

Law for Medical Students and Physicians:
Standard of Care
Wheaton B. Wood, MD JD
Athens Ohio

I. Learning Objectives

At the end of the learning session, the student or physician will:

- Know the sources of the standards of care for physicians' non-negligent practice
- Know the sources of the minimal standards to maintain licensure
- Know about the standards of care for nurses, and hospitals
- Understand the basics of expert testimony to prove the standard of care

II. Pre-Lecture Questions: True or False?

- 1) The standard of care, below which negligence leading to malpractice may occur, is set by the International Board of Medical-Legal Pundits, Inc.
- 2) The standard of minimum practice is in part set by the AOA.
- 3) If a doctor chooses between two equally acceptable procedures, and his case goes bad, he should have chosen the other one.
- 4) If a doctor does not tell her patient of the risks of a procedure, and none of those risks occur, she is still liable in malpractice.
- 5) The medical board of the state of Ohio is an expert in minimal medical practice standards.
- 6) In Ohio, only a physician in active practice can be an expert witness as to the standard of care for another physician.

III. Preamble

The following chapter in your Law for Medical Students and Physicians course is about the "standard of care". This phrase refers to three basic things:

- 1) The standard of practice which a reasonable physician would employ so as to not be negligent: i.e., the medical malpractice standard.
- 2) The minimal standards of practice and behavior below which one may not fall and still remain licensed to practice in Ohio.
- 3) Standards of practice for nurses, hospitals, and others.

This chapter is only about the first item: the standard of care below which negligence can be proved.

This chapter is enormously condensed, and consists mostly of cases in various specialties, three of which we will develop in class. The reason for this is that the standard of care evolves as medical science and practice evolves, and therefore is difficult to pin down.

The basic formulation of the standard of care in medical malpractice is: “Under Ohio law , as it has developed, in order to establish medical malpractice, it must be shown by a preponderance of the evidence that the injury complained of was caused by the doing of some particular thing or things that a physician or surgeon of ordinary skill, care, and diligence would not have done under like or similar circumstances, or by the failure or omission to do some particular thing or things that such a physician or surgeon would have done under like or similar conditions and circumstances, and that the injury complained of was the direct result of such doing or failing to do some one or more of such particular things.” *Bruni v. Tatsumi* (1976) 46 Ohio St. 2d 127.

In order to show the things that should have been done, or should not have been done, an expert has long been required in Ohio (and other) law. Circuit Judge William H. Taft, the ancestor of our current governor, wrote in 1897: “Before the plaintiff can recover, she must show by affirmative evidence, first, that defendant was unskillful or negligent; and, second, that his want of skill or care caused injury to the plaintiff. If either element is lacking in her proof, she has presented no case for the consideration of the jury. ... But when a case concerns the highly specialized art of treating an eye for a cataract, or for the mysterious and dread disease of glaucoma, with respect to which a layman can have no knowledge at all, the court and jury must be dependent on expert evidence. There can be no other guide, and, where want of skill or attention is not thus shown by expert evidence applied to the facts, there is no evidence of it proper to be submitted to the jury.” *Ewing v. Goode* 78 Fed 442 (CCSD Ohio 1897).

It’s that simple: an expert must prove the standard of care; and an expert must prove that the doctor’s failure to stick to that standard caused the plaintiff’s injury.

A Brief Aside about the Medical Board

Now as it happens, your state medical board has a rule, RC 4731.22 *Grounds for Discipline; Investigations; Reinstatement; Withdrawal of Application; Quality Intervention Program*, which spells out another standard, which is that standard below which, in practice or in some cases in personal life, a physician may not lapse and still be appropriate for licensure to practice in this state. Your medical boards also has a lot of regulations [OReg 4731-01-01 *et seq*] which give a more precise meaning to those rules; there is also a substantial set of cases clarifying these rules: that you should not have sex

with the mothers of your pediatric patients [*Gladioux v. Ohio St. Med. Bd.* (1999) 133 Ohio App. 3d 465]; or with your grownup patients [*Pons v. Ohio State Med. Board* (1993) 66 Ohio St. 3d 619]. You should be aware of amphetamine regulations [*In re Williams* (1991) 60 Ohio St. 3d 85]; steroid regulations [*State Med. Bd. Of Ohio v. Murray* (1993) 66 Ohio St. 3d 527]; and you should not be convicted of a felony [*Williams v. Ohio St. Med. Bd.* (1992) 78 Ohio App. 3d 743; *DeBlanco v. Ohio St. Med. Bd.* (1992) 78 Ohio App. 3d 194; and *Bouquett v. Ohio State Medical Board* (1991) 74 Ohio App. 3d 203]. The board is advised by the Attorney General's office, and so in a sense one department of the government can prosecute you for a crime, punish you for it, and take your license also for the same crime. [*Arlene v. State Medical Board* (1980) 61 Ohio St. 2d 168 *Snyder v. State Medical Board* (1984) 18 Ohio App. 3d 47]. These standards are much more arbitrary, and include by reference the AMA and AOA codes of ethics. In other words, if you violate the relevant code of ethics, even if not a member of that professional association, you may be disciplined. [*Arlene v. State Medical Board* (1980) 61 Ohio St. 2d 168]. The board may not have patient records, however, without patient consent. [*Manthey v. Ohio State Med. Bd.* (1987) 36 Ohio App. 3d 181].

