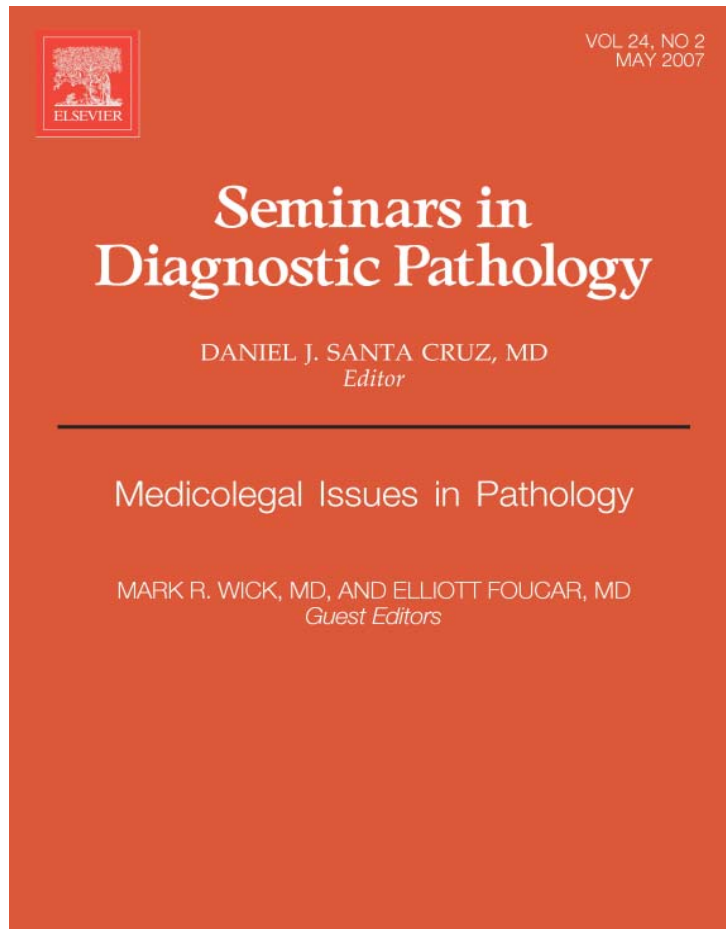


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# Tort reform: the pathologists' perspective

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## KEYWORDS

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Physicians who become ensnarled in malpractice litigation often feel that the tort system has treated them unfairly. This negative perception has fueled physician efforts to enact "reforms" intended to mitigate the damage that allegations of medical negligence currently have on both individual physicians and on the practice of medicine itself. Although physicians are generally enthusiastic about "reform," there is currently no definition that allows tort "reform" to be separated from related initiatives. Some physicians largely restrict the term to defendant-friendly changes in the rules and procedures governing the workings of the tort system, whereas others take a somewhat broader view. In the present paper, we have favored the broader approach to the topic, leading to a discussion of 30 measures that have been presented in the context of tort "reform." Although most of these measures involve changes in the complex rules governing the malpractice tort system itself (eg, capping jury awarded damages), our broader view of "reform" also includes attempts to exert influence on the tort system from the outside (eg, peer review of expert testimony) and measures designed to keep patient dissatisfaction out of the tort system (eg, apology for error). Some would argue for an even broader view of tort "reform" that would include measures for reducing the pool of dissatisfied patients. For example, trial lawyers have claimed that physicians have put far too much effort into "reforms" that reduce the legal consequences of committing medical errors, and not enough effort into "reforms" that would reduce the errors themselves. The latter point may or may not have some validity, but there is a natural demarcation between measures designed to align medical outcomes with patient expectations (eg, error reduction, better diagnostic technology) and others designed to improve the processes that resolve patient dissatisfaction. Only the latter meet our definition of tort "reform."

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*"Recurrent (malpractice) crises have exposed the rawness of physician antipathy toward attorneys and the legal system."*  
 From 2005 JAMA article discussing the relations between attorneys and physicians.<sup>1</sup>

*"...we...have this awful, awful system. This is a terrible system."*

William Plested III, MD, president of the American Medical Association, describing the tort system in a 2006 press interview.<sup>2</sup>

*"...the current system of medical malpractice litigation is expensive as a social policy and irrational as a compensatory mechanism."*

Medical historian James C. Mohr, PhD<sup>3</sup>

*"It appears that supporters of 'tort reform' are rearing their ugly heads again, pumping volumes of rhetoric across the airwaves. Don't fall for the rhetoric."*

From a template letter addressed to "Dear Legislator" appearing on the Web site of a Florida plaintiff attorney firm to respond to a legislative battle over capping noneconomic damages.<sup>4</sup>

*"Tort 'reforms' (or tort 'deforms') are cruel laws that reduce the protections and rights our country provides to those who are injured by defective products, toxic chemicals, medical malpractice, and other wrongdoings."*

Center for Justice and Democracy (CJ&D): Glossary of "tort reforms"<sup>5</sup>

"Reform" from the Latin *reformare* (re -'back' + forme -'to form') is one of the most common labels applied by advocates of any hoped-for administrative change. Whether it be tort reform, social security reform, tax reform, or some

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other type of “reform,” opponents of “reform” can be positioned as being against the “amendment of what is defective, vicious, corrupt, or depraved.”<sup>6</sup> Of course, for “reform” to be achieved without major conflict, the involved parties must share the view that the “reforms” are beneficial, or, alternatively, opponents must be too weak to prevent change. With regard to malpractice litigation, it is probably safe to assert that all parties would agree that an ideal tort system would quickly and fairly compensate harm due to medical negligence; that “frivolous” cases would be quickly and inexpensively dismissed; and that the same system would be an effective partner in the effort to reduce medical error. Unfortunately, beyond these few platitudes, powerful interest groups have such different and opposing views that even such limited shared goals are presently unattainable.

The lack of middle ground with regard to “reform” of malpractice litigation contrasts with other areas of the law (eg, patent infringement), where a consensus approach to change is possible. In patent cases, many of the litigants know that, although they will sometimes be in court as plaintiffs, in other actions they will be the defendants.<sup>7,8</sup> Therefore, participants are not locked into any particular posture. In contrast, in malpractice litigation, plaintiffs’ lawyers will virtually never represent physicians, and physicians rarely are plaintiffs. As a result, trial attorneys consistently and strongly oppose any rule changes that might favor the defense, and they strongly support those that may weaken their opponents. Physicians are just as strong in their support of changes that make it harder to file a suit or collect a settlement or judgment.

If the rules governing the tort system were immutable, then legal rules would not be a source of conflict between physicians and attorneys. However, none of the rules has the absolute quality of a law of nature such as the speed of light, and none is the result of a scientific discovery, such as the relationship between the structure of a segment of DNA and the structure of a corresponding protein. For example, there are certain arbitrary restrictions on the time frame in which a patient can file a malpractice suit, just as there are certain arbitrary restrictions on the size of a golf ball. The malleability of legal rules creates an opportunity for conflict, and because the tort system is structured as a zero-sum game, any rule change automatically favors one side or the other.

Over the last four decades, as the tort “reform” movement has gained momentum, certain key initiatives such as caps on damages awarded by juries have come to symbolize “reform.” However, it is important for physicians to recognize that even that “reform” has many different variations and different impacts on the functions of the tort system. Furthermore, the effectiveness of any given “reform” or package of “reforms” will be affected by details of the legal and economic context in which the “reform” is enacted.

## Methods

Because of the huge size and somewhat unconventional nature of the topic of tort “reform,” the authors based this presentation on their own experience, supplemented by articles from the scientific literature, newspapers, and magazines, as well as court decisions, state and federal statutes, and textbook chapters. To give the reader an idea of the scope of the topic, we would refer them to the results of searching the following data bases for “tort reform”: PubMed, 288 articles; The New York Times, 448 articles between 1981 and the present; The Wall Street Journal, 505 articles between 1996 and the present; and Amazon.com, 1300 books and articles. In addition, the numerous groups that favor or oppose tort “reform” self-publish their own studies and position papers, providing another source of information. We make no claim to have reviewed all of this material.

In addition to these potential sources of information, there are relevant decisions from state and federal courts, as well as legislation at both state and federal levels that have a direct impact on malpractice litigation. The laws that govern the activities of each state’s medical board can also be important. However, these various opinions and statutes are seldom the final word on any issue. Court opinions are challenged and sometimes overturned at a higher level; they may apply only in a certain jurisdiction; or they are narrowly tailored to a certain set of circumstances. Statutes can pass in one legislative body and be defeated in another; they can be vetoed at the executive level or overturned by the courts; and they are subject to modification by appropriate legislatures.

