

Habit Forming: Evidence of Physician Habit in Medical Negligence Litigation

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Abstract:

”Habit” is a time-honored component of the law of evidence. Habit evidence is generally understood as specific conduct which occurs repetitively, over a period of time, in response to a known stimulus. Habitual conduct is also thought to be non-volitional, suggesting that it encompasses conduct without thought.

This paper focuses on whether the practice of medicine is, in any respect, “habitual.” Are medical negligence litigants, plaintiffs and physicians, entitled to introduce evidence of physician habit to demonstrate deviation from or compliance with the applicable standard of care? Is the practice of medicine entirely volitional and judgmental, such that classic habit evidence is inapplicable to medical negligence litigation? This Article addresses these topics in an effort to identify the various positions adopted by courts in the United States and recommends that courts receive physician habit evidence in medical negligence trials.

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A habit, from the standpoint of psychology, is a more or less fixed way of thinking, willing, or feeling acquired through previous repetition of a mental experience.¹



The physician acquires a volitional habit of taking the pulse and asking patients certain questions. The habit is the familiar way in which his consciousness runs its course during a diagnosis.²

INTRODUCTION

Habit is a venerable topic of the law of evidence, pre-dating its appearance in the Federal Rules of Evidence by many years.³ Of course, habit is currently memorialized by Federal Rule of Evidence 406, which provides:

Rule 406. Habit; Routine Practice

Evidence of a person's habit or an organization's routine practice may be admitted to prove that on a particular occasion the person or organization acted in accordance with the habit or routine practice. The court may admit this evidence regardless of whether it is corroborated or whether there was an eyewitness.⁴

Rule 406 is an important rule of relevance⁵ and admissibility,⁶ yet it neither defines "habit" nor specifies who or what may be the source of habit evidence.

By not defining "habit," Rule 406 does not address the nature of habit evidence. On this point, commentators urge that habit "represents semi-automatic or unreflective behavior,"⁷ also referred to as "nonvolitional activity that occurs with invariable regularity."⁸ One commentator has emphasized that "[i]t is

1. B.R. Andrews, *Habit*, 14 AM. J. PSYCHOL. 121, 121 (1903).

2. *Id.*

3. *See generally* SIMON GREENLEAF, A TREATISE ON THE LAW OF EVIDENCE 53, § 14j. (1899); JOHN HENRY WIGMORE, TREATISE ON THE ANGLO-AMERICAN SYSTEM OF EVIDENCE IN TRIALS AT COMMON LAW, § 270, Rule 40 (1935).

4. FED. R. EVID. 406.

5. *See id.* at 401 (providing the basic definition of "relevance").

6. *See* GLEN WEISSEBERGER, & JAMES J. DUANE, FEDERAL RULES OF EVIDENCE: RULES, LEGISLATIVE HISTORY, COMMENTARY AND AUTHORITY 181 (7th ed. 2011).

7. CHRISTOPHER MUELLER ET AL., EVIDENCE 234-35 (6th ed. 2018); *see also* CHARLES TILFORD MCCORMICK, MCCORMICK'S HANDBOOK OF THE LAW OF EVIDENCE 463 (Edward W. Cleary ed., 2d ed. 1972); ROGER C. PARK ET AL., EVIDENCE LAW, A STUDENT'S GUIDE TO THE LAW OF EVIDENCE AS APPLIED IN AMERICAN TRIALS 296 (4th ed. 2018).

8. *Weil v. Seltzer*, 873 F.2d 1453, 1460 (D.C. Cir. 1989) (discussing physician habit in the

critical that a specific stimulus and a corresponding response can be discretely identified.”⁹ Examples of conduct indicative of habit include walking down stairs in a particular fashion, and signaling while driving an automobile¹⁰—essentially conduct undertaken without thought.

This discussion invites attention to the intersection of habit evidence and the practice of medicine. Do physicians engage in “nonvolitional [professional] activity that occurs with invariable regularity”¹¹ such that they may avail themselves of habit evidence in defense of medical negligence claims? Conversely, should medical negligence plaintiffs be able to use physician habit evidence to establish that defendant-physicians violated applicable standards of care? Or is medical treatment so necessarily patient specific, by virtue of involving the exercise of patient-specific thought and judgment, that the concept of “physician habit” is a misnomer?

This Article focuses on multiple physician habit evidence topics, including: medical judgment, the “requirement” of nonvolitional conduct, the sources of physician habit evidence and jurisprudence developed in the state and federal courts. Additionally, this paper concentrates on physician habit in non-informed consent litigation. The plan, therefore, is to explore the topic to determine whether physician habit evidence is a realistic evidentiary topic.

I. PHYSICIAN HUMANISM—CHARACTER VS. HABIT

Authors from the University of Pennsylvania have noted that “[h]umanism in medicine combines scientific knowledge and skills with respectful, compassionate care that is sensitive to the values, autonomy, and cultural backgrounds of patients and their families.”¹² They identified the following “habits” which support the humanistic practice of medicine: self-reflection, seeking connection with patients, teaching/role modeling humanism, striving to achieve balance, mindfulness and spiritual practice.¹³

The identification of these “habits” requires a discussion of the distinction between character traits and habits. This distinction is necessary to an understanding of the inadmissibility of character evidence and the admissibility

context of medical negligence). It should be noted that not all courts require non-volitional conduct as a condition of admissibility. The volitional nature of the conduct in question may “go to weight . . . not admissibility.” *Rosebrock v. E. Shore Emergency Physicians, LLC*, 221 Md. App. 1, 20-22 (Md. Ct. Spec. App. 2015).

9. WEISSENBERGER & DUANE, *supra* note 6, at 182.

10. MUELLER ET AL., *supra* note 7, at 234-35; MCCORMICK *supra* note 7, at 462.

11. *Weil*, 873 F.2d at 1460.

12. Carol M. Chou et al., *Attitudes and Habits of Highly Humanistic Physicians*, 89 ACAD. MED. 1252, 1252 (2014).

13. *Id.* at 1254.

of habit evidence. Federal Rule of Evidence 404(a)(1) provides:

Rule 404—Character Evidence; Crimes or Other Acts

(a) Character Evidence.

(1) *Prohibited Uses.* Evidence of a person’s character or character trait is not admissible to prove that on a particular occasion the person acted in accordance with the character or trait.¹⁴

“[I]t is understood that character, for evidentiary purposes, means ‘that the person has an ingrained propensity to act in a certain way.’”¹⁵ Many commentators have explained the reasons for the underlying the inadmissibility of character evidence. I have previously provided the following example and explanation:

[T]wo automobiles, driven by A and B, collide in a traffic-controlled intersection. Driver A has been involved in previous traffic accidents and has received traffic citations for poor driving—failure to conform to the traffic laws. Driver A tends to drive carelessly. Driver A’s propensity, in this regard, is inadmissible to prove negligence in the intersection collision litigation. Driver A’s prior carelessness does not prove the Driver A caused the intersection collision. In fact, Driver B may have caused the collision.¹⁶



What is the harm of allowing Driver B to “prove” Driver A’s careless character trait? It has been explained that there are two justifications for this exclusionary rule: (1) the evidence may be too influential on the jury, and (2) “the prevention of nullification prejudice,”—the idea that the jury will use character evidence to reach a verdict despite evidence suggesting a different result.* Another equally cogent explanation is that: “character evidence carries a very high *intuitive* value . . . [t]his raises the distinct possibility that the jury will

14. FED. R. EVID. 404.

15. Marc D. Ginsberg, *An Evidentiary Oddity: “Careful Habit” – Does the Law of Evidence Embrace This Archaic/Modern Concept?*, 43 OHIO N.U.L. REV. 293, 297 (2017) (citing Glen Weissberger, *Character Evidence Under the Federal Rules: A Puzzle with Missing Pieces*, 48 CIN. L. REV. 1, 2 (1979)).

16. *Id.* at 297.

greatly overvalue character evidence as a predictor of conduct, and make an inaccurate assessment of the facts.”¹⁷

It is quite clear that the concern with inadmissible character evidence in medical negligence litigation has been recognized for well more than one hundred years.¹⁸

I mention these fundamentals of character evidence in an admittedly circuitous attempt to urge that the six previously mentioned “habits” supporting a humanistic practice of medicine¹⁹ are not habits as contemplated by Rule 406.²⁰ Instead, they are inadmissible character traits governed by Rule 404.²¹

Insofar as Rule 406²² requires semi-automatic or non-volitional conduct,²³ it is fair to question whether physicians demonstrate professional habitual conduct at all. Patients are not fungible, and often require individualized treatment. Sir William Osler, a preeminent physician, notes: “Variability is the law of life, and as no two faces are the same, so no two bodies are alike, and no two individuals react alike and behave alike under the abnormal conditions which we know as disease.”²⁴ Osler, therefore, suggests the need for thought and judgment in the treatment of patients. If so, is medical treatment consistent with semi-automatic or non-volitional conduct?

II. ONCE IS NOT ENOUGH—HABIT REQUIRES REPETITION

It seems intuitively obvious that habit evidence requires proof of repetition. At least one appellate court, in a medical negligence context, has made this point. In *Gerke v. Norwalk Clinic*,²⁵ a patient commenced a medical negligence claim

17. *Id.* at 298 (citing Barrett J. Anderson, *Recognizing Character: A New Perspective on Character Evidence*, 121 YALE L.J. 1914, 1928-29 (2012) (quoting Roger C. Park, *Character at the Crossroads*, 49 HASTINGS L.J. 717, 745 (1998)); Miguel A. Mendez, *The Law of Evidence and the Search for a Stable Personality*, 45 EMORY L.J. 221, 223-24 (1996); David P. Leonard, *The Federal Rules of Evidence and the Political Process*, 22 FORDHAM L. REV. 305, 311 (1995)).

18. *See Holtzman v. Hoy*, 118 Ill. 534 (1886) (discussing the impropriety of asking a defense medical witness about the defendant-physician’s “reputation . . . in the community, and amongst the profession, as being an ordinarily skillful and learned physician”).

