



## ADVISORY OPINION OF THE CODE OF ETHICS

Subject: Expert Witness Testimony

Issues Raised: In the United States, virtually all medical-liability litigation involves the testimony of medical experts, chosen by opposing sides to explain their interpretation of medical facts and the application of those facts to the standard of care. For that reason, the integrity of the judicial process depends, to a great degree, on the truthfulness, objectivity, and avoidance of undue bias on the part of the physician's expert testimony. As members of the medical profession, ophthalmologists must recognize their responsibility to serve in this capacity and to provide expert testimony that is truthful, supported by science, and in accordance with the facts of the case. To assist Academy members in providing appropriate expert testimony, the Academy has adopted the following Advisory Opinion detailing qualifications and guidelines for Academy members who are acting as experts in the legal system.

Applicable Rule: Rule 16. Expert Testimony

### Background

The courts generally depend on medical experts to establish the standard of care in malpractice litigation, to help identify conformance with or breach of those standards, and to determine whether a breach has caused injury. Expert medical testimony therefore plays an essential role in establishing whether there was medical negligence. Beyond establishing negligence, an expert may be called upon to testify about the current clinical status of a patient and the patient's prognosis as part of the process of determining damages.

The testimony of a medical expert witness is unique in that it is distinguishable from that of a "witnesses of fact." In proceedings involving allegations of medical negligence, witnesses of fact are those who testify because they have personal knowledge of the incident or people involved in the lawsuit. They generally are restricted to testifying about what they saw and heard that is relevant to the case. The medical expert witness is given greater latitude to bring a professional fund of knowledge to bear in order to interpret facts, to compare the applicable standards of care with the care in question, and to offer opinions as to whether the evidence indicates a deviation from or conformance with the standard of care. The medical expert also provides opinions as to whether the alleged breach in the standard of care was, to a reasonable degree of medical certainty, the most likely cause of the patient's injury. It is presumed that without the expert's explanation of the range of acceptable treatment modalities within the standard of care and interpretation of medical facts, juries would not have the technical expertise needed to distinguish malpractice (an adverse event caused by negligent care, or "bad care") from maloccurrence (an adverse event, or "bad outcome").

Because the expert's testimony is often the pivotal factor in the medical tort process, expert-witness testimony must be given responsibly and professionally, and it should be truthful, non-deceptive, and based on scientifically valid information. In opinions about the standard of care, analysis should be objective and based on a comprehensive understanding of the

relevant medicine and on the facts of the case.

Rule 16 of the Academy's Code of Ethics governs member behavior in providing expert witness testimony. It outlines the qualifications for such witnesses and the guidelines for conduct.

#### Qualifications for Expert Witnesses

1. The ophthalmologist expert should hold a current, valid, and unrestricted license to practice medicine.
2. The ophthalmologist expert shall not misrepresent his or her credentials, qualifications, experience, or background.
3. The ophthalmologist expert shall provide testimony that is objective, unbiased, and not false, deceptive, or misleading.
4. The ophthalmologist expert shall clearly distinguish between negligence and maloccurrence.
5. The ophthalmologist expert shall be knowledgeable about the relevant standard of care and the available scientific evidence for the condition in question during the time and place and in the context of the medical care provided.
6. The ophthalmologist expert shall not accept payment based on the outcome of the case, that is, "compensation that is contingent upon the outcome of litigation."

#### Guidelines for Conduct

1. The ophthalmologist expert shall review all relevant case-related material and should not deliberately exclude or ignore information that contradicts or does not support the hiring litigator's arguments.
2. The ophthalmologist expert shall evaluate the medical condition and care provided in light of generally accepted ophthalmic standards of care at the time and place and in the context of the medical care provided.
3. The ophthalmologist expert shall identify the alleged medical actions as within, outside, or close to the margins of accepted ophthalmic standards of care.
4. The ophthalmologist expert shall assess the relationship of the alleged substandard practice to the patient's outcome to determine whether other factors unrelated to medical negligence may have caused or contributed to the adverse outcome.
5. The ophthalmologist expert shall be prepared to state the basis of his or her testimony, whether it is based on personal experience or specific clinical or scientific evidence, and how and why the testimony varies from generally accepted standards, including addressing known or potential limitations of the testimony.
6. The ophthalmologist expert shall answer all properly framed questions truthfully and objectively. If the question asked by the lawyer is unclear, then it is the responsibility of the ophthalmologist expert to ask for clarification of the question.

