

A PROPOSAL FOR ADDRESSING THE EFFECTS OF
HINDSIGHT AND POSITIVE OUTCOME BIASES
IN MEDICAL MALPRACTICE CASES

Michael A. Haskel

I. Introduction	896
II. Current Trends in Medical Malpractice Litigation	898
A. General Observations.....	898
B. The Consequences of Increased Severity and Frequency.....	899
1. Absence of Affordable Medical Malpractice Insurance.....	899
2. Shortage of Physicians in Certain Specialties.....	900
3. Increase in the Practice of Defensive Medicine	902
C. Possible Causes of the Crisis.....	904
III. Hindsight Bias and Positive Outcome Bias.....	905
A. Hindsight Bias	906
B. Positive Outcome Bias	906
IV. Ways in Which Current Jurisprudence Treat Hindsight and Positive Outcome Biases and the Shortcomings of Such Jurisprudence.....	907
A. Summary Judgment.....	908
B. Applications to Disqualify Expert Testimony.....	909
C. The Intersection of Summary Judgment Motions and Applications to Disqualify Experts.....	912
D. Jury Voir Dire and Challenges to Venire Persons.....	913
E. Post-Trial Motions	914
V. Substantive Law Treating Hindsight and Positive Outcome Biases: The Medical Judgment Rule.....	916

Michael A. Haskel has been a practicing New York attorney since 1976. The author gratefully acknowledges the suggestions, research, and thoughtful comments of Miranda W. Turner and Brandon M. Zlotnick.

VI. Changes in the Substantive Law and Its Application	
Are Necessary	921
VII. Expanding the Medical Judgment Rule to Better Address	
Hindsight and Positive Outcome Biases.....	925
A. The Business Judgment Rule.....	925
B. The Medical Judgment Rule in Psychiatric Cases.....	926
C. Expanding to Nonpsychiatric Cases the Psychiatric	
Standard for Determining the Applicability of the	
Medical Judgment Rule	931
1. The Uncertainty Facing Decision Makers in	
Nonpsychiatric Cases Supports the Application of	
the Psychiatric Standard to Nonpsychiatric Cases	931
2. The Disincentives for the Exercise of Medical	
Judgment in the Best Interests of the Patient	933
VIII. The Author's Proposal to Hold a Medical Judgment Hearing	
as a Means of Reducing Hindsight and Outcome Biases	933
A. Proposed Substantive Changes to the Medical	
Judgment Rule	934
B. Proposed Procedures for Applying the Modified Medical	
Judgment Rule	936
1. The Circumstances That Trigger a Medical	
Judgment Rule Hearing.....	936
2. The Requirement That the Defendant Physician	
Have Made a Decision Under Uncertain Conditions	937
3. The Consideration of Public Policy as a	
Precondition to a Medical Judgment Hearing.....	937
IX. The Medical Judgment Rule Hearing	938

I. INTRODUCTION

Recent increases in the size and frequency of medical malpractice awards have been factors in what some scholars are referring to as a new “medical malpractice insurance crisis,” inviting comparison with the critical experience of the 1970s and 1980s.¹ Increased premium burdens, which are both a symptom of and a contributor to the problem, are correlated with adverse consequences in the practice of medicine, such as increases in the practice

1. See, e.g., Alan Feigenbaum, *Special Juries: Deterring Spurious Medical Malpractice Litigation in State Courts*, 24 CARDOZO L. REV. 1361, 1384–85 (2003); see also Kenneth E. Thorpe, *The Medical Malpractice “Crisis”*: Recent Trends on the Impact of State Tort Reforms, HEALTH AFFAIRS (Jan 21, 2004), available at <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.20v1DC1>.

of defensive medicine,² the limitation of services provided by some providers in high-risk specialties, relocation of such providers to less expensive areas, and their withdrawal from medicine altogether.³ Some legislative initiative addressing the burgeoning problem is the most often considered means of solving the problem.⁴ However, by taking a more active role, the judiciary can help alleviate some aspects of the medical malpractice crisis without the need for statutory reforms (e.g., limitations on noneconomic damages, that do not address the sources of the quagmire.⁵ In the author's view, a judicial solution would be best achieved by modifying the manner in which the Medical Judgment Rule is applied so as to empower judges to determine whether there has been a deviation from good and accepted practice prior to trial.

To promote an appreciation of the efficacy of the approach advocated in this article, the author will: (1) discuss the current state of medical malpractice litigation; (2) consider hindsight and positive outcome biases, which affect medical malpractice verdicts; (3) review current judicial treatment of these biases, including the Medical Judgment Rule; (4) identify inadequacies of existing law; and (5) propose an expanded application of the Medical Judgment Rule consistent with the advancement of public policy. In presenting arguments in support of change, the author will pay particular

2. Defensive medicine can be defined as follows: "Medical practices designed to avert the future possibility of malpractice suits. In defensive medicine, responses are undertaken primarily to avoid liability rather than to benefit the patient. Doctors may order tests, procedures, or visits, or avoid high risk patients or procedures, primarily (but not necessarily solely) to reduce their exposure to malpractice liability. Defensive medicine is one of the least desirable effects of the rise in medical litigation. Defense medicine increases the cost of health care and may expose patients to unnecessary risks." MedicineNet.com, Definition of Defensive Medicine, at www.medterms.com/script/main/art.asp?articlekey=33262. A recent survey of high-risk specialists in Pennsylvania found that 93 percent of respondents reported engaging in some type of defensive medicine, and that specialists' confidence in the adequacy of their liability coverage and their perceptions of premium burdens was the strongest predictor of all types of defensive medicine practices. David M. Studdert et al., *Defensive Medicine Among High Risk Specialist Physicians in a Volatile Practice Environment*, 293 JAMA 2609 (2005).

3. Michelle M. Mello et al., *Effects of a Malpractice Crisis on Specialist Supply and Patient Access to Care*, available at www.pewtrusts.org/pdf/EffectsOfaMalpracticeCrisis0605.pdf.

4. See, e.g., Council of State Governments, *Medical Malpractice Crisis*, TRENDS ALERT (Apr. 2003), available at <http://csg-web.csg.org/pubs/Documents/TA0304MedMal.pdf>. However, legislation often involves sweeping changes that may lead to unintentional consequences. For an interesting article that illustrates this possibility see Sharkey, *Unintended Consequences of Medical Malpractice Damages Caps*, 80 N.Y.U. L. REV. 391 (2005).

5. The Fair and Reliable Medical Justice Act, S. 1337, 109th Cong. (2005), on which hearings were recently held in the Senate Committee on Health, Education, Labor, and Pensions, acknowledges the importance of the judiciary's role, and proposes funding for pilot programs including special medical malpractice courts wherein judges experienced with medical-legal issues would hear and decide various aspects of malpractice claims. *Id.* § 3. Supporters urge that the use of special health courts would eliminate the use of "hired guns" and increase the consistency of awards. See, e.g., Editorial, "Health Courts" Offer Cure, USA TODAY, July 4, 2005, available at www.usatoday.com/news/opinion/editorials/2005-07-04-our-view_x.htm.

attention to the specialty of obstetrics and gynecology, which best exemplifies the current crisis.⁶

II. CURRENT TRENDS IN MEDICAL MALPRACTICE LITIGATION

A. General Observations

Increasing frequency, which represents the number of claims brought against insured physicians, and severity, which refers to the size of awards, settlements, and defense and administrative costs, have contributed to rising medical malpractice insurance premiums.⁷ Rising malpractice premiums have resulted in doctors' restricting services or leaving their practices altogether, thereby leading to loss of patient access to care in states including Nevada, Pennsylvania, West Virginia, Mississippi, and New Jersey.⁸ According to the American College of Obstetrician and Gynecologists ("ACOG"), twenty-three states, including New York, are facing a medical liability crisis

6. For example, a 2004 news release issued by the American College of Obstetricians and Gynecologists ("ACOG") reported that one in seven ACOG Fellows has stopped practicing obstetrics because of the risk of liability claims, and others are restricting services due to perceived liability risks or changes in liability insurance costs and coverage, while medical students are increasingly reluctant to specialize in obstetrics and gynecology, with only 65 percent of residency slots in the specialty filled in 2004. News Release, ACOG, Medical Liability Survey Reaffirms More Ob-Gyns Are Quitting Obstetrics (July 16, 2004), available at www.acog.org/from_home/publications/press_releases/nr07-16-04.cfm.

7. See Thorpe, *supra* note 1. See also OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, U.S. DEP'T OF HEALTH & HUMAN SERVS., CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING OUR COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM (2002), available at <http://aspe.hhs.gov/daltcp/reports/litrefm.pdf>. This report, which discusses problems with the current medical liability system and consequences thereof, notes that the mean and median awards are increasing rapidly. *Id.* at 9. Between 1996 and 1999, the average award rose by 76 percent. The median award rose by nearly 43 percent between 1999 and 2000. *Id.* The report noted that obstetricians and gynecologists were especially hard hit by increasing award severity; the median award jumped from \$700,000 to \$1,000,000 in just one year. Furthermore, the report noted that the number of verdicts in excess of \$1,000,000 is rapidly increasing. While in the period of 1994-1996, 34 percent of jury awards in malpractice cases provided for damages of at least \$1,000,000, by 1999-2000 over half of the time juries awarded damages those damages were at least \$1,000,000. *Id.* The cost of settlements has also increased; the average payment per claim settled more than doubled between 1987 and 1999. *Id.* at 10. Some of the consequences of the increasingly severe awards that were noted in the report are discussed *infra* at note 8.

8. For example, *Confronting the New Health Care Crisis*, *id.*, noted that "Nevada is facing unprecedented problems in urgently needed care," citing examples including the ten-day shutdown of the University of Nevada Medical Center's trauma unit after all of its surgeons quit because they could no longer afford medical malpractice insurance. The problem was temporarily solved when some of the surgeons were hired as temporary county employees, capping their liability if sued. The report noted that the next closest Level 1 trauma center was five hours away. *Id.* at 2. In Pennsylvania, the report noted that all of Frankford Hospital's active orthopedic surgeons stopped practicing in 2001 after their insurance rates nearly doubled. *Id.* at 3. In West Virginia, the only community hospitals in two rural counties closed their OB units because the obstetricians in those areas could not

threatening the availability of obstetrical services.⁹ Numerous studies and articles have called attention to the problem. Often the authors have given color to the crisis by reporting incidents that dramatize the situation, such as doctors walking off the job, clinics being forced to close, and physicians quitting or moving to venues where insurance premiums are lower.¹⁰

B. *The Consequences of Increased Severity and Frequency*

1. Absence of Affordable Medical Malpractice Insurance

The absence of affordable medical malpractice insurance covering certain specialties is an often discussed effect of the increase in frequency and severity of claims, largely because this circumstance adversely affects patient care, as discussed below. In some states, medical malpractice insurance has become or is becoming an unbearable burden. For instance, in December 2001, the national average premium increase for internists was 22 percent, for general surgeons, 21 percent, and for obstetricians/gynecologists, 19 percent.¹¹ Increases have varied widely across states, with some states experiencing increases of up to 75 percent in the 2000–2001 period.¹² Obstetricians/gynecologists in Florida paid between \$143,000 and \$203,000 in 2001 for malpractice insurance; in New York, premiums during the same period ranged from \$34,000 to \$115,000.¹³ In Florida, the state with the highest premiums for obstetrician/gynecologists, the average 2004 premium was more than \$195,000, with some metropolitan areas facing even higher rates. For example, the average premium in Miami-Dade County was \$277,000 in 2004, an 11 percent increase over the previous year's rates.¹⁴ Between 2003 and 2004, rates rose approximately 67 percent,

afford malpractice insurance. *Id.* Most of the cities in Mississippi with populations under 20,000 no longer have any obstetricians willing to deliver babies. *Id.* In New Jersey, 65 percent of hospitals reported doctors leaving due to increased premiums. *Id.* at 4. See also Feigenbaum, *supra* note 1, at 1386–87 (discussing a threatened mass work stoppage of Pennsylvania physicians in 2002 as a result of increasing medical malpractice insurance costs). According to the American College of Obstetrics and Gynecology (“ACOG”), as of 2004, 23 states were facing what they described as a “medical liability insurance crisis... threatening the availability of physicians delivering babies.” See ACOG Press Release, *supra* note 6.

9. AOG Press Release, *supra* note 6.

10. See, e.g., CONFRONTING THE NEW HEALTH CARE CRISIS, *supra* note 7; U.S. GEN. ACCOUNTING OFFICE, REPORT TO CONGRESSIONAL REQUESTERS: MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 12–15 (Aug. 2003), available at www.gao.gov/new.items/d03836.pdf; see also Linda Denicola, *Physicians Decry Rising Cost Of Insurance: Medical Malpractice Fees Have Doctors Calling For Legislative Reforms*, TRI TOWN NEWS, Nov. 14, 2003 (discussing rallies held in New Jersey to protest rising insurance rates).

11. See CONFRONTING THE NEW HEALTH CARE CRISIS, *supra* note 7, at 12.

12. *Id.*

13. *Id.*

14. See Press Release, Univ. of Mich. Health Sys., High Cost of Malpractice Insurance Threatens Supply of Ob/gyns, Especially in Some Urban Areas, available at www.med.umich.edu/opm/newspage/2005/obgyn.htm.

to \$230,000, in the Chicago area, and by approximately 18 percent, to \$194,000, in the Detroit area.¹⁵

In New York, which is among the ten highest-premium states in the nation,¹⁶ the cumulative rate increase for physicians from 2003–2006 was more than 24 percent.¹⁷ Notwithstanding such increase, medical malpractice carriers, the rates of which must be approved by the New York State Department of Insurance, are in a financially distressed situation.¹⁸ For the year 2006–2007, the Superintendent, who had previously refused to allow carriers to increase rates to levels that they believed were adequate, approved an increase of 9 percent for physicians.

2. Shortage of Physicians in Certain Specialties

In some locales the lack of affordable insurance contributes to the shortage of physicians in certain specialties. This shortage can be the product of early retirement, withdrawal from the practice of such specialty, and career choices by medical students, and is precipitated, in part at least, by a desire to avoid specialties that are the subject of significant increases in insurance premiums. ACOG has documented the effects of the medical malpractice crisis in relation to the practice of obstetrics/gynecology, finding that “[d]isruptions to obstetrical care are now prevalent in almost half of the states across the country.”¹⁹ For example, as of 2002, seven of New York’s sixty-two counties lacked practicing obstetrician/gynecologists.²⁰

15. *Id.*

16. *Id.* However, premium rates vary widely across the state, especially in the ob/gyn specialty. In 2005, Rockland and Westchester County obstetrician/gynecologists paid an average annual premium of \$110,767 while in Erie and Niagara Counties, the average annual premium was only \$42,734. See Nick Reisman, *Report: Big Discrepancy in Malpractice Premiums*, J. NEWS (Westchester, Rockland, and Putnam Counties, N.Y.), Sept. 16, 2005, available at www.thejournalnews.com/apps/pbcs.dll/article?AID=/20050916/BUSINESS01/509160315/1066. Premiums for Long Island ob-gyns in 2004 were approximately \$126,000. See, e.g., David S. Guzick, Univ. of Rochester Sch. of Med. & Dentistry, *Dean’s Newsletter*, Jan. 12, 2005, available at www.urmc.rochester.edu/SMD/about/newsletter/Archive/newsletter01122005.cfm.

17. *The Medical Malpractice Crisis: Continuing Effects*, HEALTH CARE NEWS (Greater N.Y. Hosp. Ass’n), Aug. 22, 2005, available at www.gnyha.org/pubinfo/skyline/skyid20050822.pdf.

