The Medical Malpractice Action in Louisiana

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ceedings are incompatible with the procedures of articles 765 and 768. In both instances the requirements of these articles would only undermine the desired informalities in such proceedings.

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Medical malpractice in Louisiana has been defined as a physician or surgeon's dereliction from his professional duty to possess and exercise the skill ordinarily employed by the members of his profession; or as a breach of his duty to apply this skill to the case with reasonable care and diligence, along with his best judgment. If the definition of medical malpractice were so limited, those actions arising out of professional conduct, but not based upon a want of professional skill and reasonable care, would be excluded. However, actions which may not fall within the above definition, such as abandonment or unauthorized medical treatment, are frequently classified as malpractice actions. The primary purpose of this paper is to compare the principles of tort law to the problems of the medical malpractice action.

60. LA. CODE CIV. P. art. 15: "A. The provisions of this Code, except as otherwise specifically provided by other statutes, shall govern and regulate the procedure in criminal prosecutions and proceedings in district courts. They also shall govern criminal prosecutions in city, parish, juvenile, and family courts, except insofar as a particular provision is incompatible with the general nature and organization of, or special procedures established or authorized by law for, those courts." (Emphasis added.)

Comment (d) lends direction in interpreting article 15 by providing that application of this Code to city courts presents a particularly difficult and important problem. Many rules of the Code apply to all criminal prosecutions. Others, by their very nature, are inapplicable to the more informal procedures for the trial of minor cases in city courts.

1. "Malpractice. A dereliction from professional duty whether intentional, criminal or merely negligent by one rendering professional services that result in injury, loss or damage to the recipient of those services or to those entitled to rely upon them or that affects the public interest adversely." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY (1969).

2. See Meyer v. St. Paul-Mercury Indem. Co., 225 La. 618, 619, 73 So.2d 781, 782 (1953): "A physician, surgeon or dentist . . . is not required to exercise the highest degree of skill and care possible. As a general rule it is his duty to exercise the degree of skill ordinarily employed, under similar circumstances, by the members of his profession in good standing in the same community or locality, and to use reasonable care and diligence, along with his best judgment, in the application of his skill to the case."
Existence of Duty

A basic principle of tort law is that, as a prerequisite to tort liability, the defendant must have breached a legal duty owed to the injured party; furthermore, this breach must have been the legal cause of the injury.

In most jurisdictions the physician’s duty has been grounded in his tort obligation to exercise reasonable care and skill toward his patient; however, some jurisdictions view the physician-patient relationship as contractual. Louisiana courts apparently have adopted the view that the physician’s and surgeon’s duty to possess and exercise skill and care is founded in tort and is not the result of an implied contract.

Once the physician-patient relationship is established, the law imposes a duty upon the physician or surgeon to exercise reasonable care and skill. However, the physician is under no duty to undertake the treatment of a case, nor is he liable for his failure to do so. Further, he may limit his practice with

3. Prior to the emergence of negligence as a separate tort, the physician’s duty to possess and exercise skill and care appears to have been founded on the notion that his was a public calling, somewhat like that of an innkeeper or public carrier; hence, he had undertaken to render proper service, for the breach of which he might be liable. See D. LOUISELL & H. WILLIAMS, TRIAL OF MEDICAL MALPRACTICE CASES § 8.03 (rev. ed. 1968) [hereinafter cited as LOUISELL & WILLIAMS]; W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 28, at 139 (4th ed. 1971) [hereinafter cited as PROSSER]. As modern contract concepts developed, the physician’s duty to exercise care and skill toward his patient was expressed in terms of implied contract, and much of the development of the law on professional liability of physicians and surgeons was based on this theory. See McCoid, The Care Required of Medical Practitioners, 12 VAND. L. REV. 549, 551 (1959). Since the emergence of negligence as a separate tort, the physician’s duty has been grounded in his tort obligation to exercise due care toward his patient. But recent decisions have not entirely abandoned the view that the physician-patient relationship is contractual. See LOUISELL & WILLIAMS § 8.03.


regard to working hours and to the place where services are rendered as well as to the scope of services offered.

Normally the physician-patient relationship is a consensual one, i.e., the patient seeks the services of the physician, and the physician knowingly accepts him as a patient and undertakes treatment. However, the physician-patient relationship may be established under other circumstances. Once the physician begins treatment, he is under a duty to continue his services until they are no longer needed and is not free to terminate the relationship at will. An unjustified termination of the relationship which worsens the position of the patient is a breach of duty and constitutes abandonment.

