

DOCTORS, THE ADVERSARY SYSTEM, AND PROCEDURAL REFORM IN MEDICAL LIABILITY LITIGATION

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INTRODUCTION.....	944
I. THE LESSONS OF THE NINETEENTH AND EARLY TWENTIETH CENTURIES	948
A. Medical Malpractice Litigation in the Nineteenth Century	949
1. The Increase in Claiming	949
2. Physician Perspective	952
3. Physician Response	954
B. Critiques of the Litigation System	955
1. Criticisms of the Adversary Expert System.....	956
2. Proposals for Reform	964
3. Counter-arguments.....	969
4. The Dwindling Impetus for Reform.....	971
C. Professional Coordination and Control	972
D. Critiques of Self-Regulation and Increases in External Accountability.....	973
E. Connections to the Present Debate	975
II. EMPIRICAL DATA AND PROCEDURAL REFORMS	975
A. Data on Malpractice Claims.....	976
B. The Performance of Judges and Juries.....	980
1. Judges.....	980
2. Juries	982
C. Procedural Reforms that Reflect Physicians' Concerns....	988
1. Medical Screening Panels	988

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2. Specialized Courts	996
3. A Novel Approach to Remittitur	1000
4. Self-Help on the Part of the Medical Community	1001
D. The Existence of Procedural Alternatives.....	1004
1. Less-Adversarial Use of Experts	1004
2. Jury Reforms.....	1007
3. Remittitur Under a Heightened Standard.....	1009
III. MEDICAL LIABILITY REFORM AND THE QUESTION OF TRANS-SUBSTANTIVE PROCEDURE.....	1010
A. The Debate Over Federal Trans-Substantive Rules	1011
B. Trans-Substantivity and State-Level Medical Liability Reform	1012
CONCLUSION	1015

INTRODUCTION

Interest groups and policymakers agree that there is a medical liability problem in the United States, but they are deeply divided concerning the nature of the problem and the choice of measures to address it.¹ Physicians and many politicians point to high jury awards as the cause of rising malpractice insurance premiums. Doctors warn that unaffordable premiums will drive them out of high-risk specialties and away from underserved communities. Proponents of reform argue that the fear of malpractice suits leads physicians to practice “defensive medicine” by performing unneeded tests and procedures.² At the same time, recent studies have suggested that there is a high incidence of medical error, and that most patients who are injured by medical negligence never seek compensation.³ Underclaiming by patients with valid claims results in undercompensation of those patients, and—some argue—in underdeterrence of physicians whose performance may be substandard.

The sense of crisis drives a number of current proposals for change. Bills aimed at medical liability reform are pending in Congress and in state legislatures around the country. Much of the public debate

1. The lack of consensus is not new. *See, e.g.*, U.S. Gen. Accounting Office, *Medical Malpractice: No Agreement on the Problems or Solutions*, GAO/HRD Rep. 86-50, at 3 (1986) (“GAO found no agreement among the major interest groups surveyed regarding the problems, their severity, their solutions, or the proper role of states or the federal government.”).

2. *See, e.g.*, Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q.J. Econ. 353, 388 (1996) (“We conclude that treatment of elderly patients with heart disease does involve ‘defensive’ medical practices, and that limited reductions in liability can reduce these costly practices.”). *But see* Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 Tex. L. Rev. 1595, 1607 (2002) (“It is likely that defensive medicine, to the extent that it ever took place, has diminished over time in response to the growing presence of managed care.”).

3. *See infra* text accompanying notes 172-75.

focuses on capping damages—in order to curb jury awards—and on limiting contingent fees—in order to limit the compensation paid to plaintiffs' attorneys.

Several notable reforms address not the *substantive* law of medical malpractice, but rather the *procedures* by which that substantive law is enforced.⁴ For example, twenty states provide for “medical screening panels,” staffed partly or wholly by physicians, to consider evidence and opine on liability (and sometimes damages).⁵ A number of states have tightened the requirements concerning expert witness qualifications.⁶ More than one state has revised its remittitur standard to make it more likely that courts will require plaintiffs to accept a reduced damages award (or face a new trial).⁷ Another proposal would create a special court system dedicated to hearing medical malpractice claims; both state legislators and a nationally prominent reform organization have proposed such a system, though no jurisdiction has yet adopted it.⁸

The procedural reforms described above affect varying stages and aspects of malpractice litigation, but they share a common theme: Each springs from the perception that participants in such litigation need greater expertise. Some reformers focus, in particular, on the need for medical expertise. In many malpractice cases, each element of the claim—standard of care, breach, causation, and damages—requires medical expert testimony.⁹ Party-retained experts are the standard source of such expertise in the United States. Critics argue that the use of partisan expertise permits plaintiffs to bring meritless claims and deludes juries into rewarding such claims with mistaken verdicts.¹⁰ Some commentators assert that plaintiffs can find venal or ignorant experts to support almost any position;¹¹ that judges lack the

4. Obviously, procedure and substance blend into one another. Nonetheless, for purposes of this Article, I use the following distinction: “[T]he basic thrust of substantive rules—controlling . . . behavior in society—is primary, while procedural rules are secondary, and are invoked only in connection with litigation.” Richard L. Marcus, *Of Babies and Bathwater: The Prospects for Procedural Progress*, 59 *Brook. L. Rev.* 761, 777 (1993).

5. See *infra* notes 249-50 and accompanying text.

6. See, e.g., 40 Pa. Cons. Stat. Ann. § 1303.512 (West Supp. 2003) (setting qualifications for experts in medical malpractice cases).

7. See *infra* text accompanying notes 301-02, 353-54.

8. See *infra* text accompanying notes 282-86.

9. Other types of expert testimony may also be presented—for example, the parties may retain economists to testify concerning future damages.

10. See Peter Huber, *Junk Science in the Courtroom*, 26 *Val. U. L. Rev.* 723, 731 (1992). Huber argues, with respect to tort claims, that “[m]ost juries decide cases in a way that is consistent with mainstream science. But some do not, delivering substantial payoffs for questionable claims.” *Id.*

11. Such concerns extend beyond the context of medical malpractice litigation. See, e.g., Troyen A. Brennan, *Helping Courts with Toxic Torts: Some Proposals Regarding Alternative Methods for Presenting and Assessing Scientific Evidence in Common Law Courts*, 51 *U. Pitt. L. Rev.* 1, 4 (1989) (discussing causation testimony

ability to screen out suspect testimony; and that juries lack the capacity to assess the competing claims offered by partisan experts.¹²

Such critiques drive several of the procedural reforms. The findings of medical screening panels could provide a putatively neutral source of expertise at trial.¹³ Stringent requirements for the qualifications of expert witnesses might eliminate some faulty testimony.¹⁴ Judges on a specialized medical liability court might be particularly skilled at determining the quality of proposed expert testimony.¹⁵ A revised remittitur standard holds the promise of improving damages determinations by empowering judges to reduce outlier jury awards.¹⁶

To assess how best to incorporate medical expertise into malpractice litigation, policymakers should consider the role physicians should play in determining medical liability. A key question here, as elsewhere in health law, is the extent to which lay decision makers¹⁷ should delegate authority to medical professionals.¹⁸ Should judges rely on the medical community to determine whether a medical witness is qualified, or should judges independently assess the witness's qualifications? Should the court system call upon other physicians in the community to assess the merits of the case? Should the decision maker be swayed by concern that a malpractice verdict might prompt physicians to leave an underserved community?

Policymakers should also ask whether the adversarial system provides the best means for conveying expert knowledge to the jury. Partisan experts may be biased in favor of the parties who retain

in toxic tort litigation and noting that “[j]udges fear that juries can be misled by highly paid experts who will find at least some support in the voluminous scientific literature for any position, even when that position is repudiated by the majority of scientists”); Samuel R. Gross, *Expert Evidence*, 1991 Wis. L. Rev. 1113, 1130 (“Some expert can almost always be found to testify to any plausible (and many implausible) expert opinions; if nothing else, a friendly expert can serve to undermine any expert who testifies for the opposition.”).

12. See, e.g., Daniel W. Shuman, *Expertise in Law, Medicine, and Health Care*, 26 J. Health Pol., Pol’y & L. 267, 275 (2001) (noting the argument “that jurors lacking scientific or technical expertise have relied on irrational, superficial criteria to assess the believability of experts”).

13. See *infra* note 247 and accompanying text.

14. See Huber, *supra* note 10, at 749 (applauding state laws that tighten qualification requirements for experts in medical malpractice cases).

15. See *infra* text accompanying note 292.

16. See *infra* text accompanying notes 353-54.

17. My reference to “lay decision makers” includes judges, because judges—though they possess legal training—generally lack medical training.

18. I am indebted to Jay Gold’s thoughtful discussion of this insight as it relates to several areas of health law. See Jay Alexander Gold, *Wiser Than the Laws?: The Legal Accountability of the Medical Profession*, 7 Am. J.L. & Med. 145, 145 (1981) (arguing “that many seemingly disparate questions in health law are related to the issue of how experts are to be held accountable to non-experts—how the principle that decisions should be made by those most affected is to be reconciled with the principle that decisions should be made by those with experience and training in the area”).

them.¹⁹ Judges who view themselves as neutral, passive umpires may be less likely to take an active role in screening and channeling expert testimony. The standard structure of adversarial trials may make it difficult for juries to understand and assess such testimony.

The last two questions relate closely to one another. Reforms that aim to replace, or supplement, the partisan “battle of the experts” with nonpartisan medical expertise may result in an increased delegation of authority to the medical community, or parts of it.²⁰ A court-appointed expert might convey a view dominant in the medical community, to the exclusion of dissenting views.²¹ A medical screening panel composed of local physicians might give local medical communities significant influence over jury determinations concerning the liability of another member of the same community.²²

In this Article, I contend that policymakers should assess the question of procedural reform within the larger context of the relationship between physicians and society. In Part I, I argue that a proper understanding of that relationship requires consideration of doctors’ experiences not only in recent decades but also in the nineteenth and early twentieth centuries. Such an inquiry discloses some basis for doctors’ distrust of the litigation system, but it also suggests that the medical community should not be given undue control over the choice and content of medical evidence in malpractice litigation. Part I also discusses the fact that complaints about partisan expert testimony have deep roots in nineteenth century medical jurisprudence.

Nineteenth century medico-legal writers advanced conceptual critiques of the adversary system and supported their assessments with anecdotal evidence. We now possess a wealth of empirical data against which to test their claims. Part II surveys existing studies concerning the performance of judges and juries in medical malpractice and other complex cases. It also briefly reviews the available data on the procedural reforms mentioned above, and closes

19. Researchers who surveyed practicing lawyers and federal trial judges in the late 1990s asked respondents to indicate how frequently they had encountered each of a list of twelve possible difficulties with respect to expert witnesses; the problem identified by both groups as most frequent was “[e]xperts abandon objectivity and become advocates for the side that hired them.” Carol Krafska et al., *Judge and Attorney Experiences, Practices, and Concerns Regarding Expert Testimony in Federal Civil Trials*, 8 Psychol., Pub. Pol’y, & L. 309, 314, 316, 328 (2002) (using a scale of from “1 (*very infrequent*) to 5 (*very frequent*)” and reporting mean scores—with respect to the objectivity issue—of 3.69 from judicial respondents and 3.72 from attorney respondents).

20. Thus, for example, a jury might give more weight to the views of a court-appointed expert or a medical screening panel than to the views of a party-retained expert witness, because the jury might view the court-appointed expert or the screening panel as less biased.

21. See *infra* text accompanying note 337.

22. See *infra* text accompanying notes 278-79.

by considering the promise of those reforms as well as possible alternatives.

My discussion thus far has assumed that the relevant procedural reforms should be assessed as they relate to medical malpractice litigation in particular. This focus raises the question whether litigation procedures should be trans-substantive, or whether they should be substance-specific. In Part III, I contend that the problem of medical liability merits consideration of reforms aimed specifically at medical malpractice cases. However, studying proposed reforms in the light of their relation to medical liability in particular does not mean that the resulting reforms necessarily should apply only to malpractice cases, or that such reforms should apply to all malpractice cases. Some of the changes considered in this Article may also be useful in other fields, such as products liability. Conversely, the difficulty of the issues in medical malpractice cases varies widely, and reforms that may be worthwhile in more complex malpractice cases may be superfluous, or even counterproductive, in simpler disputes.

I. THE LESSONS OF THE NINETEENTH AND EARLY TWENTIETH CENTURIES

Consider the following summary of malpractice liability and medical evidence: Improvements in medical knowledge and technology have heightened consumer expectations, and have led to lawsuits over imperfect results where previously—under less sophisticated treatment—no suit would have been possible. Doctors complain that the threat of malpractice litigation is forcing them to leave risky specialties or else to make undesirable treatment choices. Doctors charge that the outcomes in malpractice suits are random because plaintiffs frequently bring meritless claims, lawyers can buy the testimony of disreputable experts, and judges and juries are incompetent to assess medical testimony. Critics suggest that the adversary litigation system is a poor choice for determining malpractice claims. They assert that determining whether a doctor breached the standard of care is a delicate question, because of the inherent difficulty and uncertainty of medical judgments. They propose that alternatives—such as delegating medical judgments to expert panels—could help.

This description highlights some of the key complaints about today's malpractice liability system; but such a description would have been equally familiar to a doctor in the mid-to-late-nineteenth century. Accounts of the current medical malpractice problem usually begin their narrative, at the earliest, with the mid-twentieth century.²³

23. Cf. James C. Mohr, *Doctors and the Law: Medical Jurisprudence in Nineteenth-Century America* 255 (1993) (noting that Americans "have seldom viewed" the medical malpractice issue "as the product of specific nineteenth-century

I argue in this part that a thorough assessment of medical malpractice issues should include consideration of the events of the nineteenth and early twentieth centuries as well.

In Part I.A., I detail the rise of malpractice litigation in the nineteenth century, and I note evidence of physicians' responses to that litigation. In Part I.B., I consider nineteenth century doctors' critiques of the litigation system, both with respect to malpractice litigation and with respect to the experience of medical expert witnesses more generally. I also discuss the (usually unflattering) comparisons drawn between the United States system and the systems established in France and Germany, and I survey nineteenth century proposals for changing the United States adversarial system of expert evidence. Those proposals failed; in Part I.C., I describe the introduction of other means by which the medical profession attempted to protect its members from malpractice liability. I bring the discussion up to the present time, in Part I.D., by summarizing some aspects of medical self-regulation in the twentieth century, as well as developments that brought greater external control over the profession.

A. *Medical Malpractice Litigation in the Nineteenth Century*

In the mid-to-late nineteenth century, physicians perceived a medical liability crisis. Some apparently responded by avoiding treatments or specialties that they thought entailed a high risk of litigation; others proposed that the profession take coordinated defensive measures.

1. The Increase in Claiming

Though data concerning the incidence of malpractice suits in the nineteenth century are scarce,²⁴ it seems clear that the frequency of such suits rose markedly beginning in the 1830s and 1840s.²⁵ In his informative book on nineteenth century medical malpractice suits,

historical circumstances or placed it in the larger context of evolving relations between American physicians and the nation's legal processes").

24. Cf. John J. Elwell, *A Medico-Legal Treatise on Malpractice and Medical Evidence, Comprising the Elements of Medical Jurisprudence* 70 (1860) ("The reported cases on the subject of Malpractice are few, as they but seldom reach the Supreme courts.").

25. See Kenneth Allen De Ville, *Medical Malpractice in Nineteenth-Century America: Origins and Legacy* 25 (1990) ("Although medical malpractice suits were virtually nonexistent between 1790 and 1835, thereafter patients suddenly began to sue their physicians at an increasing and unprecedented rate."); see also Mohr, *supra* note 23, at 111 ("After 1840 the frequency of malpractice actions shot suddenly upward, and well-established physicians, not charlatans, found themselves the targets of an almost revolutionary and certainly unprecedented surge in malpractice accusations.").

Kenneth Allen De Ville argues that a combination of medical and social factors prompted the increase in malpractice claims.

The shortcomings of medical technology played a role, because some medical practices were quite harmful to the patient.²⁶ At the same time, progress in medical knowledge also led to malpractice suits. In particular, advances in the treatment of fractures led physicians to save limbs, rather than amputate them—with the result that suits might be brought for limbs that healed imperfectly.²⁷ As one standard text noted at mid-century:

It is well known, that fractures and dislocations, when cured, are often attended either with some slight *deformity* of the limb, or with some impairment of its functions. This result is occasionally inevitable under the best treatment; but it is commonly set down as a sign of unskillfulness in the medical attendant. Actions for malapraxis are instituted, and in spite of good evidence in his favor, the surgeon is sometimes heavily fined for a result which could not be avoided.²⁸

Changes in the business of medicine fostered suits, because the increasing number of physicians made suits against a given doctor more palatable to the public²⁹ and because some physicians may have aided malpractice suits against competitors.³⁰

26. See De Ville, *supra* note 25, at 68 (arguing that “heroic” medical treatments were “the object of considerable derision and one of the main sources of public antipathy toward the profession”). Continental medicine in the early nineteenth century apparently was open to similar charges; discussing public mortality in France, Foderé asserted that standard medical treatments for children and adolescents often did more harm than good. See 5 F.E. Foderé, *Traité de Médecine Légale et d’Hygiène Publique, ou de Police de Santé* 84-85 (2d ed. 1813).

Public sentiment sometimes posed an obstacle to medical progress: Doctors complained that public opposition to the dissection of cadavers kept them at a disadvantage, by preventing them from improving their understanding of the human body. See De Ville, *supra* note 25, at 70 (“Medical societies and contemporary observers argued that physicians would be subject to malpractice suits if they did not understand the workings of the human body and yet were being denied the primary source of that knowledge.”). In France, Foderé had proposed a chilling alternative method for obtaining medical knowledge: He advocated trying new remedies and operations on those condemned to death or to life imprisonment. See 6 Foderé, *supra*, at 427 (“To risk such experiments on free men goes against justice and humanity, and it would conflict with neither of those principles to do such things to criminals already condemned to death” (author’s translation)).

27. See De Ville, *supra* note 25, at 100 (“Though unnecessary or incompetent amputations were seldom penalized, physicians who saved limbs with compound or complex fractures were regularly sued.”); see also Mohr, *supra* note 23, at 114 (“Improved techniques and more careful training produced an advance; but because the consequences of the advance were often imperfect, those who tried to save limbs in difficult cases often found themselves being sued.”).

28. Alfred S. Taylor, *Medical Jurisprudence* 320 (2d Am. ed. 1850); see also Henry F. Campbell, *The President’s Address*, 4 JAMA 477, 484 (1885) (“Unavoidable deformities and disabilities remaining after the treatment of fractures and dislocations have been made the most frequent occasions for arraignment of the surgeon . . .”).

29. As De Ville explains:

Social views contributed to the increase as well, because of greater interest in physical health,³¹ an increased social tolerance for litigation,³² and unrealistic expectations of what medicine could do. John Elwell's 1860 treatise on malpractice decried the effect of perfectionist beliefs:

As in the case of amputations and dislocations, much error exists in the popular or unprofessional mind, as to what the surgeon can really do in the treatment of fractures. It has been generally supposed, if the patient is healthy at the time of the accident, that a perfect cure should be the result, if the treatment instituted is proper. This is another of the errors that has had a serious effect upon the profession, being often the source of ruinous litigation.³⁴

Criminal cases might also have made the question of medical malpractice more prominent. Medico-legal commentators observe that in cases where a victim died after receiving medical treatment the defendant would likely argue that faulty treatment, rather than the

[B]y 1850 the number of physicians in some areas had increased to the point of a glut. If a malpractice suit destroyed a physician's career, there was always another doctor, or more, ready to take his place. In this situation, juries and judges were less likely to shelter physicians from unhappy, litigious patients.

De Ville, *supra* note 25, at 78.

30. *See id.* ("The surplus of physicians in many parts of the country . . . subverted the medical profession's status and gave rise to malpractice suits by engendering and exacerbating competition among regular practitioners."). A physician speaking at the Medico-Legal Society of New York in 1871 acknowledged this suspicion:

Putting aside the loud boasters, the selfish, inconsiderate, and even ignorant men to be found in the profession, whose conduct may sometimes deserve the infliction of a lawsuit, I do not hesitate to assert that a very large proportion of actions for malpractice brought against medical practitioners are instigated by unworthy motives. Some, indeed, go further, asserting that were the secret of such cases known it would unveil the promptings of malevolent professional rivals. This may be true, although I prefer to think not to the extent asserted.

James O'Dea, *The Sphere, Rights, and Obligations of Medical Experts*, reprinted in *Papers Read Before the Medico-Legal Society of New York*, from its Organization 403, 440 (1st series, 3d illustrated ed. 1889).

31. *See* De Ville, *supra* note 25, at 92 ("Malpractice suits were, in part, an expression of a transformed view of the human body and an unprecedented concern for physical well-being."); Mohr, *supra* note 23, at 112.

32. De Ville argues:

The two essential preconditions for the rise of malpractice suits were the dissolution of community stigmatization of certain types of litigation and the decline in belief in the concept of providence that held misfortune to be an expression of divine will. Without these two underlying, long-term developments, the widespread prosecution of physicians would have been inconceivable.

De Ville, *supra* note 25, at 115.

33. *See* De Ville, *supra* note 25, at 103 (noting, with respect to the problem of "unrealistic expectations," that "[p]hysicians and medical writers began to believe that mechanical, standardized treatment yielded consistent, faultless cures").

34. Elwell, *supra* note 24, at 75.

original attack, led to the victim's death: "The surgeon who undertakes to dress or treat a case of criminal wounding... assumes... more than ordinary responsibility. If his treatment is in the least out of the usual course in either direction,—whether novel or negligent,—it will be urged in mitigation of the crime."³⁵

2. Physician Perspective

Physicians reacted strongly to the upswing in malpractice suits. Medical writers asserted that many, if not most, suits were meritless.³⁶ An 1845 treatise on forensic medicine included in a list of reasons for feigning disease: "Magnifying slight ailments or inconveniences, into serious illness or permanent disability, with the hope of receiving exorbitant damages from physicians for pretended malpractice."³⁷ A couple of decades later, John Ordranax asserted in his treatise on medical jurisprudence that many malpractice suits arose merely from bad results, rather than from fault on the physician's part, and he argued that "the physician consequently practices his art in chains, being perpetually exposed to the risk of a suit which may ruin his reputation as well as his fortune."³⁸ Physicians suggested that some patients brought malpractice suits in an attempt to avoid paying their doctors' bills.³⁹ Alfred S. Taylor, an English physician whose treatise

35. *Id.* at 561. English authors concurred:

It will be obvious that a serious responsibility is thrown on practitioners, who undertake the management of a case of criminal wounding. Any deviation from common practice should therefore be made with the greatest caution, since novelties in practice will, in the event of death, form one of the best grounds of defence in the hands of a prisoner's counsel.

Taylor, *supra* note 28, at 259; see also W. Bathurst Woodman & Charles Meymott Tidy, *Forensic Medicine and Toxicology, A Comprehensive Work on Medical Jurisprudence* 635 (1882) ("In criminal trials it is often sought to fix the responsibility of a terminal erysipelas, etc., after trephining, or similar operations, upon the surgeon who operates, rather than upon the assailant whose violence caused the original injury.").

36. European physicians made similar assertions. See 2 Johann Ludwig Casper, *A Handbook of the Practice of Forensic Medicine, Based Upon Personal Experience* 304 (George William Balfour trans., 3d ed. 1862) (stating that "perfectly groundless accusations" are often "made both against medical and non-medical men, dictated by ignorance, by wrath at a supposed overcharge for attendance, or in other cases entirely by a contemptible love of gain").

37. William A. Guy, *Principles of Forensic Medicine* 233 (1st Am. ed. 1845). This treatise was written by William A. Guy, an English physician and professor of forensic medicine. See *id.* at v. For the "American edition" of the treatise, Charles A. Lee, an American physician and professor, took up "the task of revising the text, correcting errors, and adapting the publication to the existing laws and institutions of" the United States. *Id.* at vi. Dr. Lee identified his additions to the text by means of brackets. See *id.* Unless otherwise specified, my references to this treatise are to the additions that were written by Dr. Lee.

