

WISCONSIN STATE
LEGISLATURE
COMMITTEE HEARING
RECORDS

2005-06

(session year)

Assembly

(Assembly, Senate or Joint)

**Task Force on
Medical
Malpractice
(ATF-MM)**

Sample:

Record of Comm. Proceedings ... RCP

- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

➤ Appointments ... Appt

➤ **

➤ Clearinghouse Rules ... CRule

➤ **

➤ Committee Hearings ... CH

➤ **

➤ Committee Reports ... CR

➤ **

➤ Executive Sessions ... ES

➤ **

➤ Hearing Records ... HR

➤ **

➤ Miscellaneous ... Misc

➤ **05hr_ATF-MM_Misc_pt37a**

➤ Record of Comm. Proceedings ... RCP

➤ **

Articles

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

Catherine T. Struve [FNa1]

Copyright © 2004 Fordham Law Review; Catherine T. Struve

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
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

***944 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. [FN1] 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. [FN2] 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. [FN3] 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 *945 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. [FN4] 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). [FN5] A number of states have tightened the requirements concerning expert witness qualifications. [FN6] 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). [FN7] 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. [FN8]

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. [FN9] 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. [FN10] Some commentators assert that plaintiffs can find venal or ignorant experts to support almost any position; [FN11] that judges lack the *946 ability to screen out suspect testimony; and that juries lack the capacity to assess the competing claims offered by

partisan experts. [FN12]

Such critiques drive several of the procedural reforms. The findings of medical screening panels could provide a putatively neutral source of expertise at trial. [FN13] Stringent requirements for the qualifications of expert witnesses might eliminate some faulty testimony. [FN14] Judges on a specialized medical liability court might be particularly skilled at determining the quality of proposed expert testimony. [FN15] A revised remittitur standard holds the promise of improving damages determinations by empowering judges to reduce outlier jury awards. [FN16]

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 makers [FN17] should delegate authority to medical professionals. [FN18] 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 *947 them. [FN19] 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. [FN20] A court-appointed expert might convey a view dominant in the medical community, to the exclusion of dissenting views. [FN21] 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. [FN22]

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 *948 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. [FN23]

*949 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, [FN24] it seems clear that the frequency of such suits rose markedly beginning in the 1830s and 1840s. [FN25] In his informative book on nineteenth century medical malpractice suits, *950 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. [FN26] 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. [FN27] 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. [FN28]

Changes in the business of medicine fostered suits, because the increasing number of physicians made suits against a given doctor more palatable to the public [FN29] and because some physicians may have aided malpractice suits against competitors. [FN30] *951 Social views contributed to the increase as well, because of greater interest in physical health, [FN31] an increased social tolerance for litigation, [FN32] and unrealistic expectations of what medicine could do. [FN33] 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. [FN34]

Criminal cases might also have made the question of medical malpractice more prominent. Medico-legal commentators observed that in cases where a victim died after receiving medical treatment, the defendant would likely argue that faulty treatment, rather than the *952 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."

[FN35]

2. Physician Perspective

Physicians reacted strongly to the upswing in malpractice suits. Medical writers asserted that many, if not most, suits were meritless. [FN36] 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." [FN37] 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." [FN38] Physicians suggested that some patients brought malpractice suits in an attempt to avoid paying their doctors' bills. [FN39] Alfred S. Taylor, an English physician whose treatise *953 was popular in the United States, [FN40] 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." [FN41]

Medical commentators stressed that treatment decisions could be difficult, [FN42] and they contended that physicians should not be held liable for reasonable errors in judgment. [FN43] 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." [FN44] 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" [FN45]--rather than on physicians who merely made an error in judgment. [FN46] 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]he *954 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." [FN47] 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." [FN48]

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. [FN49] 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." [FN50]

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. [FN51]

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." [FN52] Ordranax's 1869 treatise quoted the American *955 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. [FN53]

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. [FN54]

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. [FN55] Doctors argued that *956 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. [FN56] 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. [FN57] A standard American treatise on medical *957 jurisprudence declared that "[d]oubtless there is too little discrimination exercised in receiving all who are called doctors, as witnesses."