That is all we shall say about that standard.

Back to the Main story

This chapter is densely researched and contains most of the significant appeals cases on standard of care, in the malpractice sense, in Ohio, in the last 25 years. This is the only way to build up an understanding of the concept of standard of care, and in the next section, I shall go through it by specialties.

Many of the cases imply a standard, but in fact are about abstruse procedural points in Ohio law, which need not concern you. However, you do need to know that the elicitation of standards from such cases involves a certain amount of extrapolation.

Most (Not all) Med-mal Cases Require an Expert

You must remember one thing about standard of care: it is mostly elaborated by your fellow professionals, testifying for hire, in medical malpractice cases. Medical malpractice cases cannot go forward without expert testimony [*Crosswhite v. Desai* (1989) 64 Ohio App. 3d 170] except in cases where a battery has occurred [*Guth v. Huron Rd. Hospital* (1987) 43 Ohio App. 3d 83] or, in rare cases, where the negligence is very obvious even to a layperson

[*Burks v. Christ Hospital* (1964) 19 Ohio St. 2d 128 ; *Eannottie v. Carriage Inn of Steubenville* (2003) 155 Ohio App. 3d 157; *Dimora v. Cleveland Clinic Foundation* (1996) 114 Ohio App. 3d 711; *Jones v. Hawkes Hospital of Mt. Carmel* (1964) 175 Ohio St. 503; but contrast *Richards v. Broadview Heights-Harborside*(2002) 150 Ohio App. 3d 537]. The “obvious” exception cases are mostly foreign bodies like sponges left in someone; or someone falling in a hospital. In one case, however, where a dentist left a bit of one of his tolls in a tooth, the case could not go forward without an expert [*Rogoff v. King* (1993) 91 Ohio App. 3d 438].

In Ohio, to testify as to the standard of care, you must be a doctor, licensed to practice in this or any US state, and practice clinical medicine at least half of your working hours (O.R. Ev 601 (D)) *Aldridge v. Garner* 2005-Ohio-829; *Marcum v. Holzer Clinic* 2004-Ohio-4124. Other states have similar rules *Hinkley v. Koehler* Virginia 04-0389.

The closer your specialty is to the specialty of the defendant, the better; but overlapping specialists can testify against one another, for instance a podiatrist could testify in the limited area of casting against an orthopod [*Alexander v. Mt. Carmel Medical Center* (1978) 56 Ohio St. 2d 155]. A psychologist may not testify against a psychiatrist as to the standard of care, as not being licensed to practice medicine [*Parsons v. Mansfield General Hosp.* (May 18, 1989) 1989 WL 63260 (2d)]. In one interesting case, someone was his own expert [*Baker v. Mervis* (1989) 63 Ohio App. 3d 819]. In another case, an MD/DDS tried to prevent a DDS but not MD from testifying against him in a maxillofacial surgery case [*Sarnovsky v. Snyder, Evans, and Anderson, Inc.* (1987) 38 Ohio App. 3d 33] but since the patient regarded him as a dentist, not an MD, his gambit was foiled by the court. Of course, to find another MD/DDS would be pretty impossible, and the suit would go away if the gambit had paid off (no expert, no case).

As to causation, a scientist or non-practicing physician may be an expert. [*McCrary v. State* (1981) 67 Ohio St. 2d 99]. An expert may rely upon medical records to make his opinion [*ODMH v. Milligan* (1988) 39 Ohio App. 3d 178] or use textbook illustrations to get his point across [*Yeager v. Riverside Methodist Hosp.* (1985) 24 Ohio App. 3d 54]. You cannot make a contract for someone to testify in a certain way, as this would be against public policy [*Fletcher v. Bolz* (1987) 35 Ohio App. 3d 129]; nor, if you are an expert or a defendant, can your own medical records be used against you without your permission [*Calihan v. Fullen* (1992) 78 Ohio App. 3d 266].

A developing theme seems to be the liability for shoddy expertise whether scientific or standard of care. There are no cases showing a liability for malpractice in expert witnessing that I am aware of in Ohio yet, but I think this theme will play out in the next few years. One case in Ohio struck down an expert’s testimony because he gave no reason for it: *Flinn v. Parcinski* 2004-

Ohio-3032. A Virginia case (not med-mal but about the proof of the cause of silicosis) struck down the expert based on his own testimony, which showed illogic in its application *Norfolk and Southern Railway Co. ... v. Rodgers* Virginia 05-0160.

IV. Standards of Care Cases, by Specialty

The student will see a list of specialties, with a general description of several fact patterns, and then a set of citations at the end of that section. The specialties go from those with the most cases, to those with the least. The student must remember, that this is the most appealed cases; there may be more cases in a particular specialty that do not make it to appeal; but probably the number of appeals mirrors the number of cases in general .

