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Special Law for Medical Specialists

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SPECIALIZATION IS A FACT of life today that few will dispute. In no field is this more evident than in medicine. Today it is rare for an individual to visit a doctor for treatment of a case of dandruff and find that the physician is also willing to look at an ingrown toenail.[1]

We do not question the need for, or the benefits of specialization, but rather point to some of the confusion which results, in legal cases involving the medical specialist. The apparent contradiction that appears in proceedings involving specialists is illustrated by two cases where the patient's heart stopped beating while on the operating table.

Quintal v. Laurel Grove Hospital[2] was an action against the operating ophthalmologist on behalf of a six year old boy who had undergone an operation to correct an inward deviation of the eyes. During the administration of the anesthetic the patient's heart stopped. The anesthetist asked the ophthalmologist to perform a thoracotomy,[3] necessary for internal heart massage. The ophthalmologist stated that he was not able to perform a thoracotomy and left the operating room to summon a capable surgeon.

Approximately four minutes elapsed before a surgeon capable of performing the thoracotomy entered the operating room and was able to start the heart. The child was revived, but survived a mute, spastic, blind quadriplegic from the lack of oxygen and the resultant brain damage. At trial, defendant's motion for dismissal, notwithstanding the verdict, was granted. On appeal, judgment n.o.v. was reversed, and a new trial for defendant was ordered.

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1 Oleck, New Medicolegal Standards of Skill and Care, 11 Clev.-Mar. L. Rev. 443 (1962). After a discussion of recent advances in medicine Dean Oleck points to the need for attorneys to keep abreast of these advances and their possible impact upon litigation.

2 41 Cal. Rptr. 577, 397 P. 2d 161 (1964).

3 A surgical incision in the wall of the chest.

The comments of the court were interesting. Both the anesthesiologist and the ophthalmologist were highly qualified specialists. Cardiac arrest was shown to be a known risk when general anesthesia is administered; by the same token, the generally accepted procedure of handling this problem was open chest surgery, if external massage was ineffective. Local medical associations had sponsored lectures, movies, etc., on the procedures, and there were even plaques containing directions placed in the operating room. In addition, although the ophthalmologist had become a specialist, he had received instruction in general surgery in medical school. All of these factors could have provided bases for an inference that, if the defendant ophthalmologist was not capable of opening the chest (and it may well have been that he should have been able to) a capable surgeon should have been in the operating room. Even experts sympathetic to the defendant's case were forced to admit that normal procedure was not followed. Yet, in spite of these facts, the trial court was unable to determine whether or not there was negligence, and found for the defendant.

A different result was reached in *Kolesar v. United States.*[4] Plaintiff was the wife of a member of the Armed Forces, thirty-eight years old and a good surgical risk when admitted to a Navy hospital for an exploratory laparotomy.[5] During the operation she suffered a cardiac arrest. The surgeon performing the operation tried to revive heart action by injecting ephedrine into the heart, but this was not successful. Another surgeon was then summoned and performed a thoracotomy and internal heart massage. The patient survived, but had suffered brain damage and survived in a condition comparable to paraplegia. The judge found that cardiac arrests and circulatory insufficiencies are generally known occurrences in connection with surgery, and that a surgeon beginning a surgical procedure should have the ability to perform a thoracotomy and manual heart massage. Judgment was awarded to the plaintiff.

In both cases there was a failure to observe what has become a standard procedure in cardiac arrest, that is, manual heart massage. The operation in the *Kolesar*[6] case was performed in a

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[4] 198 F. Supp. 517 (S.D. Fla. 1961).

[5] A surgical entering of the interior of the abdomen.

[6] Kolesar v. U. S., *supra* n. 4.

military hospital where clearly defined procedures and standards were prescribed and, in this case, were not observed. On the other hand, in *Quintal*,[7] while there admittedly was a standard procedure, the expert witnesses hedged enough to make it difficult for the judge to find negligence on the part of the defendant.

Standards of Care for Specialists

It is generally accepted that a doctor must exercise the skill and care common to the medical profession in his community. This standard, carried one step further as to the specialist, is relatively the same; that is, the specialist should observe the degree of skill and care ordinarily used by similar specialists in like circumstances.[8] Thus, while performing the duties in his particular field, the specialist must observe its standards no less, but certainly no more.

