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The Care Required of Medical Practitioners

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THE CARE REQUIRED OF MEDICAL PRACTITIONERS*

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> I swear by Apollo, the Physician, and Asclepius and Health and Panacea, and all the gods and godesses, that, according to my ability and judgment, I will keep this Oath and this stipulation—. . . I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; . . . I will not cut persons laboring under the stone but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption. . . .—*Oath of Hippocrates.*

These words, allegedly formulated by the "Father of Medicine," define the duties which physicians and surgeons over the years have sworn to perform toward those whom they undertake to treat. Like many oaths, however, the noble sentiments of the Greek physician are not sufficient to provide protection for the public. This is evidenced by the fact that over the twenty year period from 1935 to 1955, according to a survey made by the American Medical Association, some 605 decisions of appellate courts in the United States dealt with "malpractice" by medical practitioners[1] and by the further estimates that within a single year thousands of malpractice actions are commenced.[2] Certainly not all of these actions represent meritorious claims, but a substantial portion do represent a failure on the part of the medical practitioners to "abstain from whatever is deleterious and mischievous" or a failure to use proper care in the treatment of their patients.

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1. See Sandor, *The History of Professional Liability Suits in the United States,* 163 J.A.M.A. 459 (1957); Stetler, *The History of Reported Medical Professional Liability Cases,* 30 TEMP. L.Q. 366 (1957). This survey was limited to defendants who were licensed doctors of medicine as distinguished from those who were involved in related practices such as dentistry, osteopathy, chiropractic, etc. The classification of cases by the American Digest System and the Annotated Reports under "Physicians and Surgeons" does not make a differentiation.

2. REGAN, DOCTOR AND PATIENT AND THE LAW 521 (3d ed. 1956); Silverman, Medicine's Legal Nightmare, Part One, The Saturday Evening Post, April 11, 1959. p. 13, 14.

The professional liability of the medical practitioner is almost as old as personal injury actions. The first recorded case in Anglo-American law goes back to the year 1374 when one J. Mort, surgeon, undertook to treat a wounded hand and allegedly acted in such a negligent manner as to maim the hand.[3] While the action against the surgeon was dismissed because it was brought in "trespas sur son case" rather than in trespass vi et armis, the court indicated that if the surgeon had done as well as he was able and had employed all his diligence in administering to the patient, "it is not right that he should be held culpable," reflecting the standard of care suggested by the Hippocratic Oath. Much of the early development of professional liability of physicians and surgeons appears to have been in terms of a "contractual" undertaking of one in a "common calling"[4] to exercise his calling with the skill commonly possessed by those engaged in it.[5] The court in *Slater v. Baker*[6] held the surgeon liable for ignorance and lack of skill, while the appellate court in *Seare v. Prentice*[7] relied heavily upon the statements of Blackstone as to the implied contract of "every one who undertakes any office, employment, trust or duty . . . to perform it with integrity, diligence and skill. And if by his want of either of these qualities any injury accrues to individuals, they have therefor their remedy in damages . . . ."[8] Similarly, the earliest reported American case on professional liability of doctors, *Cross v. Guthery*,[9] held sufficient a complaint alleging that the defendant, having held himself out as a practicing physician skilled in surgery, had undertaken to perform a mastectomy (removal of a breast) on the plaintiff's wife "with skill and safety" and that said defendant "performed such operation in the most unskilful, ignorant and cruel manner, contrary to all the well known rules and principles of practice in such cases." Somewhat later the Pennsylvania court stated that the obligation of the physician was "to treat the case with diligence and skill . . . such reasonable skill and diligence as are ordinarily exercised in his profession . . . such as thoroughly educated surgeons ordinarily employ";[10] while the New

3. Y.B. Hill. 48 Edw III, f. 6, pl. 11 (1374).
4. See Ames, *The History of Assumpsit*, 2 HARV. L. REV. 1, 2 (1888); Arterburn, *The Origin and First Test of Public Callings*, 75 U. PA. L. REV. 411 (1927); Winfield, *The History of Negligence in the Law of Torts*, 42 L.Q. REV. 184, 187 (1926).
5. For discussion of the early English and American cases, see Sandor, *The History of Professional Liability Suits in the United States*, 163 J.A.M.A. 459 (1957). Some earlier history of professional liability is to be found in 3 BELLI, MODERN TRIALS 1975-1977 (1954); Arthur, *Some Liabilities of the Physician in the Use of Drugs*, 17 ROCKY MT. L. REV. 131, 131-32 (1945).
6. 2 Wils. 359, 95 Eng. Rep. 860 (K.B. 1767).
7. 8 East 348, 103 Eng. Rep. 376 (K.B. 1807).
8. 3 Blk. Comm. *163.
9. 2 Root 90 (Conn. 1794).
10. McCandless v. McWha, 22 Pa. (10 Harris) 261, 267-68 (1853).

Hampshire court stated the undertaking of the physician or surgeon to be:

> 1. That he possesses that reasonable degree of learning, skill and experience which is ordinarily possessed by the professors of the same art or science, and which is ordinarily regarded by the community, and by those conversant with that employment, as necessary and sufficient to qualify him to engage in such business. . . .
> 2. [T]hat he will use reasonable and ordinary care and diligence in the exertion of his skill and the application of his knowledge, to accomplish the purpose for which he is employed. He does not undertake for extraordinary care or extraordinary diligence, any more than he does for uncommon skill. . . .
> 3. In stipulating to exert his skill, and apply his diligence and care, the medical or other professional men contract to use their best judgment. . . .[11]

These decisions, of course, antedated any fully developed theory of negligence as a separate basis for action. Although more recent decisions have not entirely abandoned the view that the physician-patient relation is a contractual one to which certain implied undertakings attach, the emphasis today is far less on contract and far more upon the law of negligence as a basis for liability.[12]

Putting aside the problems of express agreements to cure or to undertake other particular obligations[13] and the characterization of unauthorized medical treatment or operation as an assault and battery,[14] what follows is an examination of the law of "medical negli-

11. Leighton v. Sargent, 27 N.H. 460, 469-72 (1853). See also a later opinion in the same case in which the court says, "The fact essential to be proved was, that he was as skillful as surgeons generally in the section of the country in which he practiced, or, in other language, that his skill was equal to the ordinary skill of the members of the profession in practice." 31 N.H. 119 (1855).

12. See, *e.g.*, Yeager v. Dunnavan, 26 Wash. 2d 559, 174 P.2d 755 (1946). See also REGAN, DOCTOR AND PATIENT AND THE LAW, 17, 29-30 (3d ed. 1956).

13. While it is generally accepted that a doctor does not promise or undertake to accomplish an absolute cure when he undertakes to treat a patient, Watterson v. Conwell, 258 Ala. 180, 61 So. 2d 690 (1952); Meyer v. St. Paul-Mercury Indemnity Co., 61 So. 2d 901 (La. App. 1952), *aff'd*, 225 La. 618, 73 So. 2d 781 (1953); Evangelista v. Black, 97 Ohio App. 390, 126 N.E.2d 71 (1953); McPeak v. Vanderbilt University Hospital, 33 Tenn. App. 76, 229 S.W.2d 150 (1950), a breach of a specific undertaking to cure is actionable, *e.g.*, Hedin v. Minneapolis Med. & Surg. Inst., 62 Minn. 146, 64 N.W. 158 (1895) (deceit action); Hawkins v. McGee, 84 N.H. 114, 146 Atl. 641 (1929) (contract action); Robins v. Finestone, 308 N.Y. 543, 127 N.E.2d 330 (1955); Colvin v. Smith, 276 App. Div. 9, 92 N.Y.S.2d 794 (3d Dep't 1949), and a patient may recover for failure to perform a promised Caesarean section, Stewart v. Rudner, 349 Mich. 459, 84 N.W.2d 816 (1957), or for breach of warranty of safety of therapy, Johnston v. Rodis, 251 F.2d 917 (D.C. Cir. 1958). As yet, however, there appear to have been no recoveries by patients for breach of a contract to sterilize, largely on the ground that no actionable harm has resulted when an unwanted child is born. See Christensen v. Thornby, 192 Minn. 123, 255 N.W. 620 (1934); Shaheen v. Knight, 6 Lycoming 19, 11 Pa. D. & C.2d 41 (1957).

14. Discussions of the law relating to unauthorized operations and their treatment as "assault" are found in REGAN, DOCTOR AND PATIENT AND THE LAW,

gence." Even within such limitations, the topic is sufficiently broad to provide the basis for an entire book, as evidenced by the recent publication of Lord Nathan's study by this name of medical malpractice in Great Britain.[15] Here I have undertaken to compare the general principle of negligence with the specific problem of the liability of the medical practitioner in terms of the definition of the standard of conduct required of the medical practitioner and the nature of proof required to establish a deviation from that standard. The citation of cases is largely illustrative.[16] While reference is made

ch. 11 (3d ed. 1956); McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381 (1957); Smith, *Antecedent Grounds of Liability in the Practice of Surgery*, 14 ROCKY MT. L. REV. 233 (1942); Wasmuth, *Consent to Surgical Procedures*, 6 CLEV.-MAR. L. REV. 235 (1957); Notes, *Civil Liability of Physicians and Surgeons for Malpractice*, 35 MINN. L. REV. 186 (1951); *Consent as a Prerequisite to a Surgical Operation*, 14 U. CINC. L. REV. 161 (1940); *Surgery Without the Patient's Consent—A New Test for Liability*, 4 U.C.L.A.L. REV. 627 (1957); Annot., 56 A.L.R.2d 695 (1957).

15. NATHAN, MEDICAL NEGLIGENCE (1957).

16. The reader seeking a more exhaustive citation of cases from most jurisdictions would do well to consult REGAN, *op. cit. supra* note 14, particularly chapters 1, 2, 3, 8, 11 and 19 or the following annotations in the *American Law Reports, Annotated* and supplements thereto (arranged by subject matter):

Specific types of malpractice: Liability to patient for results of medical or surgical treatment by one not licensed as required by law, 44 A.L.R. 1418 (1926), supplemented, 57 A.L.R. 978 (1928); Liability of surgeon leaving sponge or other foreign matter in incision, 65 A.L.R. 1023 (1930); Liability for malpractice as effected by failure to take or advise the taking of an x-ray picture after operation, or resort to other means of determining advisability of a supplementary operation or special treatment, 115 A.L.R. 298 (1938); Duty of physician or surgeon to advise patient of the possibility or probability of better results from treatment by a specialist or by a mode of treatment which he is not qualified to give, 132 A.L.R. 392 (1941); Duty and liability of physician or surgeon in pregnancy or childbirth cases, 141 A.L.R. 111 (1942); Malpractice: Diagnosis and treatment of brain injuries, diseases or conditions, 29 A.L.R.2d 501 (1953); Liability for injury by x-ray, 41 A.L.R.2d 329 (1955); Malpractice as to treatment of skin disease, disorder, blemish or scar, 45 A.L.R.2d 1271 (1956); Malpractice: Treatment of fractures or dislocation, 54 A.L.R.2d 200 (1957); Malpractice: diagnosis of fracture or dislocation, 54 A.L.R.2d 273 (1957); Malpractice in diagnosis and treatment of cancer, 55 A.L.R.2d 461 (1957); Liability of physician or surgeon for extending operation or treatment beyond that expressly authorized, 56 A.L.R.2d 695 (1957); Malpractice in nose and throat treatment and surgery, 58 A.L.R.2d 216 (1958); Liability for injury or death from blood transfusions, 59 A.L.R.2d 768 (1958).

Proof in malpractice actions: Competency of physician or surgeon of school of practice other than that to which defendant belongs to testify in malpractice case, 78 A.L.R. 697 (1932); Necessity of expert evidence to support an action for malpractice against a physician or surgeon, 141 A.L.R. 5 (1942); Presumption or inference of negligence in malpractice cases: res ipsa loquitur, 162, A.L.R. 1265 (1946).

Other elements of malpractice cases: Proximate cause in malpractice actions, 13 A.L.R.2d 11 (1950); Contributory negligence and assumption of risk as defense in action against physician or surgeon for malpractice, 50 A.L.R.2d 1043 (1956).

Vicarious Liability: Responsibility of physician or surgeon for acts or negligence of substitutes, 4 A.L.R. 191 (1919); Responsibility of one physician or surgeon for malpractice of another, 46 A.L.R. 1454 (1927); Liability of operating surgeon for negligence or lack of skill of nurse assisting him, 60 A.L.R. 147 (1929).

to the practice of persons other than doctors of medicine, it is with the liability of the latter that I am chiefly concerned. The problem of the liability of hospitals, as contrasted with members of the staff, is not considered separately.

THE EXISTENCE OF A DUTY

Before examining in detail the nature of the care which a doctor is required to use, attention may appropriately be focused upon the question of when the doctor is required to use any care or to render any professional service. Perhaps the classic example of non-negligent and non-actionable omission to act is that of the doctor who is called upon to treat an ill person and who responds with a refusal to exert his skill at all. In this country the first case to clearly state this proposition appears to have been *Hurley v. Eddingfield*[17] in 1901, although Wharton writing in the 1870's had stated that no question could exist as to the legal right of a physician to decline to render service unless he were an officer of the government charged with the specific duty towards members of the public.[18] Subsequent cases have sustained this conclusion.[19]

While some authorities have discerned an increasing tendency on the part of courts to impose an affirmative duty to act where a relation such as master-servant or owner-invitee is present,[20] the trend has not as yet reached the point where a physician by undertaking to practice medicine generally is held to have subjected himself to an obligation to provide service for all who come to his door.[21] Indeed,

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Liability of other "medical practitioners": Duty and liability of dentists to patient, 69 A.L.R. 1142 (1930), supplemented, 129 A.L.R. 101 (1940); Liability of drugless practitioner or healer for malpractice, 19 A.L.R.2d 1188 (1951); Nurse's liability for her own negligence or malpractice, 51 A.L.R.2d 970 (1957); Malpractice; duty and liability of anesthetist, 53 A.L.R.2d 142 (1957). *Failure to act:* Liability of physician for lack of deligence in attending patient, 57 A.L.R.2d 379 (1958); Liability of physician who abandons case, 57 A.L.R.2d 432 (1958).

17. 156 Ind. 416, 59 N.E. 1058, 53 L.R.A. 135 (1901).

18. WHARTON, NEGLIGENCE § 731 (1874).

19. Findlay v. Board of Supervisors, 72 Ariz. 58, 230 P.2d 526 (1951); Buttersworth v. Swint, 53 Ga. App. 602, 186 S.E. 770 (1936); Childers v. Frye, 201 N.C. 42, 158 S.E. 744 (1931); Rice v. Rinaldo, 67 Ohio L. Abs. 183, 119 N.E.2d 657 (1951).

20. 2 HARPER & JAMES, TORTS 1048-49 (1956); PROSSER, TORTS 184-85 (2d ed. 1955); McNiece and Thornton, *Affirmative Duties in Tort,* 58 YALE L.J. 1272 (1948), which concludes that affirmative duties are imposed in those situations where the one under a duty to act has brought himself into a relationship with others from which he derives or expects to derive benefit.

21. Although in the course of their study of affirmative duties, Professors McNiece and Thornton, *supra* note 20, at 1283, make the statement that, "In the case of certain public trades, such as inn-keepers, carriers, barbers, [the precursors of surgeons] and physicians, the notion grew up that the persons plying these trades were under a duty to accept any member of the public as a customer," this author has found no case law supporting a general imposition of duty to undertake service on the part of physicians and surgeons. Arterburn in his study of *The Origin and First Test of Public Callings,* 75 U. PA.

any tendency in that direction would appear to be undesirable since unlimited demands upon a doctor's time and energy would be likely to result in inadequate care for all. The distinction is validly drawn between the duty and no-duty situation in terms of a voluntary undertaking by the doctor to render medical service.

Where the medical practitioner has entered into a specific contract to render service or to give treatment to the plaintiff or members of his family in return for a specified retainer, there is little question but that the relation of physician-patient exists and that the physician may be liable if his failure to render service is the cause of injury.[22] This may be true even when the physician has undertaken to provide service for a group of employees and the specific employee's name does not appear on his list, provided that the employee has in fact contributed to the fund which pays the physician's fee.[23] The physician-patient relation which imposes a duty to use care may also come into being through an agreement by the physician and a third party that service will be rendered or by the physician in fact undertaking for a third person to examine or treat the "patient."[24]

Where no compensation or "consideration" has been received in return for the physician's promise to render assistance or give treatment, a somewhat more difficult problem arises. The doctrine of *Thorne v. Deas*,[25] that gratuitous promises are not enforceable, rears its head. In subsequent non-medical cases the courts have on occasion permitted a plaintiff to recover for injuries resulting from a failure to perform a gratuitous promise where some affirmative action in performance has been taken by the promisor,[26] or where the plaintiff

L. REV. 411, 420-25 (1927), indicates that except for the imposition of a duty to serve upon all trades during economic and social crises such as the Black Death in the Fourteenth and Fifteenth Centuries, the duty to serve and the duty to use care if service were undertaken were in fact distinct.

22. Cartwright v. Bartholomew, 83 Ga. App. 503, 64 S.E.2d 323 (1951); Randolph's Adm'r v. Snyder, 139 Ky. 159, 129 S.W. 562 (1910); Klein v. Williams, 194 Miss. 699, 12 So. 2d 421 (1943). These cases suggest that the liability is one of contract rather than tort, where the doctor has merely failed to render assistance when called rather than undertaking treatment and then performing negligently.

23. Klein v. Williams, *supra* note 22.

24. One of the oldest cases on this point is Everard v. Hopkins, 2 Bulst. 332, 80 Eng. Rep. 1164 (K.B. 1615), in which a master sued the physician who had contracted to care for an injured servant and the court stated that the servant might have an action on the case for malpractice unless the physician had been discharged. More recent decisions are Johnson v. Borland, 317 Mich. 225, 26 N.W.2d 755 (1947) (physician called to examine prisoner in jail is liable for failure to discover cardiac trouble, pulmonary edema and hemorrhage which resulted in death); Du Bois v. Decker, 130 N.Y. 325, 29 N.E. 313, 14 L.R.A. 429 (1891) (physician employed by city to treat patients in city almshouse is liable to patient injured through negligence).

25. 4 Johns. 84 (N.Y. Sup. Ct. 1809) (failure to insure cargo).

26. Siegel v. Spear & Co., 234 N.Y. 479, 138 N.E. 414 (1923). See also Gregory, *Gratuitous Undertakings and the Duty of Care*, 1 DE PAUL L. REV. 30 (1951); Seavey, *Reliance Upon Gratuitous Promises or Other Conduct*, 64 HARV. L. REV. 913 (1951).

has been deterred from seeking other assistance in reliance on the promise.[27] These cases have found their counterparts in the medical field.[28] It was also recognized at an early date that the obligation to use reasonable care and skill in the treatment of a patient did not depend upon any financial benefit to the doctor but was equally applicable to gratutious service for charity patients.[29]

Short of an actual promise to render assistance, the physician-patient relation and the resulting duty to use care may arise from the fact that the physician has in fact undertaken to care for the patient. This may consist of commencement of actual treatment or performance of an operation.[30] It may also consist of setting an arm and failing thereafter to do anything more.[31] It is not clear that mere examination of a patient and diagnosis of his ailment, without more, would impose a further duty of care. In at least one case, the doctor was excused from liability for failure to render care after examining an automobile accident victim and ordering that he return to his home until he became sober.[32] Where the diagnosis indicates that a specialist should be called in and the examining physician advises his patient to consult the specialist, this may be sufficient to absolve him from further obligation to treat the patient for the ailment.[33] Or where the doctor is a diagnostician who does not undertake treatment at all, no further liability may exist. Absent such circumstances, however, the average patient would assume that when he goes to the doctor for an examination and diagnosis the doctor will continue

27. Brunelle v. Nashua Bldg. & Loan Ass'n, 95 N.H. 391, 64 A.2d 315 (1949).

28. Fortner v. Koch, 272 Mich. 273, 261 N.W. 762 (1935); Ritchey v. West, 23 Ill. 385 (1860), in which treatment had been undertaken followed by promise to return; McGulpin v. Bessmer, 241 Iowa 1119, 43 N.W.2d 121 (1950), where there was apparent reliance upon the defendant's statements that further treatment would be undertaken. *But see* Carroll v. Griffin, 96 Ga. App. 826, 101 S.E.2d 764 (1958); Ballou v. Prescott, 64 Me. 305 (1874); Sibert v. Boger, 260 S.W.2d 569 (Mo. 1953), in which there appear to have been neither reliance by the patient nor failure to consult other available doctors and no recovery is permitted.

29. *Compare* McNevins v. Lowe, 40 Ill. 209 (1866), *with* Ritchey v. West, 23 Ill. 385 (1860).

30. McGulpin v. Bessmer, 241 Iowa 119, 43 N.W.2d 121 (1950); Becker v. Janimski, 27 Abb. N. Cas. 45, 15 N.Y. Supp. 675 (N.Y. Com. Pl. 1891); Stohlman v. Davis, 117 Neb. 178, 220 N.W. 247, 60 A.L.R. 658 (1928); Burnett v. Layman, 133 Tenn. 323, 181 S.W. 157 (1915); Tucker v. Gillett, 22 Ohio C.C. 664, *aff'd*, 67 Ohio St. 106, 65 N.E. 865 (1902); Gross v. Partlow, 190 Wash. 489, 68 P.2d 1034 (1957).

31. Ritchey v. West, 23 Ill. 385 (1860).

32. Childers v. Frye, 201 N.C. 42, 158 S.E. 744 (1931).

33. *But see* Welch v. Frisbie Mem. Hosp., 90 N.H. 337, 9 A.2d 761 (1939), in which the doctor had directed that an x-ray be taken of the entire leg but received only an x-ray of the upper three-fifths of the leg which did not show the ankle joint, and made a diagnosis on the basis of oral reports from this x-ray that there was no fracture; the court says that the doctor's responsibility did not cease when the patient left the hospital and his care, since he later received the x-ray itself and knew that it was not what he had ordered and also knew that the continuation of treatment by the family physician was likely to be dependent upon the original diagnosis.

the relationship and undertake treatment within his competence.

Once the medical practitioner has undertaken to treat a patient, without specific limitation as to time or nature of treatment, the courts say that

> he cannot cease his visits, except—*First,* with the consent of the patient; or, *secondly,* upon giving the patient timely notice so that he may employ another doctor; or *thirdly,* when the condition of the patient is such as no longer to require medical treatment; and of that condition the physician must judge at his peril.[34]

Although the initial creation of the relation of physician and patient is dependent upon the physician's voluntary undertaking, its continuance is not wholly within the discretion of the physician. The "contract" carries with it some obligations imposed by law and failure to meet the obligation of attendance upon the patient may constitute "abandonment" which is actionable. Such abandonment has been found in cases where the physician failed to return after several examinations of the patient although he had reason to know the patient was not cured,[35] where the physician declined to attend a pregnant woman saying that her time of delivery had not yet arrived,[36] where a physician with notice of symptoms which indicate serious illness delayed a visit to the patient's bedside without adequate explanation,[37] where the physician neglected to act after knowledge of symptoms of serious illness,[38] and where the doctor refused to continue treatment until pre-existing bills were paid.[39] This does not mean that the patient may demand that the physician attend or treat him at any specific time;[40] nor does it require a physician whose practice is known to be limited to his office to go to the patient's home;[41] nor is a doctor required to disregard other patients,[42] nor travel to other communities at some distance from his normal place of

34. Becker v. Janinski, 27 Abb. N. Cas. 45, 49, 15 N.Y. Supp. 675, 676 (N.Y. Com. Pl. 1891). See also Dale v. Donaldson Lumber Co., 48 Ark. 188, 2 S.W. 703 (1887); Mucci v. Houghton, 89 Iowa 608, 57 N.W. 305 (1894); Ballou v. Prescott, 64 Me. 305 (1874); Gray v. Davidson, 15 Wash. 2d 257, 130 P.2d 341 (1942); Lawson v. Conaway, 37 W.Va. 159, 16 S.E. 564 (1892).

35. McGulpin v. Bessmer, 241 Iowa 1119, 43 N.W.2d 121 (1950); Becker v. Janinski, 27 Abb. N. Cas. 45, 15 N.Y. Supp. 675 (N.Y. Com. Pl. 1891).

36. Norton v. Hamilton, 92 Ga. App. 727, 89 S.E.2d 809 (1955); Mehigan v. Sheehan, 94 N.H. 274, 51 A.2d 632 (1947).

37. Van Sickle v. Doolittle, 173 Iowa 727, 155 N.W. 1007 (1916).

38. Moeller v. Hauser, 237 Minn. 368, 54 N.W.2d 639 (1952); Vann v. Harden, 187 Va. 555, 47 S.E.2d 314 (1948).

39. Ricks v. Budge, 91 Utah 307, 64 P.2d 208 (1937).

40. Dabney v. Briggs, 219 Ala. 127, 121 So. 394 (1929).

41. Nash v. Meyer, 54 Idaho 283, 31 P.2d 273 (1934); Urritia v. Patino, 297 S.W. 512 (Tex. Civ. App. 1927), sub. op., 10 S.W.2d 582 (Tex. Civ. App. 1928). *But see* Saunders v. Lischkoff, 137 Fla. 826, 188 So. 815 (1939).

42. Rodgers v. Lawson, 170 F.2d 157 (D.C. Cir. 1948). *But see* Sinclair v. Brunson, 212 Mich. 387, 180 N.W. 358 (1920) (doctor should not accept more patients than he can satisfactorily attend).

practice.[43] Furthermore, the courts have stated that there is no abandonment where the doctor makes it clear that unless he is called he will not plan to return to the patient,[44] if at the time he leaves the patient there is no reason to believe that further medical attention is necessary.[45]

Although some attempt may be made to distinguish between "abandonment" of the patient, consisting of an attempted severance or termination of the physician-patient relation, and a failure to use proper care in the treatment of a patient, the line is not clearly drawn. For example, in *Groce v. Myers,*[46] the patient was lodged in the doctor's clinic for about eight days and during the course of this stay apparently got under her bed and had to be dragged out. In the process her arm was broken. When her family was called some days after this event they discovered bruises of an aggravated nature upon her face, body, hips and limbs and her arm had swollen to an enormous size and hung down by her body. The doctor informed her father that he should tie something around the arm and let it hang down, but there was no indication that any tape or dressing had been applied or that other care had been taken of the arm in the clinic. The court talks largely in terms of negligent treatment, but indicates that the facts give rise to an inference of abandonment. The same may be true in such cases as *Moeller v. Hauser*[47] or *Goheen v. Graber,*[48] where the doctors failed to act or to make frequent visits to the patient or to make careful examinations during visits.[49] In these cases the courts look more to the standard of acceptable practice in the profession itself than to any independent duty formulated by the courts. It may be argued that even in the decisions referred to in the foregoing paragraph the imposition of a continuing duty to treat and the qualifications thereof are really reflections of a standard of conduct defined by recognized practices in the profession. The extent to which it is appropriate for the courts to look to the practice in the profession as the standard for due care is developed in a later portion of this paper.

43. McNamara v. Emmons, 36 Cal. App. 2d 199, 97 P.2d 503 (1939).
44. See, *e.g.,* Ballou v. Prescott, 64 Me. 305 (1874).
45. *But see* Vann v. Harden, 187 Va. 555, 47 S.E.2d 314 (1948), where the doctor testified that on his last visit prior to leaving town for a vacation the patient had normal temperature and did not complain of pain from the cast on his thigh nor request that it be examined, although there was other evidence that complaint had been made and his hospital chart indicated that during the 48 hours prior to the last visit the patient's temperature had varied from 101.6 to 101 and 100.8 on the morning of the last visit.
46. 224 N.C. 165, 29 S.E.2d 553 (1944).
47. 237 Minn. 368, 54 N.W.2d 639, 57 A.L.R.2d 364 (1952).
48. 181 Kan. 107, 309 P.2d 636 (1957).
49. See also Wilson v. Martin Mem. Hosp., 232 N.C. 362, 61 S.E.2d 102 (1950). For a detailed study of the lack of diligence as contrasted with abandonment see Annots., 57 A.L.R.2d 379, 432 (1957).

THE STANDARD OF CONDUCT

In General

When the average layman is charged with negligence in a personal injury action, his conduct is evaluated by the jury in terms of the hypothetical conduct of a reasonable and prudent man under the same or similar circumstances, a standard which may differ considerably from what the defendant and those like him in fact do. Yet one of the circumstances to be taken into account in determining this hypothetical conduct is the special knowledge or skill of which the defendant is possessed or purports to be possessed.[50] To this extent the standard becomes somewhat subjectively related to the specific defendant.

In medical malpractice cases a somewhat similar non-subjective standard which takes into account specialized knowledge or skill is applied. However, the standard is more precisely defined as follows:

> This legal duty requires that the physician undertaking the care of a patient possess and exercise that reasonable and ordinary degree of learning, skill and care commonly possessed and exercised by reputable physicians practicing in the same locality, or in similar localities, in the care of similar cases; it requires also that the physician, in caring for the patient, exercise his best judgment at all times.[51]
>
> Good medical practice is the standard; it comprehends what the average careful, diligent and skillful physician in the community or like communities, would do or not do in the care of similar cases.[52]
>
> The duty imposed on a physician or surgeon is to employ such reasonable skill and diligence as is ordinarily exercised in his profession in the same general neighborhood having due regard to the advanced state of the profession at the time of the treatment. . . . The physician must use such ordinary skill and diligence and apply the means and methods generally used by physicians and surgeons of ordinary skill and learning in the practice of the profession, i.e., in the same general line of practice in like cases to determine the nature of the ailment and to act upon his honest opinion and conclusions.[53]
>
> [The physician] assumes toward the patient the obligation to exercise such reasonable care and skill in that behalf as is usually exercised by physicians or surgeons of good standing, of the same system or school of

50. See, *e.g.*, RESTATEMENT, TORTS § 290, comment e: "If the actor has special knowledge, he is required to utilize it, but he is not required to possess such knowledge, unless he holds himself out as possessing it or undertakes a course of conduct which a reasonable man would recognize as requiring it." *Id.* § 299, comment b: "One may voluntarily do an act which as a reasonable man he should recognize as involving an unreasonable risk to others unless he exercises peculiar skill. If so, he must possess and exercise such skill and is liable if through his lack thereof his act causes harm to another. . . . On the other hand, if the actor in fact possesses greater skill than that which he, as a reasonable man, is required to possess, he must exercise his superior skill with reasonable attention and competence."