19. Chou et al., *supra* note 12.

20. FED. R. EVID. 406.

21. *Id.* at 404.

22. *Id.* at 406.

23. *But see, Rosebrock*, 221 Md. App. 1; *Aikman v. Kanda*, 975 A.2d 152 (D.C. 2009) (parenthetical would be helpful here, please!).

24. SIR WILLIAM OSLER, *On the Educational Value of the Medical Society*, in AEQUANIMITAS: WITH OTHER ADDRESSES TO MEDICAL STUDENTS, NURSES AND PRACTITIONERS OF MEDICINE, p. 3 (1914); *see also* Mary V. Seeman & Robert E. Becker, *Osler and the Way We Were Taught*, 27 MED. SCI. EDUC. 555, 556 (2017). As to Osler’s prominence as a physician, *see* Richard L. Golden, M.D., *William Osler at 150: An Overview of a Life*, 282 J. AM. MED. ASS’N 2252 (1999).

25. *Gerke v. Norwalk Clinic, Inc.*, 2006-Ohio-5621, ¶ 1 (Ohio Ct. App. 2006).

against a physician and clinic for improper treatment of an ovarian cyst.²⁶ At trial, the jury returned a verdict for the defendants.

During trial, plaintiff unsuccessfully sought to introduce evidence of the defendant-physician's treatment of plaintiff's cyst eleven years earlier to demonstrate how the physician treated plaintiff in 1999. The Court of Appeals easily disposed of plaintiff's position, stating that:

In order for evidence of habit to be admissible, it must establish a regular or routine practice. Evidence as to one or two isolated occurrences does not establish a sufficient regular practice of admission pursuant to Evid.R.406. [citations omitted].

Here, appellant attempts to use a single act . . . to show that [defendant-physician] acted similarly in 1999 . . . The 1988 treatment is a single occurrence and does not establish a regular practice as required by Evid.R.406.²⁷

There was nothing surprising or improper about the trial court's exclusion of the proposed "habit" evidence and the Court of Appeals' approval of the ruling. For habit to exist, evidence of repetition is required.

III. PHYSICIAN JUDGMENT AND VOLITION

Physician judgment is no stranger to the medical literature.²⁸ It is central to the practice of medicine. "Judgment has been defined as the ability to make correct decisions with uncertain, incomplete, or inconsistent information."²⁹ The primacy of medical clinical judgment has been explained as follows:

A basis of this profession is *clinical judgment*. It lies at the heart of the doctor's connoisseurship, expertise and skills, being

26. "An ovarian cyst is a sac or pouch filled with fluid or other tissue that forms in or on an ovary." *What is an Ovarian Cyst?*, AM. C. OBSTETRICIANS & GYNECOLOGISTS, <https://www.acog.org/Patients/FAQs/Ovarian-Cysts?IsMobileSet=false> (last visited Aug. 14, 2019).

27. *Gerke*, 2006 WL 3041095, at *12.

28. See Michael Accad & Darrel Francis, *Does Evidence Based Medicine Adversely Affect Clinical Judgment?*, 362 BRITISH MED. J. 1 (2018); Gunver S. Kienle & Helmut Kiene, *Clinical Judgment and the Medical Profession*, 17 J. EVALUATION CLINICAL PRAC. 621 (2011); Christopher A. Feddock, *The Lost Art of Clinical Skills*, 120 AM. J. MED. 374 (2007); Mark R. Tonelli, *The Philosophical Limits of Evidence-based Medicine*, 73 ACAD. MED. 1234 (1998); Harold Laufman, *Some Thoughts on Surgical Judgment*, 38 SURGICAL CLINICS N. AM. 1171 (1958); Robert M. Bartlett, *The Teaching of Surgical Judgment*, 121 AM. J. SURGERY 220 (1971); John R. Clarke, *Decision Making in Surgical Practice*, 13 WORLD J. SURGERY 245 (1989).

29. Clarke, *supra* note 28, at 245.

‘almost as important as the technical ability to carry out the procedure itself.’ Clinical judgment is developed through practice, experience, knowledge and continuous critical analysis. It extends into all medical areas: diagnosis, therapy, communication and decision making.³⁰

Surgical judgment has been the focus of comment for many years. It has been referred to as “the most vital single factor in the practice of surgery—the judgment on which treatment is based.”³¹ It is “a special form of clinical judgment consisting of the decisions whether or not to operate and what operation to perform.”³²

The concepts of clinical and surgical judgment fit well with Osler’s teachings of patient individuality. Consider the following commentary, more than sixty years ago, on the obligations of a surgeon, emphasizing the need:

[T]o know that there is no such thing as an “average” patient. Even the most ‘ordinary’ patient with the “simplest” lesion has certain sensitivities, stresses, patterns peculiarly his own, requiring the surgeon’s individual attention to his particular problem.

A surgeon who works in the climate of this basic attitude will be swiftly and sensitively respondent to unexpected reactions and events for which surgeons who think in stereotypes may be unprepared.³³

• • • • •

Even as a patient must not be regarded as ‘average,’ so the tendency to regard procedures as ‘routine’ must be avoided. . . . It suggests an unthinking, undifferentiating stereotypy in the surgeon’s attitude which will, if adopted, obviate any real potential for what is called surgical judgment.³⁴

If volition “refers to the capacity of humans . . . to initiate actions based on internal decision and motivation, rather than external stimulation,”³⁵ it may be

30. Kienle & Kiene, *supra* note 28, at 621 (internal citations omitted).

31. Fred R. Fairchild, *Surgical Judgment*, 24 CAL. & W. MED. 471, 471 (1926).

32. Clarke, *supra* note 28, at 245.

33. Laufman, *supra* note 28, at 1173.

34. *Id.* at 1174.

35. Patrick Haggard & Hakwan Lau, *What is Volition?*, 229 EXPERIMENTAL BRAIN RES. 285, 285 (2013).

fair to suggest that the exercise of judgment is inextricably bound to volitional actions. If this analysis is viable, physicians do not treat patients through non-volitional conduct seemingly required to establish habit evidence pursuant to Rule 406.³⁶

IV. IS NON-VOLITIONAL PHYSICIAN CONDUCT REQUIRED TO ESTABLISH EVIDENCE OF PHYSICIAN HABIT?

There is case law to support the proposition that a physician's volitional conduct does not defeat an effort to utilize that conduct to establish evidence of habit.³⁷ In *Aikman v. Kanda*, the defendant cardiac surgeon repaired plaintiff's mitral valve³⁸ through an open-heart procedure. Post-operatively, plaintiff developed multiple complications and sued the defendant, "contending that her injuries resulted from air that accumulated in her heart while it was open during the surgery and that traveled to her brain[.]"³⁹ Specifically, plaintiff alleged that the defendant surgeon "either failed to employ procedures to remove air from her heart (so-called 'air drill' procedures) before completing the surgery, or performed the air drill inadequately."⁴⁰ The jury returned a verdict in favor of the surgeon.⁴¹

On appeal, plaintiff claimed error in that the surgeon was permitted to testify to his habit (or routine practice) of performing an intraoperative procedure to remove air from plaintiff's heart. The basis of the alleged evidentiary error was "that there was no contemporaneous notation in [plaintiff's] medical records indicating that [the surgeon] had performed an air drill before completing the surgery."⁴² Furthermore, "by the time the lawsuit was filed, no one on the surgical team could specifically recall the details of [plaintiff's] surgery."⁴³

The surgeon's trial testimony insofar as it related to habit was explained as follows:

36. FED. R. EVID. 406.

37. *Rosebrock*, 221 Md. App. 1; *Aikman*, 975 A.2d. 152.

38. *Aikman*, 975 A.2d at 155.

39. Heart "valves prevent the backward flow of blood." *Anatomy and Function of the Heart Valves*, JOHNS HOPKINS MEDICINE, <https://www.hopkinsmedicine.org/health/conditions-and-diseases> (last visited Feb. 5, 2019). The mitral "valve is located between the left atrium and the left ventricle." *Id.*

40. *Aikman*, 975 A.2d at 155. The court's description suggests that plaintiff alleged central nervous damage resulting from air embolization during heart surgery. See Jens Tingleff et al., *Intraoperative Echocardiographic Study of Air Embolism During Cardiac Operations*, 60 ANNALS THORACIC SURGERY 673 (1995); Jean-Paul Dalmas et al., *Intracardiac Air Cleaning in Valvular Surgery Guided by Transesophageal Echocardiography*, 5 J. HEART VALVE DISEASE 553, 555 (1996).

41. *Aikman*, 975 A.2d at 155.

42. *Id.*

43. *Id.* at 157.

[He] explained during . . . trial that he performed the air drill “100 percent of the time” as an “integral part” of mitral valve surgery, but he attributed his inability to recall his actions during [plaintiff’s] surgery to his having performed over 500 mitral valve operations over the course of his career (with an average of forty or fifty such procedures each year).⁴⁴

The Court of Appeals referred to the often-pronounced nature of habit evidence as a “regular response to a repeated situation to the point where the doing of the habitual act may become *semi-automatic*,”⁴⁵ and noted the defendant-surgeon’s testimony as follows:

[He] established that he had performed more than 500 mitral valve operations . . . and he testified that the air drill “is an integral part of the procedure. So, I do it every time.” In addition, [he] described his air drill routine step by step, and in great detail, and described his specific responses to various triggers and developments that occur over the course of the procedure . . . [I]n light of the high . . . “ratio of reactions to situations” that [he] described and the specificity of his account of his routine, we cannot conclude that [the court] erred in determining that, for [him] the air drill was semi-automatic in nature.⁴⁶

It is not clear from the Court’s recitation of the surgeon’s testimony that each “trigger and development” occurs with every patient. If this is so, it is fair to suggest that the air drill procedure involves volition and judgment. On the other hand, if an air drill procedure is always performed during mitral valve surgery, the performance is automatic, even if the details of performance may vary among patients.

