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Common Knowledge In Medical Malpractice Litigation: A Diagnosis and Prescription

ROBERT DAHLQUIST*

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I. INTRODUCTION

For well over two centuries, the law has exalted the "reasonable man of ordinary prudence," a purely mythical person who never acts or fails to act without an appropriate measure of prudence and caution.¹ Indeed, the law has required all persons to either conform to the standards of conduct exhibited by this fictitious reasonable person or pay for the damages resulting from the failure to so conform. This requirement of conforming to the standards of the "reasonable man" has provided an amazingly stable foundation on which much of the law of torts has been built.

The "reasonable man of ordinary prudence" concept has served its function well in the all too common situations where someone is injured because another person fails to look where he is going, fails to maintain his property, or otherwise acts without prudence and caution in the ordinary course of events. In the ever-expanding and complex field of medicine, however, defining the attributes of a "reasonable physician" has become increasingly difficult. Determining whether a particular act by a physician breaches the standards of a reasonable physician is often a difficult question even for those trained in medicine.

Because lay juries are not trained in determining how a reasonable person in a technical field, such as medicine, would act, the law has generally required plaintiffs in medical malpractice actions to produce expert medical testimony to establish the standard of care by which a defendant-doctor's conduct may be measured.² Thus, a plaintiff must

1. Professor Prosser attributes the origin of the "reasonable man of ordinary prudence" to *Vaughan v. Menlove*, 3 Bing. N.C. 468, 132 Eng. Rep. 490 (1738). W. PROSSER, *THE LAW OF TORTS* 150 n.16 (4th ed. 1971).

2. A thorough discussion of the general requirement of producing expert testimony on technical, scientific and medical matters and the problems arising therefrom is found in Morris, *The Role of Expert Testimony in the Trial of Negligence Issues*, 26 TEX. L. REV. 1 (1947). The cases applying the general requirement to medical negligence claims are collected in Annot., 40

establish by expert testimony what standards or procedures a reasonable physician under the circumstances would follow. If a plaintiff fails to produce such testimony, he will have failed to establish a *prima facie* case and the action will be dismissed.

The general rule requiring expert testimony in medical malpractice cases to establish the applicable standard of care is extremely harsh in those cases where the plaintiff's alleged injuries have resulted from conduct that would be expected to fall within the sphere of knowledge common to lay persons. Additional objections to the rule arise where institutional restraints limit the availability of experts to testify. The inequities that would result from a blind and absolute application of the expert testimony requirement in medical malpractice cases has resulted in the so-called "common knowledge" exception to the requirement: "[w]here the matter is regarded as within the common knowledge of laymen, as where the surgeon saws off the wrong leg, or there is injury to a part of the body not within the operative field, it has been held that the jury may infer negligence without the aid of an expert."³ This "common knowledge" exception to the general rule requiring expert testimony establishing the standard of care is simply a common sense recognition that there may be cases that so blatantly deviate from the expected standard of conduct that establishment of the precise standard by expert testimony is unnecessary.

While there has been little dispute over the theoretical basis for the use of common knowledge in medical malpractice actions, an ever-increasing sphere of judicially recognized "common knowledge"⁴ raises

A.L.R.3d 515 (1971) (claims against hospitals) and Annot., 81 A.L.R.2d 597 (1962) (claims against physicians). For a representative sample of such cases, see, e.g., *Phillips v. Stillwell*, 55 Ariz. 147, 99 P.2d 104 (1940); *Sinz v. Owens*, 33 Cal.2d 749, 205 P.2d 3 (1949); *Chubb v. Holmes*, 111 Conn. 482, 150 A. 516 (1930); *Hogmire v. Voita*, 319 Ill. App. 644, 49 N.E.2d 811 (1943); *Treptau v. Behrens Spa, Inc.*, 247 Wis. 438, 20 N.W.2d 108 (1945) cited in Comment, *Medical Malpractice—Expert Testimony*, 60 Nw. U.L. REV. 834, 834 n.1 (1966).

3. PROSSER, *supra* note 1, at 164-65 (footnotes omitted).

4. See D. LOUISELL & H. WILLIAMS, TRIAL OF MEDICAL MALPRACTICE CASES §14.02 (1977 & 1979 Supp.). See also *infra* notes 47-59 and accompanying text.

The use of radiation in medical treatment is a good example of the expanding realm of common knowledge. Early cases involving radiation treatment held that such treatments were outside the scope of common knowledge. This early approach is typified by *Dietze v. King*, 184 F. Supp. 944, 946 (E.D. Va. 1960), wherein the court stated that "[t]he standard for the measure of skill exercised by the physician or surgeon [in the use of x-ray treatment] should not . . . be left to the whim or caprice of a jury, or trier of fact upon non-expert evidence." In *Dietze*, the court took notice of the fact that "in the treatment of cancer and other diseases it is often necessary to use x-ray extensively" and asserted that haphazard application of the common knowledge rule or the *res ipsa loquitur* doctrine in this context "would do violence to the medical profession and subject practitioners to a handicap too hazardous to carry." 184 F. Supp. at 946. Before too long, however, the tide shifted and courts began to hold that injuries resulting from radiation treatment were within the sphere of common knowledge. For example, in *ZeBarth v. Swedish Medical Center*, 81 Wash.2d 11, 499 P.2d 1, (1972), the court held that "high voltage radiation in the treatment of cancer has been widely enough and long enough employed in this country to allow

important questions about the limits of the doctrine.⁵ Moreover, in recent years, the use of common knowledge in medical malpractice actions has become intertwined inextricably with an expanded use of *res ipsa loquitur*,⁶ which allows the finder of fact in a negligence action to infer or presume negligence from the mere fact of injury.⁷ The marriage of these two doctrines further warrants a review of both their underlying justifications and their proper application to specific cases.

This article will examine the justifications for the use of common knowledge in medical malpractice litigation, its relationship to the *res ipsa loquitur* doctrine, and the joint application of the common knowledge and *res ipsa loquitur* doctrines. After concluding that the doctrines are inadequate tools for remedying a perceived wall of silence within the medical profession and that they have been improperly applied, the article will propose methods of dealing directly with the wall of silence while retaining consistent and logical use of common knowledge in medical malpractice litigation.

II. JUSTIFICATIONS FOR THE USE OF COMMON KNOWLEDGE IN MEDICAL MALPRACTICE LITIGATION

There appear to be two separate and distinct strands of analysis that are advanced to justify a retreat from the usual burden placed on medical malpractice plaintiffs in establishing the applicable standard of care by expert testimony. The first strand of analysis involves what I would label "the blatant blunder cases": cases in which lay judges and juries are allowed to weigh the propriety and skill of a doctor without the assistance of expert testimony because of blatant blunders in the rendering of medical care. Cases in which a medical practitioner "treats"

the jury to find that, within the experience and observation of mankind, myelopathy or paralysis ordinarily will not result from its use" 81 Wash 2d at 20, 499 P.2d at 7.

5. For a highly critical review of some of the cases expanding the use of common knowledge in medical malpractice actions, see Rubsamen, *Res Ipsa Loquitur in California Medical Malpractice Law—Expanding a Doctrine to the Bursting Point*, 14 STAN. L. REV. 251 (1962).

6. *Res ipsa loquitur*, which means "the thing speaks for itself," first appeared in *Byrne v. Boadle*, 2 H. & C. 722, 159 Eng. Rep. 299 (1863). In that case, a pedestrian was struck and injured by a barrel of flour that fell out of a warehouse window. In the pedestrian's action against the warehouse owner, the court held that "[a] presumption of negligence can arise from the occurrence of the accident itself." 2 H. & C. at 728; 159 Eng. Rep. at 301. Modern cases generally apply the doctrine if three conditions are met: (1) the event that resulted in the injury must be of a type that ordinarily does not occur in the absence of someone's negligence; (2) the event must be caused by an agency or instrumentality of the defendant; and (3) the event must not have occurred because of any voluntary action of the plaintiff. PROSSER, *supra* note 1, at 214.