[FN58] A few decades later, John Ordronaux 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." [FN59]

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. [FN60]

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." [FN61]

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, Ordronaux 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" [FN62] A number of medical writers asserted that judges *958 lacked the knowledge necessary to assess expert qualifications and testimony. [FN63] 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." [FN64] 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. [FN65]

Physicians who testified in court proceedings often hated the experience. [FN66]

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 import [FN67]

Doctors resented even more strongly the mode of examination--especially the rough

treatment they experienced during some cross-examinations [FN68]--and the habit of some counsel of disparaging opposing witnesses. [FN69] As early as 1826, a writer in a medical journal *959 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." [FN70] 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." [FN71] 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."

[FN72] 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. [FN73]

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." [FN74] The problem appears to *960 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. [FN75]

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." [FN76]

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. [FN77] 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. [FN78] Some duties of the medical witness required expertise that general practitioners normally lacked. T.R. Beck argued in 1828 that post-*961 mortems required a knowledge of anatomy and chemistry beyond that possessed by many practicing doctors. [FN79] Likewise, Isaac Ray argued that expert testimony on insanity should only be given by specialists. [FN80] 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." [FN81] 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 incurred [FN82]

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." [FN83]

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]." [FN84]

Even if disagreement did not betoken lack of knowledge, it was seen to diminish the credence lay people gave to medical testimony. [FN85] An 1845 treatise quoted Taylor's remark, concerning deaths after *962 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." [FN86] A medical professor who addressed a county medical society in 1878 posed the question, "Why has expert testimony fallen into such universal disrepute?" [FN87] 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." [FN88] 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." [FN89]

Critics also charged that the United States system contributed to partisan bias among medical experts. [FN90] 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. [FN91]

Though commentators may have been sympathetic to the plight of *963 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. [FN92] 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." [FN93]

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. [FN94]

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." [FN95]

Such problems did not simply tarnish the profession as a whole; they could also prove very harmful to the witnesses themselves. [FN96] A Boston doctor addressing the Massachusetts Medical Society in 1851 asserted that opposing counsel "not unfrequently, in the summing-up *964 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." [FN97] 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." [FN98]

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. [FN99]

Medico-legal authors often spent several pages discussing the physician's claim to fair compensation. [FN100]

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. [FN101] 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 *965 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 English [FN102]

Well-read American observers would also have noticed that the German system of expert opinion operated differently. [FN103] 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." [FN104] 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. [FN105] 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. [FN106] *966 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. [FN107] 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. [FN108]

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," [FN109] 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. [FN110] 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." [FN111]

Other commentators, though not proposing a permanent *967 appointment, argued that the expert witnesses for a particular case should be chosen and examined by the court. John Ordronaux, 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." [FN112] 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." [FN113]

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. [FN114] 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." [FN115]

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." [FN116] 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 *968 bias." [FN117] 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. [FN118]

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. [FN119]

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.

[FN120] 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." [FN121]

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 *969 opinion to be received by the jury as conclusive of the issue tried by them." [FN122]

Expert panels seem to have struck observers as a particularly attractive method for determining questions of insanity. [FN123] 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." [FN124] Similarly, Isaac Ray proposed the use of a commission to determine insanity. [FN125]

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. [FN126] 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. [FN127] 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." [FN128] Thurman admitted that juries could err, and that "a jury of physicians" might "be more likely to decide a medical question correctly." [FN129] Thurman argued, however, that "[i]f medical questions should be tried by *970 medical men alone, upon the same principle, mercantile questions should be tried by merchants, financial questions by bankers, . . . and so on." [FN130] 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." [FN131] 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." [FN132] A "thorough and public investigation," Thurman maintained, "takes place only upon the proper trial of a cause." [FN133] 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." [FN134]

