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Panacea or Pandora's Box: The "Two Schools of Medical Thought" Doctrine After Jones v. Chidester, 610 A.2d 964 (Pa. 992)

Douglas Rader Brown

PANACEA OR PANDORA'S BOX: THE "TWO SCHOOLS OF MEDICAL THOUGHT" DOCTRINE AFTER *JONES v. CHIDESTER*, 610 A.2d 964 (Pa. 1992)

In negligence actions alleging improper medical treatment, plaintiffs must show that the physician's failure to administer reasonable treatment proximately caused their injury.[1] Negligence law looks to the customs of the medical profession in an effort to define reasonable treatment.[2] Often, however, medical experts differ as to what consti-

1. For cases dealing with the reasonableness standard, *see, e.g.*, Campbell v. United States, 904 F.2d 1188, 1193 (7th Cir. 1990) (affirming a finding that a vascular surgeon acted reasonably when he performed carotid surgery to try to prevent patient's stroke); Chumbler v. McClure, 505 F.2d 489, 493 (6th Cir. 1974) (upholding a decision that found that a physician acted reasonably when he prescribed a specific drug for patient's cerebral vascular insufficiency); MacDonald v. United States, 767 F. Supp. 1295, 1309 (M.D. Pa. 1991) (holding a surgeon's actions reasonable when he conducted arterial bypass surgery to correct blockage in patient's left calf); Estate of Smith v. Lerner, 387 N.W.2d 576, 583 (Iowa 1986) (affirming a verdict that the physician acted reasonably when he administered a drug designed to prevent patient's impending heart attack); Brannan v. Lankenau Hosp., 417 A.2d 196, 201 (Pa. 1980) (reversing trial court's ruling of nonsuit in favor of physicians who unreasonably delayed treating patient with antibiotics).

2. Jack R. Bierig et al., *Practice Parameters: Malpractice Liability Considerations for Physicians*, *in* LEGAL MEDICINE 1991 207, 213 (Cyril H. Wecht ed., 1992). *See, e.g.*, *Chumbler*, 505 F.2d at 492 (noting that "[d]eviation from accepted medical practices . . . is a prerequisite for maintenance of a medical malpractice suit"); *MacDonald*, 767 F. Supp. at 1307 (stating that a plaintiff must present an expert witness who will testify that the physician's acts deviated from good and acceptable medical standards); *Brannan*, 417 A.2d at 199 (providing that "appellant must introduce expert testimony to show that appellee physicians' conduct varied from accepted medical practice"); GRAHAM DOUTHWAITE, JURY INSTRUCTIONS ON MEDICAL ISSUES 55 (4th ed. 1992) ("Ordinarily, unless a medical practitioner's negligence is so blatant and obvious as to be a matter of common knowledge to any lay observer, proof of breach of duty by a physician or surgeon must rest on the testimony of an expert witness qualified to state what the particular standard of care required, and expert opinion that the treatment accorded to the patient did not meet such a standard."). *But see* Helling v. Carey, 519 P.2d 981, 983 (Wash. 1974) (en banc) (reversing verdict for ophthalmologist and holding him negligent as a matter of law for his failure to give an eye pressure test to prevent

tutes reasonable treatment or care.[3] In such cases, courts refuse to find physicians liable for negligent treatment if, in using their best judgment,[4] the physicians adhered to one of two or more alternative treatments recognized as acceptable in the profession.[5] The test to determine whether a physician's treatment falls under this "two schools of thought" doctrine is unclear.[6] In *Jones v. Chidester*,[7] the

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glaucoma, even though the defendant met the standard of care in the ophthalmology profession).

To reduce medical malpractice costs, commentators have examined the possible development of formally accepted medical practice parameters to replace the customary standard of care in the medical profession. *See, e.g., Bierig et al., supra*, at 207; Joseph H. King, Jr., *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 VAND. L. REV. 1212, 1238 (1975) (urging the adoption of an "accepted practice" standard, focusing on the reasonable expectations of the medical profession regarding how doctors should manage the care of patients).