## Tort “reform” initiatives

Physicians advocating tort “reform” have supported a broad spectrum of measures designed to change how patient perceptions of negligence are resolved. One way of classifying “reforms” is to divide them into three categories based on their major objectives. Although there is certainly some overlap, most can be assigned as follows: 1) those that lower the cost of dealing with a claim or a potential claim, ie, lower claim severity; 2) those that decrease the number of cases that result in a demand for compensation (lower claim frequency); and 3) those that bring final decisions regarding negligence closer to the scientific mainstream, making the decisions of the tort system more rational and therefore more predictable.

### Category #1 reforms: lowering the cost of malpractice defense by decreasing claim severity (Table 1)

Claim severity is on a continuum that begins at zero, rises to “nuisance value,” and then extends upward to the

**Table 1** Reforms designed to lower the cost of malpractice defense primarily by decreasing claim severity

Cap jury damage awards
Eliminate the collateral source rule
Pay future medical costs to a successful plaintiff as the costs are accrued
Eliminate joint and several liability
Obtain a more defense-friendly jury composition
Recognize the plaintiff's contributory negligence
Use offer of judgment (settlement) as a tool to transfer costs
Allow judicial review of jury awards
Mandate advance notice of claim
Encourage alternative methods of dispute resolution

extremely high costs of trials where the jury becomes angry at the physician and is affected emotionally by the plight of the plaintiff. Measures that lower the claim severity of the latter cases have the greatest impact on overall defense costs, but any measure that lowers claim severity saves money.

#### A) Caps on jury damage awards

There are many types of costs (eg, Xeroxing, billable defense attorney hours) that accrue when physicians become defendants in a malpractice suit, but the cost of most concern is the potential for an astronomical jury award. Even the possibility of that outcome is a powerful bargaining chip for the plaintiff. This potential may translate into pressure from physicians' insurance companies to settle the case, and physicians are reluctant to defend cases where their personal assets might be at risk from a jury award that could exceed their insurance coverage. Many physicians consider caps on jury awards as virtually synonymous with tort "reform."

Currently, 30 states have imposed some form of cap on malpractice awards, leaving 20 states and the District of Columbia with none.<sup>9</sup> To our knowledge, no state has a cap on accrued or future medical expenses arising from negligence, but otherwise, rules regulating caps differ geographically in regard to dollar amounts and what categories of jury award are capped. For example, a cap could apply only to noneconomic damages (California's Medical Injury Compensation Reform Act [MICRA]), or it could be a "hard cap" on the total of economic and noneconomic damages [as in New Mexico]). A separate cap may apply to punitive damages,<sup>10</sup> but intentional torts such as battery or sexual harassment would be specifically exempted.<sup>11</sup> Other variations include whether the cap rises automatically in line with inflation, and whether juries are informed of the cap before reaching their verdict.<sup>11</sup> In general, a cap limits the total amount that a plaintiff can recover in the contextual category (eg, capped noneconomic damages), regardless of the number of defendants or the number of legal theories explaining the harm.<sup>10</sup>

Three major objections have been raised to capping jury awards:

1) *Effectiveness*. Plaintiffs' attorneys and their allies have argued that caps on noneconomic damages have little or no effect on malpractice premiums or patient access to care,<sup>12-14</sup> but the majority of studies on this topic have concluded that caps can be designed so that they produce lower malpractice premiums.<sup>15</sup> A key feature of the 1975 California MICRA was a \$250,000 cap on noneconomic damages that has not been adjusted for inflation.<sup>11,16</sup> A study by the National Association of Insurance Commissioners found that California's increases in malpractice premiums in the years following MICRA were dramatically lower than the national average.<sup>17</sup> More recently, caps enacted as part of tort reform in several other states have been followed by decreasing insurance rates.<sup>18-20</sup>

2) *Fairness*. If fairness means that similar levels of harm will be matched to comparable total awards ("horizontal fairness") and that greater harm brings a larger award ("vertical fairness"), caps can create unfair awards. For example, with a cap, horribly damaged persons find themselves compensated in the same manner as patients who have experienced a lesser degree of damage.<sup>11</sup> One solution offered for this problem has been the creation of "severity brackets," each with its own cap.<sup>11</sup> The caps for each bracket could be set by law after a study of previous jury awards, but bracket migration could essentially negate any value that a cap would have in lowering claim severity.

Another plaintiff group that in some settings could appear to be treated unfairly by a cap is the poor or unemployed, who, by definition, have relatively low economic damages. When noneconomic damages are capped, an unemployed person with minor economic damages might receive a much smaller total award than would be given to a wealthy person whose case is otherwise identical.

3) *Violation of rights*. Some state courts have found that caps violate plaintiffs' "constitutional rights to equal protection guarantees,"<sup>21</sup> or that they "impermissibly burden the right to a trial by jury."<sup>7</sup> Trial lawyers have repeatedly argued that the Constitutional right to a trial by jury is threatened if a cap limits jury options to compensate the plaintiff for damages.

#### B) Eliminating the collateral source payment rule

Patients who are injured may have several sources of financial support, such as commercial disability insurance, social security payments, or health insurance. The collateral source rule prevents judgments against defendants from being affected by these collateral sources, and precludes the jury from learning of them. Some reforms have accordingly proposed a reduction in payments to a defendant based on collateral income sources, or informing juries of their existence. For example, MICRA allows a defendant to introduce evidence of the plaintiff's collateral source payments (such as a health insurance policy), but, in turn, the plaintiff can produce evidence concerning the cost of his or her health insurance premiums.<sup>16</sup>

### C) Payout of future medical costs to a successful plaintiff as accrued, rather than as a lump sum

This reform prevents the successful plaintiff from receiving future medical costs as single sum. For example, in New Mexico, the cost of medical care is compensated as it is needed, in the form of periodic payments.<sup>22</sup>

Payment delays potentially may have a large impact on the cost of those cases where it is difficult to predict expenses or life expectancy. For example, in a “bad baby” case, the plaintiff’s attorney might claim that the patient would require medical support for a life expectancy of 60 years. If the jury agreed and the entire claim was paid, there would be a giant windfall if the patient were to live only 2 years more.

### D) Eliminating joint and several liability

The theory of joint and several liability is that each liable party is individually responsible for the entire amount of a damage award, regardless of the relative degree of responsibility. This is also known as the “deep pocket” rule, because it incentivizes plaintiffs to identify someone among their caregivers who is capable of paying an entire award. Currently, about 40 states in the U.S. have some type of limitation on joint and several liability.<sup>23</sup> Complexities abound in this area of the law, including statutes that eliminate joint and several liability for noneconomic damages, but retain it for economic damages.<sup>24</sup>

In a state with joint and several liability, that rule has the potential to increase claim severity. For example, an insured physician might be only peripherally involved in a case where an uninsured colleague was largely responsible for a patient’s damages. In the event of a lawsuit, and providing that the uninsured physician lacked funds to pay a judgment, the plaintiff’s attorney would likely try to convince the jury that some part of the damage was caused by the insured physician. If that argument succeeded, the eventual award could be the sole responsibility of the insured physician’s carrier.<sup>24</sup> In another scenario, if a physician were to go to trial after all other defendants had already settled, that physician, if he or she lost the case at trial, would be held responsible for the sum of the entire judgment.<sup>25</sup> The term “proportional liability” is applied when a defendant is held responsible only for their adjudicated portion of any damages that are awarded.

### E) Favorable jury composition

In his 1987 novel *Bonfire of the Vanities*, author Thomas Wolfe famously referred to the Bronx jury as “a vehicle for redistributing the wealth.” Subsequently, the term “Bronx effect” has been used to describe the plaintiff-friendly jury decisions often encountered in certain jurisdictions.<sup>26</sup> Aside from the question of whether the Bronx is truly a venue that is particularly biased against defendant physicians, it is apparent that some jurisdictions have jury pools that generally favor either defendants or plaintiffs in civil suits. For example, the small town of Marshall, Texas has become a

center for patent infringement litigation, partly because of the allegedly plaintiff-friendly nature of Marshall’s jury pool. Over the last 15 years, plaintiffs filing patent infringement cases there have won 78% of the time, compared with 36% in cases tried in the New York Southern District.<sup>27</sup> The point of filing a lawsuit is to win it; hence, if “forum shopping” is permitted, litigants will inevitably attempt to “. . . obtain biased decision makers.”<sup>28</sup>

A physician being sued for care provided in California will, of course, not face a jury in infamously defense-unfriendly Madison County, Illinois, even if the plaintiff happens to live there. However, it is indisputable that different areas of the country or of even in the same state are much more “plaintiff-friendly” or “defense-friendly” than others. If the plaintiff is able to become a “judicial vagabond” who can file a suit in the most favorable locale, the defense is at considerable disadvantage. Missouri, Georgia, Mississippi, and Pennsylvania have recently passed laws to stop this practice, ruling that the court venue must be the county in which the alleged malpractice took place.<sup>29,30</sup>

In their own version of selecting juries, physicians have attempted to ecumenicalize jury pools by passing laws that broaden the geographic region from which jurors are chosen. For example, Philadelphia, Pennsylvania is considered to be extremely plaintiff-friendly. That fact has led Pennsylvania physicians to propose legislation which would require Philadelphia’s malpractice cases to be tried before juries that are drawn from broad areas of the state, effectively eliminating juries consisting only of residents of the city of Philadelphia.<sup>7</sup>

### F) Contributory negligence

To prevent plaintiffs from profiting from their own folly, some states recognize a doctrine of contributory or comparative negligence in medical malpractice cases.<sup>10</sup> If, for example, a patient did not follow clear instructions to return for follow-up evaluation after a Pap test that later proved to be false-negative, the jury might agree that the patient’s actions contributed to an adverse outcome. The defendant pathologist would be responsible for only his or her assigned share of the damages, and, in some instances, a finding of contributory negligence could even bar the plaintiff’s recovery entirely.

