Are Thoracic Surgeons Ethically Obligated to Serve as Expert Witnesses for the Plaintiff?

Donald C. Watson, Jr, MD, Francis Robicsek, MD, PhD, and Robert M. Sade, MD

Pediatric Cardiovascular Surgery, Memphis, Tennessee; Department of Thoracic and Cardiovascular Surgery and Carolinas Heart Institute, Department of Thoracic and Cardiovascular Surgery, Carolinas Medical Center, Charlotte, North Carolina; and Department of Surgery and Institute of Human Values in Health Care, Medical University of South Carolina, Charleston, South Carolina

Introduction

Robert M. Sade, MD

Medical negligence lawsuits have been growing in both number and size of awards to plaintiffs for many years. In the last few years, however, the effect on physicians, especially surgeons, has become noxious, and record numbers of surgeons are choosing early retirement or abandoning medicine to work in other fields. Tort reform is high on the agenda of nearly every medical association and specialty society.

The villain of this piece is generally believed to be trial lawyers, who profit greatly from huge awards in malpractice cases, often far beyond their injured clients’ share of the bounty. The anger of many if not most physicians is directed at the plaintiff’s bar, to the extent that they refuse to testify for the plaintiff in any malpractice suit, especially when the defendant is a member of their own specialty.

Yet, there may be problems with this viscerally held position. In providing legal testimony, a physician’s primary ethical obligation is to tell the truth as he sees it without bias that favors one side or the other. That may make irrelevant the side of a lawsuit for which a physician testifies. There are many other considerations of course, but there is an underlying vexing question: if a thoracic surgeon regularly testifies in medical negligence lawsuits, does he have an ethical obligation to serve as expert witness for plaintiffs as well as defendants?

This question was debated at the 50th Annual Meeting of the Southern Thoracic Surgical Association by two of our most esteemed colleagues, both former presidents of the Association and both possessing special expertise in legal issues: Donald Watson and Francis Robicsek. They present their adversarial positions after the presentation of this case, which served to focus the debate.

Doctor Loyall is a cardiothoracic surgeon with a large experience and excellent results in aortic surgery. He has been sued several times by patients who had complications of surgery, usually paraplegia, but also false aneurysms and other problems. He has lost a case only once when, contrary to the merits of the case, a jury was emotionally swayed by the appearance of the plaintiff, an attractive young woman whose right leg was amputated because of a complication after aortic surgery.

Doctor Loyall testifies in negligence cases two to three times a year in defense of other surgeons who have been sued, usually for complications of aortic surgery. He receives a telephone call from an attorney in another state. He hears the story of a 55-year-old man who is now paraplegic after removal of a descending thoracic aortic aneurysm extending into the distal aortic arch. The operation in question was done with a clamp-and-sew technique, with a cross-clamp time of 67 minutes. It was done by a thoracic surgeon who has been in practice for 5 years, after finishing his training at a program that is now on probation for inadequate operative experiences for their trainees. The surgeon is not yet board certified.

It then becomes clear to Dr Loyall that the lawyer represents the plaintiff. He has a personal policy of never testifying for plaintiffs, so he ends the conversation, declining to be involved, despite the strong likelihood of substandard judgment or technique or both.

Was Dr Loyall wrong in refusing to testify for the plaintiff in this case, on the grounds that physicians have an ethical obligation to testify for plaintiffs as well as for defendants in medical liability cases?
Pro
Donald C. Watson, Jr, MD

The principle question is important: are thoracic surgeons ethically obligated to serve as expert witnesses for the plaintiff? Two ethical arguments follow showing that absent other disqualifying factors, thoracic surgeons are obligated to serve as expert witnesses for the plaintiff or the defense. That of course assumes that the surgeon is able to offer testimony and that the merits of the case justify such testimony. Doctor Loyall was wrong in refusing on only ethical grounds to testify for the plaintiff.