7. Professor Prosser notes that modern common knowledge cases "usually involve the doctrine of *res ipsa loquitur*." PROSSER, *supra* note 1, at 165 n.62. See also King, *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 VAND. L. REV. 1213, 1257-1261 (1975) ("The common knowledge principle finds its widest application in conjunction with the doctrine of *res ipsa loquitur*, which is based upon an assumption that the negligence may be circumstantially inferred from the nature of the resulting injury.")

the wrong part of a patient's body⁸ or in which a foreign object is left in a patient's body after surgery⁹ are the classic examples of such cases.

The second strand of analysis in the common knowledge cases relies on policy justifications that support a relaxation of the general rule necessitating expert testimony to establish the standard of care in all technical and scientific matters. The most frequently cited policy justification is the reluctance of doctors to testify against each other in malpractice actions.¹⁰ Because of this often noted reluctance, courts and commentators have argued that the requirement of producing expert testimony on medical matters places a nearly insurmountable obstacle in the path of most would-be malpractice plaintiffs.¹¹ There have also been references to other institutional barriers, such as the traditional locality rule,¹² that combine to exacerbate the problem of obtaining competent and qualified expert medical witnesses. Because the two strands of analysis in common knowledge cases are fundamentally different, a separate evaluation of each is merited.

A. Blatant Blunders

The simplest cases for application of the common knowledge rule are those cases where extreme departures from accepted medical practices, as understood by the community at large, are known, alleged and

8. See, e.g., *Steinke v. Bell*, 32 N.J.Super. 67, 107 A.2d 825 (1954) (dentist pulls the wrong tooth).

9. See, e.g., *Leonard v. Watsonville Community Hospital*, 47 Cal.2d 509, 305 P.2d 36 (1956) (clamp left in abdomen after operation); *Jefferson v. U.S.*, 77 F. Supp. 706 (1948) (towel left in abdomen after operation); *Ales v. Ryan*, 8 Cal.2d 82, 64 P.2d 409 (1936) (sponge left in abdomen after operation).

10. See, e.g., *Halldin v. Peterson*, 39 Wis.2d 668, 159 N.W.2d 738 (1968); *Morgan v. Rosenberg*, 370 S.W.2d 685 (Mo. 1963); *Salgo v. Leland Stanford Univ.*, 154 Cal.App.2d 560, 317 P.2d 170 (1957); *Simon v. Freidrich*, 163 Misc. 112, 296 N.Y.S. 367 (1937). For a review of the commentary on the subject, see Kayajanian, *Confronting the Conspiracy of Silence: We Have a Tiger by the Tail*, 6 U. WEST. L.A. L. REV. 40 (1974); Kelner, *The Silent Doctors—The Conspiracy of Silence*, 5 U. RICH. L. REV. 119 (1970); Comment, *Medical Malpractice—The "Locality Rule" and the "Conspiracy of Silence"*, 22 S.C.L. REV. 810 (1970); Seidelson, *Medical Malpractice Cases and the Reluctant Expert*, 16 CATH. U.L. REV. 158 (1966); Note, *Malpractice and Medical Testimony*, 77 HARV. L. REV. 333 (1963); Note, *Overcoming the "Conspiracy of Silence": Statutory and Common-law Innovations*, 45 MINN. L. REV. 1019 (1961). The traditional reluctance of medical professionals to testify against each other was first indicted as a "conspiracy" by Melvin Belli in his stinging criticism of medical malpractice law, Belli, *An Ancient Therapy Still Applied: The Silent Medical Treatment*, 1 VILL. L. REV. 250 (1956).

11. The earliest and most vocal criticism of medical doctors' unwillingness to testify in malpractice actions came from judicial "champions of plaintiff's rights," see, e.g., *Clark v. Gibbons*, 66 Cal.2d 399, 416 n.3, 426 P.2d 525, 537, 58 Cal. Rptr. 125, 137 (1967) (Tobriner, J., concurring); *Demchuk v. Bralow*, 404 Pa. 100, 107, 170 A.2d 868, 872 (1961) (Musmanno, J., dissenting) cited in King, *supra* note 7, at 1257 n.178; and from the plaintiff's bar, see, e.g., Belli, *supra* note 10, Belli, *Ready for the Plaintiff*, 30 TEMPLE L.Q. 408 (1957).

12. The "locality rule," now abandoned or relaxed in most jurisdictions, required "that a medical witness, in order to qualify as an expert, [had to] be a practicing physician in the same community as the defendant." Note, *Malpractice and Medical Testimony*, 77 HARV. L. REV. 333, 338 (1963) (footnote omitted). This rule is discussed more fully in the text and notes at *infra* notes 72-75.

proven. In such cases, it is still admitted that a lay jury would not know the precise standard of care required by a reasonable physician under the circumstances; but some actions are deemed to be so far from any acceptable standard of care that the jury's ignorance of the precise standard is not relevant. Therefore, lay juries have "common knowledge" that an extreme departure has occurred, but do not have "common knowledge" of the procedures or standards that would be employed by a reasonable physician.

A good example of this type of case is *Jefferson v. United States*.¹³ In that case, the plaintiff alleged and proved that prior to being released from military service he underwent an abdominal operation for gall bladder trouble in a government hospital at Fort Belvoir, Virginia. The plaintiff further alleged and proved that the operation was performed by an Army medical officer. Some eight months later, after complaining of severe abdominal pain, the plaintiff underwent another abdominal operation performed by a civilian doctor. In the course of the second operation, the doctor discovered a towel "in the lower part of the plaintiff's stomach which had partly worked into the duodenum."¹⁴ The civilian doctor removed the towel, which was 30 inches long by 18 inches wide and bore the inscription "Medical Department U.S. Army." In deciding the plaintiff's malpractice claim against the first doctor and the government, the court recognized the theoretical possibility that the plaintiff had swallowed the towel¹⁵ but nonetheless had little difficulty in finding that the towel must have been placed in the plaintiff's abdomen at the time of the first operation and that the failure to remove it constituted negligence.¹⁶

Cases such as *Jefferson*, where a foreign object is alleged to have been left in the patient's body during surgery, constitute the most widely recognized category of common knowledge cases. Judges and juries in these cases are able to decide the negligence issue without the assistance of expert testimony because it is assumed that everyone knows "it is not the practice in the community for competent surgeons to leave a sponge [or other foreign object] in the operative wound following an open operation."¹⁷

In addition to the cases involving foreign objects left in a patient's body, several other categories of "blatant blunders" have developed.

13. 77 F. Supp. 706.

14. *Id.* at 709.

15. *Id.*

16. *Id.* at 710. However, the court went on to hold that the injury to the plaintiff was a "service-connected disability," and therefore not actionable under the Federal Tort Claims Act. *Id.* at 711.

17. *Dietze v. King*, 184 F. Supp. 944, 947 (E.D. Va. 1960).

For example, cases in which the doctor treats the wrong part of the body,¹⁸ and cases in which a fairly harmless instrument causes an obvious injury, such as a hot water bottle causing a serious burn,¹⁹ have been held to be within the common knowledge exception to the requirement of producing expert medical testimony. These cases have been accepted for the same reasons as the "foreign objects" cases; there are some acts that appear so obviously contrary to a general understanding of common aspects of medical treatment that a layperson can pass judgment on them without expert testimony.²⁰

The important characteristic of these so-called "blatant blunder" cases is that they involve known, alleged and proven acts that appear to fall so far below any acceptable standard of care that it is unnecessary to require expert testimony to establish the precise standard of care. In these cases, common knowledge is allowed to establish a deviation from the standard of care while direct proof is used to show the acts constituting the deviation. Because there is direct proof of negligence in these cases, they differ from *res ipsa loquitur* cases, where negligence is inferred or presumed from the simple fact of injury.

