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THE LAW OF MEDICAL MALPRACTICE
IN VIRGINIA

By Robert E. Shepherd, Jr.*

"If the surgeon has made a deep incision in (the body of) a (free) man with a lancet of bronze and causes the man's death or has opened the caruncle in (the eye of) a man and so destroys the man's eye, they shall cut off his fore-hand."

The Code of Hammurabi

The law's attitude toward the medical profession has mellowed somewhat over the years since the above provision was promulgated some 4,000 years ago. However, medicine and the law still have some difficulty in reaching a reasonable plateau of understanding and trust, and one major point of contention concerns the law of medical professional responsibility, or medical malpractice. Although there is a paucity of case law in this field in Virginia, the number of claims being made against physicians has increased, and it is reasonable to assume that the number reaching the courts has increased proportionately. This article will discuss the rules of law that have developed


This article is based on a paper originally prepared for a graduate Legal Medicine Course at the Georgetown Law Center, Washington, D.C.

3 This term often causes some difficulty. Malpractice is defined as "any professional misconduct, unreasonable lack of skill or fidelity in professional or fiduciary duties, evil practice, or illegal or immoral conduct." Black, Law Dictionary 1111 (4th ed. 1951). The term is also used in the Virginia Code as a ground for suspension or revocation of a doctor's license: "is grossly ignorant or careless in his practice, or is guilty of gross malpractice." Va. Code Ann. § 54-316(4) (Repl. Vol. 1958). The term is used in this article because it has more meaning to physicians and attorneys than any other, and as used it means nothing more than professional negligence.

Statistics furnished to the writer by the National Bureau of Casualty Under-
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in this area, with particular reference to Virginia, and to point out some of the more vexatious problems peculiar to this field and the plans, proposals, and mechanisms which have been devised in an endeavor to solve them. Professional negligence is not a problem for medical men and women alone, but this paper will be limited to the law of medical malpractice as it applies to doctors, dentists, and nurses.

I

STANDARDS OF CARE AND SKILL

In medical malpractice cases the standard of care and skill is based on the specialized knowledge or skill of the physician. This standard is defined by the Supreme Court of Appeals as follows:

"A physician is not required to exercise the highest degree of skill and diligence possible, in the treatment of an injury, unless he has by special contract agreed to do so. In the absence of such special contract, he is only required to exercise such reasonable and ordinary skill and diligence as are ordinarily exercised by the average of the members of the profession in

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The experience for 1954 is based solely upon Bureau members and subscribers. The statistics for the subsequent years reflect the experience of all companies reporting to the Bureau. The latest year for which statistics were available is 1960.


good standing, in similar localities and in the same general line of practice, regard being had to the state of medical science at the time.'"

While the general rules of negligence are applicable to malpractice cases, there are several unusual features. These elements are the keystones of the "common law" of malpractice in the United States. However, the last twenty years has been marked by considerable flux, with the development of some variations on these elements. With only a few exceptions, Virginia has adhered to the basic rule; (a) the reasonable exercise of skill and diligence; (b) such as is ordinarily exercised by members of the profession in good standing; (c) who are of the same general line and school of practice; (d) in similar localities; and (e) with regard being had to the state of medical science at the time.

(a) Reasonable Exercise of Skill and Diligence

The Code of Hammurabi, quoted above,9 imposed the liability of an insurer on the physicians of that day. Under the modern law of medical malpractice, however, the physician is not an insurer "of a cure, or even of beneficial results, unless he has bound himself by special contract to effect a cure."10 As the Supreme Court of Appeals said in Ropp v. Stevens:11

"This court and other courts have gone and will go far to support the rule that physicians do not and cannot guarantee successful results, and only owe their patients ordinary but expert care, attention, and skill such as is usually exercised by reputable physicians in similar cases; and that they can be held responsible only in case their patients suffer because of their negligence. A patient may not recover damages simply because he does not get well, and where actionable negligence is alleged against a physician it must be established by the evidence."12

Similarly, a bad result may be considered by the jury as having some weight, but the result, no matter how bad, "is of itself alone, insufficient evidence to establish the unskillfulness or the negligence of a

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10See text accompanying footnote 1.
12Id. at 308, 154 S.E. at 554.
physician . . . . " This poor result by itself is insufficient to raise even an inference or presumption of negligence.14

These basic rules are applied to the treatment and also to preliminary examinations. The first case decided in Virginia on malpractice, Hunter v. Burroughs,15 dealt with treatment of a patient's eczema10 on legs and ankles by X-ray and salves, a relatively new technique at that time. The treatment resulted in severe burns and the plaintiff obtained judgment in the trial court which was affirmed on appeal. One of the counts in the plaintiff's declaration rested on the defendant's duty to make certain tests and examinations before undertaking treatment. The court agreed with the defendant's position that this duty is to be measured by reference to what other like specialists of good standing, in the same or similar localities, would do.17 The court recognized that such a duty does exist: "it is the duty of a physician in the exercise of ordinary care to warn a patient of the danger of possible bad consequences of using a remedy."18

