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Insuring Bias: Does Evidence Of Common Insurance Demonstrate Relevant Expert Witness Bias In Medical Negligence Litigation?, 55 Duq. L. Rev. 339 (2017)

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INSURING BIAS: DOES EVIDENCE OF COMMON INSURANCE DEMONSTRATE RELEVANT EXPERT WITNESS BIAS IN MEDICAL NEGLIGENCE LITIGATION?

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I. INTRODUCTION

> The objectivity of the expert witness . . . is one of the more valued qualities that an expert hopes to bring to the legal system, despite the latter's necessarily partisan adversarial structure. Despite this ideal, dealing with bias constitutes one of the central challenges for expert witnesses in the legal system. The issue has been considered throughout the history of forensic work.[1]

> When the medical profession sets a moral standard that demands that a physician, testifying under oath in court, must state his opinion fairly and fully without bias and without regard to the side that calls him, neither suppressing nor over-emphasizing any aspect of the case, then, and only then, you will have real medical expert testimony.[2]

Consider the following scenario: plaintiff, a former patient, sues defendant-physician for medical negligence. An expert witness-physician[3] is engaged by defense counsel to testify at trial that the care and treatment rendered by the defendant-physician complied with the applicable standard of care.[4] Fortuitously, the defendant-physician and the defendant-physician's expert witness maintain professional liability insurance with the same liability insurer. Does this "common insurance"—insurance shared by the defendant

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1. Michael Lamport Commons, Patrice Marie Miller & Thomas G. Gutheil, *Expert Witness Perceptions of Bias in Experts*, 32 J. AM. ACAD. PSYCHIATRY & L. 70, 70 (2004).

2. Lee M. Friedman, *Expert Testimony, Its Abuse and Reformation*, 19 YALE L.J. 247, 254 (1910).

3. For an explanation of the function of the medical expert witness, see Fred L. Cohen, *The Expert Medical Witness in Legal Perspective*, 25 J. LEGAL MED. 185, 191–92 (2004).

4. *See* Joseph H. King, Jr., *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 VAND. L. REV. 1213, 1236 (1975); Charles Markowitz, *Medical Standard of Care Jurisprudence as Evolutionary Process: Implications Under Managed Care*, 2 YALE J. HEALTH, POL'Y L. & ETHICS 59, 59 (2002); Larry W. Myers, *"The Battle of the Experts:" A New Approach to an Old Problem in Medical Testimony*, 44 NEB. L. REV. 539, 539 (1965).

and defense expert—establish expert witness bias, constituting ammunition for cross-examination at trial?[5]

It is well understood that "evidence" of the presence or absence of liability insurance is simply inadmissible to prove fault, pursuant to Federal Rule of Evidence 411[6] (and similar state evidentiary rules), which provides:

> Rule 411—Liability Insurance
> Evidence that a person was or was not insured against liability is not admissible to prove whether the person acted negligently or otherwise wrongfully. But the court may admit this evidence for another purpose such as proving a witness's bias or prejudice or proving agency, ownership, or control.[7]

But Rule 411 is not a complete bar to admissibility and allows the trial court to admit evidence of liability insurance to prove "a witness's bias or prejudice."[8] Is a medical expert witness more likely to testify in support of the defendant-physician simply because of common insurance? On the periphery, this argument for admissibility appears rather tenuous, but, beneath the surface, it may have some traction. In the past ten to fifteen years, the common insurance question has received attention by state courts.[9] A comprehensive examination of the topic is appropriate at this time.[10]

Essentially, the common insurance concern is as follows: an expert witness insured by the same professional liability insurer as the defendant-physician has a financial interest in a jury verdict in favor of defendant. A verdict in favor of the plaintiff would cause

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5. *See* Steven Feola & Richard A. Alcorn, *Expert Witness Advocacy: Changing Its Culture*, ARIZ. ATT'Y, Mar. 2009, at 24, 25 (urging that commonality of insurance is one of the "[n]umerous factors [which] appear to cause or contribute to the problem of expert witness advocacy").

6. FED. R. EVID. 411.

7. *Id.*

8. *Id.*

9. *See* Hawes v. Chua, 769 A.2d 797 (D.C. 2001); Bonser v. Shainholtz, 3 P.3d 422 (Colo. 2000); Vasquez v. Rocco, 836 A.2d 1158 (Conn. 2003); Chambers v. Gwinnett Cmty. Hosp., Inc., 557 S.E.2d 412 (Ga. Ct. App. 2001); Cetera v. DiFilippo, 934 N.E.2d 506 (Ill. App. Ct. 2010); Kan. Med. Mut. Ins. Co. v. Svaty, 244 P.3d 642 (Kan. 2010); Woolum v. Hillman, 329 S.W.3d 283 (Ky. 2010); Anderson v. O'Rourke, 942 A.2d 680 (Me. 2008); Wells v. Tucker, 997 So. 2d 908 (Miss. 2008); Reimer v. Surgical Servs. of the Great Plains, P.C., 605 N.W.2d 777 (Neb. 2000); Cobb v. Shipman, 35 N.E.3d 560 (Ohio Ct. App. 2015); Schultz v. Mayfield Neurological Inst., No. C–120764, 2013 WL 5432103 (Ohio Ct. App. Sept. 25, 2013), *appeal denied*, 3 N.E.3d 1218 (Ohio 2014); Givens v. Sorrels, No. M2012–01712–COA–R3–CV, 2013 WL 4507946 (Tenn. Ct. App. Aug. 21, 2013).

10. For a prior examination of this topic by a law student, see Maggie C. Bednar, *Medical Expert Witness Bias Due to Commonality of Insurance*, 23 J. LEGAL MED. 403 (2002).

the professional liability insurer to a pay a potentially sizeable sum to the plaintiff and this payment (and other similar payments in other litigation) would cause professional liability insurance premiums to increase to cover losses. Therefore, the defendant-physician's expert would be financially motivated to testify in favor of the defendant-physician. Of course, the concept of impeaching an expert witness by demonstrating financial interest in the litigation is nothing new. A physician's income derived from medico-legal consultation and testimony, the frequency of consultation, and the party for whom the expert consults (plaintiff or defendant-physician) have always been proper subjects for cross-examination.[11] Common insurance is different, and likely does not evidence more than a theoretical, indirect financial interest of the medical defense expert.

II. PURCHASING PROFESSIONAL MEDICAL LIABILITY INSURANCE AND PHYSICIAN NEGLIGENCE

As far back as 1954, a professor of legal medicine noted "[t]he likelihood of being sued for malpractice is now so great that the practicing physician must recognize that it constitutes a definite occupational hazard."[12] Medical literature has reported efforts to predict the risk of such claims.[13] Therefore, a physician does not purchase professional liability insurance because the physician is planning to provide negligent care to patients. Professional liability insurance, much like other liability insurance, is purchased consistent with the "[virtue] of spreading the risk of loss among many to make it possible for the individual to bear the economic burden of adversity."[14]

Purchasing (or not purchasing) liability insurance does not evidence negligent conduct and, therefore, is not admissible to prove fault pursuant to Federal Rule of Evidence 411.[15] McCormick's evidence treatise explains the policy supporting this exclusion:

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11. *See* Trower v. Jones, 520 N.E.2d 297 (Ill. 1988) (annual income from services related to expert testimony; frequency with which expert testifies for plaintiffs/defendants); *see also* Julie A. Correll, Trower v. Jones*: Expanding the Scope of Permissible Cross-Examination of Expert Witness*, 20 LOY. U. CHI. L.J. 1071 (1989); Michael H. Graham, *Impeaching the Professional Expert Witness by a Showing of Financial Interest*, 53 IND. L.J. 35, 38 (1977).

12. Louis J. Regan, *Malpractice, An Occupational Hazard*, 156 JAMA 1317, 1317 (1954).

13. *See, e.g.*, Sara C. Charles et al., *Predicting Risk for Medical Malpractice Claims Using Quality-of-Care Characteristics*, 157 W.J. MED. 433 (1992); Anupam B. Jena et al., *Malpractice Risk According to Physician Specialty*, 365 NEW ENG. J. MED. 629 (2011).