Nearly everyone would agree that there is good reason to deviate from the general rule requiring expert medical testimony in these blatant blunder cases. As a matter of theory, expert testimony is necessary only to the extent that a jury is uninformed of the proper standard of care and since a jury has some general understanding of the standard in these cases, expert testimony is not necessary. As a practical matter, it would be extremely inefficient to require expert testimony on some questions, such as whether it is good medical practice to leave equipment inside a body after an operation. Although there are lines to be drawn, the common knowledge doctrine, as based on blatant blunder cases, is a justified and workable exception to the general rule requiring expert testimony in all technical and medical matters.

B. The Conspiracy of Silence

1. *Common knowledge cases.* Aside from the cases involving blatant blunders in medical treatment, there are numerous cases and considerable commentary that focus on policy factors supporting

18. See, e.g., *Steinke v. Bell*, 32 N.J.Super. 67, 107 A.2d 825 (1954) (dentist pulls the wrong tooth).

19. See, e.g., *Trimbrell v. Suburban Hospital*, 4 Cal.2d 68, 47 P.2d 737 (1935) (Patient burned while unconscious); *Vonault v. O'Rourke*, 97 Mont. 92, 33 P.2d 535 (1934) (patient burned during operation).

20. See, e.g., *Waynick v. Reardon*, 236 N.C. 116, 72 S.E.2d 4 (1952) (performance of operation without complete biopsy or diagnosis); *Wilson v. Martin Memorial Hospital, Inc.*, 232 N.C. 362, 61 S.E.2d 102 (1950) (failure to examine stitches after delivery of child despite patient's complaints of pain).

relaxation for the general rule requiring expert testimony in technical and medical matters. The primary focus in the cases and commentary has been on the reluctance of doctors to testify for medical malpractice plaintiffs.²¹ Both the cases and the commentary recognize that a malpractice plaintiff's inability to procure a competent and qualified doctor to testify will effectively bar the door to the courthouse for the majority of malpractice claims.

One of the earliest and most powerful indictments of the so-called "conspiracy of silence" among medical doctors was made by Melvin Belli.²² Belli's analysis of the medical profession's "conspiracy" consists mostly of first hand experiences. He recites a case in San Francisco involving a "drunken doctor" who failed to recognize classic symptoms of appendicitis and allowed the patient's appendix to burst. Despite all efforts, Belli "couldn't persuade a single one of this drunken doctor's colleagues to testify to the obvious in court."²³ In fact, according to Belli, "[f]ive doctors testified in [the doctor's] behalf."²⁴ Belli also refers to a medical malpractice case for which "in the whole state of Nevada" he "could not find one single doctor who dared testify against the operating surgeon."²⁵ Claims such as these may have motivated one would-be malpractice plaintiff's unsuccessful suit against a California medical society alleging a conspiracy to deprive her of the expert medical testimony necessary to sustain her malpractice action.²⁶

Of course, the conspiracy of silence claim is not entirely one-sided. It is not altogether clear that medical malpractice plaintiffs are still confronted with all the difficulties in obtaining expert witnesses as Belli and others have asserted.

Although competent expert witnesses may have been difficult to come by thirty years ago when Belli's stinging critique was written, changing attitudes and various reforms have made obtaining necessary expert testimony much less difficult.²⁷ Today's lawyer need only pick up any issue of the American Bar Association Journal to find access to

21. See the cases and commentary cited in *supra* note 10.

22. Belli, *supra* note 11.

23. *Id.* at 409-410.

24. *Id.*

25. *Id.* at 413.

26. See *Agnew v. Parks*, 172 Cal.App.2d 756, 343 P.2d 118 (1959).

27. See Leonard, *Medical Negligence: Perspective on the Coming Decade*, 16 FORUM, 403, 403 (1981) ("The last two decades have seen a strong trend toward liberalization and/or erosion of any rules which would exclude and/or preclude witnesses from offering testimony to establish appropriate standards of medical practice and deviations from those standards."); Vogel & Delgado, *To Tell the Truth: Physicians' Duty to Disclose Medical Mistakes*, 28 U.C.L.A. L. REV., 52, 52 (1980) [hereinafter referred to as Vogel] ("Developments in tort theory and practice, including the establishment of national standards for specialists, the creation of common knowledge exceptions, and the use of *res ipsa loquitur*, have done much to overcome the 'wall of silence' that once made medical malpractice actions such high-risk, low-gain efforts.").

"450 Board Certified physicians in all specialties, nationwide" that are available, and even "guaranteed for meritorious cases," for medical malpractice cases.²⁸

The debate over the asserted difficulty in obtaining competent medical witnesses cannot be settled here. It is sufficient for purposes of analyzing the common knowledge doctrine in medical malpractice litigation to note that the asserted existence of a conspiracy of silence remains a strong policy justification for a liberal application of the common knowledge doctrine.

2. *Joint application of common knowledge and res ipsa loquitur.* The common knowledge doctrine "finds its widest application in conjunction with the doctrine of *res ipsa loquitur*" ²⁹ *Res ipsa loquitur* allows a trier of fact in certain circumstances³⁰ to infer from the mere fact of injury that the person who controlled the instrumentality of injury was negligent.³¹ Joint application of common knowledge and *res ipsa loquitur*, therefore, allows a jury to infer negligence from an injury purely on the basis of its common knowledge.

It is increasingly common for cases involving joint applications of common knowledge and *res ipsa loquitur* to rely upon the so-called conspiracy of silence. In the leading case of *Ybarra v. Spangard*,³² for example, there are applications of both the common knowledge and *res ipsa loquitur* doctrines based upon the conspiracy of silence notion. In that case, the patient-plaintiff discovered injuries to his shoulder after undergoing an appendectomy and brought an action against the nurses and doctors who participated in the operation and against the hospital where it had been performed. The court, using a typical common

28. 68 A.B.A. J. 373 (1982). Similar advertisements can be found in numerous legal journals and periodicals. See, e.g., 4 NAT. L.J. No. 30 p. 30 (April 5, 1982).

29. King, *supra* note 7, at 1258.

30. *Res Ipsa Loquitur* will generally be applied only if three conditions are met: (1) the event that resulted in the injury must be of a type that ordinarily does not occur in the absence of someone's negligence; (2) the event must be caused by an agency or instrumentality of the defendant; and (3) the event must not have occurred because of any voluntary action of the plaintiff. PROSSER, *supra* note 1, at 217; see also Comment, *The Application of Res Ipsa Loquitur in Medical Malpractice Cases*, 60 NW. U.L. REV. 852 (1966).

31. The procedural result of the application of the *res ipsa loquitur* doctrine varies from jurisdiction to jurisdiction. In most jurisdictions, the doctrine creates an inference of negligence; in others, it gives rise to a presumption of negligence that must be rebutted by the defendant. See Comment, *Res Ipsa Loquitur: Its Place in Medical Malpractice Litigation*, 8 U.S.F.L. REV. 343, 356-361; Comment, *Res Ipsa Loquitur: A Case For Flexibility in Medical Malpractice*, 16 WAYNE L. REV. 1136, 1146-1151 (1970).

Several jurisdictions have enacted statutes that define or limit the situations in which *res ipsa loquitur* may be applied to medical malpractice claims. See NEV. REV. STAT. §41A.100; TENN. CODE ANN. §29-26-115.

32. 25 Cal.2d 486, 154 P.2d 687 (1944).

knowledge approach, had little difficulty in finding a breach of the standard of care:

We have here [a] problem . . . of distinct injury to a healthy part of the body not the subject of treatment, nor within the area covered by the operation. The decisions of this state make it clear that such circumstances raise the inference of negligence, and call upon the defendant to explain the unusual result³³

As for the application of *res ipsa loquitur*, the defendants argued that *res ipsa loquitur* could not be applied because the plaintiff was unable to produce proof as to the cause of injury or that the instrumentality of injury was under the exclusive control of one or more of the defendants. The court rejected the defendant's argument, stating that it would be "manifestly unreasonable for them to insist that [the plaintiff] identify any one of them as the person who did the alleged negligent act."³⁴ The court expressly indicated its unwillingness to protect the defendants in their silence and required each of them to either "meet the inference of negligence by giving an explanation of their conduct" or be held liable for the plaintiff's injuries.³⁵ Thus, the *Ybarra* court essentially allowed common knowledge to establish the applicable standard of care and then allowed *res ipsa loquitur* to create an inference that the defendants breached the standard.

