CHAPTER VI

THE USE OF EXPERTS IN ARBITRATION

I. EXPERT MEDICAL EVIDENCE: A VIEW FROM THE END OF THE TABLE

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In this Twenty-Second Annual Meeting, the Academy focuses attention on new problems in a changing era. It is proper that we do so. In this session, however, it is my role to take another look at a recurrent basic problem in the hope that as arbitrators we can refine our understanding of it.

The annals of arbitration disclose little reason for new concern about the problems encountered in handling medical evidence or the testimony of a medical expert. Even a cursory review of published decisions shows that the issues arising today are much the same as those which arbitrators have faced for many years. It is not my purpose here to catalogue the problems or present a consensus as to the proper resolution of disputes which turn wholly or in part on medical questions. Indeed, the pragmatic flavor of published decisions suggests that medical controversy is rarely susceptible to settlement by accepted formula. Rather, I propose a brief exploration into the nature of medical evidence for the purpose of arriving at some tolerable conclusions as to its effective use by arbitrators.

First, a preliminary observation about the general character of medical evidence. Perhaps more often than not in arbitration such evidence is presented in the form of written documents, reports, or statements, rather than in oral testimony. I suspect that most doctors prefer not to appear in adjudicatory proceedings and risk the rigors of cross-examination by one who is not a member of their profession. Frequently, written medical statements are couched in

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technical terms which tend to confuse rather than enlighten. More often the evidence consists of a cryptically written statement submitted on a drugstore prescription blank. Arbitrators forced to decide issues on this kind of evidence may proceed with little confidence. Parties who rely on it should recognize the inherent risks. In a book entitled *Lawyer's Guide to Medical Proof,* by Marshall Houts, I found this verse: [1]

With an erudite profundity,
And subtle cogitabundity,
The medical expert testifies in Court:
Explains with ponderosity,
And keen, profound verbosity,
The intricate nature of the plaintiff's tort.

Discoursing on pathology,
Anatomy, biology,
Opines the patient's orbit suffered thus;
Contusions of integuments,
With ecchymosed embellishments,
And bloody extravasation forming pus.

A state of tumerosity,
Producing lacrimosity,
Abrasions of the cuticle severe;
All diagnosed externally,
Although, he feared, internally,
Sclerotic inflammations might appear.

The jury sits confused, amazed,
By all this pleonasm dazed,
Unable to conceive a single word;
All awed, they think with bated breaths,
The plaintiff dies a thousand deaths,
What agony, what pain he has endured.

Said then the counsel for defense,
Devoid of garrulous eloquence,
Would I be correctly quoting you
To say his eye was black and blue?
To this the doctor meekly answered
"Yes."

[1] *Lawyer's Guide to Medical Proof* (New York: Matthew Bender, 1966).

My further observations in this paper are premised on the idea that the arbitrator is dealing with medical evidence which does not suffer from these defects.

Medical Facts

In evaluating expert medical evidence, it is important to distinguish medical *fact* from medical *opinion.* By medical *fact,* I mean objective data gathered by some recognized laboratory or clinical procedure, or by some accepted process of empirical measurement, for example, weight, temperature, pulse rate, blood pressure, or conditions such as a fracture, swelling, sugar in the urine, and dilation of the pupils. Medical *opinion,* on the other hand, consists of conclusions and implications drawn by a doctor from a given set of medical facts. The pertinent difference is that an *opinion,* even though objectively given, is not susceptible to the same kind of beforehand tests and proofs which apply in a search for *facts.*

Faced with conflicting evidence concerning medical *facts,* the arbitrator's problem is essentially that of finding a rational and defensible basis upon which to choose one set of medical "facts" over the other. In some cases, the record itself may provide an acceptable basis for the choice. That is, there may be convincing testimony that the measuring procedure employed by one doctor has been shown to produce significantly more accurate data than that employed by another. Or, there may be evidence that observation of the patient by one doctor was made under such unusual conditions as to render the data suspect.

These few examples are intended to suggest a limited class of credibility indices—those which relate to the fact-gathering process itself. Excluded are tests which relate solely to the experience or professional standing of the individual doctor. Although such factors may engender some confidence, their subjective nature may render them of little probative value to the arbitrator who is faced with evaluating conflicting facts submitted by doctors he does not know. Gathering medical facts is an essential part of the disciplines of medicine. The likelihood that blood pressure as recorded by a renowned heart specialist is significantly more nearly correct than a different reading by a qualified general practitioner is so minimal

as to provide little basis for arbitral selection. Here, I refer to my experience in a recent case where an employee's claim for a promotion turned on whether he had hypertension. The evidence presented to me included reported blood pressure readings in the range of 140/90 by grievant's doctor and readings made on the same day by the company's doctor in the range of 240/140. The only agreement I could elicit was that this difference in fact was "medically inexplicable."