The physician may also enter into an express contract to render services; and if he fails to perform, he is liable for all injuries proximately caused by the breach of his contractual duty. But if he begins performance by undertaking treatment,

8. LOUISELL & WILLIAMS § 8.02, at 192.
10. The relationship may be established when a third person, such as a parent, guardian or employer has employed the physician and the patient has accepted his services. See Nations v. Ludington, Wells & Van Schalck Lmbr. Co., 183 La. 657, 63 So. 257 (1918); Klein v. Williams, 199 Miss. 699, 12 So.2d 421 (1943). Further, the relationship may be established when the physician volunteers his services, perhaps to one who is unable to consent. But the rendering of gratuitous emergency services may not render the physician liable in Louisiana for his acts or omissions in rendering such services. See LA. R.S. 37:1731 (1950). Some contacts between a person and a physician do not result in a physician-patient relationship, e.g., when an examination is conducted for purposes of insurance, employment or litigation. See Metropolitan Life Ins. Co. v. Evans, 183 Miss. 859, 184 So. 428 (1938). However, if services are offered and accepted, a physician-patient relationship will be established. See Rannard v. Lockheed Aircraft Corp., 26 Cal. 2d 149, 157 P.2d 1 (1945).
12. Actions founded upon abandonment are a separate entity in malpractice law. See McGulpin v. Beesmer, 241 Iowa 119, 43 N.W.2d 121 (1950); Gray v. Davidson, 15 Wash. 2d 257, 130 P.2d 341 (1942); Annot., 57 A.L.R.2d 432 (1957). Abandonment is an unjustified termination of the relationship which worsens the position of the patient. The physician's services may be justifiably terminated only if his services are no longer required, the patient consents to the termination, or the physician withdraws giving proper and reasonable notice to the patient under circumstances where the patient can procure another physician if necessary. See Dale v. Donaldson Lmbr. Co., 48 Ark. 188, 2 S.W. 703 (1887); Gray v. Davidson, 15 Wash. 2d 257, 130 P.2d 341 (1942).
the law imposes upon him the duty to exercise care and skill, in addition to his contractual duties. Thus, the plaintiff's action may be founded in tort or in contract. The type of action that the plaintiff chooses is important with regard to the effect upon prescription, the theory of proof, and the recovery of damages.

The Standard of Care

The most widely accepted expression in Louisiana of the standard of care and skill expected of physicians and surgeons appears in Meyer v. St. Paul-Mercury Indemnity Co., where the court said:

"A physician, surgeon or dentist, . . . is not required to exercise the highest degree of skill and care possible. As a general rule it is his duty to exercise the degree of skill ordinarily employed, under similar circumstances, by the members of his profession in good standing in the same community or locality, and to use reasonable care and diligence, along with his best judgment in the application of his skill to the case."

This duty has not only been imposed upon physicians, surgeons and dentists, but has been extended to veterinarians and
nurses, as well as technicians, attendants and others engaged in related branches of the medical profession. However, this standard has not been applied to a defendant chiropractor.

The qualifying term “in good standing” which appears in the Meyer standard simply refers to those physicians who are licensed practitioners. The qualification “under similar circumstances” alludes to the circumstance of the case, thus reducing the range of comparisons and producing a more relevant standard.

The medical practitioner is to be judged by the customary practice of the members of the class of practitioners to which he belongs. This principle was recognized by the Louisiana


21. In Edkins v. Edwards, 235 So.2d 200 (La. App. 4th Cir. 1970), the defendant chiropractor was found to have manipulated the plaintiff’s neck in such fashion as to cause a cervical disc rupture. The court refused to apply a professional standard to his actions and evaluated his conduct under ordinary tort law. The basis of this refusal was that he was not licensed by the State Board of Medical Examiners and that there was no evidence presented as to the standard of care required in the practice of chiropractic. Perhaps a better reason for applying ordinary tort law would have been that the defendant’s conduct was such that it could readily be evaluated by laymen without resort to expert testimony.

22. Dyess v. Caraway, 190 So.2d 666 (La. App. 2d Cir. 1966) (veterinarian is to be judged by the standard practice of veterinarians); Norton v. Argonaut Ins. Co., 144 So.2d 244 (La. App. 1st Cir. 1962) (nurse was negligent in not following the customary practice of nurses); Whyte v. American Motorist Ins. Co., 122 So.2d 297 (La. App. 2d Cir. 1960) (treatment given by defendant chiropodist was “in line with what any other chiropodist or surgeon would do”).

In Favalora v. Aetna Cas. & Sur. Co., 144 So.2d 544 (La. App. 1st Cir. 1962), the court stated that a physician has a duty to exercise the skill and care usually exercised by “similar practitioners” in the same community or locality.

