Who is an expert? A quick primer on an evasive concept

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To many physicians, the term *expert witness* not only raises the specter of a "hired gun" willing to testify against his colleagues for financial gain, but often leads to exasperation when learning that the expert is not even in the same field of medicine as the person he is testifying against. Similarly, many physicians express reluctance to act as an expert in legal proceedings because they do not consider themselves to be an expert in their field. The effort here is to clarify what the term *expert* means in legal proceedings and how courts determine whether that label is merited.

Each jurisdiction has procedural rules that outline what is generally required to be considered as an expert witness (1). Two circumstances must exist before an individual can testify as an expert witness in a legal proceeding. First, the court must find that there is an issue before it in which expert testimony is needed to guide the jury. Otherwise, the opinion of the expert is not relevant. Second, the court must find that the individual tendered as an expert has sufficient qualifications.

In Texas, the rules provide that expert testimony is relevant and allowable "if scientific, technical, or other specialized knowledge will assist the [jury] to understand the evidence or determine a fact issue" (2). More simply put, there must be an issue before the jury that is outside the lay public's general knowledge and experience (3). The applicable standard of care and whether or not improper care caused injury ("causation") in health care liability claims are two such instances in which it is well recognized that expert testimony is relevant (4). In fact, because the common experience of lay persons is not sufficient to allow a jury to determine liability and causation in health care liability claims, expert testimony on those issues is required (5). Since expert testimony in health care liability claims is almost always relevant, the focus in health care liability claims is on the second issue, the qualifications of the witness tendered as an expert.

In vetting an expert's qualifications, the role of the trial court is to ensure that "those who purport to be experts truly have expertise concerning the actual subject about which they are offering an opinion" (6). The burden is on the party offering the witness as an expert to establish that the individual has the proper credentials to qualify as an expert (6). In general, courts base this determination on review of the witness's "knowledge, skill, experience, training or education" (1).

In Texas, when expert testimony pertains to whether a physician departed from the applicable standard of care, the party tendering the expert must also establish that the witness meets four criteria:

- Is a physician
- Is practicing medicine at the time of the testimony or was practicing at the time the claim arose
- Has knowledge of accepted standards of care applicable to the diagnosis, care, or treatment of the condition or illness at issue
- Is qualified to offer an opinion on the applicable standard of care based on training or experience (7)

Court judges receive a great deal of discretion in determining whether or not an individual qualifies as an expert witness. When these decisions are reviewed by appellate courts, the focus is not on whether the appellate court considers the trial judge's decision correct but on whether or not the trial judge followed the applicable guiding principles in reaching his decision (8). Given this standard of review, it is not surprising that a great deal of judge-to-judge and even case-by-case variation exists. While resolution of a particular situation is highly dependent on the individual judge addressing the situation, a few cases are illustrative of what is needed to pass muster.

While physicians do have specialized knowledge beyond that of the lay public based on their knowledge, skill, experience, training, and education, that general specialized knowledge alone is not necessarily adequate to qualify a physician as an expert witness (9). The witness must be shown to have "special knowledge as to the very matter on which he proposes to give an opinion" (6). To meet this burden, the evidence should show how the witness has particular expertise in a relevant area, not simply that the witness has more expertise than the man on the street. The ultimate goal is to provide the court with sufficient information to ensure "that those who purport to be experts truly have expertise concerning the actual subject matter about which they are offering an opinion" (6). However, it is not required that the witness be from the same specialty

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area as the defendant. The touchstone issue is whether or not the witness has "practical knowledge of what is usually and customarily done by other practitioners under circumstances similar to those that confronted the defendant charged with malpractice" (10).

Pack v Crossroads, Inc., probably best illustrates these points. *Pack* was a wrongful death action in which the claimants alleged that their father died in a nursing home from inadequate care. In support of their claims, the family tendered nurse Dolores Alford as an expert to support their claims of negligent care by the nursing home and its employees. As evidence that Ms. Alford was qualified as a standard of care expert, the family established that she had a nursing diploma and a PhD, that she had been a staff nurse and clinical instructor in nursing, that she was an assistant professor of nursing at a university, that she worked with the Department of Justice and the Texas Department of Health Services on nursing home–related issues, that she had published on nursing care in nursing homes, that she had worked with nurses in nursing homes to assess residents and develop plans of care, that she had experience in nursing home investigations, and that she had knowledge of the regulations that governed the duties nursing homes owed their residents.

These credentials, however, did not establish that Nurse Alford was qualified to be an expert on nursing home standards of care. In support of that finding, the court specifically pointed to the fact that she had never worked as a staff nurse or charge nurse in a nursing home, had never been a nursing home administrator, and had never consistently performed nursing functions in a nursing home on a day-to-day basis (10). While the evidence clearly showed that Nurse Alford had more experience than the lay public in the treatment of nursing home patients, she was not qualified to testify because the evidence did not show that she truly had expertise or practical knowledge of how a nursing home should treat its patients.

