BOOK REVIEWS

MEDICAL MALPRACTICE. By David M. Harney. Indianapolis, Indiana: The Allen Smith Co., 1973. Pp. x, 595. $24.50.

*Reviewed by Joseph H. King, Jr.**

GENERAL

A lengthy discourse on the explosion in medical malpractice litigation over the past two decades would be an unnecessary ingemination. A few facts will suffice. One out of every four physicians practicing medicine today can expect to be sued.[1] Some states, such as New York, show a ninety percent increase in the number of malpractice suits since 1968.[2] Nor has the increase in malpractice litigation been restricted solely to the sheer number of cases. The size of the verdicts and settlements has also mushroomed dramatically. Twenty years ago a $100,000 verdict in a malpractice case was practically unheard of.[3] In the last two years, by comparison, there have been at least one medical malpractice verdict in excess of $4,000,000[4] and a number of million dollar settlements.[5] It is not surprising, then, that in addition to an

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1. *See* TIME, July 15, 1974, at 78. *See generally Magnitude and Impact of the Medical Malpractice Problem*, in U.S. DEP'T OF HEALTH, EDUC. & WELFARE, MEDICAL MALPRACTICE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 5-20 (1973); Rudor, Muers & Mirabella, *Medical Malpractice Insurance Claims Files Closed in 1970*, in U.S. DEP'T OF HEALTH, EDUC. & WELFARE, APPENDIX, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 1-25 (1973).

HEREAFTER THE FOLLOWING CITATION WILL BE USED IN THIS REVIEW:

D. HARNEY, MEDICAL MALPRACTICE (1973) [hereinafter cited as HARNEY].

2. *See* TIME, *supra* note 1.

3. *See* Stetler, *History of Reported Medical Professional Liability Cases*, 30 TEMPLE L.Q. 367, 381 (1957).

4. *See* Niles v. City of San Rafael, No. 624,337 (San Francisco County Super. Ct., Feb. 5, 1973), *noted in* 16 AM. TRIAL LAWYERS ASS'N NEWSLETTER 65 (1973). In *Niles* a jury verdict was rendered against multiple defendants for alleged medical malpractice in connection with emergency room care. The total award was $4,025,000 to compensate for quadriplegic injuries to an eleven year old boy.

5. For instance, a recent malpractice case in which the fourteen year old patient reportedly suffered quadrispactity and blindness was settled for $2,001,000. *See*

acute public awareness of the malpractice potential inherent in the physician-patient relationship, we find a profound concern with medical malpractice among many sectors of the legal and medical communities. For the torts scholars and teachers, the dynamic developments in malpractice have infused the quiescent and sometimes stultified subject of tort law with perhaps its most excitement since the late Dean Prosser and others chronicled the fall of the fault- and privity-based citadel in products liability.[6] The practicing attorney, faced with the uncertainties of an unrelenting march toward no-fault, clearly greets medical malpractice as a liability-producing surrogate for the automobile accident case.[7] And numerous members of the medical profession, with their hard-won careers, prosperity, and repose threatened, entertain an almost obsessive presentiment over the increase in their malpractice exposure.

The interest of these groups is reflected in the wide variety of recent literature on medical malpractice.[8] Most treatises purport to address not only the practicing attorney, but also the legal scholar and physician. Consequently, many books, with varying degrees of success, have included sections embracing substantive law, practical guidance for trial counsel, and frequent reference to the medical occurrences most commonly implicated in medical malpractice. Nevertheless, most books appear to at least incline toward a particular group's perspective. The author of *Medical Malpractice*, Mr. David Harney, is a prominent plaintiffs' trial attorney. Therefore, one might expect to find the practical side of the subject stressed. However, in many respects Mr. Harney has striven to present an amalgam combining the significant features of books prepared by or primarily for the legal

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Weaver v. Tucson Medical Center, No. 133796 (Pima County, Arizona Super. Ct., Dec. 31, 1973), *noted in* 17 AM. TRIAL LAWYERS ASS'N NEWSLETTER 103 (1974).

