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Physicians and Surgeons—Malpractice—Court Disregard for the Standard of the Profession—The Legislative Response—Helling v. Carey, 83 Wn. 2d 514, 519 P.2d 981 (1974); Wash. Rev. Code § 4.24.290 (Supp. 1975)

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PHYSICIANS AND SURGEONS—MALPRACTICE—COURT DISREGARD FOR THE STANDARD OF THE PROFESSION—THE LEGISLATIVE RESPONSE—*Helling v. Carey*, 83 Wn. 2d 514, 519 P.2d 981 (1974); WASH. REV. CODE § 4.24.290 (Supp. 1975).

Plaintiff Barbara Helling first consulted the defendant ophthalmologists in 1959 complaining of myopia (nearsightedness). She was fitted with contact lenses and thereafter returned occasionally for examination and treatment for complications believed by defendants to have been caused by her lenses. Nine years after her initial visit a combination of symptoms existed which, in light of current medical standards, required the defendants to test her eye pressure and peripheral vision. The tests indicated that plaintiff, then 32 years of age, had been suffering from primary open-angle glaucoma[1] for approximately 10 years.

Plaintiff alleged at trial that defendants were negligent in failing to administer the eye pressure test at an earlier time and that, as a proximate result, she sustained permanent damage to her eyes.[2] Plaintiff requested an instruction which would have permitted the jury to find defendants liable despite their adherence to the degree of care and skill ordinarily exercised by members of their profession.[3] The trial court refused to give the requested instruction, and judgment for the defendant physicians was entered upon a verdict in their favor. The Washington Court of Appeals affirmed.[4] The Washington Supreme

1. Glaucoma is defined as "a group of eye diseases characterized by an increase in intraocular pressure . . . ." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 650 (25th ed. 1974). For other symptoms, see note 51 *infra*. The mechanism which normally permits drainage of the fluid contained within the eyeball malfunctions and the continued addition of fresh fluid causes a buildup of fluid pressure against the walls of, and the structures within, the eye. 1 J. SCHMIDT, ATTORNEYS' DICTIONARY OF MEDICINE AND WORD FINDER G-19 (1974). "Primary" glaucoma occurs in an eye which has not been diseased previously, while "open-angle" refers to a form of primary glaucoma in which, although the angle mechanism remains open, the tissues of the mechanism cause the diminished drainage. DORLAND'S, *supra*, at 650–51. The disease causes pathological changes in the eye and, if not arrested, eventual loss of vision. 1 J. SCHMIDT, *supra*, at G-19.

2. 83 Wn. 2d at 516–17, 519 P.2d at 982. The eye pressure test revealed that plaintiff had permanently lost most of her peripheral vision and that her central vision was reduced to approximately five degrees vertical by 10 degrees horizontal. *Id.*

3. *Id.* at 517, 519 P.2d at 982. Plaintiff sought to argue to the jury that the standard of the ophthalmologic profession was inadequate to protect her from the incidence of glaucoma. *Id.*

4. Helling v. Carey, 8 Wn. App. 1005 (1973) (unpublished opinion).

Court reversed and remanded for a new trial on the issue of damages. *Held*: Although defendant physicians had complied with the standard practices of their profession, they were negligent as a matter of law in their failure to perform the pressure test at a time when plaintiff's permanent disability could have been avoided. *Helling v. Carey*, 83 Wn. 2d 514, 519 P.2d 981 (1974).

This note will examine the relationship between the standard of care and the role of expert medical testimony in medical malpractice actions, discuss various interpretations of the *Helling* decision, and suggest the most practical of those interpretations, particularly in light of the subsequent enactment of R.C.W. § 4.24.290.[5] The purpose of this statute was to nullify the *Helling* decision and re-establish the pre-*Helling* standards of negligence in medical malpractice cases.[6] As will be demonstrated, although the statute in large part succeeds in allaying the fears of medical practitioners and defense attorneys which

5. WASH. REV. CODE § 4.24.290 (Supp. 1975) provides:

In any civil action for damages based on professional negligence against a hospital which is licensed by the state of Washington or against the personnel of any such hospital, or against a member of the healing arts including, but not limited to, a physician licensed under chapter 18.71 RCW, an osteopathic physician licensed under chapter 18.57 RCW, a chiropractor licensed under chapter 18.25 RCW, a dentist licensed under chapter 18.32 RCW, a podiatrist licensed under chapter 18.22 RCW, or a nurse licensed under chapters 18.78 or 18.88 RCW, the plaintiff in order to prevail shall be required to prove by a preponderance of the evidence that the defendant or defendants failed to exercise that degree of skill, care and learning possessed by other persons in the same profession and that as a proximate result of such failure the plaintiff suffered damages, but in no event shall the provisions of this section apply to an action based on the failure to obtain the informed consent of a patient.

6. WASHINGTON HOUSE COMM. ON THE JUDICIARY, 44th LEGIS., 1st EX. SESS., BILL REPORT ON SUB. HOUSE BILL 246 (March 24, 1975). The report states, in pertinent part:

Purpose of Bill and Effect on Existing Law: This bill is occasioned by a recent holding by the Wash. State Supreme Court regarding the standard of care required of physicians. In *Helling v. Carey* the court held that in a malpractice suit it is sufficient for plaintiff to prove that the physician failed to provide reasonable and prudent care in light of all of the circumstances—even though he in fact adhered to that standard of care expected of the average practitioner in his field. *Helling* says, regardless of established practice, if the facts involved indicate that a certain duty to perform should exist then the professional is liable for breaches of that duty. The bill as introduced would re-establish the pre-*Helling* standards of negligence that have been developed through case law in Washington. (See *Pederson v. Dumouchel* [72 Wn. 2d 73, 431 P.2d 973 (1967)] and *Hayes v. Hulswit* [73 Wn. 2d 796, 440 P.2d 849 (1968)]).

Effect of SUBSTITUTE BILL: Requires medical malpractice plaintiff to show that defendant failed to exercise the degree of skill, care and learning possessed by others in the same profession and that such failure caused damages. Excludes from this requirement actions based on failure to obtain informed consent of a patient.

were induced by *Helling v. Carey*, the case retains significance in its potential for expanding lay participation in determining the applicable standard of care in medical malpractice cases.

