Concern regarding medical malpractice has increased recently, in part because of skyrocketing costs of medical care and premium increases in health and malpractice insurance.1 Health care reform has moved to the

---


---

Meghan O’Connor is an attorney in the Milwaukee office of von Briesen & Roper, s.c., where she is a member of the Health Care Practice Group. This paper was originally written for Professor John J. Kircher’s Advanced Torts course and placed first in the 2010 Tort Trial & Insurance Practice Section Law Student Writing Competition.
forefront of political debates; malpractice insurance, social services, physician incentives, and reimbursement methodologies are discussed as possible contexts for such cost-containment and reform. Despite a recent political interest in managed care health reform, debate surrounding tort reform has remained consistent, as caps on noneconomic damages, limits on contingency fees, introduction of collateral source rules, changes to statutes of limitation, and mandatory arbitration remain contentious suggestions for cost-containment in the tort system. Despite the renewed political debate, scholars argue that a more nuanced and practical method defining standards of care and of evaluating medical negligence principles may lead to the desired cost-containment and litigation reduction goals of tort reform without the need for a dramatic reformulation of the tort system.

Medical error and preventable death statistics are shocking. The Institute of Medicine reports that up to 98,000 deaths per year occur as a result of medical error. These deaths from medical error represent more deaths per year than occur from motor vehicle accidents (43,548) or breast cancer (42,297). In addition, according to a Harvard study, only 12.5 percent of patients injured as a result of physician negligence actually bring a lawsuit against providers. Furthermore, only one in sixteen of these patients will recover any economic compensation for his or her injuries.


4. See Blumstein, supra note 3, at 1021.


6. Id.


8. Id.
With high incidences of medical error and low incidences of recovery, the area of medical negligence is ripe for reform. Developing improved methods to define and delineate the conceptual foundation of medical negligence—the physician–patient relationship and the physician standard of care—can be a context for achieving the cost-containment goal of tort reform by limiting unmerited cases before the inception of such lawsuits. Reexamining basic concepts of medical negligence brings a more streamlined approach to assessing medical negligence. However, this reform need not severely alter the health care delivery system, insurance industry practices, or the tort system like the dramatic alterations required by many other proposed methods of tort reform.

In order to achieve these improved methods of evaluating negligence within the context of physician malpractice, it is crucial to understand the foundation of these concepts and their roles in tort law. In this article, I will analyze these concepts—the physician–patient relationship and the professional standard of care for a physician—as they relate to establishing a claim for medical negligence and how they may serve the cost-containment and litigation reduction purposes of tort reform. First, I explore the physician–patient relationship from its inception through its termination, including legislation that restricts its termination. I discuss the fiduciary relationship and the duty of continuing attention on the part of the physician. Second, I examine methods for setting the standard of care for a physician as a requirement of a medical negligence lawsuit. This discussion includes the evolution of the locality rule and the national standard of care, as well as the issue of judicial standard setting. Finally, I analyze proof of negligence in a medical malpractice claim with expert witness testimony.

II. PHYSICIAN–PATIENT RELATIONSHIP

The physician–patient relationship is the foundation of a medical negligence suit. The plaintiff must establish that a physician–patient relationship existed between the defendant-physician and the plaintiff-patient in order to succeed. If the plaintiff does successfully prove that the physician–patient relationship existed between the defendant and plaintiff, the plaintiff may introduce evidence of the fiduciary duty and obligation of continuing attention on the part of the physician that attach under the physician–patient relationship.

A. Establishing the Physician–Patient Relationship

The foundation of medical negligence and the standard of care for physicians is the physician–patient relationship. This relationship is similar to a

9. See Blumstein, supra note 3, at 1018–19.
10. See id.; Morreim, supra note 1, at 1740–43.
contractual relationship, and the necessary elements of a contract are present. First, a patient going to the physician’s office with a problem or condition is the patient’s offer for treatment.\footnote{11} Next, the physician may accept the offer and provide treatment or reject the offer and refuse treatment.\footnote{12} The physician is not generally required to accept every patient who seeks treatment from him; however, the physician cannot discriminate against protected classes or on the basis of certain conditions, including acquired immunodeficiency syndrome.\footnote{13} In addition, the traditional fee-for-service reimbursement method may constitute the required consideration element under a traditional contract.\footnote{14} The physician–patient relationship is similar to an implied contract because express written contracts are rarely part of the physician–patient relationship.\footnote{15} In addition, the physician–patient relationship takes on a quasi-contractual principle as well: “[t]he exact nature of the work to be done” is vaguely defined at best.\footnote{16}

For a physician to be liable for medical negligence, the defendant-physician and plaintiff-patient must have a physician–patient relationship.\footnote{17} In Wisconsin, establishing a physician–patient relationship is relatively straightforward: “[a] physician–patient relationship is a trust relationship, created when professional services are provided by a physician and accepted by a patient.”\footnote{18} However, not every jurisdiction employs a practical and clear method for establishing a physician–patient relationship. In the context of physician liability, defining the scope of the physician–patient relationship can encompass a number of factors, including whether the treatment sought is within the capabilities or specialties of the physician, and, for physicians who practice under a provider contract with a managed care entity, whether an adequate referral has been issued. In addition, a number of courts have found a physician–patient relationship to exist based on public policy factors instead of whether the physician actually rendered care.\footnote{19} In \textit{Millard v. Corrado} and

\footnote{12. \textit{Id}.}
\footnote{13. \textit{See Wis. Stat. § 252.14(2)(a)–(d) (2009) (listing exceptions to general rule that physicians are not required to accept every patient); \textit{see also id. § 440.20(4) (2009) (discussing penalties for violation of Wis. Stat. § 252.14(2), including suspension or revocation of physician’s credentials for intentional violations).}}
\footnote{14. \textit{Furrow et al., supra} note 11, at 202.}
\footnote{15. \textit{See id}.}
\footnote{16. \textit{See id}.}
\footnote{17. \textit{Ande v. Rock}, 256 Wis. 2d 365, 377, 647 N.W.2d 265, 271 (Ct. App. 2002); \textit{see, e.g., Froh v. Milwaukee Med. Clinic, S.C.}, 85 Wis. 2d 308, 311, 270 N.W.2d 83, 84 (Ct. App. 1978).}
\footnote{18. \textit{Ande}, 256 Wis. 2d at 377, 647 N.W.2d at 271; \textit{see Brown v. Dibbell}, 227 Wis. 2d 28, 46–47, 595 N.W.2d 358, 368 (1999).}
\footnote{19. \textit{See Millard v. Corrado}, 14 S.W.3d 42 (Mo. Ct. App. 1999); \textit{Hoover’s Dairy, Inc. v. Mid-Am. Dairymen, Inc./Special Prods., Inc.}, 700 S.W.2d 426 (Mo. 1985).}
Hoover’s Dairy, Inc. v. Mid-America Dairymen, Inc., a physician–patient relationship and duty was found based on six public policy factors:

1. The social consensus that the interest is worth protecting,
2. The foreseeability of harm and the degree of certainty that the protected person suffered the injury,
3. The moral blame society attaches to the conduct,
4. The prevention of future harm,
5. The consideration of cost and ability to spread the risk of loss, and
6. The economic burden upon the actor and the community.