OB/GYN: The winner is OB/GYN with eighteen cases.

The most common fact patterns are labor related, with six cases; three involved charges of negligent use of pitocin, but in all, the doctor prevailed; one case involved failure to alert the mother to a spina bifida possibility, but no action lay for wrongful life, so the doctor prevailed; in one case, a pregnant mother with a corrected aortic coarctation ruptured an aneurysm after delivery; and yet, even though the OB assumed the role of a cardiologist, he prevailed because he gave the same care a cardiologist would have. A failure to diagnose eclampsia was a departure

Three cases involved pre-eclampsia. In *Wells*, a 34 week pregnancy was delivered by C-section, but the mother required a CVP; this was misplaced at surgery, and the mother died of cardiac tamponade, which developed over several hours, and which the PGY-2 did not correctly diagnose; the doctor lost in that case; in *Berdyck*, the doctor admitted a breach of the standard of care in not diagnosing pre-eclampsia, but the hospital (through the nurse) was also liable for not correctly informing the doctor of the rising BP. In *Hale v. Rosenberg* a failure to diagnose a seizure disorder leading ultimately to coma and quadriplegia was a departure; oddly, this illness, developing one week post-partum, was claimed to be eclampsia.

Two cases arose out of the same incident of a death by amniotic fluid embolus, occurring a few days after an amniocentesis but hours after a precipitous delivery. The doctor prevailed, but much of that case was really about informed consent. Amniotic embolus is so rare a complication of amniocentesis that warning of it was not within the duty of care.

Two cases dealt with unwanted pregnancy: in one, a failed tubal ligation led to damages for the costs of the pregnancy, but no more, under a doctrine of

limited damages: *Bowman*. In *Hester*, there was a denial in Ohio of damages for the birth of a healthy baby (no “wrongful life”).

Two cases involved missed products of conception leading to Ashermann’s syndrome in one case, and failure to diagnose a colonic cancer (odd facts: poor bowel prep in correction of missed products led to failure to diagnose). In the Ashermann’s case, the patient prevailed; in the other, the doctor did.

One case, *Marcum*, was odd. In this a D.O. had surgery for endometriosis; despite reasonable care, a hole was made in the large bowel. No departure from the standard of care was found. The plaintiff could find no expert to support her claim of medical malpractice, so provided her own affidavit. The affidavit failed, not because it was obviously biased, but because the plaintiff failed to state whether she was in at least 50% clinical practice.

In the last two cases the doctor was negligent. One was a prisoner, who died of choriocarcinoma in jail because the doctor did not believe she was sick; and the other was a bizarre “love surgery” which was actually a surgical mutilation.

Allen v. University of Cincinnati (1997) 122 Ohio App. 3d 195; *Bedel v. OB/GYN Associates, Inc.* (1991) 76 Ohio App. 3d 742; *Bedel v. Univ. Cincinnati Hosp.* (1995) 107 Ohio App. 3d 420; *Berdyck v. Shinde* (1993) 66 Ohio St. 3d 573; *Berlinger v. Mt. Sinai Med. Ctr.* (1990) 68 Ohio App. 3d 8; *Bowman v. Davis* (1976) 48 Ohio St. 2d 41; *Browning v. Burt* (1993) 66 Ohio St. 3d 544; *Flanagan v. Williams* (1993) 87 Ohio App. 3d 768; *Hale v. Rosenberg* 2004-Ohio-1204; *Hester v. Dwivedi* (2000) 89 Ohio St. 3d 575; *Hudson v. Arias* (1995) 106 Ohio App. 3d 724; *Marcum v. Holzer Clinic, Inc.* 2004-Ohio-4124; *Mayhorn v. Pavey* (1982) 8 Ohio App. 3d 189; *Schmitz v. Blanchard Valley OB/GYN Inc.* (1989) 63 Ohio App. 3d 756; *Sorina v. Armstrong* (1990) 68 Ohio App. 3d 800; *Tirpak v. Weinberger* (1986) 27 Ohio App. 3d 46; *Wells v. Miami Valley Hosp.* (1993) 90 Ohio App. 3d 840; *White v. Moody* (1988) 51 Ohio App. 3d 16.

Internal Medicine/Family Practice. Second prize goes to internal medicine, with seventeen cases, most verdicts being for the patient, and most being missed diagnoses.

In *Hubach*, from 1938, a doctor applied too much radium to acne, and a lesion resulted; but the experts could not agree whether it was a radium burn, or scleroderma, and the doctor prevailed. In one case, the patient arrived at the insta-care doctor, told him he had appendicitis, three doctors then missed it, and the patient died of peritonitis. In another, left arm pain was diagnosed as possibly cardiac, a thallium scan was ordered and this scan was abnormal; and read as such on the 16th; but the patient died of a massive MI the next

day. A failure to diagnose CVA led to hospitalization in a psychiatric hospital, where the CVA was belatedly diagnosed; and in another prison case, the doctor did not believe the patient was ill, and the patient fell on inadequate crutches.

