

THE COMMON KNOWLEDGE EXCEPTION TO THE EXPERT  
TESTIMONY REQUIREMENT FOR ESTABLISHING THE  
STANDARD OF CARE IN MEDICAL MALPRACTICE

*Joseph H. King\**

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I. THE COMMON KNOWLEDGE CHALLENGE

The liability of health care providers is based on negligence principles and thus on objective criteria. In an ordinary negligence claim, a defendant’s conduct is evaluated in terms of the conduct expected of a similarly situated reasonable person. There is a substratal difference in medical malpractice claims against health care providers as compared to garden-variety defendants in negligence cases. Rather than have the defendant’s conduct assessed by a reasonable person standard, there is an additional screen for medical negligence “malpractice” claims. Such claims are determined in accordance with the professional standards applicable to the profession in which the defendant was undertaking to perform when the allegedly negligent conduct occurred. A universal corollary to this professional-standards-based regime of medical negligence law is that testimony by a competent expert witness is generally necessary in order for the plaintiff to make out a prima facie case. In other words, expert testimony will generally be essential for the plaintiff to be permitted to submit his claim to the trier of fact—usually a jury—for a determination on the merits. Expert testimony is also often required to satisfy the causation element in medical malpractice

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\*. UTK and Walter W. Bussart Distinguished Professor of Law, University of Tennessee College of Law. Research for this Article was supported by a generous summer research stipend from the College of Law. I am also indebted to Christopher Loeffler and Brittian Sexton, former and current research assistants, for their help with reference material for this Article.

claims as well. I will focus in this Article, however, on proof of the standard of care and will not address the causation requirement.

For decades, the attention of the courts, commentators, and increasingly, legislatures, has been insularly focused on delineating both the contours of the expert witness requirement and, in particular, the characteristics required to render a putative expert witness competent to offer an expert opinion on the standard of care and thus make his expert testimony admissible and probative on the standard of care question. Once exclusively the province of the courts, the expert witness rules have since the early 1970's increasingly evolved as a jointly fashioned product of not only the courts, but also importantly, of state statutes. Throughout this fluid period of protean legal developments, the courts have for the most part continued to recognize an important exception to the expert testimony requirement, often referred to as a "common knowledge" rule or exception.

The common knowledge rule holds that notwithstanding the general prerequisite for expert testimony to establish the standard of care<sup>1</sup> and its breach in medical malpractice cases, such expert testimony is not required when the subject matter of the allegedly substandard conduct is within the common knowledge of non-medically-trained persons, or in other words, fully comprehensible to ordinary non-medical members of the public. The facile simplicity of the easy "common knowledge" expression, however, belies the challenging nature of the concept. Whereas most courts have recognized the common knowledge exception in principle, meaningful definition or explication of the contours and nature of the rule and under what circumstances it applies have eluded the courts.

Some cases warranting application of the common knowledge rule seem relatively straightforward. Consider, for instance, a situation in which it is alleged that a dentist extracts the wrong tooth,<sup>2</sup> a veterinarian operates on the wrong horse,<sup>3</sup> or a health care provider with responsibility for removing an instrument or device fails to remove it from inside the patient.<sup>4</sup> Other

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1. The common knowledge question also arises frequently in the context of causation questions. Here, too, expert testimony is the norm, but an exception is often recognized when the existence of a causal connection between the alleged medical negligence and the plaintiff's injury is deemed a matter of common knowledge. The scope of this Article, however, is limited to the use of the common knowledge exception to address the standard of care element in medical negligence and malpractice cases. The Article does not address the element of causation or whether or when expert testimony may or may not be required to establish causation in a medical malpractice claim.

2. See *Hubbard ex rel. Hubbard v. Reed*, 774 A.2d 495, 500-01 (N.J. 2001) ("It has long been settled that pulling the wrong tooth is negligent as a matter of common knowledge."); cf. *Anderson v. Attar*, 841 N.E.2d 1286, 1288-89 (Mass. App. Ct. 2006) (holding, in case where a dental patient allegedly suffered a broken tooth because, he contended, the dental assistant used an improper cement when reattaching his bridge, which then required the defendant dentist to use excessive force to remove it and that "[j]urors are not competent from their own knowledge and experience to determine the appropriate kind of cement to be used to install a dental bridge, and the appropriate amount of force necessary to remove it").

3. *Durocher v. Rochester Equine Clinic*, 629 A.2d 827 (N.H. 1993) (holding that no medical expert testimony was necessary to determine whether defendant-veterinarian was negligent in allegedly operating on the wrong horse, which falls within the common knowledge of laymen).

4. See *infra* notes 228-241 and accompanying text.

cases fall at the other end of the spectrum and manifestly are not appropriately matters of common knowledge. An example might involve allegations that a surgeon was negligent in his decision to treat the plaintiff's injury with one surgical technique rather than another.<sup>5</sup> That leaves a vast range of cases falling somewhere in between. Consider, for example, *Seippel-Cress v. Lackamp*.<sup>6</sup> A frail elderly patient had undergone a barium swallow test of her upper gastro-intestinal tract because she suffered from rapid weight loss and difficulty in swallowing solid foods.<sup>7</sup> Some evidence showed that the patient's condition changed during the x-ray procedure, that the procedure was terminated due to her "apparent discomfort, fatigue and inability to swallow the thicker material," and that she "needed to be placed on a gurney."<sup>8</sup> According to the patient's daughter, the patient did not say anything on the way home, and when they reached the house, the patient's "head fell back and she did not seem to be breathing."<sup>9</sup> An ambulance took the patient to the emergency room, and within a short time, it was determined that she was brain dead.<sup>10</sup> The plaintiff alleged *inter alia* that the healthcare providers sent the patient home without treatment for the aspiration of the barium-impregnated solution or the conditions it caused, resulting in a toxic reaction to the test substance, chemical pneumonia, and anoxia causing brain damage and central nervous system depression.<sup>11</sup> But, was the question of whether the defendants were negligent a matter within the common knowledge of laymen, or was expert testimony necessary on the issue?<sup>12</sup>

The question of whether to apply the common knowledge exception to a particular set of facts has been decided on a case-by-case basis where the suitability of the common knowledge rule seems to depend on the eyes of the beholder trial and appellate judges. Indeed some courts have used simplistic tests for the common knowledge exception, such as the insouciant formulation that the common knowledge exception may apply "when medical negligence is, so to speak, as plain as a fly floating in a bowl of butter-

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5. See *Garaffa v. JFK Med. Ctr.*, No. A-4105-04T24105-04T2, 2006 WL 2033752, at \*5 (N.J. Super. Ct. App. Div. July 21, 2006) (holding the common knowledge exception inapplicable in a case in which the plaintiff alleged that the defendant orthopedic surgeon was negligent in his decision to treat the plaintiff's fractured arm by performing a closed reduction and placing it in a splint instead of performing a surgical open reduction).

6. 23 S.W.3d 660 (Mo. Ct. App. 2000).

7. *Id.* at 663.

8. *Id.* at 668-69.

9. *Id.* at 664.

10. *Id.*

11. *Id.* at 665.

12. The court agreed with the plaintiff that "as to the events following the termination of the test, she did not need to use expert testimony to show a breach of the standard of care." *Id.* at 669. The court explained that:

[T]he average non-physician layperson knows that when the condition of a patient is altered unexpectedly during a medical procedure, a medical provider must determine the status of the patient and the cause of the alteration in order to know whether the matter involves an emerging threat to the life or condition of the patient. We believe that this is so obviously a responsibility of medical providers that it cannot be questioned.

*Id.*

milk.”<sup>13</sup> That such deceptively reassuring, but basically meaningless “tests” have proven popular<sup>14</sup> is perhaps tacit acknowledgment of the absence of meaningful guidance from the courts. The cold reality remains that the decision whether the common knowledge rule applies will often determine the outcome of a negligence claim against a health care provider. If it is determined that the exception does not apply, then a plaintiff who has no qualified expert witness will often face a summary judgment or some other adverse pretrial disposition.

The facile simplicity of the common knowledge rule masks very real competing concerns. Moreover, prospective malpractice plaintiffs have legitimate concerns over the high costs of expert witnesses and the challenge of identifying suitable and willing medical experts. There is also the ever-present risk that a legitimate claim for a negligently caused injury will go unredressed when the outcome depends on the traditional battle of paid experts whose persuasiveness may lie in marketing their client’s side, or at least in selectively presenting the case or obfuscating the medicine, rather than in objectively educating the triers of fact and reaching just resolutions.<sup>15</sup> On the other hand, there is the simple fact that some medical errors arise in circumstances that are perfectly amenable to fair and cogent assessment by persons not formally trained in the medical professions.

Health care providers, the potential defendants, fear that lay jurors, if left exclusively to their “common knowledge,” may not understand or appreciate the complexity of modern medical decision making and practice.<sup>16</sup> Jurors may be inclined through hindsight to unfairly second-guess the conduct of health care providers and equate an unfortunate outcome with substandard care. Health care professionals also fear that without the normative winnowing and sifting inherent in the requirement of expert testimony, many more disappointed or disaffected patients may be inclined, driven by a variety of motivations, to sue for malpractice, increasing the incidence and threat of malpractice litigation.<sup>17</sup> That will in turn induce physicians to practice defensive medicine, with all its attendant costs in professional attention and resources.<sup>18</sup>

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13. German v. Nichopoulos, 577 S.W.2d 197, 202 (Tenn. Ct. App. 1978), *overruled on other grounds by* Seavers v. Methodist Med. Ctr. of Oak Ridge, 9 S.W.3d 86 (Tenn. 1999). The *German* case was apparently the first one to use this felicitous phrase in the present context.

14. See, e.g., Patterson v. Arif, 173 S.W.3d 8, 12 (Tenn. Ct. App. 2005) (“The ‘common knowledge’ exception to the general rule is applicable when ‘the medical negligence is as blatant as a ‘fly floating in a bowl of buttermilk’ so that all mankind knows that such things are not done absent negligence.’” (quoting Murphy v. Schwartz, 739 S.W.2d 777, 778 (Tenn. Ct. App. 1986))); Martin v. Sizemore, 78 S.W.3d 249, 272–73 (Tenn. Ct. App. 2001) (“[T]he professional negligence must be ‘as plain as a fly floating in a bowl of buttermilk’ to trigger the common knowledge exception.” (quoting German v. Nichopoulos, 577 S.W.2d 197, 202 (Tenn. Ct. App. 1978))).

15. See Steven E. Pegalis, *Medical Malpractice: The Art of Advocacy When Engaging in the “Battle of the Experts,”* 23 AM. J. TRIAL ADVOC. 259, 259 (1999).

16. See Neil Vidmar, *Are Juries Competent to Decide Liability in Tort Cases Involving Scientific/Medical Issues? Some Data from Medical Malpractice,* 43 EMORY L.J. 885, 889–90 (1994).

17. See *infra* notes 143–147 and accompanying text.

18. See *infra* note 149 and accompanying text.

Finally, the broader and complex interests of society generally should be considered. On the one hand, members of society should be rightly concerned about the common knowledge rule potentially increasing the incidence, costs, and uncertainty of medical malpractice cases. To the extent that the common knowledge rule makes it easier and less expensive to pursue malpractice claims, an increase in such litigation would be a likely concomitant. The uncertainty surrounding the common knowledge rule seems increasingly to necessitate appellate intervention, thereby adding to the costs and delays in this already costly and time-consuming type of litigation.<sup>19</sup> Malpractice cases are relatively inefficient vehicles for compensating supposed victims of medical negligence when one considers not only the costs and resources expended in resolving and paying such claims, but also the adverse effects on the overall practice of medicine, including fostering wasteful defensive medicine.<sup>20</sup> So in one respect, application of the common knowledge exception could be seen as compounding the shortcomings of the malpractice cases by increasing their numbers. That being said, however, it is not the case that we should automatically always prefer proof by expert over the application of common knowledge. Society also has an interest in the integrity of the adjudicatory process for resolving malpractice claims. The current hired-expert-based system for establishing the professional standard of care in malpractice litigation is far from perfect. While a requirement for expert testimony may admittedly inhibit the growth of malpractice cases, there are also dangers in overreliance on medical experts that are selected, paid, and prepared for trial by the parties. There are not only the obvious risks of bias and lack of objectivity, but there is also the danger that the outcome of cases may too often depend on the experts' success in marketing their clients' side, or at least in selectively presenting the case or obfuscating the medicine, rather than in objectively educating the triers of fact and facilitating a just resolution of the matter.

A convincing argument can be made that there is room for some continuing application of the common knowledge rule. That leaves the question of where the balance should be struck. With so much riding on the common knowledge question, the rule's lack of clarity and predictability is lamentable but also not surprising. There is an inherent and confounding incongruity in the common knowledge rule that defies attempts at formulating a meaningful standard. It lies in the circularity of it all—how does one determine a subject matter is within common knowledge and not dependent on professional medical assessment without the very medical input that the application of the rule says is unnecessary? The challenge is to develop meaningful criteria for deciding when conduct by health care providers can

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19. See, e.g., *Smith ex rel. Smith v. Gilmore Hosp., Inc.*, 952 So. 2d 177, 181–82 (Miss. 2007) (holding that the appellate court had incorrectly determined that the common knowledge exception applied to the case).

20. See Jonathan Todres, *Toward Healing and Restoration for All: Reframing Medical Malpractice Reform*, 39 CONN. L. REV. 667, 679–82 (2006).

be fairly assessed by lay jurors without the input or guidance from medical expert witnesses. The task is compounded by the fact that the common knowledge rule has traditionally largely been a function of a case-by-case approach.<sup>21</sup> Ideally, criteria should be developed that provide some intelligible demarcations and predictable standards while at the same time preserving some needed flexibility for deciding these necessarily fact-laden questions. This dialectic between the tugs of predictability and flexibility is nothing new.<sup>22</sup> Justice Neely refers to it as “the age-old conflict between society's need for predictability accomplished through legal formalism versus society's need to do justice in individual cases.”<sup>23</sup> The challenge really comes down to arriving at an optimal balance between the conflicting forces of a definitive rule and a more adaptable ad hoc approach.

I believe that the common knowledge exception to the expert witness requirement should be retained, but subject to some guidelines and parameters defining its scope. Accordingly, I suggest the following threshold criteria to help in deciding when conduct by health care providers can be fairly assessed by lay jurors without input from medical expert witnesses. I propose a construct of two alternative preconditions the presence of either of which would then allow a court discretion to hold that the common knowledge exception was applicable to the facts at issue:

- a. The specific conduct that allegedly constituted negligence was of such a nature that not only could an unlicensed layperson legally perform it without violating or offending applicable medical or health care licensure statutes or duly authorized regulations governing the practice of the health care professions, but also that such an unlicensed layperson would ordinarily be deemed competent and foreseeably expected to routinely perform such conduct; or,
- b. The specific decision making by the health care provider that allegedly constituted negligent conduct that caused the injury in question did not involve the exercise of uniquely professional medical skills, a deliberate balancing of medical risks and benefits, or the exercise of therapeutic judgment.

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21. See *supra* note 19 and accompanying text.

22. It is an incessant interaction, a permanent tension throughout the law of torts, and in the life of the law generally. Judge (then law school professor) Robert Keeton has described this conflicting interaction this way:

Two yearnings influence development of any legal rule. One is the yearning for a precise rule that serves as an unfailing guide to the judge in making decisions and to the lawyer in predicting them. The other is the yearning for a flexible rule that is most conducive to sensitively administered justice—a rule that never compels bad decisions in the interest of symmetry, elegance, or simplicity.

ROBERT E. KEETON, *LEGAL CAUSE IN THE LAW OF TORTS* vii (1963).

23. *Sprouse v. Clay Commc'n, Inc.*, 211 S.E.2d 674, 696 (W. Va. 1975).

Thus, at least one of these preconditions should be present before a trial court should have discretion to apply the common knowledge exception and permit the plaintiff's malpractice claim to proceed without expert testimony on the standard of care with respect to the question under consideration.

## II. NATURE OF THE COMMON KNOWLEDGE EXCEPTION

### A. *Current Incarnations*

It is useful to place the common knowledge question into the larger conceptual framework. Liability for medical negligence or "malpractice" is based on two core principles. First, such liability is fault-based (rather than strict liability) and the plaintiff must therefore adduce proof that the defendant's conduct was substandard.<sup>24</sup> Secondly, the defendant's conduct must be evaluated according to objective criteria.<sup>25</sup> In an ordinary negligence claim, a defendant's conduct is judged in terms of reasonable care, meaning that level of care expected of a reasonable person under similar circumstances.<sup>26</sup> Likewise, medical negligence depends on a reasonable care standard as well, but with a twist. In medical negligence, or so called "malpractice" claims, rather than simply have the defendant's conduct assessed by a reasonable person standard, there is an intervening filter. Specifically, such claims are determined in accordance with a professional standard of care encompassing standards reflecting the teachings and practices of the relevant medical profession applicable to the profession in which the defendant was undertaking to perform when the allegedly negligent conduct occurred.<sup>27</sup>

This professional standard of care typically consists of three frames of reference, the details of which tend to vary from state to state. The first is a *professional* frame of reference in the sense that the standard of care for a health care provider is formulated in terms of that provider's specific health

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24. Joseph H. King, Jr., *Reconciling the Exercise of Judgment and the Objective Standard of Care in Medical Malpractice*, 52 OKLA. L. REV. 49, 49 (1999); see also, e.g., *Watson v. Hockett*, 727 P.2d 669, 672 (Wash. 1986) (en banc).

25. "Objective means according to some external referent or test. By contrast, a subjective evaluation would have an internal perspective, evaluating a person's conduct in terms of his individual capabilities." King, *supra* note 24, at 49.

26. See RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL HARM § 3 (Proposed Final Draft No. 1, 2005) ("A person acts negligently if the person does not exercise reasonable care under all the circumstances."). The comments make clear that this "reasonable care" terminology contemplates the same standard as that expressed in terms of a "reasonably careful person." *Id.* § 3 cmt. a.

27. See Tim Cramm et al., *Ascertaining Customary Care in Malpractice Cases: Asking Those Who Know*, 37 WAKE FOREST L. REV. 699, 699-700 (2002); King, *supra* note 24, at 51-52. See generally Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 172-87 (2000) [hereinafter Peters, *The Quiet Demise*] (discussing the erosion of a custom-based standard). On the respectable minority rule or two schools rule that sometimes elaborates on the general professional standard, see Cramm, *supra*, at 704-05; and Philip G. Peters, Jr., *Empirical Evidence and Malpractice Litigation*, 37 WAKE FOREST L. REV. 757, 774 (2002) [hereinafter Peters, *Empirical Evidence*].

care profession and specialty.<sup>28</sup> The courts and legislatures have differed on the form of such a professionally oriented standard, and on the extent to which they should conclusively defer to the practices of the medical profession in defining the relevant standard. One traditional construct defined the standard of care for health care providers such as physicians in terms of “custom” or customary practices and medical lore.<sup>29</sup> Under a customary practice formulation, the focus was on the professional practices that had customarily been followed.<sup>30</sup> In more recent years, the standard of care for malpractice purposes has frequently been defined by statute. Some cases and statutes have expressly defined the professional standard in terms of custom or customary practice, or at least have language that facially seems to contemplate a standard based on what conduct has traditionally been followed, and thus may reflect a customary practice perspective.<sup>31</sup> A number of other state statutes and cases contain language that seems more normative than the customary practice formulation. It is couched in terms of the level of care expected of reasonable members of the defendant’s profession and specialty.<sup>32</sup> The second frame of reference is based on a geographic perspective. Professionally based standards have often been defined with a geographic orientation, thus being the standards of the defendant’s profession and specialty within a specified geographic area or type of area.<sup>33</sup> The states have used a variety of geographic formulations, most commonly a standard defined in terms of the same or similar locality or a national standard.<sup>34</sup> Moreover, although many states use a uniform geographic rule for all physicians, at various times some states have employed different rules depending on whether or not the defendant was acting as a specialist or a general practitioner.<sup>35</sup> Finally, the standard commonly incorporates a third frame of

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28. The description of the three frames of reference is drawn from my summary in King, *supra* note 24, at 51–54. For background, see generally Joseph H. King, *In Search of a Standard of Care for the Medical Profession: The “Accepted Practice” Formula*, 28 VAND. L. REV. 1213 (1975) [hereinafter King, *In Search of a Standard of Care*] for a discussion of the formulation of the professional standard of care; and Joseph H. King, *The Standard of Care for Residents and Other Medical School Graduates in Training*, 55 AM. U. L. REV. 683, 701–02 (2006).

29. For a useful overview, see Cramm et al., *supra* note 27, at 701–07.

30. *Id.* at 699.

31. See King, *supra* note 24, at 51–52, 51–52 nn.9–11. See generally James F. Blumstein, *Medical Malpractice Standard-Setting: Developing Malpractice “Safe Harbors” as a New Role for QIOs?*, 59 VAND. L. REV. 1017, 1023–26 (2006) (on the customary practice standard).

32. See King, *supra* note 24, at 52–53, 53 nn.12–13; see also Cramm et al., *supra* note 27, at 707–08; Richard Lempert, *Following the Man on the Clapham Omnibus: Social Science Evidence in Malpractice Litigation*, 37 WAKE FOREST L. REV. 903, 923 (2002); Peters, *The Quiet Demise*, *supra* note 27, at 172–85; Philip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 909, 911 (2002). For an early article sometimes credited with spurring the reformulation of the professional standard away from a strictly custom-based rule, see King, *In Search of a Standard of Care*, *supra* note 28. See also Cramm et al., *supra* note 27, at 703, 703 n.14 (“Professor Joseph King, well before the reform . . . began, argued for modifying the customary standard with an ‘accepted medical practices’ standard that would closely resemble a reasonableness-within-the-profession standard.”).

33. On the geographic frame of reference, see King, *supra* note 24, at 53, 53 n.14; and John C. Drapp III, Comment, *The National Standard of Care in Medical Malpractice Actions: Does Small Area Analysis Make It Another Legal Fiction?*, 6 QUINNIPAC HEALTH L.J. 95, 100–01 (2003).

34. See Drapp, *supra* note 33, at 101–15.

35. King, *supra* note 24, at 53 n.14.

reference defining the applicable professional standards as those that existed at the time the allegedly negligent conduct occurred.<sup>36</sup>

The professional standard of care construct for health care providers with its three frames of reference may impact malpractice claims in two basic ways. First, as a substantive tort rule, it will determine the relevant litmus against which a defendant's conduct will be judged. And, secondly, it will define the characteristics that an expert witness must possess to be deemed qualified to offer an expert opinion on the relevant professional standard of care and its violation. Thus, a universal corollary to the professional-standards-based regime of medical negligence law is that testimony by a legally competent medical expert is (subject to various exceptions) usually essential for the plaintiff to make out a *prima facie* case of professional medical liability.<sup>37</sup> In other words, such expert testimony will generally be essential for the plaintiff to submit his claim to the trier of fact—usually a jury—for a determination on the merits. It is frequently held that not only is expert testimony required generally, but also that the plaintiff must present such testimony that both identifies the relevant professional standard and also establishes its violation.<sup>38</sup>

Satisfying this expert testimony requirement is no mean task. In order for an expert to be deemed qualified (or legally “competent”) to offer an expert opinion on the standard of care, he must be found qualified to ad-

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36. *Id.* at 53–54.

37. DAN B. DOBBS, *THE LAW OF TORTS* § 246, at 639 (2000) (stating that unless some exception applies, “courts require the plaintiff to establish the medical ‘standard’ itself by expert testimony”); BARRY R. FURROW ET AL., *HEALTH LAW, CASES, MATERIALS AND PROBLEMS* 198 (5th ed. 2004) (“The standard of practice in the defendant doctor’s specialty or area of practice is normally established through the testimony of medical experts.”); Leonard J. Nelson III, *The Law of Expert Testimony*, in 5 DAVID W. LOUISELL, HAROLD WILLIAMS & GORDON L. OHLSSON, *MEDICAL MALPRACTICE* § 29.01[1], at 29-2 (2006); RICHARD E. SHANDELL, PATRICIA SMITH & FREDERICK A. SCHULMAN, *THE PREPARATION AND TRIAL OF MEDICAL MALPRACTICE CASES* § 7.01[1], at 7-1 (release 23 2002) (“As a general rule, a medical malpractice case cannot be successfully prosecuted without the testimony of an expert witness to establish the applicable standard of care and a departure by the defendant from accepted practice.”); Pegalis, *supra* note 15, at 259 (“The plaintiff in a medical malpractice case usually employs at least one medical expert in order to establish a *prima facie* case.”).