3. *See* Leech v. Bralliar, 275 F. Supp. 897, 898-99 (D. Ariz. 1967) (noting physicians' differing opinions on treating patient's whiplash injuries); Sims v. Callahan, 112 So.2d 776, 782-83 (Ala. 1959) (on performing cataract surgery); Rickett v. Hayes, 511 S.W.2d 187, 194 (Ark. 1974) (on removing teeth when performing surgery to repair a fractured jaw); Estate of Smith v. Lerner, 387 N.W.2d 576, 580 (Iowa 1986) (on use of drugs before patient's impending heart attack); Reid v. North Caddo Memorial Hosp., 528 So.2d 653, 657-58 (La. Ct. App. 1988) (on the correct way to treat a human bite on the hand); Haase v. Garfinkel, 418 S.W.2d 108, 114 (Mo. 1967) (on use of anticoagulant drug for patients suffering from coronary artery disease); Maxwell v. Howell, 174 S.E. 553, 555 (W. Va. 1934) (on proper method to repair patient's broken leg); Holton v. Burton, 222 N.W. 225, 228 (Wis. 1928) (on proper sling use to mend a separated shoulder).

4. A physician is not negligent simply for an error in judgment. *See* Rickett v. Hayes, 511 S.W.2d 187, 194 (Ark. 1974) (holding that "a physician who uses his own best judgment cannot be convicted of negligence, even though it may afterward develop that he was mistaken" (quoting Haase v. Garfinkel, 418 S.W.2d 108 (Mo. 1967))); Duckworth v. Bennett, 181 A. 558, 559 (Pa. 1935) (holding that "[w]here the most that the case discloses is an error of judgment on the surgeon's part, there is no liability").

5. Wasfi v. Chaddha, 588 A.2d 204, 209 (Conn. 1991). This doctrine is referred to as the "two schools of thought" doctrine. *See* MacDonald v. United States, 767 F. Supp. 1295, 1308 (M.D. Pa. 1991) (tracing the history of the doctrine); *see, e.g.*, Young v. United States, 574 F. Supp. 571, 581 (D. Del. 1983) (holding that a treatment recognized in the medical profession as one of two or more proper alternative treatments is a complete defense to a negligence suit); *Sims*, 112 So.2d at 783 (same); *Rickett*, 511 S.W.2d at 195 (same); Joy v. Chau, 377 N.E.2d 670, 673 (Ind. Ct. App. 1978) (same); *Estate of Smith*, 387 N.W.2d at 581 (same); *Reid*, 528 So.2d at 658 (same); *Haase*, 418 S.W.2d at 114 (same); McGuire v. Rix, 225 N.W. 120, 123 (Neb. 1929) (same); Scheuler v. Strelinger, 204 A.2d 577, 585 (N.J. 1964) (same); *Maxwell*, 174 S.E. at 555 (same); *Holton*, 222 N.W. at 228 (same).

6. Currently, there are three prevailing doctrines as to what qualifies a medical treatment as a school of thought. *See infra* notes 25, 32, 52 and 57 and accompanying text for discussions of the "considerable number," "respectable minority" (also called "reputable, respected") and "reasonable and prudent doctor" standards.

Pennsylvania Supreme Court held that a physician's treatment must be supported by a "considerable number" of respected and recognized medical experts for the physician to be protected from negligence liability under the "two schools of thought" doctrine.[8]

In *Chidester*, the plaintiff commenced a medical malpractice action against the defendant physician, alleging that the defendant's use of a tourniquet during surgery deviated from proper medical standards and proximately caused the plaintiff's leg injuries.[9] The jury returned a verdict in favor of the defendant.[10] The plaintiff moved for a new trial on the grounds that the court's jury instruction on the "two schools of thought" doctrine constituted reversible error because it omitted the phrase "considerable number."[11] The trial court disagreed, holding that the jury instruction correctly articulated the "two schools of thought" doctrine.[12] The superior court affirmed the lower court's

7. 610 A.2d 964 (Pa. 1992).

8. *Id.* at 969. In effect, the *Chidester* court redefined the "two schools of thought" doctrine. *See infra* note 57 for the court's new definition.

9. *Chidester*, 610 A.2d at 966. Dr. Chidester performed orthopedic surgery to repair Billy Jones' broken leg. *Id.* at 965. To establish a "bloodless field" for the surgery, Dr. Chidester utilized a pneumatic tourniquet that he inflated and deflated at intermittent intervals. *Id.* During follow-up treatment, Jones began to exhibit symptoms of "drop foot" and difficulties with plantar flexion (defined as turning the foot or toes downward). Appellee's Brief at 4, Jones v. Chidester, 610 A.2d 964 (Pa. 1992) (No. 209). Dr. Chidester referred Jones to a neurosurgeon who concluded that Jones suffered permanent nerve damage behind his right knee. *Id.*

10. *Chidester*, 610 A.2d at 966.