### G) Offers of judgment (settlement)

One mechanism that is used to encourage legal opponents to settle their issues before trial, and therefore avoid protracted and expensive litigation, is known as an “offer of judgment rule” (OJR). This legal concept began at the state level, and, in 1937, it was adopted at the Federal level as Federal Rule of Civil Procedure 68 (“Rule 68”). Most states subsequently have adopted their own OJRs, and most of them were modeled to some extent after the federal version.<sup>31</sup>

In its simplest form, the OJR allows a defendant to submit a formal settlement offer to the court. If the plaintiff

refuses it, and thereafter fails to recover an award which is greater than the settlement offer, the plaintiff would be required to pay the defendant's postoffer costs, excluding attorney's fees. Unfortunately, because those costs are comparatively trivial in the context being considered here, the OJR has typically had little effect on how either side approaches a case.<sup>31</sup>

OJRs could, of course, be written so that they would have more impact, with greater cost-shifting to the party rejecting the offer. For example, in 1994, a New Jersey law was enacted that allows both the plaintiff and defense to make pretrial offers to settle the case (a so-called "bilateral" OJR). The party that refuses the offer is subject to paying the other side's uncapped costs *plus* attorneys' fees, if the jury award is  $\geq 20\%$  more favorable than the rejected offer.<sup>31</sup> A study of the effect of this law in New Jersey indicated that it had no effect on the size of damage awards, but it did diminish transactional costs (litigation costs, time, and attorneys' fees) through a statistically significant reduction in the duration of litigation.<sup>31</sup>

#### H) Judicial review of jury awards

In New York State, judges are required to compare jury awards in any given case to those that have been made in other similar cases. If a judgment "deviates materially" from "reasonable compensation," the judge must offer a new trial unless the parties accept a judicially modified award ("additur" or "remittitur").<sup>32</sup> Proponents of this system claim that it is fairer than caps because the latter only operate to decrease jury awards. In contrast, judicial review also has the potential to raise them. However, practically speaking, judicial review of awards tends to function as a type of cap, with the amount being set by the precedent of previous jury awards in similar cases, rather than by statutes.

#### I) Advance notice of a claim

Requiring advance notice of a claim is designed to provide opposing parties an opportunity to resolve their dispute before the case enters the tort system, hopefully avoiding costly litigation. For example, MICRA requires a claimant to give 90-day notice of his or her intention to bring a suit.<sup>16</sup>

#### J) Alternate methods of dispute resolution

"Alternative dispute resolution" (ADR) is a generic term that is applied to various methods of resolving malpractice allegations. This may occur outside of the tort system, or within it but before a trial. One objective of ADR is to resolve cases at costs that are lower than those of jury trials; occasionally, ADR may even dispose of a case with no payment at all.<sup>15</sup> A factor that interferes with the effectiveness of ADR in the field of malpractice litigation is that unless both parties are prevented from entering the tort system at all, the ADR is tainted by expectations of what the litigants think the outcome would be if the case *did* go to trial. In other words, they bargain "in the shadow of the law."<sup>31</sup> As a result, the sides will likely come to an agree-

ment only when they believe that the terms of agreement are at least as favorable as the anticipated trial outcome. For example, placing a cap on jury awards establishes the parameters for valuation of damages by ADR.<sup>11</sup> Ideally, ADR could save time and expense, but it also can incur delay and added expense.

The following are the most common forms of ADR:

1) *Negotiation*. In this, the simplest and most frequently used form of ADR, opposing parties confer together in an effort to settle a dispute. Although strong emotional responses to the conflict may make compromise difficult, both parties also have strong incentives to resolve the dispute.<sup>33</sup> The parties are aware of the long delays inherent in the tort system, prompting both sides to compromise. Another factor leading to negotiated settlements is the difficulty in predicting the outcome of any jury trial.

2) *Mediation*. Mediation is similar to direct negotiation between the parties, but it is more formal because a neutral third party is involved to facilitate the process.<sup>33</sup> The mediator usually has no authority to impose a result, but can identify issues, propose solutions, and encourage accommodation. South Carolina recently passed malpractice "reform" bills that promote mediation.<sup>29</sup>

In the context of malpractice litigation, mediation occurs most frequently as a result of a court order after a suit has been filed, and adversarial interactions accordingly ensue, in a process which has been described bluntly as "lawyers talking about money."<sup>34</sup> However, as is true of direct negotiation, a mediated settlement can have advantages to both parties.

Voluntary mediation is thought to be especially productive in cases where the patient's dissatisfaction centers on issues that can be addressed without receiving a large financial settlement. For example, if what the patient really wants are out-of-pocket expenses, a detailed explanation of events, an apology, or assurances that steps have been taken to minimize the possibility of similar adverse events in the future, these goals can often be achieved through mediation.<sup>35,36</sup>

3) *Arbitration*. The proceedings of arbitration are closer to a civil trial than they are to negotiation, but in arbitration there is no jury. Instead, the case is evaluated by a neutral third party who is acceptable to both sides. The arbitrator conducts a hearing during which each side presents evidence. The decision of the neutral third party can be binding or nonbinding, depending on a prior agreement reached between the parties. In the former of those scenarios, the neutral party may be empowered to determine both liability and the amount of an award. Both federal and state laws impact the details of arbitration, and pertinent laws differ substantially from state to state.<sup>15,37</sup>

A dispute between a patient and a physician may be resolved in arbitration because the patient has agreed before treatment that any disputes will be subject to this process. In California, because of MICRA, a patient and a health care provider can agree that any disputes arising in the future will be resolved through binding arbitration.<sup>16</sup> Virginia is

another state with similar provisions, but the patient has the option of withdrawing from the agreement within 60 days after treatment has concluded.<sup>10</sup>

There is some evidence from the mid-1970s California Hospital Arbitration Project that arbitration can result in fewer court claims, and, when compared with claims handled routinely in the tort system, alternate modes of resolution often result in more rapid payment to patients and less cost to hospitals.<sup>15</sup> Nonetheless, a fundamental weakness of this system is that patients who wish to sue can simply claim that they were not fully informed about waiving their right to a jury trial. Even when the patient *was* fully informed, an argument can be made that a patient cannot sign away the right to a jury trial because that is a fundamental right of citizenship.

4) *No-fault compensation.* In a no-fault (strict liability or liability even if no harm was intended and care was exercised to avoid harm) system, compensation claims would be decided “administratively,” without a determination of negligence. The extant models for this approach are workman’s compensation and product liability.<sup>15</sup> In a health care setting, a no-fault system is usually presented as a mechanism to compensate victims of “preventable” adverse events, whether or not the standard of care was provided. A panel of experts would hear cases, and then attempt to achieve uniformity of awards by using predetermined guidelines. Alleged physician negligence would be evaluated using a separate system.

Several objections have arisen to no-fault compensation, including concerns that drastically simplifying the compensation process would create an explosion of claims; this would result in even greater expense than the current tort system incurs. Currently, claims for compensation immediately and automatically involve a provider who is intensely interested in evaluating the validity of patient claims. Unfortunately, we know that health care is characterized by many events that are unpleasant, and many of them may, in some sense, be “preventable.” A set of guidelines sufficient to describe all avoidable medical harm, together with rules for compensating it, would likely be impossible to obtain.