In any event, the Court of Appeals agreed with the trial court “that the volitional nature of habitual conduct is relevant to its probative force, not its admissibility.”⁴⁷ This approach relaxes the evidentiary burden on physicians seeking to introduce habit evidence.

Aikman v. Kanda was recently cited, with approval, in *Rosebrock v. E. Shore Emergency Physicians, LLC*.⁴⁸ In *Rosebrock*, a nurses’ aide “slipped and fell on a wet floor in a patient’s room” in a nursing home.⁴⁹ The evidentiary issue was

44. *Id.*

45. *Id.*

46. *Id.* at 163.

47. *Id.* at 163.

48. *Rosebrock*, 221 Md. App. 1.

49. *Id.* at 5.

whether a physician could testify regarding his routine examination for a patient on a backboard.⁵⁰ After testifying that he treated multiple “patients per shift who were presented by ambulance on a backboard,”⁵¹ that annually he saw thousands of patients, “and conduct[ed] a spine examination on every patient on a backboard before removal,”⁵² he further testified that:

I do the same process every time I have a patient on the backboard. The nurses don’t take patients off the backboard. The paramedics don’t take them off the backboard. It’s only the physician that can, what we call, clear the spine and I do it the same way, every single time, every day that I work.⁵³

On appeal, the appellant urged that the physician’s trial testimony did not meet the requirements of habit because the physician’s examination of patients positioned on backboards was “variable activity which requires thought and decision making,”⁵⁴ essentially arguing that the patient examination involved volitional conduct.⁵⁵ The Court rejected appellant’s position, citing *Aikman v. Kanda*,⁵⁶ specifically referring to that court’s holding that the volitional nature of medical treatment relates to weight, not admissibility of habit evidence.⁵⁷

Volitional conduct/semi-automatic conduct by physicians is not always viewed so charitably by courts with respect to habit evidence. Very recently, the Court of Appeals of Ohio considered unique patient presentations and individual patient assessments as mitigating against acceptable semi-automatic conduct or “responsive behavior to a repeated stimulus” necessary to establish admissible physician habit.⁵⁸

Similarly, the Superior Court of Pennsylvania recently commented on the nature of emergency medicine treatment⁵⁹ as non-habitual conduct:

[T]he manner in which [the defendant-physician] treated patients with Decedent’s symptoms was not reflexive, instinctive, semi-automatic or mundane in nature. Medical patients are not

50. For a paper on the use of backboards for spinal immobilization, see Derek Cooney et al., *Backboard Time for Patients Receiving Spinal Immobilization by Emergency Medical Services*, 6 INT’L J. EMERGENCY MED. 17 (2013).

51. *Rosebrock*, 221 Md. App. at 21.

52. *Id.*

53. *Id.*

54. *Id.*

55. *Id.*

56. *Aikman*, 975 A.2d at 163-63.

57. *Rosebrock*, 221 Md. App. at 22.

58. *Robinson v. Mercy St. Vincent Med. Ctr.*, 113 N.E. 3d 1100, 1116 (Ohio Ct. App. 2018).

59. *Sutch v. Roxborough Mem’l Hosp.*, 151 A.3d 241, 253 (Pa. Super. Ct. 2016).

manufactured on assembly lines; they each have unique attributes and idiosyncrasies that call for individualized care. The notion that [the defendant-physician] treats each patient with Decedent's symptoms as reflexively as, for example, the manner in which he climbs stairs is preposterous. His proposed testimony fell well outside the boundaries of Pa.R.E. 406.⁶⁰

In *Figueroa v. Highline Medical Center*,⁶¹ the Court of Appeals of Washington reviewed a trial court's exclusion of proposed habit evidence from the defendant-emergency medicine physician. On appeal from an adverse verdict, the defendant-physician urged "that the trial court improperly precluded him from testifying as to his habit and routine practice of orally instructing patients with compartment syndrome."⁶²

The Court of Appeals referred to Washington state precedent and noted that "not all behavior claimed as regular and consistent in similar circumstances is admissible as habit evidence[.]"⁶³ The Court of Appeals characterized the defendant-physician's conduct as "not consistent and automatic."⁶⁴ The physician had not encountered this medical condition "either before or since [the patient]."⁶⁵ Accordingly, the defendant-physician's proposed testimony did not rise to the level of habit evidence.

In *Glusaskas v. Hutchinson*,⁶⁶ the New York Appellate Division reviewed and reversed a jury verdict in favor of the defendant-cardiovascular surgeon. Curiously, the trial court admitted in evidence "a videotape prepared exclusively for trial by defendant physician of a surgery performed by him on another patient."⁶⁷ Apparently, the trial court "permitted the use of the tape . . . , ruling that it was sufficiently relevant to show the jury how the procedure was done[.]"⁶⁸ The appellate opinion clearly reveals that the videotaped surgical procedure involved a patient of a different sex, a different age, and with a different physical condition than the patient at issue.⁶⁹ Although the defendant-physician believed the videotape would assist in educating the jury, the Appellate

60. *Id.* at 252-53.

61. *Figueroa v. Highline Med. Ctr.*, No. 68272-5-1, 2013 WL 5636674, at *2 (Wash. Ct. App. Oct. 14, 2013).

62. *Id.* at *4. For an excellent discussion of compartment syndrome, see Kirsten G.B. Elliott & Alan J. Johnstone, *Diagnosing Acute Compartment Syndrome*, 85 J. BONE & JOINT SURGERY 625 (2003).

63. *Figueroa*, 2013 WL 5636674, at *2.

64. *Id.*

65. *Id.*

66. *Glusaskas v. Hutchinson*, 148 A.D.2d 203, 209 (N.Y. App. Div. 1989).

67. *Id.* at 204.

68. *Id.* at 205.

69. *Id.*

Division concluded that “it is evident that the actual effect of exhibiting the film, if not the defendant’s unexpressed intention, was to endeavor to persuade the jury that because he had carefully and successfully operated on another heart patient, he had applied the same degree of care”⁷⁰ during the surgery he performed for the patient at issue.

The Appellate Division was not impressed by the defendant-physician’s rationale. It commented that “proof of regular usage or habit might be warranted where deliberate and repetitive practice is involved”⁷¹ but physicians performing surgery treat patients with unique medical conditions and that “the actions of the operating doctor”⁷² are unique, as well.

The point here is that habit evidence is in the eye of the beholder. Physician conduct is different than one’s habit of stopping the car at a red light, always locking the door upon leaving home, or descending stairs one step at a time. Understanding that there is no bright line test for the admissibility of physician habit evidence, this paper will now focus on the sources of physician habit evidence and the various contexts in which physician habit evidence has been admitted in evidence.

V. SOURCES OF PHYSICIAN HABIT EVIDENCE

As mentioned earlier, Rule 406 does not specify sources of habit evidence. It is fair to expect that physician habit evidence would derive from the physician’s own testimony about the physician’s practice habit. The physician is the obvious choice as the witness to testify about their own practice habits. In various jurisdictions, courts have considered whether patients, nurses, physician staff, and records can be the source of physician habit evidence. These less obvious but potentially controversial sources of habit evidence are worthy of attention here.

A. Patients

Whether a physician’s patient or patients can be the source of physician habit evidence raises serious evidentiary concerns. A patient, even a series of patients, only are aware of their respective experiences. If patient testimony is a theoretical source of physician habit evidence, how many patients must testify to establish evidence of habit? The text of Rule 406 does not speak to this question. Additionally, patients, as lay persons, do not have the knowledge, skill or expertise to testify about medical treatment or conditions. As non-expert

70. *Id.* at 205-06.

71. *Id.* at 206.

72. *Id.*

witnesses,⁷³ patients are very likely unqualified to testify to the detail necessary to establish physician habit. Furthermore, the testimony of a physician's other patients' experiences runs the risk of implicating impermissible character evidence, inadmissible pursuant to Federal Rule of Evidence 404.⁷⁴

This having been said, some courts have embraced patient testimony as the source of physician habit evidence. That jurisprudence is now addressed.

1. Patients Permitted to Provide Physician Habit Evidence

In *Crawford v. Fayez*, the Court of Appeals of North Carolina approved the trial court's decision pursuant to which "five of defendant's former patients were permitted to testify . . . that defendant had informed them of Medrol's⁷⁵ possible side effects, including bone damage."⁷⁶ Predictably, plaintiff contended "that 'habit' may not be proven by the testimony of a succession of witnesses who observed the behavior in question on a single occasion"⁷⁷ and requires proof "by the testimony of a witness who has regularly observed the habitual behavior."⁷⁸

The Court of Appeals referred to the state's evidentiary rule 406⁷⁹ and noted (as with Federal Rule of Evidence 406) its silence "as to the methods by which the existence of habit may be proven[.]"⁸⁰ It then precisely raised the issue on appeal, as follows: "It is unclear, however, whether habit may be shown by a succession of witnesses who observed the relevant conduct on separate, single occasions."⁸¹

To address this issue, the Court of Appeals purported to review and consider federal authority regarding Rule 406 and concluded that the trial testimony of defendant's former patients was permissible to establish habit.⁸² Specifically, the Court of Appeals referred to *Wetherill v. University of Chicago*,⁸³ a case

73. See FED. R. EVID. 702; *Daubert v. Merrell Dow Pharm.*, 43 F.3d 1311 (9th Cir. 1995).

74. FED. R. EVID. 404; see also Marc D. Ginsberg, *Good Medicine/Bad Medicine and the Law of Evidence: Is There A Role For Proof of Character, Propensity, or Prior Bad Conduct in Medical Negligence Litigation?*, 63 S.C.L. REV. 367 (2011).

75. See Akbar K. Waljee et al., *Short Term Use of Oral Corticosteroids and Related Harms Among Adults in the United States: Population Based Cohort Study*, 357 BRITISH MED. J. j1415 (2017). It is unclear how, precisely, this supports your statement. Are you offering examples of side effects? If so, consider adding this at the end of the sentence and elaborating more in a parenthetical.

