

1-1-1992

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Recommended Citation

Paul D. Rheingold, *The Admissibility of Evidence in Malpractice Cases: The Performance Records of Practitioners*, 58 Brook. L. Rev. 75 (1992).

Available at: <https://brooklynworks.brooklaw.edu/blr/vol58/iss1/5>

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THE ADMISSIBILITY OF EVIDENCE IN MALPRACTICE CASES: THE PERFORMANCE RECORDS OF PRACTITIONERS

*Paul D. Rheingold**

INTRODUCTION

The availability of statistical information about the mortality and morbidity rates associated with specific treatments by individual practitioners and hospitals raises the question of the use of these data in medical malpractice litigation. The purpose of this Commentary is to explore the precedents and arguments for and against the use of such data.

Any analysis of the problem of admissibility of performance data must at the threshold ascertain the cause of action involved. Generally there are two causes of action in suits against physicians: the action for negligence or malpractice and the action for lack of informed consent.¹ As will be demonstrated, the potential legal usefulness of the statistical data on performance differs as greatly as the nature of these two causes of action. In the negligence suit the data are offered as evidence; in the informed consent action, they are offered as information.

A further important distinction may be made between the potential use of performance data in an action against an individual practitioner and against a hospital. The hospital is considered separately in the third section of this Commentary because of special issues relating to its responsibility as an operator of an institution and as one that extends privileges to independent practitioners to use its facilities.

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¹ See 1 DAVID W. LOUISELL & HAROLD WILLIAMS, *MEDICAL MALPRACTICE* ¶ 8.04-06 (1969).

I. THE MALPRACTICE CAUSE OF ACTION

A. *Potential Admissibility of Proof*

Were performance data available and admissible, it is quite predictable how counsel would utilize such data in court. If the defendant physician had a rate of deaths in open heart surgery, for example, that exceeded by several times the average for like practitioners (after adjustment was made, of course), plaintiff would assert that fact as at least some evidence on the issue of whether the defendant used due care during the operation or treatment at issue. Likewise, if the defendant were shown to be statistically far superior to other physicians, his own counsel would produce this as proof of some evidence of due care at the time of the disputed treatment.

Even if performance data were admissible, it is not likely that the side favored by them would argue that they were conclusive on the central issue, as compared to the "some-weight" approach for which most evidence is admitted in medical malpractice and other negligence cases—that is, for whatever weight the jury may attach to it. It is most unlikely that the mere fact that the doctor was superior statistically would be a total defense, or that the plaintiff could make out a *prima facie* case on the mere showing that the doctor was a substantial laggard overall.

It is predictable, however, that courts, at least in the initial years of hearing testimony on performance data, will not allow the evidence. This position is based upon: consideration of the few analogous legal areas that exist; generally confused and negative judicial attitudes toward statistics; the unreliable and inconclusive nature of the data that are so far available; and the ease with which their reliability can be attacked.

If one wants to pigeonhole evidence on performance into an existing rule of evidence justifying its admissibility, one might look first at the law of similarity evidence. This has been somewhat codified under Federal Rules of Evidence 401.² While the rule seems extraordinarily permissive on what is similar since it

² Rule 401 defines relevant evidence as "evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." FED. R. EVID. 401. See also JACK B. WEINSTEIN ET AL., EVIDENCE ¶ 401[08] (1992).

speaks in terms of "any tendency" to make something more or less probable, it is predictable that most courts would find that what a doctor did in general during a period of time has little meaning for what he did on a specific occasion.

If one did want to argue for admissibility under the similarity rule, there are recent cases in other legal areas where statistical evidence was used to prove a specific fact, such as in employment discrimination cases, or in the use of profiles in stopping persons.³ There are, however, a great number of judicial decisions and much review literature that show a distrust of the use of statistics as a means of proving a specific fact in personal injury cases and especially toxic tort litigation.⁴

In the actual litigation of malpractice cases, one rarely sees admitted "similarity" evidence such as that the doctor injured another patient, had been sued before or since for malpractice, or had lost privileges or a license. At the same time, one can hardly say what the law is in an area where lawyers have not tried to advance it by offering new types of proof.⁵ Nor would defense attorneys generally think that they could properly ask their client if he or she had many successful surgeries, or had ever been sued before for malpractice.