It is probably true that a more experienced practitioner will make more reliable medical judgments, but there is no necessary correlation between experience and accurate data-gathering. Thus, for the arbitrator to make a choice between two sets of medical facts on the basis of credibility factors other than those directly related to the reliability of the fact-gathering process itself is to make a decision on a highly artificial basis. Such a decision settles for something short of a reliable answer to the question "Who is right?" where such an answer should be objectively available.

Where there is no adequate basis in the record for selection from the medical facts presented, the arbitrator is seemingly left with little choice but to flip a coin. Heads the grievant has high blood pressure—tails he doesn't. But there is a more intelligent procedure. If critical medical *facts* are in dispute, the arbitrator can profitably make use of a third medical expert. And if he chooses such a person carefully, he should be able to assure accurate fact-determination and thus be reasonably certain of resolving the conflict in medical evidence.

The use of a third, nonaligned medical expert to ascertain the true facts may present some practical problems relating to added costs, time delay, and mounting liability. While these are not insurmountable, the arbitrator should be prepared to state whether he has the power to order an examination by a third doctor when one or both parties oppose that procedure.

The arbitrator may find himself leaning toward a "yes" when he considers that his basic function is to do substantial justice with respect to the issues before him. Certainly, no arbitrator cares to make decisions without knowing the facts. The prospect of obtaining an objective statement of them is enticing. Still, if the parties indicate their preference for a decision based on the mate-

rial presented, he has little choice but to proceed with the evidence at hand.

A more difficult choice arises where only one party consents to the use of a third expert and expresses willingness to bear the cost of such a procedure. Where this is the posture, the interest of one party in the most intelligent decision possible would seem to be paramount to any conflicting interest of the other party. No party can be said to have a vested interest in a less-than-fully-informed decision, and the agreement of the other party to bear the additional cost removes that potential burden. Where the nonconsenting party is the one facing a mounting liability, the time factor should be considered, but the delay seldom need be so long as to outweigh the desirability of reasonable certainty as to important facts.

Medical Opinion

When the conflict between expert medical witnesses involves a difference of medical *opinion,* rather than disagreement on medical *facts,* the basic problem of the arbitrator remains the same. He must find some intelligent and fair basis on which to make a decision. Hopefully, the hearing record will be such as to enable him to discern medical opinion which may be faulty or questionable because it is not shown to represent some recognized segment of medical thinking.

The troublesome case is one in which there is a legitimate split of medical authority on some aspect of the question raised. The arbitrator should understand that not all medical knowledge is exact, and that part of the medical spectrum is as much art as science. In the *opinion* area, reasonable medical men may legitimately differ in both diagnoses and prognoses, even though they are in full agreement on the medical facts. As Dr. George O. Eaton expressed it in a statement I daresay most arbitrators would endorse:

> Given exactly the same facts, even conscientious experts can and will disagree with regard to their significance and potentialities, so that mere disagreement between experts does not imply dishonesty or incompetence on the part of one or both of them.[2]

[2] "The Viewpoint of the Traumatic Surgeon," *The Doctor in Court: Expert Medical Testimony,* 18 *Maryland L. Rev.* 204 (1953).

Take the example of one doctor who observes and records the following medical facts in the process of examining a patient: heavy, dark circles under bloodshot eyes, poor digestion, nervousness, irritability, insomnia—in short, a miserable physical specimen. His training and experience might lead him from these facts to the opinion that the patient is obviously suffering from what many of you will recognize as *Arbitrator's Disease.* This same doctor might be of the further opinion that the patient is likely to develop a stomach ulcer since, in his opinion, reliable medical learning and experience indicate that there is a high incidence of stomach ulcers among persons suffering from this strange malady.

But let us have another doctor look at the patient. This doctor may observe and record the identical medical facts but from them form the opinion that the patient is suffering from what others among you will quickly recognize as *Advocate's Syndrome.* He may be certain that the prognostic implications of this disease are susceptibility to shock, massive frustration, and possible hypertension or even cardiovascular arrest.

It is fair to assume that each doctor reached his conclusions in good faith and might well be able to show a respectable body of medical authority which supports his position. Assuming also that the doctors are competent and reliable and that the positions of both gain support from recognized authorities, how does the arbitrator choose then between equally authoritative, equally credible opinions?