76. *Crawford v. Fayez*, 112 N.C. App. 328, 331 (1993).

77. *Id.*

78. *Id.*

79. N.C. Gen. Stat. § 8C-1, Rule 406 (2018).

80. *Crawford*, 112 N.C. App. at 332.

81. *Id.*

82. *Id.* at 336.

83. *Wetherill v. Univ. of Chi.*, 570 F. Supp. 1124 (N.D. Ill. 1983).

involving a claim of “injury by exposure in utero to diethylstilbestrol (“DES”)⁸⁴ administered to . . . mothers as part of a study . . . conducted in the early 1950s at the University of Chicago . . . hospitals.”⁸⁵ It is true that in *Wetherill* patients were permitted to testify regarding a “routine practice of securing [patient] consent;”⁸⁶ however, physicians testified as well. The *Crawford* court omitted this reference to physician testimony when holding that the testimony at trial of five of defendant’s former patients was sufficient to establish physician habit.⁸⁷

Patient testimony to establish physician habit was also approved in *Hall v. Arthur*.⁸⁸ Here, the Eighth Circuit Court of Appeals considered an informed consent claim in the context of a neurosurgical procedure, “an anterior cervical discectomy and fusion[.]”⁸⁹ At trial, the court permitted “testimony from patients other than [plaintiff] concerning what [defendant] told them about [disk replacement material] prior to surgery.”⁹⁰ Without citation to authority other than Rule 406, the Eighth Circuit held that this testimony “was properly admitted under Fed. R. Evid. 406, as evidence of the routine practice of an organization.”⁹¹ Frankly, unless the Eighth Circuit was implicating an informed consent process utilized by the medical center at which the defendant practiced medicine, it seems that the Eighth Circuit should have approved the patients’ testimony as evidence of habit of a physician, not as evidence of the routine practice of an organization.

2. Patients Not Permitted to Provide Physician Habit Evidence

Not all courts are receptive to permitting patient testimony as evidence of physician habit. Of course, a danger of patient testimony is the admission of character evidence, prohibited by Rule 404 and state counterparts. An additional evidentiary concern is “relevance.” A physician’s treatment of any single patient is not logically related to the treatment of another patient.

84. See Linda Titus et al., *Birth Defects in the Sons and Daughters of Women Who Were Exposed in Utero to Diethylstilbestrol (DES)*, 33 INT’L J. ANDROLOGY 377 (2010).

85. *Wetherill*, 570 F. Supp. at 1125.

86. *Id.* at 1127.

87. *Crawford*, 112 N.C. App. at 331.

88. *Hall v. Arthur*, 141 F.3d 844 (8th Cir. 1998).

89. *Id.* at 847. For literature regarding the use of anterior cervical discectomy and fusion to treat cervical spine disorders, see Rahul Yadav et al., *Post-Operative Complications in Patients Undergoing Anterior Cervical Discectomy and Fusion: A Retrospective Review*, 4 J. NEUROANAESTHESIOLOGY & CRITICAL CARE 170 (2017).

90. *Hall*, 141 F.3d at 849.

91. *Id.*

a. United States Court of Appeals, District of Columbia

In *Weil v. Seltzer*,⁹² the Court of Appeals for the D.C. Circuit framed the appellate issue as follows: “whether the district court erred in permitting the testimony of five of the defendant’s former patients in order to establish the defendant’s habit and routine practice of prescribing steroids to his patients.”⁹³ This issue arose from medical negligence litigation involving a physician who allegedly “prescribed steroids to [the patient] on his first visit in 1963 and continued to prescribe steroids over a period of more than twenty years.”⁹⁴ The Court of Appeals opinion reveals an astounding amount of steroid tablets purchased by the treating physician. Apparently, he routinely advised patients that the prescribed tablets were antihistamines and decongestants, not steroids.⁹⁵

The medical negligence claim against the defendant-physician was tried twice, the second trial yielding a verdict for plaintiff. It was during this trial that five former patients of the defendant-physician were permitted to testify to establish “that [defendant-physician] had prescribed steroids to other allergy patients while representing the drugs to be antihistamines or decongestants.”⁹⁶

The Court of Appeals undertook an extensive analysis of habit evidence pursuant to Rule 406. In so doing, the Court of Appeals acknowledged the non-volitional nature of habit: “activity that occurs with invariable regularity,”⁹⁷ a “consistent method or manner of responding to a particular stimulus,”⁹⁸ with a “reflexive, almost instinctive quality.”⁹⁹ The Court of Appeals questioned whether the defendant-physician’s treatment of other patients *as explained by the patients*, would satisfy the need for proof of a physician’s conduct with sufficient regularity.¹⁰⁰

The Court of Appeals focused on the patients’ inability to know how the defendant-physician treated other patients. It noted that “[f]or the former patient testimony to be at all probative [of physician habit] it must show that [the defendant-physician] responded the same way with each patient as he did with the testifying patient.”¹⁰¹ As the testimony of the former patients did not establish physician habit, the testimony constituted character evidence, which was

92. *Weil*, 873 F.2d 1453.

93. *Id.* at 1455.

94. *Id.* at 1456.

95. *Id.*

96. *Id.* at 1460.

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.* at 1461.

inadmissible under Federal Rule of Evidence 404.¹⁰² Accordingly, the Court of Appeals vacated the district court's judgment on the jury verdict in favor of the plaintiff.¹⁰³

b. California

A California Court of Appeal considered the issue of patient supplied, physician habit evidence in *Jackson v. Hajj*,¹⁰⁴ a case involving a medical negligence claim against a surgeon who performed disk compression surgery for a patient with a herniated lumbar disk.¹⁰⁵ Regrettably, post-operatively, the patient suffered serious complications and died.¹⁰⁶ The apparent cause of death was a lacerated abdominal aorta which occurred during surgery.¹⁰⁷

At trial, “the court had excluded evidence . . . of an allegedly similar misadventure with another patient, which took place some time after the decedent's surgery.”¹⁰⁸ Plaintiff offered this evidence to establish the custom and habit of the surgeon.¹⁰⁹

The Court of Appeal held that plaintiff's proposed evidence “was manifestly insufficient . . . to establish any ‘habit’ or ‘custom’ of [the defendant]”¹¹⁰ but used somewhat equivocal language in so holding. In finding a lack of evidentiary foundation for habit evidence, the Court of Appeal stated that plaintiff “never sought to elicit any evidence from [the defendant-physician]—or from any other competent source—to establish [defendant-physician's] actual habits or customs.”¹¹¹ The Court of Appeal never suggested the identity of another competent source for evidence of habit. The Court of Appeal also noted that plaintiff's expert witness would “not have had any actual knowledge of [defendant's] habits and customs.”¹¹² Additionally, it commented on the impossibility of attempting to compare the other patient to the decedent and that the other “patient's surgery involved a different portion of the spine, and resulted

102. *Id.*

103. *Id.*

104. *Jackson v. Hajj*, No. E030178, 2003 WL 21329772 (Cal. Ct. App. June 10, 2003).

105. *Id.* at *3. For a paper discussing this surgery, see Mahsa Sedighi & Ali Haghnegahdar, *Lumbar Disk Herniation Surgery: Outcome and Predictors*, 4 GLOBAL SPINE J. 233 (2014); see also N.K. Anjarwalla et al., *The Outcome of Spinal Decompression Surgery 5 Years On*, 16 EUR. SPINE J. 1842 (2007).

106. *Jackson*, 2003 WL 21329772, at *3.

107. *Id.* This intra operative injury has been reported in the medical literature. See W. Roy Smythe & Jeffrey P. Carpenter, *Upper Abdominal Aortic Injury During Spinal Surgery*, 25 J. VASCULAR SURGERY 774 (1997).

108. *Jackson*, 2003 WL 21329772, at *7.

109. *Id.* at *3-4.

110. *Id.* at *4.

111. *Id.*

112. *Id.*

in injury to a different vessel[.]”¹¹³

The Court of Appeal reached the correct decision in *Jackson v. Hajj*. Clearly, the defendant-surgeon would have been the appropriate source of evidence to establish his habit (if he had offered such evidence). The reference to an unidentified potential other source of habit evidence was curious.

c. Louisiana

In *Joseph v. Williams*,¹¹⁴ the Court of Appeal of Louisiana reviewed a podiatry malpractice claim in which the trial court granted the defendant’s “motion in limine to exclude the testimony of his former patient, . . . in [plaintiff’s] case-in-chief.”¹¹⁵ Plaintiff’s strategy in proposing this testimony, along with her own, was to “establis[h] that [the podiatrist] had a habit of persuading patients to submit to surgery based on his failure to disclose the risks of surgery.”¹¹⁶ The podiatrist was permitted “to testify as to his habit . . . in obtaining informed consent[.]”¹¹⁷ The Court of Appeals noted the propriety of the podiatrist’s own habit testimony at trial¹¹⁸ and that “the former patient’s testimony was inadmissible other similar acts (character) evidence.”¹¹⁹

d. Ohio

In *Cardinal v. Family Foot Care Centers, Inc.*,¹²⁰ the Court of Appeals of Ohio considered a defense verdict in a podiatry malpractice case. An evidentiary issue was whether plaintiff should have been permitted “to introduce the testimony of several former patients who would have testified that they were cajoled into unnecessary surgery by the [sic] [defendants].”¹²¹ Without any particular analysis, the Court of Appeals referred to Ohio Evidence Rule 406 and held that “[t]he testimony in the instant case did not rise to the level of habit.”¹²²

e. Texas

In *Pisharodi v. Saldana*,¹²³ the Court of Appeals of Texas affirmed a

113. *Id.*

114. *Joseph v. Williams*, 105 So.3d 207 (La. Ct. App. 2012).

115. *Id.* at 218.

116. *Id.*

117. *Id.*

118. *Id.* at 219.

119. *Id.*

120. 40 Ohio App. 3d 181 (1987).

121. *Id.* at 182.

