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AN ANCIENT THERAPY STILL APPLIED:
THE SILENT MEDICAL TREATMENT

MELVIN M. BELLI †

I.

IS IT REALLY true that doctors won't testify for plaintiffs in medical malpractice cases? The answer is:

"Anyone familiar with cases of this character knows that the so-called ethical practitioner will not testify on behalf of a plaintiff regardless of the merits of his case. This is largely due to the pressure exerted by medical societies and public liability insurance companies which issue policies of liability insurance to physicians covering malpractice claims. While court records show that some of these claims may be questionable, many have substantial merit, and ethical considerations are generally with the plaintiff's side of the case. But regardless of the merits of the plaintiff's case, physicians who are members of medical societies flock to the defense of their fellow member charged with malpractice and the plaintiff is relegated, for his expert testimony, to the occasional lone wolf or heroic soul, who for the sake of truth and justice has the courage to run the risk of ostracism by his fellow practitioners and the cancellation of his public liability insurance policy."

I am a lawyer who has long been identified with the plaintiff's side of the docket. I have obtained redress for mutilated plaintiffs in a satisfying proportion of the many, many medical malpractice cases that have come my way in the past twenty years. So, no one would be surprised if I had uttered the words just quoted. But such statements, coming from me, would be shrugged off as just another biased complaint, a plaintiff's attorney's airing of an "occupational persecution complex."

But it was not I who made those statements. They emanated from the lips (and from the heart) of a respected Supreme Court justice—The Honorable Jesse Carter of the Supreme bench of California.¹

† Member of the San Francisco Bar; past international President, NACCA (National Association Claimants' Compensation Attorneys); Dean, International Academy of Trial Lawyers; author of *Modern Trials* (Bobbs-Merrill Co., 1955), *Ready for the Plaintiff* (Henry Holt & Co., April, 1956), "The Adequate Award," 39 CALIF. L. R. 1 (1951); contributor to VIRGINIA LAW WEEKLY, RUTGERS L. REV., and many other publications.

1. See *Huffman v. Lindquist*, 37 Cal. 2d 465, 234 P.2d 34, 46 (1951).

Justice Carter is not, of course, the only jurist who recognizes how the cause of justice suffers because of the reluctance—indeed, in effect, the refusal—of medical men to go to court and tell the truth about their fellow practitioners. Almost any judge will admit (off the record and in private, of course), that such is the incredible state of affairs in justice-loving America today. But Justice Carter is one of the few who have thus far dared to stand right up in meeting and spell out the situation.²

Why won't doctors testify in malpractice cases? Are they, as George Bernard Shaw once charged, members, not of a *profession* but of a conspiracy?³ Is it sheer caprice or cold-blooded indifference that makes these defenders of the Hippocratic oath look unconcernedly the other way when some innocent victim of a doctor's carelessness seeks economic reparation for his physical damage?

I don't think so. The doctor does face a real dilemma. Doctors are members of a conspiracy, in a sense, but it is a conspiracy not entirely of their own making or choosing.

Is it then, that our law demands the impossible of physicians and surgeons? Is it that a "guarantee" of success is demanded of them in every case they undertake? Is it that the honest physician, knowing that medicine isn't an exact science and that perfection is as rare in the medical profession as elsewhere, feels that his testimony, given in a courtroom, would result in the unjust condemnation of a fellow practitioner for the sole malfesance of being less than perfect—of being, in other words, merely human?

Just the opposite. In fact (and law) this is the type of instruction ordinarily given by judge to jury in the typical malpractice case:

2. Examples of comments by other courts are:

"We cannot overlook the well-known fact that in actions of this kind it is always difficult to obtain professional testimony at all. It will not do to lay down the rule that only professional witnesses can be heard on questions of this character, and then, in spite of the fact that they are often unwilling, apply the rules of evidence with such stringency that their testimony cannot be obtained against one of their own members." *Johnson v. Winston* 68 Neb. 425, 430, 94 N.W. 607, 609 (1903).

"Malpractice is hard to prove. The physician has all of the advantage of position. He is, presumably, an expert. The patient is a layman. The physician knows what is done and its significance. The patient may or may not know what is done. He seldom knows its significance. He judges chiefly by results. The physician has the patient in his confidence, disarmed against suspicion. Physicians, like lawyers, are loath to testify that a fellow craftsman has been negligent, especially when he is highly reputable in professional character, as are these defendants. In short, the physician has the advantage of knowledge and of proof." *Christie v. Callahan* 124 F.2d 825, 828 (D.C. Cir. 1941).

See 11 NACCA L. J. 172. See also 3 BELLI, *MODERN TRIALS* p. 1984. (1954).

3. See *The Doctor's Dilemma*; also see BELLI, *READY FOR THE PLAINTIFF* chapters 8 and 9. See also, 11 NACCA L.J. 172, 255; 16 NACCA L.J. 337.

“To aid you in finding on the issue whether defendant was guilty of malpractice, there are a few discriminations that you should have in mind. The law does not require of a physician and surgeon perfection, nor prophetic insight, nor infallible judgment; nor does it condemn him simply because his efforts prove unsuccessful. The difficulties and uncertainties in the practice of medicine and surgery, the unpredictable variations in response to treatment, are such that no practitioner can guarantee results.

“Where there is more than one recognized method of diagnosis or treatment, and no one of them is used exclusively and uniformly by all practitioners of good standing, it is not negligence for a physician and surgeon if, in exercising his best judgment he selects one of the approved methods, which later turns out to be a wrong selection, or one not favored by certain other practitioners.

“In short, it is quite possible for a physician and surgeon to err in judgment, or to be unsuccessful in his treatment, or to disagree with others of his profession, without being negligent.

“On the other hand, if a physician and surgeon does not possess that degree of learning and skill required of him by the law, or if he fails to exercise the care required of him, it is no defense to a charge of negligence that he did the best he could.

“In determining whether defendant’s learning, skill and conduct fulfilled the duties imposed on him by law, as they have been stated to you, you are not permitted to set up arbitrarily a standard of your own. The standards, I remind you, were set by the learning, skill and care ordinarily possessed and practiced by others of the same profession in good standing, in the same locality, at the same time. It follows, therefore, that the only way you may properly learn that standard is through evidence presented in this trial by physicians and surgeons called as expert witnesses.”⁴

Clearly, then, a physician or surgeon is not a *guarantor* or *insurer* or *warrantor* of the success of his treatment.⁵ That’s good sound law and good common sense. What’s more, it is fair play. If the above-quoted instruction is given, that should be all the more reason for doctors to go to court, not to stay away.

Yet, they remain reluctant. The practice in most jurisdictions is to impose all kinds of restrictions as to precisely which doctor is qual-

4. See 2 BELLI MODERN TRIALS, § 314(11) (1954).

5. In the words of Judge Taft in *Ewing v. Goode*, 78 Fed. 442, 443 (C.C.S.D. Ohio 1897):

“A physician is not a warrantor 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.’”

ified to testify. For a long time these restrictions included geographical limitations that would have been ludicrous if they had not so often resulted tragically for the injured plaintiff. Thus, in one case, doctors from San Bernardino, California, were not allowed to testify as to medical standards in Ontario, California, a short distance away.⁶ Similarly, a Los Angeles physician was barred from testifying as to medical conditions in Ventura, 60 miles distant.⁷ However, in another case, it was held error for the lower court to exclude testimony of doctors practicing in Los Angeles as to standards of care in Long Beach, some 20 miles distant,⁸ and in *Sinz v. Owens*,⁹ (a leading case) the more liberal test of occupational experience replaced that of mere geographical location.¹⁰

Happily, "geographical limitation" is no longer the law in most communities.¹¹ Common medical, as well as legal, sense has finally recognized that treatment for piles in Vermont should be just about the same as a hemorrhoidectomy in San Diego. The same *treatment* should prevail at the same end of the human body. It's only the *law* that's being applied at opposite ends of the country. Human bodies don't vary in three thousand miles—neither should the law nor doctors' treatment.¹²

But the real villain of the piece is not the law, any more than it is the individual doctor. The real conspirators are the insurance companies. Insurance companies wield the whip that keeps medical men silent and in line.

6. *McNamara v. Emmons*, 36 Cal. App. 2d 199, 97 P.2d 508 (1939).

7. *Wheeler v. Barker*, 92 Cal. App. 2d 776, 208 P.2d 68 (1949).

8. *Lewis v. Johnson*, 12 Cal. 2d 558, 86 P.2d 99 (1939).

9. 33 Cal. 2d 749, 205 P.2d 3 (1949), 8 A.L.R. 2d 757.

10. See 3 BELL MODERN TRIALS § 330 (1954). As to comprehensiveness of term "locality" in standard of care, see also Swan, *The California Law of Malpractice of Physicians, Surgeons, and Dentists*, 33 CALIF. L. REV. 248, 261 (1945).

11. See *McGulpin v. Bessmer*, 241 Iowa 1119, 43 N.W. 2d 121 (1950); *Tvedt v. Haugen*, 70 N.D. 338, 294 N.W. 183 (1940), 132 A.L.R. 379; *Cooper v. St. Paul City 1 Ry.*, 54 Minn. 379, 56 N.W. 42 (1893); *Pridgeon v. Gibson*, 194 N.C. 289, 139 S.E. 443 (1927), 54 A.L.R. 855; *Pecos & N. T. R.R. v. Coffman*, 56 Tex. Civ. App. 472, 121 S.W. 218 (1909); 25 So. CALIF. L. REV. 220 (1952).

12. See *Gist v. French*, 288 P.2d 1003 (Cal. 1955), involving an operation for removal of a tumor. Without preoperative tests or biopsy, a spinal anaesthetic was administered without an assistant surgeon, and the uterus, cervix and appendix were removed without the patient's consent. Moreover, in the course of this delicate operation, there occurred a vaginal breach of the uterine artery and the defendant doctor failed to tie it off. Ten days later, the plaintiff being very sick, the doctor operated again and removed her left tube and ovary, part of the broad ligament and any area that had become saturated with blood from the injured uterine artery. A medical expert who had never practiced in the county in which the trial was held, was held competent to testify for the plaintiff. The court in commenting on the "community rule" declared: ". . . it is not to be understood that 'community' means a village or section of a town; but rather, it means such an area as is governed by the same laws, and the people are unified by the same sovereignty and customs."

Doctors, for all their Hippocratic oaths and occasional bursts of high-sounding sentiment (particularly when decrying socialized medicine) are "people" like you and me. Though he (or she) in any "trade" may be accorded the appellation "professional," he (she) still is a human being. Doctors have families to feed and houses to pay for. They are not, generally speaking, crusading philanthropists by any means. They are just ordinary, hard-working men and women who have to make a living. And they have found out the hard way, over a period of many years, that unless they stay in the good graces of the insurance industry, they cannot make that living. Staying in those good graces frequently means not only (1) refraining from testifying for the plaintiff in a malpractice case, but (2) actually offering perjured testimony to bolster the defendant insurance company's side of the case.

And believe me, I've seen, not once but many times, heads of national medical societies, chancellors of universities and chairmen of hospital boards grit their teeth, raise their hands, charge to the witness stand, distastefully spit out their rehearsed piece of perjury and embarrassedly bolt from the court room.¹³ What's more, that judge before whom they're testifying knows they are (let's call it what it is) deliberately lying. To date he's done very little about it.

It's not exaggeration to report that there's more actual alteration of records, more "lost" reports, more "phony findings," more down-right perjury in the medical malpractice case on *defendants' side* than in any other kind of law suit including the criminal case! What's more, otherwise respectable doctors countenance it; and otherwise respectable lawyers, who'd never think of such tactics in a divorce case, a will contest, a tax suit, or even in a murder trial with a client's life at stake, lend a perjured hand! You don't believe it? I'm doing an article now citing actual cases that make your legal, medical and ethical hair stand on end.

How can such totalitarian control be exercised by one group over another? It's very simple, really.

For one thing, the doctor's natural inclination, even as yours or mine, gives the real defendant, the insurance company, a psychological advantage. Almost any competent doctor is a busy doctor. He doesn't want to deprive his patients of his services, or himself of his

13. In one of my early cases a young boy died from a burst appendix. Defendant doctor had been in attendance some forty-eight hours before the boy's appendix burst. The head of one of the largest and most "respected" hospitals on the Pacific Coast testified for defendant doctor (insurance company) that modern medicine adopts a policy of *enemas* and *cathartics* and "watchful waiting" in suspected appendix cases! (The defendant doctor had afforded this treatment. He had been drinking heavily).

patients' fees for the length of time he would have to spend in court, even in a very short and simple case. (Of course, when he appears for an insurance company, he is always and generously compensated!)

Second, he doesn't want to undergo the ordeal of cross-examination—and cross-examination in any adversary proceeding is an ordeal for most people. Moreover, if doctors were to testify *carte blanche*, one against the other, and let down the barrier as it were, they'd spend more time in court than in surgery, for everyone who went to a doctor and wasn't cured would have a lawsuit. (But can't the same thing be said of lawyers? In every lawsuit someone *must* lose. That's a higher casualty rate than in surgery—at least in medicine the odds aren't so rigged that one side *must* lose in *every* surgical procedure. Yet lawyers are willing to testify against one another and they are not always in court—on their own cases).

