

UIC School of Law

UIC Law Open Access Repository

UIC Law Open Access Faculty Scholarship

1-1-2011

Good Medicine/Bad Medicine And The Law Of Evidence: Is There A Role For Proof Of Character, Propensity, Or Prior Bad Conduct In Medical Negligence Litigation?, 63 S.C. L. Rev. 367 (2011)

Marc Ginsberg

The John Marshall Law School, mgins@uic.edu

Follow this and additional works at: <https://repository.law.uic.edu/facpubs>



Part of the [Evidence Commons](#), [Health Law and Policy Commons](#), [Litigation Commons](#), [Medical Jurisprudence Commons](#), and the [Torts Commons](#)

Recommended Citation

Marc Ginsberg, Good Medicine/Bad Medicine And The Law Of Evidence: Is There A Role For Proof Of Character, Propensity, Or Prior Bad Conduct In Medical Negligence Litigation?, 63 S.C. L. Rev. 367 (2011)

<https://repository.law.uic.edu/facpubs/352>

This Article is brought to you for free and open access by UIC Law Open Access Repository. It has been accepted for inclusion in UIC Law Open Access Faculty Scholarship by an authorized administrator of UIC Law Open Access Repository. For more information, please contact repository@jmls.edu.

**GOOD MEDICINE/BAD MEDICINE AND THE LAW OF EVIDENCE:
IS THERE A ROLE FOR PROOF OF CHARACTER, PROPENSITY, OR
PRIOR BAD CONDUCT IN MEDICAL NEGLIGENCE LITIGATION?**

Marc D. Ginsberg*

I. INTRODUCTION.....	368
II. RULES OF EVIDENCE INVOLVED.....	370
III. PHYSICIAN REPUTATION	373
IV. PRIOR LAWSUITS AGAINST THE PHYSICIAN DEFENDANT	378
V. EVIDENCE OF PHYSICIAN TREATMENT OF OTHER PATIENTS— INADMISSIBLE	380
VI. EVIDENCE OF PHYSICIAN TREATMENT OF OTHER PATIENTS— ADMISSIBLE	383
VII. OTHER CATEGORIES OF PHYSICIAN CONDUCT EVIDENCE	389
A. <i>Alteration of Medical Records</i>	389
B. <i>Poor Performance in Medical Education and Training</i>	390
C. <i>Defendant Physician’s Failure to Achieve Board Certification</i>	390
D. <i>Defendant Physician’s Medical License Suspension or Other Discipline</i>	392
E. <i>Defendant Physician’s Hospital Privileges Suspension</i>	395
VIII. PHYSICIAN HABIT.....	395
IX. CROSS-EXAMINATION OF MEDICAL EXPERT WITNESSES	397
A. <i>Medical License Revocation or Limitation</i>	398
B. <i>Failure to Achieve Board Certification</i>	399
C. <i>Termination/Suspension of Staff Privileges</i>	399
D. <i>Negative Performance Evaluation</i>	400
E. <i>Prior Lawsuits Against the Expert</i>	400
1. <i>Admissible Evidence</i>	400
2. <i>Inadmissible Evidence</i>	401

*Assistant Professor, The John Marshall Law School (Chicago). Contact via email at 9ginsberg@jmls.edu. B.A., University of Illinois-Chicago; M.A., Indiana University; J.D., The John Marshall Law School; LL.M. (Health Law) DePaul University College of Law. The author thanks his wife, Janice Ginsberg, for her inspiration and support. The author also thanks his former research assistants Jennifer Barton and Mark Swantek, and his current research assistant Levon Barsoumian, for their cite checking and proofreading efforts.

X. CONCLUSION	402
---------------------	-----

I. INTRODUCTION

“The likelihood of being sued for malpractice is now so great that the practicing physician must recognize that it constitutes a definite occupational hazard.”¹

There are many patients injured or who die as a result of medical negligence.² The American Medical Association³ (AMA) has reported results of a physician survey, revealing that more than 40% of the physicians surveyed “had a medical liability claim filed against them at some point in their career.”⁴ Certainly, some of these medical negligence claims are without merit.⁵ However, the meritorious claims implicate physician carelessness—the failure to comply with the applicable standard of care.⁶

Even if medical negligence claims are predictable, they are not the only professional problems facing physicians. Physicians admit patients to hospitals

1. Louis J. Regan, *Malpractice, An Occupational Hazard*, 156 JAMA 1317 (1954). Of course, it is most interesting that this “hazard” was recognized or predicted almost sixty years ago.

2. See Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, the Contingency Fee System, Juries, and Social Policy*, 38 LOY. L.A. L. REV. 1217, 1220–21 (2005) (citing PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 44, 44 tbl. 3.2., 124–29 (1993)) (discussing the results of a Harvard study of medical negligence).

3. *Our Mission*, AMA, <http://www.ama-assn.org/ama/pub/about-ama/our-mission.page> (last visited Nov. 13, 2011). The AMA is an influential voluntary medical association. Its mission is “[t]o promote the art and science of medicine and the betterment of public health.” *Id.* For historical and organizational background, see Note, *The American Medical Association: Power, Purpose, and Politics in Organized Medicine*, 63 YALE L.J. 938 (1954).

4. Carol K. Kane, *Policy Research Perspectives: Medical Liability Claim Frequency: A 2007–2008 Snapshot of Physicians*, AMA, 2 (Aug. 2010), <http://www.ama-assn.org/ama1/pub/upload/mm/363/prp-201001-claim-freq.pdf>.

5. See THOMAS H. COHEN & KRISTEN A. HUGHES, U.S. DEP’T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, SPECIAL REPORT: MEDICAL MALPRACTICE CLAIMS IN SEVEN STATES, 2000–2004 NCJ 216339, at 1 (2007), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/mmics04.pdf> (suggesting that a large percentage of medical negligence claims are closed without payment to claimants).

6. See DAN B. DOBBS, THE LAW OF TORTS 631–32 (2000) (footnotes omitted) (noting that the standard of care contemplates “physicians acting within the ambit of their professional work [exercising] the skill, knowledge, and care normally possessed and exercised by other members of their profession of the same school of practice in the relevant medical community” (citing *Keebler v. Winfield Carraway Hosp.*, 531 So. 2d 841, 845 (Ala. 1988) (defining reasonable skill); *Self v. Exec. Comm. of Ga. Baptist Convention of Ga. Inc.*, 266 S.E.2d 168, 168–69 (Ga. 1980) (defining what constitutes professional negligence); *Purtill v. Hess*, 489 N.E.2d 867, 872 (Ill. 1986) (same); RESTATEMENT (SECOND) OF TORTS § 299A cmt. e (1965) (same))).

and practice medicine on hospital premises through grants of staff privileges.⁷ Physician misconduct or performance problems can lead to privilege suspension, limitation, or revocation.⁸

Physicians also may suffer disciplinary problems. Disciplinary action is taken by “regulatory bodies that investigate and adjudicate alleged violations of law, ethics, or practice standards.”⁹ More than one study has identified multiple transgressions leading to discipline, including negligence/incompetence, inappropriate prescribing, alcohol/drug use, sexual misconduct, unlicensed activity, fraud, mental/physical illness, and misrepresentation of credentials.¹⁰

Assuming the truth of the lawsuit as an “occupational hazard” phenomenon, medical negligence litigation is common enough that a discussion of certain evidentiary issues is worthwhile.¹¹ These issues relate to proof of physician character and reputation,¹² propensity to practice medicine in a specific exemplary or substandard fashion,¹³ prior lawsuits,¹⁴ treatment of other patients,¹⁵ and prior restrictions on privileges and licensing.¹⁶ Is there a place for

7. See generally *Jimenez v. Wellstar Health Sys.*, 596 F.3d 1304, 1307 (11th Cir. 2010) (“Medical staff privileges allow a physician both to treat patients at the privilege-granting hospital and to receive patient referrals from that hospital.”); BARRY R. FURROW ET AL., *HEALTH LAW* 97–98 (2d ed. 2000) (footnote omitted) (“A physician or other health care professional may admit or treat patients in a particular hospital only if the practitioner has admitting or clinical privileges at that hospital.”); Andrew K. Dolan & Richard S. Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 HOUS. L. REV. 707, 709–12 (1981) (explaining the nuances of hospital privileges).

8. See *Jimenez*, 596 F.3d at 1307 (recounting the suspension of medical staff privileges following complaints that the physician “failed to promptly respond to emergency-room calls, failed to timely make rounds to see patients, and performed inappropriate operations”); Dolan & Ralston, *supra* note 7, at 712 (discussing revocation of privileges).

9. James Morrison & Peter Wickersham, *Physicians Disciplined by a State Medical Board*, 279 JAMA 1889, 1889 (1998).

10. See *id.* at 1891 tbl.2; Neal D. Kohatsu et al., *Characteristics Associated with Physician Discipline: A Case-Control Study*, 164 ARCH. INTERN. MED. 653, 655 tbl.2 (2004).

11. See Regan, *supra* note 1, at 1317.

12. See, e.g., *Blevins v. Clark*, 740 N.E.2d 1235, 1238–39 (Ind. Ct. App. 2000) (noting that although the trial court allowed testimony of the obstetrician’s professional reputation, the error was harmless); *Holiday v. Cutchin*, 316 S.E.2d 55, 58–59 (N.C. 1984) (noting that character evidence offered by the physician himself was inadmissible, without determining whether the error was harmless).

13. See, e.g., *Mousseau v. Schwartz*, 756 N.W.2d 345, 354 (S.D. 2008) (concluding that the injured plaintiff should have been able to introduce the relevant stipulation to the jury that the neurosurgeon “failed to even possess the degree of knowledge and skill ordinarily possessed by neurosurgeons”).

14. It has been reported that a physician’s early claim history is predictive of subsequent claims. See Randall R. Bovbjerg & Kenneth R. Petronis, *The Relationship Between Physicians’ Malpractice Claims History and Later Claims: Does the Past Predict the Future?*, 272 JAMA 1421, 1425 (1994).

15. See, e.g., *Birudavol v. Bd. of Registration in Med.*, 864 N.E.2d 494, 495, 497 (Mass. 2007) (affirming the trial court’s ruling that the state medical board properly sanctioned a physician for substandard treatment of four patients which “called into question his competence to practice medicine”).

proof of these matters in a medical negligence suit when the focus of the litigation is whether the defendant physician complied with the applicable standard of care in treating a particular patient at a particular time?

II. RULES OF EVIDENCE INVOLVED

This inquiry implicates questions of relevance and the scope of cross-examination. Only relevant evidence is admissible, pursuant to Federal Rule of Evidence 402.¹⁷ Relevance is defined by Rule 401 of the Federal Rules of Evidence as follows:

Rule 401. Test for Relevant Evidence

Evidence is relevant if:

- (a) it has any tendency to make a fact more or less probable than it would be without the evidence; and
- (b) the fact is of consequence in determining the action.¹⁸

For evidence to constitute relevant evidence, it need not clear a very high hurdle—“[r]elevant evidence is evidence that in *some* degree advances the inquiry.”¹⁹ However, even though the relevance hurdle is low, not all relevant evidence is actually admitted into evidence pursuant to Rule 403, which operates to exclude certain evidence with a probative value outweighed by concerns of prejudice, confusion, misleading the jury, or other reasons.²⁰

In focusing on a defendant physician’s prior practice history, disciplinary and privileges problems, and prior lawsuits, Rule 404²¹ takes center stage. In relevant part, Rule 404 provides:

16. *See, e.g., Mitchell v. Kardesch*, 313 S.W.3d 667, 674, 679 (Mo. 2010) (en banc) (holding that after finding that the physician’s licenses to practice medicine in two states had been suspended due to unrelated felony convictions, “the trial court abused its discretion in prohibiting counsel from examining [the physician] about his statements about his suspensions in his interrogatory answer and deposition”).

17. FED. R. EVID. 402.

18. FED. R. EVID. 401.

19. KENNETH S. BROUN ET AL., *MCCORMICK ON EVIDENCE* § 185, at 309 (6th ed. 2006) (emphasis added).

20. FED. R. EVID. 403.

21. FED. R. EVID. 404.

Rule 404. Character Evidence; Crimes or Other Acts**(a) Character Evidence.**

(1) Prohibited Uses. Evidence of a person's character or character trait is not admissible to prove that on a particular occasion the person acted in accordance with the character or trait.

....