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. [FN135] In particular, Rogers pointed out that experts in one aspect of medicine "often have but a superficial knowledge of other branches"; [FN136] 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. [FN137] 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. [FN138]

Though Thurman and Rogers were both lawyers by training, some physicians were also wary of the proposed reforms. Edward Mann, *971 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." [FN139] 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. [FN140] 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." [FN141]

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. [FN142] 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. [FN143] 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 prevailed. . . . [FN144]

*972 C. Professional Coordination and Control

To the extent that the momentum of medico-legal reform efforts declined at the turn of the century, [FN145] 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. [FN146] 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. [FN147] Neal Hogan has described state medical societies' adoption, in the early 1900s, of programs which defended, but did not indemnify, participating physicians. [FN148] 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. [FN149] Physicians, however, wanted not just defense but also protection against liability, and eventually the medical societies responded by providing insurance for their members. [FN150]

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. [FN151] The American Medical Association and state and local medical societies developed interconnections and extended their authority. [FN152] Changes in medical education "increased the homogeneity and cohesiveness of the profession." [FN153] Medicine's contributions to public health heightened the profession's social influence. [FN154] These trends "reflected a movement toward the strengthening of professional status *973 and the consolidation of professional authority," [FN155] 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. [FN156] 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." [FN157] 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;

[FN158] 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." [FN159] 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." [FN160] 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." [FN161]

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." [FN162] Though the profession took some actions in response to these concerns, [FN163] questions remained. As late as 1983, Robert Derbyshire, a former President of the Federation of *974 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." [FN164] 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. [FN165]

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. [FN166] In addition, a growing number of patients seek to inform themselves and to exercise judgment with respect to their treatment options. [FN167] Viewed in this context, the threat and reality of *975 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. [FN168]

As Jay Gold has argued, that tension pervades all areas of health law. [FN169] 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. [FN170]

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. [FN171] Before *976 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. [FN172] 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. [FN173] Although the researchers cautioned that their medical record review might not reveal some types of malpractice (such as a failure to diagnose), [FN174] 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." [FN175]

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. [FN176] 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. [FN177] 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 *977 "from 13.5 percent to 53 percent, with a median win rate of around 29 percent." [FN178]

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. [FN179] 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. [FN180] 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). [FN181] Predictably, *978 many claimants will drop their suits when it becomes apparent that the claims lack merit. [FN182] Moreover, a plaintiff might drop a valid claim because litigation costs become prohibitive, or because the lawsuit proves emotionally stressful. [FN183]

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.

[FN184] In general, an industry's practices do not define the standard of care, though they may be relevant to it. [FN185] 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. [FN186] 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. [FN187] 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. [FN188]

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 *979 appropriate care than on systematic knowledge of the relevant community. [FN189] Even if the parties present empirical data concerning what doctors do in practice, as some commentators advocate, [FN190] there is often

substantial variation in appropriate treatment. [FN191] 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. [FN192]

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. [FN193] In other words, a showing of causation often will be based on probabilistic evidence. [FN194] Moreover, it may be hard to untangle the defendant's actions from the patient's preexisting medical problems. [FN195]

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 *980 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. [FN196] 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. [FN197] The plaintiff may also request punitive damages, which are designed to punish willfully wrongful behavior on the part of the defendant. [FN198] However, punitive damages are rarely awarded in medical malpractice cases. [FN199]

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 *981 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*, [FN200] the judge asks whether the proposed expert employs an approach that is generally accepted in the relevant medical or scientific community. [FN201] As commentators have observed, this approach delegates authority to the expert community to determine which experts' testimony will be admissible in court. [FN202] 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*, [FN203] promises increased accuracy but demands greater judicial expertise. [FN204] 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. [FN205]

*982 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*." [FN206] 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." [FN207]

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." [FN208] 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." [FN209] 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. [FN210]

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. [FN211] Many *983 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. [FN212] 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. [FN213]

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. [FN214] However, they observed that jurors with higher levels of understanding appeared to play an important *984 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. [FN215] 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.