51. REGAN, DOCTOR AND PATIENT AND THE LAW 17 (3d ed. 1956).

52. *Id.* at 30.

53. McHugh v. Audet, 72 F.Supp. 394, 399 (M.D. Pa. 1947).

54. Loudon v. Scott, 58 Mont. 645, 654, 194 Pac. 488, 491 (1920). See also Nelson v. Nicollet Clinic, 201 Minn. 505, 509, 276 N.W. 801, 803 (1937).

> practice in the community in which he resides, having due regard to the condition of medical and surgical science at that time.[54]

While by no means exhausting the various verbal formulations of the test[55] the foregoing suggest that the common elements to be found are:

(1) a reasonable or ordinary degree of skill and learning;
(2) commonly possessed and exercised by members of the profession
(3) who are of the same school or system as the defendant
(4) and who practice in the same or similar localities;
(5) and exercise of the defendant's good judgment.

The term "average" appears in some formulations in modification of "skill and learning" or "members of the profession."[56] But as the Illinois court pointed out in *Holtzman v. Hoy*:[57]

> While this rule [imposing the standard of the knowledge, skill and care of a *good* physician], on the one hand, does not exact the highest degree of skill and proficiency attainable in the profession, it does not, on the other hand, contemplate merely average merit. In other words, in order to determine who will come up to the legal standard indicated, we are not permitted to aggregate into a common class the quacks, the young men who have had no practice, the old ones who have dropped out of practice, the good, and the very best, and then strike an average between them.

"Average" is probably used in the sense of "ordinary," as pointed out by some courts.[58] But this may not be the meaning or connotation conveyed to the jury unless there is an explicit instruction on this point.[59] And even where the term is qualified by "average member in good standing" there may be a question as to whether this does anything more than eliminate those doctors or quacks who have actually lost their licenses or never obtained them.

The courts indicated rather early that it was the actual possession and exercise of knowledge, skill and diligence which was significant

55. The following decisions also deserve noting for their formulations of the standard of care: Ayers v. Parry, 192 F.2d 181, 184 (3d Cir. 1951); Sinz v. Owens, 33 Cal. 2d 749, 753, 205 P.2d 3, 5 (1949); Force v. Gregory, 63 Conn. 167, 169, 27 Atl. 1116, 1116 (1893); Adkins v. Ropp, 105 Ind. App. 331, 334, 14 N.E.2d 727, 728 (1938); Viita v. Fleming, 132 Minn. 128, 135, 155 N.W. 1077, 1081 (1916); Carpenter v. Blake, 60 Barb. 488, 516-18 (N.Y. Sup. Ct. 1871); Kelly v. Carroll, 36 Wash. 2d 482, 496, 219 P.2d 79, 87 (1950).

56. See Staloch v. Holm, 100 Minn. 276, 281, 111 N.W. 264, 266 (1907); Pike v. Honsinger, 155 N.Y. 201, 210, 49 N.E. 760, 762 (1898); Hazelwood v. Adams, 245 N.C. 398, 401, 95 S.E.2d 917, 919 (1957); Hathorn v. Richmond, 48 Vt. 557, 558 (1876).

57. 118 Ill. 534, 536, 8 N.E. 832, 832 (1886). See also Sim v. Weeks, 7 Cal. App. 2d 28, 42, 45 P.2d 350, 357 (1st Dist. 1935).

58. See, *e.g.*, Whitesell v. Hill, 101 Iowa 629, 635, 66 N.W. 894, 895 (1896); Carpenter v. Blake, 60 Barb. 488, 517 (N.Y. Sup. Ct. 1871).

59. See, *e.g.*, Hathorn v. Richmond, 48 Vt. 557, 558 (1876).

and not merely the reputation for having them.[60] In accordance with this, it seems to be well established that one of the qualifications of the standard is not that the doctor be licensed to practice, although the standard is based on the practice of the licensed practitioner.[61]

The two principal aspects of the somewhat varied standards just described are: (1) That the physician or medical practitioner is not only to be held to the standard of practice generally accepted by his branch of the profession but is to be protected by this standard since compliance with accepted practice is generally taken as conclusive evidence of due care, and; (2) that the patient-plaintiff in most cases is compelled to rely upon expert medical testimony to establish his case. What follows is an exploration of some of the qualifications of the general standard, an evaluation of "custom" as the standard of care, and the problem of proving deviation therefrom.

"School of Practice" or Specialties

The early cases which defined the standard of conduct for medical practice qualified the obligation by the statement that the practitioner was entitled to be judged by the standards of that "school" or "system of medicine" which he himself practiced.[62] The qualification

60. See Holtzman v. Hoy, 19 Ill. App. 459 (1886), *aff'd*, 118 Ill. 534, 8 N.E. 832 (1886); Leighton v. Sargent, 31 N.H. (11 Foster) 119 (1855); Mertz v. Detweiler, 8 W. & S. 376 (Pa. 1845).

61. See, *e.g.*, Andrews v. Lofton, 80 Ga. App. 723, 57 S.E.2d 338 (1950); Janssen v. Mulder, 232 Mich. 183, 205 N.W. 159 (1925); Brown v. Shyne, 242 N.Y. 176, 151 N.E. 197, 44 A.L.R. 1407 (1926); Hardy v. Dahl, 210 N.C. 530, 187 S.E. 788 (1936); Willett v. Rowekamp, 134 Ohio St. 285, 16 N.E.2d 457 (1938); Martin v. Carbide & Carbon Chem. Corp., 184 Tenn. 166, 197 S.W.2d 798 (1946); Kelly v. Carroll, 36 Wash. 2d 482, 219 P.2d 79 (1950). A few courts seem to have treated practice without a license as at least some basis for action if shown to be the proximate cause of injury, see, *e.g.*, Whipple v. Grandchamp, 261 Mass. 40, 158 N.E. 270 (1927); Joly v. Mellor, 163 Wash. 48, 299 Pac. 660 (1931).

62. See, *e.g.*, Force v. Gregory, 62 Conn. 167, 27 Atl. 1116, 22 L.R.A. 343 (1893); Bowman v. Woods, 1 Greene 441 (Iowa 1848); Patten v. Wiggen, 51 Me. 594 (1862).

The schools of medicine which are mentioned most often in the cases are: "allopathic," a system using remedies which produce effects upon the body differing from those produced by disease; "homeopathic," a branch of medicine which deals with the investigation and application *simile phenomenon* or the law of similars, like is cured by like; "eclectic," a system of medicine in which physicians select from the various schools what they consider to be the best doctrines or methods of treatment, special importance being attached to the development of indigenous plant remedies; "osteopathy," a school of healing which teaches that the body is a vital mechanical organism whose structural and functional integrity are coordinate and interdependent, the perversion of either constituting disease, the major means of treatment being manipulation, although surgery is also sometimes undertaken; "chiropractic," a system of therapeutics based on the theory that disease is caused by abnormal function of the nervous system and which attempts to restore normal function through manipulation and treatment of the structures of the body, principally the spinal column; "Christian Science," a system of healing through prayer and the triumph of the mind over matter, founded by Mary Baker Eddy; "drugless healing," a system of treatment involving no drugs or severing or penetration of body tissues except severing of the umbilical cord at birth.

seems to have been based on the inability of the jury to evaluate the merits of each school's tenets and principles or to determine which had the preferable mode of treatment.[63] This did not mean that any form of treatment which differed from a generally recognized and accepted form was entitled to equal weight. For example, in *Nelson v. Harrington*,[64] the court refused to permit a "spiritualist or clairvoyant physician" to defend an action brought by the parent of his patient on the ground that his treatment was in accordance with the ordinary and customary practices of spiritualists and clairvoyants in diagnosing, attending and treating human ailments. While recognizing the general principle that a doctor is entitled to be judged by the practice of his particular school, the court said that:

> To constitute a school of medicine under this rule, it must have rules and principles of practice for the guidance of all its members, as respects principles, diagnosis, and remedies, which each member is supposed to observe in any given case. Thus, any competent practitioner of any given school would treat a given case substantially the same as any other competent practitioner of the same school would treat it.[65]

The court found that the "clairvoyant school" agreed only on one fact, that the means of ascertaining disease and determining the treatment was through the use of the trance, and that beyond this there was no uniformity of practice. The mode of acquiring knowledge or information is said not to be determinative of the existence of a "school" which the courts will recognize, except that all regular physicians of any school must acquire professional knowledge through the study of the general principles of science. Along the same lines, a "magnetic healer"[66] and a Chinese herb doctor[67] were denied the right to have their treatment judged exclusively by the alleged practices of their "schools" and to exclude the testimony of registered medical doctors on behalf of the plaintiffs.

In *Grainger v. Still*,[68] the court spoke of osteopathy as sui generis in that, while it was declared by statute to be outside the practice of

63. See Force v. Gregory, 63 Conn. 167, 171, 27 Atl. 1116, 1117, 22 L.R.A. 343, 345 (1893): "[F]or, as was said in Patten v. Wiggen, *supra*, 'the jury are not to judge by determining which school, in their own view, is best.' . . . [T]he jury, we think should have been told that the relative merits of the two schools were in no sense before them for their consideration; . . ."; Bowman v. Woods, 1 Greene 441, 442 (Iowa 1848): "The regular, the botanic, the homoeopathic, the hydropathic, and other modes of treating diseases, are alike unprohibited; and each receives more or less favor and patronage from the people. Though the regular system has been advancing as a science for centuries, aided by research and experience, by wisdom and skill, still the law regards it with no partiality or distinguishing favor; nor is it recognized as the exclusive standard or test by which the other systems are to be adjudged."

64. 72 Wis. 591, 40 N.W. 288, 1 L.R.A. 719 (1888).

65. *Id.* at 598-99, 40 N.W. at 231, 1 L.R.A. at 722.

66. Longan v. Weltmer, 180 Mo. 322, 79 S.W. 655, 64 L.R.A. 969 (1904).

67. Hansen v. Pock, 57 Mont. 51, 187 Pac. 282 (1920).

68. 187 Mo. 197, 85 S.W. 1114, 70 L.R.A. 49 (1905).

medicine and surgery, its practitioners were permitted to cure diseases of the human body "according to the system, method, or science as taught by the American School of Osteopathy at Kirksville, Mo., or any other legally chartered and regularly conducted school of osteopathy."[69] The court then went on to say that since there was no evidence as to what the system of osteopathy was or how it differed from the practice of medicine, and since the plaintiff introduced evidence to the effect that osteopaths used the same texts as medical students and had no fixed rule of practice for the treatment of hip disease, testimony of medical doctors could be relied upon to establish the negligence of the defendant's diagnosis and treatment of the plaintiff's ailment. In other cases the courts also recognized that there may be a common area of practice to be tested by the principles of any or all recognized schools, most commonly diagnosis of ailments.[70]

In making the qualification of the standard in terms of the practice of a particular "school" or system, the courts are really recognizing the respectable division of medical opinion as to the proper methods of treatment. The statutory imprimatur of license, as in *Grainger*, adds only slightly to the acceptance of the group practice as a standard; the essential element is a "fixed rule of practice" to which all members are expected to comply, coupled with some basic background of scientific knowledge. Some courts in support of the "school of medicine" qualification pointed to the fact that the patient had knowingly sought the practitioner and accepted his mode of diagnosis and treatment.[71] Where, however, the plaintiff was led to believe that the defendant had ability to make a diagnosis or render treatment which was actually beyond his limitations, the "assumed risk" argument was ineffective.[72] It may well be argued that aside from such special groups as Christian Scientists, the patient is ill equipped to understand the scope of practice and limitations of the practitioner and therefore the qualification of the practitioner's standard of conduct should not be based on any alleged assumption of risk or consent theory.

With the development of medical science, the older "schools" of medicine have tended to give way to what may properly be termed "the regular practice of medicine" which encompasses much of the older practice of the allopathic school. Today the regular physician

69. *Id.* at 224, 85 S.W. at 1123, 70 L.R.A. at 58. See MO. REV. STAT. § 337.010 (1949).

70. *E.g.*, Van Sickle v. Doolittle, 173 Iowa 727, 155 N.W. 1007 (1916); Kuechler v. Volgmann, 180 Wis. 238, 192 N.W. 1015, 31 A.L.R. 826 (1923).

71. Nelson v. Dahl, 174 Minn. 574, 219 N.W. 941 (1928); Kirschner v. Keller, 70 Ohio App. 111, 42 N.E.2d 463 (1943).

72. See Janssen v. Mulder, 232 Mich. 183, 205 N.W. 159 (1925) where plaintiff recovered on the claim that defendant held himself out as capable of ascertaining disease and of determining whether his treatment was proper.

treats all aspects of disease and employs a variety of procedures and methods of treatment. To this extent the qualification of the school or system to which he belongs is almost meaningless. It does retain meaning, however, with respect to some related specialties such as dentistry,[73] nursing,[74] X-ray technician's work,[75] and veterinary medicine,[76] each of which is to be judged by the principles and practices of the specialty.

The regular practice of medicine may also be distinguished today from other disciplines of healing and therapy, the principle ones being osteopathy, chiropractic, Christian Science, "drugless healing" and other forms of treatment which rely upon such natural elements as heat, light, water, "nature food" or massage. Some of these "schools" or systems, have legislative recognition,[77] and where they do the courts may be bound to accept them as separate systems to be judged independently.[78]

The extent of differentiation between the practice of medicine and osteopathy varies considerably from state to state. In some the osteopath is denied the right to use drugs or perform surgery; in such states the distinction between the two schools is a pronounced one. For example, in Kansas, although osteopaths must be examined in many subjects common to medicine, the courts maintain a clear distinction between the practice of medicine and the practice of osteopathy,[79] and the standards of conduct remain distinct.[80] On the

73. *E.g.*, Stallcup v. Coscarart, 79 Ariz. 42, 282 P.2d 791 (1955); Simone v. Sabo, 224 P.2d 487 (Cal. App. 1950), *subsequent opinion*, 37 Cal. 2d 253, 231 P.2d 19 (1951); Bryan v. Grace, 63 Ga. App. 373, 11 S.E.2d 241 (1940); Hazelwood v. Adams, 245 N.C. 398, 95 S.E.2d 917 (1957); Malila v. Meacham, 187 Ore. 330, 211 P.2d 747 (1949).

74. *E.g.*, Valentin v. La Societe Francaise, 76 Cal. App. 2d 1, 172 P.2d 359 (1946). For more detailed discussion of the special duties and liability of nurses see LESNIK & ANDERSON, NURSING PRACTICE AND THE LAW 247-93 (2d ed. 1955); Annot., 51 A.L.R.2d 970 (1957).

75. *E.g.*, Facer v. Lewis, 326 Mich. 702, 40 N.W.2d 457 (1950) (x-ray technician); Wood v. Miller, 158 Ore. 444, 76 P.2d 963 (1938) (diathery operator).

76. *E.g.*, Kerbow v. Bell, 259 P.2d 317 (Okla. 1953).

77. For a list of the licensing statutes in the United States, see 1 LAWYERS' MEDICAL CYCLOPEDIA OF PERSONAL INJURIES AND ALLIED SPECIALTIES 33-41 (Frankel et. al. ed. 1958).

78. See, *e.g.*, Cummins v. Donley, 173 Kan. 463, 249 P.2d 695 (1952) (osteopath); Bryant v. Biggs, 331 Mich. 64, 49 N.W.2d 63 (1951) (osteopath); Hardy v. Dahl, 210 N.C. 530, 187 S.E. 788 (1936) (naturopath); Willett v. Rowekamp, 134 Ohio St. 285, 16 N.E.2d 457 (1938) (chiropractor); Sheppard v. Firth, 334 P.2d 190 (Ore. 1959) (chiropractor); Benz v. Levin, 62 York 149 (Pa. C.P. 1948) (chiropodist); Simms v. Gafney, 227 S.W.2d 848 (Tex. Civ. App. 1950) (osteopath); Forrest v. Eason, 123 Utah 610, 261 P.2d 178 (1953) (naturopath).

79. State *ex rel.* Beck v. Gleason, 148 Kan. 1, 79 P.2d 911 (1938), 148 Kan. 459, 83 P.2d 425 (1938) interpreting KANS. GEN. STAT. ANN. §§ 65-1201 to 65-1208 (1949), as limited to the fundamental principles of osteopathy which the court finds not to include drug therapy or operative surgery with surgical instruments as distinct from "osteopathic surgery" or manipulation of the body with hands.

80. Cummins v. Donley, 173 Kan. 463, 249 P.2d 695 (1952).

other hand, where the osteopathic physician or surgeon is permited to make use of drugs, and, with proper training and testing, to engage in surgery and obstetrics,[81] the courts seem to treat the practice of osteopathy as almost co-existent with the practice of medicine so far as the standard of conduct and the use of experts from medical practice is concerned.[82] While in states such as Massachusetts and New York, where chiropractors are not licensed to treat human ailments,[83] the courts have shown little willingness to recognize chiropractic as having the status of a special school or system of treatment, and decisions such as *Whipple v. Grandchamp*[84] and *Epstein v. Hirschon*[85] are typical in demanding that the chiropractor live up to the standards of care established by licensed practitioners of the healing arts.

The experience of the Washington courts with regard to "drugless healers" is perhaps illustrative of a development away from the qualification of the standard of care in terms of schools of practice. In *Wilcox v. Carroll*,[86] the court affirmed judgment for the parent of an 8 year old child who died of peritonitis after the drugless healer had brushed aside the mother's fears of appendicitis and diagnosed an "inflammation of the spine and congestion of the bowels" and treated accordingly. While recognizing that the defendant's conduct was to be judged by the degree of skill and learning which ordinarily characterized the school or class of physicians to which he belonged, the court found that there was a common ground of diagnosis on which regular medical practitioners might and did testify adversely to the defendant. Twenty-seven years later the same drugless healer again failed to diagnose appendicitis and prescribed a laxative and "sine wave" treatment for the patient, while telling the patient's wife that there was no need to call an M.D. and threatening to leave the case if an M.D. was called in. After the patient's death, the wife brought action. At the trial medical doctors testified for the plaintiff, and drugless healers testified for the defendant. The trial court refused to charge that the defendant must be judged by the standards of drugless healers. In affirming judgment

81. *E.g.*, ME. REV. STAT. ANN. c. 71, § 7 (1954).

82. Josselyn v. Dearborn, 143 Me. 328, 62 A.2d 174 (1948) where no particular distinction is made between a physician and an osteopathic physician and surgeon.

83. See list of licensing acts, 1 LAWYERS' MEDICAL CYCLOPEDIA 36, 38 (Frankel et. al. ed. 1958).

84. 261 Mass. 40, 158 N.E. 270 (1927).

85. 33 N.Y.S.2d 83 (N.Y. Sup. Ct. 1942). *Cf.* Walkenhorst v. Kesler, 92 Utah 312, 67 P.2d 654 (1937), in which the court concludes that there is no "school" of chiropractic since, although it is mentioned in the medical arts statute, no provision is made for licensing of chiropractors. Therefore a witness qualified to practice medicine is permitted to testify in action against chiropractor although admitting ignorance of chiropractic.

86. 127 Wash. 1, 219 Pac. 34 (1923).

for the plaintiff, the appellate court in *Kelly v. Carroll*[87] went to some pains to point out that the drugless healer was not a "doctor" in the medical sense and could not practice medicine as such; that within the general realm of medicine and surgery a drugless healer could not qualify as a medical expert witness; and finally that a drugless healer does not belong to a school of medicine and therefore cannot claim to be judged by any standard distinct from that applicable generally to medical practice. In this latter decision the court seems motivated largely by a desire to protect the public and to uphold the legislative power to limit the practice of treating human ailments rather rigidly. How far the court would go in disregarding the claims of other "schools" of medicine is not clear, although it did comment in the course of its opinion:

> With the advance of medical science, it is apparent that there is less and less occasion to invoke the rule . . . "each school of medicine is entitled to practice in its own way, and because one does not use the methods of the other is no reason for holding the one for malpractice."[88]

and pointed to the fact that today the distinctions between the homeopathic and allopathic schools of thought have become unknown to the modern doctor. This may well indicate that within the area of licensed medical practice in Washington the qualification is no longer valid.

While the "school of practice" doctrine may now have lost much of its vigor, there still remains the correlative principle that where doctors differ as to the proper medical procedure, a doctor who follows the practice espoused by a reputable minority is not to be treated as having committed malpractice by doing so.[89] This doctrine requires no such formal definition of principles and systems as the allopathic-homeopathic distinction did. It is necessary, however, for the evidence or testimony from competent experts to show that some actual difference of opinion does exist and that there is expert opinion other than the defendant's in support of his practice. In one case, such approval of treatment was found to exist in other areas such as Chicago, Cincinnati, and Vienna, Austria, although at the time of treatment the defendant was the only one using the procedure in the St. Louis area.[90]

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87. 36 Wash. 2d 482, 219 P.2d 79 (1950).

88. *Id.* at 495, 219 P.2d at 87.

89. See, *e.g.*, Graham v. Alcoa S.S. Co., 201 F.2d 423 (3d Cir. 1953); McHugh v. Audet, 72 F. Supp. 394 (M.D. Pa. 1947); Boyce v. Brown, 51 Ariz. 416, 77 P.2d 455 (1938); Church v. Bloch, 80 Cal. App. 2d 542, 182 P.2d 241 (1947); Staloch v. Holm, 100 Minn. 276, 111 N.W. 264 (1907); Duckworth v. Bennett, 320 Pa. 47, 181 Atl. 558 (1935); Gresham v. Ford, 192 Tenn. 310, 241 S.W.2d 408 (1950); Reed v. Church, 175 Va. 284, 8 S.E.2d 285 (1940). *Cf.* Baldor v. Rodgers, 81 So. 2d 658 (Fla. 1955) (original opinion); Fritz v. Horsfall, 24 Wash. 2d 14, 163 P.2d 148 (1945); Treptau v. Behrens Spa, 247 Wis. 438, 20 N.W.2d 108 (1945).

90. McClarin v. Grenzfelder, 147 Mo. App. 478, 126 S.W. 817 (1910). See

At the same time that the medical profession was abandoning many of the various "schools" of practice and formulating a single regular school of medicine, there were developing subdivisions in the form of specialties which dealt with distinctive portions of the body, such as dermatology (diseases of the skin), gynecology and urology (diseases of the sexual organs of female and the urinary tracts of female and male patients), neurology (dealing with the nervous system), internal medicine (diseases of the circulatory, digestive and respiratory systems), opthamology (diseases of the eye), otolaryngology (diseases of the ears, nose and throat), proctology (diseases of the anus and rectum), hematology (dealing with the blood); specialties dealing with given ailments or forms of treatment such as obstetrics, pathology, pediatrics, psychiatry, physical medicine and rehabilitation, plastic surgery, radiology, surgery and anesthesiology.[91] The recognition accorded to these specialties by special certifying "boards" within the profession itself and the growing practice of many hospitals to insist upon "board certification" prior to permitting a doctor to engage in the use of its facilities within these specialized areas, raises the question of whether in place of "school of practice" the court may properly qualify the required standard of conduct in terms of a medical specialty or certification by a specialty "board."

It is generally accepted that where a doctor holds himself out as a specialist in a specific area of medical practice, he may be held to a somewhat higher standard of knowledge and skill than is the general practitioner.[92] This does not mean, however, that everyone who engages in surgical procedures must meet the standards which are common among "board" specialists, i.e., a surgeon who has done postgraduate work in surgery or a subspecialty thereof and has received a certification from the American Board of Surgery. In *Sinz v. Owens*,[93] for example, where the patient claimed that the doctor should have used skeletal traction in reduction of a double comminuted fracture of the leg, the trial court charged that if the doctor undertakes to perform service in a special branch of medicine and at that time other members of the profession practicing in that locality limit their

pages 569 to 575, *infra*, for discussion of the locality of practice as a qualification.

91. For a summary of the recognized medical specialties, see 1 LAWYERS' MEDICAL CYCLOPEDIA §§ 1.8, 1.9 (Frankel et. al. ed. 1958).

92. See, *e.g.*, Ayers v. Parry, 192 F.2d 181 (3d Cir. 1951); Scarano v. Schnoor, 158 Cal. App. 2d 612, 323 P.2d 178 (1958); Crovella v. Cochrane, 102 So. 2d 307 (Fla. App. 1958); Worster v. Caylor, 231 Ind. 625, 110 N.E.2d 337 (1953); Rule v. Cheeseman, 181 Kan. 957, 317 P.2d 472 (1957); Carbone v. Washburton, 11 N.J. 418, 94 A.2d 680 (1953); Coleman v. Wilson, 85 N.J.L. 203, 88 Atl. 1059 (1913); Rayburn v. Day, 126 Ore. 135, 268 Pac. 1002 (1928); Rann v. Twitchell, 82 Vt. 79, 71 Atl. 1045 (1909); Fox v. Mason, 139 Va. 667, 124 S.E. 405 (1924); Hunter v. Burroughs, 123 Va. 113, 96 S.E. 360 (1918); Huttner v. MacKay, 48 Wash. 2d 378, 293 P.2d 766 (1956).

93. 33 Cal. 2d 749, 205 P.2d 3 (1949).

practice to that particular branch of medicine, the doctor must possess the degree of learning and skill ordinarily possessed by specialists. The appellate court found error in such a charge saying that such duty would devolve upon the doctor-defendant only if he found or should have realized that something more than the skill of a general practitioner was required. Similarly in *Marchlewski v. Casella*[94] the Connecticut court said that "the defendant was not required to use a degree of care commensurate with that exercised by those classified as experts." And in other cases the courts have excused obstetricians from failure to call other specialists when spinal anesthesia used in the process of childbirth resulted in paralysis, without indicating that either in administering the anesthetic[95] or in attempting treatment of the patient thereafter[96] was the obstetrician required to use any different standard of care than that of other obstetricians under similar circumstances.

Somewhat in contrast to these cases is that of *Simone v. Sabo*[97] in which a dentist who had been in general practice for eight months but had never removed an impacted second bicuspid, was found by the jury to have been negligent in the process of removing such a tooth. Experts for the plaintiff testified that it was customary for a general practitioner to refer such extractions to an exodontist or oral surgeon, and to inform the patient of the danger of injury to the "mental nerve," neither of which the defendant had done. An oral surgeon testifying for the defendant stated that it was customary and proper for general practitioners to extract impacted teeth. The intermediate appellate court affirmed judgment for the patient on the basis of failure to refer the case to an exodontist.[98] The Supreme Court of California reversed the trial court,[99] relying on the defendant's evidence and upon the absence of any evidence that he had failed to act with the care of "a reasonably prudent and skillful oral surgeon." While accepting the defendant's argument that it is not malpractice per se for a general practitioner to fail to refer a complicated case to a specialist, the court does not reject specifically the trial court's charge that if a general practitioner undertakes the treatment of a case within the field of specialists practicing in the same

94. 141 Conn. 377, 106 A.2d 466 (1954).
95. Hall v. United States, 136 F. Supp. 187 (W.D. La. 1955), *aff'd per curiam*, 234 F.2d 811 (5th Cir. 1956).
96. Seneris v. Haas, 45 Cal. 2d 811, 291 P.2d 915 (1955).
97. 37 Cal. 2d 253, 231 P.2d 19 (1951).
98. 224 P.2d 487 (Cal. App. 1950).
99. See note 97 *supra*. Under California practice, the granting of a hearing by the Supreme Court renders the decision of the intermediate District Court of Appeals null and void and the appeal is in effect direct from trial court to Supreme Court, although the opinion of the District Court of Appeal may be treated as a "brief on the legal questions involved therein . . . ." Knouse v. Nimocks, 8 Cal. 2d 482, 483-84, 66 P.2d 438 (1937).

locality, "it is the duty of the general practitioner to possess that degree of learning and skill ordinarily possessed by such specialists."[100]

While the general practitioner may be judged by the standards of practice of general practitioners, the courts will permit a specialist to testify in actions against general practitioners. In *Wilson v. Corbin*[101] the Iowa court says that a case against a physician and surgeon in general practice may go to the jury where a specialist from the State University Hospitals gives testimony as to the general recognition of the necessity and importance of lateral view X-rays in diagnosis of injury to the spine, saying "most surgeons would think so." In *Sinz v. Owens*[102] the court does not say that testimony from experts would not be admissible to show the desirability of having a specialist called into the case, and in *Simone v. Sabo*[103] the court relied on the testimony of an oral surgeon in finding some basis for a jury determination that non-referral was permissible practice for a general practitioner. What the courts indicate in these opinions is that, although the specialist may testify, his testimony should be limited to a statement of medical facts or a definition of what is customary practice among doctors of the class of the defendant, i.e., general practitioners. I am somewhat skeptical, however, as to whether the distinction between what the specialist believes a general practitioner ought to do in a given situation and what general practitioners do in fact do in such situation is clearly drawn in the minds of the specialists testifying in these cases.

It might be argued that with the development of widely recognized specialties, requiring intensive post-graduate training and subject to professional boards of certification, it is appropriate for the courts to rely upon the standards of the specialist within the area of practice covered by such specialists. It might appear that this would give greater protection to the patient. The principal difficulty with such argument lies in the necessity for relying upon general practitioners to care for the large proportion of human ills today. At the moment, medical schools and the specialty boards do not turn out enough specialists to provide care for all, and it would be unwise for them to reduce their existing standards of performance simply to provide greater numbers of "specialists." Since the specialties which have wide recognition cover most of the areas of medical practice today, any wholesale acceptance of their higher standards of practice as the general standard would tend to force the general practitioner out of the picture entirely.

