 1364.

⁵⁷ *McCay v. Mitchell*, 62 Tenn. App. 424, 463 (1970).

⁵⁸ Lewis, *supra* note 51, at 2634.

To enable medical malpractice cases to become more evidence-based, a resource-based, nationwide standard of care should be adopted in all jurisdictions . . . In jurisdictions that maintain the locality rule, basic principles of justice may not be met for patients who have been harmed as a result of suboptimal local standards.⁵⁹

Tacit acceptance of this position may help explain the demise of the locality rule.

b. Rules Regarding the Same School of Practice

As noted earlier, mainstream physicians and members of other schools of medicine, formally educated and licensed or not, routinely testified against one another in the first part of the nineteenth century. Allopaths and non-allopaths were required to provide ordinary care and skill according to their respective systems of treating disease but also might be held accountable if they did not follow the practices of another school.⁶⁰ In the 1860s, however, as medical licensing was becoming more widespread, legislatures and appellate courts began to limit practitioners from different schools from testifying against one another.⁶¹ Thus, homeopathic physicians could no longer testify against allopaths, who in turn could not testify against osteopaths until osteopathy and allopathy developed similar training programs in the twentieth century.

States today generally require that experts be of the same school as defendant physicians, although testimony may be allowed if one school has the same knowledge base as the other.⁶² Thus, in the 1979 case of *Dolan v. Galluzzo*, which involved the testimony of

⁵⁹ *Id.* at 2636.

⁶⁰ DE VILLE, *supra* note 9, at 53.

⁶¹ *Id.*

⁶² Arntz, *supra* note 45, at 1369.

orthopedic surgeons in a claim against a podiatrist, the Illinois Supreme Court agreed that in order for an expert to testify as to the standard of care of a particular school of medicine, the expert had to be licensed in that school because their standards and practices differed.⁶³ On the other hand, in the 1990 case of *Melville v. Southward*, the Colorado Supreme Court allowed orthopedists to testify against a podiatrist because they both performed the same procedure even though their licenses were not the same.⁶⁴

c. Rules Regarding the Same Practice Specialty

Throughout the 19th century, most mainstream physicians in the U.S. were general practitioners—also known as GPs or “country doctors”—who often numbered dentistry, pharmacy, psychiatry, medicine, and surgery among their professional activities.⁶⁵ In his history of the AMA, Fishbein writes that the national organization was founded by this sort of general physicians. Specialists were not mentioned as such at the first meeting of the AMA in 1846; twenty-two years later, the Committee on Specialization spoke for many AMA members in declaring that “the chief objection brought against specialties is that they operate unfairly toward the general practitioner in implying that he is incompetent to properly treat certain classes of diseases and in narrowing his field of practice.”⁶⁶ Over ninety percent of American

⁶³ *Dolan v. Galluzo*, 77 Ill. 2d 279, 396 (1979).

⁶⁴ *Melvin v. Southward*, 791 P. 2d 383, 388 Colo. Supreme Court (1990)

⁶⁵ John M. Luce & Richard L. Byyny, *The Evolution of Medical Specialism*, 22 PERSPECTIVES IN BIOLOGY AND MEDICINE 377, 381 (1979).

⁶⁶ MORRIS FISHBEIN, A HISTORY OF THE AMERICAN MEDICAL ASSOCIATION 19 (1947).

physicians were generalists at the end of the nineteenth century; as late as 1928, seventy-four percent of the country's 112,000 physicians still identified themselves as GPs.⁶⁷

Nevertheless, medical specialism gradually supplanted generalism in the U.S., to the extent that specialists now outnumber general practitioners. The process of medical specialization generally follows the following steps. First, as a result of clinical advances or the development of diagnostic or therapeutic equipment, a new group gains expertise in a given area. A society or organization is formed for an exchange of ideas and advances, and soon a publication appears, sponsored either by the organization itself or with the help of a larger body like the AMA, which now publishes several specialty journals in addition to JAMA. Membership in the organization then becomes a mark of distinction; certification in the field becomes established by the organization under the overall aegis of the American Board of Medical Specialties; institutions accept certification as evidence of accomplishment; and soon the institutions limit treatment, research, and teaching opportunities to those who are certified in the field.⁶⁸

The first medical specialty organization in the U.S. was the Boston Phrenological Society, which was founded in 1832.⁶⁹ (Based on the Greek words for "mind" and "knowledge," phrenology was a pseudoscience based on measurements of the skull.) The next in sequence, and the first whose descendant organization came to represent a legitimate scientific specialty, was the Association of Medical Superintendents of American Institutions for the Insane, created

⁶⁷ JAMES B. STERN, AMERICAN MEDICAL PRACTICE 46-45 (1945).