The elements required for establishing a physician–patient relationship vary among jurisdictions. However, the relationship must be proven in order to establish the physician’s duty to the patient—the first element of medical negligence. From the legal practitioner’s perspective, understanding the point at which the physician–patient relationship is formed in the jurisdiction for the case at hand is crucial. If the alleged malpractice occurred before the inception of the physician–patient relationship, proof of the defendant-physician’s duty to the injured plaintiff-patient is likely impossible, and the medical negligence claim will fail. A court’s use of public policy factors as the method for determining the inception and existence of a physician–patient relationship is a situation in the medical negligence framework that could be more clearly reframed to achieve a more cost-effective and streamlined process for medical negligence. The physician–patient relationship is the foundation of a medical negligence lawsuit, and if courts abandoned vague methods for defining this relationship, a number of lawsuits may not be brought. However, if courts have the discretion to apply inconsistently broad public policy factors, a greater number of otherwise unmerited cases will bypass the first issue in medical negligence—establishing a physician–patient relationship.

B. Physician Duty Under the Physician–Patient Relationship

Once the physician–patient relationship is established, the relationship requires a fiduciary obligation and an obligation of continuing attention. First, the law imposes a fiduciary obligation on the physician. Black’s Law Dictionary defines a fiduciary as “one who owes to another a duty of good faith, trust, confidence, and candor.” Furthermore, a fiduciary relationship “exists when one person is under a duty to act for the benefit of the
other on matters within the scope of the relationship.”

24 In the medical context, a fiduciary relationship necessitates “that the physician focuses exclusively on the patient’s health; the patient assumes the doctor’s single-minded devotion to him; and the doctor–patient relationship is expected to be free of conflict.”

25 This physician–patient relationship requires a fiduciary duty on the part of the physician because the physician is “a voluntary undertaker acting for the patient’s benefit.”

26 Physicians who are under contract with managed care organizations (e.g., health maintenance organizations (HMOs), preferred provider organizations (PPOs)) may be required, under their provider contracts, to “assume control and responsibility over all the health care decisions and treatments for the beneficiaries of the HMO.”

27 However, when patients and employers contract directly with the HMO instead of the provider, the fiduciary duty is passed on to the HMO through the provider contract.

28 In addition to the physician’s fiduciary duty, once the physician–patient relationship is established, the physician is under an obligation of continuing attention to the patient until the condition no longer requires attention.

29 In Wisconsin, the obligation of continuing attention attaches “after the first operation or first treatment, so long as the case requires attention.”

30 The Wisconsin Supreme Court set forth the legal duty for a physician when terminating the physician–patient relationship:

The obligation of continuing attention can be terminated only by the cessation of the necessity which gave rise to the relationship, or by the discharge of the physician by the patient, or by the withdrawal from the case by the physician after giving the patient reasonable notice so as to enable the patient to secure other medical attention. A physician has the right to withdraw from

24. Id.
25. Furrow et al., supra note 11, at 199.
27. Id. at 356.
28. Id. at 360.
29. Ricks v. Budge, 91 Utah 307, 64 P.2d 208, 212 (1937) (citing Ballou v. Prescott, 64 Me. 305, 306, 1874 WL 3814 (1874)) (“The care and skill which a professional man guarantees to his employer are elements of the contract to which he becomes a party on accepting a prof ered engagement. They are implied by the law as resulting from that engagement, though it be but verbal, and nothing said in relation to such elements. So continued attention to the undertaking so long as attention is required in the absence of any stipulation to the contrary, is equally an inference of the law”); id. (citing Mucci v. Houghton, 89 Iowa 608, 57 N.W. 305, 306 (1894)) (“If a physician or surgeon be sent for to attend a patient, the effect of his responding to the call, in the absence of a special agreement, will be an engagement to attend the case as long as it needs attention, unless he gives notice of his intention to discontinue his services, or is dismissed by the patient; and he is bound to exercise reasonable and ordinary care and skill in determining when he should discontinue his treatment and services”).
Physician–Patient Relationship and Professional Standard of Care

a case, but if the case is such as to still require further medical or surgical atten-
tion, he must, before withdrawing from the case, give the patient sufficient
notice . . . 31

Although reasonable notice is often described as thirty days, the Seventh
Circuit has suggested (in dicta) that sufficient notice may be a time frame as
short as ten days.32

In addition to the obligation of continuing attention, a physician’s abil-
ity to terminate the physician–patient relationship is constrained by statute
and provider contracts. First, legislation such as the Emergency Medical
Treatment and Active Labor Act (EMTALA) constrains a physician’s ability
to terminate treatment and end the physician–patient relationship.33
EMTALA applies to hospitals that have entered into provider agreements
with the Department of Health & Human Services, Centers for Medicare &
Medicaid Services to accept Medicare reimbursement.34 The statute gov-
erns when and how a patient may be refused treatment or be transferred
to another hospital, and EMTALA imposes civil monetary penalties up to
fifty thousand dollars per violation assessed against on-call physicians who
fail to respond or refuse to respond within a reasonable time after notifi-
cation.35 EMTALA requires physicians to respond to patients who present
to hospitals with an emergency medical condition.36 Moreover, the phy-
sician is constrained from terminating the physician–patient relationship
and withdrawing from treatment by case law, permitting a cause of action
against the physician for abandonment.37

Second, the physician–patient relationship is terminated when a physi-
cian is terminated from his provider contract. However, a contractual duty
of continuing care may arise for the terminated physician.38 In Wisconsin,
the Continuity of Care Law provides patients, providers, and payors with rights and responsibilities regarding continued treatment of patients by their current healthcare providers, and the reimbursement for such treatment, if the provider’s participation within the patient’s health plan (i.e., the provider contract) is terminated. The time period for providing continuing care to patients of terminated providers varies based on the physician’s relationship with the patient (e.g., primary care physician, specialist, maternity care), with the continuing care extending up to the end of the plan year for primary care physicians.

