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Torts--Medical Malpractice--Sources of a Physician's Standard of Care: The Medical Profession or the Courts--Helling v. Carey

create among landowners as much uncertainty about liability or fear of litigation. Free of these concerns, a landowner is not likely to take precautionary measures such as closure.

IV. CONCLUSION

Section 339 of the *Restatement (Second) of Torts* requires a weighing of the risk of injury to the child against the utility of the condition to the landowner and the burden on him of removing it. [71] Dean Prosser once suggested that not only the utility of the condition to the landowner, but also its utility to society should be considered.[72] The Oregon court, in refusing to extend attractive nuisance liability to natural conditions because of a public interest in keeping wild land open, in fact considered the utility of the condition to society. But the refusal to extend liability to natural hazards under attractive nuisance for the reason given by the court can only be justified for landowners whose land is suitable for outdoor recreation.

Torts–MEDICAL MALPRACTICE–SOURCES OF A PHYSICIAN'S STANDARD OF CARE: THE MEDICAL PROFESSION OR THE COURTS–*Helling v. Carey*, 83 Wash. 2d 514, 519 P.2d 981 (1974).

In 1959, Barbara Helling consulted Thomas F. Carey and Robert C. Laughlin, medical doctors and partners specializing in the practice of ophthalmology, concerning myopia and was fitted with contact lenses. In September 1963, she contacted them again regarding irritation to her eyes, and over the next 5 years further consultations took place.[1] The doctors considered Mrs. Helling's visual problems to be solely related to complications with her contact lenses until they tested her eye pressure and field of vision in October 1968. As a result of these tests, the doctors discovered that Mrs. Helling, who was then 32 years of age, had glaucoma[2] and that she had lost her peripheral vision and a significant portion of her central vision. Mrs.

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[71] RESTATEMENT (SECOND) OF TORTS § 339, comment *n* (1965).

[72] *Trespassing Children* 463.

[1] These additional consultations occurred in October 1963, February 1967, September 1967, October 1967, May 1968, July 1968, August 1968, September 1968, and October 1968.

[2] Plaintiff was found to be suffering from primary open angle glaucoma, a condition in which the nourishing fluids of the eye are unable to escape and flow from the eye properly. This condition causes an increase in intraocular pressure which ultimately results in damage to the optic nerve and permanent and irreversible loss of vision. 83 Wash. 2d at 515, 519 P.2d at 981.

Helling brought suit alleging damage to her eyes as a result of the doctors' negligence in failing to make an earlier diagnosis of the disease.

At trial, medical testimony for both sides established that even those doctors specializing in ophthalmology did not perform routine tests for glaucoma[3] upon patients under 40 years of age. Accordingly, the trial court entered judgment for the defendants and the court of appeals affirmed. On appeal, the Washington Supreme Court reversed, holding that the defendants were negligent as a matter of law in that they failed to give a "simple, harmless pressure test" to the plaintiff. The court decided that doctors had a duty to administer the test for glaucoma even though the standards of the ophthalmology profession did not require such a level of care.

I. THE STANDARD OF CARE IN MEDICAL MALPRACTICE ACTIONS

The crucial element in a medical malpractice action is the standard of care against which the defendant physician's conduct is measured.[4] Traditionally, the law has required that the defendant physician's conduct conform to the standard of care and practice of doctors generally. In other words, what doctors do customarily is what the law says any individual doctor ought to do. This principle, universal until pronouncement of the decision in the instant case,[5] thus operates to make the medical profession itself the source of the standard of care applied in a medical malpractice action.

It should be noted, however, that over the years the courts have developed several variations on the above stated general principle in response to such factors as the defendant's degree of specialization or opportunity to keep abreast of advances in medical knowledge.[6] For example, in a medical malpractice action brought against a specialist, the courts apply, depending on the jurisdiction, one of three standard practice rules: (1) the locality rule, (2) the same general neighborhood rule, and (3) the average specialist rule.

The locality rule requires a specialist to exercise the degree of care applied by other specialists in his locality or in other cities of similar

[3]The primary diagnostic tool available for discovering glaucoma in its early stages is the Schiotz Tonometer, which measures intraocular pressure. A so-called pressure test takes 60 seconds and is harmless to the patient. STEDMAN'S MEDICAL DICTIONARY 1305 (22d ed. 1972).