I. THE TRADITIONAL APPROACH TO ESTABLISHING MEDICAL MALPRACTICE LIABILITY

A. Standard of Care

The standard of care, as used herein, is a rule of law which provides the trier of fact with the controlling test for negligence.[7] The standard of the profession, on the other hand, is the degree of skill and knowledge ordinarily exercised within a particular profession as observed by the courts.[8] In most negligence actions, the standard of care to which the defendant must conform is that degree of care which, in the jury's view, a reasonable person of ordinary prudence would have exercised in the defendant's place in the same or similar circumstances.[9] In medical malpractice actions, however, the standard of care traditionally has been that degree of skill and learning which is ordinarily possessed and exercised by members of the medical profession in good standing.[10] In short, the standard of care has generally been held to be the standard of the profession.

When the standard of care in a medical malpractice action is so

7. For further discussion of the controlling test for negligence see W. PROSSER, LAW OF TORTS §§ 30–33 (4th ed. 1971) [hereinafter cited as PROSSER].

8. These definitions are proffered to delineate the terms, which courts have occasionally confused. *See, e.g.*, Chappetta v. Ciaravella, 311 So. 2d 563 (La. App. 1975); Marchlewicz v. Stanton, 50 Mich. App. 344, 213 N.W.2d 317 (1973); Douglas v. Bussabarger, 73 Wn. 2d 476, 438 P.2d 829 (1968); Stafford v. Hunter, 66 Wn. 2d 269, 401 P.2d 986 (1965).

9. *See* PROSSER, *supra* note 7, § 32, at 150; Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729 (1970).

10. Fritz v. Horsfall, 24 Wn. 2d 14, 163 P.2d 148 (1945), and Derr v. Bonney, 38 Wn. 2d 678, 231 P.2d 637 (1951), are perhaps the best exponents of this standard. Both cases hold that a physician who follows all the customary procedures in his treatment is not liable for malpractice. In *Fritz*, the court concluded that the attending physician exercised that degree of skill and care required of the average practitioner performing a gall bladder operation. The *Derr* court found that the physician did not deviate from the standard of care ordinarily practiced by other doctors in failing to take an X ray of the patient's ankle *after* it was placed in a cast. *See also* Skodje v. Hardy, 47 Wn. 2d 557, 288 P.2d 471 (1955) (physician's failure to take blood count, blood pressure, temperature or pulse not a departure from customary diagnostic procedures); Woods v. Pommerening, 44 Wn. 2d 867, 271 P.2d 705 (1954) (gold injections recognized treatment for skin lesions). *See generally* PROSSER, *supra* note 7, at 161–65.

defined, it follows that a physician who has conformed to the standard of the profession cannot be found negligent. Thus, in *Fritz v. Horsfall*,[11] the Washington court held that a physician was not negligent in using a recognized and approved procedure for removing the plaintiff's gall bladder, even though the patient suffered serious complications thereafter. More recently, the Washington court in *Pederson v. Dumouchel*,[12] while abolishing the locality rule,[13] continued to recognize the care and skill possessed by the average medical practitioner in a given specialty as the standard for determining whether a breach of professional competence had occurred.[14]

The standard of the profession, and consequently the standard of care, is based on proof of the customary and usual practices within the medical profession.[15] This result is contrary to the general rule of tort law that customary practice and usage are not solely determinative of the reasonableness of conduct.[16] The deference to the medical pro-

11. 24 Wn. 2d 14, 163 P.2d 148 (1945).

12. 72 Wn. 2d 73, 431 P.2d 973 (1967). *Pederson* involved the negligent use of general anesthesia, administered by a nurse when the defendant physician was not present. Expert medical testimony revealed that the plaintiff's permanent severe brain damage resulted from the anesthesia.

13. The locality rule required that a rural practitioner meet only the standard of his colleagues practicing in the same or similar localities. This rule insulated many physicians from the higher standards of medical practitioners in metropolitan areas. *See generally* McCoid, *The Care Required of Medical Practitioners,* 12 VAND. L. REV. 549, 569 (1959), reprinted in I. ROADY & W. ANDERSON, PROFESSIONAL NEGLIGENCE 13 (1960) [hereinafter cited as McCoid]. *Pederson* replaced the rule with one requiring a physician to meet a standard of care established in an area coextensive with the medical means available and within ready access to the patient. For a detailed discussion of the *Pederson* case and the locality rule see Note, *Expanded Standards of Care for Washington Physicians, Dentists and Hospitals,* 44 WASH. L. REV. 505 (1969).

14. Recent pronouncements of this rule in other jurisdictions include: Brown v. Colm, 11 Cal. 3d 639, 522 P.2d 688, 114 Cal. Rptr. 128 (1974) (use of surgical sutures not absorbable by body); McKinney v. Reardon, 337 A.2d 514 (Del. Super. 1975) (physician's willingness to allow patient-amputee to negotiate stairs while emerging from a hypnotic state); Chappetta v. Ciaravella, 311 So. 2d 563 (La. App. 1975) (pad left in patient's abdominal wound); Scaria v. St. Paul Fire & Marine Ins. Co., 68 Wis. 2d 1, 227 N.W.2d 647 (1975) (informed consent).

15. *See* McCoid, *supra* note 13, at 606; Morris, *Custom and Negligence,* 42 COLUM. L. REV. 1147, 1163 (1942) [hereinafter cited as Morris].

16. *See, e.g.,* F. HARPER & F. JAMES, THE LAW OF TORTS § 17.3, at 977–79 (1956); 1 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE § 8.04, at 200 (1960); Comment, *An Evaluation of Changes in the Medical Standard of Care,* 23 VAND. L. REV. 729 (1970).

