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Medical Societies' Self-Policing of Unprofessional Expert Testimony

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In the current medical malpractice maelstrom fingers are pointed in every direction: why does the crisis exist? Who is responsible? What can be done? And, in the eyes of some academics, does a crisis truly exist? Whether fault lies in an overly aggressive plaintiffs' bar, a litigation-happy society, or a rise in the awareness of medical errors, no one can deny that, at least from the perspective of the medical profession, a crisis of unprecedented magnitude is upon us. Apart from the thousands of physicians retiring early, or limiting their practices, or moving to less litigious jurisdictions, one only has to look at the growing number of hospitals whose insurance retained-retention levels have been raised to astronomical heights to know that the next major judgment against many such institutions will put them permanently out of business.

Many possible culprits may be responsible for this crisis, however little attention has been paid to the irresponsible or unethical plaintiff's medical expert. While studies have produced slightly different results, one study reported that in only one out of six medical malpractice claims filed was there an injury caused by demonstrable medical negligence.[1] *That means that in eighty-four percent of the claims made there was no patient injury which was the result of medical negligence.* An earlier study concluded that approximately thirty percent of malpractice plaintiffs who were paid in settlement would have lost if they had proceeded to verdict.[2] Yet, in virtually every one of the cases involved in both studies there was an expert involved, usually a physician, willing to swear under oath that an injury, real or imagined, was the direct result of negligence on the part of the treating physician or hospital staff.

At least some percentage of the current medical malpractice crisis is a direct result of unprofessional, sometimes outrageous, "expert" testimony offered by members of the medical profession and, just as importantly, the

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1. *See* App. A, Graph: The Tort System Undercompensates Victims of Negligence.

2. PATRICIA M. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY 43 (1985).

inability or refusal of responsible parties to seriously police that conduct. Moreover, the medical profession has not only the self-interest, but also the responsibility to discipline its members who testify irresponsibly as expert witnesses. Indeed, as discussed below, the medical profession may be uniquely positioned to be proactive in this area.

I. DEFINING THE PROBLEM

Improper or unethical expert testimony given by medical professionals is not an issue about legitimate differences of opinions between professionals. That can occur in any area, particularly in medicine with its often rapidly advancing technology coupled with the vagaries of the human condition. Rather, the focus here is on physicians who take the stand as expert witnesses and misstate or misrepresent their expertise, or knowingly misstate the standard of care. This may also include physicians who purport to diagnose a patient without having reviewed the patient's medical records, or who have not kept current in the area in which they claim expertise, or who refuse to acknowledge differing views or the fact that the views they express may be in a distinct minority in their specialty.

The obligation to provide sound and accurate testimony applies to experts testifying on both sides in professional liability litigation, and the problems set forth above do not only apply to plaintiff's experts. However, that being said, there is a perception in the medical community that the enumerated problems are more commonly found in testimony provided by physicians testifying as plaintiff's experts.

II. HOW CAN FALSE TESTIMONY BE DEALT WITH?

Having stated the problem, that is, that too often expert testimony provided by physicians is inaccurate, unprofessional or outright false, what are the ways in which that type of testimony can best be dealt with?

Some would argue that this problem should be addressed during legal proceedings. The argument is that a competent trial judge should be able to bar false or misleading medical testimony, especially if appropriate objections are raised by opposing counsel. However, that is an unrealistic expectation. In the recent landmark decision of *Austin v. American Ass'n of Neurological Surgeons*, in which the Seventh Circuit Court of Appeals upheld the right of a professional association to discipline members who testify falsely as expert witnesses, Chief Judge Richard Posner stated:

> It is no answer that judges can be trusted to keep out such testimony. Judges are not experts in any field except law. Much escapes us, especially in a highly technical field, such as neurosurgery. When a member of a prestigious professional association makes representations

> not on their face absurd, such as that a majority of neurosurgeons believe that a particular type of mishap is invariably the result of surgical negligence, the judge may have no basis for questioning the belief, even if the defendant's expert testifies to the contrary.[3]

Indeed, in a recent study conducted on district court judges in Florida, where the judges were asked to differentiate junk science from real science, eighty-three percent of the judges were substantially unable to tell the difference between good and junk science.[4]

