THOMSON WEST

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WEST'S
MEDICAL MALPRACTICE
LAW REPORT

COMMENTARY

REPRINTED FROM VOLUME 2, ISSUE 25 / MAY 11, 2007

A Critique of ALI's Proposal to Bar Expert Testimony to a 'Reasonable Degree Of Professional Certainty'

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Since its founding 84 years ago, the ALI has been addressing "uncertainty in the law through a restatement of basic legal subjects." The ALI consults with experts in the field of law to draft its restatements, and after years of review the ALI approves final statements that have been "accorded an authority greater than that imparted to any legal treatise." Recently, the ALI issued tentative draft No. 5 of the Restatement (Third) of Torts, Liability for Physical and Emotional Harm. That draft has not yet been considered by the members of the ALI and does not represent the position of the ALI.

Chapter 5 of that draft, "Factual Cause," has only one section in it, Section 28. Section 28 states in the first paragraph a general rule that plaintiffs have the burden of causation, and then, in the second paragraph, a version of the old *Summers v. Tice* form of alternative causation. 33 Cal.2d 80 (Cal. 1948). There is only one comment under Section 28, incongruously denominated "comment e," and that comment has very little to do with either of the black-letter paragraphs.

Instead, comment e purports to abolish any requirement that an expert witness testify to a "reasonable degree of medical certainty" or "medical probability" or any of the similar formulations that courts have used for generations to ensure that in-court expert witnesses use the same standards before a jury that they would use in their everyday practices. Instead of those standards, an expert witness would be allowed to state an opinion — in a civil case, at least — that he or she held merely as "more likely than not":

> [T]his section adopts the same preponderance standard that is universally applied in civil cases. Direct and cross-examination can be employed to flesh out the degree of certainty with which an expert's opinion is held and to identify opinions that are speculative and therefore inadmissible.

Restatement (Third) of Torts, Liability for Physical and Emotional Harm, § 28, comment e (Tentative Draft 5, 2007).

The comment offers three reasons for doing away with the "reasonable professional certainty" requirement. First, the old standard "is problematic because the medical and scientific communities have no such 'reasonable certainty' standard." *Id.* Second, "[t]here is a troubling inconsistency in imposing a higher threshold for the admissibility of expert testimony than is required for a party to meet the burden of proof." *Id.* Third, "the reasonable-certainty standard provides no assurance of the quality of the expert's qualifications, expertise, investigation, methodology or reasoning." *Id.*

We respectfully dissent.

In our home states, Ohio and Pennsylvania, the "reasonable degree of professional certainty" standard is well-established and creates no difficulties. *See State v. Jackson*, 751 N.E.2d 946, 961 (Ohio 2001); *McMahon v. Young*, 276 A.2d 534, 535 (Pa. 1971); *Corrado v. Thomas Jefferson Univ. Hosp.*, 790 A.2d 1022, 1027, 1031 (Pa. Super. Ct. 2001). Nor do experts seem to have much trouble with the standard. Of course, those experts are doing what experts are supposed to do: evaluate cases by the same standards that they would use when they are not in court.

"Reasonable degree of medical certainty" has always been a relatively rigorous standard under the law.

That is its purpose. This is the same standard that the law requires for "pulling the plug" in the "right-to-die" context. *See* Ala. Code § 22-8A-3; Cal. Prob. Code § 4701; 16 Del. Code § 2501; Ga. Code § 31-39-2; Iowa Code § 144A.2; Neb. Rev. Stat. § 30-3402; N.J. Stat. Ann. § 26:2H-55; N.Y. Surr. Ct. Proc. Act § 1750-b (4); N.C. Gen. Stat. § 90-321; 20 Pa. Cons. Stat. Ann. § 5401; Ohio Rev. Code §§ 2133.02(A)(2-3), 1337.13(E).

This standard arose to require experts to use the same standards of professional certainty in court that they use in their regular employment. *E.g., McMahon*, 276 A.2d at 535 ("doctors must make decisions in their own profession every day based on their own expert opinions").

Consider the three reasons given by comment e for abolishing the traditional standard for expert testimony. The first is that the relevant professional communities do not employ professionally a "reasonable certainty" standard.