As the specialties become more firmly established and more and

100. 37 Cal. 2d at 254, 231 P.2d at 22.
101. 241 Iowa 593, 41 N.W.2d 702 (1950).
102. 33 Cal. 2d 744, 205 P.2d 3 (1949).
103. 37 Cal. 2d 253, 231 P.2d 19 (1951).

more "board" specialists appear in practice in most areas, the tendency may well be toward an increase in the care demanded of all practitioners, at least to the extent of requiring referrals by general practitioners in more cases than are required today. To some extent this is already being done by the extra-legal practice of hospitals in restricting the use of their facilities to accredited specialists in such fields as surgery, radiology, pathology, and anesthesiology. This has the effect of limiting the general practitioner to home and office treatment and of encouraging him to refer serious cases to the specialist for treatment. But here the standard of practice is one set by the profession itself and not imposed upon it from outside.

Locality of Practice

The second principal qualification of the general standard is in terms of the locality or community in which the defendant-doctor practices. This appeared in the American decisions of the nineteenth century[104] and is repeated in some recent decisions.[105] The object of the qualification was to protect the country physician. In *Small v. Howard*[106] the defendant was a general practitioner in a country town of 2,500 people. He undertook to care for a serious wound in the plaintiff's wrist, which required considerable skill in treatment, although there was an eminent surgeon living only four miles away and no emergency presented itself. The trial court charged that the defendant, having undertaken to practice in a town of comparatively small population,

> was bound to possess that skill only which physicians and surgeons of ordinary ability and skill, practicing in similar localities, with opportunities for no larger experience, ordinarily possess; and he was not bound to possess that high degree of art and skill possessed by eminent surgeons practicing in larger cities, and making a specialty of the practice of surgery.[107]

104. *E.g.*, Force v. Gregory, 63 Conn. 167, 27 Atl. 1116 (1893); Smothers v. Hanks, 34 Iowa 286 (1872); Tefft v. Wilcox, 6 Kan. 46 (1870); Small v. Howard, 128 Mass. 131, 35 Am. Rep. 363 (1880); Hathorn v. Richmond, 48 Vt. 557 (1876); Gates v. Fleischer, 67 Wis. 504 (1886). See also SHEARMAN & REDFIELD, NEGLIGENCE 491 (3d ed. 1874). Lord Nathan in his recent treatise on Medical Negligence states that this qualification has never been suggested in England and that it is probable that the courts would reject the contention that the standard of care should differ from one part of England to another. NATHAN, MEDICAL NEGLIGENCE 21 (1957). See also, *Fleming, Developments in the English Law of Medical Liability,* 12 VAND. L. REV. 633 (1959).

105. *E.g.*, Stallcup v. Coscarart, 79 Ariz. 42, 282 P.2d 791 (1955); Horton v. Vickers, 142 Conn. 105, 111 A.2d 675 (1955); Moeller v. Hauser, 237 Minn. 368, 54 N.W.2d 639 (1952); Huttner v. MacKay, 48 Wash. 2d 378, 293 P.2d 766 (1956). *Cf.* Booth v. United States, 155 F. Supp. 235 (Ct. Cl. 1957), in which in an action for malpractice of U.S. Army doctors stationed in Germany, the court considers the testimony of German medical experts as to the treatment and practices followed in that country.

106. 128 Mass. 131, 35 Am. Rep. 363 (1880).

107. *Id.* at 132, 35 Am. Rep. at 365.

On appeal, the Supreme Judicial Court of Massachusetts stated that it was common knowledge that a doctor in a small community did not make a specialty of surgery and would seldom be called upon to perform difficult operations, and furthermore that he would have fewer opportunities to observe others in practice than would be available in larger cities and public hospitals.[108] Other decisions also place emphasis upon the country doctor's lack of opportunity for wide experience and acquisition of knowledge.[109]

Some decisions recognized that the test must not be one of practice in the single locality in which the defendant resided, but should extend to "similar localities" because of the possibility that the defendant would be the only doctor in his own community or that practice of others in a small or limited area would be below the general standard of practice by rural physicians.[110] Conversely, in *Tanner v. Sanders*[111] the court specifically limited the standard applicable to a dentist practicing in Louisville, Kentucky, a city of some 350,000, to the practice in that community, saying that the defendant was not entitled to rely upon any larger area since there was an adequate sample within the city itself.

In *Viita v. Dolan*,[112] in 1916, one defendant offered to testify, on the basis of his experience and observation of practice in Cloquet, Minnesota, that the treatment applied by his partner and co-defendant was that used by physicians of ordinary care, skill and caution. This testimony was excluded by the trial court and the Supreme Court of Minnesota held that the exclusion was proper because the area of practice was too narrowly limited. The court went on to approve an instruction that the defendants were required to exercise such reasonable care and skill as an ordinary physician would exercise under like circumstances, "and that, among the circumstances to be considered, was the location of the physician in Cloquet rather than in Duluth, St. Paul, or some other place."[113] While retaining some reference to local conditions which might limit the doctor's opportunity for acquiring experience and his access to the most modern facilities for treatment, the court expanded the standard considerably by making this only one possible consideration. In fact, at one point

108. *Id.* at 136, 35 Am. Rep. at 365.
109. Smothers v. Hanks, 34 Iowa 286 (1872); Tefft v. Wilcox, 6 Kan. 46 (1870).
110. Gramm v. Boener, 56 Ind. 497 (1877); Whitesell v. Hill, 101 Iowa 629, 70 N.W. 750 (1897); Burk v. Foster, 114 Ky. 20, 69 S.E. 1096 (1902); Pelky v. Palmer, 109 Mich. 561, 67 N.W. 561 (1896); McBride v. Huckins, 76 N.H. 206, 81 Atl. 528 (1911); McCracken v. Smathers, 122 N.C. 799, 29 S.E. 354 (1898); Mutschman v. Petry, 46 Ohio App. 525, 189 N.D. 658 (1933); Bigley v. Fisher, 26 R.I. 402, 59 Atl. 72 (1904).
111. 247 Ky. 90, 56 S.W.2d 718 (1933).
112. 132 Minn. 128, 155 N.W. 1077 (1916).
113. *Id.* at 137, 155 N.W. at 1081.

the court indicates that "the same general locality" in which the standard practice is found to exist may be "the Northwest or the state" since a physician or surgeon in a village like Cloquet through frequent meetings of medical societies, articles in journals and work in hospital facilities available may be placed on an equal footing with his city brother.

The lessening effect of locality as a qualification of the standard has become even more apparent within the past twenty years. In 1940, in *Tvedt v. Haugen*,[114] the plaintiff was injured on his farm and was treated by defendant, a general practitioner in Larimore, North Dakota. Plaintiff's injuries included a spiral fracture of the tibia and rough transverse fracture of the fibula. Defendant's treatment consisted of fluoroscoping the injury, reducing the fracture, applying first a splint and then a plaster cast and taking an X-ray, followed by irregular examinations of plaintiff's leg over a period of three months. Six months after the injury, defendant learned that plaintiff had consulted doctors in a clinic in Crookston, Minnesota, and then for the first time recommended that the plaintiff see a specialist in Fargo. Plaintiff brought action for malpractice against defendant and obtained a judgment. In affirming the judgment, the court said:

> The duty of a doctor to his patient is measured by conditions as they exist, and not by what they have been in the past or may be in the future. Today, with rapid methods of transporation and easy means of communication, the horizons have been widened, and the duty of a doctor is not fulfilled merely by utilizing the means at hand in the particular village where he is practicing. So far as medical treatment is concerned, the borders of the locality or community have, in effect, been extended so as to include those centers readily accessible where appropriate treatment may be had which the local physician, because of limited facilities or training, is unable to give.[115]

On the West Coast, one District Court of Appeal in California extended the "locality" qualification to permit testimony by Los Angeles physicians in an action against a surgeon practicing in Pasadena on the basis that the two cities were contiguous, located in the same county and had the same general hospital;[116] while another such court refused to permit physicians from San Bernardino, a city of 50,000, to testify in an action brought against a physician in nearby Ontario, population 15,000.[117] In 1949, the California Supreme Court in *Sinz v. Owens*[118] sought to clarify this situation. Relying on the earlier decisions of the Minnesota and North Dakota courts, as well

114. 70 N.D. 338, 294 N.W. 183 (1940).
115. *Id.* at 349, 294 N.W. at 188.
116. Warnock v. Kraft, 30 Cal. App. 2d 1, 85 P.2d 505 (1938).
117. McNamara v. Emmons, 36 Cal. App. 2d 199, 97 P.2d 503 (1940).
118. 33 Cal. 2d 749, 205 P.2d 3 (1949).

as the lower court's opinion, the California court rejected geographic proximity as a necessary test for determining the qualifications of an expert on the standard of care. The court recognized that the opportunity for a doctor to keep abreast of advancement in the profession and his access to facilities for treatment must be given consideration. It was unwilling to say that the area in which the standard of practice must be found to exist would be so extensive as the entire San Joaquin Valley, containing two large cities and towns ranging in size down to "way stations." But pointing to the fact that the experts who testified as to what was proper treatment for the plaintiff's ailments had practiced in towns not too different in size from Lodi, the location of defendant's practice, and noting that all of these towns were tributary to Stockton and that there was testimony to the effect that the degree of care at the place of treatment was equal to that in Stockton, the court concluded: "The essential factor is knowledge of similarity of conditions; geographical proximity is only one factor to be considered."[119] Mr. Justice Carter, dissenting, would have gone further and have held that any physician licensed to practice in the State of California was competent to testify as to the standard of practice throughout the state.[120] He noted that there were only four medical schools within the state which were qualified to meet the requirements of the State Board of Medical Examiners and concluded that there was a presumption of uniformity of education and training which should be treated as the critical element rather than the locality in which practice was carried on.

The following year the Iowa Supreme Court permitted testimony by doctors from Evanston, Illinois, in an action against doctors practicing in Davenport, Iowa, on the theory that the practice in and around Davenport was comparable to practice in and around metropolitan Chicago.[121] Courts in Idaho,[122] New Jersey,[123] and Pennsylvania[124] have also taken the position that the standard of practice can no longer be narrowly restricted to the community in which the doctor operates nor even to communities of the same size, considering modern means of communication and transportation and the growing availability of clinical facilities in most parts of the country. The Florida trial court has permitted a plaintiff to rely upon expert witnesses from Chicago to establish a claim of malpractice, although on appeal the court limits itself to the question of prox-

119. *Id.* at 756, 205 P.2d at 7.
120. *Id.* at 761, 205 P.2d at 10 (dissenting opinion).
121. McGulpin v. Bessmer, 241 Iowa 1119, 43 N.W.2d 121 (1950).
122. Flock v. J. C. Palumbo Fruit Co., 63 Idaho 220, 118 P.2d 707 (1941).
123. Carbone v. Warburton, 11 N.J. 418, 94 A.2d 680 (1953).
124. Hodgson v. Bigelow, 335 Pa. 497, 7 A.2d 339 (1939).

imate cause, apparently on the theory that breach of due care might be established without expert testimony.[125]

These recent decisions do not mean that the nature of the locality in which the defendant practices may be totally disregarded. For example, in *Josselyn v. Dearborn*,[126] where the defendant practiced in a small Maine town some one hundred thirty miles from the nearest hospital and laboratories and the disease from which the plaintiff suffered was a rare one, the test approved by the court was that reasonable degree of learning and skill ordinarily possessed by other physicians under like circumstances. One of these circumstances, the court pointed out, was the remoteness of the locale. In a recent Minnesota case the plaintiff relied upon experts from the Mayo Clinic in Rochester to establish his claim against defendant who practiced in Ancker Hospital, the municipal hospital in the state capitol, St. Paul. The defendant requested an instruction that the fact that certain practices were or were not followed in the Mayo Clinic was not conclusive and that the defendant should not be judged solely by the standards of the Clinic. The supreme court held that refusal of such instruction was not error, but stated that the defendant "is only required to possess the skill and learning possessed by the average member of his school of the profession in good standing in his locality . . . ."[127] The decision is justified on the basis of earlier decisions of the court and the fact that the Mayo Clinic and Ancker Hospital are not remote from each other nor are they, or the communities in which they are located, likely to be distinguishable in terms of the character of practice found there. However, had the plaintiff's experts come from the University of Minnesota or any other "teaching institution" (as contrasted with a proprietary and primarily treatment institution) some question might be raised as to whether the standards of treatment or practice were necessarily identical. It is expected that in a teaching institution advances in practice may be attempted more rapidly than in clinics or private practice, that a certain amount of "experimental medicine" may be undertaken. Perhaps this sort of distinction between quasi-experimental and conservative treatment can be as appropriate as between the "city" and "country" doctor of another era.

This last comment is not intended to rule out the case of the doctor practicing in a remote area or in areas which are so sparsely populated as to make clinics or modern facilities unavailable in many cases. Even so, some of the decisions of recent years have unduly

125. Montgomery v. Stary, 84 So. 2d 34 (Fla. 1955), where application of steaming hot towels to the arm of a premature infant in an effort to restore circulation resulted in severe burns and loss of fingers.
126. 143 Me. 328, 62 A.2d 174 (1948).
127. Moeller v. Hauser, 237 Minn. 368, 54 N.W.2d 639 (1952).

emphasized locality, it seems. In *Stallcup v. Coscarat*,[128] an oral surgeon in Phoenix, Arizona, persuaded the appellate court that his standard of care should be qualified in terms of the community in which he was practicing, although that community was the largest metropolis in the state and in close communication with the rest of modern medicine. In *Huttner v. MacKay*,[129] the plaintiff's offer of testimony by an anatomist as to the propriety of invading certain portions of the brain in the course of surgery was excluded not only because the witness was not a neurosurgeon (which might not necessarily disqualify him as an expert on the dangers of injury to the brain) but also because he did not practice in Seattle in the years 1949 and 1950 when the defendant treated the patient.

One of the more doubtful decisions qualifying the standard of care in terms of locality would appear to be *Horton v. Vickers*,[130] decided in 1955. The defendant was a general surgeon whose work was primarily in bone and joint surgery and who held himself out to the public as a specialist in orthopedic surgery in Greenwich, Connecticut. His background consisted of an M.D. from Johns Hopkins University in 1924, internships in Detroit and Cooperstown, New York, further study in Vienna, periods as an instructor in medicine at Johns Hopkins and at Yale University, service as junior assistant on the staff of Bellevue Hospital and as instructor in surgery at the College of Physicians and Surgeons in New York City, followed by private practice in Greenwich from 1932. The trial court sitting as trier of fact was permitted to disregard the testimony of an expert to the effect that the practice of the defendant was "bad practice," apparently on the basis that "the test in this state, in determining what constitutes reasonable care, skill, and diligence, is that which physicians and surgeons in the same general neighborhood and in the same general line of practice ordinarily have and exercise in like cases"[131] and that "it was impossible to determine from his [the witness's] use of that phrase whether he meant 'bad practice' as measured by his 'subjective standards, or by Bellevue Hospital standards, or by indefinite and unfixed standards of orthopedic surgery.' "[132] While the precise nature of the witness's own qualifications or the answer which he gave is not clear, the background of the defendant and the modern opportunities for communication suggest that the orthopedic surgeon in Greenwich may well be held to either the standards of Bellevue Hospital or those accepted by orthopedic surgeons throughout the country.

128. 79 Ariz. 41, 282 P.2d 791 (1955).
129. 48 Wash. 2d 378, 293 P.2d 766 (1956).
130. 142 Conn. 105, 111 A.2d 675 (1955).
131. *Id.* at 113, 111 A.2d at 679.
132. *Id.* at 112, 111 A.2d at 678.

Although locality of practice, like "school of medicine," has declined in importance as a qualification of the standard of care with modern developments in medicine and communication, it retains some vigor today. The emphasis is properly placed less upon the geographic location and more upon the character of the defendant's practice in terms of the opportunities for experience and acquisition of information concerning developments in medical science and techniques. By doing this, as by tending toward acceptance of a single "school of medicine," the courts may achieve a relatively uniform standard of practice throughout the country. While this standard will still rely upon the actual practice accepted as proper by the profession itself, the national level of practice is likely to be improved by such uniformity.

Some Particular Duties

In addition to the limitations of the standard of care in terms of the school or system of medicine or specialty practiced by the doctor and the locality of his practice, the courts may attempt to frame some particular standards or obligations which a doctor must observe. In this section of the paper some of these special obligations are examined with a view to determining whether these obligations are anything more than a recognition by the courts of professional standards established by the medical profession itself.

Duty to keep abreast of progress

One specific or more nearly specific standard which court and jury may apply in determining whether a physician or surgeon is negligent is the obligation "to keep abreast of progress in the profession and to utilize accepted and recognized methods in diagnosis and treatment."[133]

Perhaps the commonest example of an alleged failure to keep abreast of progress is the failure to use X-ray for diagnosis of fractures or dislocations.[134] The California court has found it to be a

133. Regan, Doctor and Patient and the Law 41 (3d ed. 1956); Pike v. Honsinger, 155 N.Y. 201, 210, 49 N.E. 760, 762 (1898) may be the source of this language, although the idea is to be found in McCandless v. McWha, 22 Pa. (10 Harris) 261, 269 (1853): "And in judging of this degree of skill, in a given case, regard is to be had to the advanced state of the profession at the time. Discoveries in the natural sciences for the last half-century have exerted a sensible influence on all the learned professions, but especially on that of medicine, whose circle of truths has been relatively much enlarged. . . . The physician or surgeon who assumes to exercise the healing arts, is bound to be up to the improvements of the day. The standard of ordinary skill is on the advance; and he who would not be found wanting, must apply himself with all diligence to the most accredited sources of knowledge."

134. *E.g.*, Kingston v. McGrath, 232 F.2d 495 (9th Cir. 1956); Agnew v. City of Los Angeles, 82 Cal. App. 2d 616, 186 P.2d 450 (1947); Johnston v. A.C. Lumber Co., 37 Idaho 617, 217 Pac. 979 (1923); Wilson v. Corbin, 241 Iowa 457, 41 N.W.2d 702 (1950); James v. Grigsby, 114 Kan. 627, 220 Pac. 267 (1923); Hoover v. McCormick, 197 Ky. 509, 247 S.W. 718 (1923); De Haan v. Winter,

breach of duty to fail to use an X-ray in locating a piece of steel imbedded in the patient's eye;[135] and the Kentucky court has held it a breach of a dentist's duty of care to fail to use X-ray to locate the source of pain (a broken fragment of tooth) following an extraction.[136] In *Lawless v. Calaway*,[137] however, the California court refused to follow such cases to the extent of requiring the use of X-ray to diagnose appendicitis. In *Hunt v. Bradshaw*,[138] where some five X-ray pictures were taken in an effort to locate a piece of steel inside the body, the court concluded that there was no compulsion to take more pictures although some expert testimony indicated that more views giving all planes would aid in obtaining a clearer and more concise idea of where the piece of metal rested. The Washington court in *Derr v. Bonney*[139] found that failure to make use of X-ray after applying a plaster cast and after the patient complained of pain was not negligence per se or even evidence of negligence, when an expert testified that he used X-ray to check alignment of fractured bones but that the picture to be obtained through a plaster cast was not too clear and probably would not have benefited the plaintiff. Several courts have refused to find that failure to use an X-ray was evidence of negligence absent expert testimony that such use would be necessary.[140]

Failure to make use of biopsies or other pathological examinations which are available to determine the malignancy of a tumor may give rise to liability,[141] although the Nevada court has not found this conclusive evidence of negligence.[142] Failure to make commonly recognized tests for pregnancy when such condition is suspected and reliance on palpation only in a case where surgery may be in order, has been treated as failure to comply with reasonable medical prac-

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258 Mich. 293, 241 N.W. 923 (1932); Viita v. Dolan, 132 Minn. 128, 155 N.W. 1077 (1916); Whitson v. Hillis, 55 N.D. 797, 215 N.W. 480 (1927); Willett v. Rowekamp, 134 Ohio St. 285, 16 N.E.2d 457 (1938). See also Annot., 54 A.L.R.2d 273, 297, 302 (1957).

135. McBride v. Saylin, 6 Cal. 2d 134, 56 P.2d 941 (1936).

136. Butts v. Watts, 290 S.W.2d 777 (Ky. 1956).

137. 24 Cal. 2d 81, 147 P.2d 604 (1945).

138. 242 N.C. 517, 88 S.E.2d 762 (1955).

139. 38 Wash. 2d 678, 231 P.2d 637 (1951).

140. *E.g.*, Boyce v. Brown, 51 Ariz. 416, 77 P.2d 455 (1938); Pilgrim v. Landham, 63 Ga. App. 451, 11 S.E.2d 420 (1940); Bierstein v. Whitman, 360 Pa. 537, 62 A.2d 843 (1948); Duckworth v. Bennett, 320 Pa. 47, 181 Atl. 558 (1935); Gresham v. Ford, 192 Tenn. 310, 241 S.W.2d 408 (1950); Floyd v. Walls, 26 Tenn. App. 151, 168 S.W.2d 602 (1941); *cf.* Sibert v. Boger, 260 S.W.2d 569 (Mo. 1953).

141. See Valdez v. Percy, 35 Cal. App. 2d 485, 96 P.2d 142 (1940); Corn v. Grench, 71 Nev. 280, 289 P.2d 173 (1955).

142. See Corn v. Grench, 331 P.2d 850 (1958), affirming judgment for defendant and indicating the prior opinion merely permitted the jury to conclude that there was negligence but did not compel such conclusion.

tice.[143] In *Fortner v. Koch*,[144] failure to make use of X-ray, blood tests or biopsy in examining a patient who suffered from syphilis and had a swelling on his knee which showed symptoms of cancer, syphilis, simple tumor, abscess or tuberculosis, was held to be negligent, apparently on the basis of expert testimony as to the usual practices of physicians to use these diagnostic techniques in the community.

In *Flock v. J. C. Palumo Fruit Co.*,[145] the court relied upon expert testimony that the use of deep X-ray therapy or radium treatments were the effective treatments for plaintiff's condition and imposed liability for failure of the contract doctors to provide such treatment rather than abandoning the patient-employee as incurable. Failure to give tetanus antitoxin or to incise a "puncture wound" in accordance with generally accepted practice subjected a doctor to liability in *Hodgson v. Bigelow*.[146] Similarly, failure to administer silver nitrate solution to a newborn baby's eyes to prevent infection may fall below the standard established by modern medical practice.[147]

In *Hansen v. Pock*[148] a Chinese herb doctor was held responsible for aggravation of the patient's tuberculosis by following his traditional method of treatment. The court points out that the defendant's own testimony "discloses that he was profoundly ignorant of the circulation of the blood or the relations of the various organs of the body or their several functions or where the pulse is situated."[149] The plaintiff had relied upon expert testimony from doctors of the regular school of medicine in this case.

In the course of extracting eight of his patient's teeth, a dentist injected novocain three times around each tooth. In an action brought by the patient for ensuing osteomyelitis, an expert testified that this type of anesthetizing of the jaw could have caused the disease of the bone and there was other evidence that a "deep block" method of anesthetizing was in general use which did not create such risk of further infection from an already infected mouth. The court concluded that the failure to use the safer method or to send the patient to a doctor who could administer it could be negligence.[150]

143. *In re* Johnson's Estate, 145 Neb. 333, 16 N.W.2d 504 (1944); Peterson v. Hunt, 197 Wash. 255, 84 P.2d 999 (1938).
144. 272 Mich. 273, 261 N.W. 762 (1935), 277 Mich. 429, 269 N.W. 222 (1936) (decision on second appeal).
145. 63 Idaho 220, 118 P.2d 707 (1941).
146. 335 Pa. 497, 7 A.2d 338 (1939); *cf.* Hembree v. Von Keller, 189 Okla. 439, 119 P.2d 74 (1941).
147. *E.g.*, Walden v. Jones, 289 Ky. 395, 158 S.W.2d 609 (1942); Medlin v. Bloom, 230 Mass. 201, 119 N.E. 773 (1918); Jordan v. Skinner, 187 Wash. 617, 60 P.2d 697 (1936).
148. 57 Mont. 51, 187 Pac. 282 (1920).
149. *Id.* at 54, 187 Pac. at 284.
150. Vigneault v. Dr. Hewson Dental Co., 300 Mass. 223, 15 N.E.2d 185 (1938), 129 A.L.R. 95 (1940).

With the exception of some of the X-ray cases, all of these decisions appear to be based on expert medical testimony in the case itself. And even in the X-ray cases the courts rely upon the commonly known fact that X-ray is widely used in the diagnosis of fractures. The Washington court in *Peterson v. Hunt*[151] makes this reliance upon the professional practice clear in distinguishing an earlier decision which had refused to permit a finding of negligence solely on the basis of failure to use X-ray.[152]

Perhaps one of the best illustrations of the change in medical techniques and the problem of "keeping abreast of progress" is to be found in the Pennsylvania case of *Powell v. Risser*[153] and later developments. There a patient, who was a manic-depressive, escaped from a state hospital and was returned in a manic state, "violent, threatening to run away and liable to injure himself and others," but otherwise in good physical condition. The doctors in charge directed nurses to administer a "wet pack" treatment consisting of wrapping the patient's body and limbs in six or seven wet sheets, tying two of these around his body so that he was able to move his limbs but unable to free himself, and then immersing him in a tub of warm (94-96° F.) water. Three such wet packs were administered in fairly rapid succession during a 24 hour period, each administration involving the patient being in water for approximately six hours. Following the administration of the wet packs the patient suffered a sixty per cent impairment of the use of his arms and hands. He brought action against the doctors, claiming that the nature of the wet packs and the method of administration had caused constriction of his arms and the resulting disability. The jury brought in a verdict against the defendants. On appeal, the Supreme Court of Pennsylvania reversed and entered judgment in favor of the doctors. The majority said:

> These wet packs differed in no way from the accepted and standard practice, not only at the Allentown State Hospital but in all other mental institutions operated and maintained by the Commonwealth. Such treatments are the most modern and humane method yet devised for the restraint of violent, raving and desperate patients.[154]

Mr. Justice Musmanno, dissenting, commenced his opinion with the statement:

> The assumed therapeutics administered to the plaintiff in this case read like the chronicle of a medieval torture. This does not say that the plaintiff's condition might not have warranted such treatment. The care

151. 197 Wash. 255, 259, 84 P.2d 999, 1000 (1938).
152. Wells v. Ferry-Baker Lumber Co., 57 Wash. 658, 107 Pac. 869 (1910).
153. 375 Pa. 60, 99 A.2d 454 (1953).
154. *Id.* at 63, 99 A.2d at 455.

> of mental patients sometimes requires the application of physical restraint which must seem cruel and brutal to those unfamiliar with the routine of mental institutions. However, the unnecessary or reckless use of violent measures which steal away physical assets from one already robbed of the treasures of a sound mind constitutes a misdeed which humanity abhors, justice condemns, and the law should correct.[155]

The facts occurred in May, 1946. The court's decision was rendered in October, 1953. Within a few years, the development of such "tranquilizers" as chlorpromazine (Thorazine), reserpine and meprobamate (Miltown) have changed the picture of the treatment of psychiatric and psychotic patients tremendously.[156] The former two have proved fairly effective in the control of such cases as Mr. Powell's, and in some institutions have made the "wet pack" an obsolete form of treatment or restraint. Quaere whether if the same case were to occur today the court would be willing to absolve the doctors from responsibility.

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155. *Id.* at 69-70, 99 A.2d at 458. I should include at this point the comments of Dr. William Fleeson, Department of Psychiatry and Neurology, University of Minnesota Medical School, with regard to the *Powell* case and the quoted portion of Mr. Justice Musmanno's dissenting opinion: "The wet sheet pack is a procedure which, if properly done, does *not* cause disability, either permanent or temporary, nor even discomfort. Duration of a wet sheet pack treatment is variable—20 minutes to 7 hours with two hours an average, see HORMER & HENDERSON, PRINCIPLES AND PRACTICE OF NURSING 484 ff. (4th ed. 1939); Kindwall & Henry, *Wet Packs and Prolonged Baths,* 92 AM. J. PSYCHIATRY 73 (1934). . . . "Now, if the patient did indeed suffer this disability of 60% impairment of the use of his hands and arms it would certainly appear that the packs or tubs were improperly used. The issue would then be whether or not the packs (tubs) were properly used according to the then prevailing standards of practice" rather than whether their use at all was proper. [This last is a point well taken.]
"Mr. Justice Musmanno, in his dissent, could be interpreted as meaning that he personally was horrified and emotionally traumatized by his own phantasy of the nature of the treatment. (Most people are—hence my willingness to show our own psychiatric wards to interested visitors—there is nothing like reality to dispel phantasy.) This leads me to speculate, as others have done before me, on the problem of dramatizing the exotic and bizarre, fostering emotional reaction to the feared and fearful and thus, in a way, obscuring the issues before the court. It is an unusual person, Mr. Justice Musmanno not excepted, who does not think to himself, 'I would feel thus and so if this happened to me.' Most of us then find rational explanations for the feelings we experience when confronted with such a situation. This appears to me to be the dynamic consideration behind such statements as 'I don't want them experimenting on me' or 'I'd never let them do that to me.' "

156. Although the testing of such drugs began earlier, the reports of clinical evaluation of their use in the control and treatment of psychiatric and psychotic states seem to have begun to appear in 1954 and 1955. See, *e.g.,* Barsa & Kline, *Treatment of Two Hundred Disturbed Psychotics with Reserpine,* 158 J.A.M.A. 110 (1955); Borrus, *Study of Effect of Miltown on Psychiatric States,* 157 J.A.M.A. 1596 (1955); Elkes and Elkes, *Effect of Chlorpromazine in the Behavior of Chronically Overactive Psychotic Patients,* 2 BRIT. MED. J. 560 (1954); Freund, *Observations During the Treatment of 175 Psychotic Patients with Reserpine,* 29 PSYCHIATRIC QUARTERLY 381 (1955); Selling, *Clinical Study of New Tranquilizing Drug: Use of Miltown,* 157 J.A.M.A. 1594 (1955); Winkelman, *Chlorpromazine in the Treatment of Neuropsychiatric Disease,* 156 J.A.M.A 18 (1954); Zeller, Graffagnio, Cullen & Rietman, *Use of Chlorpromazine and Reserpine in the Treatment of Emotional Disorders,* 160 J.A.M.A. 179 (1956).