Varying degrees of liability have been found by the courts. An anesthesiologist applying a saddleblock anesthesia to a patient about to give birth was found to be liable even though it was questionable that the plaintiff could show negligence in his malpractice action. The court felt that there was an absolute liability on the part of the defendant as he is charged with the knowledge of the nature and effect of such an anesthetic on the body.[9]

The tragic case of *Schwartz v. United States*[10] presents a situation where the court felt that the patient was entitled to reasonable medical care, and that the failure to check plaintiff's medical record deprived him of that reasonable care. Plaintiff, while in military service in 1944, was treated for sinusitis. As part of the treatment, umbrathor[11] was injected into his sinus

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[7] Quintal v. Laurel Grove Hospital, *supra* n. 2.

[8] Barnes v. Bovenmeyer, 255 Ia. 220, 122 N.W. 2d 312 (1963); Natanson v. Kline, 186 Kan. 393, 350 P. 2d 1093 (1960); Correia v. U. S., 339 F. 2d 596 (1st Cir. 1964); Delaney v. Rosenthall, 196 N.E. 2d 878 (Mass. 1964); Stone v. Proctor, 259 N. C. 633, 131 S.E. 2d 297 (1963); but see Oberlin v. Friedman, 1 Ohio App. 2d 499, 205 N.E. 2d 663 (1965), where court felt qualification was necessary in applying the standard.

[9] Rothman v. Silber, 83 N. J. Super. 192, 199 A. 2d 86 (1964); also Mayor v. Dowsett, 400 P. 2d 234 (Ore. 1965).

[10] 230 F. Supp. 536 (E.D. Pa. 1964); see also Moon v. Mercy Hospital, 150 Colo. 430, 373 P. 2d 944 (1962), where plaintiff sought to have hospital found liable for malpractice. The court ruled the doctor liable for activities reasonably connected with the treatment or operation.

[11] Trade-mark for a 25 per cent suspension of thorium oxide used as a radiopaque medium.

cavity for the purpose of taking x-rays. Plaintiff was discharged from the service in 1945. Between 1946 and 1956, the plaintiff visited Veterans Administration hospitals on a number of occasions, and despite complaints and severe symptoms in later years, the presence of the umbrathor was not discovered, although the word umbrathor was prominently noted and underlined on his medical record. After 1945 it became known generally that umbrathor was dangerous in that it had carcinogenic properties.

A routine tooth extraction in 1956 finally disclosed plaintiff's true condition. The umbrathor had in fact caused cancer, and plaintiff underwent a severe operation requiring removal of a substantial portion of the left side of his face, including bone structure and his left eye. Judgment was awarded to the plaintiff on two grounds. The judge ruled that it was negligent to fail to check the plaintiff's medical record and held that the work of a government physician cannot be so compartmentalized that one physician's knowledge of danger, based on the plaintiff's complaints and symptoms, could be disregarded merely because he had examined the patient for another purpose.

An Outmoded Rule

The so called *locality rule* has provided a route of escape for the defendant in malpractice actions.[12] The often cited case of *Lockart v. Maclean*[13] provides an example of the rule in action. After plaintiff's fractured leg had a pin inserted in it he developed an infection in the bone and consequently sued the physician for malpractice. The operation was performed and the suit brought in Reno, Nevada. Plaintiff's expert witness was trained in Colorado and Kansas and practiced in California, and because of this the court felt that he was not qualified to give testimony as to the standard of conduct for surgeons in Nevada.

The results of a thyroidectomy performed in Wilmington, Delaware, included nerve damage.[14] When plaintiff sought to

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[12] See: Note, Medical Specialties and the Locality Rule, 14 Stan. L. Rev. 884 (1962). In a short discussion the author points to evidence gathered through a survey that indicates uniformity among the individual specialties even though geographically distributed across the country.

[13] 77 Nev. 210, 361 P. 2d 670 (1961); see also, Fontenot v. Aetna Casualty and Surety Co., 166 So. 2d 299 (La. 1964); Riggs v. Christie, 342 Mass 402, 173 N.E. 2d 610 (1961); Richardson v. Doe, 176 Ohio St. 370, 199 N.E. 2d 878 (1964).

[14] DiFilippo v. Preston, 53 Del. 539, 173 A. 2d 333 (1961).

introduce a New York surgeon as an expert witness, his testimony was stricken from the record, as the court felt he was not familiar with techniques that were employed by the physicians of the Wilmington area. The defendant came prepared, utilizing the testimony of surgeons from his own area. It did appear here that an honest difference of opinion in surgical techniques arose; however, the court felt impelled to follow the opinion of the local physician and not even consider that of plaintiff's expert.

On the other hand, a defendant's attempt to show that standards in Portland, Oregon, were different from those in Longview, Washington—50 miles away—was not successful.[15] The proximity of the two cities; the experience of plaintiff's witness in the general area for several years; and the fact that defendant had been educated and had practiced in both cities led the court to refuse to bar the testimony of the plaintiff's expert.