It is essential for attorneys representing both plaintiffs and physicians to understand the inception and termination of the physician–patient relationship. If a physician’s duty to the plaintiff, and consequently any negligence, is conditioned upon a patient–physician relationship, a plaintiff’s success in a medical malpractice trial must begin with adequately proving the existence of the physician–patient relationship. Refining the standards of care that physicians must meet to avoid liability for medical negligence should begin with an analysis of the foundation of this standard—the duty owed to the patient (i.e., when the physician–patient relationship attaches and what the standard of care requires). A clearer understanding of the physician–patient relationship and more accurate methods to predict when courts will find the existence of this relationship may be one of the tactics to more accurately streamline the tort system and contain costs by eliminating unmerited claims where no physician–patient relationship existed.

III. SETTING THE STANDARD OF CARE FOR PHYSICIAN LIABILITY

After a plaintiff establishes the existence of a physician–patient relationship, the next step in establishing a successful medical negligence claim is to offer proof of the physician’s negligence. For each medical malpractice claim, a plaintiff must successfully prove the four elements at the foundation of any negligence claim—duty, breach, cause, and harm. In terms of medical negligence, a plaintiff generally must show (1) the applicable stan-

39. See Wis. Stat. § 609.24(1)(d) (2006) (discussing the requirements of Wisconsin’s Continuity of Care Law, including that the law does not apply if the provider no longer practices in the geographic area of the payor’s plan or if the provider was terminated from the plan for misconduct).
40. Id. § 609.24(1)(c).
41. James Gibson, Doctrinal Feedback and (Un)reasonable Care, 94 Va. L. Rev. 1641, 1656–57 (2008) (discussing the “famously ambiguous reasonable care standard”).
42. See Clark C. Havighurst et al., Health Care Law & Policy: Readings, Notes, and Questions 992 (2d ed. 1998); Gil v. Reed, 381 F.2d 649, 658 (7th Cir. 2004) (citing Paul v. Skemp, 242 Wis. 2d 507, 625 N.W.2d 860, 865 (2001)) (“To make out a claim for medical malpractice or negligence in Wisconsin, a plaintiff must prove the following four elements: (1) a breach of (2) a duty owed (3) that results in (4) injury or injuries, or damages”).
Physician–Patient Relationship and Professional Standard of Care

standard of care creating the physician’s duty to the plaintiff, (2) defendant’s breach of that standard of care, (3) legal causation between the alleged breach and the plaintiff’s injury, and (4) plaintiff’s legally compensatory injury. Stated differently, “[i]n order to succeed at trial, the plaintiff must establish the standard of care, show that the defendant failed to conform to the standard of care, and prove that the defendant’s failure to conform to the standard of care caused the plaintiff’s injury.”

In ordinary claims of negligence, the standard of care is “the degree of care that a reasonable person of ordinary prudence would have exercised under the same or similar circumstances.” According to the Restatement (Second) of Torts, a defendant is negligent if he departs from the objective, external standard of care “demanded by the community for the protection of others against unreasonable risk.” The reasonable man of ordinary prudence is never negligent, and his conduct matches this standard. This reasonable man standard is the standard applied to any analysis of a physician’s standard of care.

Although all of the elements of negligence are required for a successful suit, establishing the applicable standard of care—and, subsequently, the defendant’s duty to the plaintiff—may be the most important, as it sets the tone for how evidence is introduced. Based on basic principles of tort law, the standard of care for physicians is the same “reasonable man” standard, except the reasonable man is attributed with the skill and care of a physician of like training and skills to the defendant–physician. A suit for medical malpractice can arise “when a physician fails to exercise the degree of care and skill usually employed by the average practitioner under similar circumstances.” This is an important aspect of physician liability because defendant-physicians are evaluated alongside and held to the level of care provided by “a reasonable physician with like skill and care under the same or similar circumstances.” Accordingly, with generally only one exception, a physician is held to the standard of care of a reasonable physician with like training and knowledge. The exception to this standard is that a physician who holds himself out as having specialized skill, training,
or knowledge will be held to the reasonable standard of a physician who truly holds the specialized knowledge.\textsuperscript{51}

The application and analysis of the reasonable man standard to determine physician negligence is effectuated differently under three methodologies: the locality rule, the national standard of care, and judicial standard setting. Use of these methodologies varies among jurisdictions, and the process of setting the standard of care varies with the application of each different methodology.

A. Locality Rule

The locality rule developed as a method for assessing the physician standard of care taking into account a “variety of resource conditions.”\textsuperscript{52} The locality rule holds the physician to the standard of care “exercised by physicians in the defendant’s own community or locality.”\textsuperscript{53} The Massachusetts Supreme Judicial Court case \textit{Small v. Howard} is credited as the origin of the locality rule.\textsuperscript{54} In \textit{Small}, the defendant was a country surgeon who treated the plaintiff for a severe cut on his wrist (the gash split tendons and muscles down to the bone), despite the fact that a more experienced and eminent surgeon was a mere four miles away.\textsuperscript{55} The plaintiff was unhappy with his treatment, and in his suit for medical malpractice, the plaintiff claimed the defendant “did not furnish that degree of skill, learning, and experience which was required of him . . .”\textsuperscript{56} The Massachusetts Supreme Judicial Court affirmed the trial court judgment for the defendant-surgeon and created the locality rule:

\begin{quote}
[W]e think it was correct to rule that “he was bound to possess that skill only which physicians and surgeons of ordinary ability and skill, practising \textsuperscript{[sic]} in similar localities, with opportunities for no larger experience, ordinarily possess; and he was not bound to possess that high degree of art and skill possessed by eminent surgeons practising \textsuperscript{[sic]} in large cities, and making a specialty of the practice of surgery.”\textsuperscript{57}
\end{quote}

“No wrong was done to the plaintiff in the trial,” but the court held, however, that if the defendant-surgeon was not qualified to treat the

\begin{footnotes}
\item[51] See id. ("It does not matter whether the physician led any specific patient to have an actual expectation that the physician would exercise a greater level of skill, so long as the physician has taken ‘affirmative steps’ to present himself or herself to the public as a specialist.").
\item[52] Morreim, \textit{supra} note 1, at 1729.
\item[56] Id. at 135, 1880 Mass. LEXIS 24, at *7.
\item[57] Id. at 136, 1880 Mass. LEXIS 24, at *10.
\end{footnotes}
plaintiff’s condition, the case should have been referred “to a more skilful surgeon.”