Although many recent cases involve both the common knowledge doctrine and *res ipsa loquitur*, it is important to recognize that there are differences in the two doctrines. The common knowledge cases "differ from standard *res ipsa loquitur* cases because they involve known, alleged, and proven omission[s]"³⁶ while *res ipsa loquitur* cases permit an inference of negligence from the simple fact of injury.³⁷ Common knowledge cases allow an inference as to the standard of care but require proof of a breach of that standard. *Res ipsa loquitur* cases generally require proof of the standard of care but allow a breach of the established standard of care to be inferred by the fact of injury. The combined use of these two doctrines allows the jury to establish the standard of care by their common knowledge and infer a breach of that standard from the simple fact of injury.

33. *Id.* at 491, 154 P.2d at 690.

34. *Id.*

35. *Id.* at 494, 154 P.2d at 691.

36. Note, *supra* note 12, at 346.

37. See, e.g., *ZeBarth v. Swedish Medical Center*, 81 Wash.2d 11, 499 P.2d 1 (1972); *Zentz v. Coca Cola Bottling Co.*, 39 Cal.2d 436, 446, 247 P.2d 344, 349 (1952) ("[A]s a general rule, *res ipsa loquitur* applies where . . . it can be said, in light of past experience, that [the injury] was the result of negligence by someone and that the defendant is probably the person who is responsible.").

III. PROBLEMS IN THE APPLICATION OF COMMON KNOWLEDGE AND *RES IPSA LOQUITUR*

The common knowledge doctrine has traditionally been applied in medical malpractice litigation only where the events in question involve "medical and surgical errors on which any layman is competent to pass judgment"³⁸ Under this analysis, common law development has resulted in certain classes of cases being declared subject to the common knowledge and experience of the lay public—i.e., those cases where "objects [are] left in the patient's body at the time of surgery and the removal of the wrong part of the body."³⁹ Similarly, *res ipsa loquitur* has traditionally been applied only where three conditions are met: 1) the event that resulted in the injury must be of a type that ordinarily does not occur in the absence of someone's negligence; 2) the event must be caused by an agency or instrumentality of the defendant; and 3) the event must not have occurred because of any voluntary action of the plaintiff.⁴⁰

Many modern courts, however, have not felt bound by the traditional rules governing common knowledge and *res ipsa loquitur*. There has been an "increased judicial receptivity toward" the doctrines,⁴¹ with many recent cases holding that "lay common knowledge may be utilized to satisfy the first requirement of *res ipsa*"⁴² Indeed, it is generally conceded that the number and types of medical malpractice cases applying either the common knowledge doctrine or *res ipsa loquitur*, or both, has multiplied over the last several decades.⁴³ Some commentators have praised the perceived expansions of the doctrines,⁴⁴ while others have been decidedly critical.⁴⁵ One commentator has gone so far as to suggest that the expansion of the doctrines by California courts has essentially moved the medical profession into the realm of

38. PROSSER, *supra* note 1, at 227.

39. Note, *Res Ipsa Loquitur in California Medical Malpractice Law*, 18 HASTINGS L.J. 691, 693 (1967).

40. PROSSER, *supra* note 1, at 217.

41. Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 51, 71 (1977).

42. Note, *supra* note 39, at 693.

43. See C. GREGORY, H. KALVEN & R. EPSTEIN, CASES AND MATERIALS ON TORTS 244 (3rd ed. 1977) ("The doctrine of *res ipsa loquitur* has also been extended in recent years to actions against multiple defendants sued under different substantive theories."); Meisel, *supra* note 41, at 70 ("Because expert medical testimony is generally a prerequisite to the establishment of the defendant's negligence, a number of jurisdictions have refused to apply *res ipsa loquitur*. However, the overall trend has been toward liberalization of the conditions under which it may be invoked by a medical-accident victim."); King, *supra* note 7, at 1258 ("In recent years a tendency has developed to enlarge the scope of the common knowledge exception to reach ever more complex factual situations.").

44. See, e.g., Vogel, *supra* note 2.

45. See, e.g., Rubsamen, *supra* note 5; Meisel, *supra* note 41.

strict liability.⁴⁶ A review of the modern applications of the common knowledge doctrine, both by itself and in conjunction with *res ipsa loquitur*, reveals two major problems: an unjustified reliance on the so-called "conspiracy of silence" and a failure to distinguish between negligence that falls within the scope of common knowledge and uncommon injuries.

A. *The Unjustified Reliance on the Conspiracy of Silence*

The unavailability, or limited availability, of expert medical testimony has often been advanced as a reason for applying the common knowledge doctrine or *res ipsa loquitur* in individual cases. And, in many instances, these "legal doctrines have been expanded to allow a plaintiff to prove malpractice without [expert] testimony"⁴⁷ because of the unavailability of expert testimony.⁴⁸ As a factual matter, it could be—and has been—debated whether it is difficult for medical malpractice plaintiffs to obtain competent expert witnesses.⁴⁹ It seems, however, that whether there are significant barriers to obtaining expert medical testimony is essentially a question of fact; it is a question of the type that courts are quite competent to address. Therefore, if courts are asserting and finding that medical malpractice plaintiffs have difficulty in locating competent expert witnesses to testify in their behalf, it may be assumed for purposes of analysis that these assertions are true.

But even assuming that significant barriers to obtaining adequate expert testimony exist, it is nonetheless illogical and unreasonable to deal with the barriers by acting as if a myriad of medical procedures and techniques are within the common knowledge and experience of lay persons. Just because a medical malpractice plaintiff has difficulty in obtaining expert testimony does not mean that lay juries have common knowledge to deal with the issues arising from paralysis after receiving

46. See Adamson, *Medical Malpractice, Misuse of Malpractice Res Ipsa Loquitur*, 46 MINN. L. REV. 1043 (1962).

47. Kroll, *The Etiology, Pulse, and Prognosis of Medical Malpractice*, 8 SUFFOLK U.L. REV. 598, 610 (1974).

48. See, e.g., *Salgo v. Stanford Univ.*, 154 Cal. App.2d 560, 568, 317 P.2d 170, 175 (1957), wherein the court noted:

[G]radually the courts awoke to the so-called "conspiracy of silence." No matter how lacking in skill or how negligent the medical man might be, it was almost impossible to get other medical men to testify adversely to him in litigation based on his alleged negligence. Not only would the guilty person thereby escape from civil liability for the wrong he had done, but his professional colleagues would take no steps to insure that the same results would not again occur at his hands.

49. The ever-increasing mass of cases and commentary on the conspiracy of silence issue reflects the stakes involved in the debate and the vigor with which the various positions are defended. See the sources cited in *supra* note 10. See also, Wasmuth, *The Conspiracy of Silence: Physician's View*, 15 CLEV.-MAR. L. REV. 85 (1966).

cortisone,⁵⁰ inflammations and thrombosis after receiving medication,⁵¹ paralysis after receiving radiation treatment,⁵² paralysis following childbirth,⁵³ and the "commonplace procedure" of giving myelograms.⁵⁴ The whole process of turning such questions over to the jury to decide on the basis of common knowledge because a plaintiff may have difficulty producing expert testimony on the question is inconsistent:

On the one hand it is said that because laymen are not knowledgeable about medical problems, it is unfair to impose upon the plaintiff the responsibility of explaining whether and how something went wrong in the performance of the medical procedure. But on the other hand, it is said that because of the increased lay comprehension of medical matters, the jury will be able to determine whether the defendant has been negligent without the aid of expert testimony.⁵⁵

Of course, courts have not gone so far as to hold that *all* injuries are within the realm of common knowledge: paralysis following injections of novacaine,⁵⁶ paralysis following aortography,⁵⁷ shock following injection of penicillin,⁵⁸ and many other situations have been held to be outside the common knowledge and experience of lay persons.⁵⁹ The obvious question that arises after reviewing these cases is what brings paralysis following radiation or injection of cortisone within the scope of common knowledge while paralysis following aortography or injection of novacaine remains outside the scope of common knowledge? The all too apparent answer is that, in fact, nearly all of the paralysis cases have equal theoretical bases for applying the common knowledge doctrine but differing equities in individual cases have prompted courts to act inconsistently, thereby leaving the landscape of medical malpractice jurisprudence littered with a confusing array of irreconcilable decisions.⁶⁰

50. *Bardessono v. Michels*, 3 Cal. 3d 784, 478 P.2d 480, 91 Cal.Rptr. 760 (1970).

