HIPAA'S Privacy Rule and State Privacy Laws: Roadblocks to Medical Organizations' Self-Policing Expert Medical Testimony

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Viral Sovereignty, Intellectual Property, and the Changing Global System for Sharing Pathogens for Infectious Disease Research

Sam Halabi

Access to biological samples is crucial to the research and development process that leads to diagnostics, therapeutics, and vaccines to address new and reemerging infectious diseases. However, access to biological samples has become an increasingly substantial barrier to this crucial step in the research and development process. Governments are increasingly asserting sovereign rights over biological resources, including human pathogens, insisting that transfer of biological samples be accompanied by agreements that specify the benefits those governments might receive with respect to future biomedical products.

The principal mechanism by which samples are shared under this system is the material transfer agreement (MTA). MTAs are contracts protected by law. If one of their provisions is not followed, the contract is breached and the wronged party has the right to bring action against the other, such as suing for damages. MTAs are used in connection with the transfer of materials for safekeeping purposes (for instance, storage in gene banks), research or commercial use.

International research collaborations in the field of infectious disease increasingly require researchers to be more extensively knowledgeable about MTA negotiations. Joint ventures and collaborations between scientists in biodiverse but resource-scarce countries in Africa, Asia, and South America are growing in importance to the identification, sampling, biobanking, and research of potentially human pathogenic viruses. Identifying these zoonotic viral threats in high-risk areas where diseases are most likely to emerge raises complex problems of material acquisition and transfer that may inhibit the research and development process.
Many biodiverse-rich countries do not have well-developed or adequate scientific capacities and resources to document and monitor the transfer of their biodiversity.

This article analyzes the substantial changes under way in the global system for infectious disease research as embodied by changing practice in negotiating MTAs. Instead of the open system of sharing bacterial and viral human pathogens that characterized the research system for much of the 20th Century, notions of “viral sovereignty”, access made contingent on sharing research benefits, and acrimonious negotiations are far more common. The increasing barriers to the flow of research material and related data, like genetic sequencing information, are posing threats to the development of diagnostics, therapeutics, and vaccines. The article assesses the extent of these barriers and proposes some win-win approaches that may address the global inequalities behind material transfer negotiation issues.

Successes and Failures of Social Health Insurance Schemes in Africa – Nigeria versus Ghana and Rwanda: A Comparative Analysis

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There is no doubt that for countries in Africa, a social health insurance (SHI) system represents perhaps the best avenue toward achieving universal health coverage (UHC) – the goal of every health system. First, the underlying ideology behind SHI, namely, solidarity, is consistent with African cosmology.

Additionally, because SHI involves a public-private sector partnership to raise funds for health care, the system addresses one of the greatest lingering challenges facing health systems and families in the region: the rising cost of health care. These two factors have led to success stories in some countries (Rwanda and Ghana), in that they have seen significant jumps in access to health care. But these same factors have also led to failures in other countries, for instance, Nigeria. The task of this paper is to determine not only the reasons for the failure in Nigeria but also to determine why Rwanda and Ghana are succeeding. Ultimately, the aim of this paper is to distill experiences from the success stories and use those lessons to transform health care financing in Nigeria and other similarly situated emerging health systems.

HIPAA’S Privacy Rule and State Privacy Laws: Roadblocks to Medical Organizations’ Self-Policing Expert Medical Testimony

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As part of the wave of medical malpractice reforms over the last several decades, efforts were initiated to ensure the reliability and credibility of expert witness opinion and testimony, which is the sine qua non of necessary proof for any such claim or lawsuit. Governing bodies of professional medical organizations and societies have crafted rules and regulations for their members that wish to
provide expert medical witness testimony. Where such testimony does not conform to these organizations’ standards, sanctions can be levied, including membership expulsion. Such self-policing has found favor with courts.

Before sanctions are imposed, however, necessary administrative investigations and hearings are conducted, focusing on the foundation of the organization member’s expert opinions. But in these proceedings, there is a significant problem which has never been examined or analyzed in the legal literature or in any published appellate court decision: the submission of the patient’s medical information by either the complaining party or the responding expert in violation of HIPAA’s Privacy Rule or state privacy laws. This article examines and confronts the roadblocks to the self-policing mechanisms of professional medical organizations that they present. It concludes by proposing alternative methodologies and relief that may overcome the legal and regulatory roadblocks presented by HIPAA’s Privacy Rule and state laws.
Foreword

The *Annals of Health Law and Life Sciences* Editorial Staff is proud to present our Winter 2019 Issue. Each year, our Editorial Board seeks out articles covering important and contemporary topics within the health law community. This issue particularly furthers the *Annals* tradition of covering a broad range of current and intriguing topics within health law and policy. These selected pieces contribute to the continued recognition of *Annals of Health Law and Life Sciences* as one of the country’s preeminent health law and policy journals.

The first article, authored by Sam Halabi, analyzes the impact of material transfer agreements on infectious disease research. Mr. Halabi discusses how important it is for researchers to have access to biological samples for infectious disease research and he further explains that the way to obtain these biological samples is through material transfer agreements. Halabi argues that these agreements are creating substantial barriers to the trade of biological samples and ultimately are posing threats to the development of diagnostics, therapeutics, and vaccines. After discussing these threats, Halabi offers solutions to address the negative consequences resulting from material transfer agreements.

The second article, authored by Obiajulu Nnamuchi, compares Nigeria’s implementation of its social health insurance (SHI) system with that of other African countries. Dr. Nnamuchi posits that the SHI system is the best route to achieve universal health care. However, Nigeria’s system has struggled to achieve success. By comparing Nigeria to Ghana and Rwanda, Dr. Nnamuchi discusses why implementing the SHI system can lead to success for some countries and failure for others. This comparison demonstrates why some countries are successful and shows how other countries, such as Nigeria, can learn from those success stories.

The final article, authored by Miles J. Zaremski, exposes how professional conduct programs’ self-policing efforts often result in the unauthorized disclosure of Protected Health Information (PHI), which violates the HIPAA Privacy Rule. Mr. Zaremski explains that professional conduct programs use a patient’s medical records to discipline the medical professional who provided an expert medical opinion in a medical malpractice claim. This use of the patient’s medical records has not been authorized by the patient, nor does it fall within an exception to the HIPAA Privacy Rule. Additionally, Mr. Zaremski analyzes Illinois privacy law, which is more strict than the HIPAA Privacy Rule. Finally, Mr. Zaremski offers solutions that could allow for the lawful use of a patient’s PHI in these specific hearings.
On behalf of the entire *Annals of Health Law and Life Sciences* Editorial Staff, I would like to thank Sam Halabi, Obiajulu Nnamuchi, and Miles Zaremski for contributing their extraordinary talent and knowledge to this outstanding issue. This issue is the manifestation of the authors’ scholarship and passion, as well as their exceptional collaboration and professionalism. The Editorial Board and I would like to thank every member of the *Annals* team for their enthusiasm, commitment, and diligence throughout the editing process. I would also like to express my sincerest gratitude to my colleagues on the Executive Board: Kaleigh Ward, Kara Simon, Allyson Thompson, Chloe Cunningham, Emily Boyd, and Lianne Foley. Additionally, I would like to acknowledge the outstanding efforts of our Senior Editors: Abigail Elmer, John Meyer, Jessica Sweeb, and Victoire Iradukunda. Finally, we would like to thank the amazing faculty at the Beazley Institute for Health Law and Policy for their continued support of our endeavors. The success of this issue would not have been possible without the hard work and dedication of everyone involved.

It is with great pride that we present the Winter 2019 Issue of *Annals of Health Law and Life Sciences*.

Sincerely,

Mary Hannosh
Editor-in-Chief
*Annals of Health Law and Life Sciences*
HIPAA’S Privacy Rule and State Privacy Laws:
Roadblocks to Medical Organizations’ Self-Policing 
Expert Medical Testimony

*Miles J. Zaremski*

*Douglas M. Belofsky*

“And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets.” – Hippocratic Oath

I. INTRODUCTION

Fifteen years ago, Russell M. Pelton published an article titled “Medical Societies’ Self-Policing of Unprofessional Expert Testimony.” Pelton addressed the “current medical malpractice maelstrom,” observing that “at least from the perspective of the medical profession, a crisis of unprecedented

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magnitude is upon us.”² He posited that “[a]t least some percentage of the current medical malpractice crisis is a direct result of unprofessional, sometimes outrageous, ‘expert’ testimony offered by members of the medical profession and, just as importantly, the inability or refusal of responsible parties to seriously police that conduct.”³ Pelton advocated self-regulation by the medical profession, and cited as a benchmark the program that had been adopted by the American Association of Neurological Surgeons, Inc. (AANS).⁴ The AANS pioneered the establishment of rules for its members’ expert testimony as well as grievance procedures for alleged violations of those rules (Professional Conduct Programs).⁵

The AANS was reacting to the medical malpractice “crisis” of the early 1970s caused by spikes in insurance premiums for providers and the number of medical malpractice claims brought against them.⁶ Thereafter, the tort reform effort grew in various venues,⁷ including civil justice reforms seeking to reign in and oversee expert testimony, the sine qua non for success or failure in a medical malpractice lawsuit.⁸ Policing medical professionals’

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². Id. at 549.
³. Id. at 549-50.
⁴. See Id. at 554 (stating that AANS’s program has been endorsed by the courts and the AMA and is the leading program in the country used to discipline member physicians).
⁷. See Hofmann, supra note 6 (outlining the various events, government, and interest groups that contributed the evolution of tort reform).
involvement in litigation by their own medical societies was one approach to
do this.9

The AANS describes why its Professional Conduct Program was
established on its website: “. . . to provide a forum and due process
procedures to evaluate complaints lodged by one AANS member against
another and to make recommendations to the AANS Board of Directors for
action (dismissal or sanctions) on such complaints.”10 The AANS’ rules for
medical expert opinion services “. . . are intended to ensure a standard of
quality and impartiality in expert testimony provided by neurosurgeons on
either side of professional liability cases.”

Several other organizations, as referenced in the pages that follow, have
adopted Professional Conduct Programs to address members that wish to
offer expert opinion in adversarial proceedings, regardless of the venue.12
The type of “policing” of expert medical testimony that Pelton advocated is
reflected in the rules of these organizations, which establish standards for
how their members should offer expert testimony.13 Additional rules have
been adopted to provide for the investigation of a charge that a member’s
expert testimony violated an organization’s standards and for hearings on
those charges if necessary.14 Proceedings under these programs are typically
initiated by a grievance filed by a defendant in a medical malpractice claim,
whether victorious or not, who feels aggrieved by an opposing expert’s
opinions on the medical care provided to the patient who asserted the
malpractice claim.15 However, to evaluate the grievance, medical records

well as medical professional organizations provide oversight of medical expert witness
testimony).

9. See Id. (stating that over the past decade medical professional societies have become
more involved in “policing expert witness testimony by their members); See Pelton, supra
note 1, at 549-50 (stating that “[a]t least some percentage of the current medical malpractice
crisis is a direct result of unprofessional, sometimes outrageous, ‘expert’ testimony offered
by members of the medical profession and, just as importantly, the inability or refusal of
responsible parties to seriously police that conduct.”).

10. AANS Bylaws, AM. ASS’N NEUROLOGICALSURGEONS, https://www.aans.org/About-

11. THE AANS PROFESSIONAL CONDUCT PROGRAM, supra note 5.

12. See sources cited infra note 54 (highlighting a number of organizations that have
adopted Professional Conduct Programs).

13. See generally AANS Rules for Expert Opinion, supra note 5; see infra notes 39 and
47 (articulating guidance for how an organization’s members should offer expert opinions).

14. See, e.g., AANS Procedural Guidelines, supra note 5, at 2-5 (adopting guidelines for
when an expert’s testimony may need to be investigated).

15. See e.g., AAOS Board Considers Grievances filed under the Professional
Nov. 15, 2018) (discussing grievance against John S. Toohey, MD regarding “statements
made. . . in his initial and second expert reports and deposition testimony as an expert in a
medical liability lawsuit”).
and information relating to the patient must be presented by both the treating physician and the opposing expert.\textsuperscript{16} Much of that evidence would have been obtained in discovery but not entered into the public record for the underlying malpractice case, even if the case went to trial and both the treating physician and the expert testified.\textsuperscript{17} Typically, the patients whose treatment is at issue are not advised of a subsequent grievance filed by their treating physicians before a medical society, nor are they asked to authorize the submission of their medical records.\textsuperscript{18}

Even before Pelton raised his concerns about the medical malpractice “maelstrom,” the judiciary had taken steps to emphasize its gatekeeping function in the use of expert testimony.\textsuperscript{19} In the 1993 decision in \textit{Daubert v. Merrell Dow Pharmaceuticals, Inc.}, the Supreme Court noted that “under the [Federal Rules of Evidence,] the trial judge must ensure that any and all scientific testimony or evidence admitted is not only relevant, but reliable.”\textsuperscript{20} Since the \textit{Daubert} decision, Federal Rule of Evidence 702 has been amended to ensure that an expert may only testify to his or her opinion when the opinion “is based on sufficient facts or data,” the opinion “is the product of reliable principles and methods” and “the expert has reliably applied the principles and methods to the facts of the case.”\textsuperscript{21}

Pelton recognized that the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA),\textsuperscript{22} and what is commonly known as the HIPAA Privacy Rule,\textsuperscript{23} imposed limits on the medical evidence available to Professional Conduct Programs.\textsuperscript{24} But Pelton doubted that they would “compromise the effectiveness” of those Programs, claiming:

Under the AANS’ program, testimony is never reviewed until the underlying litigation is completed, in order to obviate any charge of witness tampering. As a result, typically the challenged testimony and related medical evidence have already been made a matter of public record in the trial and are no longer confidential. In addition, in those instances

\begin{footnotesize}
\begin{enumerate}
\item See AANS Procedural Guidelines, supra note 5, at 1; see Prof’l Compliance Program Grievance Procedures, infra note 52, at 7 (outlining what information is provided to Committee members when reviewing grievances).
\item See infra notes 62-86 and accompanying text.
\item But see infra note 69 (emphasizing that the patient whose medical records were used in \textit{Brandner} did not authorize their submission and raised HIPAA privacy concerns).
\item Cynthia H. Cwik, \textit{Guarding the Gate: Expert Evidence Admissibility}, 25 \textit{Litig.} 6, 6 (1999) (discussing the importance of expert evidence and the unique challenges expert evidence presents to judges, juries, and litigators).
\item \textit{Fed. R. Evid.} 702(b)-(d).
\item 45 C.F.R. § 164.502 (2013).
\item Pelton, supra note 1, at 559.
\end{enumerate}
\end{footnotesize}
where some evidence is not a matter of public record it is not difficult to have it depersonalized.\textsuperscript{25}

This article argues that the HIPAA Privacy Rule and state privacy laws do, however, impose substantial roadblocks to the work of Professional Conduct Programs, prohibiting them from examining most of the medical evidence underlying expert medical testimony in most cases. The HIPAA Privacy Rule established a foundation of federal protection for protected health information (PHI), balancing the need to protect such information with the need to avoid unnecessary barriers in delivering quality health care by providing exceptions to protecting such PHI.\textsuperscript{26} The Rule generally prohibits “covered entities,” defined as health plans, healthcare clearinghouses, and healthcare providers, from disclosing a patient’s PHI.\textsuperscript{27} It allows the use and disclosure of PHI for certain health care operations, such as administrative, billing, legal and quality improvement activities.\textsuperscript{28} PHI may be disclosed to an insurance company or hospital in an invoice, or to a law firm representing the patient, or to a provider’s peer review committee for an investigation into care and treatment.\textsuperscript{29} States such as Illinois have imposed stricter privacy requirements upon providers than the HIPAA Privacy Rule.\textsuperscript{30} Patients can thus expect that providers will only use and disclose their health care information when necessary for treatment, payment, and, health care operations.\textsuperscript{31} They do not expect, nor does the HIPAA Privacy Rule or Illinois law permit, the disclosure of PHI to a private organization to evaluate the expert medical opinions offered in medical malpractice claims to which the patients were parties.\textsuperscript{32}