Several countries have instituted no-fault systems of various kinds, and one could theoretically study them to predict the fate of a similar paradigm in the U.S.<sup>15</sup> No-fault systems have been used in this country by only a few states (eg, Virginia, Florida) to address very specific types of tort cases, eg, “bad baby” cases. Those examples do not provide much guidance for wider applications, because the particular laws in question do not keep cases out of the tort system. Claimants engage in what the system terms “maximizing behavior,” and, when given an option, most families conclude that the greatest return will come from the traditional legal adversarialism.<sup>38</sup>

## Category #2 reforms: decreasing case frequency (Table 2)

Any measure that reduces the number of filed cases could save physicians and insurance carriers substantial

**Table 2** Reforms designed to lower the cost of malpractice defense primarily by decreasing claim frequency

Loser pays the costs of the winner (English rule)
Penalize attorneys who file “frivolous” suits
Make the statute of limitations more defense-friendly
Prevent physician apology from being used as a plaintiff tool in the tort system
Restrict the type of cases that can enter the tort system
Screening cases using a panel
Place limits on vicarious liability
Require an affidavit of merit by a physician prior to a suit being filed
Place limits on the amount of a judgment or settlement that can be claimed by a successful plaintiff’s lawyer

sums. It is surprisingly expensive to defend any case, even an overtly frivolous one; in other words, a high number of nuisance cases has a significant cost. For example, although >4000 of 5051 claims closed in Ohio in 2005 resulted in no payment to the plaintiff, only roughly 400 of them incurred no defense expenses.<sup>20</sup> Among those cases that cost the defense something, the average was \$24,000 for each.

### A) Loser pays the costs of the winner

The “English rule” (loser pays) requires the litigant who loses at trial to pay at least a significant portion of the winner’s reasonable costs and attorneys’ fees, adding considerably to the costs of filing a case with no merit.<sup>31</sup> Most European countries, including England, follow this “cost-shifting” rule.

In contrast to the English rule, the American model encourages lawyers to file cases and then wait for basic information on the merits of the allegations to appear during the course of early discovery. It is relatively inexpensive to file and conduct early discovery, and doing so avoids the chance that cases will be lost by the plaintiffs because of the statutes of limitations. The lack of meaningful disincentives to file baseless cases explains, at least in part, the substantial number of U.S. malpractice cases that are terminated before trial with no payment to the plaintiff.<sup>32,39,40</sup> Experienced malpractice lawyers may be able to avoid even the low costs associated with the early steps of pursuing “low-probability-of-prevailing” cases. However, some actions are filed by attorneys who are relative ingenues in medical tort law, and they lack the skills necessary to perform a proper case review for their clients.<sup>32</sup> There is reason to believe that the English rule would probably weed out these legal dilettantes, along with their cases.

In addition to the latter impact, the English rule theoretically can act as a powerful deterrent to risk-adverse litigants who might otherwise try to file “low-probability-of-prevailing” cases. Nevertheless, its effect on overall costs may not be as clear as some advocates have asserted.<sup>31</sup> The hope that one’s opponent will ultimately pay the bills may actually encourage some plaintiffs to undertake the litigation process. Their attorneys may likewise attribute greater

value to the case, and, especially if there is no associated cap on damages, the plaintiff may be emboldened to demand a very high settlement.

Actual examples from the U.S. tort system of “loser-pays” cases are uncommon, but they occasionally occur. For example, a Texas judge recently ordered a class-action lawyer to pay the defendant company’s legal expenses.<sup>41</sup> The judge reasoned that it was apparent after discovery that the plaintiff had no case, and therefore the responsible attorney was accountable for *all* subsequent legal fees. The decision was based on a section of the 1933 Securities Act that allows a court to shift costs if a case is frivolous. The decision to bill the plaintiff’s attorney rather than the plaintiff makes this case even more unusual, but the judge noted that attorneys should know better than their clients when a case is nonmeritorious.

### B) Penalties for filing “frivolous” lawsuits

One area of the legal system where judges have grown exasperated with weak cases is the U.S. Tax Court, which has been authorized to impose penalties of as much as \$25,000 if litigants make arguments that are clearly “frivolous or groundless.”<sup>42</sup>

The topic of penalizing “frivolous” malpractice lawsuits gained prominent national attention during the 2004 U.S. presidential race because of candidate John Edwards’ background as a personal injury attorney who specialized in medical malpractice. Edwards was often asked during his campaign about whether the delivery of health care was being harmed by “frivolous” lawsuits.<sup>43</sup> The Kerry–Edwards ticket took a seemingly harsh stance against “frivolous” lawsuits, proposing that any attorney who repeatedly filed those cases should be subject to severe reprimands or worse.<sup>43,44</sup>

Obviously, such harsh penalties would incentivize trial lawyers to rigorously screen their cases. Unfortunately, the pragmatic meaning of the word “frivolous” is the devil in these contextual details. When filing a tax case, one could not easily find a credible expert to support claims that wages are not income or that the 16th amendment to the U.S. Constitution was not properly ratified. Furthermore, tax cases are heard by specialized judges who are experts in tax law. In contrast, judges presiding over malpractice cases are unlikely to have any particular knowledge in the area of dispute, making it very difficult for them to confidently cull out scientifically frivolous actions.

There is an additional problem concerning possible penalties in frivolous malpractice cases. It is not clear if such cases are judged as marginal by lawyers because they have no scientific merit, or only because of the low probability that any award they may generate would adequately compensate the plaintiff’s attorney. Candidate John Edwards made much of his considerable personal fortune as a trial attorney, claiming, among other things, that doctors and hospitals were responsible for cases of cerebral palsy. Nevertheless, a preponderance of scientific studies have found little or no linkage between that condition and patient care

decisions.<sup>45</sup> That fact would appear to make Mr. Edwards a grand master of “frivolous” suits, but his cases were worth many millions of dollars in awards in the courts of North Carolina.

### C) Reducing the statute of limitations

Each state has a statute of limitations that defines the period in which a plaintiff can pursue a legal remedy for harm resulting from alleged negligence.<sup>46</sup> The statute must define the starting point for that period, its duration, and any exceptions to the basic structure of the rule. If a case is not filed during the specified window in time, it cannot be filed at all.

The two most common times regarded as the beginning of this statutory period are the date when the supposed negligent act occurred (“date of accrual” of the claim) and the date of its discovery. One interesting aspect of statutes of limitations is that they provide almost limitless opportunities for legal variations and exceptions. Many states have laws that describe some feature of a medical case (eg, a surgical instrument left in vivo) that stops (“tolls”) the statute from running for a period of time.<sup>46</sup> Other such “tolls” include fraud, concealment, or continued treatment of the condition after the alleged event of negligence.<sup>10</sup> MICRA allows suits to be filed within 3 years of the injury, or, if the injury is “discovered” at any subsequent time, a claim can be brought within 1 year thereafter.<sup>16</sup> Parts of the same case can be governed by different statutes. For example, in Virginia, parents of a minor have a longer period of time (5 years) to file for awards concerning medical expenses than for those related to other damages.<sup>10</sup>

Generally, the statute of limitations covering injury to a minor differs from the statutory structure for adults. In New Mexico, the statute for adults runs for 3 years, but, for minors, it runs for 3 years or until the patient is 19, whichever is longer.<sup>46,47</sup>

### D) Removing legal barriers to physician apology in the setting of medical error

It might be thought that physician apology would be a straightforward activity that would effectively keep cases out of the tort system in some circumstances. However, there are significant legal, cultural, and personality barriers to making apologies, leading doctors to completely avoid them, or to offer only apologies of sympathy (“I’m sorry that this happened to you”) when the patient expects and deserves an acknowledgment of responsibility (“I’m sorry that I did this to you”).<sup>36</sup>

In some states (eg, Virginia, Missouri), offering apologies now entails less legal danger, because, as a result of “reforms,” an apology is not admissible as evidence in court.<sup>29</sup> However, in jurisdictions without this protection, a doctor’s apology remains a potent plaintiff’s tool in malpractice litigation. Instead of trying to comprehend the opinions of dueling experts, a jury can be made aware of an apology that effectively transforms the defendant physician into a witness for the plaintiff.

Because apology tends to be appropriate in settings that are emotionally charged, programs designed to encourage physician apology are usually rather structured. Doctors may be trained to develop communication skills that are likely to be useful during a “disclosure conversation,” and they may depend on in-house “process experts” to assist with planning, conducting, and debriefing the apology.<sup>36</sup> Ideally, a patient who is satisfied by the apology will decide not to seek any further recourse, or alternatively, a postincident risk management program could rapidly link the apology to some form of compensatory payment.<sup>36</sup>

Physicians who resist offering apologies are often characterized as crass, arrogant, unfeeling, obstinate, or complacent.<sup>48</sup> Nonetheless, it must be recognized that doctors often have great emotional difficulty in acknowledging that they are responsible for harm to a patient. Years of hard work preparing to help patients may produce substantial “cognitive dissonance” when an error causes harm. This, in turn, activates psychological defense mechanisms such as denial or “innate disagreeability.”<sup>49,50</sup>

#### **E) Restricting types of cases that enter the tort system**

An exemplary case type that could be restricted from entering the tort system would be the provision of medical care in an emergency setting, as legislated in South Carolina.<sup>51</sup> Other areas where “reforms” have attempted to gate-keep cases from the legal system involve alleged birth injuries and complications from vaccination.