122. *Id.*

123. *Pisharodi v. Saldana*, No. 13-13-00721-CV, 2015 WL 7352301 (Tex. Civ. App. Nov. 19,

plaintiff's verdict in a medical negligence claim against a neurosurgeon relating to the patient's death following a lumbar epidural steroid injection.¹²⁴ At trial, the court permitted another patient in the defendant's office at the same time as the deceased to testify "about what he observed and experienced that day as a patient, including what he heard and saw after [decedent's] collapse, and the extent of care that Dr. Pisharodi provided to [the other patient]."¹²⁵ This testimony was permitted despite a habit evidence¹²⁶ objection. The defendant urged "that testimony from [a] lay witness . . . was improper habit evidence because it would have been impossible for [him] to know what was done as a matter of routine with all of Dr. Pisharodi's patient[s] from his one and only encounter as a patient."¹²⁷

The Court of Appeals essentially held that the other patient's testimony was not impermissible habit evidence and that this patient testified to his observations. One wonders why this patient was allowed to testify about "the extent of care that Dr. Pisharodi provided to [him]."¹²⁸ The care rendered to one patient does not tend to prove any relevant fact relating to the care rendered to another patient.

The above jurisdictional survey supports the position that patients should not constitute a permissible source of physician habit evidence. Patients are simply not qualified to testify regarding the details of medical care and treatment. They are able to testify from their personal knowledge about their experiences with a physician, but it is unlikely that they can testify to medical terminology, and their personal treatment experiences are not relevant to the experiences of other patients. Even a large number of patients treated by the same physician cannot overcome these obstacles. Each can only testify, as lay witnesses, to their personal physician encounters. Patients are not a valid source for physician habit evidence.

B. Nurses

Physicians and nurses work together in various clinical settings.¹²⁹ Certainly, there are nurses who frequently work with particular physicians and have

2015).

124. Lumbar epidural steroid injections are commonly used to treat low back pain. See James Fredrich & Mark A. Harrast, *Lumbar Epidural Steroid Injections: Indications, Contraindications, Risks, and Benefits*, 9 CURRENT SPORTS MED. REP. 44 (2010).

125. *Pisharodi*, 2015 WL 7352301, at *16.

126. FED. R. EVID. 406.

127. *Pisharodi*, 2015 WL 7352301, at *16.

128. *Id.*

129. See generally Robert Boissoneau, et al., *A National Study: The Use of Specialty Surgical Teams*, 17 HEALTH MKT. Q. 49 (1999) (explaining the reasons for the development of specialty surgical teams, including the need or specialized nursing).

observed their practices over a period of time. Courts have correctly concluded that nurses are appropriate sources of physician habit evidence.

1. Massachusetts

In *Elias v. Suran*, the Appeals Court of Massachusetts reviewed a jury verdict in favor of a defendant-neuroradiologist.¹³⁰ It framed the only appellate issue as follows: “whether the trial judge erred by admitting in evidence . . . the testimony of a nurse at the Massachusetts General Hospital (MGH) about the routine practice in 1981 at MGH for administering morphine sulfate to patients undergoing angiograms.”¹³¹

At the trial, a nurse was permitted to testify for the defendant-physician regarding the MGH practice of “premedicat[ing] nonemergency angiogram patients with five milligrams of morphine intramuscularly before they came to the department and to premedicate emergency angiogram patients in the neuroradiology department with three milligrams of morphine sulfate intravenously.”¹³² The testifying nurse had about nine years of experience in the neuroradiology department before the events at issue.¹³³

The Appellate Court noted that the nurse’s testimony “was relevant to corroborate the defendant’s testimony”¹³⁴ regarding the administration of the medication. Interestingly, the Massachusetts law of evidence did not permit the admission of habit evidence to prove conduct consistent with the habit, but it did permit “evidence of a business custom . . . to show that an act was performed in conformity with the custom.”¹³⁵ The Appeals Court approved the nurse’s testimony as she did not refer to a specific physician’s habit but referred to a hospital practice.¹³⁶ This seems to be a distinction without a difference, as the physician who ordered the medication was the defendant. It is clear that his prescribing practice would be encompassed by the hospital’s practice.

2. Illinois

In *Vuletich v. Bolgla*, the Appellate Court of Illinois reversed a jury verdict in favor of a defendant anesthesiologist based on the trial testimony of a surgical scrub nurse that the anesthesiologist “had a particular practice and method of monitoring a patient’s respiration during surgery when the anesthetic in question

130. *Elias v. Suran*, 616 N.E.2d 134, 134 (Mass. App. Ct. 1993).

131. *Id.* at 135.

132. *Id.* at 135-36.

133. *Id.* at 135.

134. *Id.* at 136.

135. *Id.*

136. *Id.* at 135.

was being used and that he usually followed that practice.”¹³⁷ It should be noted that the Appellate Court’s opinion pre-dated the Illinois Rules of Evidence by many years.¹³⁸ The opinion noted that Illinois courts frowned on habit evidence except in wrongful death cases in which there were no eyewitnesses.¹³⁹ In that exceptional circumstance, Illinois courts developed the unfortunate concept of the careful habit. This confuses inadmissible character trait evidence (carefulness) with habit evidence. Regrettably, the careful habit remains a part of Illinois’ common law of evidence.¹⁴⁰ The *Vuletich* Court noted that physician eyewitnesses did testify at trial, “so as to preclude the introduction of the evidence of Dr. Bolgla’s habits.”¹⁴¹

Additionally, the Appellate Court held that even in the absence of eyewitness testimony, the nurse’s testimony as to the defendant-anesthesiologist’s habits would be inadmissible.¹⁴² Apparently, this is so because the nurse testified to a procedure different than that utilized by the defendant-anesthesiologist.¹⁴³ Therefore, it is unclear if the Appellate Court would have approved the habit testimony if the nurse and defendant-physician had described identical procedures.

3. Florida

In *Fincke v. Peebles*, the District Court of Appeals of Florida held that a nurse could not testify regarding a physician’s habit of prematurely extubating patients.¹⁴⁴ The defendants were an orthopedic surgeon and an anesthesiologist.¹⁴⁵ The patient underwent knee surgery.¹⁴⁶ Post-operatively, the patient died and a medical negligence lawsuit was filed, focusing on whether the patient had been prematurely extubated.¹⁴⁷

Three nurses testified at trial, two of whom specifically referred to the defendants’ practice of prematurely extubating patients.¹⁴⁸ Without any detailed

137. *Vuletich v. Bolgla*, 407 N.E.2d 566, 569 (Ill. App. 3d 1980).

138. The Illinois Rules of Evidence (IRE) became effective on January 1, 2011. IRE 406 does govern the admissibility of habit evidence. ILL. R. EVID. 406.

139. *Vuletich*, 407 N.E.2d at 570.

140. See Marc D. Ginsberg, *An Evidentiary Oddity: “Careful Habit” – Does The Law Of Evidence Embrace This Archaic/Modern Concept?*, 43 OHIO N. L. REV. 293, 302 (2017).

141. *Vuletich*, 407 N.E.2d at 571.

142. *Id.*

143. *Id.*

144. *Fincke v. Peebles*, 476 So.2d 1319 (Fla. Dist. Ct. App. 1985).

145. *Id.* at 1320.

146. *Id.*

147. *Id.* at 1320-21; see Scott K. Epstein, *Extubation Failure: An Outcome To Be Avoided*, 8 CRITICAL CARE 310 (2004).

148. *Fincke*, 476 So.2d at 1321.

analysis, the Court of Appeals held that the trial “testimony consisted of nurses’ opinions on that question, not facts,” therefore, that testimony was not “admissible to show that [the defendant] had a habit of prematurely extubating patients.”¹⁴⁹ The Court of Appeals did not discuss whether a nurse or nurses could be the source of physician habit evidence.

4. California

In *Dincau v. Tamayose*, the California Court of Appeal allowed the admission of testimony by a defendant-physician’s nurse to establish the habit of the physician and his office in communicating by telephone with parents of ill children.¹⁵⁰ The Court of Appeal noted that the admission of habit evidence in this context was necessary to enable a physician to establish a defense, years after an event which prompted the litigation.¹⁵¹

Nurses may work with physicians in formal practice teams or may otherwise work closely with physicians so that they are able to repetitively observe physician practices over a substantial period of time.¹⁵² Under these circumstances, nurses should be permitted to testify and establish physician habit.

C. Former Medical Assistants

In *Lambert v. Wilkinson*, the Court of Appeals of Ohio considered whether a trial court correctly precluded two of the defendant-physician’s medical assistants from testifying that he had a habit of altering medical records.¹⁵³ These witnesses had been employees of the defendant-physician in the 1990s and “[o]f particular concern at trial was whether [the defendant] altered or fabricated the medical chart of [the patient] for his December 18, 2003 office visit.”¹⁵⁴

The Court of Appeals did not provide an analytical discussion of physician habit evidence and did not specifically disqualify medical assistants as sources of habit evidence.¹⁵⁵ The Court of Appeals dismissed the proposed testimony as “too remote in time,” noting that “the practice of [the defendant-physician] in the 1990s does not necessarily establish the existence of the habit and that the habitual response occurred on or after December 2003.”¹⁵⁶ Although the

149. *Id.*

150. *Dincau v. Tamayose*, 131 Cal. App. 3d 780, 794 (1982).

151. *Id.* at 795.

152. See Kevin Grumbach & Thomas Bodenheimer, *Can Health Care Teams Improve Primary Care Practice?*, 291 JAMA NETWORK 1246 (2004).

153. *Lambert v. Wilkinson*, 2008-Ohio-2915, at ¶ 56 (Ohio Ct. App. 2008).

154. *Id.* at ¶ 69.

