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Fitz-Gerald Ames SR

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MODERN TECHNIQUES IN THE PREPARATION AND TRIAL OF A MEDICAL MALPRACTICE SUIT

FITZ-GERALD AMES, SR.*

VOIR DIRE EXAMINATION OF JURORS

Though it is true that in malpractice suits more than in any other type of litigation, the plaintiff must have a strong case on the merits, it is equally important and almost a necessity in most malpractice cases that patient's counsel carefully and thoroughly condition the jurors' minds from the very outset to a psychological acceptance of this type of litigation.

Far too many veniremen, before they have been selected as trial jurors in a malpractice suit, have the attitude that (1) a "malpractice" suit connotes conduct either criminal, quasi-criminal or unethical on the part of the doctor or hospital; (2) the doctor may be deprived of his membership in the medical societies or lose his staff privileges at the hospital, or even lose his license to practice medicine; (3) he will lose standing with his colleagues in the medical profession; (4) his professional standing will be degraded in the eyes of his patients and the local community in which he practices; (5) as a consequence his medical practice may suffer with resulting loss of income; and (6) as a consequence of all this, a doctor or hospital should be protected from this type of litigation.

Therefore, in addition to the routine questioning of each juror individually as to whether they have any friends or relatives who are doctors, nurses, employees of hospitals or engaged in any way in the medical field and whether they are biased in favor of or prejudiced against the medical nursing or hospital profession, they should be thoroughly and intensively questioned along the following lines:

FIRST: Do you thoroughly understand that a malpractice suit does not connote anything criminal or quasi-criminal, but is merely a civil suit for damages; that the term "malpractice" is merely a legal term which the courts have invented to describe an action for negligence against professional men, including doctors, nurses, hospitals, and attorneys?

SECOND: It does not involve any charge of wilful misconduct, unethical conduct, or any act involving moral turpitude which would result in the loss of his membership in the medical societies or on the medical staff of any hospital or his license to practice medicine.

* Member, San Francisco Bar Association, Lawyers Club of San Francisco (President, 1949-50; Member of Board of Governors, since 1947). Lecturer on Legal Medicine and Elements of Medical-Legal Litigation, Law Science Court, 1952.

THIRD: Keeping in mind that this action is nothing more nor less than a suit for professional negligence of a doctor, I would like to ask you this question: if you should find the defendant liable, do you feel that he should be given a greater break than you or I, or any other person should be given were we liable as the result of our negligence? For example, if the doctor were driving his car down to his office, not in the course of his professional duty, and negligently struck a pedestrian in a crosswalk and as a result became liable in damages to the injured party, you would have no hesitancy in bringing in a verdict for damages against him, would you? If, on the other hand, the same doctor in the course of the performance of his professional duties became liable to a patient as a result of his negligence, would you feel that he should be given a greater break or better consideration because in the latter situation he was guilty of professional negligence, and in the first situation of general negligence?

FOURTH: Would you be prejudiced against my client, or against me as his attorney, if, as a result of the reluctance of doctors to testify against each other, we are unable to produce a doctor to testify against the defendant? Would you be prejudiced against my client or me if, as a result of the reluctance of doctors in this community to testify against each other, we are required to produce a doctor from another community to testify against the defendant doctor? Do you feel that doctors are reluctant to testify against each other? Why do you feel that they are not reluctant to testify? Why do you feel that they are reluctant?

It is my firm belief that it is necessary in every malpractice suit to iterate and reiterate with each and every venireman, these and similar follow-up questions along the same line, so that eventually even the judge will join with you in questioning the jurors as to their state of mind upon these subjects, so that by the time your jury is empaneled, each and every one of them has been thoroughly indoctrinated with the truisms of which you speak and that these thoughts have been firmly embedded in the conscious and subconscious minds of the jurors.

The resourceful trial lawyer can elaborate upon these themes and vary them, depending upon the answers and reactions of the jurors. These suggestions are made with the full realization that in some states and before some judges the plaintiff's counsel may not have this wide range of freedom in his voir dire examination of the jurors.

To follow up the theme that the filing of a malpractice suit against a doctor does not injure him in his professional standing, either within the medical profession or in the community, I find it advantageous to purposely develop the fact during the testimony that the defendant

doctor, since the filing of the malpractice suit and since the alleged negligent act or omission occurred, has gained steadily in his professional standing and since the malpractice and up to the date of trial has been appointed chief of staff of the hospital, or chief of one of the specialty sections of the hospital, or appointed civilian consultant to some Veterans Administration facility or hospital; or has been elected to some office in either the national, state or local medical society, or specialty association in his field. If you don't, they probably will. It is better to bring it out yourself to give the impression that you think it is favorable to your side, which, in a way, it is. You can then argue to the jury that the positions and honors which have been bestowed upon him prove that certainly the filing of the malpractice suit has not injured the doctor in his professional standing and that a judgment against him in all probability will not injure him in his professional standing.