38. John Ordranax, *The Jurisprudence of Medicine, in its Relations to the Law of Contracts, Torts, and Evidence, with a Supplement on the Liabilities of Vendors of Drugs* 58 (1869).

39. See De Ville, *supra* note 25, at 43 ("Because so many malpractice plaintiffs

was popular in the United States,⁴⁰ asserted that “[f]rom the evidence given on some of these occasions, it appears that an action of this kind is occasionally resorted to as a very convenient way of settling a long account.”⁴¹

Medical commentators stressed that treatment decisions could be difficult,⁴² and they contended that physicians should not be held liable for reasonable errors in judgment.⁴³ John Elwell suggested that lawyers “may not fully realize the necessary and formidable difficulties that the medical and surgical practitioner have to encounter at every step, and the uncertainty of the results, even in the hands of the most skillful and experienced.”⁴⁴ Though Elwell disclaimed any intent “to enter into a defense of the medical profession,” he urged that “the heaviest judgment of the law be visited on those who ignorantly, drunkenly and grossly trifle with health and human life”⁴⁵—rather than on physicians who merely made an error in judgment.⁴⁶

Relatedly, commentators argued that bad results should not, in and of themselves, give rise to malpractice liability. Bathurst Woodman and Charles Tidy, English physicians whose treatise on medical jurisprudence was printed in the United States, stated that “[t]h

had not paid their bills, physicians began to believe that their poorer patients were the most likely to sue.”); Mohr, *supra* note 23, at 115 (“Many [physicians] thought that the vast majority of malpractice suits were initiated by poor patients either trying to escape paying for a job they considered less than perfect or trying to turn a misfortune into cash at the expense of a wealthy professional.”).

40. See Mohr, *supra* note 23, at 37, 198.

41. Taylor, *supra* note 28, at 275.

42. See, e.g., *id.* (asserting, with respect to malpractice suits arising from obstetrical cases, that “much difference of opinion exists among the most eminent practitioners of midwifery respecting the treatment to be pursued in certain cases of difficulty”).

43. A Canadian lawyer pointed out that advances in medical knowledge presented risks for the physician:

The medical man has oftentimes to sail between Scylla and Charybdis. While, on the one hand, he is bound to consult the attainable literature in his profession, and to diligently gather in . . . the experience of his confreres—for in determining what is negligence, the improvements that are constantly taking place are always considered—at the same time he must not try new modes or methods too readily . . .

R. Vashon Rogers, Jr., *The Law and Medical Men* 71 (1884).

44. Elwell, *supra* note 24, at 37.

45. *Id.* at 47.

46. *Id.* at 29 (“The physician and attorney are not responsible for the errors of an enlightened judgment, where good judgments may differ.”). European commentators made similar arguments. See, e.g., J. Briand & Ernest Chaudé, *Manuel Complet de Médecine Légale, ou Résumé des Meilleurs Ouvrages Publiés Jusqu’à ce Jour sur cette Matière et des Jugements et Arrêts les Plus Récents, et Contenant un Traité Élémentaire de Chimie Légale* 46 (8th ed. 1869) (“The tribunals . . . , then, should not recognize liability, either criminal or civil, unless it is well established that the doctor acted with unforgivable thoughtlessness or carelessness, or that he showed . . . *crass ignorance* . . .” (author’s translation)).

result of operations is one of the issues on which an accusation of malapraxis is often raised against medical men, in most cases unjustly, since the result is often beyond our control."⁴⁷ Similarly, an American physician writing in the late nineteenth century argued that "until medicine becomes an exact science, in a certain proportion of cases failure must follow the efforts of the best-informed men."⁴⁸

3. Physician Response

Some physicians appear to have responded to the rise in malpractice suits by changing their fields or treatment decisions; others urged physicians, as a group, to take defensive measures. James Webster, a professor of medical jurisprudence at a medical school in New York, advised students in 1850 to avoid treating poor people who had fractures.⁴⁹ A decade later, John Elwell observed:

Civil [malpractice] suits for damages are of a frequency, alarming, both to the profession of medicine and to the public. Suits of this class, in some parts of the country, seem to be on the increase. . . . The result is, that some of the most thoroughly qualified medical men, utterly refuse to attend surgical cases,—confining their practice to that of medicine alone.⁵⁰

When physicians did treat fractures, some of them, for a time, may have chosen to amputate in order to avoid the chance that a badly healed limb would give rise to a malpractice suit.⁵¹

As the century wore on, physicians tried to discourage malpractice suits by attempting to deter other physicians from aiding the plaintiffs. Elwell's treatise quoted an 1856 report by a committee of the Ohio State Medical Association that exhorted: "[W]here it is possible to avoid it, let not a member of the profession be found in the ranks of the prosecution."⁵² Ordranax's 1869 treatise quoted the American

47. Woodman & Tidy, *supra* note 35, at 635.

48. George Ryerson Fowler, *Surgical Malpractice*, in 2 Allan McLane Hamilton & Lawrence Godkin, *A System of Legal Medicine* 573, 575 (1894).

49. See Mohr, *supra* note 23, at 117-18.

50. Elwell, *supra* note 24, at 7. This problem appears to have persisted. Writing in 1871, James O'Dea noted the frequency of malpractice suits arising from "the treatment of fractures, amputations, and dislocations," and he asserted that "honest and capable surgeons have seriously debated the necessity of retiring from a profession whose emoluments are so scanty in comparison with its risks." O'Dea, *supra* note 30, at 441.

51. See De Ville, *supra* note 25, at 101-02 ("Faced with a difficult fracture, an unethical or unscrupulous doctor might recommend a dramatic amputation to portray himself as a courageous surgeon and, at the same time, sidestep the prospect of an imperfect result and possible malpractice charge.").

52. Elwell, *supra* note 24, at 9. Elwell himself did not think this measure would solve the malpractice problem; rather, he argued that the only solution was to "elevat[e] the standard of Medico-legal knowledge in the professions of Law and Medicine." *Id.*

Medical Association's code of ethics, which gave strict advice to the doctor who took over the care of a colleague's patient:

[N]o unjust or illiberal insinuations should be thrown out in relation to the conduct or practice previously pursued, which should be justified as far as candor and regard for truth and probity will permit; for it often happens that patients become dissatisfied when they do not experience immediate relief, and, as many diseases are naturally protracted, the want of success, in the first stage of treatment, affords no evidence of a lack of professional knowledge and skill.⁵³

A physician speaking in 1871 made explicit the connection between such "insinuations" and resulting litigation:

I have no doubt many lawsuits are unintentionally originated, or at least encouraged by the indiscreet or inconsiderate judgments which medical men are too much in the habit of passing on the conduct and treatment of their professional *confrères* in presence of lay people. It is impossible to exercise too much caution in expressing opinions on the character of the professional services of a brother practitioner.⁵⁴

B. Critiques of the Litigation System

As James Mohr has documented, physicians' fears of malpractice liability were closely related to physicians' complaints about the system by which that liability was imposed.⁵⁵ Doctors argued that

53. Code of Ethics of the American Medical Association, *reprinted in* Ordranax, *supra* note 38, at 233, 246.

54. O'Dea, *supra* note 30, at 440. The English authors Woodman and Tidy made a similar argument. Regarding dislocations, they asserted:

It is not possible, after some weeks or months, to say definitely in certain cases whether such and such injuries have occurred, as, particularly in the case of dislocations, all traces of the original accident may rapidly disappear. Professional men should therefore be cautious not to judge their brethren unfairly.

Woodman & Tidy, *supra* note 35, at 630. They proceeded to issue a broader warning about testifying for malpractice plaintiffs:

It may be said, referring to malpraxis generally, that no medical man should give an adverse opinion on the conduct or practice of a professional brother, without having all the facts of the case before him; and whatever opinion he may give at an inquest, or in a police court, he should be prepared to justify before the higher tribunals, as well as before the whole medical profession. It has happened, though we hope rarely, that a medical man in condemning the practice of a brother professional, has only shown his own ignorance of the progress of science in general, and of medical science in particular.

Id. at 636.

55. I am indebted to James Mohr's illuminating book for first alerting me to the fact that these issues surfaced in the nineteenth century as well as in the present time. See generally Mohr, *supra* note 23. Mohr provides an enlightening discussion of nineteenth century physicians' complaints about the adversary system and such physicians' proposals to alter that system. The issues of medical malpractice and medical expert testimony are two of several themes that Mohr explores in his book.

juries and judges lacked the capability to judge the merits of malpractice cases. More broadly, doctors asserted that the United States litigation system was incapable of making proper use of medical expertise. Medico-legal writers condemned the adversarial nature of American litigation, and contended that civil law systems such as France and Germany did a much better job of incorporating medical expertise into adjudication. Throughout the mid and late nineteenth century, such writers proposed a number of procedural reforms designed to address this problem. Few if any of those reforms were implemented, however, and the momentum of the reform movement apparently died by the turn of the century.

1. Criticisms of the Adversary Expert System

Doctors in the nineteenth century asserted a barrage of complaints about the way in which medical expertise functioned in courts in the United States: Standards for expert qualification were too lax; the mode of expert testimony was unfair and permitted abuse; and juries were incompetent to evaluate medical evidence. Doctors identified numerous ways in which the American method of using expert testimony harmed doctors, both individually and as a profession: The system brought the medical community into disrepute and it could ruin the careers of individual doctors; and, adding injury to insult, the system often failed to compensate doctors properly for their testimony. Several types of dispute—particularly cases involving infanticide, insanity, or poisoning—seem to have been particularly hazardous to the status of medical experts in the United States; but in all areas, medical commentators asserted that the adversary mode of litigation was a hostile format for medical experts.

Prominent physicians and medical writers believed that judges were indiscriminate in their admission of medical expert testimony. The lack of regulation of the medical profession in the mid-nineteenth century meant that medical practitioners included not only regular physicians but also followers of several alternative schools.⁵⁶ This diversity affected legal as well as medical practice, as courts decided to admit medical testimony irrespective of the school to which the witness belonged.⁵⁷ A standard American treatise on medical

Building upon Mohr's insights, and drawing upon both sources Mohr cites and other sources, I focus here upon physician critiques of adversarial procedures, and upon proposals to alter those procedures.

56. *See id.* at 89 ("In the United States . . . by mid-century, medicine had become an overtly unregulated, unlicensed, overcrowded, doctrinally incoherent, and fiercely competitive profession.").

57. As Mohr explains:

Since there were no functional licensing laws to regulate the practice of medicine, no formal educational requirements, and plenty of deep-seated disagreements over what constituted effective health care, American courts during the second quarter of the nineteenth century tended more and more

jurisprudence declared that “[d]oubtless there is too little discrimination exercised in receiving all who are called *doctors*, as witnesses.”⁵⁸ A few decades later, John Ordranax observed that “courts will receive the opinions of physicians of any school as equally entitled to respect, leaving their credibility and authority to be determined by the jury.”⁵⁹

Some established physicians likely resented the fact that their testimony was weighed against that of physicians they perceived as less qualified. A committee writing in the early 1870s noted the argument that it was

unjust... to compel honest and honorable experts... to put themselves in conflict in open court upon, so far as the public saw, terms of equality with pretenders, who were willing to lend themselves, and the science to which they pretended, for hire, to promote the views or interests of their employers.⁶⁰

Courts’ leniency concerning expert qualifications may also have contributed to the cynicism of observers who suspected that parties with weak positions shopped for an expert willing to support their views: “Of course it is easy for a party to summon the single expert who may happen to have propounded the bizarre theory which is necessary to sustain such party’s case.”⁶¹

Though some medical writers decried the courts’ willingness to admit testimony by all manner of medical experts, it is not clear that physicians would have welcomed more stringent court scrutiny of expert testimony. After noting the courts’ lax approach to medical qualifications, Ordranax remarked: “It is also a fact not to be lost sight of, that a court may not be any more competent to decide that a medical witness offered is not an expert, than that he is, for its qualifications in this particular are no better than those of ordinary laymen”⁶² A number of medical writers asserted that judges

often to err on the side of inclusion in medically related cases.

Id. at 100.

58. 2 Theodric Romeyn Beck & John B. Beck, *Elements of Medical Jurisprudence* 697 (6th ed., Thomas, Cowperthwait, & Co. 1838) (1823); *see also* Mohr, *supra* note 23, at 100 (discussing the same statement in earlier edition). This critique occurs in a paragraph discussing English judicial practices, as part of a general discussion of medical evidence. *See* 2 Beck & Beck, *supra*, at 697. The critique’s application closer to home would likely have struck readers in the United States.

59. Ordranax, *supra* note 38, at 137; *see also* W.J. Conklin, *The Medical Expert*, 3 *Ohio Med. & Surgical J.* 127, 134 (1878). “[T]he courts, under the present system of receiving experts’ testimony, have no means of judging of the qualifications of a particular witness. His deportment upon the witness stand, and the reasons which he assigns for his opinions, only go to affect his *credibility*, not the question of *admissibility*.” *Id.*

60. *Expert Testimony*, 9 *Alb. L.J.* 193, 193 (1874).

61. George W. Field, *Field’s Medico-Legal Guide for Doctors and Lawyers* 13 (1887).

62. Ordranax, *supra* note 38, at 137.

lacked the knowledge necessary to assess expert qualifications and testimony.⁶³ A book review in an 1826 issue of the *New York Medical and Physical Journal* noted that “[j]udges have sometimes a most delicate part to act, viz.—to discriminate between the knowledge and acquirements of various medical witnesses.”⁶⁴ The author suggested that though “[j]udges . . . sometimes fancy their knowledge of medical matters very profound,” the judges’ assessments of medical testimony were frequently erroneous.⁶⁵

Physicians who testified in court proceedings often hated the experience.⁶⁶ Doctors disliked the trial format because the use of oral rather than written testimony could require them to give opinions based on facts they had not yet had adequate time to consider. T.R. Beck explained:

That class of witnesses who are called upon to give opinions on a certain statement of facts, have generally been unable to examine it before the trial. They often hear it imperfectly, sometimes confusedly, and at all events . . . they have but a few moments to reflect on its various import⁶⁷

Doctors resented even more strongly the mode of examination—especially the rough treatment they experienced during some cross-examinations⁶⁸—and the habit of some counsel of disparaging opposing witnesses.⁶⁹ As early as 1826, a writer in a medical journal

63. The view that lay people lacked the capacity to judge medical questions also underlay the proposal that coroners should have medical training. The American editor of Guy’s treatise on forensic medicine asked: “Suppose an ignorant coroner be summoned to hold an inquest in case of death from mal-practice, such as Thompsonian, or Homœopathic? Where is the knowledge which is to guide him to a safe decision, and interpose the shield of law and justice to the progress of ignorance and charlatanry?” Guy, *supra* note 37, at 7.

64. 5 N.Y. Med. & Physical J. 597, 607 (1826) (reviewing Letter to the Hon. Isaac Parker, Chief Justice, Supreme Court of the State of Massachusetts (“containing Remarks on the Dislocation of the Hip-joint, occasioned by the publication of a Trial, which took place at Machias, in the State of Maine, June 1824”)) [hereinafter Review].

65. *Id.*

66. See Mohr, *supra* note 23, at 197.

67. T. Romeyn Beck, *Annual Address Delivered Before the Medical Society of the State of New-York, Feb. 6, 1828*, 7 N.Y. Med. & Physical J. 9, 25 (1828); see also Elwell, *supra* note 24, at 307 (“The facts upon which the medical witness may suddenly be called to give an opinion may be new to him . . . [and] there may be no time for much reflection, or for a reference to authority.”). James Mohr provides an insightful discussion of Beck’s 1828 address. See Mohr, *supra* note 23, at 95-99.

68. James Mohr points out: “Physicians . . . were testifying in an adversarial setting, where rebuttal and contradiction were considered normal, even essential. What lawyers viewed as a positive good, physicians took as unprofessional bullying.” Mohr, *supra* note 23, at 98.

69. In 1885 Henry Campbell, who at the time was President of the American Medical Association, gave an example of the sort of insinuations that medical witnesses found so galling. He described a poisoning case in which the defense attorney did not attempt to cross-examine the prosecution’s expert on the substance of his testimony; rather, defense counsel used his cross-examination to establish that

complained that "there is scarcely a case, that we have seen reported for many years, in which a great freedom of speech is not permitted concerning the talents and medical standing of individuals."⁷⁰ Two decades later, an American physician complained of lawyers' "insolent and abusive treatment" of medical witnesses in criminal cases; he asserted that some lawyers were "in the habit of endeavouring to carry their point, by brow-beating and confusing the witnesses, and involving them in absurdities and contradictions."⁷¹ Even if lawyers were not abusive, medical writers warned that they could be manipulative: Isaac Ray, in his treatise on insanity, warned that lawyers "frame their questions so as to bring out the wished for reply."⁷²

In addition, doctors complained that some lawyers lacked the technical knowledge necessary to elicit testimony on the relevant medical issues. Samuel Gross, then the President of the American Medical Association, asserted in 1868:

My experience is that there are few lawyers... who are fully competent to elicit even the more prominent facts of a case. Often, indeed, from an anxious desire to do all they can for the defence of their clients, they do not hesitate to browbeat and bully the medical witness, especially if he is young and timid, in order to distort his testimony, and to confuse the minds of the judge and jury. Sometimes, again, even when influenced by the best and most laudable intentions, the lawyer, from sheer ignorance, propounds his interrogations in so awkward and unscientific a manner as effectually to defeat the very end he has in view.⁷³

Once the expert testimony was given at trial, there was the further question whether the jury was competent to evaluate it. Many medical commentators were pessimistic on this point. Isaac Ray, writing in 1838 of medical testimony on insanity, asserted that "the jury is seldom a proper tribunal for distinguishing the true from the false, and fixing on each its rightful value."⁷⁴ The problem appears to

in all the cases in which the prosecution's expert had tested for arsenic, he had found it. Defense counsel then argued to the jury, with respect to the expert: "[H]e is the arsenic hunter and arsenic finder for his college, and, you see, he is a good one; he always finds the arsenic." The jury acquitted. Campbell, *supra* note 28, at 482-83.

70. Review, *supra* note 64, at 606. At approximately the same time, two noted English authors suggested the existence of similar problems in England. See 1 J.A. Paris & J.S.M. Fonblanque, *Medical Jurisprudence* 153 (1823) ("[W]e do not mean to arraign the present forms of examination in general, when we assert that some abuse in practice too frequently places the [medical] witness in as painful a situation, as if he were himself a criminal.").

71. Guy, *supra* note 37, at 5.

72. I. Ray, *A Treatise on the Medical Jurisprudence of Insanity* 567 (4th ed. 1860).

73. Address of Samuel D. Gross, M.D., LL.D., *President of the Association*, in 19 *Transactions of the Am. Med. Ass'n* 57, 62 (1868) [hereinafter Gross]; see also Mohr, *supra* note 23, at 53-54 (discussing Gross's interest in medical jurisprudence and mentioning Gross's 1868 address).

74. I. Ray, *A Treatise on the Medical Jurisprudence of Insanity* 59 (1838).

have been acute in cases involving questions of mental health. The author of an 1893 treatise on insanity asserted:

One great evil is that there are some men who, because they have a little actual knowledge on some specialty, claim credit for a great deal which they do not possess, and rush to the witness stand to assume a duty for which they are entirely incompetent, and, in their character of experts, their opinions may have the same weight with the jury as those of better men.⁷⁵

In the 1870s, a committee appointed to report to the Massachusetts legislature concerning expert testimony questioned the competence of "jurors drawn from the various walks and pursuits of life, untrained and uninformed on the matters upon which they are called to judge," and noted "the haphazard result to which they might come in trying to distinguish between what was true and false in science."⁷⁶

It seems likely that doctors' mistrust of juries contributed to their fears of malpractice suits, by giving the impression that justice was random. What two British authors asserted in 1882 concerning criminal malpractice charges in England may well have resonated with American physicians with respect to civil suits:

The majority of our judges are inclined to make every allowance for the difficulties imposed by the responsible duties of medical men. It must be confessed, however, that both at their hands, and more particularly at the hands of juries, the most arrant quacks, whose practice was little better than a long series of murders, have often met with more protection when arraigned on criminal charges than registered practitioners.⁷⁷

Medical commentators were not concerned only with the outcomes of such suits, however; they also were troubled by the effects such litigation had on the way in which the public and the courts perceived the medical profession. Errors and incompetence on the part of some medical witnesses led to distrust of the profession as a whole.⁷⁸ Some duties of the medical witness required expertise that general practitioners normally lacked. T.R. Beck argued in 1828 that post-

75. Edward C. Mann, *A Treatise on the Medical Jurisprudence of Insanity* xviii-xix (1893).

76. *Expert Testimony*, *supra* note 60, at 193.

77. Woodman & Tidy, *supra* note 35, at 627.

78. Such problems were not unique to the United States. Discussing medical evidence in criminal cases, Paris and Fonblanque noted in 1823 that in several of the more interesting trials, . . . the medical witness has evinced any thing rather than a well grounded acquaintance with the philosophical bearings of the question; and while he has endeavoured to conceal his ignorance under the veil of technical phraseology, he has artfully sought to shun the embarrassments it might create by a display of bold and sweeping assertions, alike hostile to the discovery of truth, and the administration of justice.

Paris & Fonblanque, *supra* note 70, at 400.

mortems required a knowledge of anatomy and chemistry beyond that possessed by many practicing doctors.⁷⁹ Likewise, Isaac Ray argued that expert testimony on insanity should only be given by specialists.⁸⁰ He conceded that “in important cases, the testimony of one or more of this class is generally given,” but he asserted that “it may be contradicted by that of others utterly guiltless of any knowledge of the subject, on which they tender their opinions with arrogant confidence.”⁸¹ John Elwell expressed strong views on incompetent experts:

[T]he “doctors” who often intrude themselves upon the court and bar, as the representatives of the medical profession, do, by their ignorance, self-conceit, and disgusting assurance and complacency, present so perfect an embodiment of egotism and imbecility, that every man of common sense is at once disgusted . . . ; and the worthy members of a noble profession have to bear unjustly, the odium and reproach thus wrongfully incurred⁸²

A few years later, a committee of the American Medical Association opined that “there is no cause which has done more to lessen the confidence of the community in the medical profession than the manner in which physicians often give testimony before our courts.”⁸³

Apart from the quality of the testimony, the mere fact that experts often seemed to disagree with one another was seen by some to diminish the authority of the medical community as a whole. Commentators suggested that disagreement among medical witnesses indicated a lack of competence on the part of at least one of the witnesses. The Becks’ treatise asserted: “It is evident that the difference of opinion originates, in most cases, from a want of knowledge in one or the other [witness].”⁸⁴

Even if disagreement did not betoken lack of knowledge, it was seen to diminish the credence lay people gave to medical testimony.⁸⁵ An 1845 treatise quoted Taylor’s remark, concerning deaths after

79. See Beck, *supra* note 67, at 13-14.

80. Ray, *supra* note 74, at 58-59. Ordranax agreed. See Ordranax, *supra* note 38, at 164 (“The majority [of physicians are] . . . wholly inexperienced in insanity, and as such, incompetent to testify as experts in controversies upon this issue.”).

81. Ray, *supra* note 74, at 59.

82. Elwell, *supra* note 24, at 300.

83. *Report on Recommendations and Suggestions Contained in President’s Address*, 19 Transactions of the Am. Med. Ass’n 75, 77-78 (1868) [hereinafter *Report*].

84. 2 Beck & Beck, *supra* note 58, at 695. The English commentator Alfred Taylor offered a similar view concerning testimony on wounds: “A difference of opinion will often exist among medical witnesses as to whether a particular wound was or was not dangerous to life. Unanimity can only be expected when the judgment and experience of the witnesses are equal.” Taylor, *supra* note 28, at 186.