In the abstract, that is probably true; doctors and other professionals probably do not frame the decisions that they make in these terms. But it is similarly unlikely that they frame their important decisions as deciding whether a result is merely "more likely than not" correct, which is little more than a coin flip.

We personally would be very uncomfortable with an attending physician who is willing to make a life-or-death medical decision, like "pulling the plug" in the right-to-die context, on the basis of the beneficial result simply being "more likely" than some other, adverse result.

The Hippocratic Oath requires that physicians "first, do no harm." A diagnosis based upon a mere "more likely than not" standard fails that test; it flies in the face of good medical judgment. Even if a particular treatment objectively offers less than 50 percent likelihood of success, a physician employs it only because he or she feels strongly that there is nothing else that offers a better chance — not because a coin toss judged which treatment might work best.

While it is true that "reasonable certainty" is not the way in which doctors (and, we presume, other professionals, such as the economists at the Federal Reserve) articulate their decision-making process, that fact does not support the change that draft comment e proposes. If anything, that proposal recommends a step in the wrong direction. "More likely than not" moves farther away from the actual comfort level that professionals actually need before making a critical decision.

So while the fact underlying the first justification for draft comment e is probably true, it is a non sequitur.

Experts do not speak in terms of "reasonable professional certainty," but that does not mean that they act rashly. Nor dos experts' word choices support the direction in which comment e seeks to take the law.

The second critique in comment e is that it is "inconsistent" to judge expert testimony by a higher standard than that which the lay jurors are called upon to reach their ultimate decision. Not true. That "inconsistency" only exists if one fails to consider the reasons why the legal system requires expert testimony in so many situations. Experts are called upon to give opinions on scientific and technical matters that lay jurors are not supposed to be capable of evaluating on their own:

> Unlike an ordinary witness, an expert is permitted wide latitude to offer opinions, including those that are not based on firsthand knowledge or observation. Presumably, this relaxation of the usual requirement of firsthand knowledge … is premised on an assumption that the expert's opinion will have a reliable basis in the knowledge and experience of his discipline.

Daubert v. Merrell Dow Pharms. Inc., 509 U.S. 579, 592 (1993).

Experts are therefore held to a standard commensurate with their purpose in the legal system: that of their own discipline.

"It is to make certain that an expert, whether basing testimony upon professional studies or personal experience, employs in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field." *Kumho Tire Co., Ltd. v. Carmichael,* 526 U.S. 137, 152 (1999) (emphasis added); see McMahon, 276 A.2d at 534. Experts should apply their judgment as fully and as rigorously in the courtroom as outside it.

Juries, unlike experts, apply the "more likely than not" standard because jurors and experts play fundamentally different roles in the judicial process. Jurors have to decide cases. Experts are permitted to testify only when their professional opinions are "helpful" to what the jury has to do. The standard of admissibility is not automatically the same as the burden of proof.

There is also a flip side to the "inconsistency" argument. One of the benefits of the "reasonable professional certainty" standard is its uniformity across all forms of litigation. The leading Ohio "reasonable professional certainty" decision is, after all, a criminal case.

To clear up the "inconsistency" that comment e identifies would require applying internally inconsistent standards

to identical expert testimony depending on the type of case to which it was relevant. Only certain types of civil cases allow juries to reach decisions based upon what is "more likely than not." Other civil cases (most commonly, fraud) employ a "clear and convincing" standard.

Criminal cases require a "beyond a reasonable doubt" standard. If the law requires expert testimony to match the standard that the jury is called upon to decide, the admissibility of identical testimony — say, an accountant evaluating the damage caused by a disputed transaction — could be determined by at least three different (or, one might say, inconsistent) standards, depending upon whether the accountant's testimony was relevant to damages in a contract case, damages in a fraud case or amount of harm in a criminal case.

The ALI's inconsistency argument thus ignores the different roles that expert witnesses and lay jurors play in the legal system and just trades one kind of inconsistency for another.

The third and final ground offered in comment e is that the "reasonable professional certainty" standard offers "no assurance" of the "quality" of any aspect of expert testimony. The basic problem is that the comment's solution offers even less assurance of "quality." The ALI's last argument thus sets up the perfect as the enemy of the good. If preserving "quality" is the ideal, an "absolute certainty" standard would undoubtedly be the best — but then we would almost never have admissible expert testimony.