14. Melvin M. Belli, *The Social Value of Liability Insurance*, 13 HASTINGS L.J. 169, 169 (1961).

15. FED. R. EVID. 411.

> This rule rests on two premises. The first is the belief that insurance coverage reveals little about the likelihood that one will act carelessly. Subject to a few pathological exceptions, financial protection will not diminish the normal incentive to be careful, especially when life and limb are at stake. Similarly, the argument that insured individuals or firms are more prudent and careful, as a group, than those who are self-insurers seems tenuous and also serves to counteract any force that the first argument might have. Thus, the relevance of the evidence of coverage is doubtful.[16]

As previously mentioned, Federal Rule of Evidence 411 provides for evidence of insurance to prove witness bias or prejudice. How might a medical negligence plaintiff develop this evidence?

Illinois is an excellent example of a state in which common professional liability insurance may be anticipated. As of 2012, Best's Statistical Study of U.S. Professional Liability—2012 Direct Premiums Written[17] listed ISMIE Mutual Group (ISMIE) as the tenth largest writer of medical professional liability insurance in the United States.[18] In its 2013 report, the Illinois Department of Insurance reported that, in 2011, ISMIE was the largest medical malpractice insurer in Illinois, covering 62.9% of the state's market.[19] ISMIE had an even larger market share, 72.3%, in medical/surgical coverage and a 77.8% market share in other/not classified coverage.[20] Therefore, it is predictable that an Illinois physician-defendant will be insured by ISMIE. If that physician retains an expert witness-physician who practices medicine in Illinois, it is also likely that the expert will have ISMIE coverage.

The Illinois Rules of Evidence (IRE) include IRE 411, which provides:

> Rule 411—Liability Insurance
> Evidence that a person was or was not insured against liability is not admissible upon the issue whether the person acted negligently or otherwise wrongfully. This rule does

16. KENNETH BROUN ET AL., MCCORMICK ON EVIDENCE 427 (7th ed. 2013).
17. BESTLINK, BEST'S STATISTICAL STUDY, U.S. MEDICAL PROFESSIONAL LIABILITY—2012 DIRECT PREMIUMS WRITTEN 1 (2013).
18. *Id.*
19. ILL. DEP'T OF INS., 2013 COST CONTAINMENT ANNUAL REPORT TO THE ILLINOIS GENERAL ASSEMBLY 21 (2013).
20. *Id.* at 22.

> not require the exclusion of evidence of insurance against liability when offered for another purpose, such as proof of agency, ownership, or control, or bias or prejudice of a witness.[21]

Thus, IRE 411 contemplates the admissibility of evidence of insurance to demonstrate witness bias, as does FRE 411. Is it, therefore, reasonable to conclude that, in Illinois, a state in which common insurance between a physician-defendant and the expert-physician is predictable, evidence of common insurance should be admissible to provide expert witness bias? Of course, if the plaintiff retains an Illinois physician as an expert witness and that physician shares common insurance with the defendant-physician, is that expert more credible due to a willingness to provide testimony that may support a verdict to be paid by a common insurance provider? That position is no more logical than the rationale "suggesting" common insurance bias when focusing on the defense expert.

In order to explore potential common insurance and expert witness bias, it is helpful to examine an important model of professional liability insurance. Professor Tom Baker at the University of Connecticut School of Law noted that "physician-controlled mutual insurance companies have a very significant market share in many states."[22] As reported in 1991, "[o]ver half of the total dollar volume of physicians' malpractice insurance is now written by physician-owned mutual companies."[23] Furthermore, "[m]utual insurance companies by definition are owned entirely by their policyholders. Any profits earned are returned to policyholders in the form of dividend distributions or reduced future premiums."[24] The argument, then, is that physicians insured by mutual professional liability insurers directly benefit in profitable years by receiving dividend payments from their insurers. The expert witness-physician, therefore, gains a direct financial benefit if the common insurer is not required to pay jury verdicts in favor of plaintiffs.

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21. ILL. R. EVID. 411

22. Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DEPAUL L. REV. 393, 428 (2005).

23. Patricia M. Danzon, *Liability for Medical Malpractice*, 5 J. ECON. PERSP. 51, 59 (1991).

24. NAT'L ASS'N OF INS. COMM'RS, CAPITAL MARKETS SPECIAL REPORT (2015), http://www.naic.org/capital_markets_archive/150428.htm. *See also* J.A.C. Hetherington, *Fact v. Fiction: Who Owns Mutual Insurance Companies*, 1969 WIS. L. REV. 1068 (1969); Gary Kreider, *Who Owns the Mutuals? Proposals for Reform of Membership Rights in Mutual Insurance and Banking Companies*, 41 CIN. L REV. 275 (1972); Joan Lamm-Tennant & Laura T. Starks, *Stock Versus Mutual Ownership Structures: The Risk Implications*, 66 J. BUS. 29 (1993).

This argument is, presumably, the Rule 411[25] argument in favor of admissibility. The basic weakness of this argument is that the defendant's expert witness-physician is more likely to testify in support of the defendant-physician because the expert actually believes that malpractice did *not* occur and that the medical care and treatment provided by the defendant complied with the applicable standard of care. A more cynical view of medical expert witnesses and testimonial bias is that medical experts are very intelligent and understand that litigation is adversarial. Perhaps expert X, retained by plaintiff, would have been comfortable testifying for the defendant-physician, if only defense counsel would have contacted expert X before plaintiff's counsel did. This scenario simply suggests that medical experts are intelligent mercenaries, capable of convincing juries of either a plaintiff's or defendant's position in any given medical negligence case. That is a problem, which, I suggest, overwhelms the likelihood that common insurance influences a medical expert's testimony.

A corollary to the common insurance "bias" is that common professional liability insurers are directly or indirectly compensating the defendant-physician's expert for consulting, testifying at a deposition, and testifying at trial. Arguably, compensation of expert witness fees by a common professional liability insurer and administrative involvement of the expert witness with the common insurer further complicates the issue.

III. SURVEYING THE STATES

The common insurance basis for medical expert witness bias is due for comprehensive analysis and comment. To do so requires an examination of various jurisdictions that have addressed this issue.

A. Ohio—The Per Se Rule of Admissibility

The 1994 seminal case in Ohio is *Ede v. Atrium South OB-GYN*,[26] in which the Supreme Court of Ohio pronounced that evidence of common insurance between a physician-defendant and the physician-defendant's medical expert "is sufficiently probative of the expert's bias as to clearly outweigh any potential prejudice evidence of insurance might cause."[27] In *Ede*, the Supreme Court was confronted with common professional liability coverage provided by a

25. FED. R. EVID. 411.
26. Ede v. Atrium S. OB-GYN, 642 N.E.2d 365 (Ohio 1994).
27. *Id.* at 368.

mutual professional liability insurer.[28] Plaintiff urged that "each insured's policy is evidence of some fractional part ownership in [the insurer],"[29] creating a "built-in-bias—fewer successful malpractice claims means lower premiums charged for malpractice insurance."[30] The Supreme Court was quite critical of the trial court's refusal to consider any potential bias that might result from fractional ownership in a mutual professional liability insurer[31] and pronounced the aforementioned rigid rule of admissibility.[32]

Remarkably, in 2015, the Court of Appeals of Ohio, in *Cobb v. Shipman*,[33] applied the *Ede* rule of common insurance admissibility[34] even when the defendant-physician's expert was unaware of the existence of common insurance. Apparently, the expert's unawareness of common insurance simply constitutes a credibility consideration.[35] It is difficult to explain this implicit or subliminal bias.