Even if defense counsel is able to discredit such testimony by cross-examination or have it barred by a favorable ruling from the trial judge, there is no penalty imposed on the so-called expert who had attempted to alter the course of the litigation through false or misleading testimony. The expert can simply walk away with impunity. For all practical purposes, an expert who gives clearly false testimony in litigation is immune from being sued. Most states recognize a qualified immunity from litigation to anyone who testifies as an expert in court.[5] However, that immunity extends only to retaliatory litigation, and does not apply to disciplinary action taken by professional societies or state licensure boards. Therefore, it comes down to those entities—licensure boards and medical associations—to take whatever action is appropriate when false or unprofessional testimony is offered by physicians serving as purported expert witnesses in litigation.

III. DISCIPLINE BY STATE LICENSURE BOARDS

State licensure boards have unfortunately not been particularly active in this area and have only recently begun to recognize their responsibility to discipline medical licensees who abuse their license by testifying falsely in court.

The crux of the problem is that too many physicians and state regulators do not regard the provision of expert testimony as part of the practice of medicine. It is a game, a diversion, or a way for a physician to augment his income. It is not really practicing medicine, or so the logic goes, and one is not bound by the rules of ethics and standards that would apply to a surgeon in an operating room. However, there is a growing realization that that

3. Austin v. Am. Ass'n of Neurological Surgeons, 253 F.3d 967, 972 (7th Cir. 2001).

4. Margaret Bull Kovera & Bradley D. McAuliff, *The Effects of Peer Review and Evidence Quality or Judge Evaluations of Psychological Science: Are Judges Effective Gatekeepers?*, 85 J. APPLIED PSYCH. 4, 574 (2000).

5. Mary Virginia Moore et al., *Liability in Litigation Support and Courtroom Testimony: Is It Time to Rethink the Risks?*, 9 J. LEGAL ECON. 53 (1999); Leslie R. Masterson, *Witness Immunity or Malpractice Liability for Professionals Hired as Experts*, 178 REV. LIGIT. 393 (1998).

reasoning is dead wrong, that serving as an expert witness in a professional liability suit is in fact practicing medicine, and therefore breaches of professionalism and ethics in that arena should be subject to exactly the same penalties as unprofessional conduct in a hospital or a university, including loss of privileges, and licensure suspension or revocation.

One of the issues in the *Austin* case was whether or not expert testimony by a physician constituted the practice of medicine.[6] Counsel for the neurosurgeon in *Austin*, whose testimony was in question, asserted that it did not because he had never provided medical care for the patient/plaintiff.[7] The American Medical Association (AMA) and several other medical associations filed an amicus brief supporting the American Association of Neurological Surgeons (AANS), citing AMA policy that rendering expert medical testimony does in fact constitute the practice of medicine.[8] Judge Posner, speaking for the court, accepted the argument from the AANS and AMA, and held that "although Dr. Austin did not treat the malpractice plaintiff for whom he testified, his testimony at her trial was a type of medical service."[9]

In an earlier case, the District of Columbia Court of Appeals came to the same conclusion and upheld a reprimand and fine imposed by the Board of Medicine on a physician who was found to have given false testimony regarding his credentials.[10] The Court held that false testimony given by a physician in a medical malpractice case constituted a false report while engaged "in the practice of medicine."[11]

Whether expert testimony constitutes the practice of medicine is critical to the issue of whether the testimony is subject to discipline by medical licensing boards if it violates ethical standards. In a study conducted in 1997, the allopathic medical licensing boards of all fifty states were surveyed and of those that replied, forty-one percent expressed uncertainty as to whether a medical expert witness is "practicing medicine."[12] That is a disquieting statistic and illustrates why there has been so little activity on the part of licensing boards to rein in renegade physicians. In response to that same survey, seventy-two percent of the medical licensing boards reported that they had *never* disciplined a physician witness for fraudulent

6. Austin, 253 F.3d at 974.

7. *Id.*

8. Am. Med. Ass'n (AMA), AMA Policy H-265.993, *available at* http://www.ama-assn.org.

9. Austin, 253 F.3d at 974.

10. *See* Joseph v. Dist. of Columbia Bd. of Med., 587 A.2d 1085 (D.C. 1991).