While a defendant medical practitioner is to be judged by the customary practice of the class to which he belongs, the Louisiana courts will allow a practitioner of another class to testify at his trial, although the testimony of the witness must be restricted to the standard of practice of defendant’s class of practitioners. In Mournet v. Sumner, 139 So. 728 (La. App. 4th Cir. 1932), an oral surgeon testified at the trial of a general practitioner of dentistry that his procedure should have been different than that of the defendant. The court observed that a specialist and a general practitioner admittedly would have different approaches. In Stern v. Boyce, 200 So.2d 318 (La. App. 4th Cir. 1967), a thoracic surgeon testified as to the practice of thoracic surgeons, and the court observed that he was unable to testify as to the standard of practice of general surgeons, the class to which the defendant belonged. In Slack v. Fleet, 242 So.2d 650 (La. App. 1st Cir. 1970), an internist testified that his procedure would have differed from that of the defendant general practitioner, but that the defendant had conformed to the standard of practice of general practitioners in the community.
supreme court in *Stern v. Lanng,* in which the court held that an oculist must exercise the care and skill usually exercised by oculists in good standing. Apparently this principle is no more than an application of the general tort doctrine that if one holds himself out as having special skills, the standard of care is modified accordingly.

Though the standard of care as expressed in *Meyer* is qualified by a “locality rule” that a physician must be evaluated in relation to “the members of his profession in good standing in the same community or locality,” it is submitted that this qualification is not, nor should it be, as fixed and unyielding as it appears.

In other jurisdictions, until very recently, the standard of care applicable to physicians was qualified geographically to the same community in which the physician practiced. The purpose was to protect the country physician who lacked the resources and opportunities afforded the city physician. As communication improved and the physician gained the opportunity to keep abreast of advances in his profession, the “same locality” became too narrow a qualification and began to yield to an ever broadening locality rule. Jurisdictions began to express the standard of care in terms of that customarily prac-

23. 106 La. 738, 31 So. 303 (1901).
24. An interesting question is whether or not a general practitioner will be held to the standards of a specialist if he undertakes to perform services in a special branch of medicine when there is available in the community a specialist in that field. Louisiana has no case which has considered this question. The general rule is that a general practitioner is not required to exercise the degree of care and skill commensurate with that exercised by those classified as specialists. The policy underlying these decisions is that the public must rely upon the general practitioner to care for a large portion of human ills, and a wholesale acceptance of a higher standard of practice would force the general practitioner out of the picture entirely. McCoid, *The Care Required of Medical Practitioners,* 12 *VAND. L. REV.* 549, 566-69 (1959). For these same reasons a stringent duty to refer to a specialist cannot be imposed upon the general practitioner, for to do so would require that he possess the same knowledge of the specialist, a result which might discourage the general practice of medicine. 25. *Meyer v. St. Paul-Mercury Indem. Co.,* 225 La. 618, 623, 73 So.2d 781, 782 (1953).
26. For a history of the locality rule in other jurisdictions and its diminishing significance see Pederson v. Dumouchel, 72 Wash. 2d 73, 431 P.2d 973 (1967); *LOUISELL & WILLIAMS* § 8.06; *Prosser* § 32, at 164; McCoid, *The Care Required of Medical Practitioners,* 12 *VAND. L. REV.* 549, 569-75 (1959).
28. *Id.* at 77, 431 P.2d at 977.
ticed by physicians in "similar localities" or "geographic areas" within which there were similar opportunities for experience and the accumulation of knowledge.

The present trend is away from a fixed locality rule. In Pederson v. Dumouchel, the Washington court, after noting that there was no longer a lack of opportunity for a physician or surgeon to keep abreast of the advances made in his profession, stated that local practice within geographic proximity is but one of many factors to be considered in determining the standard of care. The court further stated: "No longer is it proper to limit the definition of the standard of care which a medical doctor or dentist must meet solely to the practice or custom of a particular locality, a similar locality or a geographic area." This court defined the standard of care as "that established in an area coextensive with medical and professional means available in those centers that are readily accessible for appropriate treatment of the patient."

Although Meyer did not specifically address itself to the locality rule, it was in fact part of the standard of care expressed by the court. However, recently in Uter v. Bone & Joint Clinic, the supreme court affirmed a decision in which a New

32. 72 Wash. 2d 73, 431 P.2d 973 (1967).
33. Id. at 79, 431 P.2d at 978.
34. Id.
35. See text accompanying note 17 supra. Actually, the supreme court first announced a locality rule in Roark v. Peters, 162 La. 111, 110 So. 106 (1926), where it stated that a physician was to possess the degree of skill exercised by members of his profession practicing in "similar localities." This rule was in keeping with the trend in other jurisdictions at that time and was followed by subsequent cases. See Mournet v. Sumner, 193 So. 725 (La. App. 1st Cir. 1932); Lett v. Smith, 6 La. App. 248 (2d Cir. 1927). In Well v. McGehee, 39 So.2d 196, 199 (La. App. 1st Cir. 1949), the court, purporting to follow the previous line of cases, stated that a physician must possess the skill "common with the profession in the locality where the physician or surgeon happens to practice." Later, in Meyer, the supreme court defines the standard of care as that established in "the same community or locality." It is doubtful that the court would purposefully state a rule more restrictive than that appearing in Roark, when the national trend was toward an ever broadening locality rule.
36. 249 La. 851, 192 So. 100 (1934). Some recent decisions lend support to the idea that the locality rule referred to in Meyer is not to be narrowly construed. See Zachary v. St. Paul Fire & Marine Ins., 249 So. 2d 273 (La. App. 1st Cir. 1971); Henry v. McCool, 239 So.2d 734 (La. App. 1st Cir. 1970). (New Orleans physicians testified as to the standard of practice at the
Orleans physician testified at the trial of a Baton Rouge physician as to the standard of care in both communities, intimating that the Meyer locality rule is not to be so narrowly construed.