The *Ede* dissent[36] aptly pointed out that the majority opinion stated: "[t]he scope of cross-examination of a medical expert on the questions of the expert's bias and pecuniary interest and the admissibility of evidence relating thereto are matters that rest in the sound discretion of the trial court,"[37] and that a per se rule of admissibility removes the trial court's discretion.[38] The dissent further suggested that the majority created a new Ohio rule of evidence and, "in doing so, has circumvented the proper rulemaking procedures required by the Ohio Constitution."[39]

Worthy of note is the 2013 opinion of the Court of Appeals of Ohio in *Schultz v. Mayfield Neurological Institute*.[40] Here, the Court of Appeals reviewed a defense verdict following a bench trial. The trial judge precluded the plaintiff from cross-examining the defendant's medical expert regarding common professional liability insurance.[41]

In affirming the trial court, the Court of Appeals stated:

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28. *Id.* at 366.
29. *Id.* at 366.
30. *Id.*
31. *Id.* at 368.
32. *Id.*
33. Cobb v. Shipman, 35 N.E.3d 560 (Ohio Ct. App. 2015).
34. *Ede*, 642 N.E.2d at 368.
35. *Cobb*, 35 N.E.3d at 574.
36. *Ede*, 642 N.E.2d at 369 (Wright, J., dissenting).
37. *Id.* at 369 (citation omitted).
38. *Id.* at 369–70.
39. *Id.*
40. Schultz v. Mayfield Neurological Inst., No. C–120764, 2013 WL 5432103 (Ohio Ct. App. Sept. 25, 2013).
41. *Id.* at *2.

> On the facts of this case, even if the trial court erred by excluding the testimony, we cannot say that the Schultzes' substantial rights were prejudiced as a result. The concerns expressed by the *Ede* court with respect to jury determinations were not present here—this was a bench trial where both parties had ample opportunity to argue their positions on the commonality-of-insurance matter directly to the trier of fact. So the Schultzes cannot demonstrate that the outcome of the trial would have been otherwise had the testimony not been excluded. Accordingly, we overrule the second assignment of error.[42]

On the periphery, this statement seems harmless. The problem is "the ample opportunity to argue their positions on the commonality-of-insurance matter directly to the trier of fact."[43] The Court of Appeals does not explain this opportunity. How could the trial court consider this issue in the absence of *evidence?* Without the evidence, how does the *Schultz* opinion[44] conform to the *Ede* rule,[45] even in the absence of a jury trial? I am not advocating *Ede*[46] as the sensible approach to evidence of common insurance. I am simply suggesting that the effort of the Court of Appeals in *Schultz*[47] to explain away the trial court's departure from *Ede*[48] is dubious.

The rigid, per se Ohio rule of admissibility does not address a very real evidentiary problem: What type of evidence will be necessary to prove or disprove bias allegedly resulting from common insurance? Representatives of the common insurer will need to testify about the structure of the insurer, the calculation of premiums, the determination of whether dividends may be payable to various member insureds in a given year, how jury verdicts affect the actual premium paid by a specific physician-insured, financial statements and, perhaps, other topics. These items are, of course, collateral to the issues of the alleged medical negligence. Accordingly, the Ohio rule applied to simple common insurance, without more, will likely create jury distraction and confusion, and will not yield relevant evidence probative of expert witness bias.

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42. *Id.* at *3.
43. *Id.*
44. *See generally id.*
45. *Ede*, 642 N.E.2d at 368.
46. *Id.*
47. *Schultz*, 2013 WL 5432103, at *2–3.
48. *Ede*, 642 N.E.2d at 368.

B. Kansas—Strict Exclusion or Not Quite So Strict?

As recently as 2010, the Supreme Court of Kansas suggested that evidence of common insurance should not be admissible to demonstrate expert witness bias. In *Kansas Medical Mutual Insurance Co. v. Svaty,*[49] the Kansas Supreme Court considered the propriety of an order requiring a mutual professional liability insurer, which insured a defense expert but *not* the defendant, to disclose insurance information regarding the defense expert. In its lengthy opinion, the Supreme Court noted that this was not a case of common insurance since "the defense expert[ ] is insured by a company that is the servicing carrier for [the defendant physician's] insurance plan."[50] However, the Supreme Court also noted that "[plaintiff] would have a stronger argument [for expert witness bias] if, as initially believed, [defendant] and [defendant's expert] were both insured by the same member-owned insurance company."[51]

Despite this comment, suggesting that the Supreme Court might be receptive to an argument alleging expert witness bias due to common insurance, the Court reviewed the common insurance jurisprudence of other jurisdictions. The Court acknowledged Ohio's per se rule of admissibility but then referred to "Kansas' long-standing position that insurance should not be interjected [at] trial."[52] The Court also reflected on Kansas jurisprudence "in which attorneys sought to determine juror bias by asking jurors during voir dire whether they were members of or stockholders in insurance companies,"[53] a practice uniformly condemned by the Supreme Court.[54] Significantly, the Supreme Court stated that its prior opinions "reject arguments that the financial connection of buying insurance in the same market or even having a joint ownership interest in an insurance company is a bias that would disqualify a potential juror or is of the nature that warrants interjection of insurance into a liability trial."[55]

If the *Kansas Medical Mutual Insurance Co.*[56] opinion appeared to embrace the exclusion of evidence of common insurance, the Court of Appeals of Kansas more recently may have retreated from this stance in *Hamrick v. Huebner*,[57] an unpublished opinion in

49. Kan. Med. Mut. Ins. Co. v. Svaty, 244 P.3d 642 (Kan. 2010).
50. *Id.* at 661.
51. *Id.*
52. *Id.* at 663.
53. *Id.*
54. *Id.*
55. *Id.* at 663–64.
56. *See generally id.*
57. Hamrick v. Huebner, No. 106,215, 2012 WL 2785930 (Kan. Ct. App. July 6, 2012).

2012. In *Hamrick*, the trial court excluded evidence that the defendant and his expert witnesses were insured by the same mutual professional liability insurer.[58] Plaintiff argued that "a judgment against [the defendant] could adversely affect [his experts'] medical liability insurance premiums."[59] The defense experts "testified that they were unaware of their common insurance carrier until it was pointed out by [plaintiff]."[60] The Court of Appeals cited *Kansas Medical Mutual Insurance Co.* as reflecting Kansas' policy of excluding evidence of insurance at trial,[61] but then stated:

> [W]e conclude that given the fact that the experts did not know they shared a common insurer with [defendant] until after they had formulated and disclosed their opinions in the case, the proffered evidence did not have any tendency in reason to prove bias on the part of the witnesses. Further, if the evidence did have any probative value, it was so slight that it was clearly outweighed by its prejudicial effect. The district court did not err in excluding this testimony.[62]

The *Hamrick* opinion may have retreated from a policy of complete exclusion of common insurance evidence, due to the reference to the timing of the experts' knowledge of common insurance.[63] If so, until the Supreme Court of Kansas again speaks to this issue, the state of the law in Kansas seems unclear.

C. Mississippi—Strict Exclusion

The Supreme Court of Mississippi has taken a tough stance against the admission of common insurance evidence. In *Wells v. Tucker*,[64] the Mississippi Supreme Court characterized the gist of the controversy as follows:

> The central issue on appeal involves the fact that Dr. Tucker and some, if not all of his experts were members of, and had their medical malpractice liability policies through, the same insurer—Medical Assurance Company

58. *Id.* at *2.
59. *Id.*
60. *Id.* at *3.
61. *Id.* at *2 (citing *Kan. Med. Mut. Ins. Co.*, 244 P.3d 642).
62. *Id.* at *3 (relying on *Kan. Med. Mut. Ins. Co.*, 244 P.3d at 663–64).
63. *Id.* at *2.
64. 997 So. 2d 908 (Miss. 2008).

> of Mississippi (MACM). A nonprofit corporation, MACM is a limited pool of Mississippi physicians who are self-insured for protection against medical negligence suits.[65]

The trial court refused to allow the common insurance-based cross-examination of the expert witnesses.[66] The Court of Appeals reversed this ruling based on calculations of insurance equity accounts in the event of an adverse verdict and on the calculations of premiums in the event of settlements or plaintiffs' verdicts.[67]

The Supreme Court favorably referred to the dissent in the Court of Appeals, which highlighted the experts' testimony "of economic or financial bias."[68] The jury heard testimony of the hourly rates paid to plaintiff's and defendant's experts for their work.[69] The experts could have been, but were not, asked to testify about the total sums they received for their work as experts in the case and the number of times and for whom they have testified.[70] A verdict against the defendant might have affected the equity accounts of member physicians by $136.[71] Interestingly, the Court of Appeals dissent noted that the majority opinion, supporting the admissibility of common insurance, would yield "the practical impact"[72] of limiting the medical expert witness pool (presumably for defendants) in Mississippi cases to non-Mississippi physicians.[73]

Adopting the reasoning of the Court of Appeals dissent, the Supreme Court reversed the judgment of the Court of Appeals, holding, common insurance, alone, is not sufficient to evidence medical defense expert witness bias in Mississippi.[74]

D. Common Insurance—"Plus"

Ohio appears to be the only jurisdiction adopting a per se rule of admissibility for common insurance alone—professional liability insurance carried by the defendant-physician and the defendant-physician's expert provided by the same insurer, typically a mutual,

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65. *Id.* at 909.
66. *Id.* at 910–11.
67. *Id.* at 913–14.
68. *Id.* at 916 (citing Wells v. Tucker, 997 So. 2d 925, 940 (Miss. Ct. App. 2007) (Griffins, J., dissenting)).
69. *Id.*
70. *Id.*
71. *Id.*
72. *Id.* at 917
73. *Id.*
74. *Id.* at 917.