85. See Mohr, *supra* note 23, at 198 (noting that “the process of eliciting medical evidence [made] physicians look scientifically weak, internally divided, and dangerously unprofessional”).

operations, that “[d]ifferences of opinion upon these subjects among eminent members of the profession, too justly convey to the public the impression that there are no fixed principles upon which medical opinions are based; and, consequently, that it would be dangerous to act upon them.”⁸⁶ A medical professor who addressed a county medical society in 1878 posed the question, “Why has expert testimony fallen into such universal disrepute?”⁸⁷ In answering his own question, he asserted that “[t]he conflict of opinion” among experts in prominent trials “has done much to bring about this result.”⁸⁸ A treatise co-authored in the 1890s by a physician and a lawyer asserted that contradictory testimony “must of necessity cast doubt either upon the reliability of medical opinion, or else upon the standing of medicine as an exact science.”⁸⁹

Critics also charged that the United States system contributed to partisan bias among medical experts.⁹⁰ T.R. Beck gave a sympathetic explanation of this in his 1828 address to the New York State Medical Society:

[T]he medical witness is often placed in a delicate situation from the circumstances under which he is summoned. He is a witness for one or other party . . . ; and he is so summoned, in the belief that his evidence will favour the side by which he is produced. It would be desirable, that at least the person who has made the previous examination before the coroner’s jury, should be divested of this, so far as to enable him to give a full and fair statement of all the circumstances that make for either side. I am aware that he can now do so, and indeed his oath obliges him to it. . . . But often the technicalities of an examination, and particularly by an adverse counsel, overcome that self-possession which is so essential. Pressed by perplexing questions and probably irritated in his feelings, he is apt to make declarations more strongly corroborative of opinions that he has formerly advanced, and as his examination advances, he may incur the charge of being *biassed*, more than facts will warrant.⁹¹

Though commentators may have been sympathetic to the plight of

86. Guy, *supra* note 37, at 474 (internal quotation marks omitted).

87. Conklin, *supra* note 59, at 128.

88. *Id.* at 128-29.

89. 1 Hamilton & Godkin, *supra* note 48, at 23.

90. Similar issues arose in the English system. Guy’s 1845 treatise warned:

Medical men are sometimes called on to give evidence for the prosecution, at other times for the defence. In such cases there is great necessity for caution; and it is obvious that no medical man can be justified in consenting to appear for either party, until, having heard all the facts on which his opinion must be formed, he can conscientiously give evidence in favour of the party for whom he is retained.

Guy, *supra* note 37, at 10. (Unlike my other quotations from this treatise, this passage is one from the English edition, rather than an addition by the treatise’s American editor.)

91. Beck, *supra* note 67, at 24 (citations omitted); *see also* Mohr, *supra* note 23, at 98 (discussing a portion of this passage).

the medical witness, they were deeply critical of the partisan role in which the system cast him. An 1845 treatise quoted with apparent approval Taylor's complaint that:

we are accustomed to hear of a medical prosecution and a medical defence, as if the whole duty of a medical jurist consisted in his making the best of a case, on the side for which he happens to be engaged, adopting the legal rule of suppressing those points which are against him, and giving an undue prominence to others which may be in his favour.⁹²

To guard against such problems, another American physician cautioned the medical witness to "use every effort to prevent his feelings from becoming so interested as to control his judgment, or warp his opinion."⁹³

Even if physicians heeded this advice, the adversarial nature of the proceedings may have cut against their efforts. In Samuel Gross's view:

The procedure, as generally conducted, partakes much more of the character of a combat, in which the opposing parties are pitted against each other, often with a degree of fierceness and acrimony that only shows too clearly the partisan feelings of the belligerents, instead of the dignified inquiry into the real merits of the case. The result is that, instead of enlightening the court and jury by their testimony, the medical witnesses only embarrass their minds, and this especially defeats the ends of justice.⁹⁴

In addition, some experts apparently worsened the situation by attacking the credentials of opposing witnesses. T.R. Beck warned his audience in 1828 that "medical witnesses [should] treat[] each other with respect. . . . If they do not . . . , others will with pleasure aid in the work of depreciation."⁹⁵

Such problems did not simply tarnish the profession as a whole; they could also prove very harmful to the witnesses themselves.⁹⁶ A Boston doctor addressing the Massachusetts Medical Society in 1851 asserted that opposing counsel "not unfrequently, in the summing-up

92. Guy, *supra* note 37, at 474 (internal quotation marks omitted).

93. David Humphreys Storer, *Medical Jurisprudence*, 3 *Med. Comm. Mass. Med. Soc'y* 131, 140 (1851).

94. Gross, *supra* note 73, at 61.

95. Beck, *supra* note 67, at 26; *see also* Mohr, *supra* note 23, at 99 (discussing this passage). If a physician could show that a medical witness had maliciously impugned his competence, he might be able to recover damages for libel, despite the privilege that normally attached to testimony in court. *See White v. Carroll*, 42 N.Y. 161, 164-67 (1870). A jury awarded White, a homœopathic physician, \$100 in damages against Carroll, an allopathic physician, because Carroll had testified that White was "a quack" and had asserted, on the witness stand, that "I would not call him a physician." *Id.* at 165.

96. *See* Mohr, *supra* note 23, at 197-98 (observing that "physicians risked their personal reputations each time they took the witness stand as an expert").

of the evidence and in his argument, by intimating his doubts of the credibility or competency of the medical witness, inflicts a lasting injury upon his professional character."⁹⁷ Though John Elwell seemed to take a less pessimistic view of the process, he too noted the impact the courtroom experience would have on the witness. Based on his performance on the witness stand, Elwell predicted, "The physician's influence will be either much stronger than before, or it will be annihilated. While ignorance and deception . . . may be triumphant in the sick room without being called to account or cross-examined, in open court they . . . will most certainly be exposed."⁹⁸

The unpleasant features of expert testimony were all the more repugnant to physicians because of the frequent lack of payment. For much of the nineteenth century, physicians were required to testify without compensation for the value of their time.⁹⁹ Medico-legal authors often spent several pages discussing the physician's claim to fair compensation.¹⁰⁰

2. Proposals for Reform

Nineteenth century proposals for altering the use of expert medical testimony arose both from observers' dissatisfaction with the current American system and from their awareness that France and Germany handled matters quite differently. Some proposals retained the notion of in-court expert testimony, but would alter the way in which experts were selected, prepared or examined. Other schemes entailed the submission of medical questions to panels of medical experts. Each suggestion addressed, in some way, the perceived problems with the adversarial model of expert evidence.

As James Mohr has documented, reform-minded physicians in nineteenth century America drew heavily upon ideas they found in French and, later, German medico-legal jurisprudence.¹⁰¹ As Mohr writes:

[T]he French permitted judges to call experts on behalf of the court to help settle difficult or disputed questions of a medical nature. Once the expert had ruled . . . , that ruling had a de facto presumption of truth. Disgruntled parties to the case could attack the ruling, but the burden of proof, because they had a vested

97. Storer, *supra* note 93, at 137; *see also* Mohr, *supra* note 23, at 103-04 (discussing Storer's address and his prior career).

98. Elwell, *supra* note 24, at 296.

99. *See* Mohr, *supra* note 23, at 90-92, 199-200.

100. *See, e.g.,* Elwell, *supra* note 24, at 581; Marshall D. Ewell, *A Manual of Medical Jurisprudence for the Use of Students at Law and of Medicine* 9-15 (1887); Guy, *supra* note 37, at 5; Ordranax, *supra* note 38, at 249-50; Henry Wade Rogers, *The Law of Expert Testimony* 254-64 (1883); Beck, *supra* note 67, at 30-31.

101. *See* Mohr, *supra* note 23, at 12-13, 42, 48-51 (discussing French influence); *id.* at 231-32 (discussing German influence). T.R. Beck, for example, wrote approvingly of Foderé's treatise on medical jurisprudence. *Id.* at 17.

interest, was on them. Even though the French system had evolved from fundamentally inquisitorial origins, most American champions of better medical jurisprudence considered it superior in medico-legal matters to the adversarial system they had inherited from the English¹⁰²

Well-read American observers would also have noticed that the German system of expert opinion operated differently.¹⁰³ A treatise on forensic medicine by the German physician Johann Casper boasted that Germany “possess[ed] a body of medical men expressly appointed . . . to carry out . . . all medico-legal (and sanitary police) duties.”¹⁰⁴ Casper noted that though France used court-appointed experts, the choice of the experts was in most parts of France left up to the court.¹⁰⁵ Casper argued that the German system was preferable,

for especially in criminal processes the medical authorities first called are legally only those whom the State has assigned to the judicial courts after previously ascertaining their knowledge in this department, while there is also an organised series of courts of professional experts, to whose judgment the opinion given by the medical men first employed may be referred.¹⁰⁶

102. Mohr, *supra* note 23, at 50-51. An observer of the French system might have noted, however, that French medical commentators expressed some dissatisfaction with the treatment of expert testimony. See, e.g., 2 Foderé, *supra* note 26, at 227-28 (discussing medical testimony on survival and order of death) (“It is quite true that often the men of the law pay too much attention to doctors, and that often they don’t pay enough attention to them” (author’s translation)). Mohr observes that the French approach to expert opinions

did not work as well as its American admirers believed it did. The French system was open to influence-peddling and corruption; sanction was often given to the opinions of physicians who did not merit the confidence of the courts . . . ; and the structure was constantly in need of tinkering and reform throughout the century.

Mohr, *supra* note 23, at 51.

103. Thus, for example, Henry Wade Rogers’ 1883 treatise on expert testimony discussed Casper’s description of the German expert system. See Rogers, *supra* note 100, at 56.

104. 3 Casper, *supra* note 36, at 178 (1864).

105. See *id.* at 178-79. French commentators shared some of Casper’s concerns. Briand and Chaudé noted that good practitioners did not necessarily make good experts, and discussed the need for training and selection of men in each locale to be medical experts. See Briand & Chaudé, *supra* note 46, at 20.

106. 3 Casper, *supra* note 36, at 179 (1864). However, Casper noted with disapproval a trend toward calling other, nonofficial, experts to testify “either along with the official physician or to his complete exclusion.” *Id.* at 181.

The first volume of Casper’s work gave more detail on the system for reporting the results of autopsies. Autopsy reports went through two rounds of review and revision—first by referees at a provincial medical college and then by referees at a centralized scientific commission. See 1 Casper, *supra* note 36, at 233-34 (1861). However, written reports were generally not admissible at trial, and it was seen as impracticable for a reviewing expert to appear to testify live. See *id.* at 234-35. Instead, a local physician could be “required to defend the [opinion] *vivâ voce* at the trial.” *Id.* at 235. Casper complained that juries were not bound by the reports and

Perhaps inspired by continental examples, some American commentators suggested that states should permanently appoint expert medical witnesses. For example, an 1826 book review in a New York medical journal decried the treatment of a medical witness in a recent malpractice trial, and proposed the following "remedy":

Let a set of men be particularly educated as examiners in medical cases—and, of course, as witnesses. The facts will thus be settled; and their qualifications will give force to their opinions. If any are disposed to question these, the grounds for discussion are laid out, and the differences can be understood. In this way, also, these examiners become vested with a sort of legal function, which may occasionally serve to enlighten the bench.¹⁰⁷

Similarly, having noted the difficulties arising from expert testimony on insanity in the United States, Isaac Ray suggested:

[I]t would be far better, if we had a class of men, more or less like that of the *experts* of the French, peculiarly fitted for the duty by a course of studies expressly directed to this end. They might be appointed by the government, in numbers adapted to the wants and circumstances of the population, and should be always ready at the call of courts, to examine the health of criminals, draw up reports touching the same, and deliver opinions.¹⁰⁸

A narrower application of this notion was the argument that the state should appoint physicians to serve as medical examiners. In 1828, noting that "cases of violent death . . . are the most important, as well as the most common, in which professional witnesses are summoned,"¹⁰⁹ T.R. Beck urged the adoption of the practice "of several continental countries": "the appointment of medical men in a county, a district, or a part of the state, who shall be specially charged with th[e] duty" of examining bodies.¹¹⁰ Such an arrangement, Beck argued, "would in a great degree, prevent that disputation about facts, which produces so many unpleasant collisions in courts of justice."¹¹¹

Other commentators, though not proposing a permanent

"often enough" reached verdicts "most remarkably and diametrically opposed to the medical opinion of the case." *Id.* at 234.

107. Review, *supra* note 64, at 607; *see also* Mohr, *supra* note 23, at 84 (quoting part of this passage).

108. Ray, *supra* note 74, at 60 (citation omitted).

109. Beck, *supra* note 67, at 11.

110. *Id.* at 14; *see also* Mohr, *supra* note 23, at 84-87 (quoting this passage and the passage cited in note 111, *infra*, and discussing Beck's proposal for "[s]tate-supported medical jurisprudence").

111. Beck, *supra* note 67, at 15. John Beck, T.R. Beck's brother, took a similar view. In the chapter on infanticide that he contributed to his brother's treatise, John Beck detailed a number of expert reports from French cases, and explained: "I have selected them not merely with the view of illustrating the doctrines previously advanced, but of showing the manner in which criminal cases are investigated and reported upon, on the continent of Europe. It is to be hoped that a similar mode may ere long, be adopted in this country." 1 Beck & Beck, *supra* note 58, at 439.

appointment, argued that the expert witnesses for a particular case should be chosen and examined by the court. John Ordranax, writing in 1869, asserted that if experts were chosen by the court, "and if their examination in chief could be restricted to the court solely, they would be placed above the reach of any possible assumption of bias towards either party."¹¹² He observed that such a practice "is in fact largely adopted in the courts of continental Europe, where the expert is treated more as an *amicus curiae* than he is under our common law jurisdiction."¹¹³

The concern over the partisan nature of expert testimony also led some to propose that if experts were to be retained by the parties, the experts should at least make an effort to see both sides of the dispute. The Becks' treatise advised:

The [medical] witness is not retained for one party; he does not testify for or against one or the other party A good plan . . . is to talk not exclusively with the lawyer or the witnesses on one side, but hold, if possible, free intercourse with those of the other party.¹¹⁴

The treatise recognized, however, that consultation between opposing experts was unlikely to occur: "Much [disagreement between experts] could doubtless be avoided if the medical witnesses on either part could meet and consult together; as this is not ordinarily possible, the differences will remain, and each witness must make his evidence as strong as possible."¹¹⁵

Another suggested approach was to assist the judge in managing the expert testimony. Samuel Gross proposed the appointment "in every judicial district" of an officer "to aid in the examination of witnesses in every trial involving scientific testimony."¹¹⁶ This officer would be appointed by the state's highest court, would receive a salary from the government, and would be free of "partisan feeling and personal

112. Ordranax, *supra* note 38, at 163. Likewise, a physician speaking in 1871 argued that expert witnesses should be better educated, as European experts were, that they should be less partisan, and that "the court alone should call and examine the medical experts." O'Dea, *supra* note 30, at 422-23, 428-29.

113. Ordranax, *supra* note 38, at 190.

114. 2 Beck & Beck, *supra* note 58, at 963 (C.R. Gilman rev., 11th ed., J.B. Pippincott & Co. 1860) (1823).

115. *Id.* at 970-71. Hamilton and Godkin, writing in 1894, took a stronger position: They suggested that physicians should "refuse to testify unless before doing so they can meet in conference with the expert witnesses to be called on the other side of the case, and have an interchange of views." Hamilton & Godkin, *supra* note 89, at 24.

116. Gross, *supra* note 73, at 62. The American Medical Association committee appointed to consider Gross's proposal reported favorably on it. *See Report, supra* note 83, at 78 (stating that under current circumstances, "we know of no remedy to meet the case except by the adoption of the plan recommended by our President"). In his discussion of the AMA, James Mohr quotes and discusses Gross's proposal, and the committee's response. *See Mohr, supra* note 23, at 227.

bias.”¹¹⁷ One of his major functions would be to restrain the adversarial excesses of the parties at trial:

It should be made part of his duty to prevent the bar from embarrassing the medical witness—a practice at the present day disgracefully common among lawyers—and to assist them in explaining themselves fully upon every interrogatory that may be propounded; to prompt the advocates in regard to any questions of omission, tending to supply additional information; in a word, to act as a medium between the opposing counsel, and as a light to the judge and jury, in clearing up points of an obscure or doubtful nature.¹¹⁸

As this passage suggests, Gross also envisioned that the officer would clarify and comment on the testimony of the parties’ medical experts:

He should have the privilege of summing up the medical testimony, not orally but in writing, for the benefit of the judge and jury, the latter of whom are always ignorant of the meaning of technical terms, and therefore incapable of drawing a proper distinction between the points of difference on the part of the scientific witness.¹¹⁹

While Gross’s proposal would have assigned a fair amount of influence to the expert officer, other schemes would explicitly have entrusted panels of experts with the responsibility of opining on, and in some proposals even deciding, medical questions.¹²⁰ An 1845 treatise quoted Taylor’s suggestion that the remedy for experts’ tendency to disagree over the cause of post-operative deaths was to “appoint[] a medical board of competent persons, to whom such questions might be referred.”¹²¹ Likewise, an unsigned piece in an 1874 issue of the Albany Law Journal argued that courts had done a poor job policing the qualifications of experts, and suggested submitting scientific questions to a panel of experts, “one to be selected by each party litigant, and the third by the court, . . . their

117. Gross, *supra* note 73, at 62-63.

118. *Id.*

119. *Id.* at 63. A letter to the Albany Law Journal in 1874 made a similar proposal: “Why not authorize the court to associate with itself an expert, who, jointly with the judge, would preside at the trial, direct and control the examination of the witnesses, and sum up at the close, before the summing up by the law judge?” C. Goepf, Letter to the Editor, *Experts in Judicial Proceedings*, 9 Alb. L.J. 146, 146-47 (1874), cited in Mohr, *supra* note 23, at 202.

120. See Mohr, *supra* note 23, at 115 (discussing an 1860 proposal for “medical juries to try malpractice accusations”).

121. Guy, *supra* note 37, at 474. Taylor made a similar proposal with respect to malpractice proceedings: “There is often great injustice in these proceedings, and the mischief can only be remedied by referring the facts to a medical tribunal, which alone should be competent to decide whether or not unskillfulness had really been shown in the management of a case.” Taylor, *supra* note 28, at 320.

opinion to be received by the jury as conclusive of the issue tried by them."¹²²

Expert panels seem to have struck observers as a particularly attractive method for determining questions of insanity.¹²³ Elwell, in his treatise, quoted an author who advocated referral of insanity pleas "to a board of twelve or more competent men," rather than permitting decision by a jury on the basis of testimony by "those members of the profession whom the prisoner or his friends may select, for their known support of his case."¹²⁴ Similarly, Isaac Ray proposed the use of a commission to determine insanity.¹²⁵

3. Counter-arguments

Despite the strong support among some nineteenth century physicians for changing the way in which the legal system used expert testimony, a number of commentators saw the proposals described above as problematic, while others questioned their necessity.

Not all observers believed the adversary system was an evil.¹²⁶ Allen Thurman, a former Chief Justice of Ohio's highest court, delivered a medical school commencement address in 1857 in which he took issue with the critiques of the American litigation system.¹²⁷ He noted critics' assertions "that our courts, as constituted, and especially our juries, are wholly incompetent to the decision of such questions; that in order to their correct determination the triers should be men versed in the medical art; and that from none others can a true verdict be certainly anticipated."¹²⁸ Thurman admitted that juries could err, and that "a jury of physicians" might "be more likely to decide a medical question correctly."¹²⁹ Thurman argued, however, that "[i]f medical questions should be tried by medical men alone, upon the same principle, mercantile questions should be tried by

122. *Expert Testimony in Judicial Proceedings*, 9 Alb. L.J. 122, 122 (1874); see also Mohr, *supra* note 23, at 202 (citing this source).

123. See Mohr, *supra* note 23, at 173-74 (discussing proposals for "lunacy commissions").

124. Elwell, *supra* note 24, at 423 (internal quotation marks omitted).

125. See Ray, *supra* note 74, at 64. Ray maintained that this approach would be far superior to "summoning medical witnesses to the trial—most of whom have but very imperfect notions of the disease, and probably have not had the least communication with the accused,—and forcing out their evidence, amid the embarrassment produced by the queries of ingenious counsel." *Id.* at 63.

126. Charles Tidy, an English surgeon whose medico-legal treatise was published in the United States, avoided the question "[w]hether an unscientific tribunal is capable, or should be required to decide scientific differences," but argued that so long as capable lawyers cross-examine honest experts, "no better way . . . could possibly be devised to arrive at *the truth*." 1 Charles Meymott Tidy, *Legal Medicine* 14-15 (1882).

127. See Mohr, *supra* note 23, at 106-08 (discussing Thurman's address).

128. Hon. A. G. Thurman, *Annual Address, Delivered at Commencement of Starling Medical College, March 3, 1857*, 9 Ohio Med. & Surgical J. 347, 354 (1857).

129. *Id.*

merchants, financial questions by bankers, . . . and so on."¹³⁰ Not only would this be "wholly impracticable," but a jury of physicians also would be open to the charge of bias arising either from "esprit du corps [sic]" or from "rivalry or envy."¹³¹ Moreover, Thurman argued that the trier of fact should not "decide upon its own individual knowledge"; if it did so, "[t]he case would, in effect, be tried upon ex parte testimony, mainly, and even that undisclosed except to the triers."¹³² A "thorough and public investigation," Thurman maintained, "takes place only upon the proper trial of a cause."¹³³ Thurman asserted that "the danger of wrong verdicts is much less than is generally supposed; and when we remember that the court has the power of setting them aside, I think we may rest secure that, except in rare instances that human foresight can hardly guard against, substantial justice will be done."¹³⁴

Henry Wade Rogers, in his 1883 treatise on expert testimony, took a similarly cautious view of the proposed reforms. He noted that emulating "the German system of governmental experts" could have some advantages, but he also noted potential problems.¹³⁵ In particular, Rogers pointed out that experts in one aspect of medicine "often have but a superficial knowledge of other branches";¹³⁶ thus,

if all questions of medical science . . . have to be referred to a board of governmental experts, suitors would be practically prohibited from availing themselves of the testimony of other experts, who might be much better qualified by their special knowledge on that particular subject, to form a correct and accurate opinion.¹³⁷

Rogers also disagreed with the proposal to have the court, rather than counsel, examine expert witnesses:

[I]t is necessary to a thorough and enlightened examination of an expert witness on an intricate question of medical, or other science, that the examiner should have made himself as familiar as possible with the subject matter of inquiry. . . . This the court cannot do, both for want of time, and for want of knowledge of the questions which will be raised. It is the part of wisdom that the inquisitorial and judicial functions should be so far as possible kept distinct.¹³⁸

Though Thurman and Rogers were both lawyers by training, some physicians were also wary of the proposed reforms. Edward Mann,

130. *Id.* Mohr gives particular attention to the passages quoted in the text accompanying notes 130-34. See Mohr, *supra* note 23, at 107.

131. Thurman, *supra* note 128, at 354.

132. *Id.* at 354-55.

133. *Id.* at 355.

134. *Id.*

135. Rogers, *supra* note 100, at 56.

136. *Id.* at 57.

137. *Id.* at 57-58.

138. *Id.*

the author of an 1893 treatise on insanity, observed that though “[t]he present system of calling expert witnesses may have some evils,” he doubted whether “any other system that can be suggested would not have equally great disadvantages attending it. It would be a measure of doubtful propriety to inaugurate any system that would obviate the necessity or do away with the right of cross-examination in open court in the presence of the jury.”¹³⁹ Similarly, S.V. Clevenger, writing in 1898, noted proposals for government-selected experts, but argued that “neither politicians nor the judiciary” were well qualified to judge experts’ qualifications.¹⁴⁰ He implicitly rejected the argument that the United States should adopt the expert procedures used in civil law countries, noting that “[c]onditions in one country might make practicable what would fail miserably if attempted in another.”¹⁴¹

4. The Dwindling Impetus for Reform

In the end, the nineteenth century passed without much action on the proposed procedural reforms. New York instituted a “lunacy commission” to opine on questions of insanity in criminal cases, but the commission met with criticism.¹⁴² States began to appoint medical examiners, thus providing a set of specialists to perform autopsies and testify about them, while at the same time removing the need to compel physicians to render unpaid testimony in court.¹⁴³ However, little else came of the proposals.

