



BY S. Y. TAN,
M.D., J.D.

Question: Twenty minutes into an otherwise routine endoscopic examination, the patient sustained a stroke, which left him with cognitive loss and hemiparesis. The etiology was later established to be air embolism.

A lawsuit asserts obvious negligence on the part of the gastroenterologist, as the patient was entirely well prior to the procedure. No plaintiff expert was called. Which of the following is correct?

- A. This is a case of *res ipsa loquitur*, which means the tortfeasor takes the patient as he finds him.
B. The plaintiff is alleging *res ipsa*, as

LAW & MEDICINE

Res Ipsa Loquitur

both the identity of the actor and the nature of the injury are known.

C. Since the gastroenterologist had full and exclusive control over the procedure, and the jury can impute the fault to him.

D. The average juror in this case should be able to infer that the stroke resulted from a negligent act.

E. If the court accepts the *res ipsa* theory, the plaintiff does not need an expert witness to testify to the standard of care.

Answer: E. The doctrine of common knowledge, technically called *res ipsa loquitur* or “the thing speaks for itself,” describes a situation in which the circumstantial evidence is such that a lay juror can form a reasonable belief, so the plaintiff may be entitled to waive the requirement of expert testimony. It raises a presumption of negligence, which is still rebuttable by the defendant. For the doctrine to apply, three conditions must be met: The injury would not have occurred in the absence of someone’s negligence, the plaintiff was not at fault, and the defendant had total control of the instrumentality that led to the injury. The facts are insufficient to constitute a clear case of *res ipsa*, making B and C and D incorrect. Choice A describes the “eggshell skull rule” and is irrelevant here. Thus E is the best answer. (Scenario adapted from *Hayes v. Peters*, 645 S.E. 2d 846, N.C. 2007.)

Res ipsa had its genesis in the classic 1863 English case where a barrel of flour fell from a window, striking an innocent bystander below (*Byrne v. Boadle*, 2 H. & C. 722, 159 Eng. Rep. 299, 1863). In ruling for the plaintiff, the court wrote: “I think it apparent that the barrel was in the custody of the defendant who occupied the premises, and who is responsible for the acts of his servants who had control of it; and in my opinion the fact of its falling is prima facie evidence of negligence.” (A *prima facie* case means the plaintiff has met the burden of going forward with evidence on the legal issue.)

The *res ipsa* doctrine is most useful when the plaintiff has insufficient evidence of what caused the negligent act, but circumstances strongly suggest that the defendant was negligent. *Res ipsa* offers a major advantage to the plaintiff,

who may have difficulties securing an expert willing to testify against the doctor-defendant. Still, courts generally hesitate to accept the *res ipsa* argument, and some states disallow it altogether. For example, an Illinois court rejected the claim that it was common knowledge that someone should be referred to a cardiologist for a heart condition (*Evanston Hospital v. Crane*, 627 N.E.2d 29, Ill. 1993). In another case, the parents blamed negligent circumcision for painful penile deformity in their child, but lost because the court deemed the evidence insufficient without expert testimony (*Walker v. Skiowski*, 529 So.2d 184, Miss. 1988).

However, similar cases have gone the other way—for example, where a surgeon operated on the wrong vertebrae (*Schwartz v. Abay*, 995 P.2d 878, Kan. 1999), or where injuries to the peroneal and tibial nerves occurred after knee surgery (*Hale v. Venuto*, 137 Cal.App.3d 910, Cal. 1982). And in a well-known California case, the court permitted the use of the *res ipsa* doctrine against multiple defendants in the operating room after the plaintiff sustained a shoulder injury during an appendectomy (*Ybarra v. Spangard*, 154 P.2d 687, Cal. 1944). Since the plaintiff was unconscious at the time of injury, the court felt it was appropriate to place the burden on the defendants to explain how the shoulder injury occurred.

Courtroom eloquence concerning *res ipsa* was at its best in *Cassidy*, an old English case in which a patient sustained significant injuries following hand surgery for Dupuytren’s contracture. His attorney reportedly asserted: “At the outset, only two of the plaintiff’s fingers were affected; all four are now useless. There must have been negligence *res ipsa*” (*Cassidy v. Ministry of Health*, 2 KB 343, 1951). ■

DR. TAN is professor of medicine and former adjunct professor of law at the University of Hawaii, Honolulu. This article is meant to be educational and does not constitute medical, ethical, or legal advice. It is adapted from the author’s book, “Medical Malpractice: Understanding the Law, Managing the Risk” (2006). For additional information, contact the author at siang@hawaii.edu.



HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use PATANASE® Nasal Spray safely and effectively. See full prescribing information for PATANASE Nasal Spray.

PATANASE (olopatadine hydrochloride) Nasal Spray

Initial U.S. Approval: 1996

INDICATIONS AND USAGE

PATANASE Nasal Spray is an H₁ receptor antagonist indicated for the relief of the symptoms of seasonal allergic rhinitis in patients 12 years of age and older. (1)

DOSAGE AND ADMINISTRATION

For intranasal use only.

The recommended dose of PATANASE Nasal Spray in patients 12 years and older is two sprays per nostril twice daily. (2)

Priming Information: Prime PATANASE Nasal Spray before initial use and when PATANASE Nasal Spray has not been used for more than 7 days. (2.2)

DOSAGE FORMS AND STRENGTHS

Nasal spray 0.6%: 665 mcg of olopatadine hydrochloride in each 100-microliter spray. (3) Supplied as a 30.5 g bottle containing 240 sprays.

CONTRAINDICATIONS

None.

WARNINGS AND PRECAUTIONS

- Epistaxis, nasal ulceration, and nasal septal perforation. Monitor patients periodically for signs of adverse effects on the nasal mucosa. Avoid use in patients with nasal disease other than allergic rhinitis. (5.1)
- Avoid engaging in hazardous occupations requiring complete mental alertness such as driving or operating machinery when taking PATANASE Nasal Spray. (5.2)
- Avoid concurrent use of alcohol or other central nervous system depressants with PATANASE Nasal Spray. (5.2)

ADVERSE REACTIONS

The most common adverse reactions (>1%) included bitter taste, headache, epistaxis, pharyngolaryngeal pain, post-nasal drip, cough, and urinary tract infection. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Alcon Laboratories, Inc. at 1-800-757-9195 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

References:

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2. Meltzer EO, Hampel FC, Ratner PH, et al. Safety and efficacy of olopatadine hydrochloride nasal spray for the treatment of seasonal allergic rhinitis. *Ann Allergy Asthma Immunol.* 2005;95(6):600-606.
3. Ratner PH, Hampel FC, Amar NJ, et al. Safety and efficacy of olopatadine hydrochloride nasal spray for the treatment of seasonal allergic rhinitis to mountain cedar. *Ann Allergy Asthma Immunol.* 2005;95(5):474-479.
4. Rosenwasser LJ, O'Brien T, Weyne J. Mast cell stabilization and anti-histamine effects of olopatadine ophthalmic solution: a review of pre-clinical and clinical research. *Curr Med Res Opin.* 2005;21(9):1377-1387.

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