⁶⁸ Robert A. Chase, *Proliferation of Certification in Medical Specialties: Productive or Counterproductive?* 294 N. ENGL. J. MED. 497 (1975).

⁶⁹ Luce & Bynny, *supra* note 65, at 382.

in 1844, which eventually evolved into the American Psychiatric Association.⁷⁰ After psychiatry, the next field to identify itself as a specialty was ophthalmology, as practiced along with otolaryngology at the Massachusetts Eye and Ear Infirmary after it opened in 1821.⁷¹ Ophthalmologists separated themselves from otolaryngologists after the ophthalmoscope was introduced to the U.S. in 1861; in 1864, physicians familiar with the new device founded the American Ophthalmological Society. The American Journal of Ophthalmology was created a few years later, and in 1910 the Ophthalmological Society created the nation's first specialty examining boards.⁷² At the same time, following the introduction of the laryngoscope and the otoscope, the otolaryngologists created their own professional organization, journal, and specialty examining board.⁷³

Like ophthalmology and otolaryngology, the fields of obstetrics and gynecology and pediatrics originally were unified, as indicated by the fact that one of the country's first medical journals was the American Journal of Diseases of Women and Children, which was founded in 1869. Yet the independent American Gynecological Society and the American Pediatrics Society were organized in 1876 and 1889, respectively, and specialty boards were established for the separate fields. Taking the steps described earlier, similar fields like medicine and surgery eventually developed their own organizations, publications, and board certification process.⁷⁴ Once they achieved specialty status, many of the fields then became subspecialized; for example, the American Board of Internal Medicine offers specialty certification in general

⁷⁰ *Id.*

⁷¹ *Id.* at 383.

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.* at 384.

internal medicine and subspecialty certification in gastroenterology, cardiology, infectious diseases, and more than a dozen other subspecialties.⁷⁵

American courts initially allowed general physicians to testify against specialists and vice versa.⁷⁶ As specialism and subspecialism became more common, however, and as general and specialty practice increasingly deviated, states such as Virginia and Florida passed statutes requiring that physician experts be practicing members of the same field as defendant physicians.⁷⁷ The Virginia statute requires merely that experts be in the same field as defendant physicians.⁷⁸ The Florida statute goes further, mandating that experts be certified by specialty boards in the same field as defendants.⁷⁹ Nevertheless, this requirement can be waived if the trial judge considers the expert competent to testify to the standard of care the defendant must meet.⁸⁰ Thus, in the 1981 case of *Chenoweth v. Kemp*, the Florida Supreme Court held that two neurologists could testify against an anesthesiologist and a gynecologist because the neurologists were familiar with the standard of care of the other two specialties.⁸¹

Other states have allowed latitude in expert testimony similar to that of Florida, usually making the competence of a physician expert to testify a matter of the trial court's discretion.⁸² Nevertheless, as medical specialism has grown across the U.S., courts increasingly have restricted the testimony of physician experts from one specialty for or against physicians from another. For example, in the 1984 case of *Connelly v. Kortz*, a Colorado trial court ruled that the

⁷⁵ AMERICAN BOARD OF INTERNAL MEDICINE. www.abim.org/specialty/default/asp. (Last accessed July 20, 2013).

⁷⁶ Arntz, *supra* note 45, at 1637.

⁷⁷ *Id.*

⁷⁸ VA. CODE ANN. §8.01-581.20 (Supp. 1989).

⁷⁹ FLA. STAT. ANN. §766.102 (West Supp. 1990).

⁸⁰ Arntz, *supra* note 45, at 1367.

⁸¹ *Chenoweth v. Kemp*, 396 So. 2d 1122, 1125 (Fla. 1981).

⁸² Arntz, *supra* note 45, at 1368.

plaintiff's expert, a physician of internal medicine, could testify as to when an internist would consider surgery indicated but could not testify as to when a surgeon would deem it necessary.⁸³ The Colorado Court of Appeals upheld the trial court's ruling on the grounds that the internist was not sufficiently familiar with the standard of care of the defendant surgeon's specialty.⁸⁴ Requiring that those who testify against them operate under the same standards seems fair to physician defendants. On the other hand, this requirement would be unfair to plaintiff patients if specialists were unwilling to testify against one another because they had closed ranks in a common defense.

d. Rules Regarding the Same Practice

Although state statutes and court decisions increasingly require that physician experts and defendants be in the same specialty, no universal requirement has been made that they have a similar or the same practice. This requirement might seem unnecessary because experts are supposed to testify about what physicians generally do, not about how the experts conduct themselves. Nevertheless, that a particular expert surgeon has performed the same type of operations as a defendant in the same field should naturally enhance the expert's authority. In the 2009 case of *Condra v. Atlanta Orthopedic Group, P.C.*, the Georgia Supreme Court allowed the plaintiff to inquire into the personal practice of a defense expert because such evidence could be helpful to the jury in determining the expert's credibility.⁸⁵ Because practices differ, matching physician experts with physician defendants on the basis of practice similarities is difficult to achieve for plaintiff and defense attorneys seeking witnesses. Nevertheless, when

⁸³ *Id.*

⁸⁴ *Connolly v. Kortz*, 689 P. 2d 728, 729 (1984).