Despite the sanguine approach to patient privacy advocated by Pelton and codified in some Professional Conduct Programs’ rules, the identity of the patient behind a medical malpractice claim can usually be found through

\begin{thebibliography}{99}
\bibitem{25} Pelton, \textit{supra} note 1, at 559.
\bibitem{26} \textit{When HIPAA covered entities can disclose protected health information to public health authorities}, PUB. HEALTH EMERGENCY, https://www.phe.gov/about/OPP/dhs/pdf/hipaa-policybrief.aspx (last reviewed by website publisher Apr. 21, 2016).
\bibitem{27} 45 C.F.R. § 160.103 (2014); Beard v. City of Chicago, 299 F. Supp. 2d 872, 873 (N.D. Ill. 2004).
\bibitem{28} 45 C.F.R. § 164.502 (2013); Beard, 299 F. Supp. 2d at 874.
\bibitem{29} 45 C.F.R. § 164.506 (2013).
\bibitem{30} \textit{See} Medical Patient Rights Act, 410 ILL. COMP. STAT. 50/3 (d) (2015) (establishing patients’ right to privacy and confidentiality of records, including restrictions on disclosures by physicians, health care providers, health services corporations and insurance companies).
\bibitem{31} 45 C.F.R. § 164.506(b)(1) (2013) (stating that “a covered entity may obtain consent of the individual to use or disclose protected health information to carry out treatment, payment, or health care operations”).
\bibitem{32} \textit{Supra} note 29 (listing permitted disclosures under the HIPAA Privacy Rule); \textit{supra} note 30 (listing permitted disclosures under the Medical Patient Rights Act).
\end{thebibliography}
simple internet searches of the docket for the malpractice cases giving rise to these grievances.\textsuperscript{33} Additionally, many commercial entities maintain searchable databases of personal injury cases, which includes information such as the names of the parties, their attorneys and their experts, as well as summaries of the allegations, the injuries, and the resolutions.\textsuperscript{34} The ease with which the identity of the patient can be found makes it nearly impossible for a treating physician to comply with the “de-identification” requirement of the HIPAA Privacy Rule when PHI is submitted to a Professional Conduct Program.\textsuperscript{35} Physicians against whom a malpractice claim has been brought thus routinely breach the Rule and state privacy laws when they submit PHI in support of grievances they initiate against the experts who testified against them.

Recent litigation over Professional Conduct Programs has confirmed that public policy favors the self-policing of expert testimony by medical societies.\textsuperscript{36} This is a Hobson’s choice between the ability of medical societies to self-police and a patent’s privacy under HIPAA.

There are solutions for this dilemma, which include amending Professional Conduct Programs’ rules to require a patient’s written authorization before the submission of his or her PHI or amending the HIPAA Privacy Rule to exempt Professional Conduct Programs from its requirements. This article will conclude that the best solution is to amend Professional Conduct Programs to require written authorizations from patients whose PHI will be examined due to the difficulty of amending the Rule and the varied requirements of state privacy laws, such as those in Illinois.

This article will first provide a means to identifying the problem, its severity in general and its effect on patients. It will also discuss the best method for practitioners and courts to address the “standoff” between public policy that favors private entities corralling inappropriate expert medical testimony and privacy laws that ensure the medical privacy of individuals as patients. Additionally, this article will also address the HIPAA Privacy Rule’s pre-emptive effect on state privacy laws that may be more stringent

\textsuperscript{33} The plaintiff in a medical malpractice suit is generally the recipient of the medical treatment that gave rise to the claim and is thus listed as a party on the docket.

\textsuperscript{34} See, e.g., \textit{JURY VERDICT REPORTER}, https://www.juryverdictreporters.com (last visited Nov. 15 2018) (allowing people to click on a link which lists the details of a personal injury case including party names and settlements/verdicts); \textit{See also VERDICTSEARCH}, https://www.verdictsearch.com (last visited Nov. 15, 2018) (allowing people to estimate damages, research expert witnesses and opposing counsel, project trial success, and analyze insurers’ settlement offers).

\textsuperscript{35} \textit{See generally} 45 C.F.R. § 164.514 (2013) (listing the requirements for de-identification).

\textsuperscript{36} \textit{Austin v. Am. Ass’n of Neurological Surgeons}, 253 F.3d 967, 972 (7th Cir. 2001) (determining that self-regulation furthers, rather than impedes, the cause of justice).
than that Rule.

Illinois is the Petri dish for analysis since the state is a bastion for the headquarters of notable medical specialty organizations such as the AANS, the American Association of Orthopaedic Surgeons (AAOS), and the American Medical Association (AMA). Moreover, because Illinois’ privacy law is stricter than the HIPAA Privacy Rule, courts may use its state law rather than the Rule in deciding whether there has been an unauthorized disclosure of PHI. Thus, Illinois law will be a focus to demonstrate how other states may wish to confront these privacy issues and their relationship to the HIPAA Privacy Rule.

II. PHYSICIAN ORGANIZATIONS’ STANDARDS FOR EXPERT TESTIMONY

The AMA’s code of ethics recites: “medical evidence is critical in a variety of legal and administrative proceedings. As citizens and professionals with specialized knowledge and experience, physicians have an obligation to assist in the administration of justice.” The code of ethics requires physicians who testify as expert witnesses to “[e]valuate cases objectively and provide an independent opinion.” It provides that: “organized medicine, including state and specialty societies and medical licensing boards, has a responsibility to maintain high standards for medical witnesses by assessing claims of false or misleading testimony and issuing disciplinary sanctions as appropriate.”

The AANS’ “Rules for Neurosurgical Medical/Legal Expert Opinion Services” apply to its members that choose to offer opinions as an expert witness in legal or administrative proceedings, either by way of sworn statements, depositions, or during an adversarial proceeding like a trial. In

37. See Contact Us, AM. ASS’N OF NEUROLOGICAL SURGEONS, https://www.aans.org/Contact (last visited Nov. 15, 2018) (indicating that the Executive Office of the Am. Ass’n of Neurological Surgeons is located in Rolling Meadows, Ill.); See Contact the AAOS, AM. ASS’N OF ORTHOPAEDIC SURGEONS, https://www.aaos.org/contactus/ (last visited Nov. 15, 2018) (indicating that the AAOS headquarters is located in Rosemont, Ill.); See Contact Us, AM. MED. ASS’N, https://www.ama-assn.org/eform/submit/contact-us (last visited Nov. 15, 2018) (indicating that the contact address for the Am. Med. Ass’n is in Chicago, Ill.).
38. Supra note 35; See, e.g., 815 ILL. COMP. STAT. 530/5 (2017) (showing that the Ill. statute has a broader definition of what constitutes protected personal information than HIPAA).
39. CODE OF MED. ETHICS, at 22 (AM. MED. ASS’N 2016).
40. Id. at 23.
41. Id.
42. AANS Rules for Expert Opinion, supra note 5; See also Standards of Professionalism: Orthopaedic Expert Opinion and Testimony AM. ACAD. ORTHOPAEDIC SURGEONS/AM. ASS’N ORTHOPAEDIC SURGEONS(2010), https://www.aaos.org/member/profcomp/ewtestimony_May_2010.pdf [hereinafter AAOS STANDARDS OF PROFESSIONALISM] (describing how an orthopedic surgeon can provide an
the Rules, the AANS acknowledges that “[t]he American legal system often calls for expert medical testimony.”\(^{43}\) Proper functioning of this system requires that when such testimony is needed, it be truly expert, impartial and available to all litigants.”\(^{44}\) The AANS’ rules for such testimony are organized under three headings: “Impartial Testimony”, “Subject Matter Knowledge” and “Compensation.”\(^{45}\) The rules relating to Impartial Testimony include the requirement that an expert “be an impartial educator for attorneys, jurors and the court on the subject of neurosurgical practice.”\(^{46}\)

The AAOS has adopted its own “Standards of Professionalism” for Orthopaedic Expert Opinion and Testimony.\(^{47}\) In those Standards, the AAOS recognizes that:

> It is in the public interest for orthopaedic testimony and medical opinions to be readily available, knowledgeable and objective. As a member of the orthopaedic profession, an orthopaedic surgeon must recognize a responsibility to provide testimony and expert medical opinions that are truthful, scientifically correct and appropriate for the context of the issues being considered.\(^{48}\)

The AAOS Standards apply to members “who provide expert opinions, testimony and other services. . . in the context of administrative, civil or criminal matters, [including] . . . writing expert opinions, signing certificates or affidavits of merit, reviewing medical records, and providing sworn testimony.”\(^{49}\) These Standards are drawn from the AAOS’ Code of Medical Ethics and Professionalism, which include the requirement that “[i]n providing opinions, the orthopaedic surgeon should ensure that the opinion provided is non-partisan, scientifically correct, and clinically accurate.”\(^{50}\) They include a “Mandatory Standard” that an expert witness shall provide oral or written medical testimony or expert medical opinions in “a fair and impartial manner.”\(^{51}\)

Both the AANS and the AAOS have established grievance procedures through which one member can make a complaint against another for an alleged violation of their associations’ standards for expert testimony.\(^{52}\) A

\(^{43}\) AANS Rules for Expert Opinion, supra note 5.

\(^{44}\) Id.

\(^{45}\) Id.

\(^{46}\) Id.

\(^{47}\) See generally AAOS STANDARDS OF PROFESSIONALISM, supra note 42.

\(^{48}\) Id.

\(^{49}\) Id.

\(^{50}\) CODE OF MED. ETHICS AND PROFESSIONALISM FOR ORTHOPAEDIC SURGEONS, (AM. ACAD. ORTHOPAEDIC SURGEONS/AM. ASS’N ORTHOPAEDIC SURGEONS 2011).

\(^{51}\) See AAOS STANDARDS OF PROFESSIONALISM, supra note 42.

\(^{52}\) See AANS Procedural Guidelines, supra note 5; see also PROF’L COMPLIANCE
member who is found to have violated those standards can be censured, suspended, or expelled from the organization.\textsuperscript{53} Other organizations, particularly those located in Illinois, have similar procedures.\textsuperscript{54} Typically, the complaint is heard by a designated committee, which makes recommendations to the organization’s board of directors.\textsuperscript{55} The organizations routinely receive and review medical records and information concerning the treatment of a patient by a member who is bringing charges against an expert that testified against said member.\textsuperscript{56} The accused member can appeal an adverse decision made by the board of directors to the membership at large.\textsuperscript{57}

### III. THE SUBMISSION OF PHI TO PROFESSIONAL CONDUCT PROGRAMS

A handful of physicians who have been sanctioned by Professional Conduct Programs for their expert testimony have attempted to challenge their sanctions, with a notable lack of success.\textsuperscript{58} Courts are deferential to the

\textsuperscript{53} See AANS Procedural Guidelines, supra note 5; see also Prof’l Compliance Program Grievance Procedures, supra note 52.

\textsuperscript{54} See American College of Surgeons, Statement on the Physician Acting as an Expert Witness, 96 BULL. AM. C. SURGEONS 1, 1 (2011); see also Code of Ethics of the Am. Soc’y of Plastic Surgeons (Am. Soc’y Plastic Surgeons 2017) (relating to “Expert Testimony” and “Enforcement”); see also Roger C. Bone & Edward C. Rosenow, ACCP Guidelines for an Expert Witness, 98 CHEST 1006, 1006 (1990); see also Guidelines for Expert Witness Qualifications and Testimony, (Am. Soc’y Anesthesiologists 2013); see also Am. Soc’y Anesthesiologists (ASA) Expert Witness Testimony Review Program Complaint Form (Am. Soc’y Anesthesiologists 2012); see also Committee on Medical Liability, Guidelines for Expert Witness Testimony in Medical Malpractice Litigation, 109 AM. ACAD. PEDIATRICS 974, 977 (2002); see also Stephan R. Paul & Sandeep K. Narang, Expert Witness Participation in Civil and Criminal Proceedings, 139 AM. ACAD. PEDIATRICS 1, 1 (2017) (stating that “[t]he American Academy of Pediatrics (AAP) first articulated a policy on appropriate medical expert testimony in 1989 [citation omitted] and was among the first medical specialty societies to do so.” Other revisions took place in 1994 according to expert witness guidelines from the Council of Medical Specialty Societies [citation omitted] and, thereafter, through 2016”); see also B. Sonny Bal, The Expert Witness in Medical Malpractice Litigation, 467 CLINICAL ORTHOPAEDICS & RELATED RES. 383, 385 (2009) (showing that since 1983, it was reported that through 2007 “. . .at least 18 other societies had followed the lead of the AANS”) (citing to Andrew D. Feld & William D. Carey, Expert Witness Malfeasance: How Should Specialty Medical Societies Respond?, 100 AM. J. GASTROENTEROLOGY 991, 995 (2005); see also Aaron S. Kesselheim & David M. Studdert, Role of Professional Organizations in Regulating Physician Expert Witness Testimony, 298 JAMA 2907, 2909 (2007)).

\textsuperscript{55} See AANS Procedural Guidelines, supra note 5; see also Prof’l Compliance Program Grievance Procedures, supra note 52.

\textsuperscript{56} See AANS Procedural Guidelines, supra note 5; see also Prof’l Compliance Program Grievance Procedures, supra note 52.

\textsuperscript{57} See AANS Procedural Guidelines, supra note 5 at 6; see also Prof’l Compliance Program Grievance Procedures, supra note 52, at 20.

\textsuperscript{58} Barrash v. American Ass’n of Neurological Surgeons, Inc., 812 F.3d 416 (5th Cir.)
organizations’ attempts to police their members’ expert testimony. Judge Posner, writing for the Seventh Circuit in Austin v. American Association of Neurological Surgeons, stated:

By becoming a member of the prestigious American Association of Neurological Surgeons, a fact he did not neglect to mention in his testimony in the malpractice suit against Ditmore, Austin boosted his credibility as an expert witness. The Association had an interest—the community at large had an interest—in Austin’s not being able to use his membership to dazzle judges and juries and deflect the close and skeptical scrutiny that shoddy testimony deserves. It is no answer that judges can be trusted to keep out such testimony. Judges are not experts in any field except law. Much escapes us, especially in a highly technical field, such as neurosurgery. When a member of a prestigious professional association makes representations not on their face absurd, such as that a majority of neurosurgeons believe that a particular type of mishap is invariably the result of surgical negligence, the judge may have no basis for questioning the belief, even if the defendant’s expert testifies to the contrary.

An issue apparently not addressed by the courts or in legal literature, however, is the use of PHI by organizations such as the AANS when evaluating whether their members violated their standards for providing expert testimony. Examining the judicial records developed in the handful of cases where experts attempted to challenge sanctions entered by Professional Conduct Programs shows that the submission of PHI is pervasive. Those records are easily accessible using the Public Access to Court Electronic Records (PACER) system. In each case, the parties’ efforts to de-identify the PHI submitted in support of a grievance fell short, leaving the PHI of a patient hiding in plain sight in the public record.

The difficulty of de-identification can be seen in the opinion of the U.S. District Court for the Northern District of Illinois in Brandner v. American Academy of Orthopaedic Surgeons, addressing an orthopaedic surgeon’s unsuccessful challenge to his suspension from the AAOS for violating its...
standards for expert testimony. In that opinion, the patient, the plaintiff in the medical malpractice case giving rise to the expert’s suspension, was never identified.