6. *See* Prosser, *The Fall of the Citadel*, 50 MINN. L. REV. 791 (1966). *See generally* D. NOEL & J. PHILLIPPS, PRODUCTS LIABILITY IN A NUTSHELL (1974); W. PROSSER, LAW OF TORTS 641-82 (4th ed. 1971), and authorities cited therein.

7. Some, especially physicians and the liability insurance industry, might less charitably characterize the plaintiffs' medical malpractice case as simply another form of ambulance chasing with less indirection.

8. The reviewer's references to malpractice treatises have been limited to books published during the last twenty years, with emphasis on the more current volumes. This contemporary perspective reflects the fact that, both in terms of sheer numbers of appellate opinions as well as in their relative importance, the developments since the mid-fifties have rendered much of the prior literature dated, if not useless, as secondary authority. One need only recall that broad acceptance of the doctrine of informed consent is commonly regarded as commencing in 1960 with the case of Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093, *modified*, 187 Kan. 186, 354 P.2d 670 (1960). Other developments, such as the eclipse of the locality rule for standard of care and adoption of the discovery rule for statute of limitations purposes, are of even more recent vintage.

practitioner,[9] those of a more scholarly approach or useful as a research tool,[10] and treatises with a medical orientation as well.[11] Mr. Harney has succeeded rather well in dealing with those three aspects of medical

9. One of the best practical guides for practicing attorneys is L. CHARFOOS, THE MEDICAL MALPRACTICE CASE: A COMPLETE HANDBOOK (1974), though it contains little substantive law and is addressed mostly to plaintiffs. Another excellent volume is C. KRAMER, MEDICAL MALPRACTICE (1972). *See generally* C. CUSUMANO, MALPRACTICE LAW DISSECTED FOR QUICK GRASPING (1962); R. GOODMAN & L. GOLDSMITH, MODERN HOSPITAL LIABILITY—LAW AND TACTICS (1972); M. KIMMEL, LEGAL REMEDIES FOR MEDICAL ERRORS (2d ed. 1970); M. LEVINE, SURGICAL MALPRACTICE (1970) (presented in dialogue form with the author discussing various surgical malpractice possibilities with physicians); D. LOUISELL & H. WILLIAMS, THE PARENCHYMA OF LAW (1960); R. MORRIS & A. MORITZ, DOCTOR AND PATIENT AND THE LAW (5th ed. 1971) (a successor, in part, to the treatise of the same title originally written by Dr. Louis Regan); R. MORRIS & A. MORITZ, HANDBOOK OF LEGAL MEDICINE (3d ed. 1970) (a successor, in part, to the treatise of the same title originally written by Dr. Louis Regan and Dr. Alan Moritz); L. REGAN, DOCTOR AND PATIENT AND THE LAW (3d ed. 1956); L. REGAN & A. MORITZ, HANDBOOK OF LEGAL MEDICINE (1956); J. RICHARDSON, DOCTORS, LAWYERS AND THE COURTS (1965).

10. The two most encyclopedic treatises are HEALTH LAW CENTER, HOSPITAL LAW MANUAL (ATTORNEY'S SET) (G. Stroud ed. 1974) (2 volumes published by Aspen Systems Corporation, updated quarterly with a newsletter and supplement, dealing with hospital law and liability generally) and D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE (1973) (2 volumes updated with an annual supplement). *See generally* W. MEREDITH, MALPRACTICE LIABILITY OF DOCTORS AND HOSPITALS (1956) (concentrating on Canadian law); R. SLOVENKO, PSYCHIATRY AND LAW (1973). There are also a few casebooks which deal with the law and medicine generally. *See* W. CURRAN & E. SHAPIRO, LAW, MEDICINE AND FORENSIC SCIENCE (1970); D. SHARPE & M. HEAD, PROBLEMS IN FORENSIC MEDICINE (1966). Occasionally one also discovers a law review article that is so comprehensive in its treatment of medical malpractice that it deserves to be mentioned with some of the leading treatises. For example, the best, though in parts now somewhat dated, article on the standard of care of physicians is McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549 (1959).

