Saul Boyarsky,[1] *M.D., J.D.*

Practical Measures to Reduce Medical Expert Witness Bias

REFERENCE: Boyarsky, S., **"Practical Measures to Reduce Medical Expert Witness Bias,"** *Journal of Forensic Sciences*, JFSCA, Vol. 34, No. 5, Sept. 1989, pp. 1259-1265.

ABSTRACT: To minimize bias by the testifying clinician, particularly in professional liability cases, six practical measures should be used:

(1) testify for both the plaintiff and the defense in different cases,
(2) assess the merits of the case separately from agreeing to testify,
(3) insist on reviewing all the records thoroughly,
(4) develop a solid medical posture for each case,
(5) review the case in a balanced, critical manner, and
(6) articulate carefully the standard of care in his words before expressing it in deposition or at trial.

The expert must stay within his role and duty as "expert witness" to remain effective.

KEYWORDS: jurisprudence, witnesses, bias, testimony

Expert witness activity by surgeons and other clinicians is an area of forensic science which is growing in proportion to the malpractice crisis [*1-6*] and represents an expansion of forensic science or courtroom activities beyond the medical specialties of pathology, psychiatry, dentistry, and possibly orthopedics, which were the first fields to be involved. Unfortunately, the best doctors, however that term is defined, do not always make the most effective witnesses. Busy clinicians typically testify without training or extensive preparation, thus limiting the effectiveness of their testimony. In addition to being thoroughly knowledgeable and experienced, articulate, and familiar with courtroom procedure and legal terminology, an effective forensic science expert must be objective and unbiased.

After we examine some definitions of bias, this paper proposes six practical suggestions for consideration which, if pursued, would assist the court in finding the truth more effectively.

Bias is defined in the dictionary several ways, as oblique, diagonal, or curved, so as to cause prejudice or preformed judgment which is "unreasonable" and which can be either favorable or unfavorable to a party [*7*]. Legally, however, bias is an inclination, bent, prepossession of mind, or preconceived opinion which does not leave the mind open to conviction and which will sway judgment so as to render one partial enough to deprive a party of legal rights [*8*]. The expert witness should not be biased and must not be so hostile or, alternatively, so friendly that he or she[2] cannot "hear" the other side or its arguments, that facts do not register properly, that he does not afford adequate credibility to information, or that he selectively discounts or shades part of every fact and statement he encounters. In short,

Received for publication 25 June 1988; revised manuscript received 14 Nov. 1988; accepted for publication 15 Nov. 1988.

[1]Professor of urologic surgery, Washington University School of Medicine, St. Louis, MO.

[2]All references to the male gender throughout shall refer to both male and female. To avoid unnecessary prolixity, the author has deleted further, alternative references.

the expert should stay within the role and duty of expert witness and not become an advocate for one party or the other.

It is suggested that six practices be pursued by clinicians venturing into the courtroom to testify as experts to help them remain impartial and unbiased:

(1) testify for both meritorious plaintiff and defense cases;
(2) assess the merits of each case, on a preliminary basis, before agreeing to testify;
(3) insist on thoroughly reviewing all records;
(4) develop a solid medical posture;
(5) review the case in a balanced, critical manner; and
(6) understand clearly the governing standard of care and articulate it in medical language prior to rendering an opinion.

Avoid Always Taking the Same Side

Clinicians, especially those who are not yet accustomed to the courtroom, will minimize bias by making themselves available to testify for both plaintiffs and defenses in malpractice cases, providing that they believe the party has a meritorious claim.

There is considerable emotion over the plaintiff's expert witness "for hire," particularly over one from foreign or distant jurisdictions [*9,10*]. Yet judges, attorneys, and respected members of the practicing medical community agree that his services are still necessary in cases in which local physicians are reluctant to involve themselves. To castigate this entire group as biased and venal is to expose one's own bias and to prejudge a certain number of meritorious claims. There are gravely injured patients who cannot retain local experts because of the medical profession's justifiable concerns regarding the unpredictability of jury verdicts, joint and several liability, and courtroom rhetorical games.

The physician who only ever testifies for the medical defense and never on behalf of injured patients may be manifesting a bias which might or might not influence his testimony. The same can be said for physicians who testify only *against* other physicians or only *for* insurance companies. It is as intellectually dishonest to characterize all medical malpractice suits as frivolous as it is to characterize all surgical procedures as unnecessary. One must look through the stereotype and shibboleths and examine the facts.

