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EXPERT TESTIMONY AND PROFESSIONAL LICENSING BOARDS: WHAT IS GOOD, WHAT IS NECESSARY, AND THE MYTH OF THE MAJORITY-MINORITY SPLIT

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It has been settled law ... for some time that for a plaintiff to recover even nominal damages in a malpractice case, expert testimony is [required]. Logic and due process dictate that if this requirement is to be met for the recovery of a dollar in damages ... it should also apply where [one] faces the possibility of a permanent loss of ... position and livelihood.¹

[The State Medical Board consists of ten members, eight of whom shall be physicians and surgeons licensed to practice in [this state], seven of whom must hold the degree of doctor of medicine, one the degree of doctor of podiatric medicine, and one the degree of doctor of osteopathy. The board members are selected by the Governor, with the advice and consent of the Senate. This distinguished medical board is capable of interpreting technical requirements of the medical field and is quite capable of determining when certain conduct falls below a reasonable standard of medical care.²

I. INTRODUCTION

These two quotes highlight the essence of the opposing arguments that courts consider when reviewing professional licensing board decisions. Defendants regularly argue that a board’s decision must be overturned because it is not supported by expert testimony. Boards counter that they are qualified, by virtue of their role as the guardians of the standards for their profession, to determine the appropriateness of a defendant’s conduct without the assistance of expert testimony. When courts address these arguments, they routinely ask if expert testimony is necessary to establish the standard of care in disciplinary hearings before a professional licensing board.

As demonstrated by the quotes above, courts answer this question differently. In fact there is a seeming schism among the states about the importance of expert testimony and the role of professional licensing and disciplinary boards. The nature and breadth of this schism is best expressed by the way that they frame the issue, a bare, polar question with a yes or no answer, “Is expert testimony required?” Such a question both seeks and produces a strict dichotomy of response. Not surprisingly, there is general consensus among courts that analyze the issue in this way that there are two answers to this question, two rules. The majority rule requires expert testimony, and the minority rule does not.

The problem with this dichotomy, with these pronouncements of the prevailing ‘rules,’ is that they do not accurately reflect the subtlety and the complexity of the analysis that courts actually conduct when facing this issue. No court actually requires expert testimony in all cases. Similarly, even those courts that purport to have a completely deferential rule require expert testimony in certain cases. Logi-

cally speaking, then, if there are exceptions to the stated rules, then courts must be considering more than just the fact of a hearing before a professional licensing board; there must be more factors involved in the analysis.

This Comment will outline those factors, including both the reasons why courts consider them important and the way that they affect a court’s determination as to the significance of expert testimony. From this analysis two principles emerge. First, because expert testimony is neither always nor never required, the question is not if but rather when it is required. Second, there is not so much disagreement among the courts about the role of expert testimony in professional licensing board hearings as the majority-minority rule dichotomy would have it. All courts consider a variety of factors in deciding whether expert testimony should have been presented in any particular case; differences in the ‘rules’ announced by the courts are more closely related to a difference in the factual and procedural postures of the cases than in an actual divergence of policies among jurisdictions. It is the position of this Comment that given similar cases, most courts would analyze the question using similar criteria and arrive at similar conclusions.

Part II provides a brief overview of the similarities and differences between medical malpractice actions and professional licensing board disciplinary hearings. Part III lays out the basic parameters of the majority and minority rules with an outline of the policy reasons supporting the rules. Part IV analyzes the law in four states that have recently reconsidered or revised their rules. Part V then analyzes the law in those jurisdictions that have addressed the issue of substantial evidence and expert testimony in professional licensing hearings without adopting either the majority or minority rule. The cases discussed in Parts IV and V highlight the weakness of the traditional majority-minority dichotomy.

Finally, the Comment concludes by arguing that, despite their overt adherence to the concept of the majority and minority rules, courts in nearly all jurisdictions adhere to a more complicated but also more unified rule. The appropriate question to be asked when a court reviews a decision of a professional licensing board is not whether expert testimony is required in all cases, but whether it is required in that particular case. Expert testimony is required, when it is required, not because of the type of proceeding but rather because of certain specific aspects of the hearing itself.

II. THE SHORT QUESTION: IS EXPERT TESTIMONY REQUIRED?

Perhaps the best place to begin in the process of analyzing the question of whether expert testimony is required in a professional licensing board disciplinary hearing is to consider why the question is even asked in the first place. This question is asked in the context of professional licensing board disciplinary hearings primarily because of the way it is answered in medical malpractice cases.

3. This Comment will focus primarily on malpractice actions against physicians or other health care professionals. For the purposes of the Comment, health care professionals include doctors, chiropractors, dentists, nurses, and mental health professionals. Consequently, although the term malpractice may be used to describe other professional negligence (i.e., legal malpractice), this Comment will use the term malpractice solely with respect to physicians and other health care professionals.

4. See quoted passage supra at note 1.
A. Why Would Expert Testimony Be Required: The Malpractice Standard

Malpractice is a specialized form of negligence action, brought against certain types of professionals by their patients.\(^5\) As with any negligence action, in order to recover in a malpractice claim the plaintiff must establish that the defendant owed a duty of care to the plaintiff, that the defendant violated that duty of care, and that the plaintiff was harmed as a result of the defendant's conduct.\(^6\) In a typical negligence action, the jury decides the appropriate standard of care based on the particular situation and relationship between the parties.\(^7\) In a malpractice action, however, the jury's role is limited; the applicable standard of care must be established by expert testimony of a member of the same profession as the defendant.\(^8\) In other words, although a jury may be asked to award damages for a physician's negligence, the law dictates that only a physician can pass judgment on the quality and appropriateness of the medical care provided by another physician; only a physician can say how medicine should be properly practiced.

The reasons for this rule are twofold. First, it guarantees that those with sufficient training, skill, and expertise will be charged with establishing and defining the standard of medical practice in the community.\(^9\) Next, it assists lay juries and judges, not skilled in the highly technical particulars of medical practice, with their deliberative process; it guarantees that fact finders will have sufficient evidence before them to decide the applicable standard of care.\(^10\)

This rule is so widely accepted in the realm of medical malpractice as to be axiomatic.\(^11\) One consequence of the axiomatic nature of this premise is that its actual parameters and applicability can easily be lost in the simplicity of the terms of the axiom. Health care professionals regularly appeal the decisions of professional licensing boards on the ground that the licensing board's finding was not based on expert testimony without adequate explanation of why this principle should be transferred from the tort context to the considerably different forum of professional licensure and administrative law.\(^12\) Defendants in professional licensing board disciplinary hearings argue that the similarity between the charges facing the defendant in the two fora and the magnitude of the potential loss in a disciplinary hearing justify applying the heightened malpractice expert testimony requirement in disciplinary hearings. Although compelling in its simplicity, this argument fails to recognize several significant differences between a tort-based negligence action and proceedings before a professional licensing board.

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7. See id. § 53, at 356-59.
8. See id. § 32, at 188 (“Since juries composed of laymen are normally incompetent to pass judgment on questions of medical science or technique, it has been held in the great majority of malpractice cases that there can be no finding of negligence in the absence of expert testimony to support it.”).
10. See supra note 8.
11. See supra note 8.
12. The cases cited and discussed in the remainder of this Comment should provide ample anecdotal if not empirical evidence of the truth of this assertion.
B. Is This an Appropriate Comparison: The Nature of Professional Licensing Boards

Professional licensing boards differ significantly from lay fact finders and judges in their origin, form, and function. Professional licensing boards and other forms of regulation of the practice of medicine first appeared in the United States in the post-Civil War era. The primary impetus for regulation was the emergence of modern medical science and the consequent metamorphosis of the medical profession from a self-selected group of amateurs into an educated and more disciplined profession. Rather than promulgate and constantly revise an elaborate scheme of regulation, states choose to regulate medicine with:

- a circular process of defining the scope of licensure. State medical licensing laws avoid defining allowable medical practice in terms of specific procedures or methods of practice. Instead, the practice of medicine is defined in terms of the diagnosis and treatment of illness in the manner used by physicians who meet the training requirements for licensure. This effectively delegates the definition of appropriate medical practice to medical schools, residency programs, and their private accreditation agencies.

As such, professional licensing boards provide an important link between the broad police power of the state and the dynamic body of professional skill and learning.

At present, professional licensing boards exist in every state and regulate a wide variety of professions and specialties. They have primary responsibility for regulating both entry of new professionals into their ranks and maintaining standards of professional competence and conduct. In order to accomplish these tasks, professional licensing boards are given certain broad powers, and are charged with a range of duties related to the qualification, training, and regulation of the professionals within their jurisdiction.

13. For more detailed discussion of various aspects of professional licensing boards than is appropriate in this Comment, see CHRISTOPHER F. EDLEY, JR., ADMINISTRATIVE LAW: RETHINKING JUDICIAL CONTROL OF BUREAUCRACY (1990); ROBERT L. HYAMS, EXPERT PSYCHIATRIC EVIDENCE IN SEXUAL MISCONDUCT CASES BEFORE STATE MEDICAL BOARDS, 18 AM. J.L. & MED. 171 (1992); WILLIAM A. McGrath, PROJECT: STATE JUDICIAL REVIEW OF ADMINISTRATIVE ACTION, 43 ADMIN. L. REV. 571 (1991); WILLIAM O. Morris, RECOVERY AND PROFESSIONAL LICENSES, 70 MICH. L. REV. 789 (1986).


15. See Richards, supra note 14, at 210. Richards argues that regulation at this time was implemented not only to differentiate between competent physicians and 'quacks,' but also to limit entry into the field so as to provide an economic incentive for physicians to attend medical school. See id. at 210-11.

16. Id. at 211.

17. See TIMOTHY S. Jost et al., CONSUMERS, COMPLAINTS, AND PROFESSIONAL DISCIPLINE: A LOOK AT MEDICAL LICENSURE BOARDS, 3 HEALTH JOURNAL 309, 310 (1993) ("Each state in the United States has a medical licensure board responsible for controlling entry into the medical profession by means of licensure and for disciplining physicians who are incompetent or who engage in 'unprofessional' conduct.").

18. See id.

19. See id. (All professional licensing boards "have a variety of disciplinary powers including, most commonly, the power to revoke or suspend licenses and to place physicians on probation.").
criteria used to test new applicants for licensure and are given rule-making power to set practice standards.\textsuperscript{20} Additionally, when conducting disciplinary hearings boards are explicitly authorized to use their expertise and training in their evaluation of the evidence.\textsuperscript{21} This is done both in recognition of the considerable expertise of the members of the board, and as a practical recognition of the fact that boards must have this power in order to effectively accomplish the tasks that the states have assigned to them.\textsuperscript{22} Finally, the standard of judicial review of board decisions is extremely deferential; courts will generally only overturn board decisions that are unsupported by substantial evidence in the record.\textsuperscript{23}

\textbf{C. What Role Does Expert Testimony Actually Play in a Malpractice Action: Further Considerations}

Therefore, professional licensing boards are significantly different than lay juries both because they are better qualified to interpret complex medical evidence and because they are charged with establishing and enforcing the standards of medical care within their communities. However, even without these differences it would be inappropriate to use the example of malpractice law to create a strict expert testimony requirement, because expert testimony is not always required in a malpractice action.\textsuperscript{24} In a malpractice action, expert testimony does not have independent legal significance; it is important because of what it represents and can prove: the standard of care. A malpractice action differs from a typical negligence action in the way that the applicable standard of care is determined. In a regular negligence action, the existence and scope of the defendant's duty of care is determined by the jury; it is an inference that the jury is asked to make based on the facts of the situation and the defendant's conduct. In a malpractice action, on the other hand, the standard of care is not an inference but rather a separate fact that must be proved by explicit evidence.

Consequently, what is required is not expert testimony per se, but explicit evidence of the standard of care. Such evidence is often best available in the form of expert testimony, but expert testimony is not the exclusive source. The standard of care may also be established by statute, or stipulation, or may be so obvious as to require no technical evidence. These exceptions are limited, and expert testimony is certainly the most common way to establish the standard of care, but the existence of these exceptions provides an important insight. Expert testimony, when required, is required as a means to an end, not an end itself. Its availability is intended to assist a fact finder who is not qualified by training or expertise to independently evaluate the evidence of the defendant's conduct and discern the appropriate standard of care.

Therefore, even if the expert testimony requirement for professional licensing board hearings were to be modeled directly after the requirement in malpractice actions, then it would only be required when and to the extent that it was necessary.

\begin{flushleft}
\textsuperscript{20} \textit{See id.}
\textsuperscript{21} \textit{See infra} notes 124-27 and accompanying text.
\textsuperscript{22} \textit{See infra} notes 124-27 and accompanying text.
\textsuperscript{23} \textit{See Blancor, supra} note 14, at 1080.
\textsuperscript{24} \textit{See KETTON ET AL., supra} note 5, § 32, at 189 ("Where the matter is regarded as within the common knowledge of laymen ... it is often held that the jury may infer negligence without the aid of any expert.").
\end{flushleft}
to prove the fact of the applicable standard of care. Additionally, expert testimony could only be required if it was the only competent evidence available to prove that fact. Finally, these two issues must be considered in conjunction with an evaluation of the significance of the differences between a professional licensing board and a lay jury.

III. THE SHORT ANSWER: THE MAJORITY SAYS “YES” AND THE MINORITY SAYS “NO”

The conventional wisdom among courts that have addressed the issue of expert testimony in professional board proceedings is that there are a majority and a significant minority rule.25 Although the courts have had difficulty deciding how to classify individual jurisdictions within this rule dichotomy, they have rather uniformly concluded that the majority of jurisdictions require expert testimony while the minority do not.26 Generally, the majority rule requires expert testimony in order to ensure both that the defendant’s due process rights are protected, and that the defendant is given a meaningful right to appeal.27 The minority rule, on the other hand, holds that expert testimony is not required because a professional licensing board, by its very nature, has sufficient expertise to establish for itself the standard of care against which the defendant will be judged.28 As the following discussion will demonstrate, however, neither position is as straightforward or uniform as this majority-minority dichotomy would have it.

A. The Majority Rule

Under the majority rule, expert testimony is required “to establish the standard of care to which the professional is held and to test whether that professional’s conduct fell below that standard” in professional licensing board hearings.29 The jurisdictions that are generally considered to adhere to the majority rule are Arkans-

26. The exact parameters of the majority and minority rules vary depending on the court collecting the cases, the particular question facing the court, and the time of the decision. Because the parameters of the majority and minority position, and the consequent validity of any particular state’s adherence to such a position, are the primary subjects of this Comment, those issues will be discussed in more depth in the body of the Comment rather than here in the introduction to the majority and minority rules. Therefore, when this Comment discusses the majority and minority rules, the list of adherents to each rule is gathered from an analysis of each court’s own statement of its position and the classifications done by courts in Connecticut, Georgia, and South Dakota. See Levinson v. Connecticut Bd. of Chiropractic Exam’rs, 560 A.2d 403, 412-13 (Conn. 1989); Thebaut v. Georgia Bd. of Dentistry, 509 S.E.2d 125, 132-33 (Ga. Ct. App. 1998); In re Schramm, 414 N.W.2d at 35-36; see also James J. Watson, Annotation, Necessity of Expert Evidence in Proceeding for Revocation or Suspension of License of Physician, Surgeon, or Dentist, 74 A.L.R.4th 969 (1989).
27. See In re Schramm, 414 N.W.2d at 35.
sas, California, Colorado, Georgia, Idaho, Illinois, Indiana, Massachusetts, New Jersey, Oregon, South Dakota, Texas, Wisconsin, and Wyoming. Arkansas will be discussed separately at Part IV.D because it recently clarified its rule. North Carolina, which has traditionally been included in this group, will be discussed separately at Part IV.B because it recently reversed its rule. Maine, which has occasionally been included in this group, has adopted a rule that is something of a hybrid between the majority and minority rules, and will be discussed separately at Part V.A.1.


Although Arthurs is often cited as one of the seminal majority rule cases, since Arthurs Massachusetts courts have actually followed an analytic path that closely resembles that followed by the Ohio courts. See discussion infra Part IV.A.; see also D'Amour v. Board of Registration in Dentistry, 567 N.E.2d 1226, 1233-34 (Mass. 1991) (holding that board may rely on its expertise in lieu of expert testimony as long as the record contains sufficient evidence to allow a court to review the board's decision); Morris v. Board of Registration in Med., 539 N.E.2d 50, 55 (Mass. 1989) (holding that the board could not use its own knowledge of "red flags" of witness credibility to second guess a magistrate's factual findings without disclosing the nature of those "red flags" in the record); Langlitz v. Board of Registration of Chiropractors, 486 N.E.2d 48 (Mass. 1985) (holding that board is not required to introduce expert testimony in order to construe its own regulations regarding the scope of the practice of Chiropractic).