#### **F) Pretrial screening of cases by panel review**

During the 1960s, physicians attempted to eliminate non-meritorious medicolegal cases by proposing that pretrial screening panels should be constituted.<sup>52</sup> By 1996, 25 states used some form of screening to evaluate the validity of malpractice claims.<sup>52</sup> Ideally, plaintiffs who got negative rulings from such panels would decide to drop their suits, or at least agree to settle them quickly.

None of these panels’ decisions prevent a plaintiff from subsequently going to court, and there is substantial variation in the constituency of the panels. These include the number of panelists; vocational eligibility for service on a panel (eg, lay citizens, lawyers, judges, physicians, specialist physicians in the area being contended); physician defendant eligibility for a panel hearing; administrative responsibility for empanelment; admissibility of panel decisions in court; possible trial participation by panel members; optionality of a panel hearing; whether panel decisions are legally binding; the purview of panels; types of witnesses who may present testimony to panels; rules of evidence for panels; and the consequences to either party of “losing” or having a split-decision at a panel level.<sup>53,54</sup> In some states, if one party decides to try a case after “losing” at the panel or after rejecting a panel decision-related settlement offer, that party can face financial penalties if the ultimate trial verdict is adverse for them.<sup>53</sup> In New Mexico,

the State Medical Society assists plaintiffs in finding resident New Mexico “expert” witnesses, if requested, providing that panel results have been unfavorable for the doctor defendant. On the other hand, there are no adverse consequences for the plaintiff who loses at a panel hearing in New Mexico, and it is irrelevant to either side as to whether a panel decision is unanimous.

There have been many objections to screening by panels.<sup>55</sup> Some of those bodies have functioned so poorly that they have significantly delayed the litigation process, representing an impediment to the right to trial by jury. In the early 1980s, it was reported that up to 4 years might be required to constitute a panel hearing in Manhattan, New York City. In smaller cities, it can be difficult to identify impartial physician (and lawyer) volunteers with no bias toward either party in a panel hearing. Indeed, the composition of panels is often contentious, with trial lawyers asserting that physician panel members are “akin to a manufacturer hearing a complaint about one of its own vehicles.”<sup>56</sup>

Although panel review has been supported by the medical profession with the hope of saving money, that result has been difficult to achieve. Some have observed that rather than leading to settlement, panel decisions which favor plaintiffs lead to even higher damage claims. In contrast, because physicians know of their high likelihood of prevailing at a trial, doctors who lose at the panel level do not necessarily agree to the plaintiff’s ensuing settlement offer. Another objection to panel hearings is that they “telegraph” the defense’s case to plaintiffs’ attorneys before a trial subsequently occurs.<sup>33</sup>

#### **G) Placing controls on vicarious liability**

The legal concept of vicarious liability is that responsibility for wrongdoing should be extended beyond the person whose actions actually caused harm, to others on whose behalf the defendant acted (as an “agent”). A prime example is the liability of a surgeon who functions as “captain of the ship” in an operating room, where a nursing error actually caused patient harm. Pathologists who supervise gross room physician-assistants or other laboratory employees can also be liable for the negligent acts of those individuals, even if the supervision itself was not negligent. Laws that limit vicarious liability prevent malpractice cases from being filed using those constructions. Montana has recently passed a “reform” stating that if a doctor does not immediately and physically supervise the person who makes a medical error, that physician has immunity from liability.<sup>29</sup>

#### **H) Pretrial screening (certification) of cases by physician experts who provide affidavits of merit**

At least 17 states have passed laws requiring the evaluation of alleged malpractice cases by an “expert” before a complaint is filed with the courts. Because these laws are intended to address frivolous suits, it is the plaintiff who is usually required to provide certification of the validity of the

case.<sup>29,32</sup> A few states also require that before a case can go forward, the defense must provide an expert who conversely certifies the defense's claim that the plaintiff will not likely prevail at trial. The latter arrangement addresses the perceived problem that defense lawyers may have a financial incentive to contest claims which should be settled.

How well do certificates of merit work? In 2003, Arkansas passed a comprehensive tort reform bill that included the requirement for an affidavit of merit from a physician "expert" in medicolegal actions.<sup>57</sup> Subsequently, a large insurer in that state reported a 50% drop in the number of claims filed per 100 physicians between 2002 and 2006. That decline was attributed to "the deterring effect" of the affidavit requirement on nonmeritorious claims.<sup>57</sup>

### I) Setting limits or devising sliding scales for contingency billing of plaintiffs by their attorneys

The contingency fee has been a source of physician anger since the earliest U.S. conflicts between lawyers and doctors over malpractice litigation in the mid-19th century.<sup>3</sup> Efforts by physicians to eliminate this method of legal payment have been unsuccessful, but currently 17 states have statutes or rules that establish a limit on the percentage of an award that will be paid to the plaintiff's lawyer.<sup>40</sup> Florida has one of the more complicated arrangements because there is a fee schedule passed by voters as a constitutional amendment, and also a court-established fee scale.<sup>58</sup> The Florida State Supreme Court recently ruled that plaintiffs' attorneys can "encourage" their clients to express a preference for the court-established scale, with its more generous rewards for lawyers. Interestingly, Florida physicians have responded by requesting that their patients sign an agreement to limit requests for noneconomic damages if medical care results in "any controversy."<sup>58</sup>

It has been claimed that limits on plaintiffs' attorney fees decrease the incentive to file frivolous cases.<sup>40</sup> At least theoretically, one could also suggest that a cap or sliding scale for plaintiffs' lawyers' fees might reduce their incentive to push juries to make high awards. Moreover, if jurors are made aware of contingency fee limitations, they would know that more of the monetary judgment actually goes to the harmed patient. MICRA provides codified limits on plaintiffs' attorneys' fees, which are calculated in the following manner: 40% of the first \$50,000; 33.3% of the next \$50,000; 25% of the next \$500,000; and 15% of any amount over \$600,000.<sup>16</sup>

### Category #3 reforms: bringing decisions regarding malpractice accusations closer to the scientific mainstream (Table 3)

Efforts to bring tort decisions closer to the scientific mainstream are difficult for several reasons. First, although the courts are certainly involved in evaluating scientific matters, their primary function is that of an institution which protects the rights of citizens. Because the rights of Man and

**Table 3** Reforms designed to bring decisions about malpractice accusations closer to the scientific mainstream

Judges conduct pretrial screening of the scientific quality of expert testimony
Judges advised by unbiased experts conduct pretrial screening of the scientific quality of expert testimony
Judges use reliable surrogates of testimony quality for pretrial screening of the expert testimony
Malpractice cases are transferred to health courts
Peer review/ethical review of expert witness testimony is protected from litigation
Expert testimony is publicized so as to take advantage of the improved quality that often results from observation of performance (Hawthorne effect)
Providing expert witness testimony is considered to be the practice of medicine by state medical boards, and is therefore subject to board oversight.
Judges are provided with educational opportunities designed to enable them to better evaluate scientific issues that arise in the course of malpractice litigation
Treating physicians are permitted to testify for the defense
Plaintiffs are obligated to waive their right to privacy of their medical records
Courtroom procedures are modified to assist jurors in absorbing and evaluating unfamiliar scientific information

the precepts of science have different intellectual traditions, litigants can have a right (eg, to choose a favorable expert witness) which may lead a lay jury to a scientifically incorrect decision. In our tort system, when rights conflict with science, rights prevail.

As another outgrowth of the lack of science-based underpinnings in the U.S. court system, procedural decisions are based on precedent, conjecture, and "legal logic" rather than on experimentation and the scientific method. For example, a scientist who wonders whether retired pathologists might provide inferior testimony, compared with that of pathologists in active practice, could design a simple experiment. Unbiased "blinded experts" could grade written transcripts of courtroom testimony and determine whether there was a significant difference in the scientific accuracy and completeness between the two groups in question. However, even that simple paradigm for data-generation would be a foreign concept in a political or judicial setting. The practice of Law does not actively *produce* quantifiable data of a scientific nature; instead, it typically relies on information that others have already accrued, no matter how flawed.