You can then argue that you do not contend that he is normally a careless physician or that he does not possess the care and skill of an ordinarily skillful physician and surgeon, but that you do contend that in this one situation at least, he was guilty of professional negligence, just as an experienced engineer, streetcar motorman, cab driver, truck driver or bus driver with twenty to thirty years of driving experience may normally be a careful and experienced driver and yet can be guilty of negligence on a particular occasion, which should subject him to liability for damages. You can then argue that the fact that the doctor has had all those years of training and experience in general medicine and many years of training and private practice in a particular specialty, does not guarantee that he cannot be and was not guilty of negligence in this case any more than the veteran operator of a vehicle can be insulated from liability by that fact alone. Otherwise the innocent victim of another's negligence could never secure justice. In most communities the local newspapers do not publish news items regarding the filing of a malpractice suit against a doctor or hospital or the results of the verdict unless the amount of the verdict is so large that it is news in and of itself. If this situation pertains in your community or locality I would comment upon this fact, and bring out, if it is true, that although there have been many malpractice suits filed and many judgments obtained in the last several years, no one in this community has read about them in the daily press. Therefore, you argue: "if you bring in a verdict against this defendant the probabilities are that only you twelve men and women of the jury, the judge and court attaches will know anything about it." This of course would not hold true in a small community where word seeps out by word of mouth, but it is a very effective argument in larger communities.

PREPARATION OF THE TRIAL OF A MALPRACTICE SUIT

In the preparation of the trial of a malpractice suit it is, of course, essential that the careful lawyer thoroughly prepare himself on all phases of the medical problems involved. This he must do by reading every conceivable medical article, treatise or book that deals with the subject. He should be aided in this research by consulting with a physician and surgeon, whether it be in his community or outside his community, even though the doctor will not testify at the trial on behalf of the plaintiff.

While it is perfectly true that doctors have developed a "conspiracy of silence,"[1] you should have little difficulty in securing at least one doctor in your city or state who would be willing to sit down with you and review the problem and give you technical assistance. You should not rely solely on what the doctor tells you, but you should personally read the medical articles and treatises and thoroughly understand them. You should also refer to medical illustrations, drawings and diagrams which depict the part of the body involved, which will enable you to have a thorough knowledge of the physiology, anatomy and pathology involved in your case, and a clear word picture, as well as a visual picture of the problem. If the defendant doctor or his medical experts, if known, have ever written articles on the subject you should ascertain this by referring to the *Index Medicus* and see if they have ever written anything on the subject which would be favorable to the plaintiff's contention.

Depositions should be taken in every malpractice case, not only of the defendant doctor, but every assistant, interne, resident, nurse and hospital aide or attendant who had anything to do with the case and all doctors who may have been called into consultation before and after the malpractice was committed by the defendant doctor. I realize that this cannot be done in every state, but I am speaking of California, the federal courts and other states where liberal discovery rules prevail which permit the taking of the deposition of any witness in advance of trial whether he is a party to the action or not.

A good basic general knowledge of medicine, in addition to a precise knowledge of the specific medical problem involved, is of great advantage to a trial lawyer in a malpractice case. As will be related later on in this article, there are many situations that may arise during the trial where a knowledge of basic medicine will stand the trial lawyer in good stead. It is no exaggeration to state that the trial lawyer in a malpractice suit should know as much if not more than the

1. See Salgo v. Leland Stanford Jr. Univ., 154 Cal. App. 2d 560, 317 P.2d 170 (1957), where the court took judicial notice of this conspiracy of silence as evidenced by the refusal of doctors to testify in malpractice suits.

doctor he is cross-examining, even though he be a specialist in the particular field of medicine being dealt with. This can be done. There are very few medical books that deal with the "do's and don't's" of medicine and surgery. However, there are a few, and they should be examined in every case to see whether or not the particular type of operation or medical treatment involved in your case has been covered.[2]

More and more cases are coming to our office where the negligence of a doctor or hospital appears to be in connection with the administration of a drug or medicine. In this type of case the attorney should first and foremost secure a copy of the manufacturer's brochures or pamphlets which were issued and in effect at the time of the alleged malpractice and examine them thoroughly as to recommendations for dosage, techniques of administration, contra-indications, sensitivity tests, and harmful reactions from its use. A few cases have held that manufacturer's brochures are admissible in evidence to establish a prima facie case of negligence on the part of the defendant.[3]

In addition to subpoenaing the hospital records, if any, and the doctor's private office notes, plaintiff's counsel should subpoena the individual hospital rules and regulations governing the particular hospital and if the hospital is approved by the Joint Commission on Accreditation of Hospitals he should subpoena a copy of their rules which were adopted by the hospital in which the patient was treated. The Joint Commission on Accreditation of Hospitals was organized in 1953 by the American College of Surgeons, the American Hospital Association, the American Medical Association, the American College of Physicians and the Canadian Medical Association. A copy of their model medical staff by-laws rules and regulations may be procured by writing to the Joint Commission at 660 North Rush Street, Chicago, Illinois.