47. See In re Schramm, 414 N.W.2d 31, 35 (S.D. 1987) (citing Board of Dental Exam'rs v. Brown, 448 A.2d 881 (Me. 1982)). It is not clear, however, why the Schramm court concluded that Brown was a majority rule case. In Brown, the board introduced expert testimony but there was no discussion of whether or not such testimony was required. See Board of Dental Exam'rs v. Brown, 448 A.2d at 885. The primary issue on appeal was whether the standard applied by the board was impermissibly vague without further legislative definition. See id. at 883-84.
In order to explain the nature of the majority position, this Section will first outline the primary policy justifications used by those jurisdictions that have adopted the majority rule. Then two cases from jurisdictions that have explicitly adopted the majority position will be examined. In the first case, the Supreme Court of South Dakota synthesized the law in this area, outlining the majority and minority positions and identifying the jurisdictions that fell within each group as of 1987. In the next case, a Georgia intermediate appellate court adopted the South Dakota analysis while reviewing the law of other jurisdictions as it existed in 1998.

1. Policy Behind the Majority Rule

Courts that have adopted the majority position have generally done so for three main reasons, each of which will be discussed in greater detail below. First, they have held that the defendant’s right to meaningful judicial review would be eliminated if a professional board were allowed to base its decision on its own expertise rather than expert testimony in the record. Second, some courts have concluded that without expert testimony in the record, a defendant would be denied the ability to effectively challenge the evidence used to support the board’s charge. Third, certain courts have noted that because professional licensing boards include members who are not professionals, the entire board does not necessarily possess the required expertise. Collectively, these three reasons are often collapsed into a more generalized concern that a decision is not supported by substantial evidence. Thus, often courts have simply held evidence of the standard of care was required in order to support the board’s finding, and that the board’s expertise could not serve as a substitute for such evidence.

a. Judicial Review

The most frequently cited, and perhaps the most persuasive, reason that courts have adopted the majority rule is a concern that a professional licensing board’s decision would be effectively unreviewable if the board ‘silently’ relied on its own expertise rather than expert testimony. The Supreme Court of Colorado, one of the first states to take this position, explained:

[T]he law under which the board acted, contemplates a review of the board’s action by a court presumably not expert in medical matters ... to determine whether the board ... abused its discretion. Without testimony by an expert the court cannot determine the limits of proper treatment ... nor can it assume that the board members out of their own individual knowledge and skill correctly fixed the limits [that would describe] the bounds of ordinary care and skill. ... Such

49. See In re Schramm, 414 N.W.2d 31 (S.D. 1987).
matters being only within the knowledge of experts must be shown by testimony of experts appearing in the record.\textsuperscript{52}

This concern was expressed even more forcefully in New Jersey State Board of Optometrists v. Nemitz,\textsuperscript{53} where the court worried that undue deference to board expertise would “render absolute a finding opposed to uncontradicted testimony [and] would render the right of appeal completely ineffectual.”\textsuperscript{54}

Other courts, however, have demonstrated a greater concern with trying to give proper deference to the board’s expertise without abdicating the court’s duty to review the board’s decisions. For example, in Woodfield v. Board of Professional Discipline of the Idaho State Board of Medicine,\textsuperscript{55} the court reviewed a board decision involving multiple complex clinical issues and findings.\textsuperscript{56} It went to great lengths to outline the evidence before the board and the permissible inferences that could have been drawn from them.\textsuperscript{57} The court deferred to the board’s factual findings and upheld several of the board’s legal conclusions.\textsuperscript{58} It over-

\textsuperscript{54} Id. at 745.
\textsuperscript{55} 905 P.2d 1047 (Idaho Ct. App. 1995).
\textsuperscript{56} See id. at 1051-52. The case involved twelve patients and a variety of procedures including standard examinations, the prescription of birth control pills, and both diagnostic and surgical procedures. See id. at 1057-65.
\textsuperscript{57} For example, the court’s analysis of one of the issues was as follows:

The hearing officer stated:

“I am uneasy, due to the lack of testimony, whether [Dr. Woodfield] felt the previously ordered blood to be adequate. If he felt the … blood order to be adequate, [Dr. Woodfield] would have failed to meet the standard of care required under the circumstances.”

Without making pertinent findings, the Board’s conclusion went one step further.

Apparently, the [b]oard believed that it made no difference whether Dr. Woodfield thought the previously ordered blood would be sufficient for the surgery, because if he did he simply failed in his assessment of the situation, as the hearing officer suggested above. On the other hand, if Dr. Woodfield felt the previously ordered blood would not be adequate, he should have immediately ordered additional blood products before proceeding with the hysterectomy. This he did not do. These findings could be made from the medical records that were furnished to the Board and from the evidence given by the experts who testified from personal knowledge about the circumstances presented in this case. Giving deference to the collective expertise possessed by the [b]oard and recognizing its role as the ultimate fact finder in these cases, we are unwilling to overturn the [b]oard’s findings that “Dr. Woodfield did not demonstrate … an awareness of the patient’s blood status and the need for blood products,” [at the time he proceeded with the surgery]. Likewise, we hold that the evidence supports the [b]oard’s finding that “Dr. Woodfield misstated the amount of blood loss,” apparently referring to Dr. Woodfield’s written summary report of the surgery.

As to the weight of the evidence on such questions of fact, this Court will not substitute its judgment for that of the agency. However, we cannot find as a matter of law that these actions violated the standard of care unless we speculate that the [b]oard relied on its expertise and its knowledge of the standard of care. This we will not do. On remand, the [b]oard may consider whether, based on the limited findings we have upheld, there has been a failure to meet the community standard of care.

\textit{Id.} at 1059-60 (citations omitted).
\textsuperscript{58} See id. at 1057-65.
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turned others, but only when the board’s conclusions were unsupported by suffi-
cient factual findings.59

Regardless of the particular approach and the level of deference shown to the
professional licensing boards, majority rule courts have expressed an overriding
concern that deference must not lead to an abdication of the court’s duty to review
the board’s decisions.

b. Right to Cross-Examine

In addition to the concern that reviewing courts might be deprived of the in-
formation needed to conduct a proper review, majority rule courts have also ex-
pressed concern that defendants be given the opportunity to fully confront the evi-
dence against them.60 This right to cross-examine also includes a right to present
contrary evidence. Without expert testimony in the record, the majority rule courts
argue that defendants will be unable to know the basis for the board’s decision and
thus will be deprived of a meaningful opportunity to defend against the charges.61

c. Competence of the Panel

A third justification for the majority rule flows from the fact that many boards
are comprised of a combination of professional and lay members. Courts have
held that “it is improper for the [b]oard to rely on its own expertise ... [where]
some of the members [of the board] do not hold this type of expertise.”62 Given
the majority rule courts’ general hesitance to defer to the unexamined expertise of
boards, it is understandable that they would be particularly concerned where that

59. See id.
N.E.2d 151 (III. App. Ct. 1978); Wood v. Texas State Bd. of Med. Exam’rs, 615 S.W.2d 942
(Tex. App. 1981)).
61. As the California Supreme Court observed in Franz v. Board of Medical Quality Assur-
ance, 642 P.2d 792 (Cal. 1982),
due process requires, when in an adjudication an agency intends to rely on members’
expertise to resolve legislative-fact issues, that it notify the parties and provide an
opportunity for rebuttal.

[California law] requires notice and opportunity to rebut whenever an agency
intends to take “official notice ... of any generally accepted technical or scientific
matter within the agency’s special field, [or] of any fact which may be judicially
noticed by the courts of this State.”

The agency’s notification must be complete and specific enough to give an ef-
fective opportunity for rebuttal. It must also help build a record adequate for judicial
review. If it meets those requirements we can see no prejudice to the parties.

We cannot accept the premise ... that it is improper “for the board to decide ... 
questions [of violation of professional standards] upon the basis of the opinions held
by the several members of the board,” and that “[n]either the board nor the court
could render a just decision except in reliance upon expert testimony.” As Brennan
notes, fairness is satisfied when a party “[is] apprised of the evidence against him so
that he may have an opportunity to refute, test and explain it ....”

Id. at 799-800 (citations omitted).
62. In re Schramm, 414 N.W.2d at 35; see also Thebaut v. Georgia Bd. of Dentistry, 509
N.E.2d 1129, 1141 (Ind. Ct. App. 1983) (“Where a question of medical diagnosis or treatment is
crucial to the [b]oard’s ultimate decision, expert testimony is vital. This is particularly true
where, as here, not all members of the [b]oard are educated in the same areas of expertise.”).
expertise is not only unexamined but also limited in scope. The South Dakota Supreme Court provided an example of a worst case scenario of this problem in In re Schramm where it noted:

The lack of expertise of the lay members of the board arose at this hearing when a lay member of the board stated: "Dr. Corkle, I would like to ask you a question. As a lay person, I don't know all of the terminology that the rest of the board are privy to know. Is it a normal thing that you leave caries on a tooth?"

It is notable, however, that this is the only concrete example that any court has given of such a basic lack of expertise. The other courts that have cited this concern have done so in hypothetical terms, or simply cited Schramm. Given the role that professional licensing boards play, it would be deeply troubling if they were composed of individuals, whether lay or professional, that did not understand at least the general terminology of the profession. For the same reason, though, it is also unlikely that such is the case.

Perhaps the substance of this concern would be better expressed as an issue of deference rather than basic competence. For example, in Balian v. Board of Licensure in Medicine, the Supreme Judicial Court of Maine, sitting as the Law Court, expressed a similar concern:


In a board comprised of both lay persons and persons of the regulated profession, the absence of a clear standard unduly shifts power and influence to the non-lay members. Here, the lay member on the board, without knowing the applicable ... standard, most likely had to defer to the professional members. This imbalance of power would not exist ... if all board members understood the applicable standard and based their decision thereon.

When a board is comprised of both professional and lay members, expert testimony could be useful not only to educate the lay members of the board, but also to reassure a reviewing court that all members of the board were qualified to participate fully in the deliberative process.

Interestingly, several minority rule jurisdictions have given this issue more thorough discussion and practical effect. For example, although Connecticut is

63. 414 N.W.2d 31 (S.D. 1987).
64. Id. at 35 n.4.
65. See id. at 35-36.
66. 1999 ME 8, 722 A.2d 364. Although the Maine court did not adopt either the majority or the minority rule in this case, it framed its analysis in terms similar to those used by majority rule jurisdiction. See discussion infra at Part V.A.
67. Id. ¶ 13, 722 A.2d at 367-68 (citations omitted). With respect to the composition and conduct of the Board of Medicine at the time of Dr. Balian's case, the court observed:

Presently, the board consists of nine individuals. Three individuals are representatives of the public. The remaining six "must be graduates of a legally chartered medical college or university having authority to confer degrees in medicine and must have been actively engaged in the practice of their profession in this State for a continuous period of 5 years preceding their appointments to the board."

At [Dr.] Balian's hearing in September 1996, one public member was recused and another public member could not attend. As a result, only one public member participated in the hearing.

Id. n.7 (quoting Me. REV. STAT. ANN. tit. 32, § 3263 (West Supp. 1998) (citation omitted)).
68. See Levinson v. Connecticut Bd. of Chiropractic Exam'r's, 560 A.2d 403, 412 (Conn. 1989) (discussing Ohio and Pennsylvania law); see also Jutkowitz v. Department of Health Serv., 596 A.2d 374, 386-87 (Conn. 1991) (requiring board to present expert testimony when board that hears and decides case is not composed of a majority of experts); Gonzales v. New Mexico Bd. of Chiropractic Exam'r's, 962 P.2d 1253, 1257 (N.M. 1998) (same). Actually, inas
one of the most regularly cited and longest standing minority rule states,69 in Jukowitz v. Department of Health Services70 the Supreme Court of Connecticut held that expert testimony was required when the board that heard and decided a case was composed of one expert member and one lay member.71 The court emphasized its prior requirement that a board be composed of at least a majority of expert members, and explicitly rejected the board's argument that the presence of a single expert board member was sufficient.72 The basis for the court's ruling was its fear that, otherwise, the lay members of the board would unduly defer to the expert members of the board.73

Thus majority and minority rule jurisdictions agree that the composition of the board is an important factor to consider in deciding whether expert testimony is required. The jurisdictions disagree, however, about whether a board's competence is compromised if it has even one lay member, or only when a majority of the members are non-professionals. As a practical matter, though, this disagreement may be more a function of the substance of the charge before the board or the evidentiary and administrative rules of the jurisdiction.

2. The Majority Rule in Action

a. In re Schramm

In In re Schramm,74 the Supreme Court of South Dakota adopted what it described as the majority rule,75 holding that a professional licensing board was re-

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69. See Jaffé v. State Dep't of Health, 64 A.2d 330 (Conn. 1949).
70. 596 A.2d 374 (Conn. 1991).
71. See id. at 386-87.
72. See id. at 387.
73. See id. As the court explained:

Both the rationale of our [prior decision] and the dictates of common sense, however, make it clear that the relevant bench mark in determining whether expert testimony is necessary is the composition of the board. …

… Our [prior decision] implicitly recognized the risk that, when considering matters that require knowledge of the standards of a profession, the public members of the board will simply defer to the expert members in the absence of expert testimony.

74. 414 N.W.2d 31 (S.D. 1987).
required to introduce expert testimony before finding that a health care professional had committed negligence or unprofessional conduct. In so doing, the South Dakota court reasoned that "[I]logic and due process dictate that if [expert testimony is required before] the recovery of a dollar in damages against a [health care professional in a malpractice action], it should also apply where [he or she] faces the possibility of a permanent loss of ... position and livelihood."

In Schramm, the Supreme Court of South Dakota reviewed an intermediate appellate court's affirmation of a decision by the State Board of Dentistry suspending Dr. Schramm's license to practice dentistry. Pursuant to the authority granted by South Dakota statute the board found Dr. Schramm had performed "unacceptable patient care due to his deliberate or negligent act or acts or failure to act." Dr. Schramm appealed the board's decision on the grounds that it had failed to provide expert testimony to establish both the applicable standard of care and that Dr. Schramm violated that standard. Although the board had presented the testimony of two dentists from the same community as Dr. Schramm, neither testified about the standard of care for their community or that Dr. Schramm negligently violated any specific standard.

In reviewing the board's finding, the court first attempted to establish the standard of care against which Dr. Schramm's conduct was measured. The court


South Dakota's collection of cases holding the majority position is significant because it was one of the first states to describe the majority-minority dichotomy. It is notable then, that even at the time that the South Dakota court pronounced this majority, regardless of the way the rule was defined, at least one of these states, Maine, should not have been included as a majority rule state, and another, New Jersey, should have been included. See New Jersey State Bd. of Optometrists v. Nemitz, 90 A.2d 740 (N.J. Super. Ct. App. Div. 1952); see also supra note 47.

76. See In re Schramm, 414 N.W.2d at 37.
77. Id.
78. See id. at 32.
79. The court explained the statutory authority of the board as follows:
Since the [b]oard found appellant to have negligently performed patient care, a preliminary inquiry to review that decision is to determine the standard of care he supposedly violated.
SDCL 36-6-8.4 states as follows:
The board of dentistry shall:
(1) Through its policies and activities, by rule establish standards for and promote the safe and qualified practice of dentistry, ... 
(3) By rule, establish educational training and competency standards governing the examination and practice of practitioners under this chapter. ...
Id. at 33-34 (quoting S.D. CODIFIED LAWS § 36-6-8.4 (Michie 1999)) (recodified at § 36-6A-14).
80. In re Schramm, 414 N.W.2d at 32.
81. See id.
82. See id. at 33.
83. See id. Significantly, the court framed this inquiry as a review of the Dentistry Board's decision as a question of law (i.e., is expert testimony required) rather than a determination of fact (i.e., was the evidence presented sufficient to establish the standard of care). See id. Therefore, from the beginning, the court was not concerned with the sufficiency of the evidence, but rather with the type of evidence presented. The conclusory nature of this inquiry is in keeping with the court's focus on the significance of expert testimony as a unique type of evidence, but
noted that, although South Dakota statutes authorized the board to establish standards of care for the practice of dentistry, the board had failed to promulgate any such rules or standards.\footnote{See id. at 33-34 (citing S.D. CODIFIED LAWS § 36-6-8.4 (recodified at § 36-6A-14)).} Therefore, the court concluded, the only standard that the board could have used to determine whether Dr. Schramm was negligent was the standard used in tort actions, namely that “a dentist has the duty to have that degree of learning and skill ordinarily possessed by dentists of good standing engaged in the same type of practice in the same or a similar locality.”\footnote{Id. at 34 (citations omitted).} The court then proceeded to inquire as to the permissible methods of proving that standard.\footnote{See id.}

Actually, though, the court did not ask how the standard could be proven, but rather, whether expert testimony was a necessary element of proof.\footnote{See id. at 34 (board’s authority to promulgate rules); see also id. at 37 (standards could be established by judicial notice; standards could be so obvious as to require no other evidence; defendant could admit the allegation).} Beginning with a due process-type analysis but without strict adherence to or dependence upon any particular constitutional or statutory basis, the court outlined the reasons why other jurisdictions required expert testimony.\footnote{Id. at 35-36.} First, the court found “that the due process protections of the Constitution require that [a] professional in danger of losing [his or her] license [must have] the right to confront, cross-examine and rebut the witnesses’ testimony and evidence sought to be placed in the record to establish [his or her] incompetence.”\footnote{Id. at 35.} Next, the court noted that, because the board is not totally comprised of professionals, and therefore some of the board members do not have sufficient expertise to determine the standard of care, it is improper for the board to rely on its own expertise in determining competency.\footnote{See id.} Finally, the court held that there must be expert testimony in the record to allow proper judicial review by appellate courts.\footnote{See id. at 35-36.} Of these three reasons, the court relied most heavily on the third in deciding that expert testimony was required.\footnote{See id. at 35-36.} The court rejected the counterargument that the board, by virtue of the training and expertise of its members, was qualified to substitute its own judgment for expert testimony.\footnote{Id. at 36.} Notably, although the court discussed the significance of expert testimony, it never distinguished expert testimony from other forms of evidence in a way that would explain why expert testimony was to be preferred.