Ethics discussions help us decide the bases upon which we pursue the things we value and the ultimate criteria for what we do. However, they serve only as advisory. The specifics of each situation vary. Conclusions are often subjective and almost always involve judgment. Differences in opinion between competent people can and do exist on many important ethical issues. We must be respectful of and take into consideration others’ points of view. These ethical considerations, as suggested by Pellegrino [1], are also undergoing a metamorphosis. The ethical framework of medicine is changing.

Two cautions should be acknowledged. We must beware of politically correct actions that have shaky ethical foundations. Armey [2] suggests, “Politics sooner or later makes a fool of everyone.” In the long run, actions supported by sound ethical principles should prevail. Additionally, although used in a different context, a political activist suggested, “If we don’t stand for something, we may fall for anything.” Thoracic surgeons must stand for moral principles and use professional standards or we are likely to fall for the antithesis.

Two concepts of “ethical” are expanded upon. The first involves moral, that is, right behavior standards. The second demands conforming to accepted professional standards of conduct. All other criteria being met, each line of reasoning forms an independent ethical justification for the position that thoracic surgeons are obligated to serve as expert witnesses for the plaintiff or the defense.

A brief summary of five foundations [3] of ethical thought, in idealized societies, is in order. The first finds its basis in early philosophical considerations. Plato described the common good in a society of individuals. Opining that one’s own good is firmly linked to the good of the community, he concluded that individuals are ethically bound by the pursuit of common values and goals. Subsequently Aristotle expressed the fairness and justice approach by noting that equals should be treated equally. In our judicial system, the plaintiff and the defendant are equals, thus requiring equal treatment for the plaintiff and the defendant. As this notion was later pursued in ethics discussions, favoritism and discrimination were considered unjust and wrong. Additionally, the virtue approach maintains the existence of certain ideals toward which we should all strive. Relevant virtues include compassion, generosity, integrity, fairness, self-control, and prudence. Then, in the 18th century Kant suggested a rights approach focusing on an individual’s right to choose. When living in a community, the individual’s rights include truth, privacy, freedom from harm, and what is promised by a consenting individual. Finally, the utilitarian approach, a 19th century conception of Bentham and Mill, suggested that actions are ethical only when they provide the greatest balance of good over evil.

Four medical moral principles [1] of behavior have evolved with these foundations in ethics. The Hippocratic Oath suggests that we do no harm and help others, principles of nonmaleficence and beneficence. Patient autonomy, the third principle, has recently risen in importance but is not germane to the question posed. The fourth principle of justice insists that we do the right thing for patients and be fair in those actions. Justice is, more often than not, the most difficult to resolve.

These foundational principles of ethics and medicine, that is, right behavior standards, force us to ask what implications naturally follow when applying them to the question posed? These implications are that Dr Loyall was (1) not serving the common good, (2) treating equals unequally, (3) failing to reach for virtuous goals, (4) ignoring the rights of individuals to truth and freedom from harm, (5) failing to tip the societal balance of good over evil, (6) failing to help future patients, (7) potentially allowing harm to future patients, and (8) failing to provide expert information available for the best possible evaluation of what was just. It is reasonable to conclude that by refusing, only on ethical grounds, to testify for the plaintiff, Dr Loyall was wrong.

A second independent concept of ethical actions demands conformity to accepted professional standards of conduct. A profession is an occupation whose core elements require mastery of a complex body of knowledge, used in the service of others, governed by a code of ethics, committed to competence, integrity, morality, altruism, and promotion of the public good within its domain.

