Law & Medicine

Expert Witnesses Under Fire

The notion of peer review typically arises in the context of an academic paper being reviewed by an author's colleagues—sitting as his or her peers—to determine whether the paper is of publishable quality. Another example would be a summer art show or fair, where artists tender their works to juries of suitably qualified experts. The notion of peer review has even been carried over to the presidential race, where pundits and participants are discussing the role and purpose of "superdelegates" in determining who the candidates will be for the general election.

BY MILES J. ZAREMSKI, J.D.

The concept of peer review is equally if not more significant in the world of health care, where medical care and treatment, typically in a hospital setting, is the subject of review by those who sit on what are known as peer review committees. Sometimes, however, peer review in the health care setting is abused and warped to a degree never envisioned by legislators who enacted such legislation.

Two examples of this phenomenon, now percolating their way through state legal systems, warrant attention. They are *Joseph Kamelgard, M.D. v. the American College of Surgeons* (Circuit Court of Cook County, Ill.), and *Charles Yancey, M.D. v. American Academy of Ophthalmology, et al.* (4th Judicial District, Hennepin County, Minn.).

In the Kamelgard case, Dr. Kamelgard, a well-regarded bariatric surgeon from New Jersey, testified as a medical expert for the very first time in a medical malpractice lawsuit litigated in federal court in Brooklyn, N.Y. The plaintiff was a resident of New York and was cared for at a hospital in Staten Island. The defendant was a physician who, according to court records, had been named previously in multiple professional liability cases. The jury decided in favor of the defendant physician.

The defendant physician never challenged the testimony Dr. Kamelgard gave in court. But later, the defendant filed a complaint with the American College of Surgeons (ACS), accusing Dr. Kamelgard of allegedly testifying falsely regarding relevant standards of care and his knowledge of them. Following an extensive investigation over several months, the ACS decided to charge Dr. Kamelgard with violating its rules in this regard. Shortly before a hearing on the charges was scheduled to proceed, lawyers intervened on Dr. Kamelgard's behalf. Weeks later—but still before damages had been sustained by Dr. Kamelgard—the ACS dropped the case; no explanation was ever given.

What is disturbing about this is that, despite Dr. Kamelgard's requests, the ACS refused to provide him with a copy of the complaint lodged against him, the identity of his accuser, or even the names of the three members of the ACS deemed qualified as bariatric surgeons to review the complaint and present their findings to the college, which then charged Dr. Kamelgard with violating ACS rules.

Dr. Kamelgard filed a petition seeking the identities of these three members. The ACS responded by asserting that what was being sought was protected by the state's Medical Studies Act (MSA), its peer review statute.

According to court filings, the ACS admitted that no practice of medicine occurred in Illinois, that testifying equates to the practice of medicine, and that by testifying there Kamelgard practiced medicine in New York (though New York's statute defining medical practice does not include testifying). But even though he was not licensed in Illinois and had no connection to the state except belonging to the ACS, the ACS wrote while the MSA is not a negotiated term when a physician joins it as a member, when any member does become a member, he or she agrees to be bound by Illinois law, including the application of the MSA. ACS also asserts that it only needs to show it is headquartered in Illinois before using the MSA. The ACS has over 74,000 members worldwide, so it suggests by this case that Illinois law governs its conduct.

In the Minnesota case, Dr. Yancey sued a Dr. Weis, and his expert, a Dr. Hardten, for defamation as a result of their filing an ethics complaint against him with the American Academy of Ophthalmology (AAO). At the time the ethics charge was filed, a malpractice case was ongoing in which Yancey was the expert medical witness for the plaintiff, with Weis as a defendant. Yancey also said the AAO violated its own rules when it handled the complaint against him, including not keeping the matter confidential.

Initially, a jury had returned a verdict for $3 million in favor of the plaintiff. The case was going to be retried on damages with Yancey again offering testimony; however, a day before this was to occur, the AAO served on him the ethics charge Weis and Hardten had filed. The underlying malpractice case was, as with Kamelgard, the first lawsuit in which Yancey ever testified as a medical expert.

According to his lawyer, Yancey claimed the ethics charge was an attempt to force him to alter his testimony in the underlying case, and thereafter chill his ability to testify in other, subsequent cases that may have come his way. The defendants moved to dismiss Yancey's complaint and, in the alternative, for the summary judgment.