The "reasonable professional certainty" standard has the great advantage that it emphasizes the "professional" aspect of expert testimony. The "more likely than not" standard does away with any link to an expert's professionalism and thus permits opinions in court that might amount to professional malpractice if offered anywhere outside the courtroom.

It is certainly true that there is no "assurance" of "quality" with the "reasonable professional certainty" standard. Dumbing down that standard to a coin flip, however, offers even less "assurance" that expert testimony will serve the purposes for which it is intended.

Comment e is correct on one point, however. The "reasonable professional certainty" standard could do with more content. In keeping with the reasons for expert testimony, that content should not come from legal formulations, but rather from paying more heed to how the relevant profession actually reaches decisions. That requires resort to source material outside the ordinary legal realm.

There is, in fact, a body of medical literature devoted to the process of medical decision-making. This literature makes clear that, when diagnosing and treating patients, physicians routinely employ rigorous decision-making analyses, not coin flips. For example:

> In the diagnostic process, the clinician makes a series of inferences about the nature of malfunctions of the body. These inferences are derived from existing observations (historical data, physical findings and routine tests) as well as from invasive tests and responses to various manipulations. Inferential reasoning proceeds until the clinician has discovered a diagnostic category sufficiently acceptable to either establish a prognosis, yield a therapeutic action or both.

Jerome P. Kassirer, *Diagnostic Reasoning*, 110 Ann. Intern. Med. 893 (1989).

Over the past 10 to 15 years, physicians have come to rely considerably upon what the medical community calls "evidence-based medicine." This approach supplements a treating physician's own experiences, observations and instincts with scientific and epidemiologic data to achieve the best possible diagnosis and appropriate treatment. The expectation is that doctors will seek out the best evidence to assist in making medical decisions.

"Evidence-based practice is the integration of best research evidence with clinical expertise and patient values. In clinical applications, providers use the best evidence available to decide, together with their patients, on the suitable options for care," according to Kathleen N. Lohr. *Rating the Strength of Scientific Evidence: Relevance for Quality Improvement Programs*, 16 Int'l J. for Quality in Health Care 9, 10 (2004).

The medical community realizes that scientific or statistical evidence cannot be applied in a vacuum, and clinical experience and observations will always play a key role in the diagnosis and treatment of patients:

> Clinical experience and the development of clinical instincts (particularly with respect to diagnosis) are a crucial and necessary part of becoming a competent physician. Many aspects of clinical practice cannot, or will not, ever be adequately tested. Clinical experience and its lessons are particularly important in these situations. At the same time, systematic attempts to record observations in a reproducible and unbiased fashion markedly increase the confidence one can have in knowledge about patient prognosis, the value of diagnostic tests and the efficacy of treatment.

> In the absence of systematic observation one must be cautious in the interpretation derived from clinical experience and intuition, for it may at times be misleading.

American Medical Association Evidence-Based Medicine Working Group, *Evidence-Based Medicine: A New Approach to Teaching the Practice of Medicine*, 268 J. Am. Med. Ass'n 2420, 2421 (1992). Successful practice of medicine is not something that can be accomplished by reading a few medical records handed to an expert by a retaining attorney:

> Competence depends on using expert scientific, clinical and humanistic judgment in clinical reasoning. Although expert clinicians often use pattern recognition for routine problems and hypothetico-deductive reasoning for complex problems outside their area of expertise, expert clinical reasoning usually involves working interpretations that are elaborated into branching networks of concepts. These networks help professionals initiate a process of problem-solving from minimal information and use subsequent information to refine their understanding of the problem. Reflection allows practitioners to examine their own clinical reasoning strategies.

Ronald M. Epstein et al., Defining and Assessing Professional Competence, 287 J. Am. Med. Ass'n 226, 226-27 (2002). See A. Cecile J.W. Janssens et al., A New Logistic Regression Approach for the Evaluation of Diagnostic Test Results, 25 Med. Decision Making 168 (2005) (detailing statistical models for determining the usefulness of further diagnostic testing of patients to increase the certainty of diagnosis).