Most reputable hospitals in the United States have been approved by the Joint Commission and have adopted these rules and agreed to be bound by them. It is important to establish this fact by a thorough questioning of the hospital administrator or superintendent. Do not let them give evasive answers because before the hospital could be approved, its board of directors necessarily adopted a resolution agreeing to adopt and be bound by these by-laws, rules and regulations.

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2. The following are suggested: SURGICAL CLINICS OF NORTH AMERICA, PITFALLS AND ERRORS IN SURGERY (1958); BEECHER & TODD, A STUDY OF DEATHS ASSOCIATED WITH ANESTHESIA AND SURGERY (1954); THOREK, SURGICAL ERRORS AND SAFEGUARDS (1953).

3. See Salgo v. Leland Stanford Jr. Univ., 154 Cal. App. 2d 560, 317 P.2d 170 (1957); Julien v. Barker, 75 Idaho 413, 272 P.2d 718 (1954).

Regarding the medical treatises and reference books that should be resorted to in preparing a malpractice case for trial, it is important to be aware of section 7 of the Rules and Regulations of the Joint Commission which reads as follows:

> 7. Drugs used shall be those listed in the U.S. Pharmacopeia, National Formulary, New and Non Official Remedies (now called New and Non Official Drugs) and the British Pharmacopeia or Canadian Formulary with the exception of drugs for bona fide clinical investigations. *Exceptions to this rule shall be well justified.*

Since an approved hospital is bound by these rules, you may then refer to and put into evidence excerpts from these medical publications or references, assuming that defendant's rules and regulations are admissible in evidence in your jurisdiction. The publication now known as *New and Non Official Drugs* is particularly valuable since it is an official publication of the American Medical Association and copyrighted by them and approved by their Council on Drugs and officially accepted and adopted by the American Medical Association. In the *N.N.D.,* which is issued every year and kept up to date throughout the year as new drugs are approved, by publication in the weekly issues of the *A.M.A. Journal,* will be found much valuable information. After each drug appears the recommended dosage and in many cases the action and the use of the drug is discussed with the council's recommendation. In connection with many of the drugs the technique of administration is also discussed and recommendations made.

If a new drug is prescribed and administered by the doctor and hospital before it has been accepted and approved by the A.M.A. for inclusion in the *N.N.D.,* this could be brought out as an element of negligence on the part of the defendant in using a drug which had not as yet been accepted. If it has been accepted and published in the *N.N.D.,* you might find that the defendant exceeded the dosage recommended therein or failed to follow the techniques recommended therein. You may find a reference to the *United States Pharmacopeia and National Formulary* to be of some value but not as helpful as the *N.N.D.* Where the hospital in which the patient was treated is an approved hospital, the use of any of these books are authorized under the rules and regulations of the Joint Commission.

If there is a dispute as to the exact type and description of operation which was performed on your client or the exact disease which was diagnosed by the defendants, you will find another medical reference book published by the A.M.A. to be of great value, namely, *Standard Nomenclature of Diseases and Operations.* It is not published each year. In this book is set forth practically every disease and operation designated by a standard nomenclature or name, and a standard code

number. On the admission record of the patient in practically every hospital chart will be recorded the standard nomenclature and code number of the disease or operation. This is almost invariably taken from the book just mentioned.

You will find many procedures, where injections are made by the use of hollow needles, listed in this publication as operations. Also each approved hospital keeps a card index wherein they list every operation performed in their institution, cross indexed by standard nomenclature and standard code number. On one card will be found a list of all operations of that type performed for the last several years, with the name of the doctor who performed it, the name of the patient, and the name and code number of the disease being treated. If this information is important in your case you should subpoena these records.

Such records have been helpful to me in a number of cases where the defendant doctor has exaggerated his skill and training and bragged that he had performed a large number of a certain type of operation in a particular hospital. In one case where the doctor claimed he had performed twenty-five to twenty-eight of these procedures, these records were subpoenaed and much to our surprise they revealed that he had performed none whatsoever. In another case where the doctor claimed he had performed fifty hysterectomies a year the records showed he had performed only one a year.

Another medical record, the existence of which is not generally known and which is never produced by the hospital in response to the usual subpoena duces tecum for records concerning a patient, is the record commonly called an "operating log book." Every reputable hospital has such a log book in which is recorded in chronological order the name of each patient operated upon, the name of the chief surgeon, assisting surgeons, anesthesiologist, the names of the nurses, interns and residents who participated in the operation, the type of operation, the time the operation commenced and ended, and the time the anesthetic commenced and ended, the type of anesthetic, a description of the specimens removed from the patient and the fact that these specimens were sent down to the pathological laboratory.

While it is true that these records seldom reveal more than is contained in the operating report which is usually a part of the patient's hospital chart, there may be situations where it will be of tremendous help. In one of our cases which I vividly recall, which was tried in a small community, the defendant doctor, a general practitioner, testified there were no orthopedic specialists located in the town at the time of the operation or on the staff of the hospital and no orthopedic specialists had performed orthopedic surgery in the hospital until several months after the plaintiff was operated on.