[FN216]

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. [FN217] 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. [FN218]

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, [FN219] deliberation should improve juries' ability to process complex information, to the extent that jurors with better understanding take "leadership roles" in the deliberations. [FN220]

Moreover, studies of jury performance find a degree of correlation between case strength and liability determinations. [FN221] Frank Sloan, *985 Penny Githens, and Gerald Hickson presented data on reviewing physicians' views of thirty-seven malpractice cases that went to a jury verdict. [FN222] Researchers had provided information on the claims to panels of physician reviewers, and asked the reviewers to assess negligence and

causation. [FN223] In the twenty-four cases that went to verdict and ended with a plaintiff recovering damages, [FN224] the physician reviewers were twice as likely to have found the defendants "liable" as they were to have found them "not liable." [FN225] 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." [FN226]

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. [FN227] 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. [FN228] The evaluations were performed by internal staff in many cases, but the hospital also sought outside *986 evaluations of claims that proceeded to litigation. [FN229] 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). [FN230] 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." [FN231]

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. [FN232] 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. [FN233] Notably, however, in four of those five cases the disagreement arose because physicians tended to find negligence and the jury had not. [FN234]

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 *987 individual mock jurors would have awarded. [FN235] 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. [FN236] 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." [FN237] At any rate, larger juries should tend to reach less variable results than smaller juries.

[FN238]

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. [FN239] However, significant variability may remain, particularly with respect to noneconomic damages. [FN240] 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. [FN241] 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. [FN242] The *988 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. [FN243] 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. [FN244] Indeed, as discussed in *989 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. [FN245] From the physician's perspective, a panel system might be useful to the extent that it encourages earlier, informal resolution of malpractice claims. [FN246] 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. [FN247]

*990 The available data [FN248] 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. [FN249] Only

twenty of those states still have panel systems; in the others, panel provisions were repealed and/or invalidated. [FN250] The *991 basic concept is to provide panels, composed partly or wholly of physicians, to opine on the merits of malpractice claims. [FN251] Some panel systems are mandatory, while others are voluntary. [FN252] Some screen claims prior to the filing of the complaint, while others screen claims after filing. [FN253] 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. [FN254] 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). [FN255] Some systems provide that the panel findings are admissible at a later trial, and some permit the panel members to be called as witnesses. [FN256] 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. [FN257]

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. [FN258] 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. [FN259] This presumably was not the *992 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. [FN260]

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. [FN261] Panels often will need to hold live hearings in order to reach an accurate assessment. [FN262] 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 presentation [FN263]--which will "entail the costs and delay that panels are intended to prevent." [FN264] *993 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." [FN265]

Panels may also lower plaintiffs' expected returns by delaying the resolution of claims. [FN266] 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, [FN267] some states have had severe problems with delay. [FN268]

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. [FN269] This dynamic may explain the results of a *994 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. [FN270] 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. [FN271] 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. [FN272] 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. [FN273]

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. [FN274] 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; [FN275] it would be inefficient to require all claims to go before a *995 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. [FN276] 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." [FN277]

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." [FN278] 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. [FN279]

*996 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. [FN280]

2. Specialized Courts

A different scheme for increasing decision maker expertise involves the creation of a specialized medical liability court. One well-publicized current proposal [FN281] for such a court comes from Common Good, an organization that describes itself as "a bipartisan initiative to overhaul America's lawsuit culture." [FN282] 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. [FN283]

Common Good's proposal for specialized courts arises from the organization's position that "expert judges" should create precedents concerning the standard of care. [FN284] 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. [FN285] Howard asserts that *997 judicial rulings on the standard of care would create a body of precedent on which doctors could rely in making medical judgments. [FN286]