11. Members of the medical profession have produced quite a few volumes on the subject of medical malpractice. One of the best in terms of both law and especially medicine is B. FICARRA, SURGICAL AND ALLIED MALPRACTICE (1968). Other general treatises with a medical orientation include R. LONG, THE PHYSICIAN AND THE LAW (3d ed. 1968), L. REGAN & A. MORITZ, *supra* note 9, E. SAGALL & B. REED, THE LAW AND CLINICAL MEDICINE (1970), B. SHARTEL & M. PLANT, THE LAW OF MEDICAL PRACTICE (1959) (written by law professors primarily for members of the medical profession), S. SHINDELL, THE LAW IN MEDICAL PRACTICE (1966), L. SIEGAL, FORENSIC MEDICINE (1963), and J. WALTZ & F. INBAU, MEDICAL JURISPRUDENCE (1971) (though recognized as primarily for medical students and physicians, its quality warrants broader appeal). There are also a number of books which address, *inter alia*, the medical malpractice problems of particular medical specialties or allied health professions. *See, e.g.*, S. DONALDSON, THE ROENTGENOLOGIST IN COURT (2d ed. 1954); HEALTH LAW CENTER, PROBLEMS IN HOSPITAL LAW (2d ed. 1974) (prepared primarily for hospital administrators); W. HOWARD & A. PARKS, CARNAHAN'S THE DENTIST AND THE LAW (2d ed. 1965); H. SARNER, DENTAL JURISPRUDENCE (1963); H. SARNER, THE NURSE AND THE LAW (1968); R. SLOVENKO, *supra* note 10; C. WASMUTH, ANESTHESIA AND THE LAW (1961); S. WILLIG, THE NURSES GUIDE TO THE LAW (1970); L. WOOD, A HANDBOOK OF DENTAL MALPRACTICE (1967).

malpractice when his undertaking as a whole is compared with those of others who have attempted similarly comprehensive tasks. On the other hand, the three components, when examined separately, produce a somewhat more mixed response, as one might guess, in the world of books where indeed the whole is usually greater than the sum of its parts.

EVALUATION OF *Medical Malpractice*

The Author's Restatement of the Law

The first eight chapters (encompassing 270 pages, or about half of the book) cover the decisional and statutory law of malpractice. The text is well researched and amply documented with concise, but not overly laconic, footnotes. The author touches the major bases, beginning traditionally with the physician-patient relationship and moving on to the consent cases, standard of care, causation, evidentiary matters including the expert witness requirements, vicarious liability, and the various malpractice defenses, appropriately emphasizing the statute of limitations, which is often a defendant's most successful means of defending a malpractice suit. The main utility of the substantive law portion of this book lies in its presentation of the black letter law and in its value as a good case-finding tool. The book lacks some of the perspicuousness found in parts of the works by other practitioners, such as Kramer's *Medical Malpractice*.[12] Yet this is more than offset by the thoroughness and, with one exception,[13] by the national scope of Mr. Harney's documentation.[14] By the same token, Mr. Harney falls short of the comprehensiveness of the encyclopedic two-volume Louisell and Williams set[15] and of *Hospital Law Manual*[16] published by Aspen. Yet, here again, there are countervailing advantages in

12. C. KRAMER, *supra* note 9.

13. Mr. Harney does not generally accord undue emphasis to the substantive law of any particular jurisdiction. One notable exception is the section on res ipsa loquitur, HARNEY § 4.3(A), which is essentially a restatement of the law of California. With classic cases like Ybarra v. Spangard, 25 Cal. 2d 486, 154 P.2d 687 (1944), California has led the way in the development of res ipsa in medical malpractice. However, a review, with illustrative cases, of the protean rules of res ipsa and circumstantial evidence in other jurisdictions would have been more in keeping with a book that purports to be national in its scope, notwithstanding the author's practical background in California law.

14. While Mr. Kramer's book contains an adequate statement of the law of malpractice generally, it relies upon an inordinate number of New York decisions which limits the appeal and to some extent the utility of his fine book.