As James Mohr explains,

More than a century of pressing for some modified version of Continental-style medical jurisprudence in the United States finally came to naught by the end of the nineteenth century. Physicians thereafter largely abandoned their collective efforts to persuade the state to create a system of official medico-legal experts, and instead adjusted their professional responses to the circumstances that actually prevailed¹⁴⁴

139. Mann, *supra* note 75, at xix.

140. 1 S.V. Clevenger, *Medical Jurisprudence of Insanity, or Forensic Psychiatry* 108 (1898).

141. *Id.*

142. See Mohr, *supra* note 23, at 174-75, 178-79. Mohr notes that the New York innovation “was [not] as radical a departure as it appeared to be,” because [t]he commission law authorized the experts to make a determination in criminal cases only when the defendant made no other plea than insanity. Moreover, if the defense disagreed with the commission’s ruling, the defendant could demand a regular jury trial to redetermine his or her status in the normal fashion.

Id. at 174.

143. See Mohr, *supra* note 23, at 215-18.

144. Mohr, *supra* note 23, at 252.

C. Professional Coordination and Control

To the extent that the momentum of medico-legal reform efforts declined at the turn of the century,¹⁴⁵ this decline should be viewed, as Mohr suggests, in light of other trends in medical practice. Developments were afoot that dampened the impact of malpractice suits on the medical profession. In particular, the increasing availability to doctors of malpractice insurance and the decreasing availability to plaintiffs of medical expert witnesses both seem to have helped to insulate doctors, for a time, from the threat of liability.

In the mid-nineteenth century, a malpractice suit could have a considerable financial impact on the defendant. Not only could damages awards be substantial, but the costs of litigation could be difficult to meet as well.¹⁴⁶ In the 1880s, physicians began to explore in earnest the possibility of organizing in groups to provide for the defense of lawsuits against group members.¹⁴⁷ Neal Hogan has described state medical societies' adoption, in the early 1900s, of programs which defended, but did not indemnify, participating physicians.¹⁴⁸ One apparent reason for the societies' refusal to indemnify was that they wanted to minimize the possibility that a successful plaintiff would actually collect on a judgment.¹⁴⁹ Physicians, however, wanted not just defense but also protection against liability, and eventually the medical societies responded by providing insurance for their members.¹⁵⁰

At the same time, the profession was changing in ways that increased the medical community's ability to control its members. Paul Starr has described several developments that contributed to this change. States, with physician support, enacted licensing regulations.¹⁵¹ The American Medical Association and state and local medical societies developed interconnections and extended their authority.¹⁵² Changes in medical education "increased the homogeneity and cohesiveness of the profession."¹⁵³ Medicine's contributions to public health heightened the profession's social influence.¹⁵⁴ These trends "reflected a movement toward the strengthening of professional status

145. Even if active reform efforts petered out by the turn of the century, commentators continued to discuss reform proposals through the early twentieth century. See Neal C. Hogan, *Unhealed Wounds: Medical Malpractice in the Twentieth Century* 80-86 (2003) (discussing commentary on medical expert witnesses and proposals for "a commission of doctors which the courts could refer to for expertise in medical matters").

146. See De Ville, *supra* note 25, at 189-90.

147. See *id.* at 204-05.

148. See Hogan, *supra* note 145, at 34-37.

149. See *id.* at 35.

150. See *id.* at 39, 45.

151. See Paul Starr, *The Social Transformation of American Medicine* 102 (1982).

152. See *id.* at 109-10.

153. *Id.* at 123.

154. See *id.* at 134-40.

and the consolidation of professional authority,"¹⁵⁵ and the growth of that authority gave the medical profession increasing influence over individual physicians.

Greater control over members of the profession brought a greater ability to protect those members from malpractice liability. The "locality rule" in malpractice doctrine required the malpractice plaintiff to obtain an expert witness from the same geographic area as the defendant.¹⁵⁶ As Starr observed, "[b]y adopting the 'locality rule,' the courts prepared the way for granting considerable power to the local medical society, for it became almost impossible for patients to get testimony against a physician who was a member."¹⁵⁷ Neal Hogan states that medical societies not only counted on their members to testify for defendants but also pressured them not to testify for plaintiffs;¹⁵⁸ he notes "examples of physicians who refused to testify, and even of those who gave as their reason pressure from fellow members, and their society."¹⁵⁹

At the same time that organized medicine was active in seeking to protect its members from external discipline through malpractice liability, it failed to provide an effective internal mechanism for disciplining physicians whose performance was substandard. Carl Ameringer notes that at mid-century, "[s]tate medical boards . . . were the profession's gatekeepers. They licensed the qualified, banished the unqualified, and shielded the profession from external review."¹⁶⁰ However, "formal discipline [by boards] in the form of a suspended or revoked license was rare," and control was instead exercised by "a network of institutions operating at the local level."¹⁶¹

D. Critiques of Self-Regulation and Increases in External Accountability

After World War II, "[t]he failure of physicians to adequately police their ranks led to claims that a 'conspiracy of silence' flourished in the medical community."¹⁶² Though the profession took some actions in response to these concerns,¹⁶³ questions remained. As late as 1983, Robert Derbyshire, a former President of the Federation of

155. *Id.* at 81.

156. *See id.* at 111; *see also* De Ville, *supra* note 25, at 210-13.

157. Starr, *supra* note 151, at 111.

158. *See* Hogan, *supra* note 145, at 38, 100-01; *see also id.* at 82 ("Strong pressure could be brought to bear against those physicians who chose to testify for plaintiffs.").

159. *Id.* at 99.

160. Carl F. Ameringer, *State Medical Boards and the Politics of Public Protection* 14 (1999).

161. *Id.* at 22.

162. *Id.* at 29; *see also* Hogan, *supra* note 145, at 106, 177 n.231 (discussing the use of the term "conspiracy of silence" by Melvin Belli, a prominent plaintiff's lawyer).

163. *See* Ameringer, *supra* note 160, at 29-30; Hogan, *supra* note 145, at 110, 135-37.

State Medical Boards of the United States, asserted that “many disciplinary bodies seem more interested in protecting their medical colleagues than in safeguarding the public.”¹⁶⁴ In the mid-1990s, Timothy Jost observed:

The number of physicians disciplined by medical boards, though growing in recent years, is still only a tiny fraction of practicing physicians. . . .

Though disciplinary actions specifically based on incompetence have become more common in recent years, they are still unusual. . . .

. . . .

Perhaps the most important factor limiting the effectiveness of medical boards in addressing incompetence is the fact that most licensure boards are still composed predominantly of physicians. Physicians are reluctant to criticize each other for technical and judgment errors. . . . If rehabilitative sanctions are available, these may be more palatable, as may be disciplinary actions not disclosed to the public. But physicians are clearly unenthusiastic about the use of serious licensure actions to sanction medical errors.¹⁶⁵

Though physicians’ hesitancy to discipline their colleagues may have held constant over the years, other forces have lessened physicians’ control over their profession. For example, doctors increasingly are subjected to oversight by managed care organizations.¹⁶⁶ In addition, a growing number of patients seek to inform themselves and to exercise judgment with respect to their treatment options.¹⁶⁷ Viewed in this context, the threat and reality of

164. Robert C. Derbyshire, *How Effective is Medical Self-Regulation?*, 7 *Law & Hum. Behav.* 193, 196 (1983).

165. Timothy Stoltzfus Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market?*, 37 *Ariz. L. Rev.* 825, 862-64 (1995) (citations omitted).

166. See, e.g., Timothy S. Hall, *Bargaining with Hippocrates: Managed Care and the Doctor-Patient Relationship*, 54 *S.C. L. Rev.* 689, 694-95 (2003) (noting that “[m]anaged care characteristically imposes external controls on physicians’ spending decisions” and that it “also seeks to encourage physicians to internalize the ethos of cost-cutting and cost-effective medical practice” (citation omitted)).

167. The development—in the late 1950s to early 1970s—of the modern legal notion of “informed consent” played a key role in reorienting the profession from a model of deference to physicians’ judgment to a model of patient choice. See Ruth R. Faden & Tom L. Beauchamp, *A History and Theory of Informed Consent* 125-32 (1986). As Faden and Beauchamp explain:

Physicians had heretofore considered the physician-patient relationship by beginning from the patient’s submission to the physician’s professional beneficence. The law enlarged that perspective by viewing the relationship within a wider social framework, emphasizing instead that patients voluntarily initiate the relationship and have the right to define its boundaries to fit their own ends.

Id. at 142-43. More broadly, Marc Rodwin has described ways in which “the movements involving . . . patients’ rights[,] medical consumerism[,] women’s health[,] and disability rights . . . have fostered the ideal of serving patients, promoting

malpractice litigation—in which lay judges and juries decide whether to hold a doctor liable—present yet another incursion on physicians' control of their professional lives.

E. *Connections to the Present Debate*

In the conclusion of his book on nineteenth century medical jurisprudence, James Mohr notes that then, as now,

the medical profession and the state . . . maintained a deeply ambiguous relationship over medico-legal matters in the United States. On the one hand, the influence of physicians on public policy has been substantial; on the other, the state has consistently refused to put medico-legal decision-making directly into the hands of the profession.¹⁶⁸

As Jay Gold has argued, that tension pervades all areas of health law.¹⁶⁹ In particular, this part has demonstrated that, in the nineteenth century, medical liability suits and medical evidence presented areas of conflict between physicians and the legal system. The next part discusses the current incarnation of that conflict. As will be seen, the issues raised by physicians today have their roots in the dynamics of the nineteenth century. One major change, however, is that we now possess empirical data against which to assess doctors' claims concerning the legal system.¹⁷⁰

II. EMPIRICAL DATA AND PROCEDURAL REFORMS

The current debate over medical liability includes many of the critiques physicians made in the nineteenth century. Many doctors today assert that judges are prone to admit dubious expert testimony. Doctors often charge that juries are incapable of distinguishing good expert testimony from bad, and that juries reach unwarranted findings of liability and award excessive damages. This part will assess the extent to which existing data support these critiques.¹⁷¹ Before

[patient] autonomy, and promoting a more responsible and humane health care system," though Rodwin also concludes that these movements "[have] had limited success" in achieving these goals. Marc A. Rodwin, *Patient Accountability and Quality of Care: Lessons from Medical Consumerism and the Patients' Rights, Women's Health and Disability Rights Movements*, 20 Am. J.L. & Med. 147, 150 (1994).

168. Mohr, *supra* note 23, at 252.

169. See Gold, *supra* note 18, at 145.

170. Admittedly, it would be useful to have more empirical data than we now possess. Cf. Peter H. Huang, *Lawsuit Abandonment Options in Possibly Frivolous Litigation Games*, 23 Rev. Litig. 47, 49 (2004) (noting the "demand for more empirical research and work about civil procedure and litigation"). However, as I discuss in Part II, the existing data provide a number of important insights.

171. Some of the discussion in this Part is drawn from my report for the Pew Charitable Trusts' Project on Medical Liability in Pennsylvania. See Catherine T. Struve, *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options* (2003).

examining the performance of judges and juries in malpractice cases, however, it is useful to survey some key information concerning the incidence and resolution of malpractice claims.

A. *Data on Malpractice Claims*

It is clear that there are far more potential than actual malpractice claims. Based on hospital and insurance records, the Harvard Medical Practice Study estimated that some 27,000 hospital patients in New York State in 1984 were injured as a result of negligent medical care, but that fewer than 3,800 patients asserted malpractice claims—a substantial “gap” between potential and actual claims.¹⁷² However, the study revealed not only a gap but also a mismatch: Researchers were able to connect forty-seven claims from malpractice insurance files to hospital records, and determined that harm from negligence occurred in only eight of these cases.¹⁷³ Although the researchers cautioned that their medical record review might not reveal some types of malpractice (such as a failure to diagnose),¹⁷⁴ the apparent mismatch does raise questions. A more recent study examining adverse events and claims in connection with incidents in Utah and Colorado in 1992 found both a similar “gap” and a similar “mismatch.”¹⁷⁵

Of the malpractice claims that are asserted, approximately two-fifths end without ever reaching litigation; roughly a third of the claims closed prior to litigation settle with some payment to the claimant.¹⁷⁶ Close to nine-tenths of the malpractice claims that do proceed to litigation are resolved prior to trial; roughly half of those pre-trial closures involve some payment to the plaintiff, while the other claims are dropped or dismissed without payment.¹⁷⁷ Malpractice plaintiffs who try their claims to verdict have an unusually low probability of winning, compared to plaintiffs in other sorts of cases: Studies of a number of jurisdictions at varying times during the 1960s to 1990s have yielded a range of malpractice plaintiff win rates

172. See Paul C. Weiler et al., *A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation* 69-70 (1993).

173. *Id.* at 71.

174. See *id.* Reviewing the study's findings, Randall Bovbjerg observed: “This mismatch . . . is not fully consistent with information from studies of closed claims, which are more appropriate than hospital records for examining the accuracy of liability processes. Claims files have more detail about injuries, and closed files naturally cover the full resolution of each case.” Randall R. Bovbjerg, *Medical Malpractice: Research and Reform*, 79 *Va. L. Rev.* 2155, 2163 (1993) (book review) (citation omitted).

175. David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 *Med. Care* 250, 253-55 (2000).

176. These figures are based on a nationwide sample of claims closed in 1984. See U.S. Gen. Accounting Office, *Medical Malpractice: Characteristics of Claims Closed in 1984*, at 37, 82 (1987).

177. See *id.*

“from 13.5 percent to 53 percent, with a median win rate of around 29 percent.”¹⁷⁸

Low plaintiff win rates at trial do not prove that plaintiffs bring meritless cases. The proportion of cases that go to verdict is very small in comparison to the cases that are resolved prior to trial, and various theories may explain why the mix of cases the litigants select for trial tends to produce large numbers of defendant verdicts.¹⁷⁹ Similarly, the data on malpractice lawsuits resolved prior to trial are consistent with the view that some malpractice plaintiffs lack information concerning the merits of the claim and must sue to obtain it.¹⁸⁰ This would be true, for example, if necessary evidence were contained not just in medical records but also in the recollections of those present during a medical procedure (which the plaintiff might not be able to ascertain without formal discovery).¹⁸¹ Predictably,

178. Neil Vidmar, *Medical Malpractice and the American Jury: Confronting the Myths About Jury Incompetence, Deep Pockets, and Outrageous Damage Awards* 38 (1995). Interestingly, there is some evidence that medical malpractice plaintiffs who try their claims before a judge tend to do better than those who try their claims before a jury. Kevin Clermont and Theodore Eisenberg studied data from 1979 to 1989 concerning a number of types of cases litigated in federal court. See Kevin M. Clermont & Theodore Eisenberg, *Trial by Jury or Judge: Transcending Empiricism*, 77 *Cornell L. Rev.* 1124, 1133 (1992). For thirteen types of cases, Clermont and Eisenberg compared the plaintiff win rate in cases tried before a judge with the plaintiff win rate in cases tried before a jury. See *id.* at 1134, 1136-37. They found that in medical malpractice cases tried before a judge, the plaintiff win rate was .50, whereas in medical malpractice cases tried before a jury, the plaintiff win rate was .29. See *id.* at 1137. Of course, this difference in win rates does not prove that judges are more favorable to malpractice claimants than juries are, because the difference in outcomes may be due to differences between the cases tried before a judge and the cases tried before a jury. See *id.* at 1162-66 (considering possible reasons for differences between the two sets of cases).

179. See Vidmar, *supra* note 178, at 83-92; Samuel R. Gross & Kent D. Syverud, *Getting to No: A Study of Settlement Negotiations and the Selection of Cases for Trial*, 90 *Mich. L. Rev.* 319, 360-66 (1991); Keith N. Hylton, *An Asymmetric-Information Model of Litigation*, 22 *Int'l Rev. L. & Econ.* 153, 165 (2002) (positing that “win rates will be less than 50 percent in regimes in which the legal test requires an examination of the defendant’s compliance and the defendant enjoys an informational advantage”).

180. See Henry S. Farber & Michelle J. White, *A Comparison of Formal and Informal Dispute Resolution in Medical Malpractice*, 23 *J. Legal Stud.* 777, 778 (1994) [hereinafter Farber & White, *Dispute Resolution*]; Henry S. Farber & Michelle J. White, *Medical Malpractice: An Empirical Examination of the Litigation Process*, 22 *RAND J. Econ.* 199, 200 (1991) [hereinafter Farber & White, *Empirical Examination*].

181. In many instances, patients may simply want to know why they suffered an adverse result, and may drop their claims (without filing suit) after gaining that information. Other data support the theory that a desire for information can lead people to assert malpractice claims. For example, in a study of birth-related injuries and deaths in Florida, researchers found that parents were more likely to file a malpractice claim if they had not previously been informed that there might be difficulties with the baby. See Frank A. Sloan & Chee Ruey Hsieh, *Injury, Liability, and the Decision to File a Medical Malpractice Claim*, 29 *Law & Soc’y Rev.* 413, 427 (1995).

many claimants will drop their suits when it becomes apparent that the claims lack merit.¹⁸² Moreover, a plaintiff might drop a valid claim because litigation costs become prohibitive, or because the lawsuit proves emotionally stressful.¹⁸³

The key liability questions in a malpractice case concern the applicable standard of care and the issue of causation. In assessing each of these questions, the jury will need to rely on specialized knowledge, which is usually provided by the parties' expert witnesses. The first major set of issues in a malpractice case concerns the nature of the physician's duty of care to the patient, and whether the physician breached that duty.

Outside of medical malpractice, the law of negligence usually asks whether a "reasonable person" in the defendant's position would have taken a particular precaution.¹⁸⁴ In general, an industry's practices do not define the standard of care, though they may be relevant to it.¹⁸⁵ Medical malpractice is a notable exception: The standard of care has traditionally been set by reference to "medical custom," meaning what doctors within the relevant community normally do.¹⁸⁶ Recently, however, Philip Peters has noted that a minority of states have replaced the "medical custom" standard with a "reasonable physician" standard, which permits the jury to find liability even when a physician followed a standard medical practice.¹⁸⁷ In jurisdictions that follow the "reasonable physician" standard, expert testimony may be directed explicitly to the expert's own view of appropriate care. In other words, expert testimony may seek to establish the standard of care by reference to the risks and benefits of the relevant precaution, without having to establish whether the physician deviated from prevailing medical custom.¹⁸⁸

A traditional justification for the "medical custom" standard is that lay decision makers are better equipped to ascertain what physicians actually do than what they should do. On closer examination, either task can prove challenging. A jury applying the "medical custom" standard will need expert testimony to determine what the customs are. However, experts nominally opining on medical custom frequently base their testimony more on their own views of

182. See Farber & White, *Empirical Examination*, *supra* note 180, at 200.

183. See Thomas B. Metzloff, *Researching Litigation: The Medical Malpractice Example*, *Law & Contemp. Probs.*, Autumn 1988, at 199, 204.

184. See Patrick J. Kelley & Laurel A. Wendt, *What Judges Tell Juries About Negligence: A Review of Pattern Jury Instructions*, 77 *Chi.-Kent L. Rev.* 587, 595 (2002).

185. See *id.* at 606.

186. See Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 *Wash. & Lee L. Rev.* 163, 165-66 (2000).

187. See *id.* at 170.

188. See Philip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 *Iowa L. Rev.* 909, 920-21 (2002).

appropriate care than on systematic knowledge of the relevant community.¹⁸⁹ Even if the parties present empirical data concerning what doctors do in practice, as some commentators advocate,¹⁹⁰ there is often substantial variation in appropriate treatment.¹⁹¹ To address this problem, many jurisdictions have adopted a “two schools of thought” doctrine which permits doctors to argue that they should not be held liable if they comply with a standard endorsed by part, but not all, of the relevant medical community.¹⁹²

After establishing the standard of care and the physician’s breach of that standard, the plaintiff must show that the breach caused the plaintiff’s injury. In some instances—for example, where a surgeon operated on the wrong limb—the determination of causation will be straightforward. In others, establishing causation will require examining many similar cases—more than a single practitioner is likely to see personally—to ascertain how often injuries occur in the absence of negligence.¹⁹³ In other words, a showing of causation often will be based on probabilistic evidence.¹⁹⁴ Moreover, it may be hard to untangle the defendant’s actions from the patient’s preexisting medical problems.¹⁹⁵

In addition to questions of liability, medical malpractice cases also present questions concerning the amount of damages. Determining damages is not simply a matter of totaling the plaintiff’s past medical bills and lost wages. The jury also will need to assess the degree and duration of the impairment a surviving plaintiff will suffer in the

189. See Mark A. Hall, *The Defensive Effect of Medical Practice Policies in Malpractice Litigation*, Law & Contemp. Probs., Winter & Spring 1991, at 119, 127.

190. See Tim Cramm et al., *Ascertaining Customary Care in Malpractice Cases: Asking Those Who Know*, 37 Wake Forest L. Rev. 699, 726 (2002) (advocating the use of “surveys of a relevant population of physicians to determine customary (and, if desired, appropriate or reasonable) care”); Mark A. Hall et al., *Measuring Medical Practice Patterns: Sources of Evidence from Health Services Research*, 37 Wake Forest L. Rev. 779, 779 (2002) (discussing “sources of evidence from the field of health services research that might be used to establish the standard of care in medical malpractice cases”); William Meadow & Cass R. Sunstein, *Statistics, Not Experts*, 51 Duke L.J. 629, 631 (2001).

191. See Philip G. Peters, Jr., *Empirical Evidence and Malpractice Litigation*, 37 Wake Forest L. Rev. 757, 772 (2002) (noting evidence that “physician practices vary widely, even within narrow geographic limits”).

192. See Cramm et al., *supra* note 190, at 704-05.

193. See William Meadow, *Operationalizing the Standard of Medical Care: Uses and Limitations of Epidemiology to Guide Expert Testimony in Medical Negligence Allegations*, 37 Wake Forest L. Rev. 675, 681 (2002).

194. Cf. Troyen A. Brennan, *Causal Chains and Statistical Links: The Role of Scientific Uncertainty in Hazardous-Substance Litigation*, 73 Cornell L. Rev. 469, 490 (1988) (noting, with respect to toxic tort cases, that “[t]he scientific association between a toxic substance and injury to a person relies on probabilistic evidence: epidemiological studies and statistical associations” (citation omitted)).

195. See Randall R. Bovbjerg, Urban Inst., *Medical Malpractice: Problems and Reforms* 4 (1995) (“New harm caused by treatment can be hard to tell from normal variation in harm attending the underlying illness or injury.”).

future. Estimating the cost of lifetime care for a permanently injured plaintiff will require expert testimony on life expectancy, on the plaintiff's future medical needs, and on the projected costs of that future care.¹⁹⁶ In addition, calculations concerning the amount of the plaintiff's loss of future earning power will be necessary. Ordinarily, the plaintiff will seek damages for noneconomic losses as well, which will require the jury to assign a monetary value to the plaintiff's prospective pain and suffering.¹⁹⁷ The plaintiff may also request punitive damages, which are designed to punish willfully wrongful behavior on the part of the defendant.¹⁹⁸ However, punitive damages are rarely awarded in medical malpractice cases.¹⁹⁹

As this discussion suggests, some malpractice cases can present challenging issues of liability and damages. Moreover, the data indicating a "mismatch" between injuries from medical negligence and the claims that are actually asserted raises a question as to the system's ability to distinguish valid from invalid claims. As noted, most malpractice claims will settle prior to trial; however, the decisions made by judges and juries in the cases that do go to trial provide information used by other litigants in deciding whether to come to a pretrial resolution. Thus, Part II.B. assesses the capacity of judges and juries to address common issues in malpractice cases.

B. *The Performance of Judges and Juries*

Research indicates that judges could benefit from better training in the scientific principles necessary to the application of the *Daubert* approach to expert testimony. The available data suggest that jury performance is better than critics sometimes assert. However, juries' liability determinations might be aided, in complex cases, by a neutral and understandable exposition of issues of standard of care and causation. In addition, jury determinations of noneconomic damages could improve if juries were provided with more guidance.

1. Judges

Nineteenth century physicians' complaints about judges in malpractice cases echo through today's debates on medical liability. Physicians today, like their counterparts a century and a half ago, charge that judges allow unqualified or venal experts to present

196. See, e.g., Edith Greene & Brian Bornstein, *Precious Little Guidance: Jury Instruction on Damage Awards*, 6 Psychol., Pub. Pol'y, & L. 743, 745 (2000) (noting that "calculations [of economic damages] must take into account forecasts about future medical care needs, available job opportunities, and projected life expectancies").