To testify more objectively in court, clinicians should be willing to be called to testify both for the plaintiff and for the defense in medical negligence cases and, if possible, complement their experience with personal injury, workman's compensation, Medicare, and similar cases. This will broaden the clinician's viewpoint and assist him in recognizing that there are incompetent physicians and that serious mistakes do occur. This would also help to minimize prejudice against the plaintiff's bar and the aura of bias by the medical profession. The prospective expert should assess each dispute individually, de novo, on its own record, with due consideration for the source of the data. Traditionally, doctors do this in an exemplary manner when they accept patients for treatment. This open attitude should be applied to afford everyone a fair hearing (not to be confused with acceptance of their viewpoint).

Preliminary Assessment

We must next examine the manner in which the expert witness is retained. Much bias in testimony could be prevented if the physician would insist on making a preliminary assessment of the merits at this juncture, *before* agreeing to testify, to determine whether or not he can agree with the position and claims made by the party seeking to engage him.

When approached by a lawyer to testify, the potential expert witness should not agree to testify in a malpractice case until he has had an opportunity to make a thorough review of the medical records. His assessment must be sufficiently compatible with the client's claim and position to avoid subsequent embarrassing pressures on his candor and testimony. Of

course, if the potential expert does not feel qualified regarding the technical aspects of a particular case or if he discovers a potential conflict of interest, then he must not become involved.

It is proposed that a reasonable preliminary fee be charged for assessing the merits of the case, irrespective of the decision [*11–14*]. The clinician thus removes economic incentive or pressure to make a judgment in one direction or another and remains free to judge the merits of the case on scientific grounds, to give his evaluation and medical posture, and to agree or to decline to testify. This practice would best be part of the initial understanding between the inquiring lawyer and the potential expert.

Because it is the expert who furnishes the lawyer with much of his education about the medical science, the expert serves as an educator and almost as a cocounsel [*11–14*]. To avoid bias, the expert must lead and not follow the lawyer. Although this distinction may appear subtle in theory, its impact is obvious when applied: The doctor sticks to the facts and reports his interpretations and conclusions and must do so consistently, all the way through the case.

The review process resembles a clinical case conference. The clinician must be ready during this review with each reasonable diagnosis and treatment alternative at each significant step of the case and to judge what should, should not, may, or may not have been done. The witness needs to understand each of the legal questions listed in the following section, since they may be posed to the expert by the lawyer. A discussion of them is beyond the scope of this paper, but they differ from the legal questions in criminal law posed to the pathologist or psychiatrist.

The expert renders his assessment of the errors in management, then formulates his opinion regarding causation, importance, materiality and culpability, couched in appropriate legal prose as to the standard of care.

Professional Review of Records

The clinician must perform a thorough professional review of all the records and evidence, including nurses' notes and office records. He faces a serious decision which he must make in a responsible professional manner. His reputation and the welfare of an allegedly injured patient rest on this decision. This means that all the records must be made available to him [*11,15*]. He must insist upon this before rendering a final opinion. One cannot rely on summaries, abstracts, or excerpts of a nurse, lawyer, or layman anymore than one would rely upon these items to make a diagnosis in clinical practice. One must have clinical experience from practice, supervision, or teaching to evaluate a clinical record for deficiencies and evaluate allegations of negligence as to each of these important legal questions:

(1) duty,
(2) breach,
(3) causation,
(4) damages, and
(5) standard of care.

Sound clinical practice demands that each workup and management alternative be analyzed using the methodology of differential diagnosis, and one must examine each potential diagnosis, select the appropriate management alternative, and sequentially accept or reject each one in turn.[3] One reserves the right to do more testing or to wait for a final diagnosis to emerge. The expert witness reads the record to see how well the accused doctor performed this management in the light of the legal pleadings, potential or as filed, in light of the

[3]Basic workup taught to all medical students and residents.

requirements of informed consent, and most importantly, in the light of the facts and circumstances of the case contained in the record. The expert has only the record to guide him. He should be able to judge the case fairly, individually, and objectively.

Develop Medical Posture

Another excellent protection against bias is to formulate a solidly objective *medical posture* based on thorough and balanced analysis of the records and evidence. This can include a careful chronology, a clear analysis of causation, and a classification of the errors.

It is paradoxical that the stronger the scientific case, the more one can expect personal attacks by adversary lawyers in the depositions and at trial. This strategy seeks to discredit and weaken the expert's testimony by causing him to lose his composure [*12–14, 16*]. The more difficult it is to refute the medical substance of his testimony, the more vigorously the opposing lawyer will seek to demonstrate bias, financial interest, or lack of qualification. The expert's best protection against such personal attack in these tactics, which physicians call "courtroom games that lawyers play," is scientific objectivity and thorough preparation. In this game of planned harrassment, which is ultimately staged in front of the jury, he who loses composure first, often loses the war. Careful preparation, thorough discussion, and sound reasoning will generally prevail, be persuasive to the jury, and frustrate the opponent.