The defendant doctor also stated that he performed the surgery without any assistant surgeon. When the operating log book was produced it showed the name of the assistant surgeon and it also showed the name of an orthopedic specialist who had performed twenty-nine operations in the same hospital during the preceding nine month period and further showed that this same orthopedic specialist had just left the operating room when the defendant doctor entered the operating room to operate upon the plaintiff.

There are other hospital records which are never produced in response to the usual subpoena for hospital records. Such records include the medical staff discussions and meetings of various committees. In all approved hospitals such meetings are required by Rule 17 of the Joint Commission which reads as follows:

> 17. The medical staff discussions at meetings held as provided for under Number 1 of these Rules and Regulations shall constitute a thorough review and analysis of the clinical work done in the hospital, including consideration of *deaths, unimproved cases, infections, complications, errors in diagnosis and results of treatment from among significant cases in the hospital* at the time of the meeting and significant cases discharged since the last meeting, and analysis of clinical reports from each department and reports of committees of the active medical staff.

Note that in all cases of death, unimproved cases, infections, complications or errors in diagnosis and results of treatment and all significant cases are discussed by these various committees. One of the more important committees is frequently called the "tissue committee." This committee reviews and discusses the diagnosis and findings of the chief surgeon contained in his operative report as to the condition of body tissues, and any conflict, if any, between his findings on the one hand and the findings of the laboratory pathologist on the other hand.

Such records have proven extremely valuable in cases where the defendant surgeon contended that it was necessary to perform an unauthorized hysterectomy because of the presence of cysts, tumors, fibroids and lesions in the female organs, but where the laboratory report showed that the tissue specimens were nonpathological. Such records were helpful to us in another case where we contended that the plaintiff had developed osteomyelitis of the head and neck of the left femur bone due to the negligence of the defendant, and the defense contended that she lost the neck and head of the femur due to aseptic necrosis. The records of these committee hearings were of assistance to the plaintiff in establishing that the defendant had diagnosed the plaintiff's condition as resulting from a bone infection.

If the patient has been in a hospital it is always wise in framing the complaint to join the hospital as a party defendant as there are

many ways in which the hospital as well as the attending physician or chief surgeon may likewise be held liable, which may not become apparent until after suit has been filed, records produced and depositions taken. In connection with the duty of calling in specialists into consultation, Rule 14 of the Joint Commission provides in part as follows:

> In major surgical cases in which the patient is not a good risk, and in all cases in which the diagnosis is obscure, or when there is doubt as to the best therapeutic measures to be utilized, consultation is appropriate. . . . It is the duty of the hospital staff through its chiefs of service and Executive Committee to see that members of the staff do not fail in the matter of calling consultants as needed.
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> ....
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> In circumstances of grave urgency, or where consultation is required by the rules of the hospital, the hospital administrator shall at all times have the right to call in a consultant or consultants after conference with the chief of staff or available members of the senior attending staff.

Also in this connection see Rule 10 of the General Statement of the Fundamental Rules required by the Joint Commission:

> 10. A statement providing that, except in emergency, consultation shall be required as outlined in Section 14 of the attached Rules and Regulations of the Medical Staff.

These provisions of Rule 14 place the duty squarely on the hospital administrator to see that consultants are called in in proper cases. A failure to do so could be negligence.

Another little known hospital rule which imposes a duty on both the staff doctors and the hospital administrator, is contained in Rule 15 of the Joint Commission which reads as follows:

> 15. Each member of medical staff not resident in the city or immediate vicinity shall name a member of the medical staff who is a resident in the city, who may be called to attend patients in emergency. In case of failure to name such associate the administrator of the hospital shall have authority to call any member of the staff should he consider it necessary.

In addition to the duty imposed upon the staff doctors and the hospital administrator under this rule, the law itself imposes a duty upon the part of a hospital to call in another physician to treat the patient if the attending physician is not available; in other words, the mere fact that a patient has an attending physician does not exonerate the hospital in every case.[4] In some situations a company or corporation which is not in the hospital business which maintains a first aid station or company doctor can be held liable for the professional negligence of its medical employees.[5]

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

5. See Cooper v. National Motor Bearing Co., 136 Cal. App. 2d 229, 288 P.2d 581.

Rule 3 can sometimes be applied to impose liability on the doctor where the patient is known to the doctor to be potentially dangerous to himself or others due to the illness from which he is suffering or due to medication which is prescribed for him by the doctor. Rule 3 reads as follows:

> Physicians admitting private patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatever, or to assure protection of the patient from self harm.

Every effort should be made by deposition to question the anesthetist and any assistant surgeons in the operating room as to whether or not they receive any benefits whatsoever from the hospital which would constitute them an agent of the hospital. In many hospitals the relationship between the anesthetist and the hospital is such that they receive the use of the operating room free of charge. All of the anesthetic equipment, machines and anesthetics used in the procedures are furnished free of charge including masks, gloves, operating room gowns, private office, free telephone service and secretarial service.[6]

Also, in malpractice suits where the doctrine of res ipsa loquitur applies do not lose sight of the fact that the patient is entitled to the inference arising from the doctrine as against all of the persons in the operating room, including the chief surgeon, assistant surgeons, nurses, interns and residents.[7] Remember that in all hospitals who are certified for internship and residency training programs the residents as well as the interns are employees or agents of the hospital.