The court did not, however, hold that expert testimony was always required.\footnote{See id. at 36-37.} Instead, it held that “where the issues of competence and negligence are of a complicated nature, expert testimony is required to establish the proper ‘competency
standards' and whether or not they are met."95 In fact, in addition to the earlier recognition that the board was authorized to promulgate a standard of care different than the tort standard,96 the court also acknowledged that expert testimony would not be required if the board took judicial notice of the appropriate standard of care, if Dr. Schramm stipulated or admitted to the allegations, or if the alleged conduct is obviously a violation of the standard of care.97 This recognition of alternate means of proving the standard of care, combined with the qualified nature of the holding, indicate that the issue is not as straightforward as the court's earlier analysis indicates.

b. Thebaut v. Georgia Board of Dentistry

In Thebaut v. Georgia Board of Dentistry,98 a Georgia intermediate appellate court reviewed the state of the majority-minority dichotomy,99 and adopted the majority position.100 This case reached the Court of Appeals of Georgia by way of a different path than Dr. Schramm's case. Dr. Thebaut appealed the superior court's affirmation of a finding by the Georgia Board of Dentistry that his treatment of a patient "fell below minimal standards of acceptable and prevailing dental practice."101 Dr. Thebaut argued that the board's decision was not supported by sufficient or substantial evidence.102

Prior to the board's decision, the board had presented the case to an administrative law judge.103 The administrative law judge conducted a lengthy hearing, where the board presented one witness who testified that Dr. Thebaut's treatment of the patient in question was "not indicated" but did not testify as to the standard

95. Id. at 36.
96. See id. at 33-34.
97. See id. at 37.
99. See id. at 132-33. Although the court generally accepted the parameters of the majority and minority positions as they were outlined in Schramm, it made some changes and additions as well. See id. Four states were added to the list of majority rule jurisdictions. See id. (citing Woodfield v. Board of Prof'l Discipline of the Idaho State Bd. of Med., 905 P.2d 1047, 1057 (Idaho Ct. App. 1995); New Jersey State Bd. of Optometrists v. Nemitz, 90 A.2d 740, 745-46 (N.J. Super. Ct. App. Div. 1952); C.F. Braun & Co. v. Corporation Comm'n, 609 P.2d 1268, 1272-74 (Okl. 1980); In re Schramm, 414 N.W.2d 31, 35-37 (S.D. 1987)).
100. See id. (citing Croft v. Arizona State Bd. of Dental Exam'r's, 755 P.2d 1191, 1197 (Ariz. Ct. App. 1988); Hebert v. Louisiana State Racing Comm'n, 476 So.2d 823, 825 (La. Ct. App. 1985)). Maine was removed from the majority list and North Carolina was moved from the majority rule camp to the minority rule camp. See id. (citing Leahy v. North Carolina Bd. of Nursing, 488 S.E.2d 245, 248 (N.C. 1997)). However, one of the states added in each category was of questionable applicability. See, e.g., Hebert v. Louisiana State Racing Comm'n, 476 So.2d 823, 825 (La. Ct. App. 1985); C.F. Braun & Co. v. Corporation Comm'n, 609 P.2d 1268, 1272-74 (Okl. 1980). Interestingly, the court provided a full case citation for each majority rule state (and two cases for Illinois), but only cited four majority rule states before providing a "See also" signal to the cases cited in Schramm. See Thebaut v. Georgia Bd. of Dentistry, 509 S.E.2d at 132-33 (citing In re Schramm, 414 N.W.2d at 36). Citation form aside, the Georgia court's majority-minority split was still only thirteen majority states (excluding Georgia itself) to eleven in the minority.
101. See Thebaut v. Georgia Bd. of Dentistry, 509 S.E.2d at 133.
102. Id. at 127.
103. See id.
of care for the community or that Dr. Thebaut’s conduct fell below such a standard. 104 Dr. Thebaut, on the other hand, presented considerable evidence that his conduct was not below the standard of care. 105 After this hearing, the administrative law judge found that Dr. Thebaut had “acted appropriately.” 106 The board then decided, on its own motion, to review the administrative judge’s decision. 107

This case is significant both because it represents a relatively recent review of the majority position and because of its near verbatim adoption of the holding and logic of the Schramm court. 108 Despite considerable differences between the factual and procedural postures of the two cases 109 the Georgia court adopted the Schramm reasoning and conclusion without further examination. 110 As the South Dakota court did in Schramm, the Georgia court presented its holding as adopting a clear requirement, where the actual holding and analysis presented in the case are considerably more complicated. Yet, given the recognized exceptions to the

104. Id. at 127, 131. The Georgia court described the board’s presentation of evidence at the hearing as follows:

The [b]oard as a party presented only the deposition testimony of Dr. Stewart (an orthodontist) and the patient x-rays and dental molds he examined to support its substituted finding that Dr. Thebaut’s recommendation of the use of certain devices to correct some mild crowding of one child’s lower teeth fell below minimal standards. But Dr. Stewart did not so testify. He testified only that in his opinion the “treatment was not indicated.” He conceded that his opinion was nothing more than a philosophical difference with Dr. Thebaut (a pediatric dentist), and that the decision whether to recommend these devices in this child was purely a clinical judgment. He further admitted that he reached his conclusion that “treatment was not indicated” without referring to any textbooks, and that the learned treatises in the area recommended the use of such devices as an option to correct mild crowding, as was present in this child.

Id. at 131.

105. See id. The Georgia court described Dr. Thebaut’s presentation of evidence at the hearing as follows:

On the other hand, Dr. Thebaut called four well-credentialed dentists, all of whom testified without equivocation that Dr. Thebaut’s recommendation was clearly above minimal dentistry standards. These included Dr. Adair, Chairman of the Department of Pediatric Dentistry at the Dental School of the Medical College of Georgia; Dr. Bench, a Diplomate in the American Board of Orthodontics since 1970 and well-known lecturer on dentistry with 33 years of experience; Dr. Samson, dual-trained in pediatric dentistry and orthodontics and a professor at the University of Tennessee and the University of Alabama; and Dr. Lugus, Board Certified in Pediatric Dentistry.

Id.

106. Id.

107. See id. at 127.

108. After introducing the issue the court drew its next four paragraphs, the heart of its analysis, directly from Schramm. See id. at 132-33. After a brief introduction to the minority rationale, the Georgia court again used language directly from Schramm to reject the minority rule. See id. at 133. Finally, the court’s holding was also a direct quote. See id.

109. For instance, in Schramm neither party presented evidence as to the appropriate standard of care. See In re Schramm 414 N.W.2d at 33. In Thebaut, on the other hand, the board presented testimony that was ambiguous at best, but the defendant presented four “well credentialed” experts who testified that his conduct was not a violation of the standard of care. Thebaut v. Georgia Bd. of Dentistry, 509 S.E.2d at 131. Furthermore, in disciplining Dr. Thebaut, the board first overturned the decision of an administrative law judge who held that “the evidence did not support a finding that Dr. Thebaut’s actions fell below minimal standards of acceptable and prevailing dental practice.” Id. at 127.

110. See Thebaut v. Georgia Bd. of Dentistry, 509 S.E.2d at 133. Such is not to say that the court’s conclusion was wrong, but rather to identify the factors that could have affected the decision making process but were apparently not considered.
‘requirement’ of expert testimony (i.e., notice, obviousness, etc.) the holding could not mean that expert testimony was actually required in all cases. Consequently, although this decision clearly indicates the court’s preference for expert testimony, the holding does not address the actual requirements of proof for the standard of care.

B. The Minority Rule

Under the minority rule, expert testimony is not required in a hearing before a professional licensing board because the board itself is competent to evaluate the evidence of the defendant’s conduct and to decide whether that conduct constituted a violation of the standard of care.\(^{111}\) The jurisdictions that are generally considered to adhere to the minority rule are Alabama,\(^ {112}\) Arizona,\(^ {113}\) Connecticut,\(^ {114}\) Missouri,\(^ {115}\) Michigan,\(^ {116}\) New Hampshire,\(^ {117}\) New Mexico,\(^ {118}\) North Carolina,\(^ {119}\) Ohio,\(^ {120}\) Pennsylvania,\(^ {121}\) and Washington.\(^ {122}\) The rules adopted by North Carolina, Ohio, and Pennsylvania will be discussed further in Part IV because these states have recently clarified or limited their rule.\(^ {123}\) This Section will first

111. In *Croft v. Arizona State Board of Dental Examiners*, 755 P.2d 1191 (Ariz. Ct. App. 1988), the court framed and then explained the issue rather succinctly:

   It is well established that a doctor is not liable in negligence for mere mistakes in judgment in treating a patient, but is only liable where the treatment falls below the recognized standard of good medical practice. Ordinarily, in malpractice cases, the applicable standard of care must be established by expert testimony unless the negligence is so grossly apparent that a layman could recognize it. We must determine whether such testimony, necessary in malpractice cases, was also necessary in this disciplinary proceeding where the dentist was charged with providing inadequate treatment, or whether it was appropriate for the committee members to rely on their own expertise as to what is the applicable standard of care. We note that a majority of the members of both the [b]oard and its investigative members were licensed dentists. [Arizona law] provides that “the agency’s experience, technical competence and specialized knowledge may be utilized in the evaluation of the evidence.”

   We are aware that there are cases holding that expert testimony appearing on the record establishing the applicable standard of care would be necessary. We conclude that the better view holds that since such opinion testimony could be disregarded by the [b]oard, there is no reason to hold that it is required.

Id. at 1197 (citations omitted).


113. See *Croft v. Arizona State Bd. of Dental Exam’rs*, 755 P.2d at 1197.


115. See *State Bd. of Chiropractic Exam’rs v. Clark*, 713 S.W.2d 621, 628-29 (Mo. Ct. App. 1986).


outline the primary policy justification for the minority rule and the response of minority rule jurisdictions to the arguments advanced in favor of the majority rule. Then the law in Connecticut, a jurisdiction that has explicitly adopted the minority position, will be examined.

1. Policy Behind the Minority Rule

Courts that have adopted the minority rule have done so because of the nature, purpose, and composition of professional licensing and disciplinary boards. Expert testimony, these courts argue, is not required in a professional licensing board disciplinary hearing because of (1) what a board is, (2) who a board is not, (3) why boards were created, and (4) the evidentiary and procedural rules that apply in board proceedings.

The primary reason why minority rule courts have held that expert testimony is unnecessary is that a professional licensing board, as an entity composed primarily of experts in the field and charged with establishing professional standards, is inherently qualified to decide whether certain conduct violates the standard of care.124 Similarly, these courts have noted that the primary reason why expert testimony is required in malpractice cases is that lay juries and judges have limited technical knowledge; a circumstance which is not present in a professional licensing board disciplinary hearing. As the Ohio Supreme Court explained in Arlen v. State Medical Board:125

The need for expert medical testimony is quite evident when the trier of facts is confronted with issues that require scientific or specialized knowledge or experience beyond the scope of common occurrences. However, the need for expert opinion testimony is negated where the trier of facts, such as in the instant cause, is possessed of appropriate expertise and is capable of drawing its own conclusions and inferences.126

Furthermore, minority rule jurisdictions have found that the purpose of professional licensing boards would be compromised by a strict expert testimony requirement. As the court observed in Arlen:

[Requiring] expert testimony in the record of a license revocation proceeding [would usurp] the power of the State Medical Board's broad measure of discretion. The very purpose for having such a specialized technical board would be negated by mandating that expert testimony be presented. Expert opinion testimony can be presented in a medical board proceeding, but the board is not


[The State Medical Board consists of ten members, eight of whom shall be physicians and surgeons licensed to practice in this state, seven of whom must hold the degree of doctor of medicine, one the degree of doctor of pediatric medicine, and one the degree of doctor of osteopathy. The board members are selected by the Governor, with the advice and consent of the Senate. This distinguished medical board is capable of interpreting technical requirements of the medical field and is quite capable of determining when certain conduct falls below a reasonable standard of medical care.

Id.

125. 399 N.E.2d 1251 (Ohio 1980).
126. Id. at 1254.
required to reach the same conclusion as the expert witness. The weight to be
given to such expert opinion testimony depends upon the board’s estimate as to
the propriety and reasonableness, but such testimony is not binding upon such an
experienced and professional board.127

Thus, it is not just that boards are sufficiently qualified to avoid an expert testi-
mony requirement. Certain minority rule courts have held that requiring expert
testimony would be contrary to the very mission of the boards, and would dimin-
ish the boards’ ability to serve the purpose for which they were designed.

Finally, the evidentiary and procedural rules applicable to professional licens-
ing board disciplinary hearings both limit the significance of expert testimony and
provide sufficient protections for a defendant’s due process rights. To the extent
that minority rule courts have expressed concern that a reviewing court would be
unable to properly monitor the board’s decision making process, minority rule
courts hold that meaningful judicial review is possible as long as the board doc-
ments the charge, its deliberations, and its conclusions properly in the minutes of
the proceeding.128

2. The Minority Rule in Action: Levinson v. Connecticut Board of Chiropractic
Examiners

Connecticut was one of the first states to adopt the minority rule; its 1949
decision, Jaffe v. State Department of Health,129 is one of the defining cases for
the minority rule. In Levinson v. Connecticut Board of Chiropractic Examiners,130
the Supreme Court of Connecticut reaffirmed its adherence to the minority rule in
a decision that also outlined the primary parameters of the rule.131

In Levinson, the court affirmed132 the Connecticut Board of Chiropractic Ex-
aminers’ decision to suspend Dr. Levinson’s license for “negligence or incompete-
tence.”133 The charges against both Dr. Levinson and Dr. Weiss-Levinson (collect-
ively “the Chiropractors”) involved their joint treatment of a patient who came to
them with complaints of bronchitis, a persistent cough, and headaches.134 Despite

127. Id. at 1255.
128. For example, in Levinson v. Connecticut Board of Chiropractic Examiners, 560 A.2d 403 (Conn. 1989), the Court explained:
The only way the [board’s reasoning] can be definitely placed on record is by such a
statement as that embodied in this case. ... The notice of charges against a practitio-
nor to which he is to answer before the board should state them with sufficient par-
ticularity so that he may be fairly apprised of the nature of the offense with which he
is charged. If this is done, and the board in its minutes has stated with reasonable
certainty the conclusions it has reached, the court on appeal can know the basis upon
which it acted.
Id. at 413 (quoting Jaffe v. State Dep’t of Health, 64 A.2d 330, 337 (Conn. 1949)) (emphasis
omitted).
129. 64 A.2d 330 (Conn. 1949).
130. 560 A.2d 403 (Conn. 1989).
131. See id.
132. The procedural history of this case is somewhat complicated. The case initially in-
volved two Chiropractors, Dr. David Levinson and Dr. Debra Weiss-Levinson, both of whom
were disciplined by the board. See id. at 405. Both appealed to the Superior Court, which
upheld Dr. Levinson’s appeal but dismissed Dr. Weiss-Levinson’s appeal. See id. These deci-
sions were appealed to the appellate court, but the case was first transferred to the supreme
court. See id.
133. Id.
134. See id. at 405-06.
the patient's complaints about bronchitis, she was not given a thorough examination of her pulmonary and respiratory systems.135 Four months after the patient stopped receiving treatment from the Chiropractors, she "was admitted to New Britain General Hospital where she was found to have a malignant mass and operated on."136 Dr. Levinson was charged with misdiagnosing and mistreating the patient and Dr. Weiss-Levinson was charged with practicing chiropractic without a proper license.137

The Chiropractors challenged the board's decisions on multiple grounds, but by the time the case reached the Connecticut Supreme Court, the primary remaining issue was "the single principle issue of whether expert testimony is necessary in licensing board disciplinary proceedings."138 The Chiropractors recognized the Jaffe court's holding that expert testimony was not required, but argued that Jaffe was no longer applicable because the board was no longer composed entirely of chiropractors,139 and therefore it lacked the requisite expertise to supplant expert testimony.140

The court responded to this argument by first reviewing the basis for its decision in Jaffe, which emphasized not only the qualifications of the board members as experts but also the purpose of the board.141 First, it reiterated its observation from Jaffe about the legislature's purpose in establishing the board and choosing its membership:

In providing this method of appointment the legislature undoubtedly intended that the membership of the board should consist of men fitted by training and experience to perform the duties and responsibilities imposed upon it. We would presume—even if we did not know—that the men composing the board were themselves qualified to decide whether certain conduct of a physician or surgeon so derogated from professional standards as unreasonably to jeopardize the interests of the public, and upon that basis they were entitled to act.142

Given this purpose, the court then discussed the means by which the board was authorized to reach a decision. In order to reach a decision as to the appropriate standard of care, the board is authorized to take and evaluate whatever evidence it deemed necessary; although the board was free to accept expert testimony, it was also free to disregard such testimony.143 The requirements of due process were

135. See id. at 407.
136. Id. at 406.
137. See id. at 405.
138. Id. at 409.
139. At the time Jaffe was decided, the board was composed entirely of chiropractors. See id. at 408. However, in 1979, the composition of the Board of Chiropractic Examiners was changed to include two chiropractors and one public member. See id.
140. See id.
141. See id. at 410-11.
142. Id. (quoting Jaffe v. State Dept' of Health, 64 A.2d 330, 336 (Conn. 1949)).
143. See id. at 410-11. As the court observed:

[Expert opinions of other physicians offered before [a licensing board] could [be] disregarded by [the board], and from a practical standpoint would in all probability have little, if any, effect in bringing [the board] to a decision at variance with its own conclusion. ... With the facts of [the] conduct before it, [a] board [is] competent to determine such questions [as the relevant standard of care] without hearing expert opinion evidence.