18. For example, as of 2002, New York medical malpractice insurers had the fourth worst loss experience in the nation, paying approximately \$1.44 on claims and expenses for every dollar collected. See Dean’s Newsletter, *supra* note 16; see also Press Release, Greater N.Y. Hosp. Ass’n, *New Study Shows Growing Malpractice Insurance Crisis Taking Toll on Financially Strapped Metropolitan-Area Hospitals* (Jan. 5, 2005), available at www.gnyha.org/press/2005/pr20050105.html.

19. Press Release, ACOG, *ACOG’s Red Alert on Ob-Gyn Care Reaches 23 States* (Aug. 26, 2004), available at www.acog.org/from_home/publications/press_releases/nr08-26-04.cfm.

20. ACOG, *Red Alert: Women’s Health Care at Risk!*, at www.acog.org/acog_districts/dist_notice.cfm?recno=1&bulletin=1566 (citing 2002 ACOG New York study based on statistics provided by the New York State Department of Health). The situation is similar in many other states. For instance, one study found that as many as half of Oregon’s ob/gyns were planning to stop, or already stopped, delivering babies as of 2004. See Ariel K. Smits et al.,

Forty percent of New York counties had fewer than five practicing obstetricians.²¹ In as many as twenty-two New York counties, obstetricians and gynecologists were delivering significantly more babies than the national average of 162 babies per year.²²

This shortage is only getting worse as the crisis causes ob/gyns to retire early or give up delivering babies. close to 60 percent of New York ob/gyns who responded to a national ACOG professional liability survey in 2003 indicated that they made one or more changes to their practice as a result of the risk of being sued.²³ Half of the obstetricians/gynecologists reported that they did so in response to the lack of affordable professional liability insurance.²⁴ In addition, because of the risk of being sued, 12 percent of New York ob/gyns stopped practicing obstetrics in 2003,²⁵ compared to 8 percent in 1999.²⁶ Moreover, in 2003 almost 30 percent of New York's ob/gyns reduced the number of high-risk patients they saw,²⁷ as opposed to just 18 percent in 1999.²⁸

Adding to this concern over access to healthcare in New York is an aging ob/gyn population, with fewer prospective ob/gyns interested in replacing them when they retire. The average age at which ob/gyns stop practicing obstetrics is 48 years old.²⁹ In New York, as of 2003, 36 percent of board-certified ob/gyns still delivering babies were over the age of 60.³⁰ As retirement reduces the ranks of these ob/gyns, who are already well

Factors Influencing Cessation of Pregnancy Care in Oregon, 36 FAM. MED. 490, 492–94 (2004), available at www.stfm.org/fmhub/fm2004/July/Ariel490.pdf. According to an article in the *Honolulu Advertiser*, 42 percent of Hawai'i ob/gyns are planning to quit obstetrics. Deborah Adamson & Beverley Creamer, *Hawai'i Losing Its Doctors*" HONOLULU ADVERTISER, May 9, 2005, available at <http://the.honoluluadvertiser.com/article/2005/May/09/In/In03p.html>.

21. Red Alert, *supra* note 20 (citing 2002 ACOG New York study based on statistics provided by the N.Y. State Department of Health).

22. *Id.* (citing ACOG, 1999 Survey on Professional Liability).

23. ACOG, *District II Liability Lowdown: Overview of the 2003 ACOG Survey on Professional Liability*, at www.acog.org/acog_districts/dist_notice.cfm?recno=1&bulletin=1643 (citing ACOG, 2003 Survey on Professional Liability). Some 12.3 percent of respondents reported that they stopped practicing obstetrics, 27.3 percent decreased the level of high risk obstetric care, 8.4 percent decreased the number of deliveries, 9.1 percent stopped performing vaginal deliveries for women who had a prior cesarean section, 20.8 percent decreased gynecologic surgeries, and 5.8 percent stopped performing gynecologic surgeries. *Id.*

24. *Id.* (citing same source). Nearly 28 percent of respondents decreased the amount of high risk obstetric care, 11 percent decreased the number of deliveries, 5.2 percent stopped practicing obstetrics, 21.4 percent decreased gynecologic surgeries, and 3.9 percent stopped performing gynecologic surgery. Additionally, 8.4 percent reported relocating or retiring. *Id.*

25. Red Alert, *supra* note 20 (citing ACOG, 2003 Survey on Professional Liability)

26. *Id.* (citing ACOG, 1999 Survey on Professional Liability).

27. *Id.* (citing ACOG, 2003 Survey on Professional Liability).

28. *Id.* (citing ACOG, 1999 Survey on Professional Liability).

29. *Id.* (citing ACOG, 2003 Survey on Professional Liability).

30. *Id.* (citing 2002 ACOG New York Study based on statistics provided by the N.Y. State Department of Health).

above the average age at which ob/gyns cease delivering babies, 80,000 pregnant women in New York will be forced to find new physicians, thus interrupting established relationships and continuity of care.³¹

Meanwhile, the crisis in New York has deterred new obstetricians and gynecologists from choosing to practice in that state, for the natural consequence of increasing severity and frequency is a desire to avoid practicing in this litigious venue. Ninety percent of resident respondents in a 2004 survey said that liability insurance issues were very or somewhat important to their decision as to whether to practice in a particular state.³² Moreover, interest in obstetrics and gynecology among medical students has been significantly affected by the crisis. A national survey of medical school clerkships found that students ranked ob/gyn dead last as a specialty of interest to them.³³ In addition, a survey of 226 medical students at the State University of New York Downstate College of Medicine found that while 63 percent would or did consider ob/gyn as their chosen specialty, only 5 percent actually planned to pursue it.³⁴ While there are many possible causes for these responses, one consistent theme does recur: concerns about unlimited medical liability exposure and fears of unaffordable or unavailable liability insurance weigh heavily on specialty choice.³⁵

3. Increase in the Practice of Defensive Medicine

The medical malpractice crisis has spawned the practice of what has been called “defensive medicine,” described as an approach to the treatment of patients designed to avoid litigation, even if it is not in the patients’ best interests. California Supreme Court Justice Mathew Tobriner articulated the connection between tort liability and the practice of defensive

31. *Id.*

32. *Id.* (citing 2004 ACOG New York survey of ob/gyn residency programs).

33. *Id.* The National Resident Matching Program experienced a decline in the percentage of U.S. medical school seniors matched to available ob-gyn residencies in the early part of the decade, with a fill rate of only 65.1 percent in 2004. This was attributed by some to “major trepidations about the medical liability crisis,” see Jennifer Silverman, *Malpractice Crisis Blamed; Fewer U.S. Seniors Match to OB/Gyn Residency Slots: The Fill Rate for This Group Falls to 65.1 percent*, OB.GYN. NEWS (Apr. 1, 2004), available at www.carh.net/pdfs/OBResidency_043004.pdf. The results of the 2006 Match showed that this trend may be reversing. Graduates of U.S. allopathic medical schools filled 72.4 percent of available ob/gyn residency positions this year, the first time more than 60 percent of the positions were filled by U.S. allopathic graduates in the last three years. See Myrle Croasdale, *Match Day 2006: Liability Becoming a Lesser Factor in Specialty Choice*, AMEDNEWS.COM, Apr. 3, 2006, available at www.ama-assn.org/amednews/site/free/prsa0403.htm.

34. 103: 4 OBSTETRICS & GYNECOLOGY (supp.) (Apr. 2004).

35. A 2003 American Medical Association survey of medical students found that 48 percent of respondents stated that the medical liability situation was a factor in their specialty choice. See *Red Alert*, *supra* note 20. According to Dr. John M. Gibbons, Jr., president of ACOG, the medical liability premium crisis is the number one concern prompting medical students not to go into the ob/gyn specialty. See Silverman, *supra* note 33.

medicine: "When every patient is viewed largely as a potential plaintiff, the method of treatment chosen by the physician may well be that which appears the easiest to justify in court rather than that which seems best from a purely medical standpoint."³⁶ Not only does the practice of defensive medicine lead to physicians providing less than optimal medical care, it is quite costly. A number of studies have noted that physicians may order extensive and unnecessary testing in an effort to avoid any claim that a failure to "properly" assess the patient's condition was medical malpractice.³⁷ The practice of defensive medicine increases healthcare costs by proliferating unnecessary medical procedures. In addition to the costs associated with the practice of defensive medicine, increased litigation costs that have accompanied the rise in frequency and severity that is an aspect of the medical malpractice crisis, have carried a significant price tag.³⁸

When physicians face rising medical malpractice insurance premiums, and an increased possibility they will be sued and found liable for significant verdicts, they may, if the market and regulators allow, pass such actual or potential costs on to their patients in the form of increased fees for services.³⁹ Such increased fees would allow physicians to maintain their incomes notwithstanding the crisis. To the extent physicians cannot fully

36. *Clark v. Gibbons*, 66 Cal. 2d 399, 418 n.9 (1967) (Tobriner, J., concurring in the judgment). There is empirical evidence of such defensive medicine being practiced. See, e.g., Studdert, *supra* note 2 (finding that 93 percent of surveyed specialist physicians engaged in some type of defensive medicine, including ordering unnecessary tests, unnecessary referrals, and unwarranted procedures, and avoiding high risk patients or otherwise restricting their practices).

37. See, e.g., Studdert, *supra* note 2. Close to 60 percent of respondents reported ordering more diagnostic tests than medically indicated; emergency physicians were significantly more likely to engage in this type of defensive medicine, with 70 percent reporting unnecessary diagnostic testing. Of particular concern, 44 percent of general surgeons admitted suggesting unnecessary invasive procedures. *Id.* The GAO has noted that several studies have documented the existence of defensive behavior, but cautioned against generalizing the results of these studies; moreover, although the phenomenon is documented, the prevalence and costs of defensive medicine are difficult to reliably quantify. See IMPLICATIONS OF RISING PREMIUMS, *supra* note 10, at 26–30.

38. Total U.S. health care spending in 2003 was \$1.66 trillion. Malpractice costs have been estimated at \$16 billion to \$32 billion in that year, and the costs of defensive medicine have been estimated at ranging from \$50 billion to \$100 billion annually. See, e.g., William R. Brody, *Dispelling Malpractice Myths*, WASH. POST, Nov. 14, 2004, at B07, available at www.washingtonpost.com/ac2/wp-dyn/A46795-2004Nov12.

39. *Id.* According to Kenneth S. Abramowitz, a managing director at the Carlyle Group, an investment firm specializing in the health care industry, "[t]he rising cost of malpractice coverage is becoming one of the most important factors driving inflation for physicians' services, particularly for high-priced specialists in surgery and obstetrics." Joseph B. Treaster, *Malpractice Rates Are Rising Sharply; Health Costs Follow*, N.Y. TIMES, Sept. 10, 2001, available at <http://query.nytimes.com/gst/fullpage.html?sec=hea;th&res=9D0DE1DA1738F933A2575>.

recapture the increased costs of practicing medicine,⁴⁰ the practice of medicine becomes less lucrative, which in turn may discourage residents from entering particular markets, or cause practicing physicians to retire earlier than they otherwise would have, as has been discussed above.

C. Possible Causes of the Crisis

There is sharp debate over the causes of the medical malpractice crisis. Arguing that a small percentage of physicians is responsible for the majority of medical malpractice awards and settlements,⁴¹ groups that oppose reform of the current medical litigation system contend that the increase in the frequency and severity of malpractice claims is the fault of regulators who fail to discipline substandard physicians. Those opposed to reform also claim that escalating premiums are largely due to the economic cycle and poor returns on insurers' investments.⁴² These perceived causes ("Legally Benign Causes") support the argument of the plaintiffs' bar that the crisis is not the product of flaws in medical malpractice jurisprudence; if true, this argument leads to the possibility that the law concerning medical malpractice is not in need of fixing.⁴³

Regardless of what position one takes on whether Legally Benign Causes contribute to the crisis, at best they only partially explain the problem.⁴⁴

40. Physicians' ability to pass on costs is limited, and there is some evidence physicians' real incomes are declining, although medicine is still one of the most highly paid occupations in the United States. The fees paid by public and private health insurers are not keeping pace with inflation; this appears to be a major factor in declining physician income. For instance, although Medicare reimbursement rates rose approximately 13 percent from 1995 to 2003, inflation during the same period was 21 percent, meaning that Medicare reimbursement rates have declined in real terms. See HA T. TU & PAUL B. GINSBURG, LOSING GROUND: PHYSICIAN INCOME, 1995-2003, at 3 (Ctr. for Studying Health Sys. Change, Tracking Report No. 15, June 2006), available at www.hschange.org/CONTENT/851/851.pdf.

41. See, e.g., *Medical Malpractice Insurance Crisis in Pennsylvania a Result of Economic Cycles, Doctors Who Err; Bush Administration Study Flawed*, Jan. 16, 2003, available at www.citizen.org/pressroom/release.cfm?ID=1303. Public Citizen, which issued the report, describes itself as a consumer advocacy organization opposed to tort reform. See also CTR. FOR JUSTICE & DEMOCRACY, A SHORT GUIDE TO UNDERSTANDING THE MEDICAL MALPRACTICE INSURANCE "CRISIS (AND USEFUL QUESTIONS TO ASK)" (Sept. 25, 2002), available at www.centerjd.org/MediaGuide.pdf. The Center for Justice and Democracy, which published the guide, opposes tort reform.

42. *Id.*

43. For an explanation of the plaintiffs' bar's position, See, e.g., *CostRx: Kill All the Tort Reformers?*, available at www.upi.com/HealthBusiness/view.php?storyID=20060628-080958-5445r, containing an excerpt from a UPI reporter's interview of American Trial Lawyers Association president Ken Suggs. Suggs denied that doctors, and ob/gyns in particular, are quitting practice or relocating in response to liability and insurance concerns, or that malpractice awards are rising. Instead, he increased premiums to insurance company profiteering and suggests that U.S. Sen. Majority Leader Bill Frist (R.-Tenn.) manufactured the current "crisis" as part of a presidential bid.

44. A recent economic study evaluated competing claims concerning the causes of increased malpractice insurance premiums, finding that allegations of price gouging by

Insofar as the effect of rising claims frequency and severity cannot be discounted, it is important to determine what factors are influencing malpractice awards. To the extent that factors other than the existence of malpractice influence whether claims are brought and how claims are resolved, there is a need to understand the nature and degree of these influences. This article will concern two factors that the author believes influence claims frequency and severity, namely, hindsight and positive outcome biases. Studies concerning such phenomena, which are discussed below, suggest that the current medical litigation system does not effectively identify and correct for these forms of bias. If so, the judiciary should explore ways of mending the inadequacy.