"physician-owned" company.[75] This per se rule ignores the evidentiary problem associated with it: What type of evidence is necessary to show bias arising from common insurance? How many insurance company executives must testify to the intricacies of the mutual insurance business? Is it possible to prove that a plaintiff's verdict in a single case could cause an insurance premium to increase such that a defense expert witness would be biased to testify for the defendant-physician simply due to common insurance? The Ohio approach seems unrealistic and unfair. It would yield much collateral evidence which could distract the jury from the central issue in the litigation—whether the care and treatment rendered by the defendant-physician complied with the applicable standard of care.

Fortunately, the Ohio rule has not tempted other jurisdictions, which have adopted a common insurance "plus" analysis. This more reasonable approach, consistent with classic cross-examination of medical expert witnesses, actually consists of multiple variants, now to be explored by this paper.

1. More Than a Cursory Interest—Significant Economic Services Test (Illinois)

Illinois has rejected the admissibility of common insurance alone through two Appellate Court opinions,[76] the latest of which was delivered in 2010. In *Golden v. Kiswaukee Community Health Services Center*,[77] a case of first impression, the Appellate Court focused on a commonly insured expert who "performed significant economic services for [the insurer] in reviewing claims made against the [insurer's] doctor members to determine if those suits should have any impact on the insurance premiums they pay."[78] Furthermore, the Appellate Court noted that "[t]he possibility of some significant question of bias exceeding potential prejudice should have been recognized by the court in this instance. The benefit to the [insurer] in premium adjustments that take place is ineluctable."[79]

More recently, in *Cetera v. Difilippo* the Appellate Court rejected evidence of common insurance, alone, to demonstrate expert witness bias.[80] The Appellate Court favorably referred to the *Golden*

75. Ede v. Atrium S. OB-GYN, 642 N.E.2d 365, 368 (Ohio 1994).
76. Cetera v. DiFilippo, 934 N.E.2d 506, 524–25 (Ill. App. Ct. 2010); Golden v. Kiswaukee Cmty. Health Servs. Ctr., Inc., 645 N.E.2d 319 (Ill. App. Ct. 1994).
77. *Golden*, 645 N.E.2d 319.
78. *Id.* at 325.
79. *Id.*
80. *Cetera*, 934 N.E.2d at 524–25.

Court's adoption of the significant economic services analysis, which focuses on the actual services performed by the medical expert for the common insurer.[81]

2. The "Exceptional Case" Test (Arizona)

In 1988, the Supreme Court of Arizona recognized that evidence beyond common insurance was necessary to establish the potential bias of a defendant-physician's medical expert witness. In *Barsema v. Susong*[82] the Supreme Court considered a medical negligence claim against a physician insured by an insurance company organized as a mutual insurer. "One of defendant's expert witnesses was . . . allegedly a MICA [Mutual Insurance Company of Arizona] shareholder and insured."[83] The expert "was a vice president and member of MICA's board of directors."[84] He "was compensated for the duties he performed"[85] for the common insurer and "his duties as a board member included trying to keep premiums low."[86] Pursuant to an Arizona statute prohibiting the introduction of insurance-related evidence at a medical negligence trial,[87] the trial court granted a motion in limine designed to exclude the evidence of the relationship of the expert witness with the common insurer.[88]

The Arizona Supreme Court held that the aforementioned statute was unconstitutional as it was contrary to the Arizona Rules of Evidence, particularly Rules 401, 403, and 411.[89] The Supreme Court pronounced that **"**[i]n all but the exceptional case, a trial judge applying Rule 403 should hold that the danger of prejudice resulting from the interjection of insurance evidence substantially outweighs the probative value of evidence that the witness and a party have a common insurer.**"**[90] The Supreme Court held that the trial court **"**erred in precluding the introduction of evidence that [the expert witness] was [the common insurer**'**s] vice president and a member of its board of directors.**"**[91]

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81. *Id.* (citing *Golden* 465 N.E.2d 319).
82. Barsema v. Susong, 751 P.2d 969, 971 (Ariz. 1988).
83. *Id.*
84. *Id.*
85. *Id.*
86. *Id.*
87. *Id.* at 971–72 (citing Non-admissibility of Certain Types of Evidence Relating to Professional Liability Insurance, ARIZ. REV. STAT. ANN. § 12–569 (2016)).
88. *Id.* at 971–72.
89. *Id.* at 971–74 (citing ARIZ. R. EVID. 401, 403 & 411).
90. *Id.* at 973.
91. *Id.* at 974.

3. The Direct Interest Test (Nebraska)

The Supreme Court of Nebraska, in *Reimer v. Surgical Services of the Great Plains*,[92] recognized that evidence of common insurance between the defendant-physician and defendant's medical expert "indicate[s] only a remote possibility of bias."[93] Citing Texas authority,[94] the Supreme Court stated that "absent evidence that a witness has a direct interest in the outcome of the litigation, such as an agent, owner, or employee of the defendant's insurer, the potential for bias is too remote and is outweighed by the prejudice its admission would cause."[95] No such evidence existed in *Reimer* beyond common insurance.[96]

4. The Strong Connection Test (Kentucky)

In 2010, in *Woolum v. Hillman* the Supreme Court of Kentucky adopted a strong connection test for the admissibility of common insurance and related evidence to demonstrate expert witness bias.[97] Unfortunately, a close examination of *Woolum* reveals a troubling analysis by the Court.[98]

Woolum involved a defendant-physician and expert with a common liability insurer.[99] To be sure, the defense expert was concerned about the impact an adverse verdict would have on the cost of his insurance premiums.[100] Moreover, at his deposition, the defense expert "described how several malpractice claims against his former liability insurer had driven up his premiums and eventually drove the insurer into bankruptcy, effectively forcing him out of practice in Mississippi."[101] The trial court denied the defendant-physician's motion to exclude this evidence and "then permitted evidence of the common insurance coverage to be introduced at trial."[102]

92. Reimer v. Surgical Servs. of the Great Plains, P.C., 605 N.W.2d 777 (Neb. 2000).
93. *Id.* at 781.
94. *Id.* (citing Mendoza v. Varon, 563 S.W.2d 646 (Tex. Civ. App. 1978)).
95. *Id.*
96. *Id.*
97. Woolum v. Hillman, 329 S.W.3d 283 (Ky. 2010).
98. *Id.*
99. *Id.* at 286–87.
100. *Id.* at 287.
101. *Id.*
102. *Id.*

The Kentucky Supreme Court rejected the Ohio per se admissibility rule pronounced in *Ede*[103] and then focused on the factors supporting the trial court's decision to admit common insurance evidence at trial:

- The defense expert's "belief and opinion that malpractice cases result in, and have a direct link to, rate increases."[104]
- The defense expert's belief of "collusion between judges and lawyers in malpractice cases."[105]
- The defense expert's severe comments during his deposition.[106]
- The defense expert's "general hostility to medical negligence cases."[107]
- The defense expert and the defendant-physician "had worked side by side for twenty years in the same community hospital."[108]

These "factors" are curious because, other than the first listed, the remaining factors are likely appropriate ammunition for cross-examination, without any reference to common insurance. The Supreme Court actually recognized this.[109] Nevertheless, the Court concluded "these factors also develop a link between the shared insurance and [the expert's] bias against this malpractice claim. They demonstrate [the expert] is no average, passive policyholder, but instead a practitioner very concerned with the affairs of his insurer."[110] Finally, the Supreme Court stated, "[a]s a result of the strong connection between common insurance and witness bias, it was not an abuse of discretion to admit this evidence."[111]