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. [FN287] 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." [FN288] 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." [FN289]

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. [FN290] 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 *998 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. [FN291] Expert judges might be better equipped to evaluate the qualifications of expert witnesses. [FN292] 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. [FN293]

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, *999 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, [FN294] it is probable that a repeat player in the medical malpractice field will be habitually on one side or the other [FN295]--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. [FN296] 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." [FN297] 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." [FN298] As the ABA Commission noted, "the White case is likely to politicize judicial elections as never before." [FN299]

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. [FN300]

*1000 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." [FN301] The new statute provides no guidance to the court concerning the method by which to assess such impact. [FN302] 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." [FN303] 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." [FN304] 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.

**1001* 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; [FN305] 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 **1002* association members can institute disciplinary proceedings against fellow members for providing expert testimony. [FN306] *Austin v. American Ass'n of Neurological Surgeons* [FN307] 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. [FN308] A federal district court, sitting in diversity, dismissed Austin's claims, and the U.S. Court of Appeals for the Seventh Circuit affirmed. [FN309] 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. [FN310] 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." [FN311] 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. [FN312] 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. [FN313] 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." [FN314]

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 *1003 cannot initiate AANS complaints, unless the malpractice plaintiff also happens to be a neurosurgeon and a member of the AANS. [FN315]

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. [FN316] 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. [FN317]

A review of the performance of the AANS disciplinary procedure *1004 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. [FN318] 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. [FN319]

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. [FN320] 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 *1005 enhance support of the judicial system and confidence in its decisions. [FN321]

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. [FN322]

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. [FN323] 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. [FN324]

On the other hand, the general thrust of Samuel Gross's 1868 proposal [FN325]--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.

[FN326] The Federal Judicial Center has published a manual designed to educate judges in this respect. [FN327] 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." [FN328] The National *1006 Center for State Courts promotes programs to increase judges' understanding of scientific principles.

[FN329]

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. [FN330] 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 project [FN331] and Duke University Law School's Registry of Independent Scientific and Technical Advisors. [FN332]

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."

[FN333] 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." [FN334]

In appropriate cases, though, testimony by a court-appointed expert may aid the jury in making sense of the relevant issues. [FN335] Such an expert can "tutor[] and advis[e] the decisionmaker, supplement[] the *1007 available information, provid[e] an independent opinion, evaluat[e] party testimony," and "analyze the conflicts between the party experts." [FN336] 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."

[FN337] 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. [FN338] 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."

[FN339] 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. [FN340]

Social scientists dispute the notion of juror passivity, and jury reformers argue that the promotion of active learning by jurors can improve jury performance. [FN341] Recent studies have generated a number of proposed reforms. [FN342] Moreover, the adoption of such *1008 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.

[FN343] 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. [FN344] In cases involving complex expert evidence, the court could direct the defendant's expert to testify right after the plaintiff's expert. [FN345] 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. [FN346] Still further proposals would permit jurors to take notes and to submit questions for the court to pose to witnesses. [FN347]

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. [FN348] Moreover, jurisdictions such as Arizona, Colorado, and the District of Columbia have implemented or encouraged the use of various reforms. [FN349]

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.

***1009 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. [FN350] 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. [FN351] 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. [FN352]

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 *1010 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. [FN353] 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. [FN354]

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 **1011* 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. [FN355]

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. [FN356] 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. [FN357] 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. [FN358]

Other scholars, however, assert that the discretion conferred by the **1012* Federal Rules may be abused by trial judges, [FN359] and that explicit consideration of substance-specific rules would be preferable. [FN360] These scholars point out that maintaining a facial appearance of trans-substantivity does not remove politics from the rulemaking process. [FN361] 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. [FN362] 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. [FN363] 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." [FN364] As a result, the debate over federal rulemaking does not map directly onto the discussion of procedural reforms in medical malpractice. [FN365] 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 **1013* 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. [FN366] 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. [FN367]

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.