51. *See Wolfsmith v. Marsh*, 51 Cal.2d 832, 337 P.2d 70 (1959).

52. *See ZeBarth v. Swedish Medical Center*, 81 Wash.2d 12, 499 P.2d 1 (1972).

53. *See Seneris v. Haas*, 45 Cal.2d 811, 291 P.2d 915 (1955).

54. *Berkey v. Anderson*, 1 Cal. App.3d 790, 799, 82 Cal. Rptr. 67, 73 (1969).

55. Meisel, *supra* note 41, at 71.

56. *See LaMere v. Goren*, 233 Cal. App.2d 799, 43 Cal. Rptr. 898 (1965).

57. *See Salgo v. Stanford Univ.*, 154 Cal. App.2d 560, 317 P.2d 170 (1957).

58. *See Campos v. Weeks*, 245 Cal. App. 2d 678, 53 Cal. Rptr. 915 (1966).

59. *See, e.g., Siverson v. Weber*, 57 Cal. 2d 834, 372 P.2d 97, 22 Cal. Rptr. 337 (1962) (fistula following hysterectomy); *Edelman v. Zeigler*, 233 Cal. App.2d 871, 44 Cal. Rptr. 114 (1965) (cardiac arrest during operation).

60. *See Meisel, supra* note 41, at 70, 71.

The application of *res ipsa loquitur* represents a judicial effort to circumvent the unwillingness of the vast proportion of the medical profession to testify on behalf of patients injured at the hands of negligent colleagues, and to compensate medical-accident victims on the basis of the equities of the case rather than in accordance with strict legal rules of procedure or substance.

Rather than applying the common knowledge doctrine and *res ipsa loquitur* indiscriminately in an attempt to compensate for the conspiracy of silence and the equities of particular cases, the better course of action in this troublesome area is to attack the conspiracy itself. Such an approach would leave the theoretical doctrines of tort law intact and, in the long run, better enable medical malpractice plaintiffs and defendants to address the merits of each individual claim. Taking steps to eliminate the conspiracy of silence is a better course than expanding the common knowledge and *res ipsa loquitur* doctrines to include every case where equities favor the plaintiff because by removing the conspiracy, technical and medical information can be given to juries that will presumably enable them to make fairer decisions. Simply assuming that lay juries have common knowledge about medical and technical matters, such as the causes or risk of paralysis after receiving a given medical treatment, does nothing more than perpetuate the wall of silence and forces decisions to be made without access to necessary and helpful information.

B. Failure to Distinguish Between Uncommon Injuries and Common Negligence

The second problem that has emerged in the common knowledge cases is a failure to distinguish between cases in which persons suffer injuries that are due to negligence that is within the common knowledge and experience of lay persons and cases in which persons suffer injuries from a treatment or process that does not ordinarily result in any injury. This distinction is important because injuries that result from treatments or processes that do not ordinarily result in injuries may or may not be the result of negligence. To assume that an injury is the result of negligence just because it occurred after a process or procedure that does not ordinarily result in injuries ignores the fact that there may be many non-negligent causes of the uncommon injury.

The failure to distinguish between uncommon injuries and common negligence nearly always arises where there is a joint application of *res ipsa loquitur* and the common knowledge doctrine. An evaluation of this distinction, both within and outside the medical context, reveals its importance. Consider the following situations:

Situation 1: A drives his automobile to work every day without incident. One day while driving to work, A's automobile is struck by an automobile operated by B. Given only these facts, is it proper to infer that B has been negligent and is, therefore, liable to A for the injuries resulting from the accident? The answer has to be a resounding "No." While it is clear that A's injuries (damage to his automobile) are of a

type that ordinarily do not occur from the activity in question (driving to work), surely more information is necessary to determine whether B was at fault. Given only the above information, it is impossible to say that A's injuries are of a sort that ordinarily would not happen unless B was negligent.⁶¹

Situation 2: A and B are parties to a contract. B breaches the contract and A retains attorney C to assist in recovering on the contract. C subsequently files an action against B on behalf of A but the action is dismissed because barred by the applicable statute of limitations. A then brings an action against C for legal malpractice. Given only these facts, is it proper to infer that C has been negligent and is liable to A? A has suffered injuries (dismissal of a valid claim against B) that do not ordinarily arise from the event in question (retention of an attorney to pursue a claim). But this showing is not enough since A could have hired C after the statute of limitations had run. The mere fact that A has suffered a loss that does not ordinarily occur, without more, does not support an inference that C was negligent.

Situation 3: After feeling pain in his shoulder, A visits B, a physician who gives A several injections of xylocaine and cortisone. The injections are very painful to A. After noticing little improvement in the shoulder, A is subsequently admitted to a hospital and given another injection by B. Upon examination by C, a different physician, A is found to have nerve damage and paralysis in his arm and shoulder. A brings a malpractice action against B. A proves that an injection of cortisone and xylocaine does not ordinarily cause the sort of pain which A experienced but does not prove the cause of the paralysis. From these facts alone, is it proper to infer that B has been negligent? Again, it is clear that A has suffered injuries of a type that do not usually occur from the treatment given. But as was illustrated with situations 1 and 2 above, the mere fact that an injury is a type not ordinarily experienced is not dispositive. The important question of whether A's injuries—nerve damage and paralysis—are of a type that are likely to have been caused by B's actions requires more information than is given.⁶²

All three of the above situations present cases of "uncommon inju-

61. From the facts given in Situation 1, it is entirely possible that the collision was a result of A's negligence or was simply "unavoidable." An unavoidable accident is "an occurrence which was not intended, and which, under all the circumstances, could not have been foreseen or prevented by the exercise of reasonable precautions." PROSSER, *supra* note 1, at 140 (footnote omitted).

62. But see *Bardessono v. Michels*, 3 Cal.3d 784, 478 P.2d 480, 91 Cal. Rptr. 760 (1970). In *Bardessono*, the court, under the facts given in Situation 3, affirmed a verdict in favor of the plaintiff on the basis of *res ipsa loquitur*.

ries": they are cases in which a person was injured from some activity that does not ordinarily result in injury. The fact that an uncommon injury occurred may be one factor in determining whether the injury resulted from negligence but the mere occurrence of an uncommon injury or accident, alone, should never be enough to create an inference of negligence, either by common knowledge or otherwise. Rather than focusing on the unusualness of the event, the correct approach is to focus on the likely cause of injury. Common knowledge and *res ipsa loquitur* are properly applied jointly only in cases where, given the fact of injury, one can presume from common knowledge and experience that the injury is due to negligence. To find that an injury is of a sort that ordinarily does not occur is a far cry from finding that an injury is due to negligence. Unusual injuries may be caused by the injured person himself, or by a third person not involved in the lawsuit; such injuries may be the result of an act of nature⁶³ or may simply be unavoidable.⁶⁴

Despite the apparent necessity for distinguishing between cases involving uncommon injuries and those involving common negligence, there are numerous reported cases that ignore the distinction. For example, in *Davis v. Memorial Hospital*,⁶⁵ the Supreme Court of California held that a trial court had erred in refusing to give an instruction on *res ipsa loquitur* in a malpractice case involving a plaintiff who developed a perirectal abscess and a fistula, allegedly as a result of a presurgical enema. The record revealed several possible causes of the abscess, including a prostatic massage that the plaintiff had received by a different doctor one week before surgery.⁶⁶ The court virtually ignored the several possible causes of the injury by holding that "[a]lthough there was no expert testimony as to the probability of negligence in such a situation, it is a matter of common knowledge among laymen that the giving of an enema is not ordinarily harmful unless negligently done."⁶⁷ Similarly, in *Wolfsmith v. Marsh*,⁶⁸ the same high court held that where a malpractice plaintiff developed a thrombosis after an injection of sodium pentathol, a jury could properly draw an inference of negligence on the part of the administering physician. In

63. The law has long refused to hold persons liable for injuries that can be attributed to an act of God or nature. There has been considerable common law development of this principle, particularly in relation to common carriers, see PROSSER, *supra* note 1, at 284-286, and maritime accidents, see, e.g., *Mamiye Bros. v. Barber Steamship Lines*, 360 F.2d 774 (2d Cir. 1966); *Twery v. Houseboat Jilly's Yen*, 267 F. Supp. 722 (S.D. Fla. 1967).