However, a few courts have recently made pronouncements vaguely similar to those of the *Helling* court, stating that the customs of physicians should not be solely determinative of the standard of care. The court in Toth v. Community Hosp. at Glen Cove, 22 N.Y.2d 55, 239 N.E.2d 368, 292 N.Y.S.2d 440 (1968), held that although the defendant pediatrician had ordered reduction of the amount of oxygen administered to two infant patients (which comported with the customary practices

fession arises from the courts' realization that physicians possess unusual technical skills which laymen, in most instances, are incapable of intelligently evaluating. Therefore, in the interests of medical science and the health of the general public, physicians are generally free to make medical judgments without fear of being unfairly judged by people who may be prejudiced by unfortunate results.[17]

Thus, it is usually necessary to prove the physician's deviation from the standard of the profession in order for the trier of fact to find negligence.[18] However, there are occasions when this is not true. In two principal classes of cases, physicians who conform to the standard of the profession nevertheless may be found negligent, and thus the standard of care is higher than the standard of the profession. First, when expert medical testimony is introduced which criticizes the professional standard and claims that the standard is inadequate, the trier of fact has been permitted to conclude that use of a method generally accepted by the medical profession is negligent.[19] Second, when negligence is so grossly apparent that a layman would have no difficulty recognizing it, courts have frequently permitted the trier of fact to

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of his colleagues), where the orders were not carried out and blindness resulted to the infants a jury question was presented as to whether the pediatrician was negligent in his failure to assure that the orders were followed. In Favalora v. Aetna Cas. & Sur. Co., 144 So. 2d 544 (La. App. 1962) the court held the defendant liable after expert witnesses testified that the customary practice was faulty. *See* note 19 *infra*. *See also* Lundahl v. Rockford Mem. Hosp. Ass'n, 93 Ill. App. 2d 461, 235 N.E.2d 671 (1968) (dictum); Morgan v. Sheppard, 91 Ohio L. Abs. 579, 188 N.E. 2d 808 (Ct. App. 1963); Incollingo v. Ewing, 444 Pa. 263, 282 A.2d 206 (1971). Arguably the facts of the above cases place them within the common knowledge exception to the general medical malpractice standard of care. See text accompanying note 20 *infra*.

17. *See* McCoid, *supra* note 13, at 608. The author states that a physician would become hesitant to depend upon "his developed instinct in diagnosis and treatment" if his medical judgment was evaluated without regard to what other medical practitioners would also have done.

18. The common elements of a case of medical malpractice have been: (a) proof of what course of treatment the standard of the profession would require to deal with the plaintiff's condition; (b) proof that the defendant physician *deviated* from that standard; and (c) proof that the plaintiff's injuries were a direct result of the physician's deviation from the professional customs. *See generally* McCoid, *supra* note 13, at 614. *See also, e.g.*, Hayes v. Hulswit, 73 Wn. 2d 796, 440 P.2d 849 (1968) (malalignment of jaw); Richison v. Nunn, 57 Wn. 2d 1, 340 P.2d 793 (1959) (encasement of nerve in scar tissue).

19. *See, e.g.*, Favalora v. Aetna Cas. & Sur. Co., 144 So. 2d 544 (La. App. 1962). The Louisiana court held that conformity to the standard of the profession is not available as a defense to a physician when other physicians testify that the professional standard is not only faulty but also contrary to their medical education. *Favalora* involved the liability of a radiologist who failed to check the patient's medical records prior to treatment.

conclude that the standard of the profession, even though adhered to, is inadequate. Referred to as the common knowledge exception,[20] it is often invoked when surgical sponges or other foreign materials are inadvertently left in a surgical opening after an operation.[21] In such actions, although defendant surgeons may prove that it is customary medical procedure to rely on nurses to account for the number of sponges in use, the trier of fact nevertheless is allowed to find that particular professional standard below the required standard of care.[22]

The medical malpractice rule, with its two exceptions, provides, in effect, a presumption that the standard of care is equivalent to the standard of the profession in medical malpractice cases. This presumption arises upon proof that the defendant adhered to the standard of the profession. Unless rebutted by proof that one of the two aforementioned exceptions applies, this presumption allows defendant physicians to rely upon a standard of care established by the customs within their own profession.[23]

B. Requirement of Expert Testimony

Expert medical testimony is generally necessary to establish the defendant's liability in a medical malpractice suit,[24] for it is only by means of such testimony that the trier of fact may ascertain the standard of the profession and thus the legal duty of care[25] required of the

20. *See generally* 1 D. LOUISELL & H. WILLIAMS, *supra* note 16, § 14.06, at 439–42.

21. In Conrad v. Lakewood Gen. Hosp., 67 Wn. 2d 934, 410 P.2d 785 (1966), the trial court correctly permitted the jury to conclude that both the surgeon and his assisting general practitioner could be held liable for inadvertently leaving a 5½-inch hemostat (blood vessel clamp) inside the patient's abdomen after the incision was closed.

22. *See, e.g.*, Ault v. Hall, 119 Ohio St. 422, 164 N.E. 518 (1928).

23. C. STETLER & A. MORITZ, DOCTOR AND PATIENT AND THE LAW 307 (4th ed. 1962).

24. *See, e.g.*, R. LONG, THE PHYSICIAN AND THE LAW § 2.4, at 23 (1968); Comment, *Malpractice and Medical Testimony*, 77 HARV. L. REV. 333 (1963); Note, *Medical Malpractice—Expert Testimony*, 60 NW. U.L. REV. 834 (1966). Illustrative cases include: Sinz v. Owens, 33 Cal. 2d 749, 205 P.2d 3 (1949) (fracture); Funke v. Fieldman, 212 Kan. 524, 512 P.2d 539 (1973) (spinal anesthetic); Downer v. Veilleux, 322 A.2d 82 (Me. 1974) (fracture); Marchlewicz v. Stanton, 50 Mich. App. 344, 213 N.W.2d 317 (1973) (anthroplasty of hip socket to femur); Emmons v. Petry, 498 S.W.2d 38 (Tex. Civ. App. 1973) (catheterization of male urethra); Stafford v. Hunter, 66 Wn. 2d 269, 401 P.2d 986 (1965) (fainting); Huttner v. MacKay, 48 Wn. 2d 378, 293 P.2d 766 (1956) (craniotomy); Fritz v. Horsfall, 24 Wn. 2d 14, 163 P.2d 148 (1945) (removal of gall bladder).