It is important to thoroughly check the local hospital licensing act of your own state and the rules and regulations promulgated by the hospital board or commission that administers the act. These particular rules contain many important provisions including the statutory duty of care on the part of the hospital. As an example, the Health and Safety Code of the State of California has established a Department of Public Health, Bureau of Hospitals, which has promulgated an Administrative Rule known as Section 286 reading as follows:

> *286. Emergency Medical Service.* All institutions covered by these requirements shall arrange for one (1) or more persons, duly licensed under the provisions of the California Business and Professions Code which authorize that person to diagnose, prescribe, and treat human illness, to be called in emergency.

If you have a case where a patient dies or suffers some serious injury because the attending physician was not available and the hospi-

6. In this connection see Seneris v. Haas, 45 Cal. 2d 811; 291 P.2d 915 (1955), where the court held there was sufficient evidence before the court to warrant submitting the issue of agency to the jury.

7. See Ybarra v. Spangard, 25 Cal. 2d 486, 154 P.2d 687 (1944).

tal failed to have a qualified doctor available for emergency service they might be liable under this section.

We have a case in our office now where the following Administrative Rule adopted by the Bureau of Hospitals has been violated:

> *355. Restraint of Patients* . . . (b) *Restraints.* Confinement of patients in locked rooms and physical restraints shall not be used, except when they are necessary to prevent injury to the patient, or others and only when alternative measures are not sufficient to accomplish the purpose, and in any case only on the signed order of a physician, except in a clear-cut case of medical emergency when the physician may give such order by telephone; in such cases the physician shall sign the order on his next visit. In applying restraints careful consideration shall be given to the methods by which they can speedily be removed in case of fire or other emergency.

While this rule limits to some extent the duty of the hospital it also imposes a stronger duty on the physician to issue a signed order when physical restraints are necessary.

There are many important provisions governing the maternity wards, including Section 377 (1), reading as follows:

> *(1) Oxygen* Oxygen shall be administered to infants only on the written order of a physician, which shall include the concentration (volume per-cent) of oxygen.

This provision is extremely important since there have been many cases of blindness in the newborn infant due to the disease known as retrolental-fibroplasia. In this connection the Bureau of Hospitals or the Department of Public Health of your state should be thoroughly checked to see whether or not it has issued any special pamphlets or bulletins to hospitals and doctors. In California our Bureau of Hospitals has set up a number of important advisory committees who from time to time issue reports and recommendations. One report of the advisory committee on R.L.F. deals with the condition known as retrolental-fibroplasia. Copies of the report in pamphlet form were circularized among all of the doctors and hospitals in California in June, 1955, putting them on notice of what should and should not be done in order to avoid excessive oxygen administration to newborn infants, one of the causes of infant blindness.

If the hospital where your client was a patient had an internship training program you should subpoena a copy of the requirements and rules and regulations governing the internship training program. This program is controlled by the American Medical Association, Council on Medical Education and Hospitals, which has published a list of requirements for approved hospitals, including: *Essentials in a Hospital Approved for Interns.* In most states the Board of Medical Examiners issue permits to the interns and licenses to all hospitals

who are so approved and accept the certification by the AMA that the hospital is properly qualified for internship. In a recent case which I tried the case was won primarily upon proof that the internship training program as contemplated by these rules was violated in many respects, particularly in permitting interns to treat patients without any supervision by medical members of the medical staff and to perform minor operations without any direct supervision by qualified surgeons.

PLEADING

You should always have one cause of action in the complaint broad enough to permit you to rely upon the doctrine of res ipsa loquitur, another count alleging negligence in general terms, another count alleging various acts of negligence in specific terms and if the facts lend themselves to such proof, a cause of action for assault and battery and express warranty. Remember that unauthorized operations constitute not only negligence but an assault and battery upon the patient.[8] Where by careful questioning of the client, his family and his friends, it develops that the doctor has made an oral promise or warranty of a cure, which frequently occurs in such cases as plastic or reconstructive surgery, always include a separate cause of action for damages for breach of an express oral warranty.[9] Also keep in mind that in most jurisdictions malpractice may be alleged in general terms and with the same broad liberality as is permitted in cases of pleading negligence generally.[10] Never turn down a malpractice case just because the statutory period seems to have run from the date of the negligent act or omission. In California and many other states the statute of limitations may be tolled where the negligent act or omission has been concealed from the patient, in which case the statutory period commences to run from the date plaintiff discovered or, in the exercise of reasonable diligence should have discovered the facts upon which his cause of action is based.[11]

TRIAL TECHNIQUES

In the taking of depositions and at the trial it is very important to pin down each doctor you question as to whether or not such a result

8. See Wennerholm v. Stanford Univ. School of Medicine, 20 Cal. 2d 713, 128 P.2d 522 (1942); Figlietti v. Frick, 203 Cal. 246, 263 Pac. 534 (1928); Estrada v. Orwitz, 75 Cal. App. 2d 54, 170 P.2d 43 (1946); Valdez v. Percy, 35 Cal. App. 2d 338, 217 P.2d 422 (1950); White v. Hirshfield, 108 Okla. 263, 236 Pac. 406 (1925); Physicians and Dentists' Business Bureau v. Dray, 8 Wash. 2d 38 111 P.2d 568 (1941).