It should be noted, as indicated by Mr. Rowland Long in his book, *The Physician and the Law,* that in some instances a doctor may find himself in difficulty in following too assiduously the most recent developments in medical science.[157] For example, the administration of antibiotics for any and all ailments may prove to be dangerous and not in accord with accepted medical practice as evidence develops that these drugs may develop undesirable tolerances in the patient so that their use in case of serious infection is valueless. Another example is found in *Reed v. Church*[158] where the defendant-physician had given tryparsamide injections for the patient's cerebro-spinal syphilis. Testing of the drug had disclosed that there was a danger of ocular disturbance from its use. The patient suffered severe effects. Although the doctor attempted to bring himself within a "recognized minority" of physicians who did not discontinue the use of tryparsamide when visual disturbances occurred, the court said that his own testimony that it was usual practice to do so and that he had done so placed him outside the protection of any "doctors may differ" doctrine. In the case of the tranquilizers mentioned in connection with *Powell v. Risser,*[159] it was early recognized that certain "side effects" took place which might give pause to a doctor using them in any and all cases. Perhaps the most pronounced of these has been the development of jaundice in cases where chlorpromazine has been used, although the reports from the use of reserpine have also suggested that there may be undesirable side effects.[160] The possibility that some side effects may not appear for a considerable length of time after the drug is administered may justify hesitancy on the part of some doctors or the profession as a whole giving wholehearted acceptance to their complete substitution for older methods of treatment. Certainly this risk of side effects should make the courts hesitant to insist too adamantly that doctors adopt the most recent developments or discoveries in pharmaceuticals. The unfortunate consequences of the "Cutter Laboratories Case"[161] in which a number

157. LONG, THE PHYSICIAN AND THE LAW 38-39 (1955).
158. 175 Va. 284, 8 S.E.2d 285 (1940).
159. *Supra* note 156.
160. See Hodges, *La Zerte, Jaundice and Agranalocytosis with Fatality Following Chlorpromazine Therapy,* 158 J.A.M.A. 114 (1955); Loftus and others, *Jaundice Caused by Chlorpromazine (Thorazine),* 157 J.A.M.A. 1286 (1955); Zeller, *Use of Chlorpromazine and Reserpine in the Treatment of Emotional Disorders,* 160 J.A.M.A. 179 (1956). The latter study indicates that among patients who were treated with chlorpromazine, 9.5% developed dermatitis and 5% developed jaundice. Reserpine seems to create more uncomfortable subjective symptoms such as nausea, vomiting and nasal stiffness. Both drugs apparently may cause Parkinsonism, characterized by rigidity, tremour, akinesia and loss of spontaneous and automatic movement. The authors conclude that most of such side effects and toxic reactions are controllable by reduction or elimination of the dosage of the drug or by use of other medication.
161. Gottsdanker v. Cutter Laboratories, No. 266, 824 and Phipps v. Cutter

of children received live virus in the early days of mass immunization with the Salk Vaccine, suggests that keeping abreast of progress may require some restraint. These comments lead to the next specialized duty.

Experimentation

It is frequently reiterated in text discussions of medical negligence that in the treatment of the patient there must be no experimentation and that experimentation is undertaken at the doctor's peril.[162] A closer examination of the case law however, suggests that this is something of an over-statement.

A distinction should be drawn between "therapeutic innovation" directed primarily to obtaining relief or cure for the ills of a particular patient, which appears to be accepted as a not uncommon practice in most medical offices,[163] and experimental research which has been defined as "a sequence resulting from an active determination to pursue a certain course and to record and interpret the ensuing observations" primarily for the purpose of advancing scientific knowledge.[164] As has been pointed out in a series of recent studies, all of the cases which purport to state the rule that a physician may not experiment have dealt with the former situation.[165] Such decisions deal almost entirely with the failure of the defendant to follow a well-recognized practice or method of treatment.

In the first case, *Slater v. Baker*,[166] decided in 1767, there is reason to believe that experimental methods were being used in an attempt to straighten the patient's leg.[167] Although one writer has concluded

Laboratories, No. 272, 691, (Superior Court of California for Alameda County). In these actions brought by the children and their parents against the manufacturer of the vaccine which contained live virus, the plaintiffs have obtained verdicts on the basis of breach of warranty of fitness rather than negligence. At this writing, the cases are being appealed to the Supreme Court of California.

162. REGAN, DOCTOR AND PATIENT AND THE LAW 370 (3d ed. 1956); LONG, THE PHYSICIAN AND THE LAW 304 (1955); 41 AM. JUR. *Physicians and Surgeons* § 86 (1942); Annot., 37 L.R.A. 830, 836 (1897).

163. See Ivy, *The History and Ethics of the Use of Human Subjects in Medical Experiments*, 108 SCIENCE 1 (1948); Shimkin, *The Problem of Experimentation on Human Beings: The Research Worker's Point of View*, 117 SCIENCE 205 (1953).

164. Shimkin, note 163 *supra* at 205. See also Ladimer, *Ethical and Legal Aspects of Medical Research on Human Beings*, 3 J. PUB. L. 467, 482-86 (1954).

165. Beecher, *Experimentation on Man*, 169 J.A.M.A. 461, 470-71 (1959); Ladimer, *Ethical and Legal Aspects of Medical Research on Human Beings*, 3 J. PUB. L. 467, 476-79 (1954); Note, *Torts: Physicians and Surgeons: Malpractice: Liability for Medical Experimentation*, 40 CALIF. L. REV. 159 (1952).

166. 2 Wils. 359, 95 Eng. Rep. 860 (K.B. 1767).

167. The court in granting judgment for the plaintiff said: "When we consider the good character of Baker [the surgeon defendant], we cannot well conceive why he acted in the manner he did; but many men very skilful in their profession have frequently acted out of the common way for the sake of trying experiments. . . . It seems as if Mr. Baker wanted to try an experiment with this new instrument. . . . For anything that appears to the court, this was the first experiment made with this new instrument. . . ."

that since that case there have been no other appellate cases which really involved experimentation,[168] at least a few of the cases involve innovations in treatment or use of techniques which are somewhat out of the ordinary.[169] Of course, some cases involve mere quack cures,[170] or misdiagnosis,[171] or a failure to exercise proper care in the treatment of the patient,[172] rather than real experimental methods. It is significant that in none of the cases has the doctor himself asserted that he was engaging in either experimental or innovational techniques, probably because of the early statements of the courts in England and America indicating that such activity would be treated as per se negligence.[173]

Some of the langnage used in the leading case of *Carpenter v. Blake*,[174] suggests that the "experiment" test is really nothing more than the general standard of care in terms of practice of a reputable practitioner in the community:

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168. Note, 40 CALIF. L. REV. 159, 162 (1952).

169. *E.g.*, Brown v. Hughes, 94 Colo. 295, 30 P.2d 259 (1934) (extraction of all teeth from upper jaw and removal of tonsils at same time, a procedure which had been successfully performed in several other cases); Baldor v. Rogers, 81 So. 2d 658 (Fla. 1955) (injections of glyocylide for skin cancer seems to have had limited acceptance; verdict and judgment for patient affirmed on ground of failure to discontinue treatment when it proved inadequate); Miller v. Toles, 183 Mich. 252, 150 N.W. 118 (1914) (use of "Murphy Treatment" rather than amputation of foot); Owens v. McCleary, 313 Mo. App. 213, 281 S.W. 682 (1926) (insertion of speculum and injection of caustic fluid for treatment of mild case of piles, admitted by expert to be known to medical profession but not practiced by regular school of medicine); McClarin v. Grenzfelder, 147 Mo. App. 478, 126 S.W. 817 (1910) (injection of paraffin into groin or muscle over hernia, which was claimed to have caused peritonitis, had been undertaken by defendant in "hundreds of cases" and had been successfully used in Chicago, Cincinnati and Vienna by other physicians and was subsequently used by others in St. Louis area); Sawdey v. Spokane Falls & N. Ry., 30 Wash. 349, 70 Pac. 972 (1902) (use of long splint rather than extension and counter-extension, which had proved successful in some cases and according to one witness was approved by some authority, not treated by court as sufficient to justify disregarding usual procedure).

170. Kershaw v. Tilbury, 214 Cal. 679, 8 P.2d 109 (1932) (self-perfected "radio-treatment" for osteomyelitis); Graham v. Dr. Pratt Institute, 163 Ill. App. 91 (1911) (Use of carbolic acid to remove smallpox scars); Board of Medical Registration and Examination of Indiana v. Kaadt, 225 Ind. 625, 76 N.E.2d 669 (1948) (use of concoction of vinegar, potassium nitrate, pepsin and takadiastse, taken orally, together with sugar-heavy diet for treatment of diabetes).

171. Kershaw v. Tilbury, 214 Cal. 679, 8 P.2d 109 (1932); Jackson v. Burnham, 20 Colo. 532, 39 Pac. 577 (1895); Hodgson v. Bigelow, 235 Pa. 497, 7 A.2d 338 (1939); cf. Gleason v. McKeehan, 100 Colo. 194, 66 P.2d 808 (1937) (claim of mis-diagnosis of pending miscarriage as placenta previa, for which caesarean operation was performed).

172. *E.g.*, Langford v. Kosterlitz, 107 Cal. App. 175, 290 Pac. 80 (1930) (injection of alcohol mixed with novocaine into nasal channel in treatment of asthma caused blindness when recognized practice of injecting novocaine first would have prevented injury to optic nerve); Carpenter v. Blake, 60 Barb. 488 (N.Y. Sup. Ct. 1871) (failure to give proper directions to patient as to care of elbow set and left outside of cast or sling); Davis v. Wilmerding, 222 N.C. 639, 24 S.E.2d 337 (1943) (removal of arm from splints and cast and massage resulted in crooked arm); Allen v. Voje, 114 Wis. 1, 89 N.W. 924 (1902) (scraping of infected uterus under unsanitary conditions).

> If the case is a new one, the patient must trust to the skill and experience of the surgeon he calls; so must he if the injury or disease is attended with injury to other parts, or other diseases have developed themselves, for which there is no established mode of treatment. But when the case is one as to which a system of treatment has been followed for a long time, there should be no departure from it, unless the surgeon who does it is prepared to take the risk of establishing, by his success, the propriety and safety of his experiment.
>
> The rule protects the community against reckless experiments, while it admits the adoption of new remedies and modes of treatment only when their benefits have been demonstrated, or when, from the necessity of the case, the surgeon or physician must be left to the exercise of his own skill and experience.[175]

Later opinions have suggested that even where there is an established mode of treatment, the physician may be permitted to innovate somewhat if he can establish that in his best judgment this was for the benefit of the patient and where the established modes have proved unsuccessful.[176] There appears to be some question as to whether the patient's condition must be such that death is almost inevitable[177] or whether innovation may be permitted where it would avoid serious consequences short of death.[178] In one case, involving disciplinary action by the state medical grievance committee rather than an action by a patient, the court indicated that acknowledged experimentation with the patient's consent is at least not grounds for discipline.[179] Whether, if unsuccessful it would be a ground for civil action is not clear.

173. See Slater v. Baker, 2 Wils. 359, 362, 95 Eng. Rep. 860, 863 (K.B. 1767): "If it was (the first experiment made with a new instrument), it was a rash action, and he who acts rashly acts ignorantly . . . in this particular case they have acted ignorantly and unskillfully, contrary to the known rule and usage of surgeons"; Carpenter v. Blake, 60 Barb. 488, 514, (N.Y. Sup. Ct. 1871): "[I]t is incumbent on surgeons called to treat such an injury, to conform to the system of treatment thus established; and if they depart from it, they do it at their peril." *Id.* at 518: "It is said in *Slater v. Baker* (supra,) that it is ignorance and unskillfulness to do contrary to the rule of the profession."

174. 60 Barb. 488 (N.Y. Sup. Ct. 1871), *rev'd on other grounds*, 50 N.Y. 696 (1872).

175. *Id.* at 523-24.

176. See Jackson v. Burnham, 20 Colo. 532, 540, 39 Pac. 577, 580 (1895): "[I]f the physician sees fit to experiment with some other mode, he should do so at his peril. In other words, he must be able, in the case of deleterious results, to satisfy the jury that he had reason for the faith that was in him and to justify his experiment by some reasonable theory." Allen v. Voje, 114 Wis. 1, 22, 89 N.W. 924, 932 (1902): "Nor do we believe that a physician of standing and loyalty to his patients will subject them to mere experiment, the safety or virtue of which has not been established by experience in the profession, save possibly when the patient is in extremis, and fatal results substantially certain unless the experiment may succeed."

177. Allen v. Voje, 114 Wis. 1, 89 N.W. 924 (1902).

178. See Jackson v. Burnham, 20 Colo. 532, 39 Pac. 577 (1895); Baldor v. Rodgers, 81 So. 2d 658 (Fla. 1955); 40 CALIF. L. REV. 159, 163 (1952).

179. See Stammer v. Board of Regents, 262 App. Div. 372, 29 N.Y.S.2d 38 (3d Dep't 1941), *aff'd*, 287 N.Y. 359, 39 N.E.2d 913 (1942) in which a "cancer cure" proved successful. Compare Baldor v. Rodgers, 81 So. 2d 658 (Fla. 1955) where somewhat similar cure was not successful.

Many of these decisions appear to disregard the fact that there is no "standard patient" to whom recognized practices can be applied. Each patient may present a new and novel problem to the doctor. A realistic view of the physician's practice would seem to call for some innovation to fit the peculiar circumstances of each case. With this in mind, it is suggested that the "experiment" cases are merely a reflection of the general rule that where the defendant has deviated from the practice which a reasonable member of his profession would follow under the same circumstances or has undertaken a form of treatment which the reasonable member of the profession would not willingly undertake, he may be held liable for harm caused thereby to the patient.

The only example of judicial consideration of experimental research, as contrasted with therapeutic innovation, appears to be the "Medical Case" of the Nurenberg War Crimes Trials, in which some seven officials of the German Reich were sentenced to death and nine others imprisoned for periods ranging from ten years to life for their experimentation on human beings.[180] The judgment of the court contains ten precepts for "permissible medical experiments."[181]

180. United States v. Brandt, 1 & 2 TRIALS OF WAR CRIMINALS BEFORE THE NURENBERG MILITARY TRIBUNALS UNDER CONTROL COUNCIL LAW No. 10 (1947).

181. 2 TRIALS OF WAR CRIMINALS BEFORE THE NURENBURG MILITARY TRIBUNALS 181-82 (1947): "The great weight of the evidence before us is to the effect that certain types of medical experiments on human beings, when kept within reasonably well-defined bounds, conform to the ethics of the medical profession generally. The protagonists of the practice of human experimentation justify their views on the basis that such experiments yield results for the good of society that are unprocurable by other methods or means of study. All agree, however, that certain basic principles must be observed in order to satisfy moral, ethical and legal concepts:

"1. The voluntary consent of the human subject is absolutely essential.

"This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.

"The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engaged in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

"2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.

"3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.

"4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.

These have been expanded and somewhat modified by other authorities[182] including the Judicial Council of the American Medical Association.[183] But there appears to be unanimous approval of the proposition that experimentation on humans, where conducted by reputable and qualified investigators who have obtained understanding and enlightened consent from the subjects and have taken adequate precautions against risk of serious injury, disability or death, is not improper medical practice. Of course, within the area of permitted experimentation there is room for negligent conduct on the part of the investigator, but it is almost certain that the courts will treat the consent of the subject as limited to careful conduct of experimental research. In the Medical Case of the Nurenberg War Crimes Trials there is no question that the conduct of the experiments was at least negligent, if indeed not wilful misconduct.[184] But here, as in the

"5. No experiment should be conducted where there is an *a priori* reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.

"6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

"7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability or death.

"8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.

"9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where the continuation of the experiment seems to him to be impossible.

"10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him, that a continuation of the experiment is likely to result in injury, disability or death to the experimental subject."

182. See, *e.g.*, Beecher, *Experimentation in Man*, 169 J.A.M.A. 461, (1959); Ivy, *The History and Ethics of the Use of Human Subjects in Medical Experiments*, 108 SCIENCE 1 (1948); Ladimer, *Ethical and Legal Aspects of Medical Research on Human Beings*, 3 J. PUB. LAW 467, (1954); Wiggers, *Human Experimentation as Exemplified by the Career of Dr. William Beaumont*, ALUMNI BULLETIN School of Medicine, Western Reserve University 60 (1950). Dr. Beecher is particularly troubled by some of the problems of "understanding and enlightened consent" as required by the Nurenberg principles, as well as the difficulty of determining what are "fruitful results for the good of society" and the apparent rejection of random experiment as a permissible practice even though some substantial medical advancement has occurred through such experiments.

183. *Supplementary Report of the Judicial Council of the American Medical Association*, 132 J.A.M.A. 1090 (1946). See also *Ethics Governing the Service of Prisoners as Subjects in Medical Experiments*, 136 J.A.M.A. 457 (1948).

184. As the Judgment of the Tribunal sums up the case: "We find from the evidence that in the medical experiments which have been proved, these ten principles [see note 181 *supra*] were much more frequently honored in their breach than in their observance. Many of the concentration camps' inmates who were the victims of these atrocities were citizens of countries other than the German Reich. They were non-German nationals, including Jews and 'asocial persons' both prisoners of war and civilians, who had been imprisoned and forced to submit to these tortures and barbarities without so

therapeutic innovation cases, the courts appropriately should apply the standards of the medical profession itself in determining whether liability should exist for injuries suffered by the subject of the experimental research.

Duty to Inform or Disclose Facts

The courts frequently state that the relation between the physician and his patient is a fiduciary one and therefore the physician has an obligation to make a full and frank disclosure to the patient of all pertinent facts related to his illness. The obligation of disclosure appears to be of significance in three somewhat different contexts: in avoiding the statute of limitations, in connection with claims of unauthorized treatment, and as a basis for liability itself.

The first situation arises where the patient attempts to assert a claim for malpractice which occurred and caused injury far enough in the past so that the statute of limitations may have run prior to the commencement of any action. In such a situation some courts have adopted a sympathetic attitude toward the patient as opposed to the knowledgeable doctor and have treated the failure of the doctor to disclose the existence of a cause of action or his own negligence as "fraudulent concealment" which will toll the statute.[185] A number of the courts have indicated that in order to so toll the statute the patient must establish actual knowledge on the part of the physician of the fact of a wrong done to the patient[186] and some affirmative act of

much as a semblance of trial. In every single instance appearing in the record, subjects were used who did not consent to the experiments; indeed, as to some of the experiments, it is not even contended by the defendants that the subjects occupied the status of volunteers. In no case was the experimental subject at liberty of his own free choice to withdraw from any experiment. In many cases experiments were performed by unqualified persons; were conducted at random for no adequate scientific reason, and under revolting physical conditions. All of the experiments were conducted with unnecessary suffering and injury and but very little, if any precautions were taken to protect or safeguard the human subjects from the possibilities of injury, disability or death. In every one of the experiments, the subjects experienced extreme pain or torture, and in most of them they suffered permanent injury, mutilation or death, either as a direct result of the experiments or because of lack of adequate follow-up care." 2 TRIALS OF WAR CRIMINALS BEFORE THE NURENBERG MILITARY TRIBUNALS 183 (1947).

185. *E.g.*, Morrison v. Acton, 68 Ariz. 27, 198 P.2d 590 (1949); Stafford v. Shultz, 42 Cal. 2d 767, 270 P.2d 1 (1954); Pashley v. Pacific Elec. Co., 25 Cal. 2d 226, 153 P.2d 325 (1949); Groendal v. Westrade, 171 Mich. 92, 137 N.W. 87 (1912); Schmucking v. Mayo, 183 Minn. 37, 235 N.W. 633 (1931); Moses v. Miller, 202 Okla. 605, 216 P.2d 979 (1950); Hudson v. Shoulders, 164 Tenn. 70, 45 S.W.2d 1072 (1932). *Contra,* Graham v. Updegraph, 144 Kan. 45, 58 P.2d 475 (1936) (assuring plaintiff that radium beads inserted in body for treatment of cancer had been removed); Conklin v. Draper, 229 App. Div. 227, 241 N.Y. Supp. 529 (1930) (defendant knew that he had left forceps in plaintiff's abdominal cavity); McCoy v. Stevens, 182 Wash. 55, 44 P.2d 797 (1935) (assurances for four years that X-ray burns were superficial and would soon pass away).

186. *E.g.*, Pickett v. Aglinsky, 110 F.2d 628 (4th Cir. 1940); Hudson v. Moore, 239 Ala. 130, 194 So. 147 (1940); Carter v. Harlan Hospital Ass'n, 265 Ky. 452,

concealment or misrepresentation.[187] The cases most frequently involve the negligent act of leaving foreign objects in the patient's body, although some do arise in the situation where the doctor has assured the patient of a cure which has not been accomplished or where the doctor has failed to disclose a worsening of the patient's condition. These are to be distinguished from other cases in which the statute is tolled during the period of treatment on the theory that the doctor has a continuing duty to diagnose the patient's infirmity and to render reasonable treatment therefor, so that his failure to do so may constitute a continuing negligence.[188] In all of these cases the failure to disclose is not itself being held actionable but merely precludes the doctor from asserting that the statute has run prior to the date on which the patient acquires knowledge of his injury and the negligent acts which led to it. In a few cases the courts have said that even where the patient knows of injuries, the confidential relationship and reliance upon the assurances of the physician as to proper care may excuse the patient from further inquiry into why the injury occurs or why a cure is not accomplished.[189] It does not appear that the confidential relation of doctor and patient is being strained too far when the courts decide that a doctor who should realize something is amiss but fails to inform the patient cannot complain of the patient's delay in bringing action.

In the second type of situation, the physician or surgeon is charged with treating the patient without consent on the ground that the patient was not fully informed of the nature of the treatment or its consequences and therefore any "consent" obtained was ineffective. In *Paulsen v. Gundersen*[190] the plaintiff was having trouble with his ear and placed himself under the doctor's care. The doctor informed his patient that an operation would be necessary, but in response to the plaintiff's inquiry said that it was "a 'simple' mastoid operation unaccompanied by any danger." In fact a "radical"[191] operation was

97 S.W.2d 9 (1936); Albert v. Sherman, 167 Tenn. 133, 67 S.W.2d 104 (1934); Carrell v. Denton, 138 Tex. 145, 157 S.W.2d 878 (1942).

187. *E.g.*, Pickett v. Aglinski, *supra* note 186; De Haan v. Winter, 258 Mich. 293, 241 N.W. 923 (1932); Carrell v. Denton, *supra* note 186.

188. *E.g.*, Huysman v. Kirsch, 6 Cal. 2d 302, 57 P.2d 908 (1936); De Haan v. Winter, 258 Mich. 293, 241 N.W. 923 (1932); Schmit v. Esser, 183 Minn. 354, 236 N.W. 622 (1931); Gillette v. Tucker, 67 Ohio St. 106, 65 N.E. 865 (1902); Bowers v. Santee, 99 Ohio St. 361, 123 N.E. 238 (1919). *Contra*, Conklin v. Draper, 229 App. Div. 227, 241 N.Y. Supp. 529 (1930), *aff'd*, 254 N.Y. 620, 173 N.E. 892 (1930); McCoy v. Stevens, 182 Wash. 55, 44 P.2d 797 (1935).

189. *E.g.*, Stafford v. Shultz, 42 Cal. 2d 767, 270 P.2d 1 (1954); Wohlgemuth v. Meyer, 139 Cal. App. 2d 326, 293 P.2d 816 (1956); Adams v. Ison, 249 S.W.2d 791 (Ky. 1952).

190. 218 Wis. 578, 260 N.W. 448 (1935).

191. Used in the medical sense of going to the root of illness by removal of diseased portions of the body or extensive surgery as contracted with "conservative" treatment which attempts to save the diseased organ. Both are accepted modes of treatment.

performed in the course of which a facial nerve was severed and the plaintiff not only lost the hearing in one ear but also suffered paralysis of the left side of his face. The court indicated that failure to disclose fully the nature of the treatment might vitiate the consent. Similarly, in *Wall v. Brim*,[192] what was described as a simple operation to remove a cyst turned out to be a major operation resulting in partial paralysis of the patient's face.

In *Waynick v. Reardon*[193] plaintiff suffered from some occlusive vascular or peripheral vascular disease, not clearly diagnosed. The physician recommended a lumbar sympathectomy which was described as "a minor or simple operation requiring only a small incision in his back and a clipping of a nerve, which operation would necessitate his being in the operating room only 40 to 45 minutes." Instead an eight-inch incision was made in his torso and an operation performed which, due to complications, threatening the patient's life, lasted for over seven hours and ultimately resulted in the loss of both legs, hospitalization for a period of over four months and morphine habituation. The court indicates that the operation performed may have been unauthorized.

In *Bang v. Charles T. Miller Hosp.*,[194] the patient went to a urologist because of bladder trouble and apparently consented to a cystoscopic examination and some form of operation (although the exact extent of consent is not clear). He was not informed that part of the procedure of a prostate resection (the standard operation for the correction of the plaintiff's difficulty) would be the tying off of his sperm ducts. The Minnesota Supreme Court held that the plaintiff might recover for the sterile condition alleged to have resulted from this operation, saying:

> While we have no desire to hamper the medical profession in the outstanding progress it has made and continues to make in connection with the study and solution of health and disease problems, it is our opinion that a reasonable rule is that, where a physician and surgeon can ascertain in advance of an operation alternative solutions and no immediate emergency exists, a patient should be informed of the alternative possibilities and given a chance to decide before the doctor proceeds with the operation. By that we mean that, in a situation such as the case before us where no immediate emergency exists, a patient should be informed before the operation that if his spermatic cords were severed it would result in his sterilization, but on the other hand if this were not done there would be a possibility of an infection which could result in serious consequences. Under such conditions the patient would at least have the opportunity of deciding whether he wanted to take the chance of a possible infection if the operation was performed in one manner or to become sterile if performed in another.[195]

192. 138 F.2d 478 (5th Cir. 1943).
193. 236 N.C. 116, 72 S.E.2d 4 (1952).
194. 251 Minn. 427, 88 N.W.2d 186 (1958).

In *Corn v. French*,[196] the patient executed a written consent to the performance of a "mastectomy" (removal of the breast) without knowing the meaning of the term, although she claimed that subsequently she informed the doctor that she did not wish her breast removed. After the performance of a radical mastectomy, the doctor discovered that the patient was not suffering from carcinoma of the breast, as he had believed on the basis of visual examination, palpation and her medical history. In an action for unauthorized treatment, the court indicated some doubt as to the right of the patient to *repudiate* a written consent after the operation as distinguished from *withdrawal* of consent based on later statements to the doctor. Even in the absence of withdrawal of consent, it may be questioned whether the patient is not entitled to an explanation of the consequences of the operation in terms understandable by the layman.[197]

On the other hand, in *Hunt v. Bradshaw*,[198] the doctor had assured the patient that an operation to remove a small piece of steel which was imbedded in his neck would be "very simple." The court indicated that the evidence was such that the jury might conclude that the operation was of a very serious nature. With regard to the disclosure by the doctor, the court said:

> It is understandable that the surgeon wanted to reassure the patient so that he would not go to the operating room unduly apprehensive. Failure to explain the risk involved, therefore, may be considered a mistake on the part of the surgeon, but under the facts cannot be deemed such want of ordinary care as to import liability.[199]

In *Kinney v. Lockwood*[200] the patient claimed that the doctors had undertaken to perform a simple operation for Dupuytren's contracture and had stated that her hand would be all right in three days, whereas the operation was in fact serious, precarious and dangerous, and in a large number of cases had proved unsuccessful and caused serious permanent injury, and in fact did so in this case. The Ontario trial judge concluded that it was the duty of the defendant doctors to "enlighten the patient's mind in a plain and reasonable way as to what her ailment was, as to what were the risks of operating promptly,

195. *Id.* at 434, 88 N.W.2d at 190. In the second trial of the case the jury entered a verdict for the defendant-urologist. There appears to have been some evidence introduced by defendant to the effect that the trans-uretheral resection to which the patient had consented would itself have resulted in sterility, or that the patient's condition would have caused sterility in any event.

196. 71 Nev. 280, 289 P.2d 173 (1955).

197. See also Theodore v. Ellis, 141 La. 709, 75 So. 655 (1917) (failure to fully explain operation and necessity therefor); Hunter v. Burroughs, 123 Va. 113, 96 S.E. 360 (1918) (failure to warn patient of risk of X-ray treatment for eczema).

198. 242 N.C. 517, 88 S.E.2d 762 (1955).

199. *Id.* at 523, 88 S.E.2d at 766.

