Chapter 10
Professional Negligence

§ A. Medical Malpractice

1. Negligence

KNIGHT v. HAYDARY
165 Ill. Dec. 847, 585 N.E.2d 243 (1992)

Justice McLAREN delivered the opinion of the court

This appeal involves an action in malpractice against two doctors, A. Lee Haydary and Erwin Robin. The case is brought by Fredrick Knight, as special administrator of the estate of Patrice Knight, deceased, in a wrongful death action and a survival action. The alleged negligence resulted in severe brain damage causing death while Patrice was under the care of Dr. Haydary for treatment of a miscarriage. The case was tried before a jury in the circuit court of Kane County. At the close of plaintiff's case in chief, the trial court granted a directed verdict in favor of Dr. Robin. After a full trial, the jury returned a verdict in favor of Dr. Haydary. Plaintiff now appeals from these verdicts.

The issues presented for review are (1) whether plaintiff is entitled to a judgment notwithstanding the verdict (j.n.o.v.) on the issue of Dr. Haydary's liability and a new trial on the issue of damages, (2) whether the jury verdict in favor of Dr. Haydary was contrary to the manifest weight of the evidence, and (3) whether the trial court erred in barring one of plaintiff's experts from testifying. We affirm.

On July 18, 1983, Patrice Knight was admitted to the Sherman Hospital emergency room in order to receive care for a miscarriage occurring between the 12th and 14th weeks of pregnancy. Her obstetrician and gynecologist, Dr. A. Lee Haydary, instructed her to come to the hospital after determining through a telephone conversation that her amniotic sac had ruptured, indicating an abnormal event in her pregnancy. After passing the fetus, Patrice was admitted to the labor and delivery unit of the hospital where she received an IV of 1,000 cc's of "Lactated Ringer's" solution containing one ampule (1 cc) of Pitocin. Following surgery, patients who should not eat solid foods are given an IV which injects a nourishing solution into the body. When patients receive liquids of this type, they must also receive electrolytes in order to maintain the proper balance of certain elements in the body, such as sodium, with the fluids within the body. Electrolytes are contained in the foods people eat. However, they can also be reduced to a fluid state. "Lactated Ringer's" is a solution which contains these essential electrolytes and is administered to a patient through an IV.

Pitocin, a brand-name manufactured drug, is a synthetic preparation of a naturally occurring hormone, oxytocin, which is produced in the area of the brain called the hypothalamus. Pitocin is used to promote the expulsion of the products of conception that might still be in the uterus. If the uterus is not emptied of the products of conception, it will continue to bleed. One potential side effect of Pitocin is that it may cause hyponatremia, due to its intrinsic antidiuretic effect. In other words, it may cause an individual to retain water which would otherwise be excreted. Such water retention could result in damaging swelling to the body including parts of the brain.

Upon her admission to the hospital, a complete blood count (CBC) was taken from Patrice. A CBC is used in order to determine, among other things, whether there is a proper balance between essential

electrolytes and body water.

Approximately $2^1/2$ hours after her admission to the labor and delivery department, Patrice passed additional tissue. Later that evening, a second IV bottle of 1,000 cc's of "Lactated Ringer's" with one ampule of Pitocin was administered with Dr. Haydary's consent. The following morning of July 19, Patrice received a third IV bottle of "Lactated Ringer's" with one ampule of Pitocin. Because the previous IV became clotted with blood, it was discontinued with 200 cc's remaining in the bottle. That morning, Dr. Haydary visited Patrice, performed an examination, and diagnosed an incomplete abortion based upon his findings of uterus enlarged to six times normal size and a vagina filled with blood. In order to remove the tissue or products of conception from the uterine cavity, Dr. Haydary performed a dilation and curettage (D&C), a surgical procedure involving a scraping of the wall of the uterus. Following the D&C procedure at approximately 1:45 p.m., Patrice received a fourth IV bottle. This IV contained one ampule of Pitocin, along with 1,000 cc's of 5% dextrose and water (D5W). This IV was to be administered over a 12-hour period. The D5W solution has a nutritive value but contains no electrolytes. In addition, Patrice was permitted to have a general diet and to take fluids as desired.

Patrice received a fifth IV bottle of 1,000 cc's D5W with one ampule of Pitocin at 3:30 a.m. July 20. At this time Patrice began to develop a headache for which she received several forms of medication and treatment from the nurses on duty. At approximately 5:30 a.m., Patrice vomited and reported some relief of her headache. At approximately 8 a.m., Patrice stated to a nurse that she was experiencing a less-severe headache for which she obtained pain medication from the nurse in the form of a pill. Patrice then became weepy and spoke with the nurse about her miscarriage. Patrice subsequently vomited a small amount.

Dr. Haydary visited Patrice in her hospital room at approximately 10:50 a.m. on July 20. Patrice complained of headache, nausea, vomiting, and diarrhea to Dr. Haydary. She believed that she had the flu and felt unable to go home. As a result, Dr. Haydary decided to keep her in the hospital. Prior to leaving that morning, Dr. Haydary ordered Vistaril to control the vomiting and relieve the headache. While he was at the hospital, Dr. Haydary told a nurse to discontinue Patrice's IV with Pitocin, which had about 200 cc's of fluid remaining. A nurse hung an IV of D5W without Pitocin at around noon.

At approximately 1 p.m. Patrice was found to be unconscious and having seizure-like movement in her arms. A nurse called Dr. Haydary to inform him of Patrice's condition. Dr. Haydary, who was out of the hospital at the time, ordered a complete blood count and a blood clotting test and arranged to have a physician see Patrice. This physician was Dr. Erwin Robin, an internist with a specialty in cardiac medicine. Following the seizure-like movements, Patrice began screaming, and then she began to rest.

Dr. Robin arrived at approximately 2 p.m. and examined Patrice. In the course of this examination he was able to listen to her heart, take her blood pressure, and conduct a brief neurological examination by checking her pupillary reflexes. Patrice was unable to respond verbally to his questions. Dr. Robin found Patrice to be medically and neurologically normal and determined that her actions reflected possible psychological problems. Dr. Robin called Dr. Haydary, suggested that he come to the hospital, and advised that the patient be seen by either a psychiatrist or a neurologist.

At 3 p.m. a psychiatrist arrived who also conducted a neurological examination. This examination included a look into Patrice's eyes in order to assess whether there was pressure in the brain by examining the fundus of the eye with an ophthalmoscope. The psychiatrist found the eyes to be within normal limits. Her reflexes were also assessed to be within normal limits. However, after 10 or 15 minutes, the psychiatrist observed Patrice undergo a grand mal seizure lasting approximately 10 minutes. After witnessing the seizure and noting that one pupil was markedly dilated compared to the other one, as well as finding a positive babinski sign (where the big toe moves when the outer side of the foot is scratched) the psychiatrist felt there was an organic problem with Patrice's brain. The psychiatrist then transferred Patrice to the intensive care unit at Sherman Hospital and called Dr. Haydary to advise him of the patient's development. The psychiatrist indicated that the situation required a neurologist or a neurosurgeon. Dr. Haydary agreed. Within five minutes, a neurologist (Dr. Lupton) arrived.

When Dr. Lupton arrived at approximately

4:30 p.m., Patrice was confused and combative, so Dr. Lupton prescribed valium. Dr. Lupton proceeded to conduct a neurological examination. His initial assessment was that Patrice was normal, but at approximately 5 p.m., Patrice became less responsive and her pupils became dilated and fixed. Her blood pressure then became exceedingly elevated and suddenly fell to zero. She stopped breathing and signs of an intact brain stem were absent.

Patrice died of hyponatremia, a state characterized by the retention of water in the body and inappropriately low levels of sodium. The decreased sodium level causes the brain to swell. In this instance, the swelling took place to such an extent that the brain was herniated from the brain stem, ineluctably causing death.