#### First Inquiry\*

*Facts* - Dr. E is a member of the Academy and currently limits his practice to ophthalmic plastic and reconstructive surgery. He has been hired by a plaintiff's attorney to testify in a case of medical negligence arising from a complicated cataract procedure. The facts are as follows:

1. The defendant, Dr. D, performed cataract surgery on a pseudoexfoliation cataract by phacoemulsification.
2. Dr. D. had done hundreds of similar procedures for pseudoexfoliation without complication.

3. The medical record documented that the pupil dilated “somewhat poorly” and that the zonules “appeared loose.”
4. In the course of nucleus removal, there was zonular dehiscence, and the partially emulsified nucleus dislocated into the vitreous.
5. Dr. D aborted the procedure, closed the incision, and referred the patient to a vitreoretinal surgeon for management.
6. Subsequent management was anatomically successful, though the plaintiff lost central vision from cystoid macular edema, which was irreversible despite treatment.

At trial, Dr. E. testified that the plaintiff suffered irreversible loss of vision in the operated eye and that this was a direct consequence of Dr. D’s procedure. He further testified that dislocation of the lens in cataract surgery cannot occur unless the surgeon is careless, that Dr. D “probably rushed the operation” to stay on schedule that day, and that haste therefore was a contributing factor. He claimed that “a majority of ophthalmologists” supported the position that loss of the nucleus could only occur through a surgeon’s carelessness, and he cited two articles that he contended supported this testimony. Despite this testimony, the jury returned a verdict for the defense.

Despite his successful defense in court, Dr. D. filed a challenge against Dr. E under the Academy’s Code of Ethics, Rule 16, complaining that Dr. E’s testimony was false, biased, and misleading, in violation of this rule. He noted that as a career oculoplastic surgeon, Dr. E has no recent experience in cataract surgery, especially in complex cases like the plaintiff’s. He challenged Dr. E’s assertion that this complication could occur only through carelessness, and he provided citations to voluminous literature about nucleus dislocation that occurred despite all reasonable care.

After a thorough investigation and a hearing as described in the Administrative Procedures of the Code of Ethics, the Ethics Committee disagreed with Dr. E in his position that as an ophthalmologist he is an expert in cataract surgery. The committee also found that literature supports the assertion that nucleus dislocation is not *prima facie* evidence of a surgeon’s carelessness, and that the literature cited as support for Dr. E’s position was taken out of context and was never intended to mean that nucleus loss can always be avoided. A review of the plaintiff’s medical record and interviews with operating room personnel failed to support the assertion that Dr. D “rushed the operation.” The Committee found Dr. E in violation of Rule 16 and recommended that the Board of Trustees impose a sanction of 1-year suspension of Academy membership.

*Analysis* - The expert witness was compelled to acknowledge that he was not expert in cataract surgery, but he had nevertheless represented himself as such, and, in fact, tried to mitigate his lack of relevant experience with the argument that ophthalmologists are all equally qualified to testify about cataract surgery. He refused to acknowledge any other possible causative factors for the patient’s outcome by failing to acknowledge multiple risk factors in a complicated patient. He held this ground on the stand even when questioned under oath if there could be any other possible causative factors. He used the term “standard of care” inappropriately in the testimony, and he seemed generally ignorant of an expert’s role in his improper advocacy for the plaintiff’s side. This expert violated Rule 16 of the Code of Ethics by not providing testimony in an objective manner and by refusing to acknowledge the commonly held understanding that in complex cases there may be causative factors for the patient’s outcome other than that which is put forth by the plaintiff’s attorney (i.e., a maloccurrence without malpractice). Additionally, he failed to objectively interpret literature or recognize accepted ophthalmic standards of care at the time and in the context of the medical care provided.

## Second Inquiry

*Facts* - A 45-year-old female patient, Mrs. S, was involved in an automobile accident in which she sustained chemical injury to both eyes. The injury was presumed to be secondary to sulphuric acid from a ruptured car battery and to sodium hydroxide (alkali) from a deployed airbag. An emergency medical team arrived at the scene 10 minutes after the accident occurred. The patient complained of burning of the eyes and face. Ocular irrigation was not performed at the scene, during transport to the hospital, or promptly upon arrival to the hospital. Subsequently, the patient developed bilateral severe corneal opacification and limbal stem cell damage. She sued the County Fire Department, the ambulance service, and the hospital for failure to perform ocular irrigation. Her suit against the County Fire Department and the hospital was settled out of court, but the suit against the ambulance service was ongoing when the patient was referred to Dr. A for management of bilateral corneal stem cell deficiency and bilateral corneal opacification. Cadaveric and living-related keratolimbal stem cell transplantation was performed on her right eye, and cataract extraction with posterior capsule intraocular lens and a Boston type I keratoprosthesis implantation was performed on her left eye.