Finally, the medical man doesn't relish the idea of appearing to set himself up as an expert who knows more about medicine than the defendant, good ol' Doc Bailey, with whom he golfs on Saturday, plays bridge on alternate Thursdays. There's a camaraderie among doctors that doesn't exist among lawyers. They bloodlet, figuratively and literally, with each other. They sleep, not together, but with each other. They break bread together, and their school esprit de corps is high. Their professional ties are much more subtle, secret and esoteric than lawyers'. There's a morale that makes it unthinkable for one doctor, knowing the vagaries of his profession and the uncertainties of human life, to say that he could have done better than his fellow practitioner.

Comes the insurance man upon this scene: All the above factors make the potential expert witness in a malpractice case a soft touch for persuasive insurance company representatives. But if psychological factors fail to carry the day, up pops that most persuasive of all "persuaders"—the threat of economic reprisal.

There are no doctors self insured, and there are very few insurance companies writing medical malpractice insurance that are losing money. (At least, if they're losing money, they're waging a most vigorous battle to stay in a money-losing business!) It is the insurance companies that force the doctor to become an unwilling witness and, indeed, penalize him by yanking away his insurance if he testifies at all.

In a case I tried a few years ago¹⁴ I had managed to produce an expert witness, and the insurance company attorneys, as usual, were

14. See the actual excerpt of testimony reported in *Gluckstein v. Lipsett*, 93 Cal. App. 2d 391, 209 P.2d 98 (1949).

badgering him on the stand about his professional attainments. In response to a particularly sneering inquiry by defense counsel, my witness suddenly replied, with more truth than tact, "Yes. We had one case in Stockton a little while ago—twenty-seven doctors in Stockton, and the poor boy that lost his arm, they couldn't get one doctor to say a good word for him, not one doctor. They were all told if they testified their insurance would be cut off."

This, of course, is standard practice, and a very potent weapon indeed, since no doctor, however skilled, can afford to practice shorn of the protection of malpractice insurance.

I've had a representative of an insurance company sit in court and actually make signals, desperately trying to shunt my prospective expert medical witness off the main line and onto a siding. Usually, however, so effective is the insurance cabal, plaintiff's attorney faces nonsuit because he can't get a medical witness to come within shouting distance of the courtroom. Doctor "Smith," from the northernmost region of California, may start out bravely to testify against a fellow medico whose bailiwick is way down south in the desert. But usually before his train has reached San Francisco, about a third of the way to his destination, Dr. "Smith" has "changed his mind." Why? Well, word gets around, and Dr. "Smith" has been visited in his compartment by a persuasive man with a briefcase. In the briefcase is the insurance company's copy of Dr. "Smith's" malpractice insurance policy. Also in that same bag, obviously, in very short order, is plaintiff's erstwhile expert witness!

All the medical associations in the country, standing firm and working together, could combat the very real power of the insurance industry to control their profession. But instead—they have subscribed to the "if you can't beat 'em, join 'em" school of thought and contribute their bit by tossing in a few reprisals of their own.

There is no official action taken, of course. It just happens that if a doctor goes so far beyond the bounds of professional good taste as to tell the truth about a careless colleague, the too-outspoken doctor is no longer welcome in the halls and amphitheatres of his local hospitals. Quietly his name is dropped from one hospital roster after another, until there is no place where he can operate or hospitalize his patients. It is just as though a trial lawyer were told he could practice but he was barred from every courtroom! "That sort of thing just isn't done, you know. Old school tie, professional courtesy—all that sort of thing. Breach of etiquette, what? Tut, tut! Can't be tolerated."

This is an appalling situation, certainly. But, appalled as I am, I can see how the medical profession reached the conclusion that it was better to huddle together submissively and let the insurance industry dictate to them, rather than to stand shoulder to shoulder and fight this particular brand of dictatorship. The medical associations took a short-range view, and they were terrified by what they saw. The malpractice insurance rates for an entire community have been known to be jacked up as much as 200% following a single malpractice verdict in favor of a plaintiff for a mere \$20,000. Obviously such a sweeping increase was out of all proportion to the amount the insurance company was out of pocket or potentially out of pocket. The verdict, nominal as it was, simply was seized upon by the company as an excuse for trebling its already substantial premiums—and to serve *warning*.

Principles of Medical Ethics,¹⁵ published by the American Medical Association, sets forth the Aesculapian rule as follows:

“A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be considered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubts should arise as to the legality of the physician’s conduct, the situation under investigation may be placed before officers of the law, and physician-investigators may take the necessary steps to enlist the interest of the proper authority.”

These are stirring and worthy statements. But the experience of personal injury lawyers throughout the country would seem to indicate that the morals of the medical profession have been turned over to a body of laymen—the insurance industry—for safekeeping, and that the physician’s pride in his profession has been transcended by his sense of duty to the Mount Everest Holy Grail Insurance Company, Inc. of Nebraska, or whatever.

If it were simply a matter of honestly believing that their colleagues could do no wrong, we might deplore without denouncing such a stand on the part of the medical profession. But Dr. Eugene Perez, then president of the Northern California Chapter of the American College of Surgeons, spoke frankly at a 1953 meeting of his organization. Reporting on his speech, the *San Francisco Chronicle* of March 15 that year quoted him as saying:

15. Ch. 3, Art. 1, Sec. 4.

"The bulk of the operating is done by general practitioners who may have had no more than a few weeks' training," and "Now we must protect the patient from incompetent and unnecessary surgery by educating him to select properly qualified surgeons."

According to the *Chronicle*, Dr. Perez estimated that *only one third of the surgery done in the United States is performed by qualified surgeons!* The remaining two thirds, it must be inferred, are performed by the unqualified surgeons who undoubtedly are principally responsible for the post-operative discovery in abdomens of forgotten or lost sponges,¹⁶ gauze,¹⁷ cloth sacks,¹⁸ drainage tubes,¹⁹ rubber tubes,²⁰ needles,²¹ forceps,²² hemostats,²³ and other instruments;²⁴ of broken glass in wombs;²⁵ and of tampons²⁶ and instruments²⁷ in noses.²⁸

It's amazing how many of my clients come to me saying, "Doctor Jones looked at my scar and said, 'What butcher did that?'" Doctors are prone to criticize their brethren in private, but though they make this criticism, very, very rarely is it backed up in court—²⁹ unless the lawyer is fortunate enough to have been there in the first place and caught them off-guard with a recording or a letter or some other such device.

16. *Frederickson v. Maw*, 227 P.2d 772 (Utah, 1951); *Armstrong v. Wallace*, 8 Cal. App. 2d 429, 47 P.2d 740 (1935); *Funk v. Bonham*, 204 Ind. 170, 183 N.E. 312 (1932); *Baer v. Chowning*, 135 Minn. 453, 161 N.W. 144 (1917).

17. *Walker v. Pulley*, 74 Ind. App. 659, 127 N.E. 559 (1920); *Null v. Stewart*, 78 S.W. 2d 75 (Mo. 1934).

18. *Tiller v. Von Pohle*, 72 Ariz. 11, 230 P.2d 213 (1951).

19. *Null v. Stewart*, *supra*, note 17; *Champion v. Bennett*, 37 Cal. App. 2d 815, 236 P.2d 155 (1951); *Baer v. Chowning*, *supra*, note 16; *Evans v. Munro*, 83 Atl. 82 (R.I. 1912).

20. *Saucier v. Ross*, 112 Miss. 306, 73 So. 49 (1916).

21. *Benson v. Dean*, 232 N.Y. 52, 133 N.E. 125 (1921); *Sellers v. Noah*, 209 Ala. 103, 95 So. 167 (1923); *Reinhold v. Spencer*, 53 Idaho 688, 26 P.2d 796 (1933); *LeFaive v. Asselin*, 262 Mich. 443, 247 N.W. 911 (1933); *Johnson v. Ely*, 30 Tenn. App. 294, 205 S.W. 2d 759 (1947).

22. See actual photograph in 3 BELLI MODERN TRIALS, § 331 (1954).

23. *Leonard v. Watsonville Community Hospital*, 291 P.2d 496 (Cal. 1956).

24. *Wharton v. Warner*, 75 Wash. 470, 135 Pac. 235 (1913).

25. *Pendergraft v. Royster*, 203 N.C. 284, 166 S.E. 285 (1932).

26. *Williams v. Wurdeman*, 71 Wash. 390, 128 Pac. 639 (1912).

27. *Slimak v. Foster*, 106 Conn. 366, 138 Atl. 153 (1927).

28. For other examples of foreign body mishaps and other main causes of malpractice, see 3 BELLI MODERN TRIALS, § 327, notes 95 and 96; p. 1991, notes 13 and 14 (1954). Also see *Doctor, Patient and the Law*, by Dr. Louis J. Regan (Mosby, 1949).

29. See "Can We Trust ALL Our Doctors?," Sydney Shalett, *Ladies' Home Journal*, March, 1953, pp. 53, 192-198. This well-written article illustrates the difficulties that lawyers encounter in getting doctors to give expert testimony in malpractice cases. The author cites some flagrant examples of medical incompetence, such as (1) delivering one twin and overlooking the other, resulting in the mother's death (p. 195); and (2) amputating the wrong leg, and later removing the diseased limb, "so now the man is without either leg." (p. 197). The author concludes that: ". . . a great deal of the criticism aimed at their (medical) profession is justified, and not nearly enough is being done to correct the situation. Responsible leaders admit that the 'God' complex—the 'I-can-do-no-wrong' obsession—weighs too heavily on some of their colleagues."

So we have the word, not only of aggrieved plaintiffs and their lawyers, but of judges and even of medical men themselves that cases of malpractice do exist, that where they exist medical men should not hesitate to testify as expert witnesses for the plaintiff as well as for the defense. How, then, can these self-evident truths be implemented, so that it will no longer be next to impossible to get doctors to testify willingly and impartially in courts of law? The situation is intolerable, perhaps the most unethical, dishonest, and hypocritical in all law!

II.

Plaintiff medical malpractice victim in a bona fide case isn't as completely forsaken by the law as many too easily discouraged plaintiffs' lawyers believe. Too many lawyers throw up their hands at the sight of even the most deserving victim with the complaint, "Sure you've got a good case, but I can't get a doctor to testify for you."

There's many a good sound legal maneuver to defeat this *conspiracy of silence*, and once to a jury a defendant doctor will be penalized for his participation in it. Let's look at some. They require ingenuity. They're not for the trial novice; better should he "forward" or "associate" a lawyer specializing in these cases:

A.

SUBPOENAING AT RANDOM.

Some lawyers have checked the "silent treatment" merely by subpoenaing a doctor expert at random without any notice, rushing him to the witness stand, and eliciting his honest opinion before the defense strategists had time to suppress it.³⁰ This tactic does not always work, however. An adroit defense counsel can make it clear to such a doctor on voir dire, or on cross-examination that he can get out of testifying (in most states) simply by saying something like "Adequate arrangements for my fee have not been made" or "In order to testify in this case I would first have to engage in special studies, which I do not wish to do." Thus, while a lawyer in this country or in England can be forced to take on any case in the criminal docket, a medical man is allowed to pick and choose his professional employment!

30. In connection with this matter of suppression, in California at least,

"The failure of a doctor to testify after examining the plaintiff at the request of the defendant, is a fact from which the jury can infer that the testimony might be adverse to the defendant." *Gluckstein v. Lipsett*, 93 Cal. App.2d 391, 209 P.2d 98 (1949).

John Kennett, of Seattle, Washington, has had considerable success in subpoenaing, at random, a specialist in a particular field to testify "without warning" in a malpractice case.³¹ He has called this startled witness both on deposition and on the actual trial.³² It might be much less hazardous to depose such a "spontaneous expert witness" instead of bringing him directly into court, since if the testimony turned out unfavorably, the party calling him would not have that testimony before the jury in most states if he did not introduce his deposition at the subsequent trial. However, a detriment to deposition is that in informal deposition proceedings, defendant insurance company's counsel has more opportunity to get it across to this "unprepared expert" that he is "breaching the code." He could not so readily do this in the presence of the jury with the judge watching.

Certainly, if all other means fail in a meritorious medical malpractice case where a doctor expert refuses to testify, I would do both, *i.e.*, depose at random without notice one or two experts and failing to achieve the desired testimony, go to trial then call, unannounced, one or two specialists. Nothing could be lost if there were no other way of going by nonsuit.

B.

CHECK OTHER COURTS, COMMISSIONS, CASES, TRANSCRIPTS.

If the plaintiff's medical malpractice lawyer has a reluctant expert, or none at all, or must rely on cross-examination to make his case (see *infra*), he should examine the transcript of other cases in other courts, or even commission hearings, for the testimony of his prospective witness, adverse or friendly. Sometimes it happens that an ophthalmologist in an Industrial Accident Commission case will severely criticize a general practitioner for treating an "eye case." This specialist in that Commission case might give the very critical testimony that will help the malpractice plaintiff by nonsuit. This doctor, if adverse, could be subpoenaed at random and confronted with this testimony if he starts to stray. Too, a friendly witness could be shown his former testimony and asked for a "repeat" performance. Frequently, in informal hearings before commissions, oral testimony and letters from medical experts are received and statements made that wouldn't be made in open court. The truth is often told here as it is in informal conversation about malpractice.

