The Physician as Expert Witness: Essential, But Who Regulates?

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Medical malpractice claims against physicians in state civil courts are fact-specific inquiries as to whether the medical care provided failed to meet the accepted standard of care.¹ The center of any medical malpractice trial revolves around the expert witness testimony provided by medical experts hired by both plaintiff and defense.² The nature of the process requires that at least one physician take the witness stand and testify, under oath, that a fellow physician’s surgical or medical practice was substandard. Such testimony is provided in person, and is often taken personally by the defendant physician.

Although there is no better example of the truly adversarial nature of our tort system than the often conflicting testimony from expert physicians on the same set of facts,³ the fact that presumably equally qualified physicians can offer diametrically opposed opinions to a jury raises three interesting and disturbing questions: (1) who, if anybody, regulates medical expert witness testimony; (2) how balanced is such policing?; and (3) who should regulate such testimony?

Three Approaches: The Courts, the States, and the Medical Profession

There are three non-overlapping systems which provide oversight of medical expert witness testimony.⁵ The first two (judicial and legislative) provide somewhat complimentary mechanisms for screening such testimony before the trier of fact either hears the case or reaches a decision; in some states both are mandatory. The third – oversight by medical professional organizations – operates predominately after a verdict has been reached in a medical malpractice trial.

The role of the judge as the “gatekeeper” to keep experts who either lack qualifications or espouse scientific theories which are not mainstream was firmly established in 1993 by the United States Supreme Court in its Daubert decision.⁶ Most states accept the Daubert framework for screening medical expert witness testimony. The four Daubert factors are: (1) “whether a theory of technique can be (and has been) tested” (testing); (2) “whether the theory or technique has been subjected to peer review and publication” (peer review); (3) “in the case of a particular scientific technique, the court ordinarily should consider

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¹ KENNETH S. ABRAHAM, THE FORMS AND FUNCTIONS OF TORT LAW, FOUNDATION PRESS (2nd Ed. 2002).
⁴ Russell K. Laros, Presidential Address: Medical-legal issues in obstetrics and gynecology, 192 AM. J. OBSTET. GYNECOL. 1883 (2005).
⁵ Aaron S. Kesselheim and David M. Studdert, Role of Professional Organizations in Regulating Physician Expert Witness Testimony, 298 JAMA 2907 (2007) [Hereafter referred to as Kesselheim].
the known or potential rate of error…and the existence and maintenance of standards controlling the technique’s operation” (error rate and standards); and (4) general acceptance.7

In addition to this judicial supervision of expert witness testimony, the legislatures of several states have attempted to regulate medical expert witness testimony, either directly through legislation requiring pre-litigation independent expert review of a potential medical malpractice action which states that malpractice did occur in order to a civil torts suit to be filed,8 or attempting to delegate strong oversight of expert medical testimony to the state medical board by passing a law requiring out-of-state physicians to obtain a medical license in that state in order to testify (as was done in South Carolina).9

The third type of oversight is the increased involvement by medical professional societies in “policing” expert witness testimony by their members over the past decade. Most often these are surgical societies who choose to “discipline” their members who provide expert witness testimony in court against other physicians who are members of the same society.10 These attempts to police physician expert witness testimony, unlike those of the courts and the state legislatures, are “after the trial” efforts. How such efforts will ultimately mesh with judicial and legislative efforts to manage medical expert witness testimony remains to be seen, but the one landmark case on point provides valuable insight into the legitimacy of the role the medical profession itself is carving out in this important area of civil litigation.

**Austin v. American Association of Neurological Surgeons (AANS)**

Donald C. Austin, a neurosurgeon and member of AANS, had his membership suspended by the AANS after testifying as a plaintiff’s medical expert against Dr. Ditmore, another AANS member. Dr. Austin testified that the patient’s/plaintiff’s neurological damage would not have occurred unless the defending physician Dr. Ditmore had been careless performing an anterior neck surgical fusion surgery, a neurosurgical procedure Dr. Ditmore was an acknowledged expert on and which Dr. Austin had far less surgical experience performing. Dr. Austin’s expert testimony concerning Dr. Ditmore’s surgical care was not persuasive to the lower court jury, which ruled in favor of the defending physician. After the conclusion of the malpractice trial, Dr. Ditmore then complained to the AANS about Dr. Austin’s testimony. The AANS determined that Dr. Austin’s testimony lacked a valid evidentiary basis and thus violated AANS expert witness

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7 Id.
8 David M. Kopstein, *An unwise “reform” measure*, TRIAL, JOURNAL OF THE ASSOCIATION OF TRIAL LAWYERS OF AMERICA, May 2003 at 26. “To reduce the number of ‘frivolous’ lawsuits against health care providers and other professionals, many states require plaintiffs to provide a ‘certificate of merit.’ This is the generic germ applied to a variety of special certifications-usually supplied by medical experts-that verify the legitimacy of claims involving professional standards of care.”
9 The South Carolina Supreme Court overturned this law because it potentially could have excluded some of the nation’s leading medical scholars from testifying in South Carolina courts. See Kesselheim, supra note 5.
10 Id.
guidelines as well as the AANS ethics code. Dr. Austin subsequently sued the AANS, claiming that his suspension was retaliation for testifying against another physician.