More recent failure to diagnose cases are as follows. In *Schutte* failure to diagnose DVT is a departure and was adjudged a departure for Internal Medicine, Emergency Medicine, or Vascular surgery. *Aldridge* was a common missed diagnosis: lung cancer by reason of failure to order a CXR; and *Bingman* was a case of a prisoner, in a local prison, whose doctor failed to order a PSA which was held to have led to failure to diagnose prostate cancer. Both of these were departures.

A more unusual case is *Johnson v. Pohlman* in which an oncologist diagnosed bilateral adrenal lymphoma, but in fact the patient died (three years later) of bilateral adrenal and disseminated histoplasmosis. The departure from the standard of care was that the oncologist knew his diagnosis would have been very rare, but did not order a biopsy, fearing the patient too frail to undergo it. But a surgeon later said he could do the biopsy; and the departure was that Pohlman did not follow up with the surgeon (and get the biopsy which would have made all the difference).

Incidentally, in the last two years, the failure to follow up tests and referrals seems to have become a more prominent source of medical malpractice actions, and a more frequent departure leading to liability. *Gray v. Fairview General Hospital* 2004-Ohio-1244; *Drinkard-Nuchols v. Andrews, MD* (2005) Virginia 040585.

One case from 1969 was dismissed: in *Hundemer*, a patient coded and was revived with levophed; but the IV levophed led to sloughing of the skin. The patient was saved, and sued for the injury to his arm. No negligence was proved, however. In *Moore*, the internist treated the patient's depression and pain with various drugs including placidyl. The patient overdosed and died, but interestingly, the doctor won, as the death was seen as accidental. In *Anderson*, the patient wanted "no code" but the doctor mistakenly coded him, he lived, and went on to have many happy years. His son, upon the patient's eventual death, sued the doctor for "wrongful living". That suit failed: no action for "wrongful living" is allowed in Ohio.

Sherman illustrates the doctrine of "lost chance": if you do something which causes the patient to lose a 50% or greater chance of survival, you are liable; otherwise, not. In this case, the doctor failed to diagnose cancer; but the chance to survive at the time of failure to diagnose was only 40%, so although there was negligence, there were no damages. *Braxton-Fountain* was also a lost chance case, where a medical student negligently did a pericardiocentesis, punctured the right ventricle, and then, despite attempts to

repair, the patient died. This case also was a negligent supervision case. Last, but not least, in *Lambert v. Shearer*, a doctor missed an obvious lung cancer, consigning the patient to death, because he did not believe in X-rays.

In a bizarre case where no negligence was found, a prisoner accused a doctor of overdosing him on Cardizem 300 mg. In that case there was no negligence, no injury and if it was in retaliation it was the wrong kind of suit. *Rembert v. Ohio Dept. of Rehab. And Correction*. This puts one in mind of a Virginia case, where a social worker (same duty of care as a physician) stole away the wife of a patient. The Virginia court rebuffed the part of the case which was for "alienation of affections" (stealing the love of someone). That old cause of action was outlawed in Virginia, but the plaintiff tried to disguise it as a social work malpractice case. *Doe v. Zwelling* (2005) 050155 Virginia.

Cardiology boasts two cases. In one, the resident cut the innominate artery, using electrocautery, but the doctor prevailed even though the patient did die, because of the much superior experts used by defendant. In a placement of an Automated Implantable Cardioverter Defibrillator, in which the leads are inserted blind, the stomach was perforated. This was repaired. The plaintiff's own expert admitted that this was not a deviation from the standard of care.

In *McKinney*, the case of the sleepy cardiologist, the cardiologist on call failed to interpret information from the ER which could have led to diagnosis of a dissecting aortic aneurysm (versus "GI problems") and the consultant was liable. The last case involved a difficult patient who would not co-operate with treatment, but the doctor was liable. He suspected MI, but did a full treadmill stress test, at 10 % incline at 1.7 mph for 2 minutes; the patient died a few minutes after ending the test of a ruptured ventricle.

Aldridge v. Gardner 2005 Ohio 829; *Anderson v. St. Frances- St. George Hosp. Inc.* (1996) 77 Ohio St. 3d 671; *Bingman v. Ohio Dept. of Rehabilitation and Correction*, 2005-Ohio-6314; *Braxton-Fountain v. University of Cincinnati Hosp.* (1999) 133 Ohio App. 3d 323; *Burriss v. Lerner* (2000) 139 Ohio App. 3d 664; *Crawford v. Sanwardeker* (Jan 21, 1992) 1992 WL 12797 (8th); *Davis v. Immediate Medical Serv.* (1997) 80 Ohio St. 3d 10; *Hubach v. Cole* (1938) 133 Ohio St. 137; *Hundemer v. Sisters of Charity* (1969) 22 Ohio App. 2d 119; *Johnson v. Pohlman* 2005-Ohio-3554; *Lambert v. Shearer* (1992) 84 Ohio App. 3d 266; *Moore v. Retter* (1991) 72 Ohio App. 3d 167; *Rembert v. Ohio Dept. of Rehabilitation* 2005-Ohio-5067; *Schutte v. Mooney*, 2006-Ohio-44; *Sherman v. Millhon* (June 15, 1995) 95-LW-2677 (10th); *Sloan v. Ohio Dept. Rehab. And Correction* (1997) 119 Ohio App. 3d 331. *Bell v. Mt. Sinai Med. Ctr.* (1994) 95 Ohio App. 3d 590; *McKinney v. Schlatter* (1997) 118 Ohio App. 3d 328; *Ryne v. Garvey* (1993) 87 Ohio App. 3d 145; *Schmidt v. University of Cincinnati Med Ctr.* (1997) 117 Ohio App. 3d 427.