Plaintiff first argues that he is entitled to a judgment notwithstanding the verdict (j.n.o.v.) on the issue of Dr. Haydary's liability for damages resulting from the death of Patrice. Under the *Pedrick* standard, plaintiff is entitled to a j.n.o.v. only if all of the evidence viewed in the aspect most favorable to the defendant so overwhelmingly favors the plaintiff that no contrary verdict based on the evidence could ever stand. (*Pedrick v. Peoria & Eastern R.R. Co.* (1967)), 37 Ill. 2d 494, 510, 229 N.E.2d 504; *Connelly v. General Motors Corp.* (1989), 184 Ill. App. 3d 378, 385, 132 Ill. Dec. 630, 540 N.E.2d 370.) The *Pedrick* standard is properly applied in reviewing the denial of a motion for j.n.o.v. *Runimas v. Howe* (1981), 94 Ill. App. 3d 357, 359, 49 Ill. Dec. 936, 418 N.E.2d 956.

In a medical malpractice case, the plaintiff, by use of expert testimony, must establish the standards of care against which the defendant/doctor's conduct is measured. (*Borowski v. Von Solbrig* (1975), 60 Ill. 2d 418, 423, 328 N.E.2d 301.) The plaintiff must then prove that, judged in the light of these standards, the doctor was unskillful or negligent and that his want of skill or care caused the injury to the plaintiff. (*Borowski*, 60 Ill. 2d at 423, 328 N.E.2d 301.) Whether the doctor deviated from the standard of care and whether his conduct was a proximate cause of plaintiff's injury are questions of fact for the jury. *Borowski*, 60 Ill. 2d at 423, 328 N.E.2d 301.

It is improper for a trial court to enter a j.n.o.v. when there is a substantial factual dispute in the case, or when it is necessary to evaluate conflicting evidence in order to determine the outcome of the case. (*Connelly*, 184 Ill. App. 3d at 385, 132 Ill. Dec. 630, 540 N.E.2d 370.) This same standard is used by the reviewing court in determining whether the trial court applied the standard properly. (*Connelly*, 184 Ill. App. 3d at 386, 132 Ill. Dec. 630, 540 N.E.2d 370.) Accordingly, we will not enter a j.n.o.v. in a medical malpractice action when the jury has weighed conflicting expert testimony and determined that the essential elements of a medical malpractice case have not been sufficiently proved.

In order to prevail on this claim, plaintiff must show that the evidence overwhelmingly indicates Dr. Haydary breached his standard of care and caused injury to Patrice. The malpractice alleged here was Dr. Haydary's failure to diagnose and treat the cerebral edema (brain swelling), due to hyponatremia, that caused Patrice's death.

Experts for the plaintiff testified that the standard of care in this instance demanded that Dr. Haydary: (1) be aware hyponatremia is a known side effect of Pitocin; (2) proceed to the hospital upon learning of Patrice's condition from the nurses attending Patrice and from Dr. Robin; (3) recognize the possibility of hyponatremia in his diagnosis; (4) treat Patrice for hyponatremia; (5) properly administer Pitocin and not order it for too long of a duration; and (6) evaluate Patrice's sodium level on an emergency basis.

We determine that, when viewed in the aspect most favorable to defendant, the defendant's case gives rise to a substantial factual dispute with respect to plaintiff's assertion of Dr. Haydary's duty and his compliance with that duty. Plaintiff asserts that Dr. Haydary should have known what was wrong with Patrice and he should have treated her for it. However, there was no general agreement between the experts as to how Patrice should have been treated. We distinguish the facts of the case at bar from those in *Carman v. Dippold* (1978), 63 Ill. App. 3d 419, 427, 20 Ill. Dec. 297, 379 N.E.2d 1365, where the medical experts were in total accord as to the proper standard of medical care to be followed in the context of the facts. In *Carman*, the court held that when all the experts are in agreement on the proper standard of care, the *Pedrick* standard was met, a j.n.o.v. was proper, and the defendant/doctor could be held liable for damage resulting from his actions which

did not conform to the undisputed standard of care. *Carman*, 63 Ill. App. 3d at 428, 20 Ill. Dec. 297, 379 N.E.2d 1365.

The deciding issue in this case is whether Dr. Haydary's conduct fell below the accepted standard of care by failing to diagnose and treat Patrice for hyponatremia. Plaintiff's attempt to establish this standard of care failed, in part, because his counsel asked hypothetical questions that did not adequately address the adequacy of Dr. Haydary's diagnosis. Plaintiff's counsel's questioning at trial evoked testimony to the effect that if a patient is found to have hyponatremia, then it should be treated. All the experts unsurprisingly agreed on this point.

However, the dispute involves what Dr. Haydary's duty compelled him to do given Patrice's undiagnosed condition *at that time*, not whether a doctor, in general, should treat hyponatremia. The primary duty was to diagnose. It is only then that the adequacy of the treatment can be debated. If Dr. Haydary negligently diagnosed Patrice, then his treatment based on that diagnosis could be examined. Because medicine is a profession which involves the exercise of individual judgment within the framework of established procedures, differences in opinion are consistent with the exercise of due care. (*Walski v. Tiesenga* (1978), 72 Ill. 2d 249, 261, 21 Ill. Dec. 201, 381 N.E.2d 279.) We find that Dr. Haydary presented sufficient evidence to raise a factual issue that he acted with due care by exercising his individual judgment in diagnosing Patrice's problem and treating her accordingly.

The defendant provided expert testimony expressing opinions that Dr. Haydary carried out his responsibilities as a physician in a normal and acceptable manner and that he acted within the standard of care. One expert provided an opinion that it is a perfectly normal type of practice for a gynecologist to administer Pitocin to a woman prior to and following a D&C. The expert expressed an opinion that the dosage of Pitocin Patrice received over a 42-hour period was a minimal amount. He also expressed an opinion that Dr. Haydary met his obligations with regard to taking care of Patrice on the morning after the D&C procedure had been performed.

The expert further offered an opinion that Patrice's symptoms of nausea, vomiting, and headache could have been due to a mild viral infection, a gastroenteritis, a bowel problem, and, even more likely, to the lingering effects of coming out of the anesthesia she received. She also could have been responding negatively to the Demerol she received. In addition, Patrice had a long history of migraine headaches which, it was testified, are also associated with nausea and vomiting. The expert testified that there were probably over 100 different conditions that could be associated with the headache, nausea, and vomiting that Patrice was experiencing. He said that of these diagnoses, he would put water intoxication (hyponatremia) at the very bottom of the list. Defendants' expert testified that based on the symptoms Patrice was experiencing at 11 a.m. on July 20, there was no need to perform an electrolyte test on Patrice. The expert expressed the opinion that Dr. Haydary did not violate his standard of care by calling for an internist to see Patrice, particularly in light of the fact that Dr. Haydary had just visited with her.

The expert also opined that putting Patrice on a general diet after the operation was an effective way to replace the electrolytes that were no longer being administered through the Ringer's solution, which was discontinued on July 19. Furthermore, there was testimony that Patrice received Pitocin in connection with an earlier pregnancy and that she suffered no ill effects from it.

Both Dr. Haydary and Dr. Robin ordered CBCs on July 20. Dr. Haydary's CBC was performed at approximately 1 p.m., and Dr. Robin's at about 4 or 5 p.m. Defendant's expert pointed out that the white blood cell count went up considerably from the first CBC to the second. He indicated that he would expect the white cell count to be diluted along with the red cell count had hemodilution taken place. In addition, the plaintiff brings out testimony that the absence of certain elements of the blood could indicate the presence of hyponatremia. However, experts for the defense pointed out that such figures could also reflect the loss of blood Patrice experienced both before, during and after her operation.

Defendants' experts further testified that Dr. Haydary applied the knowledge and used the skill and the care ordinarily used by a reasonably well-qualified obstetrician/gynecologist when Dr. Haydary sought the aid of an internist to evaluate Patrice when she developed her peculiar symptoms. The expert further testified about the

possibility of Patrice's symptoms as being indicative of post-partum depression associated with pregnancy, and, thus, potentially a psychological problem.