11. *Id.* at 1091.

12. Douglas R. Eitel et al., *Medicine on Trial: Physicians' Attitudes about Expert Medical Witnesses*, 18 J. LEGAL MED. 345, 350 (1997).

courtroom testimony.[13]

Does a physician have to be engaged in the direct hands-on treatment of a patient to be practicing medicine? Both logic and practice compel the opposite conclusion. For example, in an increasing number of States physicians who provide medical advice via the internet to individuals who they never see are held to be practicing medicine without a license if they are not licensed in the State where the "patient" resides.[14]

Likewise, if a physician is asked to provide a second opinion regarding a patient who is under another physician's care, is he or she practicing medicine? Certainly. If a physician is called in by a practitioner in another area to consult on a case, is he or she practicing medicine? Of course. If a physician is hired by an insurance company to analyze and review medical claims, is he practicing medicine? Absolutely. In all those instances, the physicians are being called on to provide expert advice based on their medical background and training. They are called on or hired specifically *because* they are physicians. Just as when someone is retained as an expert medical witness, they are tendered to the court as *experst* specifically because they are *physicians*. They are called on to diagnose a patient's condition and to apply their expertise in analyzing the most appropriate treatment for that patient's medical condition. They are clearly practicing medicine when they do so.

If a physician is in fact practicing medicine while testifying as an expert medical witness, what standards of ethics and professionalism should apply? For one, a diagnosis should not be made, nor a medical report given, without reviewing *all* of the relevant medical records of the patient, not just the isolated records selectively chosen by counsel. In a hospital setting, except in an emergency situation, a physician would never render a diagnosis without being aware of the patient's full medical history. Therefore, it follows that the same standard should apply to a physician who is practicing medicine in the context of a lawsuit.

Other lapses of professionalism commonly seen in expert medical testimony include overstating or misrepresenting one's expertise, misstating the applicable standard of care, or asserting that one's opinion represents the prevailing view in the specialty while in fact it represents a distinct minority view. Remarks of this nature would rarely, if ever, be made in Grand Rounds or in the presence of one's colleagues. Why then should physicians be able to make such remarks with impunity while practicing medicine in another venue?

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13. *Id.*

14. Alison M. Sulentic, *Crossing Borders: The Licensure of Interstate Telemedicine Practitioners*, 25 J. LEGIS. 1, 9 (1999).

This is an area that is certainly in flux, and there is increasing pressure on state licensing boards across the country to modify their practices or regulations to recognize that providing expert medical testimony is in fact a form of the practice of medicine, and must be subject to the same forms of state regulation as are applied to other forms of unprofessional or unethical medical conduct. The North Carolina Medical Board, in particular, has recently been proactive in this area,[15] but the fact remains that at the present time only a minority of state licensing boards are doing so.

IV. DISCIPLINE BY MEDICAL PROFESSIONAL SOCIETIES

The result then, is self-regulation by the medical profession. The leading program in the country used to discipline member physicians who testify unprofessionally in litigation is the Professional Conduct Program of the AANS. The AANS' program has recently been in the national media spotlight because of the high profile *Austin* case, cited above, in which the propriety of such a program was not only upheld, but strongly endorsed by the Federal Court of Appeals as a paragon of professional self-regulation for medical societies.[16] For nearly twenty years the AANS' Professional Conduct Program has served to resolve all types of ethics disputes between members, and, in particular, charges of unprofessional testimony by neurosurgeons in court cases. Since the AANS' program has now been endorsed by the courts as well as by the AMA,[17] it would be instructive to review its development, current operations, and how it is impacting the medical profession as a whole.

The premise of the AANS' Professional Conduct Program is that membership in a professional association requires conduct which meets a high professional standard.[18] It stands to reason that when members believe that other members have acted outside of professional boundaries, they expect their professional association to take appropriate action. Indeed, one of the very definitions of a profession is a group which polices itself to maintain agreed standards.