15. D. LOUISELL & H. WILLIAMS, *supra* note 10.

16. HEALTH LAW CENTER, *supra* note 10. This reference work is addressed almost exclusively to problems of hospital law and liability.

the Harney book. Published recently, it displays good coherence in its treatment of the substantive law. The reader of the Louisell and Williams set will find, by contrast, increasing difficulty in bridging the gap between the basic text and the current supplement. Thus, the analytical superiority that the Louisell and Williams set once would have had over a much more black-letter-law-oriented book like Harney's has been seriously eroded. Furthermore, Louisell and Williams are at times sluggish and uncertain, which is certainly not the case with Mr. Harney. His simplicity of style and sense of significance evidences the value a trial lawyer's perspective can bring to the substantive law where the author is willing to invest the time.

Aside from its unembarrassed proffer of black letter law and its excellent case selection, the book does have limitations. It lacks persuasive force in its treatment of some difficult issues, aside from the usual imprimatur a text confers simply because it appears to be a well-documented book. Therefore, as a secondary source that must rely upon its persuasive force, the Harney book does not reach the level of some of the classic hornbook treatises in the Prosser tradition.[17] Basically, the problem seems to be one of too little analysis, and there is possibly some question as to objectivity. By way of caveat, the success of Mr. Harney's attempts "to be objective and two-sided in writing this book,"[18] is not entirely free from doubt. His resolutions of conflicts in the law on matters in a state of flux appear to favor the plaintiff-patient with predictable regularity. Thus, the author adopted the reasonable man standard rather than the reasonable physician standard to evaluate the adequacy of the doctor's disclosures of the risks of treatment;[19] he rejected the customary practice rule;[20] he urged the abandonment of the locality rules;[21] he urged strenuously for broad application of res ipsa loquitur;[22] he favored requiring less testimonial certainty to establish medical causation;[23] and he advocated the discovery doctrine for statute of limitations purposes.[24] It is true that until quite recently, the courts applied a number of doctrines which served to insulate the medical profession, to varying degrees, from malpractice liability. There are a number

17. W. PROSSER, *supra* note 6.
18. HARNEY iii.
19. *See id.* § 2.4(A).
20. *See id.* § 3.1(B).
21. *See id.* § 3.3.
22. *See id.* § 4.3(A), at 173.
23. *See id.* § 4.1, at 167-72.
24. *See id.* § 8.5, at 267-70.

of possible explanations for this tendency. The practice of medicine, as possibly no other, provides an indispensable service to the public. Furthermore, a physician-patient relationship is unique in that the association of the parties usually commences *after* the potential plaintiff has already been afflicted with an infirmity. Thus in the medical malpractice context, unlike most personal injury actions, the interface separating the physical condition of the plaintiff before and after the alleged tort is frequently obscured. This situation, coupled with the esoteric nature of medical science, presents obvious temptations to a jury to forsake its traditional role and go for the deep pocket. The validity, if any, of these observations and other factors underlying the development and subsequent partial abandonment of some of the purportedly physician-oriented rules of medical malpractice law might profitably have been explored by Mr. Harney.

To be sure, the author may have the support of some commentators and at least a respectable number of courts for many of his conclusions. Nevertheless, a more analytical and less conclusory approach would have been welcomed, especially in view of the plaintiff bias evident in the author's background.[25] For example, Mr. Harney allocates less than two pages to the complex issue of whether conformity to the customary practice should conclusively establish due care on the part of doctors. He rejects one prevailing view that it does, arguing summarily that the usual or customary practice may nevertheless be negligent.[26] Certainly this is true, and if that were the only consideration, there could be no controversy. However, there are at present perhaps a majority of courts which equate, in most instances, customary practice with good medical practice.[27] In such a setting, the author's con-

25. Mr. Harney's book has received at least the qualified endorsement of the *Defense Law Journal*, which recognizes that it is "plaintiff oriented" but nevertheless "comprehensive and well-documented." 23 DEFENSE L.J. (back cover, No. 4) (1974). It should perhaps be noted parenthetically that the Allen Smith Company is publisher of both the Harney volume and *Defense Law Journal*.