It is submitted that the locality rule should not be so narrowly construed as to limit the scope of inquiry to what is the customary procedure in the place where the defendant practices; nor should the rule limit the community from which expert testimony may be sought. Rather, more emphasis should be placed upon the character of the defendant’s practice in terms of his opportunities for experience and acquisition of information concerning advances in the medical profession.\(^{37}\)

When a question of negligence is involved, custom and usage generally are competent evidence for determining the proper standard of conduct;\(^ {38}\) but such evidence is not conclusive proof of the reasonableness of the defendant’s conduct. However, in a medical malpractice action custom does become, almost exclusively, the measure of reasonable care.\(^ {39}\) Since the first reported medical malpractice case in Louisiana, the measure of reasonable care has been the defendant’s treatment of a patient in the “usual and customary” manner employed by other physicians in good standing.\(^ {40}\) However, customary practice is not conclu-

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38. Harris Drilling Co. v. Delafeld, 222 La. 416, 62 So.2d 627 (1952); see Prosser § 33, at 166-68.
40. Meyer v. St. Paul-Mercury Indem. Co., 225 La. 618, 73 So.2d 761 (1953); see Roark v. Peters, 162 La. 111, 110 So. 106 (1926); Gouer v. Brosnan, 155 La. 1, 98 So. 681 (1923); Ayala v. King-Ryder Lmbr. Co., 145 La. 536, 83 So. 799 (1920); Stern v. Lang, 106 La. 738, 31 So. 303 (1901). In Mournet v. Sumner, 139 So. 728, 730 (La. App. Orl. Cir. 1932), the court said: “The rule is well established that a physician or dentist cannot be held liable for the death of a patient under his treatment, where there is no evidence to show negligence or lack of skill on his part, sufficient to overcome the prima facie case in his favor made by the evidence that the treatment adopted by him was the usual and customary one. The fact that the patient died under such circumstances does not raise any presumption of negligence or lack of skill on his part.” In Wells v. McGee, 39 So.2d 196, 199 (La. App. 1st Cir. 1949), the court said: “[W]here the physician or surgeon uses all the customary precautions practiced by the profession in
sive as to due care where that practice is contrary to what is taught in medical schools and is recognized by other members of the profession as being faulty, though they too may follow the same customary practice.41

In Roark v. Peters,42 the plaintiff complained that a sponge (gauze pad) had been left in her abdomen during a caesarean operation. In affirming a judgment for the defendant, the supreme court examined the customary sponge-counting procedures used to insure that no sponge would be left in a patient, intimating that the following of such a customary practice would be due care as a matter of law. The court rejected the argument that “[t]he fact that he did leave a sponge or instrument in the body . . . is, in itself, and without any explanatory expert testimony, sufficient to convince any reasonable man or any court that the defendant was guilty of negligence.”43 However, in the recent case of Grant v. Touro Infirmary,”44 on almost identical facts, the same court held that failure to remove a sponge or pad may be regarded as negligence per se, and that a physician cannot be relieved of liability by reliance on a custom or hospital rule requiring the attending nurse to count the sponges used and removed.

The position taken in Roark v. Peters seems to be the better view, for a customary practice may be reasonably safe without being absolutely safe. A physician is only required to use reasonable care, and the failure of the customary procedure to prevent the leaving of a sponge or instrument in the body of a patient should not create automatic liability. It is submitted that a jury should be allowed to infer negligence from the presence of the sponge in the body, but the physician should be able to exculpate himself by showing that the customary procedure he followed is reasonably safe. In addition, he should be allowed to show circumstances under which his act was rea-

42. 162 La. 111, 110 So. 106 (1926).
43. Id. at 115, 110 So. at 108.
44. 254 La. 204, 223 So.2d 148 (1969).
sonable, such as an emergency or other situation in which prolonged search for a sponge or instrument would be dangerous to the patient.

Other jurisdictions have expressed the standard of care expected of a physician in much the same way as has Louisiana; yet some of these jurisdictions have defined specific duties and obligations to which a physician must adhere. The Louisiana courts, with rare exception, have not chosen to define particular duties, at least not with any degree of definiteness. Thus, a physician's performance has been evaluated in terms of what other physicians in the community would do under like circumstances.