Id. (citing Jaffe v. State Dept' of Health, 64 A.2d 330, 336 (Conn. 1949)) (alteration in original).
satisfied by the requirement that the board provide the defendant with a specific notice of charges and state in its minutes the conclusions it had reached.\textsuperscript{144}

The court then concluded that the vitality of this rationale was not undermined by the inclusion of lay members on the board. It emphasized that the legislature deemed the members of the board, however that board was composed, sufficiently qualified to evaluate "charges against persons licensed by the board and the requisite standard of care by which to judge such cases."\textsuperscript{145} The court also noted that the Legislature provided for lay membership on the board knowing that it had already provided that "any agency may use its experience, technical competence and specialized knowledge in the evaluation of the evidence in contested cases."\textsuperscript{146} Consequently, the court concluded, as long as the board that heard the case consisted of at least a majority of experts, the rationale of \textit{Jaffe} remained valid and expert testimony was not required.\textsuperscript{147}

\textbf{C. The Gaps Between the Majority and Minority Rules}

Perhaps the best way to understand the weakness of the majority-minority dichotomy is to see that the courts' analysis is more complicated than the polar terms of the stated rules would indicate is necessary. Even though the courts have described the rule as a strict dichotomy, they have not analyzed the issue so simply. They each discussed and relied upon factors beyond the mere status of the proceeding and nature of the charge. If the rule were as simple as they indicated in their description of the rule they were applying, the only relevant information would have been the fact of the proceeding. The fact that the majority rule courts do not always require expert testimony, and that the minority rule courts leave open the possibility that a decision not based on expert testimony might be found unsupported by substantial evidence, indicates that there is more variability and volatility in this issue. The next Part will examine the factors that adherents to both the majority and the minority rules have considered in deciding whether expert testimony was required in particular cases.

\textbf{IV. Several Jurisdictions Reconsider or Revisit Their Rules}

These issues left unresolved by the adherents to the majority and minority rules, these cracks in the straightforward façade of the majority-minority dichotomy, are significant because they highlight the limited precedential value of such polar rules. The adherents to both rules consider factors in their decision making process that are not recognized when the issue is framed as a simple question of whether expert testimony is required. Consequently, it is not only possible but likely that if one of these unacknowledged factors changes, the putative rule will not be determinative of the outcome of the case.

Even more, the differences among the jurisdictions, and between the rules, are neither as significant nor as straightforward as the common formulation of the majority and minority positions suggests. The outcome of any individual case is significantly less dependent on whether the court adheres to the majority or minor-

\textsuperscript{144} \textit{See id. at} 413.
\textsuperscript{145} \textit{Id. at} 412.
\textsuperscript{146} \textit{Id.}
\textsuperscript{147} \textit{See id. at} 411-12.
ity rule than it is on the nature of the charge, the conduct alleged, and the rules of evidence and administrative procedure specific to the jurisdiction. Consequently, when courts frame their analysis or summarize their holding in simple, polar terms, the holdings are less analytically and procedurally valuable than they might otherwise be.

In recent years several states that were once considered firmly within one of the two camps have reexamined the issue and significantly modified, or even reversed their prior rule. However, these revisions reflect the complexity of the issues involved and the significance of the factual posture of each case more than a change in policy, and thus are more appropriately categorized as clarifications than changes or reversals. The issues raised in these subsequent, clarifying cases highlight the fundamental weakness of the majority-minority dichotomy, that the dichotomy is more a product of the facts of the particular case and the jurisdiction’s statutory framework than the result of true disagreement about the role of expert testimony in professional disciplinary board hearings.

This Part will examine four jurisdictions where courts have clarified, modified or reversed their rule, with specific focus on how the revision process highlights the significance of the issue of explicit evidence of the standard of care, as opposed to the particular type of evidence.

A. Ohio

Ohio courts have considered the question of expert testimony and professional licensing board disciplinary hearings extensively, both at the supreme court and the intermediate appellate court level. In a series of four cases from 1980 to 1993 the Ohio Supreme Court first adopted the minority rule, then limited it, and finally clarified the limitation to exclude the possibility that it had, in fact, adopted the majority position. Consequently, Ohio’s version of the minority rule is more explicitly outlined than the rule in most jurisdictions.

The Ohio Supreme Court first addressed the issue of expert testimony in professional licensing board disciplinary hearings in Arlen v. State Medical Board, where the state medical board suspended Dr. Arlen’s license to practice medicine for “dispensing ... a controlled substance, without a proper license” and “writing prescriptions for narcotics in the name of one person when such drugs were actually intended for other individuals.” The charges against Dr. Arlen were primarily focused on his prescription practices in connection with his treatment of drug addicts. At the hearing, the board presented evidence of Dr. Arlen’s conduct but it did not present any evidence, by expert testimony or otherwise, of the applicable standard of care. Dr. Arlen presented expert testimony about the general

149. 399 N.E.2d 1251 (Ohio 1980).
150. Id. at 1252.
151. See id. at 1252-53.
152. See id. The charges against Dr. Arlen involved violations of federal drug prescription regulations and the American Medical Association (AMA) Code of Ethics, in addition to or as the basis for, the allegations of violations of more general state created duties. See id. at 1252. It is unclear from the court’s opinion, however, to what extent the federal regulations or the AMA Code of Ethics were introduced into evidence or used as a basis for the proceedings.
appropriateness of his clinical approach, but his expert did not testify about the specific prescription procedures that were the basis of the pending charges. The Court of Common Pleas reversed the board’s decision on the grounds that it “was not supported by reliable, probative and substantial evidence,” and the Court of Appeals affirmed, citing the lack of expert testimony as to the appropriate standard of care.

The Ohio Supreme Court reversed, holding both that expert testimony was not required to establish the standard of care and that the board’s decision was supported by substantial evidence. With respect to the question of the appropriate standard of care, the court analyzed the issue in traditional tort terms, rather than in the language of malpractice. It discussed the importance of both the composition and purpose of the board before adopting the minority rule outlined by the Connecticut Supreme Court in Jaffe.

Once the court determined that expert testimony was not required, it went on to assess the sufficiency of the evidence that was before the board. The court noted that Dr. Arlen had essentially admitted to committing two statutory viola-

153. See id. The court described the testimony of Dr. Arlen’s expert as follows:

In order to refute the ... violations [alleged] by the board, Dr. Arlen presented the testimony of Dr. Herbert Weiss, an expert in pharmacological tendency treatment. ... Dr. Weiss did not testify as to the appropriateness of writing prescriptions for a Schedule II narcotic in the name of one individual, when its actual intended use is for another.

Id. at 1252-53.

154. Id. at 1253-54.

155. See id. at 1254, 1255-56.

156. See id. at 1254.

[Ohio Rev. Code Ann. §] 4731.22 specifies the grounds for revoking, suspending, reprimanding and refusing a license for the practice of medicine in order to maintain a criterion or minimum standard appropriate for the profession.

Similar to the reasonably prudent [person] standard of tort law, a physician, who is regulated under the mandates of [section] 4731.22, must “use reasonable care” and “conform” to “minimal standards of care of similar practitioners under the same or similar circumstances.”

In a tort action, a jury is given the delicate task of weighing and considering evidence and determining whether an individual has acted within the purview of a “reasonably prudent [person].” In tort actions, the trier of fact has knowledge or experience of common occurrences and determines whether certain acts fall below the statutory standard.

A medical disciplinary proceeding, such as in the instant cause, is a special statutory proceeding which purports to maintain sound professional conduct. The licensing board, which is comprised of individuals fitted by training and expertise to perform the duties imposed upon it, weighs and considers whether a certain act is one of “reasonable care discrimination” or a departure from the “minimal standards of care” within the medical profession.

The need for expert medical testimony is quite evident when the trier of fact is confronted with issues that require scientific or specialized knowledge or experience beyond the scope of common occurrences. However, the need for expert opinion testimony is negated where the trier of fact, such as in the instant cause, is possessed of appropriate expertise and is capable of drawing its own conclusions and inferences.

Id. at 1254-55 (citing Jaffe v. State Dep’t of Health, 64 A.2d 330, 336 (Conn. 1949)).

158. See id. at 1255-56.
tions, and that his own expert had testified that Dr. Arlen's clinical method was not "the customary manner in which to handle such addiction problems." Thus it is not clear whether the court found sufficient evidence of the standard of care, albeit not in the form of expert testimony, or whether the court found sufficient evidence of Dr. Arlen's conduct without any requirement that there be independent evidence as to the standard of care. Given the clear statutory violations, the court could have avoided the question of expert testimony altogether. However, the language of the opinion indicates that those violations were used as evidence of a violation of the standard of care, not per se violations. Although the court expressed a willingness to defer broadly to the board's discretion, the scope of the 'substantial evidence' analysis left open the possibility that such deference might be contingent on the breadth of the record before the court. In other words, while it is clear that expert testimony is not necessarily required, it is unclear whether and to what extent evidence of the standard of care is required.

Eleven years after Arlen was decided, the Ohio Supreme Court addressed the same issue in In re Williams, another case involving prescription practices and controlled substances. The court reviewed a decision by the State Medical Board suspending Dr. Williams's license for using certain stimulants as a long-term rather than a short-term treatment for weight control. Other than the medical records of the patients in question, the only evidence presented by the board was a standard prescription drug usage reference manual. Dr. Williams, on the other hand, presented the testimony of two experts, both of whom testified that there was disagreement within the medical community as to the proper use of the drugs in question and that Dr. Williams's treatment plan was within the range of accepted medical practice. Based on this evidence, the Court of Common Pleas overturned the board's decision as unsupported by substantial evidence.

159. Id. at 1256.
160. See id. (Hebert, J., concurring).
161. See id. The court analyzed the issue as follows:
[The Court of Appeals], in determining the need for expert opinion testimony in the record to support the board's finding, failed to note that the record is replete with Dr. Arlen's admissions that he did not have a DEA certificate for Schedule II narcotics at a time when he was writing prescriptions for Schedule II narcotics and that he wrote prescriptions in the name of Jablonski when he intended the use of the narcotics by others. Certainly, such admissions, coupled with Dr. Weiss' opinions concerning the propriety of certain actions taken by Dr. Arlen, can be considered reliable, probative and substantial evidence.

Id. (emphasis added).
163. See id. at 638.
164. See id. at 639.
165. See id.
166. See id. As the court explained:
The [experts] stated that there are two schools of thought in the medical community concerning the use of stimulants for weight control. The so-called "majority" view holds that stimulants should only be used for short periods, if at all, in weight control programs. The "minority" view holds that the long-term use of stimulants is proper in the context of a supervised physician-patient relationship. Both experts testified that, though they themselves supported the "majority" view, Dr. Williams's application of the "minority" protocol was not substandard medical practice.

Id.
167. See id.
Court of Appeals affirmed, with an opinion that acknowledged Arlen but implicitly invited the Ohio Supreme Court to reconsider its adherence to the minority rule. 168

The Ohio Supreme Court did revise its version of the minority rule, but stopped well short of adopting the majority position. 169 To do so it emphasized the second issue that it had considered in Arlen, the requirement that the board's decision be supported by "some reliable, probative and substantial evidence." 170 The court concluded that the charges against Dr. Williams were not supported by substantial evidence because Dr. Williams presented expert testimony that tended to show that his prescription practices were not below the standard of care, and the board had not presented any contrary evidence. 171 Although this case was factually distinguishable from Arlen, the court's analysis and resolution of the issue did not provide clear guidance for future cases. 172 The rule announced by the court was that,

[w]hile the board has broad discretion to resolve evidentiary conflicts and determine the weight to be given expert testimony, it cannot convert its own disagree-

168. See In re Williams, No. 89AP-777, 1990 WL 63027, at *6 (Ohio Ct. App. May 15, 1990). The Court of Appeals cited In re Schramm, 414 N.W.2d 31 (S.D. 1987), and Franz v. Board of Medical Quality Assurance, 642 P.2d 792 (Cal. 1982), and other majority rule cases extensively. See In re Williams, 1990 WL 63027, at **4-6. Although the court claimed that its decision was within the scope of the Arlen rule, the language and tone of the opinion provided a strong indication that the court would have preferred to adopt the majority rule. For instance, at one point, the court framed the issue as follows:

The primary rationale for the majority approach to the issue of expert testimony is the need to preserve a record for judicial review. ... 

[This approach] would also tend to lessen the problems of lack of notice and lack of an opportunity to cross-examine. In essence, [the board's] contentions would require a physician to determine, without the benefit of cross-examination or explicit testimony, what the board's expert opinion, individually or collectively, might be, and then to present evidence to refute that opinion. Indeed, in some instances, the physician would be relegated to presenting some expert testimony in the offhand chance that the testimony may be able to persuade the board that its own opinion, whatever that may be, is invalid.

We do not intend to suggest that the Supreme Court incorrectly decided Arlen or that we are not bound by the Arlen decision. Nevertheless, Arlen is not entirely dispositive of the present case, since Arlen merely held that expert testimony is unnecessary. The Arlen court did not find that judicial review, notice, or meaningful cross-examination were unnecessary.

Id. at *5.


170. Id. The court observed that, although "the board need not, in every case, present expert testimony to support a charge against an accused physician, the charge must be supported by some reliable, probative and substantial evidence. It is here that the case against Dr. Williams fails, as it is very different from Arlen." Id.

171. See id. The court concluded its examination of the evidence by observing:

Here, however, there is insufficient evidence, expert or otherwise, to support the charges against Dr. Williams. Were the board's decision to be affirmed on the facts in this record, it would mean that a doctor would have no access to meaningful review of the board's decision. The board, though a majority of its members have special knowledge, is not entitled to exercise such unbridled discretion.

Id.

172. A point made vigorously by two justices in dissent. See id. at 641.
ment with an expert's opinion into affirmative evidence of a contrary proposition where the issue is one on which medical experts are divided and there is no statute or rule governing the situation.\textsuperscript{173}

However the court's rather brief opinion did not explain the difference between weighing the evidence and converting its own opinion into affirmative evidence.\textsuperscript{174} It also left unanswered the question of whether and to what extent it was necessary for the board to present explicit evidence of the standard of care, rather than evidence of the allegedly improper conduct only.

Two years later, the court clarified its rule and largely resolved these issues when it decided two cases where defendant physicians had argued that Williams effectively overruled Arlen.\textsuperscript{175} In State Medical Board v. Murray,\textsuperscript{176} the court upheld\textsuperscript{177} the State Medical Board's revocation of Dr. Murray's certificate to practice medicine where Dr. Murray was found to have improperly prescribed steroids.\textsuperscript{178} Dr. Murray argued that because his conduct did not violate any statutorily established standard of care, the rule of Williams required that "in the absence of expert medical testimony, his alleged failure to meet minimal standards of care was not supported by substantial, probative evidence."\textsuperscript{179} The court rejected this reading of Williams, distinguishing that case on the ground that Dr. Williams introduced affirmative evidence that his conduct did not violate the standard of care and the board did not introduce contrary evidence. The court also noted that "in its case against [Dr.] Murray, the board presented an extensive compilation of documentation, exhibits, and testimony."\textsuperscript{180} Thus the court affirmed the board's authority to adopt a standard of care based on evidence other than expert testimony or a statutory duty.