[4]*See, e.g.*, Davis v. Duplantis, 448 F.2d 918 (5th Cir. 1971); Riley v. Layton, 329 F.2d 53 (10th Cir. 1964); Dunham v. Elder, 19 Md. App. 360, 306 A.2d 568 (1973); Hayes v. Hulswit, 73 Wash. 2d 796, 440 P.2d 849 (1968); Merriman v. Toothaker, 9 Wash. App. 810, 515 P.2d 509 (1973).

[5]*See* note 13 *infra* and accompanying text.

[6]*See* Linden, *The Negligent Doctor*, 11 OSGOODE HALL L. J. 31 (1973); McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549 (1959); Sherman, *The Standard of Care in Malpractice Cases*, 4 OSGOODE HALL L. J. 222 (1966); Comment, *Standard of Care for Medical Specialists*, 16 ST. LOUIS U.L.J. 497, 498 (1972); Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729 (1970) [hereinafter cited as *An Evaluation*]; 44 WASH. L. REV. 505 (1969).

size and with similar medical resources.[7]

The same general neighborhood rule establishes a higher standard. Unlike the locality rule's comparison to the practice in localities of similar size, this standard is based on practices occurring within a geographical proximity to the specialist's community. Under such a standard, a specialist is required to treat his patient with the same degree of skill and care as would be available anywhere within a geographical proximity to the specialist's community, even though the available communities may be much larger and may have access to more advanced medical facilities and resources.[8]

The highest standard of care to which the specialist has been held is that of the average specialist in the same field of medicine.[9] This standard is nongeographical and is determined by the present level of scientific knowledge within a particular field. The trend of the law, especially regarding specialists, is toward the establishment of such minimum national standards and the adoption of the average specialist rule.[10]

In contrast to the standard of care applied in medical malpractice actions—that is, the degree of care exercised in the profession—the normal standard of care for negligence actions is one of average prudent conduct. What constitutes such conduct is determined on the basis of all the available evidence and is not limited by professional pronouncement. In the language of Justice Holmes,

> What usually is done may be evidence of what ought to be done, but what ought to be done is fixed by a standard of reasonable prudence, whether it is usually complied with or not.[11]

The jury, or the court if the judge is sitting without a jury, determines in each case the standard of care, that is, average prudent conduct, on the basis of several factors: the foreseeability of possible harm, the severity of possible injury, and the cost of taking precautions to minimize risk of harm and avert injury. In the typical negli-

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[7]*See, e.g.,* Harris v. Campbell, 2 Ariz. App. 351, 409 P.2d 67 (1965) (gynecologist); Crovella v. Cochrane, 102 So. 2d 307 (Fla. Ct. App. 1958) (obstetrician); Runyan v. Reid, 510 P.2d 943 (Okla. 1973) (psychiatrist); Dinner v. Thorp, 54 Wash. 2d 90, 338 P.2d 137 (1959) (obstetrician).

[8]*See, e.g.,* Campbell v. Oliva, 424 F.2d 1244 (6th Cir. 1970) (plastic surgeon); Orange v. Shannon, 284 Ala. 202, 224 So. 2d 236 (1969) (neurological surgeon); Decho v. Shutkin, 144 Conn. 102, 127 A.2d 618 (1956) (orthopedic surgeon); Geraty v. Kaufman, 115 Conn. 563, 162 A. 33 (1932) (surgeon).

[9]Kronke v. Danielson, 108 Ariz. 400, 499 P.2d 156 (1972) (neurosurgeon); McCarthy v. Boston City Hospital, 358 Mass. 639, 266 N.E.2d 292 (1971) (radiation treatment); Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968) (anesthesiologist); Naccarto v. Grob, 384 Mich. 248, 180 N.W.2d 788 (1970) (pediatrician).

[10]*See* 14 STAN. L. REV. 884, 887-89 (1962). Members of the board of editors of the Stanford Law Review conducted a survey and concluded on the basis of uniform requirements for certification, subscriptions to specialty journals, and statements of the various specialty boards, that the practice of medicine by certified specialists is similar throughout the country. This similarity of practice lends itself to the establishment of minimum national standards.

[11]Texas & Pac. Ry. v. Behymer, 189 U.S. 468, 470 (1903).

gence action, each of these factors must be considered in determining the standard of care, with the ultimate standard representing a balancing of all the factors involved.