The physician may be negligent by being too optimistic in his predictions of success, especially when these are joined with a failure to warn of the dangers involved. The doctor may be "giving, not a mere opinion, but a positive assurance of cure,"19 In Fox v. Mason,20 decided in 1924, the defendant, sued by a doctor for his fee, denied that he owed the doctor anything because the post-operative treatment was negligent. The trial court had set aside a verdict for the plaintiff which action was reversed and the jury verdict ordered reinstated. The court cautioned, however, that a physician should continue such treatments as may be reasonably necessary after an operation or instruct some other physician or trained person how to carry out this treatment or, at the very least, give the patient notice that he cannot continue such treatment.21

10Hunter v. Burroughs, 123 Va. 113, 135, 96 S.E. 360, 367 (1918). (Emphasis by the court.)
14Id. at 137, 96 S.E. at 368; Fox v. Mason, 139 Va. 667, 671-72, 124 S.E. 405, 407 (1924); Alexander v. Hill, 174 Va. at 253, 6 S.E.2d at 663.
17Note 13 supra.
19Eczema is an inflammation of the skin, Stedman, Medical Dictionary 496 (Lawyer's ed. 1961) (hereinafter cited as Stedman). See annotations on skin diseases and X-ray in 41 A.L.R.2d 329 (1955), and 45 A.L.R.2d 1273 (1956). Throughout this article medical terms will be defined where appropriate and other references will be given regarding the specific condition or treatment.
20123 Va. at 131, 96 S.E. at 366.
21Id. at 133, 96 S.E. at 366.
22Id. at 134, 96 S.E. at 367.
23139 Va. 667, 124 S.E. 405 (1924).
24Id at 672-73, 124 S.E. at 407.
Another Virginia case, *Vann v. Harden*, involved the same problem, that of the abandonment of a patient by a physician. This case has been repeatedly cited in texts as the leading case on this point. The plaintiff's leg had been fractured between the knee and the ankle with slight comminution, or splintering. The defendant reduced the fracture and set the leg in a plaster cast. He visited the plaintiff on the two days following this treatment and was told by the plaintiff's father that the boy was suffering pain and numbness in his toes. The father expressed his lay opinion that the cast was too tight but the defendant disagreed, even though the plaintiff had been running a temperature of up to 103 degrees. On the third day the father tried to contact the defendant but discovered that he had left town without leaving instructions; another doctor finally bivalved the cast and noted some nerve involvement. After nine days the defendant returned to town and discharged the plaintiff from the hospital. A week after discharge the defendant again refused to examine the leg. A year and a half later the leg was amputated after extensive treatment by other physicians. The plaintiff's position at trial was not that the cast had been negligently applied, but that the defendant had ignored several basic danger signals and had abandoned his treatment at a critical time. The Supreme Court of Appeals affirmed a judgment for the plaintiff and said:

"After a physician has accepted employment in a case it is his duty to continue his services as long as they are necessary. He cannot voluntarily abandon his patient. Even if personal attention is no longer necessary in the treatment of an injured limb, the physician, if the case calls for it, must furnish the patient with instructions as to its care, and his failure to do so might become actionable negligence." Thus, a doctor's obligation to his patient may begin prior to treatment, and it may continue long after the critical phase of such treatment.

(b) The Care Ordinarily Exercised by Members of the Profession in Good Standing

The physician must meet the standard exercised by the average of the members of the profession in good standing. He impliedly warrants that he will use that degree of skill, knowledge, and care

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22 Va. 555, 47 S.E.2d 314 (1948).
22 Id. at 565-66, 47 S.E.2d at 319. See Annot., 57 A.L.R.2d 432 (1958), on abandonment.
offered by the average reputable physician, which is neither the highest, nor possibly even a high, degree of skill and care. An identical standard is applied to a dentist. In *United Dentists, Inc. v. Bryan*, the Supreme Court of Appeals dealt with a situation in which the defendant extracted a tooth after injecting Novocain. An abscess later developed—the plaintiff established that the needle used in administering the Novocain had not been properly sterilized after being used just fifteen minutes earlier on another patient. The Court of Appeals affirmed a judgment for the plaintiff and said:

"It seems to be settled that a dentist who holds himself out to the world as such implies that he possesses the necessary and proper skill to practice his profession. The degree of care and skill required is the same as that which would be exercised by the ordinary prudent dentist, in good standing, in his community. He does not guarantee or warrant a cure. He is not required to exercise the highest degree of care and skill known to the profession."\(^{20}\)

In *Alexander v. Hill*,\(^{27}\) the plaintiff had consulted Dr. Alexander, a dentist, concerning the advisability of having some of her teeth removed. Dr. Alexander determined that eleven of her upper teeth were diseased and he removed them. She was directed to return home and to apply alternating hot and cold compresses to her face. Shortly afterwards the defendant was called to her home to remove a piece of tooth or bone which was protruding from her jaw. The plaintiff made several subsequent visits to Dr. Alexander who referred her to another dentist to have a plate fitted. A temporary plate was fitted, but the plaintiff had a great deal of difficulty with it. Upon examination, fragments of roots were discovered in six of the sockets from which teeth had been extracted and their removal necessitated the installation of a new plate.