We find that this evidence presented by the defense was sufficient to create a substantial question of fact concerning the elements of Dr. Haydary's standard of care and how his actions should have conformed to that standard. Viewing this dispute in the aspect most favorable to defendant, we cannot say that the evidence overwhelmingly favors plaintiff. Therefore, we hold that it was appropriate for the trial court to deny plaintiff's motion for a j.n.o.v.

* * *

Affirmed.

WOODWARD and INGLIS, JJ., concur.

Questions and Notes

1. RESTATEMENT (2D), TORTS, § 299A, comment f, provides: "Where there are different schools of thought in a profession, or different methods are followed by different groups engaged in a trade, the actor is to be judged by the professional standards of the group to which he belongs. The law cannot undertake to decide technical questions of proper practice over which experts reasonably disagree, or to declare that those who do not accept particular controversial doctrines are necessarily negligent in failing to do so. There may be, however, minimum requirements of skill applicable to all persons, of whatever school of thought, who engage in any profession or trade." Based on this comment, by what standard should a chiropractor be judged if his treatment is unsuccessful, and if his treatment differs significantly from that of an orthopedic surgeon?

2. At one time the plaintiff had to produce an expert familiar with the practice of medicine in the locality where the alleged malpractice occurred. This severely restricted the list of eligible witnesses to ones likely to be disinclined to testify negatively about a colleague. Most jurisdictions have moved to a standard that requires the plaintiff to supply an expert familiar with the practice of that type of medicine in the state where the case arose. (This is the standard adopted in RCW 7.70.040, *infra*.) While this is the standard applied for general practitioners, some jurisdictions now apply a standard of care for specialists that is nationwide in scope. This reflects both the more limited number of qualified witnesses and the recognition that the practice of medical specialties does not vary significantly from state to state.

2. Informed Consent

WACHTER v. UNITED STATES

877 F.2d 257 (4th Cir. 1989)

ERVIN, Chief Judge

Jean M. Wachter appeals from an order granting defendant, the United States, summary judgment in Wachter's Federal Tort Claims Act ("FTCA"), 28 U.S.C.A. § 2671 *et seq.*, suit for medical malpractice. The district court found no evidence creating genuine issues that harm had accrued to Wachter from the misrepresentations and failures to disclose that she alleged. We agree, and affirm.

I

A

Wachter, then fifty-five years old, entered the Bethesda Naval Hospital ("Bethesda") for double coronary artery bypass surgery on March 1, 1983. Wachter's attending surgeon during this hospitalization was Commander Reginald Peniston. Commander Edward L. Woods, Jr., a resident in thoracic surgery, performed Wachter's March 4, 1983, operation under Peniston's direct supervision. Woods used segments of saphenous veins removed from Wachter's leg to bypass occluded portions of the native coronary arteries. Prior to the operation, Woods had apprised Wachter of what the saphenous vein graft procedure ("SVG") involved, what alternative procedures existed, the possible complications and sequelae of SVG[1] and that the decision whether to proceed was ultimately hers. Wachter indicated

[1] Woods specifically indicated the possibilities of post-surgical hemorrhage, myocardial infarction, stroke, death, infection, and occlusion of the grafted veins.

that she understood what Woods had said and signed an SVG consent form.

By July, 1983, it had become clear that Wachter's SVG had failed. Wachter's symptoms, and the results of a cardiac catheterization, revealed that the grafted veins were between seventy and ninety percent occluded. Bethesda surgeons recommended a second double bypass procedure.

Wachter had begun reading about the heart and bypass surgery while hospitalized after the March operation. After her doctors counseled a second procedure, and with her husband's assistance, Wachter began a concerted campaign of self-education.[2] After investigating alternative techniques and facilities, Wachter satisfied herself that entering Bethesda for a second bypass was her only alternative.

It is on what Bethesda surgeons told her when she submitted herself for the second procedure that Wachter's claims center. Wachter's primary surgeon for the August 1, 1983, operation was Dr. Donal M. Billig. Billig was then Bethesda's chief of cardiothoracic surgery.

Since Wachter's second SVG, the Navy has cashiered Billig based on a number of revelations.[3] One of Wachter's complaints is that she was unable to give her informed consent to the second SVG because Bethesda withheld word of Billig's shortcomings.

Wachter first met Billig in July, 1983, when Billig delivered the results of Wachter's cardiac catheterization and recommended an immediate second SVG. Wachter, having reviewed other facilities and procedures, returned to Bethesda later that month. Wachter was still uncertain whether to accept Billig as her primary surgeon, and proceeded to interview one of Billig's colleagues, Dr. George W. Haggerson,[4] about Bethesda's and Billig's record on second SVGs.

There can be little doubt that Wachter's questions to Haggerson were designed to elicit information about Billig rather than about SVG or alternative procedures.[5] Haggerson recited mortality rates for Bethesda and for Billig that apparently did not alarm Wachter. Wachter stated that Haggerson finished by assuring her that in Billig she "was getting one of the finest doctors in the country … and it was rather senseless … to go to outside doctors when [she] had the best right here." There is no evidence that Haggerson then knew anything that should have persuaded him that his statements about Billig were untrue.

The second root of Wachter's grievance, after her conviction that she received harmful misinformation about Billig, is her belief that Bethesda should have told her about an alternative to SVG, the internal mammary artery bypass

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2 Despite her doctor's advice that she remain hospitalized for a prompt second SVG following her cardiac catheterization, Wachter insisted that she be discharged to plumb her options. "This time," Wachter explained in her deposition, "I wanted to get smart."

3 While this case only incidentally involves Billig's relationship with the Navy and patients other than Wachter, we digress to summarize what the record reveals about an imbroglio that has achieved considerable notoriety. The report of the Navy's Formal Board of Investigation of the Billig affair records a story that, while most disturbing, suggests that Wachter was among the lucky fraction of patients not hurt by Billig's shortcomings.

The report reveals that at least two Navy officers recommended that the Navy hire Billig as a surgeon while withholding or softpedaling information that two civilian health centers had terminated Billig's privileges because of incompetence and lack of diligence and that the Air Force had found Billig unqualified for service because of reduced vision in his right eye. The report found Billig's cardiothoracic surgery mortality rate at Bethesda "unacceptably high", and presented a number of histories of Bethesda patients who had died from what other surgeons opined was Billig's culpable negligence. A Navy court-martial subsequently found Billig guilty of, among other things, dereliction of duty.

4 Haggerson, with Dr. Geoffrey M. Graeber, Director of the Division of Surgery at Washington, D.C.'s Walter Reed Army Institute of Research, and a fourth surgeon, would assist Billig at Wachter's August 1 operation.

5 Wachter does not allege that she received insufficient or incorrect reports about her SVG operations. Wachter did not discuss the SVG with Haggerson because, as she stated, "they [i.e. Bethesda] knew I knew" the particulars from her March, 1983, briefing and her independent investigation. Haggerson related that the second SVG would use veins from the leg not used in the first surgery and that a second SVG imported a higher risk of complications, including death, than had the first surgery.

Wachter stated that she had gotten information on "probably three" surgeons other than Billig before entering Bethesda in late July. On the eves of the March and August SVGs, Wachter signed identical consent forms. Among the form's acknowledgments is that the "possibility of complications [has] been fully explained to [the signatory, who] acknowledge[s] that no guarantees have been made to me concerning the results of the operation or procedure...."

procedure (IMA).[6] IMA uses chest rather than leg vessels as the graft stock for a coronary bypass.

Dr. Robert D. Brickman, whose affidavits Wachter tendered in opposition to the United States' motion for summary judgment, opined that Billig should have offered Wachter the option of an IMA. Brickman stated that IMA, "although not commonly used throughout the United States in July, 1983, [was] a preferable alternative in selected patients." While Brickman admitted that the question remained unsettled until well after Wachter's second SVG, he opined that IMA could have had a higher chance of success than a second SVG in a patient like Wachter. Brickman's statements make plain that the availability as well as the advisability of IMA for Wachter was problematic in 1983.