II. THE NEW STANDARD OF *HELLING V. CAREY*

In the instant case, expert testimony established the defendants' conduct satisfied even the most rigorous "average specialist" standard. Nevertheless, the court found as a matter of law that the defendants were liable. The case is unique, therefore, because the court rejected the most demanding of the three standard practice rules—the standard of the ophthalmology profession—and held the defendants liable despite the fact that they followed the established practice of their profession.[12] In effect, the *Helling* court created and imposed a new standard of care upon the medical profession—a *judicially* determined standard of care. The court rejected the average specialist rule reasoning that it is ultimately the court which must determine what degree of care is required, and that where a simple, inexpensive test can be administered to arrest the devastating results of a disease, universal professional disregard of the test will not insulate a physician from liability for failure to give such test.

The concurring opinion suggests an even broader and more radical departure from the general rule—a theory of strict liability. Under this theory, even if a doctor complies with the most demanding of the standard practice rules or with the average prudent conduct standard, he is not insulated from liability where the applicable standard is inadequate to protect the plaintiff. Accordingly, the risk of loss is placed not on an innocent plaintiff but on the doctor whose conduct, though not blameworthy, caused the loss. This strict liability approach recognizes "[a] strong and growing tendency, where there is blame on neither side, to ask, in view of the exigencies of social justice, who can best bear the loss and hence to shift the loss by

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[12]Other situations in which compliance has been held insufficient include: Favalora v. Aetna Cas. & Sur. Co., 144 So. 2d 544, 550-52 (La. App. 1962) (standard of care in community, although followed by others in same field, cannot be relied on where it is recognized as faulty and contrary to what has been taught in medical school); Toth v. Community Hospital, 22 N.Y.2d 255, 263, 239 N.E.2d 368, 373, 292 N.Y.S.2d 440, 447 (1968) (compliance with customary practice does not automatically free one from liability where physician knows or believes there are unnecessary dangers in the community practice); *An Evaluation, supra* note 7, at 744. Despite the fact that there have been other cases in which a specialist has been held liable for malpractice in spite of his compliance with the most demanding of the standard practice rules, *Helling v. Carey* remains unique. In the earlier cases in which compliance was held to be insufficient, the specialist either knew the practice was faulty, believed there were unnecessary dangers in its practice, or practiced according to a standard disapproved by medical schools. In *Helling v. Carey*, the entire medical community agreed upon the soundness of the defendants' conduct, yet the defendant physicians were still found liable. Properly interpreted, the cases cited above do not represent a move in the direction of strict liability, *but see* Comment, *Medical Malpractice: A Move Toward Strict Liability*, 21 LOYOLA L. REV. 194, 207–11 (1975), or abandonment of the standard practice rule. *Cf.* 28 VAND. L. REV. 441, 446–47 (1975) (noting Helling v. Carey, 83 Wash. 2d 514, 519 P.2d 981 (1974)).

creating liability where there has been no fault."[13] In other words, it is not compliance or noncompliance with a standard of care which defines the limits of liability. The burden of loss, occasioned by no one's "fault," is placed on the party best able to bear and distribute that loss.

III. THE SCOPE OF THE *HELLING* STANDARD

The scope and proper application of the new standard of care for medical malpractice actions announced in *Helling* is unclear. On one hand, the *Helling* standard may be read to require that in all medical malpractice actions the prudence and reasonableness of the doctor's conduct ought to be measured in light of all relevant evidence, with the standard practice in the profession serving merely as some, but not conclusive evidence. This would be the broad interpretation and application. On the other hand, the instant case may be read very narrowly: the judicially determined standard of care will be applied, in derogation of the standard medical practice rules, only in those cases with unusual factual circumstances closely resembling the fact situation in *Helling*.

The narrow reading of *Helling* would suggest that the unique facts of the case led the court to reject the most rigorous of the standard practice rules and that the imposition of the judge-made standard is limited to similar factual situations. The court emphasized specific factual circumstances which made the standard of care for the ophthalmology profession an inadequate legal standard. These circumstances are the touchstones in determining what other factual situations may result in a similar imposition of a judicial standard and a concomitant rejection of the standard practice rules. First, glaucoma has few symptoms—it is a silent disease, and the symptoms do not become obvious until serious damage has already occurred. Second, a simple, inexpensive pressure test which takes only 60 seconds to administer can determine the presence of the disease. Third, grave and devastating harm results from the disease. Last, the defendants had numerous opportunities to test the plaintiff for glaucoma during her repeated visits. The court intimated that because of this unique fact situation the risk of harm to the patient far outweighed the slight burden placed on the specialists in giving the simple glaucoma test. In other words, the customary practice of opthalmologists—that glaucoma tests are not routinely given to those under 40—was not a reasonable test of what should be required.