11. *Id.* The trial court gave the following instruction to the jury:

> Ladies and gentlemen, I instruct you upon this additional principle of law known as the two schools of thought doctrine. This principle provides that it is improper for a jury to be required to decide which of two schools of thought as to proper procedure should have been followed in this case, when both schools have their respective and respected advocates and followers in the medical profession.
>
> In essence, then, a jury of lay persons is not to be put in a position of choosing one respected body of medical opinion over another when each has a reasonable following among the members of the medical community.
>
> Thus, under the two schools of thought doctrine, a physician in the position of Dr. Chidester will not be held liable to a plaintiff merely for exercising his judgment in applying the course of treatment supported by a reputable and respected body of medical experts, even if another body of medical experts' opinion would favor a different course of treatment.

Id.

12. Jones v. Chidester, No. 89-345, slip op. at 8 (Chester County Pa. Aug. 4, 1989). The Court of Common Pleas asserted that "the two schools of thought doctrine applies only to a school of thought advocated by a 'considerable number' of reputable and respected physicians." *Id.* at 6. Yet, the court's charge to the jury provided that a

jury instruction that a physician would be excused from liability if "reputable, respected and reasonable" medical experts supported his treatment.[13] The Pennsylvania Supreme Court reversed and remanded,[14] and held that a physician would escape liability if his medical treatment received the support of a "considerable number" of medical experts.[15]

Traditionally, courts would not find a physician's treatment to be negligent if the doctor adhered to the standard of care followed in the particular locality or in similar communities.[16] Gradually, however, many jurisdictions abandoned the "locality rule" and adopted a national standard of care.[17] Despite the jurisdictional trend toward a more universal standard of care, courts have held that physicians may digress from widely recognized methods of treatment and still avoid malpractice liability by treating patients in accordance with other legally acceptable schools of thought.[18] Under the "two schools of thought" doctrine, physicians are not subject to liability if their treat-

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physician would be exonerated if his treatment were "supported by a reputable and respected body of medical experts." *Id.* at 8.

13. Jones v. Chidester, 579 A.2d 423 (Pa. Super. Ct. 1990).

14. *Chidester*, 610 A.2d at 969.

15. *Id.* at 967. The Pennsylvania Supreme Court determined that, based on the facts of each case, a jury would determine how many recognized and respected medical experts were necessary to create another "school of thought." *Id.*

16. *See, e.g.*, McHugh v. Audet, 72 F. Supp. 394, 399 (M.D. Pa. 1947) (explaining a physician's duty to possess the learning and skill of the ordinary physician in the locality); Meier v. Ross Gen. Hosp., 445 P.2d 519, 526 (Cal. 1968) (same); Force v. Gregory, 27 A. 1116, 1116 (Conn. 1893) (same); Walkenhorst v. Kesler, 67 P.2d 654, 663 (Utah 1937) (same).

17. *See Bierig et al., supra* note 2, at 213. *See generally* Bobby Gibson, Note, *National Standard of Care — A New Dimension of the Locality Rule*, 36 ARK. L. REV. 161 (1983) (concluding that a nonlocal specialist can testify that a local specialist breached the national standard of care); Sherry A. Scott, Comment, *Locality Rule Abandoned In Alabama and Family Practitioner Held To National Medical Neighborhood Standard of Care*, May v. Moore, 14 CUMB. L. REV. 251 (1984) (analyzing the court's holding that general practitioners as well as specialists must adhere to national medical standards). *But cf.* Youngberg v. Romeo, 457 U.S. 307, 323 (1982) (holding a professional immune from liability if budgetary constraints caused the professional to digress from the accepted standard of care). Recent case law stresses that the courts consider the resources available to the physician when determining compliance with the national standard. Mark A. Hall, *The Malpractice Standard in an Era of Cost Containment*, 17 LAW, MEDICINE & HEALTH CARE 347, 349-50 (1989).