Brickman believed that "[p]robably 20 percent" of U.S. hospitals offered IMA in 1983; it is undisputed that Bethesda was not among them.[7] In 1983, though, only one facility had compared the success rates of IMA and SVG for patients undergoing a second bypass. Brickman was "not sure of" the results of that study. As to Billig's performance of Wachter's second SVG, Brickman had no opinion whether Billig "deviated from the acceptable standard in the manner and technique employed in the performance of the bypass grafts.[8]

[6] Wachter's memorandum in opposition to the United States' motion for summary judgment also argued that Bethesda should have told Wachter of a third alternative, that of angioplasty. Angioplasty is a procedure, less intrusive than SVG or IMA, in which a surgeon maneuvers small balloons into the occluded portions of the coronary blood vessels. When inflated, the balloons compress the occluding material against the walls of the vessels, allowing for improved blood flow and eliminating the need for bypass grafts. Wachter's deposition makes clear that she was familiar with the alternative of angioplasty through her own research, and that she had elected not to pursue the alternative, which Bethesda did not then offer, before entering Bethesda for her second SVG. There is, therefore, no doubt that Bethesda's omission of the angioplasty alternative did not affect Wachter's ability to give informed consent to an SVG.

[7] Brickman cited the Norfolk [Va.] General Hospital as a facility near Bethesda that offered IMA in July, 1983. Brickman also stated, however, that of "hundreds" of United States medical institutions, "probably about four or five" would have urged Wachter to elect IMA in 1983.

[8] Brickman candidly admitted that "[t]here's no way that I could comment on [Wachter's] case ... because I was not present in the operating room and, therefore, did not observe what actually took place." Brickman also testified that nothing he had read concerning the second SVG had led him to suspect surgical error. Similarly, Brickman stated at his deposition that he could not conclude that Wachter has been misinformed or underinformed of the risks attending a second SVG."

(continued...)

B

Wachter, with her husband, Robert, commenced this action on August 6, 1987. The Wachters sought $3,000,000.00 in damages for the failure of Jean Wachter's second SVG. The second set of vein grafts had, like the first, become occluded and unable to transfer blood at a rate sufficient to alleviate Wachter's preoperative symptoms.

Wachter's complaint presented four theories of recovery. The first count generally alleged that Bethesda failed properly to obtain Wachter's informed consent. The second count charged various acts of medical negligence by Bethesda personnel. Counts three and four alleged that Bethesda negligently hired, supervised, and credentialed Billig.

In response to the United States' June 3, 1988, motions for summary judgment and for dismissal for lack of subject matter jurisdiction under the FTCA, the Wachters moved voluntarily to dismiss the last three counts of the complaint and so much of the first count as bore on the first SVG. The district court granted both parties' motions, dismissing with prejudice the bulk of Wachter's complaint and granting the United States summary judgment on Wachter's informed consent objection to the second SVG. We do not understand Wachter to dispute the district court's construction of the applicable law of informed consent. Our attention is accordingly directed only toward the question of whether any genuine issues exist that should have precluded summary judgment.

II

Maryland law supplies the rules of decision on informed consent in this action. 28 U.S.C. § 1346(b). *Sard v. Hardy*, 379 A.2d 1014 (Md. 1977), is Maryland's principal elaboration of the doctrine of informed consent. The doctrine "imposes on a physician ... the duty to explain the procedure to the patient and to warn [her] of any material risks or dangers inherent in or collateral to

the therapy, so as to enable [her] to make an intelligent and informed choice about whether or not to undergo such treatment." *Id.* at 1020. (Citations omitted).[9] The duty to disclose specifically requires a physician "to reveal … the nature of the ailment, the nature of the proposed treatment, the probability of success of the contemplated therapy and its alternatives, and the risk of unfortunate consequences associated with such treatment." *Id.* (Citations omitted). As to what data are significant enough to warrant disclosure, *Sard* held the measure to be that of materiality, of whether a reasonable person in the patient's position would consider the data significant to the decision whether to submit to a particular treatment or procedure. *Id.* at 1022.

In keeping with the tort character of an informed consent action, Wachter is bound to show that Bethesda's breach of its duty of informed consent, if it occurred, caused her harm. *Lipscomb v. Memorial Hosp.*, 733 F.2d 332, 338 (4th Cir. 1984) (applying Maryland law). *Lipscomb* interpreted *Sard* to articulate three elements of a prima facie case of medical malpractice by failure to obtain informed consent. *Id.* The elements are that: (1) a material, undisclosed risk existed; (2) the risk occurred; and (3) injury flowed from the occurrence. 733 F.2d at 338.

A

We read *Sard* to leave at issue whether revelations of information about one's physician are within the scope of the duty to disclose as Maryland has chosen to define it. We conclude, however, following the district court, that the evidence speaks with one voice that the failure of Wachter's second SVG does not trace to the competence of Billig and that for another surgeon to have performed the second SVG would not have increased the procedure's likelihood of success. We refer to Brickman's affidavit and deposition and to Graeber's affidavits as the only lode of information about Billig's performance as it bears on this case. Brickman was forthright about his inability to critique Billig's conduct, even though Brickman had reviewed evidence of Wachter's condition after the second SVG. By contrast, Graeber, who had assisted Billig in the August, 1983, surgery, stated that there had been no "notable intraoperative complications" and that the second set of grafts had failed "for reasons not apparently related to the conduct of the [second SVG]."[10] We therefore conclude, following *Sard* and *Lipscomb*, that the district court correctly granted summary judgment in favor of the United States on Wachter's claim insofar as it bears on Billig's competence.

B

The district court granted the United States summary judgment on Wachter's claim that she should have been told of the IMA alternative based on its conclusions that IMA was not, in 1983, a "medically significant" alternative to SVG and that no credible evidence suggested that IMA would have produced a better result. We agree with the district court that Maryland did not require Bethesda to educate Wachter about every conceivable alternative to a second SVG. This conclusion is implicit in *Sard's* definition of material information, because a reasonable person would not consider information about experimental or arcane "alternatives" as significant to her decision whether to submit to a recommended procedure. *Lipscomb*, 733 F.2d at 838; *Sard*, 379 A.2d at 1022. Rather than expressly ratify the district court's assessment of the evidence of IMA's significance in 1983, however, we rest our affirmance on our perception that the evidence does not suggest that information on IMA would have prompted Wachter to elect the procedure or that the procedure would have averted the health problems Wachter now experiences.

The only evidence in Wachter's favor on this point is Brickman's affidavit statement that Wachter "was an ideal candidate for an IMA graft." We believe the district court properly discredited this statement as a "bare conclusion." The affidavit does not explain the conclusion. A medical journal article, an excerpt from which accompanies Brickman's affidavit in the record

[9] We assume what the parties have not elected to quarrel over directly, that Bethesda, rather than Haggerson alone, stood as Wachter's "physician" for purposes of our analysis of the sufficiency of disclosures concerning Billig.

[10] Graeber observed that Wachter's outcome "is often associated with short stature female patients who are obese or have abnormally high serum cholesterol levels" but admitted that he knew "of no definitive means of establishing the precise pathogenesis" of the unfortunate result.

before us, reveals considerable disagreement among surgeons on the relative merits of SVG and IMA.[11] Brickman's deposition also shows that in 1983, only one clinic in the United States had information about the benefits of IMA for a patient whose earlier SVG had failed. Brickman was not sure what results that clinic had witnessed in patients such as Wachter. Brickman remarked that "[t]here's all kinds of stuff in literature subsequent to [that clinic's pioneering turn]", but referred specifically only to the 1980 article attached to his affidavit and to another paper, apparently the product of the same physicians as contributed to the first, that is not in the record. We do not believe Brickman's evidence suggests that Wachter would have done anything differently had she learned everything known about IMA in 1983.