31. In a Washington case, *Skeels v. Davidson*, 18 Wash.2d 358, 139 P.2d 301 (1943), certain throat specialists were subpoenaed to appear and testify, but refused to do so without payment of an expert fee. They were adjudged in contempt.

32. See 3 BELLI, *MODERN TRIALS*, p. 1980, footnote 62 (1954).

Certainly when an adverse witness is to testify, if he is a medical expert, his testimony in other cases should be checked by means of the former transcript to see how he therein deported himself. Likewise, access should be had to *Index Medicus* and other such journals for a run-down on everything this doctor has written.

C.

EXPERT AS LAY WITNESS.

Of course, an expert cannot refuse to accept a "\$2.00 lay subpoena" and appear as a *lay witness* (see *infra*). He might refuse, after he's called to testify *expertly*, with some such expression: "Arrangements haven't been made for my fee," etc., but on an ordinary "\$2.00 subpoena," the expert, whether he likes it or not, must join the "common herd" and give *lay* testimony.

Sometimes when the expert is called on the lay subpoena, he can be urged into expert testimony; and sometimes he becomes angry enough to depart from lay testimony and leave himself open to expert evidence on cross-examination. Sometimes, too, defendant's lawyer may overstep the bounds of lay testimony and "open the gates" so that this expert, subpoenaed at random, can be examined as an expert instead of as a lay witness as he was called.

In *Gluckstein v. Lipsett*,³³ I represented a plaintiff suing for malpractice done in the course of plastic surgery to her breasts. One of the leading surgeons in San Francisco, off the record, told me: "Mel, we should drive this doctor from the profession." Yet when it came time for this fearless medical man so to express himself on the witness stand, he demurred. "Some other time," he said. I knew my plaintiff had been to him for a number of examinations after the errant doctor had performed his malpractice surgery, and I knew this subsequent doctor had told my plaintiff: "There is a *lump* in your breast; it should be excised."

So, I gave this subsequent doctor a lay "\$2.00 subpoena," had him come to court, and put this question to him: "Doctor, you examined my plaintiff, found a lump in her breast, subsequent to the other doctor's surgery, and told her this lump should come out."

The doctor could only answer the truth—"Yes."

But I had planted the inference, and particularly was it nurtured when defendant's counsel, in a dilemma, did not ask any questions.

33. 93 Cal. App.2d 391, 209 P.2d 98 (1949). In this case, I did have another doctor take me by nonsuit. Some of his testimony is reported in the opinion. The verdict for \$115,000 was sustained; not even seriously attacked as excessive.

Of course, if defendant's counsel had asked any questions, he would have "opened it up." Since he asked none, I was permitted later to argue to the jury that *every woman* knows the danger of having a lump in the breast.

D.

RES IPSA LOQUITUR.

Res ipsa loquitur is, of course, the "way" to become injured if you're going to be injured at all in a malpractice case:³⁴ the surgical towel left in the wound, the forceps left in the abdomen after surgery, the other seemingly incredible instances of gross professional incompetence.^{34a} These are the cases in which plaintiff malpractice victim goes to the jury without needing a doctor's testimony because the untoward event simply doesn't happen unless someone is negligent.³⁵ These are the cases where a physician's or surgeon's want of skill or lack of care is so gross that a *layman* would have no difficulty in recognizing it. He doesn't need the assistance to his common sense (or experience) of expert medical reasonings or "conclusions" ("opinions").

Medical testimony is similarly held to be unnecessary in many cases where the courts do not specifically refer to res ipsa loquitur, but nevertheless substantially apply the principle by declaring that certain circumstances establish a prima facie case, or constitute negligence in themselves, or require an explanation from the accused, or "shift to the defendant the burden of proof" or of "going forward with the evidence."³⁶ Other courts, while not going that far, will say that the fact of injury to plaintiff following X-ray treatment, let us say, may be considered with all other evidence by the jury in the course of its

34. For discussion of res ipsa loquitur in medical malpractice cases, see 16 NACCA L.J. 336-340; for examples of such instances, see p. 258, *supra*; 3 BELLI MODERN TRIALS, Vol. 3, § 327, p. 1987, notes 95, 96, and p. 1991, notes 13, 14, (1954); 13 A.L.R.2d 84.

34a. Even those jurisdictions that purport to exclude the doctrine of res ipsa in medical malpractice cases make an exception where "there is manifest such obvious gross want of care and skill as to afford, of itself, an almost conclusive inference (of negligence)." *Slimak v. Foster*, 106 Conn. 366, 138 Atl. 153 (1927); see also *Mitchell v. Saunders*, 219 N.C. 178, 13 S.E.2d 242 (1941); 17 So. CALIF. L. REV. 217 (1944).

35. *Whetstine v. Moravec*, 228 Iowa 352, 291 N.W. 425 (1940); *Davis v. Kerr*, 239 Pa. 351, 86 Atl. 1007 (1913), 46 L.R.A. (ns) 611; *Sellers v. Noah*, 209 Ala. 103, 95 So. 167 (1923); *LeFaive v. Asselin*, 262 Mich. 443, 247 N.W. 911; *Engelking v. Carlson*, 13 Cal. 2d 216, 88 P.2d 695 (1939); *Ybarra v. Spangard*, 25 Cal. 2d 486, 154 P.2d 687, (1944), 162 A.L.R. 1258.

36. *Hawkins v. McCain*, 239 N.C. 160, 79 S.E.2d 493 (1954); *Smith v. American Cystoscope Makers*, 443 Wash.2d 202, 266 P.2d 792 (1954). See also 162 A.L.R. 1266, and 33 CALIF. L. REV. 248, 272 (1945).

determination as to whether or not the injury was negligently caused.³⁷ (While, generally, X-ray burns received during *diagnosis* is "res ipsa," it is not necessarily so if the burns were incurred during treatment.)³⁸

However, one should not be lulled into such a sense of security as to forget that some courts are using the doctrine of *lack of proximate cause* to knock out even a good res ipsa case. Such cases are those, *i.e.*, of the doctor coming into court and saying, "Yes, it's true we did do something wrong, *but that patient would have died anyhow!*"

I recall a case in which a carcinoma of the male organ was not operated upon until a year later. No biopsy or accurate diagnosis was attempted, and therein I claimed lay malpractice.³⁹ While we proved our case and the jury returned a verdict of \$100,000 for my plaintiff, the trial judge, on motion for new trial, said *he* (!) wasn't satisfied that plaintiff wouldn't have had the precancerous lesion turn into cancer and *perhaps* would have required the complete penectomy regardless of the accuracy or time of diagnosis. So, even assuming that defendant doctors were "academically," or "abstractly" negligent, and a year tardy, in failing to diagnose, there was no tort to plaintiff because their wrong might not have been the causation of the ultimate drastic operation.⁴⁰ (I was claiming, in accordance *with the recognized cancer literature*, "an early treatment means an early—and less radical cure!")

1. California Cases in "Res Ipsa."

The California cases⁴¹ should be considered in "res ipsa" because the California courts have probably gone further faster toward a more

37. *Shockley v. Tucker*, 127 Iowa 456, 103 N.W. 360 (1905); *Berg v. Willett*, 212 Iowa 1109, 232 N.W. 821 (1930); *George v. Shannon*, 32 Kan. 801, 142 Pac. 967 (1914); *Lett v. Smith*, 6 La. App. 248 (1926); *Evans v. Clapp*, 231 S.W. 79 (Mo. App. 1921); *King v. Ditto*, 142 Ore. 207, 19 P.2d 1100 (1933); *Kelly v. Young*, 135 Pa. Super. 528, 7 A.2d 582, *aff'd*, 338 Pa. 190, 12 A.2d 579 (1939); *Hunter v. Burroughs*, 123 Va. 113, 96 S.E. 360 (1918).

38. See cases cited in footnote 73, *infra*.

39. See *Spraker v. Haverhill*, Superior Court, Fresno, #87077, April, 1953.

40. See *Silvers v. Wesson*, 123 Cal. App.2d 902, 266 P.2d 169 (1954) where plaintiff charged that he developed incurable cancer because, two years before, defendant doctor negligently failed to give him a cystoscopic examination when the plaintiff consulted him about an enlarged prostate gland. Defendant's motion for new trial was granted upon the ground of the insufficiency of the evidence to justify the verdict, in that there was not sufficient evidence in the record that defendant's negligence was the proximate cause of plaintiff's alleged damage. The Appellate Court affirmed the trial court. This is an example of how a medical malpractice case, by going off on the theory of proximate cause, may end up adversely for plaintiff, when perhaps the better strategy may have been to proceed on the basis of *res ipsa loquitur*.

41. According to Newsweek of July 11, 1955, more suits for medical malpractice are filed in New York and California than in any other states. In each of these two jurisdictions, about 500 cases per year get into the courts. For a further breakdown of California medical malpractice cases, see 3 Belli MODERN TRIALS, pp. 1968-69 (1954); for additional statistics, see "Why Doctors Face So Many Lawsuits," Look Magazine, November 1, 1955.

modified and extended acceptance. Probably the first malpractice case in California in which "res ipsa" was applied was *Brown v. Shortlidge*,⁴² where a tooth was knocked out during a tonsillectomy. Since that year, 1929, to the *Seneris* case,⁴³ and *Dierman v. Providence Hospital*⁴⁴ and *Ybarra v. Spangard*⁴⁵ the California courts have gone a long, long way. Indeed in one case, *Cavero v. Franklin General Hospital*,⁴⁶ the California courts probably have gone further (in the right direction) than any other courts in the country (see *infra*).

Compare, also these two spinal anaesthesia cases: *Ayers v. Parry*,⁴⁷ where the U. S. Circuit Court of Appeals, in a New Jersey case, held that res ipsa loquitur was not applicable and affirmed judgment for defendant, and *Seneris v. Haas*,⁴⁸ where the California Supreme Court declared that the jury, under appropriate instructions, should have been permitted to determine whether each of the conditions necessary to bring into play the rule of res ipsa loquitur was present. The trial court's judgment of nonsuit was reversed. While these decisions appear to be inconsistent (no expert medical in the *Ayers* case), nevertheless compare.

42. 98 Cal. App. 352, 277 Pac. 134 (1929).

43. *Seneris v. Haas*, 281 P.2d 278 (Cal. 1956). This case involved a negligently administered spinal anaesthetic during childbirth, as a result of which the mother suffered partial paralysis. She brought action against the anaesthetist; against the obstetrician, on the ground that he knowingly allowed the anaesthetist to administer the anaesthetic; and against the hospital, on the theory that it was liable under the doctrine of *respondent superior*. The plaintiff contended that all three defendants were liable under the doctrine of res ipsa loquitur; as joint venturers; and because they failed to call in a neuro-surgeon and arrange for a laminectomy after discovering the paralysis. The trial court's judgment of nonsuit was affirmed as to the obstetrician but reversed as to the other defendants.

44. 31 Cal. 2d 290, 188 P.2d 12 (1947). In this case plaintiff entered the defendant hospital to have a wart removed from her nose and her tonsils excised. She was completely anaesthetized by a nurse, and then the doctor used a hot electric needle to remove the wart. After the wart had been taken off, and as the doctor was cauterizing the wound, there was an explosion about the face of the unconscious plaintiff and she sustained contusions and hemorrhages. Although the jury found for the defendants, judgment on the verdict was reversed, the Supreme Court holding that, upon the record, the jury should have been directed to find for the plaintiff; that the evidence, as a matter of law, was insufficient to sustain the verdict.

45. 25 Cal. 2d 486, 154 P.2d 687 (1944), 162 A.L.R. 1258. Here after plaintiff awakened from an appendectomy, he felt a sharp pain between his neck and the point of his right shoulder, so that he was unable to rotate or lift his arm, and this condition, developed into paralysis and atrophy of the muscles around the shoulder. The trial court's judgment of nonsuit was reversed, the court holding that the doctrine of res ipsa loquitur applied. The court also declared, "An examination of the recent cases, particularly in this state, discloses that the test of actual exclusive control of an instrumentality has not been strictly followed, but exceptions have been recognized where the purpose of the doctrine of res ipsa loquitur would otherwise be defeated. Thus, the test has become one of right of control rather than actual control."

46. 36 Cal. 2d 301, 223 P.2d 471 (1950). Where the court upheld a judgment for plaintiff and an instruction as to res ipsa loquitur in a case involving the death of a three-year-old child while under anaesthesia for a tonsillectomy.

47. 192 F.2d 181 (3d Cir. 1951).

48. See note 43, *supra*.

However, the most significant development in *res ipsa loquitur* is the role of the medical expert, something heretofore little considered by plaintiffs' lawyers. Suppose for example, plaintiff's counsel has induced a doctor to go so far as to say, "I don't know what happened in this case, I wouldn't want to say—both because of lack of knowledge and because I don't want to accuse the doctor of specific errancy. However, I do feel that if ordinary safeguards had been taken, this untoward surgical result would not have happened."

Is that a *res ipsa loquitur* case?