18. *See supra* note 5 and accompanying text for a discussion of the "two schools of thought" doctrine.

ment adheres to an accepted school of medical thought.[19] Courts differ, however, as to when a specific medical treatment becomes an acceptable school of thought.[20]

The earliest Pennsylvania case to introduce the "two schools of thought" doctrine was *Remley v. Plummer*.[21] In *Remley*, a steel worker accidentally suffered a partial amputation of his left index finger.[22] During an operation to repair the finger, the patient died.[23] The decedent's mother sued the physician for medical malpractice and alleged that the defendant's improper use of anesthetics during the operation proximately caused her son's death.[24] The court reasoned that the defendant did not act negligently if a "considerable number" of colleagues agreed with his use of anesthetics.[25] Many Pennsylvania cases followed *Remley* and applied the "considerable number" standard when qualifying a treatment as a school of thought.[26]

In *Tobash v. Jones*,[27] however, the Pennsylvania Supreme Court altered the definition of the "two schools of thought" doctrine.[28] *Tobash* involved the issue of whether the defendant physician's excision of plaintiff's spinal cord tissue for biopsy purposes constituted negligent treatment.[29] The trial court's jury instruction provided that the physi-

19. *See supra* notes 4-5 and accompanying text for a discussion of negligence liability.

20. *See infra* note 48 for a list of illustrative cases.

21. 79 Pa. Super. 117 (Pa. Super. Ct. 1922).

22. *Id.* at 119.

23. *Id.*

24. *Id.* at 119-20. Medical experts differed as to whether medical personnel should have administered a heart stimulant to the patient and whether chloroform should have been substituted for ether as an anesthetic in the midst of the operation. *Id.* at 120.

25. *Id.* at 122. In its opinion, the *Remley* court later substituted "majority of brethren who testified" and "large proportion of their professional associates" for "considerable number." *Id.* at 123-24.

26. *See, e.g.*, McHugh v. Audet, 72 F. Supp. 394, 400 (M.D. Pa. 1947) (asserting that a method or form of treatment must be supported by a "considerable number" of medical experts); Brannan v. Lankenau Hosp., 417 A.2d 196, 200 (Pa. 1980) (same); Duckworth v. Bennett, 181 A. 558, 559 (Pa. 1935) (same); D'Angelis v. Zakuto, 556 A.2d 431, 435-36 (Pa. Super. Ct. 1989) (Kelly, J., concurring) (same); Hodgson v. Bigelow, 7 A.2d 338, 347 (Pa. Super. Ct. 1939).

27. 213 A.2d 588 (Pa. 1965).

28. *Id.* at 593. The plaintiff failed to challenge the definition of the "two schools of thought" doctrine. *Id.* at 592. Instead, the plaintiff contended that the doctrine did not apply to the facts and issues of the case. *Id.*

29. *Id.* at 593. Tobash suffered intense and frequent backaches when he came under the care of Dr. Jones. *Id.* at 588. After discovering a partial block of Tobash's

cian should be exculpated of any wrongdoing if "reputable, respectable and reasonable medical experts" endorsed his surgical excision.[30] The Pennsylvania Supreme Court affirmed the trial court's jury instruction.[31] Thus, the court adopted the standard that a physician may not be held negligent if "reputable, respected and reasonable medical experts" supported the doctor's treatment,[32] but did not define how many of such experts qualified as a school of thought.

Subsequently, the Pennsylvania Supreme Court reaffirmed the "considerable number" test in *Brannan v. Lankenau Hospital*.[33] In *Brannan*, expert testimony conflicted as to whether the defendants negligently delayed the administration of antibiotics for the plaintiff's perforated esophagus.[34] The court held that in order for the "two schools of thought" doctrine to apply, the physicians' treatment must

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spinal cord, Dr. Jones performed surgery to alleviate the blockage and found the spinal cord to be "quite abnormal." *Id.* Dr. Jones excised a section of nerve tissue for further examination. *Id.*

30. *Id.* at 592. To support its holding, the court cited the following excerpt from *Remley*:

> The question actually passed upon by the jury was not whether the [two doctors] in their handling of the case, had been guilty in not following a well-recognized and established mode of treatment, but rather, which of two methods, both having their respective advocates and followers of respectable authority, was the safer and better from a surgical standpoint.

Id. at 593.

31. *Id.*

32. Other courts have also accepted the "reputable, respected" standard. *See, e.g.*, Harrigan v. United States, 408 F. Supp. 177, 186 (E.D. Pa. 1976) (holding that a method or form of treatment is not negligent when supported by reputable, respected medical experts); Sinclair v. Block, 594 A.2d 750, 756 (Pa. Super. Ct. 1991) (same); Levine v. Rosen, 575 A.2d 579, 581 (Pa. Super. Ct. 1990) (same).

