Trial Law TIPS

Roy D. Wasson's
TIP #36

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Proving Medical Standards of Care

Introduction

Many capable trial lawyers shun medical malpractice cases for a variety of reasons. The cases are expensive to try, mentally and emotionally taxing, and subject to an ever-changing body of confusing statutes. But few types of cases can produce the level of professional satisfaction as that which results when a jury returns a verdict which fairly compensates your injured client. Such a verdict confirms your ability to simplify for six laypeople complicated issues of science, and to cut through the smoke screens frequently raised by the defense to further obfuscate the truth.

The ultimate liability issue in a med mal case is whether the defendant doctor's conduct (treatment or failure to treat) fell below the applicable "standard of care." To get to the jury on that issue requires proof of that standard of care. This "TIP" deals with a few of the ways of presenting such proof.

Expert Testimony in General—Necessary But Not Exclusive

Much of the difficulty posed by medical negligence cases is the requirement that another doctor take the witness stand on behalf of the plaintiff and testify that a brother or sister trained in the healing arts fell below the applicable standard of care. "In medical malpractice cases, the standard of care is determined by a consideration of expert testimony." *Pate v. Threlkel*, 661 So. 2d 278, 281 (Fla. 1995).

But other types of evidence also are admissible in determining the standard of care issue, once you have met the burden of presenting some expert testimony on the subject. "The provisions of section 766.102, Florida Statutes . . . that require the claimant in a medical malpractice action to establish the standard of care by expert testimony does not preclude the introduction of other evidence." *Moyer v. Reynolds*, 780 So. 2d 205, 208 (Fla. 5th DCA 2001). Some types of other evidence are addressed in more detail below.

Finding willing experts is complicated by more than mere peer pressure against those who testify for plaintiffs. Malpractice insurers have responded vindictively against plaintiffs' experts. Medical societies have threatened disciplinary proceedings to revoke the licenses and practice privileges of doctors seen as betraying their professional colleagues. The law has thrown up barriers to medical experts' opinions unlike those in existence under *Frye* and *Daubert* applicable to other disciplines. Many of those barriers are legislative.

Recent Statutory Amendments

The new version of § 766.102(1), Fla. Stat. retains the vague definition of the applicable general standard of care from the prior version of the statute, as follows: "The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers."

Likewise, the new Act keeps the prior description of a breach of the standard of care in cases where there is both informed consent

and "affirmative medical intervention of the health care provider" as being limited to those cases in which "the injury was not within the necessary or reasonably foreseeable results of the surgical, medicinal, or diagnostic procedure constituting the medical intervention," when performed by the hypothetical "reasonably prudent similar health care provider." § 766.102(2), Fla. Stat. (2003). Cases under the prior statute have held that this standard does not apply in the misdiagnosis/failure to treat situation. *See Auster v. Gertrude & Philip Strax Breast Cancer Detection Institute*, 649 So. 2d 883 (Fla. 4th DCA 1995).

The new Malpractice Act purportedly changes the prior statutory definition of which expert will be deemed qualified to testify. Instead of the prior definition of a "similar health care provider" who is qualified to render opinions on the standard of care, the Act provides:

> (5) A PERSON MAY NOT GIVE EXPERT TESTIMONY CONCERNING THE PREVAILING PROFESSIONAL STANDARD OF CARE UNLESS THAT PERSON IS A LICENSED HEALTH CARE PROVIDER AND MEETS THE FOLLOWING CRITERIA:
>
> (A) IF THE HEALTH CARE PROVIDER AGAINST WHOM OR ON WHOSE BEHALF THE TESTIMONY IS OFFERED IS A SPECIALIST, THE EXPERT WITNESS MUST:
>
> 1. SPECIALIZE IN THE SAME SPECIALTY AS THE HEALTH CARE PROVIDER AGAINST WHOM OR ON WHOSE BEHALF THE TESTIMONY IS OFFERED; OR SPECIALIZE IN A SIMILAR SPECIALTY THAT INCLUDES THE EVALUATION, DIAGNOSIS, OR TREATMENT OF THE MEDICAL CONDITION THAT IS THE SUBJECT OF THE CLAIM AND HAVE PRIOR EXPERIENCE TREATING SIMILAR PATIENTS; AND

2. HAVE DEVOTED PROFESSIONAL TIME DURING THE 3 YEARS IMMEDIATELY PRECEDING THE DATE OF THE OCCURRENCE THAT IS THE BASIS FOR THE ACTION TO:

A. THE ACTIVE CLINICAL PRACTICE OF, OR CONSULTING WITH RESPECT TO, THE SAME OR SIMILAR SPECIALTY THAT INCLUDES THE EVALUATION, DIAGNOSIS, OR TREATMENT OF THE MEDICAL CONDITION THAT IS THE SUBJECT OF THE CLAIM AND HAVE PRIOR EXPERIENCE TREATING SIMILAR PATIENTS;

B. INSTRUCTION OF STUDENTS IN AN ACCREDITED HEALTH PROFESSIONAL SCHOOL OR ACCREDITED RESIDENCY OR CLINICAL RESEARCH PROGRAM IN THE SAME OR SIMILAR SPECIALTY; OR

C. A CLINICAL RESEARCH PROGRAM THAT IS AFFILIATED WITH AN ACCREDITED HEALTH PROFESSIONAL SCHOOL OR ACCREDITED RESIDENCY OR CLINICAL RESEARCH PROGRAM IN THE SAME OR SIMILAR SPECIALITY.

(B) IF THE HEALTH CARE PROVIDER AGAINST WHOM OR ON WHOSE BEHALF THE TESTIMONY IS OFFERED IS A GENERAL PRACTITIONER, THE EXPERT WITNESS MUST HAVE DEVOTED PROFESSIONAL TIME DURING THE 5 YEARS IMMEDIATELY PRECEDING THE DATE OF THE OCCURRENCE THAT IS THE BASIS FOR THE ACTION TO:

1. THE ACTIVE CLINICAL PRACTICE OR CONSULTATION AS A GENERAL PRACTITIONER;

2. THE INSTRUCTION OF STUDENTS IN AN ACCREDITED HEALTH PROFESSIONAL SCHOOL OR ACCREDITED RESIDENCY PROGRAM IN THE GENERAL PRACTICE OF MEDICINE; OR

3. A CLINICAL RESEARCH PROGRAM THAT IS AFFILIATED WITH AN ACCREDITED MEDICAL SCHOOL OR TEACHING HOSPITAL AND THAT IS IN THE GENERAL PRACTICE OF MEDICINE.

(C) IF THE HEALTH CARE PROVIDER AGAINST WHOM OR ON WHOSE BEHALF THE TESTIMONY IS OFFERED IS A HEALTH CARE PROVIDER OTHER THAN A SPECIALIST OR A GENERAL PRACTITIONER, THE EXPERT WITNESS MUST HAVE DEVOTED PROFESSIONAL TIME DURING THE 3 YEARS IMMEDIATELY PRECEDING THE DATE OF THE OCCURRENCE THAT IS THE BASIS FOR THE ACTION TO:

1. THE ACTIVE CLINICAL PRACTICE OF, OR CONSULTING WITH RESPECT TO, THE SAME OR SIMILAR HEALTH PROFESSION AS THE HEALTH CARE PROVIDER AGAINST WHOM OR ON WHOSE BEHALF THE TESTIMONY IS OFFERED;

2. THE INSTRUCTION OF STUDENTS IN AN ACCREDITED HEALTH PROFESSIONAL SCHOOL OR ACCREDITED RESIDENCY PROGRAM IN THE SAME OR SIMILAR HEALTH PROFESSION IN WHICH THE HEALTH CARE PROVIDER AGAINST WHOM OR ON WHOSE BEHALF THE TESTIMONY IS OFFERED; OR

3. A CLINICAL RESEARCH PROGRAM THAT IS AFFILIATED WITH AN ACCREDITED MEDICAL SCHOOL OR TEACHING HOSPITAL AND THAT IS IN THE SAME OR SIMILAR HEALTH PROFESSION AS THE HEALTH CARE PROVIDER AGAINST WHOM OR ON WHOSE BEHALF THE TESTIMONY IS OFFERED.

(6) A PHYSICIAN LICENSED UNDER CHAPTER 458 OR CHAPTER 459 WHO QUALIFIES AS AN EXPERT WITNESS UNDER SUBSECTION (5) AND WHO, BY REASON OF ACTIVE CLINICAL PRACTICE OR INSTRUCTION OF STUDENTS, HAS KNOWLEDGE OF THE APPLICABLE STANDARD OF CARE FOR NURSES, NURSE PRACTITIONERS, CERTIFIED REGISTERED NURSE ANESTHETISTS, CERTIFIED REGISTERED NURSE MIDWIVES, PHYSICIAN ASSISTANTS, OR OTHER MEDICAL SUPPORT STAFF MAY GIVE EXPERT TESTIMONY IN A MEDICAL NEGLIGENCE ACTION WITH RESPECT TO THE STANDARD OF CARE OF SUCH MEDICAL SUPPORT STAFF.