The closer one gets to the actual situation involved in the trial, however, such as whether the doctor had made the very same mistake before, or what the doctor's failure rate was for the same exact surgery, the more likely proof of other occurrences would be admissible under the similarity doctrine. Under

³ *Id.* at ¶ 401[10] *et seq.*

⁴ RICHARD A. WEHMHOFER, *STATISTICS IN LITIGATION: PRACTICAL APPLICATION FOR LAWYERS* (1985); Bert Black & David E. Lillienfeld, *Epidemiological Proof in Toxic Tort Litigation*, 52 *FORDHAM L. REV.* 732 (1984); Troyen A. Brennan, *Causal Chains and Statistical Links: The Role of Scientific Uncertainty in Hazardous-Substance Litigation*, 73 *CORNELL L. REV.* 469 (1988).

⁵ Cases presenting situations perhaps analogous to the topic of this article include *Evans v. Dugger*, 908 F.2d 801 (11th Cir. 1990) (attempt, in an action for bad care of one prisoner, to introduce statistical studies about 17 years of bad care generally to patients in the system); *Johnson v. Meyers*, 165 S.E.2d 739 (Ga. 1968) (Plaintiff-patient could not introduce evidence that defendant-doctor had previously performed unnecessary surgery as proof that defendant-doctor had performed similarly unnecessary surgery on plaintiff.); *Boddy v. Parker*, 45 A.D.2d 1000, 358 N.Y.S.2d 218 (2d Dept. 1974) (where plaintiff in malpractice action sought records from defendant's doctor and hospital relating to all other hysterectomies doctor had done within past two years, presumably as to information bearing on her own injury during a hysterectomy, disclosure was denied on a privilege basis).

this approach, and even if one favored some admissibility of data, it would be easy to state that what the general experience of a doctor was over a year with one type of surgery is not similar *enough*. That would leave open the possibility that someday there could be data so tailored to the facts of the case, controlling for all its many variables, that such data would be admissible.

In counterbalance with the liberal rules of admissibility, as reflected in Rule 401, provisions in the law of evidence deny admission on the basis of prejudice. Rule 403 in the federal system expresses this concept: probative value can be found to be outweighed by "unfair prejudice, confusion of the issues, or misleading the jury."⁶ It is here, certainly, that many judges would look for the source of power to reject performance data since they would fear that the jury would give too much weight to the data. Hearing the statistics that in general showed the doctor to be a far outlier (statistically at an extreme) good or bad doctor, jurors might decide solely on that issue, especially if they had difficulty resolving the issue presented to them. There is at least an analogy to the exclusion of evidence of other crimes in a criminal case.⁷

B. *Attack on Reliability*

We have so far just considered the admissibility *vel non* of performance data. Even if the use of the data were permitted, the attorney offering the proof would have to make sure that the proof is in admissible form—a special problem when statistics are involved. Of course, satisfying the requirements of the hearsay and authentication rules would not be complicated, but it could be time consuming and expensive, since witnesses might be called to obtain and interpret the evidence.

Of much greater importance to the subject of this Commentary would be to inquire how one might attack the reliability of the data as to a physician or institution. This attack might come at two stages of a trial. The more likely is as a threshold matter where the opponent makes known the objection to the proposed

⁶ FED. R. EVID. 403.

⁷ Federal Rule of Evidence 404(b) states: "[e]vidence of other crimes, wrongs, or acts is not admissible to prove the character of a person in order to show action in conformity therewith." FED. R. EVID. 404(b).

evidence and demonstrates to the judge, either on papers or by witnesses, the unreliability of the proof. Or, if the data are allowed into evidence for whatever weight the jury wants to give them, the same type of attack could take place upon cross-examination of a witness in an effort to nullify the impact of the statistics.

The attack upon the reliability of performance statistics would proceed along traditional lines of attack for any statistical evidence offered.⁸ In brief outline, the attorney would attack:

- 1) errors in the collection of the data and math errors in the data's manipulation, unrelated to whatever theories are involved;
- 2) bias errors—failure to consider factors that may confound the numbers, *e.g.*, the failure to consider that the patients of the doctor in question in some way differed materially from those of other doctors in the study;
- 3) demonstration of internal contradictions, such as a great year-to-year variability of performance (and what year would one use for comparison purposes anyway?); and
- 4) lack of significant differences—to what degree would we demand that chance be eliminated or how many standard deviations would be required?

Aside from attacking statistics on their own level, one could also anticipate a broad attack on more emotional bases. The doctor-defendant will argue that the patient-plaintiff differed from her other patients in the database, or that her practice differs in ways not studied, such as the fact that she was willing to take on harder cases. Even if these were factors considered in the statistical workup, still one would have to prove this.