The most honest answer is also the hardest to face. It is, simply, he doesn't—at least not on any rational medical basis. Factors of professional credibility, such as experience, reputation, and specialization, should be of some help in evaluating the relative weight to be given expert opinion testimony. However, once the arbitrator has concluded that there is a reasonable basis for divergent opinions, then there is nothing magical about being an arbitrator that would qualify him to label one opinion "more reliable"—and thereby unavoidably label the other "less reliable"—where medical science itself does not acknowledge a right and a wrong.

Faced with this dilemma, what an arbitrator may do is acknowledge, at least tacitly, that the split of medical authority is not reconcilable on any objective basis, and proceed to a decision guided in

large measure by other standards of equity and fairness appropriate to the particular situation. Since individual situations admit of almost infinite variety, so do arbitral decisions.

The arbitrator's approach is to look to the circumstances in which the conflict in medical *opinion* arises to satisfy himself as to the appropriate controlling principles. The case may involve a question as to whether an employee's extended absence from work for an alleged disability was justified, or whether such an employee is physically able to return to work; whether an active employee may be terminated or laid off for medical reason; whether an employee may be disqualified from his present job, or be denied advancement to a better job, because of some physical condition. In one instance the arbitrator may hold for the company on the theory—contractually expressed or not—that it is entitled to rely on the views of its medical advisors where there is no reason to question their veracity and good faith, even though their medical opinion might be challenged. In another case he might accept the company's position on the notion that the right to protect itself from legal claims overrides other considerations. In still other cases, he might reason that an employee's seniority, interest, and stake in his job outweigh any speculative danger involved in his advancement, retention, or return to a job. The point I make here is that whatever principles of equity and fairness are held controlling in cases of this type, the arbitrator avoids direct resolution of the irreconcilable conflict in medical *opinion.*

A Third Expert Opinion

It has been suggested that arbitrators can make use of nonaligned experts to resolve conflicts in medical opinion. However, where the situation involved is one on which the medical profession is itself divided, referral to a third expert, while it may offer a tie-breaking vote, does not assure any greater certainty, for the third expert's opinion will merely reflect his alignment with one or the other school of medical thought. It may be true that two out of three (or four out of five) doctors tested prefer the single-ingredient remedy to the buffered product. But, for the arbitrator, that cannot change the fact that there is no definitive or single answer to the medical issue involved. Use of a third medical ex-

pert in such a situation is merely handing the coin to someone else to flip.

For example, if the medical issue in a given case is whether grievant's diabetes is under control, the experts for each party might well differ. According to Dr. Edward Tolstoi:

> There are two schools of thought regarding the treatment of diabetes at present. One is called the "chemical"; the other the "clinical." The former is the old school which reasons that an elevated blood sugar and sugar in the urine are abnormal, and therefore sound treatment must be directed to restore them to normal or physiological states. To achieve this, a diet is prescribed sufficient in calories for a particular patient . . . ; and sufficient insulin is given with this diet to render the urine free from sugar. . . .
>
> The "clinical" approach is radically different. It disregards sugar in the urine provided the *patient has no symptoms of diabetes, is maintaining his optimum weight, and has no acetone in the urine.* [Emphasis in original.] This treatment is based on experimental evidence showing clearly that excretion of even large amounts of sugar in the urine is compatible with freedom from symptoms, ability to maintain weight and be useful economically. . . .[3]

Let us assume that grievant, although there is sugar in his urine, is otherwise free of diabetic symptoms and is maintaining his proper weight. In seeking to establish that his diabetes is under control, grievant might present a medical expert who is an adherent of the "clinical" school. If management's interests would best be served by a negative resolution of the issue, the company would be likely to produce as its expert an adherent of the "chemical" school. This could result in a situation in which grievant's doctor asserts that his patient's diabetes is under control because he is free of symptoms and maintaining proper weight, while the company's doctor would testify that it is not under control because the presence of sugar in the urine is an abnormal physiological state.

Referring this issue to a third medical expert would merely confirm the division of medical authorities on the question of what constitutes control of diabetes and contribute nothing helpful to objective resolution of the conflict. The additional opinion would simply reflect the alignment of the particular doctor, either with

[3] *Courtroom Medicine,* Marshall Houts, ed. (New York: Matthew Bender, 1960), p. 152.

the "chemical" or the "clinical" school of thought. Admittedly, this is merely one example, but it does illustrate the nature of the problem whenever there is a genuine split of medical authority.