38. *See, e.g.*, TENN. CODE ANN. § 29-26-115 (2000 & Supp. 2006); *Musser v. Gentiva Health Servs.*, 356 F.3d 751, 760 (7th Cir. 2004) (applying Indiana law and stating “[a] plaintiff must present expert testimony to establish the applicable standard of care and to show whether the defendant’s conduct falls below the standard of care”); *Williams v. Mem’l Med. Ctr.*, 870 So. 2d 1044, 1054 (La. Ct. App. 2004) (“[T]he plaintiff must establish the standard of care applicable to the doctor [and] a violation by the doctor of that standard of care,” and “[t]o meet this burden of proof, the plaintiff generally is required to produce expert medical testimony.”); *Whittington v. Meagher*, No. 03AP-569, 2004 WL 1828831, at \*2 (Ohio Ct. App. Aug. 17, 2004) (“Generally, proof of the standard of care, as well as a deviation from that standard, is established through expert medical testimony.”); FURROW ET AL., *supra* note 37, at 198 (“Expert testimony is needed to establish both the standard of proper professional skill or care and a failure by the defendant to conform.”); *Drapp, supra* note 33, at 98–99 (“Establishing the applicable standard of care in a medical malpractice action is only half of the proverbial battle. After the plaintiff has established the applicable standard of care, he must next prove that the defendant doctor was negligent because he breached that standard. Much like the process of establishing the applicable standard of care in the first place, a defendant doctor’s deviation from that standard of care must be established by expert testimony. . . . Furthermore, the expert must be able to testify ‘that the defendant’s failure breached a general medical practice’ and not merely that the expert would have done something different.”) (citations omitted).

dress the professional standard of care from the perspective of each of the three frames of reference.<sup>39</sup> Moreover, states sometimes impose additional, more specific competency requirements on prospective expert witnesses.<sup>40</sup> There is also the expense of hiring qualified expert witnesses, a particularly onerous burden when the prospects of recovery on the merits are problematic or the potential damages limited by the relatively moderate nature of the injury. Facing the daunting challenge of locating and paying for qualified medical expert witnesses, it is easy to see why a plaintiff might be interested in the possibility of avoiding that requirement. The common knowledge exception has at least the semblance of being an attractive, costless avenue for establishing a prima facie case of medical negligence or malpractice. It can also be a trap for the unwary.

The common knowledge rule holds that notwithstanding the general prerequisite for expert testimony on the standard of care question<sup>41</sup> in medi-

39. See Nelson, *supra* note 37, § 29.02.

40. See, e.g., ARIZ. REV. STAT. ANN. § 12-2604 (2003 & Supp. 2006); FLA. STAT. ANN. § 766.102 (West 2005); 735 ILL. COMP. STAT. ANN. 5/8-2501 (West 2003 & Supp. 2007); MICH. COMP. LAWS ANN. § 600.2169 (West 2000); MONT. CODE ANN. § 26-2-601 (2005); N.C. GEN. STAT. § 8C-7, R. 702(b)-(e) (2005 & Supp. 2006); TENN. CODE ANN. § 29-26-115(b) (2000 & Supp. 2006). These statutes vary considerably from state to state, which makes generalization infeasible. These statutes typically particularize the requirements with respect to one or more of the three frames of reference. In other words, they may require more than familiarity with the relevant professional practices and standards. For example, some statutes require that an expert not merely be familiar with the relevant professional standards, but also have specialized in the same specialty as the defendant. See, e.g., ARIZ. REV. STAT. ANN. § 12-2604 (2003 & Supp. 2006). Michigan not only requires that an expert witness be licensed, specialize, and be board certified to the same degree as the defendant, but it also requires in part that:

(b) . . . [D] uring the year immediately preceding the date of the occurrence that is the basis for the claim or action, [an expert must have] devoted a majority of his or her professional time to either or both of the following:

(i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.

(ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

MICH. COMP. LAWS ANN. § 600.2169(1)(b) (West 2000). The Tennessee statutory language provides in part:

No person in a health care profession requiring licensure under the laws of this state shall be competent to testify in any court of law to establish the facts required to be established by subsection (a), unless the person was licensed to practice in the state or a contiguous bordering state a profession or specialty which would make the person's expert testimony relevant to the issues in the case and had practiced this profession or specialty in one (1) of these states during the year preceding the date that the alleged injury or wrongful act occurred. This rule shall apply to expert witnesses testifying for the defendant as rebuttal witnesses. The court may waive this subsection (b) when it determines that the appropriate witnesses otherwise would not be available.

TENN. CODE ANN. § 29-26-115(b) (2000 & Supp. 2006).

41. The common knowledge question may also arise in the context of causation questions. Here, too, expert testimony is the norm, but an exception is often recognized when the existence of a causal connection between the alleged medical negligence and the plaintiff's injury is deemed a matter of common knowledge. See Nelson, *supra* note 37, § 29.03[1][a], at 29-40 to 29-41 (“[E]xpert testimony may not be necessary to establish causation where a layperson could infer the causal relationship.”). The scope of this Article, however, is limited to the use of the common knowledge exception to address the

cal negligence or malpractice cases, such expert testimony is not required either to identify a professional practice or standard or to establish that the allegedly negligent conduct violated it *when* the nature of the allegedly substandard conduct is within the common knowledge of and comprehensible to non-medically-trained laypersons.<sup>42</sup> In many malpractice cases, plaintiffs allege multiple acts of negligence, often against multiple health care providers. As a result, it is not unusual for the court to have to parse the alleged facts, and perhaps to apply the common knowledge exception to some alleged malpractice and to require expert testimony for other allegedly substandard conduct.<sup>43</sup>

The common knowledge exception is a widely recognized exception to the requirement for expert testimony on the standard of care in professional medical negligence or malpractice claims.<sup>44</sup> The rationale for the exception

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standard of care element in medical negligence and malpractice cases. The Article does not address the element of causation, and whether or when expert testimony is or is not required to establish causation in a medical malpractice claim.

42. See Nelson, *supra* note 37, § 29.03[1][a], § 29.03[1][a] n.1, at 29-42.33 (“[I]n those situations where the the [sic] physician’s conduct is so grossly negligent, or the treatment is of such a nature that the common knowledge of laypersons is sufficient for appraisal, the plaintiff is not required to present expert testimony to make out a prima facie case.”).

43. See, e.g., Miller v. Jacoby, 33 P.3d 68, 71–72 (Wash. 2001). In *Miller*, the patient sued two of her physicians and the hospital (for the actions of a nurse) for harm suffered from the failure to completely remove a Penrose drain placed in the wound to facilitate postoperative healing. *Id.* at 68–71. The court held that expert testimony was required to establish malpractice by the *surgeon* who placed the drain in the wound, noting that “the proper use, purpose, and insertion of a Penrose drain are not within the common understanding or experience of a layperson.” *Id.* at 71. The court explained:

It was speculated that [the surgeon] acted negligently by suturing the drain in place during surgery. Such a conclusion would require medical knowledge beyond that possessed by laypersons. [Plaintiff’s] expert witness stated that it is not the usual and customary practice to suture a drain in place in a wound. However, this opinion is not the equivalent of concluding that [the surgeon’s] procedure violated the standard of care.

*Id.* at 72 n.3. On the other hand, the court did apply the common knowledge exception for the purpose of assessing the conduct of the physician and nurse who were involved in the *post-operative*, failed attempt to completely remove the drain, thereby resulting in a foreign object inadvertently remaining in the patient’s body. *Id.* at 72–73.

44. See, e.g., DOBBS, *supra* note 37, at 648–49 (“In a few cases, courts have considered the negligence of a physician . . . to be so obvious or gross that a jury should be allowed to find negligence even without expert medical testimony, either because gross and obvious negligence is an independent exception or because *res ipsa loquitur* can be invoked in such cases.”); O. Fayrell Fun, Jr. & Carolyn Furr Ohanesian, *Medical and Health Professionals*, in 27 SOUTH CAROLINA JURISPRUDENCE § 32 (Johnson et al. eds., 1996) (recognizing the exception); Nelson, *supra* note 37, § 29.03[1][a], § 29.03[1][a] n.1, at 29-42.33 (“[I]n those situations where the the [sic] physician’s conduct is so grossly negligent, or the treatment is of such a nature that the common knowledge of laypersons is sufficient for appraisal, the plaintiff is not required to present expert testimony to make out a prima facie case.”); SHANDELL ET AL., *supra* note 37, § 7.01[2] (expressly recognizing the “common knowledge” exception); Thomas J. Hurney, Jr. & Rob J. Aliff, *Medical Professional Liability in West Virginia*, 105 W. VA. L. REV. 369, 401 (2003) (“In medical malpractice cases where lack of care or one of skill is so gross, so as to be apparent, or the alleged breach relates to noncomplex matters of diagnosis and treatment within the understanding of lay jurors by resort to common knowledge and experience, failure to present expert testimony on the accepted standard of care and degree of skill under such circumstances is not fatal to a plaintiff’s prima facie showing of negligence.” (quoting McGraw v. St. Joseph’s Hosp., 488 S.E.2d 389 (W. Va. 1997))); Charles Markowitz, *Medical Standard of Care Jurisprudence as Evolutionary Process: Implications Under Managed Care*, 2 YALE J. HEALTH POL’Y L. & ETHICS 59, 66 (2001) (“While expert medical testimony is usually indispensable for establishing a medical standard of care,” an exception applies “for lapses in care subject to ‘common knowledge.’”); Paula Sweeney, *Medical Malpractice Expert Testimony in Texas*, 41 S. TEX. L. REV. 517, 539 (2000) (“Another exception to the expert requirement exists

is that medical expertise and background is not necessary in order to understand whether the conduct in question was negligent.<sup>45</sup> Most states have approved the “common knowledge” exception at least in principle, where it is most often articulated, not suprisingly, in terms of “common knowledge.”<sup>46</sup> Some courts address the matter at two analytical levels, addressing the question both in terms of whether the claim should be characterized as malpractice or ordinary negligence and, if the former, whether the common knowledge exception should be applied.<sup>47</sup> Some courts, although

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where the negligence is so plain as to be within the common knowledge of laymen, such as where the negligence alleged is in the use of mechanical instruments, operating on the wrong portion of the body, or leaving surgical instruments or sponges within the body.”)

45. See Gordon L. Ohlsson, *Theories of Recovery*, in 1 MEDICAL MALPRACTICE, *supra* note 37, at 8-1, § 8.04[3][b]; see also *Syfu v. Quinn*, 826 N.E.2d 699, 703 (Ind. Ct. App. 2005) (“Application of this exception is limited to situations in which the physician’s conduct is so obviously substandard that one need not possess medical expertise in order to recognize the breach of the applicable standard of care.”).

46. See, e.g., *Coleman v. United States*, No. Civ.A. 05-0132, 2006 WL 1627805, at \*3 (W.D. La. June 12, 2006) (articulating issue in terms of whether common knowledge exception applied); *Baker v. Allen*, No. Civ. 03-2600, 2006 WL 1128712, at \*12 (D.N.J. Apr. 24, 2006) (stating that whether the “common knowledge exception” applies depends on whether “these matters [were] readily apparent to anyone of average intelligence and ordinary experience”); *Carver v. United States*, Nos. 3:04-0234, 3:04-0991, 2005 WL 2230025, at \*7 (M.D. Tenn. Aug. 30, 2005) (“[I]f the common knowledge exception is applicable, a plaintiff does not have to prove his case by expert testimony.”); *Massey v. Chauhan*, No. CA 05-1055, 2006 WL 864551, at \*5 (Ark. Ct. App. Apr. 5, 2006) (“The point at which a radiologist examining appellant’s mammograms should have detected the possibility of cancer is not within a jury’s common knowledge. As such, it was appellant’s burden to prove by expert testimony the standard of care governing radiologists.”); *Lawrence v. Frost St. Outpatient Surgical Ctr.*, No. D042108, 2004 WL 2075401, at \*4 (Cal. Ct. App. Sept. 17, 2004) (referring to “[t]he ‘common knowledge’ exception in medical care negligence cases”); *Bryant v. Oakpointe Villa Nursing Ctr.*, 684 N.W.2d 864, 872 (Mich. 2004) (“The determination whether a claim will be held to the standards of proof and procedural requirements of a medical malpractice claim as opposed to an ordinary negligence claim depends on whether the facts allegedly raise issues that are within the common knowledge and experience of the jury or, alternatively, raise questions involving medical judgment.” (quoting *Dorris v. Detroit Osteopathic Hosp.*, 594 N.W.2d 455, 465 (Mich. 1999))); *Howell v. Macomb MRI*, No. 260774, 2005 WL 2514262, at \*1 (Mich. Ct. App. Oct. 11, 2005) (stating the issue in terms of “whether the claim raises questions of medical judgment beyond the realm of common knowledge and experience”); *Hubbard ex rel. Hubbard v. Reed*, 774 A.2d 495, 500-01 (N.J. 2001) (“It has long been settled that pulling the wrong tooth is negligent as a matter of common knowledge.”); *Garaffa v. JFK Med. Ctr.*, No. A-4105-04T24105-04T2, 2006 WL 2033752, at \*4 (N.J. Super. Ct. App. Div. July 21, 2006) (“The doctrine of common knowledge serves as an exception to the general rule requiring expert testimony, and thus an affidavit of merit, when ‘the experience possessed by lay persons, without the explanations of experts, would enable a jury to determine that a defendant acted without reasonable care.’”) (quoting *Estate of Chin v. St. Barnabas Med. Ctr.*, 734 A.2d 778, 786 (N.J. 1999)); *Carter v. State*, No. 104863, 2006 WL 1029686, at \*3 (N.Y. Ct. Cl. Mar. 22, 2006) (stating that medical negligence cases can be established “without the necessity of expert testimony” when the alleged negligence “can be readily determined by the fact finder using common knowledge”); *Taliaferro v. S. Pointe Hosp.*, No. 86999, 2006 WL 832510, at \*2-3 (Ohio Ct. App. March 30, 2006) (“We recognize that Ohio courts have infrequently applied the common knowledge exception to obviate the need for expert testimony in medical negligence cases. . . . Upon our review of the record, we find that this case falls within the common knowledge exception.”).

47. See, e.g., *Patterson v. Arif*, 173 S.W.3d 8, 11 (Tenn. Ct. App. 2005). In *Patterson*, the plaintiff urged two bases for circumventing the expert witness requirement. The court described both characterizations, noting:

Ms. Patterson’s argument before this Court, as we perceive it, is two-fold. First, she asserts that this is not a medical malpractice case, but one for ordinary negligence. Second, she asserts that, if this is a malpractice action, expert testimony was not required to establish breach of the standard of care because “[i]t is within the common knowledge of a layperson that a physician, or his staff, who is called by a patient experiencing shortness of breath, should ad-

accepting the common knowledge exception in principle, prefer to address directly the underlying question of whether expert testimony is required given the nature of the allegedly tortious conduct.<sup>48</sup> Regardless of the differences in terminology, the focus ultimately seems to be on the essential issue of whether the subject matter of the alleged tortious conduct of the defendant was within the understanding of lay members of the public.

The common knowledge exception has for the most part been a creation of the courts.<sup>49</sup> Although quite a few of the states have enacted statutes that address medical malpractice claims,<sup>50</sup> including the standard of care and the requirement of expert testimony, only a few of those statutes have expressly addressed the status of the common knowledge exception.<sup>51</sup> Thus, in states

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wise that patient to call an ambulance or go to an emergency room.” We disagree with both assertions.

*Id.*; see also *Cunningham v. Riverside Health Sys., Inc.*, 99 P.3d 133, 136 (Kan. Ct. App. 2004) (identifying the plaintiff’s arguments, “[f]irst, . . . that this is an ordinary negligence case rather than a medical malpractice case and . . . therefore, that she is not required to present expert testimony,” and “[n]ext, . . . that even if this was a medical malpractice case, she was not required to present expert evidence to establish either the breach of the standard of care or causation because the common knowledge exception applied to her case”); *Grossman v. Barke*, 868 A.2d 561, 567 (Pa. Super. Ct. 2005) (stating that “even in a negligence suit characterized as ‘medical malpractice,’ expert testimony is not always required if the alleged negligence is obvious or within the realm of a layperson’s understanding” because the “matter under investigation is so simple, and the lack of skill or want of care so obvious, [that it was] within the range of the ordinary experience and comprehension of even non-professional persons” (quoting *Welsh v. Bulger*, 698 A.2d 581, 585 n.11 (Pa. 1997))).

48. *Ward v. Shawnee County Bd. of Comm’rs*, 103 P.3d 993, 2005 WL 81551, at \*3 (Kan. Ct. App. 2005) (unpublished table decision) (stating that the plaintiff “assumes that classifying a cause of action as ordinary negligence or medical malpractice is determinative of whether expert testimony is required,” but the “test, however, does not depend on the cause of action but rather whether the subject matter is outside the common knowledge of the jurors”).

49. See generally H.H. Henry, Annotation, *Necessity of Expert Evidence to Support an Action for Malpractice Against a Physician or Surgeon*, 81 A.L.R. 2d 597 (1962 & Supp. 2001) (discussing cases addressing the common knowledge exception to the necessity of expert evidence in malpractice cases).

50. See generally Holly Pehler Rockwell, Annotation, *What Patient Claims Against Doctor, Hospital, or Similar Health Care Provider Are Not Subject to Statutes Specifically Governing Actions and Damages for Medical Malpractice*, 89 A.L.R. 4TH 887 (1991 & Supp. 2006) (discussing the scope of such special malpractice statutes); see also Leonard J. Nelson III, *The Defense of Malpractice Cases*, in 1 MEDICAL MALPRACTICE, *supra* note 37, at 9-1, § 9.07[2] (discussing the scope of some of the certification and affidavit requirements under such special statutes).

51. Occasionally, however, it has been expressly incorporated into the standard of care provision of a state statute governing medical malpractice. See ARK. CODE ANN. § 16-114-206 (2006) (specifying what the plaintiff’s burden of proof in “any action for medical injury,” entails “when the asserted negligence does not lie within the jury’s comprehension as a matter of common knowledge”); 735 ILL. COMP. STAT. ANN. 5/2-1113 (West 2003) (stating that in determining whether the doctrine of *res ipsa loquitur* applies in a medical malpractice case, “the court shall rely upon either the common knowledge of laymen, if it determines that to be adequate, or upon expert medical testimony”); see also NEV. REV. STAT. ANN. § 41A.100 (LexisNexis 2006). The Nevada statute provides *inter alia* that expert medical testimony on the standard of care is not required in the following circumstances:

- (a) A foreign substance other than medication or a prosthetic device was unintentionally left within the body of a patient following surgery;
- (b) An explosion or fire originating in a substance used in treatment occurred in the course of treatment;
- (c) An unintended burn caused by heat, radiation or chemicals was suffered in the course of medical care;
- (d) An injury was suffered during the course of treatment to a part of the body not directly involved in the treatment or proximate thereto; or,

that have enacted special statutes governing various aspects of medical malpractice claims and where those statutes are silent on the standing of the common knowledge exception, there may be an additional level of analysis necessary. The question may then be not only whether the common knowledge exception would otherwise be applicable under the circumstances, but if so also whether the common knowledge exception should operate to avoid the application of the special expert testimony requirements contained in the malpractice statute. In other words, may a plaintiff avoid at least some of the special requirements of a state's medical malpractice act in situations where the alleged negligence of the health care provider is deemed a matter of common knowledge? Even when a state's medical malpractice statute was silent about the standing of the common knowledge exception, the courts have usually continued to recognize the common knowledge exception to the expert testimony requirement (although the decisions are divided).<sup>52</sup> This question may arise not only in those jurisdictions with malpractice statutes that require expert testimony in malpractice cases, but also in states with statutes requiring the plaintiff to satisfy some sort of procedural threshold by filing an expert's statement, such as a certificate of merit,<sup>53</sup> as a condition to proceeding with one's malpractice claim. The matter of the construction of specific state malpractice statutes is beyond the scope of this Article. Rather, for present purposes, I shall address only the underlying question of the criteria that should be used to guide the decision on whether a particular factual situation should be deemed a matter of common knowledge. The separate question of the effect of such a conclusion under a state's medical malpractice statute will depend on the specific statutory language and the courts' construction of the statute in question. That being said, I would urge the courts to construe their statutes in a way that allows the common knowledge exception to continue to operate not only in states with statutes that require expert testimony,<sup>54</sup> but also in the ones that may in addition require an expert's certificate of merit.<sup>55</sup>

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(e) A surgical procedure was performed on the wrong patient or the wrong organ, limb or part of a patient's body.

*Id.*

52. See *infra* notes 54–55.

53. See generally Nelson, *supra* note 50, § 9.07[2] (discussing the certificate of merit requirement and similar requirements in various jurisdictions).

54. See, e.g., *Ex parte HealthSouth Corp.*, 851 So. 2d 33, 40 (Ala. 2002) (“[T]he AMLA requires expert testimony in medical-malpractice cases, but this Court has recognized exceptions to that rule, when medical expertise is not necessary to prove the plaintiff's case, such as here when nurses have failed to respond to a routine, custodial call from a patient.”); *Seavers v. Methodist Med. Ctr. of Oak Ridge*, 9 S.W.3d 86, 93 n.10 (Tenn. 1999) (“We have carefully reviewed the statute and the existing case law and conclude that there remains a common-knowledge exception to the requirement of expert testimony.”). *But see Stearrett v. Newcomb*, No. C.A. 83C-SE-74, 1988 WL 77660, at \*2 (Del. Super. Ct. July 20, 1988) (mem.) (rejecting contention “that there is a ‘common knowledge’ doctrine which allows an exception to the requirement of expert testimony in those cases where ‘the act under scrutiny is such a clear departure from norms of ordinary care that persons of ordinary experience could evaluate it,’” and stating that the “only exceptions to the requirement of expert testimony are explicitly set forth” in the statute (quoting Answer Brief for Plaintiff at 16)).

55. See *Tinius v. Carroll County Sheriff Dep't.*, 321 F. Supp. 2d 1064, 1085–87 (N.D. Iowa 2004)

The common knowledge exception has frequently been applied in conjunction with the doctrine of *res ipsa loquitur* when the suggestion of negligence from the occurrence of the injury lay within the common knowledge of laypersons.<sup>56</sup> The common knowledge exception and the *res ipsa loquitur* doctrine are, however, conceptually discrete doctrines. While they often operate in conjunction, they also may operate independently, as when the common knowledge rule is applied in situations where the circumstantial evidence rule of *res ipsa* is not applicable, or when the suggestion of negligence in *res ipsa* depends on expert testimony rather than common knowledge.<sup>57</sup>

Application of the common knowledge rule tends to vary by jurisdiction.<sup>58</sup> Despite regnant acceptance of the common knowledge rule in principle, the courts have not offered meaningful guidance on the relevant criteria for deciding questions of applicability of the exception. The absence of analysis is evident in the almost dismissive attitude found in some decisions; one court even characterizing one common knowledge argument as

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(recognizing the common knowledge exception to the statute requiring that the expert's name, qualifications and the purpose for calling the expert be certified to the court and all other parties within a specified time period); *Szydel v. Markman*, 117 P.3d 200, 204 (Nev. 2005) (holding, in case where one of the surgical needles was left inside the patient during her breast lift operation, that the statutory requirement of an affidavit from a medical expert was unnecessary in light of the statute stating that expert testimony is not required when a foreign substance is found in the patient's body following surgery); *Hubbard ex rel Hubbard v. Reed*, 774 A.2d 495, 497 (N.J. 2001) (holding that "an affidavit need not be provided in common knowledge cases when an expert will not be called to testify" on the standard of care); *Mosberg v. Elahi*, 605 N.E.2d 353, 354 (N.Y. 1992) (holding that affidavit of merit was required in medical malpractice actions "except as to matters within the ordinary experience and knowledge of laypersons"); Melinda L. Stroub, Note, *The Unforeseen Creation of a Procedural Minefield—New Jersey's Affidavit of Merit Statute Spurs Litigation and Expense in Its Interpretation and Application*, 34 RUTGERS L.J. 279, 297–300 (2002). *But see* *Fields v. Metroplex Hosp. Found.*, No. 03-04-00516-CV, 2006 WL 2089171, at \*2 (Tex. App. July 28, 2006) (suggesting in case where the plaintiff "contends that the premise that medical professionals should not apply compresses so hot that they cause second-degree burns . . . does not require expert testimony," the plaintiff must still satisfy the statutory certificate requirement even where the case may ultimately turn out once discovery is completed not to require expert testimony); *Belcher v. Scott & White Clinic*, No. 10-05-00324-CV, 2006 WL 2067981, at \*2 n.1 (Tex. App. July 26, 2006) (noting that even if common knowledge *res ipsa loquitur* is applicable, "an expert report or some form of expert testimony is still required").