The Supreme Court of Appeals reversed a judgment for the plaintiff since the evidence showed that an examination of the plaintiff's mouth, or of the extracted teeth, would not have disclosed the broken roots, and there was no evidence that "it was the usual and approved custom and practice of dentists in Richmond to make an X-ray examination after such an operation. Hence no inference of negligence

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\(^{20}\)See 15 Michie's Juris., Physicians and Surgeons § 12 (1951); McCoid at 558; Louisell & Williams para. 8.04; Stetler and Moritz, Doctor and Patient and the Law 308-10 (Regan, 4th ed. 1962) (hereinafter cited as Stetler & Moritz).

\(^{21}\)Id. at 884, 164 S.E. 554 (1932).

\(^{22}\)Id. at 884, 164 S.E. at 555. See Carnahan, The Dentist and the Law (1955).

\(^{23}\)174 Va. 248, 6 S.E.2d 661 (1940).
can be drawn from the failure to make such examination." This statement points up the practical significance of this part of the rule pertaining to the standard of care. Since the defendant must be tested against the skill and diligence usually exercised by the average of the members of the profession in good standing, there must be testimony relative to what these physicians would have done under similar circumstances. Consequently, expert testimony for the plaintiff is a necessary prerequisite to the successful conclusion of a suit against a physician for malpractice.

The standard applied to a nurse is stated in *Norfolk Protestant Hospital v. Plunkett*, to be as follows:

"It is not sufficient to say that a nurse is competent simply because she is capable of discharging the manual duties incumbent upon her as a nurse. It is a matter of common knowledge that the welfare of a patient is as much the responsibility of the nurse as it is of the physician. If she is lacking in educational preparation, or if she is guilty of indiscretions that impair her physical or mental status, if she is lacking in that moral character which imbues the patient with confidence, then it cannot be said that she is a competent person to be placed in charge of a helpless patient."

The court agreed with the verdict of the lower court that the nurse was negligent in discharging her duties and that the defendant hospital was negligent in its selection and retention of the nurse. All of the other cases involving nurses or other technicians have been concerned with the vicarious liability of either a hospital or a physician.

(c) The Same General Line and School of Practice

This facet of the general rule insures that the physician will be tested only against the standards of his own particular specialty or school of practice. There are two aspects of this rule which have some importance—first, a physician will not be tested by the testimony of other practitioners or unlicensed healers who do not practice in, or are not familiar with, the defendant's specialty; and second, a physician who subscribes to a particular theory, albeit a minority one, will

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28 Id. at 253, 6 S.E.2d at 663. For a discussion of the necessity of X-ray examinations after treatment, see Annot., 115 A.L.R. 298 (1938).
30 VA. 151, 173 S.E. 363 (1934).
generally only be tested against the standards applicable to good practice within that theory.

From the time of the decision in the Hunter case\textsuperscript{32} the Supreme Court of Appeals has adhered to this rule. The Fox case\textsuperscript{33} offers the first clear exposition, through the quotation of various authorities, of the rule that specialists are held to the standard of care and skill exercised by like specialists.\textsuperscript{34} The court said

"'[O]ne who accepts employment as a specialist must have that degree of skill and knowledge which is ordinarily possessed by physicians engaged in that specialty and must exercise his best judgment in the application of his skill and in the use of ordinary care.'"\textsuperscript{35}

The court also stated that:

"'One who holds himself out as a specialist in the treatment of a certain organ, injury, or disease is bound to bring to the aid of one so employing him that degree of skill and knowledge which is ordinarily possessed by those who devote special study and attention to that particular organ, injury or disease, its diagnosis, and its treatment, in the same general locality, having regard to the then state of scientific knowledge.'"\textsuperscript{36}

This rule has been consistently followed in Virginia.

In 1940 the Court of Appeals decided the principal case dealing with the standard to be applied when there are conflicting schools of practice, Reed v. Church.\textsuperscript{37} In 1923 the plaintiff had lost his consciousness for a period of thirty days and the defendant was called to treat him. Spinal taps were taken with the assistance of another doctor and the plaintiff was found to be suffering from cerebrospinal syphilis.\textsuperscript{38} The defendant treated the plaintiff by removing some spinal fluid to prevent convulsions and by giving him certain injections, and the plaintiff regained consciousness. According to the plaintiff’s testimony, the doctor assured him he was cured.

\textsuperscript{32}See text accompanying footnote 17.

\textsuperscript{33}Va. 667, 124 S.E. 405 (1924).

\textsuperscript{34}For general discussion of law applicable to specialists, see Annot., 59 A.L.R. 1071 (1929).