⁸⁵ *Condra v. Atlanta Orthopedic Group, P.C.* 681 S. E. 2d 152, 154 (2009).

such experts are available, their testimony may be highly compelling, especially if they can speak not only to what they do in their own practices but also what other specialists in their field would do. Moreover, surveys of specialists could be used to complement the testimony of single adversarial experts in determining the standard of care.⁸⁶

C. The Development of Federal Rules of Evidence Regarding Physician Experts

For many years, expert opinion was admissible as evidence if it met the test of being generally accepted in a particular discipline.⁸⁷ This test was articulated in the 1923 case of *Frye v. United States*, when the D.C. Court of Appeals held as follows:

When the question involved does not lie within the range of common experience or common knowledge, but requires special experience or special knowledge, then the opinions of witnesses skilled in that particular science, art, or trade to which the question relates are admissible in evidence. . . Just when a scientific principle or discovery crosses the line between the experimental and demonstrable stages is difficult to define. Somewhere in this twilight zone the evidential force of the principle must be recognized, and while courts will go a long way in admitting expert testimony deduced from a well-recognized scientific principle or discovery, the thing from which the deduction is made must be sufficiently established to have gained general acceptance in the particular field in which it belongs.⁸⁸

In the *Daubert* case, the United States Supreme Court interpreted Federal Rule of Evidence 702 and found that *Frye* did not provide the standard for admitting expert scientific testimony in federal trials.⁸⁹ *Daubert* moved the standard for admissibility of scientific evidence from *Frye*'s general acceptance test to one that considered the scientific basis of such

⁸⁶ Tim Cramm, Arthur J. Hartz & Michael D. Green, *Ascertaining Customary Care in Malpractice Cases: Asking Those Who Know*, 37 WAKE FOREST L. REV. 699, 725 (2002).

⁸⁷ *Frye v. United States*, 293 F. 2d 1013 (1923).

⁸⁸ *Id.* at 1014.

⁸⁹ *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579, 589 (1993).

evidence. In order to assist courts in assessing the reliability and validity of the principles and methods underlying expert testimony, *Daubert* provided several non-exclusive guidelines, including: 1) whether a theory or technique is based on a testable hypothesis (and has been tested), 2) whether the theory or technique has been subjected to peer review and publication, 3) whether the theory or technique has a known or possible error rate, and 4) whether the theory or technique is generally accepted.⁹⁰ In subsequent cases—*General Electric Co. v. Joiner* in 1997⁹¹ and *Kumho Tire*⁹² in 1999—the Court clarified the standard of appellate review of *Daubert* trial court rulings and held that trial court judges should evaluate all expert testimony, including that requiring technical but not necessarily scientific knowledge, to determine its admissibility.

Although the Federal Rules are determining only in federal courts, they have influenced state courts across the country. In some states, judges closely scrutinize both the qualifications and opinions of expert witnesses, including physician experts in medical malpractice matters, to determine whether their testimony should be admitted. In other states, either the *Daubert* rules are used only nominally, or the *Frye* rule is applied instead. But regardless of which rules prevail, the assumption that expert witnesses are expected to “help the trier of fact understand the evidence or determine a fact in issue” under Federal Rule 702 is accepted throughout the U.S. As Bal cautions, courts assume “that expert witnesses retained by feuding parties are independent, and that they will testify honestly as educators and not as advocates for one side

⁹⁰ *Id.* at 595-596.

⁹¹ *General Electric Co. v. Joiner*, 522 U.S. 136, 142 (1997).

⁹² *Kumho* at 152.

or another.”⁹³ In their capacity of educators, physician experts have an obligation not only to support their own positions but also to identify positions inconsistent with their own.

Bal’s caution is consistent with the decision in *Kumho Tire* in that it holds physician experts who are testifying to the same intellectual rigor they would use at the bedside. When evaluating patients, for example, physicians generally sort through a list of diagnoses—called the differential diagnosis—and weigh the pros and cons of each in coming to conclusions about what ails the patients. After the physicians decide on the most likely diagnoses in their differentials, they discuss them with the patients or their surrogates. Available therapeutic options then are explored, along with whatever scientific research supports their use and the physicians’ recommendations regarding them. The patients or surrogates then select what they believe to be the most suitable option. This process of achieving consent that is truly informed usually requires that physicians consider and elucidate a number of alternative diagnoses and treatments at the bedside, just as they may be asked to do during a deposition or in court.