Louisiana courts have intimated that a physician's failure to inform a patient of the nature, risk and consequences of treatment is a breach of duty vitiating consent. This duty to inform usually involves cases in which the physician fails to make sufficient disclosures concerning the treatment to enable the patient to exercise an informed consent. This failure of

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45. Some of these particular duties are: to keep abreast of his profession; to take and examine the history of the patient; to heed the complaints of the patient; to instruct the patient in self-care; to attend the patient as long as his services are needed; to inform or disclose facts; to follow the progress of the patient. See LOUSSELL & WILLIAMS § 8.05.


47. Steinberg v. Indemnity Ins. Co. of North America, 364 F.2d 266 (5th Cir. 1966) (failure to heed complaints of patient); Ross v. Hatchette, 251 So.2d 820 (La. App. 3d Cir. 1971) (failure to properly examine, e.g., failure to use X ray in diagnosis); Thompson v. Brent, 245 So.2d 751 (La. App. 4th Cir. 1971) (failure to heed complaints of patient); Langston v. St. Charles Hospital, 202 So.2d 386 (La. App. 4th Cir. 1967) (failure to use X ray in examination).

48. See Theodore v. Ellis, 141 La. 709, 75 So. 655 (1917), where a physician performed an unnecessary and dangerous operation on the plaintiff. In rendering judgment for the plaintiff, the court relied in part on the failure of the physician to inform the patient of the nature and purpose of the operation. In Rogers v. Lumbermens Mut. Cas. Co., 119 So.2d 649, 650 (La. App. 2d Cir. 1960), where the court stated: "The general rule prohibiting the performance of an operation without the consent of the patient extends to the performance of . . . operations involving risk and results not contemplated."
consent must be distinguished from the situation in which a physician, absent an emergency, renders treatment or operates without first obtaining consent, or performs an operation different in nature than that to which the plaintiff has consented. Whether there is a want or failure of consent, the physician's action "clearly constitutes a trespass against the person in the nature of an assault and battery and subjects him to liability for damages." This liability results even though there is no malpractice on the part of the physician.

In early cases in other jurisdictions the courts treated a physician's failure to disclose the nature and consequences of a proposed treatment as a breach of duty vitiating consent. In later years this trend was reversed when it was recognized that each patient presented a different problem and that full disclosure may be undesirable or even dangerous to the welfare of some patients. The generally accepted theory today is that a physician must make a reasonable disclosure of the nature, risk and consequences of the proposed treatment. Whether his disclosure is reasonable depends upon what physicians in the community would have disclosed under the same or similar circumstances.

49. Except in real and serious emergencies, a physician must acquaint the patient or, when circumstances require, someone properly acting for him, of the diagnosis and treatment proposed and obtain express or implied, consent thereto. Lester v. Aetna Cas. Co., 240 F.2d 676 (5th Cir. 1957); Wells v. McGehee, 39 So.2d 198 (La. App. 1st Cir. 1949).

50. In Rogers v. Lumbermens Mut. Cas. Co., 119 So.2d 649, 650 (La. App. 2d Cir. 1960), where the plaintiff had consented to an appendectomy and the defendant surgeon performed a complete hysterectomy without the consent of the patient, with her husband or relatives reasonably available in the hospital, the court said: "[T]he general rule is that the consent of a patient is a prerequisite to a surgical operation, and the surgeon who performs an operation without his patient's consent, express or implied, is liable in damages. This rule is subject to exceptions in event of an emergency requiring immediate action for the patient under circumstances in which it is impossible or impracticable to obtain the patient's consent or the consent of anyone authorized to assume such responsibility. The general rule prohibiting the performance of an operation without the consent of the patient extends to the performance of operations different in nature from that for which a consent was given, and to operations involving risk and results not contemplated.

51. Id. at 651.


53. Hanks v. Charles T. Miller Hospital, 251 Minn. 427, 88 N.W.2d 186 (1958); Prosser § 32, at 165.


Vicarious Liability

As a general rule the physician is liable for the negligent acts of his employees under the doctrine of respondeat superior. However, an important malpractice question is the liability of the surgeon for the negligent acts of operating room nurses and other assistants who are employees of the hospital. Generally, a surgeon is responsible for all operating room procedures and cannot escape liability by delegating part of his function to another. However, modern operating room techniques require team performance and, as a result, nurses and other assistants are not always under the immediate control and direction of the operating surgeon. There is a division of control in the operating room, and under these circumstances there is a presumption that the general employer (the hospital) is liable; therefore, to escape liability, the general employer must show that the servant was borrowed and was under the control of the surgeon. The customary practice of the profession plays an important role in defining this division of control. For example, in Andrepont v. Ochsner and Meyer v. St. Paul-Mercury Indemnity Co. it was shown that customarily the anesthesiologist worked independently and was not under the control and direction of the operating surgeon.