9. See Crawford v. Duncan, 61 Cal. App. 647, 215 Pac. 573 (1923).

10. See Stafford v. Shultz, 42 Cal. 2d 767, 270 P.2d 1 (1954); Bowman v. McPheeters, 77 Cal. App. 2d 795, 176 P.2d 745 (1947).

11. See Stafford v. Shultz, 42 Cal. 2d 767, 270 P.2d 1 (1954); Hurlimann v. Bank of America, 141 Cal. App. 2d 801, 297 P.2d 682 (1956); Greninger v. Fischer, 81 Cal. App. 2d 549, 184 P.2d 694 (1947).

"as sustained by the plaintiff would ordinarily and usually occur if due care and skill were exercised." If a doctor hedges by saying that it "can and has happened" press him for a direct answer to your question. If he still hedges, ask him "Then I understand that such unfortunate results *do* ordinarily and usually occur even though due care and skill is exercised in the performance of this operation." He will usually back up and say no, it doesn't usually or ordinarily occur, particularly if due care and skill is exercised. If you can drag such an admission from the doctor before trial you have all the makings of a res ipsa loquitur case.[12]

Based upon the admission of one of the defendant doctors, that when "due care and proper practice was followed permanent paralysis did not follow the spinal anesthetic," the supreme court in the *Seneris* case held that the first element of the doctrine was satisfied by the foregoing testimony and since the instrumentalities were under the control of the defendant, and there was no voluntary action or contribution on the part of the plaintiff, it was a matter for the jury to determine if the elements were present, and if so, to invoke the doctrine and apply the inference. It is well to keep in mind that in California and many other states the source of expert medical testimony as to custom and practice may come from the lips of the defendant under cross examination.[13]

It is very important to thoroughly question the client, the family and friends before the deposition is taken and before the trial as to any conversations between the doctor and any hospital employees and the plaintiff, family and friends. It is possible to establish a prima facie case and get by a nonsuit if the defendant has made any admissions against interest. This is true even though the doctor may deny making these alleged admissions. It is for the jury to determine who they must believe. Of course where the defendant doctor makes the judicial admission in a deposition or at the trial admitting his negligence or admitting that he did not exercise ordinary care and skill, or did not follow the accepted custom and practice, you have no problem. Your case is made. This is extremely rare. However, even where the defendant doctor has made extra-judicial admissions which he later denies at the time of the trial, it is possible to make out a prima facie case sufficient to get by a nonsuit.

Where the plaintiff testified that the defendant doctor admitted to him that he had shoved the needle into the cartilage which was very tough and which the doctor said was the cause of the needle breaking, and that the doctor told him that he should have injected it on either

12. See Seneris v. Haas, 45 Cal. 2d 811, 291 P.2d 915 (1955).
13. Seneris v. Haas, *supra*. Lashley v. Koerber, 26 Cal. 2d 83, 156 P.2d 441 (1945); Lawless v. Calaway, 24 Cal. 2d 81, 147 P.2d 604 (1944).

side, which the doctor denied, the court held that if the jury believed the plaintiff's testimony it was sufficient to sustain a verdict.[14]

In the case of *Scott v. Sciaroni*,[15] defendant's admission to a family member that "it was his fault that she was in the condition she was in" was held equivalent to an admission of negligence even though the doctor denied it at the time of trial. In the very recent case of *Wickoff v. James*,[16] the only evidence the plaintiff presented in connection with the defendant's negligence was plaintiff's claim that he heard the defendant doctor make the following extra-judicial admission while walking down the hospital corridor: "Boy, I sure made a mess of things." In both cases the testimony of the plaintiff or family was sufficient to establish a prima facie case of negligence against the doctor and warranted a submission of the case to the jury and it was error to grant a nonsuit.

Another type of situation where liability may be fastened upon the defendant is where the defendant admits that if he performed a procedure or operation in a certain manner, it would not be consistent with due care and skill, but at the same time denies that he did the operation and procedure in the manner as charged. If the patient testifies that the doctor did the operation and procedure in a manner which is admittedly negligent, and the jury chooses to believe the plaintiff's testimony, this is sufficient to get the case to the jury and to support a verdict and judgment for plaintiff. As an example, if the patient testifies that the defendant doctor or nurse did not sterilize the instruments or the skin before inserting the needle or instrument, and the doctor or nurse testify that they did sterilize, but admit that it is not good practice not to sterilize, a case has been made out for the jury.[17] Thus, in *Salgo v. Leland Stanford Jr. Univ.*,[18] the plaintiff's medical expert was held not qualified to testify as to custom and practice, but did testify that from the x-rays it was his opinion that the defendants inserted the needle and injected the dye outside of the aorta and in the spinal cord or circulation. The defendants admitted that if they had done that, it would not be in accordance with due care and skill, but denied that they did it and contended that the needle was inserted and the dye injected in the aorta which was the proper procedure. The court held it was still a question for the jury, and if the jury chose to believe that the needle was inserted and the