56. For discussions of the intersection of the common knowledge exception and *res ipsa loquitur*, see Timothy C. Caress & Katherine Amy Lemon, *Recent Developments in Indiana Tort Law*, 35 IND. L. REV. 1583, 1587–89 (2002); Joyce Lipton Rogak, *New Court of Appeal Ruling Bolsters Use of Res Ipsa Loquitur in Medical Malpractice Cases*, N.Y. ST. B.J., June 2003, at 28–29; Kimberly Haag, Note, *Res Ipsa Loquitur: A Step Along the Road to Liability Without Fault, Do Physicians Have a Fighting Chance in the Face of the Modern Application of this Doctrine in Medical Malpractice Cases? A Closer Look at the New Fiction*, 42 BRANDEIS L.J. 149, 151–54, 167 (2003).

57. For a discussion of the discrete nature of the two doctrines, see *Carver v. United States*, Nos. 3:04-0234, 3:04-0991, 2005 WL 2230025, at \*9 (M.D. Tenn. Aug. 30 2005), explaining:

The common knowledge exception and the doctrine of *res ipsa loquitur* . . . while similar, are not the same. For example, the *Seavers* court recognized the proposition that [res ipsa loquitur] . . . could apply in a case in which plaintiff's injury was not within the common knowledge of lay persons. Additionally, the *Baldwin* court applied the common knowledge exception to the rule requiring expert testimony in a case in which the defendant's physician failed to detect the presence of a foreign body in a wound sustained by plaintiff while mowing his lawn. That case was not a *res ipsa* case, however . . .

58. Markowitz, *supra* note 44 at, 66.

“nonsense.”<sup>59</sup> Courts and commentators frequently recite examples or list types of recurring factual situations in which the exception has been applied. Thus, courts have variously commented that “[g]enerally, the common knowledge exception is applicable in cases where a physician fails to remove a foreign object from a patient’s body or where a patient enters the hospital for treatment on one part of the body and sustains injury to another part of the body”;<sup>60</sup> that “[t]he use of this exception has been limited to cases in which obvious mistakes have been made in surgery”;<sup>61</sup> that it is typically “limited to cases involving the failure of an operating physician to remove some surgical implement or other foreign object from the patient’s body”;<sup>62</sup> and that it applies “where the physician does an obviously careless act, such as fracturing a leg during examination, amputating the wrong arm, dropping a knife, scalpel, or acid on a patient, or leaving a sponge in a patient’s body, from which a lay person can infer negligence.”<sup>63</sup> Commentators state as “[c]ommon examples . . . situations where a foreign instrument is found in a patient’s body following surgery or where the injury is to a part of the body unrelated to the condition for which the patient sought treatment.”<sup>64</sup>

When courts have attempted to generalize about the scope of the common knowledge exception, their language has been couched in such a level of generality as to be essentially meaningless. For example, we are told in general nonspecific terms that “[o]nly in unusual cases in which the alleged act of malpractice lies within the common knowledge of a layman is expert testimony unnecessary,”<sup>65</sup> or that the common knowledge exception has been “narrowly construed”<sup>66</sup> and rarely applied.<sup>67</sup> Even attempts at a more

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59. *Long v. Pearle*, No. G033471, 2005 WL 289708 (Cal. Ct. App. Jan. 25, 2005) (holding in case where decedent patient was taken to emergency room by police due to an apparent drug overdose and died of acute methamphetamine intoxication, alleged negligence of emergency room physicians in treating the drug overdose and its effects was not within the common knowledge exception). The court in *Long* stated: “The Plaintiff asserts that the issues of breach of the standard of care and causation were within the common knowledge of laypersons and, therefore, expert testimony was not required. Nonsense!” *Id.* at \*5.

60. *Keys v. Guthmann*, 676 N.W.2d 354, 359 (Neb. 2004).

61. *Musser v. Gentiva Health Servs.*, 356 F.3d 751, 760 (7th Cir. 2004) (citing *Gold v. Ishak*, 720 N.E.2d 1175, 1183 (Ind. Ct. App. 1999)) (“[E]xpert testimony is not required because a fire occurring during surgery where an instrument that emits a spark is used near a source of oxygen is not beyond the realm of the lay person to understand.” (alteration in *Musser*)).

62. *Weinberg v. Geary*, 686 N.E.2d 1298, 1302 (Ind. Ct. App. 1997).

63. *Pfiffner v. Correa*, 643 So. 2d 1228, 1233 (La. 1994); *see also Johnston v. Sw. La. Ass’n*, 693 So. 2d 1195, 1198 (La. Ct. App. 1997) (upholding a jury award of damages where a doctor left a sponge in the plaintiff during hernia surgery).

64. FURROW ET AL., *supra* note 37, at 281; *see Nelson, supra* note 37, § 29.03[1][a], at 29–41 (providing “typical examples” of situations in which a sponge or instrument is left in the patient’s abdomen).

65. *Joiner v. United States*, 89 F. App’x 586, 587 (6th Cir. 2004) (applying Tennessee malpractice law).

66. *Weinberg v. Geary*, 686 N.E.2d 1298, 1302 (Ind. Ct. App. 1997).

67. *Todd v. Shankel*, 83 F. App’x 952, 954 (9th Cir. 2003) (noting that the common knowledge exception is rare in application); *Taliaferro v. S. Pointe Hosp.*, No. 86999, 2006 WL 832510, at \*2 (Ohio Ct. App. March 30, 2006) (“We recognize that Ohio courts have *infrequently applied* the common knowledge exception to obviate the need for expert testimony in medical negligence cases.” (emphasis added)); SHANDELL ET AL., *supra* note 37, § 7.01[2] (stating that the “common knowledge” exception “is

detailed benchmark are usually not helpful.<sup>68</sup> We are duly reminded that the question of the application of the common knowledge exception is to be determined on a “case-by-case basis.”<sup>69</sup> We are also told that the common knowledge exception “is invoked only for intuitively egregious errors.”<sup>70</sup> This ad hoc, unstudied, and intuitive method may accurately describe the current approach to common knowledge questions, but it is also why there is so much unpredictability in the matter. One leading treatise cautions us vaguely that “counsel should exercise care in attempting to use this exception, since the court is likely to strictly regulate its use.”<sup>71</sup> Again, while such cautionary language is appropriate, it contributes little to understanding the dynamics of the common knowledge exception or to predicting its outcome in particular medical situations.

Although there continues to be widespread recognition of the common knowledge exception in principle by the courts, there is no guarantee that a court will apply the exception to the particular facts in the case in question. In recent years, one finds numerous cases going both ways, with a significant number of cases holding the exception applicable to the alleged facts in question,<sup>72</sup> and perhaps a larger number of cases finding the exception inap-

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rare in application”).

68. For instance, one case advises:

When weighing the factors to consider [whether a claim is one of malpractice] . . . a court should consider whether the injury occurred during the patient’s care, treatment, supervision, or lack thereof. Additionally, a court should take into account whether determination of the wrong can be made based on everyday experience or knowledge, or whether the claim requires professional expert testimony to assist a fact finder in making that determination.

*Ference v. V.I. Family Sports & Fitness Ctr., Inc.*, No. Civ. 657/2002, 2004 WL 626280, at \*5 (V.I. Feb. 23, 2004).

69. *Id.*

70. Ohlsson, *supra* note 45, § 8.04[3][b], at 8-76.2.

71. Nelson, *supra* note 37, § 29.03[1][a], at 29-42.

72. *See Barnes v. United States*, 137 F. App’x 184, 188–89 (10th Cir. 2005) (noting that if the plaintiff “verified his factual allegations, a reasonable jury might conclude that Mr. Al-Ruballe breached the standard of care by giving him medicine from an unlabeled bottle,” and that a reasonable jury could conclude that such alleged negligence injured the plaintiff), *aff’d on remand*, 173 Fed. App’x 695 (10th Cir. 2006) (affirming summary judgment for the defendant); *Gil v. Reed*, 381 F.3d 649, 660–61 (7th Cir. 2004) (holding in case where physician’s assistant, Penaflor, allegedly “simply refused to provide a prescribed antibiotic to a person with a serious infection,” then “[i]t is within a layperson’s purview to know that when a serious infection at the site of a surgical wound is diagnosed and an antibiotic is prescribed, failure to supply or delay in supplying the antibiotic can result in unnecessary pain, discomfort and a spreading of the infection”), *on remand*, No. 00-C-0724-C, 2006 WL 42344, at \*12 (W.D. Wis. Jan. 6, 2006) (granting defendants summary judgment on remand because, inter alia, “plaintiff cannot show that defendant’s alleged negligence caused him injury”); *Carver v. United States*, Nos. 3:04-0234, 3:04-0991, 2005 WL 2230025, at \*10 (M.D. Tenn. Aug. 30, 2005) (stating that expert testimony was not necessary to establish that leaving a part of the scissors tips or the shears of endoscopic instrument in the patient during a laparoscopic assisted vaginal hysterectomy and bilateral salpingo-oophorectomy was within the common knowledge of ordinary laymen); *Wilson v. Manning*, 880 So. 2d 1101, 1111 (Ala. 2003) (holding that, in case where plaintiff being treated by antibiotics for osteomyelitis prior to her incarceration, and where her pre-arrest physician stated that based on his communication with medical personnel at the prison it was his “clear understanding” that antibiotics would be continued, that the allegation that defendant allowed patient to be without fourteen consecutive doses of necessary medicines sufficient to allow the fact-finder to infer from it that defendant health-care prison provider Manning breached the standard of care); *Lawrence v. Frost St. Outpatient Surgical Ctr.*, No. D042108, 2004 WL 2075401, at \*5 (Cal. Ct. App. Sept. 17, 2004) (holding in case where patient who had undergone an outpatient hernia repair procedure at surgical center and upon his discharge fell and injured himself when

plicable to the particular situation alleged and at issue.<sup>73</sup> It should be noted that many of the cases addressing the common knowledge issue come at an

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being helped to transfer from a wheelchair into his car, “[a] layperson can apply common knowledge to evaluate how to safely transfer a patient with a numb leg from a wheelchair to a vehicle after outpatient surgery”); *Dugas v. Massiha*, 934 So. 2d 878, 882 (La. Ct. App. 2006) (discussed in text accompanying *infra* notes 208–209); *Ullrich v. Jefferson Parish Hosp. Serv. Dist. No. 2*, 867 So. 2d 7, 8, 12 (La. Ct. App. 2004) (holding that the common knowledge exception applied in conjunction with *res ipsa loquitur* where “[t]he plaintiff alleged that as a result of inadequate care provided by the surgery staff and anesthesiologists, one of her teeth was knocked out . . . during surgery [and] . . . lodged in her lung”); *Bryant v. Oakpointe Villa Nursing Ctr.*, 684 N.W.2d 864, 867, 876 (Mich. 2004) (holding in case where nursing home resident died from positional asphyxiation, and where “[p]laintiff’s claim that defendant failed to take action after its employees found Ms. Hunt entangled in her bedding on the day before her asphyxiation,” “[a] fact-finder relying only on common knowledge and experience can readily determine whether the defendant’s response was sufficient”); *Howell v. Macomb MRI*, No. 260774, 2005 WL 2514262, at \*2 (Mich. Ct. App. Oct. 11, 2005) (holding that, in case where a 75 year-old man rolled off a table while being positioned for an MRI examination, “the reasonableness of the MRI technician’s action is within ‘the realm of common knowledge and experience,’ and can be evaluated by lay jurors without expert testimony on the standard of care and the medical issues presented”) (citation omitted); *Durocher v. Rochester Equine Clinic*, 629 A.2d 827 (N.H. 1993) (holding that no medical expert testimony was necessary to determine whether defendant-veterinarian was negligent in operating on the wrong horse, a case which falls within the common knowledge of laymen); *Hubbard ex rel. Hubbard v. Reed*, 774 A.2d 495, 500–01 (N.J. 2001) (holding that, where the plaintiffs allege that dentist pulled patient’s mandibular left second bicuspid instead of her mandibular left lateral incisor, the average layperson “could apply his or her general understanding and knowledge” to find that dentist was negligent); *Palanque v. Lambert-Woolley*, 774 A.2d 501, 506–07 (N.J. 2001) (“[A] person of ordinary understanding and experience can judge whether defendant acted with reasonable care when she misread the specimen identification numbers as the test results and erroneously determined that plaintiff had an ectopic pregnancy.”); *Grimm v. Summit County Children Servs. Bd.*, No. 22702, 2006 WL 1329689, at \*4 (Ohio Ct. App. May 17, 2006) (holding that no expert testimony was required in order to find a breach of the duty to report child abuse, and that “whether any Summa employee knew or suspected child abuse is a matter within the common knowledge and experience of lay jurors”); *Czarney v. Porter*, 853 N.E.2d 692, 698 (Ohio Ct. App. 2006) (“[T]he discontinuation and administration of fluids is outside the realm of the knowledge and experience of average jurors, but the concept of following orders is not. When a physician gives an order and it is not followed by a nurse or the medical staff, expert testimony may not be required to explain that this may be negligent.”); *Taliaferro v. S. Pointe Hosp.*, No. 86999, 2006 WL 832510, at \*2 (Ohio Ct. App. March 30, 2006) (holding in case where a hospital patient who suffered from multiple sclerosis, seizures, frequent falls, impaired balance, left lower limb weakness, progressive decline in function, and increased spasticity, and who allegedly fell three times the day she was admitted, after being left unattended in the bathroom, and after she got out of her bed on her own to walk to the bathroom, “case falls within the common knowledge exception”); *Pete v. Youngblood*, 141 P.3d 629, 631–37 (Utah Ct. App. 2006) (holding in case where the patient had undergone surgery to repair her facial fractures that it was a matter of common knowledge whether failure to remove two five-inch pieces of gauze from her cheek when they were supposed to be removed was “more probably than not the result of negligence”) (citation omitted).

Other cases conflate common knowledge and violation of a regulation. *See, e.g., Kindernay v. Hillsboro Area Hosp.*, 851 N.E.2d 866, 870, 877 (Ill. App. Ct. 2006) (holding, in case where the plaintiff alleged that she “suffered lost wages and emotional distress due to the defendant’s failure to administer her drug test in accordance with . . . regulations . . . [that] proximately caused the results . . . to be falsely positive for cannabis,” that “[n]o further evidence of the appropriate standard of care was necessary,” and therefore “[t]his is not a case where jurors not skilled in the practice of medicine would find it difficult without the help of expert testimony to determine whether a health care professional lacked the necessary scientific skill”).

73. *See Musser v. Gentiva Health Servs.*, 356 F.3d 751, 760 (7th Cir. 2004) (holding that, where infant on a ventilator and receiving twenty-four hour home nursing care, and where the tube apparently became disconnected and child eventually died, and the parents alleged that the apnea monitor was not attached during nurse’s shift, and that her monitoring and attempted resuscitation of the child were negligent, that “[t]his is not an appropriate case to apply the ‘common knowledge’ exception”); *Todd v. Shankel*, 83 F. App’x 952, 954 (9th Cir. 2003) (holding that alleged negligent failure to remove feeding tube during surgery “is not obvious to a lay juror drawing only on his or her ‘ordinary experience’ [and] expert testimony is required to prove that failure to remove the feeding tube amounts to negligence”).

(citation omitted); Callahan v. Cho, 437 F. Supp. 2d 557, 563 (E.D. Va. 2006) (discussed in text accompanying *infra* notes 229–234); Coleman v. United States, No. Civ.A. 05-0132, 2006 WL 1627805 (W.D. La. June 12, 2006) (holding that alleged premature removal of a catheter at discharge could not be comprehensively evaluated based on common knowledge and that expert testimony was necessary); Baker v. Allen, No. Civ. 03-2600, 2006 WL 1128712, at \*12 (D.N.J. Apr. 24, 2006) (holding that question of the adequacy of the medical care of the plaintiff for the five days following an assault was not “apparent to anyone of average intelligence and ordinary experience” and therefore the common knowledge exception did not apply) (citation omitted); Dukes v. Georgia, 428 F. Supp. 2d 1298, 1336 (N.D. Ga. 2006) (holding that, where the plaintiff allegedly suffered blindness from a delay in initiation of antifungal eye treatment, that the alleged negligence of the laboratory in not sending an individual paper report to the physician or somehow calling his “attention to these particular test results by ‘flagging’ the new test results in the electronic report” was not within the common knowledge exception) (citation omitted), *aff’d*, 212 F. App’x 916 (11th Cir. 2006); Manzo v. United States, No. CVF036451AWISMS, 2006 WL 547993, at \*5 (E.D. Cal. Mar. 7, 2006) (holding that whether doctor should have found uncooked bean in child’s throat that led to asphyxiation several days later, was not within the common knowledge exception); Gallant v. United States, 392 F. Supp. 2d 1077, 1080 (D. Alaska 2005) (holding that placing a patient who had undergone chemotherapy, stem cell transplant, and radiotherapy for cancer, in a room with an HIV-positive woman, is “not a situation where negligence could be evident to a lay person”); Smith v. United States, No. 03 Civ. 701(FM), 2005 WL 2298133, at \*3 (S.D.N.Y. Sept. 21, 2005) (holding in case where the plaintiff alleged that the VA hospital used the wrong size hip replacement, that “[t]he common knowledge exception . . . is inapplicable because the standard of care relating to hip replacements and the defendant’s alleged deviations therefrom obviously are beyond the ken of ordinary persons”); Duke v. Atria, Inc., No. 2:03CV00934DRB, 2005 WL 1513158, at \*3 (M.D. Ala. June 27, 2005) (holding in case where the elderly patient fell while being assisted in dressing at an assisted living facility then owned by defendant, that plaintiff could not succeed on any of her “liability claims without establishing by expert testimony both the standard of care . . . and a breach of that standard which resulted proximately in the physical injuries and damages claimed”); Thomas v. United States, No. Civ. A. 04-0114, 2005 WL 757268, \*8 (E.D. La. Mar. 31, 2005) (holding that alleged negligent failure to give decedent-patient life saving blood transfusion did not fall within “obvious negligence” exception), *aff’d*, 176 F. App’x 474 (5th Cir. 2006); Sorrell v. King, 946 So. 2d 854, 865–66 (Ala. 2006) (holding that whether alleged failure to perform a pelvic examination during one of patient’s postoperative visits does not fall within common knowledge exception); Mitchell v. Lincoln, No. 05-1369, 2006 WL 1702635 (Ark. June 22, 2006) (discussed in text accompanying *infra* notes 105–111); Massey v. Chauhan, No. CA 05-1055, 2006 WL 864551, at \*5 (Ark. Ct. App. Apr. 5, 2006) (“The point at which a radiologist examining appellant’s mammograms should have detected the possibility of cancer is not within a jury’s common knowledge.”); Long v. Pearle, No. G033471, 2005 WL 289708 (Cal. Ct. App. Jan. 25, 2005) (holding that alleged negligence of emergency room physicians in treating an apparent drug overdose was not within the common knowledge exception); Boone v. William W. Backus Hosp., 864 A.2d 1, 15–16 (Conn. 2005) (holding that whether defendant negligently administered Rocephin to the 4-year-old decedent and whether emergency medical personnel negligently determined the nature or severity of a patient’s reaction to prescribed medication and the necessity of admission to the hospital were not within the knowledge of a typical layperson); Berkow v. Lucy Webb Hayes Nat’l Training Sch. for Deaconesses & Missionaries Conducting Sibley Mem’l Hosp., 841 A.2d 776, 780 (D.C. 2004) (“When the question is one of distinguishing the subtleties between lymphoma and sarcoma from a set of biopsy samples, ‘common knowledge and experience’ will not equip one to discern whether a doctor failed to use the required care.”); Conway v. Sonntag, 106 P.3d 470, 473 (Idaho 2005) (noting that where the patient’s lens capsule of her left eye was punctured during cataract surgery, the alleged negligence of the defendant-physician’s post-operative treatment was not “generally” within the knowledge or experience of lay persons); Garley v. Columbia LaGrange Mem’l Hosp., 813 N.E.2d 1030, 1043 (Ill. App. Ct. 2004) (holding that, in case where attending physician charted that post-surgical patient should be “ambulated with assistance” to decrease the risk that a DVT [deep vein thrombus] might develop,” and where the plaintiff alleges that the patient died after she developed pulmonary complications from DVT, “it is doubtful that the layman would understand the importance of ambulating a patient after surgery, [and therefore] the nurses’ conduct cannot be deemed so grossly negligent that plaintiff was not required to offer expert testimony”); Bryant v. LaGrange Mem’l Hosp., 803 N.E.2d 76, 85 (Ill. App. Ct. 2003) (“[T]he issue of whether the nurses completed their preparations for the C-section within the standard of care pertained to matters involving medical judgment [and therefore] expert testimony was required.”); Syfu v. Quinn, 826 N.E.2d 699, 705 (Ind. Ct. App. 2005) (holding that, in case where a patient who had undergone eight hour surgery and suffered a wound around her eye where the guard device had been in place to protect her eyes, sued the anesthesiologist, “conduct and the medical reasons for alleviating

early stage in the legal proceedings, usually in connection with deciding whether to grant a defendant a motion for summary judgment based on the failure of the plaintiff to introduce sufficient expert proof.<sup>74</sup> Even if the court applies the common knowledge exception so as to allow a plaintiff to avoid a summary judgment, plaintiff still faces the challenge of proving the facts he alleges on the merits and of satisfying the various elements of the case, albeit perhaps in the framework of common knowledge.