Even if we assume that Wachter would have sought and been approved for IMA, though, the evidence does not suggest that Wachter would have benefited from the procedure. The evidence tendered by the United States speaks with one voice that Wachter's current health problems do not stem from the sort of bypass procedure used. Graeber noted that "in [Wachter's] case SVG grafting of at least one artery was required, even if IMA grafting was attempted, because of specific perfusion needs." Billig recalled that he did not discuss IMA with Wachter because IMA was "not known to produce a superior result, and required a longer operation ... [Wachter] ... was short and very heavy [and] using an IMA graft would have been very difficult." Like Graeber, Billig averred that Wachter would have had to have at least one saphenous vein graft in the second procedure and stated "it was not advisable to use both IMA and [SVG] because it required a more tedious dissection ... and might have required more blood transfusions." This evidence that IMA would not have benefited Wachter, and the infirmity of Brickman's conclusion that Wachter might reasonably have sought IMA in 1983, persuades us that the district court correctly ruled for the United States on Wachter's IMA claim.

III

For the foregoing reasons, we believe the district court was correct to order summary judgment in favor of the United States.

Affirmed.

MURNAGHAN, Circuit Judge, concurring in part and dissenting in part:

I agree with the majority that Wachter produced no evidence that Dr. Billig's alleged surgical incompetence contributed to the failure of her saphenous vein grafts (SVG). The district court therefore properly granted summary judgment in favor of the United States on Wachter's claim insofar as it focused on the failure of Bethesda personnel to disclose Billig's purported surgical shortcomings.

However, the district court erred in granting summary judgment against Wachter insofar as she based her informed consent claim on the failure of Billig and other physicians at Bethesda to advise her of the internal mammary artery (IMA) procedure as an alternative to an SVG bypass. Wachter has raised genuine issues of material fact as to the three elements necessary to sustain an informed consent claim under Maryland law: (1) whether the physicians at Bethesda had a duty to disclose the existence of the IMA alternative as well as its risks and prospects for success, (2) whether a causal link existed between Wachter's consent to the SVG bypass and the physicians' failure to disclose information about IMA and (3) whether Wachter suffered any harm as a result of undergoing the SVG procedure rather than the IMA alternative.

In upholding the grant of summary judgment, the majority has overlooked crucial evidence favorable to Wachter and has usurped the function of the fact finder by resolving disputed issues of material fact. For those reasons, I dissent from the majority decision on the IMA issue.

I. Duty to Disclose

I begin with an issue that the majority declined to address, namely, whether the physicians at Bethesda had a duty to inform Wachter of the IMA alternative to the SVG bypass procedure. Maryland law imposes on physicians a duty to disclose the existence of alternatives to proposed surgery or treatment, as well as the risks and benefits adhering to each option, if such information would

[11] The article, entitled *Comparison of Saphenous Vein and IMA Grafts*, appeared in the September, 1980 issue of the *Journal of Thoracic and Cardiovascular Surgery*, and appears to be a transcription of a surgeons' colloquium on experiences with the two procedures.

be "material to the intelligent decision of a reasonably prudent patient." *Sard v. Hardy*, 281 Md. 432, 444, 379 A.2d 1014, 1022 (1977).

The evidence here would allow a trier of fact to find that a reasonable patient in 1983 would have considered information about IMA material to her decision to undergo bypass surgery.[1] Dr. Brickman, Wachter's expert, testified in deposition that medical evidence in 1983 demonstrated that IMA grafts had superior long-term patency rates (in other words, remained non-occluded or non-obstructed longer) than SVG grafts. Brickman also testified that he and other physicians in 1983 found IMA grafts especially preferable to the SVG option for women, such as Wachter, who had previously experienced blockage of saphenous vein grafts.

The IMA alternative had been used in bypass surgery since at least 1968, and Brickman pointed to medical studies from as early as 1980 indicating that IMA grafts remained patent longer than the saphenous vein grafts. The results of those studies were contained in a 1980 medical journal article which Wachter submitted in support of Brickman's affidavit. In that article, at least one surgeon characterized IMA patency rates as "vastly superior" to those for saphenous vein grafts. *Comparison of Saphenous Vein and IMA Grafts*, *Journal of Thoracic & Cardiovascular Surgery*, Sept. 1980, at 341 [hereinafter "*Comparison*"].

To be sure, many physicians in 1983 apparently disagreed with Brickman over the relative merits of the IMA and SVG options. However, evidence of such disagreement in no way compels summary judgment in favor of the United States. A reasonable patient may find information about an alternative medical procedure material to her decisionmaking even though the medical community is divided over its relative benefits as compared to other surgical options. The medical community need not reach a consensus on the superiority of a particular surgical alternative before a physician has a duty under Maryland law to inform the patient of that option. The doctrine of informed consent in Maryland rests on the notion that the patient, not her physician, has the ultimate right to decide what is best for her own body: Thus, the appropriate test is not what the physician in the exercise of his medical judgment thinks a patient should know before acquiescing in a proposed course of treatment; rather, the focus is on what data the patient requires in order to make an intelligent decision. *Sard*, 281 Md. at 442, 379 A.2d at 1021. The patient cannot exercise her "fundamental right of physical self-determination," *id.*, when she is kept in the dark about a medical alternative favored by a significant number of physicians.

Wachter's evidence at a minimum raises a factual question as to the degree of acceptance the IMA option enjoyed in the medical community in 1983. It is impossible to quantify, as a matter of law, the percentage of the medical community that must accept or favor a given alternative before that option becomes "material". That percentage will vary depending on the circumstances of each case. In some cases, a reasonably prudent patient might find a medical alternative material to her decision even though only a minority of the medical community favored the procedure. To require a clear majority of the medical community to prefer a procedure before it could be considered a material option would fly in the face of the decision of the Maryland Court of Appeals in *Sard*, which expressly refused to allow the medical community's view of the significance of a procedure to define the scope of the duty to disclose. *See id.*

Of course, certain procedures may be so experimental or accepted by such a small fringe of the medical community that, as a matter of law, information about them cannot be considered "material" to a reasonably prudent patient's decisionmaking. However, Wachter has produced evidence that as early as 1980 many members of the medical community preferred the IMA option to the SVG for most bypass grafts. Moreover, Brickman's testimony and the medical journal article submitted in support of his affidavit suggest that even some of the physicians who preferred SVG over IMA for first-time recipients of bypass grafts favored using IMA for patients who had previously received SVG grafts that had failed. At the very least, the evidence raises a question for the fact finder as to whether a reasonable patient in Wachter's position in 1983 would have considered IMA a significant medical option.

That only about 20% of the hospitals in the United States offered the IMA procedure in 1983 does not render irrelevant a belief that a reasonably

[1] The case turns on the state of medical knowledge in 1983, the year of Wachter's surgery.

prudent patient could have considered information about IMA material to her decision to undergo bypass surgery.[2] A patient who faces a serious health risk may wish to know about important medical procedures, particularly those that might prove highly successful, even though only a few hospitals offer such procedures. At any rate, 20% is a significant proportion of the hospitals in the country. That one-fifth of the medical facilities offered IMA strongly suggests that the procedure was neither purely experimental nor isolated to a small fringe of the medical community.

I find unacceptable the district court's argument that, as a matter of law, the choice between SVG and IMA grafts represented a mere "choice of tactical surgical approaches" akin to a surgeon's selection of which sutures to use or the location of an incision, and that Billig and his colleagues therefore had no duty to inform Wachter about the IMA option. *Wachter v. United States*, 689 F. Supp. 1420, 1424 (D. Md. 1988).[3] To be sure, some mechanical or technical choices in surgery will be so immaterial to a patient's decisionmaking that, as a matter of law, the surgeon need not discuss them with the patient. The evidence here, however, would allow a trier of fact to find that the IMA option was more than an insignificant tactical choice, but instead was an important medical alternative which a reasonable patient would find material to her decision to submit to bypass surgery. That the medical community actively debated the relative benefits of IMA and SVG well before 1983 suggests that most patients in Wachter's position would have wanted to know about the IMA option before deciding to have a second bypass operation.