Proof of the Malpractice Case

The plaintiff in a malpractice action must prove his allegations of negligence by a fair preponderance of the evidence. He must show that the physician breached a legal duty to conform to the standard of care and that this breach is the legal cause of his compensable injury. When the physician under-

59. 84 So.2d 63 (La. App. Orl. Cir. 1955).
60. 225 La. 618, 73 So.2d 731 (1954).
62. Medical malpractice cases present more difficult causation issues than those found in the ordinary negligence suit. Most plaintiffs in malpractice suits are suffering from some affliction making it difficult to
takes to treat, he owes the patient the duty to conform to the professional standard of conduct. Under this standard the physician must exercise the degree of skill ordinarily employed, under similar circumstances, by the good-standing members of his profession in the same community or locality; further, he must use reasonable care and diligence, as well as his best judgment in the application of his skill to the case.

The standard of skill is that of a complex and erudite profession upon which laymen cannot exercise an intelligent judgment requiring medical opinion to prove presence or absence of skill. The element of care and diligence (as distinguished from the element of skill) is stated in terms of "reasonable" and suggests that the trier of fact may draw from his own experience and judgment in evaluating the conduct of the defendant. However, there is much of the physician's professional conduct which is not within the common knowledge of the layman. Therefore,

distinguish the natural consequences of the malady from those which may have been caused by the defendant. For example, see the factual situation presented in Dowling v. Mutual Life Ins. Co., 168 So.2d 107 (La. App. 4th Cir. 1964), at note 69 infra. What portion of the plaintiff's injuries were caused by the delay resulting from the defendant's conduct? Frequently, the layman is incompetent to evaluate the issue of causation as in Herbert v. Travelers Indemn. Co., 239 So.2d 387 (La. App. 4th Cir. 1970), where the plaintiff had suffered permanent injury allegedly caused by the injection of a highly toxic spinal anesthetic into a nerve root. Causation was a crucial issue and obviously peculiarly within the knowledge of experts. Depositions and testimony of numerous physicians were received in evidence, proving that the injection of the toxic drug directly into nerve root was an act contrary to professional standards in the community.

For other Louisiana cases briefly discussing causation see Meyer v. St. Paul-Mercury Indem. Co., 225 La. 618, 73 So.2d 781 (1954) (oral surgeon's failure to examine teeth prior to preparatory procedure was not the cause of injury); Henry v. McCool, 239 So.2d 734 (La. App. 1st Cir. 1970) (failure to take follow-up X ray of plaintiff's hand was not cause of his injury); Langston v. St. Charles Hospital, 202 So.2d 386 (La. App. 4th Cir. 1967) (failure to take X ray to locate wire embedded in plaintiff's leg was not the cause of the subsequent injury); Stern v. Boyce, 200 So.2d 318 (La. App. 4th Cir. 1967) (failure to take post operative X ray was not the cause of death).

63. See cases cited note 5 supra.


66. Id. at 311.
there must frequently be a resort to medical expertise to prove the customary local practice and the defendant’s conformity therewith. If, however, the alleged professional conduct is within the common knowledge of the trier of fact, he should be allowed to draw an inference of negligence. For example, if the physician spills a bottle of acid on the patient during treatment, or fails to report an X ray result, or fails to heed the complaints of a patient that the procedure is causing injury, or if the physician has left a sponge or instrument in the patient’s body, the trier of fact should be allowed to infer negligence without resort to expert opinion.

When expert testimony and opinion are required to prove the standard of care and diligence, the expert need not be a member of the class of practitioners to which the defendant belongs, but his testimony must be restricted to what is the customary practice of the defendant’s class, for the defendant is to be judged by that standard alone. Frequently there are areas of practice common to the various branches of the medical profession; under these circumstances, there should be no objection to testimony on these common matters by a physician from a different class.

When the plaintiff is unable to produce an expert witness, the defendant may be cross-examined as an expert in order to establish the standard of professional practice. Once the standard is established, the plaintiff may then rely on other evidence, such as admissions, to establish the failure of the defen-

67. Id.
69. Consider the fact situation presented in Dowling v. Mutual Life Ins., 168 So.2d 107 (La. App. 4th Cir. 1964): The patient consulted his regular physician complaining of chest pains. The physician caused a chest X ray to be taken and informed the patient that the reports were negative. In fact, there was a positive indication of tubercular infiltration and the condition was discovered some months later, necessitating extensive hospitalization and a lobectomy.
70. Thompson v. Brent, 245 So.2d 751 (La. App. 4th Cir. 1971).
72. See note 22 supra.
73. In Steinberg v. Indemnity Ins. Co. of North America, 364 F.2d 266 (5th Cir. 1966), a general practitioner was allowed to testify at the trial of a plastic surgeon as to the proper procedure for applying a cast. The court found that the test for qualification as an expert is whether the witness has actual knowledge of the particular procedure attacked as negligent.
74. Davis v. Duplantis, 448 F.2d 918 (5th Cir. 1971); Oleksiw v. Weidener, 2 Ohio St. 2d 147, 207 N.E.2d 375 (1965); La. CODE Civ. P. art. 1634.
dant to conform to that standard. The inability of the plaintiff to produce an expert witness raises the question as to whether he may employ, in lieu of medical expert testimony, medical texts, treatises and articles in professional journals to establish the standard practice of the profession. This type of evidence is usually excluded under the hearsay rule. It may be argued that these works should not be excluded for they are both necessary, in that they may be the only evidence available, and trustworthy.\textsuperscript{76} Additionally, the qualifications of the author may be established or questioned as if he were present, and the defendant would have an opportunity to challenge content by showing authority to the contrary. Since the purpose of the rules of evidence is to control what the jury hears, these arguments should have greater validity where the trial is before a judge rather than a jury.\textsuperscript{76}