Such was the case in 1983 when the AANS addressed the question of how the Association should respond to a complaint brought by one member against another member. There was neither a mechanism in place to evaluate the seriousness of member complaints, nor a uniform and equitable

15. *N.C. Board Suspends License for Neurosurgeon's Expert Testimony,* ASSOCIATED PRESS, Nov. 23, 2003.

16. Austin, 253 F.3d at 972.

17. *See* AMA Board Report Regarding Expert Witness Testimony, Report 18-1-98, 104-110 (Dec. 1998).

18. AM. ASS'N OF NEUROLOGICAL SURGEONS (AANS) BYLAWS, ART. I, § 2 (1983) (updated 2003), *available at* http://www.aans.org/about/aansbylawspdf.pdf.

procedure to deal with them.

In response to these problems, the AANS' Professional Conduct Program was created. The Bylaws were amended to designate the Professional Conduct Committee as the arbiter of all member complaints of any nature, including complaints that other AANS members had testified unprofessionally as expert witnesses in litigation.[19] The Committee's charge was to address complaints on an impartial basis, to conduct hearings where appropriate—with due process protections for all parties concerned—and to make unbiased recommendations to the Board.

In 1983 Procedural Guidelines were adopted to provide the ground rules under which the Committee would evaluate complaints.[20] Under those Guidelines, which remain modified but intact today, the AANS never *initiates* a complaint. Rather, it is the complainant member's responsibility to collect all relevant evidence and present it to the Committee. The Guidelines further provide that after the complainant's supporting material is received, copies are sent to the charged neurosurgeon who is given the opportunity to respond in whatever fashion he or she believes appropriate. Submissions from both sides are furnished to the other party and to all members of the Professional Conduct Committee for review before a hearing.

Hearings often are scheduled in conjunction with major national neurosurgical meetings to minimize schedule disruption and expense for all parties. Both sides are expected to attend, with counsel if they wish, and the proceedings are recorded by a court reporter. Attorneys who attend are advised that they can ask clarifying questions of the other side, but extensive cross-examination is not permitted. After both sides make their presentations, the Committee goes into Executive Session to determine whether unprofessional conduct has been established and, if so, what penalty is appropriate: censure, suspension of membership, or expulsion from the AANS.[21] The Professional Conduct Committee's report is then sent to the Board of Directors as well as to the complainant and the respondent. If adverse action is being recommended, the respondent has the opportunity to make a further presentation to the Board before final action is taken.[22] Finally, any member can make a further appeal to the AANS' General Membership, anonymously if they wish.

At the same time that the Professional Conduct Committee's Procedural

19. AANS BYLAWS, ART. II, § 4 (1983) (updated 2003), *available at* http://www.aans.org/about/aansbylawspdf.pdf.

20. AANS POLICY MANUAL 52-54 (2001).

21. AANS BYLAWS, ART. II, §4 (1983) (updated 2003), *available at* http://www.aans.org/about/ aansbylawspdf.pdf.

22. *Id.*

Guidelines were adopted in 1983, the Board of Directors also adopted Expert Witness Guidelines.[23] The Guidelines were intended to ensure a standard of quality and impartiality in expert testimony provided by neurosurgeons on either side of professional liability cases. Violations of those Guidelines, if supported by credible evidence, could be brought before the Professional Conduct Committee and, ultimately, the Board of Directors, for appropriate discipline. The Guidelines were expanded in 1987, and restated in 2003 by the AANS Board as Rules for Neurosurgical Medical/Legal Expert Opinion Services. The salient points of those Rules are as follows:

- The neurosugical expert witness should be impartial, and not an advocate.
- The neurosurgical expert witness should not be evasive for the purpose of favoring one litigant over another. The neurosurgical expert should answer all properly framed questions pertaining to his or her opinions on the subject matter thereof.
- The neurosurgical expert witness should not present his or her views as the only correct ones if they differ from other accepted views in the specialty.
- The neurosurgical expert witness must acknowledge differing views, if there are any.
- The neurosurgical expert witness should become familiar with all the pertinent medical history of the patient prior to rendering an opinion on the appropriateness of the patient's care.
- The neurosurgical expert witness should be familiar with current concepts of the medical practices in question before providing an opinion on the appropriateness of the treatment provided to the patient.
- The neurosurgical expert witness must never accept a fee that is in any way contingent on the outcome of the litigation.[24]

The Procedural Guidelines of the AANS' Professional Conduct Committee were refined in 1995 to permit the Committee, after reviewing written submissions from both sides, to make a preliminary determination as to whether or not a prima facie case of unprofessional conduct has been established.[25] If so, a hearing is scheduled. If the Committee believes that

23. AANS POLICY MANUAL, *supra* note 20, at 51.

24. Rules & Regulations of the Board of Directors of the AANS, *available at* http:// www.aans.org/about/ RulesReg03Dec04.pdf.