Balanced Review of Records

In his review of the evidence, the expert should read first in the light most favorable to the injured patient and then in the light most favorable to the accused clinician. This balanced "judicial" approach superimposed upon the clinical logic of differential diagnosis and multiple alternatives will protect all parties concerned, that is, the expert witness, the accused doctor, and the injured patient, from much grief and error. This approach will also protect the expert witness in subsequent depositions and at trial from embarrassment and will help to eliminate bias.

This "judicial" logic of balancing requires that the records be reviewed from the viewpoint of the plaintiff and the treating physician. The analysis must compare with what the medical profession calls a critical analysis.

Procedurally, the expert witness function passes through four stages which require an increasing degree of transition from a documentary level (reading, writing, and research) to a testimonial level (oral, explanatory, and arguing in the legal sense of the word) [*17*]. These stages are

1. The validity of the complaint or determination of the merits of the case. This would translate to the "*probable cause*" of the legal action.
2. The development of the *medical posture.* This would be used to document the initial opinion letter, affidavits, and pleadings.
3. The initial contact with the adversary counsel would occur in the *deposition,* in which the expert witness must orally defend his opinion on direct examination and defend himself against accusations and manifestations of bias, lack of objectivity, or lack of qualification, and so forth.
4. Finally is the *trial,* at which, after previous preparation and rehearsal, the expert will explain his findings, reasoning, and conclusions to a lay jury or judge and then defend those opinions and conclusions upon cross-examination.

How does one counteract the temptation to argue and the emotional bind on cross-examination when one is accused of bias when he is merely being legally partisan and appropriately firm? Not by slugging it out. One must repeat calmly, patiently, and unemotionally what one

has already said or tried to say, demonstrating clear reasoning based upon professionally established beliefs, assumptions, and axioms. An adversarial approach is inferior to a simple listing of facts and observations [*18*]. After all, one is fighting for the truth with faith in the belief that the truth will lead to justice [*18*].

Applicable Standard of Care

It helps to articulate the standard of care with precision [*19*]. It should be discussed with the lawyer and with medical colleagues to clarify the gravity and medical deficiency of the diagnostic and treatment errors from a legal standpoint and then be clearly articulated. An off-the-cuff answer to the question of standard of care will ruin the entire thrust of one's testimony. The issue of standard of care is a serious matter.

First, standards vary. They can be aspirational, educational, and represent desirable *top* goals to be achieved in practice. These are not for the courtroom. Or, standards can represent the floor or a "bottom line" of acceptable practice, conceptually the fine line below which everything else is *unacceptable.* This is what negligence requires. This leads to the arguments of "who says so?" or "how do you know?"

Or, the standard of care can be viewed as the broad band of average practice in a community or profession, deviation from which is unacceptable. This articulation can be expected on cross-examination to evoke the arguments of "how much deviation?" or "can such an error occur to good doctors in a non-negligent manner? or, one can employ a bell-shaped curve of normalcy to ascertain whether the deviation is "far enough" from normal to constitute negligence.

Although the locality rule for medical specialties [*20–25*] has been overruled in many jurisdictions, an expert will still be cross-examined to see how familiar he is with the type of practice in the area where the alleged negligence occurred. Certain jurisdictions have retained it, at least for certain purposes [*19–24*]. In the replacement of the locality rule by a national standard of care, we often take the local hospital rules and the "*circumstances*" of the case into account instead. The same omission or error in a tertiary center may have a different connotation from that error occurring in a clinic, office, or rural community where sophisticated equipment may be unavailable.[4]

The standard of care changes with medical progress. What state of the art and rate of innovation should one require of a defendant physician to keep up to stay abreast with change [*26–29*]. Does the testifying expert have the proper perspective and sympathy to both parties to be able to set this standard fairly and objectively? Of course, the law recognizes the existence of different schools of thought within every profession.

Setting the standard of care is a serious responsibility for the expert. He is participating in the disposition of a dispute on behalf of society and our legal system. He has therefore undertaken a major responsibility. This task is a public trust [*30–39*].