The comments in the accompanying text are not meant to imply that Mr. Harney's writing lacks clarity or vigor, which it certainly does not. In fact, in parts his shorthand style of describing a rule of law proves quite refreshing. For example, he describes the typical causation argument of defendant as the "so what" gambit—that is, so what if my client was negligent, the patient would have died, suffered disability or infection, etc., when he did in any event. HARNEY § 4.1, at 165.

26. *See* HARNEY § 3.1(B), at 90.

27. *See, e.g.*, 1 D. LOUISELL & H. WILLIAMS, *supra* note 10, ¶ 8.04; W. PROSSER, *supra* note 6, § 32, at 165; McCoid, *supra* note 10, at 609; Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147, 1163-67 (1942), and cases cited therein. For persuasive argument against the customary practice rule (which is useful to compare with the quality of the Harney analysis), see Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 741-47 (1970).

clusions would have been more credible and more plausible had he relied not only upon a few isolated malpractice cases but also upon the fact that the rule in negligence law *generally* lends support to his argument. There, compliance with the customary practice is usually merely *evidence* of due care; it is seldom conclusive.[28] What's more, in the name of evenhandedness, the author perhaps should have confronted and disposed of the arguments most often urged in support of the special treatment accorded physicians under the customary practice rule, namely, that the physician's professional education is often the emanation of customary practice, and therefore the doctor has a genuine reliance interest in the law's deference to the usual practice; and that absent the customary practice rule, how are juries to decide with any predictability issues of due care involving matters of professional judgment? One might also inquire what the effect of the Professional Standards Review Organization (PSRO) Amendments[29] to the Social Security Act[30] will be. This legislation includes a provision for civil immunity from suit by Medicare, Medicaid, and Maternal and Child Health Care patients where the attending physicians have complied, under somewhat vague circumstances,[31] with certain professionally-developed norms of care applied by a professional standard review organization.[32] In short, it would have behooved Mr. Harney to have at least fleshed out his arguments (which may, incidentally, ultimately hold sway) with more searching analysis.

In a few instances the recommendations of the author are not merely conclusory, but even precipitous. For example, in his discussion in Chapter 1 of the scope of a private hospital's duty to accept patients, Mr. Harney advocates the imposition of a duty to treat any individual requesting emergency care even where the patient had not

28. *See, e.g.*, W. PROSSER, *supra* note 6, § 33.

29. 42 U.S.C. § 1320c (Supp. II, 1972).

30. 42 U.S.C. §§ 301-1396(i) (1970).

31. The grant of immunity is clouded somewhat by the ambiguously worded qualification that the doctor must first have "exercised due care in all professional conduct taken or directed by him and reasonably related to, and resulting from, the actions taken in compliance with or reliance upon such professionally accepted norms of care and treatment." 42 U.S.C. § 1320c-16(c) (Supp. II, 1972). Depending on the construction the courts ultimately give to this language, it may simply create a presumption that the complying physician exercised due care in relying upon the prescribed standards, or it may actually immunize him from liability to the extent that the selection or administration of the treatment was in reliance upon the prescribed norms. *See* Note, *Federally Imposed Self-Regulation of Medical Practice: A Critique of the Professional Standards Review Organization*, 42 GEO. WASH. L. REV. 822, 838-42 (1974). *See generally* Comment, *PSRO: Malpractice Liability and the Impact of the Civil Immunity Clause*, 62 GEO. L.J. 1499 (1974).

32. See authorities cited in notes 29 & 31 *supra*.

relied on a past custom of the hospital to do so.[33] Presumably, this duty would apply even in the absence of special statutory provisions for reimbursement for the hospital's services to insolvent patients. Where such pervasive precepts in the law are espoused, one might have expected the author to weigh more of the implications. What of the surely enormous costs; who will pay? Do we really want medical personnel exercising their professional judgment against their will? Do we similarly prescribe an affirmative duty for all members of society to render emergency aid to those requesting it? Would the fact that emergency treatment was available without regard to ability to pay encourage the public to postpone preventive medical care until an emergency arises?