The "reputable, respected" standard is also identified as the "respectable minority" test. Telephone Interview with Nicholas P. Papadakos, Justice, Pennsylvania Supreme Court (Sept. 2, 1992). *See also* Borja v. Phoenix Gen. Hosp., 727 P.2d 355, 357 (Ariz. Ct. App. 1986) (holding a physician not liable when his treatment garnered the approval of a respectable minority of physicians); Schwab v. Tolley, 345 So.2d 747, 753 (Fla. Dist. Ct. App. 1977) (same); Gruginski v. Lane, 30 P.2d 970, 971 (Wash. 1934) (same).

33. 417 A.2d 196 (Pa. 1980).

34. *Id.* at 199. Brannan consented to an esophagoscopy to remove a piece of beef that was obstructing his esophagus. *Id.* at 198. During surgery, a screw on the surgeon's forceps broke off in Brannan's esophagus, causing the forceps' pointed ends to contact the walls of the esophagus. *Id.* Although the surgeon suspected that he may have perforated Brannan's esophagus, neither he nor another physician prescribed antibiotics for Brannan until 16 hours after surgery. *Id.* Brannan suffered an infection that led to other complications and a subsequent meningeal stroke. *Id.*

be supported by a "considerable number" of medical practitioners.[35] The court reasoned that a "small respected body" of physicians did not qualify as a "considerable number" of medical experts.[36]

More recently, however, the Pennsylvania Superior Court has ignored the *Brannan* standard and has adopted the *Tobash* standard, interpreting the "two schools of thought" doctrine as an absolute defense when a physician's treatment receives the support of "reputable, respected and reasonable" medical experts.[37] In *Furey v. Thomas Jefferson University Hospital*,[38] expert testimony conflicted as to whether the defendant's performance of surgery constituted an acceptable alternative to a more conservative antibiotic treatment.[39] The court applied the "reputable, respected" standard of the "two schools of thought" doctrine while inexplicably citing both *Brannan* and *Tobash* as authority.[40] The court failed to distinguish between the "considerable number" and "reputable, respected" standards discussed in *Brannan*.[41]

In *D'Angelis v. Zakuto*,[42] expert testimony conflicted as to whether the defendant physician properly diagnosed the plaintiffs' son's pneumonia.[43] Because the medical experts differed on the proper diagnosis and not the treatment, the court held that the lower court erred in giving a jury instruction on the "two schools of thought" doctrine.[44]

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35. *Id.* at 200-01.

36. *Id.* at 201. Brannan's expert witness explained that the "great majority" of physicians would have administered antibiotics immediately if they perceived the possibility that a patient sustained a perforated esophagus. *Id.*

37. *See* Sinclair v. Block, 594 A.2d 750, 756 (Pa. Super. Ct. 1991) (holding that "a doctor will not be liable for medical malpractice if he follows a course of treatment supported by reputable, respected and reasonable medical experts"); Levine v. Rosen, 575 A.2d 579, 581 (Pa. Super. Ct. 1990) (same); Trent v. Trotman, 508 A.2d 580, 584 (Pa. Super. Ct. 1986) (same); Furey v. Thomas Jefferson Univ. Hosp., 472 A.2d 1083, 1089 (Pa. Super. Ct. 1984) (same).

38. 472 A.2d 1083 (Pa. Super. Ct. 1984).

39. *Id.* at 1090. Plaintiff suffered from a bacterial infection which caused severe abdominal pain. *Id.* at 1085. After preliminary tests, defendant performed exploratory surgery to discover the cause of plaintiff's discomfort. *Id.* at 1086.

40. *Id.* at 1089. More recent Pennsylvania Superior Court decisions have cited *Furey* when outlining the "two schools of thought" doctrine. *See supra* note 37 for cases that have adopted *Furey*'s definition.

41. *Id.* at 1089-91.

42. 556 A.2d 431 (Pa. Super. Ct. 1989).

43. *Id.* at 432. The defendant diagnosed the twenty-six month old boy with an upper respiratory infection. *Id.* at 431. The boy died, and the autopsy revealed that he had suffered from pneumonia. *Id.* at 432.

44. *Id.* at 433-34. *Accord* Morganstein v. House, 547 A.2d 1180, 1183 (Pa. Super.