\textsuperscript{35}Va. at 670, 124 S.E. at 406, quoting Wharton and Stille, Medical Jurisprudence § 473, p. 459 (5th ed. 1905).

\textsuperscript{36}Va. at 671, 124 S.E. at 406, quoting Rann v. Twitchell, 82 Vt. 79, 71 Atl. 1045 (1909).

\textsuperscript{37}Va. 284, 8 S.E.2d 285 (1940).

\textsuperscript{38}Cerebrospinal syphilis is an infectious disease of the brain and spinal cord. Stedman at 296, 1470. See 1 Gray, Attorney’s Textbook of Medicine para. 93-49 (3d ed. 1961) (hereinafter cited as Gray).
In 1937 the plaintiff fainted again and was treated by the defendant for a recurrence of the same disease by dosages or tryparsamide, an approved treatment for his disease. The plaintiff testified that after the third of twelve injections of this drug he complained about his eyes, but Dr. Reed paid no attention to these complaints. The drug manufacturer’s pamphlet warned that the drug could cause such problems, but the plaintiff’s disease could also cause blindness. The plaintiff finally saw an optometrist and learned there was permanent atrophy of the optic nerve. The defendant immediately ceased using the drug and started using other drugs to counteract these effects. At the time of trial the plaintiff was almost totally blind.

The doctor contended that there were two schools of medical opinion concerning the development of optical difficulties—one suggested that the drug’s use be continued in order to alleviate the syphilitic condition, and the other school contended that the use of the drug be discontinued and counteracting drugs be administered. The defendant therefore argued that if he followed either of these theories he could not be held negligent. However, the court held this doctrine inapposite since the defendant, by his own testimony, had committed himself to one school, and he must be tested by the standards of that school. When the plaintiff’s optical complaints were confirmed the defendant ceased the administration of the drug. By this act he showed adherence to the theories of the second school, and whether he properly followed the standards of that school was a question of fact for the jury. The judgment for the plaintiff was affirmed.

The same problem was involved in a 1958 federal case arising from the Eastern District of Virginia, Nardini v. Gilbert. The plaintiff suffered from a painful and swollen knee and the defendant decided on surgery after other treatments failed. He tentatively diagnosed the problem as a torn medial meniscus, but he performed an exploratory operation to make sure. The surgical entry was made from the lateral, rather than the medial, side of the knee, and the anterior por-

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30 Tryparsamide is a drug containing arsenic for the treatment of syphilis. Stedman at 1580.
31 Atrophy is a wasting away or deterioration. Stedman at 168.
32 175 Va. at 292, 8 S.E.2d at 288. See the discussion of testimony by physicians of a different school in Annot., 78 A.L.R. 697 (1932).
33 Ibid.
34 360 F.2d 177 (4th Cir. 1965).
35 The medial meniscus (also semilunar cartilage) is an internal cartilage of the knee joint attached to the medial border of the upper articulating surface of the tibia, or shin bone. Stedman at 919; 1 Gray at paras. 7.14-7.15.
tion of the medial meniscus was removed with a tear in it. The plaintiff subsequently suffered from infection in the area and had some restriction of the motion of her knee. Her expert witnesses testified that the customary approach to the medial meniscus would be from the medial, and not the lateral, side, but they did not state that the defendant acted negligently. They only said that they would have operated from a different direction. Therefore, the defendant could not be found negligent merely because he proceeded in an unorthodox manner, but only if he was inexpert or unskilful in proceeding that way.

Thus, this facet of the overall standard can be a two-edged sword. The medical practitioner is protected by being tested only against the standards of care and skill exercised by other physicians within the same specialty who adhere to the same theories of treatment. However, the physician may reach the level of care and skill exercised by the average doctor in the same or similar community and yet fall short of that standard as exercised by the average member of the same specialty. Also, if the physician relies upon the “school of practice” as a defense he must be sure he measured up to the proper standard of practice and technique in following that school or theory.

(d) Similar Localities

Almost every medical malpractice case in Virginia has stressed the fact that the standard of care and skill to be exercised is that exercised in similar localities. Courts have used language implying that the standard might be more narrowly delineated but without amplification. The rationale behind this restriction on the standard is that courts have reasoned that there are significant differences between the facilities, opportunities for research, and even the extent of medical knowledge of physicians practicing in large cities and those practicing in rural areas. However, the present-day uniformity in the standards of medical schools and licensing boards have caused the significance of the locality to diminish. There is still a need for the courts to recognize the fact that “due care in a lumber camp might be gross

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4 Hunter v. Burroughs, 123 Va. at 131, 96 S.E. at 964; Henley v. Mason, 154 Va. at 384, 153 S.E. at 653. 
negligence at Johns Hopkins," but this consideration might be cast in a different context than the locality of practice.