However, the opinion did disclose certain medical information about the patient, along with information sufficient to locate the docket of the malpractice case and, hence, the name of the patient. The opinion recited: “[i]n October 2004, Brandner was contacted to perform a records review and provide possible expert testimony in a medical malpractice case in Arizona. A minor patient was suing Dr. Kipling Sharpe for nerve damage that occurred during a surgery, a proximal tibial osteotomy, he performed on the patient’s leg.”

An internet search reveals where in Arizona Dr. Sharpe practices medicine. An online docket search for the Arizona state court in Dr. Sharpe’s jurisdiction reveals the malpractice case and the name of the minor patient.

Indeed, the pleadings that Dr. Brandner filed in the District Court alleged that Dr. Sharpe had not complied with the HIPAA Privacy Rule’s patient de-identification requirements in his grievance report to the AAOS. An affidavit submitted by the AAOS’ assistant general counsel addressed that deficiency, which was deemed rectified when Dr. Sharpe “resubmitted his grievance materials and de-identified the patient information.”

Dr. Sharpe also submitted fourteen pages of his treatment notes for his patient to the

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63. Id.
64. Id. at *2.
66. The Judicial Branch of Arizona, Maricopa County: Docket Civil Court Cases, http://www.superiorcourt.maricopa.gov/docket/CivilCourtCases/caseSearch.asp (last visited Oct. 11, 2018). The website for the Superior Court in Maricopa County allows anyone to search for a case in which Dr. Sharpe was a party. See www.superiorcourt.maricopa.gov/docket/CivilCourtCases/caseSearch.asp. The district court’s opinion in Brandner contains sufficient details of the proceedings in the malpractice case filed against Dr. Sharpe to confirm the identity of the plaintiffs. The opinion recites that Dr. Brandner was first consulted in October 2004, testified at his deposition on August 5, 2004 and testified at trial on April 29, 2008. Brandner, 2012 WL 4483820 at *2-3. A search of the docket for the Superior Court in Maricopa County reveals seven cases filed against Dr. Sharpe. Two were filed in 2003, and one was filed in 2004. Of those three, only one went to trial in April 2008.
67. Complaint ¶ 52, Brandner, 2012 WL 4483820 (opinion granting summary judgment) (No. 1:10-cv-08161) (Document No. 6, filed Dec. 30, 2010 which can be found on PACER system for N.D. Ill.).
68. Affidavit of Melissa A. Young ¶ 29, Brandner, 2012 WL 4483820 (opinion granting summary judgment) (No. 1:10-cv-08161) [hereinafter Young Affidavit] (Document No. 74, filed Nov. 22, 2011) (document can be found on PACER system for N.D. Ill.).
AAOS, with only the patient’s name and date of birth redacted. Those notes detailed the patient’s medical complaints, the history of his leg injury, the results of examinations, tests and x-rays, Dr. Sharpe’s diagnoses and treatment plans and the patient’s post-surgical complications. Dr. Sharpe’s grievance report also contained a portion of the patient’s deposition transcript, which identified the jurisdiction in which the case had been filed, the names of all of the defendants, and the attorneys representing the parties. Even the record of the District Court’s proceedings on Dr. Brandner’s claims against the AAOS contains vast amounts of PHI, which was contained in the affidavit submitted by the AAOS assistant general counsel. The affidavit contained exhibits of Dr. Sharpe’s grievance report, excerpts from the deposition, and trial testimony of the parties and their medical experts, all of which detailed the medical condition and treatment of Dr. Sharpe’s easily-identified patient.

Moreover, the affidavit submitted by the AAOS’ assistant general counsel acknowledged that the attorney for Dr. Sharpe’s patient had raised HIPAA objections to the AAOS proceedings. Dr. Brandner complained that he had no access to the records he had reviewed in the malpractice case because “the patient’s attorney refused to produce the materials because of privacy concerns under HIPAA.” One of the documents that Dr. Brandner submitted to the AAOS recited that the patient’s attorney had sent Dr. Sharpe a letter notifying him that he was violating the plaintiff’s HIPAA rights and demanding the return of all of the patient’s records submitted to third parties. The record is unclear as to what, if anything, the AAOS or Dr.

69. Young Affidavit supra note 68, at Exhibit 7.
70. Id.
71. Young Affidavit, supra note 68, ¶ 33; See Young Affidavit at Exhibit 8, at 3, Brandner, 2012 WL 4483820 (opinion granting summary judgment) (No. 1:10-cv-08161) (Document No. 74-8) (detailing the names of the attorneys who represented the parties); Young Affidavit at Exhibit 6 (Document No. 74-6, filed Nov. 22, 2011) (all documents can be found on PACER system for N.D. Ill.).
72. Young Affidavit, supra note 68.
73. See Young Affidavit at Exhibit 6, supra note 68 (including Dr. Sharpe’s grievance report); Young Affidavit at Exhibit 7, supra note 68 (including Dr. Sharpe’s treatment notes); Young Affidavit, supra note 68, ¶ 33 (including excerpts of plaintiff’s deposition transcript); Young Affidavit at Exhibit 11, Brandner, 2012 WL 4483820 (opinion granting summary judgment) (No. 1:10-cv-08161) (Document No. 74-11, filed Nov. 22, 2011 (including excerpts of Dr. Brandner’s deposition transcript); Young Affidavit at Exhibit 14 (Document No. 74-14, filed Nov. 22, 2011 with excerpts of plaintiff’s trial testimony); Young Affidavit at Exhibit 26 (Document No. 74-26 with transcript of the hearing on Dr. Sharpe’s grievance before the AAOS Comm. on Professionalism) (all documents can be found on PACER system for N.D. Ill.).
74. Young Affidavit at ¶ 63.
75. Id.
76. Young Affidavit at Exhibit 22, at 3, Brandner, 2012 WL 4483820 (opinion granting summary judgment) (No. 1:10-cv-08161) (Document No. 74-22, filed Nov. 22, 2011
Sharpe did in response to those allegations of violations of the HIPAA Privacy Rule. 77

The record of the District Court proceedings in Barrash v. American Association of Neurological Surgeons, Inc. also demonstrates how pervasive the submission of PHI is, at least to the AANS’ Professional Conduct Program. 78 In 2013, the Executive Director of the AANS submitted an affidavit in that case as part of the AANS’ efforts to resist the plaintiff’s attempts to review all of the grievance files from its Professional Conduct Program. 79 The affidavit recited that a typical grievance file consisted of at least one thousand pages of documents, including medical records, deposition transcripts, and trial transcripts submitted by the parties. 80 The brief submitted by the AANS in opposition to the plaintiff’s motion noted that, as of 2013, sixty-six grievances had been filed with its Professional Conduct Program. 78 79 80

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77. The Third Circuit’s opinion in Graboff v. Colleran Firm highlights the difficulty in protecting the identity of another patient whose treatment was at issue in a grievance proceeding. Graboff v. Colleran Firm, 744 F.3d 128 (3rd Cir. 2014). The case involved an AAOS member’s challenge to his two-year suspension from the organization after it found that he had violated its standards for expert testimony in a malpractice case filed against Dr. Menachem Meller. Id. at 131-32. The opinion did not name the patient, but recited: “In 2007, Dr. Graboff drafted an expert report that was used in Jones v. Meller, a malpractice case against Dr. Meller filed in the Court of Common Pleas of Philadelphia County, Pennsylvania.” Id. at 132. The patient’s full name can be found by searching for cases filed against Dr. Meller using the “Civil Docket Access link” at www.courts.phila.gov/publicaccess. Access to the Public Records of the First Judicial District of Pa., THE PHILA. COURTS: FIRST JUDICIAL DIST. OF PA., www.courts.phila.gov/publicaccess (last visited Nov. 15, 2018) (“Civil Docket Access Link” is under “Requests for Case Records of the Philadelphia Court of Common Pleas and Philadelphia Municipal Court”). Even without knowing that the plaintiff’s name was Jones, the malpractice case at issue in Graboff can be ascertained from the list of twenty-nine cases filed against Dr. Meller by reference to the date of Dr. Graboff’s report. Moreover, the public record in the District Court proceedings in Graboff contains documents submitted by both parties that not only name Dr. Meller’s patient, but also disclose the patient’s PHI in a number of ways. Those documents include the initial grievance report filed by Dr. Meller to the AAOS Committee on Professionalism, a letter authored by Dr. Graboff relating to the patient’s malpractice claim, and the report of the AAOS Committee on Professionalism on the grievance, all of which contained extensive discussions of the patient’s medical history. See Memorandum in Law in Support of Defendants Motion for Summary Judgment at Exhibit B, at 8, Graboff, 744 F.3d 128 (No. 2:10-cv-01710) [hereinafter Memorandum] (Document 80-4, filed 2/24/12) (showing the grievance report filed by Dr. Meller); Id. at Exhibit C, at 20 (Document 80-4, filed 2/24/12) (showing the letter authored by Dr. Graboff); Id. at Exhibit N, at 15 (Document No. 80-7, filed 2/24/12) (all documents can be found on PACER system for E.D. Pa.).


79. Defendant’s Opposition to Plaintiff’s Motion to Compel Response to Production Request at Appendix 3, Barrash, 2014 WL 5628807 (No. 4:13-cv-1054) (Document No. 38-3, filed 10/15/13 (document can be found on PACER system for S.D. Tex.).

80. Id. ¶ 6.
Conduct Program alleging a violation of its Rules for Expert Opinion Services.\textsuperscript{81} That brief acknowledged that the AANS’s grievance files contained identifiable PHI, and claimed that the production of those files “implicates the privacy rights of patients under HIPAA. Absent patient authorizations, the AANS would be forced to review medical records and transcripts from all 66 grievance files in order to locate and redact patient identifying information.”\textsuperscript{82}

The details of the AANS’ proceedings on the grievance filed against Dr. Barrash show how broadly the PHI submitted in those proceedings was disseminated to AANS members. The AANS’ bylaws permitted Dr. Barrash to appeal the sanction entered against him to the entire voting membership of the organization.\textsuperscript{83} As part of that appeal, the AANS sent each voting member a statement by Dr. Barrash and a response in support of the sanction written by the president of the organization (See Appendix A).\textsuperscript{84} Both Dr. Barrash’s statement and the president’s response contained extensive discussion of the PHI of the patient in question, but the president’s statement noted the jurisdiction in which the treating physician had been sued for malpractice.\textsuperscript{85} With that information, any member of the AANS could determine the patient’s identity.\textsuperscript{86}

\textit{A. Severity of the PHI Breach}

PHI of any one patient is important because it is private and confidential to that person. Accordingly, if PHI appears in a public domain stemming from any portion of a grievance proceeding that ultimately becomes public, that leads to that person’s identity to be in the public domain. Thus, privacy boundaries have been crossed. However, determining with any scientific


\textsuperscript{82} Id. at 8.

\textsuperscript{83} See Barrash, 812 F.3d at 418.

\textsuperscript{84} Def.’s Mot. Summ. J., Att. 23 at 16, Barrash, v. Am. Ass’n of Neurological Surgeons, Inc., No. 4:13-cv-01054, 2014 WL 5628807 (S.D. Tex. Nov. 4, 2014) (decision on cross-motions for summary judgment) (Document No. 78, filed Aug. 8, 2014 with the portion containing the president’s response to Dr. Barrash’s appeal included in this article as Appendix A) (document can be found on PACER system for S.D. Tex.).

\textsuperscript{85} Id. at 23.

\textsuperscript{86} The treating physician was identified only as Dr. Oishi, and the jurisdiction for the malpractice case filed against him was the “District Court of McLennan County, Texas.” That case can be found through a search begun at www.co.mclennan.tx.us/993/Case-Index-Search. By simply entering “Oishi” in a search for civil cases, three results with dates of filing are returned. Knowing the relative dates of the litigation and searching for Dr. Barrash’s name in the docket for the three cases, the relevant case, and thus the name of the patient can be readily ascertained.
accuracy just how prevalent this type of disclosure is during any given time frame can be difficult. Progressing through a step-by-step process elucidates why this problem has not been addressed.87

To begin with, the volume and contents of grievances actually filed with these organizations is unknown.88 To obtain such data generally requires membership and a member’s password or a PIN.89 Next come the investigations arising from these grievances.90 Only a fraction of grievances filed may rise to this level.91 From there, investigations that result in hearings may become an even smaller population.92 Even fewer are those cases that result in sanctioned conduct levied against the offending physician-respondent.93 Organizations typically make their membership and the public aware of those physicians so sanctioned, perhaps including the information in a membership publication or on the Internet.94 Lawsuits then challenging these sanctions are even a smaller lot, with published opinions yet an even smaller pile.95 Since violations of the HIPAA Privacy Rule are not determinative of an outcome decided by the organization’s grievance hearing committee, it would be an accident or merely fortuitous to uncover any mention of the Rule in a grievance, for example, as uncovered in the record in the Brandner case.96

87.  KATHY BAKICH & KAYE PESTAINA, EMPLOYER'S GUIDE TO HIPAA PRIVACY REQUIREMENTS ¶ 215 (Bus. & Legal Res. 2018) (giving an example of document with scientific data located on it but it was only used for the document and not the data in the proceeding).
88.  Id. at ¶ 214.
89.  Id. at ¶ 610 (explaining that online breaches of electronic PHI usually results from inadvertently enabling online access); see also Steve Emery et al., Compliance in Practice: Mitigating Risk in Clinics and Physician Practices, 81 J. AM. HEALTH INFO. MGMT. ASS'N 28, 31 (2010).
90.  BAKICH & PESTAINA, supra note 87, at ¶ 610 (describing OCR’s investigation process).
91.  Id.
92.  Id.; Tammy Worth, Lawsuits for Information Breaches May Be on the Rise, RENAL & UROLOGY NEWS (Nov. 13, 2017), https://www.renalandurologynews.com/hipaa-compliance/hipaa-noncompliance-information-breach-lawsuits-rising/article/706860/ (explaining that doctors traditionally did not have to deal with these types of lawsuits).
93.  BAKICH & PESTAINA, supra note 87, at ¶ 610; see Nadia N. Sawicki, Character, Competence, and the Principles of Medical Discipline, 13 J. HEALTH CARE L. & POL’Y 285, 298 (2010) (explaining that medical boards have been criticized for not imposing proper sanctions on physicians).
94.  See generally RONALD L. KATZ, AM. SOC’Y OF ANESTHESIOLOGISTS COMM. ON EXPERT WITNESS TESTIMONY REVIEW FINDINGS REGARDING EXPERT WITNESS TESTIMONY (reproduced in the Appendix of this article at Tab B).
95.  FED’N OF STATE MED. BDS., U.S. MED. REGULATORY TRENDS AND ACTIONS 22 (2016) (depicting the number of doctor’s reciprocal actions to imposed sanctions is less than the number of imposed sanctions).
Because of this lack of transparency and the confidential nature of the proceedings, it is unknown (1) how many grievances are filed by medical malpractice defendants since the grievances themselves are confidential; and (2) among those private grievances, how many patients whose care and treatment formed the basis for a grievance are made aware of the filed grievance. Despite lacking any scientifically sound evidence to make these determinations, the Brandner and Barrash cases demonstrate this point, as if in microcosm to what other similarly situated organizations might have accumulated and disclosed in their publications.

Despite that portion of the Hippocratic oath quoted atop this article which requires physicians hold as “holy secrets” their patients’ PHI, the parties involved in a grievance — claimant, claimant’s lawyer, respondent, respondent’s lawyer, and the organization with its lawyer — probably give short shrift to whether or not an investigation and a hearing on a grievance violates the HIPAA Privacy Rule. As seen in Brandner, many may not care or may find privacy breaches so unimportant as to never address them as a determinative issue for the grievance. The physicians who administer Professional Conduct Programs that accept wrongfully-submitted PHI may never disclose a violation.