Surgey and surgical specialties: Third prize with nine cases.

General surgery:

Most recently in *Beard*, no negligence was found when a surgeon performed an elective hernia repair on a man with a WBC of 2,300; in that case the neutropenia was chronic and familial, was not related to his death one week later of infection. The infection itself was a complication of the surgery which had been warned of, and informed consent had been obtained.

In *Wise*, a patient developed a bedsore, and the surgeon was called to debride it; sepsis ensued and the patient died; in fact, the blame was laid on the referring surgeon, not the debriding surgeon, for not referring earlier. In *Pretty*, a surgeon worked for a company, and in a bizarre verdict, the jury held the surgeon harmless but the company liable. This was reversed. The case involved failure to diagnose diverticulitis.

In *Nickell*, a surgeon did a thoracic outlet syndrome release surgery; and a brachial plexus palsy resulted. This was so rare as not to have required informed consent. This is the case that enunciates the elements for the tort of failure of informed consent: 1) the physician fails to disclose material risks; 2) one of those risks arises and damages the patient; and 3) a reasonable patient, knowing of this risk, would have elected to avoid the procedure.

Beard v. Meridia Huron Hospital (2005) 106 Ohio St. 3d 237; *Pretty v. Mueller* (1997) 132 Ohio App. 3d 717; *Nickell v. Gonzalez* (1985) 17 Ohio St. 3d 136; *Wise v. Doctors' Hospital North* (1982) 7 Ohio App. 3d 331.

Urological Surgery: “Where a ureter, previously healthy, is severed in a hysterectomy, there is a strong, but rebuttable, presumption of negligence by the surgeon.” A presumption is a set of facts whereby, if the other side does nothing to oppose it, you win the point. Ohio is a “bursting bubble” state meaning, if you oppose any evidence whatsoever to the presumption, it disappears. *Adamson v. May Co.* (1982) 8 Ohio App. 3d 266. The next was a tubal ligation failure, resulting in wrongful pregnancy, such that damages are limited to the expense of the birth, and some pain and suffering and loss of consortium. It is also obvious that both of these cases are really OB/GYN performed by general surgeons. The last case is interesting. The family doctor found a large prostatic node, and referred to a urologist, who referred to another urologist for surgery after he received back confirmation of adenocarcinoma from the pathologist. Surgeon number two did a radical retropubic prostatectomy and – low and behold – the post surgical specimens (sent to a different pathologist) were negative for adenocarcinoma. Plaintiff tried to enunciate a principle that before any surgery, the receiving surgeon should get a second pathology report. That was shot down as way outside the current standard of care. GU was exonerated. Needless to say, pathologist # 1 would have been at fault – but did anyone figure that out in time to sue him? If so, why the tortured argument about second opinions?

Faulkner v. Pezeshki (1975) 44 Ohio App. 3d 186; *Johnson v. the University Hosp. of Cleveland* (1989) 44 Ohio St. 3d 49; *Wise v. Doctors' Hospital North* (1982) 7 Ohio App. 3d 331.

Vascular surgery: In *Finn* a vascular surgeon was held blameless for refusing to operate on a crushed toe too swollen to safely re-vascularize.

Flinn v. Parcinski 2004-Ohio-3032

Cardiothoracic surgery: In bypass surgery, the phrenic nerve was paralyzed. In *Lewis v. Toledo Hospital*, the plaintiff claimed that the doctor was negligent for not insulating or protecting the phrenic nerve when using an ice slush to slow or stop the heart. The doctor won, as phrenic nerve injury was shown to be a possible complication of this surgery even when the utmost care is used. This is a good case demonstrating the principle that a bad result does not necessarily mean negligence has occurred.

Lewis v. Toledo Hospital 2004-Ohio-3154

Orthopedics. Fourth prize, with seven cases, goes to orthopedics.

In *Whiteleather*, the plaintiff tried to go to trial without an expert when a staple was placed and associated with an infection. The plaintiff hoped that this was a foreign body case not needing an expert; but an expert was required and the doctor prevailed.

Freeman was a sad case, in which a promising athlete has an accident, such that he could no longer play basketball, this leading to depression and to his dropping out of Oberlin. When he committed suicide, the family tried to say that the orthopedist should have referred him to a psychiatrist, and in failing to do so was responsible for his death. This was particularly disingenuous, as the patient was in counseling with a psychologist. At any rate, that case went for the doctor.