In *Carroll v. Richardson*, the plaintiff's blood was being drawn by a student technician in a hospital at the behest of the defendant. The plaintiff stood up after the taking of the blood, fainted, and suffered injuries when he struck the floor. He did not allege that his blood had been negligently taken but that he should have been advised to remain seated for a while. There was expert testimony that it was not always advisable to speak to a patient after taking blood. The court ruled that there was no evidence that it was the custom in the general area to instruct the patient to remain seated, so it reversed the lower court and entered final judgment for the defendant.

As early as 1916, the Minnesota Supreme Court said:

"We think it is plainly correct that the locality in which the physician or surgeon practices must be considered in determining whether he has the requisite skill and learning, but we do not think that he is bound to possess and exercise only that degree of skill and learning possessed by other practitioners in the same locality, if by that is meant the same village or city. If the same general locality is meant, as, for instance, the Northwest, or the state, no fault could be found with such a rule. But in these days the physician or surgeon in a village like Cloquet is not hampered by lack of opportunity for advancement. Frequent meetings of medical societies, books by acknowledged authorities, and extensive experience in hospital work put the country doctor on more equal terms with his city brother. He would probably resent an imputation that he possessed less skill than the average physician or surgeon in the large cities, and we are unwilling to hold that he is to be judged only by the qualifications that others in the same village or similar villages possess."

While the protection of the similar localities rule is still probably necessary, its importance has been diminished a bit. There has been great progress in medical education, the exchange of medical knowledge, and medical licensing since this subrule was engrafted to the

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47 Fox v. Mason, 139 Va. at 671, 124 S.E. at 406.
49 This is apparently one of only two cases in Virginia involving the vicarious liability of a physician for the acts of another and it does not discuss this troublesome problem. See also Henley v. Mason, note 10 supra. See Louisell & Williams paras. 16.01-16.08; Stetler & Moritz 343-62. Likewise, few cases have arisen in the area of the vicarious liability of hospitals; see Note, Hospital Tort Liability and Immunity, 49 Va. L. Rev. 622, 699 (1963).
larger rule, and the language of the Minnesota court almost fifty years ago should have even more meaning today.

(e) The State of Medical Science

The law has for many years required a physician to keep reasonably abreast of medical progress, and the basic legal standard of duty is directly related to the state of current medical practices. In the Reed case the court stated that the physician "impliedly represents that he is keeping abreast of the literature and that he has adopted those techniques which have become standard in his line of practice." It would seem, however, that this requirement would be a part of the requirement that the physician exercise the skill and care normally exercised by the average of the members of the profession in good standing who are of the same general line and school of practice. Other physicians in good standing would seem to be reasonably aware of the advancements in medicine.

II

Proximate Cause

The ordinary rules of negligence are not cast aside in a malpractice action and, despite the legal rules peculiar to such a case, the plaintiff's action may often founder on the rocks present in any other negligence case. Proximate causation may be such a rock. In Honaker v. Whitley, the plaintiff went to Dr. Honaker for treatment of an impacted wisdom tooth. The defendant had to exert a great deal of force to attempt to pull a good tooth to get at the bad tooth and this tooth broke. The plaintiff became sick and had to go home where he experienced some pain and locking of his jaws. A second dentist later pried the jaws open and removed the broken root and the wisdom tooth. He testified that the jaw appeared to be all right at that time. Several days later X-rays revealed that the upper portion of the plaintiff's jaw was broken. A judgment for the plaintiff was reversed on appeal because there was no proof that the defendant fractured the jaw, and his evidence did not negative the possibility that the second dentist was the negligent party.

\[1\] Va. at 293, 8 S.E.2d at 288; see also United Dentists, Inc. v. Bryan, 158 Va. at 884-85, 164 S.E. at 555.

\[2\] See Stetler & Moritz 311-12. See also Oleck, New Medicolegal Standards of Skill and Care, 11 Clev.-Mar. L. Rev. 443 (1962).

In *Corbett v. Clarke,* the plaintiff had executed a release after dismissing a prior action against another dentist and a corporation. Dr. Clarke entered a plea of release which the trial court accepted. The Supreme Court of Appeals considered the question as to whether a dentist whose wrongful acts cause substantial injury to a patient is liable for the separate and distinct injuries flowing from the negligence of the original tortfeasor. The defendant had treated the plaintiff on numerous occasions subsequent to the original injury and had failed to discover the true condition of an infected gum. The court held that the damages were separate and distinct, and the plaintiff could maintain her suit.

The *Reed* case previously discussed, involved this problem because the plaintiff's sight problems could have been caused by either the administration of the drug or by his disease. The court stated that "if the proof leaves it equally probable that a bad result might have been due to a cause for which the defendant was not responsible as to a cause for which he was responsible the plaintiff cannot recover." The jury had held for the plaintiff under proper instructions, and the court would not disturb this decision. The question of proximate causation was close enough in *Vann v. Harden* so that Justice Eggleston dissented from the majority opinion on this very ground. He felt that there had not been an adequate showing that there was a causal connection between the defendant's actions and the infection which led to the loss of the plaintiff's leg. The majority, however, felt that the evidence supported the verdict.