Under a narrow reading of the case, one would have to show the following in order to fall within the *Helling v. Carey* exception to the rule of *medically* determined standard practice rules: first, a pathological condition which has very few apparent symptoms or symp-

[13]Helling v. Carey, 83 Wash. 2d 514, 520, 519 P.2d 981, 984 (1974) (Utter, J., concurring).

toms which reveal themselves only after severe damage has been done; second, an inexpensive test which can readily determine the presence of the disease or condition; third, a condition which gives rise to grave and devastating harm; and finally, a series of consultations giving ample opportunity to diagnose the condition. The *Helling* decision may represent an affirmation of the standard practice rule with a caveat that, in limited situations, only adherence to a higher standard of care, to be imposed by the court, will insulate a specialist from liability.

Such a narrow interpretation of the case is not without its possible problems. It is likely that the courts would find some difficulty in determining when a particular set of facts sufficiently paralleled the facts of *Helling* to justify the application of a judicial standard. For example, under what circumstances can a court justifiably conclude that a test is "simple"? Similar difficulties would also face the doctor as he attempts to determine when a pathological condition has "few apparent symptoms" or when the condition gives rise to a "grave" result.

Emphasis on the narrow and unique factual setting of the case is not the only reasonable interpretation of the result. One might conclude that *Helling v. Carey* speaks more broadly and announces the court's general refusal to rely solely on standards determined by the medical profession. Testimony by medical experts would remain a factor to be considered in the ultimate determination of the physician's duty to his patient, but such testimony would not be conclusive. Rather, the jury would have the ultimate responsibility to determine whether the physician's conduct was reasonable in light of all of the evidence. Hence, medical malpractice actions would fit within the traditional mold of general negligence actions wherein an individual's conduct is measured against the standard of reasonableness as established by all the circumstances and not solely by a professionally determined norm.

In assessing the potential impact of a broad reading of the case, a number of factors should be considered. First, a broad interpretation raises the issue of judicial competency to establish the appropriate standard of care. The justification for allowing the medical profession to establish its own standard of care is that the courts are not competent to establish such a standard. Only another doctor is qualified to determine what is the appropriate degree of professional care in the diagnosis and treatment of patients.[14] In fact, the concurring opinion in *Helling* suggests that because judges lack medical training it is illogical for a court to say that a physician failed to exercise reasonable care. Allowing the medical profession to establish its own standard recognizes the notion that physicians are in the best position to determine what constitutes competent medical practice.

A broad interpretation also raises the spectre of an increasing in-

[14]*See* 6 TEXAS TECH L. REV. 279, 283 (1974).

cidence of defensive medical tactics as doctors seek to minimize or avoid the threat of increased medical malpractice liability. Indeed, there recently has been considerable discussion regarding the alleged practice of defensive medicine.[15] Defensive medicine takes two forms: (1) a doctor practices positive defensive medicine when he prescribes diagnostic tests and other procedures which are not clearly necessary in order to shield himself from the risk of a malpractice suit, and (2) he engages in negative defensive medicine when he fails to employ procedures which could be helpful, but which have a high risk or are known to be hazardous.[16] As the number of malpractice claims increases, it is possible or even likely that many physicians will order additional but unnecessary laboratory tests, resort prematurely to outside consultations, and hospitalize patients not so much from medical necessity as from a conscious effort to diminish the threat of malpractice suits.[17] In addition, physicians may not experiment with new procedures or employ recently developed drugs because of their novelty, uncertainty, and risk, even though such procedures or drugs may be all that remains to the doctor in an effort to save a life.[18]

An empirical study of the incidence of defensive medicine indicates "[t]hat the malpractice threat does induce physicians to practice some positive defensive medicine, but the practice is not extensive and does not have as significant an impact as previously alleged."[19] If, however, the medical profession views the results in cases such as *Helling v. Carey* as a continuing judicial liberalization of the rules governing the law of medical malpractice, the practice of both positive and negative defensive medicine may increase. An increase in the practice of defensive medicine would inevitably lead to increased costs of medical care to the patient. Moreover, to the extent that doctors do prescribe unnecessary medical procedures, scarce medical resources are improperly allocated.