(3) Exceptions for a Witness. Evidence of a witness's character may be admitted under Rules 607, 608, and 609.

(b) Crimes, Wrongs, or Other Acts.

(1) Prohibited Uses. Evidence of a crime, wrong, or other act is not admissible to prove a person's character in order to show that on a particular occasion the person acted in accordance with the character.

(2) Permitted Uses; Notice in a Criminal Case. This evidence may be admissible for another purposes, such as proving motive, opportunity, intent, preparation, plan, knowledge, identity, absence of mistake, or lack of accident. . . .²²

Rule 404(a) and (b) operate to focus the evidence, and the jury, on the claim for which the defendant is on trial and to exclude evidence of prior good or bad deeds, the admission of which might influence the jury to decide the defendant's fate based on reputation or history. The goal is not to distract the jury but to have the jury concentrate on the case at bar.

To the extent that a physician's prior professional problems may have occurred on a regular, repetitive basis, Rule 406²³ may be involved. It provides as follows:

Rule 406. Habit; Routine Practice

Evidence of a person's habit or an organization's routine practice may be admitted to prove that on a particular occasion the person or organization acted in accordance with the habit or routine practice. The court may admit this evidence regardless of whether it is corroborated or whether there was an eyewitness.²⁴

Evidence of habit is relevant pursuant to Rule 406 and may be admissible,²⁵ whereas character and propensity evidence is typically inadmissible pursuant to Rule 404.²⁶ The distinction between character and habit has been explained as

22. FED. R. EVID. 404(a)(1), (a)(3), (b)(1)–(2).

23. FED. R. EVID. 406.

24. *Id.*

25. *See* FED. R. EVID. 402, 406.

26. FED. R. EVID. 404.

follows: “Character is a generalized description of a person’s disposition, or of the disposition in respect to a general trait, such as honesty, temperance or peacefulness. Habit, in the present context, is more specific. It denotes one’s regular response to a repeated situation.”²⁷

Therefore, admissible habit evidence could “save” otherwise inadmissible character evidence and create serious evidentiary problems for physicians in medical negligence cases.²⁸

At the trial of a medical negligence case, physician witnesses, including expert witnesses, are subject to cross-examination.²⁹ The credibility of a witness is a focus of cross-examination.³⁰ Rules 607 and 608 are implicated here and provide, in relevant part, as follows:

Rule 607. Who May Impeach a Witness

Any party, including the party that called the witness, may attack the witness’s credibility.³¹

Rule 608. A Witness’s Character for Truthfulness or Untruthfulness

(a) Reputation or Opinion Evidence. A witness’s credibility may be attacked or supported by testimony about the witness’s reputation for having a character for truthfulness or untruthfulness, or by testimony in the form of an opinion about that character. But evidence of truthful character is admissible only after the witness’s character for truthfulness has been attacked.

(b) Specific Instances of Conduct. Except for a criminal conviction under Rule 609, extrinsic evidence is not admissible to prove specific instances of a witness’s conduct in order to attack or support the witness’s character for truthfulness. But the court may, on cross-examination, allow them to be inquired into if they are probative of the character for truthfulness or untruthfulness of:

(1) the witness; or

(2) another witness whose character the witness being cross-examined has testified about.³²

27. BROWN ET AL., *supra* note 19, §195, at 322.

28. *See, e.g.*, Gasiorowski v. Hose, 897 P.2d 678, 681 (Ariz. Ct. App. 1994) (referring to the physician’s “habit or routine practice of threading epidural catheters to excessive depth”).

29. *See* Daubert v. Merrell Dow Pharm., Inc., 509 U.S. 579, 596 (1993). As the Court in *Daubert* indicated, “[v]igorous cross-examination, presentation of contrary evidence, and careful instruction on the burden of proof are the traditional and appropriate means of attacking shaky but admissible evidence.” *Id.*

30. FED. R. EVID. 611(b); BROWN ET AL., *supra* note 19, § 33, at 60–61.

31. FED. R. EVID. 607.

Rule 608 “governs the use of character and conduct evidence for the purpose of impeaching the general character of a witness for honesty.”³³ Rule 608 does not concern “other matters that might tend to make the witness’s testimony less credible in the particular case.”³⁴

Witnesses are always subject to cross-examination as to “matters relevant to the witness’s credibility.”³⁵ Cross-examination offers the “opportunity to elicit answers impeaching the witness’s veracity, capacity to observe, impartiality and consistency.”³⁶ The cross-examination of a physician witness may become quite uncomfortable if a physician’s prior history of litigation and discipline is fair game for inquiry.

This paper will explore the willingness of state and federal trial courts to admit evidence of a physician’s character, reputation, and prior acts in medical negligence litigation. This analysis will yield some ground rules for courts to follow when considering the admissibility of highly influential and prejudicial evidence. Additionally, to the extent that potentially damaging evidence of this sort may be well received by trial courts, the medical profession might consider the instruction of medical students, physicians in training, and practitioners on this topic. The law of medical evidence relates quite well to the concept of medical negligence litigation as an occupational hazard.

III. PHYSICIAN REPUTATION

There is a core of older, classic cases supporting the position that a physician’s reputation for skill or lack thereof is not relevant to the determination of a physician’s negligence in treating a particular patient at a particular time.³⁷ These cases conform to the principle that “[m]ost courts . . . reject proof of an actor’s character for care by means of reputation evidence.”³⁸

In *Holtzman v. Hoy*, the Supreme Court of Illinois considered a medical negligence action against a surgeon who provided treatment for a leg fracture.³⁹ A defense witness, also a physician, was asked this question, which the trial court did not permit the witness to answer: “I will ask you what his [Dr. Holtzman’s] reputation is in the community, and among the profession, as being an ordinarily skillful and learned physician?”⁴⁰

32. FED. R. EVID. 608.

33. GLEN WEISSENBERGER & JAMES J. DUANE, FEDERAL RULES OF EVIDENCE: RULES, LEGISLATIVE HISTORY, COMMENTARY AND AUTHORITY § 608.1, at 312 (6th ed. 2009).

34. *Id.*

35. BROWN ET AL., *supra* note 19, § 21, at 47.

36. *Id.* § 22, at 49.

37. *E.g.*, *Holtzman v. Hoy*, 8 N.E. 832 (Ill. 1886); *Stevenson v. Gelsthorpe*, 27 P. 404 (Mont. 1891); *Green v. Shaw*, 136 S.C. 56, 134 S.E. 226 (1926); *Hackler v. Ingram*, 196 S.W. 279 (Tex. Civ. App. 1917).

38. BROWN ET AL., *supra* note 19, § 189, at 314.

39. *See Holtzman*, 8 N.E. at 832.

40. *Id.* (alteration in original).

The Supreme Court of Illinois, with flourish, explained its approval of the exclusion of evidence of the defendant's reputation as follows:

It does not, however, follow that because the defendant's skill, or rather the want of it, was put in issue, that it could be either established or disproved by showing his general reputation. While his skill, or the want of it, was put in issue, his reputation in that respect was not put in issue, and therefore evidence to establish it was properly excluded. Suppose it appeared from the evidence that the treatment of the plaintiff's leg was proper, and in every respect according to the most approved surgery, and evidence of the character offered had been admitted, would it have availed the plaintiff anything if it further appeared from the evidence that the defendant was generally reputed to be an unskillful and unsafe surgeon? Surely not. The hypothesis here suggested, as we conceive, is but a presentation, from a different standpoint, of the principle contended for, but in a way that more forcibly illustrates its unsoundness.

There are many reasons outside of those mentioned why evidence of this character is not admissible. *First*, its bearing upon the issue is too remote, and in many, if not in most, cases it would tend to mislead the jury, rather than enlighten them. The veriest quack in the country, by his peculiar methods, not unfrequently becomes very famous for the time being in his own locality, so much so that every person in the neighborhood might safely testify to his good reputation. It is true that one's reputation, thus acquired, is generally of short duration. His patrons sooner or later must pay the penalty of their credulity by becoming the victims of her ignorance, and with that his good name vanishes. Yet, according to the principle contended for, the quack, in such case, when called to account for his professional ignorance, might successfully entrench himself behind his previous good reputation. Again, one may in many respects be a good practitioner, and deservedly stand well in the neighborhood in which he lives, and yet, at the same time, be grossly ignorant about some matters, in the line of his profession which would render him liable if, by reason thereof, his patient should be improperly treated, and thereby subjected to loss or injury. In such case, it is manifest evidence of the defendant's good reputation would be no answer to an action brought for the injury sustained, and its admission would be clearly calculated to mislead the jury. Other illustrations might be given of the impropriety of admitting such testimony, but it is not necessary to do so.⁴¹

41. *Id.* at 832-33.

Almost five years following *Holtzman*, the Supreme Court of Montana spoke on this topic in *Stevenson v. Gelsthorpe*.⁴² *Stevenson* involved a medical negligence action against a physician who treated the plaintiff's broken wrist.⁴³ The jury returned a verdict against the defendant physician and the trial court denied the defendant's request for a new trial.⁴⁴

Unlike in *Holtzman*, where the trial court excluded evidence of the defendant physician's reputation,⁴⁵ the trial court in *Stevenson* permitted "witnesses to testify as to defendant's reputation . . . for skill and ability as a physician."⁴⁶ Finding that testimony improper, the Montana Supreme Court stated:

Defendant's reputation as a physician was not in issue. It was his specific acts in the treatment of a certain case, and the facts as to whether his acts were unskillful and negligent in this treatment was the matter in issue. A doctor's reputation for skill and ability will not exonerate him, where gross negligence and want of the application of skill is alleged and proved. Nor can the fact that a doctor is reputed to be negligent or unskillful be allowed as proof to establish negligence or unskillful treatment in a particular case, because he may have treated that case with unusual skill and care. The introduction of that evidence was not only improper from a legal view, but it was of a character which may have unjustly prejudiced defendant's case before the jury upon a point where defendant had made no preparation to defend.⁴⁷

In 1917, the Court of Civil Appeals of Texas, in *Hackler v. Ingram*,⁴⁸ held that a physician's reputation or character for care is inadmissible in a medical negligence case.⁴⁹ *Hackler* concerned a claim against a surgeon who had operated on the patient and was allegedly negligent in closing the operative wound.⁵⁰ The jury returned a verdict against the defendant physician.⁵¹

On appeal, the defendant urged that the trial court erred in refusing "to permit evidence of numerous physicians who offered to testify that they had observed [the defendant] in operations, and that he was a skillful, competent, and careful surgeon."⁵² The Court of Civil Appeals agreed with the trial court's ruling, noting that "[h]owever careful and competent a person may be generally,

42. 27 P. 404 (Mont. 1891).

43. *Id.* at 404.

44. *Id.*

45. *Holtzman*, 8 N.E. at 832.

46. *Stevenson*, 27 P. at 406.

47. *Id.* at 406-07.

48. 196 S.W. 279 (Tex. Civ. App. 1917).

49. *Id.* at 281.

50. *Id.* at 280.

51. *Id.*

52. *Id.*

such fact is no defense to a specific act of negligence.”⁵³ The court elaborated its position by referring to Texas Supreme Court jurisprudence,⁵⁴ which cited Massachusetts case law with approval, stating that “[w]hen the precise act or omission of a defendant is proved, the question whether it is actionable negligence is to be decided by the character of that act or omission, and not by the character for care and caution that the defendant may sustain.”⁵⁵ The jury verdict against the defendant physician was affirmed.⁵⁶

In 1926, the Supreme Court of South Carolina decided *Green v. Shaw*,⁵⁷ which involved a medical negligence claim against a physician who had treated the plaintiff for a finger malady.⁵⁸ The jury returned a verdict for the defendant.⁵⁹ Plaintiff appealed, claiming “[e]rror in admitting the testimony of Dr. Jennings and of Dr. McIntosh ‘as to the efficiency and carefulness of [the defendant] and as to his reputation.’”⁶⁰

The testimony of these physicians developed as follows:

When Dr. R. T. Jennings, a witness for the defendant, was on the stand, he testified as follows; this testimony being admitted by the court over the objection of the plaintiff.

“Q. What is your observation of Dr. Shaw as to his efficiency or carefulness in general?

Mr. Herbert: We object. We haven’t attacked Dr. Shaw’s reputation as a physician. That hasn’t been put in issue. He may be a very good physician, and he may have done a very careless thing; he may be very careful, and he may have done a very careless thing.

The Court: It seems to me it has some probative value. I think it is competent.