25. AANS POLICY MANUAL, *supra* note 20, at 52-54.

such a case has not been established, a report is sent to the Board of Directors recommending that the complaint be dismissed.[26] Approximately twenty-five percent of the cases presented to the Committee are now resolved in this fashion.[27] The Professional Conduct Program was further fine-tuned in 1996 with a bylaw amendment that permitted the AANS' Board of Directors to refuse to accept any resignation tendered by a member who was the subject of pending charges before the Professional Conduct Committee.[28]

In the twenty years in which the AANS' Professional Conduct Program has been in effect, eight neurosurgeons have been issued formal Letters of Censure for unprofessional conduct while testifying as expert witnesses in medical malpractice litigation; eleven others have had their membership in the AANS suspended; and one was expelled from the AANS for a second offense. Disciplinary actions which result in suspension of membership or expulsion are reported to the National Practitioners' Databank, however censures are not reported.[29]

Not surprisingly, the AANS' Professional Conduct Program has drawn judicial challenges, all of which have been resolved in the AANS' favor. In 1991, after charges of unprofessional conduct were brought against Dr. George Jacobs, a New Jersey neurosurgeon, he filed a complaint for an injunction against the AANS in Bergen County, New Jersey, attempting to block the proceedings.[30] His complaint asserted that only a trial judge can measure the appropriateness of expert witness testimony and that it should not be permissible for a medical association to attempt to review and possibly criticize that testimony after the trial.[31]

The trial court in New Jersey granted the AANS' motion to dismiss the complaint, a decision that was affirmed by the New Jersey Appellate Court and the New Jersey Supreme Court.[32] All three levels of courts in New Jersey focused on the fact that there was nothing improper with the AANS' procedures and that the key question was whether the plaintiff, Dr. Jacobs,

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26. *Id.*

27. W. Ben Blackett, *AANS Hears Complaints, Takes Action*, AANS BULL., Spring 2002, at 12.

28. AANS BYLAWS, ART. II, § 3 (1983) (updated 2003), *available at* http://www.aans.org/about/ aansbylawspdf.pdf.

29. U.S. DEP'T OF HEALTH & HUMAN SERVS., PUB. NO. HRSA-95-255, NATIONAL PRACTITIONER DATA BANK GUIDEBOOK (Sept. 2001), *available at* http://www.npdb-hipdb.com/pubs/gb/NPDB%20Guidebook.pdf.

30. Jacobs v. Am. Ass'n of Neurological Surgeons, No. A-2894-91T5 (N.J. Super. Ct. App. Div. Nov. 18, 1992).

31. *Id.*

32. *Id.*

would receive appropriate due process.[33] The courts noted that there was nothing in the record of the AANS' Professional Conduct Committee or its Procedural Guidelines that would indicate the contrary. Although the *Jacobs* decision was unpublished, it became fairly well-known in the neurosurgical community.

A second court challenge to the AANS' Professional Conduct Program occurred in 1997 in the *Austin* case.[34] The Professional Conduct Committee found that Dr. Donald Austin, a Detroit neurosurgeon, provided inappropriate and unprofessional testimony as a plaintiff's expert in a medical malpractice case, and recommended suspension of his membership for six months.[35] Dr. Austin testified in the underlying litigation that permanent damage to the recurrent laryngeal nerve of a patient during the course of an anterior cervical fusion procedure could *only* have occurred as a result of negligence on the part of the surgeon, and that, as he testified, "the majority of neurosurgeons" would concur with his opinion. The Committee concluded that Dr. Austin was wrong in both respects.[36] They held that the type of injury in the case was a known risk in such a procedure, and all neurosurgeons know, or should know that.[37] Dr. Austin had either misrepresented the standard of care, or he had misrepresented his expertise, either of which was grounds for disciplinary action. The AANS' Board of Directors agreed and approved the suspension of Dr. Austin's membership.[38] His appeal to the AANS' General Membership was unsuccessful.[39] Dr. Austin attempted to resign during the pendency of his case before the Committee, but the Board refused to accept his resignation until the case was completed, in accordance with the AANS' Bylaws. When Dr. Austin's suspension became final, his resignation was accepted.