Our profession has standards and is guided by major organizations with established principles of behavior. As a matter of ethical behavior, thoracic surgeons are obligated to comply with them in their actions. The American Medical Association (AMA) suggests [4] that as citizens and professionals, physicians have an ethical obligation to assist in the administration of justice. The American College of Surgeons (ACS) Code of Conduct [5, 6] suggests that surgeons, in part, must accept responsibilities to serve as effective advocates for patients’ needs, to provide the highest quality of surgical care, and to participate in self-
regulation by setting, maintaining, and enforcing practice standards. By refusing on purely ethical grounds to testify, Dr Loyall was wrong by not fulfilling this ethical obligation to conform to accepted standards of physician conduct. Doctor Loyall would not be assisting in the administration of justice, would not accept responsibilities to advocate for patients, and would not help to calibrate and improve the quality of surgical care, or setting, maintaining, and enforcing standards of practice.

In general, when considering two ethical alternatives it is helpful to ask five questions [2], namely, which alternative (1) best respects the moral rights of those affected, (2) leads to the best overall consequence, (3) treats in process, the parties equally, (4) advances the common good, and (5) develops moral virtues? In balance, greater good over evil is achieved when physician experts provide the best possible information and advice to a system adjudicating a dispute. Physicians are ethically obligated to testify for the plaintiff or the defendant depending on their ability and the merits of the case. We must stand for moral principles of behavior. Professional standards define those principles.

A few caveats are in order. First, this issue is emotionally charged. Emotional reactions about colleagues testifying against colleagues are intense. Thoracic surgeons are not exempt from these most human reactions. This response often interferes with our collective ability to objectively engage the question posed.

Second, many other important issues are related to this ethics question, distracting us from the principle at hand. These distractions include but are not limited to disordered, even chaotic, medical-legal systems, qualifications of experts, legal requirements of experts, adversarial nature of legal proceedings, differences between medical truth and legal truth, specific case circumstances, and practicality of testifying. The most distracting appears to be the nature of our medical-legal systems. Since jurisdiction for these issues resides at the state level, we have many systems, one differing from another. This fragmentation fosters disorder. Another reasonable question, distracting us from the issue at hand, arises: what is one to do in a system that appears to be functioning poorly? This question has great practical significance, but does not change the response to the question posed. Issues of correcting a malfunctioning system do not change the fundamental goals.

Third, in our daily actions, we must consider practical consequences. Politically correct actions, which may be in opposition to moral obligations, allow us to get along within our community and to survive with less stress. The penalty for violating a strictly moral obligation is primarily personal. The penalty for adhering to a moral principle, in violation of loyalty, can be steep. Some surgeons, in all subspecialties, have stood on moral principle only to have their lives adversely affected because the community viewed that moral stance as not loyal.

Fourth, if one is to testify, one should adhere to established standards. The ACS [5] and the Society of Thoracic Surgeons (STS) [7] have described qualifications and standards of behavior for expert witnesses. Qualifications include the following: possess a valid current and unrestricted license to practice, have board/specialty certification, practice in a specialty appropriate to the case, possess familiarity with the standards of care at the time and place of the case, have continuing medical education relevant to the specialty and the case, and have the ability to document time spent and fees. The ACS and STS suggest there is an obligation to testify when appropriate. Behavior standards include telling the truth, reviewing the case making fair and honest inferences, distinguishing between an unfortunate outcome and negligence, reviewing the appropriate standards of practice, stating the bases for opinions and alternative views, and receiving reasonable compensation not linked to the outcome of the legal case. The AMA also suggests [8] that expert witnesses, irrespective of being called by either the plaintiff or the defense, must not become advocates and must remain nonpartisan.

In conclusion, based on fundamental ethical principles for behavior of individuals living within a community and professional code of conduct standards, Dr Loyall was wrong in refusing on purely ethical grounds to testify as an expert witness for the plaintiff. The reality of medical-legal proceedings in our society, however, presents a number of confounding issues making adherence to this ideal practice difficult.

**Con**

Francis Robicsek, MD, PhD

Society has its way of dealing with important issues. One way is to make them laws. The treating physician is a “factual” witness who has a legal obligation to testify to the treatment his patient received. In contrast, just as an uninvolved physician does not have any legal obligation to accept an unknown patient, a medical expert may testify voluntarily, albeit paid. While he is supposed to render an unbiased opinion in our peculiar medicolegal system, his involvement is called upon only if it promotes the invoking party. If it does not, his testimony will neither be given nor heard.

