POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION
RESOLUTION G06

SUBJECT: WHITE PAPER ON EXPERT TESTIMONY IN LONG-TERM CARE

INTRODUCED BY: ETHICS COMMITTEE

INTRODUCED IN: MARCH 2006

Background:

Over the past two decades, an increasing number of lawsuits have been filed throughout the United States against nursing homes and sometimes against nursing home physicians and other practitioners. Increasingly, nursing home finances and physician practices are being affected either by involvement in lawsuits or by the fear or threat of such litigation.

Both plaintiff and defense lawyers typically retain individuals to testify for their clients as experts. Typically, these experts purport to be able to judge the appropriateness of care and to specify whether and how the facility and/or practitioner have either breached or adhered to the standard of care. Such persons may claim expertise in the ability to relate a breach of Standard of Care to causation of injury or death, or to judge multiple breaches by multiple caregivers to a causation. However, there is evidence that even expert opinion about the standard of care can differ markedly. For example, among 65 experts (out of 98 mailings) in the field of pressure ulcer care who responded to a survey containing questions about pressure ulcer care, 62% disagreed with the statement that all pressure ulcers are preventable, and most respondents disagreed that pressure ulcers are necessarily a sign of neglect and that nursing homes should be sued when a resident develops a pressure ulcer. However, 38% agreed with the concept that lawsuits are an appropriate way to stimulate improvement in nursing home care.[1]

Generally, juries consist of individuals with little or no background in geriatrics, long-term care, or medical care provision. They are not trained or knowledgeable to be able to distinguish valid

from misleading arguments regarding appropriate and unacceptable practice. Thus, they depend heavily on expert testimony.

However, it is unclear whether states, professional associations, and judicial systems have or use meaningful criteria for expertise in relation to long-term care. In fact, it appears that many individuals with little or no knowledge of geriatrics or long-term care practice or direct personal experience in providing long-term care are allowed to testify as experts.

It is not uncommon for some of these experts to make invalid or misleading statements under oath; especially in regard to problematic areas of care such as pressure ulcers or falls. Some experts testify to similar conclusions in multiple cases, without regard to the facts; for example, they will invariably state no matter how severely ill or functionally and cognitively impaired the patient, that some other treatment would have materially changed the patient's outcome. They may be unaware of, or deny the relevance of, publications that identify reasonable care process, realistic expectations, and the impact of comorbidities and cognitive and functional impairment on patient outcomes.

It is possible to fairly and consistently judge the performance of nursing home staff and practitioners in the care of their residents / patients. However, the current judicial system does not appear to do so meaningfully or consistently. While the legal community claims that lawsuits are necessary to punish wrongdoing and to improve the level of care, it appears that many suits that have been brought against nursing homes and nursing home practitioners are of limited merit, and there is little substantive evidence that the threat of lawsuits has reduced the incidence of problematic care or helped differentiate appropriate from inappropriate care.

Expertise of the Long-Term Care Expert Witness:

The expert witness in long-term care issues should have a higher level of expertise in the knowledge of total patient care than a specialist in just one or few of the domains involved in the total management of a long-term care resident.

As a duly recognized expert, he or she has knowledge, experience, and skill related specifically to providing care to residents / patients in long-term care facilities. He or she can relate pertinent medical principles, long-term care guidelines and publications, and regulatory requirements to the care of specific patients, as follows.

Training, knowledge and experience:
He or she has specific, pertinent, and meaningful knowledge and experience related to providing primary care for individuals who have chronic illnesses and disabilities, such as those who receive care in nursing facilities —and/or experience in consulting with the health care professionals serving LTC patients about applying current knowledge and principles about providing quality care for patients in this setting. He or she should have substantial (several years or more) experience in diagnosing and treating medical, functional, and psychological problems and their underlying causes, in those with chronic illnesses and disabilities.

Ability to provide comprehensive evaluation and analysis of the total care and management of a long-term care patient:
He or she can discuss comprehensively and in the appropriate context, the multiple issues related to a patient; for example, how the diagnosis and management of a specific problem or condition, such as heart failure or stroke relates to the patient's overall care status (involving physical, functional, and psychosocial domains).

He or she can accurately explain the clinical significance of specific symptoms and physical findings. He or she can distinguish and explain normal variation compared with problematic symptoms. He or she can weigh the clinical relevance of multiple, simultaneous abnormalities of a patient's symptoms/signs of illness, laboratory or other abnormalities, the influence of aging, and the burden of illness, leading to consideration of the best care choices in a given scenario.