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pressure off of a patient's face during prolonged surgery are matters not within the realm of a laypersons [sic] knowledge and thus require expert testimony"); *Ward v. Shawnee County Bd. of Comm'rs*, 103 P.3d 993, 2005 WL 81551, at \*3 (Kan. Ct. App. 2005) (unpublished table decision) (holding that alleged negligent failure to timely administer antibiotics for a foot infection was outside common knowledge); *Baptist Healthcare Sys., Inc. v. Miller*, 177 S.W.3d 676, 680–81 (Ky. 2005) (holding alleged negligence of hospital phlebologist in allegedly placing a tourniquet on patient's arm and leaving for ten minutes not within the common experience of jurors); *Davis v. Atchison*, 859 So. 2d 931, 934 (La. Ct. App. 2003) (holding that expert testimony was needed to support allegations that due to the patient's age and medical conditions, the two surgeons "were at fault in performing the simultaneous knee replacement surgery"); *Anderson v. Attar*, 841 N.E.2d 1286, 1289 (Mass. App. Ct. 2006) ("Jurors are not competent from their own knowledge and experience to determine the appropriate kind of cement to be used to install a dental bridge, and the appropriate amount of force necessary to remove it."); *Woodard v. Custer*, 702 N.W.2d 522, 526 (Mich. 2005) (holding where infant patient suffered leg fractures, the alleged negligence in "the placement of arterial lines or venous catheters . . . [was] not within [the] common knowledge of a reasonably prudent fact finder") (citation omitted); *Keys v. Guthmann*, 676 N.W.2d 354, 359 (Neb. 2004) (holding alleged cutting of an anal sphincter while performing an episiotomy was not within the common knowledge exception); *Garaffa v. JFK Med. Ctr.*, No. A-4105-04T24105-04T2, 2006 WL 2033752, at \*1, \*5 (N.J. Super. Ct. App. Div. July 21, 2006) (holding that alleged negligence of orthopedic surgeon who performed a closed reduction and placed plaintiff's arm in a splint instead of performing a surgical open reduction of the fracture was not within the common knowledge exception); *Carter v. State*, No. 104863, 2006 WL 1029686, at \*2 (N.Y. Ct. Cl. Mar. 22, 2006) (holding that alleged failure to conduct physical examination of the patient's feet prior to the prescription of medications for the one-month and five-day period prior to diagnosis of plantar fasciitis did not fall within the common knowledge exception); *Ullmann v. Duffus*, No. 05AP-299, 2005 WL 3047433, at \*5 (Ohio Ct. App. Nov. 15, 2005) (holding where alleged death of birds was due to prescribed drug, "choice of appropriate drugs to treat avian medical conditions" required expert evidence on the veterinary standard of care); *Barbato v. Mercy Med. Ctr.*, No. 2005 CA 00044, 2005 WL 2401870, at \*7 (Ohio Ct. App. Sept. 26, 2005) (holding that the way the on-call physician managed the patient's condition for colon and gall-bladder perforated during prior biopsy was not within the common knowledge exception); *Whittington v. Meagher*, No. 03AP-569, 2004 WL 1828831, at \*2 (Ohio Ct. App. Aug. 17, 2004) ("The proper reading of an MRI lies within the province of medically trained professionals and is outside . . . common knowledge and experience."); *Martin v. Mansfield Corr. Inst.*, No. 2004-05180, 2005 WL 1208866, at \*2 (Ohio Ct. Cl. May 16, 2005) (holding that which "medications should have been prescribed to treat plaintiff's narcolepsy" and "what type of diet is appropriate to manage his diabetes" was not "within a lay person's common knowledge"); *Grossman v. Barke*, 868 A.2d 561, 571 (Pa. Super. Ct. 2005) (holding that where patient fell while waiting on examination table to have sutures removed, the alleged negligence related to professional knowledge of patient's condition and medical factors, including an alleged history of dizzy spells, was not so simple and obvious as to be within the ordinary experience and comprehension of nonprofessional persons); *Payne v. Pelmore*, No. M2004-02281-COA-R3-CV, 2006 WL 482922, at \*4 (Tenn. Ct. App. Feb. 28, 2006) (holding that treatment for hepatitis not within the common knowledge of laymen); *Patterson v. Arif*, 173 S.W.3d 8 (Tenn. Ct. App. 2005) (discussed *infra* note 242); *Ference v. V.I. Family Sports & Fitness Ctr., Inc.*, No. Civ. 657/2002, 2004 WL 626280, at \*5 (V.I. Feb. 23, 2004) (discussed in text accompanying *infra* notes 184–192); *Farley v. Shook*, 629 S.E.2d 739, 744–45 (W. Va. 2006) (holding that where podiatry surgery patient developed infection, allegations that the emergency room doctor negligently failed to remove patient's surgical dressing, that nurses failed to repeat patient's vital signs, and that the podiatric defendants negligently performed her cyst removal surgery and mismanaged her care postoperatively, were not within jurors' common knowledge).

74. See cases cited *supra* notes 62–63.

The potential impact of the courts' decisions on the question of the applicability of the common knowledge exception can be manifested in a number of ways. In most cases addressing the question of the applicability of the common knowledge exception, the common knowledge question arises because a defendant moves for a summary judgment, supported by expert depositions or affidavits, and the plaintiff fails to respond with his own expert proof.<sup>75</sup> The question then becomes whether expert evidence will be necessary in order for the plaintiff to state a prima facie case and avoid a summary disposition of the claim. In addition to the typical summary judgment setting, sometimes the common knowledge questions arise in jurisdictions with malpractice statutes that not only have express expert testimony requirements, but also special threshold expert witness procedural requirements that defendants may rely on in seeking pre-trial dismissal of the claims or other sanctions.<sup>76</sup> These latter provisions may require various preliminary filings that may include certificates or affidavits from plaintiffs' medical experts,<sup>77</sup> and the plaintiffs may seek to invoke the common knowledge exception in an attempt to circumvent the statutory requirements.<sup>78</sup> Moreover, some courts addressing the common knowledge exception may rely on both the summary judgment procedure generally and on the specific affidavit of merit requirement as well.<sup>79</sup> Questions of the applicability of the common knowledge exception may figure into other procedural contexts as well, such as in deciding whether to impose sanctions against plaintiff's attorney for not dismissing a medical malpractice claim against a physician,<sup>80</sup> or in deciding questions in malicious prosecution claims by defendant physicians sued for malpractice.<sup>81</sup>

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75. See, e.g., *Treaster v. Healthsouth Corp.*, 442 F. Supp. 2d 1171, 1184 (D. Kan. 2006) (granting defendant partial summary judgment because common knowledge exception not applicable, and plaintiff failed to present expert proof).

76. Nelson, *supra* note 50, § 9.07[2], at 9-52 ("The applicability of the requirement of an expert affidavit may depend upon a finding that expert testimony will be necessary to establish a prima facie case of malpractice."); see, e.g., *Howell v. Macomb MRI*, No. 260774, 2005 WL 2514262, at \*1-2 (Mich. Ct. App. Oct. 11, 2005). The court in *Howell* stated:

[A] court must ask two fundamental questions in determining whether a claim sounds in ordinary negligence or medical malpractice: (1) whether the claim pertains to an action that occurred within the course of a professional relationship; and (2) whether the claim raises questions of medical judgment beyond the realm of common knowledge and experience. If both these questions are answered in the affirmative, the action is subject to the procedural and substantive requirements that govern medical malpractice actions.

*Id.*

77. See generally Nelson, *supra* note 50, § 9.07[2] (discussing the certificate of merit requirement and similar requirements in various jurisdictions). The nature of the sanctions imposed on a plaintiff who fails to comply with the requirement may vary. See *id.* at 9-58 to -66.

78. On the question of whether the application of the common knowledge rule will obviate compliance with these procedural requirements, see *supra* notes 52-54 and accompanying text.

79. See *Garaffa v. JFK Med. Ctr.*, No. A-4105-04T24105-04T2, 2006 WL 2033752 (N. J. Super. Ct. App. Div. July 21, 2006).

80. See *Barbato v. Mercy Med. Ctr.*, No. 2005 CA 00044, 2005 WL 2401870 (Ohio Ct. App. Sept. 26, 2005). In *Barbato*, the trial court granted defendant's motion for sanctions against one of the plaintiff's attorneys, finding her continuing assertion of malpractice against defendant-physician "was not warranted under existing law and could not be supported by a good faith argument for an extension, modification, or reversal of existing law." *Id.* at \*5. In opposing sanctions, the plaintiff's attorney argued

Application of the common knowledge exception has been unpredictable and inconsistent. This is a function of the dearth of meaningful guidance from the courts and the fact that the question is decided on a case-by-case basis, which together lead to highly subjective outcomes. The complicated factual sequence of events, the presence of multiple health care providers and often multiple defendants, and the fact that the subject medical care may extend over a prolonged period of time, all combine to make for highly individualized outcomes on the common knowledge question.

The divergence of outcomes of the cases is reflected not only in the substantial number of cases going both ways on the question,<sup>82</sup> but can also be discerned among some ostensibly similar types of cases. Consider, for example, cases in which a patient suffered a fall arising in the medical setting (some fall cases may carry relatively high stakes).<sup>83</sup> Numerous cases have held that the falls arising in the health care setting are within the common knowledge exception.<sup>84</sup> Moreover, some of these cases arose in the

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that “a physician’s responsibility to keep apprised of his patient’s condition, while . . . in a hospital, is not scientific . . . but rather, within the common knowledge of an ordinary person.” *Id.* at \*6. Thus, she contended that “the events at issue were within the common knowledge of ordinary persons and did not require medical expert testimony.” *Id.* The court held on appeal:

We find the claim against Dr. Maycon involved issues regarding the on-call system, duties of the nursing staff, protocol and guidelines for the nursing staff when monitoring a patient and protocol and guidelines for communications between the on-call doctor and nurses monitoring a patient at the hospital. These are not issues that are within the common knowledge of jurors. . . . [T]his is not a case in which counsel could make a good faith argument for an extension of the “common knowledge” exception.

*Id.* at \*7.

81. See *Mittal v. Padrino*, No. B166461, 2004 WL 668935 (Cal. Ct. App. Apr. 1, 2004). In *Mittal*, the court denied the defendant’s motion to strike (under the anti-SLAPP statute) the doctor’s malicious prosecution claim based on his having been sued for medical malpractice. *Id.* at \*5. SLAPP is an acronym for “strategic lawsuits against public participation.” *Id.* at \*2 (quoting *Slaney v. Ranger Ins. Co.*, 8 Cal. Rptr. 3d 915, 916 n.1 (Cal. Ct. App. 2004)). The patient and her husband had filed an action for a medical negligence claim alleging that the patient’s pacemaker was incorrectly installed. *Id.* at \*1. The doctor sued in the underlying malpractice case subsequently brought a malicious prosecution case asserting that “he demonstrated a lack of probable cause by establishing that appellants commenced and continued to prosecute the underlying action without ever having a qualified expert to opine that Dr. Mittal acted below the standard of care.” *Id.* at \*4. The court held that “in the absence of any evidence that appellants procured or attempted to procure a standard-of-care opinion from a competent expert, we conclude that Dr. Mittal made a prima facie showing that the underlying action was initiated without probable cause.” *Id.* at \*5. It explained that whether or not the patient’s “pacemaker had been installed correctly was not a matter within a layperson’s knowledge, and therefore required expert testimony from a cardiologist or other cardiac specialist.” *Id.*

82. See *supra* notes 72–73.

83. Compare *William Jordan, \$5 Million Verdict in Suit Arising from Injuries Caused by Complications from Patient’s Fall*, 26 6 VERDICTS, SETTLEMENTS & TACTICS 12, (2006) (reporting on a \$5,015,700 plaintiff’s verdict in case arising out of the fall of a 68 year-old patient at defendant-hospital’s Extended Care Facility, allegedly leading to the need to remove the anticoagulants, which in turn lead to the formation of clots and a pulmonary embolism, atrial fibrillation, decreased oxygen levels and tachycardia, and death while spinal anesthesia was being injected), with *William Jordan, Defense Verdict in Suit Arising from Patient’s Fall*, VERDICTS, SETTLEMENTS & TACTICS, *supra*, at 13 (reporting on defense verdict in case arising after a 77 year-old Convalescent Hospital patient with dementia allegedly fell and broke her neck after her restraints were removed).

84. See, e.g., *Lawrence v. Frost St. Outpatient Surgical Ctr.*, No. D042108, 2004 WL 2075401, at \*5 (Cal. Ct. App. Sept. 17, 2004); *Howell v. Macomb MRI*, No. 260774, 2005 WL 2514262, at \*1–2 (Mich. Ct. App. Oct. 11, 2005); *Taliaferro v. S. Pointe Hosp.*, No. 86999, 2006 WL 832510, at \*3 (Ohio Ct. App. Mar. 30, 2006); *Banfi v. Am. Hosp. for Rehab.*, 529 S.E.2d 600, 606, 608 (W. Va. 2000) (“that

context of complex medical procedures, such as during post-surgical care,<sup>85</sup> or while a patient was hospitalized,<sup>86</sup> or was being attended during a diagnostic procedure such as an MRI.<sup>87</sup> Other cases, however, have held that the common knowledge exception did not apply to the facts presented in cases involving patient falls.<sup>88</sup> Interestingly, some of these later cases may seem to arise in situations that strike one as less complex than some of those where the common knowledge rule was held to apply. For example, the court declined to apply the exception in a case in which an elderly resident of an assisted living facility fell while being assisted in dressing,<sup>89</sup> and where a patient fell off a treadmill at the defendant's rehabilitation center after she mistakenly set the speed of the treadmill too high.<sup>90</sup> Some fall cases drawing different conclusions on the common knowledge question seem strikingly similar in terms of the health care setting.<sup>91</sup>

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claims of negligence arising from a hospital patient's fall generally do not require expert testimony as the applicable standard of care is within the common knowledge of the average lay jury."). *But cf. id.* at 606 ("[T]he majority of jurisdictions considering the question of whether restraining a patient is, in fact, a technical medical decision have concluded that it is a complex determination, and therefore expert testimony is required to educate the jury as to the appropriate standard of care."). See generally John E. Theuman, Annotation, *Hospital's Liability for Patient's Injury or Death as Result of Fall from Bed*, 9 A.L.R. 4TH 149, 155 (1981). According to Theuman:

A number of courts have held that the question whether restraints or special supervision should have been provided to prevent an accident is not one which requires specialized knowledge, but is a matter of common sense which the jury is competent to assess without expert guidance. There is, however, some precedent to the contrary.

*Id.* (footnotes omitted).

85. *Lawrence*, 2004 WL 2075401, at \*5 (holding that, in case where patient who had undergone an outpatient hernia repair procedure at surgical center and upon his discharge fell and injured himself when being helped to transfer from a wheelchair into his car, "[a] layperson can apply common knowledge to evaluate how to safely transfer a patient with a numb leg from a wheelchair to a vehicle after outpatient surgery").

86. *Taliaferro*, 2006 WL 832510, at \*3 (holding in case where a hospital patient who suffered from multiple sclerosis, seizures, frequent falls, impaired balance, left lower limb weakness, progressive decline in function, and increased spasticity, and who allegedly fell three times the day she was admitted, after being left unattended in the bathroom, and after she got out of her bed on her own to walk to the bathroom, "case falls within the common knowledge exception").

87. *Howell*, 2005 WL 2514262, at \*1-2 (holding in case where a 75 year-old man rolled off a table while being positioned for an MRI examination, the reasonableness of the MRI technician's actions were within "'the realm of common knowledge and experience,' and can be evaluated by lay jurors without expert testimony on the standard of care and the medical issues presented").

88. See, e.g., *Duke v. Atria, Inc.*, No. 2:03CV00934DRB, 2005 WL 1513158, at \*3 (M.D. Ala. June 27, 2005) (holding that, in case where the elderly patient fell while being assisted in dressing at an assisted living facility then owned by defendant, plaintiff could not succeed on any of her liability claims "without establishing by expert testimony both the standard of care . . . and a breach of that standard which resulted proximately in the physical injuries and damages claimed"); *Ference v. V.I. Family Sports & Fitness Ctr., Inc.*, No. Civ. 657/2002, 2004 WL 626280, at \*5 (V.I. Feb. 23, 2004) (discussed in text accompanying *infra* notes 184-192).

89. See *Duke*, 2005 WL 1513158, at \*3.

90. See *Ference*, 2004 WL 626280, at \*5.

91. Compare *Howell*, 2005 WL 2514262, at \*2 (holding in case where a seventy-five year-old man rolled off a table while being positioned for an MRI examination, the reasonableness of the MRI technician's actions were within "'the realm of common knowledge and experience,' and can be evaluated by lay jurors without expert testimony on the standard of care and the medical issues presented"), with *Hector v. Christus Health Gulf Coast*, 175 S.W.3d 832, 837 (Tex. App. 2005) (stating where patient undergoing ear surgery and under general anesthesia fell off the table as she was being rotated, that "how an operating table works, the method of securing a patient to an operating table, or the procedures for rotating a patient during surgery are not necessarily within the common knowledge of laymen").

Matters can be complicated by the tendency to parse and differentiate the allegations, segment the analysis, and then apply the common knowledge exception selectively to some aspects of the conduct of the health care providers and not to others. Thus, in *Banfi v. American Hospital for Rehabilitation*,<sup>92</sup> a seventy-seven-year old stroke victim who was transferred to the defendant hospital for rehabilitation fell in the bathroom less than a week after her arrival.<sup>93</sup> Neither direct observation nor restraint of the patient had been ordered.<sup>94</sup> With respect to the alleged negligence of the health care providers, the court held that the failure specifically to order restraints for the patient were not matters of common knowledge,<sup>95</sup> but it also more generally held that plaintiff's allegations that the defendants were negligent in failing to prevent the patient's fall were within the common knowledge exception.<sup>96</sup>

The fall cases are not the only instances of apparent disparate outcome of common knowledge questions arising from cases with ostensibly similar factual patterns. Consider situations involving the alleged failure of a subordinate, supporting, or lower ranked health care provider or sometimes even another physician to follow orders or a prescribed or recommended treatment plan of an attending physician. A sampling of recent cases reveals decisions going both ways. In *Gil v. Reed*,<sup>97</sup> for example, the patient, who was a federal prison inmate, underwent three surgical procedures. Following the first one, the plaintiff alleged that although the medical staff had prescribed an antibiotic, a prison physician's assistant, defendant Penaflor, refused to supply him with the prescribed antibiotic when initially requested.<sup>98</sup> The plaintiff underwent a second surgery about two months later, also to correct the rectal prolapse.<sup>99</sup> After the surgery, the surgeon, Dr. Kim,

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92. 529 S.E.2d 600 (W. Va. 2000).

93. *Id.* at 603, 603 n.3.

94. *Id.* at 603.

95. *Id.* at 606 (“[T]he majority of jurisdictions considering the question of whether restraining a patient is, in fact, a technical medical decision have concluded that it is a complex determination, and therefore expert testimony is required to educate the jury as to the appropriate standard of care.”).

96. *Id.* at 608 (“[C]laims of negligence arising from a hospital patient's fall generally do not require expert testimony as the applicable standard of care is within the common knowledge of the average lay jury.”).

97. 381 F.3d 649 (7th Cir. 2004), *remanded to*, No. 00-C-0724-C, 2006 WL 42344, at \*12 (W.D. Wis. Jan. 6, 2006) (granting defendants summary judgment on remand because, *inter alia*, “plaintiff cannot show that defendant's alleged negligence caused him injury”); *see also* Czarney v. Porter, 853 N.E.2d 692, 698 (Ohio Ct. App. 2006) (“When a physician gives an order and it is not followed by a nurse or the medical staff, expert testimony may not be required to explain that this may be negligent.” In this case, “[the doctor] ordered that the decedent be monitored by a telemetry unit; however, there is no evidence of compliance with this order.”); *cf.* *Wilson v. Manning*, 880 So. 2d 1101 (Ala. 2003) (holding, in case where plaintiff being treated by antibiotics for osteomyelitis prior to her incarceration and where her pre-arrest physician stated that based on his communication with medical personnel at the prison it was his “clear understanding” that antibiotics would be continued, that allegation that defendant allowed patient to be without fourteen consecutive doses of necessary medicines was sufficient to allow the fact-finder to infer from it that defendant prison health-care provider Manning breached the standard of care).

98. *Gil*, 381 F.3d at 52-53; *Gil*, 2006 WL 42344, at \*1.

99. *Gil*, 381 F.3d at 653; *Gil*, 2006 WL 42344, at \*4.

prescribed Vicodin for pain and Colace, Milk of Magnesia, and Metamucil to prevent fecal impaction and warned the patient not to take Tylenol III because it may cause constipation.<sup>100</sup> The plaintiff alleged that thereafter the prison physician, Dr. Reed, “gave [the plaintiff] Tylenol III and cancelled Dr. Kim’s prescriptions for Metamucil and Milk of Magnesia when he knew [the plaintiff] was experiencing constipation.”<sup>101</sup> On appeal, the court of appeals held<sup>102</sup> that no expert testimony was necessary in considering the claim that Penaflor’s conduct was tortious.<sup>103</sup>

Other recent cases involving an alleged failure to follow prescriptions or recommendations of an attending (or prior attending) physician draw a different conclusion.<sup>104</sup> In *Mitchell v. Lincoln*,<sup>105</sup> the patient was treated for leukemia by oncologists at the renowned M.D. Anderson Cancer Center, receiving a bone marrow transplant.<sup>106</sup> Following his discharge there, an M.D. Anderson physician sent a letter to the defendant–patient’s treating physician back in Arkansas recommending a specific type of red blood cell or platelet if the patient needed a transfusion.<sup>107</sup> Plaintiff alleged that his eleven transfusions did not use the cell or platelet type specified.<sup>108</sup> Patient died several months later.<sup>109</sup> In a malpractice action, the plaintiff argued that her case was “a matter of common knowledge . . . [and] she did not need

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100. *Gil*, 381 F.3d at 653; *Gil*, 2006 WL 42344, at \*4. There was no evidence that Dr. Kim warned prison medical staff to avoid use of Tylenol III. *Id.* at \*4 n.1.

101. *Gil*, 381 F.3d at 653.

102. *Id.* at 660.

103. The court explained:

Construing the facts in [plaintiff’s] favor, Penaflor simply refused to provide a prescribed antibiotic to a person with a serious infection. His angry tone of voice at the time of the refusal could indicate that he had no legitimate reason for the refusal and may have been motivated by malice. It is within a layperson’s purview to know that when a serious infection at the site of a surgical wound is diagnosed and an antibiotic is prescribed, failure to supply or delay in supplying the antibiotic can result in unnecessary pain, discomfort and a spreading of the infection.

*Gil*, 381 F.3d at 660–61. The court also noted in the alternative that “Dr. Kim could supply the necessary testimony about the standard of care for a person in Penaflor’s position.” *Id.* at 661.

104. *See, e.g.*, *Mitchell v. Lincoln*, No. 05-1369, 2006 WL 1702635 (Ark. June 22, 2006); *Garley v. Columbia LaGrange Mem’l Hosp.*, 813 N.E.2d 1030, 1033, 1043 (Ill. App. Ct. 2004) (holding that, in case where attending physician charted that post-surgical patient should be “ambulated with assistance” to decrease the risk that a DVT [deep vein thrombus] might develop,” and where the plaintiff alleges that the patient died after she developed pulmonary complications from DVT, “it is doubtful that the layman would understand the importance of ambulating a patient after surgery, [and therefore] the nurses’ conduct cannot be deemed so grossly negligent that plaintiff was not required to offer expert testimony”); *Thomas v. State*, 814 N.Y.S.2d 565, 2005 WL 3681655, at \*2 (N.Y. Ct. Cl. 2005) (unpublished table decision) (holding in case where the claimant alleged that after he was moved to a different correctional facility he was denied his prescribed back brace and medication, that “[t]here is no medical evidence on any medical issue and thus no proof that accepted standards of care were not met. Accordingly, the claim of medical malpractice must be dismissed.”). In *Garley*, although the patient had argued that the disregard of the doctor’s instructions brought the case within the common knowledge exception, the court also specifically held that the nursing staff “did not disregard Dr. Multack’s order” and made several attempts to ambulate the patient. 813 N.E.2d at 1043.

105. No. 05-1369, 2006 WL 1702635 (Ark. June 22, 2006).

106. *Id.* at \*1.

107. *Id.*

108. *Id.*

109. *Id.*

expert testimony to create a fact question.”<sup>110</sup> The Supreme Court of Arkansas disagreed, stating that, although the plaintiff

attempts to frame the issue as being whether a jury of laymen can understand that an internist should follow a specialist's recommendations, the issue is more complicated than that, because it also requires an understanding of *why* such recommendations should be followed. That is, without expert testimony demonstrating why the recommendations should be followed, the jury cannot know how, why, or whether the alleged negligence caused the plaintiff's harm.<sup>111</sup>

The courts too often fail to adequately explain why the common knowledge exception is applicable in one case and not in another that, at least outwardly, seems to involve a similar alleged failure. It would be more helpful if the courts were to suggest some underlying basis for the divergent results to guide future cases. The common knowledge question is too often shrouded in uncertainty and unpredictability, a dangerous environment for litigators, patients, and health care providers alike. In fact, as a hedge against the possibility that they might ultimately lose the common knowledge argument later in the proceedings, some courts recommend that counsel fulfill, for example, the expert's affidavit requirement even if they intend to rely on the common knowledge exception.<sup>112</sup> The Supreme Court of New Jersey has cautioned that “[a]lthough we understand that in some cases plaintiffs may choose not to expend monies on an expert who will not testify at trial, there is some uncertainty in relying on common knowledge in professional malpractice cases.”<sup>113</sup>

More broadly, the absence of a predictable construct of the common knowledge principle abets subjective judicial judgments that devitalize the rule of law.<sup>114</sup> The transcendent principle of the *rule of law*, according to

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110. *Id.* at \*3.

111. *Id.* at \*5.