25. Although this is the general rule, there are two exceptions to the use of expert testimony in this manner. *See* notes 19–22 and accompanying text *supra*.

defendant. Traditionally, the jury has also considered medical testimony in determining whether the defendant failed to meet the standard of the profession. Recently however, in *Douglas v. Bussabarger*,[26] the Washington Supreme Court continued a trend and further liberalized the medical testimony rule[27] by requiring medical testimony only to *establish* the standard of the profession.[28] Once that standard was established, the court allowed other evidence to be considered in determining whether the physician departed from that standard.[29] Thus the *Douglas* rule curtails the scope of the expert testimony requirement, limiting the need for such evidence. This, in turn, expands the manner in which one of the basic prerequisites for malpractice liability—a departure from the standard of the profession—may be proven.

II. *HELLING*—A BREAK FROM THE PAST?

The decision in *Helling v. Carey*, that the defendant physicians were liable for negligence despite their compliance with recognized professional standards, is inconsistent with traditional medical malpractice doctrine. In *Helling*, uncontradicted testimony on both sides established the standard practices of the ophthalmologic profession and demonstrated that the defendants had adhered to those practices.[30] Testimony revealed that, as a matter of statistical probability,

26. 73 Wn. 2d 476, 438 P.2d 829 (1968). *Douglas* involved a plaintiff who underwent surgery for a gastric ulcer and suffered paralysis afterwards, allegedly from the injection of a spinal anesthetic. The question of causation was to be submitted to the jury upon remand.

27. A general liberalization of the expert testimony requirement has occurred by: (a) the expansion of the pool of experts in some states (through the abolition of the locality rule which restricted the use of medical experts to the same or similar communities as the one in which the defendant practiced); and (b) the use of medical books and treatises in some jurisdictions instead of expert testimony. *See* Comment, *Malpractice and Medical Testimony*, and Note, *Medical Malpractice—Expert Testimony*, *supra* note 24.

28. The *Douglas* court mistakenly referred to the standard of the medical profession as the standard of care. 73 Wn. 2d 476, 478, 438 P.2d 829, 831 (1968). By referring to the standard of the profession as the standard of care, the court gave further weight to the conclusion that a presumption of due care exists in this regard.

29. The lay evidence which was excluded from consideration by the jury in *Douglas* consisted, *inter alia*, of various records showing the diagnosis of the patient's injuries to be spinal cord damage, a possible indication that she had been given an excessive amount of spinal anesthetic. The court held that such evidence was admissible to establish whether a departure from the professional standard had occurred. 73 Wn. 2d at 481, 438 P.2d at 833.

30. 83 Wn. 2d at 517, 519 P.2d at 982.

only one out of 25,000 persons under the age of 40 is expected to contract open-angle glaucoma.[31] Since the incidence of glaucoma is so minimal, the universal standard of the profession has been to refrain from administering a routine pressure test for detection of the disease to anyone under 40.[32]

The *Helling* court concluded that, on the facts of the case, the defendant physicians' failure to administer the pressure test at an earlier time constituted negligence as a matter of law. Determining that the test is simple to administer, relatively inexpensive, extremely reliable, and involves no judgment factor,[33] the court held that reasonable prudence necessitated the timely giving of the pressure test to the plaintiff.[34] The court concluded that it is the "duty of the courts to say what is required to protect patients under 40 from the damaging results of glaucoma."[35]

The normal presumption that professional custom is equivalent to the legally required standard of care was not recognized by the court. Unless *Helling* can be placed within one of the established exceptions to the general presumption,[36] the conclusion is virtually inescapable that the court abolished the presumption in *Helling* and made a drastic change in medical malpractice law. On the surface, *Helling* does not appear to fit within either of the exceptions—there was no medical criticism of the professional standard, and the necessity for a timely administration of the test does not appear to be a matter of lay competence.[37] Consequently, *Helling* represents a possible break from past medical malpractice law. The enactment of R.C.W. § 4.24.290 represents the legislature's attempt to rectify that break.[38]

31. *Id.* at 518, 519 P.2d at 983.
32. *Id.*
33. *Id.*
34. *Id.* at 519, 519 P.2d at 983.
35. *Id.*
36. See text accompanying notes 10–23 *supra.*
37. Previous courts considering the alleged negligence in diagnosis or treatment of glaucoma have concluded that the issue is beyond the common understanding of a layman. *See, e.g.,* Ewing v. Goode, 78 F. 442 (S.D. Ohio 1897); Evans v. Sarrail, 208 Cal. App. 2d 478, 25 Cal. Rptr. 424 (Dist. Ct. App. 1962); Hurspool v. Ralston, 48 Wn. 2d 6, 290 P.2d 981 (1955).
38. *See* note 6 *supra.*

III. THE INTERPRETATIONS OF *HELLING* AND THEIR CONSEQUENCES—LEGISLATIVE PRE-EMPTION OR CONTINUING VALIDITY?

A major difficulty with the decision in *Helling* is the uncertainty of its rationale. In stating that reasonable prudence required the timely giving of the pressure test to the plaintiff regardless of the standard of the profession,[39] the *Helling* court may have developed a new standard of care for the medical profession; yet it failed to clarify the new legal requirement. This failure encourages an examination of four legal rationales[40] concerning the standard of care and the expert testimony requirement, any one of which would account for the result reached by the court in *Helling*.

A. An Abolition of the Presumption that the Standard of Care Is Equivalent to the Standard of the Profession?

The first interpretation is that the court no longer recognizes the presumption that the standard of care in medical malpractice actions

39. 83 Wn. 2d at 519, 519 P.2d at 983.