The district court misconstrued Maryland law when it suggested that the doctrine of informed consent has no applicability whatsoever when the choice presented is between various techniques of accomplishing a type of operation (*e.g.*, bypass surgery), instead of between surgery and a non-surgical treatment. *See Wachter*, 689 F. Supp. at 1424. *Sard*, the premier case on informed consent in Maryland, clearly demonstrates that a physician may have a duty under some circumstances to inform the patient of the various methods of performing a given operation. That case held, inter alia, that a jury could reasonably conclude that a physician had a duty to disclose to a patient the various methods of accomplishing female sterilization through tubal ligation. *Sard*, 281 Md. at 437, 445-46, 448, 379 A.2d at 1018, 1023, 1024. The physician in *Sard* had informed the patient of birth control methods other than tubal ligation, but had failed to discuss with her the most common methods of performing tubal ligation, even though success rates among the options varied considerably. *Id.* at 437, 379 A.2d at 1018. The facts of *Sard* belie the district court's suggestion that once a physician discloses the alternatives to surgery, he or she never has a further duty to disclose the various methods of accomplishing the operation.

In sum, the evidence in the record raises a genuine issue as to whether a reasonably prudent patient would have considered information about IMA material to her decision to undergo bypass surgery. Were the IMA information material, Maryland law would have required Billig and his colleagues to discuss it with Wachter before performing surgery.

II. Causation

I disagree with the majority's assertion that Wachter has presented no evidence that she would have chosen the IMA procedure had she received information about it prior to her surgery on August

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[2] It is unclear from Brickman's deposition whether he meant that 20% of all hospitals in the United States offered the IMA option in 1983, or instead, that 20% of the nation's hospitals that performed bypass surgery provided the IMA alternative. Whichever Brickman meant, his testimony suggests that IMA was available in 1983 at a significant number of medical centers in the United States.

[3] Although the recent decision of the Maryland Court of Special Appeals in *Nash v. Raneri*, 77 Md. App. 402, 550 A.2d 717 (1988), quoted extensively from the Wachter opinion below, nothing in *Nash* suggests that the Court of Special Appeals intended to endorse the district court's analysis of the evidence or its decision to grant summary judgment. At most, *Nash* illustrates that Maryland law does not require a physician to discuss every tactical decision in surgery with the patient. I fully concur in that reading of Maryland law. What I find objectionable is the district court's decision to deprive the fact finder of the opportunity to decide whether the IMA was an insignificant tactical surgical choice or, as Wachter asserts, an important medical option that she would have found material to her decisionmaking. *Nash* certainly did not endorse the district court's depriving the fact finder of the opportunity to assess the materiality of the IMA procedure. In *Nash*, the trial court had allowed the jury to decide the informed consent issue, and the Court of Special Appeals agreed that the matter was properly left to the jury. *See* 77 Md. App. at 408-10, 550 A.2d at 720-21.

1, 1983. The majority has ignored crucial evidence in Wachter's favor in reaching its conclusion.

Maryland has adopted an objective standard for determining causation in informed consent cases. No causal link exists between the plaintiff's injury and the physician's violation of the duty to disclose medial alternatives unless a reasonable person in the patient's position would have made a different choice had she been fully informed. *Sard*, 281 Md. at 450, 379 A.2d at 1025. The evidence in the record would support a finding that a reasonable person in Wachter's shoes would have chosen the IMA procedure over the SVG if given a choice.

The majority and the district court improperly dismissed as "bare conclusion" Brickman's assertion that Wachter "was an ideal candidate for an IMA graft." Contrary to the majority's assertion, the record contains abundant support for Brickman's conclusion. Brickman testified that the IMA grafts had a significantly greater patency rate than the SVG. That opinion was echoed by a number of physicians who sang the praises of the IMA option in a medical journal article submitted in support of Brickman's affidavit. Most notably, Brickman emphasized that IMA was especially preferable to SVG for patients, particularly females, who had earlier already experienced failure with saphenous vein grafts.

In concluding that Wachter would not have chosen IMA if given a chance, the majority places too much emphasis on the lack of consensus in the medical community in 1983 as to whether IMA or SVG was preferable for bypass grafts. The majority misperceives the nature of the dispute over IMA. Brickman emphasized that the conflict in the medical literature over IMA focused on the preferable approach for patients receiving bypass grafts for the first time, not on the proper choice for individuals, such as Wachter, who had already experienced failure of a saphenous vein graft. The medical journal article submitted in support of Brickman's affidavit suggests that some physicians who preferred SVG to IMA grafts in first-time bypass operations would opt for IMA grafts the second time around in patients who had experienced SVG failure. For example, the article provides the following summary from Dr. Alexander S. Geha, a skeptic about claims of IMA superiority:

> I really do not see much of a controversy. I do not think that, at present, the difference in results between these two types of grafts is worth the effort of dissecting the IMA and using it except in patients who have had failure of a previous vein graft or in whom a relatively high risk of occlusion of a vein graft into a small anterior coronary artery can be anticipated. *Comparison*, at 339 (emphasis added).

Even assuming, arguendo, that the evidence here would preclude a finding that a reasonable patient would have chosen IMA grafts for first-time bypass surgery, Wachter's evidence would allow a fact finder to infer that such a patient would have opted for IMA in 1983 for a second bypass that was necessitated by previous failure of saphenous vein grafts.

To be sure, the government has presented evidence that the IMA alternative would have made the bypass operation more complicated and perhaps more dangerous than SVG surgery. A trier of fact could permissibly find, however, that a reasonable person in Wachter's position would have chosen to risk the added surgical hazards in exchange for the greater likelihood of long-term success presented by the IMA alternative.

III. Injury

Wachter can succeed on her informed consent claim only by showing that she suffered some injury by receiving the saphenous vein grafts rather than the IMA option. Under the circumstances presented here, Wachter need not prove that her bypass grafts would not have occluded had Billig performed the IMA procedure rather that the SVG. To require such a showing where the plaintiff has never received an IMA graft would present a virtually insurmountable barrier to her claim. Instead, Wachter need only show that she would have enjoyed a better chance of success with the IMA grafts than with the SVG.[4]

The evidence here would allow a fact finder to

[4] Perhaps the standard would be different had Wachter undergone a third bypass operation using IMA grafts which subsequently occluded. Such failure of the IMA grafts would present strong evidence that the grafts would also have occluded had she received them in the second operation. However, I have seen no evidence in the record that Wachter had submitted to a third bypass operation at the time the district court granted summary judgment.

conclude that IMA grafts would have offered a greater likelihood of success for Wachter's second bypass operation than the SVG option provided. Wachter produced evidence that IMA grafts provided greater long-term patency than saphenous vein grafts. Brickman, Wachter's expert, also testified that IMA grafts were a particularly superior option for women who had previously experienced failure with saphenous vein grafts.

I find utterly unsupportable the majority's assertion that the evidence "speaks with one voice that Wachter's current health problems do not stem from the sort of bypass procedure used." Majority Op. at 11. The majority apparently finds dispositive the government's assertion that Wachter's bypass surgery would have required at least one saphenous vein graft, even if IMA were used. Wachter's evidence contradicts the government's allegation that her surgery could not have been performed with IMA grafts alone. The principal support for the government's contention is Billig's affidavit, which states that "Wachter was having a double bypass (left anterior descending and obtuse marginal grafts) and we could not use IMA for the obtuse marginal graft." Although Brickman never contradicted Billig's assertion that Wachter needed a double bypass, his affidavit does dispute Billig's claim that IMA could not be used for both grafts. Specifically, Brickman declared in his affidavit that:

> The left internal mammary artery can be used to bypass the left anterior descending *or the obtuse marginal branch* of the circumflex artery. The right internal mammary can be used to bypass *either of the same two vessels*. (Emphasis added).