In a concurring opinion, Judge Kelly argued that the court gave an incorrect jury instruction because it failed to use the "considerable number" definition of the "two schools of thought" doctrine.[45] Judge Kelly recognized the "reputable, respected" standard as a more liberal standard of care than that required by Pennsylvania law.[46]

The above-referenced cases illustrate the difficulties Pennsylvania has faced in its attempt to precisely define the "two schools of thought" doctrine.[47] By contrast, other states have not attempted to define the standard by which to measure a "school of thought" with the same level of specificity.[48] Few states have addressed the "two schools of

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Ct. 1988) (holding an instruction on the "two schools of thought" doctrine incorrect where medical experts disagreed on the diagnosis of decedent's ailment).

45. *D'Angelis*, 556 A.2d at 435-36 (Kelly, J., concurring). Judge Kelly cited *Remley* and *Duckworth* as authority. *Id.* at 435.

46. *Id.* at 436. *See supra* note 32 for Judge Papadakos' interpretation of this standard.

47. *See* Michael P. Barrett, *Pennsylvania's Two Schools of Medical Thought Rule*, THE BARRISTER (Pennsylvania Trial Lawyers Ass'n), Winter 1989-90 at 15-19 (tracing the inconsistencies in Pennsylvania's law).

48. *See, e.g.*, Ward v. United States, 838 F.2d 182, 186 (6th Cir. 1988) ("supported by other physicians in good standing"); O'Neill v. Kiledjian, 511 F.2d 511, 513 (6th Cir. 1975) ("when both alternatives have the support of a considerable body of competent medical opinion in the community"); MacDonald v. United States, 767 F. Supp. 1295, 1308 (M.D. Pa. 1991) (citing both "considerable number" and "reputable, respectable, and reasonable experts" standards); Young v. United States, 574 F. Supp. 571, 581 (D. Del. 1983) ("recognized as a proper medical procedure"); Sims v. Callahan, 112 So.2d 776, 783 (Ala. 1959) ("[w]here there are various recognized methods of treatment"); Borja v. Phoenix Gen. Hosp., 727 P.2d 355, 357 (Ariz. Ct. App. 1986) ("respectable minority"); Rickett v. Hayes, 511 S.W.2d 187, 194 (Ark. 1974) ("room for an honest difference of opinion among competent physicians"); Meier v. Ross Gen. Hosp., 445 P.2d 519, 529 (Cal. 1968) ("one of alternative accepted methods of treatment, with which other physicians [agree]"); Wasfi v. Chaddha, 588 A.2d 204, 209 (Conn. 1991) ("one of choice among competent physicians"); Schwab v. Tolley, 345 So.2d 747, 753 (Fla. Dist. Ct. App. 1977) ("methods approved by others of their profession who are reasonably skilled"); Newell v. Corres, 466 N.E.2d 1085, 1089 (Ill. App. Ct. 1984) ("[w]here alternative methods of treatment are shown to be proper"); Joy v. Chau, 377 N.E.2d 670, 673 (Ind. Ct. App. 1978) ("[when] more than one method of treatment is recognized"); Estate of Smith v. Lerner, 387 N.W.2d 576, 581 (Iowa 1986) ("recognized alternative course of action"); Reid v. North Caddo Memorial Hosp., 528 So.2d 653, 658 (La. Ct. App. 1988) ("acceptable method"); Downer v. Veilleux, 322 A.2d 82, 87 (Me. 1974) ("recognized course [ ] of treatment"); Ouellette v. Subak, 391 N.W.2d 810, 816 (Minn. 1986) ("accepted treatment"); Haase v. Garfinkel, 418 S.W.2d 108, 114 (Mo. 1967) ("room for an honest difference of opinion among competent physicians"); McGuire v. Rix, 225 N.W. 120, 123 (Neb. 1929) ("recognized methods"); Scheuler v. Strelinger, 204 A.2d 577, 585 (N.J. 1964) ("still being fought in the halls of medical schools and lectures"); Becker v. Hidalgo, 556 P.2d 35, 38 (N.M. 1976) ("recognized standard"); Fallon v. Loree, 525 N.Y.S.2d 93, 93 (N.Y. App. Div. 1988) ("one of sev-

thought" doctrine in considerable depth.[49]

The Texas Supreme Court rejected both the "considerable number" and "respectable minority" (or "reputable, respected") standards in *Hood v. Phillips*.[50] In *Hood*, the court articulated a new standard while confronting the issue of whether a surgeon improperly treated an emphysema patient by removing one of the carotid bodies from the patient's neck.[51] The court held that a physician is free from liability if a "reasonable and prudent doctor" would have treated the physician's patient in the same manner under similar circumstances.[52] In reaching its holding, the court concluded that the "considerable number" and "respectable minority" standards misleadingly quantify the standard for malpractice.[53]