197. See *id.*

198. See *id.*

199. See Thomas H. Koenig & Michael L. Rustad, In Defense of Tort Law 136 (2001).

dubious testimony. Despite the similarity of the criticisms, however, the landscape of the law concerning expert testimony has changed in the interim.

As discussed in Part I.B., the law governing the admissibility of medical expert testimony in the mid-nineteenth century was confounded by the lack of regulation of the medical profession itself. Because all manner of regular and irregular physicians could practice medicine, courts similarly permitted all kinds of physicians to testify. In the twentieth century, more control has been exercised over the testimony of medical expert witnesses, though the nature and source of the control have varied.

In courts that follow the test set forth in *Frye v. United States*,²⁰⁰ the judge asks whether the proposed expert employs an approach that is generally accepted in the relevant medical or scientific community.²⁰¹ As commentators have observed, this approach delegates authority to the expert community to determine which experts' testimony will be admissible in court.²⁰² The *Frye* test has the advantage of requiring relatively little expertise from the judge. However, because it seems likely that there is a time lag between the introduction of an advance in knowledge and its general acceptance in the pertinent scientific community, the *Frye* test might be either under- or over-inclusive in certain cases: It might erroneously exclude testimony based on a method that will soon be accepted as valid, or it might erroneously admit testimony based on a method soon to be condemned as outdated.

The competing approach, formulated in *Daubert v. Merrell Dow Pharmaceuticals*,²⁰³ promises increased accuracy but demands greater judicial expertise.²⁰⁴ Rather than relying on the judgment of the relevant professional community, a judge following *Daubert* performs an independent evaluation of the expert's method, considering such factors as "whether it can be (and has been) tested," whether it "has been subjected to peer review and publication," the method's error rate, any applicable standards for its application, and whether the method is generally accepted in the relevant expert community.²⁰⁵

200. 293 F. 1013 (D.C. Cir. 1923); see also *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 587 (1993) (holding, with respect to litigation in federal courts, that "the *Frye* test was superseded by the adoption of the Federal Rules of Evidence").

201. See *Frye*, 293 F. at 1014.

202. See, e.g., Samuel R. Gross & Jennifer L. Mnookin, *Expert Information and Expert Evidence: A Preliminary Taxonomy*, 34 Seton Hall L. Rev. 141, 148 (2003), (noting that the *Frye* standard "pass[es] the buck back to the expert field itself, and accept[s] the standards it imposes on itself").

203. 509 U.S. at 579.

204. See Arti K. Rai, *Specialized Trial Courts: Concentrating Expertise on Fact*, 17 Berkeley Tech. L.J. 877, 890 (2002) ("The exacting requirements that *Daubert* and its progeny impose on lay judges have been the subject of considerable controversy.").

205. *Daubert*, 509 U.S. at 593-94.

Some data suggest that many judges may need training in order properly to apply the *Daubert* test. In one recent study, researchers who surveyed several hundred state court judges found that “many of the judges surveyed lacked the scientific literacy seemingly necessitated by *Daubert*.”²⁰⁶ In particular, “[j]udges had the most difficulty operationalizing falsifiability and error rate, with only 5% of the respondents demonstrating a clear understanding of falsifiability and only 4% demonstrating a clear understanding of error rate.”²⁰⁷

Apart from the standard debate over the competing merits of the *Frye* and *Daubert* approaches, there is an additional question, in the malpractice context, concerning the extent to which courts actually follow either approach. Daniel Shuman argues that the *Frye* test has not figured prominently in malpractice litigation: “[O]nce the expert was determined to be qualified, the reliability of the expert’s methods and procedures was typically left to the jury.”²⁰⁸ Moreover, Shuman asserts that even in jurisdictions that have adopted *Daubert*, courts do not appear to use the *Daubert* factors to scrutinize medical malpractice expert testimony. On the question of standard of care, Shuman argues that the lax approach to expert testimony is closely related to the courts’ willingness to “accept testimony as to customary practice without demanding methodologically sound survey evidence of its adoption, let alone rigorous proof of efficacy.”²⁰⁹ Even on questions of causation, though, where “it might be expected that *Daubert* would have a more profound effect,” Shuman’s review of reported decisions found only a “modest” impact.²¹⁰

It seems, then, that not all judges currently apply rigorous scrutiny to medical expert testimony in malpractice cases. However, to the extent that judges are engaged in assessing the appropriateness of medical or scientific testimony under *Daubert*, those judges would likely benefit from improved training with respect to basic scientific and medical principles.

2. Juries

Contemporary critiques of jury performance resonate with the complaints physicians made in the nineteenth century.²¹¹ Many

206. Sophia I. Gatowski et al., *Asking the Gatekeepers: A National Survey of Judges on Judging Expert Evidence in a Post-Daubert World*, 25 *Law & Hum. Behav.* 433, 433 (2001).

207. *Id.*

208. Shuman, *supra* note 12, at 280.

209. *Id.* at 280-81 (citations omitted); see also *supra* note 190 (listing sources that propose empirical methods for ascertaining medical custom).

210. Shuman, *supra* note 12, at 281.

211. Current indictments of jury performance are not limited to the medical malpractice context. See, e.g., Clermont & Eisenberg, *supra* note 178, at 1127 (noting a popular perception, with respect to personal injury lawsuits, that “[j]uries . . . find liability when judges would not, . . . grant higher awards than judges, and . . . grant

physicians today believe that outcomes in medical malpractice cases are largely random, or are linked only to the severity of the plaintiff's disability and not to the presence or absence of fault on the part of the physician.²¹² Some physicians assert that this apparently haphazard threat leads them to engage in defensive medicine or drives them out of high-risk practice or geographic areas.²¹³

Criticisms of jury competence can now be measured against two sets of data: studies concerning jury performance in cases involving complex evidence, and studies of jury performance in malpractice cases in particular. Those studies reveal some room for improvement with respect to both liability and damages determinations.

Some studies suggest that jurors may experience difficulty in processing complex information, and, in particular, that jurors may have trouble evaluating the strength of statistical evidence. For example, Joe Cecil, Valerie Hans and Elizabeth Wiggins reviewed a general study of juror performance in twenty-nine protracted civil trials, as well as case studies of a handful of other complex trials, and concluded that the jurors studied showed varying degrees of understanding of the evidence.²¹⁴ However, they observed that jurors with higher levels of understanding appeared to play an important

inappropriate punitive damages awards" (citations omitted)); Arthur R. Miller, *The Pretrial Rush to Judgment: Are the "Litigation Explosion," "Liability Crisis," and Efficiency Clichés Eroding Our Day in Court and Jury Trial Commitments?*, 78 N.Y.U. L. Rev. 982, 988 (2003) (noting tort reformers' propensity to "characteriz[e] juries as unsophisticated bodies more concerned with compensating sympathetic victims than with administering consistent justice").

212. For example, one set of researchers surveyed physicians who practiced in neonatal intensive care units in 1993. See William Meadow et al., *Physicians' Experience with Allegations of Medical Malpractice in the Neonatal Intensive Care Unit*, Pediatrics, May 1997, at <http://www.pediatrics.org/cgi/content/full/99/5/e10>. The researchers asked the respondents about the respondents' personal experiences with malpractice claims. The results were dramatic:

On a scale of 1 to 4 (4 being most reasonable) the median assessment of the reasonableness of malpractice allegations was 1, mean 1.2. On a scale of 1 to 4 (4 being the highest) the median assessment of effectiveness of the current system in identifying true malpractice was 1, mean 1.4.

Id. The study relied on the respondent physicians' perceptions of the claims with which the respondents had been personally involved, and did not attempt to assess independently the accuracy of the respondents' perceptions. Although the study thus does not provide an objective assessment of the malpractice litigation system, the study does provide a vivid illustration of physicians' perceptions of that system.

213. See, e.g., Richard E. Anderson, *Billions for Defense: The Pervasive Nature of Defensive Medicine*, 159 Archives Internal Med. 2399, 2400 (1999) ("[P]hysicians are so averse to malpractice suits that nearly all clinical judgments are influenced."); Press Release, American Medical Association President-elect, Donald J. Palmisano, AMA Supports Health Act to Bring Common Sense to Our Liability System (Feb. 6, 2003) ("In crisis states, ob-gyns have been forced to stop delivering babies, trauma centers have closed, and physicians are grappling with how they can continue to provide other high-risk procedures."), at <http://www.ama-assn.org/ama/pub/article/1617-7251.html>.

214. Joe S. Cecil et al., *Citizen Comprehension of Difficult Issues: Lessons From Civil Jury Trials*, 40 Am. U. L. Rev. 727, 756 (1991).

part in deliberations, and they suggested that modifications in trial procedure—such as narrowing or sequencing issues, using court-appointed experts, and permitting jurors to take notes and ask questions—might improve overall jury performance.²¹⁵ They also reviewed a number of jury simulation studies which suggest that jurors may misperceive the persuasiveness of statistical evidence and may have difficulty spotting faulty reasoning in probabilistic testimony. Although one of those studies presented a more positive view of jury comprehension than the others, all the studies suggested that jurors experience some difficulty with statistical evidence.²¹⁶

Cognitive biases also appear to affect jury findings on liability. “Hindsight bias”—the human tendency to view an event as having been more probable because it in fact occurred—and “outcome bias”—the tendency to view a decision as poorer quality because the decision in fact led to a bad outcome—affect assessments by various decision makers, including juries.²¹⁷ Thus, the fact that a medical malpractice plaintiff suffered harm may make juries more inclined to find a breach of the standard of care. However, to the extent that juries rely on evidence of medical custom to determine the question, hindsight bias may play a smaller role.²¹⁸

Despite these potential difficulties, there are reasons for optimism concerning jury performance. For one thing, juries may tend to perform better in assessing liability than their members would individually. Although group deliberation probably will not eliminate the effects of hindsight bias,²¹⁹ deliberation should improve juries’ ability to process complex information, to the extent that jurors with better understanding take “leadership roles” in the deliberations.²²⁰

Moreover, studies of jury performance find a degree of correlation between case strength and liability determinations.²²¹ Frank Sloan,

215. *See id.* at 766-72.

216. *See id.* at 756-60.

217. *See* Jeffrey J. Rachlinski, *A Positive Psychological Theory of Judging in Hindsight*, 65 U. Chi. L. Rev. 571, 587-88 (1998).

218. *See id.* at 574, 612. Rachlinski notes that the comparative negligence doctrine may reduce the extent to which juror hindsight bias favors plaintiffs, because the bias may also make jurors more likely to find the plaintiff partially responsible for the poor outcome. *See id.* at 594-95. However, malpractice cases may be less likely than other types of personal injury tort suits to support a comparative negligence defense, because in many malpractice cases the patient played a passive role in the treatment. Thus, to the extent that viable comparative negligence arguments are less frequently available to medical malpractice defendants than to other tort defendants, the hindsight bias may have a somewhat stronger systematic effect than it otherwise would.

219. *See id.* at 595.

220. Cecil et al., *supra* note 214, at 753 (citation omitted).

221. By contrast, at least one study suggests that parties’ *settlement* decisions may fail to reflect actual liability. In a follow-up to the Harvard study of New York hospitals, researchers examined fifty-one malpractice claims. *See* Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical-*

Penny Githens, and Gerald Hickson presented data on reviewing physicians' views of thirty-seven malpractice cases that went to a jury verdict.²²² Researchers had provided information on the claims to panels of physician reviewers, and asked the reviewers to assess negligence and causation.²²³ In the twenty-four cases that went to verdict and ended with a plaintiff recovering damages,²²⁴ the physician reviewers were twice as likely to have found the defendants "liable" as they were to have found them "not liable."²²⁵ Conversely, in the thirteen cases which went to verdict and ended with no damages recovery by the plaintiff, the reviewers were twice as likely to have found the defendants "not liable" as they were to have found them "liable."²²⁶

Henry Farber and Michelle White studied hospital records concerning claims made against a particular hospital or its staff with respect to incidents that occurred between 1976 and 1989.²²⁷ The hospital records included evaluations of the quality of care, which were protected from discovery and which the hospital used to make decisions about litigation.²²⁸ The evaluations were performed by internal staff in many cases, but the hospital also sought outside

Malpractice Litigation, 335 New Eng. J. Med. 1963, 1963 (1996). Forty-six of the claims were closed by the end of 1995; of these claims, only one went to a jury trial. *See id.* at 1964. Interestingly, although Brennan et al. had identified that case as involving an adverse event due to negligence, the jury found for the defendant. *See id.* at 1964-65. Of the other forty-five claims, twenty-four closed without payment and twenty-one settled with a payment by the defense. *See id.* at 1964. The researchers found that "neither the presence of an adverse event nor that of an adverse event due to negligence was associated with the outcome of the litigation"; rather, the reviewers' rating of the plaintiff's degree of disability "was the only significant predictor of payment." *Id.* at 1965.

Of course, this study tells us nothing about jury behavior, beyond the fact that in the one case that went to a jury, the jury found for the defendant despite evidence of negligence. It does provide some evidence of the defense's *expectations* of what a jury would do, because the defense's expectation of the risk of losing at trial will inform the decision to settle. However, the defense's willingness to pay to settle a case will also reflect the defense's projected cost of litigating a case to verdict, even if the defense expects to win at trial. In this regard, it is suggestive that in eight of the twenty-one cases where the plaintiff obtained a settlement, the settlement was less than \$25,000—and as the authors note, "discussions with insurers indicated that settlements of less than \$25,000 were nuisance settlements—settlements of claims thought to be without merit that could be resolved with a relatively small payment." *Id.* at 1967.

222. *See* Frank A. Sloan et al., *The Dispute Resolution Process*, in *Suing for Medical Malpractice* 153-86 (Frank A. Sloan et al. eds., 1993).

223. *See id.* at 166.

224. Some of these recoveries apparently occurred by means of a post-verdict settlement. *See id.*

225. *See id.* at 166-68; Neil Vidmar, *The Performance of the American Civil Jury: An Empirical Perspective*, 40 *Ariz. L. Rev.* 849, 859 (1998).

226. *See* Sloan et al., *supra* note 222, at 166-68; Vidmar, *supra* note 225, at 859.

227. Farber & White, *Dispute Resolution*, *supra* note 180, at 786. Their review was limited to claims "that were resolved by mid-1993." *Id.*

228. *See id.* at 787.

evaluations of claims that proceeded to litigation.²²⁹ Cases were coded either "bad" (where raters perceived clear negligence), "good" (where raters perceived clear absence of negligence), or "ambiguous" (where ratings were ambiguous or inconsistent).²³⁰ By comparing jury verdicts with the hospital's internal ratings, Farber and White determined that the jury found for the defendant in all the cases that the hospital had rated as having "good" care, that the jury found for the plaintiff in two of the four cases that the hospital had identified as involving "bad" care, and that the jury found for the plaintiff in one of the four lawsuits for which the hospital's rating was "ambiguous."²³¹

Bryan Liang provided summaries of the facts of twelve actual cases to academic anesthesiologists and asked them to rate whether or not the defendant was negligent.²³² He found that the physicians' evaluations accorded with the juries' actual verdicts only fifty-six to fifty-eight percent of the time, and that in five of the twelve cases there was "significant" disagreement between the anesthesiologists and the jury.²³³ Notably, however, in four of those five cases the disagreement arose because physicians tended to find negligence and the jury had not.²³⁴

Taken together, these findings suggest a fair degree of correlation between jury determinations of liability and independent evaluations of case strength. They also illustrate that in the cases where physician reviewers and juries disagree, it is not always because the juries find liability where the reviewers do not; often, the converse is true. Critics, however, focus not only on liability determinations but also on damage awards; they argue that jury awards are unpredictable and that, while some awards may fall within reasonable ranges, others are inordinately high.

As an initial matter, it is worth noting that group deliberations will affect a jury's ultimate award. When David Schkade, Cass Sunstein and Daniel Kahneman performed a study of punitive damages awards using six-person mock juries, they found that the jury awards were both higher and more variable than the pre-deliberation amounts that

229. *See id.*

230. *Id.*

231. *Id.* at 802. The figures provided by Farber and White are slightly confusing. They state that plaintiffs won four of the twenty-six cases that went to verdict. *See id.* They then specify that plaintiffs won none of the thirteen lawsuits in which care was rated "good," and that plaintiffs won "two of the four lawsuits with bad care and one of the four lawsuits with ambiguous care." *Id.* These more specific figures, however, seem to account for only three of the four plaintiff wins and twenty-one of the twenty-six verdicts cited by the authors.

232. *See* Bryan A. Liang, *Assessing Medical Malpractice Jury Verdicts: A Case Study of an Anesthesiology Department*, 7 Cornell J.L. & Pub. Pol'y 121, 125-27 (1997).

233. *Id.* at 129.

234. *See id.* at 129, 158-60 tbls. 2A-2F.

individual mock jurors would have awarded.²³⁵ Shari Seidman Diamond, Michael Saks and Stephan Landsman used six-person mock juries to examine the effects of deliberation on damages awards for economic loss and for pain and suffering. This study, like the Schkade study, found that mean jury awards tended to be higher than the mean award that the individual jurors would have awarded absent deliberation.²³⁶ However, Diamond et al. found that “[a]s a percentage of mean award . . . jury variability was lower than juror variability for both types of damage awards.”²³⁷ At any rate, larger juries should tend to reach less variable results than smaller juries.²³⁸

In general, studies indicate that appropriate factors such as the severity of the plaintiffs’ injuries explain a considerable portion of the variation in jury awards.²³⁹ However, significant variability may remain, particularly with respect to noneconomic damages.²⁴⁰ To the extent that the variation in awards remains unexplained by legitimate factors, problems other than jury incompetence or irresponsibility may be to blame. In many jurisdictions, juries are not permitted to pose questions to witnesses or to take notes.²⁴¹ Jury instructions sometimes are phrased in confusing language. Defendants’ lawyers may compound the problem by deciding not to put in evidence concerning damages, for fear of appearing to concede liability.²⁴² The

235. See David A. Schkade et al., *Deliberating About Dollars: The Severity Shift, in Punitive Damages: How Juries Decide* 43-44 (Cass R. Sunstein et al. eds., 2002).

236. See Shari Seidman Diamond et al., *Juror Judgments About Liability and Damages: Sources of Variability and Ways to Increase Consistency*, 48 DePaul L. Rev. 301, 316 (1998). On the other hand, another recent experimental study compared awards by six and twelve-person juries with awards by individuals, and found that the mean award by individuals was greater than the mean award by juries (though the difference was only weakly significant). See James H. Davis et al., *Effects of Group Size and Procedural Influence on Consensus Judgments of Quantity: The Examples of Damage Award and Mock Civil Juries*, 73 J. Personality & Soc. Psychol. 703, 714 (1997). The same study found that the mean twelve-person jury award was smaller than the mean six-person jury award. See *id.* at 713.

237. Diamond et al., *supra* note 236, at 317.

238. See Vidmar, *supra* note 225, at 897.

239. See, e.g., Frank A. Sloan & Chee Ruey Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?*, 24 Law & Soc’y Rev. 997, 1019, 1025 (1990).

240. In their jury experiment, Diamond, Saks and Landsman found that the amounts juries awarded for pain and suffering were about twice as variable as the juries’ awards for economic damages. See Diamond et al., *supra* note 236, at 317. Likewise, in a study of actual jury verdicts in personal injury cases in Florida and Kansas City during 1973-1987, Randall Bovbjerg, Frank Sloan, and James Blumstein found that awards of noneconomic damages were more variable than total awards. See Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling “Pain and Suffering,”* 83 Nw. U. L. Rev. 908, 937 tbl. 3 (1989).

241. Though each of these practices has potential drawbacks, each might help to improve jurors’ understanding and retention of relevant evidence. See Cecil et al., *supra* note 214, at 768-69.

242. See Vidmar, *supra* note 178, at 197-98, 247. One treatise designed for use by medical malpractice defense lawyers advises defense lawyers to put in evidence on

result is that juries may be given little direction on noneconomic damages.

C. *Procedural Reforms that Reflect Physicians' Concerns*

States have implemented a number of procedural reforms in response to the asserted crisis in malpractice litigation. I focus here on three reforms that connect with the physician critiques identified in Part I. I first discuss states' use of medical screening panels to provide pretrial opinions on malpractice claims. Panel proposals can be seen to reflect both physicians' suspicion of malpractice determinations by lay jurors and some physicians' preference for informal, nonjudicial resolution of malpractice claims.²⁴³ Next, I discuss proposals for special medical liability courts. Proposals for specialized courts arise from the perceived need for expertise in adjudicating malpractice claims, and in particular in setting the standard of care. I then examine a novel remittitur standard, recently adopted in Pennsylvania, that requires the judge, in considering a defendant's assertion that damages are excessive, to take into account the anticipated effect of the damages award on access to health care in the community. Finally, I review briefly some indications that the medical community itself is resorting to certain kinds of "self-help" in combating perceived problems with medical liability litigation.

1. Medical Screening Panels

At first glance, medical screening panels might seem a promising way to address some physician concerns about the way in which the legal system handles malpractice claims.²⁴⁴ Indeed, as discussed in

damages; the authors state that "[p]ost-verdict interviews . . . with jurors who heard a full damages defense presented by economic experts called by the defense . . . revealed that jurors rarely felt that the defense was conceding liability by offering an alternative damages presentation." Miles J. Zaremski & Frank D. Heckman, *Reengineering Healthcare Liability Litigation* 287 (1997).

243. As noted, support for medical screening panels arises partly from criticism of the performance of lay judges and juries in handling medical questions. In this respect, the panel proposals somewhat resemble proposals to send complex scientific questions to a "science court" composed partly or wholly of scientists. See Brennan, *supra* note 11, at 10-19 (reviewing proposals for, and examples of, "science courts" and "science panels"); see also James A. Martin, *The Proposed "Science Court,"* 75 Mich. L. Rev. 1058, 1069 (1977) (advocating experimentation with a "science court" to aid "Congress or the Executive . . . in the determination of global policy issues").

244. Cf. Glen O. Robinson, *The Medical Malpractice Crisis of the 1970s: A Retrospective*, Law & Contemp. Probs., Spring 1986, at 5, 25 (discussing 1970s legislative initiatives to address medical malpractice, and stating that "[t]he goal in establishing . . . screening panels was to improve the quality of fault-finding by the system and thus both to discourage the bringing of questionable claims and to encourage the settlement of valid ones"). In addition, panels might be expected to address other problems of less interest to physicians but of concern to other commentators. Only a small portion of potential malpractice claims are ever asserted. Panels might address this underclaiming problem by encouraging the assertion of

Part I, some medico-legal writers in the nineteenth century proposed the use of systems resembling such panels in malpractice cases and other cases involving medical issues.²⁴⁵ From the physician's perspective, a panel system might be useful to the extent that it encourages earlier, informal resolution of malpractice claims.²⁴⁶ Physicians who believe that most malpractice claims are meritless might hope that a negative panel determination would encourage the early withdrawal of the claim. Physicians might also be reassured by the fact that if the case proceeded to trial, the jury would hear not only the opinions of the parties' experts, but also the views of the medical screening panel.²⁴⁷

claims. Similarly, to the extent that some patients simply want to find out what went wrong, panels might provide a relatively low-cost venue for acquiring such information.

245. See *supra* text accompanying notes 120-25. Stakeholders in a number of states that adopted screening panel provisions have held positive views of them. For example, a mid-1980s study of interest groups in Indiana found that a physician group, the state bar association, and the state department of insurance "agreed that the panel process had decreased the number of claims that go to trial." U.S. Gen. Accounting Office, *Medical Malpractice: Case Study on Indiana* 12 (1986). The state medical association also believed that the panel system "decreases the time required to close claims," and a large insurance company "attributed its much lower legal costs to defend claims in Indiana to the panel process." *Id.* A similar survey of groups in Florida found varying assessments: An official of a trial lawyers' association recounted that plaintiffs' lawyers viewed the panels as biased (due to the presence of a physician on the panel) and thus that plaintiffs who lost before the panel tended to pursue the claim nonetheless. See U.S. Gen. Accounting Office, *Medical Malpractice: Case Study on Florida* 11-12 (1986). On the other hand, a physician group, a hospital association, a defense lawyers' association, and the state insurance department "strongly supported" reinstatement of panels. As one insurance company executive argued, "Our tort system cannot supply a jury that is truly comprised of the defendant's peers." *Id.* at 35. In New York, by contrast, the state bar association, a trial lawyers' association, and a hospital underwriters' association all opined that panels led to undesirable delay. See U.S. Gen. Accounting Office, *Medical Malpractice: Case Study on New York* 20 (1986).