The courts are concerned about bias that might diminish a person's right to a "fair" trial, but in an effort to eliminate perceived bias, the judicial system has made itself prone to accept scientifically illogical conclusions. For example, the judiciary has opined that finders of fact *who bring no knowledge of the subject of a dispute* are the most unbiased contributors to resolution of the dispute (!). This concept seems strange (or even bizarre) to persons with scientific training, but it is often employed. For example, an individ-

ual who previously worked in a regulated industry might be appointed as a government regulator, and this choice would presumably ensure a high level of regulatory expertise. However, such “inside” appointees are frequently opposed legally and politically, with the argument that ignorance is preferable to possible bias. In 1919, President Woodrow Wilson (an attorney) exemplified that precept. When Wilson was criticized over his choice of chairpersons for a commission on the Middle East, he defended his decision by emphasizing that they “knew nothing” about the Middle East.<sup>59</sup>

Because legal tradition links expertise with bias, it is relatively easy to find legal statements that dismiss the importance of scientific training and scientific experience. For example, the following statements are taken from a Web site where lawyers’ opinions were posted on whether physicians should have some oversight of expert testimony in malpractice litigation<sup>60</sup>:

“. . . medical facts are simply not that mysterious and can be fairly well understood by someone with patience, intelligence, and a basic background in science.”

“Let the lawyers and judges handle what goes on in court and let the doctors handle what goes on in the hospital.”

Another basic legal concept that juxtaposes the tort system with medical science is the law-school emphasis on presenting the best argument for one’s client. In a criminal setting, this means that even if the client is an obvious and despicable murderer, the defense lawyer will be highly regarded by his or her peers for providing a successful, or at least legally skillful, presentation of the case.<sup>61</sup> This mindset enters the civil system as well, where the ability to win cases—regardless of their scientific merits—yields both financial gain and professional respect. The scientific validity of a malpractice claim is relevant to attorneys, but only because it impacts the skill required for the attorney to prevail in court.

Despite these inherent obstacles, “reforms” focusing on improved science in the courtroom have been initiated by the courts, by legislative bodies, and by physicians. They include the following suggestions:

#### **A) Pretrial screening of the scientific quality of “expert” testimony by judges**

Because juries typically do not have the skills necessary to evaluate allegations of medical negligence, it has been acknowledged that they are vulnerable to biased or frankly delusive “expert” opinions.<sup>28</sup> This situation created a role for judges to screen out defective testimony. In a 1923 decision (*Frye v. United States*), the U.S. Supreme Court concluded that “expert” opinions should not be admissible in court if they lacked “general acceptance in the relevant scientific community.”<sup>63,64</sup> Many state courts subsequently adopted the “general acceptance” criterion to evaluate testimony for admissibility.

Beginning in 1993, the Court again addressed the problem of culling-out flawed “expert” testimony with three

decisions attempting to equip judges for that task.<sup>65</sup> The first of these cases (*Daubert v. Merrell Dow*) provided the judiciary with a list of rules to follow, to determine if an opinion was based on valid science.<sup>63,66-68</sup> A second decision (*General Electric v. Joiner*), in 1997, emphasized that a judge must determine that expert testimony is based on valid science, and also that the scientific findings were relevant to the specific case being litigated.<sup>63,69</sup>

Interestingly, the *Daubert* and *General Electric* decisions failed to close the issues of which scientific disciplines were included in the new rules, and which “experts” could continue to provide *ipse dixit* (Latin: “because I say so”) opinions. In 1999, the *Kumho Tire v. Carmichael* decision addressed those topics; it concluded that all expert opinion must have a “valid and reasonable basis, whether it is accounting or rocket science.”<sup>68</sup>

Currently, most state courts have followed the Federal rules, and they rely on *Daubert* to guide evaluations of “expert” witness testimony. Nineteen states and the District of Columbia continue to adhere to the *Frye* “general acceptance” standard, and three states use their own admissibility standards.<sup>70,71</sup>

Whether rulings such as *Daubert* have had an actual impact on the quality of “expert” testimony is the subject of controversy.<sup>72</sup> Some authors feel that the rulings are powerful, and that their wider application would improve the quality of testimony.<sup>62</sup> However, despite widespread endorsement of the *Daubert* rule, low-quality or even fraudulent “expert” pronouncements continue to confuse jurors. Malpractice “crises” have been linked to the absence of tort “reform” measures, but, to our knowledge, no attempt has been made to link “crisis” status with the rules used by judges to evaluate expert testimony in any given locale.

*Daubert’s* lack of influence is easily understandable when one realizes that most medical malpractice issues hinge on the unique features of a particular case. Questionable testimony often takes a form such as “these particular cells on this particular Pap test should have been recognized as malignant.” No list of general rules will enable a lay judge to evaluate whether or not that statement is based on scientific truth.

#### **B) Pretrial screening of expert testimony by judges, but advised by unbiased expert consultants**

Judges who must evaluate scientifically complex “expert” testimony are in an awkward position. Their training does not equip them to challenge anything except obvious charlatanry; hence, it is difficult for them to perform competently as gatekeepers. Most judges respond by simply favoring admissibility, leaving the rest to the jury. However, if state-based or specialty-related medical societies were to create unbiased panels of experts that were available to advise judges, the scientific quality of judicial decisions could improve. The Federal Rules of Evidence specifically allow a Federal court to “appoint expert witnesses of its own choosing” (Rule 706),<sup>73</sup> and most state rules of evidence are comparable. However, judges almost never request assis-

tance from unbiased experts, and medical organizations do not have established procedures to provide it.

### C) Providing surrogates of quality to be used by judges for screening testimony

Unfortunately, when judges make decisions regarding “expert” testimony, it is improbable that they will have detailed knowledge in the technical areas addressed in the testimony. This forces them to rely on surrogate measures of validity, possibly including such factors as the age of the “expert,” specialty society credentials, board certification, number of academic publications, and institutional affiliations.<sup>74</sup> In general, one is suspicious of bias when an expert’s testimony is so frequent and repetitive that it suggests appearing in court is his or her real business, rather than the practice of science or medicine.<sup>75</sup>

Some state statutes have been designed to increase the scientific quality of “expert” testimony by providing guidelines for judges to use. In Pennsylvania, an “expert” testifying about the standard of care must practice in a comparable specialty as that of the defendant, and must be board-certified if the defendant is board-certified. Another restriction in that state holds that the “expert” generally cannot have been retired for >5 years.<sup>76</sup> Retirement status was also recently cited as a reliable surrogate for the quality of “expert” testimony by the College of American Pathologists (CAP). A CAP guideline states that pathologist “experts” should have been in the active practice of pathology for the 3 years immediately before the date of the incident in question.<sup>77</sup> Unlike the Pennsylvania law, the CAP guideline has no formal standing in any court, but could be used by opposing counsel to challenge the credibility of adversarial “expert” opinions.

In a recent and somewhat surprising ruling, the Florida Supreme Court decided that a potential “expert” could not testify because that individual had obtained the opinions of several colleagues as part of the preparation for court appearance. Testimony representing a medical consensus would logically seem to be an improvement over individual opinion on standards of care, but the court ruled that it should be barred.<sup>78</sup> That decision arose when the court determined the *process* of how the expert’s opinion was formed could be used to exclude testimony, and had nothing to do with the underlying validity of the opinion itself.

### D) Transfer of malpractice cases to “health courts”

The current practice of using lay juries to hear malpractice cases is considered an advantage for the plaintiff. No matter what the scientific merit of the case may be, the plaintiff always has at least a small chance of success. Some studies have shown a “correlation between jury determinations of medical liability and the decisions of unbiased experts,” but many physicians feel that the outcome of malpractice litigation should provide more than “correlation” with the truth.<sup>32</sup>

Because the 7th amendment to the U.S. Constitution guarantees citizens a right to trial by a jury of their peers, it might seem that transfer of malpractice litigation to a system without lay jurors is not a possibility. However, advocates of “health courts” note that civil juries were intended to resolve disputed facts, not to “decide standard of care as a matter of law.”<sup>79</sup> Further support for separate medical courts can be found in other branches of the law. Bankruptcy cases are heard by special courts, because it is obvious that many of those disputes are too complex for lay juries to understand.<sup>80</sup> This “complexity exemption” means that judges with particular expertise will decide such cases. Family courts, juvenile courts, patent courts, and tax courts are other examples of comparable approaches to specialized litigation.

Unfortunately, it is not clear how medical malpractice cases should be defined so as to guarantee their placement in a specialty court. Other civil cases, potentially involving complex financial issues or arcane legal rules, are, in fact, decided by lay jurors with no special training. Thus, a common response to calls for “health courts” is: “what is so special about malpractice?”