Also of interest is a recent Utah case.[16] Here, over objections of defendant, plaintiff was allowed to introduce an expert from the San Francisco area. This surgeon, besides having practiced in California for almost seven years, had spent part of World War II in the service, where he had performed 130 to 150 operations such as the one in dispute. Furthermore he had done some writing, traveling and lecturing on the subject, and was familiar with the general practice in small towns across the country as to proper treatment of the fracture plaintiff had received. Helpful to plaintiff's case also was an admission by the defendant that the procedure for setting this fracture was fairly uniform.

The problem of just what the community or locality actually consists of today becomes an even greater task. Population centers expand constantly, so that in the not-too-distant future on the East Coast of the United States, say, you may travel several hundred miles through five or six states and not leave an urban or suburban area. Secondly, the communications systems have increased so that it becomes possible for a medical student in California to watch an operation performed at a New York hospital over closed-circuit television. By the same token, that student may finish school in California, take his internship and resi-

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[15] Teig v. St. John's Hospital, 63 Wash. 2d 369, 387 P. 2d 527 (1964); see also, Cook v. Lichtblau, 144 So. 2d 312 (Fla. 1962) where the court felt that Miami and West Palm Beach were certainly in the same urban complex; and see, Sinz v. Owens, 205 P. 2d 3 (Cal. 1949); Kolesar v. U. S. *supra* n. 4.

[16] Riley v. Layton, 329 F. 2d 53 (10th Cir. 1964).

dence in the East, and return to California to practice. The reasons for considering the "locality rule" have thus become less compelling.

Making the Defendant the Plaintiff's Witness

Plaintiffs in malpractice actions may be getting a chance to twist the tiger's tail, if a recent New York decision[17] has widespread effect. As the specialist works in his own little niche, it becomes a difficult task to obtain the proper expert witnesses to support the plaintiff's case and attack the defendant's position. The answer to this problem may be in using the defendant as the plaintiff's expert. The *McDermott* case involved a corneal transplant that proved to be unsatisfactory, and the plaintiff subsequently lost the sight of her left eye. The malpractice suit was brought under two theories: One, that the doctors who advised the operation made misrepresentations as to the outcome; the other, that the operation itself should not have been performed, and the fact that it was contrary to accepted medical practice.

Miss McDermott's case depended on her ability to introduce expert testimony which would support her allegations. At trial, besides her own testimony, she called on two of the defendant doctors. She did not introduce expert testimony of her own, but sought to show malpractice by questioning the defendants as to their knowledge of the particular operation and the accepted medical standard for it. The trial court upheld defendant's objection to testifying and was forced to dismiss the case due to lack of expert testimony. The Appellate Division upheld the decision, but modified to allow plaintiff to introduce expert testimony in a new action.

The Court of Appeals further modified this decision to allow a new trial, and in so doing discussed the difficulty in obtaining expert testimony:

> The importance of enabling the plaintiff to take the testimony of the defendant doctor as to both "fact" and "opinion" is accentuated by recognition of the difficulty inherent in securing "independent" expert witnesses. It is not always a simple matter to have one expert, a doctor in this case, condemn in open court the practice of another, particularly if the latter is a leader in his field. In consequence, the

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[17] McDermott v. Manhattan Eye, Ear & Throat Hospital, 15 N. Y. 2d 20, 203 N.E. 2d 469 (1964).

> plaintiff's only recourse in many cases may be to question the defendant doctor as an expert in the hope that he will thereby be able to establish his malpractice claim.[18]

The court could see nothing wrong in permitting plaintiff to call the defendant, discarding the claim that it was, at least, unfair to do so. In summing up, they went on to say:

> In short, then, a plaintiff in a malpractice action is entitled to call the defendant doctor to the stand and question him both as to his factual knowledge of this case (that is, as to his examination, treatment and the like) and, if he be so qualified, as an expert for the purpose of establishing the generally accepted medical practice in the community. While it may be the height of optimism to expect that such a plaintiff will gain anything by being able to call and question (as an expert) the very doctor he is suing, the decision whether or not to do so is one which rests with the plaintiff alone.[19]

Prior to the *McDermott* case Ohio followed the rule laid down in *Forthofer v. Arnold*[20] that, if the defendant objected, plaintiff could not use the defendant as his expert via the route of cross-examination; however, a recent Ohio decision[21] seems to agree with the New York view. Citing *McDermott*,[22] the Ohio Supreme Court now says that it is possible to use the defendant as an expert and to require him to testify to things other than the specific facts of the case.