One case involved a bowel perforation with successful re-anastomosis resulting from a premature removal of NG tube (to reduce likelihood of rupture).

In one case, the doctor did a beautiful job of fixing the wrong disc, not checking his position. Actually, that disc was ruptured, and he also offered to fix the first disc free of charge.

In *Shull* an orthopedist was not held liable to search for unrelated illnesses, just because they were in the neck and he had operated on the neck.

Lastly, an orthopedic case in which anesthesia was used resulted in neck pain; a subsequent surgeon fixed it; no one could say for sure what had happened. Doctor prevailed.

Anderson v. Motta (1991) 73 Ohio App. 3d 1; *Campbell v. Warren General Hosp.* (1995) 105 Ohio App. 3d 417; *Clark v. Doe* (1997) 119 Ohio App.3d 296; *Freeman v. Cleveland Clinic Foundation* (1998) 127 Ohio App. 3d 378; *Promen v. Ward* (1990) 70 Ohio App. 3d 560; *Whiteleather v. Yosowitz* (1983) 10 Ohio App. 3d 272.

Fifth Place: Radiology with five cases.

In a recent case, *Gray*, liability for failure to diagnose lung cancer was shifted to the radiologist who did make the diagnosis but failed to communicate it to the ER doctor who had requested the CXR.

Other cases include *Fowerbaugh*, where the radiologist was held not liable for not calling the family practitioner with a possible cancer-positive CXR; because he had sent the report. In *Harris*, the radiologist clearly stated that he could not visualize C7, wherein the problem turned out to lie; and he was held not to have a duty to redo the study more than once. However, in *Phillips*, because the radiologist did not communicate his diagnosis of fracture, he was liable. In *Reed*, the neurologist asked for a cerebral angiogram; but because of technical problems, the radiologist could not visualize the left vertebral artery; as it happened, that was where the fatal aneurysm lurked. But, the neurologist had accepted the limited study, and the radiologist had clearly labeled the study as limited, so he was not liable.

Fowerbaugh v. University Hospital (1997) 118 Ohio App. 3d 402; *Gray v. Fairview General Hospital* 2004-Ohio-1244; *Harris v. Middletown Radiologic Associates* (July 20, 1987) 1987 WL 14316; *Phillips v. Good Samaritan Hospital* (1979) 65 Ohio App. 2d 112; *Reed v. Weber* (1992) 83 Ohio App. 3d 437.

Sixth Place: psychiatry with four cases.

In a notorious case, *Joyce-Couch v. DeSilva*, the doctor gave the patient over 150 sodium pentothal treatments, contrary to the prevailing standard of 10, and failed to inform her of “repressed memories”. The patient became psychotic, and also was really mad. Nowadays, we would call that a failure to diagnose a psychotic illness. At any rate, that Dr. was liable. In *Littleton*, however, a psychiatrist was not liable for the violent acts (killing her own child by aspirin poisoning) of a voluntary patient where he had made a good faith balancing between freedom and safety. In *Trisdale* the psychiatrist was held liable when his patient died of heat stroke in 84 degree weather, in part because the defendant’s expert, although famous, was wishy washy. Finally,

Wilburn was a case where a patient had TTP and strokes thereby; the psychiatrist was held liable, not for failing to diagnose TTP, but for failing to rule out conversion disorder (which would have led to return referral to internal medicine, and probable diagnosis, the court said).

In a rather weird case from New Hampshire, a patient with PTSD, alcohol abuse, and borderline features sued and won when she claimed that the doctor's failure to treat her, and in fact his sending her instead to jail for drunkenness, worsened her illness. *Carlisle v. Frisbie Memorial Hospital* 2004-555 (New Hampshire).

Joyce-Couch v. DeSilva (1991) 77 Ohio App. 3d 278; *Littleton v. Good Samaritan Hospital and Health Ctr.* (1988) 39 Ohio St. 3d 86; *Trisdale v. Ohio Dept. Mental Health* (1999) 103 Ohio Misc. 2d 5; *Wilburn v. Cleveland Psychiatric Institute* (2000) 139 Ohio App. 3d 275.

Seventh place goes to pediatrics with three cases.

In one case, a state-required screening revealed probable homocysteinuria; but no one counseled the parents as to what to do. Somehow, the doctor got off scott free, because it was the duty of the state to contact the parents. In another case, the infamous Gomco clamp case, a child was circumcised but the clamp slipped and cut the penis badly; but the injury was repaired. In this case, the plaintiffs had no expert, hoping to go to trial on the "obvious to a layperson" exception to the requirement for expert testimony. Expert testimony was required, but by excellent plaintiff's lawyering, the defense expert won the case for plaintiff, admitting a breach of the standard of care (in letting the clamp slip). The last case involved a failure to diagnose an evolving seizure due to dPT and to communicate the relative contraindication to dPT (recommending dT only), leaving the child brain-damaged after his second and third dPT. Here, liability was found.

Hanshaw v. River Valley Health Systems (2003) 152 Ohio App. 3d 608; *Johnson v. Hammond* (1990) 68 Ohio App. 3d 491; *Turner v. Children's Hosp. Inc.* (1991) 76 Ohio App. 3d 541.