However, as grievances certainly exist and will continue to be filed and administratively adjudicated, considering a privacy breach is much more than an academic exercise. Just because a privacy breach, generally speaking, is not on the radar of the participants in grievance proceedings does not mean it is less important and consequential than whether a doctor proffered proper expert testimony. For instance, a privacy breach could be a possible defense by the accused expert physician, who could assert that the hearing cannot proceed because the HIPAA Privacy Rule has been breached absent prior patient authorization. But before landing on this strategy, it is necessary to define the parameters of the HIPAA Privacy Rule’s requirements.

IV. THE REQUIREMENTS OF THE HIPAA PRIVACY RULE

The HIPAA Privacy Rule prohibits “covered entities,” defined as health plans, healthcare clearinghouses, and healthcare providers, from disclosing PHI. Providers such as doctors, clinics, psychologists, dentists,

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97. See BAKICH & PESTINA, supra note 87, at ¶ 214 (explaining grievance process).
99. See supra Part I.
chiropractors, nursing homes and pharmacies are covered entities. Private organizations like the AANS or AAOS are not themselves subject to the HIPAA Privacy Rule because they are not covered entities.

Nor do those private organizations qualify as “business associates,” as that term is defined in the HIPAA Privacy Rule. Generally, business associates are persons or entities that are not employed by a covered entity but perform certain functions or activities that involve the use or disclosure of PHI. Such functions or activities on behalf of a covered entity include claims processing, data analysis, utilization review, billing, or the provision of data storage or hosting services.

The HIPAA Privacy Rule allows covered providers and health plans to disclose PHI to their business associates if the providers or plans obtain satisfactory assurances that the business associates will use the information only for the purposes for which they are engaged by the covered entity and will safeguard the information from misuse. Covered entities may disclose PHI to a business associate only to assist the covered entity in carrying out its health care functions – not for the business associate’s independent use or purposes. Business associates may use or disclose PHI only as permitted or required by its business associate contract, and may not use or disclose it in a manner that would violate the HIPAA Privacy Rule if done by a covered entity. Business associate contracts must give a covered entity satisfactory assurances, in writing, that the business associate will appropriately safeguard the PHI.

The HIPAA Privacy Rule requires covered entities and their business

104. See generally 45 C.F.R. § 160.102 (2013) (a healthcare provider is subject to the Privacy Rule if it furnishes, bills for, or is paid for healthcare in the normal course of business).
105. 45 C.F.R. § 160.103.
107. Id.
108. Id.
109. Id.
associates to protect the confidentiality of “individually identifiable health information,” which is defined as:

information that is a subset of health information, including demographic information collected from an individual, and:

(1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

(2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

(i) That identifies the individual; or

(ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.\(^\text{112}\)

In nearly all proceedings of Professional Conduct Programs, “there is a reasonable basis to believe the information can be used to identify the individual” even if the individual’s name is redacted from all of the records submitted by the parties.\(^\text{113}\) Information submitted to support these grievances can be used to identify the patient, including information about the respondent’s expert testimony, the complaining physician’s care and treatment of the patient, where the care was provided and the venue where the underlying dispute was adjudicated. Thus, even redacted submissions qualify as “individually identifiable health information” under the HIPAA Privacy Rule and its submission by covered entities to Professional Conduct Programs is prohibited.\(^\text{114}\)

\textbf{A. Authorized Disclosure of PHI}

Although the HIPAA Privacy Rule generally prohibits the disclosure of PHI, it does provide for exceptions.\(^\text{115}\) Certain of those exceptions permit a covered entity to obtain an authorization from the patient for the disclosure of his or her PHI or permit the entity to “de-identify” the patient by following specified requirements.\(^\text{116}\)

But since de-identification of the patient’s identity in a grievance proceeding is nearly impossible, obtaining an authorization from the patient

\begin{itemize}
\item \footnotesize{112.  45 C.F.R. § 160.103 (2014).}
\item \footnotesize{113.  \textit{Id.}}
\item \footnotesize{114.  \textit{Id.}}
\item \footnotesize{115.  45 C.F.R. § 164.502 (2016).}
\item \footnotesize{116.  45 C.F.R. § 160.103 (2014); 45 C.F.R. § 164.502 (2016).}
\end{itemize}
may be the only way his or her PHI can be submitted to a Professional Conduct Program. In any event, requiring an authorization should be the gold standard for every Program.117 A patient can, however, revoke an authorization at any time.118

PHI may also be used or disclosed for a covered entity’s treatment, payment, and healthcare operations without written patient authorization.119 “Healthcare operations” include conducting quality assessment and improvement activities, such as outcome evaluation, development of clinical guidelines and reviewing the competence or qualifications of health care professionals.120 A covered entity may also disclose PHI to another covered entity for its own healthcare operations, if each entity either has or had a relationship with the individual subject of the PHI. The PHI must pertain to such relationship and the disclosure must be for the purpose of its own and/or healthcare providers’ treatment, payment, or healthcare operations or for health care fraud and abuse detection and compliance.121 Providers, who are typically the complainants in a grievance, cannot submit PHI to private organizations such as the AANS or AAOS under the HIPAA Privacy Rule’s provisions for healthcare operations because those organizations are not themselves covered entities and have no relationship with patients.122

However, PHI may be disclosed without prior patient authorization in certain other circumstances. Among them are disclosures for public health purposes; disclosures by a covered entity that reasonably believes that a patient is a victim of abuse, neglect, or domestic violence; and disclosures for health oversight activities (e.g., audits, investigations, inspections, licensure actions, disciplinary proceedings or actions).123 For all other instances, including discovery in a personal injury action in which the patient is a plaintiff, PHI can be disclosed only if (1) the patient signs a written authorization to release the PHI or (2) it is subject to a court order.124

B. “De-Identification” of PHI

In recognition of the potential utility of health information even when it is not individually identifiable, the HIPAA Privacy Rule permits a covered entity or its business associates to create information that is not individually

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118. 45 C.F.R. § 164.508(b)(5) (2016).
121. 45 C.F.R. § 164.506(c)(4) (2013).
122. 45 C.F.R. § 160.103 (2014).
123. 45 C.F.R. § 164.512(b)-(e) (2016).
identifiable by following certain de-identification standards. These provisions allow the entity to use and disclose information that neither identifies nor provides a reasonable basis to identify an individual. Professional Conduct Programs, either expressly in their rules or as part of their established practices, do require some form of de-identification of PHI that is submitted to them.

However, as shown above, the “de-identification” of PHI for use in Professional Conduct Programs is fraught with difficulties. The HIPAA Privacy Rule’s standard for de-identified health information requires that it “does not identify an individual and. . . there is no reasonable basis to believe that the information can be used to identify an individual.” The Rule also provides that: “disclosure of a code or other means of record identification designed to enable coded or otherwise de-identified information to be re-identified constitutes disclosure of protected health information.” As grievance proceedings typically involve medical malpractice litigation that is a matter of public record, and, to reiterate from preceding pages, disclose the name of the malpractice defendant and the plaintiff’s medical expert, the name of the patient can be easily deduced from an online search of the docket for the court located in the defendant’s home jurisdiction or from information

128. See generally Letter from William W. Stead, Chair of the Nat’l Comm. on Vital and Health Statistics, to Thomas E. Price, Sec’y of the Dep’t of Health and Human Services (Feb. 23, 2017) (available at https://www.ncvhs.hhs.gov/wp-content/uploads/2013/12/2017-Ltr-Privacy-DelIdentification-Feb-23-Final-w-sig.pdf) (describing broad challenges with de-identification such as that de-identification is temporary and can still contain elements which can be used, directly or indirectly, to identify individuals, as well as weaknesses in the current approaches for de-identification); see also, Bonnie Kaplan, Selling Health Data: De-Identification, Privacy, and Speech 20 (Yale Inst. for Soc. and Policy Studies-Bioethics, Working Paper No. 14-024, 2014) (“De-identification is becoming increasingly untenable as a means of protecting privacy when supposedly anonymized data can be combined with other identifying data.”).
129. 45 C.F.R. § 164.514 (2016).
130. 45 C.F.R. § 164.502 (2016).
about malpractice cases and experts that are regularly posted online. Thus, no matter how well the PHI is de-identified, it can be easily re-identified. Indeed, the HIPAA Privacy Rule’s standards for de-identification will not be met if the covered entity has “actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.”

C. Professional Conduct Programs’ Attempts to Comply with the HIPAA Privacy Rule

The AAOS attempts to address the HIPAA Privacy Rule in its grievance procedures, which require that: “all grievance material submitted must follow HIPAA guidelines for de-identifying patient information.” Consider as well the policies of three additional Illinois-based medical organizations, The Society of Thoracic Surgeons (STS), the Society for Vascular Surgery (SVS), and the North American Spine Society (NASS). Paragraph 2 of the STS’s “Procedural Guidelines for Handling Ethics Complaints” states:

Any physician or the Committee may initiate an ethics complaint. It is the complainant’s obligation to provide supporting records and other evidence. Any such materials must be de-identified and otherwise submitted in accordance with the applicable privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996.

The SVS’ Professional Conduct Program states:

The Complainant shall de-identify all Protected Health Information, as that term is defined in the Health Insurance Portability and Accountability Act ("HIPAA"), prior to submitting such information to the Committee. Protected Health Information that has not been de-identified will be returned to the Complainant in the absence of patient consent or an exception to HIPAA’s privacy regulations; however, documents or records which have been admitted into evidence in litigation or filed with any court are considered a matter of public record and need not be de-identified. In the event the Respondent submits Protected Health Information to the

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132. See Stead, supra note 128, at 8 (discussing ways PHI can be re-identified indirectly, through changing datasets, or due to inconsistent approaches to de-identification that provide inconsistent results).
133. 45 C.F.R. § 164.514 (2016).
134. AM. ASS’N ORTHOPAEDIC SURGEONS, supra note 52, at 7.
135. SOC’Y THORACIC SURGEONS, supra note 127.
Committee, said information shall be de-identified by the Respondent.

Protected Health Information that has not been de-identified will be returned to the Respondent in the absence of patient consent or an exception to HIPAA’s privacy regulations, or the litigation exception stated in the preceding paragraph.  

Similarly, the NASS’ Professional Conduct Procedural Guidelines provides in pertinent part: Sec. A (2): “. . .the Complainant shall [sic] de identify all Protected Health Information, as that term is defined in the Health Insurance Portability and Accountability Act (‘HIPAA’) prior to submitting such information to the Committee.” It then provides language similar to that provided by the SVS.  

Few, if any, challenges to a party’s compliance with HIPAA’s de-identification requirement are found in published legal opinions. There is a practical problem why including a de-identification requirement in an organization’s expert witness rules is more a facially appealing requirement than an issue for a court or trier-of-fact to adjudicate; as in Brandner, the issue is one that has failed to require judicial scrutiny. On another level, as previously recognized, administrative hearings are generally confidential. The language of a published sanction can identify the patient on whose behalf the sanctioned provider testified in a medical malpractice lawsuit as well as some of the details of the medical care provided. Of course, the underlying litigation was already concluded and its record may not reveal such confidential information. The fact that the patient may never be aware of the use of his or her PHI in private reviews of the testimony of the expert hired in the patient’s medical malpractice case does not make the breach of his or her expectations of privacy any less egregious.

138. Compare N. Am. Spine Soc’y, supra note 137 with Soc’y for Vascular Surgery, supra note 127 (indicating that PHI that has not been de-identified will be returned to the Complainant in the absence of patient consent or an exception to HIPAA’s privacy regulations).
139. See supra notes 67-68; see generally supra notes 74-77 and accompanying text.
140. Compare Am. Soc’y of Anesthesiologists, ASA Member Sanctioned for Expert Witness Testimony, 76 ASA Monitor 46, 46 (2012) http://monitor.pubs.asahq.org/article.aspx?articleid=2445922 with Katz, supra note 94 (demonstrating that both administrative hearings and published summaries of administrative hearings are kept confidential, detailing only the sanction imposed against the offending physician and the underlying bases for it).
141. See Katz, supra note 94.
142. See Katz, supra note 94.
D. Remedies for Unauthorized Disclosure of PHI

The unauthorized disclosure of PHI by a covered entity in a grievance proceeding constitutes a “breach of unsecured protected health information” under the HIPAA Privacy Rule, and triggers a requirement of notifying the patient and reporting to HHS through its Office of Civil Rights (OCR). The covered entity must notify each individual whose PHI has been “accessed, acquired, used, or disclosed” by the breach and include a description of what happened, the types of PHI involved, the steps individuals should take to protect themselves from potential harm resulting from the breach, and what the covered entity is doing to mitigate harm and to protect against any further breaches. If the breach of unsecured PHI affects fewer than 500 individuals, a covered entity must notify HHS of the breach through its web portal within sixty days of the end of the calendar year in which the breach was discovered.

OCR is responsible for enforcing the HIPAA Privacy Rule and investigating complaints filed. If it accepts a complaint for investigation, it will notify the person who filed the complaint and the covered entity named in it. The complainant and the covered entity are then asked to present information about the incident or problem described in the complaint.

143. 45 C.F.R. § 164.402 (2009).
144. 45 C.F.R. § 164.404 (2009).
145. Id.
147. How OCR Enforces the HIPAA Privacy & Security Rules, U.S. DEP’T. OF HEALTH & HUMAN SERVICES, https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/examples/how-ocr-enforces-the-hipaa-privacy-and-security-rules/index.html (last reviewed June 7, 2017); Enforcement Highlights, U.S. DEP’T. OF HEALTH & HUMAN SERVICES, https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/data/enforcement-highlights/index.html (last reviewed Aug. 17, 2018). The authors tendered a Freedom of Information Act request on July 23, 2018 to OCR, as clarified on October 5, 2018, requesting whether any HIPAA Privacy Act violations were filed against any of the following organizations since mandatory reporting was required in April 2003: American College of Surgeons, American Society of Plastic Surgeons, American College of Chest Surgeons, American Society of Anesthesiologists, American Academy Pediatrics, American Association of Neurological Surgeons, American Academy of Orthopedic Surgeons, Society of Thoracic Surgeons, Society for Vascular Surgery, and North American Spine Society. The Office of the Secretary of HHS responded on October 15, 2018, as supplemented on November 27, 2018. There was only one filing involving any of these organizations, but was unrelated to a patient whose PHI was disclosed in a matter brought against a member of any of these organizations that rendered expert opinions. As of July 31, 2018, “since the compliance date of the Privacy Rule in April 2003, OCR has received over 186,453 HIPAA complaints and has initiated over 905 compliance reviews. [They] have resolved ninety-six percent of these cases (178,834).”
149. How OCR Enforces the HIPAA Privacy & Security Rules, supra note 147.
Covered entities are required by law to cooperate with complaint investigations. If the evidence indicates that the covered entity did not comply, OCR will attempt to resolve the case with the covered entity by obtaining voluntary compliance, corrective action or a resolution agreement. A resolution agreement is a settlement agreement, signed by HHS and a covered entity or business associate, in which the covered entity or business associate agrees to perform certain obligations and make reports to HHS. The resolution agreement is generally for a period of three years. During the period, HHS monitors the covered entity’s compliance with its obligations. A resolution agreement may include the payment of a resolution amount. If HHS cannot reach a satisfactory resolution through the covered entity’s demonstrated compliance or corrective action through other informal means, including a resolution agreement, civil money penalties may be imposed for noncompliance.

OCR concludes most HIPAA Privacy Rule investigations using these types of resolutions. The HHS website warns that “if the covered entity does not take action to resolve the matter in a way that is satisfactory, OCR may decide to impose civil money penalties on the covered entity.” The HIPAA Privacy Rule, though, does not provide a private cause of action to individuals affected by a health care privacy breach.