Kentucky's strong connection test, five years earlier referred to as "a more compelling degree of connection" test,[112] may be reasonable. However, the requisite connection must be between the common insurance and expert witness bias. The *Woolum* opinion misses the mark.[113] It may be fair to suggest that any physician is concerned about potential increases to insurance premiums. The

103. *Id.* at 288 (citing Ede v. Atrium S. OB-GYN, 642 N.E.2d 365, 368 (Ohio 1994)).
104. *Id.* at 289.
105. *Id.*
106. *Id.*
107. *Id.*
108. *Id.*
109. *Id.*
110. *Id.*
111. *Id.* at 290.
112. Bayless v. Boyer, 180 S.W.3d 439, 447 (Ky. 2005).
113. *Woolum*, 329 S.W.3d at 289–90.

other "factors" emphasized in *Woolum* are unrelated to common insurance and would have been proper topics for cross-examination of the defense expert in any event.[114]

5. The Substantial Connection Test

After surveying jurisdictions that have considered the admissibility of common insurance to establish expert witness bias, it is apparent that the substantial connection test is the most often utilized. The substantial connection test operates to exclude evidence of common insurance, alone. Instead, it focuses on specific links of the defense expert to the common professional liability insurer, typically a mutual company. Substantial connection examples may be distilled from reviewing the jurisprudence of Colorado,[115] Connecticut,[116] Georgia,[117] Maine[118] and Oklahoma,[119] as follows:

- Co-founded the insurance trust[120]
- Sat on the original board of directors[121]
- Founded the insurer to provide good quality dentists with affordable insurance and to benefit the public[122]
- Testified that an adverse judgment could impact the expert financially[123]
- Had an employment relationship with the insurer[124]
- Received an annual salary from the insurer[125]
- Set the compensation paid by the insurer for expert testimony[126]
- Reviewed claims for the insurer[127]

Certainly, any of these examples in combination, and possibly alone, in addition to evidence of common insurance, should satisfy the substantial connection test for admissibility.

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114. *Id.*
115. Bonser v. Shainholtz, 3 P.3d 422 (Colo. 2000).
116. Vasquez v. Rocco, 836 A.2d 1158 (Conn. 2003).
117. Chambers v. Gwinnett Cmty. Hosp., Inc., 557 S.E.2d 412 (Ga. Ct. App. 2001).
118. Anderson v. O'Rourke, 942 A.2d 680 (Me. 2008).
119. Mills v. Grotheer, 957 P.2d 540 (Okla. 1998).
120. *Vasquez*, 836 A.2d at 1165; *Bonser*, 3 P.3d at 426; *Chambers*, 557 S.E.2d at 416.
121. *Vasquez*, 836 A.2d at 1165; *Bonser*, 3 P.3d at 426; *Chambers*, 557 S.E.2d at 416.
122. *Bonser*, 3 P.3d at 426.
123. *Id.*
124. *Chambers*, 557 S.E.2d at 416; *Mills*, 957 P.2d at 543.
125. Anderson v. O'Rourke, 942 A.2d 680, 684 (Me. 2008).
126. *Id.*
127. *Id.*; *Mills*, 957 P.2d at 543.

E. The Indiana Patient Compensation Fund

The State of Indiana maintains a statutorily-created Patient Compensation Fund[128] which assists in paying medical malpractice damages:

> The [Patient Compensation Fund] is administered by the Indiana Department of Insurance . . . and overseen by the insurance commissioner . . . . The [Patient Compensation Fund] is used to pay out large medical malpractice claims levied against an eligible provider . . . . The [Patient Compensation Fund] takes effect when a claim exceeds $250,000. The health care professional's primary insurer is required to pay up to $250,000 either by judgment of more than $250,000 or by agreeing to settle for $250,000 and then the court orders a remedy in excess of that amount . . . . After a settlement or judgment is reached, the defendant hospital or physician is removed from the process and the [Patient Compensation Fund] comes into play . . . . [T]his provision . . . positions the State as the insurer for a large portion of a medical malpractice claim if the judgment grants the maximum recovery to the claimant.[129]

In 2012, the Court of Appeals of Indiana discussed the Indiana Patient Compensation Fund in *Tucker v. Harrison*.[130] Here, the patient sought to introduce evidence that every Indiana physician is biased as they all participate in the Fund, **"**which acts as a sort of supplemental mutual insurance provider for all qualified healthcare providers licensed in Indiana, and therefore have a financial interest in whether payouts are made from the Fund.**"**[131] By state statute, all Indiana-licensed physicians must be available to serve as members of a review panel and each panel member must take an oath to render a non-biased opinion.[132] Under Indiana law, all medical negligence complaints are reviewed by a panel consisting of an attorney and three health care providers.[133] The Court of

128. IND. CODE ANN. § 34–18–6–1 (LexisNexis 2017).

129. Bruce D. Jones, *Unfair and Harsh Results of Contributory Negligence Lives in Indiana: The Indiana Medical Malpractice System and the Indiana Comparative Fault Act*, 6 IND. HEALTH L. REV. 107, 115–16 (2009). *See also* Frank A. Sloan et al., *Public Medical Malpractice Insurance: An Analysis of State-Operated Patient Compensation Funds*, 54 DEPAUL. L. REV. 247 (2005).

130. 973 N.E.2d 46 (Ind. Ct. App. 2012).

131. *Id*. at 54.

132. IND. CODE. ANN. § 34–18–10–17(e) (LexisNexis 2017).

133. IND. CODE. ANN. § 34–18–10–3 (LexisNexis 2017).

Appeals rejected the notion that any physician's participation in the Fund's required process evidenced any more than a remote potential for bias.[134]

IV. WHAT EXACTLY IS THE (THEORETICAL) COMMON INSURANCE BIAS?

Presumably, the common insurance "plus" bias suggests that the physician-defendant's medical expert, who "shares" a liability insurer with the defendant, will be inclined to support the defendant at trial due to a financial interest in a verdict favorable to the defendant. Of course, the common insurance "plus" bias is not disqualifying—it is simply ammunition for cross-examination of the defense expert as "bias" is relevant to the weight of testimony, not admissibility. Cross-examination of the defense expert does not occur until the expert, on direct examination, has testified to standard of care opinions that support the defendant-physician. Therefore, logic dictates that expert witness bias is revealed in the substance of the expert's testimony, which favors the defendant-physician because of the bias.

Of course, I am mindful of another position, attractive to plaintiffs, which urges the admissibility of common insurance "plus" to demonstrate bias. This position is, essentially, analogous to Federal Rule of Evidence 609,[135] which provides for witness impeachment by evidence of a criminal conviction. Rule 609 "[m]odern practice rests upon the assumption that certain convictions of a witness are probative of lack of credibility, or as courts have suggested, that a witness's demonstrated willingness to engage in antisocial conduct in one instance is probative of willingness to give false testimony."[136] Rule 609 does not require any causative link to particular testimony. The party successfully impeaching a witness with a prior conviction can argue to the jury that the witness is simply not honest and not credible, due to the prior conviction. It is unlikely that such a deep-rooted policy supports the Rule 411[137] admissibility of insurance to demonstrate witness bias. It seems a stretch to urge that a commonly-insured defense expert witness will testify in support of the defendant purely as a result of the common insurance. If a plaintiff urges that a defense expert is biased only due to common insurance and any other link to the common insurer, the

134. *Tucker*, 973 N.E.2d at 55.
135. FED. R. EVID. 609.
136. GLEN WEISSENBERGER & JAMES J. DUANE, FEDERAL RULES OF EVIDENCE: RULES, LEGISLATIVE HISTORY, COMMENTARY AND AUTHORITY 377 (7th ed. 2011).
137. FED. R. EVID. 411.

defendant must interpose a Rule 403[138] objection, urging that the resulting distraction and trial of collateral matters outweighs any conceivable probative value of common insurance.