III. HINDSIGHT BIAS AND POSITIVE OUTCOME BIAS

Hindsight and positive outcome biases are related phenomena. Hindsight bias refers to the human tendency to look back upon past events and view them as being expected or obvious.⁴⁵ Positive outcome bias refers to the tendency of individuals evaluating the decision making process utilized in the past by others under uncertain conditions, to rate decision makers more favorably when the outcome was itself favorable.⁴⁶ Both hindsight and outcome biases distort the perceptions of those called upon to judge the propriety of a particular decision or course of action. In the context of medical litigation, the existence of these biases suggest that it may be difficult for finders of fact to evaluate fairly (e.g., without reference to whether the decision, in retrospect, turned out to be the right choice).

insurance companies were not supported by the economic data, and that medical malpractice awards were the major source of change in insurance premiums. Alexander Tabarrak & Amanda Agan, *Medical Malpractice Awards, Insurance, and Negligence: Which Are Related?*, CIVIL JUSTICE REP. No 10, May 2006, available at www.manhattan-institute.org/html/cjr_10.htm. With regard to malpractice claims themselves, claims severity was impacted as much by tested variables unrelated to medical malpractice (such as the selection method used for judges) as it was by factors rationally related to awards (such as per capita income and death rate). The only statistically significant relationship for claims frequency was the poverty rate, which was positively correlated, although most of the state to state variation in frequency was not related to any of the tested variables. *Id.*

45. See the definition provided at <http://psnet.ahrq.gov/glossary.aspx#hindsightbias>. Hindsight bias is also referred to as outcome bias. The classic study demonstrating this phenomenon is B. Fischhoff, *≠ foresight : the effect of outcome knowledge on judgment under uncertainty*, 1 J. EXPERIMENTAL PSYCH.: HUMAN PERCEPTION & PERFORMANCE 288-99 (1975), available at <http://qhc.bmjournals.com/cgi/content/full/12/4/304>. The study confirmed the existence of "creeping determinism": finding that a particular outcome occurred, increases its perceived likelihood. Moreover, test subjects were either unaware of the effect hindsight had on their estimation of probabilities, or were unable to correct for its effects.

46. Jonathan Baron & John Hershey, *Outcome Bias in Decision Evaluation*, 54 J. PERSONALITY & Soc. PSYCH. 569 (1988), available at www.sas.upenn.edu/~baron/judg.html.

A. *Hindsight Bias*

In 1975, Baruch Fischhoff conducted a series of experiments, which on the whole, demonstrated that the outcome of an event increased its perceived likelihood of occurrence,⁴⁷ and that despite instructions to ignore a known outcome, the participants were unable to do so.⁴⁸ Fischhoff also reported that the perception of whether an event is predictable is affected by the passage of time; with time, participants remembered giving higher probabilities to events that had actually occurred.⁴⁹ For example, on the eve of diplomatic initiatives, test subjects were asked to estimate the likelihood of differing potential outcomes of the initiatives. Then, at various intervals following the initiatives, these test subjects were asked: (1) whether they believed that the outcome had occurred; and (2) to remember their original estimates as to the likelihood of the outcomes. Fischhoff found that in those cases where the subjects believed that the outcome had occurred, they were likely to recall assigning a higher probability of the likelihood of the outcome. Fischhoff also showed that the longer the lapse in time from the event, the more susceptible the test subjects' memory would be to their belief that the outcome had occurred.⁵⁰ Fischhoff concluded that what he termed the "unperceived creeping determinism" demonstrated by his experiments could "seriously impair our ability to judge the past," and that when "second guessed by a hindsightful observer" a decision that, in retrospect, led to a poor outcome, "appears to have been [the product of] incompetence, folly, or worse."⁵¹

B. *Positive Outcome Bias*

Presenting subjects with a questionnaire that included a list of medical decisions and asking them to evaluate the quality of the medical decisions, researchers Jonathan Baron and John Hershey conducted a study that directly addressed the effect of after-acquired knowledge of the outcome of an event upon the evaluation of decision makers who did not have such knowledge. The study showed that in almost half of the cases, a positive outcome led to a more favorable evaluation of the decision maker.⁵² Additional experiments conducted by the researchers as part of the same study also consistently revealed a bias towards positive outcomes, even though test subjects recognized that outcome should not effect their evaluations.

47. See Fischhoff, *supra* note 45.

48. *Id.*

49. *Id.*

50. *Id.*

51. *Id.*

52. *Id.* Higher ratings were given to the case with failure 9.3 percent of the time, and 46.4 percent of the time, equal ratings were given. However, many subjects reported remembering their response to the previous cases and repeated them regardless of outcome. *Id.*

The authors observed: "The main practical implication [of the study] concerns those many cases in which people judge the decisions of others after knowing the outcomes, as occurs in law, regulation, politics, institutions, and every day life." The authors' findings "suggest we may confuse our evaluation of the decisions with the evaluations of the consequences themselves. Mere understanding that such confusion contaminates our evaluations is not enough to eliminate it."⁵³

IV. WAYS IN WHICH CURRENT JURISPRUDENCE TREAT HINDSIGHT AND POSITIVE OUTCOME BIASES AND THE SHORTCOMINGS OF SUCH JURISPRUDENCE

A host of factors can result in a jury's misapplication of applicable law to the facts.⁵⁴ Verdicts rendered by juries who have not properly applied the law may be characterized as unjust.⁵⁵ Procedural mechanisms attempt to minimize unfair results by: (1) ensuring only genuine controversies go to trial, thereby eliminating the risk of an erroneous verdict in situations where it is apparent that the law permits only one outcome; (2) limiting the evidence that can be placed before juries, thereby eliminating the use of irrelevant, overly prejudicial, unduly confusing, or misleading information; (3) providing a means of challenging biased venire members in an effort to empanel only jurors that can be objective; and (4) providing for the setting aside of verdicts that are against the weight of evidence. Unfortunately, the manner in which these mechanisms are currently applied limits their utility in ensuring fair resolutions of medical malpractice cases.

53. *Id.*

54. See, e.g., Betsey McCaughey, *Medical Courts Would Heal Infirmities of Legal System*, available at <http://cgood.org/healthcare-newscommentary-inthenews-45.html>. See also Hal Arkes & Cindy Schipani, *Medical Malpractice v. The Business Judgment Rule*, 73 OR. L. REV. 587 (1994) (discussing impact of hindsight bias on medical malpractice juries).

55. Gregory Mandel, *Patently Non-Obvious: Empirical Demonstration That the Hindsight Bias Renders Patent Decisions Irrational*, available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=871684 (discussing study finding significant cognitive distortions in decisions by mock jurors in patent cases). But, for a contrary opinion, see Neil Vidmar, *Are Juries Competent to Decide Liability in Tort Cases Involving Scientific/Medical Issues? Some Data from Medical Malpractice*, 43 EMORY L.J. 885 (1994) (arguing criticisms of jury competence are overstated). For the purposes of this article, justice will be defined as the imposition of liability upon a physician in a medical malpractice case only when, based on an objective standard of practice set by the specialty in question, the physician has departed from good and accepted practice. Of course, there is likely to be a dispute as to what the standard is and as to whether there has been a departure from it. As shall be demonstrated, these conflicts often lead to a case being submitted to the jury, and it is in that context the biases that have been discussed have their most damaging effects. The author will also include, as an injustice, the exoneration of a physician who has committed medical malpractice on the basis of such objective standard.

A. *Summary Judgment*

Summary judgment is granted only when there are no material⁵⁶ or genuine⁵⁷ issues of fact. “In a medical malpractice action, a plaintiff, in opposition to a defendant’s summary judgment motion, must submit evidentiary facts or materials to rebut the prima facie showing by the defendant that it was not negligent in treating plaintiff so as to demonstrate the existence of a triable issue of fact.”⁵⁸ To defeat a motion for summary judgment made by the defendant in a medical malpractice case, plaintiff must satisfy “. . . two basic evidentiary steps, followed by proof relating to proximate cause and damages, (1) evidence of the generally accepted and recognized standard of care or skill in the medical community . . . and (2) a showing that the physician or surgeon in question negligently departed from that standard in his treatment of the plaintiff. The burden of establishing both these essential elements rests upon the plaintiff’s introduction of expert medical testimony.”⁵⁹ Plaintiff’s expert’s affidavit submitted in opposition to the motion must aver that the defendant violated the applicable standard of care. “The testimony of other physicians that they would have followed a different course of treatment than that followed by the defendant, or a disagreement of doctors of equal skill and learning as to what the treatment should have been, does not establish negligence.”⁶⁰ This is because “surgeons of eminence frequently differ” regarding the proper treatment called for in a particular instance. Allowing juries to decide malpractice merely because physicians testify they would have employed another course of treatment “would be to make a physician or surgeon a guarantor of the success” of his work. “The result would be to return a verdict for the plaintiff, notwithstanding the same [result] might have followed the other kind of treatment. If such were the law, there would be few physicians and surgeons who would undertake to treat a case. For every failure to effect a cure would lay the basis for a lawsuit.”⁶¹

56. *E.g.*, see *Bush v. St. Clare’s Hosp.*, 82 N.Y.2d 738 (1993) (applying CPLR RULE 3212’s material issue of fact standard.)

57. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986) (applying FEDERAL RULE OF CIVIL PROCEDURES 56’s genuine issue of fact standard.)

58. *See, e.g.*, *Bowman v. Chasky*, 30 A.D.3d 552, 552 (N.Y. App. Div. 2006) (citing *Alvarez v. Prospect Hospital*, 68 N.Y.2d 320, 324 (N.Y. 1986)). Although the cited case involved a motion by the defendant, motions for summary judgment may also be made by the plaintiff. However, the latter are far less common and therefore, this article will discuss these motions in the context of the former scenario.

59. *Kortus v. Jensen*, 195 Neb. 261, 268 (1976). *Kortus* involved an appeal of a directed verdict in favor of defendant, but the rules articulated therein are equally applicable to cases seeking summary judgment on the issue of medical negligence.

60. *Id.* at 270.

61. *Id.* at 271 (quoting *Gramaldi v. Zeglio*, 3 N.J. Misc. 669 (1925)); see also *Smith v. Beard*, 110 P.2d 260, 265, 266, 269 (Wyo. 1941).

In the context of deciding a motion for summary judgment, where the court's role is not to evaluate credibility or resolve evidentiary issues,⁶² it is insufficient for plaintiff's expert to merely attest to a difference of opinion, as opposed to a violation of the applicable standard of care. However, most plaintiffs understand this distinction and easily negotiate the issue to their advantage. Under the current state of the law, if the plaintiff submits an expert affidavit that meets the technical requirements for establishing medical negligence, proximate cause, and injury, an issue of fact requiring trial is deemed to exist.⁶³ Based on the relative scarcity of summary judgment applications granted in medical malpractice cases, it would appear that it is not difficult for plaintiffs to find an expert willing to attest in the required manner.⁶⁴

B. Applications to Disqualify Expert Testimony

Motions to disqualify an opposing party's trial expert may be made in federal and most state courts, although the criteria for granting such relief varies. Such applications are directed to the competency of witnesses to give testimony that may prove useful to jurors in evaluating evidence. Insofar as expert testimony will determine whether there has been a departure from good and accepted medical practice, producing an expert witness is essential for the plaintiff in medical malpractice litigation. Acting in the role as gatekeepers, courts assess proffered expert testimony to assure that minimum standards of reliability are satisfied. There are two general approaches taken.

62. See, e.g., *Samonte v. Bauman*, 2006 WL 2092384 at *5 (D. Haw. 2006); *Dandrea v. Hertz*, 23 A.D.3d 332, 333 (N.Y. App. Div. 2005).

63. See, e.g., *Dandrea*, 23 A.D.3d at 333; *Friedlander v. Lefrak*, 7 Misc. 3d 1032(A) (Kings Cty 2005) (stating that "the submission of conflicting medical opinions by the parties necessarily present(s) an issue of fact requiring denial of a summary judgment motion). See also *Petkus v. Girzadas*, 177 Ill. App. 3d 323 (1989) (summary judgment inappropriate where plaintiff's expert testified to the existence of a standard of care and its breach, despite fact that plaintiff's expert was a cardiologist and defendant was an orthopedic surgeon).

64. Concerns about the availability of such witnesses have been longstanding. For instance in *Smith v. Beard*, 110 P.2d at 265, the court stated that if every jury verdict holding a physician liable for malpractice "must be sustained if any of his professional brethren can be adduced to swear that...the physician had made a mistake of judgment or had been guilty of unscientific practice, then the profession would be one which unmerciful disaster follows fast..." In 1995, the president of the American Bar Association expressed concerns about the availability of experts who are willing to provide dubious opinions in a more colorful manner, reportedly referring to such experts as "\$2 hookers who pimp their dubious talents and hustle the public." Alan Feigenbaum, *Special Furies: Detering Spurious Medical Malpractice Litigation in State Courts*, 24 CARDOZO L. REV. 1361, 1396 (2003). In light of the general approach to conflicting expert opinion, it is clear that only a change in the substantive law, such as the one that is proposed below, will enable the litigators to effectively address hindsight and positive outcome biases by disposing of those cases that are most likely to be influenced by such biases.

First, in *Frye v. United States*,⁶⁵ the D.C. Circuit held that the admissibility of expert testimony is dependent upon the general acceptance in the particular field to which the testimony relates, of the scientific principle or discovery that forms the foundation of that testimony.⁶⁶ The *Frye* court cautioned that, “[j]ust when a scientific principle or discovery crosses the line between the experimental and demonstrable stages is difficult to define,” and observed that while courts will allow proffered experts a great deal of latitude in making deductions based on well-recognized scientific principles or discoveries, the underlying principle or discovery must have gained sufficient “standing and scientific recognition” to be generally accepted amongst authorities in the relevant discipline.⁶⁷ Although *Frye* is no longer the standard applicable in federal courts,⁶⁸ many states, including New York, follow the *Frye* approach to some extent.⁶⁹ In the context of medical malpractice cases where the *Frye* standard is applied, defendants may raise challenges to evidence such as proffered expert testimony concerning causation,⁷⁰ testing procedures,⁷¹ or extrapolations concerning the

65. 293 F. 1013 (D.C. Cir. 1923), *superseded* in federal court by Fed. R. Evid. 703. *See also* *Daubert v. Merrell Dow Pharm., Inc.* 509 U.S. 579, 588–89 (1993) (discussing incompatibility of *Frye* with FED. R. EVID. 703, and concluding *Frye* should not be applied in federal trials).

66. *Frye*, 293 F. at 1014.

67. *Id.*

68. *See supra* note 45. FED R. EVID. 703 currently governs the admissibility of expert testimony in federal court. The Rule stated that expert testimony is admissible when “(1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.” *Id.*

69. The *Frye* standard is still “the applicable standard in New York courts.” *See, e.g.,* *Li v. Phillips*, 358 F. Supp. 2d 135, 142 (E.D.N.Y. 2005) (citing *People v. Wesley*, 83 N.Y.2d 417, 422 (1994)). *See also* *Agnew v. Shaw*, 823 N.E.2d 1046, 1052 (Ill. App. Ct. 2005) (stating that *Frye* is still the applicable standard in Illinois); *Craig v. Oakwood Hosp.*, 684 N.W.2d 296, 307 (Mich. 2004) (all scientific expert testimony introduced in Michigan must meet *Frye* standards); *Grant v. Boccia*, 137 P.3d 20, 22 (Wash. Ct. App. 2006) (applying *Frye* test and upholding exclusion of plaintiff’s proffered expert testimony; while theory relied upon by expert was not new, neither was it generally accepted in the relevant scientific community); *Gelsthorpe v. Weinstein*, 897 So. 2d 504, 509 (Fla. Dist. Ct. App. 2005) (stating that while Florida applies *Frye* to judge the admissibility of testimony based on new or novel scientific techniques, it does not apply *Frye* to what it terms “pure opinion testimony which is based on an expert’s personal experience or training”); *Folger v. Dugan*, 876 A.2d 1049, 1058 (Pa. 2005) (stating that the *Frye* test applies in Pennsylvania when “an expert witness employs a novel scientific methodology in reaching his or her conclusion,” although the admissibility of scientific evidence is not always governed by the standards set forth in *Frye*).