Limits of Medical Opinion

Once the arbitrator decides to resolve such a case according to some rationale which requires acceptance of the opinion of one expert over another—not because he finds one more reliable but because the equities call for such a choice—it becomes important then that he recognize the proper limits of medical opinion, for there is a difference between expert medical opinion and the opinion of a medical witness.

The function of the "medical expert" is to inform the arbitrator on medical matters. Once the doctor has presented his findings of fact concerning the individual's present and probable future medical condition, and his opinion as to the concomitant physical or mental limitations, he has fulfilled his role as "expert."

It is probably safe to say that most doctors would prefer to stay within the limits of their medical expertise. Given the choice, they would be likely to confine themselves to careful, professional delineation of the medical condition of the patient and its implications. In practice a doctor would pursue the matter to a course of treatment consistent with his findings. For example, he might prescribe restrictions against prolonged standing, lifting, bending, or heavy exertion, or advise avoidance of temperature extremes or dust-filled atmosphere. Clearly, judgments of this sort fall well within the scope of one trained in medicine. As it may be assumed that the patient will follow his doctor's advice in his private conduct, so should it be that the employer will observe the proscriptions, absent conflicting medical judgments.

Job placement is a recognized managerial function. Subject, of course, to applicable contract provisions, it is within management's province to determine whether to promote, retain, dismiss, or assign. In making such determinations management will look to all the reasonably pertinent information, such as education, job experience, aptitude, seniority, work performance, and physical fitness. After reviewing all the available data—not excluding the

judgments or recommendations supplied by the employee's doctor or its own doctor—management will reach its own conclusions. Assuming that the decision to promote or not, retain or dismiss, assign or not, turns on medical evidence, the decision is nevertheless a managerial one, not a medical one. It involves *not* the formulation of a medical judgment, but the consideration of such a judgment in the exercise of a common managerial function. In short, the decision comprehends judgments beyond those which qualify a doctor as an "expert medical witness."

Doctors who agree to submit evidence or testify in arbitration may venture or be drawn into expressions of opinion on questions which are not purely medical in nature. The arbitrator should be alert to this so that he can distinguish between "expert medical evidence" in the record as opposed to nonexpert opinion by a medical witness.

There is no sound reason why the arbitrator should defer to doctors in deciding issues such as an employee's qualifications to do a particular job. Surely job content is not a medical subject or one on which most doctors are trained. In the event a particular doctor can be said to qualify as an "expert" on job requirements, it is not because he is a doctor but because he has some special training or experience not common to the medical profession. If it is felt that "expert" testimony about a job's requirements is necessary, it would seem logical to go to individuals with personal knowledge of the demands of the particular job—for example, one who has performed it. But while testimony of that kind may be helpful, it is not essential, for once the arbitrator is in possession of the pertinent facts, there is nothing so esoteric about most industrial jobs that he cannot form a fair and correct judgment as to the particular employee's ability to perform the job in question.

At best, unquestioning acceptance of nonmedical opinion given by medical experts can lead to right decisions for wrong reasons. This is not to say, however, that such opinions should be summarily rejected or, if objected to, stricken from the record. As the late Harry Shulman once commented, the danger is not that the arbitrator will hear too much but rather that he will hear too little. Most doctors are intelligent men, trained to careful observation. Where a doctor can offer intelligent insight into nonmedical but

closely related matters, such information may be helpful to the arbitrator's understanding of a case and should be admitted and considered.

Conclusion

In conclusion, I suggest that these points are worthy of consideration by an arbitrator who is faced with the problem of evaluating medical evidence:

1. Conflict in medical *fact,* as opposed to medical opinion, is generally susceptible to resolution by approved methods of observation or some accepted laboratory or clinical procedure. When an arbitrator is unable to resolve an important conflict in fact to his satisfaction, he should make every effort to persuade the parties to engage a third qualified medical expert to ascertain the facts and report his findings.

2. Conflict in medical *opinion,* as opposed to medical fact, is not generally susceptible to objective resolution by referral to a third expert, where the opposing opinions are each shown to be supported by a recognized body of medical authority. The arbitrator must then look to resolution of the case by application of appropriate standards of equity and fairness rather than force himself into choosing between two apparently legitimate schools of medical thought.

3. The arbitrator need not defer to the opinion of a medical witness whose judgment on the matter goes beyond the scope of his professional expertise. In accepting such evidence, the arbitrator should recognize its limitations and weigh it accordingly in deciding the issue before him.

II. SHOULD THE ARBITRATOR KNOW THE SCORE?

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There may be some in attendance this afternoon who would answer the query which I have selected as the title for these brief remarks by suggesting that the institution of labor arbitration

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