200. (1931) Ont. Rep. 438, (1931) 4 D.L.R. 906 (Ont. Sup. Ct.).

what were the risks of delaying the operation, and what were the risks of not operating at all,"[201] and found for the plaintiff. On appeal the judgment was reversed,[202] the appellate court saying that there was some testimony that the doctors had explained all details to the plaintiff, although the extracts contained in the opinions indicate that the doctor admitted to having said that the operation was not a very serious one and that he had not clearly presented the alternatives to the plaintiff. One judge on the court of appeals concluded:

> The relationship between the defendant Stoddart and the plaintiff was that of surgeon and patient, and as such the duty cast upon the surgeon was to deal honestly with the patient as to the necessity, character and importance of the operation and its probable consequences and whether success might reasonably be expected to ameliorate or remove the trouble, but that such duty does not extend to warning the patient of the dangers incident to, or possible in any operation, nor to details calculated to frighten or distress the patient.[203]

and another said:

> To fasten on a physician or surgeon the obligation to discuss with his patient the possibilities and probabilities of an operation (without any request by the patient) in order that the patient might make an election as to when the operation shall take place, simply because of the fiduciary and confidential relationship existing between a patient and her surgeon or physician, is to my mind unwarranted.[204]

The conclusion to be drawn from these cases is that where the physician or surgeon has affirmatively misrepresented the nature of the operation or has failed to point out the probable consequences of a course of treatment, he may be subjected to a claim of unauthorized treatment. But this does not mean that a doctor is under an obligation to describe in great detail all of the possible consequences of treatment. Indeed, it might be argued that to make a complete disclosure of all facts, diagnoses and alternatives or possibilities which may occur to the doctor could so unduly alarm the patient that it would constitute bad medical practice. This is suggested by the results of two recent cases, *Ferrara v. Gulluchio*[205] and *Furniss v. Fitchett*,[206] decided respectively in New York and New Zealand during the past year, in which disclosure by a doctor of the facts known to him and of future possibilities gave rise to severe reactions on

201. *Id.* at 442, (1931) 4 D.L.R. at 907.
202. *Sub. nom.* Kenney v. Lockwood, (1932) Ont. Rep. 141, (1932) 1 D.L.R. 507 (Ct. App.).
203. *Id.* at 160-61, (1932) 1 D.L.R. at 525.
204. *Id.* at 167, (1932) 1 D.L.R. at 528.
205. 5 N.Y.2d 16, 152 N.E.2d 249 (1958), 23 ALBANY L. REV. 191 (1959), 33 ST. JOHN'S L. REV. 163 (1958), 45 VA. L. REV. 127 (1959), and discussed *infra* at p. 596.
206. [1958] N.Z.L.R. 398, discussed in detail in Fleming, *Developments in the English Law of Medical Liability*, *infra* pp. 633, 643.

the part of the patient. The "golden mean" between the two extremes of absolute silence and exhaustive discussion is well described by the California District Court of Appeal in *Salgo v. Leland Stanford, Jr. Univ. Board of Trustees.*[207] There the plaintiff suffered from paraplegia alleged to have resulted from performance of an aortography procedure involving injection of radio-opaque substance into the aorta. Plaintiff claimed that he had not been informed as to the nature of the procedure; the doctors contradicted this, although admitting that the details of the procedure and possible dangers had not been explained. The trial court gave a broad instruction to the effect that the doctor owed a duty to disclose "all the facts which mutually affect his rights and interests and of surgical risk, hazard and danger, if any." On appeal, the instruction was held to be overly broad:

> A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent. At the same time the physician must place the welfare of his patient above all else and this very fact places him in a position in which he must sometimes choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which these is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological result of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure necessary for an informed consent.
>
> The instruction given should be modified to inform the jury that the physician has such discretion consistent, of course, with the full disclosure of facts necessary to an informed consent.[208]

Again the claim of the patient is not strictly in terms of a breach of duty to disclose since in these cases unauthorized treatment is dealt with as the civil wrong. But the effect is to compel disclosure in order to assure that consent is obtained. The cases last discussed indicate that the duty to disclose may be limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances, possibly with a presumption on the part of the courts that disclosures will be made where the consequences are serious and substantially certain to occur.

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207. 154 Cal. App. 2d 560, 317 P.2d 170 (1957).
208. *Id.* at 578, 317 P.2d at 181.

A third class of cases involve claims somewhat more directly based on the failure to disclose facts to the patient. In *Stafford v. Shultz*[209] a succession of doctors had undertaken to treat or care for plaintiff's wounded leg and according to his allegations each had failed to repair or restore a damaged artery and severed nerve while assuring him that such repair or restoration were not necessary to effect a cure. The court indicates that plaintiff has a cause of action for the loss of his leg due to the damages not repaired over a period of time. In *Taylor v. Milton*,[210] the Michigan court affirmed a verdict for the plaintiff on the issue of whether the defendant doctor had concealed the fact that, during treatment for urinary difficulties, a filiform had been passed into the patient's urethra and broken off and that the broken piece lodged in the bladder. In *Kelly v. Carroll*[211] and *Baldor v. Rodgers*[212] the courts indicate that the practitioner has an obligation to disclose to his patient the fact that treatment which he has undertaken is not effective or will not be effective in the cure of the patient's condition. In the former case the practitioner was a drugless healer who undertook to deal with a case of acute appendicitis, which the court found to be beyond the range of his competence; in the latter the doctor had undertaken a somewhat unusual treatment for cancer and over a period of time should have discovered that this treatment was not in fact effective, but detrimental.[213] On the other hand, in *Cady v. Fraser*,[214] where the patient claimed that the doctor had failed to inform her that a broken and unhealed bone was in need of further treatment, the court said that since there was evidence that in fact gristle had formed between the ends of the bone and held them in position and there was no evidence that further treatment was required, the failure to inform the plantiff fully as to the condition of the bone was not actionable. In all of these cases the failure to disclose is interrelated to other negligent treatment.

A somewhat different situation is presented where the doctor discovers a condition which may require further treatment or a variation in the patient's way of life and fails to disclose this. In *Aberson v. City of New York*[215] and *Welch v. Frisbie Memorial Hosp.*[216] a

209. 42 Cal. 2d 767, 270 P.2d 1 (1954).
210. 353 Mich. 421, 92 N.W.2d 57 (1958).
211. 36 Wash. 2d 482, 219 P.2d 79 (1950).
212. 81 So. 2d 658 (Fla. 1955).
213. See also Lewis v. Dwinell, 84 Me. 497, 24 Atl. 945 (1892) (failure to discover ruptured perineum or concealment); Tvedt v. Haugen, 70 N.D. 338, 294 N.W. 183 (1940) (failure to disclose that bones were misaligned or to urge specialist be consulted); *cf.* Benson v. Dean, 232 N.Y. 52, 133 N.E. 125 (1921) (failure to disclose presence of broken surgical needle not to be actionable).
214. 122 Colo. 252, 222 P.2d 422 (1950).
215. 205 Misc. 727, 132 N.Y.S.2d 357 (City Ct. 1954).
216. 90 N.H. 337, 9 A.2d 761 (1939).

discovery of mistake in diagnosis of fracture on the basis of X-rays imposed upon the doctor an obligation to disclose, although there is no suggestion of prior negligence in diagnosis. In *Union Carbon & Carbide Corp. v. Stapleton*[217] the plaintiff was an employee who received periodic examinations and chest X-rays in the medical department of his employer. Over a period of eight years some fourteen such X-rays were taken, all of which indicated that the worker suffered from an arrested case of pulmonary tuberculosis without significant change. The company doctors and the company did not notify the worker of this fact. The worker did not consult any other doctors during this period. When the tubercular condition became worse and the worker suffered total incapacity, he brought action. The court affirmed a jury verdict for the plaintiff, saying that the company (and its physicians) had a duty to give warning to the worker of the condition. More recently, in *Maertins v. Kaiser Foundation Hosp.*[218] the patient had consulted an internist specializing in the field of cardiology concerning a heart murmur. X-ray films were taken as part of the diagnosis. The radiologist reported to the internist that there was an area of infiltration of the left lung and suggested that plaintiff be evaluated for possible lung disease. Although treatment by the internist extended over a period of a year and other X-rays were taken which indicated that the infiltration had almost completely cleared, the patient was never informed of this condition. Later the patient developed a cough and temperature and was referred to a specialist in lung disease, who diagnosed a moderately advanced case of tuberculosis. At the trial of the resulting malpractice action, one specialist testified that he could not answer for certain whether the plaintiff-patient had had tuberculosis a year before diagnosis, but that he would be suspicious of it from the films presented in evidence, although it was a minimal case. Another doctor testified that where there was any infiltration of the mid-lung area discovered it was standard medical practice to make every effort to establish a diagnosis including a full history of contacts with tuberculosis, complete physical examination and whatever laboratory work was necessary. The appellate court reversed a jury verdict and judgment for the defendant saying that there was no presumption of proper care on the facts.

In *Brown v. Scullin Steel Co.*,[219] on the other hand, failure to disclose information discovered in a medical examination for employment purposes was not held actionable. The employee had originally been examined on his employment in 1943, at which time the company

217. 237 F.2d 229 (6th Cir. 1956).
218. 328 P.2d 494 (Cal. App. 1958).
219. 364 Mo. 225, 260 S.W.2d 513 (1953).

doctor discovered a heart murmur or whistle which indicated some lesion in the heart. The doctor, relying on his past experience with men having similar lesions, who had done regular work, approved the worker for heavy labor involving lifting and carrying weights of 25 to 175 pounds. The doctor claimed he had told the worker of the murmur, but the worker denied this. There were further examinations in 1946 and 1947 and 1948. In August, 1948, the worker went to the company medical department claiming he had "busted his heart" in a fall, and after examination the doctor told the worker merely to take a few days off and to take it easy, but failed to mention the heart murmur. Later it was discovered that the worker had cardio-vascular syphilis and he became unable to work. The trial court dismissed the worker's action against his former employer. This was affirmed on appeal, the appellate court saying that although the doctor may have been wrong, there would be no liability in the absence of further proof that he did not possess the requisite skill or that he failed to use this skill and knowledge in arriving at his conclusion or that the conclusion was not based upon nor in accord with recognized medical theory. In short, the duty to disclose was framed in terms of the performance of a reasonable and prudent practitioner under the circumstances rather than in the form of an absolute duty.

Failure to give a patient proper instructions as to his own care has been treated as actionable.[220] In *Newman v. Anderson*,[221] the doctor applied an ointment to the patient's body. The ointment caused irritation and burning for which the patient sought to recover. Both defendant and another doctor testified to the practice among physicians in the locality of washing off the ointment if it produced irritation, but there was no evidence that any instruction to this effect was given to the patient or his family. The court stated that the doctor had an obligation to give such instructions and reversed judgment for the defendant following a jury verdict for the plaintiff. Similarly, giving a patient six 1½ grain Nembutal capsules with directions to take "one when necessary for pain" without warning as to the possible effect upon the patient's mental and physical faculties, may result in liability where the patient takes several capsules and then drives off the road.[222] Also a failure to warn the family or attendants or

220. *E.g.*, Beck v. The German Klinik, 78 Iowa 696, 43 N.W. 617 (1889) (failure to give proper instructions on discharge of fracture case from hospital); Pike v. Honsinger, 155 N.Y. 201, 49 N.E. 760 (1898) (failure to give proper instructions to patient with broken kneepan); Everts v. Worrell, 58 Utah 238, 197 Pac. 1043 (1921) (failure to inform patient that he was suffering from syphilis); Miles v. Hoffman, 127 Wash. 653, 221 Pac. 316 (1923) (failure to give careful instructions to lay persons nursing and attending patient after serious wound).

221. 195 Wis. 200, 216 N.W. 306 (1928).

222. See Whitfield v. Daniel Construction Co., 226 S.C. 37, 83 S.E.2d 460 (1954).

third persons of the dangers resulting from contact with the patient may give rise to liability.[223]

In *Corn v. French*,[224] where the defendant performed a radical mastectomy after diagnosis of malignancy based on physical examination and palpation but without a biopsy or pathological examination of tissues, the court indicated that the jury might be justified in concluding that the doctor was negligent in failing to disclose to his patient the fact that no local pathologist was available but that a biopsy and pathological examination could be obtained at cities within a few hours airplane trip from Las Vegas. On a second trial, the plaintiff requested an instruction "that the jury must find for plaintiff if there was no emergency and no explanation was given as to why a specimen could not have been sent to an outside pathologist or the plaintiff referred to another city for treatment where these services were available or why she was not advised of Clark County's lack of such facilities and the availability of these facilities in some other city that could readily be reached by air transportation." The request was refused and the jury brought in a verdict for the doctor. On appeal, the Nevada court indicated that while its original opinion had been that the evidence raised issues requiring a jury determination, it was not held there that such evidence would compel a finding for the plaintiff.[225] The trial court had given instructions that the doctor might be held liable if he failed to follow standard practice in the community, which the appellate court indicated was the sole legal standard applicable, expert evidence of any standard of practice being negative.

Thirteen years ago, in a pair of articles in the *Tennessee Law Review*,[226] Drs. Charles C. Lund and Hubert Winston Smith discussed at some length the physician's obligation to disclose to his patient "the whole truth" concerning the patient's illness and the possibility of a "therapeutic privilege" of the physician to withhold some facts. Their respective conclusions were that while the doctor is bound to do whatever is best for the patient,

223. Jones v. Stanko, 228 Ohio St. 147, 160 N.E. 456 (1928) (failure to warn neighbors that patient suffered from smallpox, so that neighbors caring for him contracted it); *cf.* Davis v. Rodman, 147 Ark. 385, 227 S.W. 612 (1921) (failure to give notice to family of typhoid fever not shown to have caused harm); Bullock v. Parkchester General Hospital, 3 App. Div. 2d 254, 160 N.Y.S.2d 117 (1st Dep't 1957) (failure to warn nurse of psychotic condition of patient not sufficient where doctor had no knowledge of aggressive tendencies when patient assaulted nurse).

224. 71 Nev. 280, 289 P.2d 173 (1955). The consent issue in this case is noted above at p. 589.

225. 331 P.2d 850 (Nev. 1958).

226. Lund, *The Doctor, The Patient and the Truth*, 19 TENN. L. REV. 334 (1946); Smith, *Therapeutic Privilege to Withhold Specific Diagnosis from Patient Sick with Serious or Fatal Illness*, 19 TENN. L. REV. 349 (1946).

> In discussing his patient's condition, the doctor realizes that there are some circumstances where he cannot, for the patient's own good, tell him the "whole truth."[227]

and

> The writer [Dr. Smith] believes that, in general, no medical privilege should be recognized to withhold the diagnosis in ordinary cases where the usual patient would feel entitled to have the information as a basis for charting his course and there being no apparent grounds for supposing that a disclosure of the truth would engender in the patient reactions dangerous to his health or life. . . . .
> . . . . The writer strongly believes that the physician should be recognized to have a therapeutic privilege to withhold part or all of the facts regarding a dread illness, when he has reason to believe that communicating them freely to the patient will involve risks of causing his death or serious impairment of his health without any countervailing gain. It is suggested that this should be in the nature of an imperfect privilege, to be passed upon by the presiding judge in the light of evidence adduced in the particular case.[228]

It should be noted that neither doctor was urging any right to withhold information which the patient should know for purposes of future treatment and that both assumed that the doctor could and would be held responsible for negligence in diagnosis and/or concealment of essential facts resulting in a worsening of the patient's condition.[229] What is indicated is that the obligation to disclose information should not be an absolute one but should be qualified in terms of reasonable medical practice. This is a point made in an early Massachusetts case in which the court said:

> Upon the question whether it be good medical practice to withhold from a patient in a particular emergency, or under given or supposed circumstances, a knowledge of the extent and danger of his disease, the testimony of educated and experienced medical practitioners is material and peculiarly appropriate.[230]

I am unaware of any American case similar to the recent New Zealand decision in *Furniss v. Fitchett*,[231] in which the doctor's disclosure to the patient's husband of her mental condition was held to be actionable when the patient learned of it and suffered a severe reaction. A related situation has arisen in *Ferrara v. Galluchio*,[232]

227. Lund, *supra* note 226 at 348.
228. Smith, *supra* note 226 at 350-51.
229. See also FLETCHER, MORALS AND MEDICINE 60-61 (1954) and symposium review, 31 N.Y.U. L. REV. 1157 (1956) in which the moral obligation of the doctor to tell his patient "the truth" is recognized by all but imposition of any legal liability for breach of this moral obligation is found to be doubtful.
230. Twombly v. Leach, 65 Mass. (11 Cush.) 397, 405-06 (1853).
231. (1958) N.Y. L. REV. 398, discussed in detail in FLEMING, DEVELOPMENTS IN THE ENGLISH LAW OF MEDICAL LIABILITY 12-16.
232. 5 N.Y.2d 16, 152 N.E.2d 249 (1958); 23 ALBANY L. REV. 191 (1959); 33 ST. JOHN'S L. REV. 163 (1958); 45 VA. L. REV. 127 (1959).

where the patient developed a "cancerphobia" following disclosure by a dermatologist that X-ray burns negligently caused by the defendants might result in cancer. The court's decision that the cancerphobia might be a basis of action against the doctors who negligently caused the X-ray burn of which this was a proximate consequence, is not without precedent.[233] Certainly the informing doctor should not be treated as negligent in giving the information since it was necessary to alert the patient to the importance of periodic checkups. However, the two cases raise the interesting question of whether a doctor, with reason to know that the patient's reaction to disclosure of medical facts is likely to be severe, might not be held liable for disclosure which was not so essential to further treatment. Certainly the determination of when disclosure is necessary and when it is dangerous should be considered in the light of medical knowledge and probably should be governed by the standards of acceptable medical practice rather than by any absolute obligation imposed by the courts or jury in the absence of expert testimony.

Duty to Refer to Specialist

The possibility of formulating a specific standard or duty on the part of a general practitioner or non-specialist to refer a patient to a specialist has already been raised by cases discussed above.[234] Each of these indicates that while the defendant may have an obligation to refer the patient when the situation is beyond his capacity or requires knowledge and skill of a character which he does not possess, the precise point at which this duty arises is to be defined by the medical profession itself. It may be assumed, however, that if the average general practitioner were to undertake brain surgery, or open heart surgery, in the present state of the medical profession the court would not hesitate to say that this went so far beyond normal practice of the profession as not to require precise medical expert testimony. In one case,[235] a third year resident in surgery (already a licensed M.D.) undertook to perform an apparently delicate operation involving cutting of the sympathetic nerve controlling the muscles around blood vessels in the patient's leg. The diagnosis of the patient's difficulty was apparently uncertain, ranging from Buerger's disease

233. Halloran v. New England Tel. & Tel. Co., 95 Vt. 273, 115 Atl. 143 (1921) (patient suffering from malignant disease requiring surgery recovered for emotional distress resulting from physician's disclosure that such surgery would not be advisable because of the damage done to her heart through the defendant's negligence).

234. See Seneris v. Haas, 45 Cal. 2d 811, 291 P.2d 915 (1955); Simone v. Sabo, 37 Cal. 2d 253, 231 P.2d 19 (1951); Sinz v. Owens, 33 Cal. 2d 749, 205 P.2d 3 (1949); Tvedt v. Haugen, 70 N.D. 338, 294 N.W. 183 (1940); Derr v. Bonney, 38 Wash. 2d 678, 231 P.2d 637 (1951); Kelly v. Carroll, 36 Wash. 2d 481, 219 P.2d 79 (1950).

235. Waynick v. Reardon, 236 N.C. 116, 72 S.E.2d 4 (1952).

to arteriosclerosis. The court made point of the fact that the resident did not call upon any senior staff member to be present and that when he ran into unexpected difficulties there was considerable delay before the head of the department could be contacted and arrive to repair the damage done. The combination of the resident's inadequacies and the delay in obtaining a more competent surgeon resulted in the loss of the patient's legs, a four month hospital stay and ultimately morphine addiction as a consequence of the drugs used to deaden his pain. But even here, the court seemed to rely upon the testimony of experts in determining when a referral or calling in of a specialist would be necessary.

At the conclusion of this survey of the general standard of care and of some possible specific duties which a doctor owes to his patient, it appears that the standard throughout is largely one established by the profession itself. After a short view of a related problem, we shall pass on to a consideration of the merits of using "customary practice" as a standard of care.

VICARIOUS LIABILITY

Although the central focus of this article is on the professional conduct of the doctor and the way in which "professional negligence" varies from the garden variety, some reference should be made to the problem of the vicarious liability of the doctor for the acts of others. I will not discuss the possible liability of a doctor as a partner for the torts of a co-partner, although this is not uncommon.[236] Instead I wish to direct attention to the possible liability of the doctor for the conduct of nurses, X-ray technicians and assistants in the performance of operations or other treatment or diagnostic procedures. I shall also refer only in passing to the liability of hospitals as that may bear on the liability of the doctor working in a hospital.

Generally the principle of respondeat superior is applicable to professional men and the primary factor in imposing liability is the right of the doctor to control the conduct of subordinates or assistants. For some time, the courts were reluctant to impose any liability upon hospitals for the conduct of nurses and staff members in the operating room, either on the theory that these were "professional activities" over which the hospital could not have a right of control since it was not competent to practice medicine,[237] or on the theory

236. See, *e.g.*, Hess v. Lowrey, 122 Ind. 225, 23 N.E. 156 (1890); Haase v. Morton & Morton, 138 Iowa 205, 115 N.W. 921 (1908); CRANE, PARTNERSHIPS § 280 (2d ed. 1952); REGAN, DOCTOR AND PATIENT AND THE LAW 114 (3d ed. 1956).

237. This view was largely limited to New York, where it originated in Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914), 52 L.R.A., (n.s.) 505 (1914) (non-liability of hospital for acts of physician and nurses in performance of unauthorized operation), and further refined in Phillips v. Buffalo General Hosp., 239 N.Y. 188, 146 N.E. 199 (1924) (non-

that the nurses and others became "borrowed servants" of the head surgeon and, for the time being, were subject to his exclusive right of control.[238] The head surgeon then became responsible for the torts of these assistants. There has been a growing tendency in recent years, however, to recognize that hospitals may be liable for the miscarriage of those services which hospitals normally provide for patients, including the professional services of staff members.[239] One aspect of this is illustrated in the recent case of *Swigert v. City of Ortonville,*[240] in which the court treats the activities of a nurse in administering a heat treatment prescribed by a physician as not being subject to the immediate control of the doctor but "administrative" in character so that the hospital could be held liable. The "administrative-professional" distinction used in New York to immunize hospitals from liability for the conduct of employees has fallen into some disrepute,[241] and it may be unfortunate that it appears again in the allocation of responsibility between the hospital and a doctor who is not an employee of the hospital.[242] If an allocation of responsibility for the acts of hospital employees is to occur, and it may be possible to have both the private doctor and the hospital liable, the more appropriate technique would be in terms of actual supervision

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liability for acts of orderly performing work normally done by nurse); Sheehan v. North Country Community Hosp., 273 N.Y. 163, 7 N.E.2d 286 (1937) (liability for negligence of "ordinary employee"); Berg v. New York Society for Relief of the Ruptured and Crippled, 1 N.Y.2d 499, 136 N.E.2d 523 (1956) (liability for non-professional employees). The latter case sheds considerable doubt on the administrative-professional or medical distinction, which has been abandoned completely in Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3 (1957). For details see 25 A.L.R.2d 29, 170-74 (1952). The distinction may be applicable in Minnesota and Pennsylvania as well, see Swigert v. City of Ortonville, 246 Minn. 339, 75 N.W.2d 217 (1956); Benedict v. Bondi, 384 Pa. 574, 122 A.2d 209 (1956).

238. *E.g.,* St. Paul-Mercury Indem. Co. v. St. Joseph's Hosp., 212 Minn. 558, 4 N.W.2d 637 (1942); Aderhold v. Bishop, 94 Okla. 203, 221 Pac. 752 (1923); Minogue v. Rutland Hosp., 119 Vt. 336, 125 A.2d 796 (1956); Hillyer v. Governor of Saint Bartholomew's Hosp., (1909) 2 K.B. 820 (C.A. 1909).

239. See REGAN, *op. cit. supra* note 236, at 133. Included among these are such procedures as the preparation of the patient for an operation, Clary v. Christiansen, 54 Ohio L. Abs. 254, 83 N.E.2d 644 (1948); and post-operative care, *e.g.,* Shull v. Schwartz, 364 Pa. 554, 73 A.2d 402 (1950).

240. 246 Minn. 339, 75 N.W.2d 217 (1956).

241. See Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3 (1957) and comments thereon, 57 COLUM. L. REV. 1041 (1957); 32 N.Y.L.F. 435 (1957); 32 N.Y.U.L. REV. 1314 (1957); 9 SYRACUSE L. REV. 123 (1957); 5 U.C.L.A. L. REV. 128 (1958); Berg v New York Soc'y for Relief of the Ruptured and Crippled, 1 N.Y.2d 499, 136 N.E.2d 523 (1956); Bobbe, *Tort Liability of Hospitals in New York,* 37 CORNELL L. Q. 419 (1952); 2 HARPER & JAMES, TORTS 1397 n.9 (1956) refers to the "ultimate absurdity" of distinguishing between the ministerial acts of an employee-doctor and his "professional" acts.

242. See also Benedict v. Bondi, 384 Pa. 574, 122 A.2d 209 (1956) in which the court uses the distinction in determining whether the doctor who directs the placing of hot water bottles at the patient's feet should be held responsible.

or control of the staff by the doctor in the conduct of various procedures.[243]

So long as the conduct of an auxiliary is in fact directed and supervised by the private physician or surgeon, there seems to be no reason not to hold him responsible for negligence of the auxiliary. The service being rendered is service which the doctor himself would presumably have to provide if the nurse or assistant were not available. The right to control does exist, whether or not it is exercised. Moreover, the patient may not be conscious of who actually renders the individual services to him and may appropriately look to the one principal contact he has with medical services, his physician. Whether the doctor should then be entitled to indemnification from the nurse, or assistant, or attendant depends on whether one is committed to the common law theory of indemnification by the active wrongdoer[244] or accepts the more recent view that "respondeat superior" is a device for imposing upon the head of an economic enterprise the responsibility for all conduct within the enterprise and that indemnity should not be permitted to defeat the possibility of better distribution of loss through "enterprise liability" and insurability.[245] Of course, where the hospital is in the picture and the patient is paying this enterprise for the services of its staff members, the concept of enterprise liability may warrant absolving any individual staff member or doctor from responsibility for the acts of other members of the staff and imposing sole liability upon the hospital itself. While the case law indicates that hospitals are being subjected to liability for the acts of professional staff,[246] there is as yet no indication of any legal absolution of the individual staff member from responsibility

243. For cases imposing liability on the hospitals, see, *e.g.*, Rice v. California Lutheran Hosp., 27 Cal. 2d 296, 163 P.2d 860 (1945); Piedmont Hosp. v. Anderson, 65 Ga. App. 491, 16 N.E.2d 90 (1941); Flower Hosp. v. Hart, 178 Okla. 477, 62 P.2d 1248 (1936). For cases imposing liability on supervising physician or surgeon, see, *e.g.*, St. Paul-Mercury Indem. Co. v. St. Joseph's Hosp., 212 Minn. 558, 4 N.W.2d 637 (1942); Aderhold v. Bishop, 94 Okla. 203, 221 Pac. 752 (1923); Johnson v. Ely, 30 Tenn. App. 294, 205 S.W.2d 759 (1947); Minogue v. Rutland Hospital, 119 Vt. 336, 125 A.2d 796 (1956).

244. See 2 HARPER & JAMES, TORTS 723 (1956); PROSSER, TORTS 250 (2d ed. 1955); RESTATEMENT, RESTITUTION § 96 (1937).

245. See 2 HARPER & JAMES, TORTS 770-71, 1370-74 (1956).

246. *E.g.*, Garfield Memorial Hosp. v. Marshall, 204 F.2d 721 (D.C. Cir. 1953) (physicians and nurses); Brown v. Moore, 247 F.2d 711 (3rd Cir. 1957) (neuropsychiatrist who is medical director); Bourgeois v. Dade County, 99 So. 2d 575 (Fla. 1957) (interne diagnosing); Moeller v. Hauser, 237 Minn. 368, 54 N.W.2d 639 (1952) (resident in diagnosis and treatment of gangrene); Waynick v. Reardon, 236 N.C. 116, 72 S.E.2d 4 (1952) (resident operation): See also Gold v. Essex County Council, (1942) 2 K.B. 293; Cassidy v. Ministry of Health, (1951) 2 K.B. 343; Roe v. Ministry of Health, (1954) 2 K.B. 66, in which the English courts have avoided the apparent holding in Hillyer v. Governor of St. Bartholomew's Hosp., *supra* note 238, to the effect that the operation room was not under the control of the hospital and therefore it could not be responsible for its employees therein. The liability of hospitals in England is discussed in Fleming, *Developments in the English Law of Medical Liability*, *infra* p. 633.

for his own acts or possibly for those acts which he has a duty to supervise. I will not pursue here the possibility of imposing liability upon the hospital for all injuries occurring to patients while in the hospital due to the negligence of anyone operating in its facilities with its consent, which might have the advantage of assuring a solvent defendant capable of distributing the loss broadly while leaving open the opportunity of the hospital to require indemnity from the private doctor making use of its facilities.[246a]

Absent such "enterprising" theory, however, there is a real problem involved in the possible imposition of liability upon the head surgeon in the operating room. In an earlier day when the operating room was a relatively simple place with one or two nurses and an assistant whom the surgeon actively supervised, it was not inappropriate to impose liability upon him. Today, however, the hospital operating room has become an increasingly complex enterprise in itself which involves increasing specialization of the participants in the operation. The responsibility for anesthetizing the patient and maintaining his physical well-being during the operation has passed largely from the joint control of the surgeon and a nurse-anesthetist into the hands of a doctor-anesthesiologist who is himself a product of graduate medical training. The job of keeping track of sponges and instruments used in the operation is largely in the hands of the "sponge nurse" or the "scrub nurse" and the head nurse who supervises them. Thus the surgeon is left free to concentrate his full attention on the actual operative procedure.[247] It is no longer true that the head surgeon necessarily supervises all the participants in the operating room. Yet in 1957, the Colorado court imposed liability upon a surgeon for injuries suffered by a patient who fell from the operating table because the orderly who had been caring for him left the table momentarily in response to the surgeon's request for a strap.[248] The court reasoned that the surgeon was in fact in charge of the orderly and in any event since the patient was unconscious, unless the surgeon in charge of the operation was held responsible or was charged with a duty to see that no preventable harm occurred, the patient might be remediless. And in 1949, the Pennsylvania court imposed liability upon an obstetrician for damages caused when an intern negligently

246a. I am indebted for this suggestion to Professor William Cohen of the University of Minnesota Law School.