Emergency medicine, and Neurology/neurological surgery share eighth place with three cases each (and that by combining neuro and neurosurgery).

Neurology and Neurosurgery: *Bruni* is the grandfather of all modern medical malpractice cases in Ohio, and has been dealt with in lecture 4 of 18. *Pesek* is a case in which the "professional judgment" rule is invoked: where there are two schools of thought or practice, each being efficacious, there is

no penalty to choosing either. In this case, however, there was only one way to treat a B6 dependent seizure: give B6. The doctor, who missed the seizure etiology, was liable.

In *Perla* the patient's family seemed to be embroidering the evidence, but careful record keeping held the neurosurgery resident blameless. An epidural hematoma developed and produced objective neurological signs at 2:30 AM; the resident was busy but got there in an hour and a half, and the MRI was obtained by 5:30 AM (tech had to be called in). Surgery was at 6:30 AM. This was well within the standard of care. It is worth noting that the patient complained of pain for two days, but careful charting revealed the pattern of events as set out above. Chart those neuro exams!

Bruni v. Tatsumi (1976) 46 Ohio St. 2d 127; *Perla v. Cleveland Clinic Found.* 2004-Ohio-2156; *Pesek v. University Neurologists Assn., Inc.* (2000) 87 Ohio St. 3d 495.

Emergency Medicine: Three cases.

Two cases were MI's. Case #1: Patient experienced chest pain at 4 AM, drove to ER at 10 AM but pain was so severe, he pulled over; police came along, and sent him to hospital in an ambulance. At ER, evaluated, but incomplete history taken (pain since 4 AM); discharged at 155 PM; dead at home at 3 PM of an MI. Case #2: Chest pain; Family Practice sent pt. to ER for evaluation; resident misread EKG as normal; discharged patient after talking to Family Practice attending. FP's partner saw patient back to work on 6-25 (believing EKG normal); pt died on 6-27 of MI.

One case, *Taulbee*, was a failure to diagnose a dissecting aneurysm. It is not clear whether the failure was deemed negligent, but if it were, this would be a departure from the standard of care for radiology.

Taulbee v. Dunskey 2003-Ohio-5988; *Taylor v. C. Lawrence Decker, MD, Inc.*(1986) 33 Ohio App. 3d 118; *Jenkins v. Clark* (1982) 7 Ohio App. 3d 93

Blood Banking gets ninth place with two cases. In one, the patient was negligently and wrongfully diagnosed with HIV after donating blood; error corrected by infectious disease specialist. Held: there is no infliction of emotional distress for a feared thing which does not exist. There was a similar case for syphilis false diagnosis.

Heiner v. Moretuzzo(1995) 73 Ohio St. 3d 80;*Fisher v. American Red Cross Blood Serv.* (2000) 139 Ohio App. 3d 658.

And here come the stragglers, sharing tenth place:

Anesthesia: removed ET tube too soon and patient died. Held liable.

Ulmer v. Ackerson (1993) 87 Ohio App. 3d 137

ENT: A septoplasty was performed, using cocaine anesthesia, but with the patient not restrained; the patient became wild, and was injured. The doctor was not liable for failure of informed consent, and it was the hospital's duty to restrain (in this case).

Becker v. Lake City Memorial Hospital W. (1990) 53 Ohio St. 3d 202.

Research Oncology: In a two armed study of radiotherapy versus radiotherapy plus chemotherapy, the researchers did not tell the patient that chemo plus radio had proved more successful. They intimated that patient could not choose radio plus chemo, which he said he would have, if he had known, because he wanted to get better. This was held to be a failure of informed consent, with research institution liable.

Stewart v. Cleveland Clinic Foundation (1999) 136 Ohio App. 3d 244.

Again, the student must bear in mind that the exact proportions a of cases for each specialty may vary according to the case-collection method; but the take home message is plain:

- 1) Making a rule, not understanding the procedural basis of these cases, is hard, if one tries to make it based on medical principles.
- 2) However, there is a hidden rule: the way to win at malpractice, should you be sued, is top lawyering and top quality experts. Anything less is suicide.

V. Odds and Ends

There are twenty-five cases which illustrate about as many "odds and ends" points about standard of care.

Don't do stupid things. Enraged doctor sent letter to judge about how bad the opposing lawyer was. He lucked out, but it was a silly thing to do. *Gruenspan v. Seitz* (1997) 124 Ohio App. 3d 197.

Don't hide behind clever procedural safeguards. Good lawyering is key. Get it on your side. *Dornbirer v. Paul* (1993) 91 Ohio App. 3d 266; *Hiatt v. S. Health Facilities Inc.* (1994) 65 Ohio St. 3d 236.

Don't hire a pit bull lawyer. *Calderon v. Sharkey* (1982) 70 Ohio St. 2d 218

Know whether or not you are an employee. *Cox v. Ohio State Univ. Hosp.* (1996) 117 Ohio App. 3d 254; *Norman v. Ohio State University Hosp.* (1996) 116 Ohio App. 3d 69.