40. Associate Justice Utter's concurring opinion in *Helling*, 83 Wn. 2d at 520, 519 P.2d at 984 (1974), affords another possible explanation of the decision. The concurring opinion stated that the imposition of liability on defendants who had acted reasonably according to the standards of the ophthalmology specialty and the facts of the case, apparently foreclosed under normal negligence principles, approached application of strict liability doctrine. Justice Utter advocated the imposition of liability without fault in this instance because the activity was defined with sufficient precision to avoid a miscarriage of justice in most cases. *Id.* at 521, 519 P.2d at 984–85. He stated:

> Lacking . . . training in this highly sophisticated profession, it seems illogical for this court to say they failed to exercise a reasonable standard of care. It seems to me we are, in reality, imposing liability, because, in choosing between an innocent plaintiff and a doctor, who acted reasonably according to his specialty but who could have prevented the full effects of this disease by administering a simple, harmless test and treatment, the plaintiff should not have to bear the risk of loss. As such, imposition of liability approaches that of strict liability.

Id. See generally Peck, *Negligence and Liability Without Fault in Tort Law*, 46 WASH. L. REV. 225, 239–43 (1971).

The concurring opinion can be commended for recognizing that the majority chose between an innocent plaintiff and a defendant whose conduct in the situation was representative of that of members of a highly skilled and respected profession. However, it fails to note that strict liability, as applied to the medical profession, would create difficulties in determining whether every injury or unfortunate result should be compensated (for example, when a calculated risk was taken in the patient's treatment in order to prevent more severe injuries). *See* A. Lanzone, *No-Fault Medical Malpractice: Is This Really the Solution?*, 11 TRIAL, May/June 1975, at 46.

is equivalent to the standard of the profession. Under this interpretation the special treatment accorded medical practitioners would be eliminated, placing the medical profession squarely within the ordinary tort rules of reasonable prudence. This interpretation, probably the most widely held, was the instigating force behind the Washington legislature's subsequent enactment of R.C.W. § 4.24.290.[41]

If *Helling* is interpreted in this fashion, the court discarded the customary practice test for use in determining the reasonable care standard within the medical profession. The court's reliance on two well-known cases concerning customary practice, *Texas & Pac. Ry. v. Behymer*[42] and *The T. J. Hooper*,[43] lends credence to this notion. Both cases stand for the general tort rule that custom is only a factor, and not necessarily a determinative one, to be considered when judging the reasonableness of a defendant's actions. Yet *Behymer* and *Hooper* differ from *Helling* in that they involved business customs,[44] which are often determined exclusively by profit motives. In contrast, courts before *Helling* seemed to assume that medical customs are more often determined by ethical concern for the patient's welfare, so that medical practitioners act reasonably when they follow medical custom.[45] If physicians are precluded from relying on the guideline of custom, the uncertainty involved in losing that guideline creates serious and unjust difficulties for both the medical profession and the trier of fact. Physicians will not know whether their commonly used procedures are reasonable or not, and the trier of fact will be unable to render an intelligent decision if unable to rely on testimony concerning customary methods.

Moreover, this alternative leaves uncertain the future of heretofore standard malpractice evidentiary requirements. If the customary practice test is eliminated in determining the standard of care, the impact of expert medical testimony is greatly lessened. The expert testimony requirement is inextricably bound to the process of establishing the

41. *See* notes 5 & 6 *supra*.
42. 189 U.S. 468 (1903).
43. 60 F.2d 737 (2d Cir. 1932).
44. *Behymer* concerned a customary procedure in the railroad industry—picking up extra freight cars with brakemen standing on top of them—while *Hooper* involved the failure of tugboat owners to equip tugs with radio receiving sets.
45. Morris, *supra* note 15, at 1164, implies that this could be one reason the medical profession has been immune from the general tort rule of *Hooper* in the past, although he asserts that the workability of equating the standard of care with the standard of the profession is probably the controlling factor.

standard of care in medical malpractice law,[46] so that change in one area causes a corresponding change in the other. Therefore, while *Helling*'s creation of a standard of care contrary to the recognized practices of physicians would deflate the requirement for medical testimony, the *need* for such expertise nevertheless remains. As evidenced by the court's statements concerning the tonometer test,[47] laymen still need medical testimony in order to make reasoned decisions.

If courts are to give less weight to the normal practices of the medical profession, judicial conclusions concerning matters of medical expertise may express erroneous views of such matters. Since a judicial decision is based on testimony admitted into evidence, the result is more likely to hinge on incomplete or oversimplified information under ordinary tort standards as compared to the collective medical judgment expressed through the customary practice test. Some aspects of the *Helling* opinion support this conclusion. The court stated that the tonometer test involved no judgment factor and that its reliability was such that if glaucoma were present, the test's results would detect the disease immediately.[48] Medical experts in the field, however, are not as certain of the test's capabilities.[49] The test, though usually harmless, has been known to injure the cornea.[50] Also, its results are not as definitive as the court asserted in that the test measures the ocular hypertension within the eye, which is not always diagnostic of glaucoma.[51]

46. *See* text accompanying notes 24–29 *supra*.

47. The *Helling* court viewed the Schiotz tonometer test as simple, harmless, inexpensive and capable of providing accurate results which do not require medical judgment for interpretation. The tonometer measures the indentation pressure of the globe, indicating the intraocular pressure by means of a plunger, which rests against the cornea. Movement of the plunger is transmitted to a measured scale. *See, e.g.*, Calkins, *The Eyes* in M. DELP & R. MANNING, MAJOR'S PHYSICAL DIAGNOSIS 62, 81–82 (7th ed. 1968); Henderson, *Eye* in R. JUDGE & G. ZUIDEMA, PHYSICAL DIAGNOSIS: A PHYSIOLOGIC APPROACH TO THE CLINICAL EXAMINATION 75, 98 (2d ed. 1968).

48. 83 Wn. 2d at 518, 519 P.2d at 983.

49. A medical response to *Helling* is found in Bradford, *A Unique Decision*, 2 J. LEGAL MED., September/October 1974, at 52 [hereinafter cited as Bradford]. Dr. Bradford maintains that experts in the field of ophthalmology would disagree with the court's pronouncements on the pressure test.

50. *Id.* at 53. The Schiotz tonometer test may scratch the cornea. Interview with William Mulligan, M.D., a specialist in ophthalmology, in Seattle, May 12, 1975 [hereinafter cited as Mulligan Interview].