For a long time it was ruminated that *res ipsa loquitur* could be based only upon facts elicited from the testimony of *laymen*—that when experts were called in the doctrine was no longer available. For example, in *Escola v. Coca Cola*,⁴⁹ and *Zentz v. Coca Cola*⁵⁰ and cases similarly using the *res ipsa loquitur* doctrine (these were exploding bottle cases) it was reported by the California appellate courts that the doctrine of *res ipsa loquitur* could be used only where the testimony was given by a lay person, and *expert testimony* could not be the basis of it. In *Costa v. Regents*⁵¹ and on a rehearing this subject was expressly raised. An "*expert res ipsa doctrine*" delivered itself in California.

In *Cavero v. Franklin General Hospital*⁵² Justice Traynor of the California Supreme Court complained that there was no expert testimony. In this case there was an inhalation general anaesthesia, a tonsillectomy and a death. Recovery was allowed under *res ipsa loquitur* and this is a unique case standing for the proposition that an unusual event, while a patient is under anaesthesia, puts the (deservedly?) impossible burden of disproof upon the hospital. Note how in the *Dierman*⁵³ and *Ybarra*⁵⁴ cases this doctrine is enunciated.

I urged the decision in the *Costa* case, *supra*, in a Federal tort claim action in San Diego, *Ross v. U. S.*,⁵⁵ June 1955. In this case, \$210,000 was awarded, by U. S. District Judge Tolin sitting without a jury. The malpractice and damage: paralysis from spinal anaesthesia.

49. 24 Cal. 2d 453, 150 P.2d 436 (1944).

50. 92 Cal. App. 2d 130, 206 P.2d 653 (1949).

51. 116 Cal. App. 2d 445, 254 P.2d 85 (1953).

52. 36 Cal. 2d 301, 223 P.2d 471 (1950).

53. See note 44 *supra*.

54. See note 45 *supra*.

55. No. 1949 U.S. Dist. Court, Southern Division, California, 16 NACCA L. J. 437.

Plaintiff's sole medical expert testified in effect, "I don't know what happened but something *must* have gone wrong; otherwise there would not have been this paralysis"—thus, medical expert *res ipsa loquitur*. *Seneris v. Haas*, referred to above, represents the most recent judicial evaluation of such medical testimony.⁵⁶

While the law of the practitioner's particular jurisdiction should be examined, the trend now seems to be that *specific* acts (of malpractice) may be proved and *res ipsa loquitur* still be relied on.⁵⁷ Certainly the medical malpractice case should be pleaded in general terms and the pleader should not limit himself.⁵⁸ Some such pleading should be employed as: "Defendants (the defendants being the hospital, the nurses, the X-ray technicians, the pathologists, the toxicologists, all of them), negligently diagnosed, negligently treated, negligently operated, negligently administered, negligently prognosed, negligently prescribed and negligently cared for——"

2. Infection Can Be *Res Ipsa*.

There is abundant authority to the effect that many of the "infection cases" are *res ipsa loquitur*.⁵⁹ Some practitioners overlook this possibility and give up when an expert is not available. For example, the case of *Barham v. Widing*:⁶⁰ a dentist extracted a tooth from plaintiff's jaw, and an infection developed that could be traced to the use of a nonsterile hypodermic needle or solution inserted to anaesthetize the jaw.

56. For an excellent summary of the California law of malpractice before the *Seneris* case and pointing to that decision, see Swan, *The California Law of Malpractice of Physicians, Surgeons and Dentists*, 33 CALIF. L. REV. 248 (1945).

57. See *Doke v. Pacific Crane & Rigging Co.*, 80 Cal. App. 2d 601, 182 P.2d 284 (1947). For cases holding that *res ipsa loquitur* cannot be invoked where specific charges of negligence are made, see *Kaltenbach v. Cleveland, Columbus, Cincinnati Hy. Inc.*, 82 Ohio App. 10, 80 N.E.2d 640 (1948); *Worster v. Caylor*, 231 Ind. 625, 110 N.E.2d 337 (1953); *King v. Ditto*, 142 Ore. 207, 19 P.2d 1100 (1933); *Hess v. Millsap*, 72 S.W.2d 923 (Tex. Civ. App. 1934).

58. See 33 CALIF. L. REV. 248, 264, 267 (1945); 162 A.L.R. 1274.

59. See *Dierman v. Providence Hospital*, 31 Cal. 2d 290, 188 P.2d 12; *Ybarra v. Spangard*, 25 Cal. 2d 486, 489, 154 P.2d 687, 162 A.L.R. 1258; *Lawless v. Calaway*, 24 Cal. 2d 81, 86, 147 P.2d 604; *Bellandi v. Park Sanitarium Assn.*, 214 Cal. 472, 480, 6 P.2d 508; *Meyer v. McNutt Hospital*, 173 Cal. 156, 159 Pac. 436; *Dean v. Dyer*, 64 Cal. App. 2d 646, 149 P.2d 288; *Mastro v. Kennedy*, 57 Cal. App. 2d 499, 504, 134 P.2d 865; *Walter v. England*, 133 Cal. App. 676, 680, 24 P.2d 930; *Inderbitzen v. Lane Hospital*, 124 Cal. App. 462, 467, 12 P.2d 744, 13 P.2d 905. In other cases the doctrine has been recognized. *Sinz v. Owens*, 33 Cal. 2d 749, 753, 205 P.2d 3 (1949); *Engelking v. Carlson*, 13 Cal. 2d 216, 221, 88 P.2d 695, and cases cited (1939); *Church v. Bloch*, 80 Cal. App. 2d 542, 548, 549, 182 P.2d 241 (1947); *Rising v. Veatch*, 117 Cal. App. 404, 408, 3 P.2d 1023 (1931); *Donahoo v. Lovas*, 105 Cal. App. 705, 709, 288 Pac. 698 (1930).

60. 210 Cal. 206, 291 Pac. 173 (1930). See also *Soest v. Balsinger*, 60 Cal. App. 2d 441, 141 P.2d 13 (1943).

In another case, *Clemons v. Smith*,⁶¹ the court, in upholding an instruction that a surgeon's use of a nonsterile or unclean instrument constitutes negligence,⁶² pointedly declared:

“. . . it is not too exacting in this modern age of science to require physicians and surgeons to use sterile instruments where there is every facility available to make them so. There was a day in the dim and misty past when it was thought necessary for the surgeon to wash his hands after the operation but not before. Needless to say, that day has long since passed.”

However, it is true that the rules are not clear.⁶³ And some courts have been reluctant to apply *res ipsa* where there is evidence that the infection resulted from some source theretofore existing in the plaintiff's system, *i.e.*, some kind of prior infection.⁶⁴ But, at least, everything else failing, these cases should be considered or at least “checked” to take plaintiff by nonsuit if a medical witness is not available to him.

3. Negligent Hospital Care as *Res Ipsa*.

Counsel for aggrieved hospital patients should not only be alert to the possibility that *res ipsa loquitur* applies to injuries sustained during surgery, but also to other injuries suffered during the hospital stay. For example, the doctrine has been successfully invoked in a case involving injuries to a delirious patient who jumped from a hospital window: there was a gross failure to protect and safeguard the patient.⁶⁵ However, regardless of whether *res ipsa loquitur* is applicable in this type of case, most courts hold that lay testimony is sufficient where the lack of care is grossly apparent or a matter of

61. 170 Ore. 400, 134 P.2d 424 (1943).

62. For discussion of judicial notice of such negligence, see “Judicial Notice of Negligent Acts,” pp. 283-284, *infra*. See also *Lanier v. Trammel*, 207 Ark. 372, 180 S.W.2d 818 (1944), where the court held that upon a showing by lay testimony that the defendant doctor did not employ sterile procedures during a surgical operation, it was a question for the jury whether his unsterile methods were the proximate cause of the infection.

63. See 162 A.L.R. 1284, 1326; 13 A.L.R. 2d, 54, 67, 80.

64. *Moore v. Belt*, 34 Cal. 2d 525, 212 P.2d 509 (1949). See also *Snow v. Allen*, 227 Ala. 651, 151 So. 468 (1933) which seems to represent the death sentence for malpractice verdicts in Alabama: Childbirth. The testimony showed the baby's head was crushed. There was also evidence of prenatal negligence by the doctor. The mother died pending appeal from a verdict in her favor. The appellate tribunal, although admitting there were contradictory inferences to be drawn from the evidence took the arbitrary position that the verdict was so contrary to the great weight of evidence that it could not give it its approval. The reason given: “proof that the plaintiff sustained injury in the parturition of the child will not suffice to show that this injury was the result of negligence. Nor will the fact that pus and infection developed after the delivery of the child, as it is made to appear from expert testimony in the case that medical science has found no way to absolutely prevent infection from taking place in some cases. . . . The doctrine of *res ipsa loquitur* does not apply. . . .” The Alabama court split both infinitive and reason in this decision.

65. *Maki v. Murray Hospital*, 91 Mont. 251, 7 P.2d 228 (1932).

common knowledge. Under this rule, lawyers for this category of aggrieved hospital patients have spared themselves the often futile quest for expert medical testimony where injuries were sustained by an insane person while being improperly subdued;⁶⁶ where a patient in a private hospital tried to commit suicide by hanging herself with strips torn from her nightgown;⁶⁷ where a mentally deranged person jumped or fell from a hospital window;⁶⁸ where a doctor broke an unruly patient's arm when trying to get her out from under her bed;⁶⁹ and where a patient seized by intrapartum psychosis during labor jumped from the window of the labor room.⁷⁰

4. Extension of Res Ipsa to Tight Bandage and Cast Cases.

The ingenious and alert practitioner should attempt the extension of res ipsa where expert testimony is not available. For example, too tight a cast resulting in a Volkmann's contracture may serve as a basis for invocation of the doctrine⁷¹ and obviate the necessity for the expert medical testimony. See *Norden v. Hartman*.⁷²

5. Area of Operation.

The doctrine of res ipsa loquitur can apply to a patient, who, while unconscious on an operating table, receives injuries to a healthy part of his body, not subject to treatment nor within the "area covered by the operation."⁷³ Res ipsa has been applied not only where the injured

66. *Bellandi v. Park Sanitarium Ass'n.*, 214 Cal. 472, 6 P.2d 508 (1931).

67. *Stallman v. Robinson*, 260 S.W.2d 743 (Mo. 1953).

68. *Rural Education Ass'n. Inc. v. Anderson*, 261 S.W.2d 151 (Tenn. App. 1953); *Richardson v. Dumas*, 106 Miss. 664, 64 So. 459 (1914).

69. *Groce v. Myers*, 224 N.C. 165, 29 S.E.2d 553 (1944).

70. *Santos v. Unity Hospital*, 301 N.Y. 153, 93 N.E.2d 574 (1950); see also *Mosley v. Vanderbilt Univ.*, 1st Cir. Ct. for Davidson County, Tenn., Dec. 16, 1949, where hospital was held liable for injuries sustained by obstetrical patient falling from bed while under influence of drug.

71. Aside from res ipsa loquitur, the courts have upheld the position that casts or tight bandages resulted in infection of fractures because of impeded circulation, in the following cases: *Lorenz v. Lerche*, 157 Minn. 437, 196 N.W. 564 (1923); *Seewald v. Gentry*, 222 Mo. App. 367, 286 S.W. 445 (1926); *Hanson v. Thelan*, 42 N.D. 617, 173 N.W. 457 (1919); *Lundgren v. Minty*, 64 S.D. 217, 236 N.W. 145 (1936); *Treptan v. Behrens Spa Inc.*, 247 Wis. 438, 20 N.W.2d 108 (1945); and tight bandaging as a cause of Volkmann's disease was presented as a case for the jury in: *Priestly v. Stafford*, 30 Cal. App. 523, 158 Pac. 776 (1916); *Sim v. Weeks*, 7 Cal. App. 2d 28, 45 P.2d 350 (1935); *Vander Bie v. Kools*, 284 Mich. 468, 250 N.W. 268 (1933); *Gruginski v. Lane*, 177 Wash. 121, 30 P.2d 970 (1934); *Phifer v. Baker*, 34 Wyo. 415, 244 Pac. 637 (1926); *McCoy v. Clegg*, 36 Wyo. 473, 257 Pac. 484 (1927); 27 *NACCA L. J.* 756.

72. 111 Cal. App. 2d 751, 245 P.2d 3 (1952).

73. See 162 A.L.R. 1307. Res ipsa loquitur is also applicable to an X-ray injury to a part of a body not intentionally exposed. *Emrie v. Tice*, 174 Kan. 739, 258 P.2d 332 (1953); *Martin v. Eschelmann*, 33 S.W. 2d 827 (Tex. Civ. App. 1930). But in some of the X-ray injury cases in which res ipsa loquitur has been applied, the courts have indicated that the rule applied because the particular cases involved injury from X-ray being used for *examination*, that is, diagnostic purposes, the rule being inappli-

healthy part of the body is in a "remote area"⁷⁴ but also where such part is within the area of operation.⁷⁵ Moreover, in a late California decision,⁷⁶ it was held that *res ipsa loquitur* applied even though the patient was not unconscious: following an operation, patient was in great pain, his senses were dulled by pain-relieving drugs, he was confined to a hospital bed, virtually helpless. It was while in that bed that a third degree burn was found on his abdomen. And many courts invoke the doctrine without any discussion at all about "area of operation" or unconsciousness.⁷⁷

Whereas there was formerly a California doctrine that if the untoward event happened in or about the area of operation, *res ipsa loquitur* would not apply, this rule now seems abandoned. The former cases were those such as *Engelking v. Carlson*,⁷⁸ where, in an operation about the knee the external peroneal nerve was severed. Here was an untoward result, but an untoward result such as could have happened in ordinary surgery because the peroneal nerve is near the area of the operation.