Similarly, in Pons v. Ohio State Medical Board,\textsuperscript{181} the court upheld\textsuperscript{182} the State Medical Board's decision to suspend Dr. Pons's certificate to practice medicine for engaging in an improper sexual relationship with a patient.\textsuperscript{183} The board found that Dr. Pons's treatment of the patient in question violated both the clinical standards of care and his ethical duties.\textsuperscript{184} Although the board presented expert evidence tending to show that Dr. Pons's conduct violated both of these standards, there was no explicit evidence that such violations were sufficient to constitute a

\textsuperscript{173} \textit{Id.} at 640 (citations omitted).

\textsuperscript{174} The dissenting justices argued that the court's decision would severely limit a board's ability to discipline a physician for any conduct that was not a statutory violation (i.e., conduct that was not "illegal—just improper."). \textit{Id.} at 641.

\textsuperscript{175} \textit{See} State Med. Bd. v. Murray, 613 N.E.2d 636 (Ohio 1993); Pons v. Ohio State Med. Bd., 614 N.E.2d 748 (Ohio 1993). Notably, since these two cases were decided, Ohio's intermediate appellate courts continue to decide cases involving this issue, but the Ohio Supreme Court has not published an opinion that cites any of the four cases discussed in this Section for a proposition related to the expert testimony requirement.

\textsuperscript{176} 613 N.E.2d 636 (Ohio 1993).

\textsuperscript{177} The Court of Common Pleas affirmed the board's decision, but the Court of Appeals reversed on other grounds. \textit{See id.} at 637.

\textsuperscript{178} \textit{See id.}

\textsuperscript{179} \textit{Id.} at 641.

\textsuperscript{180} \textit{Id.}

\textsuperscript{181} 614 N.E.2d 748 (Ohio 1993).

\textsuperscript{182} The Court of Common Pleas affirmed the board's decision, but the Court of Appeals vacated the judgment. \textit{See id.} at 750.

\textsuperscript{183} \textit{See id.}

\textsuperscript{184} \textit{See id.} at 749.
violation of the requirement that "a physician...provide competent medical service with compassion and respect for human dignity, deal honestly and objectively with a patient, uphold the dignity and honor of the medical profession, seek consultation where appropriate, and safeguard the public against physicians deficient in moral character."185 The court concluded that it was "well within [the board's] statutory authority" to determine that Dr. Pons's conduct, shown by expert testimony to be an ethical violation, was also deceitful, dishonorable, and constituted a failure "to uphold the dignity and honor of [the] profession."186

These four cases show both a debate and an evolution in Ohio law on the question of the significance of expert testimony in hearings before the State Medical Board.187 The evolution of the rule has been driven by both theoretical and practical concerns. In the end, the rule is deferential to the board, but not blindly so. The rule is considerably less rigid and more fact intensive than a bare statement of the minority rule. Its practical effect is to give deference to a board's determination as to the standard of care as long as that determination is either supported by some positive evidence, or not opposed by contrary evidence. In order to overcome this deference, a defendant must present positive evidence that his or her conduct was within the parameters of the standard of care.

B. North Carolina

The North Carolina Supreme Court has twice considered the issue of expert testimony in professional licensing board disciplinary hearings, first adopting the majority position and then reversing itself and embracing the minority rule. The North Carolina court first addressed the issue in Dailey v. North Carolina State

185. Id. at 752.
186. Id.
187. In Arlen, three judges concurred in the judgment only, arguing that Dr. Arlen admitted to violating the law and therefore the court need not have reached the question of the expert testimony requirement. See Arlen v. State Med. Bd., 399 N.E.2d 1251, 1256 (Ohio 1980). In re Williams, was decided 5-2 with a strong dissent arguing that the majority opinion undermined Arlen and sent a troubling message about whether conduct that was not illegal could be improper. See 573 N.E.2d 638, 641 (Ohio 1991). With Murray and Pons, however, the court reached a broader consensus. Justice Resnick, one of the dissenting justices in Williams, wrote the majority opinion in Murray, an opinion that was supported by a nearly unanimous court. See State Med. Bd. v. Murray, 616 N.E.2d 636, 644 (Ohio 1993). One Justice, Justice Pfeifer, wrote a concurring opinion, however, expressing concern that the State Medical Board was conducting "trial[s] by ambush." Id. Justice Pfeifer noted that "[o]n future occasions [he would] be less likely to uphold medical board decisions revoking or suspending licenses when the accused doctor has not been permitted to conduct elementary discovery procedures." Id. In Pons, Justice Pfeifer, the lone dissenter, argued that the court was deferring too much to the unfettered expertise of the board. See 614 N.E.2d 798, 752-54 (Ohio 1993).

These four cases demonstrate that consensus on this issue evolved as the rule was refined; the consensus that developed was based on compromise and modification of the rule rather than simple changes in the composition of the court. Justice Pfeifer's move from concurrence to dissent indicates, however, the fine line between deference and abrogation of responsibility. In this sense, it is significant that all four of these cases involved some sort of statutory or ethical duty. It remains to be seen how the court would view a case that was more strictly clinical; one that was not susceptible to judgment according to published or promulgated standards. In such a case, Justice Pfeifer's distrust of the sufficiency of the board's procedures and its willingness to consider contrary evidence would likely be more significant; especially given that this type of distrust is the foundation of the majority rule's requirement that a board base its decision on expert testimony in the record.
Board of Dental Examiners,188 where the court reviewed189 a decision of the State Board of Dental Examiners suspending Dr. Dailey's license to practice dentistry for negligence and malpractice.190 The board made explicit findings as to the standard of care applicable to Dr. Dailey's conduct, but did not introduce expert testimony to support these findings.191

The court acknowledged the breadth of the board's expertise and its qualification to "make its own judgment of the evidence and reject even uncontradicted expert testimony."192 However, the court then observed that "while it is true that the determination whether by common judgment certain conduct is disqualifying is left to the sound discretion of the board, the record must include an indication of the basis upon which the board or other agency exercised its discretion."193 Consequently, the court held that expert testimony was required in order to provide a basis for subsequent judicial review.194

Fourteen years later, however, the court reached a contrary conclusion about the significance of expert testimony in Leamy v. North Carolina Board of Nursing.195 In Leamy, the court upheld196 a decision of the North Carolina Board of Nursing revoking Ms. Leamy's nursing license for one year for negligence and incompetence.197 The board presented extensive evidence of Ms. Leamy's conduct, including "[f]our witnesses who were either registered nurses (RNs) or licensed practical nurses (LPNs) [who] testified as to instances of alleged negligence or incompetence of [Ms. Leamy]."198 Ms. Leamy testified on her own behalf and also offered a "nursing expert" who "testified that in her opinion [Ms. Leamy] did not violate the standard of nursing care."199 Additionally, Ms. Leamy intro-

188. 309 S.E.2d 219 (N.C. 1983).
189. The board's opinion was affirmed (after an initial remand and revision) by the Superior Court, but partially reversed by the Court of Appeals. See id. at 224-26. The primary basis for the Court of Appeals's decision was the sufficiency of the evidence of the relevant standard of care. See id. at 226.
190. See id. at 220.
191. See id. at 224-25.
192. Id. at 227.
193. Id. (citations omitted). The depth of the court's concern with the viability of judicial review is further illustrated by its citation to the following passage from the Supreme Court's opinion in Burlington Truck Lines v. United States:

We are not prepared to and the Administrative Procedure Act will not permit us to accept such adjudicatory practice [no findings and no analysis to justify the choice made, no indication of the basis on which the Commission exercised its expert discretion]. Expert discretion is the lifeblood of the administrative process, but 'unless we make the requirements for administrative action strict and demanding, expertise, the strength of modern government, can become a monster which rules with no practical limits on its discretion.' "Congress did not purport to transfer its legislative power to the unbounded discretion of the regulatory body."

Id. at 228 (quoting 371 U.S. 156, 167 (1962) (alterations in original) (citations omitted)).

194. See id.
195. 488 S.E.2d 245 (N.C. 1997).
196. The Superior Court affirmed the board's decision, but the Court of Appeals reversed on the grounds that the board's decision was not supported by expert testimony as to the applicable standard of care. See id. at 247-49.
197. See id. at 245.
198. Id. Although these witnesses testified about both Ms. Leamy's conduct in specific situations, and offered alternate, more appropriate actions that should have been taken, it appears that they did not testify explicitly as to the applicable standard of care.
199. Id. at 246.
duced affidavits from the three attending physicians for the patients in question, all of whom said that, in their opinions, Ms. Leahy treated their patient appropriately.200

Ms. Leahy, citing Dailey, argued that the board’s order was not supported by substantial evidence because, despite the volume of evidence that was presented, the board failed to introduce “expert testimony defining the standard of care for registered nurses.”201 The court rejected this argument, both distinguishing Dailey and clarifying the Dailey rule as follows:

The concern in Dailey was that the board would use its own expertise to decide the case without any evidence to support it. That is not the case here. There is evidence in the record which the [b]oard could use its expertise to interpret, including its expertise as to whether the petitioner had violated the standard of care for registered nurses. From the record, we are able to determine the validity of the [b]oard’s action.202

Thus the court held that the important consideration was the presence of evidence in the record, whether that evidence was in the form of expert testimony or otherwise.203 However, given the extensive evidence presented in this case, including testimony of four nurses, it is not clear whether and to what extent a board must present evidence of anything other than the conduct in question.

C. Pennsylvania

Pennsylvania, a state that, like Connecticut and Ohio, has traditionally been considered a minority rule jurisdiction, recently clarified its standard as well. A Pennsylvania appellate court first addressed the issue of expert testimony in professional licensing board proceedings in Kundrat v. Commonwealth State Dental Council and Examining Board,204 where the Commonwealth Court of Pennsylvania-

200. See id. at 246-47.
201. Id. at 248.
202. Id. It is somewhat unclear whether the court meant to overrule or merely clarify Dailey. With respect to Dailey the court stated, “w[e] can understand why the Court of Appeals applied Dailey as it did, but we believe our interpretation is better. So far as Dailey is inconsistent with this case, it is overruled.” Id. at 248-49. Given the substance of the court's concern in Dailey, i.e., with assuring the reviewability of a board's decision, the court's holding in this case is not necessarily inconsistent with Dailey's holding.
203. The extent of this deference is highlighted by the broad sweep of the court’s description of the board’s authority:
[Under North Carolina administrative law, an] agency may use its experience, technical competence, and specialized knowledge in the evaluation of evidence presented to it. The knowledge of the [b]oard includes knowledge of the standard of care for nurses. The [b]oard currently consists of nine registered nurses, four licensed practical nurses, one retired doctor, and one lay person. The [b]oard is authorized to develop rules and regulations to govern medical acts by registered nurses. It is empowered to administer, interpret, and enforce the Nursing Practice Act. The [b]oard is required to adopt standards regarding qualifications of applicants for licensure and to establish criteria which must be met by an applicant in order to receive a license. To meet these requirements, the [b]oard must know the standard of care for registered nurses in this state. There is no reason it should not be allowed to apply this standard if no evidence of it is introduced.

Id. at 248 (citations omitted). It is obvious from this language that the court is legitimately concerned only with the susceptibility of the board’s decisions to review. There is no indication that the court harbors a deeper mistrust of the board’s power or procedures.
nia\textsuperscript{205} adopted the minority rule.\textsuperscript{206} The court upheld an order of the State Dental Council and Examining Board revoking Dr. Kundra's license to practice dentistry where the board found Dr. Kundra guilty of making "misleading and deceptive representations" to a patient, and engaging in "both gross malpractice and unprofessional conduct."\textsuperscript{207} The board based its decision on considerable evidence from both sides as to the conduct involved, but it does not appear from the court's decision that either side presented any evidence as to the applicable standard of care.\textsuperscript{208} In its final order, the board found that, given the patient's condition, the course of treatment Dr. Kundra selected was "highly unreasonable" and that its failure was "all but inevitable."\textsuperscript{209}

The court discussed the role of expert testimony in a fact finder's delinquent process, and specifically noted the difference between the board and a lay jury.\textsuperscript{210} It then concluded that the board was competent to find Dr. Kundra guilty, even without expert testimony as to the applicable standard of care, because "the [b]oard is as competent in ruling on the propriety of dental practices as any other dentist who might be called upon to testify as an expert witness."\textsuperscript{211}

In \textit{Batoff v. State Board of Psychology},\textsuperscript{212} the Commonwealth Court reviewed a decision of the State Board of Psychiatry where the board explicitly relied on \textit{Kundra} for the proposition that expert testimony was not required.\textsuperscript{213} In \textit{Batoff}, the board reprimanded and fined Dr. Batoff for irregularities in his billing and documentation practices constituting violations of "the [b]oard's regulations and


\textsuperscript{207}. \textit{Id.} at 357.

\textsuperscript{208}. \textit{See id.} In fact, it does not appear from the court's decision that Dr. Kundra contested the medical appropriateness of the procedure performed. The thrust of his defense seems to have been that he gave the patient in question three "alternative procedures" and then performed the procedure selected by the patient. \textit{Id.} at 357-58. Although he testified before the board, and later argued that the board's decision was not supported by evidence as to the standard of care, he did not testify that, in his professional opinion, the procedure he performed was appropriate. \textit{See id.} at 357.

\textsuperscript{209}. \textit{Id.}

\textsuperscript{210}. \textit{See id.} As the court explained:

Expert testimony is utilized to assist a trier of fact to understand the evidence presented or to determine a fact in issue. It is appropriately employed in situations where the subject matter of the inquiry is one involving special skills, knowledge and training which are normally beyond the experience of the factfinder. However, if all of the pertinent facts can be accurately described to the factfinder and the factfinder is capable of comprehending such facts and drawing the proper conclusions, then the testimony of an expert witness is not needed.

... [T]he dentists sitting on the [b]oard which heard the case are knowledgeable and experienced in the field of dental medicine and the procedures connected therewith. As such, they are permitted to draw on their expertise in ruling on matters which come before them.

\textit{Id.} at 357-58 (citations omitted).

\textsuperscript{211}. \textit{Id.} at 358.


\textsuperscript{213}. \textit{See id.} at 367.
... committing immoral or unprofessional conduct."214 A hearing examiner conducted hearings, where the board presented two experts who testified that Dr. Batoff's training was insufficient to qualify him "to give and to evaluate the psychological tests that he administered to many of [his patients]."215 However there was also evidence that one of these experts was biased against Dr. Batoff and the other had limited qualifications with which to provide such testimony.216 In addition, Dr. Batoff presented an expert who testified that Dr. Batoff's "reports were within the standard of competency despite their quality."217

After the hearings, the hearing examiner "issued [a] proposed adjudication and order in which she recommended that all of the charges against [Dr.] Batoff be dismissed."218 Nonetheless, the board found Dr. Batoff guilty of six charges.219 In so doing, the board "emphasized that its decision was drawn from the collective expertise of its members and that it was based on the [b]oard's independent judgment" rather than this expert testimony.220

The court overturned the board's decision, holding that it had impermissibly based its judgment on its own opinion rather than the evidence in the record.221 The court distinguished Kudrat by noting that Dr. Kudrat had not provided any affirmative evidence that his conduct was within the standard of care.222 More specifically, it held that "[t]he relevant evidence offered in this case simply [did] not support the conclusions reached by the [b]oard. The facts that purportedly [supported] portions of the [b]oard's decision [were] so inadequate and forcefully contradicted by uncontroverted facts of record that the administrative findings [were] mere conjecture."223 Thus in Batoff the Pennsylvania court modified its rule to mirror the rules in Ohio and North Carolina. A board may use its expertise to infer the applicable standard of care, but a standard established by such an inference may not constitute 'substantial evidence' when countered by evidence in the record that the defendant's conduct was not a violation of the relevant standard of care.

214. Id. at 365. As the court explained:
The charges fell into two broad categories: (1) Batoff misrepresented his degree, qualifications and credentials in stationery and in testimony during litigation over the bills that he submitted to State Farm for the services rendered to the insureds; and (2) Batoff failed to recognize the boundaries of his competence while he provided the services to the insureds.