Mr. Herbert: Dr. Shaw’s reputation as a careful physician?

The Court: Yes, sir.

Mr. Herbert: I ask to note my objection.

A. He has always been very careful with me and I have got good results.

The Court: I don’t think he is entitled to go into specific cases, but only his general reputation.”

When Dr. James H. McIntosh, who was also a witness for the defendant, was on the stand, he testified along the same line:

53. *Id.* at 281 (citations omitted).

54. *Id.* (citing *Missouri, K. & T. Ry. Co. v. Johnson*, 48 S.W. 568, 569 (Tex. 1898)).

55. *Id.* (quoting *Tenney v. Tuttle*, 83 Mass. 185, 186–87(1861)).

56. *Id.*

57. 136 S.C. 56, 134 S.E. 226 (1926).

58. *Id.*

59. *Id.* at 59, 134 S.E. at 226.

60. *Id.*

“Q. From your general knowledge, please state what is Dr. Shaw’s reputation professionally as a careful and expert operator.

Mr. Herbert: We object for the same reasons.

The Court: The same ruling.

Witness: I have used him in a great many cases where X-ray work was necessary.

The Court: One minute—what is his reputation?

Witness: His reputation is good as an X-ray man.”⁶¹

The Supreme Court of South Carolina held that the admission of this testimony was reversible error, stating that:

A physician might be ever so skillful or competent in a general way, or might have an unexcelled reputation, and yet be guilty of the grossest negligence in his treatment of a particular case. It is clear to reason, therefore, that, in the case at bar, testimony as to Dr. Shaw’s reputation was inadmissible⁶²

The court cited with approval *Stevenson v. Gelsthorpe*, *Hackler v. Ingram*, and *Holtzman v. Hoy*.⁶³ Referring to physician specialists and general practitioners, the court noted that they “are alike subject to the rule that they cannot escape the consequences of their negligent acts in a special case by showing or attempting to show their general reputation for skill and competency.”⁶⁴

These venerable cases teach that evidence of physician reputation, good or bad, is inadmissible in medical negligence litigation. They pre-date the Federal Rules of Evidence by many years.⁶⁵ These cases, nevertheless, would withstand the test of time and the current Rules 401/403 analysis. Even if evidence of reputation arguably survives Rule 401 scrutiny—the “any tendency”⁶⁶ relevancy test—which is unlikely, it does not survive Rule 403 scrutiny. Reputation evidence would tend to mislead the jury and focus it on matters collateral to the trial. Therefore, reputation evidence should be excluded.⁶⁷

61. *Id.* at 59–60, 134 S.E. at 226–27.

62. *Id.* at 60, 134 S.E. at 227.

63. *Id.* at 60–62, 134 S.E. at 227–28 (citing *Stevenson v. Gelsthorpe*, 27 P. 404 (Mont. 1891); *Hacker v. Ingram*, 196 S.W. 279 (Texas Civ. App. 1917); *Holtzman v. Hoy*, 8 N.E. 832 (Ill. 1886)).

64. *Id.* at 63, 134 S.E. at 228.

65. See Act to Establish Rules of Evidence for Certain Courts and Proceedings, Pub. L. No. 93-595, 88 Stat. 1926 (1975) (establishing the Federal Rules of Evidence).

66. FED. R. EVID. 401.

67. For two more recent examples of the well-founded rule excluding reputation evidence in medical negligence cases, see *Holiday v. Cutchin*, 316 S.E.2d 55, 58 (N.C. 1984), in which the defendant physician attempted to utilize the following reputational evidence:

Q. Dr. Wilkerson, are you personally acquainted with Dr. Lawrence Cutchin?

A. Yes, sir.

Q. Do you know his general character and reputation?

MR. McLEOD: Objection.

IV. PRIOR LAWSUITS AGAINST THE PHYSICIAN DEFENDANT

The simple fact that a defendant physician has been named as a defendant in prior medical negligence cases should not constitute admissible evidence. Previously filed lawsuits are not admissible to prove that the defendant is negligent in the case at bar.⁶⁸ Therefore, a pre-trial motion in limine⁶⁹ should address this potential evidence and should include references to all prior lawsuits for medical negligence filed against the defendant physician.⁷⁰

Comments by counsel in an opening statement regarding prior medical negligence lawsuits filed against a physician defendant are improper.⁷¹ Consider the interesting strategy of plaintiff's counsel reported by the Maryland Court of Appeals in *Lai v. Sagle*.⁷² Here, in opening statement, plaintiff's counsel remarked, "Dr. Lai moved to Hagerstown in August of 1994 at the invitation of his friend, Dr. Su. He never looked for . . . other practice environments. By the

THE COURT: Overruled.

Q. Do you know his general character and reputation?

A. Yes, sir.

Q. What is it?

MR. McLEOD: Objection.

THE COURT: Overruled.

A. I have known Dr. Cutchin since he was a resident in Chapel Hill and since his starting practice in Tarboro. And he's not only a fine physician but also a public spirited individual who has done many things to help the health care of people in eastern North Carolina, particularly in his county.

MR. McLEOD: Objection. Not responsive

THE COURT: Denied.

Q. Go ahead.

A. I have also known him socially, and he's come to some social events here in Greenville and I have met him at State Medical Society meetings and other medical meetings, and have found him to be interested in the subject matter at hand but the welfare and health of people of eastern North Carolina but he had a fine spirit in trying to provide for that welfare.

MR. McLEOD: Move to strike.

THE COURT: Denied.

See also *Hudson v. Lenz*, No. H025047, 2004 WL 823492, at *21 (Cal. App. Dist. Apr. 16, 2004) (defendant physician "introduced testimony from two witnesses, Nurse Kohler and Nurse Parrish, to the effect that Dr. Lenz: (1) was a 'careful practitioner'; and (2) was never observed to jeopardize the safety of his patients (either mother or baby)").

68. See, e.g., *Lai v. Sagle*, 818 A.2d 237, 247 (Md. 2003).

69. See ROGER C. PARK ET AL., EVIDENCE LAW: A STUDENT'S GUIDE TO THE LAW OF EVIDENCE AS APPLIED IN AMERICAN TRIALS 43 (3d ed. 2011) ("A motion in limine is a common method for raising evidentiary matters of a substantial or highly prejudicial nature, the resolution of which will influence the conduct of the trial. This anticipatory motion, usually made in writing before the beginning of the trial, gives the lawyers an opportunity to ensure that objectionable and particularly prejudicial information will never be offered in front [sic] the jurors, who will never hear it.").

70. See *Lai*, 818 A.2d at 244 (discussing the need for a motion in limine to prevent prejudicial evidence from being introduced at trial).

71. E.g., *id.* at 248.

72. *Id.* at 240.

way, when Dr. Lai was practicing in Michigan for eight years, he was sued five times for malpractice.”⁷³

Defense counsel successfully objected.⁷⁴ Plaintiff’s counsel argued that the prior lawsuits were relevant evidence as “[i]t shows that he has this ongoing phenomena of negligent care and treatment.”⁷⁵ The trial court rejected the position of plaintiff’s counsel, but denied defendant’s motion for a mistrial.⁷⁶ Ultimately, the jury returned a verdict for the plaintiff and the Court of Special Appeals affirmed.⁷⁷

The Court of Appeals of Maryland found that the prejudicial impact of the reference to prior lawsuits in the plaintiff’s opening statement outweighed the curative value of the trial court’s jury instruction.⁷⁸ The court honed in on the effort to introduce evidence of prior medical negligence lawsuits against the defendant physician and stated:

There could be any number of reasons why Dr. Lai was sued, and not all, if any, of them may have been legitimate. The fact of prior litigation has little, if any, relevance to whether he violated the applicable standard of care in the immediate case. The admission of evidence of prior suits, instead of aiding the fact finder in its quest, tends to excite its prejudice and mislead it.⁷⁹

The court stated that prior lawsuits would constitute prohibited propensity evidence.⁸⁰ In closing, the Maryland Court of Appeals held “that mention by the plaintiff in opening statement in a medical malpractice jury trial of prior malpractice litigation brought by third parties against the defendant doctor is unduly and highly prejudicial and ordinarily shall result, upon proper objection and motion, in a mistrial.”⁸¹ The Maryland Court of Appeals reversed the judgment of the Court of Special Appeals and ordered a new trial.⁸²

An effort to cross-examine the physician defendant with evidence of prior lawsuits against the physician is similarly improper.⁸³ A simple example of this improper tactic is demonstrated with a question such as: “Doctor, is it true that in your career, you have been sued for medical malpractice six or eight times?”⁸⁴

73. *Id.*

74. *Id.*

75. *Id.*

76. *Id.* at 241.

77. *Id.* at 241–42.

78. *Id.* at 244, 248–49.

79. *Id.* at 247 (footnote omitted).

80. *Id.*

81. *Id.* at 248 (footnote omitted).

82. *Id.* at 249.

83. *See Persichini v. William Beaumont Hosp.*, 607 N.W.2d 100, 105–06 (Mich. Ct. App. 1999).

84. *Id.* at 103.

This effort is designed to introduce propensity evidence and to attack the defendant's credibility.⁸⁵ "Mere unproven accusations of malpractice stated in a complaint cannot be used as a basis for attacking a physician's knowledge and credibility."⁸⁶

V. EVIDENCE OF PHYSICIAN TREATMENT OF OTHER PATIENTS—INADMISSIBLE

There is substantial jurisprudence that supports the notion that evidence of a physician defendant's treatment of other patients is inadmissible to prove a physician's negligence in a particular instance.⁸⁷ It is fair to suggest that this jurisprudence reflects the general policy of Rule 404, and similar state evidentiary rules, to focus the jury on the case at bar and exclude evidence of the treatment of other patients. A review of this jurisprudence follows.

Evidence of the treatment of other patients, when offered by the defendant physician to show a history of successful treatment should be excluded.⁸⁸ This is true irrespective of whether the testimony is provided by the defendant physician or physician witnesses called by the defendant physician.⁸⁹ Evidence of the treatment of other patients "entirely disconnected from the treatment" of the subject patient, "whether the result was good or bad," is inadmissible.⁹⁰

85. *Id.* at 105 (citing *Heshelman v. Lombardi*, 454 N.W.2d 603, 609 (Mich. Ct. App. 1990)) (discussing why prior acts should not be admitted).

86. *Id.* (quoting *Heshelman*, 454 N.W.2d at 609).

87. *See, e.g.*, *Buford v. Howe*, 10 F.3d 1184, 1188–89 (5th Cir. 1994) (stating that the trial court did not abuse its discretion in excluding evidence of other surgeries performed by the surgeon on the basis that the prejudicial effect of the evidence outweighed the probative value, if any, on punitive damages claim); *Hinson v. Clairemont Cmty. Hosp.*, 267 Cal. Rptr. 503, 510 (Cal. Ct. App. 1990) (holding evidence of physician's performance in medical school and prior employment termination properly excluded), *disapproved of on other grounds by Alexander v. Superior Court*, 859 P.2d 96, 100, 102 (Cal. 1993); *Baker v. Hancock*, 63 N.E. 323, 324 (Ind. App. 1902) (finding physician's submission of evidence indicating his prior success with a certain cancer treatment was inadmissible for the purposes of establishing his competency); *Lund v. McEnerney*, 495 N.W.2d 730, 734 (Iowa 1993) (holding that the trial court properly excluded evidence that the defendant doctor had, subsequent to the plaintiff's procedure, caused injuries to one or two other patients because the plaintiff failed to demonstrate how these later injuries related to her injury); *Cerniglia v. French*, 816 So. 2d 319, 323–25 (La. Ct. App. 2002) (stating that the testimony of two previous patients of a doctor being sued in connection to a surgery was neither proof of medical malpractice, nor proof that doctor lacked necessary knowledge or skill, and thus was not relevant where all experts who testified admitted the fact that a cerebral spinal fluid leak did not by itself prove that the doctor negligently performed the surgery); *Kunnanz v. Edge*, 515 N.W.2d 167, 177 (N.D. 1994) (holding that the trial court's refusal to admit evidence regarding the defendant doctor's settlement of a recent lawsuit based on the same procedure was proper as its admission would have injected a collateral matter into the trial and confused the jury); *Rayburn v. Day*, 268 P. 1002, 1005–06 (Or. 1928) (finding surgeon's statement to the plaintiff's sister that it was not the first time the surgeon had left a sponge in a patient's abdominal section was inadmissible as evidence of the defendant's negligence in the specific action).