246. See, e.g., James W. Hughes, *The Effect of Medical Malpractice Reform Laws on Claim Disposition*, 9 *Int'l Rev. L. & Econ.* 57, 65 (1989) (arguing that a screening panel's "impartial opinion should greatly improve the parties' information of the expected value of the claim, increasing the probability of a claim being settled"). In this respect, a screening panel might perform a function analogous to "early neutral evaluation." See, e.g., Thomas B. Metzloff, *Alternative Dispute Resolution Strategies in Medical Malpractice*, 9 *Alaska L. Rev.* 429, 453 (1992) (noting that Alaska's screening panel system is "akin to an early neutral evaluation process"); *id.* at 442 (stating that the goal of early neutral evaluation is "that the parties will benefit by the evaluator's neutral assessment of the value of the case and therefore reconsider their positions"). Some data suggest, however, that some physicians may wish to go to trial rather than settle, in order to attempt to clear their professional reputations. See Samuel R. Gross & Kent D. Syverud, *Don't Try: Civil Jury Verdicts in a System Geared to Settlement*, 44 *UCLA L. Rev.* 1, 58 (1996) (arguing that "the high rate of zero offers in medical malpractice cases is best explained by the desire of physicians for vindication at trial").

247. Cf. Deborah R. Hensler, *Science in the Court: Is There a Role for Alternative Dispute Resolution?*, *Law & Contemp. Probs.*, Summer 1991, at 171, 193 (noting that "some ADR procedures, particularly early neutral evaluation, expert panels, and

The available data²⁴⁸ suggest, however, that panels are not a good option for providing expertise to the jury at trial. Panels may encourage the pretrial resolution of claims, but there is no way to assess whether this result is an improvement from a public policy standpoint without knowing whether the resolved claims would have been brought if panel proceedings had not been available and whether claims that were dropped due to the panel system lacked merit.

In all, some thirty-one states adopted screening panels of some sort.²⁴⁹ Only twenty of those states still have panel systems; in the others, panel provisions were repealed and/or invalidated.²⁵⁰ The

medical malpractice screening panels, may offer opportunities for expanding the role of neutral experts in the litigation process”).

248. It should be noted that the evidence on panel performance provides only limited guidance for current policymaking. Of the available multistate studies that looked at panel performance, one analyzes data concerning 1992; four other studies analyze data that extends into the mid-1980s; and the rest use data from the 1970s. These studies may be of limited predictive value to the extent that malpractice litigation has changed in recent years. Cf. William M. Sage, *Understanding the First Malpractice Crisis of the 21st Century*, in *Health Law Handbook* 1, 2 (Alice G. Gosfield ed., 2003) (noting that “[t]he current crisis is not simply a reprise of events in the 1970s or 1980s”). Moreover, some studies may not have captured the longer-term effects of panel systems: Because the first wave of panel system adoptions occurred in the mid-1970s, data from the 1970s only gives a sense of panels’ short-term effects. Finally, some studies’ results may have been blurred by the fact that researchers aggregated differing panel systems into one or only a few categories: Aggregating different systems into one variable (panel versus no panel), or even into a couple of variables (panel versus no panel, mandatory versus voluntary panels, admissible versus non-admissible panel findings), means that panel systems which produce particularly strong effects may be balanced out by panel systems with weaker systematic effects, such that the overall impact of panels looks weaker than it may, in fact, be in some states.

249. Alaska, Arizona, Connecticut, Delaware, Florida, Hawaii, Idaho, Illinois, Indiana, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Utah, Virginia, Wisconsin, and Wyoming adopted panel provisions, but (as noted below) not all these states still have them. See *infra* note 250 and accompanying text.

250. Panel provisions have been repealed in Arizona, Nevada, New Jersey, New York, North Dakota, Rhode Island, and Tennessee. Illinois instituted two different panel systems, and repealed them both; however, to list Illinois as a repeal state might be viewed as double-counting, because both provisions were judicially invalidated prior to their repeal. Likewise, Florida repealed a panel provision in 1983, but the repeal followed the judicial invalidation of that provision in 1980. (Subsequent to the 1983 repeal, Florida adopted new provisions permitting procedures that have some aspects of a medical screening panel.)

Panel provisions have been invalidated in Florida, Illinois, Missouri, Pennsylvania, and Wyoming. See *Aldana v. Holub*, 381 So. 2d 231, 238 (Fla. 1980) (invalidating panel system because, as implemented, it deprived doctors of their right to mediation because proceedings in many cases did not conclude within the statutory deadline, and because extending that deadline would deprive malpractice plaintiffs of their right of access to the courts); *Wright v. Cent. Du Page Hosp. Ass’n*, 347 N.E.2d 736, 739 (Ill. 1976) (striking down panel provision because it mixed lay and judicial functions in violation of state constitution); *Bernier v. Burris*, 497 N.E.2d 763 (Ill. 1986) (striking down subsequent panel provision on similar grounds); Cardinal

basic concept is to provide panels, composed partly or wholly of physicians, to opine on the merits of malpractice claims.²⁵¹ Some panel systems are mandatory, while others are voluntary.²⁵² Some screen claims prior to the filing of the complaint, while others screen claims after filing.²⁵³ Panels typically have from three to seven members, and panel composition varies: Some panels include only physicians, while others include lawyers, judges, and/or laypeople.²⁵⁴ There also are variations in the amount of discovery permitted, the types of evidence allowed, the extent of the panel proceedings, and the scope of the panel findings (liability only, or liability and damages).²⁵⁵ Some systems provide that the panel findings are admissible at a later trial, and some permit the panel members to be called as witnesses.²⁵⁶ Finally, some systems attempt to discourage the party who loses before the panel from proceeding further, by providing for the imposition of costs or other fees.²⁵⁷

The existing studies are less useful than they might be because they did not look directly at whether panel systems increase the accuracy of adjudication.²⁵⁸ Rather, these studies focused mostly on panels' effect on the frequency and/or severity of malpractice claims, or on their effect on malpractice premiums. From a public policy standpoint, increases in frequency and severity of claims could be a good thing—if the additional claims are valid—or a bad thing—if the additional claims lack merit. Similarly, a decrease in malpractice premiums is desirable, but not if it is achieved by preventing plaintiffs from recovering on valid claims.

Some data suggest that the presence of a panel mechanism may actually increase claim frequency.²⁵⁹ This presumably was not the

Glennon Mem'l Hosp. v. Gaertner, 583 S.W.2d 107, 110 (Mo. 1979) (holding that panel provision violated state constitutional right of access to courts); *Mattos v. Thompson*, 421 A.2d 190, 196 (Pa. 1980) (invalidating panel system because, as implemented, it resulted in such delays as to violate state constitutional right to a jury trial); *Hoem v. State*, 756 P.2d 780 (Wyo. 1988) (holding that panel provision violated state constitutional guarantee of equal protection).

251. See Jean A. Macchiaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills*, 58 Geo. Wash. L. Rev. 181, 186 (1990).

252. See *id.* at 188-89.

253. See *id.* at 189.

254. See *id.* at 189-90.

255. See *id.* at 190-91.

256. See *id.* at 193-94.

257. See *id.* at 194-96.

258. Admittedly, it is difficult to measure the accuracy of litigation results.

259. Researchers at the National Center for State Courts examined state court data on the frequency of medical malpractice claim dispositions in twenty-one states during 1992, and found that states with mandatory panels had a significantly greater rate of litigation. See Roger Hanson et al., *What is the Role of State Doctrine in Understanding Tort Litigation?*, 1 Mich. L. & Pol'y Rev. 43, 65-71 (1996). Because Hanson et al. focused only on litigation resolved in 1992, and did not examine changes over time, their results leave open the possibility that the causal link might run the other way—i.e., that states with higher litigation rates might have been more likely to

intent of physicians who supported the adoption of panels. However, these data imply that at least some panel systems might provide a less costly alternative to litigation for claimants with smaller claims and for those who simply want to know more about the cause of their injury.²⁶⁰

However, even if panels encourage claiming by some plaintiffs, panels' costs in time and money may discourage claiming by others. In many instances, the parties will need to conduct discovery in order to gather the evidence necessary for a comprehensive panel presentation.²⁶¹ Panels often will need to hold live hearings in order to reach an accurate assessment.²⁶² In jurisdictions where the panel's findings are admissible at trial, the parties will likely feel the need to engage in exhaustive discovery and a plenary presentation²⁶³—which will “entail the costs and delay that panels are intended to prevent.”²⁶⁴

adopt mandatory panel systems. Nonetheless, their finding is suggestive.

Shmanske and Stevens studied Arizona's panel system, using insurance claim file data from 1972-1979. See Stephen Shmanske & Tina Stevens, *The Performance of Medical Malpractice Review Panels*, 11 J. Health Pol., Pol'y & L. 525, 527 (1986). The 1972-1979 time period provided baseline data, because Arizona adopted its panel system in 1976. See *id.* at 528. Shmanske and Stevens looked only at claims files closed within two years after they were opened, and excluded claims for which the file was opened in a year other than that in which the incident occurred. See *id.* They found that the yearly rate of claim files opened per doctor was significantly higher after the start of the panel system than before. See *id.* at 529-33. They theorized that the increase they observed in claim frequency was due to the fact that panels “lower the expected cost to plaintiffs of acquiring information about the outcome of their lawsuits.” *Id.* at 533.

260. For some claims that are resolved at or soon after the panel stage, the plaintiff's litigation costs may be relatively low. This would be particularly true if the plaintiff does not present an expert witness during the panel proceeding, and relies instead on the panel's expertise. Moreover, some plaintiffs might hope that if they succeed in front of the panel, they could call one or more panelists to testify at trial, instead of retaining an expensive expert witness. Thus, a claimant whose primary motive is to find a cause for an injury may take advantage of the panel procedure, perhaps pro se, in order to obtain an expert assessment of what went wrong. In addition, for some claims that would otherwise be too small to justify the cost of litigation, panels might encourage claiming by providing patients with a lower-cost way to evaluate the strength of claims, see Frank A. Sloan, *State Responses to the Malpractice Insurance “Crisis” of the 1970s: An Empirical Assessment*, 9 J. Health Pol., Pol'y & L. 629, 636 (1985), and—in the event of a positive panel assessment—with a low-cost expert witness for trial, see Patricia M. Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, Law & Contemp. Probs., Spring 1986, at 57, 72.

261. Restrictions on pre-panel discovery would be particularly unfair to plaintiffs, because plaintiffs are less likely than defendants to have informal access to information concerning liability.

262. In one survey of judge, physician, and attorney panelists in Arizona, a large majority of all three types of panelists stated that they could not have reached their findings without such a hearing. See Dale Ann Howard, *An Evaluation of Medical Liability Review Panels in Arizona*, St. Ct. J., Spring 1981, at 19, 24.

263. See Sloan, *supra* note 260, at 636.

264. Patricia M. Danzon, *Medical Malpractice: Theory, Evidence, and Public Policy* 199 (1985). For example, a 1981 study of panels in Arizona asked attorneys to

Though some of the costs of panel proceedings may be discovery-related, a substantial portion of the costs are likely to represent attorney time and expert witness fees. A plaintiff who must go through a panel proceeding in order to litigate her claims will, in effect, face the prospect of having to "try her case twice."²⁶⁵

Panels may also lower plaintiffs' expected returns by delaying the resolution of claims.²⁶⁶ Although one study found that the existence of a panel system was associated with a roughly one-year reduction in time from filing to claim resolution,²⁶⁷ some states have had severe problems with delay.²⁶⁸

To the extent that panels make claiming more costly, panels may discourage plaintiffs from initiating claims and may increase the probability that plaintiffs who have asserted claims will drop them without a settlement.²⁶⁹ This dynamic may explain the results of a

estimate the additional expense attributable to panel hearings; the mean cost (counting time and out-of-pocket expenses) reported by survey respondents was between \$3,000 and \$4,000. See Howard, *supra* note 262, at 24. The cost of such a proceeding will only have increased since 1981.

265. Frank M. McClellan, *Medical Malpractice: Law, Tactics and Ethics* 90 (1994).

266. The impact of this effect will vary depending on factors such as the availability of prejudgment interest. See Robinson, *supra* note 244, at 29 ("[T]he availability of prejudgment interest in a growing number of states partially offsets the cost to claimants, and, even where such interest is not authorized explicitly, juries apparently make an implicit allowance for it in setting general damages." (citation omitted)).

267. See Frank A. Sloan et al., *Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis*, 14 *J. Health Pol., Pol'y & L.* 663, 677 (1989).

268. For example, the Pennsylvania panel system was eventually held unconstitutional, in *Mattos v. Thompson*, 421 A.2d 190, 196 (Pa. 1980), based on a finding that the system caused such delay that it impermissibly burdened the state constitutional right to a jury trial. Arizona, Indiana, Rhode Island, and New York also experienced problems with panel delay. See Howard, *supra* note 262, at 21-22; James D. Kemper et al., *Reform Revisited: A Review of the Indiana Medical Malpractice Act Ten Years Later*, 19 *Ind. L. Rev.* 1129, 1133 (1986); Shmanske & Stevens, *supra* note 259, at 533; Betsy A. Rosen, Note, *The 1985 Medical Malpractice Reform Act: The New York State Legislature Responds to the Medical Malpractice Crisis with a Prescription For Comprehensive Reform*, 52 *Brook. L. Rev.* 135, 162 (1986).

269. The panel assessment may facilitate settlement in some instances, by bringing the parties' valuations of the case closer together. See Hughes, *supra* note 246, at 65; Metzloff, *supra* note 246, at 442, 453. Some defense attorneys have stated that a panel's finding of liability can help to persuade the physician defendant to consent to settlement, which is a requirement in some insurance policies. See Barbara F. Klein, Comment, *A Practical Assessment of Arizona's Medical Malpractice Screening System*, 1984 *Ariz. St. L.J.* 335, 348. On the other hand, panels may sometimes delay settlement talks because parties may be inclined to hold off on serious settlement discussions until they obtain the panel's assessment of the case. For example, in a 1990 survey of eighty-eight malpractice plaintiffs' and defendants' attorneys in Arizona, Jona Goldschmidt found that thirty-five percent of the respondents "agreed or strongly agreed" with the statement that "there is no reason to enter into meaningful settlement negotiations until a panel finding is made." Jona Goldschmidt, *Where Have All the Panels Gone? A History of the Arizona Medical Liability Review Panel*, 23 *Ariz. St. L.J.* 1013, 1054-57 (1991).

study of insurance company data which found that the presence of a panel system "significantly increased the probability" that the plaintiff would drop the claim.²⁷⁰ In that study, panels were also associated with a decrease in the probability that claims would settle; combining the probabilities of the claim being dropped *or* settled produced an increased probability of pretrial resolution.²⁷¹

Some might argue that to the extent panels encourage plaintiffs to drop claims, panels are beneficial. However, that would be true only if the claims that are dropped lack merit.²⁷² Plaintiffs who drop claims because of expense and delay may be doing so only because the size of the claim is insufficient to justify the expense. Moreover, even if panel findings help to eliminate weaker claims, as proponents suggest, it is hard to tell whether panels provide an overall benefit without knowing whether the plaintiffs would have brought those claims if the panel procedure had not been available: If panels encourage an increase in claiming, if a portion of the additional claims are weak, and if the panel findings then discourage the pursuit of those weak claims, it would seem that little benefit arises from the panels in this respect.²⁷³

In general, panels seem ill-designed to provide expertise to the jury. Making the panel's findings admissible in later proceedings will tend to increase the cost and length of panel proceedings. The prospect of being called to testify may make physicians even less eager to serve on panels, which could increase the already pronounced difficulties of finding panelists.²⁷⁴ Ironically, a requirement that panel physicians must testify in court would be reminiscent of the coerced and undercompensated testimony that nineteenth century physicians so resented.

Nor do the benefits of panel findings outweigh these costs. As noted above, some nine-tenths of malpractice suits are resolved prior to trial;²⁷⁵ it would be inefficient to require all claims to go before a

270. Hughes, *supra* note 246, at 75.

271. *See id.* at 75-77.

272. *Cf.* Goldschmidt, *supra* note 269, at 1109 ("Claims exclusion should not be the measure of 'efficiency.'").

273. A 1980 study cited figures indicating that plaintiffs who lost before panels were less likely to proceed with their claims than plaintiffs who won before panels; the study asserted that these data "may indicate . . . that screening panels are effectively weeding out a number of unjustified claims." Peter E. Carlin, *Medical Malpractice Pre-Trial Screening Panels: A Review of the Evidence* 30 (1980). However, as Thomas Metzloff has pointed out, "Absent comparative insight into whether these claims would in fact have been asserted in court in the absence of a panel procedure, the conclusions drawn are questionable." Metzloff, *supra* note 183, at 215.

274. *See* Carlin, *supra* note 273, at 32-33 (discussing difficulties several state systems encountered in obtaining panelists, and noting statements by some New Jersey officials that the possibility of being called to testify at trial "deters many doctors from participating as panelists").

275. *See supra* text accompanying note 177.

panel in order to provide opinions in the one-tenth of claims that eventually will reach a jury. In addition, not all cases that reach trial will need a neutral expert's opinion; in some cases, the issues will be relatively straightforward and the jury will be capable of sorting through the testimony of the parties' experts.

In the small subset of cases where a neutral expert opinion could be useful, it is questionable whether screening panels provide the best source of such opinions. Medical screening panels—as this Article defines them and as they are commonly understood—include at least one physician, presumably in order to bring medical expertise to bear on the issues. It is not obvious, however, that the presence of doctors on the review panels will improve the panels' accuracy. As many nineteenth century medico-legal writers commented, not all good physicians make good experts; many medical questions that arise in litigation may require expertise that a generalist practitioner does not possess.

Admittedly, doctors will understand basic medical concepts more readily than most lawyers, judges, or laypeople. On the other hand, to the extent that the duty of care is set according to medical custom, doctors may not have as much of a comparative advantage as one would at first assume, because few practicing physicians will have more than an anecdotal sense of the practices of other doctors.²⁷⁶ More generally, studies in other contexts have raised questions concerning the degree to which multiple physicians are likely to agree on the quality of care in a given case. A researcher who reviewed twelve studies that provided data on the inter-rater reliability of physicians' assessments of quality of care found that “[o]nly two of the 12 studies had indexes of chance-corrected agreement that were consistently above .40, the minimum value for agreement that is better than poor.”²⁷⁷

There is some question, as well, concerning doctors' willingness to find other doctors liable; discussing a survey of New York physicians, Weiler et al. “found marked variation among physicians in their willingness to label certain kinds of medical outcomes as iatrogenic, and an even more pronounced reluctance to label as negligent those treatment decisions that, *ex post* at least, were clearly erroneous.”²⁷⁸ In the twenty-first century, as in the nineteenth, physicians may be reluctant to hold their colleagues liable for errors in judgment that do not rise to the level of gross neglect.²⁷⁹

276. See Cramm et al., *supra* note 190, at 710-12.

277. Ronald L. Goldman, *The Reliability of Peer Assessments of Quality of Care*, 267 JAMA 958, 958 (1992) (citations omitted).

278. Weiler et al., *supra* note 172, at 125.

279. Although Liang found that the anesthesiologists in his study had “a significant propensity . . . to be extremely critical of the defendant anesthesiologists in the cases” they reviewed, he noted that this may have been because academic physicians are

Medical screening panels reflect a paradoxical view of malpractice cases: On one hand, proponents believe such cases are so complex that better medical expertise is needed; on the other, proponents assert that with proper encouragement, the parties can assess their contentions and resolve the claims early in the process. Those contradictory views give rise to the conflicting goals of providing an accurate expert assessment for trial and resolving cases quickly and cheaply prior to trial. These incompatible goals may help to explain why panels have met with little success.²⁸⁰

2. Specialized Courts

A different scheme for increasing decision maker expertise involves the creation of a specialized medical liability court. One well-publicized current proposal²⁸¹ for such a court comes from Common Good, an organization that describes itself as “a bipartisan initiative to overhaul America’s lawsuit culture.”²⁸² Common Good’s assessment of today’s medical malpractice environment resembles the complaints physicians made in the nineteenth century:

Justice today resembles a free-for-all. The lottery-like litigation system, with lawyers taking over half the money, leaves some victims without compensation at the same time that it provides huge rewards for a few, often irrespective of fault. The random quality to modern justice infects daily relations in healthcare with debilitating distrust.²⁸³

Common Good’s proposal for specialized courts arises from the organization’s position that “expert judges” should create precedents concerning the standard of care.²⁸⁴ Philip Howard, the most prominent advocate of Common Good’s specialized courts proposal, argues that questions of standard of care should be viewed as questions of law to be decided by the judge.²⁸⁵ Howard asserts that

more willing to remark upon perceived flaws in other physicians’ performance. Liang, *supra* note 232, at 135.

280. See Thomas B. Metzloff, *The Unrealized Potential of Malpractice Arbitration*, 31 Wake Forest L. Rev. 203, 217 (1996) (“The conventional wisdom is that these panels, which looked something like arbitration panels, were ineffective in impacting the culture or reality of malpractice litigation; indeed, several states have recently abandoned their programs.” (citation omitted)).

281. See Stuart Taylor, Jr. & Evan Thomas, *Civil Wars*, Newsweek, Dec. 15, 2003, at 43, 51 (discussing the proposal).

282. Common Good, *Common Good: Why We Have Come Together*, at <http://cgood.org/about/> (last visited Jan. 20, 2004).

283. Common Good, *Common Good Petition: America Needs a New System of Medical Justice: Current Proposals are Not Enough*, at http://cgood.org/medicine/item?item_id=19297 (last visited Jan. 20, 2004).

284. Philip K. Howard, Op-Ed, *The Best Course of Treatment*, N.Y. Times, July 21, 2003, at A15.

285. See *id.* (“A reliable system of medical justice could take many forms, but because the critical issue in virtually all cases is whether the doctor complied with

judicial rulings on the standard of care would create a body of precedent on which doctors could rely in making medical judgments.²⁸⁶

This proposal recalls the writings of some nineteenth century medico-legal authors. John Elwell's 1860 treatise explicitly drew a comparison between legal precedent and good medical practice:

What is well and clearly settled, either by the courts or by statute, must be known and applied by the attorney, for it is only where there may be a reasonable ground of difference of opinion, that he is excusable for errors of judgment; so with the physician—he must know what is well settled in his profession—for he will be held responsible, if he fails to apply, in a particular case, what is settled in the profession, as being applicable to the case.²⁸⁷

To this end, Elwell spent a number of pages setting forth standards of care that he believed were “settled.” For example, his third chapter detailed “What Definite Knowledge is Possible and Essential for the Physician and Surgeon.”²⁸⁸ Elwell did not, however, claim to be describing standards that would last for decades; rather, he stressed that physicians must keep abreast of improvements in medical knowledge: “A medical man can not, with any safety or propriety, practice, year after year, without keeping himself informed as to the improvements of his science, especially if he practice surgery, involving amputations, from which so many law suits result, and which are so fatal to the patient.”²⁸⁹

As Elwell recognized, the standards of medical care change with each advance in medical knowledge and technology; and even if the standards were static, their application could vary depending on the facts of each case.²⁹⁰ Thus, under the current substantive law of medical malpractice—which requires determinations of the standard of care, breach, causation, and damages—a set of precedents on the standard of care might not provide much lasting help.

However, it is certainly true that if judges were tasked with setting “precedents” on the standard of care, then there would be a need for expertise and consistency in their decisions. Even under the current system, judges need some kinds of expertise in order successfully to perform a number of tasks—for example: managing the case, ruling

appropriate standards of care, the key element must be expert judges ruling on standards of care.”).