However, with *Cavero v. Franklin General Hospital*⁷⁹ and *Sen-eris v. Haas*,⁸⁰ this *Engelking* case is actually overruled, since once a patient is unconscious and an untoward result follows, it would now seem so does *res ipsa loquitur* and generally everyone is held in.⁸¹

cable in situations in which the injury resulted from treatment with X-ray. *Ragin v. Zimmerman*, 206 Cal. 723, 276 Pac. 107 (1929); *Moore v. Steen*, 102 Cal. App. 723, 283 Pac. 833 (1929); *Holt v. Ten Broeck*, 134 Minn. 458, 159 N.W. 1073 (1916); *Bennett v. Los Angeles Tumor Institute*, 102 Cal. App. 2d 293, 227 P.2d 473 (1951). But see *Lett v. Smith*, 6 La. App. 248 (1926). See also 152 A.L.R. 638; 41 A.L.R. 2d 367. See also, DR. SAMUEL WRIGHT DONALDSON, *THE ROENTOLOGIST IN COURT* (1954) published by C. C. Thomas, Springfield, Illinois.

74. *Ybarra v. Spangard*, 25 Cal. 2d 486, 154 P.2d 687 (1944); *Quillen v. Skaggs*, 233 Ky. 171, 25 S.W.2d 33 (1930); *Vonault v. O'Rourke*, 97 Mont. 92, 33 P.2d 535 (1934); *Meadows v. Patterson*, 21 Tenn. App. 283, 109 S.W.2d 417 (1937). See also 162 A.L.R. 1311. See also *Wolfe v. Feldman*, 158 Misc. 656, 286 N.Y. Supp. 118 (N.Y. City Ct. 1936), where a dentist failed properly to apply restraining straps when anaesthetizing a patient, and the patient's finger was broken when the dentist used force to open her hand because she had grasped his testicles while in the so-called "fighting stage."

75. *Brown v. Shortlidge*, 98 Cal. App. 352, 277 Pac. 134 (1929); *Whetstine v. Moravec*, 228 Iowa 352, 291 N.W. 425 (1940); *Keily v. Colton*, 1 City Ct. Rep. (N.Y.) 439 (1882).

76. *Oldis v. La Societe Francaise De Bienfaisance Mutuelle*, 130 Cal. App. 2d 461, 279 P.2d 184 (1955); 16 NACCA L. J. 339.

77. *Passey v. Budge*, 85 Utah 37, 38 P.2d 712 (1934); *Vergeldt v. Hartzell*, 1 F.2d 633 (8th Cir. 1924); *Ellering v. Gross*, 189 Minn. 68, 248 N.W. 330 (1933).

78. 13 Cal. 2d 216, 88 P.2d 695 (1939).

79. 36 Cal. 2d 301, 223 P.2d 471 (1950), involving anaesthesia, tonsillectomy, followed by death.

80. 281 P.2d 278 (Cal. 1956).

81. The mere fact that several doctors and surgeons are involved (i. e., where there are two or more defendants and the instrumentality that causes the damage is not exclusively under the control of one of them) does not prevent the application of *res ipsa loquitur* in a suit against all of them. *Ybarra v. Spangard*, 25 Cal. 2d 486, 154 P.2d 687 (1944); *Ales v. Ryan*, 8 Cal. 2d 82, 64 P.2d 409 (1936); *Meyer v. St. Paul Mercury*

Compare *Ybarra v. Spangard*⁸² where an appendectomy was being done on a patient under an anaesthetic. There was an injury to the shoulder after the patient recovered consciousness. This accident was out of the area of operation, but a conspiracy of silence was attempted. Apparently the court finally, at last, got fed up; then came the *Gist*⁸³ and the *Seneris*⁸⁴ cases.

E.

DRUGLESS HEALERS.

The rule is well established that if a medical doctor cannot qualify as an expert on the theories and methods of the defendant's school of healing, he may not give evidence as to treatments by drugless healers such as chiropractors,⁸⁵ allopaths,⁸⁶ osteopaths,⁸⁷ or Christian Science Healers.⁸⁸ But if a drugless practitioner goes outside the limits of his theory of practice and into the fields of general medicine, a regular physician may testify.⁸⁹

It is important to note, however, in cases of gross negligence or lack of care, that plaintiff's case may be proved by lay testimony without expert evidence. See *Morrison v. Lane*,⁹⁰ involving the fracture of a rib by a chiropractor; *Bolles v. Kinton*,⁹¹ involving erroneous diagnosis of broken femur by an osteopath; and *Farrah v. Patton*,⁹² involving osteopathic treatment of a stiff neck.

Ind. Co., 61 So. 2d 901 (La. 1952); *Summers v. Tice*, 33 Cal. 2d 80, 199 P.2d 1 (1948); 5 A.L.R. 2d 91; *Oldis v. La Societe Francais De Bienfaisance Mutuelle*, *supra*, note 76. But the rule of the *Ybarra* case will not be indiscriminately applied to an assisting surgical nurse where the plaintiff's injury on the operating table clearly points to the responsibility of specific surgeons. *Leonard v. Watonsville Community Hospital*, 291 P.2d 496 (Cal. 1956).

82. 25 Cal. 2d 486, 154 P.2d 687 (1944).

83. *Gist v. French*, *supra*, note 12, where facts are discussed.

84. 281 P.2d 278 (Cal. 1956).

85. *Janssen v. Mulder*, 232 Mich. 183, 205 N.W. 159 (1925).

86. *Bush v. Cress*, 181 Minn. 590, 233 N.W. 317 (1930); *Ennis v. Banks*, 95 Wash. 513, 164 Pac. 58 (1917).

87. *State v. Smith*, 25 Idaho 541, 138 Pac. 1007 (1914); *Sima v. Wright*, 268 Mich. 352, 256 N.W. 349 (1934).

88. *Spead v. Tomlinson*, 73 N.H. 46, 59 Atl. 376, 68 L.R.A. 432 (1904).

89. *Brown v. Shyne*, 242 N.Y. 176, 151 N.E. 197, 44 A.L.R. 1407 (1926); *Trepau v. Behrens Spa*, 247 Wis. 438, 20 N.W.2d 108 (1945). For an excellent discussion of the liability of drugless practitioners or healers for malpractice, see *Kelly v. Carroll*, 36 Wash. 2d 482, 219 P.2d 79 (1950), 19 A.L.R. 2d 1174. Medical doctors may testify in spinal anaesthesia cases against osteopaths since both schools are familiar with the proper practice. *Porter v. Puryear*, 258 S.W.2d 182 (Tex. Civ. App. 1953), *aff'd*, 262 S.W.2d 933 (1954); see also *Walkenhorst v. Kesler*, 92 Utah 312, 67 P.2d 654 (1937).

90. 10 Cal. App. 2d 634, 52 P.2d 530 (1935).

91. 83 Colo. 147, 263 Pac. 26, 56 A.L.R. 814 (1928).

92. 99 Colo. 41, 59 P.2d 76 (1936).

F.

BATTERY.

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages."⁹³

This well-established rule makes defendant doctor liable if he performs more surgery than the patient has authorized, or if he substitutes another kind of surgery for the type authorized.⁹⁴ A plea that his motives were of the purest, or that he was only trying to do his good deed for the week, will be of no avail. Only in emergency cases, where the patient's life is in immediate peril, may a surgeon perform with impunity an operation for which specific consent has not been obtained, either from the patient or from someone qualified to represent the patient.⁹⁵

It is not enough that surgery not explicitly consented to may have been advisable from a medical viewpoint. Thus, a patient who consented to an operation on the right ear brought suit successfully against the doctor who, finding an identical condition in the left ear, operated on the left ear as well.⁹⁶ In an Oregon case,⁹⁷ a doctor authorized to perform nasal surgery performed a tonsillectomy instead. When the patient sued, defense contended that only breach of contract was involved, but the court held the doctor liable for assault and battery.

In those tragic cases where a surgeon mistakes one patient for another, the "consent" rule also applies, and the doctor is liable for damages on that basis.⁹⁸ The human body is held sacrosanct even

93. *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914), 52 L.R.A. (n.s.) 505, Annot., 1915C L.R.A. 581.

94. A doctor is an assaulter if he uses a method he was instructed by plaintiff not to use, as where an anaesthetist administers a spinal block, after reading the hospital record and thereby informing himself that the patient did not want a spinal block. *Woodson v. Huey*, 261 P.2d 199 (Okla. 1953); 13 NACCA L. J. 237.

95. *Wheeler v. Barker*, 92 Cal. App. 2d 776, 208 P.2d 68 (1949); *Preston v. Hubbell*, 87 Cal. App. 2d 53, 196 P.2d 113 (1948); *Jackovach v. Yocum*, 212 Iowa 914, 237 N.W. 444 (1931), 76 A.L.R. 551; *Wells v. McGehee*, 39 So. 2d 196 (La. 1949); *Tabor v. Scobee*, 254 S.W.2d 474 (Ky. 1953) (where surgeon while operating for appendicitis, also removed diseased Fallopian tubes, without consent, held liable for assault; reviewed in 32 CHI.-KENT L. REV. 152 (1954)). *Delahunt v. Finton*, 244 Mich. 226, 221 N.W. 168 (1928); *Luka v. Lowrie*, 171 Mich. 122, 136 N.W. 1106 (1912), 41 L.R.A. (n.s.) 290; *McGuire v. Rix*, 118 Neb. 434, 225 N.W. 120 (1929), 76 A.L.R. 560; 139 A.L.R. 1374. RESTATEMENT, TORTS § 62 (1934).

96. *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905), 1 L.R.A. (n.s.) 439; *Hively v. Higgs*, 120 Ore. 588, 253 Pac. 363 (1929), 53 A.L.R. 1052.

97. *Hively v. Higgs*, *supra*, note 96; see also *Woodson v. Huey*, 261 P.2d 199 (Okla. 1953).

98. *Gill v. Selling*, 125 Ore. 587, 267 Pac. 812 (1928), 58 A.L.R. 1556; *Samuelson v. Taylor*, 160 Wash. 369, 295 Pac. 113 (1931).

after death. Thus, autopsies not authorized through statute or judicial process, nor by the next of kin, constitute assault and battery and are actionable.⁹⁹

In most of these battery cases, expert testimony is not required, and in many of them the facts are undisputed. Not infrequently, the award is substantial.

G.

ABORTION, STERILIZATION AND ARTIFICIAL INSEMINATION.

In addition to the more familiar medical malpractice cases discussed above, quite a few, involving abortion, sterilization and artificial insemination arise from unjustified interference with the family relationship. The plaintiff's lawyer faced with this type of case should not be deterred by the fact that his client consented to the operation. It sometimes happens that even the consent of the patient is not sufficient to put a physician in the clear.

1. Abortion.

Thus, in an Illinois case,¹⁰⁰ an incompetent wife consented to removal of her ovaries and uterus, yet subsequently obtained a judgment against the surgeon on the grounds that her husband's consent had not been obtained. An Alabama court held that a father could bring action for the tort of abortion performed on his minor daughter, with her consent, but without the consent of the father.¹⁰¹ In Maine, similar right of action was accorded a husband whose wife had consented to an abortion but who had not himself consented.¹⁰²

2. Sterilization.

Although the practice of sterilization¹⁰³ is much older than that of artificial insemination, there is very little legal lore on the matter

99. See, *Schwab v. Connely*, 116 Colo. 195, 179 P.2d 667 (1947) (but city not liable since immune from suit); *Liberty Mutual Ins. Co. v. Lipscomb*, 56 Ga. App. 15, 192 S.E. 56 (1937); *Aetna Life Ins. Co. v. Burton*, 104 Ind. App. 576, 12 N.E.2d 360 (1938); *Alderman v. Ford*, 146 Kan. 698, 72 P.2d 981 (1937); *Beller v. New York*, 269 App. Div. 642, 58 N.Y.S. 2d 112 (1st Dep't 1945).

100. *Pratt v. Davis*, 224 Ill. 300, 79 N.E. 562 (1906), 7 L.R.A. (n.s.) 609.

101. *Hancock v. Hullett*, 203 Ala. 272, 82 So. 522 (1919).

102. *Lembo v. Donnell*, 116 Me. 505, 101 Atl. 469 (1917).

103. According to REGAN, *DOCTOR AND PATIENT AND THE LAW*, p. 67: "Sterilization may be defined as a surgical or radiological procedure that prevents parenthood on the part of the individual upon whom it is performed. Sterility may occur as an incidental effect of surgery required to be performed upon the patient because of disease or injury of some or all of the organs of reproduction. In such cases, the sterilization of the patient is a medical necessity. Sterilization is also classified as medically necessary when it is done because pregnancy would endanger the life of the particular patient."