In the Kamelgard case, which is pending in Illinois but now on appeal, it remains to be seen whether an Illinois court will opine on how the ACS believes the Illinois statute should be used. The Yancey case is also still pending.

It is well recognized that state peer review statutes—each state and the District of Columbia has one—were put in force with the purpose of maintaining and improving quality health care within a state. This is achieved by keeping privileged from discovery the products of a peer review committee. (The exception to this is when certain cases are litigated in federal court—see my column "A Matter of Privilege," January 2008, p. 30.)

However, the Yancey and Kamelgard cases show there is an attempt to redefine peer review statutes to include judging expert testimony within the practice of medicine. Such statutes were also not intended to apply solely because an organization is headquartered in a particular state without any health care rendered there, or to chill an expert from further testifying during the course of a legal proceeding.

At the same time, these cases demonstrate a penchant among professional medical organizations to muzzle health care providers from testifying to other than what these entities believe is appropriate. This trend may be influenced in part by a resolution adopted years ago by the American Medical Association declaring that testifying is considered the practice of medicine.

Granted, there are those among the physician ranks who don't belong in a courtroom offering expert testimony in the first instance. However, the Kamelgard and Yancey cases are but in microcosm examples of the Damoclean swords professional societies may now think they can wield in order to prevent physicians from offering legitimate expert medical testimony. After all, giving expert opinion is not rendering patient care, and thus is not generally considered the practice of medicine under state law.

If you are a physician wishing to consult or testify, don't be dissuaded from doing so—as long as you review all medical records properly and thoroughly, you are well credentialed, and you are familiar with all applicable medical standards by way of background, experience, and training. In addition, consult not only with your own organizations as to their standards and policies on testifying, but enquire of the lawyer who retains you as to what your state law requires of experts who testify in legal cases. ■

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United States Health Care Spending Seen Hitting $4.3 Trillion by 2017

Health care spending in the United States is projected to consume nearly 20% of the gross domestic product by 2017, according to estimates from economists at the Centers for Medicare and Medicaid Services.

Health care spending growth is expected to remain steady at about 6.7% a year through 2017, with spending estimated to nearly double to $4.3 trillion by 2017, the CMS analysts said in a report published online in the journal Health Affairs. The 10-year projections come from the National Health Statistics Group, part of the CMS Office of the Actuary, and are based on historical trends, projected economic conditions, and provisions of current law.

The analysts project that spending for private sector health care will slow toward the end of the projection period, while spending in the public sector, including Medicare and Medicaid, will increase. Much of the increase will be fueled by the first wave of baby boomers entering Medicare in 2011. The increase in the number of Medicare enrollees is projected to add 2.9% to growth in Medicare spending by 2017.

The CMS economists projected that growth in spending on physician services would average about 5.9% per year through 2017, compared with 6.6% from 1995 to 2006. These projections are based on current law, which calls for steep cuts to Medicare physician payments over the next few years.

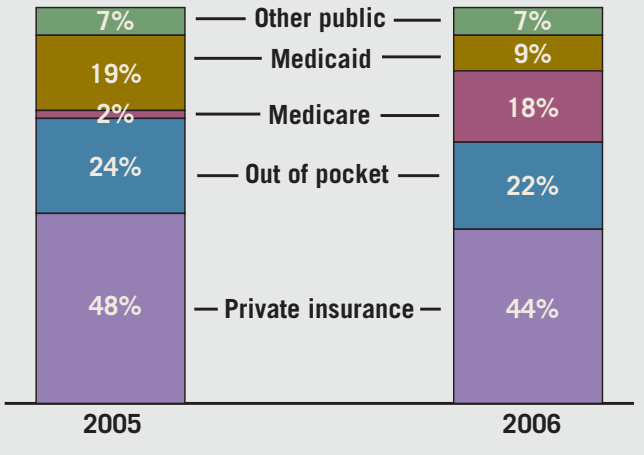
Home health care will likely be one of the fastest-growing sectors in health care from 2007 through 2017, with a 7.7% average annual spending growth rate.

Growth in prescription drug spending is expected to accelerate through 2017 because of increased utilization, new drugs entering the market, and leveling off of the growth in generics.

—Mary Ellen Schneider

DATA WATCH

Funding for Retail Prescription Drugs



Note: Based on data from the Centers for Medicare and Medicaid Services.
Source: Health Affairs