Numerous cases\textsuperscript{77} have quoted \textit{Meyer v. St. Paul-Mercury Indemnity Co.} with regard to the burden of proof, intimating that the burden is upon the defendant in a malpractice suit to exculpate himself. When the standard of care and skill was formulated in \textit{Meyer}, the court said:

"\textit{[This]} rule makes it incumbent on the physician, surgeon or dentist who becomes defendant in a malpractice case to show that he is possessed of the required skill and competence indicated and that in applying that skill to the given case he used reasonable care and diligence along with his best judgment."\textsuperscript{78}

\textsuperscript{75} \textit{See} Dallas County v. Commercial Union Ass'n Co., 286 F.2d 388 (5th Cir. 1961). Alabama is the only jurisdiction which today allows the use of books and treatises as substantive evidence on the basis of jurisprudence. City of Dothan v. Hardy, 237 Ala. 603, 188 So. 284 (1939). However, some states have adopted statutes which allow the use of books, treatises and periodicals in a medical malpractice action. \textit{Mass. Ann. Laws} ch. 233, § 79c (1956); \textit{Nev. Rev. Stat.} § 51.040 (1968); \textit{S.C. Cons Ann.} § 26-142 (1962).

\textsuperscript{76} The author could find but one Louisiana case reporting that the defendant was allowed to introduce a medical text in support of his defense that the use of X ray to discover the presence of a fishbone embedded in flesh is a useless gesture, considering its translucent characteristics. Lindsey v. Michigan Mut. Liab. Co., 156 So.2d 313 (La. App. 4th Cir. 1963).\textsuperscript{77} LeMay v. General Acc. Fire & Life Assur. Corp., 228 So.2d 713 (La. App. 1st Cir. 1969); Langston v. St. Charles Hospital, 202 So.2d 356 (La. App. 4th Cir. 1967); Stern v. Boyce, 200 So.2d 318 (La. App. 4th Cir. 1967); Osburn v. Saltz, 169 So.2d 687 (La. App. 1st Cir. 1964); Favalora v. Aetna Cas. & Sur. Co., 144 So.2d 844 (La. App. 1st Cir 1962); Jacobs v. Beck, 141 So.2d 920 (La. App. 4th Cir. 1962); Thomas v. Lobrano, 76 So.2d 599 (La. App. 2d Cir. 1954).

Few cases have actually followed this rule, and when it has been applied, the situation was such that the doctrine of res ipsa loquitur may be said to have applied. The above quotation does not mean that failure to obtain a favorable result gives rise to a presumption of negligence against the practitioner which shifts the burden of establishing freedom from fault upon him. This same court has said, that "the fact that the treatment has resulted unfavorably does not even raise a presumption of want of proper care, skill or diligence." If the physician shows that he treated the patient in the usual and customary manner there is a prima facie case in his favor which may be overcome only by plaintiff's evidence showing lack of skill or that the practice followed was negligent.

Res Ipsa Loquitur

A case in which res ipsa loquitur applies does not differ from other cases in which negligence is proved by inferences drawn from circumstantial evidence. The accident is the dominant fact from which the inference is drawn, but before the court will allow the doctrine to apply, it will require a showing of the same nature that would be required in any case proved by circumstantial evidence. Louisiana courts have consistently held that to utilize the doctrine of res ipsa loquitur the plaintiff must show that (1) the injury was caused by an agency within

81. Phelps v. Donaldson, 243 La. 1118, 1120, 150 So.2d 35, 37 (1963): "When a physician undertakes the treatment of a case he does not guarantee a cure, nor is any promise to effect a cure or even a partial healing to be implied, nor does the law raise from the fact of employment an implied undertaking to cure, but only an undertaking to use ordinary skill and care. Of course a physician might contract specifically to cure and he would be liable on his contract for failure, but, in the absence of such a special and peculiar contract, the fact that the treatment has resulted unfavorably does not even raise a presumption of want of proper care, skill or diligence. A dentist, like a physician or surgeon, is not an insurer or guarantor of results, in the absence of an express agreement." (Citations omitted.)
the exclusive control of the defendant, (2) evidence of the full cause of the accident is more readily accessible to the defendant, and (3) the accident must be one which common knowledge indicates does not ordinarily occur in the absence of negligence.85

The first element is merely a device to assure that there is little room for competing inferences,86 for the doctrine cannot be applied if there are conflicting inferences.87 The second element appears to have no valid purpose other than encouraging the parties with access to the evidence to bring it before the court.88 The purpose of the third is to prevent the trier of fact from inferring negligence when he cannot reasonably do so. Therefore, res ipsa loquitur is applied in cases in which the trier may draw from his knowledge and experience, and, from the facts presented, conclude that negligence is more probably present than not.