The Small court created the locality rule, but it did not delineate a necessary size or scope for a sufficient locality. This has led to a number of variations and the modified locality rule. The standard of care under the locality rule developed as a recognition of varied standards of medical education, available resources, and funding that created a disparity between opportunities for learning and practice in urban versus rural areas. However, the Small court did not define the appropriate locality, medical technology advanced, and the availability of resources increased; consequently, courts modified the locality rule to expand the physician’s community or locality to include the “same or similar community,” “similar communities nearby,” or “communities across the state.”

For example, in Walls v. Boyett, the standard of care was a modified locality rule:

[A] physician or surgeon in the treatment of patients is required to possess and to exercise that degree of skill and learning ordinarily possessed and exercised by members of his profession in good standing, practicing in the same line, and in the same general neighborhood, or in similar localities.

At one time, most states adopted the locality rule or the modified locality rule, but use of the locality rule as a basis to evaluate physician skill and knowledge is becoming the minority. Advances in technology, standardization in medical schools, required physician certification, and increased availability of technology and resources no longer necessitate taking into account “local” factors to qualify a standard of care. In fact,
the Massachusetts Supreme Judicial Court overruled Small in a 1968 case, Brune v. Belinkoff, where the court held that “the ‘locality’ rule of Small v. Howard . . . is unsuited to present day conditions.”64

B. National Standard of Care

The national standard of care developed in the context of advancements in the medical field and difficulties acquiring expert witnesses under the locality rule. First, technology and medical education evolved, and physicians throughout the country began receiving education with little variation.65 Second, finding physicians willing to testify as a plaintiff’s medical expert against another physician in the community was almost impossible.66 The “conspiracy of silence” developed as other physicians or professional medical associations in the community intimidated and excluded physicians who were willing to testify against physicians in the community.67 As a result, plaintiffs’ attorneys were forced to go outside the locality of the alleged malpractice to find witnesses willing to testify as to the defendant-physician’s deviation from the standard of care; these “national” witnesses were not seen as credible as “local” witnesses because they did not have knowledge and experience of the specific practice standards of the locality that impacted upon the defendant-physician’s available treatment options. Difficulties finding expert witnesses in combination with increasing advancements in medicine and medical education set the context for the development of the national standard of care.

Under the national standard of care, the physician must act with the “degree of skill and care ordinarily possessed by a reasonable and prudent physician in the same medical specialty acting under the same or similar circumstances.”68 Wisconsin follows the majority of jurisdictions who now use a national standard of care instead of a locality rule to set the standard of care for physician negligence.69

In Hall v. Hilbun, the Mississippi Supreme Court adopted a national standard of care.70 Hall, a relatively healthy woman, was admitted to a hos-

65. Id.
67. Id.
69. See, e.g., Johnson v. Misericordia Cmty. Hosp., 97 Wis. 2d 521, 543, 294 N.W.2d 501, 513 (Ct. App. 1980), aff’d, 99 Wis. 2d 708, 301 N.W.2d 156 (1981) (“[T]he legal duty of a physician . . . is the reasonable exercise of that standard of care which is maintained by the average practitioner or institution in the same class or professional calling, acting under the same or similar circumstances”); Shier v. Freedman, 58 Wis. 2d 269, 206 N.W.2d 166 (1973), modified on other grounds and reh’g den’d, 58 Wis. 2d 269, 208 N.W.2d 328 (1973).
70. See generally 466 So. 2d 856 (Miss. 1985).
hospital in Pascagoula, Mississippi, with abdominal discomfort. 71 Dr. Hilbun, a general surgeon, consulted on the case, held himself out as having the adequate skill and knowledge to handle Hall’s case, suggested the pain was caused by an obstruction of the small bowel, and recommended a fairly noninvasive exploratory laparotomy. 72 After an apparently successful surgery, Dr. Hilbun left for the evening and did not check in with his patient or the hospital nursing staff about the postoperative course of treatment. 73 Hall complained of chest pain and was given sedatives. 74 Hall died over the night. 75 An autopsy performed on Hall’s body revealed that a sponge had been left in her abdominal cavity; although the sponge may have contributed to the pain, the medical examiners found that it did not cause Hall’s death. 76 Hall’s husband brought a wrongful death action against Dr. Hilbun, alleging fault in the defendant’s postoperative treatment. In a directed verdict for the defendant-physician, the trial court held that the plaintiff’s expert witness, a cum laude graduate of Harvard Medical School and a retired surgeon from Cleveland, Ohio, was “not qualified to give an opinion as to whether Dr. Hilbun’s post-operative regimen departed from the obligatory standard of care.” 77 The Mississippi Supreme Court affirmed the directed verdict, but upon rehearing, the court adopted a national standard of care. 78 In adopting the national standard of care, the court analyzed the “‘nationalization’ of medical education” that sparked the development of this rule:

We would have to put our heads in the sand to ignore the “nationalization” of medical education and training. Medical school admission standards are similar across the country. Curricula are substantially the same. Internship and residency programs for those entering medical specialties [sic] have substantially common components. Nationally uniform standards are enforced in the case of certification of specialists. Differences and changes in these areas occur temporally, not geographically.