The difficulty of proving that the defendant's negligence was the proximate cause of the plaintiff's injury is often intensified by the fact that the injury complained of may often be the natural and logical result of the disease or injury for which the plaintiff is being treated. Consequently the principles applicable to the ordinary negligence case cannot be ignored merely because there are other principles to be considered. Many a malpractice case has fallen in shambles around the feet of a plaintiff's attorney, even though he effectively and exhaustively proved malpractice, because he failed to prove proximate cause.

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*Va. 222, 46 S.E.2d 327 (1948), commented upon in 6 Wash. & Lee L. Rev. 103 (1949).*
*Va. at 224, 46 S.E.2d at 328.*
*Note 37 supra.*
*Va. at 293, 8 S.E.2d at 288; see also Hunter v. Burroughs, 123 Va. at 142, 96 S.E. at 369.*
*Note 22 supra.*
One of the most controversial developments in the law of medical malpractice has been the application of the doctrine of *res ipsa loquitur.* Despite the recent controversy over this rule of law, courts for some time have been asked to apply it. In fact, its application has been urged in Virginia from the time of *Hunter* case. There the court quoted from the decision by Mr. Chief Justice Taft, then a Circuit Judge, in the leading case of *Ewing v. Goode*.

"If the maxim "res ipsa loquitur" were applicable to a case like this, and a failure to cure were held to be evidence, however slight, of negligence on the part of the physician or surgeon causing the bad result, few would be courageous enough to practice the healing art, for they would have to assume financial liability for nearly "all the ills that flesh is heir to.""

The court also rejected the applicability of the doctrine in *Fox v. Mason.* The first frontal assault on the court's reticence was made in *Henley v. Mason,* where the plaintiff lost two teeth during a tonsillectomy. The customary practice at that time was to anesthetize the patient with ether and then insert a metal gag to keep the mouth open during the operation. When the ether spray was withdrawn, however, the plaintiff's jaw muscles contracted and she bit down on the gag with such force that two teeth broke off. The plaintiff appealed from the trial court setting aside the jury verdict and maintained that *res ipsa loquitur* was applicable. The court said:

"It is also a well-settled rule of law that, unless the doctrine of *res ipsa loquitur* is clearly applicable, then the standard for the measure of the skill exercised is not to be left to the whim or
caprice of a jury upon nonexpert evidence, but is to be shown or judged by the testimony of medical experts of good standing in the same line of practice. A careful study of the record leads us to the conclusion that the doctrine invoked is not applicable when viewed in the light of the facts of this case.\footnote{Id. at 384, 153 S.E. at 653. Contra Brown v. Shortlidge, 98 Cal. App. 352, 277 Pac. 134 (1929).}

The court also rejected the doctrine in the *United Dentists*\footnote{Note 25 supra.} and *Alexander*\footnote{Note 27 supra.} cases.

The doctrine was first applied in *Danville Community Hospital Inc. v. Thompson*.\footnote{186 Va. 746, 43 S.E.2d 882 (1947). Although this is a case involving a hospital the principles are equally applicable to physicians.} The plaintiff had been burned shortly after her birth by either the application of a hot water bottle to her body, or by being placed in a special resuscitator bassinet. The court rejected an attack on a verdict for the plaintiff based on the doctrine by stating that the "doctrine applies in negligence cases where the instrumentality which caused an injury is within the exclusive possession and control of the person charged with negligence, and such person has, or should have, exclusive knowledge of the way that instrumentality was used, and the injury would not ordinarily have occurred if it had been properly used."\footnote{Id. at 384, 153 S.E. at 653. Contra Brown v. Shortlidge, 98 Cal. App. 352, 277 Pac. 134 (1929).}

The court recognized that it had hitherto refused to apply the doctrine, stating that the doctrine only applies to certain factual situations. The leading California case of *Ybarra v. Spangard*,\footnote{25 Cal. 2d 486, 154 P.2d 687, 162 A.L.R. 1238 (1944), cited and quoted in 186 Va. at 761-62, 43 S.E.2d at 488-89. See Louisell & Williams para. 14.07.} was quoted by the court with restrained approval, but approval nonetheless.

The principal discussion of this doctrine in Virginia took place in the 1960 federal court opinion in *Dietze v. King*.\footnote{184 F. Supp. 944 (E.D. Va. 1960).} The plaintiff had undergone a radical mastectomy\footnote{A mastectomy (also mammectomy) is an amputation of the breast. Stedman at 904.} and was treated at the defendant's office for a period of time until she left for England with the defendant's knowledge. Following her arrival in England, X-ray photographs were taken and the presence of a surgical sponge in the operative wound was discovered. It was subsequently removed. The trial judge held that under the facts of the case it seemed clear that Virginia would, in a similar case, invoke the doctrine of *res ipsa loquitur*.
The court held that the doctor was not negligent in leaving the sponge in the wound because of certain complications which arose during the operation. However, the plaintiff's wound had continued draining, and the defendant had even noted the possibility of a foreign body being in the wound in his records. The usual practice in the community was to resort to X-rays to check on such suspicions, and in failing to do so the defendant was negligent.