64. See *supra* note 60.

65. 58 Cal.2d 815, 376 P.2d 561, 26 Cal. Rptr. 633 (1962).

66. 58 Cal.2d at 816, 376 P.2d at 562, 26 Cal. Rptr. at 634.

67. *Id.*

68. 51 Cal.2d 832, 337 P.2d 70 (1959).

so holding, the court explained that "[i]t is a matter of common knowledge among laymen that injections in the arm, . . . as well as other portions of the body . . . do not ordinarily cause trouble unless unskillfully done or there is something wrong with the serum."⁶⁹

These decisions, and others like them,⁷⁰ are fundamentally wrong. They essentially allow defendants to be held liable because it has been shown that the defendants were involved in uncommon events. While such an approach might be supported in a system of liability based purely on spreading risks or compensating injured persons, it is inherently inconsistent with a system of liability based on fault.

IV. A PROPOSAL: DIRECT ATTACKS ON THE CONSPIRACY OF SILENCE AND CONSISTENT APPLICATION OF THE COMMON KNOWLEDGE DOCTRINE

A. *Direct Attacks on the Conspiracy of Silence*

The common knowledge doctrine operates on an assumption that there are some acts that appear to fall so far below any acceptable standard of care that it is unnecessary to require expert testimony to establish the precise standard of care. Similarly, *res ipsa loquitur* operates on an assumption that there are some types of accidents or injuries that are best explained by inferring negligence on the part of a third person. While neither of these doctrines were originally developed to deal with the so-called conspiracy of silence within the medical profession, repeated application of the two doctrines, both individually and jointly, have yielded a powerful weapon to combat the silence.

Unfortunately, assuming that causes of paralysis, inflammations, or any other medical problem are within the scope of common knowledge⁷¹ and are best explained by negligence neither solves the conspiracy nor produces consistent malpractice jurisprudence. In fact, attacking the conspiracy of silence with the common knowledge doctrine is inherently inconsistent since the conspiracy presumably exists because laymen are unable to address specific medical questions while the common knowledge doctrine assumes the exact opposite.⁷² Moreover, the attempt to attack the conspiracy of silence through expanded applications of the common knowledge doctrine and *res ipsa loquitur* is counterproductive since the assumption that lay persons have common knowledge of anything other than the most minor of medical problems

69. *Id.* at 835, 337 P.2d at 72.

70. *See, e.g.,* Bardessono, 3 Cal.3d 784, 478 P.2d 480, 91 Cal. Rptr. 760 (1970).

71. *See supra* notes 49-53 and accompanying text.

72. Meisel, *supra* note 41, at 71.

will almost always be erroneous. In sum, the common knowledge doctrine and *res ipsa loquitur* are very ineffective means of dealing with the conspiracy of silence.

There are, however, other tools that can and have been used to chip away at the wall of silence. Some of these tools are changes in the law that were probably not intended primarily as responses to the wall of silence. Two changes that have been made by most American jurisdictions are the relaxation of the traditional locality rule⁷³ and the elimination or relaxation of the school of practice rule.⁷⁴ The locality rule "require[d] that a medical witness, in order to qualify as an expert, [had to] be a practicing physician in the same community as the defendant."⁷⁵ It has been said that "[t]he erosion of the locality rule, perhaps more than any other change in the law, has made it possible for plaintiff to prosecute successfully a malpractice claim."⁷⁶

The school of practice rule held that a practitioner adhering to one school of medical thought was not competent to testify in an action involving a practitioner adhering to a different school.⁷⁷ The rule also

73. At early common law, a physician was required to adhere to the standard of care that existed in the locality or community in which he practiced. PROSSER, *supra* note 1, at 164. Because the local or community standard of care was the guidepost by which all conduct was measured, the only competent medical witnesses were practitioners from the same community.

74. The school of practice rule is a second early common law limitation on the qualification of expert medical witnesses. The rule is often phrased in protective terms—i.e., that a physician "is entitled" to have his conduct measured against "the school of medicine to which he belongs and not by those of some other school." *Wammett v. Mount*, 134 Ore. 305, 313, 292 P. 93, 96 (1930).

75. Note, *supra* note 12, at 338. This rule effectively barred many plaintiffs from obtaining competent expert testimony by limiting the number of available expert witnesses and by producing a pool of acceptable witnesses that were likely to be extremely reluctant to testify.

The locality rule evolved at a time when physicians practicing in remote and rural areas did not have the same access to medical advances, techniques and equipment as did urban doctors. The rule essentially protected physicians practicing outside urban areas from being held to the undoubtedly higher standards that would apply in the major urban areas. An interesting, but fairly typical, early example of this fact is found in *Small v. Howard*, 128 Mass. 131 (1880). In that case, a physician practicing in a small country village was required to perform surgery with which he was unfamiliar. Alleged negligence in the surgery resulted in injuries to the plaintiff, but the doctor was held not liable. The court "accepted the fact of the physician's inferior training and awareness of medical technique, and held him only to the standard of a physician in a similar locality." Kroll, *supra* note 47, at 607 n.36.

76. Kroll, *supra* note 47, at 607. It should be noted that in most instances the relaxation of the locality rule has been a gradual process. The rule was originally modified during the first half of this century in most jurisdictions to allow experts from "similar" localities to testify as expert witnesses. PROSSER, *supra* note 1, at 164; Kroll, *supra* note 47, at 607-608. More recently, many jurisdictions have further relaxed the locality rule so that locality is simply considered as one factor in establishing the standard of care. Some jurisdictions have abandoned the rule altogether. See PROSSER, *supra* note 1, at 164.

The changes in the locality rule have been brought about both by statute, *see, e.g.*, WIS. STAT. §147.14(2)(a), and by judicial decision, *see, e.g.*, *Brune v. Belinkoff*, 354 Mass. 102, 235 N.E.2d 793 (1968). But *see* LA. REV. STAT. ANN. §9:2794(A)(1) (locality rule preserved by statute).

77. The relaxation of the school of practice rule has enabled doctors from different fields and training to testify as expert witnesses in malpractice actions even though the testimony may not be conclusive of the applicable standard of care. There are now many reported decisions allowing medical doctors and osteopaths to testify in actions involving the other. *See* Comment, 17 U. MIAMI L. REV. 182 (1962) and cases cited therein. There are even reported cases allowing a

served to preclude medical specialists from testifying in actions against a general practitioner, and *vice versa*, since specialists and general practitioners are generally held to different standards of care.⁷⁸ The relaxation of this rule has expanded the pool of available witnesses to testify in any given action, thereby increasing the likelihood that a malpractice plaintiff will be able to secure expert testimony.⁷⁹

The arguments for and against the relaxation of the locality rule and the school of practice rule need not be evaluated here.⁸⁰ It is sufficient to note that the relaxation of these rules has "done much to overcome the 'wall of silence' that once made medical malpractice actions such high-risk, low-gain efforts."⁸¹ These changes aptly demonstrate the fact that there are direct methods of increasing the availability of expert medical testimony.