Even if Wachter's double bypass would have required at least one SVG, that fact would not compel summary judgment in favor of the United States. The majority apparently assumes that had Wachter received both an SVG and IMA graft in the August 1983 surgery, the single SVG would have failed as it had after the first bypass surgery. Even were I to accept that assumption, I cannot agree with the majority's further implicit assumption that Wachter would have been no better off with the combination of a successful IMA graft and an occluded SVG than with two occluded saphenous vein grafts. I respectfully submit that we on the panel simply lack the medical expertise to engage in such speculation, especially in the absence of any supporting evidence in the record. The question is a factual one best left to the trier of fact which would have the benefit of expert medical testimony.

IV. Conclusion

Wachter has raised a genuine issue of material fact as to each of the three elements — duty to disclose, causation and injury —she must prove to succeed on her informed consent claim under Maryland law. I therefore dissent from the majority opinion insofar as it upholds the grant of summary judgment on the IMA issue.

Questions and Notes

1. In determining whether the patient gave truly informed consent, the trier of fact must determine whether the patient was informed of material risks and alternative treatment options. Particularly where the risks are remote or the alternatives novel, the question arises as to who decides which risks are "material." What is agreed upon is that the standard is what would be reasonable. But jurisdictions differ on whether the standard is set by the "reasonable physician" or by the "reasonable patient." The two should be very close, but the standard of the reasonable patient may suggest a greater willingness to recognize subjective and idiosyncratic considerations unique to the patient—so long as those have been disclosed to the physician. *See Eccleston v. Chait*, 492 N.W.2d 860 (Neb. 1992); *Scott v. Bradford*, 606 P.2d 554 (Okla. 1979); *Reyes v. Wyeth Laboratories*, 498 F.2d 1264 (5th Cir. 1974).

3. Statutory Modifications

REVISED CODE OF WASHINGTON
(1988)

4.16.350 · Actions for injuries resulting from health care or related services —
Physicians, dentists, nurses, etc. —Hospitals, clinics, nursing homes, etc.

Any civil action for damages for injury occurring as a result of health care which is provided after June 25, 1976 against:

(1) A person licensed by this state to provide

health care or related services, including, but not limited to, a physician, osteopathic physician, dentist, nurse, optometrist, podiatrist, chiropractor, physical therapist, psychologist, pharmacist, optician, physician's assistant, osteopathic physician's assistant, nurse practitioner, or physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his estate or personal representative;

(2) An employee or agent of a person described in subsection (1) of this section, acting in the course and scope of his employment, including, in the event such employee or agent is deceased, his estate or personal representative; or

(3) An entity, whether or not incorporated, facility, or institution employing one or more persons described in subsection (1) of this section, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his employment, including, in the event such officer, director, employee, or agent is deceased, his estate or personal representative;

based upon alleged professional negligence shall be commenced within three years of the act or omission alleged to have caused the injury or condition, or one year of the time the patient or his representative discovered or reasonably should have discovered that the injury or condition was caused by said act or omission, whichever period expires later, except that in no event shall an action be commenced more than eight years after said act or omission: Provided, That the time for commencement of an action is tolled upon proof of fraud, intentional concealment, or the presence of a foreign body not intended to have a therapeutic or diagnostic purpose or effect.

For purposes of this section, notwithstanding R.C.W. 4.16.190, the knowledge of a custodial parent or guardian shall be imputed to a person under the age of eighteen years, and such imputed knowledge shall operate to bar the claim of such minor to the same extent that the claim of an adult would be barred under this section. Any action not commenced in accordance with this section shall be barred.

* * *

4.28.360 · Personal injury actions — Complaint not to include statement of damages —Request for statement

In any civil action for personal injuries, the complaint shall not contain a statement of the damages sought but shall contain a prayer for damages as shall be determined. A defendant in such action may at any time request a statement from the plaintiff setting forth separately the amounts of any special damages and general damages sought. Not later than fifteen days after service of such request to the plaintiff, the plaintiff shall have served the defendant with such statement.

7.70.010 · Declaration of modification of actions for damages based upon injuries resulting from health care

The state of Washington, exercising its police and sovereign power, hereby modifies as set forth in this chapter and in R.C.W. 4.16.350, as now or hereafter amended, certain substantive and procedural aspects of all civil actions and causes of action, whether based on tort, contract, or otherwise, for damages for injury occurring as a result of health care which is provided after June 25, 1976.

7.70.020 · Definitions

As used in this chapter "health care provider" means either:

(1) A person licensed by this state to provide health care or related services, including, but not limited to, a certified acupuncturist, a physician, osteopathic physician, dentist, nurse, optometrist, podiatrist, chiropractor, physical therapist, psychologist, pharmacist, optician, physician's assistant, midwife, osteopathic physician's assistant, nurse practitioner, or physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his estate or personal representative;

(2) An employee or agent of a person described in part (1) above, acting in the course and scope of his employment, including, in the event such employee or agent is deceased, his estate or personal representative; or

(3) An entity, whether or not incorporated,

facility, or institution employing one or more persons described in part (1) above, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his employment, including in the event such officer, director, employee, or agent is deceased, his estate or personal representative.

7.70.030 · Propositions required to be established —Burden of proof

No award shall be made in any action or arbitration for damages for injury occurring as the result of health care which is provided after June 25, 1976, unless the plaintiff establishes one or more of the following propositions:

(1) That injury resulted from the failure of a health care provider to follow the accepted standard of care;

(2) That a health care provider promised the patient or his representative that the injury suffered would not occur;

(3) That injury resulted from health care to which the patient or his representative did not consent.

Unless otherwise provided in this chapter, the plaintiff shall have the burden of proving each fact essential to an award by a preponderance of the evidence.

7.70.040 · Necessary elements of proof that injury resulted from failure to follow accepted standard of care.

The following shall be necessary elements of proof that injury resulted from the failure of the health care provider to follow the accepted standard of care:

(1) The health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he belongs, in the state of Washington, acting in the same or similar circumstances;

(2) Such failure was a proximate cause of the injury complained of.

7.70.050 · Failure to secure informed consent — Necessary elements of proof — Emergency situations

(1) The following shall be necessary elements of proof that injury resulted from health care in a civil negligence case or arbitration involving the issue of the alleged breach of the duty to secure an informed consent by a patient or his representatives against a health care provider:

(a) That the health care provider failed to inform the patient of a material fact or facts relating to the treatment;

(b) That the patient consented to the treatment without being aware of or fully informed of such material fact or facts;

(c) That a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts;

(d) That the treatment in question proximately caused injury to the patient.

(2) Under the provisions of this section a fact is defined as or considered to be a material fact, if a reasonably prudent person in the position of the patient or his representative would attach significance to it deciding whether or not to submit to the proposed treatment.

(3) Material facts under the provisions of this section which must be established by expert testimony shall be either:

(a) The nature and character of the treatment proposed and administered;

(b) The anticipated results of the treatment proposed and administered;

(c) The recognized possible alternative forms of treatment; or

(d) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment administered and in the recognized possible alternative forms of treatment, including nontreatment.

(4) If a recognized health care emergency exists and the patient is not legally competent to give an informed consent and/or a person

legally authorized to consent on behalf of the patient is not readily available, his consent to required treatment will be implied.

7.70.060 · Consent form —Contents —Prima facie evidence —Failure to use

If a patient while legally competent, or his representative if he is not competent, signs a consent form which sets forth the following, the signed consent form shall constitute prima facie evidence that the patient gave his informed consent to the treatment administered and the patient has the burden of rebutting this by a preponderance of the evidence:

(1) A description, in language the patient could reasonably be expected to understand, of:

(a) The nature and character of the proposed treatment;

(b) The anticipated results of the proposed treatment;

(c) The recognized possible alternative forms of treatment; and

(d) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment, including nontreatment;

(2) Or as an alternative, a statement that the patient elects not to be informed of the elements set forth in subsection (1) of this section.

Failure to use a form shall not be admissible as evidence of failure to obtain informed consent.