The medical literature consistently emphasizes the need for an integrated approach to decision-making, using all available evidence, to achieve the highest possible accuracy and confidence available under the circumstances. Application of state-of-the-art methodology for statistical analysis requires approaches that go beyond mere "subjective judgments":

> In the end, statistical inference … can take us only so far. In fact, our clinical decisions are rarely based on subjective judgments or objective data alone, but rather on something between and beyond the two — the ethical doctrines that ultimately imbue the decisions with meaning and value. … The current emphasis on clinical outcomes and prescriptive guidelines is a clear reflection of both the influence on modern medical practice and the importance of probabilistic reasoning to clinical decision-making. In this context, good decisions succeed in balancing the objective scientific data against our subjective ethical values; they are evidence-based, but not evidence-bound.

George A. Diamond *et al.*, Prior Convictions: *Bayesian Approaches to the Analysis and Interpretation of Clinical Megatrials*, 43 J. Am. Coll. Cardiol. 1929, 1936 (2004).

Thus the literature establishes that doctors should take an integrated approach to clinical decision-making, combining evidence-based approaches with their own experience and perspective, to reach the highest degree of confidence — not mere 51 percent — in diagnosis and treatment:

> Mindfulness [in the clinical setting] can link evidence-based and relationship-centered care to help overcome the limitations of both approaches. The success of evidence-based approaches depends on the ability of the practitioner to decide which issues require further investigation and how to frame a question.
>
> These, in turn, require that the practitioner identify his or her own biases and the influences of the patient-physician relationship on framing of the question to investigate. This personal knowledge should also be considered a form of evidence and could be integrated into decision-making to incorporate patients' preferences. Evidence-based data that are not specific to one patient-physician relationship would then be applied in a more mindful way.

Ronald M. Epstein, *Mindful Practice*, 282 J. Am. Med. Ass'n 833, 837 (1999).

The overriding theme of the medical literature is that doctors should seek all available methods to attain the most accurate and appropriate diagnosis and treatment for each patient.

In discussing the principles of evidence-based medicine, the American Medical Association's Evidence-Based Medicine Working Group outlined a hierarchy of medical evidence based upon its reliability and usefulness to treating physicians:

> Foremost among these principles are that value judgments underlie every clinical decision, that clinicians should seek evidence from as high in the hierarchy as possible and that every clinical decision demands attention to the particular circumstances of the patient.

Gordon H. Guyatt et al., Users' Guides to the Medical Literature XXV: Evidence-Based Medicine: Principles for Applying the Users' Guides to Patient Care, 284 J. Am. Med. Ass'n 1290, 1295 (2000).

Medical and research professionals constantly refine and improve their diagnostic approaches — to drive medicine as far away from the essentially random chance model of 51 percent as possible.

"A fundamental tenet of all scientific and scholarly work is that every aspect of it must be subjected to critical appraisal; only those findings and principles that withstand such appraisal become established." Tom Jefferson *et al.*, *Measuring the Quality of Editorial Peer Review*, 287 J. Am. Med. Ass'n 2786 (2002).

The National Academy of Sciences, the National Academy of Engineering and the Institute of Medicine have all said "[i]ndividual scientists have a fundamental responsibility to ensure that their results are reproducible, that their research is reported thoroughly enough so that the results are reproducible and that significant errors are corrected when they are recognized." Responsible Science: Ensuring the Integrity of the Research Process at 7 (National Academy Press 1992).

A coin-flip approach to expert testimony is contrary to what the law is trying to accomplish by allowing that testimony. To the extent that the "reasonable professional certainty" standard needs more content to make it explicable to both lay jurors and experts alike, that content is not to be found in yet another legal standard like "more likely than not" (or "clear and convincing" or "beyond a reasonable doubt"), but rather in the standards that the relevant profession chooses to follow.

Judges should raise the bar to improve the quality of expert testimony permitted in their courtrooms. The ALI should not be pressing the law to move in the opposite direction.

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Beck and Herrmann co-host the Drug and Device Law blog (http://druganddevicelaw.blogspot.com), where an earlier version of this article first appeared. The views expressed in this article are those of the authors and not necessarily of their clients or firms.