In another subsection of the book, Mr. Harney adopts a disquietingly one-dimensional attitude toward the practice of defensive medicine.[34] He concentrates on the possibility that the *in terrorem* effect of threatened liability might on occasion produce a greater measure of care by the profession,[35] whereas he fails completely to acknowledge the inflated costs[36] and potentially adverse medical results[37] of conducting more tests and medical procedures than are medically warranted.

There have been recent calls for a restatement of medico-legal principles that might be more universally acceptable throughout the

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33. HARNEY § 1.1(B), at 4.

34. The relation of malpractice suits to the practice of defensive medicine is discussed in *The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939.

35. *See* HARNEY § 3.1(D), at 92, *quoting* Fernandi v. Strully, 35 N.J. 434, 451, 173 A.2d 277, 286 (1961).

36. The Secretary's Commission on Medical Malpractice has recently described the inflationary effect of defensive medicine in the following terms:

> One of the most pervasive impacts of the medical malpractice problem arises out of what is commonly called "defensive medicine". . . .
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> Overutilization of health care facilities, particularly unnecessary hospital stays, is often cited as an especially abusive practice of defensive medicine, *one that could have a tremendous impact on the nation's health bills.* U.S. DEP'T OF HEALTH, EDUC. & WELFARE, MEDICAL MALPRACTICE, *supra* note 1, at 14-15 (emphasis added).

It should be noted that the recent PSRO Amendments to the Social Security Act were designed to reduce unnecessary medical utilization by providing a limited civil immunity which, it was hoped, would obviate the need for defensive medicine. See authorities cited in notes 29 & 31 *supra*.

37. The physiological dangers to the patient of defensive medicine are self-evident. For example, the potential danger of repeated exposures to X-rays during radiological examinations has been divined by the courts. *See, e.g.*, Favalora v. Aetna Cas. & Sur. Co., 144 So. 2d 544 (La. Ct. App. 1962). The heretofore unquestioned widespread use of X-ray therapy is also coming under increasing public scrutiny. *See Radiological Time Bomb*, TIME, Sept. 23, 1974, at 99.

United States.[38] While this book suffers in parts from sparse or hurried legal analysis and may inspire reservations about its overall objectivity, it nevertheless does constitute a meaningful contribution to a more nationally-targeted law of medical malpractice. Moreover, Mr. Harney's book is one of the most readable and extensive statements of the substantive law to date by a practicing attorney.

Handling Malpractice Cases—Practical Guidance

Chapter 10 (consisting of fifty-three pages) is devoted to the handling of a malpractice case for the plaintiff. About half of that space is consumed by sample procedural forms and a section which the author dubs "Examples of Strong Cases." The latter consists of a sampling of the gravamen (in a sentence or two) of forty or fifty malpractice cases. What remains is a scant thirty-odd pages to guide the lawyer in the management and trial of malpractice cases.

It almost seems that Mr. Harney ran short of time as he reached this last chapter. Some of the material pays short shrift to critical matters affecting litigation strategy and procedure. For instance, on the crucial question of "whom to sue," Mr. Harney simplistically suggests joinder of all individuals or entities which have contributed to the injury, but not of an individual if he is innocent of wrongdoing.[39] This perfunctory advice offers little meaningful succor to the untutored plaintiffs' attorney. It assumes a degree of omniscience on his part in the early stages of the case regarding the nature of the involvement of various potential defendants in the injury-producing transactions that is rarely borne out in reality. It also manifestly ignores crucial tactical considerations that may influence one's attitude toward joinder. These include the hastening effect that statutes of limitations, which are typically short in malpractice actions, have on the joinder decision; the fact that the testimony of named defendants will be regarded as "interested" and thus perhaps will be accorded less weight by the jury; and the fact that joinder may eliminate the possible argument that the real culprit (by his own admission after any action against him personally has become time-barred) is a non-party.[40]

There are also statements in the text which occasionally raise questions as to the quality of the synthesis between the law and practice

38. *See Summary of Recommendations,* in U.S. DEP'T OF HEALTH, EDUC. & WELFARE, MEDICAL MALPRACTICE, *supra* note 1, at xx.