In addition to the HIPAA Privacy Rule, organizations like the AANS and AAOS have their own ethical standards that require their members to maintain the confidentiality of patients’ medical information. In the
AANS, a grievance alleging a violation of those ethical standards is subject to the same procedures and claims of violations of their standards for expert testimony.161

V. ILLINOIS’ LAW IS MORE STRINGENT THAN THE HIPAA PRIVACY RULE

Until now, the focus of this article has been on the HIPAA Privacy Rule. Equally concerning and problematic for any organization’s Professional Conduct Program is the interplay between federal and state privacy laws. Typically, federal law preempts state law if the two are concerning the same subject matter.162 HIPAA supersedes any contrary provisions of state law subject to certain exceptions, one of which allows state laws to prevail if they impose requirements more stringent than those of HIPAA.163 A state law is deemed more stringent when it affords patients more control over their medical records than federal law.164 Illinois’ law has been held to be more stringent,165 and Illinois courts have articulated a broad public policy protecting the confidentiality of the patient-physician relationship.166 This policy is based on Illinois’ Medical Privacy Law,167 as well as common law.168 Thus, as in Petrillo v. Syntex Labs., Inc. and its progeny,169 physicians are required to maintain the confidentiality of their patients’ medical information even in personal injury litigation in which those patients have made their own medical condition an issue.170

Illinois codified the physician-patient privilege in its Medical Privacy Law, which provides: “no physician or surgeon shall be permitted to disclose any information he or she may have acquired in attending any patient in a professional character, necessary to enable him or her professionally to serve

\[\text{law}.)\]; Principles of Medical Ethics and Professionalism in Orthopaedic Surgery, AM.

ACAD. OF ORTHOPAEDIC SURGEONS § V (May 2002),
https://www.aaos.org/uploadedFiles/PreProduction/About/Opinion_Statements/ethics/Principles.pdf (stating that “the orthopaedic surgeon should respect the rights of patients, of colleagues, and of other health professionals and must safeguard patient confidences within the constraints of the law.”).

161. AM. ASS’N OF NEUROLOGICAL SURGEONS, supra note 160.
169. Petrillo, 148 Ill. App. 3d at 588-89; Roberson, 198 Ill. App. 3d at 336.
170. Petrillo, 148 Ill. App. 3d at 588-89; Roberson, 198 Ill. App. 3d at 336.
This prohibition is subject to fourteen enumerated exceptions, including “in actions, civil or criminal, against the physician for malpractice.” Illinois courts have held that the Medical Privacy Law’s protections apply even if the patients’ names and identification numbers are redacted from their medical records. None of the fourteen enumerated exceptions to the Medical Privacy Law’s privacy protections would apply to a grievance brought before a professional organization by one physician against another.

The Illinois Supreme Court examined the scope and purpose of the physician-patient privilege in People ex rel. Dept. of Prof. Reg. v. Manos. The Manos court held that a court could not compel the production of confidential medical records unless one of the statutory exceptions contained in the Medical Privacy Law applied: “[t]he legislature established a limited number of circumstances in which physicians and surgeons are allowed to produce confidential patient record information. Courts must apply these existing exceptions and cannot create additional exceptions to the privilege.”

In Petrillo v. Syntex Laboratories, Inc., the Appellate Court recognized a broad public policy that bars any ex parte communications between an attorney for a defendant in a personal injury case and the plaintiff’s treating physician. The Petrillo court stated: “[b]ecause public policy strongly favors both the confidential and fiduciary nature of the physician-patient relationship, it is thus axiomatic that conduct which threatens the sanctity of that relationship runs afoul of public policy.”

Although the Petrillo court recognized that when a patient files suit, the patient implicitly consents to his or her physician releasing any of the medical information related to the mental or physical condition that the patient has placed at issue, it held that such consent was limited:

The patient’s implicit consent, however, is obviously and necessarily limited; he consents only to the release of his medical information (relative to the lawsuit) pursuant to the methods of discovery authorized by Supreme Court Rule 201(a). A patient certainly does not, by simply filing suit,

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176. Id. at 576.
178. Id. at 588.
consent to his physician discussing that patient’s medical confidences with third parties outside court authorized discovery methods, nor does he consent to his physician discussing the patient’s confidences in an ex parte conference with the patient’s legal adversary.179

The Illinois Supreme Court has repeatedly endorsed the ruling in Petrillo.180 In addition to the protections recognized by Petrillo, Illinois law may require even stronger privacy protections than the “de-identification” standard under the HIPAA Privacy Rule.181 In Parkson v. Cent. DuPage Hosp., the Appellate Court held that merely redacting patients’ names and identifying numbers was insufficient to protect patient confidentiality.182 The Court stated: “[t]he patients’ admit and discharge summaries arguably contain histories of the patients’ prior and present medical conditions, information that in the cumulative can make the possibility of recognition very high.”183 The Illinois Supreme Court echoed that reasoning in People ex rel. Dept. of Prof. Reg. v. Manos: “[e]ven if the names were redacted along with any other identifying information, the possibility of recognizing and equating a record to each patient would not be difficult. Thus, it is reasonable to suggest that merely deleting the patient names and other identifying information from patient records would violate the physician-patient privilege.”184 This de-identification requirement may be even stricter than the one imposed by the HIPAA Privacy Rule.185

The Illinois Medical Privacy Law does not expressly provide a private cause of action for its violation.186 Decisions from courts outside of Illinois, however, have recognized state-law claims for the unauthorized disclosure of private medical information.187 While it appears that no reported decision of

179. Id. at 591 (emphasis in original; citation omitted).
181. See discussion infra note 185.
183. Id.
184. People ex rel. Dept. of Prof. Reg. v. Manos, supra note 175.
185. Compare 45 C.F.R. §164.514 (2013) (stating health information that cannot reasonably identify an individual is not individually identifiable health information), with Parkson, 105 Ill. App. 3d at 855 (holding patient-physician privilege would have been violated had the names and identifying numbers of patients been excluded from a report), and Manos, 202 Ill. 2d at 563 (discussing that simply deleting names and identification numbers from patient records would violate physician-patient privilege).
187. See, e.g., Sheldon v. Kettering Health Network, 2015-Ohio-3268, ¶ 24 (Ohio Ct. App. 2d Dist. 2015) (showing the independent Ohio tort “for the unauthorized, unprivileged disclosure to a third party of nonpublic medical information that a physician or hospital has learned within a physician-patient relationship”).
an Illinois court has addressed this precise issue, there are two bases that would suggest pleading a violation of this statute, even without an allegation of actual harm, would be sufficient to state a claim. The first is the *Petrillo* line of cases, which suggests that a physician would violate his or her fiduciary duties to a patient by disclosing PHI to third parties.\(^{188}\) The second is recent decisional law interpreting Illinois’ Biometric Information Privacy Act (BIPA).\(^{189}\)

Last year, a California federal court held in *In re Facebook Biometric Information Privacy Information* that under the BIPA, a person need not suffer an actual injury beyond a violation of his or her right to privacy.\(^ {190}\) Illinois law is now in accord with the Supreme Court’s decision in *Stacy Rosenbach v. Six Flags Entertainment Corporation*.\(^ {191}\) The Illinois’ high court held, “an individual need not allege some actual injury or adverse effect, beyond violation of his or her rights under [BIPA], in order to qualify as an ‘aggrieved’ person and be entitled to seek liquidated damages and injunctive relief pursuant to the Act.”\(^ {192}\) This analysis follows the model established in the AIDS Confidentiality Act.\(^ {193}\) The Court went on to say that a person becomes prejudiced or aggrieved, “in the legal sense, when a legal right is invaded by the act complained of or his pecuniary interest is directly affected by the decree or judgment.”\(^ {194}\)

The analysis and holding in the Illinois Supreme Court’s *Rosenbach* decision suggests that a strong foundation now exists for a patient’s right to relief under the Illinois’ Medical Privacy statute when his or her PHI is disclosed in a medical organization’s administrative proceedings without his or her authorization. If it is used as precedent, Illinois law appears to effectively strengthen a cause of action for breach of PHI privacy even if a patient does not, or cannot, plead actual harm.

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\(^{188}\) See *Petrillo*, 148 Ill. App. 3d at 595-96, 499 N.E.2d at 962 (explaining that “[c]ourts which have recognized the existence of a fiduciary relationship between a patient and his physician have consistently acknowledged that an *ex parte* conference is contrary to the fiducial obligations owed by a physician.”).

\(^{189}\) 740 ILCS 14/ et seq. (2008).

\(^{190}\) *In re Facebook Biometric Info. Privacy Litig.*, 326 F.R.D. 535, 545-547 (N.D. Cal. 2018).


\(^{192}\) *Ex rel. Rosenbach*, 2019 WL 323902 at ¶ 40.

\(^{193}\) 410 ILCS 305/1 et seq. (2016); *Id.* at ¶ 26, 27.

\(^{194}\) *Ex rel. Rosenbach*, 2019 WL 323902 at ¶ 30 (citing to *Glos v. People*, 259 Ill. 332, 340 (1913)) (emphasis added); see also *Dixon v. Wash. and Jane Smith Cmty.-Beverly*, 2018 WL 2445292, *9* (N.D. Ill. May 31, 2018) (a complaint states a cause of action where biometric data was disclosed to an employer’s out-of-state, third-party clock vendor of an employer’s time clocks without informing the plaintiff or obtaining the plaintiff’s prior consent.).
A. Which Jurisdiction’s Law Applies?

Although this article is focused on Illinois law, the law of other jurisdictions may be applicable to Professional Conduct Programs. For instance, although the AANS and AAOS are both based in Illinois, their proceedings might be held in one or more other states.\(^\text{195}\) Moreover, the state in which those proceedings are held might not be the state where the treatment at issue took place.\(^\text{196}\) Illinois follows the Restatement (Second) of Conflict of Laws (1971) in making choice-of-law decisions.\(^\text{197}\) While it appears that no reported Illinois decision has addressed which jurisdiction’s laws might apply to a patient’s privacy rights in his or her medical information, Illinois courts have applied Section 139 of the Restatement to choice of law questions involving evidentiary privileges.\(^\text{198}\) Section 139 provides:

(1) Evidence that is not privileged under the local law of the state which has the most significant relationship with the communication will be admitted, even though it would be privileged under the local law of the forum, unless the admission of such evidence would be contrary to the strong public policy of the forum.

(2) Evidence that is privileged under the local law of the state which has the most significant relationship with the communication but which is not privileged under the local law of the forum will be admitted unless there is some special reason why the forum policy favoring admission should not be given effect.\(^\text{199}\)

The comments to Section 139 recite that the state with the most significant relationship with the communication is usually the state where the communication took place.\(^\text{200}\) Given Illinois’ strong public policy favoring the privacy of medical information, it seems likely that an Illinois court would apply Illinois law, even if the state where the physician-patient relationship took place had less stringent privacy requirements. Since only

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195. For instance, in *Brandner*, the medical treatment at issue took place in Arizona, as has been noted above in note 65. The AAOS’ grievance proceeding was conducted in Illinois, but Brandner’s appeal hearing was conducted in Louisiana. Young Affidavit at Exhibits 26 & 32, Brandner, 2012 WL 4483820 (opinion granting summary judgment) (No. 1:10-cv-08161) (Document Nos. 74-26 & 74-32, filed Nov. 22, 2011) (documents can be found on PACER system for N.D. Ill.).
196. *Id.*
199. RESTATEMENT (SECOND) OF CONFLICT OF LAWS § 139 (AM. LAW INST. 1971).
200. *Id.* at cmt. e.
the patient would have standing to bring a breach of privacy claim, his or her choice of forum may also result in the application of the law of a different state.\textsuperscript{201} As there is no “one size fits all” solution to the privacy requirements of the HIPAA Privacy Rule and the laws of all fifty states, Professional Compliance Programs should require a patient to execute a release that complies with the state law of his or her residence before receiving his or her PHI regarding a grievance.

VI. PROPOSED SOLUTIONS TO OVERCOME THE PRIVACY ROADBLOCKS

In Austin v. American Association of Neurological Surgeons, Judge Posner recognized the important public function served by an association’s policing of its members’ expert testimony, writing:

We note finally that there is a strong national interest, which we doubt not that Illinois would embrace, in identifying and sanctioning poor-quality physicians and thereby improving the quality of health care. Although Dr. Austin did not treat the malpractice plaintiff for whom he testified, his testimony at her trial was a type of medical service and if the quality of his testimony reflected the quality of his medical judgment, he is probably a poor physician. His discipline by the Association therefore served an important public policy exemplified by the federal Health Care Quality Improvement Act, 42 U.S.C. §§ 11101 et seq., which encourages hospitals to conduct professional review of its staff members and report malpractice to a federal database.\textsuperscript{202}

Among the rationales for the Health Care Quality Improvement Act (HCQIA) that Judge Posner was confident that Illinois would embrace were the public interest in improving quality medical care by decreasing medical malpractice and providing a means of protecting effective peer review.\textsuperscript{203} As

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\item \textsuperscript{201} Sheldon v. Kettering Health Network, 2015-Ohio-3268, 40 N.E.3d 661, at ¶ 24 (Ohio Ct. App. 2d Dist. 2015).
\item \textsuperscript{202} Austin, \textit{supra} note 36, 253 F.3d at 974.
\item \textsuperscript{203} 45 C.F.R. § 60.3, 60.12(a) (2013); RANDOLPH D. SMOAK JR., REPORT 18 OF THE BOARD OF TRUSTEES OF THE AMERICAN MEDICAL ASSOCIATION, 1-98, (AM. ACAD. PSYCHIATRY & LAW), www.aapl.org/expert-witness-testimony (last visited Nov. 11, 2018) (showing that while it is unclear whether it ever was or remains the official position of the AMA, there is a report of the AMA Board of Trustees that is cited by others for the proposition that the AMA considers expert witness testimony to be the practice of medicine subject to peer review); Diaz v. Provena Hosp., 352 Ill. App. 3d. 1165, (App. 2d Dist. 2004) (pet. lv. app. den’d., 213 Ill. 2d 556 (2005)) (holding that when a physician allows her medical staff privileges at a hospital to lapse when under a corrective proceeding for inappropriate medical care and treatment instituted by the hospital, i.e., the physician was “under investigation” by the hospital, an element under the Health Care Quality Improvement Act’s mandatory reporting requirements was triggered, thus mandating the hospital to file a report with the National Practitioner’s Data Bank (NPDB)). Extrapolating from this analysis, and pursuant to definitions found in 45 C.F.R. § 60.3, if a professional organization sanctions one of its
\end{thebibliography}
previously noted, covered entities may not disclose PHI to organizations such as the AANS or AAOS under the HIPAA Privacy Rule’s provisions for healthcare operations.\textsuperscript{204} Thus, even if their Professional Conduct Programs qualified as peer-review programs under HCQIA as furthering quality health care, they would not be entitled to review any PHI for those purposes.\textsuperscript{205}

The standoff between protecting PHI under the HIPAA Privacy Rule and private medical organizations continuing to advance public policy by policing expert medical testimony thus remains a very real concern, despite there not being any objectively identifiable data to confirm its presence.\textsuperscript{206} As long as there is expert testimony to substantiate or defend an adversarial proceeding, the risk of apparently inappropriate expert witness testimony that could result in the filing of grievances will always remain. But by doing so, grievances continue to breach the HIPAA Privacy Rule by failing to de-identify the patient whose care and treatment becomes the underpinning for members for rendering expert medical testimony not in conformance with the organization’s rules or regulations governing such testimony, its sanction may well be reportable to the NPDB if the organization is deemed to be a professional society “of health care practitioners that engages in professional review activity through a formal peer review process, for the purpose of furthering quality health care” and the sanction was entered “in the course of professional review activity” and was “[b]ased on the professional competence or professional conduct of an individual health care practitioner which affects or could affect adversely the health or welfare of a patient or patients”; see, e.g., Committee on Medical Liability, Guidelines for Expert Witness Testimony in Medical Malpractice Litigation, 109 PEDIATRICS 974, 976 (2002) (highlighting “the important role of medical societies and licensing boards in maintaining the integrity of physicians who provide expert witness testimony”); compare Fullerton v. Florida Med. Ass’n, Inc., 938 So. 2d 587, 593 (Fla. Dist. Ct. App. 1st Dist. 2006) (“The narrow question we must address is whether HCQIA can be reasonably construed as authorizing peer review of a physician’s testimony given in a medical-malpractice action for the purpose of furthering the quality of health care. In our judgment, it cannot.”); declining to extend this holding, see In re Higby, 414 S.W. 3d 771, 783 (Tex. App. 1st Dist. 2013) (stating that providing expert opinion testimony and opinions implicates the competence of a physician, which falls within the purview of the American College of Obstetrics and Gynecology (ACOG) Grievance Committee, which is styled after the HCQIA).