Dr. Austin then filed a suit in U.S. District Court in Chicago alleging that he was deprived of due process, a charge he later dropped, and alleging that the AANS' program violated public policy by discouraging physicians from testifying for plaintiffs in medical malpractice cases.[40] He further alleged that the AANS' actions had sullied his reputation and had resulted in a substantial drop in his expert witness income. The District Court granted the AANS' motion for summary judgment, which was affirmed on appeal

33. *Id.*
34. Austin, 253 F.3d at 967.
35. *Id.*
36. *Id.* at 970.
37. *Id.* at 971.
38. *Id.*
39. Austin v. Am. Ass'n of Neurological Surgeons, 98 C 7685 (N.D. Ill. 2000) (Memorandum Opinion by Judge Elaine Bucklo).
40. Austin, 253 F.3d at 968.

by the Seventh Circuit Court of Appeals.[41] On appeal the AANS was supported by an *amicus* brief filed on behalf of the AMA, the American College of Surgeons and the Illinois State Medical Society. In writing the Seventh Circuit's affirming opinion, Chief Judge Posner praised the AANS Professional Conduct Program as a public service, saying that "this kind of professional self-regulation furthers, rather than impedes, the cause of justice."[42] Judge Posner went on to state:

> By becoming a member of the prestigious American Association of Neurological Surgeons, a fact he did not neglect to mention in his testimony in the malpractice suit against Ditmore, Austin boosted his credibility as an expert witness. The Association had an interest—the community at large had an interest—in Austin's not being able to use his membership to dazzle judges and juries and deflect the close and skeptical scrutiny that shoddy testimony deserves.[43]

In January 2002 the U.S. Supreme Court refused to hear a further appeal by Dr. Austin's counsel.[44] The *Austin* decision stands today as the definitive court opinion supporting the right, and arguably the duty of professional associations to discipline their members who engage in unprofessional conduct while testifying as expert witnesses in litigation.

Some have questioned whether the recent promulgation of HIPAA regulations with their confidentiality requirements will compromise the effectiveness of professional conduct programs such as that used by the AANS. Those concerns are misplaced. Under the AANS' program, testimony is never reviewed until the underlying litigation is completed, in order to obviate any charge of witness tampering.[45] As a result, typically the challenged testimony and related medical evidence have already been made a matter of public record in the trial and are no longer confidential. In addition, in those instances where some evidence is not a matter of public record it is not difficult to have it depersonalized.

V. CONCLUSION

It is difficult at this point to quantify the impact of self-policing programs such as the AANS' on the integrity of expert testimony presented in professional liability litigation. But perhaps one indication of the success of

41. *Id.* at 970, 974.
42. *Id.* at 972.
43. *Id.*
44. Austin, 253 F.3d at 972 (7th Cir. 2001).
45. Procedural Guidelines of AANS Professional Conduct Committee § a(1) (unpublished).

such programs was reflected in a recent article in the *New York Times* which discussed the AANS' program and quoted a prominent plaintiffs' attorney as saying that, as a result of that program, "it is more difficult to get a good neurosurgeon as an expert than in any other specialty."[46] The same observation was expressed by a prominent plaintiff's attorney participating in Loyola University School of Law's Health Law Colloquium in Chicago in November, 2003.[47]

There are currently at least a dozen other medical specialty societies in various stages of considering and adopting professional conduct programs similar to that used by the AANS,[48] and it has been predicted that within two to three years, most medical societies in this country will have similar programs. Indeed, the Florida Medical Association recently adopted a variation of the AANS' program, with the additional element that if disciplinary action is taken against a member physician, a report of that action and the supporting evidence is sent to the Florida Board of Medicine for further action regarding his or her license.[49]