Practice within your capabilities, refer frequently. *Sabol v. Richmond Heights Gen. Hosp.* (1996) 111 Ohio App. 3d 598; *Barbee v. Finerty* (1995) 100 Ohio App. 3d 466.

Know what your nurses, PA's, residents, blood bank and lab are up to and check up on them. *Blodgett v. Khan* (1996) 113 Ohio App. 3d 465; *Hitch v. ODMH* (1996) 114 Ohio App. 3d 229; *Jenks v. West Carrollton* (1989) 58 Ohio App. 3d 33; *Johnson v. Grant Hospital* (1972) 32 Ohio St. 2d 169; *Lownsbury v. VanBuren* (2002) 94 Ohio St. 3d 231; *Morris v. Children's Hospital Med Ctr.* (1991) 73 Ohio App.; *Northeast Ohio Emergency Affiliates v. Ohio State Med Bd.* (1994) 93 Ohio *Oppenheimer v. Sterling Drug* (1964) 7 Ohio App. 2d 103; *Petratos v. Markakis* (1993) 92 Ohio App. 3d 626; *Price v. Cleveland Clinic Foundation* (1986) 33 Ohio App. 3d; *Ramage v. Central Ohio Emergency Services* (1992) 64 Ohio St. 3d 97; *Starkey v. St. Rita's Medical Ctr.* (1997) 117 Ohio App. 3d 164; *Traster v. Steirreich* (1987) 37 Ohio App. 3d 99; *re Williams* (1996) 116 Ohio App. 3d 237.

Don't assume that just because someone is moribund, they deserve less care. *McMullen v. Ohio State University Hosp.* (2000) 88 Ohio St. 3d 332.

Don't let others push you around, if you reasonably believe you are right.. *Robb v. Community Mutual Ins. Co.* (1989) 63 Ohio App. 3d 803. *Nimmer v. Purtell* (1975) 69 Wis. 2d 21 (Wonderful Wisconsin case: osteopath could be found liable to himself for directing the treatment given him by another osteopath)

Don't try to hide things. *Moskovitz v. Mt. Sinai Med. Ctr.* (1994) 69 Ohio St. 3d 638 *Ingram v. Adena Health System* (2002) 149 Ohio App. 3d 497.

If you get a lucky break, grab it! *Boltenhouse v. Ohio State University Hosp.* (1989) 44 Ohio Misc. 2d 1.

VI. Post-Lecture Questions: True or False?

- 1) The most important tools for winning a malpractice case are a top lawyer and top expert witnesses.
- 2) The standard of care for medical negligence comes from your colleagues, testifying for hire, in medical malpractice cases; and to a lesser extent from statutes and regulations.
- 3) The minimal standards for practice and, in some cases, private behavior, are construed by your medical board, without the need for outside experts.

- 4) If you practice outside your specialty, you assume the burden of performing up to the standards of that specialty in that case; but if you do a good job, you have committed no negligence.
- 5) The tort of failure to obtain informed consent only can occur where the risk not warned of actually happens.
- 6) Almost all cases involving physician malpractice require two kinds of expert testimony: standard of care, and causation.
- 7) Only a licensed physician, practicing in his or her specialty 50% of his or her work time, can be an expert as to standard of care in Ohio.

VII. Cases and Statutes Cited

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- 4731-11-01 Definitions
- 4731-11-02 General provisions
- 4731-11-03 Schedule II Controlled Substance Stimulants
- 4731-11-04 Controlled Substances: Utilization for Weight Reduction
- 4731-11-05 Use of Drugs to Enhance Athletic Ability
- 4731-11-06 Waivers for New Uses
- 4731-11-07 Research Utilizing Controlled Substances
- 4731-11-08 Utilizing Controlled Substances for Self and Family
- 4731-11-09 Prescribing to Persons not Seen by Physician
- 4731-14-01 Pronouncement of Death
- 4731-15-01 Licensee Reporting Requirements; Exceptions
- 4731-15-02 Hospital and Surgical Center Reporting Requirements
- 4731-15-03 Malpractice Reporting requirement
- 4731-15-04 Professional Society Reporting
- 4731-15-05 Liability; Reporting Forms; Confidentiality and disclosure
- 4731-16-01 Definitions
- 4731-16-02 General procedures in impairment cases
- 4731-16-03 Mental or Physical Impairment
- 4731-16-05 Examinations
- 4731-16-06 Consent Agreements
- 4731-16-10 Aftercare Contracts
- 4731-16-11 Revocation, Suspension, or denial of certificate of good standing
- 4731-16-12 Out of State impairment cases
- 4731-16-13 Patient consent; revocation of consent
- 4731-16-15 Patient Rights
- 4731-17-02 Universal Precautions
- 4731-17-03 Hand washing
- 4731-17-05 Handling and Disposal of Sharps and Waste
- 4731-17-06 Barrier Techniques
- 4731-18-01 Standards for Surgery
- 4731-19-02 Licensee's duty to report infection with HIV or HBV
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