247. For an interesting and technically accurate description of the workings of an operating room see the recent book, ENGEL, THE OPERATION (1958), which describes an open-heart operation at the University of Minnesota Hospitals. Although the operation there described is undoubtedly far more complex than the average one, much of the routine of preparation of equipment and handling of equipment during the operation is duplicated every day in many hospitals across the country.

248. Beadles v. Matayka, 135 Colo. 366, 311 P.2d 711 (1957).

administered silver nitrate to a newborn baby's eyes.[249] At the time of the activity the obstetrician was fully occupied attempting to stop severe hemorrhaging of the mother, although he admitted at the trial that everyone in the operating room was subject to his control. The act of administration of the silver nitrate and tying off the umbilical cord were conceded to be simple and routine procedures frequently left to the hospital staff as a matter of course.

In contrast to these two cases is the situation presented to the federal district court in the recent case of *Thompson v. Lillehei*,[250] in which the court takes a more realistic view of the allocation of responsibility in the modern operating room. In this case an open heart operation was to be performed on an eight-year-old girl to correct a congenital defect in her heart. The operation involved the use of "controlled cross circulation," a special procedure perfected at the University of Minnesota Hospitals by Drs. Lillehei and Varco, two of the defendant-surgeons, which contemplated that the patient be temporarily sustained by a "donor" who occupied an adjoining table during the operation and through a system of connecting tubes furnished the heart and lung facilities to the patient while the heart was being operated upon. In this case the donor was the patient's mother, and the plaintiff in the action. The medical procedures preceding the operation took several hours. The patient and donor were placed on two operating tables some four feet apart; both were anesthetized and prepared for the operation. Before this operation actually got under way, and before the donor and patient were joined by the cross circulation mechanism, it was found that the donor's heart beat and blood pressure could not be detected. It appeared that a bottle of glucose and water hanging over the donor and connected into her veins had become empty. An operating diagnosis of an air embolism was made and the donor was restored, but serious damage had been done to her brain, apparently or allegedly through bubbles of air entering her veins and being carried to the brain. The operation was terminated. The court described the situation:

> Dr. Lillehei was the surgeon at the patient's table. He performed no surgical procedure upon the donor. He was solely occupied with the preparatory operation upon the patient. Of necessity his back was to the donor's table. There was no showing that he failed in any responsibility following the emergency when it became impossible to detect the donor's pulse, or at any other time.
>
> Dr. Varco served as an assistant surgeon to Dr. Lillehei at the patient's table. He had no responsibility in connection with the surgical procedures or anesthetics on the donor.

249. McConnell v. Williams, 361 Pa. 355, 65 A.2d 243 (1949).
250. 164 F. Supp. 716 (D. Minn. 1958).

> Dr. Buckley was the anesthesiologist at the patient's table. He had no responsibility in connection with any procedures at the donor's table. Dr. Warden was assigned as surgeon at the donor's table. There was no evidence that he negligently performed or failed to discharge any of his responsibilities. One Dr. X, not a defendant in this lawsuit, was anesthesiologist at this table and, it would appear, was solely responsible for the administration of anesthetics and the operation of the "i.v." of glucose and water which allegedly became empty. There was no evidence indicating that this was Dr. Warden's duty.[251]

It was noted that each of the named defendants was a member of the University of Minnesota Medical School faculty, engaged in teaching duties and surgical practice as members of a "team" on the assignment of their respective superiors, the surgeons being assigned by the head of surgery, Dr. Wangensteen, and the anesthesiologists by Dr. VanBergen, the head of the corresponding department of anesthesiology; that each doctor was responsible to his own department head and that none of them were receiving a fee from the patient. Therefore, when the jury failed to agree upon a verdict, the court granted judgment notwithstanding failure to agree[252] to each of the named defendants, finding that there was no personal negligence on the part of any of them and that none of them could be held vicariously responsible for the conduct of Dr. X. The court concluded:

> To extend the doctrine of respondeat superior to a situation such as that reflected in the evidence would be to strain the doctrine beyond the basis for its creation. See Prosser, Torts, 2d Ed. 1955, Sec. 62. There is no evidence that Lillehei engaged or directed Dr. X or any of the others in the operating room, or that he had the authority to do so. The evidence is to the contrary. The only evidence is that Lillehei was the one through whom the operation was arranged—the one who dealt with the plaintiffs in connection with it. This relationship does not spell out responsibility by Lillehei for every event which transpired in the operating room. It is manifest from the evidence, and especially from one of the exhibits received in evidence, that the plaintiffs contracted that the operation be performed, not by Lillehei, but by the "staff of the University Hospital."[253]

Since the University Hospital is an agency of the State of Minnesota, it was immune from tort liability.[254] In support of its conclusion, the court cites prior cases which had recognized the separation of func-

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251. *Id.* at 719-20.

252. This procedure is authorized by FED. R. CIV. P. 50 (b).

253. 164 F. Supp. at 721.

254. Minnesota does not recognize the "charitable immunity" of non-profit hospitals, see Mulliner v. Evangelischer Diakonniessenverein, 144 Minn. 392, 175 N.W. 699 (1920). Nor has it immunized a city-owned hospital which is treated as a proprietary rather than governmental activity. See Borwege v. City of Owatonna, 190 Minn. 394, 251 N.W. 915 (1933). But the State and its immediate instrumentalities are immune from tort liability, see Dunn v. Schmid, 239 Minn. 559, 60 N.W.2d 14 (1953).

tions within the operating room.[255] While most of these dealt either with non-liability of hospitals for the conduct of their professional employees,[256] or the non-liability of an anesthetist for the conduct of the operating surgeon,[257] some recognized the non-liability of the head surgeon for the conduct of a skilled anesthetist whose services were provided for by the hospital or were arranged for on an independent basis.[258]

Another recent example of division of function is found in *Salgo v. Leland Stanford Jr. Univ.*[259] where the attending physician had ordered an aortograph of a patient for purpose of diagnosing cardiovascular difficulties. The attending physician was present when the procedure started but gave no instructions and did not participate in the actual administration of the aortography procedure. The procedure was in fact done by a "team" of the hospital staff members. The evidence indicated that it was not customary for attending physicians to perform or be present at the performance of an aortography procedure and that it was customary to have such procedure performed by the hospital personnel who were accustomed to work together. The court indicated that the attending physician might be responsible if he had failed to determine that the hospital team was competent, but criticized instructions which were open to the interpretation that the attending physician should be responsible for the negligence of an apparently competent team of staff members. While the attending physician was a member of the faculty of the Stanford Medical School, his relation with the patient appears to have been on the basis of a special referral to him as an individual and not merely as a staff member of a hospital.

The conclusion which I draw from these cases is that the customary practices of the medical profession again are significant, this time in determining who does have control of a given situation and who has supervisory power over the negligent assistant. Where the individual physician undertakes to treat a patient as his private patient and has control over or the right to exercise control over the conduct of others

255. Morey v. Thybo, 199 Fed. 760 (7th Cir. 1912); Runyan v. Goodrum, 147 Ark. 481, 228 S.W. 397 (1921), 13 A.L.R. 1403 (1921); Huber v. Protestant Deaconess Hosp. Ass'n, 127 Ind. App. 565, 133 N.E. 864 (1956); Nelson v. Sandell, 202 Iowa 109, 209 N.W. 440 (1926), 46 A.L.R. 1447 (1926); Meyer v. St. Paul-Mercury Indem. Co., 61 So. 2d 901 (La. App. 1952), *aff'd* 225 La. 618, 73 So. 2d 781 (1953); Brossard v. Koop, 200 Minn. 410, 274 N.W. 241 (1937); Richardson v. Denneen, 192 Misc. 871, 82 N.Y.S.2d 623 (Cty. Ct. 1947); Woodson v. Huey, 261 P.2d 199 (Okla. 1953). See also REGAN, DOCTOR AND PATIENT AND THE LAW 104 (3d ed. 1956).

256. Runyan v. Goodrum, Huber v. Protestant Deaconess Hosp. Ass'n, *supra* note 255.

257. Morey v. Thybo, Nelson v. Sandell, Brossard v. Koop, *supra* note 255.

258. Huber v. Protestant Deaconess Hosp. Ass'n; Meyer v. St. Paul-Mercury Indem. Co.; Woodson v. Huey, *supra* note 255.

259. 154 Cal. App. 2d 560, 317 P.2d 770 (1957).

in accordance with accepted medical practice, he may be held responsible; but where accepted professional practice recognizes a division of function, the courts should recognize a division of responsibility. This may not fully meet the argument of some of the courts that the patient may have no way of knowing who is "medically responsible" for given acts or which of a number of individuals has been negligent in handling him, the basis upon which liability of the head surgeon or physician in charge of the case may be justified.[260] Perhaps this difficulty may be overcome, however, not by a wholesale imposition of liability on whomever has dealt with the patient as "his physician," but by permitting the patient to join his physician and the assistants and the hospital as defendants or permitting the physician to interplead the others as possible defendants, and then allow the co-defendants to establish the existing medical practices and explain, if possible, how the accident or injury to the patient occurred. This is basically a problem of procedure and proof which is discussed later. Arguments in favor of imposing liability upon the head surgeon based on "enterprise liability" and "loss distribution" seem inappropriate in situations in which the "inferior" may be another equally highly trained professional with equal means of distributing loss through insurance or an employee of a hospital-enterprise to which the patient normally has paid some fees and which is as good, if not a better, loss distributor. Moreover, because of the reflection on professional competency and professional reputation incident to any recovery against a doctor in a "malpractice" action, the significance of "respondeat superior" as a loss distribution device probably should be greatly diminished and the emphasis placed on the older view of right to control.

Customary Practice as the Standard of Care

Evidence of custom or a relatively well defined and regular usage among a group of persons, frequently a trade or occupational group, is generally admissible in determination of the proper standard of conduct in negligence actions,[261] although, as Professor Clarence Morris has pointed out,[262] evidence of compliance or non-compliance with custom is really relevant only to the determination of (a) whether an imposition of liability upon the defendant will have an unduly disrupting effect on existing business practices, (b) whether

260. Aderhold v. Bishop, 94 Okla. 203, 221 Pac. 752 (1925); McConnell v. Williams, 361 Pa. 355, 65 A.2d 243 (1949).

261. 2 Harper & James, Torts 977 (1956); Prosser, Torts 135 (2d ed. 1955); 2 Wigmore, Evidence, 460-90 (3d ed. 1940). The Harper and James treatment of custom as a test of due care originally appeared as James, *Particularizing Standards of Conduct in Negligence Cases*, 5 Vand. L. Rev. 697 (1952).

262. Morris, *Custom and Negligence*, 42 Colum. L. Rev. 1147, 1147-55 (1942).

some other precautions than those taken by the defendant are feasible or practicable, and (c) whether the defendant had an opportunity to know of other precautions from the existing practices of others. With few exceptions,[263] however, evidence of customary practice is not conclusive on the question of the care to be taken.[264]

When we examine cases of medical negligence, however, we find that custom does become, almost exclusively, the measure of due care. As one author has put it, "Good medical practice is the standard,"[265] and it is a standard to be established by expert medical testimony as to what is accepted as good practice by reputable members of the profession practicing under similar conditions. One might argue that "customary practice" is not the same as "good medical practice" and that the test requires that for non-liability something more than mere compliance with local custom must be established, i.e., that the local custom is in fact reasonable. But aside from broadening the standard to include more than a limited portion of the profession in terms of "school of practice" and more than a limited area of practice, the courts have not so indicated. It might also be argued that the standard of practice accepted by the profession is in fact more demanding than a standard framed in terms of "a reasonable and pru-

263. The "exceptional" cases tend to be those of a servant suing a master for failure to provide safe tools or safe working conditions, Shadford v. Ann Arbor St. Ry., 111 Mich. 390, 69 N.W. 661 (1897); Warmacj v. Orr, 352 Mo. 113, 176 S.E.2d 477 (1943); Ellis v. Louisville & N.O. R.R., 136 Pa. 618, 20 Atl. 517 (1890), and generally are not followed in other cases in the jurisdictions, see Clark's Adm'r v. Kentucky Util. Co., 289 Ky. 225, 158 S.W.2d 134 (1942); Barnes v. F. C. Garrell & Sons, 196 Ky. 583, 177 S.E.2d 395 (1943); Steggal v. W. T. Knapp & Co., 241 Mich. 260, 217 N.W. 16 (1928); Cameron v. Small, 182 S.E.2d 565, (Mo. 1944); Carver v. Missouri-Kentucky-Texas R.R., 362 Mo. 897, 245 S.W.2d 96 (1952); Maise v. Atlantic Refining Co., 352 Pa. 51, 41 A.2d 850 (1945); Donnelly v. Fred Whittaker Co., 369 Pa. 387, 71 A.2d 61 (1950).

264. Texas & Pacific Ry. v. Behymer, 189 U.S. 468, 470 (1903): "What usually is done may be evidence of what ought to be done, but what ought to be done is fixed by a standard of reasonable prudence, whether it usually is complied with or not." See also, Uline Ice Co. v. Sullivan, 187 F.2d 82 (D.C. Cir. 1950) (defendant's use); Troupe v. Chicago D. & G. Bay Transit Co., 234 F.2d 253 (2nd Cir. 1956) (defendant's use); Pauly v. King, 44 Cal. 2d 649, 284 P.2d 487 (1955) (defendant's use); Albrethson v. Carey Valky Reservoir Co., 67 Idaho 529, 186 P.2d 853 (1947) (defendant's use); Langer v. Caviness, 238 Iowa 774, 28 N.W.2d 421 (1947) (defendant's use); Clark's Adm'r v. Kentucky Util. Co., 289 Ky. 225, 158 S.W.2d 134 (1942) (defendant's use); Hartman v. National Heater Co., 240 Minn. 264, 60 N.W.2d 804 (1953) (plaintiff's use); Buccafusco v. Public Service Elec. & Gas Co., 49 N.J. Super. 385, 140 A.2d 79 (App. Div. 1958) (plaintiff's use); Carver v. Missouri-Kansas-Texas R.R., 362 Mo. 897, 245 S.W.2d 96 (1952); (plaintiff's use); Morris v. Cleveland Hockey Club, 157 Ohio St. 225, 105 N.E.2d 419 (defendant's use); Donnelly v. Fred Whittaker Co., 369 Pa. 387, 72 A.2d 61 (1950) (defendant's use); J. Avery Bryan, Inc. v. Hubbard, 32 Tenn. App. 648, 225 S.W.2d 282 (1949) (relied on by defendant to establish contributory negligence of plaintiff); and secondary authorities cited in note 261 *supra*. Note that this does not deal with the plaintiff's attempting to establish negligence on the basis of defendant's failure to continue or to comply with customary practices on which plaintiff has come to rely, see, *e.g.*, Erie R.R. v. Stewart, 40 F.2d 855 (6th Cir. 1930); Illinois Cent. Ry. v. Maxwell, 292 Ky. 660, 167 S.W.2d 841 (1943).

265. REGAN, *op. cit. supra* note 255, at 30.

dent man under the same circumstances." No very clear resolution of the comparative demands of the two tests can be reached on the basis of opinions which concentrate largely on the professional test. It should be noted, however, that to a substantial degree the professional standard is assumed to offer the medical practitioner as much if not more protection than would a more general standard.[266] Of course, where a layman or quack purports to act as a qualified physician the professional standard may become a "sword" for the plaintiff rather than a "shield" for the defendant.

Reliance upon professional custom as the primary test of conduct might be explained historically by the fact that before the law of negligence had developed or the "reasonable and prudent man" had seen the full light of day, the older English cases had dealt with physicians and surgeons in terms of the knowledge, skill and care which they held themselves out to the public as possessing, *i.e.,* at least that commonly had by members of their "profession."[267] This is not a wholly satisfactory explanation, however, since other persons engaged in "common callings" such as innkeepers, ferrymen and common carriers failed to achieve any special "immunity" on the basis of reliance on accepted practices of their trade. In fact the courts tended to impose a stricter standard of care on the persons engaging in such common callings than on the general run of mankind.[268]

A second, and somewhat more persuasive, explanation for the reliance on custom of the profession is the lack of capacity of any layman trier of fact, be he judge or juryman, to adequately evaluate the conduct of a doctor or to determine what a reasonable and prudent man under the same circumstances (including specialized training and knowledge of the physician or surgeon) would have done or re-

266. See statements such as "A physician is only required to possess and exercise the degree of skill and learning ordinarily possessed by members of his school of the profession in good standing, and to apply that skill and learning with reasonable care and diligence and his best judgment," Nelson v. Nicollet Clinic, 201 Minn. 505, 509, 276 N.W. 801, 803 (1938). See also Morris, *Custom and Negligence,* 42 COLUM. L. REV. 1147, 1165 (1942); James, *Particularizing the Standards of Conduct in Negligence Trials,* 5 VAND. L. REV. 697, 710 and n. 74 (1952), which suggest that there is some special protection in the standard for the doctor. *Cf.* Malone, *Ruminations on Cause in Fact,* 9 STAN. L. REV. 60, 86-88 (1956), dealing with the related question of the more exacting requirement as to the persuasive character of evidence as to the causal relation between the alleged "negligence" of a doctor as compared, for example, with the "causal relation" which the plaintiff in a hunting accident case must establish.

267. See, *e.g.,* Y.B. 48 Edw. III, f. 6, pl. 11 (1374); Everard v. Hopkins, 2 Buls. 332, 80 Eng. Rep. 1164 (K.B. 1615); Slater v. Baker, 2 Wils. K.B. 359, 95 Eng. Rep. 860 (K.B. 1767); Seare v. Prentice, 8 East. 348, 103 Eng. Rep. 376 (K.B. 1807).

268. See Cooley's description of the liabilities of innkeepers and common carriers, which approaches that of an insurer for the goods of the guest or shipper or owner, COOLEY, TORTS 635-42 (1st ed. 1879).

frained from doing. This is, of course, reflected in the general requirement that expert medical testimony is essential on the issue of the standard of care and breach thereof. But again, the answer is not wholly satisfactory for in some cases the court permits the jury to evaluate medical conduct without expert medical testimony.[269]

A third explanation seems even more persuasive. The "preferred position" granted by the courts to the medical profession (and to other professions) may be in recognition of the peculiar nature of the "professional" activity. The qualified practitioner of medicine has undertaken long years of study to acquire knowledge of man, his body and its illnesses and the means of combatting such ailments, coupled with an intensive training of the senses and mind of the physician to respond to stimuli in a manner best described as "the healing art." A large measure of judgment enters into the practice of this art. That judgment should be free to operate in the best interests of the patient. If the "judge" is himself to be judged by some outsider who relies on after-acquired knowledge of unsatisfactory results or unfortunate consequences in reaching a decision as to liability, the medical judgment may be hampered and the doctor may become hesitant to rely upon his developed instinct in diagnosis and treatment. If, on the other hand, the doctor knows that his conduct is to be evaluated in terms of what other highly trained medical practitioners would have done or would accept as competent medical practice, he is more likely to pursue his own judgment when he is confident of the diagnosis and line of treatment, and is more likely to provide good medical service for his patient. While no absolute proof of the deterring effect of a non-professional standard of conduct is available, the concern expressed by doctors at the growing number of malpractice claims[270] and some statements of hesitancy to engage in free use of medical judgment[271] support this conclusion.

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269. The most notable examples are the X-ray cases discussed *supra* p. 575, and the "sponge" cases discussed *infra* p. 610.

270. See REGAN, *op. cit. supra* note 155, at 521-28; Sandor, *The History of Professional Liability Suits in the United States,* 161 J.A.M.A. 459 (1957); Stetler, *The History of Reported Medical Professional Liability Cases,* 30 TEMP. L. Q. 366 (1957); *Analysis of Professional Liability Claims and Suits* 165 J.A.M.A. 608 (1957).

271. See REGAN, *op. cit. supra* note 155, at 524-25, 526-27; Wachowski & Stronach, *The Radiologist and Professional Medical Liability,* 30 TEMP. L. Q. 398, 399-400 (1957). See also the statement of an anonymous doctor reported in Silverman, *Medicine's Legal Nightmare, Part One,* Saturday Evening Post, April 11, 1959, p. 13 at p. 48: "Now, whenever a new patient comes into my office, I ask myself, 'Is this the fellow who's going to sue me?' and, God help me, I'm beginning to decide my treatments not on the basis of what's best for the patient, but on what will look best in court." This latter article also points to the increased cost of medical care in terms of additional consultations and diagnostic procedures which doctors may feel compelled to undertake not for the benefit of the patient but for their own legal protection.

I believe that the courts are fully justified in taking a position which accepts customary medical practice as the standard of care. This does not protect the activities of the quack or charlatan. It does not condone malafide practice nor slipshod methods, except as the medical profession itself approves these. There is no persuasive evidence that the profession does so approve. At most it recognizes human weakness and is somewhat less blinded to the inadequacies of its own members than is the average layman. Knowing that inherent inadequacies of judgment and skill do exist, the medical profession may be hesitant to judge too harshly the conduct of its members.

All of this, however, does not bring much comfort to the maimed, the injured and the infirm, nor to their families. In this day of increasing emphasis upon "loss distribution" and "adequate compensation" by business enterprises for the injuries caused by their activities, those who suffer injuries in the course of medical treatment may argue that it is appropriate to impose the burden of loss upon the professional practitioner who can then distribute it in the form of increased fees to all persons who benefit from his ministrations or by insurance to all who benefit from medical practice. Two replies may be made to this argument. First, unlike much business enterprise the cost of medical service is not distributed on a pro rata basis. A substantial portion of medical care is provided either on a charitable or reduced fee basis, while other patients with more adequate resources may make up the difference. Unlike workmen's compensation or automobile liability insurance, the distribution of loss is likely to be unequal and unrelated to risk to the individual patient and therefore possibly undesirable. Second, the imposition of liability in malpractice cases involves a great deal more than mere loss distribution. The doctor who is sued for malpractice is immediately under some suspicion; the doctor against whom such a claim is successful is branded as professionally incompetent or worse. While many of the defendants against whom verdicts are rendered may be lacking in professional competence, it seems not unlikely that many are also guilty only of a single act of deviation from competent practice. Moreover, the increasing number of malpractice claims—it is estimated that one in every seven doctors in the country, and as high as one in four in some states, have been sued[272]—points to a substantial danger of undermining public confidence in the medical profession unless such claims are measured by a standard determined by persons fully cognizant of the perils and practicalities of medical practice.

272. Silverman, *supra* note 271 at p. 14. For an indication that 12.8% of doctors are involved in such suits see *Analysis of Professional Liability Claims and Suits,* 165 J.A.M.A. 608 (1957).

The "Sponge" Cases

That the "custom of the profession" may not always be the standard applied by the courts is suggested by the "sponge" cases involving sponges (gauze pads) and other foreign objects left in incisions by surgeons. In an early such case, *Samuels v. Willis*[273] the patient complained that a sponge which was left in her body for some thirty days following an abdominal operation had resulted in infection and injury to her internal organs. Several of the medical experts for the defendant testified that "the best of surgeons sometimes left a sponge or some foreign substance in the bodies of their patients in performing similar operations." The court refused to accept the defendant's argument that this established that he had used ordinary care, saying:

> Because all men are at some time careless does not relieve any man from the legal consequences of his careless act; but even that was for the jury to say whether appellant exercized the degree of care in the case which ordinarily prudent and skilled surgeons, who practice in similar localities, usually exercise in such matters.[274]

There was, moreover, some expert evidence for the proposition that the defendant had not followed all of the customary precautions for verifying that all sponges were removed before he closed the incision.

In later cases medical experts have testified that it is common practice for the operating surgeon to delegate to a nurse the job of keeping track of the gauze pads and instruments used in the operation. The procedures vary somewhat from place to place, the commonest being "sponge counts" made prior to the operation of all sponges available for use and subsequent to the operation of used and unused sponges, the use of tabs, tags, strings, etc., to be attached to each and every sponge handed to the surgeon or others working in the body so as to leave telltale appendages outside of the wound, and the use of sponges marked with radio-opaque materials to permit their discovery by the use of x-ray or fluoroscopy of the area of operation. In spite of these precautions, sponges and other items do remain in wounds in a number of operations.[275]

A summary of the law relating to such accidents as of the year 1930[276] concluded that: (1) the operation did not terminate until the incision was closed and the surgeon had a duty to use due care to remove all foreign matter used in the operation; (2) the question of whether the failure to remove a sponge was negligent was gener-

273. 133 Ky. 459, 118 S.W. 339 (1909).
274. *Id.* at 466, 118 S.W. at 342.
275. For a recent survey estimating that the "sponge" cases represent about 8% of the malpractice claims, see *Analysis of Professional Liability Claims and Suits*, 165 J.A.M.A. 608, 610 (1957).
276. Annot., 65 A.L.R. 1023 (1930).

ally left to the jury, although some courts treated it as negligence per se; (3) the burden of explaining a failure to remove sponges was placed on the defendant in most cases which considered the question; and (4) while a custom of having attending nurses make a careful count of sponges before and after the operation was reasonable, proper and wise, it did not excuse the surgeon from liability if the foreign object was in fact left in the wound.[277] A few cases, however, did recognize that the surgeon might reasonably rely upon the customary practices such as the count of an assisting nurse,[278] and others permitted the doctor to introduce evidence of such custom as one factor to be used by the jury in determining whether due care had been observed.[279] Almost thirty years later these conclusions still seem to be supported by the courts. Courts will permit the jury to infer negligence from the presence of a foreign object in the patient's body following an operation,[280] or may treat evidence of such fact as creating a presumption of negligence,[281] and generally the surgeon is not permitted to relieve himself of responsibility by showing reliance on customary practices for avoiding injuries of this sort.[282]

The few cases which indicate that reliance upon customary procedures in this area may be due care deserve some examination. In *Harris v. Fall*[283] the plaintiff complained that the surgeon had failed to remove from her incision pieces of fabric used in draining the wound. Although the court refused to permit the defendant to rely upon a purely local custom, limited to practice in Chicago hospitals when the patient and surgeon were from out of the locale, it did reverse the trial court's giving of an instruction to the effect that the defendant-surgeon must discharge his obligation to care for the patient as though no house doctor were present. The Court of Appeals for the Seventh Circuit said that the doctor could rely upon

277. *E.g.*, Spears v. McKinnon, 168 Ark. 357, 270 S.W. 524 (1925); Walker v. Holbrook, 130 Minn. 106, 153 N.W. 305 (1915); Palmer v. Humiston, 87 Ohio St. 401, 101 N.E. 283 (1913); Davis v. Kerr, 239 Pa. 351, 86 Atl. 1007 (1913).

278. Harris v. Fall, 177 Fed. 79 (7th Cir. 1910); Funk v. Bonham, 151 N.E. 22 (Ind. App. 1926), *rev'd* 204 Ind. 170, 183 N.E. 312 (1932); Guell v. Tenney, 262 Mass. 54, 159 N.E. 451 (1928). *Cf.* Brown v. Bennett, 157 Mich. 654, 122 N.W. 305 (1909).

279. Barnett's Adm'r v. Brand, 165 Ky. 616, 177 S.W. 461 (1915); Ault v. Hall, 119 Ohio St. 422, 164 N.E. 518 (1928).

280. Leonard v. Watsonville Community Hosp., 47 Cal. 2d 509, 305 P.2d 36 (1957); Walker v. Distler, 78 Idaho 38, 296 P.2d 452 (1956); Funk v. Bonham, 204 Ind. 170, 183 N.E. 312 (1932); Jackson v. Hansard, 45 Wyo. 201, 17 P.2d 659 (1933).

281. Tiller v. Von Pohle, 72 Ariz. 11, 230 P.2d 213 (1951); Smith v. Zeagler, 116 Fla. 628, 157 So. 328 (1934); LeFaive v. Asselin, 262 Mich. 443, 247 N.W. 911 (1933); Mitchell v. Saunders, 219 N.C. 178, 13 S.E.2d 242 (1941); Carruthers v. Phillips, 169 Ore. 636, 131 P.2d 193 (1942).

282. *E.g.*, Leonard v. Watsonville Community Hosp., 47 Cal. 2d 509, 305 P.2d 36 (1957); Rule v. Cheeseman, 181 Kan. 957, 317 P.2d 472 (1957).

283. 177 Fed. 79 (7th Cir. 1910).

a general custom of hospitals providing services for the care of dressings etc. In *Brown v. Bennett*,[284] while the operating surgeon was not subject to the jurisdiction of the court, in discussing the liability of his assistant, the personal physician of the patient, the court intimated that the operating surgeon might properly rely upon the nurse and her assurances that the sponges had all been accounted for.