70. *See, e.g.,* *Grant*, 137 P.3d at 22 (successful *Frye* challenge to testimony concerning cause of plaintiff’s fibromyalgia); *Zito v. Zabarsky*, 28 A.D.3d 42 (N.Y. App. Div. 2006) (unsuccessful challenge to proffered testimony that plaintiff’s autoimmune disorder was caused by improperly prescribed Zocor).

71. *See, e.g.,* *Folger*, 876 A.2d at 1058 (unsuccessful challenge to testimony concerning results of PCR test).

existence or progress of a disease at a particular time.⁷² However, *Frye* is not generally used to challenge expert opinions concerning the applicable standard of care.⁷³

Seventy years after *Frye*, which predated the adoption of the Federal Rules of Evidence, the Supreme Court addressed the question of *Frye*'s continued viability in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*⁷⁴ The Court held that while Federal Rules of Evidence require that the "trial judge must ensure that any and all scientific evidence admitted is not only relevant, but reliable,"⁷⁵ *Frye*'s rigid "general acceptance" standard was incompatible with the language and legislative history of Federal Rule of Evidence 702 and the Federal Rules of Evidence as a whole.⁷⁶ The test for reliability "entails a preliminary assessment of whether the reasoning or methodology underlying the testimony is scientifically valid and of whether that reasoning or methodology properly can be applied to the facts."⁷⁷ The Court stated that it was "confident that federal judges possess the capacity to make this review," and discussed factors that, while not exhaustive, were considerations relevant to determining the admissibility of expert testimony,⁷⁸ including: (1) whether the theory or technique is capable of, or has been, tested, (2) whether it has been the subject of peer review, (3) the known or potential rate of error of the technique being

72. See, e.g., *Agnew*, 823 N.E.2d at 1052 (successful challenge to expert's opinion based on use of "backward extrapolation methodology").

73. Although *Frye* is supposed to limit the introduction of unreliable expert testimony, which could confuse a jury, its effectiveness can be limited depending on the interpretation it is given. For instance, compare *Grant*, 137 P.3d at 22 (excluding plaintiff's proffered expert testimony that plaintiff's fibromyalgia was caused by a car accident because there was no agreement in the scientific community concerning whether fibromyalgia could be caused by physical trauma) with *Zito*, 28 A.D.3d at 42 (finding admissible under *Frye* testimony that plaintiff's polymyositis was caused by excessive doses of Zocor although no medical literature existed reporting a causal nexus between use of the drug and development of the disorder; general methodologies underlying plaintiff's expert's reasoning were generally accepted). Furthermore, limitations on the application of *Frye* limit its usefulness in some jurisdictions. Compare *Del Maestro v. Grecco*, 16 A.D.3d 364 (N.Y. App. Div. 2005) with *Gelsthorpe*, 897 So. 2d at 509 (testimony of expert precluded by N.Y. court in *Del Maestro*, but identical testimony of same expert admitted by Florida court in *Gelsthorpe*; while N.Y. court found the proffered testimony was based upon theory not generally accepted in relevant scientific community, the Florida court held that the testimony did not have to meet the requirement of general acceptability since expert claimed to have developed theory based on his own experience, rather than use of novel scientific methodology). Because *Frye* deals with the general acceptance of scientific theories and methodologies, it is not well suited to challenge expert opinions concerning applicable standards of care and/or a defendant's compliance or lack of compliance.

74. 509 U.S. 579 (1993).

75. *Id.* at 589.

76. *Id.* at 588–89.

77. *Id.* at 593.

78. *Id.*

utilized, and (4) whether the theory or technique enjoys the “general acceptance” contemplated by *Frye*.⁷⁹ The Court noted that the inquiry is “a flexible one,” focusing on the scientific validity and evidentiary relevance and reliability of the principles and methodology underlying the proffered expert testimony.⁸⁰ Although widespread acceptance of a theory or technique is not dispositive, as it was in *Frye*, this acceptance remains “an important factor in ruling particular evidence admissible.”⁸¹

While *Frye* and *Daubert* applications do not consider the subject of hindsight or positive outcome biases, if a challenger of the proffered testimony can demonstrate that the methodology employed by the proposed expert was scientifically unreliable due to the influence of bias, such testimony would be inadmissible under either *Frye* or *Daubert*. However, motions made under *Daubert* and *Frye* are not effective ways to address the influence of hindsight and positive outcome biases in medical malpractice litigation. Given that *Frye* and *Daubert* motions generally address the reliability of an expert’s underlying theory or methodology, while the influence of unconscious bias could affect the conclusions drawn from the expert’s application of the theory or methodology to the facts, the influence of such bias would be difficult to empirically demonstrate. Furthermore, even if the expert relied on appropriate methodology and was not himself or herself influenced by bias, a jury called upon to evaluate and apply the expert evidence presented might be influenced by hindsight or positive outcome biases.⁸²

C. *The Intersection of Summary Judgment Motions and Applications to Disqualify Experts*

Given the necessity of expert testimony on issues of negligence, causation, and damages in medical malpractice cases, a motion for summary judgment may intersect with an application under *Frye* or *Daubert*. For example, if proffered expert testimony being relied upon by the plaintiff to establish a *prima facie* case is excluded under *Frye* or *Daubert*, the plaintiff would be unable to defeat a motion for summary judgment brought by a defendant.⁸³

79. *Id.* at 593–94.

80. *Id.* at 594–95.

81. *Id.* at 595.

82. *See supra.*

83. *See, e.g.,* *Domingo v. T.K., M.D.*, 289 F.3d 600 (9th Cir. 2002) (upholding district court’s finding plaintiff’s expert evidence did not meet the *Daubert* standard, and that plaintiff was therefore unable to establish causation, and upholding grant of summary judgment in favor of defendant physician); *see also* *Kourkounakis v. Dello Russo*, 167 Fed. Appx. 255 (2d Cir. 2006) (unpublished) (upholding district court’s grant of summary judgment where plaintiff’s expert lacked the qualifications necessary to raise an issue of fact as to the adequacy of the care provided by defendant).

In *Cortes-Irizarry v. Corporacion Insular de Seguros*,⁸⁴ the United States Court of Appeals for the First Circuit discussed the application of *Daubert* in the context of a summary judgment motion made by the defendant to dismiss a medical malpractice case. The *Cortes-Irizarry* court noted that “[i]f proffered expert testimony fails to cross *Daubert*’s threshold for admissibility, a district court may exclude that evidence from consideration when passing on a motion for summary judgment.”⁸⁵ The court noted that a “trial setting normally will provide the best operating environment for the triage which *Daubert* demands” and that “given the complex factual inquiry required by *Daubert*, courts will be hard-pressed in all but the most clear cut cases to gauge the reliability of expert proof on a truncated record.” Nevertheless, *Daubert* may warrant summary judgment, at least where “defects are obvious on the face of a proffer.”⁸⁶ However, in *Cortes-Irizarry*, the appellate court reversed the grant of summary judgment, on the grounds that the lower court did not purport to exclude the testimony of plaintiff’s experts under *Daubert*, and that the record was not sufficiently developed to permit the appellate court to decide whether it had properly done so.⁸⁷

D. Jury Voir Dire and Challenges to Venire Persons

One procedural device designed to address biases is the *voir dire* of venire persons and the exercise of challenges to their inclusion on the jury. Federal and state courts allow for the questioning of venire persons to ascertain the existence of bias or prejudice, and for the challenging of such persons on the results of such examinations.⁸⁸

Voir dire examination serves to protect [the right to a fair trial] by exposing possible biases, both known and unknown, on the part of potential jurors.

Demonstrated bias in the responses to questions on *voir dire* may result in a juror being excused for cause; hints of bias not sufficient to warrant challenge for cause may assist parties in exercising their peremptory challenges.⁸⁹

While *voir dire* is useful for uncovering biases concerning a particular case or for or against one of the litigants,⁹⁰ it is less useful in reducing the

84. 111 F.3d 184 (1st Cir. 1997).

85. *Id.*

86. *Id.* at 188–89.

87. *Id.* at 189. The lower court apparently decided the motion on other grounds, but on appeal defendants argued that the lower court had the power to exclude plaintiff’s expert evidence pursuant to *Daubert*, and, if it had done so, plaintiff would have been unable to establish a *prima facie* case.

88. See, e.g., FED. R. CIV. P. 47; 28 U.S.C. § 1870; MD. R. 4-32; Tex. R. Civ. P. § 232 (peremptory challenges); V.T.C.A. § 62-105 (challenges for cause); W. VA. CODE § 56-6-12.

89. See, e.g., *McDonough Power Equip., Inc v. Greenwood*, 464 U.S. 548, 554 (1984).

90. See, e.g., *Brown v. Columbus Doctors Hosp.*, 277 Ga. App. 891 (2006) (juror who indicated he would have difficulty deciding medical malpractice case in an impartial manner

effects of hindsight or outcome bias. The reason for this is the absence of a practical way in which counsel can discover the extent to which particular potential jurors are likely to be influenced by such biases.⁹¹

E. *Post-Trial Motions*

Trial and post-trial motions are additional procedural devices designed to ensure fair results. For instance, a motion for a directed verdict can be used in situations where the plaintiff fails to present evidence at trial sufficient to establish a *prima facie* case; if granted, the case is taken away from the consideration of the jury, and a verdict entered by the judge.⁹² To illustrate, in *Massingale v. Lee*,⁹³ the Tennessee Court of Appeals upheld the trial court's decision to grant defendant's motion for a directed verdict on plaintiff's malpractice claim. The alleged malpractice involved the defendant surgeon's failure to use a mesh graft when repairing plaintiff's hernia. While plaintiff's expert testified that it was his practice to use a particular type of mesh graft in such operations and that the use of such graft was, in his judgment, the standard of care, he also testified that "some surgeons use mesh and some don't and that there are risks associated with the use of the mesh, including infection," and that performing further surgeries on the area where mesh had been inserted would be "a disaster."⁹⁴ The trial court granted a directed verdict, citing a passage from *Ball v. Mallinkrodt Chem. Works*:⁹⁵

Where there is more than one accepted method of diagnosis or treatment, and no one of them is used exclusively and uniformly by all physicians of good standing, a physician is not negligent for selecting an accepted method of diagnosis or treatment that later turns out to be unsuccessful. This is true even if the method is one not favored by certain other physicians.⁹⁶

In upholding the trial court's decision, the Tennessee Court of Appeals found that the testimony of plaintiff's expert "failed to establish that the

because malpractice crisis was affecting his economic livelihood should have been struck for cause); *Clack-Rylee v. Auffarth*, 273 Ga. App. 859 (2005) (*voir dire* uncovered bias against plaintiff in medical malpractice litigation, where prospective juror revealed religious objection to lawsuit).

91. Additionally, counsel have a limited number of peremptory challenges. Studies such as those above suggest that positive outcome and hindsight biases are common to most people. Indeed, the Fischhoff study discussed previously used study participants with varying degrees of statistics training, yet the studies consistently showed that participants exhibited hindsight bias.

92. See, e.g., *Kortus v. Jensen*, 195 Neb. 261 (1976).

93. 2005 WL 990557 (Tenn. Ct. App. 2005).

94. *Id.* at *4.

95. 381 S.W.2d 363 (Tenn. Ct. App. 1964).

96. *Massingale*, 2005 WL 990557, at *13 (citing *Ball*, 381 S.W.2d at 363).

standard of care required the use of mesh” and plaintiff further failed to establish causation.⁹⁷

However, post-trial motions are of limited utility in combating the effects of hindsight and positive outcome biases. In part, the ineffectiveness of these motions is explained by the rule that “a judgment as a matter of law should be entered only when the evidence permits only one legitimate conclusion in regard to the outcome.”⁹⁸ As with a motion for summary judgment, when determining whether to grant a motion for a directed verdict, the trial court must consider the evidence in the light most favorable to the nonmoving party, drawing all reasonable inferences in such party’s favor, and cannot resolve issues of credibility.⁹⁹ The manner and extent to which hindsight or positive expectation biases influence the opinion of a plaintiff’s expert would ordinarily present only an issue of credibility. Therefore, a motion for a directed verdict is not well suited to eliminate the existence of biases. Moreover, insofar as such motions are granted only where no issues of fact exist, they fail to address the influences of bias that operate upon a jury’s deliberations.

Likewise, a motion for judgment notwithstanding the verdict (“j.n.o.v.”) is an ineffective mechanism for addressing the harmful effects of unconscious bias, because “a motion to set aside a jury verdict as against the weight of the evidence should not be granted unless the preponderance of the evidence in favor of the moving party is so great that the verdict could not have been reached upon any fair interpretation of the evidence.”¹⁰⁰ Where more than a scintilla of evidence supports the verdict, the j.n.o.v. motion will be denied.¹⁰¹ Therefore, this procedural device neither provides an effective means to challenge verdicts’ influence by hindsight or positive outcome biases, nor does it provide a means of identifying and remedying situations where the jury’s verdict is tainted by cognitive distortions as a result of the subject biases.

97. *Id.* at *15. However, the court remanded the case for a new trial on plaintiff’s claim of medical battery.

98. *Perry v. Alessi*, 890 A.2d 463, 467 (R.I. 2006) (citing *Long v. Atl. PBS Inc.*, 681 A.2d 249, 252 (R.I. 1996)). See also *Burke v. Scaggs*, 867 A.2d 213, 217–18 (D.C. Cir. 2005) (stating that a directed verdict is only appropriate where it is clear that the plaintiff did not establish a prima facie case, and that the judge may not resolve credibility issues when passing on such a motion).

99. See, e.g., *id.*

100. *Osinski v. Taefi*, 13 A.D.3d 1205, 1206–07 (N.Y. App. Div. 2004) (upholding jury verdict in favor of defendant physician and denial of plaintiff’s motion for judgment notwithstanding the verdict; conflicting testimony and expert opinions raised issues of credibility for jury to determine). See also *Williams v. Davis*, 114 S.W.3d 351, 358–59 (Mo. App. Ct. 2003) (stating that judgment notwithstanding the verdict should not be granted in favor of a defendant physician unless the evidence and reasonable inferences are so strongly against the plaintiff’s case that no reasonable person could find the physician liable).

101. See, e.g., *Coffman v. Roberson*, 153 N.C. App. 618, 627 (2002).

The inability of procedural mechanisms to treat biases is largely the result of shortcomings in substantive law. If that law changes, the procedural mechanisms will be invigorated.

V. SUBSTANTIVE LAW TREATING HINDSIGHT AND POSITIVE
OUTCOME BIASES: THE MEDICAL JUDGMENT RULE

Courts may have implicitly recognized the potential for hindsight and positive outcome biases in medical malpractice cases when they formulated the standard of care applicable in such actions; as discussed above, physicians are not insurers of good results; rather they are held to an objective standard that requires the exercise of the degree of skill ordinarily possessed by members of their profession or specialty.¹⁰² Jurisprudence that protects a physician for exercising professional judgment in choosing among different, medically acceptable, courses of action will be referred to herein as the "Medical Judgment Rule." The case of *Campbell v. United States*¹⁰³ illustrates the application of this rule to exonerate a physician who chose among one of three acceptable techniques for performing a carotid endarterectomy. The plaintiff's expert testified that he would have used a shunting technique during the operation to reduce the risk of ischemic stroke.¹⁰⁴ However, there were countervailing considerations to the use of a shunt, such as an increased risk of stroke caused by emboli.¹⁰⁵ Applying Illinois law, the United States District Court found that the plaintiff failed to establish medical malpractice. Noting that "differences of medical opinion are not inconsistent with the exercise of due care," the Court of Appeals for the Seventh Circuit upheld the District Court's determination, citing an Illinois Supreme Court case holding that a prima facie case is not established by testimony that plaintiff's expert would have acted differently.¹⁰⁶ While *Campbell* involved a decision about how to perform a particular type of surgery, the Medical Judgment Rule is broader, encompassing treatment options and differential diagnoses.