112. *See* Hubbard *ex rel.* Hubbard v. Reed, 774 A.2d 495, 501 (N.J. 2001). In *Hubbard*, the court stated:

Although we hold today that there is a common knowledge exception to the Affidavit of Merit Statute, we construe that exception narrowly in order to avoid non-compliance with the statute. Indeed, the wise course of action in all malpractice cases would be for plaintiffs to provide affidavits even when they do not intend to rely on expert testimony at trial.

*Id.*; *see also* Stroub, *supra* note 55, at 300 (noting the court's “‘better safe than sorry’ approach. . . . contravenes the purpose of the statute to reduce the costs of malpractice litigation”).

113. *Hubbard*, 774 A.2d at 501.

114. Professor Tamanaha describes the threat this way:

The threat to the rule of law . . . is not that judges are incapable of rendering decisions in an objective fashion. Rather, the threat is that judges come to *believe* that it cannot be done or believe that most fellow judges are not doing it. This skepticism—were it to become pervasive among lawyers, judges, and the public—becomes a self-fulfilling prophecy that precipitates a collapse in the rule of law.

Brian Z. Tamanaha, *How an Instrumental View of Law Corrodes the Rule of Law*, 56 DEPAUL L. REV. 469, 495 (2007).

philosopher-economist Friedrich Hayek, “means that government in all its actions is bound by rules fixed and announced beforehand . . . which make it possible to foresee with fair certainty how the authority will use its coercive powers in given circumstances and to plan one’s individual affairs on the basis of this knowledge.”<sup>115</sup> And thus, “[w]ithin the known rules of the game the individual is free to pursue his personal ends . . . certain that the powers of government will not be used deliberately to frustrate his efforts.”<sup>116</sup> And make no mistake, “[a] rule of thumb is not a binding rule.”<sup>117</sup>

### B. Interests at Stake

In considering measures to address the uncertainty in the application of the common knowledge exception, it is useful to understand the concerns of various stakeholders. The injured patients may face considerable costs<sup>118</sup> of retaining qualified experts to support their malpractice claims. The expenses of paying expert witnesses are at least theoretically initially the responsibility of the plaintiff. Quite a few states may, however, award prevailing parties as costs at least some of their expert witness fees or expenses under some circumstances.<sup>119</sup> The approaches are prone to wide variation. Whether, when, or to what extent the costs of paying a party’s expert witnesses may be awarded to a party differs widely from state to state, depends

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115. FRIEDRICH A. HAYEK, *THE ROAD TO SERFDOM* 72 (1944).

116. *Id.* at 73.

117. Tamanaha, *supra* note 114, at 486.

118. See David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It’s the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1118 (2006); Gary T. Schwartz, *Empiricism and Tort Law*, 2002 U. ILL. L. REV. 1067, 1071. Schwartz notes that:

[T]he plaintiff (or the plaintiff’s lawyer), in order to present a plausible case, must at the very least hire one or two experts who can indeed identify prevailing standards and who can then compare those standards to the facts of the treatment in the individual case. . . . [A]part from a limited number of distinctly easy cases . . . the cost of mounting a plausible malpractice claim is at least \$50,000. Accordingly, unless the victim’s damages are well in excess of \$100,000, developing a malpractice claim is not economically sensible on the part of the lawyer whom the malpractice victim might consult.

*Id.*; see also Gary T. Schwartz, *Medical Malpractice, Tort, Contract, and Managed Care*, 1998 U. ILL. L. REV. 885, 895 (discussing how non-“large-damage” medical malpractice claims are impractical); Jeffrey J. Parker, Comment, *Contingent Expert Witness Fees: Access and Legitimacy*, 64 S. CAL. L. REV. 1363, 1369 (1991) (“[F]ees to employ necessary expert witnesses constitute substantial litigation expenses.”).

According to one authority:

Medical malpractice lawsuits are extremely time consuming and expensive. It is estimated that the average medical malpractice lawsuit costs \$20,000–\$45,000 actual out of pocket cost from the time a complaint is filed until a jury reaches its [sic] decision. This does not include the cost of an appeal . . . . [L]awyers will not want to take on medical malpractice cases unless there are severe and substantial injuries or a wrongful death of an individual who was a wage earner or who had others dependant on him or was the mother of a household. . . . In complicated cases, costs for trial preparation and experts can exceed \$100,000.

Everything You Want to Know About Malpractice & Injury Type Lawsuits, <http://www.uscourt.com/know.htm#costme> (last visited Oct. 28, 2007).

119. For a useful overview, see Ally Windsor Wowell, *Using Taxation of Costs to Collect Some Litigation Expenses and Maximize Client Recovery*, 84 AM. JUR. TRIALS 367, §§ 5–104 (2002) (containing a state-by-state summary).

on a number of variables in the statutes, rules, and cases,<sup>120</sup> and is, in any case, beyond the scope of this Article. Suffice it to say that these variables may include, for example, whether the party was a prevailing party; whether federal or state law is held to apply; whether there are applicable special statutes or rules authorizing awards of such fees in particular circumstances; whether the authority, where it exists, is to routinely tax such costs or is merely discretionary; whether any such fee awards are subject to a cap or limit such as on an amount per expert, per hour, per day, in total, on the number of experts, or other significant limitations; whether costs for expert witnesses are treated differently than witnesses in general; and whether the fee was for the expert's deposition taken by an opposing party, for testimony, or for other services.<sup>121</sup> Commonly, the expense of retaining expert witnesses is initially advanced by the plaintiff's attorney.<sup>122</sup> The plaintiff may remain obligated to reimburse his attorney for those sums, although such reimbursement, when it occurs, will often be from the plaintiff's recovery if he wins.<sup>123</sup> However, depending on the governing rules, some states permit the attorney and client to agree that the client's responsibility for the repayment of these advanced expenses of litigation will be contingent on the outcome of the matter.<sup>124</sup>

Sometimes plaintiffs turn to litigation finance companies to obtain cash advances to finance their litigation.<sup>125</sup> Such financing may represent a less than ideal solution to the challenge of onerous litigation costs when one considers the potentially exorbitant rates of such financing,<sup>126</sup> the potential

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120. See generally WALTER R. LANCASTER, EXPERT WITNESSES IN CIVIL TRIALS § 7:7 (2d ed. 2005) (discussing federal and state practice, and noting that "[i]n state court, the rules vary widely from jurisdiction to jurisdiction, and no generalizations are possible"); Wade P. Webster, *Expert Witness Fees in Federal Diversity Cases*, 24 ST. MARY'S L.J. 463 (1993) (discussing fees in federal courts).

121. See, e.g., *supra* notes 119–120.

122. See TENN. RULES OF PROF'L CONDUCT R. 1.8(e) (2004) (stating that "[a] lawyer shall not provide financial assistance to a client in connection with pending or contemplated litigation, except that: (1) a lawyer may advance court costs and expenses of litigation, the repayment of which may be contingent on the outcome of the matter; and (2) a lawyer representing an indigent client may pay court costs and expenses of litigation on behalf of the client."); see also RESTATEMENT (THIRD) OF LAW GOVERNING LAWYERS § 36(2) (2000) (stating that "[a] lawyer may not make or guarantee a loan to a client in connection with pending or contemplated litigation that the lawyer is conducting for the client, except that the lawyer may make or guarantee a loan covering court costs and expenses of litigation, the repayment of which to the lawyer may be contingent on the outcome of the matter"); *id.* § 36(2) cmt. c (referring to court costs and litigation expenses as including items "such as ordinary- and expert-witness fees").

123. See *supra* note 122.

124. See *supra* note 122.

125. See Mariel Rodak, Comment, *It's About Time: A Systems Thinking Analysis of the Litigation Finance Industry and its Effect on Settlement*, 155 U. PA. L. REV. 503, 506–07 (2006). This financing sometimes takes the form of nonrecourse funding—"if the plaintiff ultimately loses her case at trial she has no obligation to repay the amount advanced, and the company thus forfeits its entire investment." *Id.* This type of financing is in response to the skyrocketing litigation costs, which include expert witness fees. *Id.* at 505, 505 n.4.

126. "A second major criticism of litigation finance is that it wrongfully takes advantage of consumers. With some contracts calling for annual interest charges as high as 200% of the amount advanced, there is concern that the victim of an accident will be 'further victimized' by a finance company charging such exorbitant rates." *Id.* at 518 (footnotes omitted). Rodak comments:

effects on settlement of the underlying claim,<sup>127</sup> and the uncertain regulatory setting.<sup>128</sup>

The bottom line, then, is that the expense of retaining plaintiff's expert witnesses may often be, at least in large part, borne by the plaintiff's side. Therefore, when a patient has suffered a relatively modest injury,<sup>129</sup> the high price of experts may arguably influence plaintiff's decisions whether to forego using medical experts<sup>130</sup> and to resort to the common knowledge

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The procedure following a plaintiff's successful resolution of her claim, be it through settlement or at trial, varies according to the structure of the agreement, which can fluctuate across the industry. Some lenders take a flat fee based on a percentage of the plaintiff's recovery, but most charge interest rates that can be up to 15% monthly and can approach 200% annually when compounded. These extraordinarily high rates are often justified by those in the litigation finance industry as necessary to compensate for the significant risk they assume by advancing money on a nonrecourse basis.

*Id.* at 507 (footnotes omitted).

127. Rodak observes that:

Litigation finance is regarded by many as an obstacle to settlement. A rational plaintiff will not settle for any amount offered by the defendant that is less than the aggregate of the principal amount advanced to her and the current interest accrued, which is often immense due to the staggering rates charged by many litigation finance companies. This artificially inflated minimum acceptable offer and the nonrecourse character of the arrangement will lead the rational plaintiff to reject otherwise reasonable settlement offers, since, if she loses at trial, she will owe nothing. In this way, litigation finance gives plaintiffs disincentives to settle and instead encourages disputes to progress to trial.

*Id.* at 522 (footnotes omitted). Others, however, disagree on the effects of litigation financing on settlements. *See id.* (noting the view that because "entering into a litigation finance contract presumably gives the plaintiff the resources and 'threat credibility' to carry her claim to trial, litigation financing may draw an otherwise obstinate defendant to the bargaining table and result in a fairer settlement award.").

128. The laws and rules governing litigation finance are beyond the scope of this Article. Suffice it to say that the situation appears dynamic; Rodak characterized the situation as "Current Status: In Legal Limbo." *Id.* at 508 (providing an overview of relevant law and stating that matters are complicated by "the states' disparate treatment of litigation finance, by an uncertainty concerning which existing legal doctrines are applicable, and by a general lack of modern law directly addressing the industry or analogous enterprises").

129. For a decision dismissing a plaintiff's medical malpractice claim because no expert evidence was adduced as required, and in which potential damages appeared modest, see *Newman v. Sonnenberg*, 81 P.3d 808 (Utah Ct. App. 2003). The plaintiff had been referred to the defendant-endodontist for a root canal. *Id.* at 810. Plaintiff alleged that after arriving at defendant's office and signing a consent form, defendant "took several x-rays, conducted a 'pulp test' on several teeth, examined an existing temporary crown, and administered a local anesthetic." *Id.* But, allegedly after directing his office administrator to review the costs and available payment options with the plaintiff, the defendant "learned that Newman was unable to pay for the procedure outright and that she did not qualify for a payment plan." *Id.* As a result, the defendant refused to perform the procedure. *Id.* Plaintiff sued the defendant for medical malpractice for abandonment. *Id.* However, since the plaintiff had the root canal work performed successfully by another dentist a week later, her damages were presumably relatively minor. *Id.* The defendant moved for summary judgment, arguing that the plaintiff's case had a fatal flaw because she withdrew before treatment began. *Id.* The appeals court framed the question as whether the defendant had begun treatment, and held that the answer to that question depended on expert testimony on the particularities of the defendant's practice, which were not within the knowledge and understanding of average citizens. *Id.* at 813.

130. *See Parker, supra* note 118, at 1369. Parker comments:

Often, fees to employ necessary expert witnesses constitute substantial litigation expenses and thus potentially act as a bar to *effective* litigation by litigants who are not wealthy or whose counsel are unable to advance witness fees and absorb them if the case is unsuccessful. Because expert testimony is such an essential component of many cases and the financial burden of obtaining the necessary experts can be so great, it is argued that only claimants with extensive, substantial injuries sufficient to support large damages and attorneys fees can obtain meaningful access to the court under the present system of witness compensation.

exception, thereby raising the stakes on the question of applicability of the exception.

Potential malpractice claimants may also face a challenge in locating qualified medical experts who have the time and are willing to offer their expert opinion in the case. As noted, in order to be deemed qualified or “competent” to offer an expert opinion on the relevant professional standard of care in a malpractice case, experts must typically pass muster in the three frames of reference and, in many jurisdictions, must also satisfy additional competency preconditions.<sup>131</sup>

Obtaining qualified legal representation is another challenge. Since many potential plaintiffs cannot afford to hire a qualified malpractice attorney on an hourly-fee basis, most qualified malpractice attorneys are retained on a contingency fee basis. This means (and has been true for years)<sup>132</sup> that the availability of such attorneys may well depend on whether the size and prospects of the potential damages yield is sufficient to prompt an attorney to agree to take the case on a contingency fee basis.<sup>133</sup> Experienced malpractice attorneys sometimes refer to this as the “damage threshold.”<sup>134</sup> David Hyman and Charles Silver have stated that “[w]hen it comes to losses that most people would regard as serious — losses ranging up to \$50,000 — the

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Litigants with lesser injuries and inadequate resources to guarantee fees may be forced to proceed without competent experts, which places them at a severe disadvantage.

*Id.* (footnotes omitted).

131. See *supra* notes 34–40 and accompanying text.

132. See LAWRENCE S. CHARFOOS, *THE MEDICAL MALPRACTICE CASE: A COMPLETE HANDBOOK* 24–25 (1974). Charfoos writes:

You cannot *win* a malpractice case where the damages are minimal. Malpractice cases are extremely expensive to prosecute. They have high direct and indirect costs. The direct costs result from the necessity of extensive pre-trial discovery, . . . travel . . . , and always the need to spend substantial sums for medical consultations as well as for medical testimony for trial, if the case cannot be settled. An additional cost is the disproportionate amount of time that an attorney must spend working on the file compared to most other personal injury cases.

*Id.* at 24.

133. See SHANDELL ET AL., *supra* note 37, § 2.02; Neil Vidmar, *Medical Malpractice Lawsuits: An Essay on Patient Interests, the Contingency Fee System, Juries, and Social Policy*, 38 *LOY. L.A. L. REV.* 1217, 1233 (2005). See generally HERBERT M. KRITZER, *RISKS, REPUTATIONS, AND REWARDS: CONTINGENCY FEE LEGAL PRACTICE IN THE UNITED STATES* (2004) (providing background on contingency fee practice in the United States). The Shandell treatise notes:

One of the difficulties and inequities of medical malpractice litigation is that the small claim cannot be presented because of the expense and time necessarily involved in the preparation and trial of medical malpractice cases. . . . [C]ases with limited damage potential are considerably more difficult to win than cases with devastating injuries. A trial is a struggle for moral ascendancy. . . . Where the injuries are not overwhelming, the jury is left to wrestle with the question of whether to label the mistake of a nice, well meaning doctor with that awful pejorative, malpractice. Mostly, the jury will not do so.

SHANDELL ET AL., *supra* note 37, § 2.02. Similarly, Vidmar observes:

Because lawyers working on a contingency fee basis have their own time and money at stake, they tend to carefully screen cases and weed out those that have minor injuries, low damages potential, or a low potential of winning at trial. In ordinary cases lawyers may decline as many as nine cases in ten; in medical malpractice cases the proportion of declined cases may be even higher. Economic reality drives lawyers' decisions to accept or reject cases.

Vidmar, *supra*, at 1233 (footnotes omitted).

134. SHANDELL ET AL., *supra* note 37, § 2.02.

malpractice system gives health care providers a free pass.”<sup>135</sup> These economic realities of the practice of law are not lost on the public and have even inspired their share of “lawyer jokes.”<sup>136</sup> Moreover, in recent years, the willingness of attorneys to take cases on a contingent fee has also been impacted by various law reform measures, especially in the form of caps on noneconomic damages in medical malpractice cases.<sup>137</sup> These economic constraints may, as a practical matter, mean that patients who suffered relatively minor injuries<sup>138</sup> may face the double challenge of not only being forced to resort to the common knowledge exception as the only practical option but also doing so without an attorney.

Prison inmates are especially likely not only to be representing themselves pro se in malpractice cases,<sup>139</sup> but also to be seeking to rely on the common knowledge exception in an attempt to state a prima facie case.<sup>140</sup> In

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135. Hyman & Silver, *supra* note 118, at 1118, 1118 n.115 (quoting LaRae I. Huycke & Mark M. Huycke, *Characteristics of Potential Plaintiffs in Malpractice Litigation*, 120 ANNALS INTERNAL MED. 792, 796 (1994) (concluding from a study that that damages of “less than \$50,000” was one of the main reasons given by attorneys for declining requests for representation)). Hyman and Silver note that the \$50,000 figure would be \$67,000 in 2006 dollars. *Id.* at 1118 n.115.

136. See MARC GALANTER, *LOWERING THE BAR: LAWYER JOKES & LEGAL CULTURE* 66–68 (2005) (noting that “ability to pay determines whether the lawyer will render any services at all”).

137. See Terry Carter, *Tort Reform Texas Style*, A.B.A. J., Oct. 2006, at 30. Carter states that “with new restrictions on medical-malpractice suits, many otherwise meritorious cases are no longer economically practical.” *Id.* He notes that the statutory caps on damages hit the elderly, poor, and stay-at-home mothers especially hard since they may have “little or nothing to show for lost earning power under economic damages.” *Id.* at 30, 33.

138. According to one respected survey, the majority (57%) of adverse events experienced by hospitalized patients resulted in minimal and transient disability. HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK 3 (1990) [hereinafter HARVARD MED. PRACTICE STUDY]; see also T. A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients, Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 370 (1991), reprinted in 13 QUALITY & SAFETY IN HEALTH CARE 145 (2004). Approximately 27.6% of adverse events were estimated to have been due to negligence. HARVARD MED. PRACTICE STUDY, *supra*, at 3; Brennan, *supra*, at 146.

139. Even non-prisoners sometimes resort to pro se representation in malpractice cases. See, e.g., *Joiner v. United States*, 89 F. App’x 586, 586 (6th Cir. 2004) (finding the common knowledge exception not applicable under the circumstances).

140. Recent cases have been commenced by prison inmates pro se in which plaintiffs sought to invoke the common knowledge exception. See *Barnes v. United States*, 137 F. App’x 184, 188 (10th Cir. 2005) (noting that if the plaintiff “verified his factual allegations, a reasonable jury might conclude that Mr. Al-Ruballe breached the standard of care by giving him medicine from an unlabeled bottle” and might conclude that such alleged negligence injured the plaintiff), *aff’d on remand*, 173 Fed. App’x 695 (10th Cir. 2006) (affirming summary judgment for the defendant); *Gil v. Reed*, 381 F.3d 649 (7th Cir. 2004) (discussed in text accompanying *supra* notes 97–103 and text accompanying *infra* notes 141–142); *Brown v. United States*, 74 F. App’x 611, 614 (7th Cir. 2003) (finding the common knowledge exception applicable to the standard of care element); *McCall v. Dale*, 129 P.3d 125 (Kan. Ct. App. 2006) (unpublished table decision) (finding common knowledge exception not applicable); *Carter v. State*, 819 N.Y.S.2d 846, at \*4 (N.Y. Ct. Cl. 2006) (unpublished table decision) (dismissing for defendant and finding common knowledge exception not applicable); *Thomas v. State*, 814 N.Y.S.2d 565 (N.Y. Ct. Cl. 2005) (unpublished table decision) (finding common knowledge exception not applicable); *Deer v. River Valley Health Sys.*, No. 00CA20, 2001 WL 243492 (Ohio Ct. App. Jan. 3, 2001) (same); *Payne v. Pelmore*, No. M2004-02281-COA-R3-CV, 2006 WL 482922 (Tenn. Ct. App. Feb. 28, 2006) (same); *White v. Bacon*, No. M2004-02110-COA-R3-CV, 2006 WL 211810 (Tenn. Ct. App. Jan. 26, 2006) (holding that the common knowledge exception was not applicable where the plaintiff alleged that following an injury, defendant-surgeon negligently performed his initial surgery). Plaintiffs have convinced the court that the common knowledge exception applied in very few of these cases. For some of the rare examples, see *Gil*, *Barnes*, and *Bacon*.

*Gil v. Reed*,<sup>141</sup> for example, an incarcerated plaintiff—a Colombian national with limited English skills and initially without his own attorney or expert witness—tried to navigate the shoals of a medical malpractice case against the Federal Government. For such plaintiffs, the warning by the courts of the perils of relying on the common knowledge exception may ring hollow where neither counsel nor an expert is practically available. To complicate

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There are some statutes that theoretically empower the court to appoint counsel for indigent persons. *See, e.g.*, 28 U.S.C. § 1915(e)(1) (2000) (stating that in federal court, “[t]he court may request an attorney to represent any person unable to afford counsel”). Occasionally, an inmate will seek appointment of an attorney under such a statute in a medical malpractice case in which the common knowledge exception is also addressed, but such requests for counsel have been met with mixed results. *Compare Gil*, 381 F.3d at 657 (appointing counsel for the plaintiff), *with Brown*, 74 F. App’x at 614 (holding that the district court’s refusal to appoint counsel was within its discretion and did not violate the inmate’s due process rights). Such power has been held to be discretionary for present purposes and to pose a high hurdle. *See Brown*, 74 F. App’x at 614 (stating that “[p]reliminarily, we note that civil litigants have no constitutional or statutory right to representation by court-appointed counsel,” but that the court may request an attorney to represent a person unable to afford one); *Hunt v. Emig*, No. Civ. 06-324-KAJ, 2006 WL 1788475, at \*2 (D. Del. June 27, 2006) (stating in a non-malpractice case under 28 U.S.C. § 1915(e)(1) that “[i]t is within this Court’s discretion to appoint plaintiff an attorney, but only ‘upon a showing of special circumstances indicating the likelihood of substantial prejudice to [plaintiff] resulting from [plaintiff’s] probable inability without such assistance to present the facts and legal issues to the court in a complex but arguably meritorious case’” (quoting *Smith-Bey v. Petsock*, 741 F.2d 22, 26 (3d Cir. 1984)); *see also* Jessica Feerman, “*The Power of the Pen*”: *Jailhouse Lawyers, Literacy, and Civic Engagement*, 41 HARV. C.R.-C.L. L. REV. 369, 369 (2006) (noting that “[m]ost prisoners are indigent and must represent themselves pro se in . . . civil suits . . . . As a result, prisoners with low literacy levels often face significant practical obstacles to court access.”).

The challenges facing incarcerated plaintiffs are evident in *Brown*, 74 F. App’x at 611. There, the district court took contradictory positions on the nature of the controversy, both of which were adverse to the plaintiff’s interests. *Id.* at 612–13. The inmate in *Brown* was “treated for prostatitis, cystitis, prosthetic hypertrophy, kidney stones, and hydronephrosis.” *Id.* at 612. His treatments included oral and intravenous analgesics and a lithotripsy. *Id.* He alleged that medical personnel “were negligent in failing to treat his symptoms in a timely and proper manner.” *Id.* On the one hand, the district court found that the facts did not warrant appointment of counsel at this time, noting that the plaintiff “‘is competent to read, express his thoughts in writing, and follow directions generally’ and therefore ‘competent to represent himself given the straightforward nature of the case.’” *Id.* (quoting *Brown v. United States*, No. 99-C-400-C (W.D. Wis. Oct. 22, 1999) (order denying appointment of counsel)) (emphasis added). The district court also reasoned that the plaintiff’s “inability to find counsel to represent him on a contingent fee basis would indicate his unlikelihood of success on the merits,” despite the reality that the ability to attract attorneys in malpractice cases is often a function of the potential for damages, which are obviously more limited for prison inmates. *Id.* Although the district court noted the “‘straightforward nature of the case’” for the purposes of the request for appointment of counsel, when it came to the question of the applicability of the common knowledge exception, the Seventh Circuit stated:

In order to determine whether the oral and intravenous administration of analgesics, in combination with the lithotripsy procedure, would satisfy the degree of care and skill required of a physician treating abdominal pain associated with Brown’s kidney stones and other medical conditions, a trier of fact would need to know precisely what degree of care and skill is required. The knowledge of a medical expert far outmatches that of a common layman for the purpose of establishing this standard. . . . [W]e agree with the district court’s interpretation of Brown’s complaint as a medical malpractice claim requiring him to provide expert testimony as to the standard of medical care he was owed.