See also, *Operations to Produce Sterility: Medicolegal Implications*, SYMPOSIUM ON MEDICOLEGAL PROBLEMS (1948).

of medical malpractice in that connection. It should be remembered, however, that sterilization laws are very strict¹⁰⁴ and doctors violating them are subject to criminal penalties, which may have a significant bearing in a malpractice action.

The question of medical malpractice in sterilization cases usually arises where either the husband or wife submits to the operation for the purpose of avoiding parenthood, and afterwards the wife gives birth to a child. However, in a Minnesota case where the wife bore a child after the husband was voluntarily sterilized to prevent conception, the court held that the wife had no cause of action against the doctor on the grounds of deceit, because there was no allegation of fraudulent intent.¹⁰⁵ In a North Dakota case, however, where the wife was the one who was sterilized in order to prevent conception, and later bore a child, the husband's action for loss of his wife's services and consortium, and medical expenses incident to the birth of the child, encountered no objections as to sufficiency of the cause, except on the grounds of the statute of limitations.¹⁰⁶

In cases of this type, obviously, a crucial evidentiary fact is the nature of assurances or misrepresentations made by the doctor as to the effect or efficacy of the operation involved.

3. Artificial Insemination.

Artificial insemination is of such relatively recent origin that it has as yet no established legal status. However, according to James F. Wright:¹⁰⁷

"The ordinary rules of law governing doctors in situations of that kind are applicable and we get those rules from the cases that have been decided principally in malpractice suits. There the rules have been laid down that a doctor must use ordinary and reasonable care and skill in the practice of his profession, and that he must exercise his best judgment. Those rules of law apply to the conduct of the physician or surgeon treating his patients regardless of what kinds of cases he may be presented with. Thus in a case of the character under discussion he would have to use ordinary care in examining his patient and in examining the donor, and in actually carrying out the technic of the artificial insemination. And that would all be a matter of his judgment in view of his learning and his study of the case."

104. See CAL. WELFARE & INST'NS CODE § 6624 (1953); KAN. REV. STAT. c.76, § 177 (1923); IOWA CODE c.168, § 3364 (1927); UTAH LAWS c.82, § 7 (1925).

105. *Christensen v. Thornby*, 192 Minn. 123, 255 N.W. 620 (1934), 93 A.L.R. 570.

106. *Milde v. Leigh*, 75 N.D. 418, 28 N.W. 2d 530 (1947).

107. *Legal Aspects of Artificial Insemination*, SYMPOSIUM OF MEDICOLEGAL PROBLEMS (1948), page 57.

It seems logical to assume, as indicated by Dr. Louis Regan in his book, *DOCTOR AND PATIENT AND THE LAW*,¹⁰⁸ that a doctor who performs the artificial insemination process should be careful to:

- (1) establish the husband's sterility beyond all doubt;
- (2) obtain written, witnessed consent from all parties concerned, including the donor, the donor's wife, if any, as well as the recipient's husband.

Failure to observe such precautions might well render the physician vulnerable to an action in tort. Also, as Dr. Regan points out, even if a "consent form" has been used, the *degree* of consent may be brought into issue and the inseminating doctor charged with assault and battery.

H.

HOSPITAL RECORDS.

Since the adoption of the Uniform Evidence Act in many states, hospital records are of inestimable value in proving cases of malpractice. Hospital records covering the period of the patient's residence are admissible in evidence to show diagnosis of his condition and the nature of his injuries. The proper foundation must be laid: a record made in the regular course of hospital business and containing matters customarily contained in such records, etc.¹⁰⁹ The gross hearsay buried in these hospital records and admissible is amazing.¹¹⁰

Frequently a doctor, a nurse, a pathologist or an autopsy surgeon makes an entry in the supposedly immutable hospital record. It speaks eloquently of errancy of procedure, of malpractice. (Such statements would never be made on the witness stand!) I have had many hospital records that were altered because of this, but such instruments are available by subpoena duces tecum, and alterations, when attempted, are generally discoverable. Counsel should never accept *photostatic* copies without seeing the original hospital records. Erasures, alterations and spoliations that are readily discernible on the original hospital record do not always show up on the sometimes too generously proffered photostats. And check the "code numbers" that describe the type of surgical procedure with *BLAKISTAN, STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS*.

108. At p.253.

109. *McDowd v. Pig'n Whistle Corp.*, 26 Cal. 2d 696, 160 P.2d 797 (1945). *Freedman v. Mutual Life Ins. Co.*, 342 Pa. 404, 21 A.2d 81 (1941).

110. *People v. Gorgol*, 122 Cal. App. 2d 281, 265 P.2d 69 (1953). See also 48 *COLUM. L. REV.* 920 (1948).

Actually, because of the *frequency with which hospital records are altered and changed*. I now, as a general practice, ask for the original records, not photostats. Furthermore, original hospital records are easier for a jury to see and I do not permit "withdrawal" after they are introduced on substitution of the photostats. I do have photostats made likewise for out-of-court study and consultation. I have "blown-up"¹¹¹ hospital records until they are five feet by five feet so that the particular part that impresses the malpractice by either the doctor's or nurse's statement or erasure can be plainly seen by a jury. I feel that this emphasis is permissible as much as is the publication in the public press of an indictment against a perjurer.

In this discussion of hospital records, attention should also be directed that statements made to a doctor in order to obtain medical advice are not subject to the hearsay rule and the doctor's records are admissible in evidence to show the number of visits, the patient's description of his condition, the treatment prescribed, etc., in the same manner, to the same effect, and subject to the same limitations as hospital records. This rule also applies to pharmacists' prescriptions and cardiogram records prepared by physicians.¹¹²

I.

CROSS-EXAMINATION MAKES A MALPRACTICE CASE.

My own technique in malpractice cases is usually to depend upon cross-examination of defendant doctor for plaintiff's recovery. (I am speaking now only of those cases in which *res ipsa loquitur* or the other procedures are not available.)

One of the first cases, in California at least, in which it was held that plaintiff could depend upon a medical defendant himself to establish a case either by deposition or by cross-examination was *Lawless v. Calaway*.¹¹³ In this case it was held that malpractice can be proved by the defendant's testimony, and if it can be proved only by an "expert," defendant himself can be that expert. This important rule was announced by the court in the following language:

"Statutes such as California Civil Code section 2055 were enacted to enable a party to call his adversary and elicit his testimony without making him his own witness. . . . They are remedial in character and should be liberally construed in order

111. For discussion of hospital charts generally and illustrations of "blown-up" hospital records, see 2 BELLI, *MODERN TRIALS* § 277 (1954).

112. *Freedman v. Mutual Life Insurance Co.*, *supra*, note 109.

113. 24 Cal. 2d 81, 147 P.2d 604 (1944); see also, *Dickow v. Cookinham*, 123 Cal. App. 2d 81, 266 P.2d 63 (1954); *Lashley v. Koerber*, 26 Cal 2d 83, 156 P.2d 441 (1945).

to accomplish their purpose. . . . Any relevant matter in issue in a case is within the scope of the examination of witnesses called pursuant to the provisions of such statutes. . . . It is well settled that a plaintiff in a malpractice action can establish his case by the testimony of the defendant therein. . . .¹¹⁴ It is equally well settled that expert testimony is ordinarily required to prove the material or relevant issues in an action for malpractice. Neither the letter nor the spirit of the statute suggests any reason why the defendant in such an action should not be examined with regard to the standard of skill and care ordinarily exercised by doctors in the community under like circumstances and with respect to whether his conduct conformed thereto. We are of the opinion that such examination should be permitted under section 2055 even though it calls for expert testimony. . . . There are cases which may support a contrary conclusion, but in our opinion a rule excluding such testimony is at variance with the theory underlying the statute.”

Of course, in order to get by nonsuit in this maneuver, I must examine defendant doctor before that motion for nonsuit is made. I generally do this by *discovery proceedings* or *depositions* before trial. I get enough information from hospital records and the doctor on cross-examination. Following is an example of the use I made of such information in the trial of *Gluckstein v. Lipsett*:¹¹⁵

Q. Now, Doctor, when we took your deposition, you expressed a familiarity with Thorek's *Plastic Surgery of the Breast and Abdominal Wall*.

A. Yes, I have read the book.

(At this point, plaintiff's counsel volunteered the statement that Thorek was the leading authority on this subject, which fact defendant later denied.)

Q. . . . You are familiar with this book, aren't you?

A. I have read the book.

Q. Let me ask you, then, on page 359, with reference to scars and keloids, if you are not familiar with this paragraph by the author?

(Defendant then objected, and the court overruled his objection.)

Q. The paragraph I refer you to, Doctor, is this:
“Any operation on the breast which subjects the patient to radial or longitudinal incisions predisposes to more or less scarring. This should be avoided.”

Do you agree with that?

A. That is his opinion.

114. Citing *Bolles v. Kinton*, 83 Colo. 147, 263 Pac. 26 (1928), 56 A.L.R. 814; *Jacobs v. Grigsby*, 187 Wis. 600, 205 N.W. 394 (1925).

115. 93 Cal. App. 2d 391, 209 P.2d 98 (1949).

Q. Do you differ?

A. No, it does not differ, but I don't know to what he alludes in this particular case.

Q. Let's read it again. I will read you the last sentence of it here.

(Again defendant objected and was overruled).

Q. Mr. Belli: Here is the last sentence:

"Scars are constantly reminding the patient of the operation which she has undergone, and should there be a tendency to keloid formation, matters are much worse, because of the effects produced by the keloid."

You are familiar with the book?

A. I don't remember those things. I have read the book, but I don't remember any particular portion of it.

Q. Do you disagree with this particular portion?

A. No, I don't disagree with it.

(These questions were preceded and followed by questioning of defendant concerning the scars left by the operation).

I have qualified an expert, when I have had one who was not practicing in the particular geographical area of venue, by cross-examination of defendant doctor, thusly: I ask defendant if it is not true that the standards of medical practice in his own *little* community are as prudent and as high as the standards of practice in, say, the large city (if my prospective expert practices and comes from a "large city"). Defendant doctor, his sense of pride being aroused, will generally accord an affirmative answer, and with it my expert from the "large city" is then qualified for the "smaller city" because the standards are the same.

J.

A HYPOTHETICAL CASE.

Suppose a plaintiff has osteomyelitis in the lower jaw. Claim is made in malpractice suit that there was an infection, that the insertion of the doctor's or dentist's needle in this infection caused the osteomyelitis in the bone. The doctor testifies that he injected away from the site of the infection (doing a mandibular injection near the condyle). There is no doctor to testify against him and in this infection case plaintiff is doubtful if *res ipsa* would apply.

This defendant doctor should be examined: "Doctor, there was an infection in the front part of this jaw, is this correct?" Answer: "Yes". "Doctor, it would be malpractice would it not, to inject into this area?" Answer: "Yes." "That is all, doctor."

Plaintiff then takes the stand and testifies that the doctor did inject into this area, if that be the fact, and defendant doctor has proved a case of malpractice.

If defendant doctor is asked directly on the witness stand, "Did you do so and so, and is that malpractice?", his answer would obviously be "No"; otherwise the law suit would have been settled before trial. An indirect approach¹¹⁶ sometimes can produce amazing results and take the case by non-suit.

Thus I have put to the defendant doctor on cross-examination, as one of my first witnesses, a hypothetical case which is the worst possible statement of the case at bar, but have distinguished it from the case at bar by using every possible different name and date. Frequently the case can be stated factually as a hypothetical case and the defendant doctor can be induced to answer, as I have had him answer, "Oh, that fellow would be a bad practitioner." I have then gone ahead, after the doctor has left the stand, and adduced all of the facts in the hypothetical case as facts in the case at bar.

K.

QUALIFICATION OF MEDICAL EXPERT.

Gist v. French,¹¹⁷ the recent important California case, and *Carbone v. Warburton*¹¹⁸ seem to indicate that, if a local doctor is not available, a doctor showing "occupational proficiency" rather than "geographical proximity" should be allowed to testify in a malpractice case.¹¹⁹ This would mean that a doctor from Vermont would be able to testify in California. If this rule is followed, it will go far toward making medical testimony available, since though one might not get a doctor in his own state, he might be able to get a capable and proficient one from two states away.

There are a number of decisions saying that the trial judge has almost unlimited discretion in the qualifications of a medical malpractice expert.¹²⁰ However, the recent trend is that trial judges,

116. See *Examining and Cross-Examining the Expert*, 2 BELLI, MODERN TRIALS, § 288 (1954).

117. 288 P.2d 1003 (Cal. 1955). For a discussion of the facts in this case see note 12, *supra*.

118. *Carbone v. Warburton*, 22 N. J. Super. 5, 91 A.2d 518 (1952), *aff'd*, 94 A.2d 680 (1953). 11 NACCA L.J. 172. Also see 11 NACCA L.J. 174; *Bosze v. Metropolitan Life Ins. Co.*, 1 N.J. 5, 61 A.2d 499 (1948).

119. As to comprehensiveness of term "locality" in standard of care, see Swan, *The California Law of Malpractice of Physicians, Surgeons and Dentists*, 33 CALIF. L. REV. 248, 268 (1945).