Dr. A was asked by the plaintiff's attorney to provide a deposition as the patient's treating physician, and he agreed to do so. In reviewing relevant materials, Dr. A noted that the defense experts contended that the "full extent of damage" to the plaintiff's corneas occurred in the first 3 to 5 minutes of exposure to the chemicals; therefore, failure to perform ocular irrigation at the scene, in the ambulance, and upon arrival at the hospital did not affect the final clinical outcome. Dr. A was asked to provide a declaration refuting the statements made by the defense experts. He reviewed relevant literature and learned that there are no reports concerning the utility of performing ocular irrigation at various time points following an ocular acidic or alkali chemical exposure in order to prevent subsequent adverse sequelae. He submitted the following written declaration:

As a result of the chemical exposure in each eye, Mrs. S has sustained debilitating visual impairment. While the situation of prompt irrigation may or may not have altered the amount of secondary tissue destruction, given the completely benign nature of irrigation with water, and the lack of definitive evidence in the medical literature to support the futility of irrigation in cases of ocular exposure of more than 3 to 5 minutes after exposure, I believe firmly that ocular irrigation should have been performed by those who cared for Mrs. S at the scene of the injury.

The plaintiff's attorney sent Dr. A a letter stating that the declaration was "inadequate" and that it should be rewritten to indicate that failure to perform irrigation at the accident scene, in the ambulance, and upon arrival to the hospital resulted in secondary injury to the plaintiff's eyes. Dr. A responded that he could not revise the declaration accordingly, as he was unable to find evidence in the scientific literature to support such a position. Dr. A then submitted a bill of \$1100 to the plaintiff's attorney for time spent researching the literature and preparing the declaration. Dr. A quickly received an email response from the plaintiff's attorney, excoriating him for "lack of cooperativeness" and questioning why he should have to pay for a declaration that was "most unhelpful" to his case. The attorney advised Dr. A that he should submit his bill to the patient, since no settlement was awarded in the case against the ambulance company.

*Analysis* - Dr. A's involvement in this case began as a "witness of fact" rather than as an expert witness, that is, as a witness who was to testify because he or she had personal knowledge of the incident or people involved in the lawsuit. Such witnesses are restricted to testimony on the facts of the case. Because of Dr. A's knowledge and experience, however, his opinions would certainly carry the weight of an expert—a fact that the attorney sought to exploit by asking his professional opinion as to negligence and causation. Dr. A conducted

appropriate research and proceeded responsibly, and he could offer no definitive substantiation to support the plaintiff's attorney's position that irrigation upon arrival of the first responders would have prevented secondary tissue destruction. Even if Dr. A's declaration had been used in court, he could not be found in violation of Rule 16 of the Code of Ethics because his testimony was provided in an objective manner using medical knowledge to form expert medical opinion. His declaration was not false, deceptive, or misleading in any respect.

### Third Inquiry

Facts – Dr. P is a comprehensive ophthalmologist who was contacted by a medical malpractice attorney to review a medical negligence claim involving a local colleague, Dr. T. The plaintiff in the case alleged that she developed loss of vision in her right eye following a cataract surgery that Dr. T performed. Although the cataract surgery was performed without complication, the patient developed persistent corneal edema following the procedure that was allegedly due to a retained nuclear fragment that was identified only when the plaintiff sought a second opinion by another eye care provider. The plaintiff alleged that Dr. T's failure to diagnose the retained nuclear fragment in a timely manner led to persistent corneal edema and cystoid macular edema (CME). Although a Descemet's stripping endothelial keratoplasty (DSEK) procedure was successfully performed to resolve the corneal edema, the chronic CME was only partially responsive to repeated intravitreal and sub-Tenon's steroid injections, and the patient's visual acuity improved only to the level of 20/80.

