Annals of Health Law

Volume 13
Issue 2 *Summer 2004*

Article 11

2004

Private Responses to the Crisis

Russell M. Pelton
McGuireWoods LLP

SESSION 2: PRIVATE RESPONSES TO THE CRISIS

PROF. BLUM: I am John Blum from Loyola University. We had an interesting start from Barry and David. The next segment of the program will be devoted to individual presentations and then a panel discussion. My role is moderator. Joining me moderating will be Professor Mary Crossley from Florida State University School of Law. She will be joining me after the presentations for our panel portion.

Our first speaker dealing with the medical professional perspective with a focus on self-policing will be Russell Pelton. Mr. Pelton is a partner at McGuireWoods Ross & Hardies. He is a corporate litigator with many years of experience representing organized medicine, including the American Association of Neurological Surgeons (AANS). He will be our first speaker, followed by Barbara Youngberg.

Barbara Youngberg is the Vice President of Insurance, Risk, Quality Management and Legal Services at the University HealthSystem Consortium. Barb is an adjunct professor at the law school where she teaches one of our most popular courses on risk management. She is a national expert in risk management patient safety. She has a new book coming out on patient safety, so I am delighted to have her participating.

Also, a friend for a number of years working with the Institute [for Health Law] is Susan Schwartz. She is a partner at Corboy & Demetrio. She will be speaking on the patient perspective with a focus on compensating harm. Susan is a speaker at many educational conferences, so we are delighted to have her with us today.

Following Susan is Robert Mulcahey who is the President of Stratum Insurance Company. He is Vice President and Chief Operating Officer of Stratum Medical, and also President of Stratum Insurance, a captive insurance company. Mr. Mulcahey will be talking about an insurance perspective on the issues that we have been dealing with this morning.

The last speaker is Dr. Joseph Murphy. Dr. Murphy is a well-known physician who has held many leadership positions in organized medicine. He is President of Medical Staff at Saint Joseph's Hospital, a board certified internist, and a graduate of our medical school. So that is our lineup.

With that said, I am going to turn the podium over to our first speaker, Mr. Pelton.

MR. PELTON: I think one of the most interesting parts of the presentations that we heard earlier this morning by Professors Furrow and Hyman was the slide they both used showing the two overlapping circles of injured patients and claiming patients.[1] As I [understood] those slides, only one malpractice claim in six involves actual negligent injury. That means eighty-four percent of the claims brought are not based on actual injury caused by negligence of the treating physician; yet I would guess that in each one of those cases [the plaintiff's attorney] got a physician as a plaintiff's expert swearing under oath that yes, indeed, these injuries were caused by negligence on the part of the [treating] physician. I am going to discuss the issue of improper, unprofessional testimony given by experts in medical malpractice litigation. I speak from the standpoint of the medical profession, and I believe this is a problem primarily involved on the plaintiff's side.

One of the definitions of a profession is a group that self-polices in order to maintain common agreed standards. It is from that perspective that the AANS, whom I represent, instituted a program—the Professional Conduct Program—about twenty years ago designed to deal with this issue. [The program focuses on] how to deal with member neurosurgeons who testify unprofessionally in litigation.

The program was set up not just to deal with plaintiff's experts. It was set up to deal with complaints of any nature brought by one member against another member. It has been used primarily over the years to review testimony provided by plaintiff's experts. The program has been successful. It's been endorsed by the American Medical Association (AMA) and most recently by the U.S. federal courts as being a prototype system for medical associations to use to evaluate the integrity of their own members.[2]

At the time the AANS set up this professional conduct program, they adopted expert witness guidelines. These are guidelines which they believe should be followed by their members. The AANS has a clear policy, as does the AMA, that physicians both collectively and individually have an affirmative obligation to testify on both sides in medical malpractice cases when appropriate. But the AANS goes on to say when you do so, you have to follow certain standards of honesty, integrity, scientific accuracy, and impartiality. That's what this program is all about.

Let me give you an outline of what the AANS expert witness guidelines consist of. They have been enforced over the years and the courts have upheld the enforcement of these guidelines. First, the expert witness should

1. *See* App. A, Graph: The Tort System Undercompensates Victims of Negligence.
2. Austin v. Am. Ass'n of Neurological Surgeons, 253 F.3d 967 (7th Cir. 2001).

be impartial and not an advocate. It's the lawyer's job to be the advocate. The expert witness should not present his or her views as the only correct views if they differ from other accepted views in the specialty. It's [the AANS'] position that expert witnesses have an affirmative obligation in their direct testimony to identify other views that differ from theirs.