88. *See Baker*, 63 N.E. at 324.

89. *Id.*

90. *Id.*

When the plaintiff offers evidence of the defendant physician's treatment of other patients to prove that the defendant has the propensity for negligence, that offer of evidence should be refused.⁹¹ It is well established that "[a] party cannot establish his opponent's negligence by offering proof that at some other time he committed a similar act; similar accidents occasioned by a party at another time are not admissible to show his negligence upon the occasion under inquiry."⁹² The defendant physician's treatment of another patient would not be "probative of the degree of his care" to the subject patient.⁹³

An excellent recent example of the appropriate exclusion of evidence of a defendant physician's prior treatment of other patients is reported in *Bair v. Callahan*.⁹⁴ *Bair* involved a medical negligence action against an orthopedic surgeon.⁹⁵ The treatment of the patient "included a spinal surgery involving placement of pedicle screws and rods into [the plaintiff's] back."⁹⁶ The jury returned a verdict for the defendant physician and the plaintiffs sought a new trial pursuant to Federal Rule of Civil Procedure 59 based, in part, on the trial court's exclusion of evidence focused on the defendant's treatment of other patients.⁹⁷

The proposed evidence of the defendant's surgical treatment of other patients was to be offered by testimony of the defendant, the plaintiffs' expert witness, and another treating surgeon.⁹⁸ The evidence related to similar surgical procedures performed on four patients, each of whom had sued the defendant.⁹⁹ Two of the cases were pending and two had been settled.¹⁰⁰ All of the cases made similar claims, "alleg[ing] that [the defendant] committed medical malpractice during back surgeries by misplacing pedicle screws and failing to remove misplaced screws."¹⁰¹ The plaintiffs' counsel in *Bair* and the other four cases were identical.¹⁰²

The defendant moved in limine to exclude any evidence of his treatment of the other patients.¹⁰³ The "[p]laintiffs opposed [the defendant's] motions in limine, seeking to introduce such evidence under Rule 404(b) or, alternatively,

91. See *Rayburn v. Day*, 268 P. 1002, 1005–06 (Or. 1928).

92. *Id.* at 1005 (citing *Davis v. Oregon & Cal. R.R. Co.*, 8 Or. 172, 174 (1879); 4 CHARLES FREDERICK CHAMBERLAYNE, A TREATISE ON THE MODERN LAW OF EVIDENCE § 3209, at 4447 (1913)) (affirming the trial court's decision to sustain the defendant's objection to a question asked by the plaintiff finding that the question was intended to elicit evidence of the defendant physician's statement that "[t]his is the second time this happened to me in twenty-four years' practice").

93. *Kunnanz v. Edge*, 515 N.W.2d 167, 171 (N.D. 1994).

94. 775 F. Supp. 2d 1163 (D.S.D. 2011).

95. *Id.* at 1166.

96. *Id.* at 1165.

97. *Id.* at 1165–66.

98. *Id.* at 1166–67.

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*

103. *Id.*

for impeachment purposes under Rule 608, or as habit evidence under Rule 406.”¹⁰⁴ The trial court reserved ruling on these matters, but at trial “did not permit Plaintiffs to ask these witnesses any questions concerning [the defendant’s] treatment of [the other four patients].”¹⁰⁵

The plaintiffs argued that the “evidence of [the defendant’s] inability to correctly perform other pedicle screw back surgeries . . . is relevant to establish his lack of knowledge and competence to safely perform such surgeries and, therefore, satisfies the Eighth Circuit requirements for admission under Rule 404(b).”¹⁰⁶ Upon deciding the motion, the trial court cited the Eighth Circuit’s Rule 404(b) admissibility test: “The evidence must be 1) relevant to a material issue; 2) similar in kind and not overly remote in time to the charged crime; 3) supported by sufficient evidence; and 4) such that its potential prejudice does not substantially outweigh its probative value.”¹⁰⁷

The trial court alluded to application of this test but then focused its analysis on Rule 404(b)(2) and its reference to “knowledge.”¹⁰⁸ Although other acts evidence may be relevant to prove knowledge, plaintiffs’ claim involved the defendant’s alleged lack of knowledge,¹⁰⁹ a topic not included in Rule 404(b)(2).¹¹⁰ The court noted that the defendant-surgeon had the requisite knowledge, but “the real question was whether [he] applied his knowledge competently in placing pedicle screws in [the plaintiff’s] back and determining whether the screws were properly placed.”¹¹¹

The trial court concluded that plaintiff’s effort to introduce other acts evidence offered mere propensity evidence which is prohibited by Rule 404(b)(1).¹¹² It characterized plaintiffs’ strategy as follows:

Plaintiffs’ desire to introduce such other acts evidence ran more to showing lack of competence or care—that is, malpractice—with respect to other patients. From such evidence, the jury could then infer that [the defendant] had a propensity to commit malpractice by misplacing pedicle screws and thus may or perhaps must have committed similar malpractice in the surgery to [the plaintiff]. However, Rule 404(b) bars the use of evidence of other alleged wrongs to show, circumstantially, action in conformity therewith. Thus, the legitimate probative value of

104. *Id.*

105. *Id.* at 1166–67.

106. *Id.* at 1170.

107. *Id.* (quoting *Am. Family Mut. Ins. Co. v. Miell*, 569 F. Supp. 2d 841, 848 (N.D. Iowa 2008)).

108. *Id.* at 1170–71.

109. *Id.* at 1171.

110. *See* FED. R. EVID. 404(b)(2) (providing that evidence of other acts may be admissible to prove knowledge).

111. *Bair*, 775 F. Supp. 2d at 1171.

112. *Id.*

the preferred other acts evidence to show “knowledge” or lack of “knowledge” was limited.¹¹³

The motion for a new trial was denied.¹¹⁴ This logic would apply to proposed evidence of defendant’s treatment of patients subsequent to the treatment provided to the patient at issue.¹¹⁵ However, a showing of subsequent similar injuries caused by the defendant physician could yield a different result.¹¹⁶

A trial court may correctly exclude evidence offered by a plaintiff consisting of testimony of a defendant physician’s former patients in an effort to prove that the physician lacked the knowledge or skill to perform the procedure involved.¹¹⁷ Again, the trial court must weigh the potential relevance of similar acts evidence with the danger of evidentiary prejudice.¹¹⁸ A similar analysis applies to plaintiff’s proposed evidence of a prior lawsuit against the defendant physician.¹¹⁹

VI. EVIDENCE OF PHYSICIAN TREATMENT OF OTHER PATIENTS—ADMISSIBLE

Courts have recognized the propriety of evidence of treatment provided to other patients in particularly egregious or compelling cases.¹²⁰ Even if adopting an “inclusionary approach”¹²¹ to admissibility of other acts evidence, the following cases should be viewed as examples of evidence not merely offered to prove a propensity to commit negligence.¹²²

113. *Id.* at 1171.

114. *Id.*

115. *See* Lund v. McEnerney, 495 N.W.2d 730, 731 (Iowa 1993).

116. *See id.* at 734 (suggesting that if the plaintiff could relate the other injuries to her own, those injuries may be admissible).

117. *See* Buford v. Howe, 10 F.3d 1184, 1188–89 (5th Cir. 1994); Cerniglia v. French, 816 So. 2d 319, 323–24 (La. Ct. App. 2002).

118. *See* Cerniglia, 816 So. 2d at 324 (applying LA. CODE OF EVID. ART. 403).

119. Gray v. Allen, 677 S.E.2d 862, 867 (N.C. Ct. App. 2009) (citing Willoughby v. Wilkins, 310 S.E.2d 90, 97–98 (N.C. Ct. App. 1983)).

120. *See, e.g.,* Carlton v. Shelton, 722 F.2d 203, 206–07 (5th Cir. 1984) (allowing evidence detailing prior incidents of “fasting” treatment where other patients similarly died from malnutrition); Cotgreave v. Pub. Admin. of Imperial Cnty., 443 N.Y.S.2d 971, 972–73 (N.Y. Sup. Ct. 1981) (holding that evidence of prior operations was admissible for “the purpose of proving a common plan or scheme to perform unnecessary and contraindicated surgery on plaintiff”), *dismissed in part, aff’d in part*, 456 N.Y.S.2d 432 (N.Y. App. Div. 1982); Siuda v. Howard, No. C-000656, 2002 WL 946188, at *6–7 (Ohio Ct. App. May 10, 2002) (noting that the trial court did not err in allowing into evidence plaintiff’s expert testimony because under the Ohio Rule of Evidence 404(b), his comment was related to showing the defendant’s motive to perform unnecessary surgeries); Farr v. Wright, 833 S.W.2d 597, 603 (Tex. Ct. App. 1992) (explaining that evidence of prior cases of discitis in doctor’s patients was admissible due to the high rate of incidents in a two month span and the extreme rarity of the condition without the breach of sterile techniques).

121. *See* Schneider v. Revici, 817 F.2d 987, 992 (2d Cir. 1987) (allowing admission of evidence as long as it is not admitted to show propensity).

122. *See id.* (quoting United States v. Levy, 731 F.2d 997, 1002 (2d Cir. 1984)).

Certainly, a case that qualifies as unique and bizarre is *Carlton v. Shelton*.¹²³ In *Carlton*, the Fifth Circuit Court of Appeals considered negligence and gross negligence claims against two chiropractic physicians.¹²⁴ These chiropractors operated a “health school” which “encourage[d] the practice of extended fasting for the treatment of numerous illnesses.”¹²⁵ The patient suffered from “ulcerative colitis.”¹²⁶ Twenty-nine days following admission to the health school, the patient “died of severe dehydration, malnutrition, and aspiration pneumonia,” weighing sixty-two pounds less than he had weighed on admission.¹²⁷

The plaintiff was the patient’s widow and she claimed both negligence and gross negligence in the treatment of her husband.¹²⁸ Following a jury trial, a verdict was returned in favor of the plaintiff.¹²⁹ The trial court admitted “evidence of prior, similar deaths” at the defendants’ facility.¹³⁰

The Fifth Circuit Court of Appeals noted that the defendants “literally allowed [the patient] to starve to death,” and highlighted “[t]he deteriorated state of [the patient’s] condition” by the time he was transferred to a hospital for “competent medical assistance.”¹³¹

The Fifth Circuit Court of Appeals held that the district court properly admitted evidence of the deaths of three other patients.¹³² They also died of “extended fasting” at the hands of the defendant chiropractor, having suffered extreme weight loss, dehydration, and starvation¹³³—although the court of appeals opinion does not state that these patients were admitted to the facility for treatment of colitis.

The court held that the evidence of unsuccessful treatment of the other patients by the defendant was relevant to the “defendant’s notice, magnitude of the danger involved, [or] the defendant’s ability to correct a known [condition].”¹³⁴ Finally, the court of appeals noted that:

123. 722 F.2d 203 (5th Cir. 1984).

124. *Id.* at 204.

125. *Id.* at 203. For additional tales of chiropractic woe, see generally GEORGE J. WAGNER, III, *CHIROPRACTIC: THE VICTIM’S PERSPECTIVE* (Stephen Barrett ed. 1995), and PAUL BENEDETTI & WAYNE MACPHAIL, *SPIN DOCTORS: THE CHIROPRACTIC INDUSTRY UNDER EXAMINATION* (2002) (discussing questionable practices of the industry).

126. *Carlton*, 722 F.2d at 204. Ulcerative colitis is an idiopathic inflammatory bowel disease. Stephen R. Gulliford & Jimmy K. Limdi, *Acute Severe Ulcerative Colitis: Timing Is Everything*, 87 *POSTGRADUATE MED. J.* 215, 215 (2011).

127. *Carlton*, 722 F.2d at 204 (stating that the patient entered treatment weighing around 192 pounds and died weighing only 130 pounds).

128. *Id.*

129. *Id.*

130. *Id.*

131. *Id.* at 205.

132. *Id.* at 206–07.

133. *Id.* at 206.

134. *Id.* (quoting *Ramos v. Liberty Mut. Ins. Co.*, 615 F.2d 334, 338–39 (5th Cir. 1980)) (internal quotation marks omitted).