Whenever a physician is asked to render an expert opinion, he may legally, as well as ethically, decide not to get involved. He may feel unprepared and unwilling to
be interrogated for hours, have his credentials questioned, his family life scrutinized, and his character assassinated by an overzealous attorney.

Or he may be a conscientious objector who believes that our tort system is wrong and does not help the injured; it does not punish the negligent but often hurts the innocent physician and provides a windfall for the attorney. He may think the only way to change it is not to participate, but he might be willing to help a colleague innocently accused and does not consider it his duty to get involved in procedures against fellow physicians.

Or he can say the “public trust,” which goes with his medical license, obliges him to try to make the best of the system, to cooperate with it, and make choices on a daily basis.

Any of the above may be fitting to one’s own ethical choice and should be respected. It is not unethical. What is unethical is for someone to render inappropriate testimony for any reason, for any party. That is today’s main ethical problem and the reason why some physicians are reluctant to testify. They simply do not want to risk identifying the readily available group of dubious witnesses who fill our courtrooms with pseudoscience and are willing to testify “for or against” depending upon who pays their fee.

To believe that obliging our profession to testify may clean up the situation is naïve. While some attorneys indeed seek an honest reliable opinion, others are looking for a witness who says what they want to hear. They will go from one potential witness to the other until one is found who is either naïve or loose enough to serve their purpose.

The Trial Bar wants us to actively support the tort system by providing a readily available list of witnesses. Our answer is this: we are ready if you are ready! Give us a process that fairly and speedily compensates the injured patient, punishes the negligent physician, protects from frivolous, costly litigation—and they will not find a more cooperative partner than we are. We are ready to sit down tomorrow to discuss no-fault insurance, review panels, mandatory mediation, free, impartial witnesses to the court—whatever.

There is indeed a problem with medical experts—not with those who do not testify, but with some of those who do. While some of them, be it motivation by either economic or by intent, do provide a fair and honest testimony, others are less than truthful. For our professional organizations to open the floodgates of “readily available” witnesses without any quality control of their testimony would be highly counterproductive. Before we accept the concept that it is everybody’s ethical duty to testify, and we provide a list of experts obliged to testify, we should fulfill our already existing ethical duty to clean up expert testifying. Ten years ago I recommended to the Council of the STS that medical expert testimony should be reorganized as a professional activity and thus subject to peer review, and that a grievance process should be made available to both parties. By this mechanism, improper testimony can be readily exposed and false witnesses censored and hence removed from the system.

This process has now been applied by the American Association of Neurological Surgeons (AANS), which found that one of their members provided “inappropriate and unprofessional” testimony and they suspended his membership [9]. The member countersued. The case in which the American Medical Association, the American College of Surgeons, and the Illinois State Medical Society filed a joint “friend of the court” brief supporting the AANS was reviewed by the Seventh Circuit US Court of Appeals and decided in favor of the AANS. The US Supreme Court declined to review the case [10]. However, the event was labeled by some trial lawyers as an “unacceptable intrusion and egregious assault by an overly anxious, embittered group of physicians who are willing to do anything to pressure their colleagues not to testify.”

Until we make significant strides in this regard, or even thereafter, medical experts testifying should remain an issue of personal conscience. I may have testified in the case in question, either for the defendant or the plaintiff, depending upon additional information, but I do not castigate those who exercised their First Amendment right by keeping their mouth shut. My feelings are best expressed by the words of Dr Mark Gorney [11] published in the Bulletin of the American College of Surgeons: “The moment of truth is at hand when you must elect all circumstances considered whether to act as an expert witness against a colleague. Only you, in the loneliness of your mind, can decide which road to follow, because in one direction the circumstances may be overwhelming for it, whereas in the other, something inside is saying, ‘There but for the grace of God go I.’”