The expert witness must acknowledge different views, if there are any, and he must do so in his direct testimony, not only if asked the right question under cross-examination. The 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.

When a physician analyzes a patient's condition, he is diagnosing that patient. Further, when he opines on the appropriateness of the treatment, he is practicing medicine. A physician normally would not practice medicine or diagnose a patient, without seeing the full medical history of the patient, except perhaps in an emergency situation.

But, [attorneys] are having physicians testify as expert witnesses based on a couple of pieces of paper selectively chosen by counsel. The AANS suggests that is unethical and improper. Physicians are practicing medicine in that environment and they should apply the same standards of diagnosing and analyzing a patient [as they normally would] before they form an opinion, which includes looking at all of the relevant records.

The expert witness should be familiar with current concepts of medical practices in question before providing an opinion on the appropriateness of the treatment of the patient. The expert must be up-to-date in the field which they claim expertise. I think that's self-evident. The expert witness, again this is self-evident, must never accept a fee that is in any way contingent upon the outcome of the litigation.

The program that the AANS set up to enforce these guidelines goes roughly as follows. The AANS does not act in any investigative function. It simply processes and handles complaints that are brought by one member against another member of the AANS. So, if a member of the AANS has provided unprofessional testimony in litigation, say as a plaintiff's expert, and has violated AANS guidelines, the complainant [the person objecting to the testimony] has the obligation of collecting the evidence (typically the transcript of the testimony), spelling out a narrative form of what's relevant and what violations have occurred, and submitting that to the AANS. I am just a traffic cop in these matters.

[Next,] we send the complaint to the respondent and ask him or her to respond in whatever manner he or she deems appropriate. Typically the response is to send articles from learned treatises to support the position by the physician. When both sides' submissions have been made, they go to the Professional Conduct Committee which reviews them *in camera* in an

executive session, and they make a preliminary determination. Has there been a prima facie showing of unprofessional conduct, looking at both side's submissions? Is there a reason to have a hearing?

In about twenty-five percent of the cases the [committee] decides no, there really is no basis to go ahead. That's the end of the case. In the remaining seventy-five percent they do schedule a hearing. [The hearing is] held usually in conjunction with one of the major national neurosurgical meetings to minimize travel. Both sides are advised in advance to attend, with counsel, if they choose, and the hearings last about an hour. Each side is given thirty minutes to make its presentation. No new evidence or witnesses can be introduced that have not been divulged in advance, although if people want to have late entries in terms of evidence, they can do so as long as they exchange it in advance of the hearing so both sides know exactly what's going to happen at that hearing. Both sides can question the other side.

The members of the panel are experienced neurosurgeons who have read all the material and know the issues better than any of the lawyers involved. They also ask questions. When there are x-rays involved, which there often are, they have x-ray boxes right there. The panelists might say, "Doctor, you say there is a clear aneurysm. Look at the x-ray. You show us what you are talking about, so we all understand exactly what it is that you said was a 'clearly shown aneurysm.'"

After both sides have completed their testimony and their presentations, the committee goes into executive session again and decides whether there has been a showing to their satisfaction of unprofessional conduct. If there has been, [the committee decides] what penalty would be appropriate to recommend to the Board of Directors. That could either be a censure, a suspension from the AANS, or expulsion. Censures are not reportable to the data bank; suspensions and expulsions are. Those are the data bank rules.

The committee's report is sent to both parties and to the Board of Directors. It includes both sides' submissions, the transcript of the hearing, and the committee's final report. In about two thirds of the cases that go to hearing, adverse action is recommended by the committee. That means that in about half of the cases where complaints are filed, there is adverse action recommended by the committee and some sort of disciplinary action taken.

The Board of Directors has the final say, with one exception that I will get to in a moment, as to the adverse action recommended. The respondent can appear before the Board and make a final statement before they make the final decision, and the final decision is by secret ballot vote by the Board of Directors.

AANS also has a procedure that, if a member who receives adverse

action wants to further appeal, the member can take an appeal to the general membership, anonymously if he wishes. So someone can't say, "I'm active in the plaintiff's area, and everyone knows that, and that's why I am being punished." The membership does not know who is filing the appeal when one is filed. We have had three of those over the years.