The evidence presented . . . demonstrated that the three prior deaths occurred under shockingly similar circumstances and from virtually identical causes. This evidence undoubtedly was probative on the issue of [the defendant's] gross negligence. The evidence proved that she was aware of the grave circumstances in which she had placed [the patient], had knowledge of the probability of death, and repeatedly ignored these patients' need for competent medical assistance. More relevant evidence of her wanton and reckless disregard for the welfare of her patients cannot be fathomed. While the evidence certainly was prejudicial to [the defendant], its admission did not constitute "unfair prejudice."¹³⁵

The Fifth Circuit recognized that the defendant chiropractor was not practicing chiropractic medicine¹³⁶ while engaging in "the practice of extended fasting."¹³⁷ The unorthodox nature of the treatment might have influenced the trial court to admit the evidence of the failed treatment of other patients. Although the court of appeals did not undertake a Rule 404(b) analysis, the *Carlton* facts would qualify as Rule 404(b)(2) non-propensity evidence.¹³⁸

In *Farr v. Wright*,¹³⁹ the Court of Appeals of Texas reviewed a jury verdict in favor of a defendant physician against whom negligence was claimed in his performance and treatment of complications arising from a discogram, "a diagnostic procedure involving entry of a needle into the inner-space between the vertebrae in the back" used to inject dye and then take x-rays.¹⁴⁰ Following this procedure, the patient got an infection, suffering discitis, "an inflammation of the disc spaces most commonly caused by infection, although it is also associated with an allergic reaction to the dye, a broken needle, or other causes."¹⁴¹

The pre-trial discovery process revealed information about the defendant physician's practice history, which, if admissible, would be highly prejudicial evidence.¹⁴² During the short time the defendant treated the plaintiff, the defendant "experienced three or four cases of discitis."¹⁴³ The defendant "had performed between thirty and fifty discograms" during his brief "career of three

135. *Id.* at 206–07.

136. *Id.* at 205.

137. *Id.* at 203.

138. See FED. R. EVID. 404(b)(2).

139. 833 S.W.2d 597 (Tex. Ct. App. 1992).

140. *Id.* at 598. See John S. Collis, Jr. & W. James Gardner, *Lumbar Discography: An Analysis of One Thousand Cases*, 19 J. NEUROSURGERY 452, 452–53 (1962) (describing the steps involved in discography).

141. *Farr*, 833 S.W.2d at 598 n.1. See generally O.L. Osti et al., *Discitis After Discography*, 72-B J. BONE AND JOINT SURGERY 271 (1990) (discussing the role of prophylactic antibiotics when administered at the time of discography).

142. *Farr*, 833 S.W.2d at 598–99 (citing TEX. R. CIV. EVID. 403).

143. *Id.* at 598.

to four years.”¹⁴⁴ The defendant’s patients suffered post-discography discitis at a rate much higher than reported studies.¹⁴⁵ The plaintiff’s expert physician sought to use this information to support his opinions that the defendant “consistently breached sterile technique during this period, and . . . breached sterile technique when he treated [the plaintiff],” and that the defendant “negligently failed to diagnose [the plaintiff’s] condition.”¹⁴⁶ The defendant sought, and was granted, a motion in limine to prohibit the plaintiff “from admitting evidence of this series of other cases of discitis.”¹⁴⁷ The trial court further did not allow plaintiff’s expert physician to base his opinions on the discitis suffered by other patients of the defendant.¹⁴⁸

The Court of Appeals of Texas referred to Texas law that recognizes the admissibility of other accidents or events “to prove that a similar incident occurred, provided that the circumstances between the incidents are reasonably similar.”¹⁴⁹ Here, the other incidents of discitis occurred within a short period of time following the same procedure performed by the defendant, and, due to the rarity of the condition, supported the claim that the defendant did not utilize a sterile technique.¹⁵⁰ The court concluded that the evidence of discitis suffered by the defendant’s other patients was “relevant to prove knowledge of prior cases of discitis, and therefore an increased probability that the dangerous condition reoccurred in [the plaintiff].”¹⁵¹ The court stated that it was also relevant to prove that defendant’s procedural technique was negligent, that he negligently failed to discover the error in technique, and that he negligently failed to diagnose the complication.¹⁵² The trial court’s judgment on the verdict was reversed and a new trial was ordered.¹⁵³

Although *Farr* provides an example of the use of prior unfortunate patient outcomes as non-propensity evidence contemplated by Rule 404(b)(2), it is problematic. Physicians routinely perform procedures on a variety of patients with a variety of illnesses, and these procedures carry risks of complications. Specialists may perform many procedures and must expect some less than satisfactory outcomes. It is difficult to know how many complications must

144. *Id.* at 598–99.

145. *Id.* at 599.

146. *Id.*

147. *Id.*

148. *Id.*

149. *Id.* at 601 (citing *Mo.-Kan.-Tex. R.R. Co. v. May*, 600 S.W.2d 755, 756 (Tex. 1980) (per curiam); *John Deere Co. v. May*, 773 S.W.2d 369, 372 (Tex. Ct. App. 1989)).

150. *Id.* at 598–99.

151. *Id.* at 602 (footnote omitted) (“The number of discitis cases was high compared to the expected number of complications. Thus, five cases was a very large number of incidents during a two-month period.”).

152. *Id.* at 602–03.

153. *Id.* at 603.

occur over a specified period of time to evidence a Rule 404(b)(2) pattern or knowledge.¹⁵⁴ Therefore, the *Farr* analysis should be used with caution.

In *Siuda v. Howard*,¹⁵⁵ a state counterpart of Rule 404(b)(2) was utilized by the Court of Appeals of Ohio to approve the introduction into evidence of a physician's "motive to perform medically unnecessary surgeries; his knowledge as an ophthalmologist; and an absence of mistake or accident."¹⁵⁶ In *Siuda*, consolidated cases were brought against an ophthalmologist, asserting "similar claims for medical negligence, negligence, lack of informed consent, fraud, conspiracy to defraud . . . battery, and punitive damages resulting from [the defendant's] care in performing or recommending surgery for glaucoma and/or cataracts."¹⁵⁷

At trial, the court admitted into evidence the following testimony of another treating physician who had attended to patients treated by defendant:

I just want to make a couple of comments on the cataracts. Just a few patients, I won't comment on.

I've shown you the anatomy of the diagnostic approach. Forget the indications for surgery. Forget the indications when you see [the defendant's] cases in a moment. Look at the size of that. There are no significant cataracts. And he's operating needlessly.

. . . I have seen four of [the defendant's] patients with permanent serious complications. One resulted in blindness.¹⁵⁸

As to the testimony regarding the complications suffered by defendant's other patients, the court found this admissible as non-propensity other acts evidence.¹⁵⁹ The evidence tended to prove the defendant's "motive to perform medically unnecessary surgeries," as well as his "knowledge" and "absence of mistake."¹⁶⁰ In essence, this evidence tends to reveal the inability of a physician to correctly perform a procedure, and a practice of performing unnecessary surgery.¹⁶¹

Another approach to the admission of prior acts evidence against a defendant physician concerns diagnostic abilities and continuous negligent conduct. In

154. See, e.g., *John Deere Co. v. May*, 773 S.W.2d 369, 374 (Tex. Ct. App. 1989) (finding that thirty-four prior incidents could be admitted to show a 404(b)(2) pattern); *Farr*, 833 S.W.2d at 602 (finding that five prior incidents could be admitted to show a 404(b)(2) pattern).

155. No. C-000656, 2002 WL 946188 (Ohio Ct. App. May 10, 2002).

156. *Id.* at *6-7 (citing OHIO R. EVID. 404(B)).

157. *Id.* at *1.

158. *Id.* at *6.

159. *Id.* at *6-7 (citing OHIO R. EVID. 404(B)).

160. *Id.* at *7; see also *Cotgeave v. Pub. Admin. of Imperial Cnty.*, 443 N.Y.S.2d 971 (N.Y. Sup. Ct. 1981) (admitting evidence of physician's prior operations to prove a "common plan or scheme to perform unnecessary and contraindicated surgery"), *dismissed in part, aff'd in part*, 456 N.Y.S.2d 432 (N.Y. App. Div. 1982).

161. *Siuda*, 2002 WL 946188, at *7, *11.

Adams v. Dunn,¹⁶² the Supreme Court of Oregon considered a medical malpractice claim against physicians who attended to a child who “died . . . of peritonitis resulting from an undiagnosed case of appendicitis.”¹⁶³ A verdict was returned for the defendants.¹⁶⁴ Here, the trial court refused plaintiffs’ request for a new trial based upon newly discovered evidence consisting of an affidavit authored by the parent of another child “who had read about the Adams trial in the newspaper and then had called plaintiffs’ attorney.”¹⁶⁵ The affidavit recounted the events surrounding the treatment of the affiant’s daughter by one of the defendants, suggesting that the defendant had failed to diagnose appendicitis in a fashion strikingly similar to the case at bar.¹⁶⁶

On appeal, the Supreme Court of Oregon viewed this “evidence as material to the issue of negligent misdiagnosis.”¹⁶⁷ It approved the admission of prior acts evidence “to prove the existence of a continuing course of negligent conduct, that the course of conduct is in fact dangerous, or that the defendant had notice of its dangerous character, provided that the prior acts occurred under similar circumstances.”¹⁶⁸ The court believed that the affidavit provided this evidence.¹⁶⁹

The logic of this opinion is troublesome. The Supreme Court of Oregon noted that the affidavit contradicted defendants’ contention “that their diagnosis and treatment of [the patient at issue] was proper practice”¹⁷⁰ and suggested “that defendants engaged in a continual course of negligent conduct with regard to misdiagnosing appendicitis in children and, most importantly, that defendants had notice of the dangerous character of the very symptoms which they misdiagnosed.”¹⁷¹ This, of course, creates a slippery slope for admission of prior acts evidence. Here, the affidavit referred to one other child treated by defendants in a similar fashion to the Adams child.¹⁷² Is that a sufficient track record to implicate Rule 404(b)(2) non-propensity evidence? It seems as if this logic would lead to the admission of evidence targeted by a rule excluding propensity evidence. If a physician experienced a similar unfortunate result with another patient, the physician might be susceptible to the admission of prior acts evidence, a rather harsh price to pay.

162. 581 P.2d 939 (Or. 1978), *withdrawn*, 587 P.2d 466.

163. *Id.* at 941. See generally Marshall Z. Schwartz et al., *Management of Perforated Appendicitis in Children: The Controversy Continues*, 197 ANNALS OF SURGERY 407 (Apr. 1983) (discussing a study of the protocol for managing a perforated appendix).

164. *Adams*, 581 P.2d at 941.

165. *Id.*

166. *Id.*

167. *Id.* at 944.

168. *Id.* (citing *Rader v. Gibbons and Reed Co.*, 494 P.2d 412, 414–15 (Or. 1972)).

169. *Id.* at 944–45.

170. *Id.* at 944.

171. *Id.* at 944–45.

172. *Id.* at 943.

Finally, there is authority to support the admission into evidence of physician treatment of other patients in order to prove fraud.¹⁷³ In *Buford v. Howe*, the Fifth Circuit Court of Appeals considered the judgment entered as a matter of law for the defendant physician at the close of the plaintiff's case in chief.¹⁷⁴ The trial court had earlier entered an order in limine prohibiting "any testimony or medical records concerning the treatment of patients other than the plaintiff."¹⁷⁵ Plaintiff "argue[d] that evidence of the other surgeries is essential to prove that [the defendant] fraudulently induced women to submit to unnecessary surgeries for financial gain."¹⁷⁶

The court of appeals approved the exclusion of the evidence because the plaintiff did not properly allege a fraud claim pursuant to Federal Rule of Civil Procedure 9(b).¹⁷⁷ However, the court noted that if the plaintiff amended her complaint to conform to the proposed proof, the plaintiff could produce evidence of the defendant's treatment of other patients in support of a fraudulent misrepresentation claim.¹⁷⁸

VII. OTHER CATEGORIES OF PHYSICIAN CONDUCT EVIDENCE

A. *Alteration of Medical Records*

The alteration of medical records is an unfortunate, known phenomenon in the medical profession.¹⁷⁹ It likely occurs as a defense mechanism after a medical negligence claim is filed.¹⁸⁰ Records alteration likely relates to physician honesty, a credibility issue, but it also may "raise[] questions about the quality of care that a physician rendered."¹⁸¹ Therefore, evidence of altered records may influence a jury to believe that the offending physician would not alter records unless medical negligence was committed.¹⁸² Evidence of records alteration is powerful and potentially devastating.