Dr. P agreed to testify as an expert witness on behalf of Dr. T, advising the attorney that retained nuclear fragments are a recognized potential complication following cataract surgery, and that Dr. T's intraoperative and postoperative care of the patient met the standard of care. During the trial, Dr. P hypothesized that Dr. T's failure to diagnose the retained nuclear fragment was due to impaired visualization secondary to the corneal edema, and that subsequent clearing of the edema more than 3 months after surgery allowed the physician who provided a second opinion to visualize the fragment. Additionally, he opined that the persistently decreased visual acuity was not secondary to care provided by Dr. T but to the care provided by the corneal and retinal specialists who managed the patient's care following the cataract surgery. Specifically, Dr. P testified that the performance of DSEK instead of Descemet's membrane endothelial keratoplasty (DMEK) as well as the failure of the retina specialist to use intravitreal anti-VEGF therapy in the management of the CME, resulted in a limitation of visual recovery following endothelial keratoplasty.

During the trial, while undergoing questioning by the plaintiff's attorney regarding his relationship with Dr. T, Dr. P revealed that Dr. T had been referring patients to him for several years for LASIK surgery, because Dr. T did not perform LASIK surgery. Dr. P did not reveal this to the defense attorney because he had not been asked directly whether he had a working relationship with Dr. T.

Analysis – It is debatable whether the failure to diagnose the retained nuclear fragments and the failure to refer the patient to a cornea specialist in a timely manner, as alleged by the patient, led to irreversible vision loss in the patient's operative eye. However, it is clear that Dr. P's testimony did not meet the required standards for unbiased, expert opinion. Dr. P should have disclosed his professional relationship with Dr. T when contacted by the defense attorney and likely should have declined to serve as an expert in the case. Even if Dr. P's testimony would not have been biased by his desire to maintain a good working relationship with Dr. T in order to continue receiving patient referrals, the potential for the appearance of such bias is sufficient to draw into question the integrity of his testimony. In addition, the

failure to disclose this relationship to the defense attorney reinforces the impression that Dr. P chose not to reveal this information for financially motivated reasons.

Dr. P's testimony also may be considered biased because it provides unlikely and unfounded statements to defend the care provided by Dr. T. Specifically, it is very unlikely that the eye care provider whom the patient saw for a second opinion was able to identify the retained nuclear fragment due to clearing of the corneal edema more than 3 months after surgery. As a comprehensive ophthalmologist, Dr. T is very unlikely to have followed a sufficient number of patients with post-cataract surgery corneal edema to give an expert opinion on the likelihood of the edema clearing more than 3 months after surgery. Additionally, as Dr. P is not a cornea or retina specialist and does not perform endothelial keratoplasty or intravitreal injections, he is not sufficiently qualified to provide expert opinion on the visual acuity outcomes of DSEK versus DMEK and intravitreal steroid versus anti-VEGF treatment for pseudophakic CME. Even if he were, these are areas of ongoing debate among experts in the field, and to present testimony that indicates that the chosen therapies were responsible for the patient's limited visual recovery is both false and misleading.

#### Applicable Rule

*"Rule 16. Expert Testimony.* Expert testimony should be provided in an objective manner using medical knowledge to form expert medical opinions. Nonmedical factors (such as solicitation of business from attorneys, competition with other physicians, and personal bias unrelated to professional expertise) should not bias testimony. It is unethical for a physician to accept compensation that is contingent upon the outcome of litigation. False, deceptive, or misleading expert testimony is unethical. For purposes of this Rule, expert testimony shall include oral testimony provided under oath; affidavits and declarations used in court proceedings; and certificates of merit signed, ratified, or otherwise adopted by the physician."

#### References

American Medical Association. Opinion 9.7.1 Medical testimony. Code of Medical Ethics. <https://www.ama-assn.org/delivering-care/ethics/medical-testimony>. Accessed Feb 2, 2022.

Ethical Challenges for the Medical Expert Witness. *AMA J Ethics*. 2016;18(3):201-208. doi: 10.1001/journalofethics.2016.18.3.ecas1-1603. Accessed Feb 2, 2022.

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\* This is a theoretical case based on *Austin v. American Association of Neurological Surgeons*, 253 F.3d 967 (7th Cir. 2001). Although it highlights issues addressed in actual case experience with ethics challenges under Rule 16 of the Academy's Code of Ethics, it is presented solely for the purpose of illustration and references no specific case other than the case noted.