Physicians are far more mobile than they once were. They frequently attend medical school in one state, do a residency in another, establish a practice in a third and after a period of time relocate to a fourth. All the while they have ready access to professional and scientific journals and seminars for continuing medical education from across the country. Common sense and

71. See id. at 860.
72. Id. at 860, 878.
73. Id. at 861.
74. Id. at 860–61.
75. Id. at 861.
76. Id.
77. Id. at 864.
78. See id. at 860.
experience inform us that the laws of medicine do not vary from state to state in anything like the manner our public law does.\textsuperscript{79}

The national standard of care, as defined in \textit{Hall v. Hilbun}, requires analysis of two elements: the competence of the physician and the facilities.\textsuperscript{80} First, the national standard of care requires that the physician’s care be competent. This competence-based duty of care uses a national standard for analysis of the defendant-physician’s knowledge and medical judgment:

Each physician . . . is expected to possess or have reasonable access to such medical knowledge as is commonly possessed or reasonably available to minimally competent physicians in the same specialty or general field of practice \textit{throughout the United States}, to have a realistic understanding of the limitations on his or her knowledge or competence, and, in general, to exercise minimally adequate medical judgment.\textsuperscript{81}

The competence-based duty of care requires that physicians meet a standard of medical knowledge or access to medical knowledge that is reasonably possessed or available to a physician with like skills (i.e., the same specialty) throughout the United States.\textsuperscript{82}

Second, under the national standard of care, the physician is required to have knowledge of available facilities. Regarding knowledge of facilities:

[E]ach physician has a duty to have a practical working knowledge of the facilities, equipment, resources (including personnel in health related fields and their general level of knowledge and competence), and options (including what specialized services or facilities may be available in larger communities . . . ) reasonably available to him or her as well as the practical limitations on the same.\textsuperscript{83}

Despite the national standard required in the competence-based duty element, the facilities element allows for introduction of evidence of local standards as a variation in “specialized services or facilities” available in larger communities.\textsuperscript{84} This “resources-based caveat” requires “adept use . . . of such medical facilities, services, equipment and options as are

\textsuperscript{79} Id. at 870.
\textsuperscript{80} See id. at 860.
\textsuperscript{81} Id. at 871 (emphasis added).
\textsuperscript{82} See id. Again, the one exception to this rule is that physicians who hold themselves out as having specialized knowledge or skill will be held to the standard of specialists with that knowledge or skill. See Zaverl v. Hanley, 64 P.3d 809, 817 (Alaska 2003) (holding that defendant-physician’s affirmative steps to present herself to the public as a specialist was sufficient to modify the standard of care to that of such a specialist).
\textsuperscript{83} Hall v. Hilbun, 466 So. 2d 856, 871 (Miss. 1985).
\textsuperscript{84} Id.
reasonably available.”85 However, the caveat recognizes that technology, equipment, and financial resources still vary across the country, and the standard takes into account that the technology and facilities available and accessible to a physician at large, urban hospitals (e.g., Harvard Medical School or Johns Hopkins) are different than those available to a physician in Pascagoula, Mississippi.86

This second facilities element of the national standard of care is surprisingly accepting of local standards for a “national” standard. The standard requires “adept use” of reasonably available options but also takes into account local variation. Despite inclusion of both a “national” component and “local” component, the facilities element does not clarify what evidence and knowledge are controlling under the national standard of care analysis. Further clarification of the required “adept use” and “working knowledge” of differences between localities may be a context for minor reform.

C. Judicial Standard Setting

In addition to setting the standard of care based on standards of practice in a locality or nationwide, courts have been willing to create and define their own standards of care when courts believe that the medical profession did not adopt the appropriate standard. Judicial standard setting is controversial and often debated as judicial activism because courts are willing to create a standard and apply it to the case at hand instead of creating solely prospective standards.87 In addition, these standards are then appropriate evidence of standards of care in any jurisdiction; courts can effectively create a national standard of care with one ruling.

For example, in *Helling v. Carey*, the Supreme Court of Washington created a standard of care for the defendant-physicians despite a jury finding that the physicians had met the standard of care.88 In *Helling*, the plaintiff met with the defendant-ophthalmologists for nearsightedness, and she was given contact lenses; the plaintiff returned to the defendants at least nine times over the next five years complaining of eye irritation.89 Until the final appointment, the defendant-ophthalmologists believed the plaintiff’s eye irritation and visual problems were attributable to complications from

85. *Id.* at 872.
86. *See id.*
89. *Id.* at 515–16, 519 P.2d at 981.
her contact lenses.90 It was at the final appointment that the defendants conducted eye pressure and field-of-vision tests on the plaintiff for the first time.91 The tests showed that the plaintiff had glaucoma, and at age thirty-two, she had effectively lost peripheral vision and had severe decreases in her central vision.92

The plaintiff brought a suit against the defendant-ophthalmologists, alleging that she “sustained severe and permanent damage to her eyes as a proximate result of the defendants’ negligence.”93 The Supreme Court of Washington discussed whether the defendants’ compliance with an established standard of care for the profession of ophthalmology—which did not require a pressure test to patients under forty years of age—should shield the defendants from liability where “the plaintiff has lost a substantial amount of her vision due to the failure of the defendants to timely give the pressure test. . .” The court reasoned that although the incidence of glaucoma for people under forty “may appear quite minimal” (one in 25,000 people), “that one person, the plaintiff in this instance, is entitled to the same protection, as afforded persons over 40, essential for timely detection . . . where it can be arrested to avoid the grave and devastating result of this disease.”95 Despite the fact that glaucoma was very rare among people under forty and the medical tests at issue had a high false positive rate, the court held that the one in 25,000 risk was sufficient to warrant additional testing on an increased number of patients under the age of forty.96

The court justified its role in creating this new standard: “What usually is done may be evidence of what ought to be done, but what ought to be done is fixed by a standard of reasonable prudence, whether it is usually complied with or not.”97 The court created a judge-made standard of care to supersede the medical profession’s existing standard of care: “Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission.”98 Because the national standard of care takes into account reasonable physicians nationwide, the standard created in *Helling* may be used as evidence

90. Id.
91. Id.
92. Id. at 516, 519 P.2d at 982.
93. Id.
94. Id.
95. Id. at 518, 519 P.2d at 983.
96. See id.
97. Id. at 518–519, 519 P.2d at 983 (citing Tex. & Pac. Ry. v. Behymer, 189 U.S. 468, 470, 23 S. Ct. 622, 623, 47 L. Ed. 905 (1903)).
98. Id. at 519, 519 P.2d at 983 (citing T.J. Hooper v. N. Barge Corp., 60 F.2d 737, 740 (2d Cir. 1932)). For criticism of the judicial activism of the *Helling* court, see Ellen Wertheimer, *Calling It a Leg Doesn’t Make It a Leg: Doctors, Lawyers, and Tort Reform*, 13 ROGER WILLIAMS U. L. REV. 154, 173 (2008).
of a standard of care in any jurisdiction, nationwide. In addition to concerns regarding judicial activism and retroactive application, the *Helling* holding is concerning because it supports courts creating standards of care that are essentially impossible to meet because they are not created until after the care has been rendered. A reform of medical negligence principles will include a needed reevaluation of judicial standard setting to decide whether courts or legislatures and the medical profession are better suited to create medical standards.