In *Schwochow v. Chung*,¹⁸³ the jury had returned a defense verdict in favor of a pediatrician who allegedly failed to diagnose an infection, which caused injury to, and the death of, a child.¹⁸⁴ The trial court had entered an order in

173. *Buford v. Howe*, 10 F.3d 1184, 1188 n.5 (5th Cir. 1994).

174. *Id.* at 1187. See also FED. R. CIV. P. 50(a) (setting forth the conditions required in order for a court to grant a motion for a judgment as a matter of law).

175. *Buford*, 10 F.3d at 1187.

176. *Id.* at 1188.

177. *Id.*

178. *Id.* at 1188 n.5.

179. See John Zen Jackson & Ann Marie Vaurio, *The Entanglements of Altered Medical Records*, FOR THE DEF., July 2010 at 57, 57; Leonard Berlin, *Alteration of Medical Records*, 168 AM. J. ROENTGENOLOGY 1405, 1405 (1997).

180. Berlin, *supra* note 179, at 1406.

181. Jackson & Vaurio, *supra* note 179, at 58.

182. *Id.* at 60.

183. 657 N.E.2d 312 (Ohio Ct. App. 1995).

184. *Id.* at 312-13.

limine “prohibiting plaintiffs from introducing . . . any evidence [t]hat the words ‘no fever’ were added to [the defendant’s] medical chart for [the child] on a date other than November 16, 1990.”¹⁸⁵ The trial court reasoned that the altered chart was offered as impermissible character evidence and was not an appropriate subject for attack on the defendant.¹⁸⁶ The Ohio Court of Appeals disagreed, holding that evidence of record alteration by the defendant physician was “relevant to the ultimate issue of the adequacy of the care that [the defendant] provided” and, therefore, was appropriate ammunition for attack of the defendant.¹⁸⁷ In such a situation, all available versions of the physician’s medical record would be admissible in evidence.¹⁸⁸

It should be noted, however, that a physician’s history of altered records, many years prior to the claim that is the subject of a medical negligence action, which does not involve altered records, should be inadmissible.¹⁸⁹ That evidence would constitute character evidence, which “tempts the jury to base its decision on emotion and to reward good people or punish bad people, rather than to render a verdict based upon the facts before them.”¹⁹⁰

B. Poor Performance in Medical Education and Training

If a physician fails to complete a residency program or other training, the fact of this occurrence is likely admissible evidence because it relates to “the possession of knowledge and skill portion of the standard of care.”¹⁹¹ However, more specific details of a physician’s education and training, such as reasons for incomplete education, would constitute inadmissible character evidence.¹⁹²

C. Defendant Physician’s Failure to Achieve Board Certification

Board certification is a highly sought status among physicians.¹⁹³ A large percentage “of licensed physicians [hold] a valid certificate.”¹⁹⁴ The

185. *Id.* at 315.

186. *Id.*

187. *Id.* at 316.

188. See *Ruperd v. Ryan*, 683 N.E.2d 166, 170 (Ill. App. Ct. 1997). See generally *Hinson v. Clairemont Cmty. Hosp.*, 267 Cal. Rptr. 503, 510–11 (Cal. Ct. App. 1990) (holding that evidence sought to be introduced was “marginal” and not relevant to the adequacy of the defendant physician’s care), *disapproved of on other grounds by Alexander v. Superior Court*, 859 P.2d 96 (Cal. 1993).

189. *Cf. Hinson*, 267 Cal. Rptr. at 510 (stating that prior negligence in medical treatment is inadmissible to show general skill of a physician).

190. *Davis v. Rudisill*, 706 S.E.2d 784, 789 (N.C. Ct. App. 2011).

191. *Hinson*, 267 Cal. Rptr. at 508.

192. *Id.*

193. Troyen A. Brennan et al., *The Role of Physician Specialty Board Certification Status in the Quality Movement*, 292 JAMA 1038, 1042 (2004) (stating that patients “highly favor what the credential of certification represents”).

194. *Id.* at 1039.

requirements for board certification of the member boards of the American Board of Medical Specialties include “between 3 and 6 years of training in an accredited training program and a passing score on a rigorous cognitive examination,” and some of the member boards have additional requirements.¹⁹⁵ Board certification is suggestive of the ability to provide quality care.¹⁹⁶ It is noteworthy, however, that hospitals do not consistently require board certification as a condition precedent to the receipt of staff privileges.¹⁹⁷

What, then, is the probative value of a defendant physician’s failure to achieve board certification? Is it relevant to the defendant’s knowledge base, understanding of the standard of care, or ability to practice medicine? Is it a professional historical fact, a character flaw so to speak, which would distract the jury and influence it to believe that a non-board certified physician was likely negligent in a specific situation?

In Illinois, for example, the law is quite clear that if a defendant physician does not offer standard of care testimony in his or her own defense, that physician’s failure to achieve board certification is inadmissible.¹⁹⁸ If, however, the defendant physician testifies as to the standard of care, that is tantamount to expert testimony and “evidence as to [the physician’s] age, practice, and like matters relating to his qualifications as an expert is admissible,” including “the failure to pass board certification examinations.”¹⁹⁹ The Supreme Court of Alaska has taken a different approach, noting that the failure to achieve board certification could constitute ammunition for impeachment, but that the probative value was outweighed by “its potential for causing prejudice and confusion.”²⁰⁰

Prohibiting the use of non-board certification against a defendant physician who does not give standard of care testimony is a sensible approach.²⁰¹ Board certification is not licensure.²⁰² A physician need not have obtained board certification to practice medicine.²⁰³ Therefore, it is appropriate to exclude evidence of non-board certification when the defendant physician will not provide standard of care or expert testimony.

195. *Id.* at 1040.

196. *See id.* at 1042 (stating that reasonable empirical evidence suggests that certification will improve quality of care).

197. Gary L. Freed et al., *Use of Board Certification and Recertification in Hospital Privileging*, 144 ARCH. OF SURGERY 746, 750 (2009).

198. *Sbarboro v. Vollala*, 911 N.E.2d 553, 567 (Ill. App. Ct. 2009) (citing *Rockwood v. Singh*, 630 N.E.2d 873, 875 (Ill. App. Ct. 1993)).

199. *Id.* at 567.

200. *Marsingill v. O’Malley*, 58 P.3d 495, 502 (Alaska 2002).

201. *See, e.g., Jones v. Rallos*, 869 N.E.2d 124, 131 (Ill. App. Ct. 2006) (“[W]here the defendant’s testimony is not used to show the standards of medical care, but is used to relate to the jury what occurred before, during, and after treatment, reference to defendant’s board-certification status is properly barred.” (citing *Rockwood*, 630 N.E.2d at 876)) *appeal denied, judgment vacated*, 873 N.E.2d 943 (Ill. 2007).

202. FURROW ET AL., *supra* note 7, at 59 (explaining the separate processes).

203. *Id.* (providing that licensing statutes govern entry into the licensed professions).

D. Defendant Physician's Medical License Suspension or Other Discipline

Medical licensure is “governed by state law through the states’ authority under the police power to protect the health, safety, and general welfare of the community,” and is a component of “quality-control.”²⁰⁴ If a physician’s license to practice medicine has been suspended, that disciplinary measure may implicate the physician’s knowledge of the standard of care and ability to deliver appropriate medical care.²⁰⁵ Therefore, the admissibility analysis of a medical license suspension may be similar to the analysis discussed in Part VII.C of this Article regarding failure to achieve board certification.

An excellent illustration of this point is the Supreme Court of South Dakota’s opinion in *Mosseau v. Schwartz*.²⁰⁶ In *Mosseau*, the plaintiff sued the defendant neurosurgeon for medical negligence arising from the defendant’s treatment of plaintiff’s spinal stenosis.²⁰⁷ The defendant had experienced prior malpractice claims and was the subject of disciplinary proceedings instituted by the South Dakota Board of Medical and Osteopathic Examiners (Board)²⁰⁸ regarding the malpractice claims.²⁰⁹ Ultimately, the defendant entered into a stipulation with the Board resulting in the “probationary status” of his license to practice medicine.²¹⁰ The conditions of the defendant’s license probation were as follows:

[R]equired to complete one year of “advanced clinical training” in neurosurgery and a minimum of three months in neuroradiology. His practice . . . was restricted to only that required to fulfill his training requirement. Further . . . for a period of five years, following the successful completion of his training, [he] was prohibited from solo practice. . . .²¹¹

204. *Id.*

205. See *Neely v. Wilson*, 331 S.W.3d 900, 907 (Tex. Ct. App. 2011) (noting that the medical board suspended the physician’s license because of the physician’s “inability to practice medicine with reasonable care and safety to patients”).

206. 756 N.W.2d 345, 360–62 (S.D. 2008).

207. *Id.* at 347–49. See generally James N. Weinstein et al., *Surgical Versus Nonsurgical Therapy for Lumbar Spinal Stenosis*, 358 NEW ENG. J. MED. 794, 795 (2008) (“Spinal stenosis is a narrowing of the spinal canal with encroachment on the neural structures by surrounding bone and soft tissue. Patients typically present with radicular leg pain or with neurogenic claudication (pain in the buttocks or legs on walking or standing that resolves with sitting down or lumbar flexion).”).

208. “The mission of the [Board] is to protect the health and welfare of the state’s citizens by assuring that only qualified doctors of medicine . . . are licensed to practice in South Dakota.” SOUTH DAKOTA BD. OF MED. & OSTEOPATHIC EXAM’RS, <http://www.sdbmoe.gov> (last visited Dec. 16, 2011).

209. *Mosseau*, 756 N.W.2d at 349.

210. *Id.* at 350.

211. *Id.*

The discipline imposed upon defendant's license to practice medicine carried with it reporting requirements.²¹² The "reason given for [defendant's] license probation was 'Malpractice.'"²¹³ This stipulation was excluded from evidence by the trial court pursuant to defendant's motion in limine.²¹⁴ Following trial, the jury returned a verdict in favor of the defendant neurosurgeon.²¹⁵

The Supreme Court of South Dakota determined that the trial court erred by excluding the stipulation from evidence.²¹⁶ This stipulation did not constitute prohibited evidence of a prior act to prove negligence in conformity therewith.²¹⁷ Instead, the "[s]tipulation as evidence of [the defendant's] deficiency in knowledge and skill . . . was relevant to [the defendant's] ability to meet the applicable standard of care that required him to have and to use the skill and care of that ordinarily possessed and used by neurosurgeons under similar circumstances."²¹⁸

A defendant physician who is practicing medicine subject to a license condition at the time of plaintiff's treatment may be required to endure the admission in evidence of that condition.²¹⁹ An Ohio court found a prior thirty day medical license suspension and a subsequent probationary period related to billing practices inadmissible as irrelevant and as inappropriate character evidence, suggesting the propensity for dishonesty.²²⁰ It may be argued that the probative value of a license suspension is simply "greatly outweighed by the danger of prejudice and confusion of the issues."²²¹ Even if a prior temporary license suspension in a given case relates to a physician's character for truthfulness or credibility, its probative value may not survive the Rule 403 balancing test.²²²

Should a defendant physician give standard of care testimony at trial, this testimony likely transforms the physician from a fact witness to an expert witness. The defendant physician's prior license suspension would be admissible to challenge his or her qualifications as an expert witness.²²³

212. *Id.*

213. *Id.*

214. *Id.* at 349.

215. *Id.* at 350.

216. *Id.* at 363.

217. *Id.* at 355; see S.D.C.L. § 19-12-5 (representing the South Dakota equivalent of FED. R. EVID. 404(b)).

218. *Mosseu*, 756 N.W.2d at 355.

219. *Lambert v. Wilkinson*, No. 2007-A-0032, 2008 WL 2404736, at *5-6 (Ohio Ct. App. June 13, 2008) (discussing whether licensure evidence is admissible).

220. *Id.* at *6-7.

221. *Dudley v. Humana Hosp. Corp.*, 817 S.W.2d 124, 127 (Tex. Ct. App. 1991).

222. *King v. Ahrens*, 16 F.3d 265, 269 (8th Cir. 1994) (holding evidence of license suspension inadmissible despite the Eighth Circuit's inclusionary approach to Rule 404(b)).

223. *Hill v. St. Onge*, No. 2:06-CV-329, 2009 WL 2833145, at *1-2 (S.D. Ohio Sept. 1, 2009); *Greene v. Beebe Med. Ctr.*, 663 A.2d 487, 487 (Del. 1995) (unpublished disposition).