Ability to explain issues in context:
He or she can apply and explain an appropriate evidence-based differential diagnosis of symptoms and clinical findings. He or she can correctly identify the nature, severity, and causes of a patient's various symptoms and abnormalities. He or she understands, and can explain, the

multiple factors that influence a nursing facility patient's course and prognosis, including those (e.g., comorbidities and medications) that may cause decline and death. He or she can explain the relative risks and benefits of various treatment options, in the context of other factors for a specific patient.

Ability to relate performance to outcomes:
He or she can explain clearly the basis for conclusions about whether a facility has provided pertinent care and how the care related to the patient's outcome. He or she can explain clearly how the facility or practitioner's performance was not consistent with the medical, geriatric and related literature regarding the management of nursing home patients and specific aspects of care as related to the case.

The expert witness in long-term care issues demonstrates a higher level of expertise than witnesses not similarly qualified in the comprehensive nature and complexities of long-term care medicine:
The Expert Witness in Long-Term Care Issues is a high-level expert, possessing requisite knowledge, experience, and skill related specifically to providing care to residents / patients in long-term care facilities, who can relate pertinent medical principles, long-term care guidelines and publications, and regulatory requirements to the care of specific patients.

The long-term care expert witness is distinguished from other expert witnesses who lack such substantive knowledge and practice expertise in the comprehensive and complex care of long-term care patients. Whereas such witnesses may have knowledge about some specific area of care or about general approaches to the geriatric patient, s/he lacks specific long-term care experience and is not familiar with available long-term care literature and guidelines, or cannot apply such information appropriately to the care of specific patients. Similarly, a non-expert witness is one who lacks both experience and specific long-term care practice knowledge, and whose knowledge is about a general topic such as nutrition or pressure ulcer care is based primarily on personal experience or habit. They are only marginally able to relate specific facts to the care of specific patients.

It is therefore recommended that the long-term care expert witness should have the following professional and behavioral qualifications:

Elements Related to Qualifications of Persons Acting as a Long-Term Care Expert Witness:[2-8]

Knowledge and Experience with Subject Matter:

The expert witness in long-term care should possess current and appropriate medical knowledge and experience in the practice issues of the particular case for which they are testifying.

Familiar with Standards of Care at Time of Occurrence:

The long-term care expert witness should be familiar with the current concepts and practices related to the standards of care, and should reflect in his or her testimony the state of medical knowledge as present at the time of the occurrence.

Elements Related to the Behavior of Persons Acting as a Long-Term Care Expert Witness:

Impartiality / Applies Standards of Fairness and Honesty:

The long-term care expert witness should review all medical facts in a thorough, fair, and impartial manner, and should provide objective, honest, and unbiased testimony.

Distinguishes Between Actual Negligence and Unfortunate Medical Outcome:

The Expert Witness should be prepared to distinguish between actual negligence and unfortunate medical outcome.

An unfortunate medical outcome is a malocurrence unrelated to the quality of care provided. Complications of medical care may occur despite appropriate medical and unrelated care. Other complications arise unpredictably yet are similarly unavoidable. In long-term care, unfortunate outcomes may result despite appropriate joint decisions between patients and physicians, following the standard of care and informed consent. Each of these situations represents a type of malocurrence, rather than an example of malpractice, and is the result of the uncertainty

inherent in all of medicine. According to the American College of Obstetricians and Gynecologists, malpractice requires a demonstration of negligence[1].

Distinguishes Basis of Testimony:

The Long-Term Care Expert Witness should be prepared to explain the applicable standard of care and medical bases for his or her testimony or opinions. He or she should be prepared to state whenever possible whether they are based on evidence-based guidelines.

Does Not Link Outcome and Compensation:

Compensation for the Long-Term Care Expert Witness should be reasonable and commensurate with the time and effort involved. It is not desirable for compensation to be contingent on the outcome of litigation.

Truthful / Subject to Peer Review:

The expert witness is ethically and/or legally obligated to tell the truth. He or she should be willing to submit testimony for peer review if requested. Fraudulent misconduct as an expert may expose the individual to disciplinary or legal action.

Recommendations:

1. The judicial system should adopt guidelines for expert witnesses in nursing home cases. Guidelines should include criteria such as those in this document. The level of an individual's expertise should be explorable as part of one's deposition and courtroom testimony. An expert witness' credibility should be based on the extent to which they meet these guidelines' criteria. Credentials such as licenses and certification (including board certification) may be relevant but should not be the primary consideration. Individuals who provide the same or rote testimony in multiple cases (for example, that all pressure ulcers are preventable) without regard to evidence or the facts of each and every specific case should be disqualified as an expert.

[1] See American College of Obstetricians and Gynecologists. *Expert Testimony*. Available at www.acog.org/from_home/publications/ethics/ethics116.pdf.