After *Helling*, the Washington legislature enacted a statute that defined a standard of care contrary to the court’s holding, which permitted physician liability “if, and only if, the defendant had failed to act as a reasonable medical professional in the circumstances.”99 Following the enactment of the statute, the Washington Supreme Court disregarded the Washington statute and reaffirmed its *Helling* holding in *Gates v. Jensen*: “[t]he doctrine of *Helling v. Carey*, that reasonable prudence may require a higher standard of care [than the applicable professional standard of care] applies.”100

A minority of courts follow the *Helling* approach.101 Instead, a majority of courts do not replace the medical profession’s custom or standard of care with a case-specific judicially determined standard.102 Wisconsin courts follow the majority approach in rejecting *Helling*:

[I]n most situations there will be no significant difference between customary and reasonable practices. In most situations physicians, like other professionals, will revise their customary practices so that the care they offer reflects a due regard for advances in the profession.103

Judicial standard setting can be contrary to the cost-effective strategies of tort reform. Courts sympathetic to plaintiffs create impossible and expensive standards requiring unnecessary treatment (*Helling*). Judicial standards apply retroactively, to the case at hand, and can be used as evidence of a standard of care in other jurisdictions (thanks to the national standard of care). One court has the ability to create a national standard of care based

---

100. *Id.* at 172–73 (discussing *Gates v. Jensen*, 92 Wash. 2d 246, 253, 595 P.2d 919, 924 (1979) (en banc)).
only on the facts of one specific case. Subsequently, physicians are no longer on notice of standards of care, and plaintiffs may bring suits for medical negligence with hopes that the court will create a standard in the particular case, thus allowing the plaintiff to proceed with an otherwise baseless claim. The fear of retroactively applicable judicially created standards of care may induce physicians to settle more malpractice claims to avoid the courtroom. Neither increasing malpractice insurance premiums nor providing false hopes for plaintiffs with otherwise unmerited lawsuits can improve methods of assessing medical negligence within the tort system. If judicial standards are to remain a viable method of setting a standard of care, they must apply prospectively to put physicians and potential plaintiffs on notice of the appropriate and required treatment methods.

D. Respectable Minority

Although courts often defer to medical customary practice in assessing violations of standards of care, a physician who departs from customary practice but still provides a standard of care that a “respectable minority” of physicians also provide can be exempt from liability for medical negligence.104 The respectable minority standard of care exception is a defense to medical negligence.105 The exception allows for variation in physician practice and clinical judgment, and a physician who pursues “one of several recognized courses of treatment” is not liable for this judgment call.106

For example, in Chumbler v. McClure, the defendant-neurosurgeon was not negligent because the defendant-physician was among a respectable minority of neurosurgeons who practiced the type of therapy at issue in the case.107 The male plaintiff was injured by an electrical explosion and subsequently consulted with the defendant, a Nashville neurosurgeon.108 The defendant diagnosed the plaintiff with cerebral vascular insufficiency and prescribed Estrogen, produced as a drug called Premarin.109 The side effects of Premarin were known to the defendant to be enlarged breasts and loss of libido.110 At trial, evidence was introduced to show that the


105. The respectable minority exception is similar to the “reasonable and prudent physician” exception to medical negligence where a physician is not liable for medical negligence if “a reasonable and prudent member of the medical profession under the same or similar circumstances” would perform the treatment performed by the defendant. Henderson v. Heyer-Schulte Corp., 600 S.W.2d 844, 847 (Tex. Civ. App. 1980).


107. See generally Chumbler, 505 F.2d 489.

108. Id. at 490.

109. Id.

110. Id.
defendant-neurosurgeon was the only neurosurgeon of nine neurosurgeons in Nashville using the Premarin therapy for the plaintiff’s condition. In light of this evidence, the court defined the respectable minority test:

Where two or more schools of thought exist among competent members of the medical profession concerning proper medical treatment for a given ailment, each of which is supported by responsible medical authority, it is not malpractice to be among the minority in a given city who follow one of the accepted schools.

The court was willing to find that one in nine physicians constituted a respectable minority so as to insulate the defendant-physician from liability for medical negligence.

In light of _Chumbler_, the question remains as to what constitutes a respectable minority. Some courts have attempted to answer this question; yet, the answers do not provide practical guidance to physicians and attorneys who represent either physicians or patients in medical negligence lawsuits. One method for defining a respectable minority is by size. A therapy or treatment that is followed by a “considerable number of physicians” is a respectable minority. However, some courts reject counting the number of physicians who practice the treatment at issue and instead require that the respectable minority approach be the “best available” treatment for the patient’s condition. With courts willing to extend the respectable minority exception to a minority of one and other courts requiring a “considerable number” or the “best available” treatment, courts have not defined a practical standard for assessing the respectable minority exception. A more definitive definition of a respectable minority will add to the cost-containment and reduction of litigation goals of tort reform. A clearer definition of a “considerable number of physicians” will allow more plaintiffs to settle their cases or succeed at the summary judgment phase because it will prevent physicians from proceeding to trial with only the respectable minority exception as their defense.

### IV. Proof of the Standard of Care

Whether a court follows a locality rule, national rule, or respectable minority rule, or adopts its own standard of care, a plaintiff must offer evidence establishing the applicable standard of care and proof of the defendant-physician’s negligent deviation from this standard. Expert medical witness

---

111. _Id._ at 492–93.
112. _Id._ at 492.
testimony is used, and often required, to establish both the standard of care and the defendant-physician’s negligent deviation from the standard.\textsuperscript{115}

With the exception of cases where a layperson is capable of comprehending the injury and alleged negligence without any specialized knowledge or medical training, medical expert testimony is essential to medical negligence cases.\textsuperscript{116} Some courts require expert testimony:

[J]uries must be informed as to the facts or criterion upon and by which the standard of ordinary skill and ordinary care and diligence rests and is regulated by the medical profession. . . . This evidence . . . must come from men learned in the profession because other witnesses are not competent to give it. Jurors and courts are not in any way conversant with what is entirely peculiar to the practice of medicine and surgery.\textsuperscript{117}

Medical experts are knowledgeable and trained in the medical profession and are thus uniquely qualified to analyze and critique the standard of care exercised by other medical professionals. The Wisconsin Supreme Court agrees that medical experts are essential to medical negligence lawsuits: “[m]edical malpractice cases require expert testimony to establish the standard of care.”\textsuperscript{118}