Would a medical expert witness, testifying on behalf of a defendant-physician, give false testimony as a result of a supposed common insurance "plus" bias? It is possible but, I suspect, unlikely due to the extraordinarily weak link between the financial interest of an expert witness and the outcome of the trial. In states such as Illinois, in which one professional liability insurer dominates the market, many highly-qualified, objective experts share an insurer with defendant-physicians. They are willing to testify on behalf of defendant-physicians, not because they share a professional liability insurer, but because they believe that the medical care provided was appropriate. This, in my opinion, is why the Ohio per se rule of admissibility and, perhaps, the common insurance "plus" rule of admissibility,[139] are flawed. To borrow a concept from tort law, neither model embraces a "causation" component—neither model requires a showing that the alleged bias produces specific false testimony.

There is another issue worthy of mention at this point. This paper has not focused on the question of whether jurors are influenced by hearing evidence of insurance because it is distinct from the question of witness bias. Will testimony at trial about the defendant-physician's and defense expert's common insurer cause the jury to enter a verdict for the plaintiff, and, perhaps, inflate a verdict because the jury is aware of the existence of professional liability insurance to cover the loss? This topic has received significant attention in the literature over a lengthy period of time.[140] This issue, of course, relates to the primary function of Federal Rule of Evidence 411[141]—to exclude evidence of the presence or absence of insurance to prove negligence. Expert witness bias due to common insurance relates to witness credibility, not liability. FRE 411 clearly distinguishes these concerns and so does this paper.

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138. FED. R. EVID. 403.

139. Ede v. Atrium S. OB-GYN, 642 N.E.2d 365, 366, 368 (Ohio 1994).

140. *See, e.g.*, Alan Calnan, *The Insurance Exclusionary Rule Revisited: Are Reports of its Demise Exaggerated?*, 52 OHIO ST. L.J. 1177 (1991); Samuel R. Gross, *Make-Believe: The Rules Excluding Evidence of Character and Liability Insurance*, 49 HASTINGS L.J. 843 (1998); J.E. Lyerly, *Evidence: Revealing the Existence of Defendant's Liability Insurance to the Jury*, 6 CUMB. L. REV. 123 (1975); R. Pettigrew, *Another Look at That Forbidden Word—Insurance*, 10 FLA. L. REV. 68 (1957).

141. FED. R. EVID. 411.

V. THE RISK ASSUMED BY THE DEFENDANT'S BIASED MEDICAL EXPERT WITNESS

The problem created by the biased defendant's medical expert witness (or the biased plaintiff's medical expert witness) is inherent in expert witness testimony. Expert medical witnesses are intelligent, influential, and believable. These "qualities" yield the potential for false testimony, incapable of recognition by the jury. The medical expert who falsifies testimony in order to support a litigant is, at trial, subject to cross-examination on matters of testimonial substance and credibility.[142] But expert witnesses who falsify their testimony will know more about the subject matter of their testimony than the cross-examining attorney,[143] may be believable, and their testimony may cause the entry of verdicts based on purposefully erroneous testimony.

Returning to the focus of this paper—common insurance—does the defendant's medical expert bear any professional risk if the expert's bias results in false trial testimony? If so, is the risk so great that it likely outweighs the reward—a verdict in favor of the defendant-physician?

A. The Risk That the Expert's Medical License Will Be Disciplined

The licensure of physicians is governed by state law.[144] The practice of medicine is defined by state law (including state court decisions)[145] and state law provides the vehicle by which physicians' licenses may be disciplined.[146] "[M]ost states authorize discipline under a broad category of "unprofessional conduct," which may include violations of codes of medical ethics, conduct that brings the medical profession into disrepute, or other unspecified forms of "dishonorable conduct," including criminal acts (typically felonies or crimes of 'moral turpitude')."[147] Medical literature suggests that physician

142. FED. R. EVID. 611(b) ("Cross-examination should not go beyond the subject matter of the direct examination and matters affecting the witness's credibility. The court may allow inquiry into additional matters as if on direct examination.").

143. Jennifer A. Turner, *Going After the 'Hired Guns': Is Improper Expert Witness Testimony Unprofessional Conduct or the Negligent Practice of Medicine?*, 33 PEPP. L. REV. 275, 288 (2006).

144. *See* BARRY FURROW ET AL., LAW AND HEALTH CARE QUALITY, PATIENT SAFETY, AND MEDICAL LIABILITY 65 (7th ed. 2013); Nadia N. Sawicki, *Character, Competence, and the Principles of Medical Discipline*, 13 J. HEALTH CARE L. & POL'Y 285, 286 (2010); Patricia J. Zettler, *Toward Coherent Federal Oversight of Medicine*, 52 SAN DIEGO L. REV. 427, 434 (2015).

145. Sawicki, *supra* note 144, at 290; Zettler, *supra* note 144, at 435–36.

146. *See* James Morrison & Peter Wickersham, *Physicians Disciplined by a State Medical Board*, 279 JAMA 1889 (1998); Sawicki, *supra* note 144, at 290.

147. Sawicki, *supra* note 144, at 293.

license discipline occurs largely for the following reasons: substance abuse, criminal conduct, sexual contact with patients, prescribing violations, financial improprieties, negligence, incompetence, and unprofessional conduct.[148] The Federation of State Medical Boards has published a lengthy list of examples of unprofessional conduct,[149] but false medical expert testimony is absent from this list. Even with these various categories of physician conduct which could lead to license discipline, it has been reported that "medical boards only take disciplinary action against less than one-half of one percent of physicians annually . . . ."[150]

There is very little reported judicial precedent relating to the question of whether false medical expert witness testimony is a proper subject for license discipline. In *Joseph v. D.C. Board of Medicine*,[151] a physician's license was disciplined in Maryland for "false testimony and misrepresentations made by him in his capacity as an expert witness in a medical malpractice case, [which] constituted a false report in the practice of medicine . . . ."[152] The District of Columbia licensing board then instituted a disciplinary proceeding against the physician and determined that giving testimony as a non-treating expert witness "is in the nature of giving a second opinion"[153] and arises from the practice of medicine.[154] The Court of Appeals found that the physician, as an expert witness, was involved in the diagnostic process.[155] The decision of the District of Columbia Board of Medicine was affirmed.[156]

In the same year *Joseph*[157] was decided, the Missouri Court of Appeals decided *Missouri Board of Registration for the Healing Arts v. Levine* (*"Missouri Board"*),[158] holding that "acting as a non-treat-

148. *See* Neal D. Kohatsu, *Characteristics Associated with Physician Discipline*, 164 ARCH. INTERN. MED. 653, 655 (2004); Morrison & Wickersham, *supra* note 146, at 1890.
149. FEDERATION OF STATE MED. BDS., U.S. MEDICAL REGULATORY TRENDS AND ACTIONS 7 (May 2014).
150. Sawicki, *supra* note 144, at 287.
151. Joseph v. D.C. Bd. of Med., 587 A.2d 1085, 1086 (D.C. 1991).
152. *Id.* at 1086.
153. *Id.* at 1087.
154. *Id.*
155. *Id.* at 1089, 1091.
156. *Id.* at 1091.
157. *Id.* at 1085.
158. Mo. Bd. of Registration for Healing Arts v. Levine, 808 S.W.2d 440 (Mo. Ct. App. 1991).

ing expert medical witness does not constitute the practice of medicine or the function or duty of a licensee . . . ."[159] Dr. Levine's alleged transgression had been false testimony regarding the number of attempts necessary to pass a board certification exam.[160]

More recently, the Court of Appeals of Mississippi, in *Mississippi State Board of Medical Licensure v. Harron*,[161] considered an interesting medical licensure matter involving expert testimony. Unlike in *Joseph*[162] and *Missouri Board*,[163] Dr. Harron was a physician involved in "producing diagnostic reports on 6,700 of the claimants in the Texas [silicosis][164] litigation,"[165] and "was listed as the diagnosing physician on 2,600 of these claims."[166] He "testified about his practices of letting medically untrained secretaries and typists interpret his reports, insert a diagnosis, stamp his signature on the reports, and sent them out with no review by him."[167] Dr. Harron's medical license was disciplined as a result of this conduct but, on review, the Chancery Court "ruled that the Board had no jurisdiction to discipline Dr. Harron because his actions were as an expert witness and he was not engaged in the practice of medicine."[168]