(7) NOTWITHSTANDING SUBSECTION (5), IN A MEDICAL NEGLIGENCE ACTION AGAINST A HOSPITAL, A HEALTH CARE FACILITY, OR MEDICAL FACILITY, A PERSON MAY GIVE EXPERT TESTIMONY ON THE APPROPRIATE STANDARD OF CARE AS TO ADMINISTRATIVE AND OTHER NONCLINICAL ISSUES IF THE PERSON HAS SUBSTANTIAL KNOWLEDGE, BY VIRTUE OF HIS OR HER TRAINING AND EXPERIENCE, CONCERNING THE STANDARD OF CARE AMONG HOSPITALS, HEALTH CARE FACILITIES, OR MEDICAL FACILITIES OF THE SAME TYPE AS THE HOSPITAL, HEALTH CARE FACILITY, OR MEDICAL FACILITY WHOSE ACTS OR OMISSIONS ARE THE

> SUBJECT OF THE TESTIMONY AND WHICH ARE LOCATED IN THE SAME OR SIMILAR COMMUNITIES AT THE TIME OF THE ALLEGED ACT GIVING RISE TO THE CAUSE OF ACTION.
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> (8) IF A HEALTH CARE PROVIDER DESCRIBED IN SUBSECTION (5), SUBSECTION (6), OR SUBSECTION (7) IS PROVIDING EVALUATION, TREATMENT, OR DIAGNOSIS FOR A CONDITION THAT IS NOT WITHIN HIS OR HER SPECIALTY, A SPECIALIST TRAINED IN THE EVALUATION, TREATMENT, OR DIAGNOSIS FOR THAT CONDITION SHALL BE CONSIDERED A SIMILAR HEALTH CARE PROVIDER.

The new Act retains the prior definition of an expert for emergency room cases as being someone with "substantial professional experience," as that term is "determined by the custom and practice of the manner in which emergency medical coverage is provided in hospital emergency departments in the same or similar localities where the alleged negligence occurred."

The new Act has yet to be tested in court to see how much it will change the standard for admissibility of expert testimony on the standard of care. Therefore, we should keep in mind the principles which have evolved through decades of common law decisions on that subject, and continue to assert that the courts have the final say over questions of procedure and evidence.

Do Not Mourn the Passing of the "Locality Rule"

Doesn't it seem that things are more difficult for the current generation of trial lawyers, when compared to the pioneers in our field? Certainly some things have changed for the worse, such as the reversal of the collateral source rule, caps on damages against some defendants, and the allocation of fault to non-parties under *Fabre*. But don't forget the changes which tended to open the

courthouse doors for our clients, which were closed to the clients of lawyers in our parents' and grantparents' generations.

The demise of the strict contributory negligence defense is one such positive change. Another example is the advent of strict liability in tort in defective product cases. Whatever may ultimately be the effect of the 2003 legislation, medical malpractice cases once were even harder to win than they have been during the last several years, back when proof of the standard of care was complicated by the "locality rule."

One statement of that locality rule is as follows:

> One who holds himself out as a physician or surgeon whether licensed or not, and accepts employment as such to treat a patient, assumes toward the patient the obligation to exercise such reasonable care and skill in that behalf as are usually exercised by physicians and surgeons of good standing, of the same system or school of practice ***in the community in which he resides***, having due regard to the condition of medical or surgical science at that time.

Annot., 78 A.L.R. 697 (emphasis added).

The courts applied the locality rule so narrowly as to exclude expert testimony from plaintiffs' experts who could not demonstrate first-hand knowledge of the applicable standard of care in the very community where the alleged malpractice occurred. In other words, the plaintiff's expert had to be someone who was now practicing, or who had recently practiced, in the same locality as the defendant.

The justification for the locality rule was that it protected small town doctors who had no access to the equipment and information available to big city practitioners:

> In the days when there was little inter community travel the courts required personal familiarity with the practice of physicians in the particular community where the plaintiff was treated

> as the bases of the experts' testimony concerning the degree of care which should have been used, on the theory that a doctor in a small community or village, not having the same opportunity and resources for keeping abreast of the advances in his profession, should not be held to the same standard of care and skill as that employed by physicians and surgeons in large cities. But the reason for the earlier rule largely disappeared with the advent of present-day rapid methods of transportation and easy means of communication, broadening both the duty of the medical practitioner and the measure of the qualifications of the expert witness to testify as to that standard of care imposed upon the practitioner since there is now no lack of opportunity for the physician or surgeon to keep abreast of the advances made in his profession and to be familiar with the latest methods and practices adopted.

Annot., Expert Witness in Malpractice Case, 8 A.L.R. 2d 772, 773.