215. Id. at 366.
216. See id. One of the experts, Dr. Paul, was both defending a lawsuit against Dr. Batoff, and had other confrontations with Dr. Batoff such that the hearing officer concluded that Dr. Paul had "carried out a vendetta against [Dr. Batoff] for 14 years." Id. The other expert, "Dr. Bersoff, [was] an attorney and an unlicensed psychologist who was qualified by the [b]oard for purposes of the hearings as an expert in professional ethics, credentials evaluation and psychological testing." Id.
217. Id. at 367.
218. Id. at 366.
219. See id.
220. Id.
221. See id. at 367.
222. See id. at 368.
223. Id. at 368 (citations omitted).
D. Arkansas

Although Arkansas is generally considered an adherent to the majority rule, Arkansas courts have recently decided two cases that clarify and complicate the law.224 Consequently, it is now clear that Arkansas law requires that a board's decision be based on substantial evidence and be made in compliance with statutory requirements, but expert testimony is not, per se, required.225

In Hake v. Arkansas State Medical Board,226 the Supreme Court of Arkansas first addressed the issue of whether expert testimony is required to establish the standard of care against which a professional is judged by a professional licensing board.227 In that case, Dr. Hake appealed an order by the Arkansas State Medical Board revoking his license to practice medicine.228 Dr. Hake argued that the board's decision was not supported by any competent evidence because "the findings and opinion of the board [were] based on testimony or conversation or other matters which arose or were presented at [an] informal and unreported hearing."229 The court agreed and reversed the revocation on the grounds that that "there [was] a virtual absence of evidence in the record to sustain the board's findings, as well as no expert testimony to provide a standard for the board's medical opinions."230

In Hollabaugh v. Arkansas State Medical Board,231 an intermediate appellate court reversed the Arkansas State Medical Board's finding that Dr. Hollabaugh had committed 'gross negligence or ignorant malpractice' by over-prescribing addictive and potentially addicting drugs.232 The court based its holding on the fact that the record of the board's proceedings did not contain any evidence of the standard of care by which Dr. Hollabaugh was judged.233 Additionally, the court implied that evidence of the standard of care could only come from expert testimony.234

However, in Finch v. Neal,235 a review of an attorney disciplinary proceeding, the Arkansas Supreme Court clarified its holding in Hake and implicitly criticized the Hollabaugh decision.236 The court rejected Mr. Finch's argument that Hake stood for the proposition that, in order for a decision to be supported by 'substantial evidence,' that evidence had to be of a particular type, i.e., expert testimony.237 Instead, the court explained, the board's decision was overturned in

227. See id. at 176.
228. See id. at 174.
229. Id. at 176.
230. Id.
232. See id. at 318.
233. See id. at 321.
234. See id.
235. 873 S.W.2d 519 (Ark. 1994).
236. See id. at 523.
237. See id.
Hake] because the board had not complied with the statutory requirement that all evidence considered by the board be included in the official record of the proceedings.238 The court, therefore, implied that if the Medical Board had properly documented the basis for their conclusion, i.e., the substance of their own expertise, their decision could have been upheld.239

E. What These Cases Teach: Any Old Evidence of the Standard

These shifts and revisions in the law of these jurisdictions highlight the problems that naturally flow from the tendency of certain courts to frame this issue too narrowly. If the question asked is too narrow, and the subsequent answer given is similarly narrow, the rule will not provide sufficient guidance the next time the court faces the issue. The rule's efficacy will be limited by its failure to consider the full range of issues that actually figured into the court's deliberative process. If the question in these cases was only whether expert testimony was required in professional licensing board disciplinary hearings, then the only variable that should matter would be the fact that a professional licensing board disciplinary hearing was held. Once a court determined whether the policy of the state required expert testimony in professional licensing board disciplinary hearings, that rule would hold as long as the purpose and power of the board and the state's due process doctrines remained unchanged.

It is notable, therefore, that the courts discussed in this Part did not base their rule revisions on any change in the policy of the state regarding the role, competence, or authority of its professional licensing boards. When the Ohio court held, in Williams, that expert testimony was required, it based its decision on the same issue of substantiality of the evidence that was discussed earlier in Arlen. Similarly, in Leaky, although the North Carolina court held that expert testimony was not required, it affirmed rather than denied the importance of the factors that led it to require expert testimony in Daily. In both of these cases, as well as the others discussed in this Part, the courts were concerned with the same policies and issues; they simply reached different conclusions as to the ultimate fact. The majority rule states were concerned with safeguarding the defendants' due process rights, maintaining the vitality of the defendants' right to meaningful judicial review, and minimizing any potential negative effect of the role of lay members of the boards. The minority rule states recognized the significance of the competence of the board, but were concerned with recognizing the importance of both the purpose and the specialized competence of the boards. In reaching the final conclusion as to whether expert testimony was required in any given case, then, the adherents to both rules

238. See id. As the court explained:

[The court of appeals in Hollabaugh reversed the circuit court, determining that there was not substantial evidence to support the board's decision. ...]

However, what [the appellant] fails to mention is that [immediately prior to that determination] the court in Hake noted ... that the Medical Board had failed to comply with the [Arkansas administrative law] which required that "all evidence considered by the [board] shall be reduced to writing and available for the purpose of appeal." ..."

Id.

239. This conclusion is supported by the fact that, because Finch was a legal malpractice action and therefore not subject to the requirements of the Medical Practices Act, the court upheld the board's decision even though no expert testimony was presented. See id.
attempted to give the boards all the power that the legislature intended them to have while maintaining the vitality of the defendants' rights to due process and judicial review.

Given this policy continuity, the questions addressed in each of these cases could not have been the same; the question addressed could not have been as straightforward as whether expert testimony was required in a professional licensing board disciplinary hearing. The fact that cases in the same jurisdiction were resolved differently indicates that something else must have entered into the equation, something other than the fact that the defendant faced a disciplinary action in front of a professional licensing board.

V. THE MISSING JURISDICTIONS

The existence of this 'something else' is demonstrated even more clearly by another group of cases: decisions from states that have not adopted either the majority or minority rule. Logically, the possibility that either the majority or minority rule could be a correct reflection of an absolute and correct rule of decision applicable to these cases is severely undermined by the fact that courts in a significant number of jurisdictions review professional licensing board decisions without the use of either the majority or minority rule. This Part will examine the law in these jurisdictions, first outlining the decisions of courts that consciously rejected the majority-minority dichotomy, and then the large group that has dealt with the issue without definitively addressing the issue of expert testimony. The law in these jurisdictions will be outlined to demonstrate the similarity of issues, concerns, and analysis between these independent jurisdictions and those that have more pointedly participated in the majority-minority discussion.

A. States that Acknowledged But Rejected the Majority-Minority Dichotomy

Courts in two states, Maine\(^{240}\) and Tennessee,\(^{241}\) have explicitly acknowledged the existence of the majority-minority dichotomy but avoided taking either side. Instead, the courts adopted a rule that requires evidence of the appropriate standard of care (when specific evidence of the standard of care is required), but do not revere expert testimony as any more significant than any other form of evidence. This Section will analyze the Maine court's decision to demonstrate the parameters and significance of this approach.

In \textit{Balian v. Board of Licensure in Medicine},\(^{242}\) the Supreme Judicial Court of

\(^{240}\) See \textit{Balian v. Board of Licensure in Med.}, 1999 ME 8, 722 A.2d 364 (discussed in the next Section); see also \textit{Seider v. Board of Exam'rs of Psychologists}, 2000 ME 118, 754 A.2d 986 (affirming board's holding that psychologist's violation of ethical standards constituted negligence).

\(^{241}\) See \textit{Williams v. State Dep't of Health and Env't}, 880 S.W.2d 955, 958 (Tenn. Ct. App. 1994) ("We choose to avoid this conflict in the authorities [between the majority and minority rules]. It is not necessary to resolve the conflict in this case, because at least one of the grounds on which the [board] has based its decision does not require the [board] to rely on its own-expertise."); see also \textit{Tennessee Dep't of Health v. Frisbee}, No. 01A01-9511-CH-00540, 1998 WL 4718, at **4-5 (Tenn. Ct. App. Jan. 9, 1998) (holding that board's conclusions need only include evidence of the standard of care when the charge is of a type that requires a separate finding of the standard of care).

\(^{242}\) 1999 ME 8, 722 A.2d 364.
Maine appeared to be consciously weighing in on the debate on whether expert testimony was required but ultimately reached a conclusion that avoided adopting either the majority or the minority position. In Balian, the court reviewed an administrative court’s judgment affirming the Maine Board of Licensure in Medicine’s decision to reprimand Dr. Balian. The board found that Dr. Balian engaged in ‘unprofessional conduct’ by refusing to release medical records as directed by a patient. In reaching that conclusion, the board “stated that, at the very least, the American Medical Association Code of Ethics [AMA Code of Ethics], basic principles of medical ethics and the common law require[]” a physician to either release a patient’s records or explain the procedure whereby records would be released. Notably, the board did not introduce into evidence the AMA Code of Ethics or any other code, or even reference any such code with specificity. Furthermore, the charges the board discussed and acted upon at the hearing were significantly different than those contained in the hearing notice, a fact that accentuated the significance of the lack of a clearly articulated standard of care.

However, the court did not address the question of expert testimony; instead it focused on the need for evidence of the applicable standard, generally. For all the same reasons that the Schramm court had held expert testimony was required, the Maine court held that all that was required was evidence. In fact, the court held that the board could satisfy the requirements of due process by “the simple admission in evidence of the applicable [provisions of the AMA Code of Ethics].”

As such, the Maine court focused squarely and appropriately on the core issue, evidence, and avoided the fallacious assumption that expert testimony is somehow intrinsically connected to proceedings before a professional licensing board. In so doing, it adopted a rule that provides explicitly what many of the majority

243. See generally id. The court also cited In re Schramm extensively, especially the three reasons given by the South Dakota court for requiring expert testimony. See id. ¶¶ 12-14, 722 A.2d at 367-68.
244. See id. ¶ 15, 722 A.2d at 368-69.
245. See id. ¶ 1, 722 A.2d at 365.
246. See id. ¶ 7, 722 A.2d at 366.
247. Id.
248. See id. ¶ 14, 722 A.2d at 368. The court noted that the “only evidence presented to this Court with respect to the ethics governing the release of medical records is confined to the Administrative Court’s decision that discusses—for the first time in these proceedings—excepts from the [AMA Code of Ethics] and two medical ethics treatises.” Id.
249. See id. ¶¶ 4-7, 722 A.2d at 365-66.
250. The court introduced the issue as follows: “Balian argues that the [b]oard violated his procedural due process rights by failing to reveal and introduce in evidence the standards of professional ethics he was alleged to have violated.” Id. ¶ 8, 722 A.2d at 366. Throughout the remainder of the opinion, the court discusses whether the board should have “disclos[ed] the standard” and the “absence of a clear standard.” Id. ¶¶ 12-13, 722 A.2d at 367. Finally, the court held, “[f]or these reasons, procedural due process requires that the [b]oard introduce in evidence the applicable standard of conduct against which the [b]oard will assess Balian’s conduct.” Id. ¶ 15, 722 A.2d at 368-69. In fact, the only time the word ‘expert’ is used in the entire opinion is in a parenthetical description of an analogous case as “suggesting that an agency may establish facts by expert witnesses or official notice.” Id. ¶ 15, 722 A.2d at 368 (citing Arthurs v. Board of Registration in Med., 418 N.E.2d 1236, 1244 (Mass. 1981)).
251. See id. ¶ 15, 722 A.2d at 368.
252. Id.
rule jurisdictions appear to have meant: that where the standard of care is itself a fact before a professional licensing board, the board must base its decision on evidence in the record rather than its own unannounced expertise.

B. Other States that Are Not Included in the Majority-Minority Dichotomy

Even in the broadest reading of the reach of the majority and minority rules, both rules combined only account for twenty-five jurisdictions. Although there are six states that do not appear to have addressed the issue, even indirectly, in a reported case, that still leaves eighteen jurisdictions unaccounted for in an analysis based on the majority-minority dichotomy.

These eighteen jurisdictions fall into three major categories. First, courts in fourteen jurisdictions, Alaska, the District of Columbia, Iowa, Kansas,

253. See supra notes 30-43, 112-22 and accompanying text.

254. Delaware, Hawaii, Nebraska, Rhode Island, Vermont, and Virginia appear to fall into this category. To the extent reasonably possible, the following list includes cases from these jurisdictions where a professional challenged a disciplinary action before one of the state's professional licensing boards: Bash v. Board of Medical Practice, 579 A.2d 1145 (Del. Super. Ct. 1989); Langvardt v. Horton, 581 N.W.2d 60 (Neb. 1998); Miele v. Board of Medical Licensure and Discipline, C.A. 90-1930, 1991 WL 789899 (R.I. Super. Oct. 9, 1991) (citing D’Amour v. Board of Reg. in Dentistry, 567 N.E.2d 1226, 1233 (Mass. 1991), a case that discusses the expert testimony requirement); In re Smith, 730 A.2d 605 (Vt. 1999); Braun v. Board of Dental Examiners, 702 A.2d 124 (Vt. 1997).

255. The District of Columbia is included as a potential jurisdiction for this calculation, and Maine and Tennessee are excluded because they are discussed in the preceding Section.


257. See Paulkenstein v. District of Columbia Bd. of Med., 727 A.2d 302, 308 (D.C. 1999) (upholding board's finding that acupuncturist lacked sufficient training and fraudulently used his license without discussing community standard of care or mentioning existence of expert testimony); Williamson v. District of Columbia Bd. of Dentistry, 647 A.2d 389, 394-96 (D.C. 1994) (upholding disciplinary action against dentist where board's decision was based on evidence of conduct but no expert testimony as to the applicable standard of care); see, e.g., Sherman v. Commission on Licensure to Practice the Healing Art, 407 A.2d 595 (D.C. 1979).

258. See Arora v. Iowa Bd. of Med. Exam’rs, 564 N.W.2d 4, 6-7 (Iowa 1997) (upholding findings with respect to patients 2, 3, 4, and 8 without reference to expert testimony as to the standard of care); Fisher v. Iowa Bd. of Optometry Exam’rs, 510 N.W.2d 873, 877-78 (Iowa 1994) (upholding board’s discipline of optometrist who conducted scoliosis examinations on female patients while the patients were nude from the waist up).

259. See Morra v. State Bd. of Exam’rs of Psychologists, 510 P.2d 614, 618 (Kan. 1973) (upholding disciplinary action against psychologist who made sexual advances toward two patients despite absence of expert testimony establishing the relevant standard of care); Hart v. Board of Healing Arts, 2 P.3d 797, 801-02 (Kan. Ct. App. 2000) (holding that board was qualified to evaluate evidence and extrapolate the relevant standard of care where expert testified that defendant physician’s conduct was inappropriate but expert did not specifically articulate the standard of care).
Kentucky, 260 Maryland, 261 Minnesota, 262 Montana, 263 Nevada, 264 North Dakota, 265 Oklahoma, 266 South Carolina, 267 Utah, 268 and West Virginia 269 addressed


261. See Barnett v. Maryland State Bd. of Dental Exam’rs, 444 A.2d 1013 (Md. 1982). Barnett is an interesting case because the issue was whether Dr. Barnett’s advertising was deceptive and he argued not that expert testimony was required, but rather that the evidence was deficient in the absence of testimony from patients or other members of the public. See id. at 1018-20. As such, the case demonstrates the fallacy of a pure reading of the majority rule (i.e., any hearing before a professional licensing board that involves a potential loss of the professional’s license necessarily requires expert testimony) because there are some cases where a professional could be disciplined for conduct that falls outside the scope of clinical expertise.

262. See Kollmorgen v. State Bd. of Med. Exam’rs, 416 N.W.2d 485, 488-89 (Minn. Ct. App. 1987) (upholding disciplinary action where record contained expert testimony that the physician’s conduct violated the medical standard of care but no expert testimony defining the standard of care for “unprofessional conduct” or “conduct harmful to the public”); see also In re Friedenson, 574 N.W.2d 463, 467 (Minn. Ct. App. 1998) (upholding board’s deference to patients’ testimony about whether defendant physician’s conduct was inappropriately ‘sexualized’); see, e.g., Padilla v. Minnesota State Bd. of Med. Exam’rs, 382 N.W.2d 876, 886 (Minn. Ct. App. 1986).

263. See Erickson v. State Bd. of Med. Exam’rs, 938 P.2d 625, 629 (Mont. 1997) (upholding board’s determination that physician’s conviction was for a crime involving “moral turpitude” despite absence of evidence or established standard defining “moral turpitude”).

264. See Nevada State Bd. of Dental Exam’rs v. Toogood, 628 P.2d 301, 304 ( Nev. 1981) (upholding board’s decision that dentist’s conduct was not only a violation of statutory requirements but also constituted “dishonorable and unprofessional conduct” despite absence of expert testimony defining the terms “dishonorable and professional conduct”). Generally, Nevada courts are more concerned with vagueness of the standard and prior notice than the use of expert testimony, or any other particular type of evidence, to prove the standard. See Nevada State Bd. of Nursing v. Merkley, 940 P.2d 144, 147-48 ( Nev. 1997).

265. See Larsen v. Commission on Med. Competency, 585 N.W.2d 801, 805-06 (N.D. 1998) (upholding board’s conclusion that physician’s sexual relationship with a patient constituted “sexual abuse, misconduct, or exploitation” despite lack of expert testimony regarding the definition of these terms); Gale v. North Dakota Bd. of Podiatric Med., 562 N.W.2d 878, 886-87 (N.D. 1997) (upholding board’s disciplinary action where podiatrist was charged with false and misleading advertising); Bland v. Commission on Med. Competency, 557 N.W.2d 379, 385 (N.D. 1996) (upholding board’s conclusion that physician who obtained access to bomb-making materials constituted “an imminent and substantial risk to the public”).