In *Guell v. Tenney*,[285] the court said that the surgeon was not to be held liable for leaving a sponge in the incision where there was no evidence to show that his care and treatment was unskillful or improper and went on to say that he would not be held responsible where the nurses provided by the hospital failed to keep an accurate count of sponges, apparently approving his reliance on the custom of nurses to do this. In *Funk v. Bonham*,[286] the surgeon attempted to defend an action for malpractice by showing that it was customary to rely upon the sponge count of hospital nurses who were not his employees. The Indiana Court of Appeals at first agreed that this would absolve him from liability,[287] but on a second trial the Supreme Court of Indiana stated that the surgeon could not delegate his duty to keep track of sponges to the employees of the hospital in which he operated.[288] In *Blackburn v. Baker*,[289] the New York court accepted testimony of compliance with customary practice as satisfying the obligation of the defendant to explain an inference of negligence arising from the presence of a sponge in the patient's body, although the evidence also indicated that the defendant-surgeon and his assistant had made a manual examination of the abdominal cavity before it was closed, and there was expert evidence for the defendant that it would have been unwise to have made a more extensive examination for foreign substances because of the danger of paralysis of the intestines. The Illinois intermediate appellate courts have also recognized that in an emergency the doctor may properly delegate the duty of counting sponges and dressings to others in an attempt to center his attention on preserving the patient's life;[290] but absent such emergency, the defendant may be held liable in spite of reliance on customary practices.[291] In *Sheridan v. Quarrier*[292] the Connecticut court absolved a staff surgeon from a claim of negligence in connection with a gauze pad left in a patient's body following an opera-

284. 157 Mich. 654, 122 N.W. 305 (1909).
285. 262 Mass. 54, 159 N.E. 451 (1928).
286. 151 N.E. 22 (Ind. App. 1926), *rev'd*, 204 Ind. 170, 183 N.E. 312 (1932).
287. 151 N.E. 22 (Ind. App. 1926).
288. 204 Ind. 170, 183 N.E. 312 (1932).
289. 227 App. Div. 588, 237 N.Y. Supp. 611 (3d Dep't 1929).
290. Olander v. Johnson, 258 Ill. App. 89 (1930).
291. Hall v. Grosvenor, 267 Ill. App. 119 (1932).
292. 127 Conn. 279, 16 A.2d 479 (1940).

tion in which the surgeon had assisted, relying upon the customary practice for after-care of the patient to be in the hands of other physicians. The case is not strong authority, however, since it appeared that it was proper and reasonable to leave the gauze dressing in the wound at the time of the operation. In two opinions, *Cassingham v. Berry*[293] and *Roark v. Peters*,[294] while the courts did not go so far as to declare that reliance upon customary procedures and the nurses' count was due care as a matter of law, the language used in affirming verdict for the doctors tended strongly in that direction.

While the case law in this area is hardly a basis for the assertion that custom is the standard of care, it may be reconciled with the general conclusion reached above. Professor Clarence Morris has treated these cases as in a class of their own.[295] He notes the various procedures for the prevention of loss of sponges in wounds and concludes that if the customary procedures described are in fact followed this should constitute due care. Even so, he asserts that the courts may permit a jury to find negligence in the face of evidence of compliance by the doctor with custom, on the ground that since customary practice should assure that no sponge or foreign object is left in the body, the evidence of the plaintiff that one did remain after the operation may indicate that the defendant's testimony of compliance is either mistaken or dishonest. He would not, of course, preclude the jury from believing the defendant rather than the plaintiff.

It may not be necessary to go so far as Professor Morris suggests in accepting custom as the standard of care even in the sponge cases. In fact the customary practices may be reasonably effective without being one hundred per cent effective. But unless doctors are under an obligation to use absolutely safe procedures as contrasted with reasonably safe procedures, and most courts have not stated this as the duty of the doctor,[296] the mere failure of the customary practice to prevent loss of a sponge or instrument should not create liability. Of course, if there is negligence in the performance of a procedure, either on the part of the nurse or on the part of the surgeon, this may give rise to liability.[297] And negligence may be inferred from the

293. 67 Okla. 134, 150 Pac. 139 (1915).

294. 162 La. 111, 110 So. 106 (1926).

295. Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147, 1166-67 (1942).

296. See, *e.g.*, Watterson v. Conwell, 258 Ala. 180, 61 So. 2d 690 (1952); Meyer v. St. Paul-Mercury Indem. Co., 61 So. 2d 901 (La. App. 1952), *aff'd*, 225 La. 618, 73 So. 2d 781 (1953); Evangelista v. Black, 97 Ohio App. 390, 126 N.E.2d 71 (1953); McPeak v. Vanderbilt Univ. Hosp., 33 Tenn. App. 76, 229 S.W.2d 150 (1950); REGAN, *op. cit. supra* note 155, at 38, for the proposition that the doctor does not insure cure or favorable progress and is required only to exercise reasonable care considering the circumstances.

297. See discussion of vicarious liability for acts of nurses and assistants *supra* pp. 598-601.

existence of the sponge in the body. However, the jury should be charged that if they believe the doctor has followed the customary practices to protect the patient, and if the persons for whose acts he is responsible have followed such procedures, they may not hold him liable simply because the sponge or other foreign matter remained in the body.

PROOF OF THE STANDARD OF CARE AND BREACH

A discussion of the standard of care required of physicians and surgeons or other practitioners of healing is incomplete without some reference to the methods by which the injured patient may establish the standard and breach thereof. In fact, in making a decision as to whether the courts may appropriately defer all determination of the standard of care to the medical profession itself, it is essential to consider how the plaintiff may go about proving his case.

Expert Opinion

Courts in all jurisdictions appear to agree to the general principles that the plaintiff in a malpractice action bears the burden of persuading the jury that the defendant doctor has failed to comply with the standard of practice accepted by the medical profession as reasonable care and skill under like circumstances and that to meet this burden of persuasion the plaintiff must generally rely upon the testimony of medical experts.[298] Sometimes the courts speak in terms of a "presumption of due care" on the part of the physician,[299] but this appears to be merely a manner of describing the burden placed on the plaintiff to persuade the jury by the introduction of expert testimony that the defendant was negligent.[300] The courts also recognize that evidence that some doctors do not approve the practice of the defendant is not sufficient where there is also evidence that at least a respectable minority of doctors would approve it, so that if unimpeached expert opinion in the case is divided the jury may not be permitted to pass on the question of liability.[301] In some cases, to

298. See 7 WIGMORE, EVIDENCE § 2090(a) (3d ed. 1940); Annot., 141 A.L.R. 5, 6 (1942).

299. See, *e.g.*, Ayers v. Parry, 192 F.2d 181, 184 (3d Cir. 1951); Stallcup v. Coscarart, 79 Ariz. 42, 45, 282 P.2d 791, 793 (1955); Shea v. Phillips, 213 Ga. 269, 271, 98 S.E.2d 552, 554 (1957); State to the use of Janney v. Housekeeper, 70 Md. 162, 171, 16 Atl. 382, 384, 2 L.R.A. 587, 589 (1889); Wintersteen v. Semler, 197 Ore. 601, 609, 250 P.2d 420, 423 (1952); Devereaux v. Smith, 213 S.W.2d 170, 172 (Tex. Civ. App. 1948).

300. Included within the requirement that the plaintiff has the "burden of proof" in a civil action are the twin requirements of the burden of coming forward with evidence from which reasonable men could infer the existence of the ultimate facts upon which the cause of action rests and the burden of persuasion of the jury that the existence of such facts is more likely than not. See MCCORMICK, EVIDENCE §§ 306, 307, 318 (1954).

301. See text at p. 565 and authorities *supra* note 89. For example, in Baldor v. Rodgers, 81 So. 2d 658 (Fla. Sup. Ct. 1955), one of the plaintiff's claims was that the defendant had undertaken to use the "Koch method" of treatment of plaintiff's cancer and that this was not a proper form of treatment. There was

be discussed later, the courts deviate from the requirement of expert medical testimony in support of the plaintiff's case on the ground that the misconduct of the defendant as established by the evidence is "so gross as to be within the comprehension of laymen."[302]

The decisions of courts which define the standard of care in terms of the care exercised by a practitioner of the school to which the defendant belongs and in the same or similar locality, might suggest that the "expert" must come from the same school and locality as the defendant. But this is not necessarily true. Where the distinction between schools of medicine is recognized, if the witness testifies that the principles of his and the defendant's schools or systems are the same, he is permitted to testify as to the care required of the defendant.[303] The most frequent example of such an area of "common practice" appears to be that of diagnosis.[304] In some cases the courts have permitted a witness from a school of practice other than that of the defendant to testify that the defendant went beyond the limits of his own system and undertook to act within an area generally limited to practice by another school, usually the regular school of medicine.[305] In a few cases the courts have stated that a doctor of medicine

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sharp conflict of medical testimony as to what was the proper method of treatment with almost uniform agreement that there was no certain cure. The appellate court decided that this issue should not go to the jury (although permitting the jury to pass on the propriety of continuation of the treatment when it proved unsuccessful), saying: "There could have been no clear-cut issue whether the appellant committed malpractice when he used a certain method, for no infallible cure has been discovered. Upon the absence of certain cure there is agreement so that it cannot be logically declared that the jury could determine the responsibility of the appellant because of a treatment that might be, from the witnesses they chose to believe, more acceptable. If there is no certain cure and if the physician did not indulge in quackery by representing he had one, both of which were well established by testimony, then the issues raised by the pleadings in this case and the facts built around them did not justify the jury in concluding that for the appellee's misfortune the appellant should pay.

"As was said by the Supreme Court of Washington in Dahl v. Wagner, 87 Wash. 492, [495], 151 P. 1079, 1080 [1915], 'the courts cannot hold a defendant in a malpractice suit to the theory of the one [opinion of physicians on a set of facts] to the exclusion of the other [contrary opinion by other physicians].' . . . No doubt is cast on the respectability of the physicians who testified that they used the treatment employed by the appellant. Some of them were emphatic in their condemnation of the 'classical' methods which the appellant is now charged with failure to use." 81 So. 2d at 660.

302. Annot., 141 A.L.R. 5, 12 (1942).

303. *E.g.*, Hundley v. St. Francis Hosp., 327 P.2d 131 (Cal. App. 1958); Van Sickle v. Doolittle, 173 Iowa 727, 155 N.W. 1007 (1916); Mann v. Grim-Smith Hospital & Clinic, 347 Mo. 348, 147 S.W.2d 606 (1941); Hansen v. Isaak, 70 S.D. 529, 19 N.W.2d 521 (1945); Porter v. Puryear, 153 Texas 82, 262 S.W.2d 933 (1953); Swanson v. Hood, 99 Wash. 506, 170 Pac. 135 (1918); Morrill v. Komasinski, 256 Wis. 417, 41 N.W.2d 620 (1950).

304. *E.g.*, Van Sickle v. Doolittle, 173 Iowa 727, 155 N.W. 1007 (1916); Grainger v. Still, 187 Mo. 197, 85 S.W. 1114, 70 L.R.A. 49 (1905); Kelly v. Carroll, 36 Wash. 2d 482, 219 P.2d 79, 19 A.L.R.2d 1174 (1950); Kuechler v. Volgmann, 180 Wis. 238, 192 N.W. 1015, 31 A.L.R. 826 (1923).

305. *E.g.*, Brown v. Guy, 144 Cal. App. 2d 659, 301 P.2d 413 (1956); Cook v. Moats, 121 Neb. 769, 238 N.W. 529, 78 A.L.R. 694 (1931); Epstein v. Hirschon,

is qualified by his training to testify as to the propriety of practice in other branches of healing.[306] Whether a witness may qualify himself to testify as to the practices of another school or system by reading the literature of that school or by talking to practitioners of the other school is unsettled.[307]

Within the regular school of medicine, a specialist is permitted to testify as to the standard of care required of general practitioners.[308] Similarly, a general practitioner may be permitted to testify as an expert witness in an action brought against a specialist, on the theory that a medical doctor may be qualified to express an opinion on any medical subject provided that the trial court is convinced that he has sufficient experience and knowledge, the absence of specialization in his practice going to the weight of his testimony rather than to its admissibility.[309] One of the notable examples of a "general expert" is the case of Dr. Frank Webb who, after ten years of general practice in New York, a short term as staff doctor in a railroad hospital, and six years of teaching anatomy and pathology first in a medical school and then in a dental school, spent over twenty-five years as autopsy surgeon in the Los Angeles County Coroner's Office, where he performed about 40,000 autopsies in connection with which he obtained medical histories of the decedents and sometimes consulted the attending physician or surgeon as well as consulting with doctors on the staff of the county hospital. On the basis of this experience he was permitted to testify as an expert in a case arising from the death of a hospital patient from tetanus alleged to have resulted from negligence in the operative and post-operative care,[310] in a case involving diagnosis of cancer and removal of the patient's breast,[311] and in a case of paralysis alleged to have resulted from negligent administration of a spinal anesthesia with regard to the location and cause of

33 N.Y.S.2d 83 (Sup. Ct. 1942); Kelly v. Carroll, 36 Wash. 2d 482, 219 P.2d 79, 19 A.L.R.2d 1174 (1950); Treptau v. Behrens Spa, 247 Wis. 438, 20 N.W.2d 108 (1945).

306. *E.g.*, Nicodeme v. Bailey, 243 S.W.2d 397 (Tex. Civ. App. 1951); Walkenhorst v. Kesler, 92 Utah 312, 67 P.2d 654 (1937).

307. *Compare* Pedler v. Emmerson, 331 Mich. 78, 49 N.W.2d 70 (1951) denying qualification on this basis, *with* Mann v. Grim-Smith Hospital & Clinic, 347 Mo. 348, 147 S.W.2d 606 (1941) *and* Swanson v. Hood, 99 Wash. 506, 170 Pac. 135 (1918) permitting testimony based on information acquired from literature. *Cf.* Quinley v. Cocke, 183 Tenn. 428, 192 S.W.2d 992 (1946) where an orthopedic surgeon was allowed to testify as to the nature and method of administration of electro-shock treatments based on knowledge of the literature and treatment of patients who had suffered fractures, as well as talking to various specialists who administered the treatment, although he had never administered electro-shock treatments himself.

308. See text at notes 101-02, *supra*.

309. See, *e.g.*, Valdez v. Percy, 35 Cal. 2d 338, 217 P.2d 422 (1950); Carbone v. Warburton, 11 N.J. 418, 94 A.2d 680 (1953); Young v. Stevens, 132 N.J.L. 124, 39 A.2d 115 (1944).

310. Valentin v. La Societe Francaise, 76 Cal. App. 2d 1, 172 P.2d 359 (1946).

311. Valdez v. Percy, 35 Cal. 2d 338, 217 P.2d 422 (1950).

paralysis, the traumatic and mechanical nature of the injury and the means by which the injury could have occurred.[312] On the other hand, the courts found him not qualified to testify as to the reasonable and proper degree of skill and care to be used in giving a spinal injection,[313] or to describe the existing standards of practice in urology (although he was found competent to testify as to the cause of infection in the genito-urinary system),[314] or to describe the proper and requisite care involved in diagnosis and treatment of an epidural hemorrhage.[315] This line of cases gives to the trial court very broad discretion in determining the qualification of the particular expert, while laying down as a test:

> [I]t must be shown that the witness (1) has the required professional knowledge, learning and skill of the subject under inquiry sufficient to qualify him to speak with authority on the subject, and (2) is familiar with the standards required of physicians under similar circumstances. . . . Where a witness has disclosed sufficient knowledge of the subject to entitle his opinion to go to the jury, the question of the degree of his knowledge goes more to the weight of the evidence than its admissibility.[316]

However, in *Hunt v. Bradshaw*[317] the trial court refused to permit a radiologist to testify as to proper surgical procedures in preparing for and performing a chest operation, and in *Huttner v. MacKay*[318] the trial court excluded testimony by an anatomist as to the negligence of a neurosurgeon in invading certain portions of the brain, both of which were affirmed by the appellate courts.

As we have already seen, the courts have tended to extend the "locality" in which the standard of practice may be found to exist so that it is possible that a medical expert may be qualified to testify in any part of the country as to the practice in a community of similar size and with similar access to clinical facilities as that in which he practices or whose practice he is familiar with.[319]

On the basis of such liberalized qualifications of an expert witness, it could be possible, though rare, that an expert other than a medical doctor might be called upon to testify as to matters relating to the

312. Seneris v. Haas, 45 Cal. 2d 811, 291 P.2d 915 (1955).
313. *Ibid.*
314. Moore v. Belt, 34 Cal. 2d 525, 212 P.2d 509 (1949).
315. Huffman v. Lindquist, 37 Cal. 2d 465, 234 P.2d 34 (1951).
316. Agnew v. City of Los Angeles, 97 Cal. App. 2d 557, 565, 218 P.2d 66, 73 (1950).
317. 251 F.2d 103 (4th Cir. 1958).
318. 48 Wash. 2d 378, 293 P.2d 766 (1956).
319. See text at notes 112-25 *supra*. Of particular interest are the cases of Montgomery v. Stary, 84 So. 2d 34 (Fla. 1955) (witnesses came from Chicago to Florida); McGulpin v. Bessmer, 241 Iowa 1119, 43 N.W.2d 121 (1950) (doctors from the metropolitan area of Chicago testified as to the care of a doctor located in Davenport, Iowa); and McClarin v. Grenzfelder, 147 Mo. App. 478, 126 S.W. 817 (1910) (it appears that some of the experts may have come from Chicago and Cleveland to testify as to the propriety of the care taken by the defendant in St. Louis).

standard of care required of a doctor of medicine. In a few cases a chiropractor[320] or osteopathic physician[321] has been permitted to testify as to the practice of a doctor of medicine. It is possible that a toxicologist or pharmacist might be called upon to testify as to the amount of a given drug commonly prescribed by doctors in the community and as to the toxic characteristics of the drug as prescribed, although in *Hawkins v. McCain*[322] the court said that in the absence of expert medical testimony as to the nature of the patient's disease or the description of the medicine which the defendant prescribed, the jury could not infer negligence from the existence of skin disorders which might be traced to the pre-existing disease. Or an anatomist or physiologist having graduate training in the basic sciences but without clinical training might be called upon to testify as to the possible or probable effects of a given treatment, or the practices normally followed by doctors with whom the witness has had professional association. In *Huttner v. MacKay*[323] however, an anatomist was not permitted to testify as to the care of a neurosurgeon in operating on a particular portion of the brain.

Some cases have indicated that the plaintiff may rely upon the statements of the defendant himself in proving the standard of care which the defendant must meet. In *McCurdy v. Hatfield*,[324] the defendant was called as a witness by the plaintiff under the California statute,[325] and gave evidence as to what he considered to be "proper procedure."[326] The appellate court reversed a nonsuit entered at the close of the plaintiff's case, stating that the plaintiff could rely upon defendant's testimony as a basis for establishing the standard of care used by physicians in the locality and upon plaintiff's own testimony to the effect that this procedure was not followed. In *Snyder v. Pantaleo*[327] the Connecticut court permitted the plaintiff to rely upon the defendant's statement as to the proper use of didrast iodine in performing a radiological diagnostic procedure and the dangers of

320. Ness v. Yeomans, 60 N.D. 368, 234 N.W. 75 (1931); Wemmett v. Mount, 134 Ore. 305, 292 Pac. 93 (1930).

321. Hundley v. St. Francis Hosp., 327 P.2d 131 (Cal. App. 1958); Mann v. Grim-Smith Hospital & Clinic, 347 Mo. 348, 147 S.W.2d 606 (1941); Swanson v. Hood, 99 Wash. 506, 170 Pac. 135 (1918); Morrill v. Komasinski, 256 Wis. 417, 41 N.W.2d 620 (1950).

322. 239 N.C. 160, 79 S.E.2d 493 (1954).

323. 48 Wash. 2d 378, 293 P.2d 766 (1956).

324. 30 Cal. 2d 492, 183 P.2d 269 (1947).

325. CAL. CODE CIV. PROC. § 2055 (West 1955) providing that one party may call an adverse party and examine him as if under cross-examination and not be bound by the testimony of such witness. Similar provisions exist under the Federal Rules of Civil Procedure, Rule 43(b), and state rules, *e.g.*, IDAHO R. CIV. P. 43(b); IOWA R. CIV. P. 140-144; MINN. R. CIV. P. 43.02; N.J. STAT. ANN. § 2A:81-11 (1957); N.D. REV. CODE § 31-0202 (1943); OHIO REV. CODE § 2317.07 (Anderson 1953).

326. See also Lashley v. Koerber, 26 Cal. 2d 83, 156 P.2d 441 (1945); Lawless v. Calaway, 24 Cal. 2d 81, 147 P.2d 604 (1944).

327. 143 Conn. 290, 122 A.2d 21 (1956).

not adequately testing the patient[328] to define the standard of care and to establish deviation from the standard by the testimony of the patient's family physician as to the admissions of the defendant with regard to the mode of administration actually followed. In other cases the courts have permitted the defendant's own admissions to be relied upon by the plaintiff in establishing lack of due care.[329] In several states which permit the defendant to be called by the plaintiff as an adverse witness whose testimony is not binding upon the plaintiff but may be impeached or contradicted, the courts have refused to permit the plaintiff to use the defendant as an expert witness on the standard of care as contrasted with obtaining defendant's testimony as to "material facts."[330] In other cases the testimony of the defendant-doctor on the stand at the plaintiff's request seems to have justified the trial court's granting of a nonsuit.[331] In California at least, the plaintiff is permitted to rely upon the statements of the defendant or his witnesses in establishing the basis for "res ipsa loquitur,"[332] but may find that the inference arising from a res ipsa case is dispelled by the defendant's testimony when called as an adverse witness.[333]

Still another means of meeting the requirement of medical expert evidence may be to rely upon publications such as medical treaties or articles in professional journals by members of the profession. Generally the use of such writings as substantive evidence has run afoul of the hearsay rule, since the authors are not present in court and therefore not subject to oath or cross-examination by the opponent.[334] A few jurisdictions, however, have recognized that such learned writings may be treated as trustworthy evidence.[335] In *Bowman v.*

328. This information came from defendant's own direct examination rather than as witness for plaintiff, as was true in Bolles v. Kinton, 83 Colo. 147, 263 Pac. 26, 56 A.L.R. 814 (1928); Jacobs v. Grigsby, 187 Wis. 660, 205 N.W. 394 (1925).

329. *E.g.*, Scott v. Sciaroni, 66 Cal. App. 577, 226 Pac. 827 (1924); Wilson v. Martin Memorial Hosp., 232 N.C. 362, 61 S.E.2d 102 (1950); Hansen v. Isaak, 70 S.D. 529, 19 N.W.2d 521 (1945). But see Quickstad v. Tavenner, 196 Minn. 125, 264 N.W. 436 (1936) indicating that defendant's own evaluation of his practice may be irrelevant where there is evidence showing that it complied with the accepted practice of the profession.

330. Osborn v. Carey, 24 Idaho 158, 132 Pac. 967, (1913); Hull v. Plume, 131 N.J.L. 511, 37 A.2d 53 (1944); Hunder v. Rindlaub, 61 N.D. 389, 237 N.W. 915 (1931); Forthofer v. Arnold, 60 Ohio App. 436, 21 N.E.2d 869 (1938).

331. *E.g.*, Shea v. Phillips, 213 Ga. 269, 98 S.E.2d 552 (1957); Pierce v. Edgerton, 151 Kan. 107, 98 P.2d 129 (1940); Bettigole v. Diener, 210 Md. 537, 124 A.2d 265 (1956); Robinson v. Wirts, 387 Pa. 291, 127 A.2d 706 (1956).

332. Costa v. Regents of Univ. of Cal., 116 Cal. App. 2d 445, 254 P.2d 85 (1953).

333. Leonard v. Watsonville Community Hosp., 47 Cal. 2d 509, 305 P.2d 36 (1957).

334. See McCormick, Evidence § 296 (1954); 6 Wigmore, Evidence § 1690 (3d ed. 1940); Annot., 65 A.L.R. 1102 (1930); Note, 12 So. Cal. L. Rev. 424 (1939); Note, 2 U.C.L.A. L. Rev. 252 (1954).

335. See particularly Wigmore's presentation of the arguments for the admissibility of such evidence. 6 Wigmore, Evidence §§ 1691-92 (3d ed. 1940).

Woods[336] the Iowa court stated that since the expert witness may base his opinion on scientific treatises of recognized authority and may even refer to such works to justify his opinion, the standard medical book should be admissible in evidence of the author's opinion upon questions of medical skill or practice. Subsequently, however, the Iowa courts took a more restrictive view of the admission of medical treatises as evidence,[337] and today their admission is controlled by a statute stating that "books of science or art . . . made by persons indifferent between the parties, are presumptive evidence of facts of general notoriety or interest therein stated"[338] which effectively precludes the plaintiff from satisfying the requirement of expert testimony by the use of books. Alabama is the only state which today recognizes the use of medical books as substantive evidence on the basis of court-made law.[339] Massachusetts and Nevada have recently adopted statutes which provide:

> A statement of fact or opinion on a subject of science or art contained in a published treatise, periodical, book or pamphlet shall, in the discretion of the court, and if the court finds that it is relevant and that the writer of such statement is recognized in his profession or calling as an expert on the subject, be admissible in actions of contract or tort for malpractice, error or mistake among physicians, surgeons, dentists, optometrists, hospitals and sanitaria, as evidence tending to prove said fact or as opinion evidence; provided, however, that the party intending to offer as evidence any such statement shall, not less than three days before the trial of the action, give the adverse party notice of such intention, stating the name of the writer of the statement and the title of the treatise, periodical, book or pamphlet in which it is contained.[340]

South Carolina permits the use of medical books, "in addition to expert testimony," as evidence of facts in actions in which the question of sanity or insanity or the administration of poison or other article destructive of human life is involved—a fairly restricted class of cases.[341] The Uniform Rules of Evidence, drawing on the earlier Model Code of Evidence, contains a provision which would permit the introduction of:

> A published treatise, periodical or pamphlet on a subject of . . . science or art to prove the truth of a matter stated therein if the judge takes

336. 1 Greene 441 (Iowa 1848).

337. Wilcox v. Crumpton, 219 Iowa 389, 258 N.W. 704 (1935); Bixby v. Omaha & C. B. Ry. & Bridge Co., 105 Iowa 293, 75 N.W. 182 (1898).

338. IOWA CODE § 622.23 (1954).

339. City of Dothan v. Hardy, 237 Ala. 603, 188 So. 264 (1939); Stoudenmeier v. Williamson, 29 Ala. 558 (1857).

340. MASS. ANN. LAWS c. 233, § 79c (1956); NEV. REV. STATS. § 51.040 (1957). The language quoted is that of Massachusetts. Nevada includes a number of other practitioners, reflecting its broader licensing laws.

341. S.C. CODE § 26-142 (1952). This section is rather restrictively interpreted, see Baker v. Southern Cotton Oil Co., 161 S.C. 479, 159 S.E. 822 (1931).

> judicial notice, or a witness expert in the subject testifies, that the treatise, periodical or pamphlet is a reliable authority in the subject.[342]

While the courts of many jurisdictions have been willing to permit the use of medical treatises for impeachment of expert witnesses,[343] they have been hesitant to permit their use as affirmative proof of facts. There appears to be no good reason why the plaintiff in a malpractice action should not be permitted to rely upon published expert opinion or statements of professional practice to establish his prima facie case, provided that the author's qualifications as an expert are established as though he were a witness at the trial. The risk of inaccuracy or untrustworthiness or undue influence of the printed word seems slight since the defendant would be free to challenge the authority of the treatise or article by evidence of his own showing that the author is not accepted by the profession as an authority, or that developments in medical science have occurred since the date of publication which would challenge the conclusions, or that there is other equally respected authority to the contrary.

Res Ipsa Loquitur[344]

In spite of the general requirement of expert testimony to support a patient's claim for malpractice, courts have been willing in some cases to permit the plaintiff to get his case to the jury without such evidence where the conduct of the defendant has been thought to be so gross and patently negligent as to be within the comprehension of laymen. Examples already discussed are the failure of a doctor to use X-ray for diagnosis of a fracture or dislocation and failure of a doctor to remove sponges or foreign matter from the patient's body.[345] This substitution of "common knowledge" for expert testimony tends to become categorized as "res ipsa loquitur," the happening of an unusual occurrence which creates an inference of negligence on the part of the doctor. The elements of the traditional elements of a res ipsa loquitur case are: that the accident must be one which normally does not occur without negligence on the part of someone, that the instrumentality or agency which caused injury was under the control of the defendant, and that the plaintiff himself was not a voluntary contributor to his own injury.[346] The courts have had the most difficulty with the first.

342. UNIFORM RULES OF EVIDENCE 63(d), adopted from A.L.I. MODEL CODE OF EVIDENCE, RULE 529.

343. See 6 WIGMORE, EVIDENCE § 1700 (3d ed. 1940), indicating that in most jurisdictions if the witness testifies that his opinion is based on standard authorities these and some other standard works may be used for impeachment purposes.

344. See Fleming, *Developments in the English Law of Medical Liability*, 12 VAND. L. REV. 633, 646 (1959) for a discussion of "The Ybarra v. Spangard Syndrome" as found in the British and Commonwealth countries.

345. *Supra*, notes 134-36, 273-82.

346. See PROSSER, TORTS §§ 42, 43 (2d ed. 1955).

Two early, and widely cited, attempts to make use of the res ipsa loquitur doctrine in malpractice cases were unsuccessful. In *Ewing v. Goode*,[347] in which the patient had lost an eye after an operation for cataracts, William Howard Taft sitting on the circuit bench said:

> A physician is not a warranter of cures. If the maxim, "Res ipsa loquitur" were applicable to a case like this, and a failure to cure were held to be evidence, however slight, of negligence on the part of the physician or surgeon causing the bad result, few would be courageous enough to practice the healing art, for they would have to assume financial liability for nearly all the "ills that flesh is heir to."[348]

In *Sweeney v. Erving*,[349] involving an X-ray burn, the trial court refused to give a charge that the fact of the burn itself was evidence of negligence which cast upon the defendant doctor the burden of proving by a preponderance of the evidence that the plaintiff's injury had not been caused in whole or in part by the doctor's negligence. The Court of Appeals affirmed, citing the language quoted above. The Supreme Court's affirmance did not clearly pass upon the propriety of the plaintiff's claim that the burn was itself evidence of negligence, turning instead on the impropriety of shifting the burden of persuasion to the defendant.[350]

In spite of such rebuffs, by the early 1940's the doctrine had found at least limited acceptance in malpractice actions.[351] It had been applied in cases involving sponges or foreign objects left in the patient's body,[352] burns from hot water bottles,[353] an unexplained burn in the course of an operation,[354] and a broken finger suffered by a dental patient while under anesthetic.[355] On the other hand, the courts tended not to apply the doctrine where a needle broke in use,[356] where the

347. 78 Fed. 442 (C.C.S.D. Ohio 1897).