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\item \textsuperscript{204} See 45 C.F.R § 160.103 (2014) (defining covered entities); see also 45 C.F.R. § 164.502(a) (2013) (HIPAA privacy rule); see also 45 C.F.R. § 164.502(a)(1)(ii) (Health care operations exception to Privacy Rule under HIPAA).
\item \textsuperscript{205} 42 U.S.C.A. § 11112(a)(1) (1986); 45 C.F.R § 160.103 (2014); see also Brown v. Presbyterian Healthcare Servs., 101 F.3d 1324, 1333 (10th Cir. 1996) (illustrating further that for HCQIA immunity to apply to a professional review body, the review action must be taken “in furtherance of quality health care”).
\item \textsuperscript{206} See Stead, supra note 128, at 2 (citing De-Identification and the Health Insurance Portability and Accountability Act (HIPAA), Hearing Before the NCVHS Subcomm. on Privacy, Confidentiality & Security of the Dep’t. of Health and Human Services, (2016) (statement of Daniel Barth-Jones), http://www.ncvhs.hhs.gov/transcripts-minutes/transcript-of-the-may-24-2016-ncvhs-subcommittee-on-privacy-confidence-security-hearing/) (“Expert testimony at our hearing suggested that the goals of preserving the individual’s right to privacy while fully using digital information to improve health and outcomes may be on a ‘collision course’.”).
\end{itemize}
such a proceeding. Again, the de-identification requirements of the HIPAA Privacy Rule remain instructive, as they set forth the standard for de-identification of PHI. As noted earlier in this article, PHI is not individually identifiable if it does not disclose the identity of an individual and the covered entity has no reasonable basis to believe it can be used to identify that person. Clearly, the former is easily accomplished; it is the latter that remains problematic for any covered entity submitting a grievance. Equally problematic is the organization which seeks sufficient information to properly adjudicate a grievance, since it is likely that the parties will tender some form of PHI. This will make it easy to identify the patient whose care and treatment became the subject of this expert’s testimony.

Accordingly, the best and most pragmatic approach is for any such organization to amend the rules of its Professional Conduct Program. Specifically, organizations should amend their rules to require prior patient authorization that complies with the state law of the patient’s residence before any proceedings on a grievance filed by a physician can be initiated. Furthermore, the rules should be amended to only permit consideration of medical information that is part of the public record of a malpractice claim absent such an authorization. The pitfalls are that patients are unlikely to give an authorization for a proceeding to which they are not a party and which was initiated by the very physician against whom the patient has just resolved a malpractice claim. This requirement could well be the death knell of Professional Conduct Programs as they are currently constituted.

A substitute for a patient authorization could be a court order permitting the parties to disclose the patient’s PHI. The following is suggested as a revision to the procedural rules governing Professional Conduct Programs:

This organization shall also accept a court order obtained at the expense of the Claimant, permitting this organization and members of its grievance and grievance appeals committees, and Respondent and its legal counsel where retained, to receive PHI from the Claimant as the covered entity and member of this organization filing a grievance, or from his or her business associate(s), arising from the legal or administrative proceeding from which expert witness medical testimony provided by the member of this organization was received or admitted into evidence or testimony. Any such order shall provide for the disclosure, use, maintenance and disposition of the PHI or what would be considered PHI by this organization in compliance and in conformity with applicable federal laws and regulations.

A second approach, although it may impose a requirement that may be
impossible to satisfy, would be to amend the rules for Professional Conduct Programs to require the parties to comply with HIPAA’s de-identification standard as expressed in this article. The following language is offered as a template:

No grievance and materials submitted with it shall be accepted for consideration without an affidavit under oath submitted by the Claimant attesting to compliance with the de-identification requirement mandated by the Health Insurance Portability and Accountability Act (HIPAA) so that any protected health information (PHI), as that term is defined in this act, will not disclose the identity of the patient. This means that the name of the patient whose care and treatment was the subject of the Respondent-member’s expert witness medical testimony is not identified and there does not exist a reasonable basis that the identity of the patient can be identified from such protected health information. If the Claimant in good faith believes that a reasonable basis exists to identify the patient from the PHI, then the Claimant must provide as part of the grievance either (1) a signed and notarized authorization from the patient to allow the patient’s PHI to be used as part of the grievance and this organization’s use of it until its administrative proceedings are concluded, or (2) provide an attestation that any PHI submitted as part of the grievance and the organization’s consideration of it arises from documentation already of public record, such as made part of an underlying administrative or legal proceeding.

While the above options are self-regulating because they ask each private organization to amend or add to their rules, problems are inherent in doing so. Some organizations reference HIPAA, some reference de-identification, and no doubt others never mention privacy. There is no uniformity. Then again, different documents can be disseminated to the membership, published on the organizations’ websites, or included in the public record in a lawsuit’s published pleadings (see Appendix A and B).

A final option, though the least likely due to its difficulty, is to amend the provisions of the Code of Federal Regulations (C.F.R.) relating to “covered entities,” “business associates” or “health care operations,” to provide uniformity among all medical organizations whose rules address expert

209. AM. ASS’N OF ORTHOPAEDIC SURGEONS, supra note 52, at 7; AANS Procedural Guidelines, supra note 5; SOC’Y FOR VASCULAR SURGERY, supra note 127.

210. See generally supra, Section III. THE SUBMISSION OF PHI TO PROFESSIONAL CONDUCT PROGRAMS.

medical witness opinion and testimony. This is particularly warranted given that the present regulations exempt certain groups of physicians, including those involved in ensuring quality assurance, peer review, patient safety, and public health and safety.

This leaves out those physicians constituting one or more committees that are selected by their respective organizations to investigate and hear grievances filed against organization members that have provided opinion or testimony, or both, as expert medical witnesses.

Thus, this article proffers the following, in the alternative or in conjunction with one or more of the suggested amendments to the C.F.R., to be considered by Congress, HHS, and lobbyists speaking for medical specialty organizations.

Adding to the definition of “business associate” in 45 C.F.R. § 160.103 is one approach to consider. A new subparagraph (iii) to paragraph (1) could be inserted to include a person who, with respect to a covered entity:

Receives a grievance from the covered entity arising out of expert medical witness opinion or testimony given by a third party and who provides rules or procedures that govern the filing of any such grievance. Also included would be the Respondent to the grievance.

A new subparagraph (iv) could be added to paragraph (3) of the definition to expressly include as a business associate: “A medical specialty organization or similarly situated entity that governs its membership relating to the offering of expert medical witness opinion or testimony. Also included would be the person that is the subject of the grievance.”

Alternatively, the definition of “covered entity” in 45 C.F.R. § 160.103 could be amended to add a new subparagraph (4) to enlarge the definition of the term to include: “A medical specialty organization or other entity that governs its members providing expert medical witness opinion or testimony, including parties involved in any grievance challenging the testimony of that member.”

Another approach would be to amend 45 C.F.R. § 164.501 to add subparagraph (6)(vi) to the definition of “health care operations” to include the following as a business management and general administrative activity of a covered entity: “[a] medical specialty organization or similarly established entity that has provisions as part of its rules those that govern expert medical witness opinion or testimony provided by any of its members.”

Absent patient consent for the use of PHI in a grievance or in a public

212. See 45 C.F.R. § 160.103 (2014); see also 45 C.F.R. § 164.506 (2014).
record, these proposed amendments would provide that when a grievance is filed by a member of the organization, the organization and the respondent automatically become covered entities, or business associates, of the aggrieved health care provider filing the grievance. By expanding the definition of covered entity, the expansion of “health care operations” would allow the organization and its grievance committees, together with the participants, to be exempted from the de-identification requirement arising from unlawful use of PHI.

VII. CONCLUSION

As the claimant is likely the only covered entity involved in a grievance proceeding involving a physician’s expert testimony, the burdens of the HIPAA Privacy Rule fall more heavily on him or her, particularly if they wish to submit PHI to a Professional Conduct Program. This article first posits a “best measure to undertake” to overcome the roadblocks imposed by the HIPAA Privacy Rule and state privacy laws when an organization seeks to examine the expert medical witness testimony offered by one of its members. The gold standard for any Professional Conduct Program should be the amendment of its rules to require an authorization from the subject patient for the release of his or her PHI before any proceedings can be initiated on a grievance filed by a physician. Absent such an authorization, the rules should only permit the consideration of medical information that is part of the public record of a malpractice claim.

To reiterate, when an unauthorized disclosure of confidential medical information occurs in a grievance proceeding, the only available remedies may be for the patient to bring an action against the treating physician for injunctive relief or damages under state law, file a complaint with the OCR or for a member of the organization to bring a grievance of their own for violation of the organization’s confidentiality rules. Equally true, the organization should be mindful of the role that it plays in encouraging the violation of patient confidentiality in the name of regulating expert testimony.

Both the organization and the parties to a grievance must recognize that complacency as a substitute for ensuring the privacy of patients’ PHI is not acceptable. Organizations’ rules requiring the parties to merely eliminate a patient’s name or other explicitly identifiable markers that will identify the patient is woefully insufficient if not unlawful given the ease with which information about the underlying medical malpractice litigation can be found. It would be incredulous if such an attitude reflected in these entities’ administrative rules continued to exist given the contents of this writing. The goal must be to find a proper balance between allowing healthcare organizations to police their members who testify as medical experts –
principally in medical malpractice cases – and requiring full compliance with state and federal law.
APPENDIX

A. Response of the AANS Board of Directors to the Appeal by J. Martin Barrash, M.D.

B. American Society of Anesthesiologists Committee on Expert Witness Testimony Review Findings Regarding Expert Witness Testimony by Ronald L. Katz, M.D.
RESPONSE OF THE AANS BOARD OF DIRECTORS
TO THE APPEAL BY J. MARTIN BARRASH, M.D.

The AANS Board of Directors voted to censure Dr. Barrash because in his testimony in the underlying lawsuit he: (1) Failed to review all of the relevant and available medical material (specifically the diagnostic imaging studies) prior to testifying; and (2) Failed at times to provide unbiased testimony. The fact that the Professional Conduct Committee and Board of Directors agreed with some of Dr. Barrash's criticisms of the treating physician's delayed diagnosis and treatment of the patient does not excuse or make acceptable his otherwise unprofessional testimony.

CLINICAL BACKGROUND
The patient was a forty year old man when he underwent a two level instrumented posterior lumbar interbody fusion by Dr. Oishi on February 2, 2004. His pre-operative symptoms stemmed from an industrial accident approximately four weeks previously. He was seen in December 2003, and was found to be neurologically intact. Imaging demonstrated two level degenerative disc disease at L4-5 and L5-S1 with moderate stenosis. No motion films were obtained. Immediately post-operatively, he awakened with severe left leg pain.
which had not been noted before the operation, as the major pre-operative complaint had been low back pain. No further imaging was obtained during the initial hospitalization. Perioperative antibiotics were administered and he was discharged on February 6, with analgesics for his back and leg pain and a seven day course of Keflex.

The patient's wife noted some oozing from the wound, and he was seen by Dr. Oishi's physician assistant on February 12. A small amount of drainage and swelling were noted and the staples were removed. There was no evidence of infection according to Dr. Oishi. On February 20, the patient was seen by a physician assistant from Dr. Oishi's office as Dr. Oishi was unavailable. Some drainage was noted.

Because the left leg pain had continued and was severe, a second operation was performed on March 7, at which time a portion of the L5-S1 interbody graft was drilled away to relieve possible nerve root pressure, and the fixation system was modified. This second operation relieved the leg pain. No infection was evident at the second operation according to Dr. Oishi.

On March 24, the staples were removed by a physician assistant and a small "scab" was noted. On March 30, the patient developed fever ranging from 102 to 103 degrees. On April 3, his wife noted intermittent but copious drainage of greenish purulent material. He was seen in the office and the wound was found to be slightly erythematous and swollen, but not draining at the time. No cultures were taken nor were an ESR nor CRP obtained, but a WBC was normal. He was given Cipro. The wound continued to drain according to his wife. On April 14, he saw Dr. Oishi with a severe cough. A chest CT was ordered and obtained on April 16. The report of this study indicated a perihepatic cystic
lesion. About ten days later, on April 27, Dr. Oishi called the patient and advised him to contact his primary physician, Dr. Trippe. Because of severe pain and fever, and the radiographic findings, Dr. Trippe prescribed Timentin and admitted him to the hospital on May 11. Infectious disease consultation was obtained and he was switched to Zosyn. The perihepatic cystic lesion was aspirated and confirmed the diagnosis of an abscess. Cultures grew out staphylococcus aureus. A third operation was carried out on May 13, to remove the hardware and debride the wound.

After a prolonged hospitalization and successful treatment of his infection, he recovered, but was left with chronic pain, instability, and depression. He was unable to work and required treatment by a pain management specialist. Ultimately, a fourth operation was done for stabilization on January 13, 2006. The outcome of this procedure was not made available to the PCC.

The patient and his wife contacted an attorney who in turn retained Dr. Barrash and filed suit against Dr. Oishi in the District Court of McLennan County, Texas. Dr. Barrash’s deposition was taken. The lawsuit was settled out of court and did not proceed to trial. Dr. Oishi then filed a complaint against Dr. Barrash with the AANS’ Professional Conduct Committee, which concluded that a hearing was warranted.

**DR. BARRASH’S TESTIMONY**

The primary issues which Dr. Barrash felt supported a negligence lawsuit against Dr. Oishi included: 1) Failure to aggressively pursue, identify, and treat the cause of the patient’s postoperative left leg pain which Dr. Barrash attributed most likely to the interbody graft having been incorrectly positioned at surgery; 2) failure to promptly recognize and adequately pursue, identify, and treat a
probable serious post-operative infection; 3) failure to obtain prompt consultation; 4) failure to manage perioperative antibiotic therapy correctly; 5) delegation of care to assistants when such care would more appropriately have been rendered by the surgeon; and 6) that these failures caused the need for a delayed fusion surgery, a chronic pain syndrome, depression, and inability to work.

During his deposition, in addition to his criticisms of Dr Oishi’s failure to timely identify and treat the infection, criticisms with which the PCC is in agreement, Dr. Barrash’s testimony also included statements that Dr. Oishi probably incorrectly positioned an interbody graft at the first surgery. However, Dr Barrash never reviewed any of the imaging studies prior to making this statement. In addition, Dr. Barrash last operated as a primary surgeon in 1999 or 2000. Dr Barrash stated that posterior hardware will prevent graft retropulsion, and that Dr. Oishi’s surgery which took four hours should only have required 2 -- 2 1/2 hours and that the four hour surgery indicates inexperience.