The Supreme Court of Missouri has considered a Rule 608-like problem concerning the cross-examination of a defendant physician regarding his prior medical license suspensions. In *Mitchell v. Kardesch*,²²⁴ the defendant physician falsely answered an interrogatory directed to a prior license suspension, asking the defendant to “[s]tate whether any professional license held by [him] ha[d] ever been suspended or revoked.”²²⁵ The defendant simply “answered ‘No.’”²²⁶ The defendant had suffered medical license suspensions in Missouri and New York.²²⁷ He ultimately admitted this fact at his deposition.²²⁸ At trial, the trial court prohibited the plaintiff from cross-examining the defendant about the Missouri license suspension, “and from introducing either the false [interrogatory] answer or [his] deposition testimony in which he admitted his answer was inaccurate and sought to justify it.”²²⁹ The trial “court permitted counsel to ask [the defendant] only a single question: whether his interrogatory answers generally were truthful.”²³⁰ The defendant answered “yes” to that question in court.²³¹ Plaintiff’s “[c]ounsel was prohibited from showing that the doctor’s . . . answer was not accurate.”²³²

The Missouri Supreme Court held that the trial court erred by limiting this effort at cross-examination.²³³ The defendant physician was subject to cross-examination regarding “specific instances of his . . . conduct that speak to his . . . own character for truth or veracity, even where the issue inquired about is not material to the substantive issues in the case.”²³⁴ Here, the defendant’s answer to the interrogatory was false, as was his in-court testimony regarding the

224. *Mitchell v. Kardesch*, 313 S.W.3d 667 (Mo. 2010) (en banc). Compare *id.* at 670 (formalizing the Missouri common-law rule that “extrinsic evidence” regarding defendant’s prior conduct is admissible “where the relevance and probativeness of such evidence on the issue of the party’s character for truth and veracity is so great that it would deprive the jury of evidence highly relevant to its resolution of material issues” if inadmissible), with FED. R. EVID. 608(b):

(b) **Specific Instances of Conduct.** Except for a criminal conviction under Rule 609, extrinsic evidence is not admissible to prove specific instances of a witness’s conduct in order to attack or support the witness’s character for truthfulness. But the court may, on cross-examination, allow them to be inquired into if they are probative of the character for truthfulness or untruthfulness of:

(1) the witness; or

(2) another witness whose character the witness being cross-examined has testified about.

225. *Mitchell*, 313 S.W.3d at 674 (internal quotation marks omitted).

226. *Id.*

227. *Id.*

228. *Id.*

229. *Id.*

230. *Id.*

231. *Id.*

232. *Id.*

233. *Id.* at 679.

234. *Id.* at 677.

truthfulness of his interrogatory answer.²³⁵ The evidence of these false statements directly related to the defendant's character for truthfulness.²³⁶ These specific instances of the defendant's conduct were appropriate ammunition for cross-examination.²³⁷ This seems the appropriate approach under Rule 608(b) as well.

E. Defendant Physician's Hospital Privileges Suspension

Arguably, a prior hospital privileges suspension would involve the same evidentiary issues as a prior medical license suspension. A physician's ability to obtain and keep hospital privileges is also a function of quality control.²³⁸ Should the defendant physician provide standard of care testimony, the evidence of a suspension of staff privileges is likely admissible.²³⁹

It is important to note, however, that physicians may suffer privileges suspensions for reasons not directly related to patient care. Suspensions may be imposed for failure to complete medical charts,²⁴⁰ or "inability to work in harmony with other hospital personnel."²⁴¹ Under these circumstances, evidence of suspensions is arguably inadmissible.²⁴²

VIII. PHYSICIAN HABIT

A defendant physician is at risk in medical negligence litigation of having habit evidence admitted against him, which appears strikingly similar to inadmissible character and propensity evidence.²⁴³ The distinction has been explained by Professor McCormick as follows:

Character is a generalized description of a person's disposition, or of the disposition in respect to a general trait, such as honesty, temperance or peacefulness. Habit . . . is more specific. It denotes one's regular response to a repeated situation. . . . A habit . . . is the

235. *Id.* at 674.

236. *Id.* at 679.

237. *See id.*

238. FURROW ET AL., *supra* note 7, at 59–60.

239. *See* *Armstrong v. Hrabal*, 87 P.3d 1226, 1232–33, 1239–42 (Wyo. 2004) (noting that the physician held privileges at three hospitals when discussing his credentials as an expert witness).

240. *See* *Gabaldoni v. Wash. Cnty. Hosp. Ass'n*, 250 F.3d 255, 258 (4th Cir. 2001) (involving a physician lawsuit following the termination of clinical privileges and the denial of an application for reappointment, and the court refers to "multiple suspensions for failure to complete medical charts").

241. William M. Copeland & Phyllis E. Brown, *Hospital Medical Staff Privilege Issues: "Brother's Keeper" Revisited*, 17 N. KY. L. REV. 513, 516 (1990).

242. *See* *Lambert v. Wilkinson*, No. 2007-A-0032, 2008 WL 2404736, at *6–7 (Ohio Ct. App. June 13, 2008) (holding that a physician's license suspension due to billing procedures was inadmissible).

243. *See* *Gasiorowski v. Hose*, 897 P.2d 678, 678–81 (Ariz. Ct. App. 1994).

person's regular practice of responding to a particular kind of situation with a specific type of conduct.²⁴⁴

The risk, then, is of evidence that reveals that a defendant physician has a habit of committing a negligent act.

This precise problem occurred for a defendant anesthesiologist in *Gasiorowski v. Hose*.²⁴⁵ Here, a claim was filed alleging that the defendant "administered an epidural anesthetic to plaintiff. . . . [and] threaded the epidural catheter too far into her spinal canal," causing "a cramping, spasmodic condition that [had] left [the plaintiff] wheelchair bound."²⁴⁶

The case against the anesthesiologist was tried and the jury returned a verdict for the defendant.²⁴⁷ The trial court excluded evidence of the anesthesiologist's suspension of "epidural and on-call privileges in response to several episodes of 'difficulty threading the epidural catheter.'"²⁴⁸

The Arizona Court of Appeals discussed the distinction between inadmissible character evidence and admissible habit evidence.²⁴⁹ It noted that the anesthesiologist "invoked habit or routine practice as a basis for reconstructing how he probably treated [the plaintiff]."²⁵⁰ The court held that Arizona Rule of Evidence 406 "supported plaintiff's attempt to establish through the observations of delivery room nurses that [the defendant] had a routine practice of threading epidural catheters to excessive depth."²⁵¹ As that evidence was improperly excluded, the judgment on the defense verdict was reversed and the case was remanded for a new trial.²⁵²

There have been unsuccessful efforts to transform character evidence into habit evidence. It has been held that the occasional alteration of medical records by a defendant physician did "not constitute proof of a regular response to a repeated, factually specific situation" and did not "rise to the level of habit."²⁵³ Furthermore, "evidence of one prior incident of alleged failure to advise a patient of risks does not establish that defendant has a habit of failing to advise patients of the risks of surgery."²⁵⁴

244. BROUN ET AL., *supra* note 19, § 195, at 322. See, e.g., *Reaves v. Mandell*, 507 A.2d 807, 810–11 (N.J. Super. Ct. App. Div. 1986) (applying this distinction).

245. *Gasiorowski*, 897 P.2d at 681–82.

246. *Id.* at 679.

247. *Id.*

248. *Id.*

249. *Id.* at 681–84.

250. *Id.* at 682. See also *Aikman v. Kanda*, 975 A.2d 152, 162–65 (D.C. Ct. App. 2009).

251. *Gasiorowski*, 897 P.2d at 682 (citing ARIZ. R. EVID. 406).

252. *Id.* at 685.

253. *Lambert v. Wilkinson*, No. 2007-A-0032, 2008 WL 2404736, at *8–9 (Ohio Ct. App. June 13, 2008).

254. *Cook v. Rontal*, 311 N.W.2d 333, 335 (Mich. Ct. App. 1981), *superseded on other grounds by Lewis v. LeGrow*, 670 N.W.2d 675 (2003).

Although physicians have been able to use habit evidence defensively, this may not always hold true. A court may adopt the position that “the relevant inquiry in a negligence action is not whether a defendant has a habit of compliance with the type of duty at issue, but whether the defendant breached a specific duty owed to a plaintiff at a particular time.”²⁵⁵ For example, in a medical negligence action concerning surgery, the defendant surgeon should not be permitted to testify as to the number of prior similar procedures performed by the surgeon without injury.²⁵⁶ Clearly, the historical successful completion of surgeries does not tend to prove that a surgeon properly performed surgery that is the subject of litigation. A court should, however, allow physicians to explain their habit or routine for treating a patient in a certain situation, or explain a medical chart entry, because physicians may attend to many patients over time and may simply not recall having given specific treatment on a specific date and time.

IX. CROSS-EXAMINATION OF MEDICAL EXPERT WITNESSES

The testimony of medical expert witnesses is often the focal point of medical negligence litigation. Crucial to the prosecution and defense of medical negligence actions is testimony that identifies the medical standard of care²⁵⁷ and whether the defendant physician’s conduct complied with or deviated from it.²⁵⁸ By definition then, the medical expert witness, when opining on the applicable standard of care, necessarily testifies as to appropriate or inappropriate care.

The medical expert witness is subject to typical witness cross-examination relating to bias, prejudice, and credibility.²⁵⁹ Additionally, when the medical expert witness is providing standard of care testimony, that expert may be subject to cross-examination concerning expert qualifications²⁶⁰ and medical judgment.²⁶¹ The scope of cross-examination of “expert witnesses rests in the trial judge’s discretion.”²⁶² The issue here, is whether the medical expert may be

255. *Ligon v. Southside Cardiology Assocs.*, 519 S.E.2d 361, 364 (Va. 1999).

256. John W. Ely et al., *Determining the Standard of Care in Medical Malpractice: The Physician’s Perspective*, 37 WAKE FOREST L. REV. 861, 864–65 (2002).

257. See *Witzmann v. Adam*, No. 23352, 2011 WL 322642, at *12 (Ohio Ct. App. Jan. 28, 2011) (holding that testimony by defendant physician “that never in over 460 surgeries has he injured a patient’s recurrent laryngeal nerve” was inadmissible habit evidence, but was harmless error).

258. See Karen L. Posner et al., *Variation in Expert Opinion in Medical Malpractice Review*, 85 J. OF THE AM. SOC. OF ANESTHESIOLOGISTS 1049, 1049 (1996).

259. See FED. R. EVID. 608.

260. See Lee Waldman Miller, *Cross-Examination of Expert Witnesses: Dispelling the Aura of Reliability*, 42 U. MIAMI L. REV. 1073, 1084 (1988).

261. See *Cook v. Wiggins*, No. 21047-9-II, 1998 WL 712832, at *3 (Wash. Ct. App. Aug. 21, 1998) (finding that the expert’s medical judgment was relevant evidence).

262. BROWN ET AL., *supra* note 19, § 13, at 36.

subject to cross-examination with evidence that relates to prior bad acts, conduct, or propensity.²⁶³

A. *Medical License Revocation or Limitation*

The fact that physicians suffer disciplinary problems is well reported, and the transgressions are varied.²⁶⁴ A medical license reprimand, restriction, or revocation is probative of a physician's credibility and should be an appropriate subject of expert witness cross-examination.²⁶⁵ A medical expert should not be subjected to cross-examination concerning a disciplinary matter pending before a licensing board.²⁶⁶ A physician expert who also held a law degree and law license was not subject to impeachment with evidence that he had been disciplined as a lawyer by a state bar association.²⁶⁷ Here, the court was concerned about "the low esteem in which the public holds lawyers,"²⁶⁸ and held that the discipline issued by the bar association had "no relevance to [the physician expert's] credibility as an expert medical witness."²⁶⁹

A Louisiana appellate court approved of the exclusion from evidence, a disciplinary action taken against an expert witness for "ethical violations associated with his involvement with a patient."²⁷⁰ The trial court considered "the remoteness in time of [the expert's] professional transgressions with their sexual nature," and the appellate court agreed that the disciplinary action "does not reflect upon [the expert witness's] expertise."²⁷¹

Finally, an appellate court in Illinois considered whether a medical expert's failure to pass the Illinois licensing exam was an appropriate subject for cross-examination when the expert held a medical license in Florida.²⁷² The court

263. See FED. R. EVID. 404.

264. See Kohatsu et al., *supra* note 10, at 653–54; Morrison et al., *supra* note 9.

265. See *Richmond v. Longo*, 604 A.2d 374, 378 (Conn. App. Ct. 1992) (finding that the trial court abused its discretion in refusing to permit defendant's cross-examination regarding the alleged termination of the expert's surgical privileges and restrictions on his license to practice medicine); *Cetera v. DiFilippo*, 934 N.E.2d 506, 520 (Ill. App. Ct. 2010) (involving an expert witness subject to cross-examination regarding a letter of reprimand from the licensing board for failing to diagnose microhematuria in a patient); *Creighton v. Thompson*, 639 N.E.2d 234, 239 (Ill. App. Ct. 1994) (expert witness subject to cross-examination regarding a license restriction—unable to practice without supervision); *Cook v. Wiggins*, No. 210-47-9-II, 1998 WL 712832, at *3 (Wash. Ct. App. Aug. 21, 1999) (license revocation).