286. *See id.* (noting the “value [of] predictability” and the fact that “[j]uries can’t make consistent rulings of what is reasonable care and what is not”).

287. Elwell, *supra* note 24, at 36.

288. *Id.* at 48.

289. *Id.* at 56.

290. Foderé’s remark that legal medicine constantly presents new and unforeseen variations, *see* 1 Foderé, *supra* note 26, at vii (“Every day in legal medicine, as in clinical medicine, there arise countless variations and cases that could not have been foreseen.” (author’s translation)), continues to be true some two centuries later.

on the admissibility of expert testimony, overseeing the trial, and ruling on post-trial motions. Specialized courts might seem a good way to improve performance in these respects.

The possible advantages of a specialized medical liability court include expertise, decision making speed, and uniformity and coherence of doctrine. Not only might the judges initially be selected for their experience with medical liability cases, but once on the bench, the judges would have the incentive and opportunity to develop additional expertise in relevant areas.²⁹¹ Expert judges might be better equipped to evaluate the qualifications of expert witnesses.²⁹² Moreover, to the extent that judicial review of damages awards takes account of the amounts that have been awarded and upheld in similar prior cases, specialized judges might be well positioned to gain that comparative knowledge with respect to medical liability cases. Expertise might also help judges to manage cases more actively, with a view to resolving them more quickly. In addition, the exclusivity of the court's jurisdiction over medical liability cases would reduce the number of judges hearing those cases, and thus might tend to increase somewhat the consistency of decisions.

It should be recognized, though, that a specialized court carries potential risks as well as possible benefits. If a specialized court proposal is eventually implemented, it likely would be implemented at the state level, and the judges might well be elected rather than appointed. Such a court would run a considerable risk of becoming intensely politicized. Commentators have long pointed out that the more specialized a court is, the greater the incentives and opportunities for interest groups to seek to influence the court's decisions, both by lobbying to select judges who will favor the desired position and by exerting pressure on the court for its decisions.²⁹³

Although interest groups on both sides of the medical liability debate may seek to influence the selection of judges on a state's trial court of general jurisdiction, their incentives to do so are dampened by the fact that there are many such judges, each of whom will likely hear a relatively small portion of the total group of medical liability cases. Moreover, a judicial candidate for a court of general jurisdiction will be judged not only on her position on medical liability issues but also on her stance on many other questions. By contrast,

291. David P. Currie & Frank I. Goodman, *Judicial Review of Federal Administrative Action: Quest for the Optimum Forum*, 75 Colum. L. Rev. 1, 63 (1975); Rochelle C. Dreyfuss, *Forums of the Future: The Role of Specialized Courts in Resolving Business Disputes*, 61 Brook. L. Rev. 1, 16 (1995).

292. Gross, *supra* note 11, at 1181-82.

293. See Richard A. Posner, *Will the Federal Courts of Appeals Survive Until 1984? An Essay on Delegation and Specialization of the Judicial Function*, 56 S. Cal. L. Rev. 761, 783 (1983); Richard L. Revesz, *Specialized Courts and the Administrative Lawmaking System*, 138 U. Pa. L. Rev. 1111, 1149 (1990).

the incentives are likely to be quite different with respect to the judges of a specialized court—both because the number of judges is much smaller, and because the court’s jurisdiction extends only to medical liability issues. Also, unlike a field such as patent law, where a repeat player will likely be on different sides in different disputes,²⁹⁴ it is probable that a repeat player in the medical malpractice field will be habitually on one side or the other²⁹⁵—thereby increasing the player’s incentive to seek the selection of judges favorable to the player’s expected position.

Recent developments in judicial selection underscore the potential dangers of politicization.²⁹⁶ A report by the American Bar Association’s Commission on the 21st Century Judiciary notes that in a number of recent state judicial elections, campaigns have been politicized due to the involvement of “interest groups that formed to promote a specific political issue.”²⁹⁷ The ABA Commission focused its discussion of this trend on elections for state high courts; but the same concern would apply to a specialized lower court. Moreover, recent changes to the rules for judicial election campaigns seem likely to exacerbate the problem. In 2002, the U.S. Supreme Court held that a Minnesota provision “prohibiting candidates for judicial election from announcing their views on disputed legal and political issues violates the First Amendment.”²⁹⁸ As the ABA Commission noted, “the *White* case is likely to politicize judicial elections as never before.”²⁹⁹

The benefits and disadvantages of a specialized court will vary depending on its structure and the structure of the court system it supplements. It is possible that if a specialized court were staffed by appointed judges, the selection process might be somewhat less politicized. In many states, however, it may not be politically possible to provide for appointed rather than elected judges. In any event, an appointive system would not eliminate the risk of politicization.³⁰⁰

294. See Rochelle Cooper Dreyfuss, *The Federal Circuit: A Case Study in Specialized Courts*, 64 N.Y.U. L. Rev. 1, 29 (1989); cf. Rai, *supra* note 204, at 894 (advocating creation of “a specialized trial court” for patent cases “with lay judges who [have] basic training in the scientific method, and who [are] given sufficient resources to appoint experts liberally”).

295. Physicians and insurance companies will be repeat players on the defense side; plaintiffs’ lawyers will be repeat players on the plaintiff side.

296. See Geoffrey C. Hazard, Jr., *The Role of the Bar in Politicized Judicial Elections*, 39 Willamette L. Rev. 1349, 1351-52 (2003).

297. American Bar Association Commission on the 21st Century Judiciary, Report: Justice in Jeopardy 22 (2003) [hereinafter ABA Report].

298. Republican Party of Minn. v. White, 536 U.S. 765, 788 (2002).

299. ABA Report, *supra* note 297, at 90.

300. See Marvin Comisky & Philip C. Patterson, *The Judiciary—Selection, Compensation, Ethics, and Discipline* 6 (1987) (“Critics of executive appointment have pointed out that the typical chief executive is subject to political pressures based on partisan considerations, and is also apt to expect a *quid pro quo* from his appointees.”); *id.* at 5 (noting that criticisms of legislative appointment of judges

Thus, consideration should be given to alternative ways to increase judicial expertise. If trial judges are found to lack expertise in assessing the admissibility of expert testimony, judicial training sessions could provide them with basic knowledge concerning the scientific method, probabilistic evidence concerning causation, and other relevant topics. Moreover, even if specialized judges are desired, a specialized court is not the only way to provide them. A specialized medical malpractice division could be created within a trial court of general jurisdiction, and judges could rotate into and out of that division. This option could reduce the politicization and perspective-narrowing problems identified above, while providing an opportunity for judges to gain concentrated experience in malpractice cases. A specialized division, moreover, would not force litigants to travel large distances in order to litigate medical liability claims.

3. A Novel Approach to Remittitur

In 2002, Pennsylvania's legislature altered the remittitur standard in medical malpractice cases by requiring the trial court to "consider evidence of the [verdict's] impact, if any, upon availability or access to health care in the community."³⁰¹ The new statute provides no guidance to the court concerning the method by which to assess such impact.³⁰² A logical analysis of the provision suggests, however, that it has the potential to operate in dramatically unfair ways.

The traditional remittitur analysis directs the court to reduce a verdict if the verdict's size "shocks the conscience of the court."³⁰³ A more rigorous approach, discussed below in Part II.D.3., requires reduction of the verdict if it "deviates materially" from what would be "reasonable compensation."³⁰⁴ Each of these standards takes into account considerations such as the amount of money necessary to compensate the plaintiff for current and future damages. The Pennsylvania legislature's enactment of a statute requiring the court *also* to consider the verdict's effect on access to health care in the community suggests the expectation that such analysis will result in reduction where a more conventional standard would not.

include the observation "that legislators are too apt to be politically motivated in selecting for judicial candidates").

301. 40 Pa. Cons. Stat. Ann. § 1303.515(a) (West Supp. 2003).

302. Pennsylvania's Civil Procedural Rules Committee has proposed a new rule to implement the statute; the proposed rule specifies the procedure for making a motion under the statute, but does not discuss what factors should be considered in determining the motion. *See* Sup. Ct. of Pa., Civil Procedural Rules Comm., Proposed Recommendation No. 189 (2003).

303. *See, e.g.,* Irene Deaville Sann, *Remittiturs (and Additurs) in the Federal Courts: An Evaluation with Suggested Alternatives*, 38 Case W. Res. L. Rev. 157, 187 (1987-88) (citations omitted).

304. N.Y. C.P.L.R. 5501(c) (McKinney 1997); *see also infra* notes 353-54 and accompanying text.

To make the issue concrete, suppose that a jury awards a catastrophically injured malpractice plaintiff \$2 million in compensatory damages, based mostly on the projected high cost of lifetime care. It appears possible that such a verdict could be reduced under the Pennsylvania standard—even if the verdict amount was reasonable in light of the projected costs of lifetime care—if the court believed that requiring the defendant to pay the judgment would reduce the availability of health care in the community.

Leaving aside the obvious practical difficulties courts will encounter in attempting to perform such an analysis, two conceptual issues stand out. First, requiring consideration of the verdict's effect on access to healthcare delegates to the medical community some authority to effect reduction of the verdict: Presumably, if the three health care providers in a small town all testify that they will leave town or cease practice if the verdict stands, the court must consider that testimony in determining whether to reduce the verdict. Second, this remittitur provision attempts to solve a perceived social problem—diminished access to health care—by imposing the problem's costs on a particularly vulnerable and demonstrably deserving segment of society—malpractice plaintiffs who have won a verdict that is not subject to reduction on grounds of insufficient evidence.

4. Self-Help on the Part of the Medical Community

I conclude Part II.C. by discussing measures physicians are taking to address their concerns with medical testimony in malpractice cases. Although these measures exist independently of the procedural reforms discussed here, they are noteworthy because in some ways they constitute an effort on the part of some physicians to achieve through self-help the same goals pursued by supporters of procedural reform. One possible self-help measure might be for a successful malpractice defendant to sue the plaintiff and/or the plaintiff's lawyer for malicious prosecution. Such suits, however, are unlikely to succeed;³⁰⁵ and a current movement seeks instead to discipline doctors who offer assertedly substandard testimony on behalf of plaintiffs.

As in the nineteenth century, there are some indications that doctors are attempting to mobilize the profession to counteract perceived defects in medical expert testimony. The movement today, however, seems more coordinated and potentially more influential than similar attempts in the nineteenth century. Several medical professional associations, including the American Association of Neurological Surgeons (“AANS”), have procedures by which

305. For a discussion of malicious prosecution claims and other claims a successful malpractice defendant might consider asserting, see generally Sheila L. Birnbaum, *Physicians Counterattack: Liability of Lawyers for Instituting Unjustified Medical Malpractice Actions*, 45 *Fordham L. Rev.* 1003 (1977).

association members can institute disciplinary proceedings against fellow members for providing expert testimony.³⁰⁶ *Austin v. American Ass'n of Neurological Surgeons*³⁰⁷ illustrates the issues at stake. Donald Austin, a neurosurgeon who was suspended by the AANS because of his testimony on behalf of a medical malpractice plaintiff, sued the AANS for asserted violations of state law.³⁰⁸ A federal district court, sitting in diversity, dismissed Austin's claims, and the U.S. Court of Appeals for the Seventh Circuit affirmed.³⁰⁹

Judge Posner's opinion for the court presented a benign view of the AANS's disciplinary procedure. Judge Posner noted that the AANS gave Dr. Austin "notice and a full hearing (with counsel) before a panel of Association members not implicated in his dispute" with the defendant in the prior malpractice suit.³¹⁰ The court reviewed Dr. Austin's trial testimony and concluded that "if the quality of his testimony reflected the quality of his medical judgment, he is probably a poor physician."³¹¹ The court noted that all AANS complaints to date concerning expert testimony had been brought against physicians who had testified for plaintiffs; however, the court rejected Dr. Austin's assertion that this fact indicated bias on the part of the AANS.³¹² In the court's view, the "asymmetry" was merely a result of the fact that AANS complaints can only be initiated by AANS members and malpractice defendants were more likely to complain than were members who had testified on behalf of a plaintiff.³¹³ Though the court noted that "[n]o doubt most members of the AANS are hostile to malpractice litigation," the court observed that "[j]udges need the help of professional associations in screening experts," and it concluded that "this kind of professional self-regulation rather furthers than impedes the cause of justice."³¹⁴

The Seventh Circuit may have taken a somewhat optimistic view of procedures such as the AANS's. If it is the case, as the court appeared to assume, that only AANS members can bring complaints concerning a member's expert testimony, the procedure appears designed to favor malpractice defendants: A malpractice plaintiff

306. See Adam Liptak, *Doctors' Testimony Under Scrutiny*, N.Y. Times, July 6, 2003, at A10. In addition, a nonprofit organization called the Coalition and Center for Ethical Medical Testimony has been formed "to make honesty and ethicality the *sine qua non* of physicians and others engaged in healthcare who serve as expert witnesses, and to eliminate the ability of unethical experts to testify with impunity in medical-legal matters." Coalition & Ctr. for Ethical Med. Testimony, Statement of Purpose 2003, at <http://www.ccemt.org/index.pl/mission>.

307. 253 F.3d 967 (7th Cir. 2001).

308. *Id.* at 968.

309. *See id.* at 971, 974.

310. *Id.* at 969.

311. *Id.* at 974.

312. *See id.* at 972.

313. *Id.*

314. *Id.* at 972-73.

cannot initiate AANS complaints, unless the malpractice plaintiff also happens to be a neurosurgeon and a member of the AANS.³¹⁵

Even apart from this imbalance, there is some question whether a procedure such as the AANS's is the best way to monitor expert testimony. The weaknesses that the Seventh Circuit panel identified in Dr. Austin's testimony were the sort of issues that a well-prepared and knowledgeable defense counsel would explore on cross-examination.³¹⁶ Though Judge Posner argued that the AANS members who conducted the AANS proceeding were much more adroit than a malpractice defendant's lawyer would be, it is worth noting that the verdict in the underlying malpractice case was for the malpractice defendant—which suggests that the jury may have rejected Dr. Austin's testimony.³¹⁷

A review of the performance of the AANS disciplinary procedure

315. An AANS member who had testified for a plaintiff presumably could bring a complaint concerning the testimony of the defendant's expert witness. It seems likely, however, that malpractice plaintiffs and defendants would have greater incentives to bring such complaints than expert witnesses would. Thus, the rule that only AANS members can initiate complaints seems likely to render complaints against plaintiffs' experts more probable than complaints against defendants' experts.

316. As the Seventh Circuit stated:

Austin had been retained to testify on behalf of a woman whose recurrent laryngeal nerve was permanently damaged in the course of an anterior cervical fusion performed by Dr. Ditmore According to the testimony that Austin was permitted to give at trial, he believes and "the majority of neurosurgeons" would concur that the plaintiff could not have suffered a permanent injury to her recurrent laryngeal nerve unless Dr. Ditmore had been careless, because she had no anatomical abnormality that might have enabled such an injury to result without negligence on the surgeon's part—though in the disciplinary hearing it emerged that, because the recurrent laryngeal nerve is difficult to see, and often is not seen during the operation, it may be impossible to determine whether the particular patient's nerve is unusually susceptible to injury. Austin testified that Ditmore must have rushed the operation (though there was no other evidence of that) and as a result retracted the tissues adjacent to the recurrent laryngeal nerve too roughly. . . . [But] Austin could hardly be considered an expert on anterior cervical fusion, having performed only 25 to 30 of them in more than 30 years in practice, although he had performed a large number of other cervical operations. Ditmore in contrast had performed 700 anterior cervical fusions—with exactly one case of permanent damage to a patient's recurrent laryngeal nerve, namely the case of the patient who had sued him.

Dr. Austin claimed at the hearing that he had based his opinion on [two articles]. . . .

Neither article supports Austin's testimony. . . . Austin admitted that he hadn't discussed the matter with any other medical professionals. . . .

. . . Asked on cross-examination at the malpractice trial to explain why the medical literature did not confirm his view of what a majority of neurosurgeons think, Austin responded lamely that the "medicolegal atmosphere that we're in these days" had deterred the surgical community from acknowledging that this particular complication of anterior cervical fusion could occur only through the surgeon's negligence.

Id. at 969-71.

317. *See id.* at 973.

and others like it lies beyond the scope of this Article. However, even if the AANS procedure reaches correct results, and disciplines only those experts whose testimony is demonstrably substandard, it is questionable whether such procedures are the best avenue for improving medical testimony. It is true, as Judge Posner pointed out, that neurosurgeons need not be members of the AANS in order to practice.³¹⁸ Some similar measures might, however, affect a physician's ability to practice: A published report indicates that the Florida Medical Association adopted in the mid-1990s a program under which complaints concerning expert testimony could result in license suspension or revocation by the state medical board.³¹⁹

To observers familiar with the history of malpractice litigation, such procedures might seem slightly reminiscent of the control that local medical societies exercised over the availability of medical expert testimony during the early twentieth century.³²⁰ For this reason, the appearance of fairness—and perhaps actual fairness as well—could be better served by exploring other means of improving the quality of expert testimony.

D. *The Existence of Procedural Alternatives*

As the preceding section has demonstrated, reforms that increase unduly the influence of physicians in medical liability litigation run the risk of the appearance, if not the reality, of unfairness. This section discusses alternatives that may help improve the performance of judges and juries without ceding inappropriate amounts of power to the medical community.

1. Less-Adversarial Use of Experts

In general, the U.S. system of litigation is founded on the notion that adversarial procedures help to produce accurate and acceptable results. As Daniel Shuman explains:

The adversarial model assumes we are more likely to uncover the truth about a contested event as the result of the efforts of the parties who have a self-interest in the discovery of proof and exposing the frailties of an opponent's proof than from the efforts of a judge charged only with an official duty to investigate the case. The adversarial model also assumes that the parties' participation in the investigation and telling of their story, and the use of a decision maker who is independent of the investigation of the case, will

318. *See id.* at 971.

319. *See* Michael Higgins, *Docking Doctors?: AMA Eyes Discipline for Physicians Giving "False" Testimony*, A.B.A. J., Sept. 1998, at 20.

320. *See supra* text accompanying notes 156-59.

enhance support of the judicial system and confidence in its decisions.³²¹

However, as nineteenth century physicians pointed out, the adversary system can sometimes make it difficult for the decision makers—judges and juries—appropriately to assess expert qualifications and expert testimony. The nineteenth century medico-legal debates produced a number of proposals for addressing this problem; although some of those proposals are unpromising, others have twenty-first century counterparts that are worth consideration. Current initiatives to educate judges and to seek nonpartisan expertise in appropriate cases could be particularly helpful.³²²

Contemporary critiques of certain nineteenth century proposals are equally valid today. As Henry Wade Rogers pointed out in 1883, a system of permanent government-employed medical experts would limit parties' ability to present testimony from the most knowledgeable specialists.³²³ Likewise, if only the court, and not counsel, were to examine the experts at trial, the presentation of issues might suffer because the court would likely not be as familiar with relevant details.³²⁴

On the other hand, the general thrust of Samuel Gross's 1868 proposal³²⁵—that the court should obtain assistance in managing expert testimony—is the basis for several promising developments. First, judges have recognized that they require assistance and training in order to master the issues in cases involving complex scientific evidence.³²⁶ The Federal Judicial Center has published a manual designed to educate judges in this respect.³²⁷ The National Academies' Science, Technology, and Law Program endeavors "to bring together the science and engineering community and the legal community to explore pressing issues, improve communication and help resolve issues between the two communities."³²⁸ The National

321. Daniel W. Shuman, *Expertise in Law, Medicine, and Health Care*, 26 J. Health Pol., Pol'y & L. 267, 269 (2001) (citing Geoffrey C. Hazard, Jr. et al., *Civil Procedure* (4th ed. 1992); Tom R. Tyler, *Why People Obey the Law* (1992)).

322. See Rai, *supra* note 204, at 892 (arguing that "[i]n technically complex cases involving conflicting expert testimony, . . . reducing the adversarial component" through "use of third-party expertise" may be useful).

323. See *supra* text accompanying note 137.

324. See *supra* text accompanying note 138.

325. See *supra* text accompanying notes 116-19.

326. See *supra* text accompanying notes 206-07. For an early proposal concerning possible ways to assist judges in handling scientific questions, see Harold Leventhal, *Environmental Decisionmaking and the Role of the Courts*, 122 U. Pa. L. Rev. 509, 546-54 (1974).

327. See Reference Manual on Scientific Evidence (2d ed. 2000).

328. The Nat'l Academies, Science, Technology, and Law Program, at <http://www7.nationalacademies.org/stl/> (last visited Jan. 19, 2004).

Center for State Courts promotes programs to increase judges' understanding of scientific principles.³²⁹

Better training in scientific principles will assist judges in assessing whether to admit the testimony of party-retained experts. In cases presenting especially difficult scientific questions, the court might also wish to consider appointing a nonpartisan expert to aid in the assessment of the qualifications of the parties' experts or to testify at trial.³³⁰ A number of resources exist to help judges make use of court-appointed experts. Examples include the American Association for the Advancement of Science's Court Appointed Scientific Experts project³³¹ and Duke University Law School's Registry of Independent Scientific and Technical Advisors.³³²

Most cases will not require court-appointed experts. In a 1998 survey of federal trial judges, some 74% of respondents reported that they never made use of such experts; roughly 16% of respondents indicated that they used court-appointed experts "exclusively in cases with difficult or complicated scientific and technical evidence."³³³ Schwarzer and Cecil note the likelihood that "the need for such appointments will be infrequent and will be characterized by evidence that is particularly difficult to comprehend, or by a failure of the adversarial system to provide the information necessary to sort through the conflicting claims and interpretations."³³⁴

In appropriate cases, though, testimony by a court-appointed expert may aid the jury in making sense of the relevant issues.³³⁵ Such an expert can "tutor[] and advis[e] the decisionmaker, supplement[] the

329. See Nat'l Ctr. for State Courts, Science, Technology and the Law, *Frequently Asked Questions*, at http://www.ncsconline.org/WCDS/Topics/topic1.asp?search_value=Science,%20Technology%20and%20the%20Law (last visited Jan. 27, 2004).

330. In federal court,

Two principal sources of authority permit a court to appoint an expert, each envisioning a somewhat different role Appointment under Federal Rule of Evidence 706 anticipates that the appointed expert will function as a testifying witness

Supplementing the authority of Rule 706 is the broader inherent authority of the court to appoint experts who are necessary to enable the court to carry out its duties. This includes authority to appoint a "technical advisor" to consult with the judge during the decision-making process.

William W. Schwarzer & Joe S. Cecil, *Management of Expert Evidence*, in Reference Manual on Scientific Evidence 39, 59 (2d ed. 2000).

331. See <http://www.aaas.org/spp/case/case.htm> (last visited Jan. 13, 2004).

332. See The Registry of Indep. Scientific & Technical Advisors, A Program of the Private Adjudication Center: Duke University School of Law, at <http://www.law.duke.edu/PAC/registry/index.html> (last visited Jan. 21, 2004).

333. Krafka et al., *supra* note 19, at 316 n.6, 325, 326 tbl. 5.

334. Schwarzer & Cecil, *supra* note 330, at 61.

335. See Brennan, *supra* note 11, at 7-8 (arguing that partisan experts ordinarily "have every incentive to take as radical a position as possible," and that, by contrast, the use of a nonpartisan expert will "moderate" the testimony of the parties' experts by motivating those experts "to demonstrate how their views relate to those of the court-appointed expert").

available information, provid[e] an independent opinion, evaluat[e] party testimony,” and “analyze the conflicts between the party experts.”³³⁶ Courts should be wary of presenting such an expert’s testimony as definitive, because “scientific disciplines are often characterized by debate and disagreement, so that the views of any one expert may not reflect a general consensus.”³³⁷ Moreover, care should be taken to involve the parties in the selection process, to assess the expert’s neutrality, and to control the circumstances under which the expert communicates with the judge, the parties, and other experts.³³⁸ Subject to these precautions, a court-appointed expert may prove useful in cases presenting particularly difficult or contentious scientific issues.