The court decided that the "very nature of the omission in leaving a sponge or other foreign body in the operative wound following an open operation commands the invocation of the doctrine of res ipsa loquitur." The judge also discussed the effect of applying the doctrine in Virginia and he concluded that: 1) it avoids a directed verdict for the defendant at the close of the plaintiff's case since it permits an inference of negligence; 2) it avoids a directed verdict for the defendant at the close of all the evidence unless he offers uncontradicted evidence explaining the accident in terms excluding any negligence on his part or leaving the question of negligence in balance; and 3) it never has the effect of shifting the burden of proof as to negligence.

IV

Statute of Limitations

Because of the nature of the injury, and of the negligence involved in such a case, the application of the pertinent statute of limitation has been somewhat of a problem in many jurisdictions. The Virginia court has not had to face this problem, but it is generally assumed that the tort statute for personal injuries will be applied un-
less a special contract is involved.\textsuperscript{80} Seventeen jurisdictions, but not Virginia, have passed special statutes applicable only to such actions.\textsuperscript{81} The wrongful death statute would probably be applicable if death resulted from the treatment.\textsuperscript{82} Most states have held that the period starts running from the date of the wrongful act and not from the date that the negligent act was discovered,\textsuperscript{83} but fraudulent concealment might toll the statute. However, some affirmative act beyond mere silence on the part of the physician is ordinarily required before this rule will be applied.\textsuperscript{84}

V

\textbf{EXPERT TESTIMONY}

It has been universally recognized that expert testimony is required in a malpractice case, and from the very first case Virginia has applied this rule.\textsuperscript{85} The necessity for the testimony of other doctors has created grave frustrations for plaintiff's attorneys, and it has also been the greatest source of criticism of the body of malpractice law.\textsuperscript{86} Doctors are naturally quite reluctant to testify against fellow doctors and to state that their compatriots fell below the standards of the com-
This reluctance must not be too readily condemned by the legal profession, however, because attorneys have been no less reluctant to take the witness stand and testify against another attorney, or for any other reason. The need for expert testimony and the difficulty in obtaining such testimony has given rise to a number of suggestions and plans for alleviating the problem.

(a) Medical Treatises and Pamphlets

One of the many suggestions has been to allow the use of medical treatises, texts, and pamphlets in demonstrating the standard of care and skill which should have been exercised. The proponents of this innovation have urged that these texts be used as affirmative proof and not solely for impeachment purposes. At this time apparently only three jurisdictions have allowed such use—Alabama by judicial decision, and Massachusetts and Nevada by statutes. The statutes require the plaintiff to give the titles of the treatises and the authors’ names to the defendant at least three days prior to trial.

This suggestion has been considered by a federal court in Virginia and a peripheral problem has been considered by the Supreme Court of Appeals. In Lawrence v. Nutter, the plaintiff was treated by the defendant in Fredericksburg for a severe fracture of the left elbow and released to return to his home in Martinsville. At home he was placed under the care of another physician who discovered the

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68Every lawyer dislikes to take the witness stand and will do so only for grave reasons. This is partly because it is not his role; he is invariably a poor witness. But he steps out of character to do it. He regrets it; the profession discourages it.” Hickman v. Taylor 329 U.S. 495, 517 (1947). See also Christie v. Callahan, 124 F.2d 825, 828 (D.C. Cir. 1941).


70See Note, Medical Treatises as Evidence—Helpful but Too Strictly Limited, 29 U. Cinc. L. Rev. 225 (1960). See also Hopkins v. Gromovsky, 198 Va. 369, 94 S.E.2d 190 (1956), wherein the Supreme Court of Appeals held that medical texts may be used for cross-examination but not read to the jury.


74203 F.2d 540 (4th Cir. 1953).
presence of gas gangrene infection. He treated the infection, but the arm finally had to be amputated. The plaintiff maintained that the defendant had been negligent in his diagnosis and treatment but was not successful. At a pretrial conference the plaintiff's attorney attempted to require the production of the defendant's hospital records pertaining to the treatment of similar cases, but the Fourth Circuit Court of Appeals upheld the trial court's denial of this motion. The trial court had also refused to allow the plaintiff's attorney the use of medical treatises in the cross-examination of the defendant and his experts. The Court of Appeals ruled "that when a witness is testifying as an expert, it is competent to test his knowledge on cross examination by reading to him extracts from scientific authorities, which he recognizes as standard upon the subject matter involved, and then ask him whether he agrees or disagrees with what has been read." The court reversed the case but left the scope of such a cross-examination to the discretion of the trial court so that the use of the material would be limited to the locality and period of time against which the defendant must be tested. The court's ruling allows their use only as impeachment evidence, however.