155. See *id.*

156. *Id.*

proposed testimony “would have revealed that [the defendant-physician] did, on occasion, alter medical records, this does not constitute proof of a regular response to a repeated, factually-specific situation.”¹⁵⁷ Accordingly, the medical assistants’ proposed testimony would have amounted to inadmissible character evidence.¹⁵⁸

It was not at all clear from the Court of Appeals’ opinion precisely the detail to which the medical assistants were prepared to testify. Apparently, the medical assistants would have testified that the defendant-physician requested that one of the medical assistants “alter piles of patient medical records so that he would avoid criminal penalty.”¹⁵⁹ How frequently the alleged medical records alterations occurred is unknown. Also unclear is how the medical assistants would have known that a physician actually altered medical records. As a result, the Court of Appeals correctly held that the proposed testimony was inadmissible.

D. Administrative Records

A New Jersey Appellate Court confronted the interesting issue of whether administrative records of the Board of Medical Examiners could be the source of physician habit evidence.¹⁶⁰ In *Delgaudio v. Rodriguera*, the plaintiff’s claim of medical negligence against the defendant-cardiologist was based on a complication, hemolytic anemia,¹⁶¹ which he allegedly suffered due to a medication prescribed by the defendant.¹⁶² At trial, “the accuracy and truthfulness of defendant’s office record and his say so, was a crucial credibility issue for the jury to resolve.”¹⁶³

Apparently, the Board of Medical Examiners records contained information about “the Board’s 1993 suspension and 1991 revocation decisions and the findings and conclusions in connection therewith”¹⁶⁴ and the defendant-physician’s “record-keeping infractions.”¹⁶⁵ At trial, plaintiff unsuccessfully sought to use these records to establish the defendant-physician’s habit of record-keeping infractions.¹⁶⁶ The appellate court simply stated that “the record is not sufficient to show ‘a regular practice of responding to a particular kind of

157. *Id.* at ¶ 70.

158. *Id.*

159. *Id.* at ¶ 56.

160. *See Delgaudio v. Rodriguera*, 654 A.2d 1007 (N.J. Super. Ct. App. Div. 1995).

161. *See Gurpreet Dhaliwal, Patricia Cornett & Lawrence Tierney, Hemolytic Anemia*, 69 AM. FAM. PHYSICIAN 2599 (2004) (explaining the disease and drugs which may cause it).

162. *Delgaudio*, 654 A.2d at 1009-10.

163. *Id.* at 1010.

164. *Id.*

165. *Id.*

166. *Id.*

situation with a specific type of conduct [i.e. habitually failing to record patient complaints].”¹⁶⁷ This is a correct result, as, in the absence of detailed, identical record-keeping errors occurring in identical circumstances, unrelated record-keeping errors likely establish an inadmissible character trait of carelessness.¹⁶⁸

E. Physicians

The defendant-physician is the obvious choice as the most likely source of habit evidence. This paper now focuses on the various contexts (other than informed consent litigation) in which physician habit evidence has been embraced by courts.

1. Performance of Surgery and Habit

Medical literature reveals that surgeons are at a higher risk of facing medical negligence claims.¹⁶⁹ Therefore, it is predictable that surgeons would desire to testify about their typical, habitual conduct in the performance of surgical procedures. Additionally, non-surgeon physicians who participate in surgical procedures, are likely candidates to provide habit testimony.

In *McCormack v. Lindberg*, the Minnesota Court of Appeals reviewed a jury verdict in favor of a thoracic surgeon.¹⁷⁰ The medical negligence claim arose from a complication of a rib resection surgery performed to address thoracic outlet syndrome.¹⁷¹ At trial, “the defendant . . . testified that he had no present recollection of the specific circumstances of [plaintiff’s] operation, but testified to his ordinary practices in performing first rib resections in order to establish what he probably did during [plaintiff’s] operation.”¹⁷²

On appeal, the defendant-physician urged that the aforementioned testimony

167. *Id.*

168. *Id.*; *See also*, *Herbstreith v. de Bakker*, 249 Kan. 67, 815 P.2d 102, 109 (1991) (noting that “any evidence offered to prove a trait of character with respect to care or skill is inadmissible . . . as tending to prove the quality of conduct on a specified occasion.”).

169. *See* Anupam B. Jena, Seth Seabury, Darius Lakdawalla & Amithabh Chandra, *Malpractice Risk According to Physician Specialty*, 365 N. ENG. J. MED. 629, 632 (2011); *See also* José R. Guardado, *Medical Liability Claim Frequency Among U.S. Physicians*, POL’Y RES. PERSP. AM. MED. ASS’N. (2017).

170. *McCormick v. Lingberg*, 352 N.W.2d 30, 32 (Minn. Ct. App. 1984).

171. *Id.* at 32. “Thoracic outlet syndrome . . . refers to compression of the subclavian vessels and brachial plexus at the superior aperture of the chest.” Harold C. Urschel Jr., *Transaxillary First Rib Resection for Thoracic Outlet Syndrome*, OPERATIVE TECH. IN THORACIC & CARDIOVASCULAR SURGERY 313, 313 (2005). “The majority of patients . . . have pain of the neck, upper chest wall, and upper extremity.” Dean Donahue, *Supraclavicular First Rib Resection*, OPERATIVE TECH. IN THORACIC & CARDIOVASCULAR SURGERY 252, 252 (2012).

172. *McCormick*, 352 N.W.2d at 32.

was admissible habit evidence.¹⁷³ The Court of Appeals embarked on an interesting, if not curious, analysis of habit evidence.¹⁷⁴ Since the defendant-physician testified “that the operation varies depending upon many factors, including the size and age of the patient,” the Court of Appeals wondered if the operative procedure satisfied the “automatic” nature of habitual conduct.¹⁷⁵ The Minnesota Court of Appeals then stated that it would not address this issue as the defendant-physician, also an expert witness, “was not testifying to his usual and customary procedure in order to prove that he acted in conformity with it, but merely to inform the jury of what such an operation entails.”¹⁷⁶ Frankly, it is difficult to recognize the distinction urged by the Court of Appeals. Undoubtedly, the defendant-physician desired to explain the operative procedure. However, the defendant-physician, at least implicitly, desired to establish that he followed the appropriate procedures in performing the surgery.¹⁷⁷ Since he did not recall plaintiff’s operative procedure, he certainly provided habit evidence.

In *Steinberg v. Arcilla*, the Wisconsin Court of Appeals considered an appeal of a jury verdict in favor of a defendant-anesthesiologist.¹⁷⁸ The plaintiff “had emergency surgery for a ruptured tubal pregnancy.”¹⁷⁹ The defendant-anesthesiologist positioned the plaintiff during surgery.¹⁸⁰ Post-operatively, the plaintiff “suffered from pain and numbness in her arms” and claimed “permanent injury to her ulnar nerve, a nerve that runs through her forearm.”¹⁸¹ Plaintiff’s theory of liability was that the defendant-anesthesiologist improperly positioned her arms during the surgical procedure.¹⁸²

At trial, the defendant-anesthesiologist “testified that he did not remember anything about [plaintiff’s] surgery, including how he positioned her arms.”¹⁸³ However, the trial court permitted him to testify regarding his “normal practice” of doing so.¹⁸⁴ On appeal, plaintiff claimed that the trial court erred in admitting this evidence.¹⁸⁵

173. *Id.* at 35.

174. *Id.*

175. *Id.*

176. *Id.*

177. *See id.* at 30.

178. *Steinberg v. Arcilla*, 194 Wis. 2d 759, 763 (Wis. Ct. App. 1995).

179. *Id.* “Ectopic pregnancy is any pregnancy that occurs outside the uterine cavity.” Anne-Marie Lozeau & Beth Potter, *Diagnosis and Management of Ectopic Pregnancy*, 72 AM. FAM. PHYSICIAN 1707, 1707 (2005). A ruptured ectopic pregnancy requires surgical management. *Id.*

180. *Steinberg*, 194 Wis. 2d at 763.

181. *Id.*

182. *Id.*; see Richard C. Prielipp et al., *Ulnar Nerve Pressure*, 91 ANESTHESIOLOGY 345 (1999) (“Ulnar neuropathy is the most common perioperative nerve injury . . .”).

183. *Steinberg*, 194 Wis. 2d at 764.

184. *Id.*

185. *Id.* at 765.

The Wisconsin Court of Appeals, not surprisingly, distinguished habit evidence from character evidence.¹⁸⁶ It then noted that the “regular response to a repeated situation,” denoting habit, “need not be ‘semi-automatic’ or ‘virtually unconscious’” under Wisconsin law.¹⁸⁷ Furthermore, the Wisconsin Court of Appeals noted that Wisconsin law did not require a specific number of repetitive instances to qualify as habitual conduct.¹⁸⁸ The defendant-anesthesiologist testified as to his usual positioning of a patient’s arms during surgery as well as to the frequency of his participation in surgical procedures.¹⁸⁹ This testimony was appropriate to evidence the defendant-anesthesiologist’s habitual conduct.¹⁹⁰

In *Aikman v. Kanda*, the District of Columbia Court of Appeals considered the appeal from a jury verdict in favor of a cardiac surgeon who performed surgery to repair the plaintiff’s mitral valve.¹⁹¹ Post-operatively, plaintiff suffered an embolic stroke, presumably cardiac in origin, and resultant disabilities.¹⁹² At trial, the issue was whether the cardiac surgeon undertook a procedure to remove air from plaintiff’s heart.¹⁹³ Plaintiff’s medical records did not contain any reference to the air removal procedure and “no one on the surgical team could specifically recall the details of [plaintiff’s] surgery.”¹⁹⁴

At trial, the defendant-surgeon was permitted to testify that he performs the air removal procedure in every mitral valve surgery he performs and that he has performed in excess of 500 mitral valve operations, averaging 40-50 of these procedures each year.¹⁹⁵ The D.C. Court of Appeals agreed that the defendant-surgeon’s testimony was appropriate to establish his semi-automatic habit.¹⁹⁶ On the issue of whether the performance of a cardiac surgical procedure is a non-volitional event, the D.C. Court of Appeals stated that “the volitional nature of habitual conduct is relevant to its probative force, not its admissibility.”¹⁹⁷

In *Maynard v. Sena*, the Connecticut Appellate Court considered an appeal

186. *Id.* at 765-68.