14. Walter v. England, 133 Cal. App. 676, 24 P.2d 930 (1933).
15. 66 Cal. 577, 226 Pac. 827 (1924).
16. 159 Cal. App. 2d 664, 324 P.2d 661 (1958).
17. See Barham v. Widing, 210 Cal. 206, 291 Pac. 173 (1930); Kalmus v. Cedars of Lebanon Hosp., 132 Cal. App. 2d 243, 281 P.2d 872 (1955); Mastro v. Kennedy, 57 Cal. App. 2d 499, 134 P.2d 865 (1943); Inderbitzen v. Lane Hospital, 124 Cal. App. 462, 12 P.2d 744 (1932).
18. See Salgo v. Leland Stanford Jr. Univ., 154 Cal. App. 2d 560, 317 P.2d 170 (1957).

dye injected outside of the aorta, coupled with the admission of the defendant doctor that it would be negligence to do so, they could base a judgment in favor of plaintiff upon such evidence. In a case where the plaintiff testified that the defendant doctor took one to two seconds in injecting novocaine and the doctor admitted that it is not good practice and where the doctor testified that he took thirty to forty-five seconds to insert the needle and inject the novocaine, the court held that this evidence was sufficient to sustain a verdict if the jury believes it.[19]

The following is an example of a set of facts which should be sufficient to get the case to a jury: The doctor admits that it is not good practice to press upon the patient's abdomen in order to expedite the rapid expulsion of the fetal head through the birth canal, and denies that he did so, but the patient testifies that he did.

In cases where the use of hospital equipment or appliances are involved there are several methods by which liability may be imposed upon the hospital. If the proof shows that the hospital used appliances such as electric heaters, x-ray therapy machines, or forced breathing apparatus used in the administration of oxygen to the patient, such as pneufore machines, which were dangerous and defective, it would appear that the hospital would be liable not only under the general rules of negligence, but would also have the burden of overcoming a presumption of negligence which arises from the use of such defective equipment.[20] We have a case in the office now where a mother and wife died, leaving a husband and six children, after the forced breathing apparatus known as a pneufore machine had broken down several times during the administration of oxygen to the patient. Not so long ago we settled a death case where the hospital record showed they had several pneufore machines, one in each of the surgery rooms and one in the delivery room. In this case the husband died following the intravenous injection of sodium urokon which threw him into shock. An intern and a resident in the hospital and the chief resident in the hospital, all of whom treated the patient after he went into shock, failed to order or use any of the pneufore machines and in their depositions testified that they had never heard of a pneufore machine or a mechanical type of forced breathing apparatus being available in the hospital. The insurance company paid off in a hurry.

We also have a case in the office where the hospital did not have either a pneufore machine or any other type of forced breathing apparatus and it is clearly established in this community at that time, that it was the custom and practice for an approved hospital to have

19. See Walter v. England, 133 Cal. App. 676, 24 P.2d 930 (1933).

20. Baker v. Leland Stanford Jr. Univ., 133 Cal. App. 2d 243, 248, 23 P.2d 1071, 1073 (1933).

this type of forced breathing apparatus as stand-by equipment in cases of emergency. It would seem that the failure to have this equipment would violate good custom and practice.

If you have trouble getting a doctor of medicine in your community you might try using an osteopathic physician and surgeon in those states where osteopathic physicians and surgeons are fully qualified to treat and operate on the same basis as doctors of medicine. In one of our recent cases in California our District Court of Appeal held that an osteopath who is familiar with the custom and practice among doctors of medicine may testify as to the custom and practice in the M.D.'s school of medicine.[21] If it is impossible to enlist the services of an M.D. or an osteopath who can qualify as to custom and practice, but you are able to get an M.D. or osteopath who is familiar with medicine generally, even though he has never performed surgery, and even though he has never treated a patient or operated upon a patient for the condition out of which the litigation arose, the court must permit the doctor to testify to general matters of anatomy, pathology, histology and causation where the doctor's testimony is not offered as expert evidence on the proper and requisite degree of skill and care used by the defendant or whether the defendant followed the practice and custom in that field of medicine in that community.

It has now been definitely established in California, at least, that such medical witness must be permitted to testify as to general matters of medicine and causation bearing upon the case at bar.[22] The advantage of using medical testimony even to this limited extent has been demonstrated above, where the plaintiff's expert testified that the needle and dye was injected into the spinal cord circulation and not in the aorta; but was held not qualified to testify as to whether this was or was not good practice. This testimony, however, coupled with the admissions of the defendants and their experts, who are qualified as to custom and practice that this was not good practice makes out a case for the plaintiff. Examples of this could be multiplied many times.