Concluding Remarks
Robert M. Sade, MD

Few topics stoke a surgeon’s fire as much as malpractice litigation. Watson and Robicsek have presented starkly contrasting views of how Dr Loyall should have responded to the plaintiff’s attorney who was soliciting his opinion. The essayists agree on the central ethical imperatives of medical testimony: all testimony should be truthful, as the surgeon understands the truth, and the witness should have expertise in the area under litiga-
tion. After that, their points of view and reasoning sharply diverge.

Watson considers ethics of a physician’s moral obligations from two perspectives, classical ethical standards (five different approaches) and standards established by professional codes. Each of these perspectives leads Watson to the same conclusion: Doctor Loyall should testify, even in the face of the many confounding issues. Those issues include a chaotic tort system, the adversarial nature of litigation, the fundamentally different medical versus legal standards of “truth,” and the adverse consequences for the surgeon in his medical community if he testifies against a fellow surgeon.

Robicsek identifies many of the same general issues of the case, but the core of his argument is a single ethical principle: autonomy. Physicians, like everyone else in our society, have the right of self-determination, so are entitled to say yea or nay for their own reasons. Doctor Loyall, according to Robicsek, was perfectly justified in deciding not to testify.

The case itself removes most of the issues that usually complicate medical-legal discussions. Disdain for the tort system is not, for Dr Loyall, a barrier to testifying because he regularly testifies in lawsuits. His qualifications as an expert witness in this case are not in doubt. The adversarial environment of negligence lawsuits and the wide chasm between medical (scientific) and legal (authoritative) standards of truth have not bothered him in the past, as he has not rejected testifying as an expert. We are left with a single reason for his consistent refusal to testify for plaintiffs and their attorneys, based in emotion: he was once deeply stung by the arbitrary injustice of the medical-legal judicial system. There are undoubtedly additional questions of fact related to the patient’s injury in the case at hand, but Dr Loyall has summarily dismissed them as irrelevant. The central question—whether Dr Loyall was wrong in refusing to testify for the plaintiff—is stark.

Watson’s conclusion that Dr Loyall was wrong not to testify is based on a nexus of ethical reasoning that stretches across several centuries of ethical thought that would now fall under the rubric of professionalism. Robicsek’s finding that Dr Loyall did nothing wrong is based on the narrow grounds of the right of every American to speak or to remain silent. At issue here is the nature of professional ethics: are the professional decisions and actions of physicians bound only by the laws governing society in general or do physicians bear additional legitimate extralegal obligations (that is, ethical obligations) by virtue of the special circumstances inherent in the patient-physician relationship?

Ethics and law are closely related, overlapping to some extent, but essentially separate. To say, as Watson does, that Dr Loyall has an ethical obligation to testify for the plaintiff if the facts justify such testimony is not to say that he should be hauled into court unwillingly or lose his medical license if he refuses to testify. He has a legal right not to testify, just as Robicsek says. But if Watson’s view of professional ethics is correct, then Dr Loyall was nevertheless wrong in refusing to testify.

Robicsek’s commitment to a legalistic view of Dr Loyall’s obligation to testify does not require that he reject professional ethics as Watson has described it. He could have it both ways, asserting both the right not to testify and the importance of professional ethics, by arguing, as some have, that legal testimony is not part of professional practice, so should not be subject to the usual ethical standards of the practice of medicine, to peer review, or to oversight by medical licensing boards [12]. He did not make that argument, however, so we can not be certain where he stands, but I suspect that he is as deeply committed to professional ethics as any of us.

Our essayists have persuasively argued distinct visions of professional decision making. Each of us is likely to face similar decisions in the future, unless there is an early resolution of the malpractice crisis, which seems unlikely. If and when that time comes, our decision to say yes or no will embody the particular view of professionalism we have embraced.

References