In *Brckett v. Coleman*,¹⁰⁷ the defendant's alleged malpractice was premised upon his failure to diagnose and treat the plaintiff's decedent's renal failure or diabetic ketoacidosis. The jury was charged with determining

102. Arkes & Schipani, *supra* note 54, at 594.

103. 904 F.2d 1188 (7th Cir. 1990).

104. *Id.* at 1190, 1193.

105. *Id.* at 1190.

106. *Id.* at 1193 (citing *Walski v. Tiesenga*, 72 Ill. 2d 249 (1978)). However, the issue being reviewed in *Campbell* was not whether plaintiff established a prima facie case, it was whether the district court's decision, after a bench trial, that plaintiff failed to prove that the defendant's conduct deviated from the standard of care, was clearly erroneous. The appellate court also upheld the District Court's finding that plaintiff failed to prove proximate cause. *Id.* at 1194.

107. 525 So. 2d 1372 (Ala. 1988).

“not whether [defendant] reached the correct diagnostic result or rendered the correct treatment, but rather whether he exercised such reasonable care, skill, and diligence as a physician would ordinarily exercise in a similar case,” and that “a physician is not liable for malpractice when he makes an informed choice between viable alternatives, even though other experts, with the benefit of hindsight, testify that they would have chosen an alternative method of treatment.”¹⁰⁸

Over a century ago, the New York Court of Appeals’ decision in *Pike v. Honsinger*¹⁰⁹ set the guidelines for medical malpractice liability in that state. *Pike* held that:

A physician and surgeon, by taking charge of a case, impliedly represents that he possesses, and the law places upon him the duty of possessing, that reasonable degree of learning and skill that is ordinarily possessed by physicians and surgeons in the locality where he practices. . . . Upon consenting to treat a patient, it becomes his duty to use reasonable care and diligence in the exercise of his skill and the application of his learning. . . . He is under the further obligation to use his best judgment in exercising his skill and applying his knowledge. The rule in relation to learning and skill does not require the surgeon to possess that extraordinary learning and skill which belong only to a few men of rare endowments, but such as is possessed by the average member of the medical profession in good standing. . . . The rule of reasonable care and due diligence does not require the exercise of the highest degree of care, and to render a physician . . . liable. . . . there must be a want of ordinary and reasonable care, leading to a bad result.¹¹⁰

108. *Id.* at 1379. Applying this standard, the jury found in favor of the defendant; the verdict was sustained upon appeal.

109. 155 N.Y. 201 (N.Y. 1898).

110. *Id.* at 210. However, the importance of the standard of care in the local, as opposed to the national, community, has diminished in New York. For instance, in *Hogland v. Kamp*, 155 A.D.2d 148, 150 (N.Y. App. Div. 1990), the court held that although plaintiff’s expert was unfamiliar with the locality’s standard of care, he could testify to minimum standards of care for those licensed by the state, which are uniform throughout the state, and defendant’s breach of those standards. In *McCullough v. University of Rochester Strong Memorial Hospital*, 17 A.D.3d 1063 (N.Y. App. Div. 2005), the court noted that while the locality rule remained the general rule, a court is permitted to deviate from the application of that rule and instead apply a minimum statewide or nationwide standard of care. *Id.* at 1064. Because New York requires that doctors exercise the degree of skill of an average doctor in the locality, and that they use their best judgment and whatever superior skill or knowledge they may have, this has been interpreted as relaxing the impact of the locality rule where, for instance, a higher national standard applies to the superior knowledge, skill, and intelligence expected of board-certified specialists. See, e.g., *Riley v. Wieman*, 137 A.D.2d 309, 314–15 (N.Y. App. Div. 1988); *Toth v. Community Hosp. at Glen Cove*, 22 N.Y.2d 255, 262–63 (1968) (stating that a physician must use his best judgment and whatever superior knowledge he may have; evidence that the defendant followed customary practice is not the sole test of malpractice because “[t]here is no policy reason why a physician, who knows or believes there are unnecessary dangers in the community practice, should not be required to take whatever precautionary measures he deems appropriate”) Although the locality rule used to be the general rule applied in most

In accordance with this formulation, New York physicians enjoy latitude in exercising professional judgment, provided they have exercised their best judgment and chosen among medically accepted alternatives.¹¹¹ The Medical Judgment Rule recognizes the complexity of the practice of medicine and considers the unfairness and destructive effect of imposing an infallibility standard upon a physician's judgment; the principle that a doctor who exercises his or her best judgment when choosing among medically acceptable alternatives is not liable for malpractice is intended to insulate New York practitioners from liability for decisions that, while proper exercises of the physician's best professional judgment and skill, turn out, in retrospect, to have been erroneous.¹¹² This principle is actually a corollary to the general principle of negligence law that persons are not liable simply because they do something that causes injury to another; rather they must act unreasonably in the face of a foreseeable harm.¹¹³

In application, when a physician is defending a medical malpractice lawsuit that alleges that the complained of decision was malpractice, he may request that the jury be given a charge explaining that a physician is not liable for mere errors in judgment. This instruction is considered appropriate in situations where there is evidence at trial of a choice between or among medically acceptable alternatives or diagnoses.¹¹⁴ Concerning such errors, New York's pattern jury instruction reads: "A doctor is not liable for an error in judgment if the doctor does what he or she decides is best after careful evaluation, if it is a judgment that a reasonably prudent doctor could have made under the circumstances."¹¹⁵

jurisdictions, some states have abandoned it in favor of a national standard of care. *See, e.g.,* Logan v. Greenwich Hosp. Ass'n, 465 A.2d 294, 301 (Conn. 1983) (rejecting locality rule and adopting national standard of care); Young v. Univ. of Mississippi Med. Ctr., 914 So. 2d 1272, 1276 (Miss. Ct. App. 2005) (stating that Mississippi applies a national standard of care).

111. O'Sullivan v. Presbyterian Hosp., 634 N.Y.S.2d 101, 104 (N.Y. App. Div. 1995) ("A physician's duty is to provide the level of care acceptable in the professional community in which he practices... He is not required to achieve success in every case and cannot be held liable for mere errors in professional judgment."). *See also* Matosic v. Gelb, 647 N.Y.S.2d 781, 782 (N.Y. App. Div. 1996) ("A doctor or dentist is not a guarantor of correct diagnosis or successful treatment, nor is he or she liable for a mere error in judgment if he or she has considered the patient's best interest after careful evaluation"); Courts in other states are in accord. *See, e.g.,* Harris v. Buckspan, 984 S.W.2d 944, 952-53 (Tenn. Ct. App. 1998).

112. Boves v. Noone, 298 A.D.2d 859, 861 (N.Y. App. Div. 2002) (stating that an error in professional judgment by a medical professional is not a basis for liability, provided that the exercise of such judgment is within the range of acceptable medical standards); Shahram v. Horwitz, 5 A.D.3d 1034, 1035 (N.Y. App. Div. 2004) (stating that "a doctor is not liable in negligence merely because a treatment, which the doctor as a matter of professional judgment elected to pursue, proves ineffective or a diagnosis proves inaccurate.") (citing Nestorowich v. Ricotta, 97 N.Y.2d 393, 398 N.Y.(2002)).

113. *See, e.g.,* Johnson v. State, 253 A.D.2d 274, 277-79 (N.Y. App. Div. 1999).

114. *Nestorowich*, 97 N.Y.2d at 399.

115. *Id.*

Under the current state of the law,¹¹⁶ where evidence, including expert opinions, conflicts as to whether a particular decision comported with the standard of care, or was merely a mistaken exercise of medical judgment, the question is left to the jury to weigh the evidence and reach a verdict. If the plaintiff is able to present expert opinion evidence that the defendant acted in a manner inconsistent with the appropriate exercise of medical judgment, the application of the Medical Judgment Rule will not generally permit resolution of the case before trial.¹¹⁷ Therefore the rule is, as applied, inadequate to address the problems presented by jury members' unconscious biases. This inadequacy is heightened because the expert opinions that the jury must weigh and evaluate in order to determine whether the defendant's actions were proper exercises of medical judgment, may themselves have been tainted by hindsight bias, positive outcome bias, or both.¹¹⁸

There are two components to the Medical Judgment Rule. The first requires that the defendant exercise his or her best judgment.¹¹⁹ This subjective aspect of the rule is analogous to the good faith requirement of the business judgment rule. In the application of the latter rule, good faith is presumed in the absence of a conflict of interest. In the context of medical treatment, there appears to be no practical way to demonstrate that the best judgment has not been exercised.

The second component of the Medical Judgment Rule is objective in nature, inquiring whether the defendant's decision making was sufficiently skillful.¹²⁰ What level of competency is sufficient varies among jurisdictions. As we have seen, the *Campbell* case required that the alternative chosen be viable. In contrast, in *Das v. Thani*,¹²¹ New Jersey's highest court held that in a medical malpractice case the jury should have been instructed that, in order for the defendant to prevail based on the exercise of medical judgment, the jury must find that the maternal fetal monitoring administered by the defendant represented an equally acceptable approach to the use of the modern fetal monitoring techniques.¹²² To the extent that New Jersey's

116. However, as will be discussed, *infra*, the Medical Judgment Rule is not uniform in its substance or its application.

117. See, e.g., *Graham v. Mitchell*, 37 A.D.3d 408 (N.Y. App. Div. 2007) (stating that summary judgment is not appropriate where the parties adduce conflicting medical expert opinions).

118. Thomas B. Hugh & G. Douglas Tracy, *Hindsight Bias in Medicolegal Expert Reports*, MED. J. AUSTRALIA, available at www.mja.com.au/public/issues/176_06_180302/hug10592.html.

119. See *Pike v. Honsinger*, 155 N.Y. 201 (N.Y. 1898).

120. *Id.*

121. 795 A.2d 876, 883–84 (N.J. 2002) (finding that court's charge to jury concerning medical judgment was overly broad, and allowed jury to excuse defendant's actions using a lesser standard than that of the best available technique or one that is accepted as its equivalent).

122. *Id.* at 883–84.

approach to the Medical Judgment Rule would result in liability being imposed for a decision that involved a viable medical alternative, but one that was inferior to any other alternative, New Jersey's approach would involve a standard that was higher than the "viable alternative" touchstone. The *Das* case is also at odds with the approach taken in *Pike*, which held that the Medical Judgment Rule is satisfied with decision making reflecting the level of skill of an "average"¹²³ physician, not an "extraordinary"¹²⁴ one.

Pike recognizes that while a physician is called upon to exercise his or her personal best judgment, an average physician in the same circumstance may render a decision that is not the best one available, not only because in hindsight the decision turned out to be wrong. This reason goes without saying for it is the essence of the Medical Judgment Rule. *Pike*'s formulation is reflected in New York's Pattern Jury Instructions which exonerate the defendant if his exercise of judgment is one a "reasonably prudent doctor" would have made.¹²⁵ Hence, a defendant could make a "less acceptable" judgment from the standpoint of an above-average physician and still be protected by the Medical Judgment Rule.

However, the disagreement over the level of skill required under the Medical Judgment Rule is not at the core of the problem. In the author's view, the Medical Judgment Rule, as currently applied even under the more relaxed *Pike* test, is inadequate to protect defendant doctors from unfair adverse outcomes in malpractice cases; at the same time, the rule fails to even ensure that persons who actually suffer from injuries caused by the negligent practice of medicine are compensated. Studies continue to demonstrate that the current legal system does a poor job of ensuring that payments in such cases are actually correlated with the existence of malpractice.¹²⁶ Notwithstanding that, in appropriate cases, juries are instructed that they may not impose liability for a physician's mere error in judgment, the effects of hindsight and positive outcome bias appear to impact the ability of juries to evaluate whether medical decisions that, in retrospect, turned out to be wrong, were reasonable choices among medically acceptable alternatives from the standpoint of the average practitioner, as opposed to unreasonable choices that fell below applicable professional standards. The likelihood that this, in fact, occurs is suggested by the studies on hindsight and positive outcome bias discussed previously in this article, and also because physicians frequently disagree with jury verdicts and are unable to predict how juries will decide particular cases,

123. See *Pike v. Honsigner*, 155 N.Y. 201 (N.Y. 1898).

124. See *id.*

125. See *id.*

126. See, e.g., HOUSE JOINT ECONOMIC COMMITTEE, LIABILITY FOR MEDICAL MALPRACTICE: ISSUES AND EVIDENCE 10 (May 2003) (citing studies and findings).

notwithstanding that the standard of care is set by the medical profession itself.¹²⁷ Moreover, “[e]ven studies that report that the tort system assesses negligence appropriately find that non-negligent physicians are still required to pay malpractice judgments against them.”¹²⁸

VI. CHANGES IN THE SUBSTANTIVE LAW AND ITS APPLICATION ARE NECESSARY

Through both legislative action and decisional law, jurisprudence is constantly being refined and adapted to address economic and social conditions and evolving community notions of justice. Insofar as the general principles of negligence law, as well as those particular to medical malpractice, are largely the product of decisional law rather than legislation, it is particularly appropriate for the judiciary to reexamine and, if appropriate, adapt precedent in this area.¹²⁹ While judicial precedent is not to be lightly discarded, where it leads to results that are inimical to society’s interest or to illogical outcomes, neither its holding nor its reasoning should be followed.¹³⁰ While jurists, guided by caution, often nibble away at the corners of unsound precedent until it is entirely consumed, when it is apparent that decisional law or the way it is applied is unsound, judges owe more to posterity than they do to precedent. As Lord Atkin viewed the matter, “When these ghosts of the past stand in the path of justice clanking their

127. *Id.* See also Bryan Liang & David Cullen, *The Legal System and Patient Safety: Charting a Divergent Course: The Relationship Between Malpractice Litigation and Human Errors*, 91 ANESTHESIOLOGY 609 (1999) (discussing studies). For instance an American Society of Anesthesiologists study found that “more than 40 percent of patients who were provided appropriate nonnegligent care as defined by neutral anesthesiologist still collected payments.” *Id.* Another study involving evaluations by academic center anesthesiologists found disagreement with jury verdicts, even in cases where the juries found in favor of the defendant. *Id.* The authors noted that “These findings are compelling because it has also been reported that lay persons, without medical or legal knowledge, are statistically better able to predict jury verdicts than anesthesiologists, who are legally informed as to the standard of care through their clinical training.” *Id.*

128. *Id.*

129. See, e.g., *Buckley v. City of New York*, 56 N.Y.2d 300, 305 (1982) (stating that a rule that originated as a matter of decisional law remains subject to judicial reexamination). In *Buckley*, the court determined that the fellow-servant rule “serves no continuing valid purpose...but instead works an unjustifiable hardship” and therefore should no longer be followed.” *Id.*

130. *Id.* (stating that “[a]lthough the policy of stare decisis is not lightly to be case aside...it was intended, not to effect a petrifying rigidity, but to assure the justice that flows from certainty and stability. If, instead, adherence to precedent offers not justice but unfairness, not certainty but doubt and confusion, it loses its right to survive and no principle constrains us to follow it,” and noting that the court “act[s] in the finest common law tradition when [it] adapt[s] and alter[s] decisional law to produce common-sense justice”). See also *Tikhonova v. Ford Motor Co.*, 10 A.D.3d 185, 190 (N.Y. App. Div. 2004) (stating that “appellate courts have the responsibility to recognize when case law has evolved in an inappropriate direction” and overrule such prior law).

medieval chains, the proper course for the judge is to pass through them undeterred.”¹³¹

Any judicial initiatives that had far-reaching consequences for the way medical malpractice cases were litigated would generate great controversy. However, this is no reason to avoid pursuing change if in society’s best interests. The role of the judiciary includes shaping law to satisfy the evolving needs of society as reflected by the circumstance that “[e]very important principle which is developed by litigation is in fact and at bottom the result of more or less definitely understood views of public policy.”¹³² The function of the judiciary is not a passive one. Blackstone described judges in his *Commentaries* as “the depositories of the law, the living oracles... who must decide the law of the land.”¹³³ Accordingly, jurists must be mindful of their duty to render decisions that make sense in light of the times in which they are rendered. In *Woodman v. Pitman*,¹³⁴ the court eloquently observed that:

[t]he inexhaustible and ever-changing complications in human affairs are constantly presenting new questions and new conditions which the law must provide for as they arise, and the law has expansive and adaptive force enough to respond to the demands thus made of it, not by subverting, but by forming new combinations and making new applications out of its already-established principles,—the result produced being only “the new corn that cometh out of the old fields.”¹³⁵

Although the medical malpractice crisis could be cured by legislation, there is authority supporting a judicial resolution of at least those aspects of the problem that are the product of judge-made law.¹³⁶ Where experience shows that precedent results in undesirable outcomes, courts acting on what they perceive to be economic or scientific reality, have shaped the law to better achieve what they believe to be fair and practical outcomes.¹³⁷

Judicial solutions to problems created by decisional law are particularly appropriate where *stare decisis* lends to unfair or arbitrary determinations.¹³⁸ On the basis of the previously discussed studies that show the effects of

131. *United Australia, Ltd. v. Barclay’s Bank, Ltd.*, 4 All. E.R. 20, 37 (1940), cited in *Amalgamated Transit Union Local 587 v. State*, 11 P.3d 762, 809 (Wash. 2000).