The relaxation of the locality and school of practice rules is essentially a *fait accompli* since virtually all American jurisdictions have abandoned the early common law formulations of the rules.⁸² There are, however, additional changes in the law that should be considered as tools to eliminate the barriers resulting from the conspiracy of silence. Two such changes are outlined more fully below.

chiropractor to testify in actions against medical doctors, *see, e.g.*, *Wemmett v. Mount*, 134 Ore. 305, 292 P. 93 (1930) (involving the use of a diathermy machine), and cases allowing a medical doctor to testify against a chiropractor, *see, e.g.*, *Epstein v. Hirschon*, 33 N.Y.S.2d 83 (Sup. Ct. 1942); *Walkenhorst v. Kesler*, 92 Utah 312, 67 P.2d 654 (1937).

The *Wemmett* case is particularly noteworthy because even under a relaxed view of the school of practice rule, chiropractors are seldom, if ever, deemed competent to testify as to the standards expected of medical doctors. Later cases have so held. *See, e.g.*, *Sheppard v. Firth*, 215 Ore. 268, 334 P.2d 190 (1959).

78. Courts have been reluctant to allow specialists to testify in actions against general practitioners. *See Note, supra* note 12, at 339. However, some courts are now willing to allow specialists to testify in actions involving general practitioners even though the testimony will be directed to a "lower" standard of care to which the general practitioner will be held. *See, e.g.*, *Simone v. Sabo*, 37 Cal.2d 253, 231 P.2d 19 (1951); *Wilson v. Corbin*, 241 Iowa 593, 41 N.W.2d 702 (1950) *cited in Note, supra* note 12, at 339.

79. The rule has essentially been relaxed or eliminated by the numerous exceptions to the rule that are now recognized in most jurisdictions—the most important being the exception for situations in which various schools would apply the same or similar treatment for a given problem. A collection of the cases illustrating the exceptions to the rule is found in *Annot.*, 85 A.L.R.2d 1077 (1962).

80. There is considerable commentary outlining the various arguments relative to the locality rule and the school or practice rule. *See, e.g.*, *Comment, Locality and Standard of Care of Medical Practitioners*, 25 ARK. L. REV. 169 (1971); *Waltz, The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DEPAUL L. REV. 408 (1969); *Comment, supra* note 2.

81. Vogel, *supra* note 26 at 52.

82. Of course, the modern treatment of the locality rule varies from jurisdiction to jurisdiction. Most jurisdictions still retain a loose form of the rule whereby the locality is simply considered as one factor in establishing the standard of care. PROSSER, *supra* note 1, at 164. There are, however, jurisdictions that have abandoned the rule altogether. *See e.g.*, *Wis. STAT. §147.14(2)(a)*; *Brune v. Belinkoff*, 354 Mass. 102, 235 N.E.2d 793 (1968). At least one jurisdiction has retained the common law locality rule by statute. *See LA. REV. STAT. ANN. §9:2794(A)(1)*.

1. *Relaxation of the rules of evidence regarding medical treatises.*

Medical treatises, like textbooks and treatises from any other field, are readily available sources of impartial, up-to-date, and specific information on the standards of the profession.⁸³ Such treatises can be useful to malpractice plaintiffs either in the absence of expert witnesses or in the course of cross examination of the defendant's medical witnesses. However, until recently, medical treatises and textbooks could not be admitted into evidence under any circumstances in virtually all American jurisdictions and could not be used in cross examination unless the expert acknowledged his familiarity with, and based his opinions upon, the particular treatise to be used in the examination.⁸⁴ This limited use of medical treatises was a logical application of the rule prohibiting hearsay evidence. Since the author of a medical textbook or treatise would not be present testifying under oath and was not available for cross-examination, the declarations found in such books would be hearsay and, therefore, inadmissible.

One of the obvious benefits of allowing greater use of medical books in litigation is the increased availability of medical and technical information that may be presented to a trier of fact. Medical textbooks and treatises are often available to substitute for or help clarify medical testimony. Although there can be problems with the use of such textbooks and treatises—i.e., a party or the jury may improperly take material out of context—many legal commentators are convinced that the advantages of allowing greater use of such books far outweigh the possible abuses. Indeed, two of the most prominent commentators on the law of evidence—Wigmore and McCormick—both “favored the admissibility of learned treatises.”⁸⁵

In the last few decades, several jurisdictions, including the federal courts, have modified their rules of evidence to allow greater use of medical treatises and textbooks. Although most of the reforms go only so far as to allow attorneys to examine witnesses on the contents of any

83. It has sometimes been asserted that books are often not current enough to be used in litigation, especially in matters requiring state-of-the-art information. This objection carries little significance if, as common sense dictates, out-of-date materials are considered irrelevant and inadmissible. In short, “[t]he lament heard by witnesses that textbooks are ‘out of date’ by the time printed (a statement which is undoubtedly true in part), is easily correctible in an age where computer retrieval can provide rapidly updated information on any issue.” Leonard, *supra* note 26, at 411.

84. See 6 J. WIGMORE, EVIDENCE §1690 (Chadbourn rev. 1976); FED. R. EVID. 803, Notes of Advisory Comm. (“[T]he great weight of authority has been that learned treatises are not admissible as substantive evidence although usable in the cross-examination of experts.”). There are some states that do allow a treatise to be used where the witness has expressly stated his reliance on the treatise. See, e.g., *Drucker v. Philadelphia Dairy Prod. Co.*, 35 Cal. 437, 166 A. 796 (1933); *Percoco's Case*, 273 Mass. 429, 173 N.E. 515 (1930); *People v. McKernan*, 236 Mich. 226, 210 N.W. 219 (1926).

85. FED. R. EVID. 803, Notes of Advisory Comm.

relevant book or treatise,⁸⁶ others allow such material to be admitted and to constitute direct evidence.⁸⁷ Such changes have been made both by judicial decisions⁸⁸ and by statute.⁸⁹ However, jurisdictions that have recognized such an exception to the hearsay rule remain a distinct minority.

2. *Creation of medical boards of review.* One of the most innovative—and controversial—steps that has been taken in light of the conspiracy of silence controversy has been the creation of local boards or panels of medical review that evaluate claims of medical malpractice against physicians who practice within the given geographical reach of the board. As of last year, it was reported that some twenty-five states have developed some type of pretrial malpractice screening mechanism and another eleven states have established arbitration procedures for malpractice claims.⁹⁰ Although the functions and procedures of the state boards vary, some boards guarantee to provide competent expert testimony for “valid” claims of medical malpractice if the claim leads to litigation.⁹¹ This unique feature of the pretrial screening process has the potential of nullifying completely any conspiracy of silence that might exist.

The potential benefits, and disadvantages, of the pretrial screening

86. See, e.g., FED. R. EVIDENCE 803 (18).

87. See, e.g., *Stone v. Proctor*, 131 S.E.2d 297 (N.C. 1963).

88. See *id.*

89. See, e.g., MASS. GEN. LAWS ANN., ch. 233, §79C; NEV. REV. STAT. §41A.100; WIS. STAT. §147.14. The text of the Nevada statute is discussed in the text at *infra* note 94. The Massachusetts statute illustrates the approach that has been taken by those states that have chosen to deal with the textbook and treatise question by statute. That statute provides:

A statement of fact or opinion on a subject of science or art contained in a published treatise, periodical, book or pamphlet shall, in the discretion of the court, and if the court finds that it is relevant and that the writer of such statement is recognized in his profession or calling as an expert on the subject, be admissible in actions of contract or tort for malpractice, error or mistake against physicians, surgeons, dentists, optometrists, hospitals and sanatoria, as evidence tending to prove said fact or as opinion evidence; provided, however, that the party intending to offer as evidence any such statement shall, not less than three days before the trial of the action, give the adverse party notice of such intention, stating the name of the writer of the statement and the title of the treatise, periodical, book or pamphlet in which it is contained.

MASS. GEN. LAWS ANN., ch. 233, §79C.