In *Reed v Granbury Hospital Corporation,* plaintiffs offered two experts to support their contention that the hospital was negligent for failure to have protocols in place for the administration of tissue plasminogen activator (tPA) to stroke patients brought to its emergency room. To support their breach of duty claims, plaintiffs tendered an emergency room physician and a neurologist as their standard of care experts.

While the evidence established that the emergency room physician had expertise in the treatment of stroke patients, there was no evidence to show expertise about hospital policies and procedures on the administration of tPA. The emergency room physician was familiar only with the protocols that existed in the two hospitals where he worked (11). This evidence was not sufficient to establish the necessary expertise to qualify this doctor as an expert in the area of hospital policy on tPA administration.

The expert neurologist tendered also had extensive expertise in the treatment of stroke patients. In addition, he had participated in the creation of a hospital protocol on stroke treatment pathways. Despite these facts, the neurologist was not qualified to address the standard of care applicable to the hospital. The sticking point again was the fact that the neurologist was not familiar with the tPA protocols at hospitals other than where he had practiced. Further, the neurologist admitted that he had not conducted any type of survey to determine how common it was for hospitals to have tPA protocols or the frequency with which hospitals have tPA protocols. As with the emergency room physician, there was no evidence to show that the neurologist possessed any special knowledge about what protocols, policies, or procedures a hospital like the defendant should have in place (11).

The take-home point from these two cases is that the proponent of a standard of care expert must go beyond simply having the witness profess that he or she is familiar with the applicable standard of care. To show a witness is qualified to address the applicable standard of care, the court must be provided with *evidence* to support the witness's contention. Evidence of information the witness obtained during his education and training, through personal experience and continuing education, and from professional reading after becoming a practicing physician should be presented and is likely sufficient to qualify the witness. The standard that appears to be advocated here is that the witness must show that he is aware of and reflective about what reasonable physicians do—possibly based on the longstanding rule that what an individual physician would or would not do under the circumstances does not establish or reflect the standard of care (12). The proper standard is what a reasonable physician would do under the same or similar circumstances (13). The same rationale seems to apply when establishing a witness's qualifications. The expert must establish how he or she is familiar with the applicable standard of care (i.e., what a reasonable health care provider would do). Showing how the expert knows what he himself would do is not sufficient. The expert must show how he is an expert on what reasonable physicians *in general* would do under the same or similar circumstances.

The most-cited Texas case addressing the adequacy of causation qualifications is the Texas Supreme Court case *Broders v Heise* (6). In *Broders,* the key issue was whether or not an untreated head injury caused the patient's death. The patient's surviving family claimed that the patient would have survived with proper and timely treatment. The defendant health care providers claimed that the patient had sustained an irreversible, untreatable, fatal brain injury prior to their involvement. At trial, the patient's family sought to introduce the testimony from an emergency room physician, Dr. Frederick Condo, that but for the negligent conduct at issue the patient would have survived. Evidence that showed Dr. Condo's training and experience gave him more medical knowledge than the general population, including the knowledge that a neurosurgeon should be called to evaluate and treat head injuries and knowledge of treatments that could be provided under the circumstances. This expertise was not sufficient to qualify Dr. Condo to address causation, since Dr. Condo did not establish that he knew the effectiveness of the available treatment options. Without this specialized knowledge, Dr. Condo's opinion that the patient would have survived with timely treatment was nothing more than speculation and did not "offer genuine assistance to the jury" in resolving that issue (6).

Subsequent to *Broders,* in *Roberts v Williamson,* the Texas Supreme Court reviewed a similar situation in which the claimants offered the testimony of a nonneurological specialist on the issue of neurological injuries. In *Roberts,* claimants offered the testimony of a pediatrician to establish that the defendants' failure to timely treat a pediatric patient caused brain injury resulting in mental retardation, antisocial behavior, and partial paralysis. In contrast to *Broders,* the court held that the pediatrician was qualified to address causation. This determination was based on evidence that the witness had studied the effects of pediatric neurological injuries and had extensive experience in advising parents about the effect of neurological injuries. Thus, while the witness was not a neurologist, the evidence produced showed exactly how the doctor had the requisite expertise to testify about the cause and effect of the patient's injuries (14).

The point illustrated by *Broders* and *Williamson* is similar to the point illustrated by the standard of care cases discussed above: that is, mere lip service that a witness is qualified is not sufficient. There must be specific *facts* that explain why the witness is qualified to say with some degree of authority what caused the patient's event/problem.