266. See Board of Exam’rs of Veterinary Med. v. Mohr, 485 P.2d 235, 239-40 (Okla. 1971) (upholding disciplinary action where record contained evidence of the defendant’s conduct but no evidence of the standard that the court used to determine that such conduct constituted malpractice); see also State v. Bridwell, 592 P.2d 520, 526 (Okla. 1979) (outlining the difference between basing a finding of professional incompetence on a criminal conviction instead of the conduct upon which the conviction was based); see, e.g., State ex. rel. Oklahoma State Bd. of Med. Licensure and Supervision v. Ray, 848 P.2d 46, 47-48 (Okla. Ct. App. 1992).


268. See Taylor v. Department of Commerce, State of Utah, 952 P.2d 1090, 1092-94 (Utah Ct. App. 1998) (upholding disciplinary action where record contained expert testimony about the standard of care for ‘negligence’ but no evidence defining the standard for ‘gross negligence’); see also Vance v. Fordham, 671 P.2d 124, 129 (Utah 1983) (The statute “requires the Committee to define unprofessional conduct, but in respect to patient care the Committee may do that on a case-by-case basis by drawing on ... statutory standards ... and on its own knowledge of the patient-care standards of the profession.” (citations omitted)). Like the Nevada courts, see supra note 264, the Utah courts are more concerned with vagueness of the standard
the issue implicitly by upholding a disciplinary action against a challenge to the 
sufficiency of the evidence despite the absence of expert testimony to define the 
standard of care for one or more of the charges. In other words, in all of these 
cases, the professional licensing board was allowed to determine that certain con-
duct met a given statutory standard (such as 'unprofessional' or 'immoral') without 
using expert testimony to define that standard.

Next, two states, Florida\(^270\) and New York,\(^271\) generally require expert testi-
mony, but courts in both states have, under certain circumstances, upheld disci-
plinary actions despite the absence of expert testimony. Finally, two states, Louisi-
siana\(^272\) and Mississippi,\(^273\) appear to have adopted a rule similar to Maine's, re-

and prior notice than the use of expert testimony or any other particular type of evidence. See 
Heinecke v. Department of Commerce, Div. of Occupational and Prof'l Licensing, 810 P.2d 
459, 465-66 (Utah Ct. App. 1991) ("Unprofessional conduct as it relates to the practice of nurs-
ing is admittedly a broadly phrased standard, one which may not have a ready and precise mean-
ing to those outside the profession. Such a general statutory standard is acceptable, however, for 
three reasons: (1) The subject of professional performance is too comprehensive to be codified 
in detail. (2) Members of a profession can properly be held to understand its standards of per-
formance. (3) Standards of performance will be interpreted by members of the same profession in 
the process of administrative adjudication." (citations omitted)).

the court may use expert testimony when it deems appropriate, but that the court is only required to 
provide detailed findings of fact to support its decision); see, e.g., Serian v. State ex. rel. West 
Virginia Bd. of Optometry, 297 S.E.2d 889 (W. Va. 1982).

270. See K.M.T. v. Department of Health and Rehabilitative Servs., 608 So. 2d 865, 873 & n.5 
(Fla. Dist. Ct. App. 1992) (holding that agency decision was not supported by substantial 
evidence where there was neither an 'agency rule' nor 'expert testimony' to establish the applicable 
standard of care) (citing McDonald v. Department of Prof'l Regulation, 582 So. 2d 660 (Fla. 
Dist. Ct. App. 1991), for the proposition that the standard of care for professional negligence 
must be established by expert testimony); Johnston v. Department of Prof'l Regulation, Bd. of 
Med. Exam'r's, 456 So. 2d 939, 943-44 (Fla. Dist. Ct. App. 1984) (holding that evidence of 
applicable standard of care must appear in the record and board cannot use its own expertise as 
a substitute); Robinson v. Florida Bd. of Dentistry, Dep't of Prof'l Regulation, Div. of Prof-
disqualifying board's only expert witness).

be considered substantial in cases ... which allege gross incompetence and incompetence on 
more than one occasion in the practice of dentistry, it must include sufficient expert testimony 
demonstrating that [the defendant] deviated from accepted standards of dental practice." 
Div. 1998) ("the evidence must include sufficient medical expert testimony demonstrating that the 
[defendant] deviated from accepted standards of podiatric practice" (citations omitted)); cf. 
(upholding board's disciplinary action against physician for overcharging patients for their 
insurance co-payment without evidence defining the standard of care); see also 84 N.Y. Jur. 2d 

272. See In re DiLeo, 661 So. 2d 162, 167 (La. Ct. App. 1995) (overturning board's decision 
because it was not based on evidence of the applicable standard of care, but noting that the 
standard of care could be established by "regulation or statute"); see also Holladay v. Louisiana 
State Bd. of Med. Exam'r's, 689 So. 2d 718, 723-25 (La. Ct. App. 1997) (holding that standard of 
care could be established by any appropriate evidence and that board was not strictly required to 
establish the standard of care by publishing written standards); see, e.g., Wilcox v. Louisiana 
State Bd. of Med. Exam'r's, 446 So. 2d 502 (La. Ct. App. 1984); Fisher v. Louisiana State Bd. of 

273. See Miller v. State Bd. of Pharmacy, 262 So. 2d 188, 190-91 (Miss. 1972) (reversing 
disciplinary action against pharmacist because "no statute, or rule or regulation ... established 
any standards" for the conduct that formed the basis of the board's finding); see, e.g., Missis-
quiring evidence of the standard of care but without any specific preference for expert testimony.

In deciding these cases, the courts expressed concerns about affording the defendant the right to examine and confront the evidence against him or her, and preserving the right to meaningful judicial review as the majority rule courts had. Similarly, courts within this group were influenced by the unique qualification of professional licensing boards to determine the appropriate standard of care as the minority rule states had been.

In short, the courts in these jurisdictions faced similar situations as those that adopted either the majority or minority rule: defendants challenged the substantiability of the evidence supporting a professional licensing board’s disciplinary action where there was no expert testimony to establish the applicable standard of care. The courts weighed similar policy concerns, and reached a range of conclusions that mirrors the range of outcomes in the majority and minority rule cases. The only significant difference between these cases and decisions is the fact that these courts did not attempt to characterize their rule in terms of the artificial majority-minority dichotomy.

C. The Significance of These Cases

In order to find the hidden complication, to unravel the elements of the question the majority-minority dichotomy courts were really addressing, the best place to begin is with the jurisdictions that considered similar questions but rejected the strict dichotomy approach. For example, in Balian, the Maine court sidestepped the issue of expert testimony altogether. Instead, the court focused its analysis on the requirement that there be some evidence of the standard of care, rather than any particular form of evidence.

This is an appropriate focus because, to the extent that a jurisdiction might require the board to make its decision based on evidence of not only the conduct in question but also the applicable standard of care, there is no requirement within the principles of due process that the evidence be presented in the form of expert testimony. Even in malpractice cases, expert testimony is not always necessary. Similarly, even those courts that have adopted the majority position commonly recognize that expert testimony is not required in certain circumstances. Although these jurisdictions indicate that there might be certain situations where expert testimony is strictly required, no jurisdiction has held that it is always required.

While the hearing panel could properly use its expertise to analyze and interpret evidence before it, it could not use such expertise to substitute for evidence. Petitioner was deprived of any opportunity to confront and cross-examine witnesses. Next, the hearing panel failed to make any findings of fact. This we deem essential in order to permit an intelligent challenge by the party aggrieved and to allow for adequate judicial review following the determination.

Finally, in relying on their expertise to analyze petitioner’s publication without the benefit of any expert testimony, the members of the panel were essentially relying on material outside the record.

Id. (citations omitted).

thermore, even in these cases, expert testimony is required only because the situation is such that no other evidence would likely be available.

This flexibility in the answer points to a similar flexibility in the actual question that the courts were addressing. The question was not ‘if’ expert testimony is required, but ‘when’ it is required. The question ‘when’ actually encompasses a range of preliminary and complementary questions. When is evidence of the alleged conduct alone enough to conclude that a violation has been committed? When must there be explicit evidence of the standard of care to adequately define the parameters of the statutory charge? To what extent may a board bridge the gap between an established standard of conduct, such as an ethical code, and a broader statutory charge such as gross malpractice or professional incompetence? In short, when is a board’s deliberative process properly characterized as interpreting evidence of conduct as opposed to substituting the board’s own unexpressed expertise for evidence in the record? These questions highlight the significant evidentiary issues, due process concerns, and matters of administrative procedure and efficiency implicated in this question of the requirement of expert testimony. The turbulence in the law of Ohio, North Carolina, Pennsylvania, and Arkansas, and the refusal of states such as Maine and Tennessee to accept the terms of the majority-minority dichotomy demonstrate the extent to which the dynamic interaction of these forces cannot be reduced to a simple polar rule.

VI. QUESTIONS BEFORE THE QUESTION: PRE-ANALYTIC CLASSIFICATION FACTORS

Now that it is clear that courts consider ‘something else’ in deciding when expert testimony is required, the next step is to identify and describe that ‘something else.’ This Part will refer to that ‘something else’ as “pre-analytic factors” because they do not necessarily provide the answer to the question; instead they frame the issue so that the courts may apply the legal and policy principles of the jurisdiction to arrive at the proper conclusion. In order to properly understand these ‘pre-analytic factors,’ this Part will first explain, generally, what they are and how they function. Then the specific factors will be examined.

A. What Are Pre-Analytic Factors?

If the issue before the courts is rephrased as a question of when rather than if expert testimony is required, the analytic process must also be refocused. When resolving the issue, the same primary analytic factors may be used, and the same policy values reflected; a court may still consider the purpose and qualifications of the board, the requirements of due process, and meaningful judicial review. However, in a ‘question of when’ analysis, it is necessary to engage in a process of preanalytic classification that was unnecessary in a ‘question of if’ analysis such as that which produced the majority-minority dichotomy. In a ‘question of if’ analysis, the only dispositive precondition is that the matter involved a professional licensing board disciplinary hearing. A ‘question of when’ analysis, on the other hand, recognizes that factors other than the bare characterization of the type of hearing are significant in deciding whether expert testimony is required.

These other factors, or “pre-analytic factors” answer two primary questions. First, must there be explicit evidence of the standard of care or may the board infer...
the standard of care from the evidence of the defendant’s conduct? Second, what types of evidence may be used to prove that standard of care? Courts generally consider three factors in answering these questions: the substance and nature of the charge, the rules of evidence and administrative procedure in the jurisdiction, and the actual evidence before the board.

B. The First Factor: The Charge Before the Board

The charge that the defendant faces should be the first consideration in deciding whether expert testimony is required, because the charge is the basis for linking the defendant’s conduct with the statutory authority of the board. However, the similarity of professional licensing board disciplinary hearings and malpractice actions often confuses the issue, focusing the analysis on the consequence rather than the charge. Further, even in a malpractice action, it is not the consequence that leads to a requirement of explicit evidence, it is the nature of the charge, the fact that the case involves complex and highly technical matters of medical judgment and practice.

The critical question then is what factual or legal link is required to connect the conduct and the charge. Must there be separate proof of the link between the two (i.e., a standard of care), or may the board make that connection by itself? As the Supreme Court of California observed in Franz v. Board of Medical Quality Assurance:

> Some questions concerning medical negligence require no expertise. Technical knowledge is not requisite to conclude that complications from a simple injection, a surgical clamp left in the patient’s body, or a shoulder injury from an appendectomy indicate negligence. Common sense is enough to make that evaluation. Only where the professional significance of underlying facts seems beyond lay comprehension must the basis for the technical findings be shown and an opportunity for rebuttal given.

Explicit evidence of the standard of care is required, when it is required, to explain the ‘professional significance’ of the ‘underlying facts’ of the case.

Determining whether the board is qualified to assess the professional significance of the facts of the case on its own implicates the legally difficult distinction between fact and inference. The Massachusetts court, in Arthurs v. Board of

276. 642 P.2d 792 (Cal. 1982).
277. Id. at 800 (emphasis added) (citations omitted).
278. The Connecticut Supreme Court described the difficulty of the issue in Levinson v. Connecticut Board of Chiropractic Examiners, 560 A.2d 403 (Conn. 1989), where it observed, [I]n administrative adjudication, official notice is frequently confused with the process of decision-making. In reaching a conclusion, the examiner or agency may rely on its special skills, whether they include particular expertise in engineering, economics, medicine, or electricity, just as a judge may freely use his legal skills in reading statutes and applying decided cases in the preparation of his opinion. But such evaluations are not within the concept of official notice. Official notice is concerned with the process of proof, not with the evaluation of evidence. The difference between an administrative tribunal’s use of non-record information included in its expert knowledge, as a substitute for evidence or notice, and its application of its background in evaluating and drawing conclusions from the evidence that is in the record, is primarily a difference of degree rather than of kind. In principle, reliance upon the examiner’s knowledge in the process of proof is permissible only within the confines
Registration in Medicine,\textsuperscript{279} attempted to distinguish between facts that needed to be proven by explicit evidence and inferences that the board was allowed to draw based on other evidence and its own expertise by concluding that “[d]eterminations as to the effect of conduct is essentially a matter of drawing inferences, and an agency’s conclusions based on inferences will not be set aside by a reviewing court unless they are unreasonable.”\textsuperscript{280}

In the end, this question is the critical question behind the entire debate about the necessity of expert testimony. If there is no separate standard of care, or if that standard of care may be inferred by the board based on the evidence of the defendant’s conduct, then there is no need for expert testimony or any other explicit evidence of that standard of care. These things will depend on the composition and qualifications of the board, but also on the nature of the charge and the amount and type of other evidence before the board.

1. The Charge Sets the Stage

In order to answer this critical question, the charge provides the first and primary guidance as to whether explicit evidence of the standard of care is necessary to link the alleged conduct and the allegedly violated statutory provision. For example, in Arthurs, the court analyzed one of the board’s holdings as follows:

The findings that prescriptions for controlled substances were not recorded, or were recorded on the wrong patient card, as well as the findings as to the quantity of drugs prescribed at short intervals to patients in excess of Arthurs’s specific directions to take one tablet daily, all support the board’s conclusion that Arthurs prescribed controlled substances for other than a legitimate medical purpose.

... .

Our review of these findings does not require the use of specialized knowledge. It requires only an examination of the board’s findings as to the dosage and frequency of Arthurs’s prescriptions, the prescriptions Arthurs failed to record on his patient cards, and a review of the testimony concerning Arthurs’s prescribing of controlled substances to [the patients]. We view these as matters of common experience and common sense, not technical expertise.\textsuperscript{281}

The most significant issue for a reviewing court is that it be able to follow the logical line connecting the conduct with the statutory prohibition. When the statutory language fails to explicitly define the type of conduct that fits within its parameters, such as ‘gross malpractice’ or ‘unprofessional conduct,’ the fact finder must provide a functional definition that connects the conduct to the charge.

Expert testimony or other explicit evidence of the standard of care is one way to provide such a functional definition. However, as the Connecticut Supreme

\textsuperscript{279} Id. at 415 (citing E. Gellhorn, Rules of Evidence and Official Notice in Formal Administrative Hearings, 1971 DUKE L.J. 1, 43 (1971)).

\textsuperscript{280} Id. at 1244-45.

\textsuperscript{281} Id. at 1243-44 & n.22.
Court explained in *Jaffe* that:

[with the facts of that conduct before it, [a] board [is] competent to determine such questions without hearing expert opinion evidence. It is true that where, in cases tried in court, an issue presented is such that its solution can only be reached upon the basis of the special knowledge of expert witnesses, such evidence must be produced. That rule, however, supports rather than contravenes our conclusion in this case because it is based on the fact that such a question goes beyond the field of the ordinary knowledge and experience of judges or jurors and this is illustrated by our decisions holding that where an issue can be determined by the application of such knowledge expert testimony is not required. So in this case, as we must presume the members of the board to have been competent to determine the issues upon the basis of their own knowledge and experience, the offer of expert testimony was not necessary.]^{282}

As such, whether expert testimony is required must be a function of not only the makeup of the board, but also the question presented. Professional licensing boards are empowered to bring a wide range of different charges, to enjoin a variety of different types of misconduct.^{283} Consequently, regardless of the potential conse-

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283. For example, in *Tennessee Department of Health v. Frisbee*, No. 01A01-9511-CH-00540, 1998 WL 4718 (Tenn. Ct. App. Jan. 9, 1998), a Tennessee court addressed the question of the range of charges available to the board as follows:

We now turn to the applicable standards of care in disciplinary proceedings involving physicians. [Tennessee law] contains twenty grounds for disciplining physicians, but not all these grounds require proof of any particular standard of care. Thirteen disciplinary grounds require only proof of specific inappropriate conduct, two grounds are general catchall provisions, and five grounds require some consideration of professional practice standards. No statute requires the use of the same standard of care for all of the latter five grounds. In fact, there is no statutory direction of any sort concerning the standard of care applicable to any of these grounds.

Only one of the five disciplinary grounds requiring some consideration of professional practice standards refers specifically to "malpractice." [Tennessee law] authorizes the Board of Medical Examiners to discipline a physician for "gross malpractice, or a pattern of continued or repeated malpractice, ignorance, negligence, or incompetence in the course of medical practice." The nature of the proof required to support a charge under this section is at the heart of the present dispute.