*Id.* at 613–14. As if to underscore this “Catch-22,” the appeals court added that just because (in the court’s mind) the plaintiff’s “medical malpractice claim is a relatively simple one does not exempt it from the requirement . . . that he provide expert testimony to establish the standard of professional care and skill he was owed.” *Id.* at 614 n.1.

141. 381 F.3d 649, 652, 654–56 (7th Cir. 2004) (appointing counsel for the plaintiff).

matters even further, the courts are not even in agreement on whether pro se litigants are entitled to some leniency from the court.<sup>142</sup>

Health care providers who are the potential targets of malpractice claims also have an obvious stake in the scope and development of the common knowledge exception. They worry that the common knowledge exception might completely unfetter the dogs of war.<sup>143</sup> This in turn would add to the feared flood of malpractice litigation, with its economic consequences on the cost of medical malpractice liability insurances, for example,<sup>144</sup> and its potentially misallocative effect on where doctors, especially those in high-risk specialties, choose to practice medicine.<sup>145</sup> There are concerns that the common knowledge exception is inherently dangerous because it bypasses the participation of medical experts in the assessment of what may in reality be complex, polycentric matters of medical practice.<sup>146</sup> There is also fear that the essentially ad hoc approach to questions of the application of the common knowledge exception is a slippery slope threatening to gradually subsume the general expert-guided regime of assessing allegations of substandard medical care.<sup>147</sup> There is also the related concern that the common knowledge exception could bypass some of the special statutory restrictions on malpractice claims that many states have enacted and thus upset the hard-won law reforms.<sup>148</sup>

Finally, the broader and complex interests of society generally should be considered. On the one hand, members of society should be concerned about the common knowledge rule potentially increasing the incidence, costs, and uncertainty of medical malpractice cases. Malpractice cases are relatively inefficient vehicles for compensating supposed victims of medical

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142. Compare *McCall v. Dale*, No. 94,164, 2006 WL 463205, at \*7 (Kan. Ct. App. Feb. 24, 2006) (unpublished table decision) (noting that the plaintiff failed to sufficiently support, in accordance with the rules, his opposition to summary judgment, and responding to the plaintiff's argument "that the court should have been more lenient because he was acting pro se," by stating that "pro se litigants are held to the same standards as litigants represented by attorneys"), with *Delso v. Tr. for Ret. Plan for Hourly Employees of Merck & Co., Inc.*, No. 04-3009, 2007 WL 766349, at \*13 (D.N.J. March 6, 2007) ("Courts often extend the leniency given to pro se litigants in filing their pleadings to other procedural rules which attorneys are required to follow.") (citation omitted)).

143. See Theodore R. LeBlang, *The Medical Malpractice Crisis—is There a Solution?*, 27 J. LEGAL MED. 1, 7 (2006).

144. *Id.* at 3 (discussing the escalating premiums for medical malpractice liability insurance).

145. See Michelle M. Mello & Carly N. Kelly, *Effects of a Professional Liability Crisis on Residents' Practice Decisions*, 105 OBSTETRICS & GYNECOLOGY 1287, 1293 (2005) (reporting results from a survey of medical residents indicating that the malpractice environment, including the costs of liability insurance, significantly affects not only residents' "practice location decisions," but also that many residents plan to "limit the scope of their clinical practice to lower their insurance costs and limit their liability risk").

146. Cf. James A. Henderson, Jr., *Expanding the Negligence Concept: Retreat from the Rule of Law*, 51 IND. L.J. 467, 475 (1976) (describing the nature of similarly complex tort claims as "polycentric" due to "the non-linear way in which the issues in such problems are interrelated").

147. See *supra* note 143 and accompanying text.

148. Cf. Beth A. Buchanan Staudenmaier, Note, *Use of Restraints in the Hospital Setting: Is the Law a Help or Hindrance to the Advancement of Changing Medical Ideology?*, 22 U. DAYTON L. REV. 149, 162 (1996) (proposing legislation that would give deference to expert testimony in medical malpractice cases resulting from the use of physical restraints, and noting the medical profession's fear of liability when the common knowledge exception is applied in this context).

negligence when one considers the costs and resources expended in resolving and paying such claims, as well as the adverse effects on the overall practice of medicine by fostering wasteful defensive medicine and distracting the attention of health care providers.<sup>149</sup> To the extent that the common knowledge rule makes it easier and less expensive to pursue malpractice claims, an increase in such litigation would be a likely concomitant. The uncertainty surrounding the common knowledge rule seems increasingly to necessitate appellate intervention, thereby adding to the costs and delays in this already costly and time-consuming type of litigation.<sup>150</sup> So in one respect, application of the common knowledge exception could be seen as compounding the shortcomings of the malpractice cases by increasing their numbers. That fact alone, however, does not mean that we should invariably prefer proof by expert over the application of common knowledge. Society also has an interest in the integrity of the adjudicatory process for resolving malpractice claims. While a requirement for expert testimony admittedly may inhibit the growth of malpractice cases, there are also dangers in overreliance on medical experts selected, paid, and prepared for trial by the parties. There are not only the obvious risks of bias and lack of objectivity, but also the danger that the outcome of cases may too often depend on the experts' success in marketing their clients' side, or, at least, in selectively presenting the case or obfuscating the medicine rather than in objectively educating the triers of fact and facilitating a just resolution of the matter.

The current hired-expert-based system for establishing the professional standard of care in malpractice litigation is far from perfect.<sup>151</sup> Under the current approach, malpractice cases are generally resolved within the adversary system with medical experts, selected and paid by the parties, who provide the jury with opinions on the relevant professional standards and whether they were satisfied or breached.<sup>152</sup> This has led to calls by some commentators suggesting alternatives, including using of neutral or court-appointed experts<sup>153</sup> or basing the standard of care on or at least allowing consideration of: clinical practice guidelines, empirical evidence or surveys of physician practices,<sup>154</sup> epidemiological data and statistics,<sup>155</sup> profession-

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149. See, e.g., Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q. J. ECON. 353, 354, 388 (1996) (noting both the perceived threat of malpractice liability may prompt physicians to order or administer costs, tests, and treatments and the adverse effects of such "defensive medicine" on both medical costs and on patient health outcomes).

150. See Cramm et al., *supra* note 27, at 714–17 (explaining the rise of litigation costs and the inefficiency of the malpractice system).

151. See David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 N. ENG. J. MED. 2024, 2031 (2006) (finding that "[o]ne in six claims involved errors and received no payment," and that "the average time between injury and resolution was five years, and one in three claims took six years or more to resolve. These are long periods for plaintiffs to await decisions about compensation and for defendants to endure the uncertainty, acrimony, and time away from patient care that litigation entails.").

152. See generally FURROW ET AL., *supra* note 37, at 185–293.

153. Samuel R. Gross, *Expert Evidence*, 1991 WIS. L. REV. 1113, 1187–1208, 1220–31.

154. See Cramm et al., *supra* note 27, at 750; Michelle M. Mello, *Using Statistical Evidence to Prove the Malpractice Standard of Care: Bridging Legal, Clinical, and Statistical Thinking*, 37 WAKE FOREST

ally developed norms of practice,<sup>156</sup> and a variety of other reform directions.<sup>157</sup> There is indeed reason to doubt the integrity of the current battle-of-hired-experts model. And this is not a new concern. A treatise written more than a century and a half ago by Judge John Pitt Taylor said that of the types of witness whose testimony should be viewed with care, the testimony of “skilled witnesses”<sup>158</sup> headed the list. Fast forward to the present, and we can find other judges echoing Judge Taylor’s misgivings. One comments that “the current practice of relying upon adverse expert opinion testimony alone to establish the standard is primitive, crassly subjective, and prone to exploitation, if not actual corruption.”<sup>159</sup> Professor Samuel Gross has explained the dangerous dynamic when a confection of testimony by experts sponsored by the opposing parties is served to juries. The fact that such expert opinion testimony “is almost infinitely malleable,”<sup>160</sup> and that “expert witnesses are paid witnesses”<sup>161</sup> leads to untoward consequences:

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L. REV. 821, 823–24 (2002); Peters, *Empirical Evidence*, *supra* note 27, at 774. For a summary of shortcomings of this type of potential reform, see Thomas Penfield Jackson, *Observations on the Search for Objective Proof of the Standard of Care in Medical Malpractice Cases*, 37 WAKE FOREST L. REV. 953, 953–54 (2002).

155. See Jackson, *supra* note 154, at 953–54; William Meadow, *Operationalizing the Standard of Medical Care: Uses and Limitations of Epidemiology to Guide Expert Testimony in Medical Negligence Allegations*, 37 WAKE FOREST L. REV. 675, 695–98 (2002).

156. See Blumstein, *supra* note 31, at 1038–46, 1049 (recommending use of federally endorsed Quality Improvement Organizations through federal QIO legislation to “establish practice standards that become the standards of care” that would “trump state-created standards by conferring immunity for conduct in compliance with the QIO standards”).

157. B. Michael Dann, *Jurors as Beneficiaries of Proposals to Objectify Proof of the Standard of Care in Medical Malpractice Cases*, 37 WAKE FOREST L. REV. 943, 945, 945 nn.6–8 (2002) (identifying a number of reforms relating to the role of juries at trial); Gross, *supra* note 153, at 1213–19 (discussing various potential directions for reform, including changing the manner and presentation of expert evidence, subjecting expert opinions to external peer review scrutiny, presenting expert opinions in written form, and having the judge supplant the jury with respect to some matters and expert issues). See generally Nancy S. Marder, *The Medical Malpractice Debate: The Jury as Scapegoat*, 38 LOY. L.A. L. REV. 1267, 1281–82 (2005) (discussing reforms directed at the role of juries in civil cases generally).

158. Gross, *supra* note 153, at 1114 (quoting JOHN PITT TAYLOR, TREATISE ON THE LAW OF EVIDENCE §§ 45-50, at 65–69 (3d ed. 1858) (stating that “[p]erhaps the testimony which least deserves credit with a jury is that of skilled witnesses . . . [I]t is often quite surprising to see with what facility, and to what extent, their views can be made to correspond with the wishes and interests of the parties who call them.”)).

159. Jackson, *supra* note 154, at 953. A retired judge had this to say:

Widespread criticism has been leveled at the usual way of proving up a party’s version of the standard of care in medical malpractice cases, that is, through opinion testimony by carefully preselected and highly paid medical experts. Most surveyed judges and many students of the litigation process decry the lack of objectivity of party-retained experts, their low rate of accuracy, their high cost, their frequent lack of firsthand knowledge about the phenomena at issue, and their faulty memories. Moreover, conflicting expert testimony too often leaves lay juries with the difficult task of deciding which expert to believe and how much weight to give their opinions.

B. Michael Dann, *Jurors and the Future of “Tort Reform,”* 78 CHI.-KENT L. REV. 1127, 1132–33 (2003) (footnotes omitted).

160. Gross, *supra* note 153, at 1129; see also Meadow, *supra* note 155, at 688 (“Even among physicians who are likely to be viewed as experts, there may be a wide range of opinions about the standard of care, and the spectrum of opinions often differs significantly from actual practice.”).

161. Gross, *supra* note 153, at 1129.

This process of selecting expert witnesses has several major consequences, most of them bad. The most important is that expert witnesses are too readily available. If eyewitness testimony is inconsistent with a party's theory of liability for a car crash, the issue may have to be conceded. . . . [T]his is rarely necessary for expert issues . . .

Because experts are paid to testify, and because they can be hired repeatedly to work on cases with similar or identical issues, they can become professional witnesses. Many do just that—

they advertise their services (a practice that is unimaginable for lay witnesses), and earn substantial sums from this line of work.<sup>162</sup>

There are strong influences on experts that pose a substantial risk of biasing their opinions in favor of the party who hired them. Experts are not only selected,<sup>163</sup> hired, and paid<sup>164</sup> by a party (under the guidance of his attorney), but thereafter those witnesses work with the attorney (or team of attorneys) as they prepare for trial.<sup>165</sup> As Gross observes, “[t]his type of preparation, perhaps even more than the processes of choice and payment, pushes the expert to identify with the lawyers on her side and to become a

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162. *Id.* at 1129–31.

163. *See* Drapp, *supra* note 33, at 125. Drapp believes that the replacement of a narrow geographic frame of reference for the standard of care with a broader construct that often is defined in terms of national standards has contributed to the problem of expert witness shopping. *Id.* at 125–26 (stating that “witness shopping” becomes much easier as the opportunities for selectivity in choice of witness grows with the enlarging parameters of the geographic frame of reference). Such expert witness shopping contributes to a lack of predictability, and health care providers become “preoccupied with thoughts about whether the actions they take will lead to medical malpractice suits in which the plaintiff patient will bring in an out-of-town doctor to testify to a standard of care that really is not applicable in the first place, but is in fact legally applicable because of a supposed national standard of care.” *Id.* at 129.

Statutes may occasionally provide for potential immunity or limit liability for conduct conforming to certain formally and professionally developed norms of patient care, at least when due care is exercised in complying with or relying upon those standards. *See* Blumstein, *supra* note 31, at 1038–44. It does not appear, however, that such potential specific ex ante standard setting has had a significant impact to date on the standard of care in malpractice claims. *Id.* at 1040; ALICE G. GOSFIELD, 2 HEALTH LAW PRACTICE GUIDE § 25:35 (2006) (“In a provision which although never used to date in a reported malpractice case may yet prove to be highly significant, the [federal] statute provides that no practitioner and no provider can be held civilly liable under the laws of the United States or of any state on account of his compliance with or reliance upon the QIO’s [Quality Improvement Organization’s] standards, provided that he exercised due care in applying them to the patient’s circumstances.”); *cf.* Jodi M. Finder, *The Future of Practice Guidelines: Should They Constitute Conclusive Evidence of the Standard of Care?*, 10 HEALTH MATRIX 67, 103 (2000) (“A strong argument can be made that where a guideline applies to the clinical situation at issue and the physician follows it with the due care of a reasonably prudent physician in similar circumstances, then the statute could provide complete protection from malpractice liability. This possibility has not yet been tested judicially.”).

164. Michelle M. Mello, *Of Swords and Shields: the Role of Clinical Practice Guidelines in Medical Malpractice Litigation*, 149 U. PA. L. REV. 645, 702 (2001) (“Expert witnessing has become a profession in and of itself, with ‘hired guns’ available for rent to the highest bidder. The sometimes-enormous fees paid to medical experts create reason to doubt their objectivity.”) (footnote omitted).

165. *See* Gross, *supra* note 153, at 1131.

partisan member of the litigation team.”<sup>166</sup> This leads to polarization into “warring extremes . . . set against each other.”<sup>167</sup> It may also foster a spiraling expert arms race. Gregory Bateson called this type of phenomenon “symmetrical schismogenesis.”<sup>168</sup> Deborah Tannen described it as occurring when “each person does more and more of the same thing in reaction to the other.”<sup>169</sup> Bateson notes that symmetrical struggles may escalate, reflecting “potentially pathological developments . . . due to undamped or uncorrected positive feedback in the system.”<sup>170</sup>

The dangers of expert testimony biased in favor of the party hiring and paying the expert is potentiated when used in conjunction with the doctrine of *res ipsa loquitur*. With garden-variety circumstantial proof, the plaintiff still generally posits specific negligent acts or untaken precautions. With *res ipsa*, however, the plaintiff does not have to specify in what respects the defendant’s conduct was negligent, or in other words, identify specifically what it was that the defendant did or failed to do that constituted negligence.<sup>171</sup> Once the preconditions of *res ipsa* are satisfied, the jury is permitted to find negligence from the mere occurrence of the injury.<sup>172</sup> In the past, use of *res ipsa loquitur* in the medical malpractice setting was mostly restricted to common knowledge situations. But, that has changed, and now a majority of states allow the doctrine to be used in conjunction with expert testimony to support the conclusion that the type of injury suffered by the patient was more likely than not the result of negligent conduct by the de-

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166. *Id.* at 1139.

167. DEBORAH TANNEN, *THE ARGUMENT CULTURE* 131 (1998) (discussing how the adversary system reduces complex human problems to just two sides). Professor Tannen writes:

The American legal system is a prime example of trying to solve problems by pitting two sides against each other and letting them slug it out in public. It reflects and reinforces our assumption that truth emerges when two polarized, warring extremes are set against each other.

*Id.* at 131.

168. GREGORY BATESON, *NAVEN* 177 (2d ed. 1958). Bateson describes schismogenesis “as a process in which each party reacts to the reactions of the other.” *Id.* at 189. He offers the following example of the progressive change he calls symmetrical schismogenesis: “If . . . we find boasting as the cultural pattern of behaviour in one group, and that the other group replies to this with boasting, a competitive situation may develop in which boasting leads to more boasting, and so on.” *Id.* at 176–77. He also points out that if the symmetrical pattern sets in and becomes more and more emphasized by schismogenesis, “it is likely that the personalities of the individuals concerned will undergo some sort of distortion with over-specialisation in some one direction.” *Id.* at 187. For later elaboration, see GREGORY BATESON, *STEPS TO AN ECOLOGY OF MIND* 108–09, 324 (Univ. Chicago Press 2000) (1972).

169. TANNEN, *supra* note 167, at 165 (discussing the pernicious effects of the escalating tactics of attorneys).

170. BATESON, *STEPS TO AN ECOLOGY OF MIND*, *supra* note 168, at 324.

171. DOBBS, *supra* note 37, at 370.

172. Professor Dobbs refers to the “core” of *res ipsa* as follows:

[T]he jury is permitted to infer that the defendant was negligent in some unspecified way when, on the evidence adduced, experience indicates (1) that the injury was probably the result of negligence, even though the exact nature of that negligence is unknown, and (2) that it was probably the defendant who was the negligent person.

*Id.* at 371. He explains that *res ipsa* goes beyond your typical circumstantial evidence because in the typical circumstantial evidence case, “plaintiff’s evidence . . . must point to specific conduct of the defendant, as where long skid marks circumstantially prove high speed. In contrast, *res ipsa loquitur* cases permit the jury to infer negligence without knowing any particular misconduct at all.” *Id.* at 372.

pendant.<sup>173</sup> This combination of *res ipsa loquitur* and the use of paid experts selected and hired by the parties presents a potent and dangerous brew, one subject to manipulation and abuse. That danger may be another good reason not to force malpractice victims to go the expert witness route in legitimate common knowledge situations.

Furthermore, expert witness, like all fallible human beings, are subject to a variety of cognitive biases.<sup>174</sup> There are also inherent and systemic reasons for caution against over-reliance on experts. Once these experts are obtained, paid, and prepared, they ultimately may engage in the “expert witnesses duel.”<sup>175</sup> But, there is a real question whether there exists a readily discernible accepted professional practice that even a fully objective expert could draw upon for his opinion. One recent commentary noted:

The difficulty with this system is that it rests on a false assumption. Physicians simply do not know how other physicians practice medicine. Even in those instances when a significant percentage of physicians respond to a common problem in the same way, they are unlikely to know that that is the case. . . . Given the variations in clinical practice . . . we should not be surprised that malpractice cases involve adversarial experts who testify to conflicting standards as “customary” care. Even without the distortions of expert testimony that the adversarial system produces, the freedom to select one’s experts provides ample opportunity to obtain supportive expert testimony in malpractice cases. We, thus, should not be surprised at the poor job the medical malpractice system does of identifying meritorious cases for entrance into the system.<sup>176</sup>

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173. States v. Lourdes Hosp., 792 N.E.2d 151, 154 (N.Y. 2003).

174. Mello, *supra* note 154, at 824. Mello notes that “even the most honest expert is prone to a range of cognitive biases.” She comments:

Recall bias is a particular problem: when asked about past events, Meadow and Lantos note that experts suffer from the human tendency to “consistently underestimate large numbers, overestimate small numbers, and skew responses in favor of outcomes deemed, in retrospect, more appropriate or desirable.” Also troubling is the optimistic bias that people tend to exhibit in predicting outcomes.

*Id.* at 824 (quoting William Meadow & John Lantos, *A Proactive, Data-based Determination of the Standard of Medical Care in Pediatrics*, 101 PEDIATRICS 1, 3 (1998)).

175. Meadow, *supra* note 155, at 677.

176. Cramm et al., *supra* note 27, at 700; *see also* Mello, *supra* note 154, at 825; Peters, *Empirical Evidence*, *supra* note 27, at 772. Mello observes:

[T]here exists a large and growing body of data on physician practice patterns that is not presently used in malpractice litigation. Exclusive reliance on expert opinion may have been justifiable at a point in history when there was no better information available, but is more difficult to defend in an era when health services researchers are publishing empirical studies of physician behavior at a rapid pace and when medicine itself is becoming increasingly evidence-driven.

Mello, *supra* note 154, at 824. Mello continues:

Processes of medical care vary tremendously in their degree of complexity and the amount of clinical discretion and individualized assessment involved. Some processes, such as cardiopulmonary resuscitation, lend themselves naturally to standardized care algorithms. Others . .

Similarly, Professor Blumstein has commented that “the existence of clinical uncertainty as reflected in variable practice data calls into question the infrastructure of medical malpractice law.”<sup>177</sup>

This system at best threatens to alienate, confuse, and frustrate jurors.<sup>178</sup>  
At worst, it threatens to mislead them, causing a miscarriage of justice.<sup>179</sup>

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. . . may proceed along radically different pathways according to the specialty of the provider, the organizational setting in which care is rendered, the patient’s medical history, and past interactions between the provider and the patient.

*Id.* at 845. Dean Peters notes:

In the past few decades, medical researchers have learned that clinical practices vary dramatically and inexplicably. . . . Many factors combine to produce this variation. The most important factor is uncertainty. This uncertainty arises out of the “bewildering variety of individual characteristics, histories, signs, symptoms, and behaviors” and the limited information about the efficacy and risks of possible treatments, both at the population level and at the level of these widely different patients. . . . This variation in patients is matched by a similar variety in possible therapeutic responses, each with its own mix of benefits, risks, and costs.

Peters, *Empirical Evidence*, *supra* note 27, at 772 (quoting David M. Eddy, *The Use of Evidence and Cost Effectiveness by the Courts: How Can It Help Improve Health Care?* 26 J. HEALTH POL. POL’Y & L. 387, 391 (2001)).

177. James F. Blumstein, *The Legal Liability Regime: How Well Is It Doing in Assuring Quality, Accounting for Costs, and Coping With an Evolving Reality in the Health Care Marketplace?*, 11 ANNALS HEALTH L. 125, 137 (2002) (footnote omitted); *see also* Blumstein, *supra* note 31, at 1027. He explains further:

Under current medical malpractice doctrine, therefore, controlling professional standards are set or at least operationalized *ex post* by selectively drawn expert witness testimony—not by a process in which a known organization systematically establishes in advance a standard of practice that governs the determination of liability. This after-the-fact process of professional standard-setting creates structural uncertainty—the uncertainty imposed by the liability system attributable to this *ex post* method of determining liability. . . . The uncertainty of the standards places medical practitioners in the uncomfortable position of not knowing what is expected or what is required to avoid liability. The cost implications of such uncertainty and the costly steps necessary to overcome that uncertainty may be substantial, as the defensive medicine account of cost escalation asserts.

*Id.* at 1028–29. Blumstein adds that in the face of uncertainty physicians can be expected to adjust their conduct for the risk of liability “resulting in excessively costly practice behavior. The prevalence of third-party payment for medical care makes this type of adaptive behavior on the part of providers easier to effectuate, thereby posing an especially significant resource allocation concern.” *Id.* at 1031.

178. *See* Dann, *supra* note 157, at 945 nn.6–8; Mello, *supra* note 154, at 702. Dann writes:

Widespread criticism has been leveled at the overwhelmingly predominant way of proving a party’s version of the standard of care in medical malpractice cases; that is, through expert opinion testimony by carefully pre-selected and highly paid medical experts. Most surveyed judges, and many students of the litigation process, decry the lack of objectivity of party-retained experts, their low rate of accuracy, their high cost, the frequent lack of firsthand knowledge about the phenomena at issue, and their faulty memories. Moreover, conflicting expert testimony too often leaves lay juries with the difficult task of deciding which expert to believe and how much weight to give their opinions.