DR. OISHI’S CHARGES

Dr. Oishi’s complaints from his letters of November 10, 2008 and November 24, 2008 include:

A. Failure by Dr. Barrash to provide impartial testimony;

B. Failure by Dr. Barrash to review all pertinent available medical information;

C. Failure by Dr. Barrash to allow for differing medical opinions; and

D. That Dr. Barrash did not have sufficient training and recent surgical experience to be competent to testify in this case.
BRIEF HEARING SUMMARY

The hearing took place in New Orleans on Sunday Oct 25 2009. Present were Dr. Oishi, Dr. Barrash and his attorney Dr. Clark Watts, PCC members Ben Blackett chairman, Dr. Volker Sonntag, Dr. Clarence Watridge, Dr. Roberto Heros, Dr. Stephen Giannotta, and Dr. Hal Hankinson.

Dr. Oishi made an abbreviated presentation without reviewing orally his prior written submissions. He presented the intraoperative X-ray showing the intervertebral grafts and the posterior instrumentation including the pedicle screws.

Dr. Barrash addressed the claim that he was not competent to testify on this case saying that although he had not operated as primary surgeon since 1999, he did assist on about 50 spine surgeries per year. He answered the charge that he was not spine fellowship trained saying that he had helped train some of the people who now have spine fellowships. He discussed his criticisms of Dr. Oishi's failure to do a timely evaluation of his patient's infection symptoms and explained his theory that the contralateral leg pain and relative graft fixation at the second surgery indicated that the graft was probably not positioned correctly at the first surgery.

The intraoperative X-ray was reviewed by Dr. Oishi, Dr. Barrash and the committee members and there was no disagreement that the grafts appeared to be properly placed on these films. Dr. Barrash agreed that it would have been better if he had looked at these films before testifying but that the attorney had not provided any X-rays for him to examine.
CONCLUSIONS OF THE PROFESSIONAL CONDUCT COMMITTEE

Infection:

The PCC had no criticism of Dr. Barrash’s testimony that Dr. Oishi fell below the neurosurgical standard of care in failing to provide a timely diagnosis and treatment of the patient’s postoperative wound infection.

Charges of Inexperience:

Dr. Oishi charged that Dr. Barrash lacks the experience to be testifying about Dr. Oishi’s spinal surgery since Dr. Barrash was not fellowship trained in spinal surgery and has not been the primary surgeon on any spinal surgeries since 1999. The AANS has no rule requiring a neurosurgical witness to be actively participating as a primary surgeon nor that a spine fellowship is required, and evaluates testimony only on the basis of the testimony itself. Dr. Oishi’s charges on these counts were dismissed.

Dr. Barrash testified in his deposition that the two level lumbar fusion by PLIF and lumbar pedicle instrumentation should have taken only two hours and that the four hours taken by Dr. Oishi was a result of his inexperience. The PCC did not consider four hours to complete the two level PLIF along with posterior pedicle instrumentation to be particularly exceptional and certainly not indicative of inexperience of the operating surgeon. Whether this statement by Dr. Barrash was intentional misrepresentation through improper advocacy or lack of sufficient subject matter knowledge is unclear but either way it was prejudicial and unprofessional. Although Dr. Barrash made no mention of his confusion at either the PCC hearing, or later before the AANS Board of Directors, he now states that he had failed to realize during his deposition that Dr. Oishi had performed a two
level decompression and a two level instrumented fusion. We think that his recently expressed apology to Dr. Oishi for this testimony is appropriate.

Failure to Review:

Dr. Barrash never personally reviewed the imaging studies relevant to this litigation, yet he testified that an interspace bone graft was probably improperly placed during the first surgery. Dr. Barrash based this assertion upon the relative fixation of the graft noted at the second surgery on March 7, 2004, the presence of posterior instrumentation and the left leg pain following the first surgery and relieved after the second surgery. The intraoperative x-rays of February 2, 2004 were reviewed by the PCC members during the hearing on October 25, 2009 and the graft appeared to the PCC members to be in proper position at both the L4-5 and L5-S1 interspaces and with the posterior instrumentation also properly placed. Dr. Barrash defended his failure to review these and other x-rays saying that they were not obtained for him by the plaintiff’s attorney. Reluctance of the other side to provide relevant medical records or films is not an acceptable excuse. Active discovery was underway in this case and subpoenas or court orders to produce documents or films are almost always available. Dr. Barrash could and should have declined to testify about the graft placement at surgery until he had been provided the relevant imaging studies. Dr. Barrash’s failure to insist on seeing the films before testifying on this issue or rendering a written opinion was contrary to Rule B2 of the AANS Rules for Neurosurgical Medical/Legal Expert Opinion Services and was unprofessional in addition to having been, in the opinion of the PCC members and later the AANS Board of Directors, incorrect about the graft position at the time of surgery.
Chronic Pain Syndrome:

Dr. Barrash in his letter to attorney Michael Miller of August 10, 2006 wrote that:

"[The patient] now has a chronic pain problem, not from the surgery, not from the injury, but from the lack of following the standard for rapid treatment of a suspected and then confirmed infection. Were it not for the negligence on the part of Dr. Oishi in not recognizing and addressing the infection that was smoldering in [the patient], his condition today would not be one of chronic pain, disability, and the attendant depression and hopelessness."

Chronic pain syndromes can follow injuries without surgery, and surgery with or without complications. For Dr. Barrash to say that the failure to properly identify and treat the infection caused a chronic pain syndrome can only be speculation, and to assert it as the proximate cause of ongoing pain damages is improper advocacy.

The PCC concluded that, notwithstanding Dr. Barrash's appropriate criticism of Dr. Oishi's delayed diagnosis and treatment of the patient's postoperative wound infection, Dr. Barrash did fail to review all of the relevant and available records before testifying, and failed at times to provide unbiased testimony. The unprofessional testimony described above was significant, was not de minimis, and in the opinion of the PCC, warranted a six-month suspension of membership.

The Board of Directors, recognizing the impropriety of that testimony, but also acknowledging the correctness of some of Dr. Barrash's criticisms, reduced
that sanction to a censure. A censure, while considered a disciplinary action, is
not reportable to the National Practitioners Databank.

We feel compelled to respond to another issue which Dr. Barrash has
raised in his appeal. Dr. Barrash asserts that there was bias against him by a
particular member of the PCC. Dr. Barrash raised no objections to this individual
participating in the PCC hearing and when Dr. Barrash raised this issue for the
first time before the Board, he presented no actual evidence that the PCC
member in question was biased against him. Nevertheless, he now cites an
article by that PCC member in supposed support of his position.

Finally, to clarify a point of AANS history raised by Dr. Barrash, the PCC
was established to deal with complaints brought by one or more AANS members
against one or more other members. Often these complaints have originated
from medical malpractice lawsuit testimony, as were the complaints in this
instance. The AANS has consistently encouraged appropriate testimony,
whether for the plaintiff or the defendant.

The Board asks that you support its decision that Dr. Barrash be
censured for unprofessional conduct while appearing as an expert witness in a
legal proceeding.

James Rutka, M.D.
AANS President

AANS_B_00497
In March 2011, the Judicial Council affirmed the findings of the Committee on Expert Witness Testimony Review and recommendation that ASA member Ronald L. Katz, M.D. be censured for failure to abide by ASA Guidelines for Expert Witness Qualifications and Testimony ("Guidelines"). In accordance with the ASA Bylaws and Administrative Procedures, a resolution for censure was referred to the ASA Board of Directors and considered by the Special Board Committee on Expert Witness Testimony Review. In November 2011, the Board censured ASA member Ronald L. Katz, M.D.

Pursuant to ASA Administrative Procedure 11.8.7, the Committee Findings affirmed by the Judicial Council are posted below.

**FINDINGS**

**A. Background**

1. ASA member David B. Zucker, M.D. brought a Complaint against Ronald L. Katz, M.D. alleging that Dr. Katz failed to abide by the ASA Guidelines with respect to expert witness testimony given in *Patient v. Toledo Hospital*, [Case No.] (Court of Common Pleas, County of Lucas, Ohio) (the “Case”).

2. Dr. Katz offered expert testimony on behalf of the plaintiff in the Case, including trial testimony on October 22, 2003.\(^1\) Dr. Zucker was a defendant in the Case. The jury in the Case returned a verdict in favor of the plaintiff. The verdict was appealed, and while the appeal was pending, the case was settled and the appeal then dismissed. Dr. Katz and Dr. Zucker are members of the ASA and are bound by the ethical requirements set forth in the ASA Guidelines.

3. We find that the matter is properly within our jurisdiction as prescribed by ASA Bylaws and Administrative Procedures. Dr. Unruh, Chairman of the Committee, asked Dr.

\(^1\) Dr. Katz also provided deposition testimony in the Case; however, the deposition occurred prior to the effective date of the ASA Expert Witness Testimony Review Program and therefore is not subject to review.
Patrick Birmingham, Dr. Robert B. Fisher, and Dr. Terry Walman (the “Committee Investigators”) to evaluate the allegations in the Complaint concerning Dr. Katz’s testimony and to make a recommendation to the Committee on whether Dr. Katz’s testimony raised a substantial question concerning compliance with the ASA Guidelines. After reviewing the Complaint and supporting material and Dr. Katz’s written Response and supporting material, the Committee Investigators determined that certain allegations in the Complaint raised a substantial question concerning compliance with the ASA Guidelines and recommended that the Committee hold a hearing on those allegations. The Committee agreed with the Committee Investigators’ recommendation, and the Committee held an oral hearing on September 29, 2010 (the “September 29 Hearing”), at which it heard testimony and argument on behalf of the Committee Investigators and Dr. Katz.

4. The patient in the Case was a 55-year old female who presented in the emergency room with abdominal pain. [Medical Records at 39.] She had a medical history of colitis, hypertension, coronary artery disease, hyperlipidemia, GERD, and diabetes mellitus type II. [Medical Records at 41.] She had not had a bowel movement for 24 hours and had no flatus. [Medical Records at 39.] According to the emergency center report, “[s]he has had some vomiting earlier” but “[s]he has had no vomiting lately.” [Medical Records at 39.] The provisional diagnosis on the emergency center report was “partial small bowel obstruction.” [Medical Records at 40.] She was admitted to the hospital on that date. According to the history and physical report, the patient was made NPO and medications (Cardizem, Tenormin, Lipitor, Prevacid, Glucophaghe, Neurontin) were to be continued “with sips only.” [Medical Records at 42-44.]
5. On the next day, the patient vomited once but had no stools or flatus. [Medical Records at 47.] The patient underwent a CT scan, which suggested some small bowel dilation. [Medical Records at 54.] According to the operative report by the surgeon, “[w]hen the pain worsened, and the bowel sounds started to come in rushes, I felt that it was likely that [the patient] had a small bowel obstruction that needed operative release.” [Medical Records at 54.]

6. The ER team, the primary care team, and the consulting surgeon elected not to place a nasogastric tube. The patient arrived at the operating room at approximately 6:00 p.m. where Dr. Zucker evaluated her. Dr. Zucker states in his Complaint: “I reviewed her medical records and personally examined the patient. During my evaluation of the patient, she reported no difficulty with previous anesthetics, and based on her physical examination, I anticipated no difficulty with intubation.” [Complaint at 2.]

7. Dr. Zucker did not place a nasogastric tube. He elected to perform a rapid sequence induction with cricoid pressure. CRNA William Boardman, with over 14 years of experience, intubated the esophagus, which was immediately recognized. CRNA Rose Demain, who had over 20 years of experience, then tried and again intubated the esophagus, which was immediately recognized. Dr. Zucker then tried to intubate using a light wand but again intubated the esophagus, which was immediately recognized. The patient was eventually intubated via a LMA in conjunction with a fiberoptic bronchoscope by another anesthesiologist, Kevin Lodge, M.D.

8. The hearing focused on two areas of testimony by Dr. Katz: (1) Dr. Katz’s testimony that Dr. Zucker breached the standard of care by allowing the patient’s esophagus to be intubated; and (2) Dr. Katz’s testimony that Dr. Zucker violated the standard of care by failing to ensure that a nasogastric tube was placed prior to induction of anesthesia.
B. Testimony Concerning Intubating the Esophagus.

9. Dr. Katz testified that Dr. Zucker deviated from the standard of care by allowing the patient’s esophagus to be intubated. In considering this area of testimony, we reviewed all of Dr. Katz’s trial and deposition testimony and considered the context in which the testimony was given. In the following excerpt from his trial testimony, Dr. Katz sets forth his opinion on intubating the esophagus and provides the bases for his opinion -- all in response to questions posed by the plaintiff’s counsel:

12 Q. Is it a deviation of accepted standard of care to put an endotracheal tube down an esophagus?
13 A. It depends upon the circumstances. Doing esophageal intubation, per se, is not below the standard of care. I have, in attempting to do an endotracheal intubation, have attempted to do an esophagus, recognized it, pulled it out, and put it in the trachea. That can happen to anyone.
15 But in this case, given the circumstances of a patient with a full stomach, to put the tube in the esophagus is to fail to properly do a rapid sequence induction and is below the standard of care.
17 Q. What is the primary cause of an esophageal intubation, as opposed to getting the tube in the trachea?
18 A. Well, It just means you didn't put it in the right place. It can be because the patient has unusual anatomy, which makes it difficult.
20 And the example I gave a minute ago where I put the tube in the esophagus, that was in a patient who had cancer surgery and their face was not normal.
21 So abnormal anatomy can be one cause.
23 A second cause can be inexperience of the person doing it or the inability of the person to have good intubation skills.
25 Q. Did you find any evidence in the records or the depositions that Patient had any anatomical abnormalities?
26 A. I asked you to send me pictures of her face in certain positions so I could get an idea of whether she had abnormal or unusual anatomy. Looking at those pictures, I didn't see that she had any
If the anesthesia care team felt she had unusual anatomy, I would have expected them to have written a note in the chart about it, and I didn't find such a note.

And, finally, this patient had several other operations. Some before this case, before this operation we were discussing, and I believe one afterwards. In those four operations, there was no evidence of any difficulty.

The reason I say that is that if a patient has a difficult airway, the anesthesiologist is supposed to tell the patient you are difficult.

And, in fact, when I encounter a patient with a difficult airway that I can intubate, I advise them to buy a med-alert bracelet, and the bracelet says I am a difficult intubation.

I also give them a letter describing what the problem is to give to the next anesthesiologist.

As far as I know, no one ever told the patient she was a difficult intubation or that she had usual anatomy.

And in looking at the picture, it didn't look like she had unusual anatomy to me.

Q. Doctor, do you have those photographs handy?

A. Yes, I do.

Q. I've marked one of them. I have the duplicate. I've marked it as Plaintiff's Exhibit 3, and it's the frontal picture of [Patient] with her mouth open. Do you have that picture?

A. Yes, I can see that. That's this one (indicating).

Q. What does that show you? Describe for us what that's demonstrating.

A. It shows me a lot of things. It shows me how widely she can open her mouth, which is good. She has good mouth opening. And I can see a lot of the anatomy of the patient, including the uvula back here (indicating).

So looking in the patient's mouth, that tells me she can open it nicely and I can see pretty far down. So that tells me she should be a straightforward, pretty easy intubation.

Q. Doctor, if a patient has no other abnormalities or problems present, do you have an opinion to a reasonable degree of medical probability
whether it was a deviation of accepted standard of
care to place the endotracheal tube down the
esophagus?
A. Given the circumstances of this case, the
answer is yes.

[Trial Testimony of Ronald L. Katz dated October dated October 22, 2003 (“Katz Trial
Testimony”) at 44:12 - 47:22.]