A few other states[23] also had previously followed this line of thinking. Obviously the problem of eliciting expert testimony has not suddenly been solved. As Judge Fuld remarked,[24] the plaintiff must be highly optimistic when putting the defendant on the stand as his own witness, but lacking all other expert testimony, skilled counsel will at least have a chance to establish the critical standard of the case, and at the same time (hopefully) elicit other information which will be helpful to the plain-

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[18] *Id.* at 474.

[19] *Id.* at 475.

[20] 60 Ohio App. 436 (1938).

[21] Oleksiw v. Weidener, 2 Ohio St. 2d 147 (1965).

[22] McDermott v. Manhattan Eye, Ear & Throat Hospital, *supra* n. 17.

[23] Lawless v. Calaway, 24 Cal. 2d 8, 147 P. 2d 604 (1944); State for use of Miles v. Brainin, 224 Md. 156, 167 A. 2d 117 (1961); Snyder v. Pantaleo, 143 Conn. 290, 122 A. 2d 21 (1956).

[24] McDermott v. Manhattan Eye, Ear & Throat Hospital, *supra* n. 17.

tiff's case. It has been the practice in some states to allow the defendant doctor to take the stand, but not to allow questions that go beyond facts within the individual's particular knowledge.[25] Hopefully, the courts will allow, in the future, the scope of testimony to be widened to include any questions the plaintiff may wish to ask relating to the defendant's particular specialty.

Other Facets of Testimony

Ordinarily, expert testimony must be used to establish negligence. This is an understandable requirement in view of the technical matters beyond the comprehension of a layman that medicine so often involves, but this is not true in all cases. The requirement of an expert witness has been relaxed where the physical facts would allow a jury to infer negligence,[26] or the incompetency is so obvious as to allow a layman to decide the question.[27]

Courts will also restrict the scope of testimony of a physician who is not a specialist in an action involving malpractice of a specialist. In *Rash v. City and County of San Francisco*[28] a general practitioner who had not been trained in the particular specialty was found to lack the qualifications to give expert testimony on techniques to be followed by the specialist, but could testify as to matters within the knowledge and observation of every physician.

A physician who had been in general practice for eleven years in Chicago and had not operated for several years, lacked the necessary qualifications as an expert to testify as to thyroid surgery in Wisconsin.[29] Here there was seemingly an attack both

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[25] Hull v. Plume, 131 N. J. 511, 37 A. 2d 53 (1944); Ericksen v. Wilson, 266 Minn. 401, 123 N.W. 2d 687 (1963); Osborn v. Carey, 24 Idaho 158, 132 P. 967 (1913); Hundler v. Rindlaub, 61 N. D. 389, 237 N.W. 915 (1931).

[26] Moehlenbrock v. Parke Davis & Co., 145 Minn. 100, 176 N.W. 169 (1920); and see, Manzoni v. Hamlin, 202 N.E. 2d 264 (Mass. 1964) even though medical evidence was lacking defendant's statement was sufficient; and, Roberts v. Young, 369 Mich. 133, 119 N.W. 2d 627 (1963).

[27] Sawyer v. Jewish Chronic Disease Hospital, 234 N. Y. S. 2d 372 (1962).

[28] 19 Cal. Rptr. 266 (1962); see also, Caton v. Richardson, 287 S.W. 2d 683 (Tex. 1965).

[29] Peterson v. Carter, 182 F. Supp. 393 (W.D. Wis. 1960); see also, Hanberry v. Fitzgerald, 72 N. M. 383, 384 P. 2d 256 (1963) where a general practitioner was conceded to be a qualified witness, but since not an expert in vascular diseases his testimony was not allowed; and Korljan v. Johnson, 96 Ariz. 25, 391 P. 2d 584 (1964).

on his qualifications as to his expertise and an alleged difference that might exist in technique between Chicago and Southern Wisconsin.

Conclusion

Undoubtedly a state of flux and uncertainty exists in the law at this time as to the treatment of medical specialists, and this condition will probably continue for some time.

The plaintive remark of an Indiana court epitomizes the vaguely hopeful (but quite unspecific) view of modern courts as to what to do about medical specialization:

> In this age of specialization in the practice of medicine it is the duty and function of the courts of law to apply rules of law with an intelligent understanding in the field of medicine and surgery.[30]

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[30] Huber v. Protestant Deaconess Hospital, 127 Ind. App. 565, 133 N.E. 2d 864, at 869 (1957).