The plaintiff has the burden of proving the standard of care required of the defendant-physician and the defendant’s negligent deviation from this standard.\textsuperscript{119} This burden is met with introduction of expert testimony regarding the required standard of care.\textsuperscript{120} The abolition of the locality rule has lessened the plaintiff’s burden because the plaintiff no longer needs to contend with the conspiracy of silence and difficult burden of finding local physicians to act as expert witnesses against their colleagues. However,

\begin{footnotesize}
\begin{enumerate}
\item[115.] See generally Glenn v. Plante, 264 Wis. 2d 361, 663 N.W.2d 375 (Ct. App. 2003), rev’d on other grounds, 269 Wis. 2d 575, 676 N.W.2d 413 (2004); Robinson v. Wirts, 387 Pa. 291, 127 A.2d 706 (1956).
\item[116.] Glenn, 264 Wis. 2d at 370, 663 N.W.2d at 379; Hall v. Hilbun, 466 So. 2d 856, 873–74 (Miss. 1985) (“As a general rule, if scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue . . . [m]edical malpractice cases generally require expert witnesses to assist the trier of fact to understand the evidence.”); Robinson, 387 Pa. at 297, 127 A.2d at 710 (“A lay jury would presumably lack the necessary knowledge and experience to render a just and proper decision, they must be guided by the opinions of witnesses having special or expert qualifications. The only exception to this otherwise invariable rule is in cases where the matter under investigation is so simple, and the lack of skill or want of care so obvious, as to be within the range of the ordinary experience and comprehension of even non-professional persons.”); Cyr v. Gliesen, 150 Me. 248, 251, 108 A.2d 316, 318 (1954) (“The recognized and accepted rule is that expert evidence is essential to sustain an action for malpractice against a physician or surgeon.”); Fed. R. Evid. 702.
\item[119.] Id. at 81–82, 699 N.W.2d at 537.
\item[120.] See id.
\end{enumerate}
\end{footnotesize}
despite acceptance of “national” witnesses, the expert medical witness must still be familiar with the practice standards in the locality: “The standard of care is typically established by expert testimony on the customary practice in the profession or specialty.” 121

The need for both local and national knowledge and qualifications is demonstrated in Hall v. Hilbun.122 In Hall, the Supreme Court of Mississippi established the national standard of care and refined an evidentiary law test under which expert testimony is used to establish the standard of care.123 This test is used to show that the national physician expert knows the practice standards of the locality of the alleged negligence. The medical expert need not practice in the same locality as the defendant-physician: “where the expert lives or where he or she practices his or her profession has no relevance per se with respect to whether a person may be qualified and accepted by the court as an expert witness.” 124 A medical expert may offer his initial opinion based on the information reasonably available to the defendant-physician, “i.e., symptoms, [patient medical] history, test results, results of the [defendant] doctor’s own physical examination, x-rays, vital signs, etc.” 125 Based on this information, the expert may express his opinion regarding the “meaning and import of the duty of care.” 126 In addition, based on this information reasonably available to the defendant-physician, the expert may express opinions regarding the conclusions that “minimally knowledgeable and competent physicians in the same specialty or general field of practice would draw, or actions (not tied to the availability of specialized facilities or equipment not generally available) they would take” under the circumstances.127

The expert medical witness need not be familiar with local custom or practice standards in order to discuss a generalized standard of care, but an expert who is not familiar with local custom cannot comment on the defendant-physician’s alleged negligent deviation from the applicable standard of care. An expert’s location may come into play in the analysis of whether he or she is sufficiently familiar with local practice standards to discuss the defendant-physician’s negligent deviation from the standard. The medical expert may not express an opinion regarding whether the defendant-physician’s care complied with or fell short of the duty until

122. See generally 466 So. 2d 856 (Miss. 1985).
123. See id. at 867.
124. Id. at 874 (emphasis in original).
125. Id.
126. Id.
127. Id. at 874–75.
the medical expert has familiarized himself with the “customs of the medical community in question” and the facilities available to the defendant-physician.\textsuperscript{128}

In \textit{Hall}, the defendant-physician’s expert witness had practiced in Cleveland, Ohio, and moved to Pascagoula, Mississippi (the community of the alleged negligence), one month prior to the trial.\textsuperscript{129} This expert, who had practiced briefly in the defendant’s hospital, testified as to the differences in equipment, staff, and resources between Cleveland and Pascagoula, but the expert did not testify to differences in skill, medical knowledge, and general competence of a physician between the two medical communities.\textsuperscript{130} The plaintiff offered two expert witnesses, both from Cleveland, Ohio, one of whom was a \textit{cum laude} graduate of Harvard Medical School.\textsuperscript{131} The plaintiff’s experts could not testify to the standard of practice in Pascagoula, but they did testify to what the standard of care should have been.\textsuperscript{132} The trial court excluded the plaintiff’s expert witnesses and granted the defendant a directed verdict because the plaintiff’s experts were not qualified to testify to whether the defendant’s postoperative treatment was a negligent deviation from the required standard of care.\textsuperscript{133} The Supreme Court of Mississippi remanded the case for a new trial and held that the testimony of plaintiff’s expert medical witnesses was improperly excluded based on the newly articulated evidentiary law test regarding determining whether an expert witness is qualified to testify.\textsuperscript{134}

Under the evidentiary law test, the expert witness may not testify as to the defendant-physician’s negligence unless the expert is familiar with local practice standards.\textsuperscript{135} In \textit{Hall}, the plaintiff’s experts were not familiar with local custom; therefore, they could not testify as to the defendant-physician’s negligence. However, the court found that their testimony should be included in the retrial because “[e]ach was clearly competent to testify regarding matters related to the level of knowledge, skill, medical judgment and general competence a surgeon should have brought to bear

\textsuperscript{128} \textit{Id.} at 875; see First Commercial Trust Co. v. Rank, 323 Ark. 390, 400, 915 S.W.2d 262, 267 (1996) (requiring that expert be familiar with the practice standards in a similar locality. In defining the expert, the court explained: “It is that of persons engaged in a similar practice in similar localities, giving consideration to geographical location, size and character of the community. The similarity of communities should depend not on population or area in a medical malpractice case, but rather upon their similarity from the standpoint of medical facilities, practices and advantages.”).

\textsuperscript{129} Hall v. Hilbun, 466 So. 2d 856, 865 (Miss. 1985).

\textsuperscript{130} \textit{Id.} at 866.