In reversing the decision of the Chancery Court, the Court of Appeals used quite broad language in pronouncing that "the [licensing] Board's jurisdiction to discipline doctors is not limited to situations where the doctor is actually practicing medicine on a particular patient."[169] Typically, expert medical testimony of the type discussed in this paper does not involve patient treatment by the expert. Standard of care and causation opinions are most often derived from the expert's review of medical and hospital records, deposition testimony, literature, and the expert's education, training, and experience. Yet, the Court of Appeals did note that Dr. Harron was, in fact, a diagnosing physician for many patients when he testified as an expert witness.[170] Therefore, despite the specific facts

159. *Id.* at 443.
160. *Id.* at 441.
161. Miss. State Bd. of Med. Licensure v. Harron, 163 So.3d 945 (Miss. App. 2014).
162. *Joseph*, 587 A.2d 1085.
163. *Levine*, 808 S.W.2d 440.
164. Brooke T. Mossman & Andrew Churg, *Mechanisms in the Pathogenesis of Asbestosis and Silicosis*, 157 AM. J. RESPIRATORY & CRITICAL CARE MED. 1666, 1667 (1998) ("Silicosis is disease produced by inhalation of one of the forms of crystalline silica, most commonly quartz.").
165. *Harron*, 163 So.3d at 945.
166. *Id.*
167. *Id.*
168. *Id.* at 951.
169. *Id.* at 952.
170. *Id.* at 953–54.

in *Harron*,[171] the opinion may very well support the position that classic medical expert witness testimony constitutes the practice of medicine.

Medical and legal scholarship has reported that the American Medical Association (AMA) considers expert witness testimony to be the practice of medicine.[172] These reports derive from an AMA resolution[173] reflecting "current AMA policy . . . that expert witness testimony is the practice of medicine subject to peer review."[174] Although a 1998 AMA Report of the Board of Trustees on expert witness testimony[175] does not define "peer review," the report does state: "Several medical and specialty organizations are working to deter false testimony. For example, the Florida Medical Association (FMA) has developed a program by which physicians who falsely testify are reported to the state licensing board for discipline. The AMA is currently is [sic] studying programs like the FMA's."[176]

Therefore, the AMA policy, which considers expert witness testimony to be the practice of medicine, appears to contemplate licensure discipline for false testimony. Additional evidence for this stance is the AMA's Code of Medical Ethics.[177] Opinion 9.07, Medical Testimony, provides, in relevant part: "Organized medicine, including state and specialty societies, *and medical licensing boards* can help maintain high standards for medical witnesses by assessing claims of false or misleading testimony and issuing disciplinary sanctions as appropriate."[178]

I do not know how well publicized the risk of medical license discipline is to potential medical expert witnesses (and physicians generally) as a sanction for false testimony. To the extent that license discipline is a realistic sanction for false expert witness testimony, the sanction is not worth the risk of the supposed common insur-

171. *Id.* at 946.

172. *See* B. Sonny Bal, *The Expert Witness in Medical Malpractice Litigation*, 467 CLINICAL ORTHOPAEDICS & RELATED RES. 383, 384–85 (2009); Juan Carlos B. Gomez, *Silencing The Hired Guns—Ensuring Honesty in Medical Expert Testimony Through State Legislation*, 26 J. LEGAL MED. 385, 393 (2005); Robert S. Peck & John Vail, *Blame it on the Bee Gees: The Attack on Trial Lawyers and Civil Justice*, 51 N.Y. L. SCH. L. REV. 324, 334 (2006); Russell M. Pelton, *Medical Societies' Self-Policing of Unprofessional Expert Testimony*, 13 ANNALS HEALTH L. 549, 550, 552 (2004).

173. AM. MED. ASS'N HOUSE OF DELEGATES, RESOLUTION 211 (1998).

174. Thoman R. Reardon, Report of the Board of Trustees: B of T Report 5–A–98 1 (1998), http://truthinjustice.org/amareport.htm.

175. *Id.*

176. *Id.* at 4.

177. AM. MED. ASS'N, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS (2014–2015 ed.).

178. *Id.* at 365 (emphasis added).

ance "plus" expert witness bias. The risk of discipline, in my estimation, makes less likely that the existence of common insurance would influence expert testimony in favor of the defendant-physician.

B. The Risk That The Expert Will Be Disciplined By A Professional Medical Society

The risk that an expert witness' false testimony may lead to discipline by a professional medical society is not theoretical. At least one author has suggested that professional medical societies play a prominent role in the discipline of medical expert witnesses.[179] Many professional medical societies, which are voluntary associations of physicians, and neither grant degrees nor board certification, have guidelines, policies, statements, and ethical opinions relating to expert witness testimony.[180]

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179. *See* Pelton, *supra* note 172, at 552.

180. *See, e.g.*, AM. ACAD. OF NEUROLOGY, QUALIFICATIONS AND GUIDELINES FOR THE PHYSICIAN EXPERT WITNESS (June 25, 2005), https://www.aan.com/uploadedFiles/Website_Library_Assets/Documents/8.Membership/5.Ethics/1.Code_of_Conduct/Membership-Ethics-American%20Academy%20of%20Neurology%20Qualifications%20and%20Guidelines%20for%20the%20Physician%20Expert%20Witness%20(2).pdf; AM. ACAD. OF OPHTHALMOLOGY, ADVISORY OPINION OF THE CODE OF ETHICS: EXPERT WITNESS TESTIMONY (Feb. 27, 2017), https://www.aao.org/ethics-detail/advisory-opinion--expert-witness-testimony; AM. ACAD. OF PAIN MED., GUIDELINES FOR EXPERT WITNESS QUALIFICATIONS AND TESTIMONY (June 12, 2012), http://www.painmed.org/files/aapm-expert-witness-guidelines.pdf.; AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, ACOG COMMITTEE OPINION NO. 374: EXPERT TESTIMONY (2016), http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Expert-Testimony; AM. COLL. OF RADIOLOGY, ACR PRACTICE PARAMETER ON THE PHYSICIAN EXPERT WITNESS IN RADIOLOGY AND RADIATION ONCOLOGY: RESOLUTION 9 (2017); AM. COLL. OF RHEUMATOLOGY, POLICY AND GUIDELINES FOR EXPERT WITNESS TESTIMONY IN MEDICAL MALPRACTICE LITIGATION (June 22, 2015), http://www.rheumatology.org/Portals/0/Files/ACR%20Policy%20and%20Guidelines%20for%20Expert%20Witness%20Testimony.pdf.; AM. SOC'Y OF ANESTHESIOLOGISTS, GUIDELINES FOR EXPERT WITNESS QUALIFICATIONS AND TESTIMONY (Oct. 16, 2013), https://www.asahq.org/about-asa/office-of-general-counsel/expert-witness-testimony-review-program; Am. Acad. of Pediatrics, *Policy Statement, Guidelines for Expert Witness Testimony in Medical Malpractice Litigation*, 109 PEDIATRICS 974 (2002); Am. Coll. of Med. Genetics, *Guidelines for Expert Witness Testimony for Specialty of Medical Genetics*, 2 GENETICS IN MED. 367 (2000); Ramsey M. Dallal et al., *American Society of Metabolic and Bariatric Surgery Patient Safety Committee Policy Statement on the Qualifications of Expert Witnesses in Bariatric Surgery Medicolegal Matters*, 8 SURGERY OBESITY & RELATED DISEASES. e9 (2012); *Expert Witness Guidelines for the Specialty of Emergency Medicine*, AM. COLL. OF EMERGENCY PHYSICIANS (June 2015), https://www.acep.org/Clinical---Practice-Management/Expert-Witness-Guidelines-for-the-Specialty-of-Emergency-Medicine; *Statement on the Physician Acting as an Expert Witness*, AM. COLL. OF SURGEONS (Apr. 1, 2011), https://www.facs.org/about-acs/statements/8-expert-witness; *Expert Witness Testimony in Medical Liability Cases*, AM. UROLOGICAL ASS'N, https://www.avanet.org/education/policy-statements/testiomony (last visited June 3, 2016).