D. Judicial Immunity of Expert Witnesses

Physician expert witnesses traditionally have been granted absolute immunity from civil liability regarding their testimony in malpractice cases. According to Cohen, “The immunity privilege is a judicially created privilege founded on the belief that the administration of justice requires witnesses in a legal proceeding to be able to discuss their views without fear of a

⁹³ Bal, *supra note* 4, at 384.

defamation lawsuit.”⁹⁴ This privilege, which was originally confined to justices, attorneys, legislators, and military personnel, was extended to expert witnesses in the 1989 case of *Bruce v. Byrne-Stevens and Assoc. Eng’r, Inc.*, in which the Washington Supreme Court granted immunity to an engineer who testified as an expert witness to “preserve the integrity of the judicial process by encouraging full and frank testimony.”⁹⁵ In the 1987 case of *Kahn v. Burman*, the U.S. District Court in Michigan granted similar immunity to a physician expert who had testified regarding the standard of care in a malpractice suit.⁹⁶

Although most state and federal courts continue to grant immunity to experts from medicine and other professions, Bal warns that the immunity privilege increasingly is challenged.⁹⁷ He points out that, in the 2000 case of *Pollock v. Panjabi*, a Connecticut trial court ruled against absolute immunity for experts whose testimony about a plaintiff’s injuries was alleged to be inadequate and incomplete.⁹⁸ In the case of *Marrogi v. Howard* in 2002, the Supreme Court of Louisiana refused to bar a claim against a retained expert witness arising from “the expert’s allegedly deficient performance of his duties to provide litigation services, such as the formulation of opinions and recommendations, and to give opinion testimony before and during trial.”⁹⁹ Cases such as these are a reminder that physicians may not enjoy absolute immunity if they do not provide the same degree of skill and care exercised by other members of their profession in providing expert testimony, especially in states that consider such testimony a part of medical practice.

⁹⁴ Cohen , *supra* note 37, at 197.

⁹⁵ *Bruce v. Byrne-Stevens and Assoc. Eng’r, Inc.*, 113 Wash, 2d 123, 126 (1989).

⁹⁶ *Kahn v. Burman*, 673 F. Supp. 210, 212 (1987).

⁹⁷ Bal, *supra* note 4, at 385.

⁹⁸ *Pollock v. Panjabi*, 27 Conn. L. Rptr. 316 (2000).

⁹⁹ *Marrogi v. Howard*, 805 So. 2d 1118, 1133 (La. 2002).

II. RECENT STATE MEDICAL BOARD ACTIONS

By 2006, some twenty-two state legislatures had enacted minimum qualifying standards for physician experts.¹⁰⁰ Most of these laws spell out the basic requirements of holding a medical license and having an active clinical practice. Some states, such as Ohio, require that physician experts spend more than half their professional time in patient care or teaching.¹⁰¹ In addition, although most state medical practice acts have not included the testimony and other activities of physician experts in their definitions of what constitutes medical practice, some states are considering this inclusion, as noted earlier. In this regard, California's Attorney General and Deputy Attorney General opined in 2004 that

(w)hen a physician testifies as an expert in a civil proceeding regarding the applicable standard of medical care and whether the defendant has breached that standard, the physician may be subject to professional discipline by the Medical Board of California if the testimony constitutes unprofessional conduct.¹⁰²

In 2004, the Medical Board of California alerted physicians in that state of the Attorney General's and Deputy Attorney General's opinion and advised that "It is clearly unethical and unprofessional conduct to offer false testimony."¹⁰³ The medical board also warned testifying physicians to avoid potential referral to the board for unprofessional conduct or dishonesty.¹⁰⁴ In 2009, the medical board revoked the license of an ophthalmologist after a charge of

¹⁰⁰ Aaron S. Kesselheim & David M. Studdert, *Role of Professional Organizations in Regulating Physician Expert Witness Testimony*, 298 JAMA, 2907, 2908 (2007).

¹⁰¹ OHIO REV. CODE ANN. §2743.43 (Baldwin 1889).

¹⁰² OFFICE OF THE ATTORNEY GENERAL, STATE OF CALIFORNIA. OPINION OF BILL LOCKYER, ATTORNEY GENERAL, AND GREGORY L. GONOT, DEPUTY ATTORNEY GENERAL (03-1201). <http://ag.ca.gov/opinions/pdfs/03-1201.pdf> (last updated April 28, 2004) (last accessed July 16, 2013).