Dann, *supra* note 157, at 947. Similarly, Mello observes:

Even if experts maintain the highest level of scientific integrity and offer genuine and thoughtful opinions, there is some doubt as to whether lay juries are able to evaluate competently the competing opinions of more than one expert. They may not understand the complicated information conveyed to them at trial. They also may not know how to choose between two seemingly well-qualified experts who have reached opposite conclusions. There is some evidence that jurors may choose to believe one expert over the other on the basis of factors irrelevant to the scientific merit of their opinion, such as the expert’s appearance, tone, and demeanor.

Mello, *supra* note 154, at 702.

179. *See* Lempert, *supra* note 32, at 917 (“A system which allows the parties to choose witnesses and to pay them well if they are willing to say what the party wants the jury to hear is not well-designed to get at the truth. The problem is compounded when experts give opinions rooted more in subjective

There is also the risk that jurors will be influenced by the source of the expert testimony instead of its persuasiveness.<sup>180</sup> Another unfortunate consequence of hiring and using one's own expert witnesses is that "it breeds contempt all around."<sup>181</sup>

### III. SUGGESTED FORMULATION

Ideally, the courts should develop an approach to the common knowledge doctrine that not only is sensitive to the preceding concerns, but that also offers more predictability and meaningful guidance. I believe that: the common knowledge exception should in principle be retained as an option for the courts. At the same time, I recognize that the common knowledge exception, as traditionally applied, represents an ill-defined, shadowy concept that, just as the proverbial camel's nose, if left to evolve ad hoc and extemporaneously could gradually subsume the general requirement of expert proof of the relevant professional standards and thus largely occupy the tent.

The common knowledge exception is a reification of what Robert Cover called the "agonistic character of law,"<sup>182</sup> the penchant of the parties through their attorneys to "search for and exploit any part of the structure that may work to their advantage."<sup>183</sup> The challenge requires wrestling with the idiomatic devil in the details; it is to formulate a meaningful common knowledge construct, one that goes beyond the traditional, unguided, case-by-case analysis of the common knowledge issues. That challenge is formidable. It springs from the almost infinite variation in the underlying circumstances and factual nuances of each alleged common knowledge situation.

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experience than in well-established scientific theories or reliable empirical data, and when jurors' backgrounds do not help them identify the more accurate of two competing experts.").

180. As Steven Pegalis observes:

When the emphasis is placed on the credibility and qualifications of the individual expert rather than the credibility of the medical information, the true purpose of the expert testimony may be lost. The jury might decide the case based on which expert they like and which experts they dislike, rather than on the substantive medical information.

Pegalis, *supra* note 15, at 259.

181. Gross, *supra* note 153, at 1135. Professor Gross explains:

The contempt of lawyers and judges for experts is famous. They regularly describe expert witnesses as prostitutes, people who live by selling services that should not be for sale. They speak of maintaining "stables" of experts, beasts to be chosen and harnessed at the will of their masters. . . . On the other side, some of the best experts in many fields have a contempt for legal proceedings that goes beyond the low regard for law and lawyers that is common in our society. They believe, correctly, that experts who agree to testify are subject to strong pressures to become partisans of the side that calls them. They also feel (again correctly) that not only is the process of providing evidence difficult and time consuming, but that they are treated in a demeaning manner, and that their evidence is poorly used. As a result, these experts refuse to be witnesses, leaving the field to those with fewer scruples or fewer options.

*Id.* at 1135–36.

182. Robert M. Cover, *Violence and the Word*, 95 YALE L.J. 1601, 1623 (1986). Arthur Leff's classic essay developed the metaphor of the law and the trial as an "agonistic game." See Arthur Allen Leff, *Law and*, 87 YALE L.J. 989, 1003, 1009 (1978); see also Bruce A. Ackerman, *Agon*, 91 YALE L.J. 219, 221 (1981).

183. Cover, *supra* note 182, at 1623.

There is also an inherent theoretical circularity here. How, after all, do non-medically-trained judges know that the conduct that produced an iatrogenic or other health care related injury can be evaluated with “common knowledge” for which expert testimony is supposedly not needed, without expert testimony to guide, educate, and confirm that conclusion?

I propose a construct of two alternative preconditions, the presence of *at least one* of which should be present before a court would be allowed discretion to go on to hold that the common knowledge exception was applicable allowing a plaintiff to proceed with his medical malpractice case without presenting expert testimony on the relevant professional standard of care and its breach:

- a. The specific conduct that allegedly constituted negligence was of such a nature that not only could an unlicensed layperson legally perform it without violating or offending applicable medical or health care licensure statutes or duly authorized regulations governing the practice of the health care professions, but also that such an unlicensed layperson would ordinarily be deemed competent and foreseeably expected to routinely perform such conduct; or,
- b. The specific decision making by the health care provider that allegedly constituted negligent conduct that caused the injury in question did not involve the exercise of uniquely professional medical skills, a deliberate balancing of medical risks and benefits, or the exercise of therapeutic judgment.

The fact that a plaintiff satisfies one of the preceding preconditions would not guarantee ipso facto that the court would apply the common knowledge exception. Rather, it would merely make it permissible for the court to do so based on its sense of the plaintiff’s allegations and the other information developed in the case. Of course, even if the court does go on to hold that the common knowledge exception is applicable, that does not necessarily mean that the plaintiff would ultimately prevail on the merits. The plaintiff would first have to prove each of the necessary elements, including that the defendant breached the standard of reasonable care.

Let me elaborate briefly on the threshold preconditions that at least one of which should be required to permit the court to apply the common knowledge exception. The first alternative requires that the conduct in question have been of such a nature that an unlicensed layperson could lawfully, foreseeably, and competently perform it. Obviously, if the relevant statutes or regulations prohibit the performance of the conduct in question by a person who does not possess a relevant license, then lay judges and jurors ordinarily will not be in a position to assess the level of medical care that the defendant health care professional delivered. It also recognizes that occasionally there may be a course of action for which a license is not required but that unlicensed lay persons nevertheless would ordinarily not be quali-

fied by training or otherwise to routinely undertake nor would they foreseeably be expected to routinely do so. In this latter situation, even though a license may not have been required in a particular jurisdiction for some health care activities, nevertheless the allegedly negligent conduct may have been sufficiently complex that expert testimony should still be required to evaluate it. Thus, under my proposed criteria, merely because a person need not have been licensed to perform the actions in question should not ipso facto be deemed to alloq application of the common knowledge exception, unless the court also found that a layperson would ordinarily be competent, by training or otherwise, to perform and foreseeably be expected to perform the actions.

In the case of *Ference v. V.I. Family Sports & Fitness Center, Inc.*,<sup>184</sup> the plaintiff was referred by her physician to the defendant, a rehabilitation center, for physical therapy due to cardiovascular problems and back pain.<sup>185</sup> On the day of her accident, after the plaintiff arrived at the center, an athletic trainer took her blood pressure and then directed her to the treadmills to begin her therapy.<sup>186</sup> The trainer did not accompany or assist the plaintiff to the treadmill, nor did he set the speed of the treadmill.<sup>187</sup> The plaintiff mistakenly set the speed of the treadmill dangerously high, was unable to keep up with the speed of the treadmill, and fell.<sup>188</sup> She alleged that the defendant was negligent in failing to supervise her treatment by “leaving her alone on the treadmill.”<sup>189</sup> One issue was whether the claim constituted “malpractice” for the purposes of the special procedural requirements of the Malpractice Act.<sup>190</sup> Despite the fact that the athletic trainer may not have been licensed to practice physical therapy (the opinion is unclear), the court held that “determination of Plaintiff’s negligence claim cannot be evaluated by a layperson with common knowledge.”<sup>191</sup> The court stated that:

Specialized knowledge is required to determine whether or not the Defendant deviated from the standard practice or care of a rehabilitation facility, such as whether it is proper to allow a patient to set the speed of a treadmill herself for her physical therapy, whether it is proper to allow employees not licensed to practice physical therapy to administer the actual therapy prescribed by a physician, or

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184. No. Civ. 657/2002, 2004 WL 626280, at \*5 (V.I. Feb. 23, 2004).

185. *Id.* at \*1.

186. *Id.* at \*2.

187. *Id.*

188. *Id.*

189. *Id.*

190. *Id.* at \*1.

191. *Id.* at \*5. The opinion is unclear whether the trainer was licensed as an athletic trainer, or whether such occupations are licensed.

whether failing to assist or monitor a patient while she is undergoing treatment is improper.<sup>192</sup>

Thus, even if the athletic trainer was not required to be licensed as a therapist, the first precondition's satisfaction would depend on whether the court found that the conduct of the trainer was something an unlicensed layperson would ordinarily be competent and foreseeably expected to routinely do for patients in the condition of the plaintiff.

In addressing the alternative preconditions, it is important to frame the question not simply in terms of the conduct and decision making of the defendant in isolation, but rather with reference to the specific medical condition of the victim. Consider *Cunningham v. Riverside Health System, Inc.*<sup>193</sup> The patient was recovering from knee replacement surgery caused by a weakened bone condition and was receiving post-surgery care in a skilled nursing unit of the defendant hospital.<sup>194</sup> She alleged:

[A] . . . nursing assistant . . . negligently twisted Cunningham's [the plaintiff's] leg while assisting her into bed, causing her femur to break. . . . Cunningham testified that after [nursing assistant] Profit assisted her into bed, Cunningham asked Profit to move her leg into a position recommended by the treating physician . . . . Profit "gave too hard of a tug" and raised Cunningham's leg off the bed, at which time she felt her leg "crack," and she yelled out. At that point, Profit dropped Cunningham's leg 16 inches onto the bed . . .<sup>195</sup>

In affirming summary judgment for the defendant, the court of appeals noted that at the time of the incident the patient had been diagnosed with "advanced degenerative joint disease,"<sup>196</sup> and "severe osteoarthritis with chronic synovitis and synovial cyst with areas of bone reabsorption,"<sup>197</sup> and

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192. *Id.*; see also *Baptist Healthcare Sys., Inc. v. Miller*, 177 S.W.3d 676, 680 (Ky. 2005). In *Baptist*, the eighty-year-old plaintiff went to defendant's hospital "to have blood drawn upon her doctor's order." *Id.* at 677–78. Plaintiff alleged that a phlebotomist employed by the hospital placed a tourniquet on her arm, left her without supervision for approximately ten minutes to answer a telephone call, and, when the phlebotomist returned, the plaintiff's arm had swelling, discoloration, and nerve problems. *Id.* at 678. The court held that the alleged negligence was not within the common knowledge exception:

Simply because having blood drawn is not uncommon or because such activity is unlicensed and unregulated does not mean that a jury would necessarily understand the specifics of the activity or the standard of care upon medical personnel, including phlebotomists, who draw blood. Other jurisdictions utilize expert testimony to aid the trier of fact in determining the standard of care in cases of harm caused by an improper blood draw. As the standard of care is not within the scope of common experience of jurors, requiring expert testimony as to the standard of care of a phlebotomist was a proper exercise of trial court discretion.

*Id.* at 680–81.

193. 99 P.3d 133 (Kan. Ct. App. 2004).

194. *Id.* at 135.

195. *Id.*

196. *Id.*

197. *Id.*

that the hospital staff was aware of her condition. The court concluded “[b]ased on these circumstances,”<sup>198</sup> that “expert testimony was necessary to show a breach of the standard of care.”<sup>199</sup>

It is instructive to compare the *Cunningham* case with *Lawrence v. Frost Street Outpatient Surgical Center, L.P.*<sup>200</sup> Following an outpatient hernia repair at defendant’s surgical center and discharge, the plaintiff fell while the defendant’s employee was helping him transfer from a wheelchair into his car.<sup>201</sup> Plaintiff alleged that, as he attempted to stand with assistance, the employee failed to properly assist him in exiting the wheelchair and entering the parked vehicle causing him to fall and fracture his leg.<sup>202</sup> On the one hand, the court held that without expert testimony, the plaintiff could not prove that he was prematurely discharged.<sup>203</sup> But, at the same time, it held that plaintiff’s other theory—that the defendant’s employee failed to properly assist his transfer from the wheelchair—was within the common knowledge exception.<sup>204</sup> The court explained that “[a] layperson can apply common knowledge to evaluate how to safely transfer a patient with a numb leg from a wheelchair to a vehicle after outpatient surgery. *This is something ordinary individuals, untrained in the medical profession, do on a regular basis when picking up family and friends after surgery.*”<sup>205</sup> The difference in the two cases can be reconciled under the first precondition, as stated above. While helping a frail person to move in bed may be something lay persons routinely do, that is not so when the person attended is in the kind of precarious post-surgical orthopedic status we find in *Cun-*

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198. *Id.* at 138 (emphasis added).

199. *Id.*; see also *Cooksey v. HCA Health Serv. of Tenn., Inc.*, No. M2001-00303-COA-R3-CV, 2001 WL 1328539 (Tenn. Ct. App. Oct. 30, 2001); cf. *Campins v. Spectrum Health Downtown Campus*, No. 247024, 2004 WL 2009264, at \*1 (Mich. Ct. App. Sept. 9, 2004) (holding that where a hospitalized patient with a broken pubic bone was alleging defendant’s employee negligently assisted her moving from the bathroom to her bed, that “[t]he act of assisting a patient *in plaintiff’s condition* in moving required training and the exercise of medical judgment to minimize discomfort and to guard against further injury,” and thus required proof of expert testimony) (emphasis added). But see *Taliaferro v. S. Pointe Hosp.*, No. 86999, 2006 WL 832510, at \*3 (Ohio Ct. App. Mar. 30, 2006) (holding where a hospital patient with multiple sclerosis, seizures, frequent falls, impaired balance, left lower limb weakness, progressive decline in function, and increased spasticity, who allegedly fell three times the day she was admitted, after being left unattended in the bathroom, and after she got out of her bed on her own to walk to the bathroom, the “case falls within the common knowledge exception”).

In *Cooksey*, the patient alleged that two nurses, who were attempting to move her in her bed after lumbar laminectomy, “injured her shoulder by using excessive force or an improper procedure . . . [and] partially tore a drainage tube from her back causing her to develop an infection.” *Cooksey*, 2001 WL 1328539, at \*1. The court of appeals held that “[t]he proper way to move or turn a patient *who has undergone a serious back operation* is not within the ken of ordinary laypersons. Therefore the negligence of the hospital employees must be established by expert proof.” *Id.* at \*2 (emphasis added). Although a layman can help another person move in bed, may do so without a medical license, and commonly does so—that may not be so when the person assisted underwent highly invasive back surgery two days earlier.

200. No. D042108, 2004 WL 2075401, at \*5 (Cal. Ct. App. Sept. 17, 2004).

201. *Id.* at \*1.

202. *Id.*

203. *Id.* at \*4 (“A layperson cannot be expected to know the criteria used in the medical profession to ascertain when it is medically safe to discharge a patient after surgery. . .”).

204. *Id.* at \*5.

205. *Id.* (emphasis added).

*ningham*.<sup>206</sup> Thus, *Cunningham* was not a matter properly within the scope of a layman's common knowledge. On the other hand, in *Lawrence*, the court specifically found that helping an outpatient move from a wheelchair to the car following outpatient surgery was what family and friends regularly do.<sup>207</sup>

Satisfying the second alternative precondition would allow a court to apply the common knowledge rule even when the medical procedure was required to be performed by licensed health care professionals or at least was one not routinely expected to be performed by non-medical personnel. If the specific decision making by the health care provider that caused the injury did not involve the exercise of professional skills, a balancing of costs and benefits, or the exercise of therapeutic judgment, the court would have discretion to apply the common knowledge rule on the standard of care question. In addressing the second precondition, it is crucial for the court to focus precisely on the specific decision making that was allegedly negligent. For example in *Dugas v. Massiha*,<sup>208</sup> the patient testified that, as the nurse was removing the sutures from her eyelid, she had difficulty removing one stitch and obtained a different set of tweezers from a container of Cidex disinfectant. The nurse allegedly dripped some of the disinfecting agent from the new tweezers into the patient's eye causing a chemical burn. The court held that "expert medical testimony was not required to prove negligence in this case."<sup>209</sup> That holding is consistent with the second precondition. The specific decision making by the health care provider and therefore the appropriate focus of the court did not relate to expertise and medical decision making in removal of surgical sutures or stitches generally. Rather, it more narrowly entailed simply making sure the tweezers held over the patient's eyes were not dripping Cidex.

Sedulous application of the second precondition, focusing precisely on the specific decision making by the health care provider, may serve to separate cases that warrant different outcomes on the common knowledge question, but that on superficial analysis might seem to involve a similar type of occurrence. Consider two cases from the same jurisdiction involving a fall by the patient. In *Harvey v. Wolfer*,<sup>210</sup> the patient alleged that after she had received an injection, and while she was being actively assisted by defendant-osteopathic physician, she ended up on the floor.<sup>211</sup> In her lawsuit

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206. See *supra* text accompanying notes 193–199.

207. 2004 WL 2075401, at \*5.

208. 934 So. 2d 878, 882 (La. Ct. App. 2006).

209. *Id.*

210. No. 03A01-9512-CV-00452, 1996 WL 94819 (Tenn. Ct. App. Mar. 6, 1996).

211. Defendant testified that following an injection:

[The patient] became nauseous and experienced numbness in her legs while sitting on an examination table. A wheelchair was provided for [the patient] because a gurney was too large for the room. But [the patient] never made it to the wheelchair. She began to fall forward and the defendant, with an assistant, "sat her on the floor." During this time interval, [the patient's] legs were numb, and the defendant testified "when she did a twisting motion her foot got twisted under her," resulting in a fractured ankle.

against the osteopathic physician, the plaintiff testified that the defendant and an assistant “either let go or dropped me.”<sup>212</sup> The court of appeals, properly focusing on the specific conduct and decision making alleged to be negligent, held that “[t]he plaintiff testified that the defendant dropped her, an act not implicative of medical science and, one that may be assessed on the basis of common experience.”<sup>213</sup> In short, the case was a matter of common knowledge because dropping someone on the floor (under the second alternative precondition) did not involve the exercise of uniquely professional medical skills, a balancing of costs and benefits, or the exercise of therapeutic judgment.

By way of contrast, consider *McBee v. HCA Health Services of Tennessee, Inc.*<sup>214</sup> The patient was injured in a fall two days after a hysterectomy.<sup>215</sup> One of the patient’s registered nurses attempted to ambulate her.<sup>216</sup> The first attempt in the morning was discontinued when the patient became dizzy and ill.<sup>217</sup> A second attempt at ambulation occurred in the afternoon, during which the patient got out of bed and then fell, fracturing her ankle.<sup>218</sup> She alleged that her nurse had negligently permitted her to ambulate without adequate assistance and support.<sup>219</sup> The court of appeals held that the attending nurse’s alleged conduct was “not so plainly negligent that it obviates the necessity of expert proof.”<sup>220</sup> The court reasoned that even based on the plaintiff’s version of the facts, “this case does not involve a circumstance in which hospital personnel undertook to help a patient and then ‘dropped’ her. The assessment of a surgical patient’s post-operative ability to ambulate and the choice of the method of ambulation involves specialized skill and training that is not ordinarily possessed by lay persons.”<sup>221</sup> In *McBee*, the nurse’s conduct under scrutiny involved professional judgment, and thus was beyond the ken of lay jurors.

Consider another factual scenario. A number of courts have held that the alleged failure of a subordinate, supporting, or lower ranked health care provider to follow orders or a prescribed or recommended treatment plan of an attending physician might fall within the common knowledge exception.<sup>222</sup> That conclusion might often be consistent with the second precondition since under normal circumstances there simply may have been no discretion to disregard for no apparent good reason a treatment plan or order

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*Id.* at \*1 (summarizing the defendant’s testimony and quoting it in part).

212. *Id.*

213. *Id.* at \*2.

214. No. M2000-00271-COA-R3-CV, 2000 WL 1533000 (Tenn. Ct. App. Oct. 18, 2000).

215. *Id.* at \*1.

216. *Id.*

217. *Id.*

218. *Id.*

219. *Id.*

220. *Id.* at \*1.

221. *Id.* at \*3 (footnote omitted).

222. See *supra* notes 97–111 and accompanying text.

that was applicable to the patient. Thus, in *Wilson v. Manning*,<sup>223</sup> the plaintiff was being treated with antibiotics for osteomyelitis prior to her incarceration, and her pre-arrest physician stated that based on his communication with medical personnel at the prison that it was his “clear understanding to continue her therapy if she were not to be released.”<sup>224</sup> The court held that the allegation that the defendant-Manning, director of nursing at the jail, allowed the patient to be without fourteen consecutive doses of necessary medicines was sufficient to allow the fact finder to infer that the defendant breached the standard of care.<sup>225</sup> The idea here may be similar to the analysis applied under the Federal Tort Claims Act in deciding whether the discretionary function exception to the government’s waiver of immunity applies.<sup>226</sup> When, however, a recommendation of one physician is made to a co-ordinate physician and the latter was at the time the patient’s attending physician or one who had undertaken the patient’s care, it may well be that such latter physician is under no obligation to follow the recommendation of the other physician. In such circumstances, because the decision of the second physician implicated his professional judgment and expertise, the allegation that the second doctor did not follow the recommendation of the first one may not fall within the common knowledge rule.<sup>227</sup>

Take another recurring type of scenario in which the second precondition may be useful. It arises when a part of a device may have been uninten-

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223. 880 So. 2d 1101, 1111 (Ala. 2003).

224. *Id.* at 1107.

225. *Id.* at 1111; *see also* *Gil v. Reed*, 381 F.3d 649, 660–61 (7th Cir. 2004) (holding where physician’s assistant “simply refused to provide a prescribed antibiotic to a person with a serious infection,” then “[i]t is within a layperson’s purview to know that when a serious infection at the site of a surgical wound is diagnosed and an antibiotic is prescribed, failure to supply or delay in supplying the antibiotic can result in unnecessary pain, discomfort and a spreading of the infection”); *Czarney v. Porter*, 853 N.E.2d 692, 698 (Ohio Ct. App. 2006) (holding “the discontinuation and administration of fluids is outside . . . the knowledge and experience of average jurors, but the concept of following orders is not,” and that “[w]hen a physician gives an order and it is not followed by a nurse or the medical staff, expert testimony may not be required to explain that this may be negligent,” and that “Dr. Korinek ordered that the decedent be monitored by a telemetry unit; however, there is no evidence of compliance with this order.”).

226. *See* 28 U.S.C. § 2680(a) (2000); *Berkovitz v. United States*, 486 U.S. 531, 536 (1988) (holding that “the discretionary function exception [to the waiver of governmental immunity] will not apply when a federal statute, regulation, or policy specifically prescribes a course of action for an employee to follow. In this event, the employee has no rightful option but to adhere to the directive. And if the employee’s conduct cannot appropriately be the product of judgment or choice, then there is no discretion in the conduct for the discretionary function exception to protect.”).