It will assist the physician to feel on more solid ground vis-a-vis the standard of care if he engages in a two-step process. First, he should articulate and describe the errors. Second, he should translate them to the legal standard of care and legal terminology. Without such preparation, a clinician may venture a confused standard in court. To prepare as objective a standard as the records of the case will allow, it should first be phrased in familiar precise medical language [*19*]. This author believes that expert witnesses should feel free to seek medical consultation from colleagues. Which legal standard the court will choose is for the judge to decide. Whether the lawyer on his side can live with it should have been resolved during the initial assessment of the merits and preparation of the complaint. Peer review of

[4]The locality rule [*24.25*] requires physicians and surgeons to possess that skill held by those practicing in similar localities, with opportunities for no larger experience, not the high degree of art and skill possessed by eminent surgeons in large cities.

expert witnesses and testimony would facilitate the development of a more uniform and fair testimony regarding standards of care.

When the expert is interrogated on the issue of standard of care, he is being asked to approve or disapprove of what happened, to stand up and be counted for quality care, and to judge the quality of care received by a patient [*26-29*]. Courts are more tolerant of ordinary, as opposed to highest care, and to differences of opinion (the existence of minority views and different schools of thought) than are medical staffs. This should not lead the expert to acquiesce to too low a standard of care.

Summary

In conclusion, to avoid bias, the expert must stay within the role and duties of expert witnesses. The role of the expert is *not* to win the case for his client, but rather to serve the *court* to help it dispense justice through truth [*18,19*]. Sympathy for the party that retained him is shown by the expert's willingness to listen to their views and claims thoroughly to establish the factual parameters for their legal arguments. His opinions and words must be tempered by personal pride and a devotion to the integrity of the profession of medicine. His fee must not be contingent upon any particular outcome. The expert witness has been qualified by the court for the party and given the following, and special, legal privileges:

(1) to use facts observed by others in testifying,

(2) to offer an opinion regarding the implications of those facts within the bounds of his or her practice and experience, and

(3) to distinguish right from wrong in the practice of his profession.

The judge and jury are keenly interested in that opinion. They need it. However, the expert witness's message is powerful and must be handled carefully and responsibly. The expert must not go so far as to usurp the Court's functions of deciding guilt, innocence, liability, and other matters of judgment. The expert who steps beyond his proper role exposes himself to bias, and an alert cross-examining lawyer will expose such bias promptly. Arrogance is easily perceived in the courtroom [*7*].

Acknowledgments

Grateful acknowledgment for critical reading is made to Michael C. Sasso, Esq., Dr. Henry G. Schwartz, and Michael A. Wolff, Esq.

References

[*1*] Pollack, S., "Observations on the Adversary System and the Role of the Forensic Scientist: Scientific Truth v. Legal Truth," *Journal of Forensic Sciences*, Vol. 18, No. 3, July 1973, pp. 173-177.

[*2*] Ferris, J. A. A., "An Honest Opinion," *Forensic Science Society*, Vol. 13, 1973, pp. 75-76.

[*3*] Curran, W. J., McGarry, A. L., and Petty, C. S., "Ethical Standards," *Modern Legal Medicine, Psychiatry, and Forensic Science*, F. A. Davis, Philadelphia, 1980, Chap. 2, pp. 29-48.

[*4*] Diamond, B. L., "The Fallacy of the Impartial Expert," *Archives of Criminal Psychodynamics*, Vol. 3, No. 2, Spring 1959, pp. 221-236.

[*5*] *Professional Liability in the 80's*, Reports 1, 2, and 3, Special Task Force on Professional Liability and Insurance, American Medical Association, Oct. 1984, Nov. 1984, and March 1985.

[*6*] Rapp, J. A., Rapp, M. T., Rapp, R. E., and Rapp, R. T., *Illinois Medical Malpractice: A Guide for the Health Sciences*, C. V. Mosby Co., St. Louis, MO, 1988, pp. 1-6.

[*7*] *Dictionary of the English Language*, 2nd ed., unabridged, S. B. Flexner, ed., Random House, New York, 1987.

[*8*] Black, H. C., *Black's Law Dictionary*, revised 4th ed., 1972, and abridged 5th ed., 1983, West Publishing Co., St. Paul, MN.

[*9*] Phillips, W. R., "Confessions of a Hired Gun," *Medical Economics*, Dec. 1986, pp. 70-87.

[*10*] Holoweiko, M., "How Malpractice Lawyers Find Their Hired Guns," *Medical Economics*, Nov. 1987, pp. 164-179.