132. OLIVER WENDELL HOLMES, *THE COMMON LAW* 35 (1881).

133. *COMMENTARIES* 53 (Lewis ed., 1900).

134. 10 A. 321 (Me. 1887).

135. *Id.* at 322.

136. See e.g., *Bernhardt v. Polygraphic Co. of Am.*, 350 U.S. 198, 205 (1956); *N.A.A.C.P. v. Acusport, Inc.*, 271 F. Supp. 2d 435, 456 (E.D.N.Y. 2003).

137. See, e.g., *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 58–59 (1977) (finding that per se rules should be applied in certain vertical restriction cases brought under the Sherman Antitrust Act because vertical restrictions may have a positive rather than a negative effect upon competition).

138. *Strubbe v. Sonnenschein*, 299 F.2d 185, 188–89 (2d Cir. 1962).

hindsight and outcome biases, it would appear that the judges who have historically been the authors of tort law are in a position to reform the Medical Judgment Rule.¹³⁹ The author is mindful of the reluctance of courts to address longstanding problems which the legislature has had an opportunity to address, but where fairness compels action, jurists should remember that the legislature can pass laws that negate judge-made law with which it disagrees.

Two recent New York Court of Appeals decisions illustrate the judiciary's approach to modifying outdated decisional law in the area of medical malpractice to address policy goals and evolving social concepts of justice. In *Broadnax v. Gonzalez*,¹⁴⁰ the Court held that, even in the absence of an independent physical injury, a woman could maintain an action when medical malpractice caused the stillbirth or miscarriage of her fetus.¹⁴¹ Prior to *Broadnax*, New York courts had not allowed such actions, finding that they did not fit into any exception to the general rule that plaintiffs may not recover for negligent infliction of emotional distress absent some physical injury.¹⁴² The *Broadnax* court noted that the situation created by the prior rule created an anomaly: while a physician could be held responsible for negligently causing injuries to a child in utero, if the injuries were so severe that the child died prior to delivery, application of the rule meant that the physician escaped liability absent some physical injury to the mother.¹⁴³ The court noted that this result was "peculiar," and caused a "logical gap" whereby a narrow class of injured parties were deprived of any remedy.¹⁴⁴ The *Broadnax* court observed that such a "logical gap" was "at odds with the spirit and direction of...decisional law..."¹⁴⁵ The Court further noted that, when the general rule was formulated that a parent was barred for suing for wrongful death of an unborn child, that rule was based in part on the assumption that the parents themselves "would have some legal recourse for a miscarriage or stillbirth resulting from negligent conduct."¹⁴⁶

A year later, in *Sheppard-Mobley v. King*,¹⁴⁷ the Court clarified the judicial remedy established by the *Broadnax* court. Noting the reasoning behind the *Broadnax* decision of providing accountability in situations where medical negligence led to the death of a fetus in utero and rectifying the "injustice created by categorically denying recovery to a narrow, but indisputably

139. Of course, in those jurisdictions where the legislature may have addressed the subject, courts should not do so. See *Desiderio v. Ochs*, 100 N.Y.2d 159 (2003).

140. 2 N.Y.3d 148 (2004).

141. *Id.* at 155.

142. See, e.g., *Tebbutt v. Virostek*, 65 N.Y.2d 931, 932 (1985).

143. *Broadnax*, 2 N.Y. 3d at 154.

144. *Id.* at 155.

145. *Id.*

146. *Id.*

147. 4 N.Y.3d 627 (2005).

aggrieved, class of plaintiffs,” the court held that *Broadnax’s ratio decidendi* would not be furthered by any expansion of the holding to encompass situations where the child was born alive and was, therefore, entitled to bring an independent medical malpractice claim seeking recovery for the injuries suffered prior to birth.¹⁴⁸

In shaping the parameters of medical malpractice liability in the context of fetal injury, the courts have focused on concerns such as fairness and the need for accountability, refining and where necessary changing the applicable common law in light of evolving social sensibilities and perceptions of physician’s duties to mother and unborn child with respect to prenatal care.¹⁴⁹ Cases such as *Broadnax* and *Sheppard-Mobley* indicate the general factors that are considered when jurists refine existing decisional law: (1) deficiencies in the law, (2) public policy goals, and (3) maintaining consistency with general common law principles. Against the background of the crisis, the application of these factors to current medical malpractice jurisprudence suggests the need for change. As discussed above, the system is leading to unfair results. Public policy is not served by a legal regime that has led to the practice of defensive medicine and reduced provider availability, while, at the same time, not furthering the common law goals of deterring negligent behavior and ensuring its victims appropriate

148. *Id.*

149. *See also, e.g.,* *Becker v. Schwartz*, 46 N.Y.2d 401 (N.Y. 1978), in which the New York Court of Appeals was called upon to determine whether changing social concepts of justice supported allowing actions for “wrongful life” or for parents’ emotional distress arising out of the birth of a child with a genetic defect. The court considered general principles of negligence law and practical and policy considerations in making the determination not to allow these new causes of action, other than the parents’ action for the pecuniary loss arising from the expenses of raising a disabled child. In contrast to *Broadnax*, where allowing the new cause of action was considered to bring the law into harmony with general tort law principles, in *Becker*, the court determined the validity of the proposed causes of action involved questions not easily addressed by general principles of negligence law and involved weighing moral considerations that were more appropriately within the province of the legislature. *See also* *Albala v. City of New York*, 54 N.Y.2d 269 (1981). In *Albala*, the plaintiff’s mother’s uterus had negligently been perforated during an abortion; plaintiff’s mother had previously brought, and settled, a medical malpractice action for her injuries. Five years after the abortion, she gave birth to the plaintiff, whose brain damage was allegedly caused by the state of his mother’s damaged uterus. *Id.* at 270. In declining to permit the child a cause of action in this circumstance, the court noted that the implications of such a major change in the parameters of negligence liability were a legislative concern. *Id.* at 273–74. The court also noted the important practical and policy considerations weighing against such liability, which would encourage doctors to refuse to treat women where the available treatments could injure future offspring, stating that “society as a whole would bear the cost of our placing physicians in a direct conflict between their moral duty to patients and the proposed legal duty to those hypothetical future generations outside the immediate zone of danger.” *Id.* at 274. The court noted its “duty to consider the consequences of recognizing a novel cause of action and to strike the delicate balance between the competing policy considerations whenever tort liability is sought to be extended beyond traditional bounds.” *Id.* at 275.

compensation.¹⁵⁰ The stage is therefore set for the modification of the Medical Judgment Rule or of its application.

VII. EXPANDING THE MEDICAL JUDGMENT RULE TO BETTER ADDRESS HINDSIGHT AND POSITIVE OUTCOME BIASES

In considering how best to reduce the effects of hindsight and positive outcome bias in medical malpractice litigation, it is useful to consider areas of the law in which courts have adopted rules that effectively limit the role of these biases. Two examples of such rules will be discussed: (1) liability of corporate officials for negligent business decisions, and (2) the relaxed standard that some courts follow when imposing liability in psychiatric malpractice cases.

A. *The Business Judgment Rule*

The “business judgment rule” is a judicial presumption that, in the absence of fraud or bad faith and provided that corporate officials were reasonably informed of all available material information prior to making a decision, such officials have acted in good faith, and in the honest belief that their actions were in the best interest of the company.¹⁵¹ Although such officials are required to act with due care, the effect of this presumption is to insulate corporate officials from liability for the bad results of business decisions, even if those decisions were negligently made.¹⁵² The business judgment rule has been justified by the need to free corporate officials from the fear of liability for rendering difficult decisions. Those who support the application of the business judgment rule make note of “widespread concern that stricter scrutiny of business decisions would induce corporate officials to become too cautious in their decision making to the shareholders’ detriment. That is, a standard of care permitting the courts to evaluate the business decision would have counterproductive effects on management decision making.”¹⁵³ A related reason given for the business judgment rule is the difficulty in evaluating, in retrospect, the quality of business decisions when they lead to poor outcomes.¹⁵⁴ Assessment of business opportunities can be a highly speculative cognitive process, and the performance of particular businesses and investments is difficult to predict with any degree of accuracy.

150. See, e.g., Liang & Cullen, *supra* note 127 (stating that the medical malpractice tort system neither provides efficient and appropriate incentives to render non-negligent care to minimize patient injury, nor compensates patients who are negligently injured.)

151. Arkes & Schipani, *supra* note 54, at 614.

152. An exception to the rule applies where there is evidence of a conflict of interest between the official and the corporation. *Id.* at 615.

153. *Id.* at 623.

154. *Id.* at 622.

The business judgment rule eliminates the role of hindsight and positive outcome biases because the question of whether a decision was an appropriate one is never reached, thereby ensuring that the courts and juries “will not substitute their judgment for the judgment exercised by the corporate official.”¹⁵⁵ The success of the business judgment rule in eliminating hindsight and positive outcome biases invites comparison with the Medical Judgment Rule. Indeed, Arkes and Schipani did so in their article which inquired whether, in medical malpractice settings, the application of a standard similar to the business judgment rule would be an appropriate way to avoid the influence of hindsight and positive outcome biases.¹⁵⁶ They concluded that several important differences between medical and business situations render application of such a standard improper in the medical context. These include the respective roles of risk taking and failure in each profession, the lack of accepted standards or scientific principles by which to judge business decisions, differing economic incentives, and the vastly different nature of the risk to which patients, as opposed to shareholders, are exposed. However, Arkes and Schipani nonetheless noted that the present influence of hindsight and positive outcome bias in medical malpractice cases needed to be reduced.¹⁵⁷

B. *The Medical Judgment Rule in Psychiatric Cases*

Expressing hesitancy over allowing fact-finders to second guess treating psychiatrists, some courts, faced with particularly difficult psychiatric diagnostic or treatment decisions, apply the Medical Judgment Rule in a way that much more closely approximates the manner in which the business judgment rule is employed to insulate corporate officials for decision making leading to a bad result. Although the New York State Court of Appeals has never definitively found that either a different liability rule, or a different application of the existing medical malpractice judgment rule, is to be employed in cases involving psychiatric malpractice, a number of decisions rendered by New York Courts leave no question that the Medical Judgment Rule has, at the very least, been applied in a more expansive manner to cases involving certain psychiatric care decisions.

This difference in approach has led to confusion concerning how the Medical Judgment Rule is to be applied to psychiatric cases in New York. To illustrate, in *Centeno v. City of New York*,¹⁵⁸ the defendant discharged plaintiff's decedent from inpatient care, and the patient committed

155. *Id.*

156. *See id.*

157. *Id.* at 623–30, 637. Arkes and Schipani favored bifurcated trials although acknowledging they were an imperfect solution to the problem. *Id.* at 637.

158. 48 A.D.2d 812 (N.Y. App. Div. 1975), *aff'd*, 40 N.Y.2d 932 (N.Y. 1976).

suicide.¹⁵⁹ Although plaintiff's expert testified that the defendant's decision was "incomplete, inadequate and thus completely wrong," and had not been in accordance with good and accepted medical practice,¹⁶⁰ the majority of the court still found that plaintiff had failed to establish a *prima facie* case.¹⁶¹ The court held, as a matter of law, that defendant's decision was protected as an exercise of medical judgment. The testimony of plaintiff's expert was characterized as a mere disagreement over the course of treatment chosen by defendant; the court noted such disagreements are an insufficient predicate upon which to base liability.¹⁶² The court found that, absent evidence that the opinion of the attending psychiatrist was "other than honest," the testimony of plaintiff's expert was "irrelevant" and observed that "[t]he prediction of the future course of a mental illness is a professional judgment of high responsibility and in some instances it involves a measure of calculated risk,"¹⁶³ imposing liability for predictions which, in retrospect, turn out to have been wrong, would preordain that "few releases would ever be made and the hope of recovery and rehabilitation of a vast number of patients would be impeded and frustrated."¹⁶⁴ This expression of public policy provides a basis for an application of the Medical Judgment Rule that more closely resembles the business judgment rule.

Another example of a more expansive application of the Medical Judgment Rule in the setting of psychiatric care and treatment is *Topel v. Long Island Jewish Medical Center*,¹⁶⁵ where plaintiff's decedent committed suicide while an inpatient in the psychiatric ward of the defendant hospital.¹⁶⁶ The defendant's staff had permitted a depressed, delusional patient to keep his belt and, rather than placing him under constant observation, were checking on him at fifteen minute intervals.¹⁶⁷ Plaintiff's expert had testified that defendants' treatment decisions were not medically acceptable and fell below the standard of care.¹⁶⁸ Setting aside the jury's verdict in favor of plaintiff, the trial court granted judgment for defendant, and dismissed the complaint for plaintiff's failure to make out a *prima facie* case.¹⁶⁹ The appellate division affirmed the trial court's decision and, upon appeal, the Court of Appeals affirmed, finding that defendants' conduct

159. *Id.* at 812–13.

160. *Id.* at 813 (Nunez, J., dissenting opinion).

161. *Id.*

162. *Id.*

163. *Id.* at 812–13.

164. *Id.* at 813.

165. 55 N.Y.2d 682 (1981).

166. *Id.* at 688 (Fuchsberg, J., dissenting).

167. *Id.* at 688–89.

168. *Id.* at 688.