266. See *Poole v. Univ. of Chi.*, 542 N.E.2d 746, 750–51 (Ill. App. Ct. 1989) (refusing to allow impeachment of a defendant when he denied having pending claims).

267. See *Unmack v. Deaconess Med. Ctr.*, 967 P.2d 783, 785 (Mont. 1998).

268. *Id.* at 784.

269. *Id.* at 785.

270. *Beaucoudray v. Walsh*, 9 So. 3d 916, 928 n.12 (La. Ct. App. 2009) (noting that the expert had been "required to refrain from sexual conduct with patients, attend psychotherapy sessions, meet quarterly with a monitor, and pay a \$1,000 fine along with some other incidental requirements").

271. *Id.* at 929.

272. *O'Brien v. Meyer*, 554 N.E.2d 257, 258 (Ill. App. Ct. 1989).

stated that “the existence of a license goes only to the initial qualifying inquiry. If the witness holds a license in one State, her failure to pass the equivalent licensing examination in another State should not preclude her from testifying”²⁷³ The “scant probative value . . . was outweighed by its prejudicial impact.”²⁷⁴

B. Failure to Achieve Board Certification

A high percentage of licensed physicians are board certified, which patients generally equate with physician quality.²⁷⁵ Obtaining board certification requires at least a period of prior training “and a passing score on a rigorous cognitive examination.”²⁷⁶ Board certification, therefore, presumes a body of knowledge, competence, and expertise in an area of specialized medical practice.²⁷⁷ The failure to pass a board certification exam speaks negatively on a medical expert’s credibility to testify as an expert and is the appropriate subject of cross-examination.²⁷⁸

C. Termination/Suspension of Staff Privileges

A physician is able to admit and treat hospital patients “only if the practitioner has admitting or clinical privileges at that hospital.”²⁷⁹ Staff privileges are granted to physicians with “membership in the hospital’s medical staff.”²⁸⁰ Staff privileges may be curtailed for reasons related to “competency and quality of care.”²⁸¹ Expert medical witnesses may be cross-examined regarding, for example, a suspension of staff privileges²⁸² or a termination of surgical privileges.²⁸³

273. *Id.* at 262.

274. *Id.*

275. Brennan et al., *supra* note 193, at 1039, 1042.

276. *Id.* at 1040.

277. *See id.* at 1041–42.

278. Kurrack v. Am. Dist. Tel. Co., 625 N.E.2d 675, 686 (Ill. App. Ct. 1993); *see also* Cook v. Wiggins, No. 21047-9-II, 1998 WL 712832, at *2–5 (Wash. App. Ct. Aug. 21, 1998).

279. FURROW ET AL., *supra* note 7, at 97.

280. *Id.*

281. *Id.* at 105. *See also* JAMES WALKER SMITH, HOSPITAL LIABILITY § 1.03(5) (1985) (citing JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS 124 (1988)) (“The reappointment, renewal or revision of clinical privileges is based upon information concerning the individual’s current licensure, health status, special performance, judgment and clinical/technical skills as indicated by the results of quality assurance activities and other reasonable indicators of continuing qualifications.”).

282. Whisenhunt v. Zammit, 358 S.E.2d 114, 117 (N.C. Ct. App. 1987).

283. Richmond v. Longo, 604 A.2d 374, 378–79 (Conn. App. Ct. 1992).

A physician may suffer a staff privilege limitation or suspension for reasons not directly related to patient care.²⁸⁴ It is certainly arguable that an expert witness should not be subject to cross-examination on these topics as they are unrelated to expertise.

D. Negative Performance Evaluation

The medical expert witness is often a practicing physician and, therefore, could have experienced his or her own professional difficulties. The Court of Appeals of Ohio in *House v. Swann*,²⁸⁵ held that the admission into evidence of the plaintiff's expert's prior "negative departmental performance evaluation he received while working at a hospital in Jersey City, New Jersey" may have contributed to "a potential bias against hospitals and the medical profession, which the jury may consider."²⁸⁶

E. Prior Lawsuits Against the Expert

There are many reasons why patients contemplate lawsuits against their physicians.²⁸⁷ Undoubtedly, some lawsuits will be filed against physicians who will act as expert witnesses in other cases. Is it appropriate to cross-examine an expert witness regarding the expert's involvement in litigation as a medical negligence defendant? This jurisprudence will be explored.

1. Admissible Evidence

There are court opinions that hold permissible the cross-examination of a defense medical expert with evidence of prior medical negligence actions filed against the expert on the basis that such evidence is relevant to the expert's bias or interest.²⁸⁸ This position is dubious. The underlying assumption must be that when a physician is sued in a medical negligence case, he or she would be thereafter inclined to testify as an expert only on behalf of defendant physicians. Allowing cross-examination of a medical expert in this manner could focus the

284. See *Gabaltoni v. Wash. Cnty. Hosp. Ass'n.*, 250 F.3d 255, 258 (4th Cir. 2001) (discussing physician's suspension for alteration of medical charts); Copeland & Brown, *supra* note 241, at 516.

285. No. L-09-1232, 2010 WL 3820372 (Ohio Ct. App. Sept. 30, 2010).

286. *Id.* at *5 (citing *Davis v. Immediate Med. Servs., Inc.*, 684 N.E.2d 292, 298 (Ohio 1997)).

287. See David A. Fishbain et al., *What Patient Attributes Are Associated with Thoughts of Suing a Physician?*, 38 ARCH. OF PHYSICAL MED. AND REHAB. 589, 589 (2007) (suggesting that there are reasons unassociated with negligence for suing a physician, such as dissatisfaction with the physician-patient relationship).

288. See, e.g., *Underhill v. Stephenson*, 756 S.W.2d 459 (Ky. 1988); *Irish v. Gimbel*, 691 A.2d 664 (Me. 1997); *Willoughby v. Wilkins*, 310 S.E.2d 90 (N.C. Ct. App. 1983).

jury on collateral litigation.²⁸⁹ The better approach, directed at exposing an expert's bias or conflicted interest, is to use the discovery process to determine how frequently an expert witness testifies for plaintiffs and defendants,²⁹⁰ to learn the expert's income earned from these services,²⁹¹ and then to cross-examine the expert at trial on these matters.²⁹²

A Connecticut appellate court held that a medical expert for the defense should be subject to cross-examination regarding a medical negligence claim filed against him involving charges similar to those he was defending as an expert.²⁹³ Here, the theory was that the defense expert was required to support the defendant physician on the standard of care in order to preserve consistency with his position in the case filed against him.²⁹⁴ Another approach to this issue would have been to simply allow cross-examination of the medical expert witness with any prior inconsistent testimony given in his own case, such as in his deposition.²⁹⁵ The fact that prior testimony was given in a case filed against the medical expert could have been the subject of a motion in limine.²⁹⁶

The United States Court of Appeals for the First Circuit, without sufficient explanation, has approved the cross-examination of a plaintiff's medical expert "about the fact that he had been a defendant in three medical malpractice cases."²⁹⁷ The court noted that this cross-examination related to the expert's "qualifications" and "credibility as a witness."²⁹⁸

2. Inadmissible Evidence

Other courts, even a Connecticut appellate court, have disapproved the cross-examination of medical experts about malpractice actions filed against them.²⁹⁹ This is simply a better approach to this evidentiary issue. Prior medical negligence lawsuits against a medical expert do not implicate an untruthful

289. See George L. Blum, Annotation, *Propriety of Questioning Expert Witness Regarding Specific Incidents of Allegations of Expert's Unprofessional Conduct or Professional Negligence*, 11 A.L.R. 5th 1 (1993).

290. See *Wilson v. Chi. Transit Auth.*, 513 N.E.2d 443, 445-46 (Ill. App. Ct. 1987).

291. See *Trower v. Jones*, 520 N.E.2d 297, 300 (Ill. 1988).

292. *Wilson*, 513 N.E.2d at 445-46 (citing *Sears v. Rutishauser*, 466 N.E.2d 210, 214 (Ill. 1984)); see *Trower*, 520 N.E.2d at 300.

293. *Hayes v. Manchester Mem'l Hosp.*, 661 A.2d 123, 125-26 (Conn. App. Ct. 1995) (citing *Richmond v. Longo*, 604 A.2d 374, 379 (Conn. App. Ct. 1992)).

294. *Id.* at 125.

295. See FED. R. EVID. 801(d)(1) (providing that prior inconsistent statements are not hearsay).

296. For a discussion of motions in limine, see MICHAEL H. GRAHAM, *HANDBOOK OF ILLINOIS EVIDENCE* 27 (8th ed. 2004).

297. *Navarro de Cosme v. Hosp. Pavia*, 922 F.2d 926, 932-33 (1st Cir. 1991).

298. *Id.*

299. *Locke v. Vanderark*, 843 P.2d 27, 31 (Colo. Ct. App. 1992); *Musorofiti v. Vlcek*, 783 A.2d 36, 49 (Conn. App. Ct. 2001) (involving a dental expert); *Mazzone v. Holmes*, 557 N.E.2d 186, 193 (Ill. App. Ct. 1990); *Wischmeyer v. Schanz*, 536 N.W.2d 760, 767 (Mich. 1995).

character.³⁰⁰ The motive, bias, or interest of an expert witness may be explored through the use of historical data relating to the frequency of expert testimony for plaintiffs and defendants, and relating to income derived from testifying as an expert witness. Furthermore, if a medical expert has given deposition or trial testimony contradictory to that given in the case at issue, that expert is subject to cross-examination with prior inconsistent statements.³⁰¹ Allowing cross-examination about prior lawsuits filed against the expert will distract the jury and undoubtedly create collateral mini-trials. It is a disruptive process which should be avoided.

X. CONCLUSION

As the above discussion and examination reveals, the law of evidence is not always favorable to physician defendants with respect to the admissibility of prior bad conduct. Although evidence of reputation as a good or bad physician and evidence of prior lawsuits against the physician defendant is typically, and properly, inadmissible, courts are receptive to evidence of prior conduct as it may relate to the defendant physician's knowledge base and the standard of care. As to defendant physicians and expert witness physicians who opine on compliance with or deviation from the applicable standard of care, those witnesses are likely subject to a wide range of cross-examination to implicate credibility, knowledge, and skill. Therefore, professional educational and experiential failings may return to haunt these witnesses.

Medical negligence litigation is emotionally charged. "Some patients will want to sue when they are disappointed, injured, or grief stricken."³⁰² The "war model"³⁰³ of medical negligence litigation is an apt characterization. Plaintiffs are particularly interested in using as much powerful evidence as is available to defeat the defendant physician. Trial judges presiding over medical negligence cases must be careful to understand that physicians commonly treat patients who suffer complications of treatment or simply suffer poor outcomes. Additionally, physicians occasionally suffer professional problems which may not directly relate to patient care, skill, and expertise. It is simply quite easy for a trial judge to adopt an overly inclusionary view of the rules of evidence, which should operate to exclude evidence that is highly prejudicial and distracting to the jury. The issue, after all, is whether the defendant physician committed malpractice upon a particular patient at a particular time.

300. *See* *Nowatske v. Osterloh*, 549 N.W.2d 256, 259 (Wis. Ct. App. 1996) (stating that evidence of prior malpractice was not relevant to witness's character).

301. *See* FED. R. EVID. 801(d)(1).

302. Sheila M. Johnson, *The Case for Medical Malpractice Mediation*, 5 J. MED. & L. 21, 22 (2000).

303. *Id.* at 24.