It is well to keep in mind that it is not always sufficient to prove negligence or even to rely on res ipsa loquitur where the doctrine applies. It is frequently necessary to establish proximate cause by expert medical testimony. It is important, therefore, if you have an expert witness, to quiz him thoroughly as to the relationship between the alleged negligent acts or omissions and the resulting injuries to the plaintiff. It is easy to be lulled into a trap by assuming that if the doctrine of res ipsa loquitur applies you need not worry about a

21. See Hundley v. St. Francis Hosp., 161 Cal. App. 2d 800, 327 P.2d 131 (1958).

22. Seneris v. Haas, 45 Cal. 2d 811, 291 P.2d 915 (1955); Agnew v. City of Los Angeles, 97 Cal. App. 2d 557, 218 P.2d 66 (1950).

nonsuit. This is a fallacious assumption. The courts have frequently granted nonsuits where res ipsa loquitur applied simply because plaintiff's counsel took proximate cause for granted.

Fortunately in most cases the courts go very far in holding that the jury or triers of fact may infer cause and effect. An example of this is the case of *Champion v. Bennetts.*[23] The court here held that although generally the plaintiff must have expert testimony to establish proximate cause, in a case where a doctor left a tube in the scrotum for forty-two days and at the end of this period the plaintiff developed a necrosis of the scrotum, that the jury could infer that the necrosis was the proximate result of the negligence in leaving in the tube. In addition to the res ipsa loquitur theory, plaintiff's counsel should not overlook the fact that there are a few situations, rare perhaps, but important, where the common knowledge theory may apply, even though the plaintiff has no expert medical testimony, no extra judicial and no judicial admissions of the defendants to rely upon and the doctrine of res ipsa loquitur is inapplicable. These are the so-called "common knowledge" cases. In California they have been applied to a few situations such as infection cases, failure to take x-rays, and injection cases.

The infection cases hold that it is a matter of common knowledge among laymen that good practice and custom requires that the needle or instrument as well as the operating field or skin be sterilized before the procedure or operation is attempted.[24] The x-ray cases hold that where a patient has an injury to a particular part of the body with substantial complaints relating to that part of the body, good practice and custom requires that the attending physician order x-rays of that area, and that it is a matter of common knowledge among laymen that a failure to do so is negligence.[25] The injection cases hold that injections of drugs in the muscle of the arm or other parts of the body do not cause trouble unless unskillfully performed or there is something wrong with the serum or drug used.[26]

It is, of course, difficult to introduce evidence at the trial showing a conspiracy of silence among the medical profession and a reluctance to testify against each other. However, there are a few matters of evidence which you may introduce, which will give you the basis for a good argument to convince the jury of this fact.

23. 37 Cal. 2d 815, 236 P.2d 155 (1951).

24. Barham v. Widing, 210 Cal. 206, 291 Pac. 173 (1930); Kalmus v. Cedars of Lebanon Hosp., 132 Cal. App. 2d 243, 281 P.2d 872 (1955); Mastro v. Kenny, 57 Cal. App. 2d 499, 134 P.2d 865 (1943); Inderbitzen v. Lane Hospital, 124 Cal. App. 462, 12 P.2d 744 (1932).

25. See Friedman v. Dresel, 139 Cal. App. 2d 333, 293 P.2d 488 (1956); Agnew v. City of Los Angeles, 82 Cal. App. 2d 616, 186 P.2d 450 (1947).

26. See Wolfsmith v. Marsh, 51 A.C. 834 (1959); Cavero v. Franklin General Benevolent Society, 36 Cal. 2d 301, 223 P.2d 471 (1950); Bauer v. Otis, 133 Cal. App. 2d 439, 284 P.2d 133 (1955).

If you get the rules and regulations of the Joint Committee into evidence you will note that Article III, Sections 3 and 4 of the by-laws provide that in all approved hospitals appointments to the medical staff should be made by the governing body of the hospital, but only "after recommendation of the medical staff and shall be for the period of one year or until the end of the fiscal year of the hospital."

Section 4, subdivision 1 provides that "the application for membership on the medical staff shall be presented to the administrator of the hospital who shall transmit it to the secretary of the medical staff."

Subsection 2 of Section 4 provides that: "At the first regular meeting thereafter the secretary shall present the application to the medical staff at which time it shall be referred to the credentials committee."

Subsection 7 of Section 4 provides that: "The governing body shall either accept the recommendation of the medical staff or shall refer it back for further consideration stating the reason for such action."

This gives the existing medical staff, consisting entirely of doctors of medicine, the actual power over the approval and recommendation of who shall be appointed to the medical staff. It is also well to bring out by cross examination of the defendant's medical experts, particularly the specialists, that the greatest percentage of the practice of all specialists comes from other doctors, rather than the general public. In some specialties such as orthopedics as many as eighty-five to ninety percent of their patients are referred from other doctors.

In arguing to the jury you may stress the fact that the doctors control the staff membership of their fellow practitioners, not the owners of the hospital; and point out further the great risk that a specialist would run in testifying against a fellow specialist or fellow practitioner when his economic prosperity depends to a large extent upon the good will of his fellow practitioners in the community.