¹⁰³ MEDICAL BOARD OF CALIFORNIA ACTION REPORT, OCTOBER 2004 <http://www.caldocinfo.ca.gov> (last accessed September 20, 2013).

¹⁰⁴ *Id.*

dishonesty, gross negligence, incompetence, and unprofessional conduct.¹⁰⁵ Among other things, the ophthalmologist was alleged to have misrepresented his expertise and giving testimony “completely unsupported by the medical community or literature.”¹⁰⁶ These dishonest acts were substantially related to the qualifications, functions, and duties of a physician and surgeon.”¹⁰⁷

Although the California ophthalmologist did not appeal the medical board’s decisions, other physicians have done so after being dismissed for allegedly giving unethical testimony. For example, when a trial court allowed the North Carolina Medical Board to revoke the license of a physician who testified that a defendant physician had falsified a medical record without supporting evidence, the North Carolina Court of Appeals, in the 2003 case of *In re Lustgarten*, overturned the revocation on the grounds that the testimony was made on the basis of good faith.¹⁰⁸ In the 1991 case of *Bd. of Reg. for the Healing Arts v. Levine*, the Missouri Court of Appeals upheld the dismissal of charges brought by the Missouri Board of Registration for the Healing Arts against a physician who, while testifying as an expert under oath, had allegedly given false testimony about how many times he had taken a specialty board examination before passing.¹⁰⁹ The court did so on the basis that the expert testimony given by the physician could not be included under the practice of medicine under Missouri law.¹¹⁰

¹⁰⁵ MEDICAL BOARD OF CALIFORNIA NEWS RELEASE—APRIL 29, 2009. http://mba.ca.gov/board/media/releases_2009_04-29_kern.html (last accessed September 20, 2013).

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ *In re Lustgarten*, 629 S.E. 2d 886, 891 (N.C. Ct. App. 2006).

¹⁰⁹ *Bd. of Reg. for the Healing Arts v. Levine*, 808 S.W. 2d 440, 441 (Mo. App. 1991).

¹¹⁰ *Id.* at 443.

The Florida legislature in 2011 revised its state statutes regarding medical malpractice to require that physician experts actively practice in the same specialty as the physicians against whom or on whose behalf they are testifying.¹¹¹ In addition, the legislature empowered the Florida Board of Medicine to issue certificates authorizing physicians licensed in other states to provide expert testimony in Florida only if they submit proof of their licenses along with an application fee. Although these certificates do not allow out-of-state physicians to practice in Florida, the statute provides that “an expert witness certificate shall be treated as a license in any disciplinary action, and the holder of an expert witness certificate shall be subject to discipline by the board.”¹¹² The implication of this provision is that out-of-state experts could be sanctioned by the Florida Medical Board for giving false testimony about either their qualifications and perhaps even about the scientific basis of their opinions. Whether the physician experts could then be sanctioned reciprocally in the states in which they are licensed to practice remains unclear.

III. OVERSIGHT BY PROFESSIONAL ORGANIZATIONS

In 1983, the then-editor of JAMA asked “Should some system of peer review be active at the level of expert witnesses just as it is in medical journal publication, academic appointments, hospital medical staff appointments, and the like?”¹¹³ In the 1990s, the AMA House of Delegates answered this question by passing resolutions stating that expert witness testimony should be considered part of the practice of medicine and subjected to peer review, the same

¹¹¹ FLA. STAT. § 766.102 (2011).

¹¹² FLA. STAT. § 458.3175 (2011).

¹¹³ George B. Lundberg, *Expert Witness for Whom?* 252 JAMA 251, 251 (1984).

answer that some states have given.¹¹⁴ The AMA ultimately developed a policy that reads “AMA policy is that (1) the giving of medico-legal testimony by a physician expert be considered the practice of medicine, and (2) all medico-legal expert witness testimony given by a physician should be subject to peer review.”¹¹⁵ By 2004, at least thirty-eight of the 104 state member organizations of the House of Delegates had incorporated into their codes of ethics provisions that addressed their members’ conduct as expert witnesses.¹¹⁶ Many of these codes now contain statements that the giving of expert testimony should be held to the same standards as medical practice.