The 1998 survey indicated that federal judges use a number of other strategies with respect to expert testimony. Among the most popular measures (measures which at least 82% of respondents said they used at least some of the time) were “[a]sk[ing] clarifying questions of experts from the bench,” “requiring or encouraging early exchange of” expert reports, and using “a special verdict, or a general verdict with interrogatories.”³³⁹ As the latter measure suggests, approaches to expert testimony may relate closely to the way in which the jury’s role is structured; the next subsection takes up that topic.

2. Jury Reforms

As seen in Part I, nineteenth century critiques of adversarial expert testimony focused on the system’s effect on the performance of judges and experts. Recent social science scholarship has pointed out that the adversarial model also may make it more difficult for jurors to understand and apply the testimony presented by expert witnesses. In this view, another problem with the adversarial model is that it treats jurors as passive receptors of information presented by the plaintiff and defendant.³⁴⁰

Social scientists dispute the notion of juror passivity, and jury reformers argue that the promotion of active learning by jurors can improve jury performance.³⁴¹ Recent studies have generated a number of proposed reforms.³⁴² Moreover, the adoption of such

336. Ellen E. Deason, *Court-Appointed Expert Witnesses: Scientific Positivism Meets Bias and Deference*, 77 *Or. L. Rev.* 59, 84, 93 (1998).

337. *Id.* at 63.

338. *See id.* at 143-55.

339. Krafka et al., *supra* note 19, at 314, 326 tbl. 5.

340. *See* Valerie P. Hans, *U.S. Jury Reform: The Active Jury and the Adversarial Ideal*, 21 *St. Louis U. Pub. L. Rev.* 85, 87 (2002).

341. *See id.* at 88-90.

342. *See, e.g.,* Greene & Bornstein, *supra* note 196, at 765 (arguing that “jurors’ determinations of damages could be assisted by preinstructions and by removing the blindfold on various provisions of damages doctrine,” and that “bifurcation and special verdict forms may be helpful in certain circumstances”).

reforms in jurisdictions around the country provides the opportunity for empirical study of their effects.

A growing number of courts and commentators argue that juries would perform better if trial procedures promoted active learning and comprehension on the part of jurors.³⁴³ Some proposed reforms address the timing of trial presentations. For example, judges could instruct jurors on the substantive law before as well as after the presentation of the evidence, and could permit lawyers to make statements periodically during the trial to introduce or summarize portions of the evidence.³⁴⁴ In cases involving complex expert evidence, the court could direct the defendant's expert to testify right after the plaintiff's expert.³⁴⁵ Other proposals seek to enhance jurors' understanding and retention of relevant law and facts by providing them with tangible aids, such as written copies of the jury instructions and juror notebooks containing copies of key exhibits.³⁴⁶ Still further proposals would permit jurors to take notes and to submit questions for the court to pose to witnesses.³⁴⁷

Social science research on these proposals is ongoing, and the recent adoption of reforms by some court systems provides an opportunity to assess how the proposals function in practice. Studies exist concerning many of the proposed reforms, such as juror note-taking, juror questioning, and the provision of preliminary and/or interim jury instructions before or during trial.³⁴⁸ Moreover, jurisdictions such as Arizona, Colorado, and the District of Columbia have implemented or encouraged the use of various reforms.³⁴⁹

Such reforms hold the promise of improving jury performance overall. One specific issue of jury performance stands out as a matter of concern, however: the variability of jury awards of noneconomic damages.

343. See, e.g., *Jury Trial Innovations* 5, 14-15 (G. Thomas Munsterman et al. eds., 1997) (Vicki L. Smith contributor).

344. See *Jury Trial Innovations*, *supra* note 343, at 151-56.

345. See *Krafka et al.*, *supra* note 19, at 316 n.6, 326 tbl. 5 (stating that 10% of respondents in the 1998 survey of federal judges reported having used this approach).

346. See *Jury Trial Innovations*, *supra* note 343, at 109-11, 174-76.

347. See *Jury Trial Innovations*, *supra* note 343, at 141-47; *Krafka et al.*, *supra* note 19, at 316 n.6, 326 (stating that some 16% of respondents in 1998 survey of federal judges reported having "[a]llow[ed] jurors to question experts directly or through the court").

348. See, e.g., Martin J. Bourgeois et al., *Nominal and Interactive Groups: Effects of Preinstruction and Deliberations on Decisions and Evidence Recall in Complex Trials*, 80 *J. Applied Psychol.* 58 (1995); Lynne ForsterLee & Irwin A. Horowitz, *Enhancing Juror Competence in a Complex Trial*, 11 *Applied Cognitive Psychol.* 305 (1997); Lynne ForsterLee et al., *Juror Competence in Civil Trials: Effects of Preinstruction and Evidence Technicality*, 78 *J. Applied Psychol.* 14 (1993).

349. See American Judicature Society, *Enhancing the Jury System: A Guidebook for Jury Reform* 21-23, 27-30 (1999).

3. Remittitur Under a Heightened Standard

The size and variability of noneconomic damages awards are central concerns in discussions of malpractice reform. A number of commentators have observed that caps on damages are a suboptimal way to limit award variability, because they impact unfairly the most severely injured plaintiffs.³⁵⁰ Providing more guidance concerning noneconomic damages could avoid such unfairness while still reducing variability.

There are a number of possible ways to provide such guidance to the jury. For example, Diamond, Saks, and Landsman suggest that lawyers could be permitted to frame their arguments concerning damages in the light of prior awards in cases they consider comparable.³⁵¹ Likewise, Bovbjerg, Sloan, and Blumstein have suggested that juries could be given one or more stylized scenarios and associated valuations, to use as benchmarks in considering how much to award.³⁵²

Alternatively, instead of presenting such an argument to the jury, lawyers could be required to make a similar case to the judge. Traditionally, judges in most jurisdictions have had the power to order remittitur based on a finding that the jury's damages award was so large that it "shocked the conscience" of the court. This standard, however, does not explicitly require the court to compare the verdict under review to verdicts approved in previous cases.

A number of commentators have argued that such a comparison could reduce the variability of awards for noneconomic damages. For example, as Diamond, Saks, and Landsman discuss, since 1986 New York State has mandated that the judge order remittitur (or additur) if the judge determines that the jury's award "deviates materially from

350. Indeed, some research suggests that caps might actually *increase* both the size and variability of jury awards in many cases, because of the potential anchoring effect if jurors know of the cap. In a recent experiment, Saks et al. found that the mean award for a low-severity injury by mock jurors who were told of the existence of a \$250,000 cap on damages was significantly higher than mean awards by jurors who were not told of the cap, and that the awards by jurors told of the cap were significantly more variable than awards by other jurors. See Michael J. Saks et al., *Reducing Variability in Civil Jury Awards*, 21 Law & Hum. Behav. 243, 249, 251, 253-54 (1997). Though this study looked at mock jurors and not at mock juries, it is still suggestive, at least in the absence of evidence that group deliberation would change the results. Although jurors in an actual trial setting might not be told of the existence of a cap, the publicity surrounding legislative deliberation over caps makes it likely that at least one juror would be aware of the cap's existence, and that information could be communicated to other jurors during deliberations.

351. See Diamond et al., *supra* note 236, at 321.

352. See Bovbjerg et al., *supra* note 240, at 953-56. Bovbjerg, Sloan, and Blumstein also suggest that awards could be set by means of "a matrix of values that would award fixed damage amounts according to the severity of injury and age of the injured party," or that awards could be constrained by "a system of flexible floors and ceilings that vary with injury severity and victim age." *Id.* at 938-39.

what would be reasonable compensation"—a directive that courts have interpreted to entail a comparison of the award in question with prior awards in similar cases.³⁵³ One study examined samples of medical malpractice verdicts from New York, Florida, and California, and found a relatively high number of New York cases in which malpractice verdicts were reduced through remittitur—a finding which suggests that the New York standard is serving its intended function.³⁵⁴

III. MEDICAL LIABILITY REFORM AND THE QUESTION OF TRANS-SUBSTANTIVE PROCEDURE

I have argued, so far, that to assess proposed reforms of the procedures for adjudicating medical liability cases, policymakers should consider both data on malpractice claims and larger questions concerning the relation of physicians to the lay community. Implicit in this approach is the notion that such reforms should be considered on a substance-specific basis—in other words, that the assessment should focus on medical malpractice and not other areas of

353. See Diamond et al., *supra* note 236, at 322 (citing N.Y. C.P.L.R. 5501(c) (McKinney 1986)). Since 1986, New York's mid-level appellate courts have been directed by statute to "determine that an award is excessive or inadequate if it deviates materially from what would be reasonable compensation," N.Y. C.P.L.R. 5501(c) (McKinney 1997), and the New York courts have interpreted this standard as applying at the trial level as well. See, e.g., *Shurgan v. Tedesco*, 578 N.Y.S.2d 658 (App. Div. 1992). The "deviates materially" standard is easier to meet than the more traditional test (under which a court would grant remittitur only if the jury's award "shocked the conscience" of the court).

Baldus, MacQueen, and Woodworth present a detailed proposal for comparative judicial review of jury awards. See David Baldus et al., *Improving Judicial Oversight of Jury Damages Assessments: A Proposal for the Comparative Additur/Remittitur Review of Awards for Nonpecuniary Harms and Punitive Damages*, 80 Iowa L. Rev. 1109 (1995). For a discussion of the challenges of comparative review, and an illustration of one approach to those challenges, see *Geressy v. Digital Equipment Corp.*, 980 F. Supp. 640, 653-76 (E.D.N.Y. 1997) (Weinstein, J.) (applying New York's "deviates materially" standard to jury awards for, *inter alia*, pain and suffering). See also Diamond et al., *supra* note 236, at 322 (discussing *Geressy*).

354. The researchers found that in a sample of 293 medical malpractice plaintiff verdicts described in a jury verdict reporter for New York City and neighboring counties during 1985-1997, at least 96 awards were diminished post-verdict: 46 through post-verdict settlement, 23 through remittitur, 17 due to comparative negligence, and 10 for unknown reasons. Because of these reductions, the mean adjusted award in the New York sample was only about 62% of the mean original jury award. See Neil Vidmar et al., *Jury Awards for Medical Malpractice and Post-Verdict Adjustments of Those Awards*, 48 DePaul L. Rev. 265, 285 (1998).

Vidmar et al. noted that these figures likely underestimate the total number of post-verdict reductions, because the results of appeals were not included. See *id.* at 286. (The researchers found three post-verdict increases, as well: two from post-verdict settlements, and one from additur (the converse of remittitur). See *id.* at 285.)

The researchers also studied samples of verdicts from Florida (1987-1996) and California (1991-1997). The data indicate that the post-verdict experience in those two states differs from that in New York. *Id.* at 290-99.

substantive law. In one sense, this notion is simply a practical one: The reforms discussed in Part II.C. specifically target medical liability cases, and not other disputes.

My focus has theoretical as well as practical implications, however. Procedural scholars have long debated whether federal procedural rules should attempt to be trans-substantive, or whether such rules instead should be tailored to accommodate distinctive features of particular types of litigation. In Part III.A., I briefly summarize this debate. Part III.B. considers how the insights drawn from the federal debate might affect consideration, at the state level, of responses to the perceived malpractice crisis.

A. *The Debate Over Federal Trans-Substantive Rules*

On their surface, the Federal Rules of Civil Procedure appear to make few, if any, distinctions among types of cases. However, by conferring broad discretion on federal trial judges, the rules in fact permit those judges to apply different procedures in different cases:

Many if not most Federal Rules make no policy choices. Rather, they confer discretion on the trial judge, thereby insulating the Rules from effective challenges under the statute delegating rulemaking power to the Supreme Court, enabling tailored justice at a level where policy choices—made by judges—may not be noticed, and (with other factors) insulating those choices from effective appellate review. Such Federal Rules are trans-substantive only in the most trivial sense.³⁵⁵

Some commentators argue that this trial-court flexibility is beneficial. In their view, procedures can be tailored to substantive needs, on an *ad hoc* basis, with less risk of arousing interest group pressure concerning the substantive effects of those variations.³⁵⁶ By contrast, if the federal rulemakers considered rules targeted at specific kinds of litigation, the resulting rules would favor the interests of those groups that were best able to influence the rulemaking process.³⁵⁷ For example, some of the litigation successes of politically disadvantaged groups have resulted from the ability of those groups to employ trans-substantive rules in ways that interest groups would likely have mobilized to oppose had substance-specific rules been proposed.³⁵⁸

Other scholars, however, assert that the discretion conferred by the

355. Stephen B. Burbank, *Procedure and Power*, 46 J. Legal Educ. 513, 514 (1996).

356. See Paul D. Carrington, *Making Rules to Dispose of Manifestly Unfounded Assertions: An Exorcism of the Bogy of Non-Trans-Substantive Rules of Civil Procedure*, 137 U. Pa. L. Rev. 2067, 2083, 2085 (1989).

357. See Geoffrey C. Hazard, Jr., *Discovery Vices and Trans-Substantive Virtues in the Federal Rules of Civil Procedure*, 137 U. Pa. L. Rev. 2237, 2246-47 (1989).

358. See *id.*

Federal Rules may be abused by trial judges,³⁵⁹ and that explicit consideration of substance-specific rules would be preferable.³⁶⁰ These scholars point out that maintaining a facial appearance of trans-substantivity does not remove politics from the rulemaking process.³⁶¹ Considering substance-specific rules would merely make explicit the underlying political issues; and such an approach would permit closer consideration of the likely effect of the proposed rule.³⁶² In addition, the resulting rules may be more useful: Rules targeted at particular types of cases could provide greater specificity, and thus greater guidance to litigants and judges.³⁶³

Substance-specific rulemaking is complicated, at the federal level, by the division of power between Congress and the rulemakers: Under the Rules Enabling Act, the Federal Rules must not "abridge, enlarge or modify any substantive right."³⁶⁴ As a result, the debate over federal rulemaking does not map directly onto the discussion of procedural reforms in medical malpractice.³⁶⁵ Those reforms generally begin their career as proposals in the state legislature, rather than as rules considered by a court rulemaking body. As will be seen in the next section, however, a number of the same themes emerge in the state-law malpractice context.

B. *Trans-Substantivity and State-Level Medical Liability Reform*

Malpractice reform has the highest political profile of any current type of litigation reform. Insurance companies and physicians' groups present the issue as a medical liability crisis, and politicians respond in the same vein. That being so, it is perhaps inevitable that proposals are made for malpractice-specific procedural changes. As noted above, action by a state legislature to target procedures in specific types of cases does not raise the same separation of powers concerns as would a similar initiative by federal rulemakers. Moreover, in the present context, the question of substance-specific procedure should be measured against the likely political alternative, substance-specific substance: Procedures that are specific to medical liability cases may be instituted as an alternative to substantive measures such as a cap on malpractice damages. In such an environment, substance-specific

359. Cf. Stephen B. Burbank, *The Transformation of American Civil Procedure: The Example of Rule 11*, 137 U. Pa. L. Rev. 1925, 1937-38 (1989).

360. See Stephen N. Subrin, *Fudge Points and Thin Ice in Discovery Reform and the Case for Selective Substance-Specific Procedure*, 46 Fla. L. Rev. 27, 41, 49 (1994).

361. See Stephen B. Burbank, *The Costs of Complexity*, 85 Mich. L. Rev. 1463, 1473 (1987) (book review).

362. See *id.*; see also Stephen B. Burbank, *Of Rules and Discretion: The Supreme Court, Federal Rules and Common Law*, 63 Notre Dame L. Rev. 693, 718 (1988); Subrin, *supra* note 360, at 54.

363. See Subrin, *supra* note 360, at 49.

364. 28 U.S.C. § 2072(b) (2003).

365. Cf. Burbank, *supra* note 361, at 1475.

procedure may be the best choice among the realistic policy options. However, policymakers should take care, if they adopt substance-specific measures, that they do so on the basis of malpractice-specific empirical study rather than simply on the basis of interest-group pressure.

Political realities, then, justify substance-specific consideration of malpractice litigation procedures. In addition, some of the issues discussed in Parts I and II suggest the presence of concerns that are distinctively powerful in the medical malpractice context. Although malpractice litigation seems quite similar, in many ways, to other state-court tort litigation, some differences appear, such as the unusually low plaintiff win rate at trial.³⁶⁶ For current purposes, perhaps the clearest distinguishing attributes of malpractice litigation center on the nature of the defendant.

Concerns over defensive medicine and doctor attrition add to the impulse for procedural reform. To the extent that physicians engage in defensive medicine or leave practice, they may do so in part because of their perception of the litigation system as random and unfair. Reforms that increase physicians' faith in the litigation system might thus hold the promise of reducing the incidence of defensive medicine and encouraging physicians to stay in key specialties or underserved communities. On the other hand, if such reforms produce unfair results or reduce the confidence of other participants in the process, such success would come at too high a cost.³⁶⁷

Another distinctive feature of medical liability litigation lies in the fact that physicians are both potential defendants and potential experts. Of course, in many fields of endeavor, those with technical knowledge may at different times testify as an expert, or find themselves associated with a defendant in litigation, or both. Scientists, for example, serve as expert witnesses; they also may be connected, by employment or through grants, with entities that typically may be defendants in products liability cases. It seems likely, however, that few fields other than medical liability present such a direct and personal overlap between potential witnesses and potential defendants.

The overlap between defendants and experts in medical liability cases was intensified, in the early twentieth century, by the locality rule, which required that expert testimony come from one who practiced in the defendant's community. The overlap in the twenty-first century may be heightened by requirements that the expert practice in the same specialty as the defendant. Moreover, some parts

366. *See supra* text accompanying notes 178-79.

367. A dramatic case in point is Pennsylvania's remittitur provision, which apparently would require reduction of an award of compensatory damages solely because the court anticipated that doctors would leave the community in response to the award. *See supra* text accompanying note 301.

of the medical community appear to be attempting to control more stringently the testimony of medical experts.³⁶⁸

These factors may support the consideration of reforms specific to medical liability cases. All other things being equal, procedural changes may be particularly helpful in malpractice cases to the extent that they either increase physician confidence in the litigation system or remove the impetus for detrimental self-help measures by the medical community.

To provide further definition to the analysis, it is useful not only to assess procedural reforms with respect to medical liability (as opposed to litigation in general), but also to consider how the system's procedural aspects could change in the face of alterations in the substantive law of medical liability.³⁶⁹ This Article has based its discussion of litigation procedures on the assumption that the current substantive law of medical malpractice applies. A number of commentators, however, advocate major changes in the substantive law.³⁷⁰ For example, one proposal would replace the current system of fault-based liability with a system in which claimants are compensated if their injuries fall within "avoidable classes of events" ("ACEs")—bad results that are clearly preventable.³⁷¹ "Avoidable classes" would be specified in advance by experts using empirical data on medical safety, removing the need for individual determinations, in many cases, of whether a physician breached the standard of care and whether the breach caused the claimant's injury. ACEs-based provisions would obviate a number of the liability-focused concerns that have motivated procedural reform, though it would still be necessary to develop guidelines for the determination of damages. Thus, changes in substantive medical liability law would change the landscape of procedural reform as well.

Having considered medical-liability reform, it makes sense to broaden the inquiry to ask whether insights gained with respect to malpractice could apply elsewhere as well. As a matter of recent

368. See *supra* text accompanying notes 306-19.

369. Cf. Shuman, *supra* note 321, at 286 ("Many of the problems that courts face in assessing medical expertise are the inevitable result of substantive legal standards.").

370. In addition to the "avoidable classes of events" approach discussed in the text, reform ideas include proposals for enterprise liability, see, e.g., Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 Harv. L. Rev. 381, 415-26 (1994); William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 Am. J.L. & Med. 1, 16-26 (1994), and no-fault compensation, see, e.g., Randall R. Bovbjerg & Frank A. Sloan, *No-Fault for Medical Injury: Theory And Evidence*, 67 U. Cin. L. Rev. 53, 64-70 (1998); David M. Studdert & Troyen A. Brennan, *Toward a Workable Model of "No-Fault" Compensation for Medical Injury in the United States*, 27 Am. J.L. & Med. 225, 229-35 (2001).

371. Bovbjerg, *supra* note 174, at 2197-98; see also Institute of Medicine of the National Academies, *Fostering Rapid Advances in Health Care: Learning from System Demonstrations* 83 (Janet M. Corrigan et al. eds. 2002).

history, it is worth noting that while the wave of legislation in the 1970s focused on reforms specific to medical malpractice cases, the wave of similar measures in the 1980s imposed "tort reform" more generally.³⁷² As a political matter, then, medical liability reforms may provide an impetus for reforms in other areas of law.

In addition, as a matter of sound policy, some reforms that may be useful in medical liability cases may also be helpful in other kinds of cases. Policymakers should consider the application of expert witness reforms and jury reforms to other types of cases—such as product liability cases—that may present challenging scientific or technical questions. Likewise, it makes sense to investigate whether other kinds of cases—perhaps other personal injury actions—tend to result in variable noneconomic damages awards that could usefully be reviewed under a more stringent remittitur standard.

Those reforms might usefully be adopted in a "function-specific," rather than "substance-specific," manner—for example, based on the degree of scientific complexity rather than based on the topic of the claim.³⁷³ A "function-specific" measure could apply to more than one type of case. It also could apply to fewer than all cases within a specific category. Some commentators tend to imply that *all* medical malpractice trials require the jury to address complex scientific questions.³⁷⁴ In reality, however, malpractice cases vary considerably in their degree of complexity and scientific difficulty.³⁷⁵ Thus, for example, not all malpractice cases will require special approaches to expert testimony or procedures to foster active learning by jurors. This variation underscores the inefficiency of approaches, such as screening panels or specialized courts, that would institute a costly procedure based on concerns that arise only in a portion of malpractice cases.

CONCLUSION

This Article was prompted by the notion of malpractice exceptionalism—the idea that medical liability cases may require litigation procedures that other kinds of cases do not need. The political reality behind this notion is that physicians and insurers have succeeded in presenting the medical liability problem as a crisis that is unique and that requires drastic, malpractice-specific reform.

Behind the political landscape lies a social and historical reality that warrants malpractice-specific analysis. In sorting through the tangle

372. See Weiler et al., *supra* note 172, at 3.

373. See Marcus, *supra* note 4, at 779.

374. See, e.g., Stephen D. Sugarman, *The Need to Reform Personal Injury Law: Leaving Scientific Disputes to Scientists*, 248 Science 823, 823-24 (1990).

375. Neil Vidmar, *Are Juries Competent to Decide Liability in Tort Cases Involving Scientific/Medical Issues? Some Data from Medical Malpractice*, 43 Emory L.J. 885, 896-99 (1994).

of issues regarding medical liability, policymakers should be aware that some key issues concern the way in which the medical community interacts with the legal system. The latter often looks to the medical community to define the standard of appropriate medical care and to provide expertise needed to resolve contested issues. Tensions have persisted over time, however, based both on the medical community's frustration with the adversarial litigation system and on the tendency of some medical communities, at some points in time, to assert undue control over the outcomes of medical liability disputes.

Medical liability reform, then, is targeted toward an interdisciplinary phenomenon: the intersection of medicine and law. Relatedly, I have argued that the proper assessment of such reform requires an interdisciplinary analysis. Drawing upon historians' work on nineteenth century medico-legal developments and upon sources from the period, Part I reviewed the ways in which the nineteenth century debate prefigured current problems. Part II made use of recent social science research to assess the performance of judges, juries, and particular procedural reforms in medical liability litigation. I argued in Part II that some of the procedural changes that physicians might prefer are inadvisable, but that other approaches—particularly reforms of expert witness procedures, efforts to promote active learning by jurors, and a more stringent remittitur standard—may prove useful.

Part III considered whether the questions addressed in this Article really ought to be viewed as specific to medical malpractice cases, or whether the procedures I advocate could apply to other areas as well. I suggested that those procedures might be useful in some other types of cases, and that such procedures might be applied on a function-specific, rather than a topic-specific, basis.

Some readers may not be persuaded, in the abstract, that substance-specific procedures are needed to address medical liability reform. However, experience supports the argument that procedural reforms should be analyzed on a substance-specific basis. Reforms targeted at medical liability are a political reality, and the only question is whether their adoption will be driven solely by interest-group politics or informed by sound substance-specific analysis.