169. *Id.* at 685.

was a protected exercise of professional judgment.¹⁷⁰ The majority determined that plaintiff's expert's testimony was insufficient because his opinion did not address and negate the factors upon which defendant testified he relied when making his treatment decision.¹⁷¹

A final example of the special approach taken in psychiatric cases is *Schrempf v. State*.¹⁷² There, the plaintiff's decedent was killed by a mentally ill person who had been released from a state mental hospital. A central issue was whether the decision to release the patient violated good and accepted medical practice. The New York Court of Appeals held that the complaint should have been dismissed, because the release decision was a protected exercise of medical judgment.¹⁷³ The court noted that, "[t]he line between medical judgment and good medical practice is not easy to draw, particularly in cases involving psychiatric treatment."¹⁷⁴ Advancing a policy argument similar to that made in the *Centeno* case, the court opined that "[b]ecause psychiatry is not an exact science, decisions with respect to the proper course of treatment often involve a calculated risk and disagreement among experts as to whether the risk was warranted or in accord with accepted procedures."¹⁷⁵ Observing that there are competing interests involved in making a decision whether to release a patient, and characterizing plaintiff's expert's testimony as simply weighing risks differently, the Court found that the patient's "treating physician... simply attached greater significance to [factors indicating a more favorable prognosis] and chose the course which appeared to offer the best opportunity for long-term rehabilitation. We know with hindsight that it was a mistaken impression... but it must be recognized as an exercise of professional judgment" to which no liability should attach.¹⁷⁶ By finding that, as a matter of law, medical judgment protected the psychiatrist's exercise of judgment, the Court deprived the jury of an opportunity to second guess the treating physician's judgment.

Subsequent to *Centeno*, *Topel*, and their progeny, cases alleging psychiatric malpractice have been reviewed by courts in a manner very similar to cases of business judgment. The focus has not been on whether the

170. *Id.* at 684.

171. *Id.* at 684-85. The defendant doctor based his decision on factors including (1) concern constant surveillance would aggravate the patient's heart condition (given his apparent belief that the nurses were "trying to kill him"), (2) the gesture-like nature of his prior suicidal ideations, (3) the rehabilitative aspects of open ward treatment, and (4) his belief he would be more likely to obtain the patient's consent for electroshock treatment if the patient was kept in the more relaxed open ward. *Id.* at 684, 687.

172. 66 N.Y.2d 289 (1985).

173. *Id.* at 291, 297.

174. *Id.* at 295.

175. *Id.* at 295-96.

176. *Id.* at 297.

decision complained of was itself negligent, but rather whether it was based on a careful examination of the patient and evaluation of the attendant circumstances.¹⁷⁷ However, policy considerations militating against second-guessing release decisions do not justify protecting such decisions when they are made without consideration of the medical information available to the psychiatrist,¹⁷⁸ inviting comparison with the business judgment rule's requirement that corporate officials make informed decisions.

The application of a different standard in psychiatric malpractice cases has been criticized. Justice Fuchsberg, who dissented in both *Centeno* and *Topel*, argued that "the fact that a departure from accepted medical practice occurs in a psychiatric rather than a nonpsychiatric setting is only an element to be weighed along with all the other circumstances in a particular case and is not the premise for an application of different legal principles."¹⁷⁹ In his dissent in *Topel*, Justice Fuchsberg warned that the majority holding that a *prima facie* case had not been established "disturb[ed] basic legal doctrine" applicable to medical malpractice cases.¹⁸⁰ He noted that in nonpsychiatric medical malpractice cases, the standard of care and whether there has been a departure involves a trier of fact's assessment of expert testimony.¹⁸¹ Yet, in both *Topel* and *Centeno*, sharply conflicting expert testimony as to whether defendants breached the standard of care was characterized as no more than differences of opinion. Justice Fuchsberg argued that this characterization did not comport with the expert testimony which "[indicated that the treatment decisions made by the defendants] if not patently unreasonable, deviated from accepted psychiatric medical practice."¹⁸² Justice Fuchsberg's dissent in *Topel* observed that the Court, while using the language of the Medical Judgment Rule,

177. See, e.g., *Bell v. N.Y.C. Health & Hosp. Corp.*, 90 A.D.2d 270 (N.Y. App. Div. 1982) (upholding jury verdict in favor of plaintiffs because the decision to release plaintiff, who later sustained injuries during an attempted suicide, was not based on a careful examination of the patient; defendant psychiatrist admitted that he did not inquire into the patient's delusions and hallucinations prior to writing that the patient was not a danger to himself or others in his note recommending release, and admitted that this was a departure from accepted medical practice); *Seibert v. Fink*, 280 A.D.2d 661 (N.Y. App. Div. 2001) (question of fact precluding summary judgment existed where defendant psychiatrist admitted he did not read plaintiff's decedent's chart before releasing her on a pass; while home on the pass, the patient committed suicide). *O'Shea v. United States*, 623 F. Supp. 380 (E.D.N.Y. 1985) (applying New York law) (decision to defer psychiatric patient's admission until the next day was professional medical judgment to which no liability could attach, since Veteran's Administration physician carefully examined patient prior to making such decision).

178. See, e.g., *Bell*, 90 A.D.2d at 280.

179. *Centeno v. City of New York*, 40 N.Y.2d 932, 933 (N.Y. 1976) (Fuchsberg, J., dissenting).

180. *Topel*, 55 N.Y.2d at 685 (Fuchsberg, J., dissenting).

181. *Id.* at 690.

182. *Id.* at 693.

was actually applying a different standard, albeit without articulating such standard or setting forth its parameters.

Justice Fuchsberg's criticism of his colleagues' failure to acknowledge that they were modifying or applying the Medical Judgment Rule differently in psychiatric cases is certainly valid. A clearer approach is invited. It is appropriate to clearly recognize that in certain psychiatric cases, the Medical Judgment Rule may have been modified and the manner of its application has altered. In such cases, the appropriateness of the exercise of medical judgment may be determined as a matter of law, notwithstanding the fact that in nonpsychiatric cases the same type of expert testimony would result in an issue of fact which could be resolved only by the trier of fact.

In these psychiatric cases, whether defendant's exercise of medical judgment is consistent with that of a reasonably skilled physician is not the test being applied. Despite conflicting testimony in such cases as to whether a physician's medical judgment fell below that of a physician with average proficiency, the court has decided that the required level of skill has been satisfied; ordinarily, a jury decides which of the experts to believe in determining what an average physician would do, and whether the defendant has departed from the norm. *Topel* and its progeny establish a *de facto* standard that the existence of competent support that a decision was acceptable ends the inquiry, whether or not that decision was within the parameters of care that would have been rendered by a theoretical "average" physician ("Psychiatric Standard").

This change in the Medical Judgment Rule has resulted in a modification in the way that certain psychiatric cases are resolved. Because the question of whether there is competent support for the decision of the defendant psychiatrist can be resolved as a matter of law, the issue is being taken away from the jury in such cases.

In his dissent in *Topel*, Justice Fuchsberg also opined that the difference of approach taken in psychiatric cases was an improper exercise of judicial power. The policy reasons discussed by the majority were not, in the dissent's view, an appropriate basis for adopting an approach that removed the issue of whether medical judgment had been properly exercised from the jury to the trial judge; in any event, Justice Fuchsberg said that the weighing of competing interests, in deciding whether to treat a patient less restrictively, implicated public policy. Significant change in the way the law resolves issues that are infused by public policy interests was, in Justice Fuchsberg's view, within the province of the legislature, not the judiciary.¹⁸³

183. *Id.* at 695-96.

However, as discussed earlier, policy reasons have factored prominently into the judiciary's approach to modifying recognized defects in the common law that have led to unfair results, and it is with this aspect of Justice Fuchsberg's dissent that the author takes exception. Insofar as the three considerations that invite changes in decisional law have all been satisfied, the judiciary has a duty to modify the jurisprudence which it previously created. The question is then how the judiciary can best modify such decisional law or its application.

Here, the precise question is how to apply the Medical Judgment Rule, or a modification thereof, in a way that effectively addresses hindsight and outcome biases in nonpsychiatric care cases.

C. Expanding to Nonpsychiatric Cases the Psychiatric Standard for Determining the Applicability of the Medical Judgment Rule

As has been discussed, the judiciary's justification for the application of the business judgment rule, and for the application of the Psychiatric Standard, has been: (1) the high degree of uncertainty facing the decision maker; and (2) the decision maker's disincentive, based upon the imposition of liability for bad results, to take appropriate risks when this is in the best interests of the recipient of the decision maker's services. These factors, which overlap, are supportive of the application of the Psychiatric Standard to nonpsychiatric medical malpractice cases.

1. The Uncertainty Facing Decision Makers in Nonpsychiatric Cases Supports the Application of the Psychiatric Standard to Nonpsychiatric Cases

Uncertainty over diagnosis or course of treatment is not limited to the psychiatric field. Medical decision making in specialties other than psychiatry also often involves a degree of subjectivity and a measure of calculated risk.¹⁸⁴ Countless examples may be cited in support of this conclusion. Among the best examples come from the field of obstetrics and gynecology, where obstetricians are often faced with great uncertainty with

184. The influence of subjective assessments, varying risk tolerances among patients and practitioners, and personal values on medical decision making in diverse circumstances are recognized in the debate over the increasing influence of clinical practice guidelines on modern medical practice. For instance, one article invited readers to compare various guidelines that govern medical decisions and to recognize that they may be based upon different considerations and emphasize different values. See Deborah Cook & Mita Giacomini, *The Trials and Tribulations of Clinical Practice Guidelines*, 281 JAMA, May 26, 1999. The recognition that certain types of medical decisions involve subjective components, such as the willingness to accept a particular risk in return for the possibility of achieving a particular benefit, suggest that such decisions are particularly vulnerable to criticism by a more risk averse practitioner viewing the choice with the perspective of hindsight. The recognition of the role values play in certain types of medical decision making also highlights the vulnerability of particular

respect to the conditions under which medical judgments are rendered.¹⁸⁵ For instance, obstetricians are often called upon to decide whether to perform a Caesarean Section or to allow a natural birth. The circumstances which exist at the time the decision is made often present competing concerns, and the risks of pursuing one course over the other are often uncertain. While in cases involving maternal or fetal risks a C-Section can be safer than a vaginal delivery, the procedure involves its own health risks. Decisions concerning which among one or more alternative procedures is to be followed invites a balancing of risks. With C-sections, the mother may suffer blood loss and the attendant risks of a major surgical procedure, such as infection, and, in cases of repeat C-Sections, the risk of bladder or bowel problems is increased. Infants delivered by C-Section are more likely to suffer respiratory-lung problems than babies delivered naturally.¹⁸⁶ While a C-Section can be a life-saving procedure in instances where there is a life threatening condition or a fetus in distress, the degree of danger present is often difficult to assess. Decision making under these circumstances cannot be treated as an exact science.

Moreover, since obstetrics involves consideration of the health of both the mother and the fetus, and acts that reduce the risk to one may increase the risk to the other, a values component also exists in obstetrical decision making; this component renders medical judgments subject to retrospective criticism by other practitioners who may weigh these values differently.¹⁸⁷

decisions to second-guessing by other experts with different values. Preventing or discouraging physicians from independently assessing a patient's individual circumstances and making particularized recommendations based on such evaluation may mean that patients in special circumstances will receive less than optimal care. See, e.g., W.W. Klein, *Current and Future Relevance of Guidelines*, 87 *HEART* 497-500 (2002). Another author noted that a traditional hallmark of the expert is flexible responsiveness. Brian Hurwitz, *LEGAL AND POLITICAL CONSIDERATIONS OF CLINICAL PRACTICE GUIDELINES*, 318(7184) *BRIT. MED. J.* 661-64 (1999). Hurwitz noted concerns that excessive reliance on guidelines would erode clinical abilities and reduce medical practice to cookbook medicine. This concern is equally applicable to a legal system that discourages doctors from making individualized medical judgments out of fear of liability.

185. Thorny problems surrounded by uncertainty may also arise because of the nature of the patient's ailment or even the condition of the physician.

186. See, e.g., *C-Section Rate at All-Time High in U.S.*, *HEALTH DAY*, Aug. 17, 2006, available at www.nlm.nih.gov/medlineplus/news/fullstory_37513.html; Gene Declercq & Judy Norsigian, *Don't Blame Mothers for C-Section Vogue*, *WOMEN'S E-NEWS*, Apr. 19, 2006, available at <http://womensenews.org/article.cfm/dyn/aid/2710/context/archive>.

187. Values can play a large role in situations where the interests of mother and fetus do not coincide, and there is a significant danger that an expert asked to evaluate a particular obstetrical decision in retrospect may be significantly influenced by his or her views on whose interests are paramount: those of the mother or those of the fetus. The role values play is apparent in the wave of litigation involving compelled C-sections, in which courts are asked to make value-laden decisions over whose interests are more important: those of the mother,

2. The Disincentives for the Exercise of Medical Judgment in the Best Interests of the Patient

Psychiatry is not the only medical specialty in which fear of liability can cause practitioners to act in a manner adverse to the best interests of a patient. In the example of the dilemma facing obstetricians as to whether to perform a C-Section or allow a natural birth, there are indications that obstetricians are performing more C-Sections because such operations are easier than natural childbirth to justify in malpractice cases, and because obstetricians are concerned about the “reality of lawsuits that may be brought even in instances when an obstetrician is not really to blame for a bad outcome.”¹⁸⁸ Thus, “[i]t is not surprising that in the grey area of clinical decision making during labor, many obstetricians have substantially lowered the threshold for when they would perform a C-Section.”¹⁸⁹ By 2004, nearly thirty percent of U.S. births occurred by C-Section, despite the fact that the “delivery method carries with it risks that aren’t acceptable if a C-Section isn’t necessary to preserve the health of the mother or baby.”¹⁹⁰

VIII. THE AUTHOR’S PROPOSAL TO HOLD A MEDICAL JUDGMENT HEARING AS A MEANS OF REDUCING HINDSIGHT AND OUTCOME BIASES

Insofar as the same considerations that support the application of the Psychiatric Standard may also present themselves in nonpsychiatric medical malpractice cases, it is appropriate to consider the adoption of certain aspects of the former’s relaxed approach as a means of combating the effects of hindsight bias and outcome bias. This is not to suggest that the Psychiatric Standard be followed without modification, or that it be applied to all medical malpractice cases. Rather, the author proposes that, under certain defined circumstances, a form of the medical malpractice rule that has been

or those of the child. See, e.g., Lisa Collier Cool, *Could You Be Forced to Have a C-Section*, BABY TALK, May 2005, available at www.advocatesforpregnantwomen.org/articles/forced_c-section.htm. See also *Pemberton v. Tallahassee Mem. Med. Ctr.*, 66 F. Supp. 2d 1247 (N.D. Fla. 1999) (disallowing damages for forced C-section). Thus, in addition to hindsight bias and positive outcome bias, evaluation of these types of decisions may be influenced by the application of differing values than those of the physician making the decision and those expressed by the patient at the time the decision was made.

188. See Declercq & Norsigian, *supra* note 186. See also *C-Section Rate in U.S. Reaches High of 1.2M in 2004 Despite Efforts to Lower Rates*, MED. NEWS TODAY, Nov. 17, 2005, available at www.medicalnewstoday.com/medicalnews.php?newsid=33650 (stating that part of the reason for the increase in the C-section rate can be attributed to physicians’ fears of malpractice lawsuits over problems arising from the natural birth process).

189. See Declercq & Norsigian, *supra* note 186.

190. See *C-Section Rate at All-Time High in U.S.*, *supra* note 186.

modified both in substance and its application be followed in accordance with the more relaxed approach taken in psychiatric cases.