The current AMA *Code of Ethics* acknowledges, first and foremost, that “In various legal and administrative proceedings, medical evidence is critical. As citizens and as professionals with specialized knowledge and experience, physicians have an obligation to assist in the administration of justice.”¹¹⁷ The code then advises that

Physicians who serve as fact witnesses must deliver honest testimony. This requires that they engage in constant and continuous self-examination to ensure that their testimony represents the facts of the case . . . When physicians choose to provide expert testimony, they should have recent and substantive experience or knowledge in the area in which they testify, and be committed to evaluating cases objectively and to providing an independent opinion. Their testimony should reflect current scientific thought and standards of care that have gained acceptance among peers in the relevant field. . . Physician testimony must not be influenced by financial compensation; for example, it is unethical for a physician to accept compensation that is contingent upon the outcome of litigation. . . Organized medicine, including state and specialty societies, and medical licensing boards can help maintain high standards for medical witnesses

¹¹⁴ Michael J. Weintraub, *Medical Expert Witnesses*, 353 LANCET, 2076, 2076 (1999).

¹¹⁵ AMA POLICY H-265.993 PEER REVIEW OF MEDICAL EXPERT WITNESS TESTIMONY. <http://search0.ama-assn.org/search/pfonline/?chkCEJ=CEJ&query=H-295.993> (last accessed July 16, 2013).

¹¹⁶ Kesselheim & Studdert, *supra* note 100, at 2908.

¹¹⁷ AMERICAN MEDICAL ASSOCIATION. OPINION 9.07-MEDICAL TESTIMONY. <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical> ethics (last accessed July 16, 2013).

by assessing claims of false or misleading testimony and issuing disciplinary sanctions as appropriate.¹¹⁸

The AMA does not discipline physicians for failing to follow its ethical guidelines. Instead, it leaves discipline up to state medical societies, most of which have adopted the guidelines developed by the AMA. However, because the actions of state societies are not available to the public, whether physicians have been disciplined for alleged unethical conduct in testifying as experts can only be learned if physicians appeal state medical society actions through the courts.

In the 2006 case of *Fullerton v. Florida Medical Association*, the Florida Court of Appeal held that the Florida Medical Association could not legitimately discipline a physician expert from California who testified against three Florida physicians because he was not a member of the medical association, even though he had a medical license to practice in that state.¹¹⁹ The court also held that Florida's peer review immunity statute did not shield the state medical association or its peer review committee from the California physician's claim that the Florida physicians had defamed him by publicly criticizing his conduct as an expert.¹²⁰ The California physician also argued that the Florida Medical Association's peer review process was designed primarily to intimidate and deter physician experts such as him from testifying against association members.¹²¹ Whether this was true or not, it is an argument that likely will be made when other state medical societies attempt to discipline their own members who testify.

¹¹⁸ *Id.*

¹¹⁹ *Fullerton v. Florida Medical Association*, 938 So. 2d 587, 588 (2006).

¹²⁰ *Id.*

¹²¹ *Id.*

In keeping with the positions taken by the AMA and state medical societies, most specialty societies have created guidelines for expert witness testimony in medical malpractice litigation and peer review mechanisms to enforce them. The first to do so, in 1983, was the American Association of Neurological Surgeons (AANS); by 2007, at least eighteen other societies—ranging from the American Academy of Pediatrics to the American College of Surgeons—had followed suit.¹²² The AANS *Code of Ethics* parallels that of the AMA. It calls upon neurosurgeons “to be an impartial advisor to attorneys, jurors, and the court. . . not to be evasive for the purpose of favoring one litigant over another. . . and to review all pertinent available medical information prior to rendering an opinion.”¹²³ Neurosurgeons also are reminded to rely on scientific knowledge or experience and a standard of care that is widely accepted among peers, as stated by the AMA.¹²⁴

The AANS is a voluntary organization like other specialty societies and the AMA itself. Yet more specialists belong to specialty societies than they do to the AMA, and specialty society membership is more professionally desirable than AMA membership because it leads to greater professional credibility. At the same time, adherence to the AANS *Code of Ethics* is considered an obligation of membership, just as adherence to the AMA *Code of Ethics* is considered an obligation of membership in the AMA, and it may be easier to enforce because the specialty societies are smaller and more intimate. Complaints to the AANS of ethics violations are evaluated by a Professional Conduct Committee, which “reviews submissions of both the

¹²² Kesselheim & Studdert, *supra* note 100, at 2908.

¹²³ AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS, BULLETIN 15, 2006. PROFESSIONAL CONDUCT – WITNESS TESTIMONY
<http://www.aans.org/AANS%20and%20JNSPG%20/Publications/AANS%20Neurosurgeon/AANS%20Neurosurgeons%20Issues/2006/Summer/%202006%20-%20/Issues%20/ProfessionalConduct> (last accessed January 22, 2013).