Another objection to those proposals is that, in any given region, only a small number of judges would hear medical malpractice cases. The resulting concentration of power could increase efforts by opposing attorneys to exert influences on the selection of the judiciary, or even worse, to openly influence judges’ opinions.<sup>32</sup>

### E) Peer review/ethical review of expert testimony by physician organizations

Peer review of medicolegal “expert” testimony by professional organizations is a highly contentious issue.<sup>81-83</sup> The position of trial lawyers and many judges is that “the courts have mechanisms to weed out bad testimony” and that the review of “expert” opinions by other physicians has the goal of “dissuading people from testifying” against their fellows. Therefore, it is alleged that such review infringes on the rights of both the “experts” and the plaintiffs.<sup>83</sup>

In contrast to that opinion, physicians who have been victimized by unethical “expert” witnesses have concluded that the courts failed abjectly in oversight. This has led to demands that specialty medical organizations establish systems to carry out ethical or peer review, in response to formal complaints about a member’s medicolegal testimony. It is apparent that medical organizations do have the expertise to perform such review, and, in addition, that review would address a worthy question: is the testimony false or true? Thus far, the courts’ evaluation of “expert” testimony has been ineffectual. To identify outright perjury, scientifically untrained judges must recognize that an opinion is factually false, and they also must know that the “expert” *intended* for the opinion to be wrong. In contrast, it is irrelevant to peer reviewers whether a person had good intentions but was incompetent (truthfully mistaken), or whether the person fully understood the topic but chose to misrepresent it (maliciously mistaken, ie, perjurious). In

both situations, the testimony is misleading and therefore represents unprofessional conduct.

Because of legal ambivalence about improving “expert” testimony through peer reviews, physicians are unsure regarding what, if any, protection can be expected from potential lawsuits filed against organizations that conduct such reviews.<sup>81,83</sup> Recently, two courts came to opposite conclusions on the role of physicians in policing “expert” testimony.<sup>83</sup> In one case, which was decided in the U.S. District Court for the District of Kansas, the ruling was that an obstetrician who complained to the American College of Obstetrics and Gynecology about a colleague’s testimony could not be sued by that colleague for defamation. This was true in part because the federal Health Care Quality Improvement Act (HCQIA) of 1986 defined “expert” testimony as “a type of medical service.” Therefore physicians who participate in “professional review action” are protected from resulting lawsuits.<sup>84</sup> This same Act was also cited in a previous Federal court decision that supported “expert” witness review by the American Association of Neurological Surgeons.<sup>82</sup>

However, those decisions in Federal court have not empowered other organizations that contemplate review of “expert” testimony. Almost simultaneously with the Kansas decision, a Florida state court unanimously held that state and federal statutes of immunity did *not* prevent an “expert” witness from pursuing a defamation case against three other physicians and the Florida Medical Association (FMA), which had initiated an evaluation of the expert’s testimony against these physicians.<sup>85</sup>

Societies who evaluate the possibility of establishing a peer review program must be aware that even in hospital-based peer reviews of clinical care, there have been successful challenges to reviewers’ immunity from liability.<sup>86-88</sup> Moreover, review of “expert” testimony has less historical foundation than that of hospital-based reviews. Problem areas include the following:

- a. “Gray-area” cases could lead to arbitrary distinctions between testimony that is censured and testimony that is considered adequate. This difficulty provides an opening for legal attacks on decisions reached by the review process.
- b. It is difficult to establish consistent criteria to link negative peer evaluations with appropriate penalties.<sup>89</sup> Which testimony should result in expulsion from an organization, or a 1-year suspension, or a 1-month suspension, etc.? Again, inconsistencies that may arise from one case to another will be difficult to defend against legal attack.
- c. National organizations that attempt to conduct peer review of expert testimony in state courts will encounter variations in state laws that may be troublesome. Allegations such as “lack of due process” or “reckless disregard for the truth” can be interpreted dissimilarly in different jurisdictions.

Finally, it must be recognized that because no organization has ever conducted review of “expert” pathologist testimony, one cannot predict what the legal ramifications of the process may be. If defamation or libel lawsuits are filed by the reviewees, specialty societies will need to defend their actions in court, probably in several different states.

The medical association with the longest record of reviewing “expert” testimony is the American Association of Neurological Surgeons (AANS); it has evaluated >50 complaints of unprofessional conduct by one member against another since 1983.<sup>90,91</sup> Russell Pelton, JD, a consultant to the AANS, has indicated that it is difficult to evaluate the effectiveness of the review program, but plaintiffs’ attorneys have found it harder to enlist an expert in neurosurgery than in any other specialty.<sup>92</sup> The American College of Radiology (ACR) is another society with an active program for evaluating “expert” testimony. ACR evaluations have led to the suspension, censure, or expulsion of members whose testimony is found to be substandard.<sup>93</sup>

Obviously, the possibility that an organization may face litigation should not, by itself, stand as a contraindication to performing peer reviews. If societies avoided all activities that might lead to lawsuits (eg, hiring employees; waxing floors at their headquarters), those groups would grind to a halt. Hence, the question of “peer-review or no peer-review” centers on organizational priorities and costs versus benefits to the organization’s membership.

#### **F) Publicizing expert testimony in an effort to improve the quality of testimony (the Hawthorne effect)**

The “Hawthorne effect” was first observed during studies of productivity and quality conducted in the 1920s at the Hawthorne works of the Western Electric Company in Chicago.<sup>94</sup> One definition of this effect is a significant improvement in performance that occurs simply because participants know that their performance is being studied.

Perhaps the best known case wherein “expert” pathologist testimony was disseminated is a malpractice suit against Dr. A. Bernard Ackerman, a renowned dermatopathologist who was sued concerning alleged misdiagnosis of a melanoma.<sup>95</sup> Before that lawsuit, expert witnesses were complacent in the likelihood that almost no one outside the trial participants would know the contents of their testimony. (“What happens in the tort system stays in the tort system.”) Dr. Ackerman changed that perception when he published the plaintiffs’ “experts” trial testimony in the printed and electronic media accessible to the pathology community. Many authorities felt that the testimony was fallacious. Subsequently, similar examples of “expert” opinion have occasionally found their way to the internet, for evaluation by other pathologists.

Despite these examples, we find that there are still significant barriers to improving the quality of “expert” testimony in pathology by employing the Hawthorne effect. For one thing, it is clear that Dr. Ackerman has great energy as

well as considerable resources at his disposal. Publishing all, or even most, “expert” pathologists’ testimony for review would be a daunting task indeed. Even verdict reporting services fail to capture all verdicts,<sup>11</sup> and therefore attempts to use the Hawthorne effect to improve courtroom testimony would likely be ineffective. Unethical experts will know that it is still unlikely that their misrepresentations will be subject to general scrutiny. Furthermore, most malpractice cases never go to court, and “expert” testimony given only in depositions or in written opinions is extremely difficult to obtain in a systematic fashion.

### **G) Oversight of “expert” testimony by state medical boards**

State medical boards have statutory authority to oversee the practice of medicine in their respective locales. That authority is based on state medical practice acts, which define “the practice of medicine” and list the infractions that will prompt board actions.<sup>96</sup> State boards deal with issues such as sexual involvements by practitioners with their patients, substance abuse and other forms of physician impairment, prescribing irregularities, and felonious behaviors, but the extent to which boards are involved in monitoring other physician activities varies greatly.

Even in “traditional” problem areas of practice, it may be difficult to determine if or when the board should intervene. A California physician who was arrested 3 times for driving while intoxicated (DWI) claimed that the Medical Board of California denied him due process when it revoked his medical license; he argued (unsuccessfully) that because he was never accused of drunkenness while providing patient care, his arrests were irrelevant to his fitness to practice medicine.<sup>97</sup> In fact, according to the Federation of State Medical Boards, offenses not directly related to medical practice were cited as the most frequent reasons for State Board disciplinary actions. These included DWI, “moral turpitude,” tax evasion, and fraud.

Boards have been encouraged by both the American Medical Association (AMA)<sup>98</sup> and the Federation of State Medical Boards (FSMB)<sup>99</sup> to define “expert” witness testimony as the practice of medicine. That step would make the giving of fraudulent testimony an unprofessional conduct subject to discipline. However, the AMA and FSMB recommendations have no power to affect state board policies.

A few state boards have, however, embraced the AMA and FSMB suggestions. In Mississippi, “expert” medical testimony must comply with ethical standards, including those of the AMA, and false or fraudulent statements are “prohibited.”<sup>89</sup> North Carolina is another state where the quality of “expert” witness testimony is evaluated by its medical board. In one case, the North Carolina State Board disciplined a neurosurgeon-“expert” witness and rescinded his license. However, after a long legal battle with the Board, he prevailed and regained his ability to practice in North Carolina.<sup>100-102</sup>

At least one state legislature—in South Carolina—passed a law requiring that out-of-state “experts” must have

their credentials evaluated by the state board before testifying in state court. After a satisfactory evaluation, the expert would have been granted a limited state medical license and been allowed to give legal evidence.<sup>89</sup> This law was quickly nullified by the South Carolina Supreme Court because the Court felt the measure had “the potential to substantially impair the orderly administration of justice.”<sup>103,104</sup>

The New Mexico State Medical Board and those in other locales have avoided dealing with “expert” testimony because they embrace the stance that it does not constitute the practice of medicine. Hence, an expert providing fraudulent information in court is viewed in the same way as if he or she lied about a golf score.