120. *Huffman v. Lindquist*, 37 Cal. 2d 465, 234 P.2d 34, 46 (1951); *Kelly v. Carroll*, 36 Wash. 2d 482, 219 P.2d 79 (1950); *Carbone v. Warburton*, *supra*, note 118, (reversing trial court for excluding testimony of retired doctor).

recognizing the difficulty of obtaining medical testimony, are allowing practitioners of different schools to testify, providing they show some knowledge of the medical subject matter at hand. Thus, in a very recent California case¹²¹ involving negligent administration of spinal anaesthesia, the Supreme Court held that the trial court clearly abused its discretion in excluding the testimony of plaintiff's doctor, a licensed physician and surgeon since 1920, who had practiced in New York, had been in charge of a railroad employees' hospital where he had treated paralysis of the spinal cord, had taught anatomy and histology in the medical and dental schools of the University of Southern California, and had been autopsy surgeon for Los Angeles County for thirty years.

Although the rule is well established that the diagnosis and treatment by a defendant is to be tested by the standards of his own school of healing, some courts permit experts of any school to qualify as to such matters of common scientific knowledge as the X-ray, anatomy and diagnosis.¹²² Thus, plaintiffs' lawyers hard put for medical experts might consider pathologists, toxicologists, chiropractors,¹²³ etc. *even from other states or districts.*

L.

PLEADING THE MALPRACTICE CASE.

While proper pleading of the malpractice case won't necessarily produce the medical expert to take the plaintiff by nonsuit, nevertheless it will make his case easier to try and it may invoke the doctrine of *res ipsa loquitur*. It has been noticed (*supra*) how to plead generally. To this admonition could be added that it is not necessary to have the plaintiff verify his complaint. This saves him from embarrassment on the stand from cross-examination on irrelevancies and legal doctrines and terms he may know nothing about.

121. *Seneris v. Haas*, 281 P.2d 278 (Cal. 1956).

122. *Dorr v. Headstream*, 173 Ark. 1104, 295 S.W. 16 (1927); *Shockley v. Tucker*, 127 Iowa 456, 103 N.W. 360 (1905); *Henslin v. Wheaton*, 91 Minn. 219, 97 N.W. 882 (1904), 64 L.R.A. 126, 103 Am. St. Rep. 504; *Mann v. Grimm-Smith Hospital, and Clinic*, 347 Mo. 348, 147 S.W. 2d 606 (1941); *Grainger v. Still*, 187 Mo. 197, 85 S.W. 1114, (1905), 70 L.R.A. 49; *Ness v. Yeomans*, 60 N.D. 368, 234 N.W. 75 (1931) (chiropractor against physician); *Hilgedorf v. Bertschinger*, 132 Ore. 641, 285 Pac. 819 (1930); *Kelly v. Carroll*, 36 Wash. 2d 482, 219 P.2d 79 (1950); *Young v. Stevens*, 132 N.J.L. 124, 39 Atl. 115 (1944).

The Supreme Court of New Jersey directly and without equivocation answers the problem of whether a general practitioner can testify against a specialist. He is *competent* to do so, even though the *weight* to be given to his opinion may be attacked. *Carbone v. Warburton*, *supra*, note 118. See also *McGhee v. Raritan Copper Works*, 133 N.J.L. 376, 44 A.2d 388 (1945).

123. See *Ness v. Yeomans*, 60 N.D. 368, 234 N.W. 75 (1931).

Also, in alleging wrongful torts, use the term "wanton" rather than "wilful" lest there be an avoidance of the doctor's malpractice insurance policy. For the same reason, in abortion cases be careful not to plead a crime.

Keep in mind that a medical malpractice complaint may properly join several groups of physicians who separately and successively treated the plaintiff.¹²⁴ And always include nurses¹²⁵ and hospitals¹²⁶ as defendants. A jury is much more inclined to return a verdict against the hospital than against a nurse or doctor. With three defendants, one may be "played off against the other" to get the truth. Furthermore, this gives plaintiff's lawyer three different examinations of records, of theories, of principles.

I recall one case in which I sued two obstetricians in malpractice and joined a well-known San Francisco hospital. The two doctors heaped all of the error on the hospital up to the point of nonsuit, —with my acquiescence, and they went out of the case on nonsuit. But after nonsuit, the hospital then heaped all of the errancy on the doctors, the hospital thinking it could go out on verdict.

I thereupon settled the case against the hospital, then moved for a new trial against the doctors and produced the transcript showing the testimony by the hospital experts against the doctors after they were let out. Both the hospital and the doctors forgot that a motion for a new trial could be made after non suit against the two doctors!

M.

WARRANTY.

One of the most grossly overlooked procedures by plaintiff's counsel in the prospective malpractice case is the possibility of suit for breach of warranty.¹²⁷ Many doctors frequently, and in more than a "bedside manner," actually do *warrant*, particularly in plastic surgery, that their procedure or surgery will be successful. A warranty might be approached with some such statement as "your health would be

124. *Stafford v. Shultz*, 42 Cal. 2d 787, 270 P.2d 1 (1954). See also 33 CALIF. L. REV. 248, 268 (1945).

125. However, see the very recent decision in *Leonard v. Watsonville Community Hospital*, 291 P.2d 496 (Cal. 1956) involving a forgotten hemostat in a patient's abdomen following surgery, where the court held that the rule that in case of an unconscious patient a *res ipsa* inference is raised as to all defendants who had any control over the body of the unconscious plaintiff or the instrument that caused the injury, should not be indiscriminately applied to an assisting surgical nurse, where the injury plainly points to the responsibility of specific operating surgeons.

126. See the *Leonard* case, cited in previous footnote, for very recent California decision affirming nonsuit as to hospital.

127. *Miller, The Contractual Liability of Physicians and Surgeons*, 4 WASH. U.L.Q. 413-36 (1953).

much better," "your nose will appear much prettier," "you will be able to work," etc. Depending upon the rules of the particular jurisdiction, a malpractice case for breach of warranty might very well be made out.

As a practical matter, the patient, very often telling the truth, will report to the lawyer the exact words of the doctor. If the lawyer then sues in one count for negligence and in another count for breach of warranty, generally the defendant doctor on deposition denies that he used those words. However, I have sued on malpractice on the one count alone in negligence, then taken the defendant doctor's deposition without forewarning and without being advised by his own counsel, he has blurted out the truth on deposition as to just what he did say. Then I have amended, having this testimony to include in a second count in my complaint, breach of warranty.

Frequently the statute of limitations in breach of warranty is longer than that in negligence.¹²⁸ The damages generally are the same, and if there is any question of contributory negligence there is at least a better chance of avoiding this defense in a warranty suit than in a straight negligence tort case.¹²⁹

Two recent cases ruled adversely on both the above, however: they are *Rubino v. Utah Canning Co.*¹³⁰ which held that the one year period applicable to tort was applicable to a warranty, and *Nelson v. Anderson*¹³¹ which held that contributory negligence was a defense in a warranty case. The modern fashion seems to be that the offense governs, whether it be called a tort or a warranty, and if it sounds in tort, no matter how it is pleaded, all of the tort intendments and defenses, etc. would apply.

N.

NURSES TESTIFYING AGAINST DOCTORS.

Some jurisdictions permit a nurse to qualify as an expert in a malpractice action against a physician;¹³² others do not.¹³³

In California, in a case involving infection following plastic nose surgery, a nurse was permitted to testify that when the packing was

128. For discussion of physician's fraudulent concealment of negligent and mal-treatment as tolling statute of limitations, see *Saffold v. Scarborough*, 91 Ga. App. 628, 86 S.E.2d 639 (1955); 16 NACCA L.J. 343.

129. See *Suit under Contract*, 3 BELLI MODERN TRIALS, § 349 (1954).

130. 123 Cal. App. 2d 18, 266 P.2d 163 (1954).

131. 72 N. W. 2d 861 (Minn. 1955).

132. *Swanson v. Hood*, 99 Wash. 506, 170 Pac. 135 (1918).

133. *MacCoy v. Gage*, 38 Cal. App. 672; 177 Pac. 296 (1918); *Gates v. Dr. Nichols' Sanitorium*, 331 Mo. 754, 55 S. W. 2d 424 (1932).

removed from the nose a week later a purulent discharge followed; that the doctor removed the packing while smoking a cigarette and without wearing a smock or cap; and that he blamed her for a slip-up in technique for not sterilizing instruments properly.¹³⁴ In another California case, nurses testified that at the time the operation in question took place, it was not hospital practice for the nurses routinely to count needles.¹³⁵

In the usual case, the nurse is called to testify as to some statement of the patient. The doctor's statutory privilege of non-disclosure, with respect to such statements to him, does not extend to the attending nurse,¹³⁶ except, perhaps, where she is acting as assistant.¹³⁷

Recently I have been able to secure medical testimony, competent and adequate among many practitioners, where a *socialized medicine plan* is involved. For instance, in a case against Kaiser Hospital, three doctors even offered to testify!

O.

USE OF LAY PUBLICATIONS.

No extended discussion of cross-examining by means of medical books is herein intended (see *Gluckstein v. Lipsett, supra*), except to refer to the so-called Massachusetts and Nevada rules, *infra*.¹³⁸ Nevertheless, consideration should be given to certain publications which can be read to a jury (even in those jurisdictions which require a doctor to be familiar with or base his testimony on the book) when the doctor denies ever having seen the publication.¹³⁹ In this category are, for example, the universally known publications of the various cancer societies. Everyone has seen such cancer literature advising early visits to the doctor, early diagnosis, and early treatment. In a case involving late diagnosis, for example, suppose defendant doctor denies that he "bases his testimony" on such pamphlets or even agrees with them. He might thus keep them out of evidence, but he is on the horns of a

134. *Soest v. Balsinger*, 60 Cal. App. 2d 441, 141 P.2d 13 (1943).

135. *Bowers v. Olch*, 120 Cal. App. 2d 108, 260 P.2d 997 (1953).

See also *Leonard v. Watsonville Community Hospital*, 291 P.2d 496 (Cal. 1956) where a supervising nurse testified that at an operation the nurses maintain a sponge and needle count, but not an instrument count, and that nurses are so taught during their training.

136. *Southwest Metals Co. v. Gomez*, 4 F.2d 215 (9th Cir. 1925); 39 A.L.R. 1416; *LaCount v. Von Platen-Fox Co.*, 243 Mich. 250, 220 N.W. 697 (1928).

137. *Meyer v. Russel*, 55 N.D. 546; 214 N.W. 857 (1926).

138. *Infra* pp. 285-86. Also see *Lawrence v. Nutter*, 203 F.2d 540 (4th Cir. 1953), 12 NACCA L.J. 260.

139. See 3 BELLI MODERN TRIALS, p. 1988 (1954).

dilemma. What sort of doctor is it, thinks the jury, who is not familiar at least with medical literature that is known even to laymen?

The literature from the various drug houses manufacturing medicines in question should certainly be solicited and the doctor cross-examined on the standards therein prescribed. Has he followed them, etc.?

P.

JUDICIAL NOTICE OF NEGLIGENT ACTS.

Another stratagem for coping with the unavailability of medical testimony is to make the fullest use of the doctrine of judicial notice.¹⁴⁰ Thus, although some courts will not permit negligence to be inferred from a doctor's failure to take an X-ray as an aid to diagnosis or treatment,¹⁴¹ the California courts will take judicial notice that such failure in fracture cases amounts to bad practice.¹⁴² Judicial notice will also be taken that an infection was caused by the doctor's negligence where an unsterile instrument was used, or the operative field is not properly sterilized.¹⁴³

There are many other decisions holding that it is common knowledge for instance, that when a tooth or its roots are extracted, neither, ordinarily, passes into the trachea and thus into the lungs;¹⁴⁴ that the removal of the soft palate and uvula is no part of a tonsillectomy;¹⁴⁵ that cataracts are removed from eyes regularly with a minimum of danger;¹⁴⁶ that injections into the muscles of the arm do not cause trouble unless unskillfully administered or unless there is something wrong with the serum;¹⁴⁷ that certain foods are prescribed in the dietary treatment of disease;¹⁴⁸ that a part of an interne's duty is to

140. For general discussion see 9 WIGMORE, EVIDENCE § 2580 (3d ed. 1940) 1955 Supp. p. 247 *et seq.*

141. *Pilgrim v. Landham*, 63 Ga. App. 451, 11 S.E. 2d 420 (1940); *Floyd v. Walls*, 26 Tenn. App. 151, 168 S.W. 2d 602 (1942); *Trask v. Dunnigan*, 299 S.W. 116 (Mo. 1927); *Wright v. Conway*, 34 Wyo. 1, 241 Pac. 1107 (1926); *Schumacher v. Murray Hospital*, 58 Mont. 447, 193 Pac. 397 (1920); *Boyce v. Brown*, 51 Ariz. 416, 77 P.2d 455 (1938); *Duckworth v. Bennett*, 320 Pa. 47, 181 Atl. 558 (1935).

142. *Agnew v. City of Los Angeles*, 97 Cal. App. 2d 557, 218 P.2d 66 (1950). See *Lippold v. Kidd*, 126 Ore. 160, 269 Pac. 210 (1928), 59 A.L.R. 875, where an eye specialist was held prima facie negligent for failing to X-ray the eye of a patient consulting him as to the possibility of a foreign object being lodged there. See also *BAJI* (California Jury Instructions) p. 295, 1955 Supp. p. 127.