The lower court granted summary judgment to the AANS, finding that Dr. Austin had a fundamentally fair hearing and was unable to demonstrate bad faith on the part of the AANS. The lower court did recognize that the disciplinary action might result in loss of significant income as an expert witness, but nevertheless embraced the essential public policy good that professional societies provide by policing medical expert testimony. This latter point was affirmed on appeal by the 7th Circuit Court of Appeals; Judge Posner expressed in particularly forceful terms the notion that poor medical expert testimony likely reflected poor medical practice, and “discipline by the Association therefore served an important public policy.” On a less distinguished note, Judge Posner also stated that a loss of up to one-third of income did not constitute a significant economic impact. Summarizing the tone of the court’s opinion, Judge Posner went on to write “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…More policing of expert witnesses is required, not less.” Of course, the logic of this position is equally applicable to medical experts who testify for the defense of physicians.

From a policy point of view, there may be a disconnect between the court’s rhetoric and what happens in the real world. In retrospect, it is unclear how Dr. Austin’s testimony satisfied all four of the Daubert criteria for expert witness testimony since the evidentiary basis for his claim was absent; there was no question that Dr. Austin had only performed a very small number of the surgical case at hand and could provide no surgical textbook or medical literature evidence to support his expert witness opinion that Dr. Ditmore, and acknowledged expert on the procedure, could only have been careless in his surgical care. This lends some support to the considerable skepticism about whether judges are effective as gatekeepers for screening expert witness testimony.

Perhaps medical professional societies or a state medical board including physicians will be tougher on their experts than judges are: when the North Carolina state medical board revoked the medical license of a physician expert because he had falsely testified in a medical malpractice trial that the defending physician had falsified a medical record without having any evidence to support the claim, an appeals court overturned the license revocation because the expert witness had made the statement in good faith.

11 Austin v. American Association of Neurological Surgeons, No. 98 C 7685 (N.D.Ill. October 20, 2000).
12 Austin v. American Association of Neurological Surgeons, 253 F.3d 967 (7th Cir. 2001).
13 Id. at 972-73.
14 Id.
15 Id.
16 Id.
18 In re James Lustgarten, 629 SE 2d 886 (NC Ct. App. 2006).
How do Medical Professional Societies Regulate Expert Testimony by Their Members?

Medical professional societies justify intervening on some occasions because expert testimony can be blatantly false, can be motivated purely by monetary concerns, may not properly address the issue of whether the conduct was below the standard of care (i.e. is not “evidence-based”), or might be “irresponsible.” Responsible testimony has been defined by some medical societies as testimony which is truthful. How such determinations are arrived at by medical societies, and precisely how the individuals passing such judgments are qualified to reach these conclusions, is not completely transparent.

The Austin case remains the only significant judicial decision on the legitimacy of disciplinary actions of medical societies against its members who provide expert witness testimony which runs afoul of medical society bylaws, and it certainly provides no impediment to medical societies’ determination to continue this policy. The issue of whether there is a single uniform standard by which expert testimony could or should be judged aside, there is a legitimate concern that the medical profession could, as least theoretically, retaliate through its professional societies against only those physicians testifying against other physicians despite having gone on record acknowledging the importance of such testimony. This would be more medical professional protection than regulation, and would not be consistent with the public policy objectives touted in Austin.

For example, although it is the stated position of the American College of Surgeons that it “encourages its fellows and other physicians to act as experts, and we look at it in a balanced fashion. We understand the need for experts, and we are not siding with defense experts,” the “Disciplinary actions taken” section of the most recent Bulletin of the American College of Surgeons reveals that three of the total of six physicians listed were “admonished following charges that this surgeon had violated Article VII, Sections 1(f) and (i) of the Bylaws when he provided expert witness testimony in a particular malpractice lawsuit” without providing either the names of the particular physicians, stating exactly how the Bylaws were violated by their expert testimony, or even noting whether the experts were testifying for plaintiff or defense. The appearance of physicians serving as medical malpractice experts in the “Disciplinary actions taken” section of this professional society journal is a relatively recent phenomenon.

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20 Gerald B Healy and Lisa H. Healy, *Honesty is the ONLY Policy: Physician Expert Witnesses in the 21st Century*, 199 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS NOVEMBER 741 (2004). For example, “A physician who testifies one way in one trial, and then gives the exact opposite opinion in a medically identical situation in a second trial, is clearly lying in one of the trials.”
21 *Austin*, supra note 7.
22 Healy and Healy, supra note 9.
24 *Id.*
25 *Id.*
Though it is possible that a plaintiff’s medical expert, or the patient him/herself could file a complaint with a medical association for irresponsible medical expert testimony by a defense expert, he or she has little incentive to do so since they are not on trial. There is no filing on an expert witness physician with the National Practitioner Data Bank if they are on the losing side. A plaintiff complaining to a medical professional society about the expert medical testimony offered in court by a defense expert might not have “standing” to complain to a voluntary medical professional society, and would likely be referred to the State Medical Board as the proper forum if disciplinary action of medical professional conduct were sought. There is simply no data on whether supervision by medical societies is being selectively applied only to plaintiffs’ experts, and little formal study of medical experts who routinely testify on behalf of physicians. Though a fair amount has been written about the composition of the pool of medical experts who work for plaintiffs’ attorneys in “bad baby” cases, virtually nothing has been written about the characteristics of the experts who defend physicians in such cases.  

Where Things Stand

At the present time the general concept of medical societies “policing” expert witness testimony seems to have been embraced by courts, and such societies appear to have a free hand thus far as to how they police their members. No data exist as to the effectiveness of the current approach by medical societies to improve the quality of physician expert witness testimony. Once punishment by surgical societies for expert testimony develops demonstrable economic and professional clout, it is likely that courts will become more involved in whether the disciplinary conduct of medical professional societies is fair and balanced. Moreover, the willingness to hear such cases may require waiting for a better case, and a closer call, than the fact pattern in Austin.  


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26 Kesselheim, supra note 5.
27 ld.