2. The nursing home industry should review the quality of experts who are used to defend nursing homes.

Representative long-term care organizations should agree on basic qualifications. The nursing home industry should seek more qualified individuals to serve as expert witnesses, based on criteria, such as in this document. Individuals who do not understand or who fail to fairly or accurately reflect the standard of care while attempting to defend nursing homes may actually do harm by perpetuating the wrong standards (#3, below).

3. The nursing home industry and judicial system should identify and acknowledge more appropriate sources of standards of care.

The nursing home industry, judicial system, and lawyers who are hired to defend nursing homes should recognize the limited role of regulatory requirements and cease citing regulatory requirements as the primary source of the standard of care. Regulations and related surveyor guidance are a framework for surveying compliance with regulatory requirements. They were not developed as, nor do they constitute reference manuals for general medical practice, geriatric medicine, or geriatric nursing care. Regulations should (but do not always) reflect, yet not create standards of care.

A substantial literature about desirable care process and practice now exists. In many cases, there is diverse opinion about the standard of care, and a single standard of care may not be readily identifiable. Often, it is appropriate to modify recommended care approaches based on individual circumstances. However, there is often substantial concurrence among multiple sources as to desirable practices of care for long-term care residents / patients. The nursing home industry and expert witnesses should review and utilize both pertinent literature and clinical practice guidelines, as developed by reputable national organizations, as the bases for their opinions concerning appropriateness of care.

The nursing home industry should also carefully review, update or change current practices that are not consistent with evidence-based medicine or published guidelines, but have become habitual conduct in many nursing homes nationwide (for example, unwarranted automatic use of nutritional supplementation in those with pressure ulcers, or excessive deferral to speech therapy

consultation to evaluate whether patients can be allowed to eat).[9] Habitual or widespread, but erroneous, practice does not constitute a standard of care, and should not be allowed to persist or be introduced into court as though it were a standard.

4. Associations representing the long-term care industry and physicians should collaborate to address the above issues and should agree on desirable physician practice and performance.

There has been, and continues to be considerable effort to clarify the roles of physicians and medical directors in long-term care. Greater consistency in identifying and applying appropriate clinical and performance expectations would help to establish more pertinent and replicable standards of care, instead of allowing external imposition of inappropriate standards through case law. Effective accountability[2] is a critical risk management measure.

Summary:

A more systematic approach to identifying expertise in testifying in lawsuits regarding long-term care facility and practitioner performance should become the national norm. It is possible to identify criteria for expertise that can be used to gauge the credibility of an alleged expert, and to exclude or to put into proper perspective those whose claims of expertise are unwarranted. The current inconsistent, largely subjective approach to expertise has contributed to problematic consequences for physicians, patients, and the nursing home industry. The judicial system, nursing home industry, physician organizations and the public all deserve a more consistent, objective approach**.**

References:

[1]Brandeis GH, Berlowitz DR, Katz P. Are pressure ulcers preventable? A survey of experts. *Adv Skin Wound Care* 2001 Sep ;14(5):244, 245-244, 248.

[2] American College of Surgeons. [ST-8] *Statement on the physician acting as an expert witness.* Available: http://www.facs.org/fellows_info/statements/st-8.html

[2] For more information on accountability as it relates to the role and responsibilities of the nursing home medical director or attending physician see www.amda.com and the Centers for Medicare and Medicaid Services Revised Nursing Home Medical Director Tag at www.cms.hhs.gov.

[3] American College of Obstetricians and Gynecologists. *Expert Testimony*. Available at www.acog.org/from_home/publications/ethics/ethics116.pdf.

[4] American Medical Association. *Actions Taken by the House of Delegates, Monday, December 6, 2004. EXHIBIT A, American Medical Association, Expert Witness Affirmation Statement*. Available: http://www.ama-assn.org/ama1/pub/upload/mm/465/bot8fin.doc

[5] American College of Radiology. *ACR Practice Guideline on the Expert Witness in Radiology*. Available: http://www.acr.org.

[6] American Academy of Pediatrics.*Guidelines for Expert Witness Testimony in Medical Malpractice Litigation*. Available: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;109/5/974.

[7] American College of Emergency Physicians. *Expert Witness Guidelines for the Specialty of Emergency Medicine*. Available: http://www.acep.org/webportal/PracticeResources/PolicyStatements/ethics/emexpwitnessguidelines.htm

[8] *Guidelines for Expert Witness Qualifications and Testimony.* American Society of Anesthesiologists. Available at: http://www..ASAhq.org/publicationsAndServices/standards/07.html

[9] Levenson SA and Crecelius CA. The facts about dysphagia and swallowing studies. *Caring for The Ages*. February 2003: 17-18

FISCAL NOTE: **None**

RESOLUTION RESULTS: Passed.