A more recent case more directly illustrates this point. In *Leland v Brandal,* a patient was instructed by his dentist to stop taking his anticoagulant medication in anticipation of a tooth extraction. Unfortunately, the patient suffered a stroke during the time that he had stopped his medication pursuant to his dentist's instructions. As a result of this stroke, the patient was paralyzed on his right side and unable to speak. To prove the stroke and resulting injuries were caused by stopping the anticoagulant, the patient relied on the opinion of an anesthesiologist from the University of Texas San Antonio, Dr. Neal Gray. Dr. Gray opined that the patient suffered a stroke because his anticoagulation medication was stopped. Dr. Gray established that he had a great deal of experience in providing anesthesia care and treatment for individuals like the claimant who were on anticoagulation medications, that he was familiar with these medications, and that he had reviewed medical literature on this issue. The court, however, found that Dr. Gray was not qualified to testify that stopping the anticoagulation medication caused the patient's stroke because the facts elicited failed "to explain how his knowledge, skill, experience, training, or education qualified him to state that cessation of [the anticoagulant] during the time period in question proximately caused [the patient's] ischemic stroke" (15). While not specifically mentioned in the *Leland* opinion, the qualifications void seemed to be the absence of *facts* that established what expertise in the area of strokes and in the cessation of anticoagulants Dr. Gray had that would allow him to reach his conclusion.

While the case law discussed above is well established and well reasoned, as a practical matter this authority is really only classroom guidance. Two practicalities prevent one from relying on witness qualifications case law to realistically evaluate whether a witness will ultimately be found qualified. The first practicality to appreciate is the fact that most trial judges are hesitant to find that a medical doctor is not qualified to testify as an expert on standard of care or causation issues. The second practicality eliminates any knee-jerk response that one can rely on the appellate courts to remedy any trial court errors. The second practicality, as mentioned above, is the fact that appellate courts grant trial courts a large degree of deference when reviewing decisions. Because appellate courts are directed to focus on whether or not the trial judge followed the proper guiding principles, and not the result, the focus is more on form rather than substance. Thus, as a practical matter, it is unrealistic to expect that an appellate court is going to reverse a trial court's decision on whether an expert is or is not qualified absent exceptional circumstances.

None of the cases discussed here, and the cases that address this issue in general, really directly state what should be and probably is the real focus of vetting an expert's qualifications. That focus should be on why the witness, as a physician, is an expert on the issue before the court relative to other physicians. Instead, particularly as a practical matter on a day-to-day basis in dealing with trial judges, the issue is more focused on why the witness has more expertise than the lay public. While that issue may indirectly answer the question about why the testimony to be offered by the witness is *relevant,* it does nothing to show why the witness should be considered an *expert.* Until such time as the qualifications question is more properly focused on why the witness is an expert because of qualifications relative to others in his profession, as opposed to the public, efforts to more definitively answer this question will be mostly futile.

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1. See Fed R Civ Proc, Rule 702; Tex R Civ Proc, Rule 702.
2. Rule 702, Tex R Civ Proc.
3. See Rule 701, Tex R Civ Proc.
4. See *St John v Pope,* 901 SW2d 420, 423 (Tex 1995); *Hood v Phillips,* 554 SW2d 160, 165–66 (Tex 1977); *Shelton v Sargent,* 144 SW3d 113, 120 (Tex App—Fort Worth 2004, pet denied).
5. See *Ruiz v Walgreen Co,* 79 SW3d 235, 239–40 (Tex App—Houston [14th Dist] 2002, no pet).
6. *Broders v Heise,* 924 SW2d 148, 152 (Tex 1995).
7. §74.401(a), Tex Civ Prac & Rem Code.
8. See *Downer v Aquamarine Operators, Inc,* 701 SW2d 238, 241–42 (Tex 1985), *cert denied,* 476 US1159, 106 SCt 2279, 90 LEd2d 721 (1986).
9. *Broders,* 924 SW2d at 153.
10. *Pack v Crossroads, Inc,* 53 SW3d 492, 506 (Tex App—Fort Worth 2001, pet denied).
11. *Reed v Granbury Hospital Corp,* 117 SW3d 404, 410–12 (Tex App—Fort Worth, no pet).
12. See *Coan v Winters*, 646 SW2d 655, 657 (Tex Civ App—Fort Worth 1983, writ ref'd nre); *Stanton v Westbrook*, 598 SW2d 331, 333 (Tex Civ App—Houston [14th Dist] 1980, no writ); *Bearce v Bowers*, 587 SW2d 217, 219 (Tex 557 SW2d 163, 166, Tex Civ App—Fort Worth 1977, writ ref'd nre); *Burks v Meredith*, 546 SW2d 366, 370 (Tex Civ App—377, 379–80, Tex Civ App—Corpus Christi 1984), *rev'd on other grounds sub nom; King v Bauer*, 688 SW2d 84 (Tex 1985).
13. See PJC, *Malpractice, Premises & Products,* §50.1 (2006).
14. *Roberts v Williamson,* 111 SW3d 113, 121–22 (Tex 2003).
15. *Leland v Brandal,* 217 SW3d 60, 63–64 (Tex App—San Antonio 2006, no pet).