The process is laced as heavily as we can with due process. [The respondent] has the right to counsel, the right to face his accuser, the right to cross-examine his accuser, the right to know in advance everything that's going to be considered by the committee, the right to two levels of appeal, the right to a copy of the transcript of the proceedings, and the right to a copy of the full findings and reports of the committee.

The [AANS] goes out of its way to give due process, because we think if someone is going to end up with a disciplinary action, he has to have all the due process in the world there. This is not a statutory peer review process. I want to make that very clear. In a statutory peer review proceeding, the results are confidential and the findings cannot be discovered in later civil litigation. Neither one of those is true with the AANS conduct program. This is not a statutory peer review program; it's an ethics program.

There have been three judicial challenges, as you might suspect, to the program. We have won them all. In the process of doing so, we have established a nice little body of law now supporting the efficacy of these kind of programs. The key case [in this arena] is the *Austin* case.[3] Austin was a Detroit neurosurgeon who was charged with unprofessional conduct. [He was the plaintiff's expert in the underlying case] and in his testimony he claimed that the patient involved had a cervical fusion procedure done with an anterior approach, that is from the front. As a result of that operation there was some damage to the plaintiff's recurrent laryngeal nerve, [commonly known as] the vocal cord. The patient had a vocal cord problem afterwards. Dr. Austin testified that that kind of injury could not have occurred but for the negligence of the surgeon, and he went on to say all neurosurgeons know that.

The AANS doesn't deal with testimony in an ongoing case; the case has to be completely resolved before it deals with the testimony. The defendant physician won the case and filed a complaint with the AANS. [After the case was over,] the AANS had a hearing where the committee concluded, and the Board agreed, that that is a known risk of that type of procedure and all neurosurgeons know or should know that. So, Dr. Austin either had misstated his expertise or misstated the standard of care, either one of which was subject to disciplinary action.

[Dr. Austin] filed a complaint in federal court in Chicago raising two

3. *See* Austin, 253 F.3d at 967.

issues: first, that he was deprived of due process, a claim he very quickly dropped, and secondly, that this was not the kind of activity that a professional association should be engaged in, that no professional association should be able to second guess the propriety of testimony admitted into evidence by the court.

Judge Bucklo [granted] summary judgment, and in doing so one of her holdings was that Dr. Austin received all the due process anybody could ask for. [She further held that] there was nothing wrong with a professional association enforcing standards, as long as there is due process involved and the standards have some reasonableness, which she found they did.

Dr. Austin's counsel appealed to the Seventh Circuit. Judge Posner affirmed and gave a great opinion holding the propriety of the program. Let me read a couple of quotes from [Judge Posner's] opinion. "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." It's a great opinion that shows the propriety of a program like this.

Dr. Austin's counsel finally filed a petition for *certiorari* to the United States Supreme Court and that was denied in January of 2002. The *Austin* decision stands today as the definitive court case upholding the propriety and, arguably, the duty of medical associations in disciplining their own members in areas like this in order to protect the integrity of their membership.

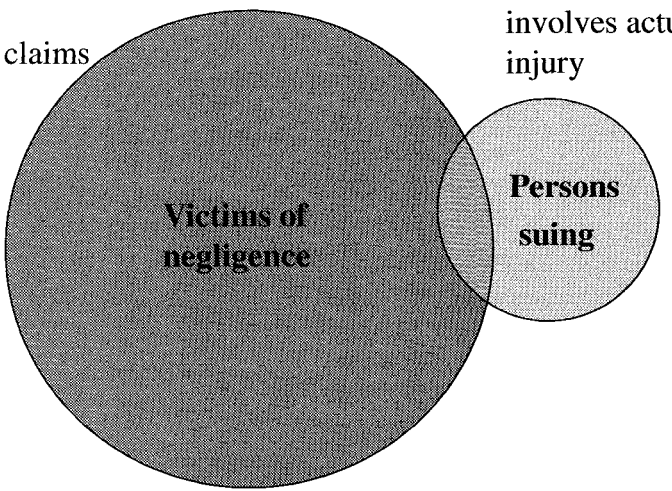
I am pleased to say that since the *Austin* decision came down, especially after the *certiorari* was denied, there are a number of other medical associations that are now looking at this program. I predict that over the next two or three years you will have a majority of medical specialty societies adopting programs very similar to that of the AANS. Thank you.

Appendix A

The Tort System Undercompensates Victims of Negligence

7.6 times as many patients are injured due to negligence as file claims

Only 1 claim in 6 involves actual negligent injury



*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.