51. Bradford, *supra* note 49, at 54. A person may have elevated pressure and yet not have glaucoma, according to Dr. Mulligan. Mulligan Interview, *supra* note 50. He stated that there are three symptoms indicative of glaucoma: (1) elevated eye pressure; (2) cupping of the optic disc; and (3) visual field loss. A high pressure indicates to a physician that he should conduct more tests, but a low pressure does

The customary practice test reduces this chance of error by presenting a collective medical opinion based upon expertise and experience over the years. Compliance with customary medical procedures should be recognized as the only realistic test for medical malpractice actions, for unless the matter is within the common knowledge or experience of a layman, the judge and jury are incapable of competently evaluating whether the physician made a medically correct judgment under the circumstances.[52]

In the past, courts have recognized the incompetence of laymen to decide these questions. As the Washington court stated in *Fritz v. Horsfall*:[53]

> Jurors and courts are not in any way conversant with what is entirely peculiar to the practice of medicine and surgery. They may not arbitrarily determine the proper methods of treating an ailment—that is a medical question.

A decision with little basis in medical testimony will therefore be regarded as suspect by the medical profession.[54]

Moreover, since the *Helling* court disregarded the undisputed testimony concerning the standard of the profession,[55] its opinion might have produced an onslaught of unworthy claims which otherwise would not have been pressed, increasing the burdens on the judicial system and the medical profession. The Washington Legislature, by enacting R.C.W. § 4.24.290, prevented the potentially dire consequences of the first interpretation.

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not preclude the possibility that a patient has glaucoma. *Id.* For an excellent discussion of all aspects of the disease, see generally B. BECKER AND R. SHAFFER, DIAGNOSIS AND THERAPY OF THE GLAUCOMAS (1961). The authors specifically state that an optic nerve may atrophy at normal intraocular pressure. *Id.* at 170–71.

52. Both McCoid, *supra* note 13, at 607–08, and Morris, *supra* note 15, at 1164, subscribe to this belief. In defense of the customary practice test, both authors state that since medical knowledge is very technical, the customary practice test provides the only feasible method of evaluating a physician's diagnosis and treatment.

53. 24 Wn. 2d 14, 18, 163 P.2d 148, 150–51 (1945). See note 10 *supra*.

54. Dr. Bradford notes that in the wake of *Helling* a patient may be misled into believing that he knows what is necessary to diagnose glaucoma. He further states:

> The measurement of intraocular tension remains a very important test and . . . should not be assigned an oversimplified value. Such matters must not be determined by common consumerist opinion, the press, presently popular medical copy, or even by the court. . . . The acceptable standard of care should be the best [professional] standard of the day, and it will only be determined by research and findings of the most knowledgeable in the field.

Bradford, *supra* note 49, at 55.

55. *See* note 30 and accompanying text *supra*.

B. *A Specific Standard of Conduct as a Rule of Law?*

A second alternative reading of *Helling* is that the court announced a standard of conduct that amounts to a rule of law. If the court regarded its decision as unique, as it did the facts of the case,[56] then it designed a rule of law for finding negligence in a very specific situation and left intact the general presumption regarding the standard of care in medical malpractice law.

If the decision imposed a court-made medical standard, the *Helling* court was remiss in failing to recognize that such attempts have not succeeded in the past, even in situations less demanding of expert evaluation. The history of Justice Holmes' "stop, look, and listen" rule of *Baltimore & O.R.R. v. Goodman*[57] provides a good example. In *Goodman*, Holmes stated that before crossing a railroad track, one *must* stop, look, and listen for oncoming trains, and possibly even get out of his vehicle if his view is obstructed. Failure to do so would constitute negligence. Justice Holmes concluded that "when the standard is clear, it should be laid down once and for all by the courts."[58]

Goodman failed to produce the desired result, however, because there were variables which often caused a finding of negligence to be unjustified. Justice Cardozo expressed dissatisfaction with the *Goodman* rule in *Pokora v. Wabash Ry.*,[59] in which he stated that to stop, get out of one's car, look, and listen would in some cases be "uncommon . . . futile, and . . . dangerous."[60] Justice Cardozo concluded:[61]

> [There is a] need for caution in framing standards of behavior that amount to rules of law. The need is the more urgent when there is no background of experience out of which the standards have emerged. They are then, not the natural flowerings of behavior . . . but rules artificially developed, and imposed from without. . . . [*Goodman*] . . . has been a source of confusion . . . to the extent that it imposes a standard for application by the judge.

If the *Helling* court was attempting an experiment similar to *Goodman*, it failed to clarify what specific conduct is required of physi-

56. 83 Wn. 2d at 517, 519 P.2d at 982.
57. 275 U.S. 66 (1927).
58. *Id.* at 70.
59. 292 U.S. 98 (1934).
60. *Id.* at 104.
61. *Id.* at 105–06.

cians. The new standard of conduct can be interpreted in at least two ways. Narrowly viewed, the holding requires Washington ophthalmologists to test for glaucoma as a routine part of every eye examination, regardless of the patient's age and corresponding probability of contracting the disease. Whenever glaucoma develops, proof of the ophthalmologist's failure to comply with the requirement will result in a peremptory finding of negligence. A more expansive view is that physicians or surgeons are required to administer routinely all tests for the detection of a serious disease which are simple, harmless, relatively inexpensive, and whose results are definitive. The two constructions of this possible standard of conduct reveal that without a description of the exact conduct required of medical practitioners, the standard of conduct is likely to be interpreted inconsistently and hence defeat the reasons for establishing a rule of law in the first instance.

C. *An Additional Means of Overcoming the Presumption?*

Another explanation of *Helling* is possible. Although the court did not do so explicitly, it may have created a third means of overcoming the traditional presumption that the standard of the profession is the applicable standard of care.[62] Perhaps the court meant that the presumption is rebutted whenever a physician fails to administer any test which can detect a disease capable of causing irreparable damage and yet is simple to give, relatively inexpensive, and reliable.

The practical ramifications of such a broad exception to the traditional rules of medical malpractice are great. The members of the medical profession would be placed in a difficult position, unable to rely on one of their major considerations—the statistical probability of harm—in determining the proper procedures for diagnosis and treatment. Since the court held the defendants liable for their failure to check for a disease of which there was only a one-in-25,000 chance, the difficulties which would face physicians in examining patients are apparent.