We all recognize the duty of physicians, both individually and collectively, to step forward and advise the courts when medical negligence has actually occurred, resulting in injury to a patient. Our judicial system is based on the premise that, in most cases, an injured patient cannot recover damages unless another physician testifies that the injury was caused by a breach of the standard of care by the treating physician; that is, negligence. Not only the AMA, but also all leading specialty societies recognize the obligation of their members to testify on both notes in professional liability cases, when appropriate. The important thing to remember, however, is that when so testifying, certain basic standards of honesty, impartiality and scientific accuracy apply and must be adhered to. If they are not, in the final analysis it is not only the right, but also the duty, of the medical profession to act to enforce those standards to protect the integrity of the profession as well as our system of law.

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46. Adam Liptak, *Doctors' Testimony Under Scrutiny*, N.Y. TIMES, July 6, 2003.

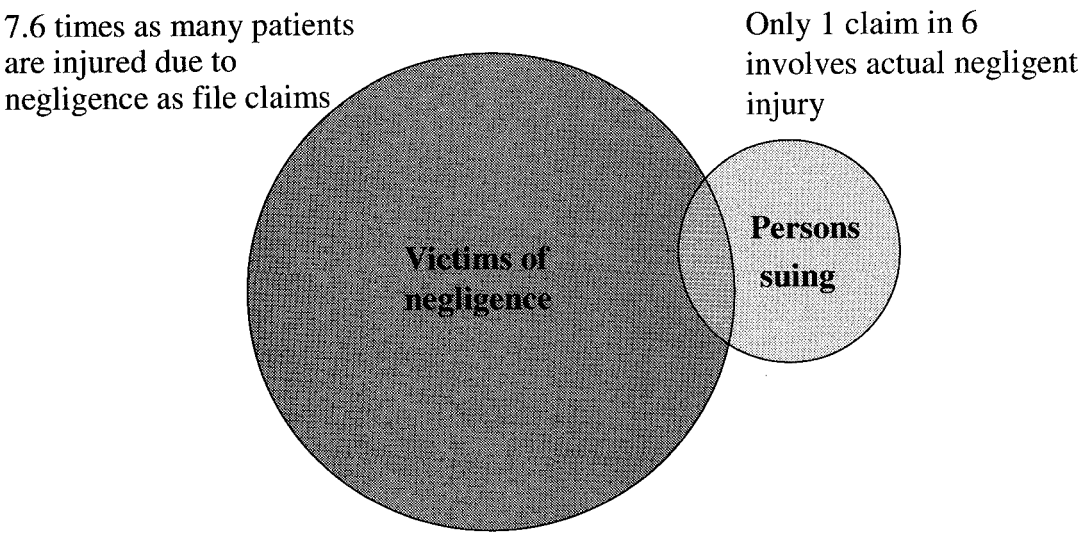
47. Susan Schwartz, Esq., Address at Loyola University Chicago School of Law's Annual Health Law & Policy Colloquium (Nov. 14, 2003).

48. *See* Am. Coll. of Radiology, *ACR Practice Guidelines on the Expert Witness in Radiology*, *available at* http://www.acr.org/departments/stand_accred/standards/pdf/expert_witness.pdf. *See also* Am. Soc'y of Anesthesiologists, *Guidelines for Expert Witness Qualifications and Testimony*, *available at* http://www.asahq.org/publicationsAndServices/standards/07.pdf; Am. Coll. of Emergency Physicians, *Expert Witness Guidelines for the Specialty of Emergency Medicine*, *available at* http://www.acep.org/1,560,0.html; *NASS Adopts Strong Professional Conduct & Ethics Program*, SPINELINE, Jan./Feb. 2003, at 35.

49. Dr. Perry Hookman, *Doctors Target Enemy Within* (Jan. 1999), *at* http://www.hookman.com/mp9901.htm.

Appendix A

The Tort System Undercompensates Victims of Negligence



*Data Source: A. Russell Localio, The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study, 324 New Eng. J. Med. 6, 377-384 (1991). Diagram Scale is only approximate. Conceptual design from Don Harper Mills and Randall Bovbjerg.