10. In the Patient Case, Dr. Katz concluded that intubating the esophagus must have
been caused by Dr. Zucker’s negligence because the patient did not appear from photographs to
have an unusual anatomy and because the patient did not have intubation problems in her other
surgeries. We find that this testimony from Dr. Katz violates ASA Guidelines B1, B2, and B3.

11. Guideline B1 provides: “The physician’s review of the medical facts should be
truthful, thorough and impartial and should not exclude any relevant information to create a view
favoring either the plaintiff or the defendant.” Dr. Katz’s testimony on intubating the esophagus
was neither thorough nor impartial.

12. First, as Dr. Katz recognized elsewhere in his trial testimony and in a presentation
he gave at a conference for the Society of Ambulatory Anesthesia in 1998, many patients who
appear to have normal airways turn out to be difficult or impossible to intubate. At trial, in
response to a question from Dr. Zucker’s counsel, Dr. Katz testified as follows:

Q. Now, Doctor, a patient can appear to have
a normal airway, but it turns out it’s a difficult
intubation regardless of that appearance; isn’t that
correct?
A. Yes. I said that in my deposition, I
believe.

[Katz Trial Testimony at 64:13-18.] And, in his 1998 presentation, he said: “While in some of
the cases it should have been suspected there might be airway problems, this was not true in
many cases. Patients who appeared to have normal airways were found to be difficult or
impossible to intubate.” Dr. Katz also confirmed during the September 29 Hearing that “notwithstanding appearances, sometimes a patient has an unrecognized difficult airway.” [Transcript from September 29 Hearing (“9/29/10 Hrg. Tr.”), Vol. II at 12:16-19.] In light of these acknowledgments by Dr. Katz, we find that a thorough and impartial review of the medical facts would not support Dr. Katz’s reliance on photographs to conclude that the patient should have been a “straightforward, pretty easy intubation.” [Katz Trial Testimony at 47:14.]

13. We also do not find Dr. Katz’s reliance on the patient’s supposed easy intubation in other surgeries to be thorough or impartial. First, we note that Dr. Katz apparently assumed that the patient did not have intubation problems with her other surgeries. He did not review the medical records from those other surgeries or speak to the anesthesiologists involved in the other surgeries. [9/29/10 Hrg. Tr., Vol. II at 15:2-10.] More importantly, we are not persuaded that the absence of intubation problems in the patient’s other surgeries establishes that negligence caused the patient’s intubation problems in the surgery at issue.

14. Practice Guidelines for Management of the Difficult Airway (A Report by the American Society of Anesthesiologists Task Force on Management of the Difficult Airway) provides: “The difficult airway represents a complex interaction between patient factors, the clinical setting, and the skills and preferences of the practitioner.” Practice Guidelines, Anesthesiology, V. 78, No. 3 (May 1993) at 597 (Record at 96). In the surgery at issue, the clinical setting was an emergency surgery to release a small bowel obstruction. The patient’s

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2 Although we did not focus on any testimony from Dr. Katz’s deposition with respect to potential violations of the ASA Guidelines, Dr. Katz’s counsel urged us to consider Dr. Katz’s deposition testimony to understand the context of Dr. Katz’s opinions. With respect to the patient’s other surgeries, Dr. Katz testified: “And actually, the eight pictures that I have indicate to me that I would not expect her to be a difficult intubation and that fits with the four other operations, three of which I’m sure were under general anesthesia, one of which I don’t know whether it was general or regional. That’s the hysterectomy. It could have been done under general or regional. So at least several of the operations were done under general anesthesia. I’m assuming she was intubated and they didn’t have a problem. And looking at the pictures, it looks to me like she’d be an easy intubation.” [Deposition of Ronald Lewis Katz dated November 20, 2002 (“Katz Dep.”) at 13:3-13.]
other surgeries include: partial hysterectomy; oophorectomy; open cholecystectomy; and appendectomy. Dr. Katz’s testimony concerning the importance of the patient’s other surgeries does not take into account that the clinical settings of those surgeries were different than the clinical setting of the surgery at issue. In fact, Dr. Katz could not even testify that all of the other surgeries were under general anesthesia. [Katz Dep. at 13.]

15. In short, given that patients who appear to have normal airways may turn out to be difficult or impossible to intubate even when an anesthesiologist satisfies the standard of care -- a fact recognized by Dr. Katz -- we find that Dr. Katz’s reliance on the patient’s photographs and prior surgeries to conclude that Dr. Zucker acted negligently in allowing the patient’s esophagus to be intubated represents neither a thorough nor impartial review of the medical facts. Accordingly, we find that Dr. Katz violated Guideline B1.

16. We also find that Dr. Katz’s testimony on intubating the esophagus violates Guideline B2, which provides: “The physician’s testimony should reflect an evaluation of performance in light of generally accepted standards, reflected in relevant literature, neither condemning performance that clearly falls within generally accepted practice standards nor endorsing or condoning performance that clearly falls outside accepted medical practice.” Dr. Katz acknowledged on Page 44 of his trial testimony that intubating the esophagus “can happen to anyone” and is not a per se violation of the standard of care. And, as discussed in Paragraph 12 above, he also acknowledged that despite appearances, a patient may turn out to have an unrecognized difficult airway. In other words, Dr. Katz acknowledged that allowing a patient’s esophagus to be intubated does not per se fall outside of generally accepted practice standards. Yet, he then condemns Dr. Zucker’s performance as falling outside of generally accepted practice standards on the basis that Dr. Zucker allowed the patient’s esophagus to be intubated.
Based on the record before us, Dr. Zucker’s performance clearly falls within generally accepted practice standards. Dr. Katz’s testimony to the contrary violates ASA Guideline B2.

17. We reviewed the literature submitted by Dr. Katz and find that it does not support his testimony that because the patient appeared from photographs to be an easy intubation and because the patient did not have intubation problems in her other surgeries, her intubation problems in surgery at issue were the result of negligence by Dr. Zucker. For example, *Practice Guidelines for Management of a Difficult Airway (An Updated Report by the American Society of Anesthesiologists Task Force on Management of the Difficult Airway)* states: “There is insufficient published evidence to evaluate the effect of a bedside medical history on predicting the presence of a difficult airway. Similarly, there is insufficient evidence to evaluate the effect of reviewing prior medical records on predicting the presence of a difficult airway.” *Practice Guidelines, Anesthesiology, V. 98, No. 5 (May 2003) at 1271 (Record at 104).

18. Finally, we find that Dr. Katz violated Guideline B3, which provides: “The physician should make a clear distinction between medical malpractice and adverse outcomes not necessarily related to negligent practice.” Here, Dr. Katz did not make such a distinction. Because the esophagus was intubated (an adverse outcome), Dr. Katz concluded that there must have been negligent practice. But as Dr. Katz acknowledged, intubating the esophagus can happen to anyone and is not necessarily the result of any negligence. Here, Dr. Katz fails to provide an adequate explanation for why in this case intubating the esophagus was the result of some type of negligent practice. Therefore, we find his testimony violates Guideline B3.

C. Testimony Concerning Placement of a Nasogastric Tube.

19. The September 29 Hearing also focused on Dr. Katz’s testimony concerning the placement of a nasogastric tube. Again, in considering this area of testimony, we reviewed all of
Dr. Katz’s trial and deposition testimony and considered the context in which the testimony was given. In response to questions from plaintiff’s counsel, Dr. Katz testified as follows concerning the placement of a nasogastric tube:

14 Q. Prior to her surgery on [Date],
15 1999, had any physician placed a nasogastric tube in
16 [Patient] to decompress her stomach?
17 A. No.
18 Q. In your opinion, was that a deviation of
19 accepted standard of care?
20 A. Absolutely. That's Anesthesia.
21 That's Medicine.
22 Q. Do you hold that opinion to a reasonable
23 degree of medical probability?
24 A. Yes.
1 Q. Doctor, earlier, you mentioned the
2 anesthesiologist working I think you said as a
3 teammate of the surgeon.
4 Who should have placed the nasogastric
5 tube in [Patient] to decompress her stomach
6 during her surgery at approximately 6:15 on [Date]?
8 A. Well, the usual practice is for the
9 surgeon to place it, so I believe the surgeon should
10 have put it in in this case initially.
11 Q. And you've already told us no one did, so
12 if the surgeon fails to do it, does anyone else have
13 the responsibility to place a nasogastric tube?
14 A. If the surgeon fails to do it, it then
15 becomes the responsibility of the anesthesiologist to
16 pass it. The example that I've used in teaching
17 medical students is that the surgeon is the linebacker
18 in this case, but if the player gets past the
19 linebacker, then the anesthesiologist is the safety
20 man, because he has the last chance to prevent the
21 touchdown or prevent damage from occurring to the
22 patient.
23 So it's the primary responsibility of the
24 surgeon. If the surgeon fails, then It's up to the
1 anesthesiologist to do it.

[Katz Trial Testimony at 33:14 - 35:1.]

20. At the September 29 Hearing, Dr. Katz affirmed his testimony:

15 Q. Dr. Katz, as I understood your testimony in the
Patient trial and today, it is your opinion that the standard of care requires the placement of a nasogastric tube in all patients with a presumed full stomach; is that right?

A. Yes.

Q. So, it’s your testimony that it is not a judgment call by an anesthesiologist?

A. That’s correct.


21. We find that Dr. Katz’s testimony on the placement of a nasogastric tube violates Guideline B2 because he condemns performance that clearly falls within generally accepted practice standards. Dr. Katz testified that the standard of care mandated the placement of a nasogastric tube because the patient had a full stomach. He told the jury that placing a nasogastric tube in a patient with a full stomach was elementary; it was “Anesthesia 1-A.” We do not agree. Placing a nasogastric tube in a patient with a full stomach is a judgment call, and we find that anesthesiologists could reasonably differ on whether to place a nasogastric tube under the circumstances of this Case.

22. Because anesthesiologists could reasonably differ on whether to place a nasogastric tube under the circumstances of this Case, Dr. Katz improperly condemned Dr. Zucker’s decision not to place a nasogastric tube. Dr. Zucker’s decision not to place a nasogastric tube under the circumstances of the case and to perform a rapid sequence induction with application of cricoid pressure clearly falls within generally accepted practice standards. Dr. Katz’s testimony to the contrary violates Guideline B2.

23. Moreover, Dr. Katz did not limit his testimony to the circumstances of this Case. Rather, he broadly and absolutely stated that placing a nasogastric tube in a patient with a presumed full stomach is the standard of care. During the September 29 Hearing, the Committee questioned Dr. Katz regarding the broad and absolute nature of his opinion, and Dr. Katz
responded: “Well, you know, I feel very strongly that -- you know, and the term -- I think it’s Barash uses the term incumbent. And, to me, that means you have to do it, and I agree with that. Unless there’s a contraindication to pass a nasogastric tube, it needs to be done in a patient with full stomach.” [9/29/10 Hrg. Tr., Vol. II at 20:4-9.] We do not dispute that Dr. Katz strongly believes that a nasogastric tube should be placed in any patient with a presumed full stomach (unless there is a contraindication), but we find that this is a personal belief of Dr. Katz’s that does not accurately reflect the standard of care.

24. Dr. Katz provided literature that identified placement of a nasogastric tube as one method that may be used to reduce the risk of regurgitation and aspiration. Dr. Katz argues that because the literature recommends the method that he testified was mandated, his testimony is supported by the literature. However, the fact that the literature recommends that an anesthesiologist consider a specific procedure to reduce the risk of aspiration does not mean that the recommended procedure is the only acceptable and appropriate method to be utilized or that other alternative methods cannot be employed.

25. The Committee Investigators proved the foregoing violations of the Guidelines by clear and convincing evidence. The Complaint also contended that Dr. Katz’s testimony violated the Guidelines in several other respects; however, the Committee Investigators did not pursue those allegations at the hearing.

D. **Other Challenges Raised by Dr. Katz at the September 29 Hearing.**

26. Dr. Katz’s counsel argued at the September 29 Hearing that the testimony identified by the Committee Investigators as violating the ASA Guidelines was excerpted and taken out of context. We reject this argument for several reasons. First, we note that we have reviewed and considered all of the material provided by both Dr. Zucker and Dr. Katz in this
proceeding, including the entirety of Dr. Katz’s trial and deposition testimony. Therefore, we have considered the testimony identified by the Committee Investigators in the context it was given by Dr. Katz. Dr. Katz’s counsel urged that we consider Dr. Katz’s deposition testimony because it provided context for Dr. Katz’s opinions. We have considered Dr. Katz’s deposition testimony and find it to be consistent with Dr. Katz’s trial testimony. We specifically considered the passages that Dr. Katz’s counsel identified on pages 45 and 50 of the deposition testimony, where Dr. Katz testified that the deviations from the standard of care that he identified (including failing to place a nasogastric tube and intubating the esophagus) together caused the aspiration. This is consistent with Dr. Katz’s trial testimony (at page 50) on causation. However, contrary to the statements of Dr. Katz’s counsel at the September 29 Hearing (at page 105-106), Dr. Katz did not testify in his deposition or at trial that the combination of intubating the esophagus, failing to place the nasogastric tube, and failing to reduce the acidity of the gastric contents in the stomach deviated from the standard of care. Rather, he testified that each of these three things separately and independently deviated from the standard of care and that the combination of them caused the aspiration. The focus of the September 29 Hearing was not on Dr. Katz’s causation opinion but on whether it was a deviation from the standard of care to intubate the esophagus and whether it was a deviation of the standard of care to fail to place a nasogastric tube. The passages identified from Dr. Katz’s deposition do not address these issues.

27. During the September 29 Hearing, Dr. Katz’s counsel also argued that the entire record from the Case must be considered to reach a decision in this proceeding. We have not identified any additional material from the Case that we believe we need to review in order to reach a decision in this matter but that was not provided to us by either Dr. Katz or Dr. Zucker. To the extent that Dr. Katz believes that there is testimony that we did not have in our possession
that we should have reviewed, he had an opportunity in these proceedings to submit any material he wished for us to review.

28. Dr. Katz’s counsel also argued in the September 29 Hearing that Dr. Katz’s testimony was constrained by the questions he was asked by defense counsel. Again, we reject this argument. First, we do not find that Dr. Katz’s testimony on intubating the esophagus or placing the nasogastric tube was constrained by any of the questions posed to him. Rather, his trial testimony and the opinions he provided on these two issues were fully consistent with his testimony at the September 29 Hearing. In fact, the key testimony we cite in Paragraphs 9 and 19 above is testimony that Dr. Katz provided on the standard of care and was testimony that Dr. Katz provided in support of the plaintiff and in response to questions from plaintiff’s -- not defense -- counsel. As Dr. Katz acknowledged at the September 29 Hearing, his standard of care opinions were fully and completely provided to the jury. [9/29/10 Hrg. Tr. Vol. II at 16-17.] In general, we reject the implication made by such an argument that an expert witness cannot be expected to comply with the ASA Guidelines when being questioned by opposing counsel. The ASA Guidelines apply regardless of which counsel is asking the questions. An expert witness can respond to the questions asked and still comply with the ASA Guidelines.

29. In stating his or her opinion as to what is accepted medical practice, the expert witness must provide a fair, objective and unbiased presentation of the facts and accepted treatment options. In fact, ethical guidelines -- such as Guideline B1 -- obligate medical experts to acknowledge plausible alternative treatment options or modes of practice, even if the expert witness would not herself or himself employ such treatment options or modes of practice. Under Guideline B1, it is improper to define the standard of care so narrowly to only encompass the mode of practice preferred by the expert witness when other acceptable treatment options exist.
Otherwise, the expert’s testimony could not be presented “unchanged for use by either the plaintiff or defendant” as required by Guideline B1.