Heretofore, much greater risks have been held not to give rise to new duties on the part of physicians. The Wisconsin Supreme Court

62. The two recognized methods of overcoming the presumption are discussed in the text accompanying notes 19–22 *supra*.

recently held in *Trogun v. Fruchtman*[63] that a one percent (0.01) chance of an adverse reaction to a drug was too remote to warrant holding a physician liable for malpractice. Similarly, the Washington Court of Appeals accepted without question an established surgical procedure for performing an esophagoscopy in which there is a three-fourths of one percent (0.0075) chance of perforating the esophagus.[64] The *Helling* court, however, in dealing with a probability of four one-thousandths of one percent (0.00004), found liability. A physician who knows or reasonably should know that there is at least a one-in-25,000 chance that the patient is suffering from a serious and incapacitating disease which can be arrested by early detection, according to this third alternative, must take certain measures to check the possibility. Failure to do so may result in liability for malpractice if, in fact, the condition exists. The difficulties with such a rule are clear. There are a considerable number of diagnostic tests which satisfy the simplicity, economy, and safety standards of the court.[65] *Helling* may

63. 58 Wis. 2d 596, 207 N.W.2d 297 (1973) (alternative holding). In *Trogun* a patient sued an internist to recover damages resulting from jaundice and hepatitis contracted after the defendant had prescribed isoniazid hydrazate (INH) to cure the plaintiff's primary inactive tuberculosis. The court declared, *inter alia,* that an adverse reaction to INH was rare. The plaintiff's own expert witness testified that in his extensive experience with the drug the probability of contracting drug hepatitis was less than one percent. Accordingly, the court held that there had been no departure from the customary practice of physicians to prescribe INH for tuberculosis and that the physician was not negligent in his treatment of the plaintiff.

64. Mason v. Ellsworth, 3 Wn. App. 298, 474 P.2d 909 (1970). The *Mason* court reversed and remanded for a new trial on the question of the propriety of the defendant physician's apparent deviation from that established procedure. In addition, the court held that both the doctrines of *res ipsa loquitur* and informed consent were inapplicable on the facts of the case. Specifically, the court found, as a matter of law, that the risk of perforation was so small that the resulting perforation was not reasonably foreseeable; therefore the defendant's failure to inform the plaintiff of that risk did not breach his duty to disclose. *Id.* at 314, 474 P.2d at 920. The opinion recognized that there is a distinction between the applicable standards of care where, for example, an injury results from surgery and the surgeon's techniques are challenged and where the question is one of what constitutes a reasonably foreseeable risk for the purposes of disclosure to obtain informed consent. *Id.* at 311, 474 P.2d at 918.

65. Many such tests are included within the following procedures: hemoglobin analysis; complete blood count; urinalysis; biopsies; a general neurological examination to test reflexes; sensation tremors; gait and memory; a cranial nerve examination to diagnose muscular dystrophy and tumors; a back examination to test for mobility; various heart, lung, throat, ear, and abdominal tests involving auscultation, percussion, and palpation; rectal and vaginal examinations; electrocardiograms; cultures of the urine, sputum, blood, feces, and throat. For eyesight alone there are many tests. *See generally* J. A. PRIOR & J. SILBERSTEIN, PHYSICAL DIAGNOSIS (4th ed. 1973). The eye examinations are discussed in Havener, *Eyes, id.* at 78–127.

These tests are all routine at one time or another in order to diagnose a symptom, but they are not administered to *every* patient who may complain of a symptom or problem totally unrelated to a particular test. Mulligan Interview, *supra* note 50.

require that all such tests be given if the physician is to avoid liability for malpractice.

If *Helling* were given the above broad reading, the undesirable practice of "defensive medicine"[66] would become even more widespread than it is today. Reports by the medical and legal professions alike reveal that increased malpractice litigation has been responsible for the increased practice of defensive medicine.[67] Use of increased precautionary measures, required for physician protection under this rule and yet unwarranted in light of the infrequency of particular diseases, would raise the costs of treatment.[68] The amount of time a physician must spend with a patient would increase and the number of patients examined would decrease.[69] Under this interpretation, the criteria emphasized by the court for identifying necessary diagnostic tests[70] would not alleviate the apprehension of physicians confronted with the uncertain dimensions of the legal rule.[71]

66. The practice of defensive medicine involves the physician's (a) assumption of extra precautions, and (b) refusal to assume high risks in both the diagnosis and treatment of the patient, with a constant eye toward the possibility of a malpractice suit. *See* Comment, *The Medical Malpractice Threat: A Study of Defensive Medicine,* 1971 DUKE L.J. 939 (1971) [hereinafter cited as *Malpractice Threat*].

67. A recent study revealed that, of the 35 percent of a random national sample of 4,020 practicing physicians who responded to a detailed questionnaire, 80 percent have taken defensive measures in their practice of medicine as a result of concern over legal liability. Seventy percent of those responding had not even been threatened with a malpractice suit, while only 10 percent had experienced malpractice litigation. Paxton, *Making Your Practice More Malpractice Proof,* MED. ECON., September 30, 1974, at 69. *See also Malpractice Threat, supra* note 66.

68. A Schiotz tonometer costs from $50 to $150, but its tendency to scratch the cornea, its relative inaccuracy, and the necessity for anesthetic drops have caused ophthalmologists and optometrists to purchase tonometer machines, which cost more than $2,000. The cost of these machines is most assuredly passed on to patients. Mulligan Interview, *supra* note 50. A random sampling of Seattle area optometrists indicates that a glaucoma test costs from $5 to $10. A similar survey among general practitioners reveals that the combined cost of the procedures listed in note 65 *supra* is from $150 to $300 (a conservative estimate). Except for electrocardiograms and cultures, which take 30 to 45 minutes to administer, all of these procedures can be administered in a matter of minutes.