187. *Id.* at 767 (quoting McCormick on Evidence § 195) (quoting Daniel D. Blinka, *Evidence of Character, Habit, and “Similar Acts” in Wisconsin Civil Litigation*, 73 MARQ. L. REV. 283, 312 (1989)).

188. *Id.* at 768.

189. *Id.* at 770.

190. *Id.*

191. *Aikman*, 975 A.2d at 155. The mitral valve “[guards] the inlet to the left ventricle” and “prevents backflow to the left atrium during ventricular systole.” S. Y. Ho, *Anatomy of the Mitral Valve*, 88 Heart iv5, iv5 (2002).

192. *Aikman*, 975 A.2d at 155; see George Ntaios & Robert G. Hart, *Embolic Stroke*, 136 CIRCULATION 2403 (2017).

193. *Aikman*, 975 A.2d at 155.

194. *Id.* at 157.

195. *Id.*

196. *Id.* at 163.

197. *Id.* at 164.

from a jury verdict in favor of a defendant-plastic surgeon.¹⁹⁸ The basis of the claim was the allegation that the defendant-plastic surgeon performed an in-office procedure “without wearing surgical gloves.”¹⁹⁹ The trial court permitted the surgeon “to testify as to his habit of wearing gloves when performing surgical procedures in his office.”²⁰⁰ The defendant-surgeon had a thirty year career “and . . . he employed the same ‘sterile technique’ when performing every one of those procedures, regardless of the nature of the procedure.”²⁰¹ He further testified “that he could not conceive of having performed the procedure on the plaintiff without gloves, because doing so would put him [sic] at risk for contracting an infection.”²⁰²

The Connecticut Appellate Court referred to the Connecticut Code of Evidence governing habit evidence and its commentary.²⁰³ The commentary noted that “[h]abit . . . refer[s] to a course of conduct that is fixed, invariable, and unthinking, and generally pertain[s] to a very specific set of repetitive circumstances[.]”²⁰⁴

Unlike other surgical procedures which, due to patient differences, are not likely fixed, invariable, and unthinking, the Connecticut Appellate Court must have viewed a surgeon’s use of surgical gloves as classic, habitual conduct as contemplated by the Connecticut Code of Evidence.²⁰⁵ A surgeon’s practice of wearing surgical gloves addresses surgical preparation and routine more so than the actual surgical procedure. The Connecticut Appellate Court was correct in approving the trial court’s decision to permit the surgeon’s testimony.

2. Non-Surgical Medical Treatment and Habit

Non-surgeon physicians are also able to avail themselves of habit testimony in medical negligence litigation. In *Thomas v. Hardwick*, the Nevada Supreme Court considered an appeal from a jury verdict in favor of an emergency medicine physician and a medical center.²⁰⁶ The key issue on appeal was the advice given to the patient by the emergency medicine physician; “[d]id [the decedent] leave the hospital . . . against medical advice, as [the defendants] maintain[,] or was [the decedent] told he was ‘fit as a fiddle’ and could safely

198. *Maynard v. Sena*, 158 Conn. App. 509, 511 (2015).

199. *Id.*

200. *Id.* at 514-15.

201. *Id.* at 515.

202. *Id.* at 517.

203. *Id.* at 518.; CONN. CODE EVID. Art. 4-6.

204. *Maynard*, 158 Conn. App. at 518 (citing to CONN. CODE EVID. Art. 4-6, commentary).

205. *See id.*

206. *Thomas v. Hardwick*, 231 P.3d 1111, 1112 (Nev. 2010).

leave, as appellant . . . maintains?”²⁰⁷ This issue, of course, relates to whether the defendant-physician complied with or deviated from the applicable standard of care: “that care which a reasonably well qualified physician would provide to a patient under the same or similar circumstances.”²⁰⁸ The Nevada Supreme Court commented on evidence of the applicable standard of care, noting that it “required [the defendant] to counsel [the patient] to agree to be admitted to the hospital for observation and testing, especially since [the patient’s] history disclosed he had no regular primary care physician.”²⁰⁹ The patient “left the emergency room . . . against medical advice” and was not admitted to the hospital.²¹⁰

At trial, the defendant-physician was permitted to testify to his “customary practice in treating chest pain patients[,]” and, therefore, “that he urged [the patient] to be admitted for observation and testing but he refused.”²¹¹ On appeal, the Nevada Supreme Court referred to the applicable Nevada evidentiary rule governing habit and routine practice evidence and held that the defendant’s trial testimony regarding his habit of counseling patients, such as the patient about which the medical negligence claim was filed, was, indeed, relevant.²¹²

Thomas v. Hardwick, although not an informed-consent-based medical negligence case, is arguably similar insofar as it involves a physician’s instruction or recommendation to a patient.²¹³ The defendant-physician’s workload made it virtually impossible for him to recall the patient.²¹⁴ Giving instructions to and counseling a patient “with chest pain complaints and inconclusive test results[,]” to be admitted to the hospital is fairly considered to be automatic or semi-automatic physician conduct.²¹⁵

The Maryland Court of Special Appeals, in *Rosebrock v. Eastern Shore Emergency Physicians*, held that a defendant-emergency medicine physician could testify regarding her habit of examining and treating patients immobilized on backboards.²¹⁶ Here, a nurse’s aide slipped and fell at a nursing home, was

207. *Id.* at 1113.

208. Marc D. Ginsberg, *Beyond Canterbury: Can Medicine and Law Agree About Informed Consent? And Does it Matter?*, 45 J. L., MED. & ETHICS 106, 106 (2017).

209. *Thomas*, 231 P.3d at 1113.

210. *Id.*

211. *Id.*

212. *Id.* at 1117.

213. *See id.*

214. *Id.* at 1116.

215. *Id.*

216. *Rosebrock v. Eastern Shore Emergency Physicians*, 108 A.3d 424, 435 (Md. Ct. Spec. App. 2015); See Derek R. Cooney, Harry Wallus, Michael Asaly & Susan Wojcik, *Backboard Time For Patients Receiving Spinal Immobilization By Emergency Medical Services*, 6 INT’L J. EMERGENCY MED. 17 (2013) (explaining the use of long spine boards and the need to minimize time of immobilization).

immobilized on a backboard by emergency medical technicians, and was taken to a hospital emergency room.²¹⁷ Absent from the emergency room record was the defendant's documentation of a back examination and any mention of the patient's back pain.²¹⁸ The patient was ultimately discharged from the hospital with a diagnosis of "knee and hip contusions."²¹⁹

The patient's condition worsened and the patient ultimately received an orthopedic consultation and x-rays, revealing "an acute compression fracture of the L3 vertebrae, 'with possible retropulsed fragment[s] causing nerve root compression.'"²²⁰ The patient underwent a spinal fusion procedure, went to a rehabilitation center, sustained an unexpected "ventricular fibrillation arrest" causing "anoxic brain injury" and lapsed "into a persistent vegetative state . . . until her death."²²¹ The medical negligence lawsuit followed, culminating in a verdict in favor of the emergency medicine physician.²²²

On appeal, the issue regarding the physician's trial testimony essentially relates to the problem addressed earlier in this paper; is physician treatment "nonvolitional activity that [is] performed with invariable regularity?"²²³ If not, should a physician be precluded from testifying to habit when the relevant medical records do not describe the physician's treatment?²²⁴ Significantly, the Maryland Court of Special Appeals cited, with approval, the opinion of the District of Columbia Court of Appeals in *Aikman v. Kanda*.²²⁵ There, the D.C. Court of Appeals held that the volitional nature of the physician's treatment was relevant to the weight to be given to the habit testimony, not to its admissibility.²²⁶ With the volitional/non-volitional issue removed from the habit evidence equation in *Rosebrock*, the key barrier to admissibility fell.

Finally, in *Dawkins v. Siwicki*, the Supreme Court of Rhode Island considered an appeal from a jury verdict in favor of the defendant-emergency medicine physician in connection with a claim that he negligently diagnosed and treated a wrist injury.²²⁷ Allegedly, the defendant-physician diagnosed a wrist sprain for which the patient was splinted and bandaged.²²⁸ This diagnosis surprised the patient, as she believed her wrist was broken.²²⁹

217. *Rosebrock*, 108 A.3d at 426.

218. *Id.*

219. *Id.*

220. *Id.*

221. *Id.* at 426-27.

222. *Id.* at 427.

223. *Id.* at 432.

224. *Id.*

225. *Id.* at 434-35 (citing to 975 A.2d 152).

226. 108 A.3d at 435 (citing to 975 A.2d at 164).

227. *Dawkins v. Siwicki*, 22 A.3d 1142, 1145-46 (R.I. 2011).

228. *Id.* at 1146.

229. *Id.*

At trial, the defendant-physician provided habit or routine practice testimony by stating that “when treating patients with similar symptoms and also, with patients who disagreed with a diagnosis, he would have advised plaintiff of the possibility that there was a fracture that was not apparent on the X-ray and that she should follow-up with her own doctor.”²³⁰ The medical record contained his note that a follow up visit with the patient’s primary care physician was advised.²³¹

On appeal, the habit evidence issue focused on the regularity of the physician’s conduct.²³² Essentially, plaintiff’s position was that in the absence of the physician’s testimony specifying how frequently he treated patients with similar injuries, the physician did not establish the foundational basis for habit evidence.²³³ The Supreme Court of Rhode Island disposed of this issue without difficulty, stating that “[t]here is no bright-line rule about the number of times the witness must have engaged in a particular practice before evidence of habit and routine may be admitted.”²³⁴ The defendant-physician’s testimony regarding the many patients he has treated over many years, suffering from “certain types of symptoms or injuries” was sufficient to establish a “specific routine” and the foundation for his habit testimony.²³⁵

3. *Advising Patients of Mammography Failure Rate and Habit*

In *Hoffart v. Hodge*, the Nebraska Court of Appeals considered an appeal from a jury verdict in favor of a defendant-obstetrician-gynecologist, who allegedly failed to diagnose breast cancer.²³⁶ The patient had a palpable breast mass and a mammogram, which was interpreted as “[n]egative bilateral” and the “[p]alpable mass must still be evaluated on a clinical basis.”²³⁷ The defendant-physician testified “that he would have told her to make an appointment in 2 months to be checked again.”²³⁸ The patient’s deposition testimony told a different, less concerning story.²³⁹ She “continued to check her breast” but did not return to see the defendant for quite a few months.²⁴⁰ At that time, she was referred by the defendant-physician “to a surgeon for a biopsy, who removed a

230. *Id.*

231. *Id.*

232. *Id.* at 1155.