It seems likely that a judge who saw such a great battle shaping up on the meaning of statistics—a subject with which most judges are uncomfortable—would find one or another justification for rejecting what, at best, is only marginal evidence of fault or lack of it. In this respect such statistical evidence would not even be on a par with evidence that a doctor has lost his license or privileges; these would be facts that could be demonstrated without knowing the higher math involved in epidemiology.

⁸ See *supra* note 4.

II. INFORMED CONSENT

A. *Nature of the Doctor's Duty*

When we turn to the use of performance data in actions for lack of informed consent, we radically change perspectives: there is now much less of a question of the weight or accuracy of the data or prejudice in their use, and much more a question of the proximate consequences of a doctor failing to meet the law's requirements. Because of these differences, it is predictable that as performance data become more available and accurate, there will be a requirement that the practitioner inform the patient of his track record.

While there are probably as many different states as there are variations of the exact duty of a physician to give information to a patient about the risks and benefits of a proposed treatment, the alternatives to treatment, and under what circumstances, there is at least a general consensus that some attempt be made to tell the patient what are the possible good and bad consequences of a proposed surgery.⁹

An argument might conceivably be made that a doctor can satisfy the duty by disclosing the specific risks known to occur in the hands of any and all practitioners. It does seem inescapable, however, that part of the information about risks would be what the doctor's own experience has been, even if all risks are lumped together. Indeed, it has always been known that risks vary with each practitioner, based upon studies of adverse consequences of surgeons at various institutions.

The doctor could not fully escape, I believe, from volunteering this information for reasons of doubt about the reliability of the statistics, at least not without describing them and then explaining their limits. Nor, as in the malpractice action, could the doctor argue that any prejudice outweighs the benefits of the evidence. It is, after all, not evidence we are dealing with in this cause of action, but the duty to obtain a consent to treat or otherwise invade the human body, a concept partially rooted in the theory of autonomy and dignity.¹⁰ As a related point, the doctor

⁹ See Aaron D. Twerski & Neil B. Cohen, *Informed Decision Making and the Law of Torts: The Myth of Justiciable Causation*, 1988 U. ILL. L. REV. 607. See also *supra* note 1.

¹⁰ See Twerski & Cohen, *supra* note 9, at 610. "Courts deem the unwanted and

would also be under a duty to respond if the patient asked her what her record was with the particular type of surgery. To deny that she had such data would be as much a violation of her duty as not to volunteer the data, if not more so.

One relevant aspect of the outcome studies done to date would be particularly important, I believe, for the doctor to share with the patient contemplating using this doctor's services: in general the more often a doctor performs a relatively complex treatment, *e.g.*, open heart surgery, the more likely a successful outcome ("practice makes perfect"). Therefore, the doctor who rarely does a particular surgery or is still on the rising part of the learning curve would have to disclose this information to the patient.

How exactly the doctor presents the required information as to his "batting statistics" is no more precise than how in general he is to satisfy the informed consent requirement. Generally courts have not laid down precise rules simply because it is a very subjective, give-and-take conversation, done in the office of the doctor. Rather, courts look at the end product: would a reasonable patient, having been told, have consented to the treatment? The doctor would be free to explain the bad statistics—and would probably tend to try to explain them away. If he over-trivialized the data, *e.g.*, assuring the patient that they are meaningless because he takes on sick patients, he might, of course, be found not to have attained the requisite informed consent.

Just as I considered in Section A the use each side might make of performance data when they were above or below par, we should consider what use might be made, properly or improperly, by a physician in the consent setting of the fact that the doctor had much *better* than average experience. Could she say there is generally a risk of such and so happening but it has not happened to her or that she has the safest rating in New York State? The answer to this would not be so much in terms of whether she has somehow vitiated the consent she otherwise

unconsented touching by the physician sufficiently egregious that they have assimilated the conduct of even a well-intentioned doctor to the more violent and antisocial acts of those wrongdoers more usually associated with intentional torts." *Id.* An early but still leading case in New York is *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914).

obtained (she did after all tell the truth), but whether she used some form of unprofessional puffing to sell the patient on the surgery. The fact that she did not have in her series a particular complication often seen nationally does not really mean that she can promise the patient that it will not happen this time. An unknowledgeable person, however, could take the information that way.