348. *Id.* at 443.

349. 35 App. D.C. 57 (1910), *aff'd* 228 U.S. 233 (1913).

350. 228 U.S. 233 (1913).

351. See, Shain, *Res Ipsa Loquitur*, 17 So. CAL. L. REV. 187, 217 (1944).

352. Sellers v. Noah, 209 Ala. 103, 95 So. 167 (1923); Ales v. Ryan, 8 Cal. 2d 82, 64 P.2d 409 (1936); Funk v. Bonham, 204 Ind. 170, 183 N.E. 312 (1932); Pendergraft v. Royster, 203 N.C. 384, 166 S.E. 285 (1932); Palmer v. Humiston, 87 Ohio St. 401, 101 N.E. 283 (1913); Davis v. Kerr, 239 Pa. 351, 86 Atl. 1007 (1913); Evans v. Munro, 83 Atl. 82 (R.I. 1912). *Cf.* Bouffard v. Canby, 292 Mass. 305, 198 N.E. 253 (1935) (glass left in wound); Passey v. Budge, 85 Utah 37, 38 P.2d 712 (1934) (doctrine rebutted by defendant's evidence).

353. Timbrell v. Suburban Hosp., Inc., 4 Cal. 2d 68, 47 P.2d 737 (1935); Quillen v. Skaggs, 233 Ky. 171, 25 S.W.2d 33 (1930).

354. Vonault v. O'Rourke, 97 Mont. 92, 33 P.2d 535 (1934).

355. Wolfe v. Feldman, 158 Misc. 656, 286 N.Y. Supp. 118 (1936).

356. Robinson v. Ferguson, 107 Ind. App. 107, 22 N.E.2d 901 (1939); Ernen v. Crofwell, 272 Mass. 172, 172 N.E. 73 (1930); Mitchell v. Poole, 229 Mo. App. 1, 68 S.W.2d 833 (1934); Tady v. Warta, 111 Neb. 521, 196 N.W. 901 (1924); Smith v. McClung, 201 N.C. 648, 161 S.E. 91 (1931). *Contra*, Benson v. Dean, 232 N.Y. 52, 133 N.E. 125 (1921); Wiley v. Wharton, 68 Ohio App. 345, 41 N.E.2d 255 (1941); Tennant v. Barton, 164 Wash. 279, 2 P.2d 735 (1931).

patient's mouth was cut during dental procedures,[357] where a tooth was dislodged[358] or a jaw fractured[359] in the course of an extraction or performance of a tonsillectomy, or where death or injury followed from anesthesia,[360] or tetanus developed following treatment.[361] In cases involving X-ray burns, the courts were divided.[362] A distinction might have been made between burns suffered in the course of diagnostic procedures and those suffered during or as a result of X-ray treatment where the very object was the burning or destruction of tissue. But in a case such as *Lewis v. Casenburg*[363] where the patient had received some 160 treatments over a period of six years, the court found that burns occurring in the course of the last treatment created an inference of negligence. The doctrine was generally inapplicable where injury occurred to the part of the body on which treatment was being performed,[364] or where there was erroneous diagnosis,[365] on the theory that in such cases it could not be said to be a matter of common knowledge and observation that such consequences would not ordinarily occur if due care were used.

The recent use of res ipsa loquitur in malpractice actions has been most notable in the California courts.[366] In late 1944, the case of

357. Chubb v. Holmes, 111 Conn. 482, 150 Atl. 516 (1930); Schmidt v. Stone, 50 N.D. 91, 194 N.W. 917 (1923); Vale v. Noe, 172 Wis. 421, 179 N.W. 572 (1920). *Contra,* Vergeldt v. Hartzell, 1 F.2d 633 (8th Cir. 1924); Evans v. Roberts, 172 Iowa 653, 154 N.W. 923 (1915); Ellering v. Gross, 189 Minn. 68, 248 N.W. 330 (1933).

358. Bollenbach v. Bloomenthal, 341 Ill. 539, 173 N.E. 670 (1930); Hazard Hosp. v. Combs' Adm'r, 263 Ky. 252, 92 S.W.2d 35 (1936); Henley v. Mason, 154 Va. 381, 153 S.E. 653 (1930). *Contra,* Whetstine v. Moravec, 228 Iowa 352, 291 N.W. 425 (1940).

359. Hill v. Jackson, 218 Mo. App. 210, 265 S.W. 859 (1924). *Contra,* Brown v. Shortlidge, 98 Cal. App. 352, 277 Pac. 134 (1929).

360. Loudon v. Scott, 58 Mont. 645, 194 Pac. 488 (1920); Lippard v. Johnson, 215 N.C. 384, 1 S.E.2d 889 (1939).

361. Hembree v. Von Keller, 189 Okla. 439, 119 P.2d 74 (1941).

362. See Annot., 152 A.L.R. 638 (1944) concluding that the courts are about equally divided as to whether the doctrine can be applied to X-ray treatment or examination. The division of the courts is further documented in Annot., 41 A.L.R.2d 329, at 355-367 (1955), indicating that the critical question is whether such injuries are likely to occur in the absence of negligence, a point on which there is considerable disagreement.

363. 157 Tenn. 187, 7 S.W.2d 808 (1928).

364. Trindle v. Wheeler, 23 Cal. 2d 330, 143 P.2d 932 (1943) (burn on ankle during diathermy for arthritis); Engelking v. Carlson, 13 Cal. 2d 216, 88 P.2d 695 (1939) (severing of nerve in knee during operation on knee).

365. Lawless v. Calaway, 24 Cal. 2d 81, 147 P.2d 604 (1944) (diagnosis of ptomiane poisoning when decedent suffered from appendicitis); Adams v. Boyce, 37 Cal. App. 2d 541, 99 P.2d 1044 (1940) (failure to discover foreign body in eye).

366. Reference should be made here to the study of Mr. R. Crawford Morris, *"Res Ipsa Loquitur"—Liability Without Fault,* 163 J.A.M.A. 1055 (1957) reprinted in 25 INS. COUNSEL J. 97 (1958), in which the author charts the use of the doctrine from 1941 to 1955. It is noteworthy that of the twenty-one applications of the doctrine during that period which he mentions, eight of them occurred in the state of California, and that in discussing the growth of the doctrine, Mr. Morris relies almost exclusively on the California experience.

Ybarra v. Spangard[367] came before the Supreme Court of California. Ybarra had submitted to an operation for appendicitis and when he regained consciousness following the operation he felt a sharp pain about half-way between his neck and the point of his right shoulder. In spite of diathermy treatment the condition became worse and ultimately developed into paralysis and atrophy of his right arm. Ybarra brought action against all of the doctors involved in the operation, the head nurse in the operating room and the special nurse who cared for him following the operation. At the trial he introduced expert evidence to the effect that his disability was of traumatic origin and testified himself that during adjustment on the operating table, his body had been placed against two hard objects at the top of his shoulders (a fact contradicted by the operating surgeons). The trial court granted nonsuit as to all defendants. The supreme court reversed and remanded for new trial. After pointing out that there was an injury to a portion of the body not involved in the operation, that the patient was unconscious during most of the relevant time and was therefore unable to describe what had occurred to him, and that the defendants as a group had control over the patient and all instrumentalities which might have caused injury, the court concluded that the doctrine of res ipsa loquitur was applicable, saying:

> We do not at this time undertake to state the extent to which the reasoning of this case may be applied to other situations in which the doctrine of res ipsa loquitur is invoked. We merely hold that where a patient receives unusual injuries while unconscious and in the course of medical treatment, all those defendants who had any control over his body or the instrumentalities which might have caused the injuries may properly be called upon to meet the inference of negligence by giving an explanation of their conduct.[368]

On a second trial, each of the defendants took the stand and testified that at all times when he or she was present at the operation or thereafter nothing occurred which could have given rise to the plaintiff's difficulty. There was also some evidence that Ybarra had suffered in the past from bad teeth and that his present disability could have been systemic in origin rather than traumatic. In spite of this, the trial judge entered judgment against all defendants, saying:

> Even though their explanations were honest, that there was something they did not appreciate happened in the course of the operation, in the course of handling the patient. This is the way I figure the case and that was my decision.[369]

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367. 25 Cal. 2d 486, 154 P.2d 687, 162 A.L.R. 1258 (1944).
368. *Id.* at 494, 154 P.2d at 691, 162 A.L.R. at 1264.
369. Ybarra v. Spangard, 93 Cal. App. 2d, 43, 46, 208 P.2d 445, 446 (1949).

The judgment was affirmed by the District Court of Appeal.[370]

While *Ybarra* extended the doctrine by making it applicable to the situation where the patient joined as defendants all persons who had some control over him or things which caused his injury, it was consistent with the earlier view that the injury must be one which normally would not occur in the course of proper care. In subsequent cases this aspect of the doctrine was also liberalized. In *Cavero v. Franklin General Benev. Soc.*[371] the plaintiff recovered for the death of a six year old child under anesthetic for a tonsillectomy, apparently on the basis of testimony that such operations were normally safe. In *Costa v. Regents of the University of California*[372] the plaintiff received X-ray treatment for an epidermal carcinoma of the tongue and mouth and suffered a burn of the mandible (jawbone) which ultimately developed osteomyelitis. In an action against the doctors and hospital the trial court entered judgment for the defendants. The district court of appeal originally affirmed saying that the *Ybarra* case was inapplicable since the injury was not to an unrelated part of the patient's body, and therefore a layman could not infer negligence from the burning of the mandible.[373] On rehearing, however, the court reversed on the basis that the plaintiff had been denied the opportunity to elicit from defendant's experts whether they had ever seen such a bad result from similar treatment, stating that had such information been elicited the doctrine of res ipsa loquitur might be applied.[374] This would appear to bring the doctrine to the point where any unusually unsuccessful treatment could be the basis for an inference of negligence. In *Bauer v. Otis*,[375] the patient felt severe pain at the time of an injection of "Thex," a vitamin B complex solution, and subsequently suffered a "wrist drop." An operation indicated that there was a lesion of the right radial nerve. In an action against the doctor who had directed the injection and whose employee administered it, testimony was introduced to the effect that if Thex had been injected into the deltoid muscle it could not have caused injury to the radial nerve and that under normal circumstances the administration of Thex would not cause a wrist drop. There was also testimony that it was possible for a solution to travel to a different portion of the arm and that almost all such solutions used in injections could be dangerous to nerves. One expert for the defendant

370. *Ibid.* See Seavey, *Res Ipsa Loquitur: Tabula in Naufragio*, 63 HARV. L. REV. 643 (1950) for a criticism of this decision; and Jaffe, *Res Ipsa Loquitur Vindicated*, 1 BUFFALO L. REV. 1 (1951) for a defense of such use of the doctrine.

371. 36 Cal. 2d 301, 223 P.2d 471 (1950).

372. 116 Cal. App. 2d 445, 254 P.2d 85 (1953).

373. 247 P.2d 21 (1952) (the major portion of this opinion is cited in the later opinion).

374. 116 Cal. App. 2d 445, 254 P.2d 85 (1953).

375. 133 Cal. App. 2d 439, 284 P.2d 133 (1955).

testified that the radial nerve had not been punctured or severed and that injections frequently caused hemorrhages which would allow the solution to gravitate to other portions of the arm resulting in scar tissue and pressure on the nerves. The trial court refused to give res ipsa loquitur instructions. In reversing judgment for the defendant on the ground that such instructions should have been given, the appellate court said:

> While injections and the use of Thex are primarily medical matters, it is a matter of common knowledge among laymen that injections in the muscles of the arm, as well as other portions of the body, do not cause trouble unless unskillfully done or there is something wrong with the serum. Needle injections of cold shots, penicillin, and many other serums have become commonplace today. . . . Certainly if expert testimony is not indispensable in cases involving improper use of anesthesia, improper tonsillectomies, failure to use x-rays, there can be no question but that it is likewise not indispensable in cases involving injections.[376]

This line of cases does not mean that in California any untoward result gives rise to recovery, as some may fear. At the same time that they were deciding the foregoing, the courts refused to permit the defendant to be held without expert testimony as to his lack of care in cases involving infection of the urinary tract following a systoscopic examination,[377] fracture of both femurs in the course of electro shock treatments,[378] a hole in the patient's bladder following a total hysterectomy,[379] and severing of the mandibular nerve in the course of extracting the patient's tooth.[380] There is no doubt, however, that the California courts have been generally solicitous of the injured patient.

Two decisions involving paraplegia following injections in or near the spine deserve special note. In *Seneris v. Haas*[381] the plaintiff received a spinal anesthetic during her accouchement. She had had four prior deliveries and prior spinals without difficulty, but on this case paralysis developed. The defendant-anesthesiologist testified as to the proper manner of administering a spinal anesthetic and stated that normally there was no paralysis where due care and proper practice were followed. He stated as his opinion that the paralysis and loss of sensory perception suffered by the plaintiff was the result of an unusual reaction to the anesthetic and a "psychic overlay" arising from domestic difficulties. The appellate court reversed a nonsuit, stating that res ipsa loquitur could apply on the basis of defendant's admission that where ordinary care was used such paralysis was un-

376. *Id.* at 443-44, 284 P.2d at 136-37.
377. Moore v. Belt, 34 Cal. 2d 525, 212 P.2d 509 (1949).
378. Farber v. Olkon, 40 Cal. 2d 503, 254 P.2d 520 (1953).
379. Dees v. Pace, 118 Cal. App. 2d 284, 257 P.2d 756 (1953).
380. Simone v. Sabo, 37 Cal. 2d 253, 231 P.2d 19 (1951).
381. 45 Cal. 2d 811, 291 P.2d 915 (1955).

likely to follow, coupled with the plaintiff's prior history. In *Salgo v. Leland Stanford Jr. Univ.*,[382] defendants injected a solution of seventy per cent urokon into the patient in the course of making an aortogram, following which the patient developed paraplegia. There was evidence from experts that paralysis or paraplegia was a rare complication of an aortography procedure, since the needle did not normally enter the spinal column itself. One witness, relying on X-rays, was of the opinion that in the course of a second injection (which was denied by the defendants) the needle was either near or in an artery supplying blood to the spinal column and that the urokon injected thereby into the spinal column caused the paraplegia. All other experts testified that the exact cause of injury could not be determined but that it could be (a) constriction of blood vessels leading to the spinal cord due to urokon; (b) damage done directly to the spinal cord by urokon in the circulatory system, or (c) plaintiff's condition, a partially blocked aorta, arteriosclerosis and high blood pressure, combined with an obligeration of the blood vessels and blood supply to the legs. Only the first two of these could have been due to the negligence of the defendants. The trial court charged that res ipsa loquitur was applicable and the plaintiff obtained a verdict. This was reversed on appeal on the ground that

> The jury were not told that the doctrine could apply only in the event they found that the needle had been inserted in the wrong place. On the contrary, the court instructed the jury that as *a matter of law,* from the "happening of all the events involved in this case, however, *as established by the evidence,*" (emphasis added) the inference of negligence arose. The jury were given no opportunity to determine the facts upon which the doctrine would or would not arise.[383]

It should be noted that in both of these cases there is some expert testimony establishing the underlying premises of the res ipsa loquitur doctrine.

Not only have the California courts liberalized the requirements for the application of res ipsa loquitur, but they have also given it a procedural effect beyond that of permitting a jury to infer negligence. As the Supreme Court of California indicated in *Ybarra,* the defendants have an obligation to come forward with an explanation.[384] In *Dierman v. Providence Hospital,*[385] the court again asserted that where the patient was ignorant of the facts because he was unconscious the defendants must make an adequate explanation and in the absence of such explanation the plaintiff was entitled to a verdict. Any question

382. 154 Cal. App. 2d 560, 317 P.2d 170 (1957).
383. *Id.* at 572, 317 P.2d at 177-78. (Emphasis is the court's.)
384. 25 Cal. 2d 486, 154 P.2d 687, 162 A.L.R. 1258 (1954). See the application of this on second trial, 93 Cal. App. 2d 43, 208 P.2d 445 (1949).
385. 31 Cal. 2d 290, 188 P.2d 12 (1947).

concerning the present effect of res ipsa loquitur in the California courts was done away with in a non-medical case, *Burr v. Sherwin Williams Co.*[386] in which the court announced:

> It is our conclusion that in all res ipsa loquitur situations the defendant must present evidence sufficient to meet or balance the inference of negligence, and that the jurors should be instructed that, if the defendant fails to do so, they should find for the plaintiff.[387]

A review of the past fifteen years (post-*Ybarra*) in other jurisdictions indicates that res ipsa loquitur has not been given quite such broad application. Only some twenty-odd cases have applied the doctrine or related rules in malpractice actions, and most of these fall within the categories of pre-1940 cases discussed above.[388] Only a few seem to have extended the doctrine to encompass cases in which it is doubtful that common knowledge would definitely indicate negligence as the cause of injury. In one, gangrene followed an operation for varicose veins, and the court concluded that, although res ipsa loquitur would not support the plaintiff's claim of specific acts of negligence, it could support a general claim of negligence since the reduction of circulation probably arose from tying off or damage to the arterial system in the course of operation on the venous system.[389] In another, a dentist's drill slipped and severely cut the patient's tongue, a fact which the court treated as giving rise to an inference of negligence,[390] although generally injuries in the immediate area being treated are not so considered.[391] Where the patient had suffered a fracture requiring an open reduction and the wound became infected and did not heal while the patient remained under the doctor's care for a period of five months but healed within a few weeks when the patient transferred to another hospital and came under the care of other doctors, the Ohio court said that the jury might infer negligence on the part of the first doctor.[392] In another fracture case,[393] the patient went to the doctor with a simple transverse "greenstick" fracture of the radius of her left forearm. The cast was removed six weeks later and after examination of the arm by the doctor the patient left the office. Two days later there was a marked displacement of the radius which ultimately necessitated an open reduction. The doctor testified that when the cast was removed he was sure that the

386. 42 Cal. 2d 682, 268 P.2d 1041 (1954).
387. *Id.* at 691, 268 P.2d at 1046.
388. See the appendix to Morris, *"Res Ipsa Loquitur"—Liability Without Fault*, 163 J.A.M.A. 1055 (1957), reprinted in 25 INS. COUNSEL J. 97 (1958) for a description of the cases from 1941-1955 in all jurisdictions.
389. McGulpin v. Bessmer, 241 Iowa 1119, 43 N.W.2d 121 (1950).
390. Higdon v. Carlebach, 348 Mich. 363, 83 N.W.2d 296 (1957).
391. See notes 357, 358, 359, 364 *supra*.
392. Bradshaw v. Wilson, 87 Ohio App. 319, 94 N.E.2d 706 (1950).
393. Olson v. Weitz, 37 Wash. 2d 70, 221 P.2d 537 (1950).

result was satisfactory, that there was some natural stiffness but that upon fluoroscoping the arm the fragments of bone appeared to be in good alignment and there was a callus formation. The plaintiff, on the other hand, claimed that she immediately noticed that her arm was crooked and that a lump projected from the top. The court concluded that if there was in fact any misalignment at this time, there was prima facie evidence of negligence, citing cases in which plaintiffs had recovered without expert evidence on the basis of testimony that the doctor had used nonsterile instruments followed by infection,[394] that the plaintiff was injured by a twelve inch spring which broke loose from an instrument in the course of treatment and was not discovered or removed by the doctor,[395] and that when the patient's arm was removed from a cast it was visibly crooked and had a large protuberance and the doctor failed to take any further measures for treatment.[396] If the negligence of the doctor was subsequent failure to treat the crooked arm, the inference of negligence may be appropriate; but if it is the failure of the doctor to achieve a good union of the bones initially of which the patient complains, the inference of negligence seems unwarranted.

During this same period, the doctrine of res ipsa loquitur or reliance upon non-expert testimony and inferences therefrom has been rejected in cases involving fractures suffered during electro-shock treatments,[397] paralysis following a spinal anesthetic,[398] a "burn" which might equally well have resulted from hot water bottles, reaction to ether used in the operating room, herpes zoster (a disease of the nerves), or collapse of the vascular structure of the plaintiff following a thrombosis,[399] development of Volkmann's contracture (claw hand) after reduction of a fracture and application of a tight cast,[400] tetanus following treatment of a scalp wound,[401] and a violent reaction to the administration of penicillin by hypodermic injection into the buttock.[402]

In *Ayers v. Parry*[403] the defendants administered a spinal anesthetic in preparation for an operation on the common bile duct. Plaintiff

394. Helland v. Bridenstine, 55 Wash. 470, 104 Pac. 626 (1909).
395. Wharton v. Warner, 75 Wash. 470, 135 Pac. 235 (1913).
396. Cornwell v. Sleicher, 119 Wash. 573, 205 Pac. 1059 (1922) (there was some expert testimony from the doctor who later treated the plaintiff from which the jury might have reached the conclusion that the treatment was improper).
397. Johnson v. Rodis, 251 F.2d 917 (D.C. Cir. 1948); Quinley v. Cocke, 183 Tenn. 448, 192 S.W.2d 992 (1946). In the Johnson case, the court permitted recovery on the basis of breach of a warranty of safety of the procedure.
398. Hall v. United States, 136 F. Supp. 187 (W.D. La. 1955), *aff'd*, 234 F.2d 811 (5th Cir. 1956).
399. Wallstedt v. Swedish Hosp., 220 Minn. 274, 19 N.W.2d 426 (1945).
400. Bowles v. Bourdon, 148 Tex. 1, 219 S.W.2d 779 (1949).
401. Williams v. Chamberlain, 316 S.W.2d 505 (Mo. 1958).
402. Toy v. Rickert, 53 N.J. Super. 27, 146 A.2d 510 (App. Div. 1958).
403. 192 F.2d 181 (3d Cir. 1951), *cert. denied*, 343 U.S. 980 (1952).

testified he felt a jabbing pain in his spinal column and a terrific pain down his right leg. He became unconscious and when he regained consciousness was unable to move his right leg and subsequently suffered partial paralysis and marked atrophy in the leg and adjacent organs. One expert was of the opinion that if there was pain it was caused by the needle striking nerve roots; another that the painful reaction was a common experience and that this patient suffered injury to the nerve roots in the lower end of the spinal cord which caused his difficulty. The trial court dismissed the action at the close of plaintiff's case. This was affirmed, the Court of Appeals pointing out that while experts were agreed that the paralysis was the consequence of the anesthetic, it was the toxic quality of the anesthetic to which reaction was unpredictable which they emphasized rather than negligence in its administration. The court said that where there is injury to healthy tissue within the region of treatment, whose cause is beyond the realm of knowledge or experience of laymen, the issue of negligence must be determined by expert testimony.

This does not mean that in no case involving administration of spinal anesthetic can the patient rely upon the doctrine of res ipsa loquitur. In *Huber v. Protestant Deaconess Hospital Association*,[404] the defendant anesthesiologist testified that the proper place to administer a spinal anesthetic was between the second and third lumbar vertebrae. Yet the patient, who was conscious at the time of the insertion of the needle, later pointed to a place higher up as the spot where the needle was inserted and his parents testified that after the operation they saw a red spot on his back a short distance below his shoulder blade and just to the left of the spine. The patient testified that when the anesthetic was administered a pain shot to his head and he felt as if he had been hit by something. Moreover, the ultimate reactions were those likely to follow from injury to the spinal cord itself. The court distinguished *Ayers* and reversed a directed verdict for the anesthesiologist. In *Walker v. Distler*[405] the defendant used a spinal anesthetic on an expectant mother rather than a "caudal analgesia" which would have avoided puncturing the spinal canal. The patient suffered foot drop and increasing paralysis of the right leg and total paralysis of the left thigh and calf as well as impairment of control of her bladder and bowels. The defendant's testimony indicated that the choice of anesthetic was dictated by the necessity for a swift-acting anesthetic, although there was other testimony that he might have commenced the procedure at least two hours earlier. The trial court granted a new trial, following a directed verdict for the doctor. This was affirmed, the appellate court saying that the doctrine of res

404. 127 Ind. App. 565, 133 N.E.2d 864 (1956).
405. 78 Idaho 38, 296 P.2d 452 (1956).

ipsa loquitur is not so clearly inapplicable as to preclude a new trial at which evidence might be admitted which would permit the jury to infer negligence. In both of these latter cases there was some evidence other than the administration of the anesthetic and the consequences. It may be that these can therefore be reconciled with the *Ayers* case and that in turn *Ayers* may be reconciled with the California decisions in *Seneris v. Haas*[406] and *Salgo v. Leland Stanford Jr. Univ.*[407] in which the courts suggest that res ipsa loquitur may be available if there is some expert testimony to the effect that paraplegia is not likely to occur if the needle is properly placed and if there is some other evidence from which the jury may infer that the needle was not properly placed. But this scarcely brings the plaintiff total relief from the necessity for producing expert testimony.

CONCLUSION

In recent years, one of the principle complaints of attorneys engaged in presenting plaintiffs' cases against doctors has been the alleged "conspiracy of silence" by which the medical profession is said to protect its members.[408] Perhaps the foremost opponent of the conspiracy has been Mr. Melvin Belli, who in article[409] and treatise[410] has bemoaned the difficulties of obtaining adequate evidence to establish a prima facie case against a doctor. The courts, too, have given recognition to the difficulty of obtaining expert testimony.[411]

To meet this difficulty the courts have liberalized the qualifications required of expert witnesses, permitting practitioners who are not within the same branch of medicine as the defendant to testify, and

406. 45 Cal. 2d 811, 291 P.2d 915 (1955).

407. 154 Cal. App. 2d 560, 317 P.2d 170 (1957).

408. See Comment, 9 STAN. L. REV. 731, 733-35 (1957) in which the results of a survey of both plaintiffs' and defendants' attorneys and doctors are reported. See also Comment, 2 VILL. L. REV. 95 (1956) for a survey of why doctors do not testify.

409. Belli, *An Ancient Therapy Still Applied: The Silent Medical Treatment*, 1 VILL. L. REV. 250 (1956); Belli, *"Ready for the Plaintiff!,"* 30 TEMP. L. Q. 408 (1957); Belli, *More on Being "Ready for the Plaintiff,"* 20 GA. B.J. 451 (1958).

410. 3 BELLI, MODERN TRIALS 1964-66 (1953).

411. See Christie v. Callahan, 124 F.2d 825, 827-29 (D.C. Cir. 1941); Salgo v. Leland Stanford Jr. University, 154 Cal. App. 2d 560, 568, 317 P.2d 170, 175 (1957); Gist v. French, 136 Cal. App. 2d 247, 258, 288 P.2d 1003, 1010 (1955); Tadlock v. Lloyd, 65 Colo. 40, 44, 173 Pac. 200, 202 (1918); McGulpin v. Bessmer, 241 Iowa 1119, 1130, 43 N.W.2d 121, 127 (1950); Butts v. Watts, 290 S.W.2d 777, 779 (Ky. App. 1956); Johnson v. Winston, 68 Neb. 425, 430, 94 N.W. 607, 609 (1903); Carbone v. Warburton, 11 N.J. 418, 427, 94 A.2d 680, 684 (1953). See also Huffman v. Lindquist, 37 Cal. 2d 465, 483, 234 P.2d 34, 46 (1951) (dissenting opinion of Carter, J.); Julien v. Barker, 75 Idaho 413, 419, 272 P.2d 718, 721 (1954); Edwards v. Clark, 96 Utah 121, 130, 83 P.2d 1021, 1030 (1938). *But see* McHugh v. Audet, 72 F. Supp. 394, 404 (M.D. Pa. 1947) refusing to impute to others the conduct of one physician; and Coleman v. McCarthy, 53 R.I. 266, 267-68, 165 Atl. 900, 901 (1933) which treats the plaintiff's counsel's statement that he was unable to obtain medical testimony as "startling" and if true "a grave concern to those charged with the administration of justice."

permitting the plaintiff to go well outside the immediate locality of the defendant's practice to obtain his experts. They may go further and permit the plaintiff to make use of the defendant's own expertise as a witness for the plaintiff or to rely upon the defendant's own testimony to establish the plaintiff's case in chief. There is some suggestion in the recent enactment of special statutes in Massachusetts and Nevada that the use of medical treatises may be expanded in the future, giving the plaintiff access to expert evidence as to the existing practices or standards of the profession. Finally, there is the recent extension of res ipsa loquitur to provide at least an inference of negligence where the injuries which the plaintiff has received are of a type unusual or not to be expected from careful treatment and where the defendant or those subject to his control have control of the instrumentalities which probably caused the injury.

Does the difficulty of obtaining expert testimony justify the courts in going further and modifying the standard of care required of doctors? There has been some suggestion, particularly in the res ipsa loquitur cases, that this is being done. Where the jury members are permitted to infer negligence from the mere existence of unusual injuries, such as damage to the mouth in a dental operation, burns in the course of X-ray therapy, or even atrophy of an arm following an appendectomy, the courts may be assuming more medical knowledge than the average layman is likely to possess and may be imposing something more than a duty of compliance with ordinary practices upon the doctor. As pointed out at the close of the discussion on customary practices as a standard of care, there is a strong argument for limiting the care required of the doctor to the accepted practice of his profession. It is therefore, undesirable I believe, for the court to use res ipsa loquitur as a basis for creating a new standard. True, if there is medical evidence that injuries of the sort which the plaintiff has suffered are highly unlikely to occur when customary practices are followed, some inference of negligence may be drawn, but here the facts merely dispute the exercise of customary care. In each case the jury should be instructed that they are to find the doctor-defendant liable only if there has been a deviation from the custom of the profession and that the custom of the profession is a matter which must be established by expert testimony or the use of learned treatises or other professional literature. By liberalizing the means available to the plaintiff in proving the custom and its safety, the burden of coming forward with expert testimony to support the practices used may be shifted to the defendant, who is more likely to have access to such proof.