¹²⁴ *Id.*

complainant and respondent and makes a decision as to whether or not unprofessional conduct is apparent.”¹²⁵ If the case is not dismissed, the case is reviewed at a hearing. The complainant and respondent, who may have counsel in attendance, present testimony, and the proceedings are reported by a court reporter. The committee then goes into executive session. If an adverse action (censure, suspension, or expulsion) is recommended, the respondent may appeal to the AANS Board of Directors or to the general membership at its annual meeting. As of 2006, “To date there have been eighty complaints filed and sixty-five of these have involved expert testimony. Sixty hearings had been held, resulting in nine letters of censure, thirty-three suspensions, and five expulsions. There have been five repeat offenders.”¹²⁶

Dr. Donald Austin, a member of the AANS, was suspended by the society because of his testimony in a malpractice suit against another member of the society. Dr. Austin subsequently brought action against the AANS on the grounds that the suspension undercut his credibility as an expert and led to economic loss.¹²⁷ The District Court for the Northern District of Illinois entered summary judgment in favor of the AANS,¹²⁸ and Dr. Austin appealed. The AMA, the Illinois Medical Association, and other groups subsequently filed a brief supporting the actions of the AANS in disciplining its member. The brief stated that

Because the rendering of expert witness testimony constitutes the practice of medicine, *amici* believe that the testimony should be subject to the same exacting standards of professionalism expected of a physician in any other sphere of his or her practice. Additionally, expert witness testimony is subject to

¹²⁵ *Id.*

¹²⁶ *Id.* at 1154.

¹²⁷ *Austin v. American Ass’n of Neurological Surgeons*, 120 F. Supp. 2d 1151, 1153 (2000).

¹²⁸ *Id.* at 1155.

peer review, and any physician failing to maintain standards set by the profession should be disciplined accordingly.¹²⁹

In the 2001 case of *Austin v. American Ass'n of Neurological Surgeons*, the Seventh Circuit upheld the District Court's decision in favor of the AANS.¹³⁰ Writing for the majority, Judge Posner noted that the neurosurgeon did not have an "important economic interest" in continued membership in the AANS, although such membership enhanced his credibility.¹³¹ Judge Posner also stated that the AANS had not acted in bad faith through its disciplinary process, and that the neurosurgeon could not obtain damages for injury to his professional reputation as a result of accurate revelation of what the AANS claimed, and the court agreed, was irresponsible testimony.¹³²

Judge Posner acknowledged in *Austin* that

There is a great deal of skepticism about expert testimony. It is well known that expert witnesses are often paid very handsome fees, and common sense suggests that a financial stake can influence an expert's testimony, especially when the testimony is technical and esoteric and hence difficult to refute in terms intelligible to judges and juries. More policing of expert witnesses is required, not less. Not that professional self-regulation is wholly trustworthy. Professional associations have their own axes to grind. No doubt most members of the AANS are hostile to malpractice litigation, and this may impart a subtle bias to the Association's evaluation of member's complaints, though there is nothing in the transcript of the hearing before the Association's hearing panel to justify such an inference.¹³³

Despite this possible bias, the court found no basis for the neurosurgeon's claim that the AANS "entertains only complaints against members who testify on behalf of malpractice

¹²⁹ Brief for Defendant-Appellee at 2 *Austin v. American Ass'n of Neurological Surgeons*. 253 F. 3d 967 (2001). (2000).

¹³⁰ *Austin v. American Ass'n of Neurological Surgeons*. 253 F. 3d 967, 974 (2001).

¹³¹ *Id.* at 971.

¹³² *Id.* at 972.

¹³³ *Id.* at 973.

plaintiffs,” reasoning that defendant neurosurgeons would be the only AANS members likely to bring complaints.¹³⁴ At the same time, the *Austin* court endorsed the disciplinary process of the AANS—and, by extension, the processes of other specialty organizations—as methods of “Identifying and sanctioning poor quality physicians and thereby improving the quality of health care.”¹³⁵

Kesselheim and Studdert agree with the court’s view in *Austin* that specialty organizations can help ensure the quality of physician experts.¹³⁶ Yet they also share the court’s concern that these organizations have an inherent conflict of interest and are unlikely to be truly impartial.¹³⁷ One reason for partiality might be that physicians generally are biased towards members of their profession and that this bias permeates their organizations. In addition, Kesselheim and Studdert argue,

Ethical reviews by professional societies have largely been used to address testimony by plaintiff’s experts. When unprofessional conduct occurs among defense witnesses, the parties most affected (the plaintiff and possibly also the plaintiff’s lawyer) will not have access to the professional organizations’ programs because they are not members. Opening access to nonmember complaints would address the problem in theory, but plaintiffs and their attorneys may still avoid them because of their intrinsic connection with the medical profession.¹³⁸

Kesselheim and Studdert believe that proper oversight of expert witnesses necessitates a neutral body, perhaps part of a state government agency or medical board. “This body could operate similarly to profession-run programs—mimicking their procedures, using their

¹³⁴ *Id.* at 972.