B. *Proximate Cause Issues*

Under most versions of the informed consent doctrine, the doctor does not pay damages merely because he did not warn a patient about risk. Further links are required: that, as a result of the failure to inform of risks, the patient (a) consented and (b) was injured.¹¹ Just as it is very difficult in practice for a former patient to convince a jury that, had she been properly informed, she would not have had the surgery and, therefore, would not have been injured, predictably it will be very difficult to prove that had the doctor only added that his performance was two standard deviations away from a supposed norm, the patient would not have had some specific consequence of the surgery befall her.

There probably would not be much jury appeal in an argument made by a patient's counsel that his client would have consented to the surgery knowing the general risks and known side effects, *e.g.*, a post-operative infection, but would have withheld her consent if she had known, in addition, that there were greater than usual risks associated with the treatment in the hands of the particular doctor. After all, even in the best of hands, the post-operative infection still had a chance of occurring.¹²

There are other problems with an informed consent cause of action. Plaintiffs' attorneys generally believe that juries will not make awards, even if there was a failure to inform, chiefly because juries themselves decide that the treatment was needed.

¹¹ The New York version of this rule has been codified. See N.Y. PUB. HEALTH LAW § 2805-d (McKinney Supp. 1986). See also Twerski & Cohen, *supra* note 9, at 609.

¹² It should be noted that considerations as to proximate cause do not arise under the negligence cause of action considered in Part I. Evidence as to departure from the standard of care is required. Once a departure is shown, the next inquiry is whether the departure was, overall, a cause of the injury.

This does not, however, negate making a valuable side use of a cause of action for informed consent teamed with the routine negligence suit: if the doctor wants to claim that the injury caused was "just one of those things," and in no way an indication of fault, then one can ask why the patient was not warned about the chance of its happening before the treatment.

A second problem is how damages might be measured. Is the doctor to pay for all of the bad, but no-fault ill consequences that happened because she didn't disclose her negative statistics? And if she lied about her statistics, might the cause of action really be one for misrepresentation and limited damages be awarded under that theory of tort?¹³

III. THE HOSPITAL SETTING

A hospital, as compared to an individual practitioner, might be under a duty to disclose statistics relating to its institution or practitioners on its staff on the basis of arguments already reviewed relating to similarity or arising out of its special relation to health care delivery. For example, if the hospital were providing clinic care, with no particular doctor involved, *i.e.*, the person is the patient of the hospital, then the issues discussed as to negligence and informed consent would apply.

The most obvious special duty of an institution arises out of the responsibility hospitals have in giving permission to physicians to practice there. The hospital must use due care in issuing credentials, reviewing them and examining new information that may come to the hospital's attention. In legal terms, failure to meet this standard may constitute negligent hiring and negligent retention.¹⁴ Specifically with regard to its duty to admitted patients, would the hospital be liable for keeping on its staff a doctor who is a major outlier from the statistical norm? Case law does not provide an exact answer, but certainly the patient would have a valid argument. If a hospital is liable for keeping on a bad apple, of what weight is it against the hospital that in general the doctor has worse than average outcomes, and against

¹³ See W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 105, at 725 (5th ed. 1984). The tort of misrepresentation in this context occurs when the physician induces a patient's consent by misrepresenting her statistical profile.

¹⁴ On negligent hiring, retention and supervision, see 1 J.D. LEE & BARRY A. LINDAHL, MODERN TORT LAW § 7.03 (Rev. ed. 1988).

what background is this to be examined—the other doctors at the hospital (it may be an especially bad or good hospital) or all doctors?

Even less resolved would be the issue of the duty of the hospital to warn patients about its own statistics. Let us assume the hospital was the worst of many studied in a state as far as deaths associated with the performance of bypass surgery: should it have a banner so proclaiming outside its admission office or, more reasonably, a notice that the results of a certain study are available for examination? Who is to explain the data? The hospital will argue that the surgeons it allows to practice there should be the ones who explain their track record. Predictably, courts would not move fast to require hospitals to make any disclosure in this area, and may never do so.

CONCLUSION

In conclusion, there are many important policy reasons for disclosing outcome statistics and helping the public understand these statistics. It probably will improve the quality of care and may rid us of bad apples, if such exist. However, these and other valuable goals will not necessarily be furthered and may even be frustrated if the proof of the information is allowed into court as some evidence of whether a doctor is good or bad. However, consistent with a doctor's duty to disclose what he or she knows about risks attendant to a treatment, such information should be disclosed.¹⁵

¹⁵ Part of the concern of any attorney who writes about this evidence is whether some day similar statistics might be gathered on the trial record of lawyers. Attorney A wins 60% of his trials; Attorney B 40%. Would I have to disclose this to prospective clients? There is, statistically, a 50-50% chance to win or lose every case.