39. *See* HARNEY § 10.11, at 369.

40. *See* C. KRAMER, *supra* note 9, at 39; M. LEVINE, *supra* note 9, at 405-06, *reprinted in* PRACTISING LAW INSTITUTE, NEW DEVELOPMENTS IN MEDICAL MALPRACTICE 172-73 (1970).

sections of the book. In his discussion of the substantive law of res ipsa loquitur, for example, Mr. Harney comments: "In the author's opinion, nowhere is the doctrine needed more than in the malpractice action. . . . The doctrine of res ipsa loquitur facilitates . . . proof [that defendant's acts caused the injury]."[41] Yet, later, in his discourse on jury instructions, he proclaims: "It has been the experience of the author that plaintiffs who rely on the res ipsa loquitur instruction without supporting proof have a dismal track record."[42]

Not all the practice materials are cursory and uncritical. Much advice, such as that rendered in the form of the author's firsthand experiences cross-examining his opponents' medical experts, is quite effective.[43] While Mr. Harney's practice materials do not match those of the outstanding Charfoos book,[44] they do fulfill a useful role in presenting to the inexperienced plaintiffs' attorney, in capsule form, a readable procedural anatomy of a medical malpractice case along with some useful insights.

Medical Discussion

While a physician certainly has an advantage over a layman in dealing with medical facts,[45] Mr. Harney nevertheless displays a competent grasp of medical information and technical matters and relates them well to malpractice in the legal context. His example may confirm the suspicion that in order to successfully try a malpractice case, counsel must know as much about the relevant medical issues as the expert witnesses do. Most of the medical materials will be informative and reassuring to the attorney facing the abyss of a new malpractice file. While most doctors will not discover anything new from the strictly medical standpoint, the medical facts cast in a legal perspective will aid the doctor in making the transference in his perception of the "medical act-legal liability" dualism. Moreover, Mr. Harney's conservative estimate of what a physician can do without incurring liability should at least not mislead physicians though it might exacerbate the defensive medicine syndrome for some.

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41. HARNEY § 4.3(A), at 173.

42. *Id.* § 10.26, at 407.

43. *Id.* § 10.25.

44. L. CHARFOOS, *supra* note 9. The Charfoos handbook is entertainingly written and offers a treasure of practical insights to the practicing plaintiffs' attorney. Moreover, it should similarly appeal to defense counsel if for no other reason than to remove some of the mystery from the subject of how plaintiff prepares his case. The book also provides worthwhile reading for the medical malpractice scholar, for whom the book offers a practical insight that cannot help but profitably stimulate the reader's subsequent legal perceptions regarding malpractice.

45. *See, e.g.*, B. FICARRA, *supra* note 11.

Some of the most useful medical information appears in Chapter 3 ("Standard of Care"), which discusses the specific medical and legal standards applicable to numerous medical procedures ranging from anesthesia and emergency room techniques to urinary catheterization.[46] The author also reviews some of the better medical and pharmaceutical texts.

The only major criticism of the medical discussion is a matter of structure. In three separate locations (in addition to the standard of care sections) the author gives brief summaries of typical malpractice situations, calling them "Common Medical Hazards";[47] "Examples of Strong Cases";[48] and, "40 Malpractice Examples."[49] The first of these—the materials in Chapter 9 ("Common Medical Hazards")—employs informative citations to cases and medical authorities and is the most valuable of the three discussions of typical acts that may constitute malpractice. The other two sections serve little useful purpose apart from filler. Here again, more care in collating is indicated. As a minimum, the divers catalogues of essentially the same material should have been consolidated.

The Appendices

It appears that as Mr. Harney progressed from front to rear in his book, the overall utility decreased concomitantly. This process culminates, with the exception of Appendix F, in the six remaining appendices.

The "Selected Good Samaritan Statutes" of Appendix A is comprised of thirty-eight statutes. A truly *selective* choice of representative statutes with citation to other identical or essentially similar statutes would have avoided senseless repetition.[50] Moreover, a grouping according to their characteristics would have afforded the reader a better opportunity to evaluate the state of the law in terms of numbers and identity of states adhering to a particular statutory configuration.