\textsuperscript{131} \textit{Id.} at 863.

\textsuperscript{132} \textit{Id.} at 864.

\textsuperscript{133} \textit{Id.}

\textsuperscript{134} See \textit{id.} at 878.

\textsuperscript{135} \textit{Id.} at 875; First Commercial Trust Co. v. Rank, 323 Ark. 390, 400, 915 S.W.2d 262, 267 (1996).
in prescribing and administering the post-operative regimen for a patient such as Mrs. Hall.\textsuperscript{136}

The defendant’s expert was familiar with local custom and testified as to “differences in medical facilities, services and resources available to the practicing physician,” but the Mississippi Supreme Court found “no basis for believing that any of these differences, however, would have resulted in any qualitative difference in the regimen of post-operative care prescribed” (i.e., “a 37 year old woman such as Mrs. Hall may be expected to respond to an exploratory laparotomy the same whether she receives her surgery and post-operative care in Cleveland, Ohio, or Pascagoula, Mississippi”).\textsuperscript{137} Essentially negating the benefit of having a “local” witness, the differences between Pascagoula and other communities, described by the defendant’s expert witness, were not differences substantial enough to establish any need for a standard of care in Pascagoula that would vary from the national standard.

\textit{Hall} is a lesson for attorneys representing defendant-physicians to find expert witnesses to testify to substantial, qualitative differences in standards of care, so as to fully disqualify the testimony of plaintiff experts who testify only to a national standard. Had Dr. Hilbun’s expert offered qualitative differences in the standard of care in Pascagoula, Mississippi, Dr. Hilbun might have been more successful in negating the testimony of the plaintiff’s national experts.

The trial judge has the discretion to decide whether the physician offered as an expert witness is qualified as an expert.\textsuperscript{138} In deciding whether a physician listed as a medical expert witness is qualified to testify as an expert, the court may consider the specialty of the defendant.\textsuperscript{139} A number of courts require that the expert practice, have practiced, or be board certified in the same specialty as the defendant.\textsuperscript{140} Other courts allow physicians who are not in the same specialty to testify as expert witnesses as long as the alleged negligence at issue is general knowledge for all physicians.\textsuperscript{141}

\begin{itemize}
\item \textsuperscript{136} Hall v. Hilbun, 466 So. 2d 856, 878 (Miss. 1985).
\item \textsuperscript{137} \textit{Id}.
\item \textsuperscript{138} \textit{Id}. at 875.
\item \textsuperscript{139} \textit{See} David Polin, \textit{Qualification of Medical Expert Witness}, 33 AM. JURIS. PROOF OF FACTS 2d 179, § 10 (2008) (listing the “facts and qualifications, among others [that] tend to establish that a person is competent to give medical opinion testimony”).
\item \textsuperscript{140} Cheryl A. Cardelli & Eric J. Warsow, \textit{Expert Witness Standards in a Medical Malpractice Action}, 88 MICH. BUS. L.J. 30, 30 (Feb. 2009); \textit{see generally} Bell v. Hart, 516 So. 2d 562 (Ala. 1987) (Plaintiff-patient brought a suit for medical malpractice against a physician for negligent prescription of antidepressant drugs. The court did not allow a pharmacist, psychologist, or toxicologist to testify as expert witnesses.).
\item \textsuperscript{141} \textit{See generally} Hauser v. Bhattager, 537 A.2d 599 (Me. 1988) (a general surgeon could testify as to defendant-plastic surgeon performing an elective procedure); Fiedler v. Spoelhof, 483 N.W.2d 486 (Minn. Ct. App. 1992) (cardiologist could testify as an expert witness for a family physician).
\end{itemize}
In addition, a number of courts allow supplemental scientific evidence on the standard of care to buttress expert witness testimony; such additional admissible evidence includes physician practice guidelines or protocols, pharmaceutical instructions, the *Physicians’ Desk Reference*, a scientific treatise, or medical journals.142

Courts greatly differ on their choices to admit expert testimony as qualified expert witness testimony. A clearer set of guidelines for determining whether a witness is qualified may help to streamline the process and reduce costs, as it will eliminate situations similar to *Hall*, where a directed verdict for the defendant was granted at the close of the plaintiff’s case, only to be overturned by the Mississippi Supreme Court and then remanded for a new trial.143 If the Mississippi trial court had had a clearer set of guidelines or precedent for qualifying expert witnesses—other than that the determination is left to the trier of fact and can be overturned on appeal—there would have been no need to move the case all the way up to the Mississippi Supreme Court just to qualify the plaintiff’s expert witnesses. Reducing the number of appeals with a clearer standard to qualify expert witnesses will help achieve the cost-reduction purpose of tort reform without dramatically impacting the fundamentals of the tort system.

In addition, court discretion on what supplemental evidence, if any, is admissible regarding the standard of care varies widely between jurisdictions, and attorneys must be aware of courts’ tendencies. If a plaintiff is able to offer scientific evidence to buttress expert testimony, the plaintiff’s case is more credible than if the plaintiff were limited to expert witnesses. The variety in admissible scientific evidence may be a context ripe for minor reform. Setting a more consistent standard for admissibility of scientific evidence is a minor change to the tort system that would both put physicians and attorneys on notice of the range of materials that are sufficient to prove the standard of care and likely lead to a more standardized, streamlined, and cost-effective process for determining credibility of expert witnesses and admissibility of scientific evidence in medical negligence suits.

V. CONCLUSION

Proponents of tort reform seek to modify the tort system in order to reduce costs and reduce meritless lawsuits. However, the suggested methods of

---


143. See generally Hall v. Hilbun, 466 So. 2d 856 (Miss. 1985).
tort reform often propose dramatic reformulation of both the tort system, from changing statutes of limitations to capping damage awards, and the health care delivery system, from reformulating reimbursement methodologies to regulating insurance industry practices. The same cost-reduction and unmerited litigation reduction may be achieved by developing clearer, more precise methods for defining and analyzing the basic foundation of medical negligence principles—the physician–patient relationship and the standard of care. Small changes to these foundational concepts will achieve a number of benefits to the medical negligence system including reducing costs for cases that currently require unnecessary appeals in order to qualify an expert witness or establish a practice standard; decreasing meritless lawsuits filed with the hope of a public policy determination to define the physician–patient relationship or a judicially created standard of care; and alleviating the clogged court system by streamlining the medical negligence system with more definitive and practical definitions and processes for considering medical malpractice cases.