143. *Barham v. Widing*, 210 Cal. 206, 291 Pac. 173 (1930); *Mastro v. Kennedy*, 57 Cal. App. 2d 499, 134 P.2d 865 (1943).

144. *Whetstine v. Moravec*, 228 Iowa 352, 291 N.W. 425 (1940).

145. *Thomsen v. Burgeson*, 26 Cal. App. 2d 235, 79 P.2d 136 (1938).

146. *Reigle v. Sholly*, 140 Pa. Super. 153, 14 A.2d 166 (1940).

147. *Bauer v. Otis*, 133 Cal. App. 2d 439, 284 P.2d 133 (1955).

148. *Bd. of Pharm. v. Quackenbush & Co.*, 22 N.J. Misc. 334, 39 A.2d 28 (C. P. Passaic 1944).

get the medical history of the patient;¹⁴⁹ that delirious patients often fall or jump out of upper story windows of hospitals;¹⁵⁰ and that diphtheria is an infectious, communicable disease.¹⁵¹

Q.

ADEQUATE FEES.

While "no amount of money" can induce most doctors to testify in a malpractice case, nevertheless it should always be remembered that adequate fees should first be proffered as well as time arrangements made for the convenience of the doctor. Some doctors justify refusals to appear in court on the basis of inconvenience and inadequacy of remuneration.

As to this matter of remuneration, a physician who has acquired knowledge of a patient or of specific facts in connection with him may be called upon to testify to those facts without any compensation other than the ordinary witness receives for attendance upon court.¹⁵² However, most courts do hold that a physician is entitled to added compensation if required to prepare himself for his testimony by conducting operations or experiments, or making special examinations for the particular case.¹⁵³ It is not recommended to spend time researching how *little* the doctor can be paid—in court.

III.

All the foregoing suggestions and devices are merely individual means of facing up to the problem. Some methods have been suggested for removing the problem entirely:

149 Eureka-Md. Assur. Co. v. Gray, 121 F.2d 104 (D.C. Cir. 1941).

150. Rural Education Ass'n v. Anderson, 261 S.W. 2d 151 (Tenn. 1953).

151. Janssen v. Mulder, 232 Mich. 183, 205 N.W. 159 (1925).

152. San Francisco v. Superior Court, 37 Cal. 2d 227, 231 P.2d 26 (1951); 25 A.L.R. 2d 1418.

McClenahan v. Keyes, 188 Cal. 574, 583, 206 Pac. 454, 458 (1922); see also, People v. Barnes, 111 Cal. App. 605, 610, 295 Pac. 1045 (1931); People v. Conte, 17 Cal. App. 771, 784, 122 Pac. 450, 457 (1912); *Ex Parte* Dement, 53 Ala. 389 (1875), 25 Am. Rep. 611; Dixon v. People, 168 Ill. 179, 48 N.E. 108 (1897), 39 L.R.A. 116; Summers v. State, 5 Tex. Crim. App. 365 (1879); Philler v. Waukesha County, 139 Wis. 211, 120 N.W. 829 (1909), 25 L.R.A. (n.s.) 1040; 3 So. CALIF. L. REV. 448 (1930); 39 YALE L. J. 761 (1930); Pennsylvania Co. for Insurance v. Philadelphia, 262 Pa. 439, 105 Atl. 630 (1918), 2 A.L.R. 1576, 1577.

153. *Ex Parte* Dement, 53 Ala. 389 (1875), 25 Am. Rep. 611; Flinn v. Prairie County, 60 Ark. 204, 29 S.W. 459 (1895), 27 L.R.A. 669, 46 Am. St. Rep. 168; North Chicago Street Ry. v. Zeiger, 182 Ill. 9, 54 N.E. 1006 (1899), 74 Am. St. Rep. 157; Dixon v. People, 168 Ill. 179, 48 N.E. 108 (1897), 39 L.R.A. 116; Swope v. State, 145 Kan. 928, 67, P.2d 416 (1937), citing R.C.L.; Barrus v. Phaneuf, 166 Mass. 123, 44 N.E. 141 (1896), 32 L.R.A. 619; Summers v. State, 5 Tex. App. 365, 32 Am. Rep. 573; Philler v. Waukesha County, 139 Wis. 211, 120 N.W. 829 (1909), 25 L.R.A. (n.s.) 1040; See also, 58 Am. Jur., Witnesses, § 880 (Supp. 1953).

A.

MINNESOTA PLAN.

One of these is the so-called Minnesota Plan—¹⁵⁴ admirable in theory, not satisfactory (in my opinion) in practice. Under this plan, judges, lawyers and physicians direct the attention of appropriate medico-legal committees to conscious deviations from the truth in the testimony of a medical expert, as evidenced by the transcript. Any doctor who testifies is subject to having his testimony reviewed by an "independent board" of doctors. If his testimony is medically errant, he is subject to professional censure. This would seem to protect against the doctor who testifies falsely for the defendant in a malpractice case, but it is my reluctant conclusion that the procedure simply does not work. Furthermore, even if it did work perfectly, it would, at most, solve only half the problem because it could only correct errant testimony (*after* the case was over), it wouldn't *produce* testimony.

B.

MASSACHUSETTS AND NEVADA RULES.

A more effective step in the right direction, perhaps, is legislation of the type recently enacted in Massachusetts to permit the offering of expert testimony in the form of recognized medical publications where no "live" medical expert is available.¹⁵⁵ The Massachusetts statute (Nevada is the only other state with such a statute) ¹⁵⁶ reads in part:

"A statement of fact or an 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 it is relevant and that the writer of such statements is recognized in his profession or calling as an expert on the subject, be admissible in actions or torts or malpractice, error or mistake against physicians, surgeons, dentists, optometrists, hospitals and sanatoria, as evidence tending to prove said fact, or as opinion evidence; provided, however, that that party intending to offer as evidence any such statement, shall, not less than three days before the trial

154. See REGAN, DOCTOR AND PATIENT AND THE LAW, p. 153 (1949).

155. MASS. STAT. c. 233, § 79 C, effective Sep. 1, 1949. For interpretation of this statute see Thomas v. Ellis, 329 Mass. 93, 106 N.E. 2d 687, (1952); 10 NACCA L.J. 256; Murawski v. Laird, 116 N.E. 2d 279 (Mass. 1953).

156. NEVADA STAT., March 13, 1953, c. 100, § 1 (cases of contract or tort involving malpractice of physicians, surgeons, dentists, etc. statements or opinions of authorities published in treatises, periodicals, books, or pamphlets, admissible under stated conditions).

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."

C.

MEDICAL PANELS.

A number of county medical boards in California have constituted "courts" to "hear" the complaints of potential medical malpractice plaintiffs—before they go to the law courts. Any semblance between such medical tribunals and the English Star Chamber sessions is certainly not coincidence: it is studied and deliberate. Admirable in theory, perhaps, they are hypocritical in performance. Furthermore, they are often used as a testimony trap for the unwary prospective plaintiff to admit away his case.

D.

JUDICIAL CONTROL.

The best solution of all, perhaps, would be to place the problem squarely on the shoulders of the trial judge—a stratagem, incidentally, that would solve a good many of the other problems of trial law today. This is the English method, and of course it is no secret that the English trial judge has solved many of the problems with which we in this country are still wrestling. Neither is it secret that the English trial judge is usually a much more competent individual than the typical American trial judge. Such is my personal observation. The most corroborative evidence of this statement lies in the fact that 95% of all personal injury cases in England are tried by a judge without a jury. Both sides are satisfied with the integrity, fairness and ability of the judge—the plaintiff on the one hand, the defendant insurance company on the other. *But in this country, if plaintiff waives trial by jury and agrees to have a judge alone try his case, defendant insurance company will demand a jury!*

While it is another story, a subject for a completely different article, I believe that the solution to our crowded calendar, too, lies not in the castigation of our legal system, such as that in a recent article¹⁵⁷ by the New York jurist, Samuel Hofstadter, but in reforms initiated by the judges themselves. I've seen court calendars cleared and made current for a period of years in one state, then crowded again, then

¹⁵⁷. *Let's Put Sense in the Accident Laws*, The Saturday Evening Post, October 22, 1955.

cleared once more. The law remained the same; the difference was in the caliber of the judges who served in the different periods.

Stopping the polished perjury of professional experts on the witness stand lies within the discretion of the individual courageous trial jurist. It should be stopped with the same alacrity as would false testimony from any layman. Similarly, it is the trial judge who should order reluctant doctors to testify, just as he would order a reluctant lay witness to give testimony. There doesn't seem to be any difficulty about getting architects, lawyers, engineers, and other professionals (even madams!) to testify against one another. But so to prostitute the medical profession? What an idea! It's about time that trial judges began to treat all witnesses as equals.

E.

"REDRRESS" RATHER THAN "GUILT".

I have another suggestion: the malpractice case should be more a matter of *redress* for the victim, less a matter of *guilt* or *fault*—of who's "right", who is "wrong." Let's not say that a doctor is "guilty of malpractice", for in many of these cases there's a very fine line between a lack of scientific understanding of the problem and downright negligence on the part of the individual doctor. Take, for instance, the "blood-contamination" cases. In many of these, the doctor can say truthfully, when asked the cause of the illness or the death, "It was caused by contaminated blood."

I remember just such a case in my practice: when defendant doctor honestly said, "The blood was contaminated!" I thought that this was certainly a clear expression of malpractice. What could be a more damning confession of guilt than that—"The blood was contaminated!"?

But then I learned that blood can be "contaminated" despite our best means of transfusion. I found that there is a great deal still to be learned about blood, even by the best of doctors. There are still many, many subdivisions, subtypes of agglutinins and substance in blood the amazing complexity of which is still not understood even by the most able practitioners.

Are these cases of malpractice? The law would seem to say "no" if the "ordinarily prudent practitioner" couldn't have been expected to have known otherwise. But the layman can't understand this. He hears "contaminated blood" is the cause of his son's death. The doctor administered it didn't he?—then he should be "guilty!" Un-

fortunately, that doctor about to be sued generally hasn't taken the time or trouble to talk it out with that potential plaintiff, and perhaps a second doctor has confounded the confusion.

F.

SHOULD DOCTORS SELF INSURE?

Another answer, that certainly is not a solution, might be for the doctors to form their own insurance companies. I neither advocate nor recommend this. Doctors dabbling in their own malpractice insurance companies will soon find that they are much more experienced in temperature readings than in premium ratings.

If there were some way doctors collectively could separate their premium money from their medical conscience, paying the former to the insurance company and keeping the latter unto themselves, this would go a long way, as we have seen (*supra*), toward solving the problem. It would restore the medical expert witness not to a favored status but simply to the same class as the rest of us.

IV.

CONCLUSION.

So, the question of expert testimony in medical malpractice cases is a problem for us all—the medical man himself; the attorneys for both sides (whose only objective, after all, is, or should be, to present the whole truth to the jury); the judge on the bench, the aggrieved and often horribly mutilated plaintiff; even, to a degree, the defendant insurance companies.

Plaintiff's counsel, with a deserving malpractice case, should research the possibilities, rather than recoil from the acknowledged evils of the law of medical malpractice. If he will examine the above suggested stratagems, where his own hand-whittled medical expert is not available to take him by nonsuit, one of the above procedures alone or in conjunction with others may take him to the jury. If not, he should use his ingenuity. (He first must determine in his own conscience whether his plaintiff has a case—remember it's easy to accuse, and doctors aren't "*guarantors of their cures*" in an "*inexact science*.")

But because of universal common knowledge of the conspiracy of the silent medical treatment, once to a jury, the malpractice plaintiff perhaps more than any other type of plaintiff has a better chance of a

successful award¹⁵⁸ . . . and a successful award is an adequate award. Modern American jurors penalize any conspiracy to withhold evidence.

158. However, defendant doctors in malpractice cases, and their insurers, who cast jaundiced eyes at jury trials should derive considerable solace from the following excerpt from the decision in the case of *Shipley v. Permanente Hospital*, 127 Cal. App. (2d) 417, 274 P.2d 53 (1954), where plaintiff's motion for new trial on the grounds of jury misconduct was denied:

"The motion for a new trial was supported by affidavits of three dissenting jurors and one juror who after having been in favor of a verdict for plaintiffs changed her vote. They declare that at the first ballot, taken after several hours of debate, the jury stood seven to five in favor of defendants. The majority of the seven jurors favoring defendants made statements substantially as follows:

'A verdict against Dr. Hallett would blast his professional career.'

'In general, a malpractice verdict against a doctor ruins him professionally.'

'Regardless of what has happened to Mrs. Shipley nothing that we can do will restore her; but any verdict which we bring against the doctor will ruin him.'

'If we were to hold doctors liable for their mistakes, they would never operate on anyone.'

'Doctors spend years in studying for their profession; they should know what they are doing, and we have no right to pass judgment on them.'

'If one can't put his faith in doctors he has no business going to them in the first place.'

"When the foreman of the jury, one of the dissenters, pointed out that the above position was based upon sympathy and prejudice in favor of doctors contrary to the oath and duty of a juror the language of the replies was to the effect that such jurors could not bring in a malpractice verdict against an individual doctor on the ground that the detriment to the individual doctor and the medical profession outweighed the justice of the individual case."