In *Meyer v. St. Paul-Mercury Indemnity Co.*,89 the court of appeal stated that res ipsa loquitur would not apply if all that was shown was that the desired results were not accomplished. But if the complaint were based on the charge that, during the rendering of professional services there occurred some untoward event, or some omission or act from which there resulted something not ordinarily found to result during such treatment or operation, the physician may be required to show that the unusual occurrence did not result from his negligence. In citing examples in which the doctrine would be applicable, the court referred to cases in which the physician had left a sponge or an instrument in the body of the patient. In these illustrative cases, the layman could rely on his experience and knowledge to infer negligence from the presence of the item in the body.90

87. Hayward v. Echols, 362 F.2d 791 (5th Cir. 1966).
90. In *Jacobs v. Beck*, 141 So.2d 920 (La. App. 4th Cir. 1962), the plaintiff had undergone abdominal surgery and, on recovering from the anesthesia, discovered that she had two broken teeth. The court denied the defendant's motion for summary judgment on the grounds that res ipsa loquitur applied and there was a genuine and material issue of fact. This is the type of
In the medical malpractice action it will frequently be impossible for the layman to draw an inference of negligence from the mere existence of an injury; he simply lacks the requisite expertise. Consequently, in these cases the doctrine of res ipsa loquitur will be of little practical value, for the court must first be acquainted with the factors pertinent to the probable cause of the injury. For example, in *Herbert v. Travelers Indemnity Co.*, the patient had suffered injury allegedly from injection of a spinal anesthetic into a nerve root. It had been proved and admitted by the defendant that this was never knowingly done, and that there were procedures available to prevent its happening. The court stated that the doctrine of res ipsa loquitur would apply, but only if the jury found, based on expert testimony, that the plaintiff's injury resulted from injection of the drug directly into the nerve root. To so find was sufficient proof of a failure to comply with the duty of reasonable care; and therefore, the application of res ipsa loquitur was inappropriate.

Thus, it seems that the doctrine of res ipsa loquitur is of little practical significance in the Louisiana medical malpractice action because its application is restricted to those situations in which the layman can draw from his common knowledge and experience and conclude that the particular occurrence would not have happened in the absence of negligence.

**Conclusion**

One of the most frequent complaints of a plaintiff's attorney in a medical malpractice action is that the burden of proof is too difficult. This is especially true when expert testimony and opinion are required to prove the plaintiff's case, for it is recognized that medical practitioners are reluctant to testify in a malpractice suit. This burden has been somewhat lessened by the policy of allowing practitioners from one specialty to accident which is within the common knowledge and experience of the trier of fact.

In several recent cases the doctrine was found inapplicable, apparently because there were conflicting inferences that could be drawn, or the subject of inquiry was not within the common knowledge of the trier of fact. *Zachary v. St. Paul Fire & Marine Ins.*, 249 So.2d 273 (La. App. 1st Cir. 1971); *LeMay v. General Acc. Fire & Life Assur. Corp.*, 228 So.2d 718 (La. App. 1st Cir. 1969); *Foster v. St. Paul Fire & Marine Ins. Co.*, 212 So.2d 729 (La. App. 4th Cir. 1968); *Britt v. Travelers Indem. Co.*, 205 So.2d 880 (La. App. 4th Cir. 1968).

91. 239 So.2d 367 (La. App. 4th Cir. 1970).
testify at the trial of a physician with another specialty. This burden could further be reduced by a construction of the "locality rule" which would allow the plaintiff to utilize experts from a different and distant community, or perhaps from out-of-state. Allowing the use of medical books and treatises to establish the standard of care would also be of benefit, especially when expert medical testimony is not available. If the courts are reluctant to allow the introduction of these materials as evidence in medical malpractice actions, perhaps legislation authorizing the use of books, treatises and other writings would be in order; however, the court should retain discretion to exclude writings which are irrelevant or to exclude writings when it finds that the author is not recognized in his profession as an expert on the subject. Further, the plaintiff's burden could be eased by allowing the defendant himself to be cross-examined as an expert witness as to the standard of care.

It is submitted that the standard of care and skill applicable to physicians and surgeons should not be altered. The physician is not only held to this standard but is also protected thereby. A change in the applicable standard which would allow the trier of fact more freedom in inferring negligence would defeat the public interest that is being served by allowing a physician to freely exercise his professional judgment with the knowledge that his acts will be judged in accordance with those of his fellow practitioners.

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