227. *See* *Mitchell v. Lincoln*, No. 05-1369, 2006 WL 1702635, at \*1 (Ark. June 22, 2006). In *Mitchell*, the patient was suffering from chronic myelogenous leukemia. *Id.* He alleged that the defendant, the subsequent-treating physician, performed eleven blood transfusions on him, but failed to use O-positive red cells or B-positive platelets. *Id.* Plaintiff contended that the defendant failed to do so despite the specific recommendation of his previous physician, an oncologist, to use O-positive red blood cells or B-positive platelets on the plaintiff if transfusions became necessary. *Id.* Although the plaintiff had attempted “to frame the issue as being whether a jury of laymen can understand that an internist should follow a specialist’s recommendations,” the court said that “the issue is more complicated than that, because it also requires an understanding of *why* such recommendations should be followed.” *Id.* at \*5. The Supreme Court of Arkansas held that alleged negligence did not fall within common knowledge exception. *Id.* at \*3. Irrespective of whether the defendant-doctor was or was not in fact negligent, that determination cannot be made by layperson under the circumstances. *Id.* at \*5.

tionally allowed to remain inside the patient where it was not supposed to be. A number of cases have readily applied the common knowledge rule in such circumstances.<sup>228</sup> Sometimes, however, the court may reach a different conclusion when the physician's decision allegedly creating the dangerous situation or dealing with the danger is fraught with judgment. In *Callahan v. Cho*,<sup>229</sup> during a surgical procedure to insert a prosthetic hip, a suturing needle broke and a small fragment lodged in the plaintiff's muscle tissue approximately six inches inside the hip.<sup>230</sup> The defendant-surgeon searched for the needle fragment but was unable to locate it without more invasive searching.<sup>231</sup> Ultimately thereafter:

[Defendant-surgeon] Dr. Cho determined that a prolonged search would destroy significant portions of muscle tissue and yet still not guarantee a successful retrieval of the small fragment. Moreover, based on his experience, Dr. Cho did not anticipate that the small needle fragment would cause the plaintiff any harm. Given these facts and circumstances, Dr. Cho made a medical judgment that, on balance, it was better to leave the needle fragment in the tissue because further invasive searching would likely be more harmful to plaintiff than leaving it in the tissue.<sup>232</sup>

The court held that neither the breaking of the needle, nor the surgeon's decision to leave the remaining fragment inside the patient fell within the

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228. See, e.g., *Boyd v. Chakraborty*, 550 N.W.2d 44, 46, 49 (Neb. 1996); *Pete v. Youngblood*, 141 P.3d 629, 631–32, 637 (Utah Ct. App. 2006). The patient in *Boyd* was treated for pneumothorax (a collapsed right lung). *Boyd*, 550 N.W. 2d at 46. Defendant-physician attempted to inflate her lung by inserting a catheter into the right side of her chest, which was removed during subsequent surgery, and another larger catheter was placed in her side to drain fluid from the lung. *Id.* Thereafter, patient was admitted to Lincoln General Hospital after complaining of stabbing pains in the right side of her chest, and an X-ray revealed that she had a fragment of chest tube in her lung. *Id.* She alleged "failure to inspect a catheter upon its removal" and "failure to remove a fragment of this catheter" from her body after surgery. *Id.* at 46. The court reasoned that:

[T]his case involves the leaving of a foreign object, namely, a tube fragment, in a patient's body, which fragment should have been removed by an act understandable by the jury without technical evidence. The only skill required in regard to the alleged negligent conduct of the appellees in this case is to inspect the equipment used in the surgical procedure to make certain everything is intact and has not been left in the patient's body. This is within the realm of knowledge of laypersons.

*Id.* at 49.

In *Pete*, the patient suffered extensive facial injuries during a horse riding accident, and underwent surgery to repair her fractured maxilla, nasal bones, orbit, mandible, and crushed sinus cavity. *Pete*, 141 P.3d at 631. Thereafter, over the next thirty years, she suffered from persistent and painful sinus infections, swelling, and headaches. *Id.* Plaintiff alleged that despite treatment by her family physician and a specialist, she was unable to determine the cause of her ailments until her dentist lanced the infected portion of her cheek, and discovered and removed two five-inch pieces of gauze from her cheek at the site of her 1970 surgery. *Id.* at 631–32. The court held that a finding of negligence is a matter of common knowledge when medical instruments, sponges, or supplies are not removed from the patient's incision or wound when they are supposed to be. *Id.* at 637.

229. 437 F. Supp. 2d 557, 563 (E.D. Va. 2006).

230. *Id.* at 559–60.

231. *Id.* at 560.

232. *Id.*

common knowledge exception.<sup>233</sup> With respect to the latter decision, the court noted:

When the fragment was not found, Dr. Cho had to make a professional medical judgment: Either undertake more invasive searches for the fragment, with the attendant risk of significant harm to plaintiff's muscle tissue, or leave the fragment in the tissue given that it would not likely cause harm or pain. This is a quintessential professional medical judgment, which if called into question in a lawsuit, can be resolved only by reference to expert opinion testimony.<sup>234</sup>

In applying the preconditions, it is also important to focus discretely on each relevant care provider. Consider *Carver v. United States*,<sup>235</sup> where the magistrate decided that expert testimony was not necessary to establish alleged negligence in leaving a part of the scissors tips or the shears of an endoscopic instrument in the patient during laparoscopic surgery, finding that it was within the common knowledge of laypersons.<sup>236</sup> What is problematic in the magistrate's analysis, however, is that it focused on the surgeon. According to the surgeon's testimony, she may not have been in position or expected to personally assess whether the instrument she removed from the surgical site was removed in its entirety.<sup>237</sup> One could argue that

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233. *Id.* at 564–65.

234. *Id.* at 563.

235. Nos. 3:04-0234, 3:04-0991, 2005 WL 2230025, at \*10 (M.D. Tenn. Aug. 30, 2005).

236. *Id.* at \*10.

237. The affidavit of Dr. Shroul, the surgeon, stated in part:

During this surgery I used Snowden Pencer endoscopic shears with a reusable shaft and disposable switch blade scissors tips. The shaft and the scissors tip separate one from the other. . .

During the laparoscopic assisted surgery, I stand next to the patient's side and place small trocars into the patient's abdomen/pelvis. A trocar in the umbilicus is used for the laparoscope which has a light source and camera attached to it. . . . I then place the laparoscopic instruments, such as the Snowden Pencer shears, through additional trocars . . . . Then I observe the monitor to watch the instrument enter into the patient's abdomen/pelvis. These instruments are used to manipulate, cut, dissect, and ligate tissue in order to achieve the desired effect. I remove the instruments from the abdomen/pelvis by pulling them out through the trocar and passing them to the scrub nurse. I continue to observe the monitor until the instrument is fully removed from the trocar. Often there is more than one instrument in the pelvis through two or more trocars. This requires the surgeon to pass off the instrument that was removed to the scrub nurse or lay it down on the surgical field without looking away from the monitor. The only time that I observe the instrument after it comes out of the trocar is when that instrument is grasping tissue, a suture, or a needle that is being intentionally removed. This allows me to ensure that the item being removed has not slipped out of the grasping instrument and fallen back into the patient's abdomen.

During and following the surgery, it is the recognized standard of acceptable professional practice, [sic] for the scrub nurse or surgical technician and the circulating nurse to perform a count of all sponges, needles and instruments, which would include the Snowden Pencer Endoscopic Shears with a reusable shaft and disposable switchblade scissors tips which was used in the Carver surgery. . . . They are to notify the surgeon whether the count is correct or incorrect.

the magistrate should have focused separately on the surgeon and the “scrub nurse or surgical technician and the circulating nurse” who would be expected “to perform a count of all sponges, needles and instruments.”<sup>238</sup> Thus, the outcome in *Carver* may not be consistent with my proposed rule. An argument can be made that at least the conduct of the surgeon should not have been deemed a matter of common knowledge. This case may boil down to decision making about the allocation of duties and division of labor in the operating theater in dealing with and accounting for multiple complex surgical devices. Perhaps evaluating the conduct of the health provider responsible for performing the instrument count was a matter of common knowledge. But crediting the testimony of the defendant-surgeon, she was not in position to evaluate or observe whether the cutting instrument was fully intact when withdrawn through the trocar.<sup>239</sup> On the other hand, where a part of a medical device was inadvertently left inside the patient, and a physician’s attention and vision was more narrowly and directly fixed on the medical device being removed, application of common knowledge exception may be more defensible.<sup>240</sup> It should be relevant in deciding the common knowledge question whether the surgeon had a reasonable opportunity to observe the instrument in question as it was removed from the patient. I should also add that a surgeon’s potential liability when part of an instrument remains in the patient, such as when a holder removed from the patient’s surgical site does not have the sponge attached, may be affected by

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It is well-recognized in the surgical community that it is possible for a tip of an instrument, a sponge, or a needle to be left in a patient while surgery is ongoing. That in and of itself does not constitute a breach of the recognized standard of acceptable professional practice for surgeons. . . . It is not the surgeon’s responsibility to perform the actual count.

I, as a surgeon, am not responsible for the actual counting of sponges, needles, instruments and disposables before or after surgery. I am responsible to ask for a count at the closing of the case. . . .

I, as a surgeon, do not become involved in counting instruments or sponges unless I am told that the count is not correct. If I am informed that a count is incorrect, then I will attempt to locate a missing item. This count is to be done at such time as the surgery is being concluded, and before the incision is closed. . . .

I asked for a count at the closing of the case. . . . I was told that the instrument [count] was correct.

*Id.* at \*3–4.

238. *Id.* at \*3.

239. *See supra* note 237.

240. *See, e.g., Miller v. Jacoby*, 33 P.3d 68 (Wash. 2001). In *Miller*, the patient sued two of her physicians and the hospital (for the actions of a nurse) for harm suffered from the failure to completely remove a Penrose drain placed in a surgical wound to facilitate postoperative healing. *Id.* at 73–74. The court applied the common knowledge exception for the purposes of assessing the conduct of the physician and the nurse who were involved in the *post-operative* failed attempt to completely remove the drain. *Id.* at 73. The nurse attempted to remove the Penrose drain as the physician had ordered, but she felt resistance and therefore notified the physician, who removed what allegedly turned out to be only part of the drain. *Id.* at 69–70. The court noted that the nurse had stated that she was concerned enough about the resistance when she tried to remove the drain to request the doctor’s assistance. *Id.* at 70. In addition, the plaintiff attributed a statement to the physician, saying “I hope I got it all,” from which the court inferred that the doctor was somewhat doubtful about complete removal of the Penrose drain. *Id.* at 72.

principles of vicarious liability and nondelegable duty doctrines in a particular jurisdiction.<sup>241</sup>

Some courts, in addressing the common knowledge question, also occasionally consider whether the defendant produced expert testimony of conformity to professional standards.<sup>242</sup> If either of alternative preconditions are satisfied, I believe that the court should be free to apply the common knowledge exception irrespective of whether a defendant seeks to offer expert testimony on the standard of care. At the same time, however, I also believe that the court should be free to consider expert testimony relating to, for example, the nature and complexity of the conduct in question and whether it involves professional expertise, along with all other relevant evidence, in deciding whether to apply the common knowledge exception. The point is that the fact that a defendant sought to avoid application of the common knowledge exception by introducing expert testimony should not ipso facto prevent the court from applying the common knowledge excep-

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241. See, e.g., *Johnston v. Sw. La. Ass'n*, 693 So. 2d 1195 (La. Ct. App. 1997). In *Johnston*, the plaintiff underwent a hernia repair procedure. *Id.* at 1197. Although the hernia surgery seemed successful, the patient's incision failed to heal. *Id.* Another physician discovered that a surgical sponge remained in the patient. *Id.* The court held that "[e]ven without expert testimony establishing the standard of care, . . . we may infer negligence from the mere fact that a surgical sponge does not ordinarily remain in the patient's body without the commission of medical negligence." *Id.* at 1198. The defendant-surgeon did not dispute that a sponge was negligently left in the patient's body. *Id.* Rather, he argued "that it was entirely the nurses' negligence in miscounting that caused [the patient's] injury." *Id.* The court relied on alternative bases for rejecting the defendant-surgeon's argument. First, the court held that "the nurses' count is a remedial measure that cannot relieve the surgeon of his nondelegable duty to remove the sponge in the first instance." *Id.* at 1199. Second, the court stated that the defendant surgeon "was personally negligent for failing to remove the sponge that he placed inside Johnston and that he could not relieve himself of his duty by pointing the finger at the nurses," and "[e]xpert testimony is not required where the physician does an obviously careless act, such as leaving a sponge in a patient's body, from which a lay person can infer negligence." *Id.* The court therefore concluded that the surgeon "was guilty of concurrent fault in failing to notice that one of the holders he withdrew from Mrs. Grant's body did not have a sponge attached." *Id.*

242. See *Henderson v. Homer Mem'l Hosp.*, 920 So. 2d 988, (La. Ct. App. 2006); *Patterson v. Arif*, 173 S.W.3d 8, 11 (Tenn. Ct. App. 2005). In *Henderson*, the decedent-patient was hospitalized at defendant hospital with pneumonia and emphysema. 920 So. 2d at 990. When a respiratory therapist entered the room to administer a breathing treatment, the patient was found face down on the floor. *Id.* He aspirated vomit into his lungs, was not breathing, and had no pulse. *Id.* Resuscitation efforts were undertaken and he was airlifted to another medical center, but died. *Id.* The plaintiffs claimed that the hospital "failed to properly monitor [the decedent] when he was nauseous, was wearing a face mask, and was not mentally able to care for himself." *Id.* In refusing to apply the common knowledge rule, the court stated:

Generally at trial, a plaintiff must prove the applicable standard of care through expert medical testimony unless the physician does an obviously careless act from which a lay person can infer negligence. *Expert testimony is especially necessary* where the defendant in a medical malpractice action has filed a motion for summary judgment supported by expert opinion evidence that the treatment met the applicable standard of care.

*Id.* at 996 (emphasis added).

In *Patterson*, the patient was experiencing shortness of breath, and the defendant-doctor allegedly advised the patient's spouse to bring patient to the defendant's office, and thereafter to be taken to a hospital miles away. 173 S.W.3d at 9. The court of appeals held that the allegedly negligent failure to direct the family to go immediately to the nearest emergency room was based on medical decisions and it was not "within the common knowledge of the layperson that a person suffering shortness of breath, without more, . . . should be taken immediately to the emergency room." *Id.* at 11-12. In so holding, the court added that "there is expert proof in the record that there was no medical negligence," and that the plaintiff may not refute the defendant's "expert opinion regarding a decision made in the course of rendering medical care with lay opinion evidence in this case." *Id.* at 12-13.

tion if one of the suggested preconditions are satisfied and the court chooses to do so.

It is useful to keep separate two different ideas. Admission of expert testimony to offer guidance on *whether the common knowledge rule is appropriate* should be distinguished from the admission of expert testimony on *whether the standard of care was breached*. Courts have frequently held both in malpractice cases and more generally that expert testimony is inadmissible on a question that is within the common knowledge of laymen.<sup>243</sup> Occasionally, a court that has applied the common knowledge exception in a malpractice case will nevertheless allow expert testimony but it may be unclear in the common knowledge context on precisely what issue such expert testimony is admitted—to help the court decide *whether to apply* the common knowledge exception or to allow expert testimony *even after* the court has determined that the claim falls within the common knowledge exception.<sup>244</sup> I will not address this evidentiary question here except to say

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243. See, e.g., *Johnston*, 693 So. 2d at 1198–99 (stating that if “a physician does an obviously negligent act, such as . . . leaving a sponge in a patient’s body,” not only can “lay persons . . . infer negligence,” but expert testimony by a defendant to “completely shift the responsibility for the sponge’s removal from the surgeon to the nurses . . . was properly excluded”); see also *Engineered Prods. Co. v. Donaldson Co., Inc.*, 313 F. Supp. 2d 951, 1010 (N.D. Iowa 2004) (citing *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 591 (1993)) (stating that under Federal Rule of Evidence 702 “[e]xpert testimony assists the trier of fact when it provides information beyond the common knowledge of the trier of fact”); *In re Conservatorship of John S.*, No. D040448, 2003 WL 21153459, at \*2 (Cal. Ct. App. May 20, 2003) (stating that “the decisive consideration in determining the admissibility of expert opinion evidence is whether the subject of inquiry is one of such common knowledge that men of ordinary education could reach a conclusion as intelligently as the witness or whether . . . the matter is sufficiently beyond common experience that the opinion of an expert would assist the trier of fact.” (quoting *People v. Cole*, 301 P.2d 854, 856 (Cal. 1956))); *Hampton v. Saint Michael Hosp.*, No. 81009, 2003 WL 1848772, at \*9 (Ohio Ct. App. Apr. 10, 2003) (“Expert opinion testimony is admissible as to an ultimate fact if the determination of such ultimate fact requires the application of expert knowledge not within the common knowledge of the jury.”); *Blue Ridge Serv. Corp. of Va. v. Saxon Shoes, Inc.*, 624 S.E.2d 55, 59 (Va. 2006) (stating that “when the issue to be decided involves matters of common knowledge or those as to which the jury is as competent to form an intelligent and accurate opinion as the expert witness, expert evidence is inadmissible”); 31A AM. JUR. 2D EXPERT AND OPINION EVIDENCE § 30 (2002) (stating that “[e]xpert opinion testimony, . . . cannot invade the field of common knowledge, as jurors are presumed to be competent in matters pertaining to the ordinary and common knowledge of humankind and thus able to draw the proper conclusions from the facts before them”) (footnotes omitted); Robert L. Sterup, *Into the Twilight Zone: Admissibility of Scientific Expert Testimony In Montana After Daubert*, 58 MONT. L. REV. 465, 469 (1997) (quoting *Montana v. Howard*, 637 P.2d 15, 17 (Mont. 1981)) (stating that “where the ‘subject is one of such common knowledge that men of ordinary education could reach a conclusion as intelligently as the (expert) witness,’ then expert testimony invades the province of the jury and is not admissible”).

244. See, e.g., *Seippel-Cress v. Lackamp*, 23 S.W.3d 660 (Mo. Ct. App. 2000). In *Seippel-Cress*, a frail elderly patient had undergone an X-ray procedure of her upper gastro-intestinal tract because she had experienced rapid weight loss and difficulty in swallowing solid foods. *Id.* at 663. Some evidence showed that the patient’s condition changed during the test, that the procedure was terminated due to her “apparent discomfort, fatigue and inability to swallow the thicker material,” and that she “needed to be placed on a gurney.” *Id.* at 668–69. The plaintiff alleged that the healthcare providers sent the patient home without treatment for the aspiration or the conditions it caused, resulting in a toxic reaction to the test substance, chemical pneumonia, and anoxia causing brain damage and central nervous system depression. *Id.* at 665. According to the patient’s daughter, the patient had not said anything on the way home, and when they reached the house, the patient’s “head fell back and she did not seem to be breathing.” *Id.* at 664. An ambulance took the patient to the emergency room, and within a short time, it was determined that she was brain dead. *Id.* The court agreed with the plaintiff that “as to the events following the termination of the test, she did not need to use expert testimony to show a breach of the standard

that if such testimony is admissible, I believe that it should not be conclusive on the common knowledge question. Moreover, irrespective of whether expert testimony is held inadmissible when offered *after* it is determined that an issue falls within the realm of common knowledge, I believe that should not preclude the admission of expert testimony on the *threshold matter* of whether or not a defendant's conduct could be adequately assessed by laymen guided by their common knowledge.

#### IV. CONCLUSION

The common knowledge rule holds that notwithstanding the general prerequisite for expert testimony to establish the standard of care in medical malpractice cases, such expert testimony is not required when the subject matter of the allegedly substandard conduct is within the common knowledge of and thus comprehensible to non-medically-trained laypersons. The facile simplicity of the "common knowledge" expression, however, belies its challenging nature. Whereas most courts have recognized the common knowledge exception in principle, meaningful explication of its contours has eluded the courts.

Some cases warranting application of the common knowledge rule seem relatively straightforward: a dentist extracts the wrong tooth, a veterinarian operates on the wrong horse, or the health care provider with responsibility for removing an instrument from inside the patient fails to do so. Other cases fall at the other end of the spectrum, and are manifestly not appropriately matters of common knowledge. An example might involve an allegation that a surgeon negligently decided to treat a plaintiff's injury with one surgical technique rather than another. That leaves a vast range of cases falling somewhere in between.

The question of whether to apply the exception has been decided on a case-by-case basis, essentially as a conclusion that exists in the eyes of the beholding judges. The courts have seldom offered meaningful guidance or much help in making the outcome more predictable or rational. The deci-

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of care." *Id.* at 669. The court explained that:

[T]he average non-physician layperson knows that when the condition of a patient is altered unexpectedly during a medical procedure, a medical provider must determine the status of the patient and the cause of the alteration in order to know whether the matter involves an emerging threat to the life or condition of the patient.

*Id.* But, then the court added the following ambiguous qualification:

We do not mean to say that the defendants in this case cannot produce medical evidence outside the awareness of lay persons which might show that under the specific circumstances of this case there was no need to evaluate her condition beyond simply observing her external appearance for any signs of distress. . . . We do not say that defendants do not have defenses; we simply say that, on the face of the basic facts proved by plaintiff, together with the causation testimony of Dr. Tuteur, a *prima facie* case was presented. Lay persons know that when there is an *unexpected* and *unusual* change in the condition of a patient which gives evidence that the patient is having significant difficulty, the medical provider cannot send that person home, as though everything were normal, without attempting to determine what is wrong with that patient.

*Id.*

sion of whether the common knowledge rule applies to the alleged facts may determine the outcome. With so much riding on the common knowledge question, the lack of clarity and predictability in the rule is lamentable, but also not surprising. There is an inherent and confounding incongruity in the common knowledge rule. It lies in the contradiction of how one determines whether a matter is within common knowledge and not dependent on professional medical assessment without the very medical input that the application of the rule says is unnecessary.

The facile simplicity of the common knowledge rule masks very real competing concerns. On the one hand, prospective malpractice plaintiffs have legitimate concerns. These include the high costs of expert witnesses, the challenge of identifying suitable and willing medical experts (and attorneys), and the ever-present risk that a negligently-caused injury may go unredressed for want of expert testimony. And, of course, there is the simple fact that some medical errors arise that are perfectly amenable to fair and cogent assessment by persons not formally trained in the medical professions.

Health care providers, the potential defendants, fear that lay jurors, if left exclusively to their "common knowledge," may not understand or appreciate the complexity of modern medical decision making and practice. Jurors may be inclined through hindsight to unfairly second guess the conduct of health care providers and equate an unfortunate outcome with substandard care. Health care professionals also fear that without the normative winnowing and sifting inherent in the requirement of expert testimony, many more disappointed or disaffected patients may be inclined, driven by a variety of motivations, to sue for malpractice. That will in turn raise the cost of insurance and medical services, and induce physicians to practice defensive medicine, with all its attendant costs in professional attention and resources.

Finally, the broader and complex interests of society generally should also be considered. On the one hand, members of the society should be rightly concerned about the impact of the common knowledge rule on the potential increase, costs, and uncertainty in medical malpractice litigation. To the extent that the common knowledge rule makes it easier and less expensive to pursue malpractice claims, an increase in such litigation would be a likely concomitant. Malpractice cases are relatively inefficient vehicles for compensating supposed victims of medical negligence when one considers the costs and resources expended in resolving and paying such claims as well as the adverse effects on the overall practice of medicine, fostering wasteful defensive medicine. So in one respect the application of the common knowledge exception could be seen as compounding the shortcomings of the malpractice cases by increasing their numbers. However, this does not mean that we should categorically prefer proof by expert over the application of common knowledge. Society also has a stake in the integrity of the adjudicatory process. The current hired-expert system for establishing the professional standard of care in malpractice litigation is far from perfect.

While a requirement for expert testimony may admittedly operate to inhibit the growth of malpractice cases, there are also dangers in overreliance on medical experts selected, paid, and prepared for trial by the parties. Not only are there the obvious risks of bias and lack of objectivity, but there is also the danger that the outcome of cases may too often depend on the experts' success in marketing their clients' side, or at least in selectively presenting the case or obfuscating the medicine, rather than in objectively educating the trier of fact and facilitating a just resolution of the matter.

I believe that the common knowledge exception to the expert witness requirement should be retained in principle. We can do a better job, however, of formulating some parameters defining the scope of the common knowledge rule. I have proposed a construct of two alternative preconditions, the presence of either of which would allow a court discretion to hold that the common knowledge exception was applicable. Either the specific conduct that allegedly constituted negligence was of such a nature that not only could an unlicensed layperson legally perform it without violating or offending applicable medical or health care licensure statutes or duly authorized regulations governing the practice of the health care professions, but also that such an unlicensed layperson would ordinarily be deemed competent and foreseeably expected to routinely perform such conduct; or, the specific decision making by the health care provider that allegedly constituted negligent conduct that caused the injury did not involve the exercise of uniquely professional medical skills, a deliberate balancing of medical risks and benefits, or the exercise of therapeutic judgment. My objective here is to develop meaningful criteria for deciding when conduct by health care providers can be fairly assessed by lay jurors without the input or guidance from medical expert witnesses. Ideally, the criteria I have suggested will provide some intelligible demarcations and predictable standards while at the same time preserving some needed flexibility for deciding these necessarily fact-laden questions.