[11] Poynter, D., *Expert Witness Handbook*, Para Publishing, Santa Barbara, CA, 1987.
[12] Gray, J. E., "The Care and Feeding of Expert Witness," presented at the Defense Practice Seminar on Expert Witnesses, Defense Research Institute, Baltimore, 10-11 Sept. 1987.
[13] Page, R., III, "Challenging the Plaintiff's Expert," presented at the Defense Practice Seminar on Expert Witnesses, Defense Research Institute, Baltimore, 10-11 Sept. 1987.
[14] Brown, K. L., "Questionable Testimony and Medicolegal Examination," *Medical Problems and the Law*, Charles C Thomas, Springfield, IL, 1971.
[15] Boyarsky, S., "Physician's Use of Medical Records," presented at the Institute for Attorneys and Doctors, sponsored by The Bar Association of Metropolitan St. Louis and The American College of Legal Medicine, Dec. 1985.
[16] Gard, S. A., *Missouri Evidence*, Chapter 14, The Lawyer's Co-operative Publishing Co., 1985.
[17] Cound, J. J., Friedenthal, J. H., and Miller, A. R., *Civil Procedure, Cases and Materials*, 2nd ed., West Publishing Co., St. Paul, MN, 1974.
[18] "Article II, Code of Ethics and Conduct," *Membership Directory*, American Academy of Forensic Sciences, Colorado Springs, CO, 1986, pp. XIII.
[19] Rapp, J. A., Rapp, M. T., Rapp, R. E., and Rapp, R. T., *Illinois Medical Malpractice, A Guide for the Health Sciences*, C. V. Mosby Co., St. Louis, MO, 1988, pp. 8-11, 124-125, 150-152.
[20] *Purtill v. Hess*, 111 Ill 2d 229 (1986), 95 Ill Dec. 305, 489 N.E. 2d 867 (Ill. 1986).
[21] *Sadnick v. Doyle*, 510 N.E. 2d 603 (Ill. App. 3 Dist. 1987), 157 Ill. App. 3d 279, 109 Ill. Dec. 735.
[22] *Weekly v. Solomon*, 156 Ill App. 3d 1011, 510 N.E. 2d 152 (Ill. App. 1987).
[23] *Hall v. Hilbun*, 466 So. 2d 856 (Miss. 1985).
[24] *Brune v. Belinkoff*, 354 Mass. 102 (1968), 235 N.E. 2d 793 (Mass. 1968).
[25] *Pederson v. Dumouchel*, 72 Wash. 2d 73 (1967), 431 P.2d (1973). Note: 23 Vand. L. Rev. 729 (1970).
[26] *Pike v. Honsinger*, 49 N.E. 760, 762 (N.Y. 1898).
[27] *Schroeder v. Perkel*, 432 A.2d 834 (N.J. 1981).
[28] *Clark v. U.S.*, 402 F 2d 950 (1968).
[29] *Helling v. Carey*, 83 Wash. 2d 514, 519 P.2d 981 (1974).
[30] Adelson, S., "Expert Witnesses Had Unquestionable Credentials: Commentary," *American Medical News*, 2 Oct. 1987, p. 34.
[31] Hays, L., "Doctors Facing Peer Reviews of Testimony," *Wall Street Journal*, 11 Jan. 1988, p. 25.
[32] Eichorn, J. H., Cooper, J. B., Cullen, D. J., Maier, W. R., Philip, J. H., and Seeman, R. G., "Standards for Patient Monitoring During Anesthesia at Harvard Medical School," JAMA, Vol. 256, 1986, pp. 1017-1020.
[33] "Guidelines for the Administration of Anesthesia," suggested by *The St. Louis Society of Anesthesiologists*, 9 Sept. 1985.
[34] Perry, S., "The NIH Consensus Development Program, A Decade Later," *The New England Journal of Medicine*, Vol. 317, No. 8, 1987, pp. 485-488.
[35] "The Management of Clinically Localized Prostate Cancer," *The Journal of Urology*, Vol. 138, Dec. 1987, pp. 1369-1375.
[36] Jacoby, I., "The Consensus Development Program of the National Institutes of Health," *International Journal of Technology Assessment in Health Care*, Vol. 1, No. 2, Cambridge University Press, 1985, pp. 420-432.
[37] Tancredi, L. R., "Designing a No-Fault Alternative," *Law and Contemporary Problems*, Duke University School of Law, Durham, NC, Vol. 49, No. 2, Spring 1986.
[38] Cound, J. J., Friedenthal, J. H., and Miller, A. R., *Civil Procedure, Cases and Materials*, 2nd ed., West Publishing Co., St. Paul, MN, 1974.
[39] Etheridge, The Honorable Jack, Judge of the Superior Court of the State of Georgia, "The Expert and the Law," publication of *The National Forensic Center*, Vol. 8, Princeton, NJ, Jan. 1988, p. 1.

Address requests for reprints or additional information to
Saul Boyarsky, M.D., J.D.
Professor of Urologic Surgery
Washington University School of Medicine
Law and Medicine—Box 8109
4960 Audubon Ave.
St. Louis, MO 63110