233. *Id.*

234. *Id.*

235. *Id.* at 1155-56.

236. *Hoffart v. Hodge*, 609 N.W.2d 397, 401 (Neb. Ct. App. 2000).

237. *Id.*

238. *Id.*

239. *Id.*

240. *Id.*

1.5 centimeter mass which was found to be malignant.”²⁴¹ Thereafter, the patient had extensive surgery, therapy and treatment, and succumbed to her disease.²⁴²

The Nebraska Court of Appeals addressed the propriety of the defendant-physician’s trial testimony regarding “his habit or routine of advising his patients about mammogram failure rates.”²⁴³ Significantly, as to the repetitive component of habit evidence, the Nebraska Court of Appeals stated that “[t]he precise contours of how frequently and consistently a behavior must occur to rise to the level of habit cannot be easily defined or formulated.”²⁴⁴ The Nebraska Court of Appeals recognized that habit evidence “may be the only vehicle available for a doctor to prove that he or she acted in a particular way on a particular occasion” insofar as it is simply not possible for a doctor to recall every patient encounter.²⁴⁵ The absence of detailed testimony “concerning regularity (which involves frequency and consistency), specificity, and involuntary response, which are the hallmarks of proof of habit by specific instances rather than by opinion, does not render the opinion evidence inadmissible.”²⁴⁶ The testimonial deficiencies relate to weight, not admissibility of the evidence.²⁴⁷

The opinion in *Hoffart* suggests two important points: (1) physician habit may be necessary for a physician’s defense and (2) the testimonial foundation necessary to the admission of habit evidence is not rigid or formulaic.²⁴⁸ The trial court is required to evaluate the factual circumstances and exercise sound discretion in admitting this evidence.²⁴⁹

4. Physician Communication with Other Physicians and Habit

Very recently, the Ohio Court of Appeals, in *Dazley v. Mercy St. Vincent Medical Center*, approved of a defendant-physician’s habit testimony regarding communicating with consulting physicians, despite reversing summary judgment entered in favor of him.²⁵⁰ In *Dazley*, a seriously ill patient was seen in a hospital emergency department by an attending physician and then defendant, a resident physician.²⁵¹ Following a cardiac work-up, the defendant-resident was directed “to contact . . . the cardiologist on call” and was instructed by the attending

241. *Id.*

242. *Id.*

243. *Id.* at 403.

244. *Id.*

245. *Id.*

246. *Id.* at 405.

247. *Id.*

248. *See id.*

249. *Id.* at 403-04.

250. *See Dazley v. Mercy St. Vincent Med. Ctr.*, 2018-Ohio-2433.

251. *Id.* At ¶ 2-3

physician to advise the cardiologist of specific information.²⁵² The resident-physician did “not remember the substance of [the] conversation” with the cardiology consultant, did not note the conversation in the chart, “and [the cardiology consultant] [did] not recall even having a conversation.”²⁵³

The trial court approved the defendant-resident’s deposition testimony “as to what his habit would have been in communicating with a specialist” pursuant to the Ohio Rules of Evidence.²⁵⁴ The Ohio Court of Appeals addressed the elements of habit evidence, stating, “[t]o be admissible as evidence of habit, the occurrence of the stimulus and the responsive behavior must occur frequently enough to constitute a pattern. [citation omitted]. A sufficient foundation must be provided for the admission of habit evidence. [citation omitted].”²⁵⁵ The foundation was established by testimony of the frequency of conversations with consultants and of the contents of the conversations.²⁵⁶ Significantly, the Ohio Court of Appeals did not discuss the volitional vs. non-volitional nature of this conduct.²⁵⁷

In *Burris v. Lerner*, the Ohio Court of Appeals reviewed a summary judgment in favor of a physician and considered the propriety of that physician’s deposition testimony relating to his habit of contacting a referring physician about test results.²⁵⁸ Here, a defendant-resident scheduled a patient for a cardiac work-up via a thallium stress test.²⁵⁹ The test result was read and interpreted by the co-defendant-cardiologist.²⁶⁰ The result was abnormal, “suggestive of either cardiomyopathy or potentially ischemia in the absence of inducible symptoms of ischemia or diagnostic EKG changes.”²⁶¹

The co-defendant-cardiologist testified, by deposition, “that, in light of the abnormalities in [the] test results, it would have been his custom and practice to have called the referring physician . . . at the time he was reviewing the scans.”²⁶² He would have “call[ed] the referring physician the very evening that he was interpreting the test results ‘[i]f there was a test that’s abnormal or . . . of moderate probability for a problem and requires further evaluation.’”²⁶³

252. *Id.* at ¶ 6.

253. *Id.* at ¶ 7.

254. *Id.* at ¶ 28.

255. *Id.* at ¶ 41.

256. *Id.* at ¶ 42.

257. *See id.*

258. *Burris v. Lerner*, 139 Ohio App. 3d 664, 666 (2000).

259. *Id.* For information on this testing, see K. Lance Gould, *How Accurate Is Thallium Exercise Testing for the Diagnosis of Coronary Artery Disease*, 14 J. AM. C. CARDIOLOGY 1487 (1989).

260. *Burris*, 139 Ohio App. 3d at 666.

261. *Id.* at 667.

262. *Id.*

263. *Id.*

Furthermore, if the co-defendant-cardiologist was unable to contact the referring physician “that evening, he would have left a message with her answering service asking her to call him.”²⁶⁴ The co-defendant-cardiologist referring physician had no recollection of receiving a call from the cardiologist.²⁶⁵ Her position was that she was never “advised of the abnormality discovered on the thallium scans.”²⁶⁶ Regrettably, the patient “died of a myocardial infarction.”²⁶⁷

The aforementioned testimony led the Ohio Court of Appeals to pose this question, and resolution: “whether [the co-defendant-cardiologist’s] testimony as to his custom and practice may suffice to controvert [the referring physician’s] testimony that she received no such call. Under the law of Ohio, we find that it may.”²⁶⁸ The Ohio Court of Appeals reviewed Ohio jurisprudence relating to habit or routine practice evidence in medical-hospital negligence litigation and concluded that the co-defendant-cardiologist’s customary practice testimony was “admissible to contradict [the referring physician’s] testimony that she never received such a call.”²⁶⁹ Summary judgment in favor of the defendant-referring physician was reversed due to this significant evidentiary conflict.²⁷⁰

VI. THE NEED FOR PHYSICIAN HABIT TESTIMONY IN NON-INFORMED CONSENT MEDICAL NEGLIGENCE LITIGATION

The Nebraska Court of Appeals, in *Hoffart v. Hodge*, correctly identified the need for physician habit as follows:

[W]e must recognize the reality that a doctor cannot be expected to specifically recall the advice or explanation he or she gives to each and every patient he or she sees and treats . . . [E]vidence of habit may be the only vehicle available for a doctor to prove that he or she acted in a particular way on a particular occasion, and, therefore, proof of habit may be highly relevant.²⁷¹

It seems apparent that physicians cannot and do not record every detail of patient encounters and procedures. I have never subscribed to the theory that “if it wasn’t documented, it didn’t happen” and, frankly, based on my experience

264. *Id.* at 668.

265. *Id.*

266. *Id.*

267. *Id.*; See Kristian Thygesen et al., *Fourth Universal Definition of Myocardial Infarction* (2018), 40 EUR. HEART J. 237 (2019).

268. *Burris*, 139 Ohio App. 3d at 671.

269. *Id.* at 673.

270. *See id.*

271. *Hoffart*, 609 N.W.2d at 168.

representing physicians, I do not believe that juries subscribe to this theory.²⁷² The nature of the practice of medicine makes physician habit evidence necessary and its admissibility will not compromise the fairness of a jury trial.

CONCLUSION

Physician habit evidence has been embraced by courts (albeit not unanimously) in non-informed consent medical negligence litigation. The admissibility of this evidence is not without controversy, particularly with respect to its source and its reliance on volitional conduct. Rule 406 and analogous state evidentiary rules neither specify the source of habit evidence testimony nor the automatic, semi-automatic, or non-volitional nature of habitual conduct which has historically occupied a role in the analysis of habit evidence.²⁷³ Of course, the most likely source of habit evidence in medical negligence litigation is the defendant-physician. An enlightened view of the non-volitional, semi-automatic or automatic nature of habitual conduct suggests that volitional, non-reflexive, judgment based physician conduct can still form the basis of habitual conduct and habit evidence, and these factors would relate to evidentiary weight, not admissibility.

Physician habit evidence in non-informed consent medical negligence litigation should be welcomed by courts as the courts have welcomed habit evidence in informed consent cases.²⁷⁴ This evidence assists physicians in providing a fair and reasonable defense in medical negligence litigation.

272. See P. Ethicist, *If It Wasn't Documented, It Didn't Happen . . . or Did It?*, 11 J. EMPIRICAL RES. ON HUM. RES. ETHICS 199 (2016).

273. FED. R. EVID. 406.

274. See Justin L. Ward, *Physician Habit Evidence In Informed Consent Cases*, 23 J. LEGAL MED. 269 (2002); *Kornberg v. United States*, 693 Fed. App'x 542, 544 (9th Cir. 2017) (showing the doctor's habit of providing patient's with informed consent).