The locality rule finally died, ironically enough, in a case dealing with the exclusion of ***defense*** experts who had been brought in from other states and cities. In *Couch v. Hutchi*son, 135 So. 2d 18 (Fla. 2d DCA 1961), the defendant, an osteopathic physician practicing in orthopedics, appealed after a verdict in favor of the plaintiff, alleging error in the trial court's exclusion of his expert witness, an osteopath from Philadelphia. There were no other osteopaths in Southwest Florida, and the plaintiff apparently had retained most of the M.D.s who were practicing orthopedics in that area of the state.

The Second District reversed, holding as follows:

> It may be noted that the locality rule ordinarily is invoked to bar a plaintiff from using experts from another community to establish malpractice; but here the defendants sought to introduce testimony of a Philadelphia osteopath who had taught orthopedic surgery and performed many of the same type of operations as Dr. Couch.

> The apparent cause of difficulty with the locality rule has been the tendency in some cases to apply it as a rigid and exclusionary rule of evidence rather than as a definition of the minimum or average standard of reasonable care required of a practitioner. The rule has, of course, an appropriate relation to the admissibility of evidence; but persuasive argument can be made for not regarding the locality rule as a rule absolute describing ***the*** definitive means of measuring reasonable care in cases of alleged malpractice, whether of diagnosis, internal medicine, manipulative therapy or surgery. It takes a strange sense of logic to hold that local practice rules out all other evidence on the central issue of reasonable care on such a widely pervasive subject.

Id. at 22-23 (emphasis by court).

Soon after that decision, in a case involving the admissibility of a Miami's expert's testimony about the standard of care applicable to a West Palm Beach doctor, the Second District traced the demise of the locality rule in other states, and noted: "While recognizing that such geographical distinctions can still exist regarding standards of medical competence and procedure, our courts have indicated that the 'locality' from which medical experts can be chosen to testify concerning the standards required of their professional brethren has been expanded from the ***same*** locality to the ***same or similar*** locality." *Cook v. Lichtblau*, 144 So. 2d 312, 314 (Fla. 2d DCA 1962)(emphasis by court). Worth remembering about the Cook case is that the plaintiff's expert was held competent to testify that the defendant's conduct was "negligent in any community in this country, ***including*** West Palm Beach."

The challenge these days, with the possible exception of emergency room cases, is not to establish familiarity with a particular community's standard of care. At least something might be a little easier than it once was.

Defendant Doctor's Customary Practice

Once you have found an expert who meets today's definition, you can focus on other evidence to establish violation of

the standard of care. The defendant may have violated his or her own customary practice in treating your client, resulting in harm which would not have occurred if that customary practice had been followed. "Evidence of a doctor's customary practice is relevant in a medical malpractice case." *Gerber v. Iyengar*, 725 So. 2d 1181, 1184 (Fla. 3d DCA 1998)(defendant who failed to administer Heparin to cardiac catherization patient, resulting in stroke, had used Heparin in fifty of sixty-seven prior similar cases).

While the defendant's usual practice "is merely some evidence of the standard of care, it is admissible for that limited purpose." *Nesbitt v. Community Health*, 467 So. 2d 711, 715 (Fla. 3d DCA 1985). Find out what the defendant has done in the past and make the jury aware that those actions speak louder than words.

Defendant's Violation of Hospital's Policies and Procedures

Where the malpractice occurs in a hospital, and that hospital had a policy or procedure in place which the defendant doctor violated, the fact of that violation may be introduced like an industry standard on the question of the standard of care. In *Marks v. Mandel*, 477 So. 2d 1036 (Fla. 3d DCA 1989), the court held:

> Appellant raises several issues on appeal. As his first point, appellant argues that it was error for the trial court to exclude as evidence Palmetto General's emergency room policy and procedure manual. We agree. . . . Courts have held repeatedly that these internal manuals should be admitted when they contain either 1) evidence of a general industry custom or standard, or 2) evidence that the defendant violated its own policy or an industry standard.

Id. at 1039. Accord, e.g. Moyer v. Reynolds, 780 So. 2d 205, 208 (Fla. 5th DCA 2001)("Dr. Slysh's testimony regarding the hospital's policy and procedure for the emergency room was relevant as some evidence of the standard of care and the error in striking this testimony constitutes harmful error requiring reversal").

Conclusion

The medical industry will keep throwing up barriers to our efforts to remedy their injurious wrongs. Don't be daunted by their

money and their might. Judges and juries will continue to mete out justice to those harmed by medical negligence, with your leadership and creativity.

Keep Tryin!

Roy

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