Another problem that may arise from widespread adoption of a broad construction of the *Helling* rule is the deterioration of the doctor-patient relationship. For some time, it has been suggested that one of the primary factors motivating many malpractice suits is a poor relationship between patient and doctor.[20] Dramatic advances in medical technique and equipment and increasing specialization have limited the personal contact between individual patients and

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[15]*See, e.g.*, Kretzmer, *The Malpractice Suit: Is It Needed?*, 11 OSGOODE HALL L.J. 55, 61–64 (1973); Stetler, *The History of Reported Medical Professional Liability Cases*, 30 TEMP. L.Q. 366, 383 (1957); Project, *The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939 [hereinafter cited as *A Study of Defensive Medicine*].

[16]*A Study of Defensive Medicine, supra* note 15, at 940–50.

[17]*See* Brooke, *Medical Malpractice: A Socio-Economic Problem from a Doctor's View*, 6 WILLIAMETTE L.J. 225, 231 (1970).

[18]*Id.* at 230–31.

[19]*A Study of Defensive Medicine, supra* note 15, at 957.

[20]*See, e.g.*, Martin, *Current Observations on Medical Malpractice*, 26 INS. COUN. J. 425, 428 (1959).

doctors and have contributed to an erosion of their relationships.[21] If doctors must labor under a judicially determined and more demanding standard of care or under some form of strict liability, they may become increasingly suspicious of their patients as they begin to view them as potential adversaries in the litigation process.

The concurring opinion suggests that defendant physicians should be found liable under a strict liability theory because doctors, it is asserted, are better able to bear and distribute the loss by means of medical malpractice insurance. This point of view causes concern, however, inasmuch as medical malpractice insurance is becoming more difficult to obtain. The insurance industry is, in many cases, losing money annually in underwriting malpractice insurance.[22] Furthermore, it is well established that there has been a dramatic increase in the number of malpractice suits brought each year in the United States.[23] Nationally, one in every seven doctors has had at least one suit brought against him; in California, one in every four.[24] If the number of malpractice claims continues to rise and insurers find it impossible to cover their losses on those claims, there is a legitimate concern that insurance companies will refuse to underwrite medical malpractice insurance.[25] The courts, therefore, should be reluctant to presume that doctors have, through medical malpractice insurance, an adequate device to help bear and distribute the burden of medical malpractice losses. A rule framed and applied because of the existence of medical malpractice insurance may be self-defeating if it operates to make such insurance unavailable.

IV. CONCLUSION

The result in *Helling v. Carey*, considering its unique facts, can only be classified as equitable and just. Nevertheless, the decision is susceptible to an overly broad interpretation which may lend itself to more problems than it solves. A broad interpretation which permits generally a judicially determined standard of care in medical malpractice actions gives rise to problems of (1) judicial competence to determine such a standard, (2) an increased tendency to practice defensive medicine in response to a lack of doctor-made guidelines, and (3) further deterioration of the doctor-patient relationship. A reading of the case which permits recovery based on a theory of strict liability and the physician's ability to better distribute loss fails to consider adequately the threat of cancellation of medical malpractice insurance. The scope of the decision is best limited to a narrow

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[21]Linster, *Insurance View of Malpractice*, 38 INS. COUN. J. 528 (1971).

[22]*See* Brant, *Medical Malpractice Insurance: The Disease and How To Cure It*, 6 VAL. U.L. REV. 152, 159 (1972); Linster, *supra* note 21, at 529.

[23]Kretzmer, *supra* note 15, at 59 n.18; *A Study of Defensive Medicine*, *supra* note 15, at 940 n.4.

[24]Daughtry, *The View of the Medical Profession*, 38 INS. COUN. J. 534 (1971).

[25]*See* Morris, *Medical Report: Malpractice Crisis — A View of Malpractice in the 1970's*, 38 INS. COUN. J. 521 (1971).

interpretation based on its unique facts. Customary practices and medically determined standards of care remain undisturbed as legally sound except in those exceptional factual situations paralleling the fact pattern of *Helling*.