7.70.065 · Informed consent —Persons authorized to provide for patients who are not competent —Priority

(1) Informed consent for health care for a patient who is not competent, as defined in R.C.W. 11.88.010(1)(b), to consent may be obtained from a person authorized to consent on behalf of such patient. Persons authorized to provide informed consent to health care on behalf of a patient who is not competent to consent shall be a member of one of the following classes of persons in the following order of priority:

(a) The appointed guardian of the patient, if any;

(b) The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions;

(c) The patient's spouse;

(d) Children of the patient who are at least eighteen years of age;

(e) Parents of the patient; and

(f) Adult brothers and sisters of the patient.

(2) If the physician seeking informed consent for proposed health care of the patient who is not competent to consent makes reasonable efforts to locate and secure authorization from a competent person in the first or succeeding class and finds no such person available, authorization may be given by any person in the next class in the order of descending priority. However, no person under this section may provide informed consent to health care:

(a) If a person of higher priority under this section has refused to give such authorization; or

(b) If there are two or more individuals in the same class and the decision is not unanimous among all available members of that class.

(3) Before any person authorized to provide informed consent on behalf of a patient not competent to consent exercises that authority, the person must first determine in good faith that that patient, if competent, would consent to the proposed health care. If such a determination cannot be made, the decision to consent to the proposed health care may be made only after determining that the proposed health care is in the patient's best interests.

7.70.070 · Attorneys' fees

The court shall, in any action under this chapter, determine the reasonableness of each party's attorneys fees. The court shall take into consideration the following:

(1) The time and labor required, the novelty and difficulty of the questions involved, and

the skill requisite to perform the legal service properly;

(2) The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;

(3) The fee customarily charged in the locality for similar legal services;

(4) The amount involved and the results obtained;

(5) The time limitations imposed by the client or by the circumstances;

(6) The nature and length of the professional relationship with the client;

(7) The experience, reputation, and ability of the lawyer or lawyers performing the services;

(8) Whether the fee is fixed or contingent.

7.70.080 · Evidence of compensation from other source

Any party may present evidence to the trier of fact that the patient has already been compensated for the injury complained of from any source except the assets of the patient, his representative, or his immediate family, or insurance purchased with such assets. In the event such evidence is admitted, the plaintiff may present evidence of an obligation to repay such compensation. Insurance bargained for or provided on behalf of an employee shall be considered insurance purchased with the assets of the employee. Compensation as used in this section shall mean payment of money or other property to or on behalf of the patient, rendering of services to the patient free of charge to the patient, or indemnification of expenses incurred by or on behalf of the patient. Notwithstanding this section, evidence of compensation by a defendant health care provider may be offered only by that provider.

Questions and Notes

1. Would it make sense to restructure medical malpractice law by switching from a system based on tort to one based on contract? How would such a system differ from the present one? *See* Epstein, *Medical Malpractice: The Case for Contract*, 1 AM. B. FOUND. RES. J. 87 (1976).

2. As demonstrated in this section, medical malpractice law has been the subject of significant statutory changes. For a general overview of the phenomenon, see Hubbard, *The Physicians' Point of View Concerning Medical Malpractice: A Sociological Perspective on the Symbolic Importance of "Tort Reform,"* 23 GA. L. REV. 295 (1989); Bovbjerg, *Legislation on Medical Malpractice*, 22 U.C. DAVIS L. REV. 499 (1989).

3. Note the issue of the constitutionality of reform legislation, considered in *Fein v. Permanente Medical Group,* 175 Cal. Rptr. 177 (1981), *supra* Chapter Four, § C.

4. One statutory response to complaints about the medical malpractice system has been the creation of pre-litigation screening panels to identify meritorious cases (and their opposite) at an early stage of litigation. The findings of the panel (usually in the form of an opinion that the standard of care was met or was not met) are usually admissible in any subsequent litigation. For a review of existing proposals and a model act, see Macchiaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills*, 58 GEO. WASH. L. REV. 181 (1990).

Another suggestion for improving relations between doctors and patients is to expand participation by patients in the decisionmaking process; *see* Dobson, *Achieving Better Medical Outcomes and Reducing Malpractice Litigation Through the Healthcare Consumer's Right to Make Decisions*, 15 J. CONTEMP. L. 175 (1989).

For a comparative analysis of British and American approaches to medical malpractice, see Note, *Medical Malpractice Litigation: A Comparative Analysis of United States and Great Britain*, 12 SUFFOLK TRANSNAT'L L.J. 577 (1989) (suggests that similarities in malpractice explosion have produced or will produce similar pressures for reform). *See also* Neil Vidmar and Leigh Anne Brown, *Tort Reform and the Medical Liability Insurance Crisis in Mississippi: Diagnosing the Disease and Prescribing a Remedy* 22 MISS. C.L. REV. 9 (2002).

5. Virginia and Florida have adopted "no-fault" plans for catastrophic obstetrical

injuries. *See* Note, *Innovative No-Fault Tort Reform for an Endangered Specialty*, 74 VA. L. REV. 1487 (1988).

6. The liability of HMOs (health maintenance organizations) has been clouded by the argument that suits against HMOs are pre-empted by ERISA. *See* Vicki Lawrence MacDougall, *The "Shared Risk" of Potential Tort Liability of Health Maintenance Organizations and the Defense of ERISA Preemption*, 32 VAL. U. L. REV. 855 (1998).

§ B. Other Forms of Professional Malpractice

Legal Malpractice. One fast developing area of professional negligence is legal malpractice. For a good overview of the state of legal malpractice law, see Symposium, *Mistakes*, 15 LITIGATION 7 (Winter 1989); *Kellos v. Sawilowsky,* 254 Ga. 4, 325 S.E.2d 757 (1985). One of the sticky questions in legal malpractice cases is deciding how far the lawyer's duty extends. In many cases the lawyer will commit malpractice in performing services for client A, but the effects of the mistakes are borne by B. For example, if lawyer L negligently draws up a will that by which testator A intended to benefit descendant B, then B may want to sue L for malpractice. But L was never B's lawyer. Does the duty extend to non-clients? *See Bohn v. Cody*, 119 Wash.2d 357, 832 P.2d 71 (1992).

Accountant Malpractice. Accountants have also been the target of professional malpractice suits. One of the difficult issues in such cases is deciding whether the accountant is liable not only to his client, but also to others who rely upon the accountant's analysis of the financial health of the company. *See Toro Co. v. Krouse, Kern & Co.*, 827 F.2d 155 (7th Cir. 1987); Sliciano, *Negligent Accounting and the Limits of Instrumental Tort Reform*, 86 MICH. L. REV. 1929 (1988).

Other Forms of Professional Malpractice. The list extends to real estate brokers, engineers, veterinarians (*Ponder v. Angel Animal Hosp.,* 62 S.W.2d 844 (Mo. App. 1988) [dog brought in for grooming, castrated instead]), *see* King, *The Standard of Care for Veterinarians in Medical Malpractice Cases*, 58 TENN. L. REV. 1 (1990); etc. So far educators have escaped significant exposure for negligent educating; but a change may be afoot. *See* McBride, *Educational Malpractice: Judicial Recognition of a Limited Duty of Educators Toward Individual Students; A State Law Cause of Action for Educational Negligence*, 1990 ILL. L. REV. 475; Todd A. Demitchell and Terri A. Demitchell, *Statutes and Standards: Has the Door to Educational Malpractice Been Opened?* 2003 BYU EDUC. & L.J. 485.

There are even claims for clergy malpractice. *See* Note, *Nalley v. Grace Community Church of the Valley (763 P.2d 948 (Cal.): Absolution for Clergy Malpractice?*, 1989 B.Y.U. L. REV. 913. A frequent basis for lawsuits against clergy is the sexual exploitation of parishioners who rely upon them for spiritual guidance. *See*, *e.g.*, *Destefano v. Grabrian,* 763 P.2d 275 (Colo. 1988); Janna Satz Nugent, *A Higher Authority: the Viability of Third Party Tort Actions Against a Religious Institution Grounded on Sexual Misconduct by a Member of the Clergy*, 30 FLA. ST. U. L. REV. 957 (2003).