90. Leonard, *supra* note 26, at 413.

91. The functions of a typical board of review program is illustrated by the Pima County Screening Plan in Arizona, as outlined in Leshner, *Pima County Screening Plan*, 17 ARIZ. MEDICINE 379 (1960). Under that program any malpractice claimant can petition the Pima County Bar Association's Medico-Legal Committee to review the claim. Upon receipt of any such petition, the Committee will call and form a panel of nine doctors and nine lawyers which will, at a formal hearing conducted after notice to both parties, review the claim. Both the claimant and the doctor have opportunities to present their cases, and are subject to cross-examination before the panel. If upon reviewing the evidence the panel finds that there is “substantial evidence of malpractice” and “substantial evidence of substantial injury arising out of this malpractice,” the local medical society agrees to provide expert testimony for the claimant if the case goes to trial. If the panel does not find that there has been malpractice or injury, the claimant is still free to pursue his malpractice action but the medical society is under no obligation to provide expert testimony.

process are fairly obvious. On the one hand, a claimant who has suffered injury as a result of medical malpractice may be able to show a board of review that malpractice has indeed occurred and thereby assure himself of competent expert testimony at trial. On the other hand, it may be difficult to convince a panel of doctors that malpractice has occurred; such panels may be "dramatically unfair to claimants."⁹² If a claimant fails to convince a panel of doctors that malpractice has occurred, the entire panel of doctors becomes potential expert witnesses for the doctor-defendant in any resulting litigation. Moreover, the process itself may become a second trial, creating "[m]onumental expenditures of time and effort."⁹³

However, all of the objections to the screening process are overcome if the process is neither mandatory nor binding on the claimant. Under such a system, a claimant could have his day in court with or without going through the screening process but the process would be available to serve the valuable function of assuring expert testimony to plaintiffs with meritorious claims who elect to use the process.

It is difficult to conclude definitively that medical boards of review will have the effect of eliminating the perceived conspiracy of silence. But assuming that such boards will make fair determinations of whether malpractice claims are meritorious, the boards will at least give the potential plaintiffs who utilize the process an opportunity to proceed to trial, if necessary, with qualified and competent expert witnesses.

B. Consistent Application of the Common Knowledge Doctrine

In connection with the direct attack on the conspiracy of silence, the common knowledge doctrine should be limited to those cases where it can properly be assumed that the type of accident or injury involved in the case is within the common knowledge of lay persons. The fact that a few or even a majority of lay persons are familiar with a medical technique or process should not be sufficient to invoke the common knowledge doctrine. Although there may be gray areas where it can be fairly doubted whether the lay public has common knowledge of a given medical procedure, there are some types of cases where common knowledge is clearly appropriate.⁹⁴

The State of Nevada has enacted a statute that reflects a consensus within that jurisdiction on the types of injuries that may be deemed

92. *See id.*

93. Leonard, *supra* note 26, at 414.

94. *Id.* at 415.

fairly to lie within the common knowledge and experience of most lay persons. The statute provides that medical evidence, in the form of either expert testimony, recognized medical texts or treatises, or regulations of the health care facility where the injury occurred, is required in all cases involving alleged negligence in the providing of medical services except in cases where:

1. A foreign substance other than medication or a prosthetic device was unintentionally left within the body of a patient following surgery;
2. An explosion or fire originating in a substance used in treatment occurred in the course of treatment;
3. An unintended burn caused by heat, radiation or chemical was suffered in the course of medical care;
4. An injury was suffered during the course of treatment to a part of the body not directly involved in such treatment or proximate thereto; or
5. A surgical procedure was performed on the wrong patient or the wrong organ, limb or part of a patient's body.⁹⁵

The statute thus limits the common knowledge doctrine to the sort of blatant blunder cases that had been developed by the common law but expands the sources of acceptable "expert testimony" to include medical books and treatises and health care facility regulations.

Enactment of a Nevada-type statute in all jurisdictions would be a positive first step in the direction of maintaining a consistent and logical common knowledge doctrine while at the same time breaking down the barriers of the perceived medical silence. The approach taken by the Nevada Legislature reflects a genuine effort to deal directly with the institutional barriers confronting a malpractice plaintiff by expressly allowing a plaintiff to meet his burden of establishing a standard of care by producing either medical treatises or medical texts or established medical regulations that address proper standards and procedures. The approach also seeks to maintain a coherent and sensible common knowledge doctrine by limiting the use of that doctrine to situations in

95. NEV. REV. STAT. §41A.100. The statute, in its entirety, provides:

Liability for personal injury or death shall not be imposed upon any provider of medical care based on alleged negligence in the performance of such care unless evidence consisting of expert medical testimony, material from recognized medical texts or treatises or the regulations of the licensed health care facility wherein the alleged deviation from the accepted standard of care in the specific circumstances of the case and to prove causation of the alleged personal injury or death, except that such evidence consisting of expert medical testimony, text or treatise material or facility regulations is not required and a rebuttable presumption that the personal injuries or death was caused by negligence arises where evidence is presented that the personal injury or death occurred in any one or more of the following circumstances:

1. [The statute enumerates the five categories quoted in the text.]

NEV. REV. STAT. §41A.100.

which practically all lay persons would have common knowledge or experience pertaining to the type of accident in question. This approach is far superior to simply dealing with the conspiracy of silence by assuming lay juries have common knowledge about every variety of medical procedures because it enables a claimant to proceed to trial even if he is unable to persuade medical witnesses to testify, and it assures that the jury will have at least some information on medical questions it must decide.

The Nevada statute also solves the recurring problem found in existing case law⁹⁶ of courts failing to distinguish between uncommon injuries and common negligence. In the absence of such a statute, many courts have focused on the fact that an injury is uncommon—that is, that it does not ordinarily occur during the activity in question—rather than on the fact that certain types of negligence are within the common knowledge and experience of lay persons.⁹⁷ Such an approach is illogical because it fails to recognize that there are many uncommon injuries that are the result of factors other than the negligence of a particular defendant. By explicitly enumerating the situations in which the common knowledge doctrine is appropriate, the statute eliminates this problem because courts will have to focus on whether an injury falls within the categories of common knowledge situations rather than on the question of whether an injury is unusual.⁹⁸ Although one could quibble with the number or types of common knowledge situations listed in the statute, the Nevada approach should be commended and followed by other jurisdictions.⁹⁹

V. CONCLUSION

Common sense dictates that not every injury occurring in a medical context has a complex medical or technical explanation. The common knowledge doctrine is simply a legal recognition of this fact.

However, application of the common knowledge doctrine by the courts has been far more complex than the doctrine's simple justification for two reasons. First, courts have insisted on using the doctrine, especially in conjunction with *res ipsa loquitur*, in their battle against the medical profession's wall of silence. Such an application has

96. See text and notes relating to the blatant blunder cases at notes *supra* 13-19.

97. See *supra* notes 60-69 and accompanying text.

98. The three hypothetical fact situations and related cases discussed in the text and notes at *supra* notes 60-69 illustrate the problems with focusing on uncommon injuries.

99. The Nevada statute might be faulted because it codifies what is perceived to be the existing state of common knowledge and fails to take into account the likely future increases in the public's awareness of medical matters. But, of course, statutes are no more immune from change than is the public's common knowledge.

proven to be counterproductive because the common knowledge doctrine and *res ipsa loquitur* can never solve the problem underlying the wall of silence—a lack of information available to plaintiffs and triers of fact. Second, courts have sought to define and apply common knowledge, again usually in conjunction with *res ipsa loquitur*, based upon the “commonness” of the injury. But this approach is entirely inconsistent and illogical since an uncommon injury may or may not be within the common knowledge and experience of lay persons and may or may not be caused by negligence.

Statutory responses to the inconsistent and illogical application of the common knowledge doctrine, such as the Nevada statute, are commendable and appropriate. Doctors, patients, courts and the public will all be served by taking whatever direct steps are necessary to overcome the wall of silence while retaining a well-defined and coherent common knowledge doctrine.