Jones v. Chidester[54] provided the Pennsylvania Supreme Court with the opportunity to clarify its definition of the "two schools of thought" doctrine.[55] The court rejected the "respectable minority" standard

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eral acceptable techniques"); Walkenhorst v. Kesler, 67 P.2d 654, 668 (Utah 1937) ("treatment employed has the approval of at least a respectable portion of the profession"); Gruginski v. Lane, 30 P.2d 970, 971 (Wash. 1934) ("respectable minority"); Maxwell v. Howell, 174 S.E. 553, 554 (W. Va. 1934) ("approved method"); Holton v. Burton, 222 N.W. 225, 228 (Wis. 1928) ("one of two accepted or recognized methods"); Smith v. Beard, 110 P.2d 260, 266 (Wyo. 1941) (citing both "considerable number" and "respectable minority" standards).

49. Tennessee adopted the "considerable number" standard. Truan v. Smith, 578 S.W.2d 73, 76 (Tenn. 1979). *But cf.* Ward v. United States, 838 F.2d 182, 186 (6th Cir. 1988) (citing *Truan* but substituting "if he chooses a course of treatment supported by other physicians in good standing" for the "considerable number" phraseology).

50. 554 S.W.2d 160 (Tex. 1977).

51. *Id.* at 162. A carotid body is a "receptor for chemical stimuli 'sensitive to the concentration of carbon dioxide in the blood, and assist[s] in reflex control of respiration.'" *Id.* at 162 n.2. (quoting HENRY GRAY, F.R.S., ANATOMY OF THE HUMAN BODY 895 (29th Am. ed. 1973)).

52. *Id.* at 165. The Texas Supreme Court defined the "reasonable and prudent doctor" test as follows: "A physician who undertakes a mode or form of treatment which a reasonable and prudent member of the medical profession would undertake under the same or similar circumstances shall not be subject to liability for harm caused thereby to the patient." *Id. Accord* Ellisa C. Huguley, Comment, *Proving Negligent Deviation From Established Medical Standards*, 37 S.C. L. REV. 245 (1985) (discussing the reasonable prudence of a physician as the issue in question under South Carolina law).

53. *Hood*, 554 S.W.2d at 165. Specifically, the *Hood* court explained that the two standards "could convey to a jury the incorrect notion that the standard for malpractice is to be determined by a poll of the medical profession." *Id.*

54. 610 A.2d 964 (Pa. 1992).

55. *Id.* at 965.

adopted by the Pennsylvania Superior Court in earlier decisions.[56] The *Chidester* court concluded that a considerable number of reputable and respected physicians must concur for a treatment to qualify as a "school of thought."[57] The court reasoned that the "reputable and respected" element insured the quality of a treatment, while the "considerable number" requirement safeguarded the treatment's acceptability within the medical profession.[58] Because the "two schools of thought" doctrine acts as an absolute defense, the court found the "respectable minority" standard to be insufficient.[59]

In fixing the meaning of the "two schools of thought" doctrine, the court did not attempt to numerically define what constitutes a "considerable number" of medical professionals.[60] Instead, the court placed the burden of proving that a considerable number of practitioners support the doctor's course of treatment on the physician, who can meet that burden using experts.[61] Once the defendant presents expert witnesses, the jury is to consider the testimony and determine whether a "considerable number of physicians and recognized and respected experts in their field" support the physician's treatment.[62]

The *Chidester* court grappled with how to determine the creation of a medical "school of thought."[63] In reviewing prior case law, the court mistakenly characterized the "reputable, respected"[64] or "respectable

56. *Id.* at 969 (implicitly overruling Sinclair v. Block, 594 A.2d 750, 756 (Pa. Super. Ct. 1991); Levine v. Rosen, 575 A.2d 579, 581 (Pa. Super. Ct. 1990); Trent v. Trotman, 508 A.2d 580, 584 (Pa. Super. Ct. 1986); Furey v. Thomas Jefferson Univ. Hosp., 472 A.2d 1083, 1089 (Pa. Super. Ct. 1984)).