Appendices B and C are excerpted from a Senate Subcommittee report on medical malpractice,[51] which includes a letter[52] by Mr. Har-

46. *See* HARNEY § 3.9.

47. *Id.* §§ 9.1-.8.

48. *Id.* § 10.5.

49. *Id.* app. C, at 456-72.

50. For instance, in the first three pages of the Appendix identical sections from the Good Samaritan statutes of California, Delaware, and Kentucky are fully set forth. Mr. Harney is not alone in his penchant for statutory filler, which is also found in the Good Samaritan statutes quoted in 2 D. LOUISELL & H. WILLIAMS, *supra* note 10, ¶ 21.01.1-21.34.

51. SENATE SUBCOMM. ON EXECUTIVE REORGANIZATION, 91st Cong., 1st Sess., RE-

ney to that Committee. These items are somewhat dated[53] and are not meaningfully integrated into the book. They could safely have been omitted or at least heroically pruned.

Appendices D and E are sample interrogatories prepared for use by plaintiffs and defendants respectively. These are probably helpful to the novice. It is not apparent (other than on the basis of length) why some forms were consigned to the Appendices and others included within the body of the book. Nor is it evident why Mr. Harney chose to throw in a single form used by defendants in this apparently plaintiff-oriented book, unless of course his object was to condition plaintiffs for the usual pre-trial procedural onslaught from the opposition. Even so, a single set of interrogatories hardly achieves that end.

Appendix F is somewhat unique in books on malpractice. It contains annotated samples of professional liability insurance policies for physicians and dentists, as well as for hospitals. This makes worthwhile reading for the lawyer who expects to be counseling medical personnel. This Appendix also contains citations to a number of authorities that are of mutual interest to both plaintiffs and defendants.[54] The subject of liability insurance has been one area sadly neglected in treatises on medical malpractice. This omission is especially remarkable in view of the critical role that insurance plays in the immediate loss shifting of the instant case as well as in the long term policy considerations that affect the development of the substantive law. Mr. Harney has taken a notable first step toward filling this yawning need for an examination of the function of the insurance carrier in medical malpractice litigation.

Appendix G is a partial trial transcript and was included to illustrate the techniques used in a plaintiff's examination of a defendant-physician as an adverse witness. The transcript affords entertaining reading, especially for those with little courtroom experience. Yet

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PORT TO COMM. ON GOVERNMENT OPERATIONS, MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN, 1-13, 25-39 (Comm. Print 1969).

52. *Id.* at 25-39.

53. The Harney letter was written (July 12, 1969) nearly four years prior to the preface of his book.

54. *See, e.g.*, HARNEY app. F, at 502-03, *discussing* L'Orange v. Medical Proteetive Co., 394 F.2d 57 (6th Cir. 1968) (holding that it would be against public policy and a breach of contract for a carrier to cancel a dentist's malpractice coverage following his testimony in a malpractice action involving another dentist covered by insurance issued by the same company). One also finds informative citations bearing on the issue of the existence of insurance coverage in partieular circumstances. The importance of the presence or absence of liability insurance to plaintiff's trial strategy as well as the prospects of an amicable settlement cannot be gainsaid.

on balance, the twenty-odd pages it consumes could, like most of the space absorbed by the appendices, have been more beneficially allocated to more detail and analysis in the substantive portions of the book and to a significant expansion of the thirty or so pages on the handling of a plaintiff's malpractice case.

CONCLUSION

Mr. Harney has produced a worthy first effort at creating a single all purpose volume for the plaintiffs' practitioner. It combines substantive law, a sense of the practical realities of litigation, and useful medical information. While there are current works which probably surpass the Harney book on each count, his is one of the best of the recent literature which attempts to cover all the facets. His composite score, then, compares favorably with anything of similar scope that is currently available. Harney's *Medical Malpractice* is a recommended addition to the practitioner's library, is worthwhile reading for members of the medical profession, and is a fairly useful starting point and case-finding tool for the malpractice researcher.