¹³⁵ *Id.* at 974.

¹³⁶ Kesselheim & Studdert, *supra* note 100, at 2909.

¹³⁷ *Id.*

¹³⁸ *Id.*

expertise, and even accepting case referrals from them—but would entertain complaints from all comers.”¹³⁹ The review committee could include patient and community representatives as well as physicians. Because of its situation within a government agency or medical board, the committee could penalize experts who are judged to have testified irresponsibly not just with revocation of membership in a professional society but also, especially in the case of repeat offenders, with license suspension or fines.¹⁴⁰

Although history suggests that mainstream physicians are biased in favor of one another, the finding that professional societies have reviewed testimony from plaintiff experts within their midst suggests that this bias is less pronounced than it once was. Indeed, through the statement in its current *Code of Ethics* that physicians have “an obligation to assist in the administration of justice,” the AMA has seemingly adopted neutrality as a necessity for expert witnesses in malpractice litigation. If this neutrality permeates specialty societies such that they review testimony by defense as well as plaintiff experts, and if the results of these reviews are made available to nonmembers of the societies, the external oversight of experts proposed by Kesselheim and Studdert may not be necessary.

IV. THE EDUCATION AND CERTIFICATION OF PHYSICIAN EXPERT WITNESSES

Physicians who serve on professional or public review committees, like the expert witnesses whose conduct they are asked to evaluate, should be as free from bias as possible. Boyarsky has offered six measures to reduce bias among expert witnesses:

¹³⁹ *Id.*

¹⁴⁰ *Id.*

1) testify for the plaintiff and the defendant in different cases, 2) assess the merits of a case separately from agreeing to testify, 3) insist on reviewing all records thoroughly, 4) develop a solid medical posture for each case, 5) review the case in a balanced and critical manner, and 6) articulate carefully the standard of care in words before expressing it in deposition or at trial.¹⁴¹

These measures are similar to those contained in the ethical codes of many specialty organizations.

Another possible prerequisite would be education in the law, at least to the extent that the legal principles underlying malpractice litigation are learned. Education of this sort could be gained through instruction in areas such as Torts, Civil Procedure, and Evidence in a Master of Studies in Law program at a law school or in postgraduate courses given by the AMA, local or state medical societies, specialty organizations, or law schools. McAbee recommends that specialty organizations review the possibility of forensic board certification, as already exists in fields like pathology and psychiatry, for suitably trained physicians.¹⁴² He argues, "Certification would require successful completion of an examination that may include basic medical-legal, statistical, and epidemiological principles applicable to the relevant specialty." Moreover, McAbee asserts, "Certification by a forensic board would subject the expert to all board regulations, which could include some form of peer review."¹⁴³

Coupled with the aforementioned experiential and educational prerequisites, certification would represent the ultimate professionalization of physician expert witnesses. It

¹⁴¹ Saul Boyarsky, *Practical Measures to Reduce Medical Expert Witness Bias*, 34 J. FORENSIC SCIENCES, 1259, 1259 (1989).

¹⁴² Gary N. McAbee, *Improper Expert Medical Testimony: Existing and Proposed Mechanisms of Oversight*. 19 J LEGAL MED. 257, 270 (1998).

¹⁴³ *Id.*

would allow specialty organizations to provide qualified, minimally biased experts for their internal review processes, for external review boards such as those proposed by Kesselheim and Studdert, and for plaintiff and defense attorneys seeking expert assistance.¹⁴⁴ Certified physician experts also might assist judges and juries either in malpractice trials and arbitration hearings as they presently exist. Certification would not necessarily give experts automatic or expedited entry to the courtroom, and judges would maintain the independence and responsibility of determining experts' qualifications, as they do under the Federal Rules of Evidence. Nevertheless, certification should be regarded as an important attribute when judges evaluate the qualifications of potential physician experts.

Conclusion

The development of professional standards for physician expert witnesses in medical malpractice litigation has resulted from the efforts of mainstream medicine to improve its performance and the efforts of governments and the courts to enhance the qualifications of physician experts if not regulate them externally. At least since *Kumho Tire*, the standards for evaluating the probative value of physician expert testimony have been the same under principles generally applicable to medicine and the law. The law requires that experts testify to empirically supported opinions and employ the same standards of professional practice that are used in evaluating medical research and in diagnosing and treating patients. The daily practice of medicine, likewise, demands that physicians rely on empirically supportable methods and, through informed consent, provide information on alternative diagnoses and treatments.

¹⁴⁴ Kesselheim & Studdert, *supra* note 100, at 2909.

These standards could be further advanced through the education and certification of physician expert witnesses.