### **H) Scientific education of judges to better enable them to exclude fraudulent testimony**

We are aware of at least two initiatives aimed at enabling judges to better understand scientific matters in court. One is the National Judges’ Medical School, which was established in March of 2006 as an outgrowth of an organization paid for by the National Institute of Environmental Health Sciences.<sup>105</sup> A second educational effort began in June of 2006, when The American Association for the Advancement of Science conducted a medical seminar for judges.<sup>106</sup> The hope is that judges who are faced with frivolous lawsuits and unscrupulous “experts” will be enabled to recognize them.<sup>105</sup>

Although arguments against more scientifically literate judges are hard to make, few if any malpractice cases actually hinge on general scientific principles that could be transmitted in abbreviated science courses such as those cited above. In fact, such educational efforts may actually be harmful, because they support the myth that with only minor preparation, lay judges can evaluate complex medical opinions. It might be more useful for state district judges to be allowed to take medical specialty board examinations in topic areas where they anticipate making decisions. For example, a judge who hears cases dealing with melanoma could take the dermatopathology board examination to obtain feedback about his or her knowledge in that area.

### **I) Allowing the treating physician to testify for the defense**

Some states have prevented treating (but nondefendant) physicians from testifying for the defense. This can mean that juries are prevented from hearing important facts and perspectives concerning the case in question. Virginia recently passed a “reform” allowing treating physicians to testify.<sup>29</sup>

### **J) Having plaintiffs waive the right to privacy**

In many states, a plaintiff’s case alleging medical negligence is subject to dismissal if the patient does not waive the right to privacy of his or her medical records. In a state system where the patient is not required to waive that right, the jury is denied access to potentially important informa-

tion. This issue was recently raised by a Georgia appeals court, which ruled that HIPAA ensures protection of private health information from “unauthorized release.” Therefore, the plaintiff was said to be under no obligation to disclose records.<sup>107</sup>

### K) Changing court procedures to make it easier for jurors to process complex information

It is possible that changes in court procedures, such as temporally grouping testimony from *all* “experts”—both plaintiff’s and defense’s—during a trial, may allow juries to better weigh the credibility of the conflicting opinions.<sup>7</sup> Allowing jurors to take notes is another provision that would allow them to organize their thoughts and conclusions.<sup>108</sup>

## Discussion

In the practice of medicine, avoiding error, declining to criticize colleagues in front of patients, and communicating clearly all contribute to decreasing patient dissatisfaction. Unfortunately, it is also true that even achieving ideal goals such as “error-free pathology” would probably not completely eliminate all patient perceptions of “negligent” care. Diagnostic disciplines such as cytopathology and histopathology have inherent rates of false positivity and false negativity that sometimes lead to adverse outcomes, and the subjective nature of image interpretation along with sometimes poorly formulated diagnostic criteria produce diagnostic disagreements.

Despite these problems, the professional status of physicians is relatively high, and we benefit as a group from constant media attention directed to medical “breakthroughs.” However, this same focus creates high, and possibly unreasonable, patient expectations. In parallel with the media’s fondness for “medical miracles,” it also is obsessed with medical error. Indeed, given the proper circumstances, a particular medical error may appear in the national news for several days. This attention to error has made it increasingly clear to the public that even when care is given by competent physicians in the “best” hospitals, some patients experience adverse events because of negligence. However, substantial sophistication is often required for observers of adverse events to determine whether they occurred despite sound patient care, or as a result of negligence.

For the foreseeable future, physicians will be forced to participate in the processes and procedures established by society to deal with allegations of medical negligence. Unfortunately, in the early phases of malpractice litigation, the tort system is highly asymmetrical in its apportionment of costs and risks. That is to say, the damage to doctors from unfounded accusations against them is much greater than damage to attorneys making the false allegations.<sup>28</sup> In fact, for practical purposes, the lawyers suffer *no* consequences from doing so. This asymmetry encourages plaintiffs’ attorneys to file poorly evaluated cases in a search for quick

profits. In New Mexico, the “nuisance value” of any given malpractice case—even a completely fatuous one—is considered to be well over \$20,000. Plaintiffs’ attorneys’ costs typically accrue most significantly only in the late stages of case litigation, but “rattling the doorknob” at the front end of the system is very inexpensive for these attorneys.

Physicians desiring “reform” in tort procedures do not dispute the fact that patient compensation is appropriate in some cases. Moreover, we agree that society must have mechanisms to decide which patients deserve it, and at what level it should be given.

However, as obvious as it is to many doctors that the tort system is ripe for change, this does not mean that reforms will, in fact, emerge. Pathologists considering a malpractice case with a \$20 million award for a Pap test problem would likely conclude that the legal system failed in properly handling that suit. In contrast, others might consider the same award to be proof that the courts still protect the “common man” from the rich and powerful. In fact, the stated jury award could be regarded as proof for either position; the political system decides which side has the greatest validity.

Physicians are largely limited to two related approaches in attempting to achieve medicolegal “reform.” The first involves efforts to convince judges and politicians that pro-medicine changes are needed to further societal goals, such as making health care more affordable or available. The second approach takes the arguments directly to the voters.<sup>40</sup> Citizens largely vote for their own self-interests, and politicians and judges will be motivated to adopt measures in line with their wishes.

Each election presents an opportunity to convince voters to replace politicians who are obstacles to “reform” with politicians who are its advocates. Initially this may seem easy, because physician arguments in favor of tort “reform” sound highly convincing to other physicians. However, these arguments do not exist in a political vacuum. Trial lawyers have successfully countered physicians by characterizing many proposed tort “reforms” as attacks on voter rights. In this context, it is worth noting that even judicial elections are now a major area of tort “reform” conflict, with 39 states currently electing judges.<sup>109,110</sup>

In 2004, spending on campaigns for state supreme court seats was reported to be \$42 million nationwide.<sup>111,112</sup> A member of the Ohio Supreme Court noted that “everyone interested in contributing has very specific interests. They mean to be buying a vote.”<sup>109</sup> Organizing political opposition to “unfriendly” judges is a tool that has been used by business groups in the past, and other groups, including physicians, have been encouraged to do likewise in regard to state elections.<sup>112</sup> It has become increasingly clear that tort “reform” is a “full contact sport” with a political identity.<sup>112</sup> Responding to this reality, doctors have attempted to be vocal during elections. The AMA reported that in 2004, physicians raised approximately \$1.7 million for the Fund for America’s Liability Reform.<sup>113</sup> Sadly, though, that

amount is dwarfed by the money that is contributed by lawyers.<sup>114</sup>

With regard to major reform of malpractice litigation, a tipping point will probably be encountered when the U.S. enters a crisis situation precipitated by the financial fragility of Medicare and Medicaid, together with growing state and local government health care obligations. Voters have grown accustomed to free and ready access to the courts, where allegations of medical negligence can be compensated lavishly. At the same time, many voters have come to expect unlimited and inexpensive availability of everything that medicine has to offer. In economic terms, both health care and malpractice litigation are “free goods” that have the status of rights. In the long term, it will become apparent that these two rights are incompatible with one another.

Currently, the major threat to many citizens’ continued right to health care access is only an accounting prediction based on extrapolations of current medical costs. However, if the extrapolations become reality, voters will undoubtedly have to reevaluate the costs and benefits of the current tort system. The savings from even radical tort “reform” will not cover anticipated shortfalls in entitlement programs, but they are sufficient to support a substantial amount of health care. According to an estimate from the U.S. Department of Health and Human Services, direct costs of medical liability insurance plus indirect costs of defensive medicine raise the federal share of health spending by \$28 billion a year.<sup>115</sup> Another recent study found that for every dollar of patient compensation given by the tort system, 54 cents was allocated to various administrative expenses.<sup>116</sup>

It is likely that the current malpractice system will resist any major “reform” until the national discussion turns to large tax increases and drastic reductions in benefits. At that point, claims from the patients covered by Medicare and Medicaid for compensation after adverse events could be handled administratively by the Federal government. Using such a program as a template, states could then replace their malpractice tort systems. The dual goals of these new paradigms would be prompt and affordable compensation of valid claims, along with error reduction.<sup>117</sup> It is unlikely that streamlined constructs would incorporate the fundamental mistakes now embedded in the tort system. For example, evaluation of physician competence after adverse outcomes would still be necessary, but that task could be separated from deliberations addressing compensation, eg, delegated to state medical boards. Although a reformed system designed to evaluate physician competence will almost certainly be cheaper, quicker, and more rational than the current tort system, it is far from a foregone conclusion that physicians will be pleased with either the experience of having their clinical care evaluated by a “reformed” system, or the outcomes that result from those evaluations.

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