A. *Proposed Substantive Changes to the Medical Judgment Rule*

As we have seen, if there is competent support for the decision made, the Psychiatric Standard protects the exercise of medical judgment in certain circumstances. From *Centeno, Topel* and *Schremppf*, it would appear that expert testimony that a certain course of treatment is appropriate will satisfy this requirement.¹⁹¹ In the face of the plaintiff's *prima facie* proof of a deviation, the Psychiatric Standard enables a court, rather than a jury, to resolve the issue of whether the defendant doctor is protected by the Medical Judgment Rule, because the proof required is not freedom from factual doubt but whether there is competent evidence that the defendant's exercise of medical judgment was within the normative range of good and accepted practice.

Replacing the average physician touchstone embedded in the Medical Judgment Rule as applied to nonpsychiatric cases with some form of the Psychiatric Standard is a positive first step. There is too much room for error in an approach that asks lay triers of fact to determine which competing trial experts should be believed when the trier of fact also must decide to which standard an average physician must conform to avoid liability. The Psychiatric Standard's focus upon whether there is *prima facie* evidence that medical judgment was exercised is a logical approach. It avoids forcing the trier of fact to determine the hazy line which is dependent upon the skill of the supposed average physician and which separates medical judgment from departures from good practice. The Psychiatric Standard is only concerned with whether there is competent evidence that the defendant physician followed a medically accepted approach in making his or her decision, in which case the decision is protected under the Psychiatric Standard.

Practical considerations also support the replacing of the average physician standard. Too often, a trier of fact is expected to correctly decide issues concerning the appropriate standard of care in a highly charged setting where the question may turn upon as unreliable a circumstance as whether the plaintiff's expert believes that any standard which is not that subscribed to by the expert, is a departure. Although the determination of the appropriate standard is meant to be objective in nature, expert testimony relating to the standard has a subtle subjective component that a juror cannot be

191. Whether the expert can be the defendant, and not an expert hired by the defendant, is a matter that need not detain us. Insofar as the test proposed by the author involves the court's evaluation of whether there is significant medical support for the decision making of the defendant, defendant's testimony alone would never satisfy the proposed test.

expected to appreciate, and which even experienced defense counsel will not be able to expose, given the limitations that surround trial practice.

The author, therefore, proposes that the test for determining if the defendant's decision making is protected by the Medical Judgment Rule be whether the exercise of medical judgment finds support in the medical community, not whether it reflects the skill of an average practitioner in the subject specialty. This, of course, leaves open the question of what level of proof is necessary, a subject that the Psychiatric Standard does not directly address. From the fact pattern of the psychiatric cases which apply the Psychiatric Standard it would appear that a competent medical expert's testimony is sufficient to trigger the application of a Medical Judgment Rule in a way that resolves the case without the need to submit the issue to the jury. However, the author does not believe that expert testimony supporting the defendant's exercise of medical judgment should be sufficient. For some of the same reasons, discussed earlier, while a plaintiff's expert witness may lack credibility, a defendant's expert witness's credibility could also be suspect. Whether medical judgment has been exercised should turn on more than the defendant's experts' say-so.

The author recommends that when the plaintiff has produced *prima facie* proof of a departure, the resolution of the issue whether there is what the author will call "credible support" in the medical community for the defendant's decision, should be decided on two points: (1) has the defendant submitted, in support of the defendant's position that his or her decision is protected by the Medical Judgment Rule, reliable evidence sufficient under the criteria set forth in the *Daubert* case for qualifying an expert; if so, the defendant should prevail unless (2) the plaintiff can demonstrate, by evidence that so preponderates in favor of the plaintiff that under no fair interpretation of the reliable evidence could the issue be one of medical judgment, but is, instead a departure.

This proposed approach recognizes that the burden is on the plaintiff to show a departure, and if the court finds the plaintiff's evidence is sufficient to defeat the protection afforded by the Medical Judgment Rule then the issue can be resolved against the defendant without submission to a jury. This application of a modified Medical Judgment Rule ("Modified Medical Judgment Rule") is consistent with Federal Rule of Evidence, Rule 401 (defining relevancy), which is a question for the court, in terms of whether evidence tends to make the existence of a fact more or less improbable. However, in the context of the Modified Medical Judgment Rule, it is not a single fact, but all relevant evidence bearing on the issue of the exercise of medical judgment, that would be considered by the court in resolving this issue.¹⁹²

192. The author is aware that Article 1, § 2, of the New York State Constitution guarantees the right of a trial by jury in cases that involve claims that existed under the common law.

The remaining question is how the Modified Medical Judgment Rule is to be applied. This raises the question of procedure, to which we now turn.

B. *Proposed Procedures for Applying the Modified Medical Judgment Rule*

The application of the Modified Medical Judgment Rule invites what may be referred to as a Medical Judgment Rule hearing (“Medical Judgment Rule Hearing”). Three considerations that relate to such a hearing are: (1) the circumstances that should trigger the Medical Judgment Rule Hearing; (2) the procedures that should be followed if such a hearing is held; and (3) the role of public policy.

1. The Circumstances That Trigger A Medical Judgment Rule Hearing

The conditions under which the author proposes that a Medical Judgment Rule Hearing be held include the requirement that there be an appropriate evaluation of the patient. The rationale for this requirement is that for medical judgment to be properly exercised, a physician must conscientiously obtain the relevant facts. This is similar to the requirement of the business judgment rule that due diligence by corporate officers be exercised in learning of the material facts as a prerequisite for the application of the business judgment rule.¹⁹³ It is also consistent with the requirement that there be a competent examination of a patient’s condition before the Psychiatric Standard is applied.¹⁹⁴ There appears to be no logical reason for departing from this requirement in cases involving the application

However, the right does not exist unless there is an issue for the jury to decide. *Gerard v. Inglese*, 11 A.D.2d 381 (N.Y. App. Div. 1960). Whether there is a material issue of fact to be submitted to the jury depends upon the extent to which existing law disposes of the case. *See Gen. Inventory Co. v. Interboro Rapid Transit*, 235 N.Y. 133 (1923). Under normal circumstances, whether a preponderance of evidence had been adduced as to a particular issue, would be a question for the jury, but there is no reason that a court cannot decide whether, as a matter of law, the quantum of proof is sufficient to warrant placing the issues before a jury. *See Paciello v. Graffeo*, 32 A.D.3d 461 (N.Y. App. Div. 2006) (holding that proof did not meet a “clear and convincing” standard as a matter of law, and setting aside the jury verdict and dismissing the complaint); *Nicastro v. Park*, 113 A.D.2d 129 (N.Y. App. Div. 1985) (holding that where no fair interpretation of the evidence supports the jury verdict, it may be set aside).

The Psychiatric Standard withdraws from the jury’s consideration testimony that there has been a departure from good and accepted practice; *a fortiori*, the judiciary can shape decisional law to provide that there is no material issue of fact as to the commission of medical malpractice where there is credible medical evidence supporting the defendant’s exercise in medical judgment and the plaintiff cannot demonstrate that the evidence so preponderates in the plaintiff’s favor that under no fair interpretation of the evidence could medical judgment have been exercised. This approach affords plaintiffs greater opportunity to prevail in their claim that there is a departure than does the Psychiatric Standard.

193. *See, e.g., Lippman v. Shaffer*, 2006 W.L. 4451558, at *4 (N.Y. Sup. Ct. Nov. 2, 2006).

194. *See, e.g., Bell v. N.Y.C. Health & Hosp. Corp.*, 90 A.D.2d 270 (N.Y. App. Div. 1982) (“A decision that is without proper medical foundation, that is, one which is not the product of a careful examination, is not to be insulated as a professional medical judgment.”).

of the Modified Medical Judgment Rule. If there is a factual issue over this precondition for triggering a Medical Judgment Rule Hearing, the issue should be decided by the jury in a trial devoted to this issue alone. If the issue is resolved against the physician, then the Medical Judgment Rule will not be available to the physician. If resolved in the physician's favor, then the next precondition to a Medical Judgment Rule Hearing would be reached.

2. The Requirement That The Defendant Physician Have
Made a Decision Under Uncertain Conditions

The second circumstance that supports the conducting of a Medical Judgment Rule Hearing is the existence of uncertainty. As we have seen, this aspect of the exercise of medical judgment is not unique to psychiatric cases. Rather, it is a quality that may attend virtually any specialty, and attaches to situations where medical science does not provide certainty in the evaluation of a patient's condition, such as the patient's diagnosis or the appropriate modality of treatment. However, while uncertainty may arise in virtually any medical malpractice setting, the frequency with which it arises varies among specialties, and in some cases it does not arise at all. To illustrate, where a pregnant mother is not experiencing contractions, but has lower abdominal pain and vaginal bleeding and there are signs of fetal distress, there is sufficient evidence of placental abruption and no uncertainty as to how to proceed. An emergency C-Section should be performed.¹⁹⁵ Considering that uncertainty is not present in all situations, it is appropriate to ascertain whether this aspect of decision making is present before the Modified Medical Judgment Rule is deemed appropriate.

If uncertainty is not present, the case should proceed as it ordinarily would have. If there is uncertainty, which is a question for the court, the next phase of the application of the Modified Medical Judgment Rule would be reached.

3. The Consideration of Public Policy as a Precondition
to a Medical Judgment Hearing

The third condition required for triggering a Medical Judgment Rule Hearing is the existence of public policy considerations supporting the application of the rule. There is precedent for considering public policy in connection with the resolution of aspects of medical malpractice cases. In Pennsylvania, for example, courts are required by statute, in remittitur applications, to "consider evidence of the [verdict's] impact, if any, upon

195. See Slava V Gaufrberg, *Abruptio Placentae*, E-MEDICINE FROM WEBMD, at www.emedicine.com/EMERG/topic12.htm (last updated Aug. 29, 2006).

availability or access to health care in the community.”¹⁹⁶ In the absence of this legislation, the standard for remittitur of damages would turn upon whether the amount shocked the court’s conscience.¹⁹⁷

The author suggests that courts should also consider the issue of whether public policy is being advanced when determining if a medical judgment hearing is appropriate. As we have seen, in the context of psychiatric cases, New York courts have considered disincentives, such as the risk of liability that psychiatrists have for exercising a medical judgment in favor of a relaxed rehabilitation regimen. Earlier, there was also a discussion of the existence of public policy considerations as they relate to the general problems associated with the practice of defensive medicine. Although it appears that the involvement of public policy issues varies from case to case, it is a matter of general concern that physicians practice in an atmosphere free of anxiety over being sued for choosing the alternative they believe is the correct one, as opposed to another approach that may be more likely to play well for the jury if something goes wrong. Therefore, it is anticipated that in most cases, the public policy requirement will be satisfied. This is a question for the court.

If the public policy requirement is not satisfied, the case would proceed as it would ordinarily have. If the public policy requirement is satisfied, the next phase of the application of the Medical Judgment Rule would be reached.

IX. THE MEDICAL JUDGMENT RULE HEARING

If the foregoing preconditions are met, it is proposed that the determination of whether a physician is protected by the exercise of medical judgment should be made following a Medical Judgment Rule Hearing. The issue of whether there had been an exercise of medical judgment would be resolved by the court *by proof* submitted at such a hearing.

As with the application of the Psychiatric Standard, the judge would not be determining the issue on the basis of the plaintiff’s expert witness’ testimony as to an alleged departure. The question is whether, on the basis of all of the relevant information reviewed by the court, the defendant has engaged in decision making protected by the Medical Judgment Rule. As noted above, the court’s inquiry at a Medical Judgment Rule Hearing would be whether there is credible evidence supporting the proposition that the doctor had engaged in medically accepted decision making. The court could make this determination with the assistance of experts which

196. 40 PA. CONS. STAT. ANN. § 1303.515(a) (West Supp. 2003).

197. Catherine T. Struve, *Doctors, The Adversarial System and Procedural Reform in Medical Liability Litigation*, 72 *FORDHAM L. REV.* 943 (2004).

the court could appoint pursuant to Federal law and the laws of some states.¹⁹⁸ In determining the issues, the court would focus upon the medical profession's approach to the applicable standard, review pertinent literature on the subject, and question witnesses. Given the additional time and resources that a court may bring to bear on the issue of medical judgment, it is less likely there will be an error than if the issue were to be submitted to a jury.¹⁹⁹

It is anticipated that in many cases courts will find themselves uncertain as to whether medical judgment was exercised. However, such uncertainty should not prevent the court from determining the issue. It is the plaintiff's burden to prove that malpractice occurred, and if the plaintiff is unable to meet this burden, then the issue should resolve against the plaintiff. If there is uncertainty over the diagnosis of the patient's condition, or over the appropriateness of a particular course of treatment, then it would be unfair to impose liability upon a physician who, after a full and careful examination of the plaintiff and relevant records, embarked upon a treatment that finds significant support in the medical community. Contrariwise, if the court finds there is no credible proof supporting the exercise of medical judgment, or that under no fair interpretation of the evidence could a jury believe that the defendant physician was entitled to the protection of the Medical Judgment Rule, the court should find against the defendant doctor, leaving any remaining issues for the jury.

It should be noted that although the author's approach is similar to the way in which the business judgment rule is applied, there are important differences. The author does not support an approach that would exonerate the defendants in medical malpractice cases in almost every situation which involved a good faith exercise of medical judgment. Rather, the preconditions for holding a Medical Judgment Rule Hearing, namely: (1) conscientious evaluation of patient, (2) uncertainty, and (3) public policy support for applying the rule in the context of a particular case, would have to be satisfied. The business judgment rule only requires proof of conscientiousness in making an informed decision by reviewing pertinent information, which is analogous to the first of the preconditions listed above; support for the decision maker is assumed with respect to factors analogous to the remaining two preconditions. Moreover, the Medical Judgment Rule Hearing would consider proofs submitted by defendant and the plaintiff that the defendant doctor had diagnosed a patient or followed a course of treatment that was not only made in good faith, but

198. Fed. R. Evid. 706.

199. Judges may also be susceptible to hindsight or positive outcome biases. However, given their training, experience, and presumed greater appreciation for the need for objectivity, the influence of such biases should have less influence on judges than on jurors.

was medically supportable. In business judgment cases, there is no inquiry into whether the decision was normative by commercial standards.

The court's role in presiding over a Medical Judgment Rule Hearing would be as a gatekeeper. However, in contrast to a *Frye* or *Daubert* application, the court would be disposing of issues raised by the Modified Medical Judgment Rule, thereby eliminating the possibility of Monday morning quarterbacking by the jury.

It is anticipated the expansion of the application of the Modified Medical Judgment Rule would be met with a great deal of resistance among the plaintiffs' bar because such expansion will often result in removing the question of medical judgment from the jury's province. However, medical judgment is not implicated in many medical malpractice cases, *e.g.*, when there has been an error in technique, such as the severance of an artery. In any event, the Modified Medical Judgment Rule will not be applied if one of the proposed preconditions to this hearing were not satisfied, *e.g.*, when an examination of the patient had not been careful. Moreover, even when medical judgment protects the defendant's decision making, the jury can still find the defendant departed from the good and accepted practice of medicine, by virtue of any failure to execute medical procedures in a skillful manner. In such cases, the court would instruct the jury as to the fact that the decision making of the defendant had been determined by the court to be within acceptable medical standards, leaving to the jury the determination of whether the defendant's treatment procedures departed from good and accepted practice, and if so, whether such departure proximately caused injury to the plaintiff. Finally, certain hearings will result in a finding that medical judgment does not afford the defendant any protection. In such cases, few though they may be, plaintiffs will be benefited by the hearing.

It is anticipated that having courts resolve the issue of medical malpractice judgment as a matter of law will result in some of the more troublesome cases being determined by judges rather than juries. It is expected that the benefits will be particularly pronounced in ob/gyn cases where hindsight and positive outcome are influences that, coupled with the sympathy factor, may frequently lead to unfair verdicts.