*Id.* at *4. The disciplinary grounds in the first group include: acts of fraud and deceit, see Tenn. Code Ann. § 63-6-214(b)(3) (1997); habitual intoxication or misuse of intoxicants, see id. § 63-6-214(b)(5); violation of the abortion statutes, see id. § 63-6-214(b)(6); false advertising or failure to comply with advertising regulations, see id. § 63-6-214(b)(8) & (9); felony convictions or any conviction involving illegal drugs or moral turpitude, see id. § 63-6-214(b)(10); signing false certificates, see id. § 63-6-214(b)(11); illegally dispensing or prescribing controlled substances, see id. § 63-6-214(b)(14); use of secret cures or methods, see id. § 63-6-214(b)(15); giving or receiving rebates, see id. § 63-6-214(b)(16); practicing under a false or assumed name, see id. § 63-6-214(b)(17); mental or physical incapacity, see id. § 63-6-214(b)(18); and the use of radiation in specific circumstances without informed consent, see id. § 63-6-214(b)(19). The disciplinary grounds the court referenced in the second group include: violations or attempted violations of statutes, board orders, or criminal statutes, see id. § 63-6-214(b)(2); and disciplinary actions by other governmental entities for conduct that constitute grounds for discipline in this state, see *id.* § 63-6-214(b)(20). The final group includes the following charges: unprofessional, dishonorable, or unethical conduct, see id. § 63-6-214(b)(1); gross malpractice or a pattern of continued or repeated acts of malpractice, see id. § 63-6-214(b)(4); willfully betraying a professional secret, see id. § 63-6-214(b)(7); and dispensing, prescribing, or distributing controlled substances contrary to professional practice or without making a bona fide effort to cure an addicted patient's habit, see id. § 63-6-214(b)(12) & (13).
quence of the professional licensing board disciplinary hearing, the nature and content of the hearing can be significantly different depending on the particular charge.

The Supreme Court of South Dakota’s decision in *In re Schramm* provides a good example of a court’s conscious disregard but unconscious acknowledgment of the significance of the charge involved. In the opinion’s conclusion, the court summarized its decision as follows:

> It has been settled law … for some time that for a plaintiff to recover even nominal damages in a malpractice case, expert testimony is [required, except in cases that meet certain obvious exceptions]. Logic and due process dictate that if this requirement is to be met for the recovery of a dollar in damages … it should also apply where [one] faces the possibility of a permanent loss of … position and livelihood.

However, in the body of the opinion, where the court actually announced its holding, its language was considerably narrower. The court held that “where the issues of competence and negligence are of a complicated nature, expert testimony is required to establish the proper ‘competency standards’ and whether or not they are met.” Immediately thereafter, the court acknowledged that “[t]his holding has obvious well-recognized exceptions” including cases where facts were judicially noticed, patently obvious, or admitted by the defendant. What the court did not recognize, however, was the possibility that a professional licensing board might bring charges that did not implicate a complicated, clinical ‘standard of care’ or even any standard of care at all.

The *Schramm* court missed this because of its focus on the consequence, the loss of license, and not the charge itself. Although the specific and limited language of the actual holding recognizes the significance of the specific charge involved in this case, the court’s later simplified announcement of the rule of the case undermines this subtlety. Concerns about the severity of the consequence of a professional licensing board disciplinary hearing may affect the degree of scrutiny applied to the board’s decision, but they do not provide the basis for a strict requirement of expert testimony. When expert testimony is required, it is so required because it is a necessary step in the process of linking the defendant’s conduct with the charge alleged.

### 2. The Significance of the Law of the Jurisdiction

A second factor related to the charge that affects whether explicit evidence of the standard of care is required is the statutory scheme in the jurisdiction. The last Section described the significance of the standard of care and how a court can decide whether explicit evidence of the standard of care is necessary. This Section, on the other hand, begins to examine how the law of the jurisdiction could give the standard of care some definition before a disciplinary hearing even begins.

For example, in some jurisdictions, malpractice and a charge before a professional licensing board are so similar that courts presume that the malpractice ex-

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284. See discussion of *In re Schramm* supra at Part III.A.2.a.
286. *Id.* at 36.
287. *Id.* at 37.
pert testimony requirement should also apply to a board hearing. In others, courts are unwilling to analogize the two as closely. In \textit{Spray v. Board of Medical Examiners}, an Oregon intermediate appellate court overturned a decision of the board where the board relied on the malpractice statute to provide the standard of care. Without the malpractice statute, the board’s decision did not contain evidence of the applicable standard of care.

Additionally, in some states, professional licensing boards are statutorily authorized to define certain charges by reference to established national ethical or other codes. Furthermore, although most states allow a board to find that a criminal conviction is a violation of the standard of care, some states refuse to allow a board to use a criminal prohibition against certain conduct to define the standard of care. Thus, in addition to establishing the basis for the board’s

\begin{itemize}
\item See id.
\item See id. at 133. The court described Oregon’s relevant statutory provisions as follows:
\begin{quote}
In Oregon, the practice of medicine is governed by ORS ch. 677. The statutory basis for the suspension or revocation of a physician’s license is ORS 677.190, which provides, in pertinent part,
\begin{quote}
"The board may suspend or revoke a license to practice medicine in this state for any of the following reasons:
\begin{enumerate}
\item Unprofessional or dishonorable conduct.
\item (19) Willfully violating any provision of this chapter or any rule promulgated by the board."
\end{enumerate}
\end{quote}
\end{quote}
\item ORS 677.188(4) defines “unprofessional or dishonorable conduct:”
\begin{quote}
“(4) ‘Unprofessional or dishonorable conduct’ means conduct unbecoming a person licensed to practice medicine, or detrimental to the best interest of the public, and includes:
\begin{enumerate}
\item Any conduct or practice contrary to recognized standards of ethics of the medical profession or any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public or any conduct, practice or condition which does or might impair a physician’s ability safely and skillfully to practice medicine;
\item Wilful performance of any surgical or medical treatment which is contrary to acceptable medical standards; and
\item Wilful and consistent utilization of medical service or treatment which is or may be considered inappropriate or unnecessary."
\end{enumerate}
\end{quote}
\end{itemize}

One further statutory provision is relevant to our inquiry. ORS 667.095 provides that:
\begin{quote}
"A physician licensed to practice medicine by the Board of Medical Examiners for the State of Oregon has the duty to use that degree of care, skill and diligence which is used by ordinarily careful physicians in the same or similar circumstances in his or a similar community."
\end{quote}

We note that this statute does not purport to be a separate ground for suspension or revocation of a medical license. \textit{Id.} at 129-30 (citing Or. REV. STAT. 677.095, 677.190, 677.188(4)).

\item See id. at 131.
\item See Balian v. Board of Licensure in Med., 1999 ME 8, ¶ 7, 722 A.2d 364, 366.
\item For example, in \textit{McKay v. State Board of Medical Examiners}, 86 P.2d 232 (Colo. 1938), the court analyzed the issue as follows:
\begin{quote}
We have held that a conviction in the United States court for the sale of morphine to an habitual user thereof for other than medicinal purposes is a conviction of a crime involving moral turpitude and warrants revocation of the physician’s license. But that matter is not in issue here for it is not charged that McKay has even been so convicted.
\end{quote}
authority to bring charges and providing the explicit definition of those charges, the jurisdiction’s statutory structure may also play a significant role in determining whether explicit evidence of the standard of care is required to give the bare language of the charge practical effect.

3. Type of Charge

Although there is no clear rule that may be used to decide which types of charges would require explicit evidence of the standard of care, there are categories of charges that are more or less likely to require it. For example, in *Gonzales v. New Mexico Board of Chiropractic Examiners*\(^{294}\) the court overturned a board finding that involved the appropriateness of Dr. Gonzales’s diagnostic and clinical methods because of a lack of either expert testimony or other evidence of the appropriate standard of care.\(^{295}\) However, the court upheld a finding that Dr. Gonzales had treated patients in an improperly equipped environment despite a similar lack of evidence.\(^{296}\) The court also upheld the board’s finding that Dr. Gonzales treated the patient without proper consent, even though such a practice was not explicitly

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It is charged that he was guilty of “grossly negligent or ignorant malpractice” and of “immoral, unprofessional or dishonorable conduct.” The board evidently proceeded on the assumption that it was sufficient if it found from evidence before it that there was a violation of the federal narcotic laws by McKay and that because a conviction of such violation in a court of competent jurisdiction carries with it the inference of moral turpitude as a matter of law, their finding of such violation has a similar effect. Such an assumption is erroneous. The board in a proceeding of this kind, until a conviction is shown, has no concern with the provisions of the Harrison Narcotic Law nor with the commissioner’s regulations made pursuant to it. It is not vested with jurisdiction to try alleged offenders for its violation and may not make its own finding of such violation and predicate either malpractice or immoral, unprofessional or dishonorable conduct on the fact of such violation which it finds. It does not follow that acts that are inhibited by the Harrison Narcotic Act may not be proper for the board’s consideration where there has been no conviction, but where such acts are proven and relied upon as malpractice or immoral, unprofessional or dishonorable conduct, it must appear from competent evidence that they are acts of such character without regard to the violation of a law that inhibits them and without regard to whether there is any law that makes the doing of them an offense.

*Id.* at 235 (citations omitted).

294. 962 P2d 1253 (N.M. 1998).

295. *See id.* at 1259. The court concluded that, “[t]here is no evidence in the record from which the [b]oard, using its expertise, could infer a violation of the standard of care with respect to these acts by Dr. Gonzales. Therefore, taking the evidence as a whole, we conclude that [this finding] is not supported by substantial evidence.” *Id.*

296. *See id.* The court explained:

We also conclude that the [b]oard acted properly in concluding that Dr. Gonzales engaged in conduct unbecoming a licensed chiropractor and conduct detrimental to the best interests of the public. Dr. Gonzales did not dispute that he treated [the patient in question] at his home. We believe it is within the professional expertise of the [b]oard to decide whether the lack of proper equipment, support, and supervision in a non-clinical setting causes this conduct to be inappropriate and “unbecoming a person licensed to practice chiropractic or detrimental to the best interests of the public.” We believe such matters, involving the manner in which chiropractic treatment is to be dispensed, are largely within the discretion of the [b]oard, subject to a general requirement of reasonableness.

*Id.* at 1260 (citations omitted).
prohibited. In this case, the court required evidence of the standard of care for clinical issues, but deferred to the board's expertise when the alleged violation concerned the "manner in which ... treatment [was] dispensed." 

Similarly, in Medical Licensing Board v. Ward, the court upheld the board's finding that Dr. Ward had engaged in "willful or wanton misconduct in the practice of medicine" by massaging the genitalia of several patients, despite the lack of expert testimony as to the standard of care. The court reasoned that "deciding whether a party is guilty of willful or wanton misconduct is a function of the trier of fact." However, the court then cautioned that "[t]his conclusion is not to intimate that expert testimony is never required in hearings of this nature. Where a question of medical diagnosis or treatment is crucial to the [b]oard's ultimate decision, expert testimony is vital." 

These are but two examples of the distinction courts draw between types of charges. Although there is no clear standard against which any particular charge may be definitively measured, as a general rule the more clinical and complex a case is, the more likely it is that a court will require explicit evidence of the standard of care. On the other hand, if a charge involves patently obvious violations of the standard of care, such as a criminal conviction or conduct that constitutes an established tort, or when the charge involves the mode of delivering care, such as billing irregularities or maintenance of the proper clinical setting, then a court is more likely to defer to the board and its authority to establish standards for the profession.

C. The Second Factor: Rules of Evidence

If explicit evidence of the standard of care is required, then the next consideration is what information constitutes the record for review according to the rules of evidence and appellate review in the jurisdiction. If the record for review is limited to evidence explicitly offered into the record, and thus the board's deliberations are not available to the reviewing court, then a court will have greater difficulty concluding that the board's decision was supported by substantial evidence. If, on the other hand, the reviewing court can consider the transcript of the board's deliberations or other less formal forms of 'evidence' then there is less reason to require explicit evidence of the standard in the form of expert testimony. If a court can review the inferences and conclusions drawn by the board as to the standard of care, and the stated bases for those conclusions then it will be able to conduct a sufficient judicial review of the board's decision.

D. The Third Factor: The Evidence that is Actually Offered

In addition to the general rules of evidence, the actual evidence offered in the case also plays an important role in determining whether the board must base its decisions on this evidence.
decision on explicit evidence of the standard of care. As discussed above, courts in North Carolina, Ohio, and Pennsylvania have decided cases differently depending on whether the defendant presented affirmative testimony showing that his or her conduct was not a violation of the standard of care. Similarly, in *Smith v. Department of Registration and Education*, the Supreme Court of Illinois held that the board’s decision was unsupported by substantial evidence where the defendant produced evidence, in the form of his own testimony, that his treatment of the patient in question was medically appropriate. The board’s charges against Dr. Smith effectively accused him of being a quack for selling useless treatments. Due in large part to the substance of Dr. Smith’s testimony, however, the court concluded that the charges were more appropriately viewed as differences of clinical opinion. Consequently, the court held that, absent expert testimony, the board’s findings were not sustainable.

Generally then, whether explicit evidence of the standard of care is required will also depend on the nature and quality of the evidence that was actually introduced at the hearing. Where the defendant offers evidence that he or she did not violate the standard of care, even minority rule courts have been unwilling to allow the board to reach a contrary conclusion based solely on their own expertise. This may be so because courts, even those that allow boards wide latitude to use their expertise, are reluctant to view a decision as supported by substantial evidence if there is evidence to the contrary and none in support in the record before it. In this sense, even when courts say that expert testimony is not required because the court will defer to the board’s expertise, what they are really saying is that there is effectively a rebuttable presumption of board competence. That presumption will not stand, however, when opposed by uncontradicted evidence that the defendant’s conduct was within the range of acceptable practice.

VII. Conclusion: The Long Question and the Long Answer

The courts that have addressed the issue of expert testimony in professional licensing board disciplinary hearings have universally described the issue as a question of *if* expert testimony was required. However, they have addressed the issue itself in their legal analysis and functional conclusions as a question of *when* it is required. No jurisdiction has held that it is always required, and none has held that it is never required. Although some have been stronger in their support of it than others, that difference can be largely explained by the facts of the cases that the courts decided when they announced their rules. Jurisdictions that have addressed the issue on multiple occasions have tended to modify their rules, soften them, in recognition of the reality that different cases present different concerns as to due process and the substantiality of the weight of the evidence.

Consequently, the existence of the distinct majority and minority rules that are so regularly touted by courts that analyze this issue is less a function of actual

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303. See discussion *supra* Parts IV.A-C.
304. 106 N.E.2d 722 (Ill. 1952).
305. See *id.* at 728-29.
306. See *id.* at 728.
307. See *id.* at 729.
308. See *id.* at 730.
divergence among the various jurisdictions than of the fact that those who have attempted to synthesize the law in this area have asked the wrong question while answering the right one. One cannot properly answer the question “is expert testimony required,” because the only true answer is “sometimes.” If, instead, the question asked is “when is expert testimony required,” then a more useful and accurate answer emerges.

In order to answer this question, a court must consider two preliminary questions. First, do the facts of the case, including the charge alleged, the competence of the board, the evidence before the board, and other factors specific to the jurisdiction, require explicit evidence of the standard of care. Is the situation one where the board is qualified to consider the evidence of the defendant’s conduct and decide whether it meets the terms of the statute that defines the charge? If the board is qualified to do that, to assess the ‘professional significance of the underlying facts,’ then expert testimony is not required.

If the board is not qualified to make such an assessment, or if such an assessment could not be sufficiently documented to allow proper judicial review of the board’s decision, then the board must base its decision on evidence of the standard of care. Even at this point, however, expert testimony is not necessarily required. Evidence of the appropriate standard of care may come in the form of a statutorily imposed duty, by stipulation, or from another form such as an established national code of ethics or conduct. Only if such evidence is unavailable or insufficient is expert testimony required.

As such, expert testimony does not have the talismanic effect often attributed to it by those courts and defendants that argue for its requirement. Expert testimony is not important in its own right, it is important because of what it represents: explicit evidence of the applicable standard of care. Expert testimony can only be required when such explicit evidence is also required, when the standard of care is deemed an independent fact that must be proven with explicit evidence. Even then, expert testimony is only required when other means of providing such explicit evidence are not available.

In reality there is no split between the states, no majority-minority dichotomy. The seeming divergence of the purported majority-minority split is a consequence of the fact that courts have been answering a different question than the one they were asking. This question-answer dissonance has led them to mischaracterize not only their own answers but those of other courts as well. The question, properly framed is: “When is expert testimony required?” The answer given by all of the courts that have addressed the issue is: “Sometimes, always and exactly sometimes.” In other words, this question cannot be answered in a short statement, as attempted by the majority-minority dichotomy. It can, however, be answered with a long statement, a paragraph perhaps, that better accommodates the actual answers given by nearly all of those courts that have addressed the question.

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