Austin v. American Association of Neurological Surgeons[181] involved a medical society membership suspension of a neurosurgeon as a result of his "irresponsible" expert testimony against another neurosurgeon.[182] Dr. Austin sued the AANS "claiming that he had been suspended in 'revenge' for having testified as an expert witness for the plaintiff in a medical malpractice suit brought against another member of the [AANS]."[183] Procedurally, the suspension occurred following a verdict for the defendant neurosurgeon and the defendant's complaint to the AANS, triggering the AANS disciplinary process.[184] Dr. Austin's lawsuit was resolved by summary judgment in favor of the AANS.[185] The Seventh Circuit Court of Appeals affirmed, and after commenting on medical literature and Dr. Austin's related trial testimony, stated:

> There is little doubt that his testimony was irresponsible and that it violated a number of sensible-seeming provisions of the Association's ethical code. These include provisions requiring that a member appearing as an expert witness should testify "prudently," must "identify as such, personal opinions not generally accepted by other neurosurgeons," and should "provide the court with accurate and documentable opinions on the matters at hand."[186]

The Seventh Circuit's opinion in *Austin*[187] certainly reveals and supports the ability of a voluntary professional medical society to discipline a member based upon that member's "irresponsible" expert testimony.[188] It was referred to more recently in the disposition of another claim by a suspended member of a voluntary professional medical society in *Brandner v. American Academy of Orthopaedic Surgeons*.[189]

In *Brandner*,[190] a member of the "American Academy of Orthopaedic Surgeons . . . and its interrelated and parallel organization, the American Association of Orthopaedic Surgeons [collectively, the

181. Austin v. Am. Ass'n of Neurological Surgeons, 253 F.3d 967 (7th Cir. 2001).
182. *Id.* at 971.
183. *Id.* at 968.
184. *Id.* at 970.
185. Austin v. Am. Ass'n of Neurological Surgeons, 120 F. Supp. 2d 1151 (N.D. Ill. 2000).
186. *Austin*, 253 F.3d at 971.
187. *Id.* at 967.
188. *Id.* at 971.
189. Brandner v. Am. Acad. of Orthopaedic Surgeons, No. 10 C 8161, 2012 WL 4483820 (N.D. Ill. 2012), *aff'd*, 760 F.3d 627 (7th Cir. 2014).
190. *Brandner*, 2012 WL 4483820.

'AAOS'],"[191] was "suspended . . . from membership based on certain expert testimony he provided during a medical malpractice case."[192] Dr. Brandner filed suit against these professional societies, contending "that the AAOS's sole intent was to punish and make an example of him for offering expert testimony against another orthopedic surgeon who was a fellow member of the AAOS,"[193] and the failure "to follow their own bylaws, acting in bad faith and violating his due process rights."[194] The trial court granted the AAOS motion for summary judgment.[195]

After the resolution of the underlying case, the medical malpractice defendant, against whom Dr. Brandner testified, filed "a grievance report with the AAOS against Brandner."[196] The District Court, in discussing the grievance procedure, noted that the AAOS Committee on Professionalism recommended "that Brandner be suspended from the AAOS for one year based on 'unprofessional conduct in the performance of expert witness testimony.'"[197] After action by the AAOS Board of Directors, and a rehearing of the matter, the Board voted to suspend Dr. Brandner for one year.[198]

Significantly, the District Court commented on the discretion of voluntary associations in Illinois while conducting internal affairs, stating:

> In Illinois, voluntary associations have great discretion in conducting their internal affairs, and their conduct is subject to judicial review only when they fail to exercise power consistently with their own internal rules or when their conduct violates the fundamental right of a member to a fair hearing.[199]

Adding to its pronouncement of the great deference to be given to the decisions of Illinois voluntary associations, the District Court further stated that:

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191. *Id.* at *1.
192. *Id.*
193. *Id.*
194. *Id.*
195. *Id.*
196. *Id.* at *4.
197. *Id.* at *6.
198. *Id.*
199. *Id.* at *8 (citing Austin v. Am. Ass'n of Neurological Surgeons, 120 F. Supp. 2d 1151, 1152 (N.D. Ill. 2000)).

> This Court's limited review of an association's actions regarding its members does not permit it to review whether the decision was right or wrong, but simply whether it was made without bias, prejudice or bad faith, by following proper association procedures and in the absence of a due process violation.[200]

The District Court opined that Dr. Brandner was not denied his due process rights.[201]

Dr. Brandner appealed the District Court's opinion to the Seventh Circuit Court of Appeals, which, in 2014, affirmed the opinion, noting a scant record on appeal.[202] Dr. Brandner's claim against the AAOS reveals that disciplinary action by a professional medical society, although not as drastic as that by a medical licensing board, is realistic following false testimony by a medical expert witness.

VI. CONCLUSION

The supposed bias of the defendant's expert witness resulting from sharing a professional liability insurer with the defendant-physician is misplaced. The expert's financial interest in a defense verdict is, at best, weak. The proof necessary to demonstrate this theoretical bias would require the introduction into evidence of the operation of a mutual insurance company and financial information which would be unrelated to the issues at trial, likely incapable of being understood by the jury, and, in my estimation, violate Federal Rule of Evidence 403.[203] The per se rule of admissibility adopted in Ohio[204] is excessively rigid, should be revisited by Ohio courts, and eliminated.

The common insurance "plus" jurisdictions allow evidence of common insurance with additional evidence linking the defense expert to the common insurer. Even in these jurisdictions, it is difficult to establish how common insurance "plus" actually influences a defense expert's testimony. In these jurisdictions, it is necessary to discover the existence of common insurance, make this existence known to the defendant's expert witness before trial (likely during a deposition) and overcome a motion in limine, pursuant to the

200. *Id.* at *12.
201. *Id.*
202. Brandner v. Am. Academy of Orthopedic Surgeons, 760 F.3d 627 (7th Cir. 2014).
203. FED. R. EVID. 403.
204. Ede v. Atrium S. OB-GYN, 642 N.E.2d 365, 368 (Ohio 1994).

state's version of Federal Rule of Evidence 403,[205] to bar this evidence. Plaintiff, in opposition to the motion in limine, must assert that evidence of common insurance "plus" is itself evidence of expert witness bias, much like the evidentiary rule allowing impeachment of a witness with a prior conviction.[206] The weakness of this position, I submit, is the lack of a policy which underscores impeachment by prior conviction, requiring no causative link to specific false testimony.[207]

Does common insurance, shared by the defendant-physician and the defendant-physician's expert witness actually *cause* false testimony in favor of the defendant-physician? This is a difficult question to answer but what appears certain is that the answer cannot be discerned during the trial of a medical negligence case. These cases are tried before lay juries, not blue ribbon juries.[208] Neither lawyers nor judges have the wherewithal to know if a medical expert witness is falsifying testimony, due to common insurance or any other reason.[209] What is known is that false expert testimony is forbidden by numerous professional medical associations, is subject to discipline by them, and may constitute the practice of medicine, subjecting it to review and discipline by state medical licensing boards. Therefore, false expert witness testimony carries a potentially substantial professional risk.

The common insurance "plus" expert witness bias, not requiring any causative link to identifiable false testimony, unfortunately will likely remain part of the jurisprudence in those states which have recognized it. Courts should understand, however, that the claim of bias is tenuous and the evidence necessary to "prove" bias will be time-consuming, distracting, and collateral to the issues central to the trial.

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205. FED. R. EVID. 403.

206. FED. R. EVID. 609

207. *See* WEISSENBERGER & DUANE, *supra* note 136.

208. A blue ribbon jury would be comprised of more highly educated jurors or jurors from the defendant's profession. *See* Grant P. Du Bois, Jr., *Desirability of Blue Ribbon Juries*, 13 HASTINGS L.J. 479 (1962); Valerie P. Hans, *Judges, Juries, and Scientific Evidence*, 16 J. L. & POL'Y 19 (2007); Deborah R. Hensler, *Science in the Court: Is There a Role for Alternative Dispute Resolution?*, 54 L. & CONTEMP. PROBS. 171 (1991); Harry H. Root, *Medical Malpractice Litigation: Some Suggested Improvements and a Possible Alternative*, 18 U. FLA. L. REV. 623 (1966).

209. For an opinion referring to "[t]he discomfort of the legal profession, including the judiciary, with science and technology . . . .[,]" see Jackson v. Pollion, 733 F.3d 786, 788 (7th Cir. 2013) (commenting on the mistaken view of two judges regarding plaintiff's medical condition). *See also* Root, *supra* note 208, at 631.