69. The survey discussed in note 67 *supra* reveals that 48 percent of the physicians responding are ordering more diagnostic tests. Among their comments: a general practitioner performs "ECG's [electrocardiograms] for any pain from neck to navel," a dermatologist biopsies "every wart," an orthopedist "x-rays each bruise and backache." *Making Your Practice More Malpractice Proof, supra* note 67, at 75. It should be noted that unnecessary taking of individually harmless X rays may expose the patient to an unhealthy cumulative amount of radiation. Thus, ironically, physicians could become susceptible to malpractice actions for performing tests to protect themselves from malpractice suits.

70. *See* text accompanying note 33 *supra.*

71. The anxieties of medical practitioners stemming from *Helling* are reflected in the many articles concerning the decision in medical magazines and newsletters.

D. *A Recognition of a Broader Scope for the Exercise of Lay Judgment?*

Helling may be interpreted in a fourth way which changes the medical malpractice rules only slightly, reduces the uncertainties accompanying the decision, and remains valid despite the subsequent enactment of R.C.W. § 4.24.290. This interpretation retains the traditional presumption that the standard of the profession is the standard of care with its two exceptions or means for its rebuttal: introducing expert testimony critical of the professional standard and establishing that the matters in question are within the competence of a layman. However, it broadens the scope of the matters within the common knowledge of laymen. Since the court in *Helling* relied on no expert criticism of the standard of the profession, it may have concluded that its decision *required* no expert testimony. Thus, the court may have decided simply that the matter was one of lay competence. If so, it was operating within the well-recognized common knowledge exception. This interpretation allows *Helling* to retain a modicum of significance despite the passage of the new legislation.

Medical testimony at the trial revealed that the professional custom of refraining from routine pressure testing of persons under 40 is based primarily on one factor—the low statistical probability that those persons will contract glaucoma. The court may well have considered itself as competent as a medical expert to conclude that despite such a low probability, reasonable prudence required the early administration of the test, especially when the seriousness of the harm resulting from the delay was viewed in light of the simplicity of the test. The Court of Appeals, in *Mason v. Ellsworth*,[72] found as a matter of law that the probability of perforation during an esophagoscopy is so low that an actual perforation is not reasonably foreseeable.[73] Hence it appears that once the trier of fact is told that the decision to administer a particular medical procedure is based primarily on the statistical probability of harm and is also informed of what that probability is, the

See, e.g., O'Hern, *Leading Cases—Unrecognized Standard of Care Imposed by Court*, 230 J.A.M.A. 1577 (1974); Bradford, *supra* note 49; *An 'Eye' to the Future?* MALPRACTICE DIGEST, May/June 1974, at 4. According to Professor [of Law] William Curran, *Helling* and other recent cases tend to make the physician the guarantor of the health of his patient. THE PHYSICIAN'S LEGAL BRIEF, January 1975, at 1.

72. 3 Wn. App. 298, 474 P.2d 909 (1970).

73. *See* note 64 and accompanying text *supra*.

determination of the applicable standard of care becomes a matter of lay competence. Prior to *Helling*, this exception, though often based on the particular facts of each case, had been primarily limited to "sponge cases,"[74] cases in which a physician failed to take an X ray,[75] and cases of gross medical misconduct.[76] By recognizing the capacity of laymen to evaluate the conduct of medical practitioners under such circumstances, this interpretation of *Helling* increases the degree of judicial respect for lay opinion and enables the case to survive the recent legislative action. Thus, under this fourth alternative, the scope of the common knowledge exception is broader than before, but the traditional presumption remains intact.

IV. CONCLUSION

Traditionally, medical practitioners have been treated with deference by courts in medical malpractice actions. The requirement of expert testimony permits physicians, by and large, to establish their own standard of care, which generally is presumed to be reasonable. The *Helling* decision raised the possibility of a drastic change from that unspoken presumption.

The failure of the *Helling* court to clarify the reasoning behind its decision allowed the postulation of several legal rationales. Of the four possible explanations, the fourth would have been clearly preferable had R.C.W. § 4.24.290 not been enacted, for it would have avoided the adverse consequences inherent in the other three. A standard of care which does not recognize the standard of the profession as presumptively reasonable would result in a greater chance of judicial error, causing serious difficulties both for the medical profession

74. *See, e.g.*, McCormick v. Jones, 152 Wash. 508, 278 P. 181 (1929) (sponge left in wound); Williams v. Wurdemann, 71 Wash. 390, 128 P. 639 (1912) (cotton packing left in nose); Wharton v. Warner, 75 Wash. 470, 135 P. 235 (1913) (metallic spring left in uterus). *See also* McCoid, *supra* note 13, at 610.

75. The exception with regard to X-ray cases was well stated in Agnew v. City of Los Angeles, 82 Cal. App. 2d 616, 186 P.2d 450 (Dist. Ct. App. 1947), in which a court held that the use of an X ray to diagnose a fracture was within the common understanding of a layman and that a failure to take an X ray of the patient's hip constituted negligence. *See also* McCoid, *supra* note 13, at 575.

76. *See, e.g.*, Helland v. Bridenstine, 55 Wash. 470, 104 P. 626 (1909) (physician's use of an infected instrument in performing a vaginal inspection); Swanson v. Hood, 99 Wash. 506, 170 P. 135 (1918) (physician's removal of a wire from a bone with such great force that splinters of the bone were pulled away).

and for patients. Thus, by maintaining the presumption and its historical exceptions, and by merely broadening the scope of a layman's common knowledge to include, when applicable, the determination of the standard of medical care on the basis of the statistical probability of harm, a major change in the law of medical malpractice can be averted in jurisdictions still open to a *Helling*-type holding.

Furthermore, while the first three interpretations have been effectively foreclosed by the enactment of R.C.W. § 4.24.290, the fourth statement of the *Helling* holding has significance even after the statute's enactment. Although the new statute has successfully removed the most serious ramifications of *Helling*, if the fourth interpretation is adopted, the case nevertheless expands the layman's role in deciding the outcome of future medical malpractice suits. The direct legislative response to *Helling* has allayed the fears of those who believe that a new standard of care had been created. However, such legislation is at best a stopgap measure in the present medical malpractice crisis and should not preclude greater lay participation in determining the applicable standards of care where accurate statistical assessments of risk are available.

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