57. *Chidester*, 610 A.2d at 969. The court set forth the "two schools of thought" doctrine as follows: "Where competent medical authority is divided, a physician will not be held responsible if in the exercise of his judgment he followed a course of treatment advocated by a considerable number of recognized and respected professionals in his given area of expertise." *Id.*

58. *Id.*

59. *Id.* The court reasoned that the "reputable and respected" test merely required a showing that there exists a "small minority" of physicians who agree with the practice. Because the test did not ensure the practice's general acceptance, the court felt it improper. *Id.*

60. *Id.*

61. *Id.* The court clarified that the physician's burden should not prove onerous. *Id.*

62. *Chidester*, 610 A.2d at 969. In a concurring opinion, Justice Zappala opined that it is a question of law for the trial judge to determine whether two schools of medical thought exist. *Id.* at 970 (Zappala, J., concurring).

63. *Id.* at 965.

64. The court implied that the phrases "reputable, respected and reasonable medical

minority"[65] standard as a qualitative standard.[66] The court later implied that the "reputable, respected" standard was too lenient because physicians could exonerate themselves if they could find one respected colleague to agree with their treatment of a patient.[67] As such, the court then correctly, though unintentionally, classified the "reputable, respected medical experts" standard as a quantitative standard.[68] Faced with deciding between two quantitative standards, the court reasoned that the "considerable number" standard more effectively ensured a treatment's quality by requiring the general approval of more physicians.[69] Although the court did not attempt to define "considerable number," juries in future Pennsylvania cases will face that burden.[70]

The better-reasoned view is the qualitative "reasonable and prudent doctor" standard articulated in *Hood*.[71] The "reasonable and prudent doctor" standard is preferable because it allows for the use of "experimental" methods of treatment.[72] By quantifying medical acceptance, the "considerable number" and "respectable minority" standards unfairly bias the jury against medical situations that demand experimentation. The *Hood* standard properly focuses the issue on whether the

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experts" and "respectable minority" were different labels for the same standard. Telephone Interview with Nicholas P. Papadakos, Justice, Pennsylvania Supreme Court (Sept. 2, 1992).

65. *See supra* note 32 & 64 for the usage of these two standards.

66. *See supra* note 53 and accompanying text for the *Hood* court's reasoning in classifying the respectable minority standard as quantitative.

67. Telephone Interview with Nicholas P. Papadakos, Justice, Pennsylvania Supreme Court (Sept. 2, 1992). *See also supra* note 59 for the court's reasoning. *Cf.* Morganstein v. House, 547 A.2d 1180, 1183 (Pa. Super. Ct. 1988) (holding a jury instruction to be erroneous where the jury could have construed that only the testimony of one medical expert, agreeing with the defendant, triggered the use of the "two schools of thought" doctrine); *But cf.* Newell v. Corres, 466 N.E.2d 1085 (Ill. App. Ct. 1984) (introducing the "two schools of thought" doctrine where one doctor supported defendant's treatment as adequate).

68. *See supra* note 53 and accompanying text for a discussion of the *Hood* court's reasoning with respect to this classification.

69. *Chidester*, 610 A.2d at 969. Specifically, the court held that the "considerable number" standard requires the adherence of more physicians "even if it does not rise to the level of a majority." *Id.*

70. *See supra* notes 54-62 and accompanying text for a discussion of the *Chidester* decision.

71. *See supra* notes 50-53 and accompanying text for the *Hood* court's analysis.

72. *See Hood*, 554 S.W.2d at 165 ("[P]hysicians should be allowed to experiment in order that medical science can provide greater benefits for humankind.").

physician acted appropriately under the circumstances.[73] Therefore, the "reasonable and prudent doctor" standard allows for more intellectual flexibility without disregarding the quality concerns of the *Chidester* court.

Within its ambit, the *Chidester* decision clarified the Pennsylvania standard for malpractice.[74] Nevertheless, the "considerable number" standard it adopted perpetuates an oscillating quantitative definition of the "two schools of thought" doctrine.[75] The *Chidester* decision quells debate over the definition of the "two schools of thought" doctrine, but unfortunately encourages a new debate over what constitutes a considerable number of physicians.

*Douglas Rader Brown**

73. The *Hood* court proffered the following factors for determining whether a physician acted prudently and reasonably: "the expertise of and means available to the physician-defendant, the health of the patient, and the state of medical knowledge." *Hood*, 554 S.W.2d at 165.

74. *Chidester*, 610 A.2d at 968-69.

75. *See supra* notes 53, 60-62 and accompanying text for a discussion of the quantitative standard.

* J.D. 1994, Washington University.

RECENT DEVELOPMENTS