A peripheral problem was discussed in the Reed case where the plaintiff introduced the manufacturer's pamphlet accompanying the drug as evidence of the proper method of using the drug. The pamphlet stated that if visual acuity were reduced by the administration of the drug any further use must be curtailed. The Supreme Court of Appeals apparently assumed that the pamphlet was erroneously admitted but held that there could be no possible prejudice to the defendant since he had testified that he followed the directions contained therein, and since the trial court had instructed the jury to consider the pamphlet only as showing that Dr. Reed had knowledge of the instructions contained in it.

(b) Common Knowledge

Another avenue of escape from the so-called "tyranny of the expert" lies in the extension of the permissible areas of common knowl-

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66Gas gangrene infection is the infection of a wound sometimes found in fracture cases. Stedman at 628. 1 Gray at para. 2.47 (5).
67203 F.2d at 541.
68Id. at 542.
69Id. at 543.
70Note 37 supra.
71175 Va. at 297-98, 8 S.E.2d at 290. In a recent case the Supreme Court of Appeals has held that a manufacturer's instruction pamphlet was admissible on the question of negligence. Barnette v. Dickens, 205 Va. 12, 135 S.E.2d 109 (1964).
edge on the part of the jury. This proposal attempts to allow for the increased sophistication of present-day jurors and it alleviates the need for expert testimony in cases in which the negligence of the defendant might be apparent without expert testimony. This avenue is often confused with res ipsa loquitur, and the two concepts are closely related. They differ in that the rule of common knowledge assumes that the issue of negligence involved in the case is not related to technical matters peculiarly within the knowledge of experts. The plaintiff must still prove the causative act or omission but he does not need expert testimony to establish the standard of care. Under res ipsa loquitur the plaintiff does not need to prove either of these elements.

(c) Impartial Testimony and Screening Panels

Two other solutions to the problem of expert testimony may be found in the plans for either obtaining impartial medical testimony, or for insuring the availability of an expert when the plaintiff has a meritorious case. The first suggestion has received a great deal of favorable comment for its use in other types of personal injury cases, particularly in New York, and it has been considered in Virginia. A doctor is appointed from a list and becomes the court's witness, but the parties are not bound by the doctor's findings. However, the plan has not so far been used in a malpractice case and it might be difficult to do so.

The second plan contemplates the creation of a Medical Malpractice Screening Panel and this plan has been adopted in Virginia. It was accepted by the Medical Society of Virginia in 1960 and the

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101 Louisell & Williams para. 14.06; Stetler & Moritz 378-83; Scott and Herring, Medical Malpractice in Florida, 12 Fla. L. Rev. 121, 139-41 (1959).
103 Sanzari v. Rosenfeld, 167 A.2d 625 (N.J. 1961); Stetler & Moritz 379-80.
Virginia State Bar Council adopted it in 1961. One primary reason for its adoption was the difficulty in obtaining medical testimony in the state. Since its organization the panel has heard only a few cases, and a reason for the minimal utilization has apparently been the reluctance of the liability insurance carriers to allow their policy holders to submit cases to the panel. The permanent panel consists of the members of the Medico-Legal Committees of the Medical Society and the State Bar, but neither committee will be represented by more than ten members. The attorney for the plaintiff initiates a hearing by addressing a request to the Executive Secretary of the Medical Society of Virginia accompanied by a statement of facts, an authorization for the panel to obtain medical records, an agreement of confidentiality, a request for a report, a statement of subscription to the plan, a fee, and a written consent to a hearing signed by the defendant and his attorney.

The panel will "consider only whether, in the light of the material presented, there is a reasonable possibility that the acts complained of constitute professional negligence, and whether there is a reasonable medical probability that the claimant was injured thereby." Where the panel has rendered an opinion favorable to the claimant, the panel and the Medical Society will cooperate with him in obtaining expert testimony. The panel's opinion is not binding on either party. As the plan receives more publicity and is better understood it will probably be used more frequently.

VI
EMERGENCY TREATMENT

One further problem which has arisen in recent years relates to

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Ibid.
110Annual Report 57-58 (1962); Annual Report 56-57 (1963); The Executive Council of the Virginia State Bar has recommended that the medical malpractice screening panel be authorized to hear cases even though the consent of the physician and his attorney cannot be obtained. 12 Virginia Bar News No. 6, p. 4, cols. 2-3 (June 1964).
111The complete plan is set forth in Annual Report 62-65 (1961); copies of the plan may be obtained from the Virginia State Bar or the Medical Society of Virginia in Richmond, Virginia.
113Letter from Robert I. Howard, Note 110 supra.
the rendering of emergency medical treatment—often no more than intelligent first aid—by a physician at the scene of an automobile accident. Although a doctor has no legal duty to render such care to persons who are not his patients, there is an ethical duty to do so. In response to the reluctance of doctors to stop at the scene because of the fear of possible legal action by a complete stranger, and in reaction to cases allowing recovery in such a case, the state of California passed the first “Good Samaritan” statute in 1959. Three years later Virginia passed a similar statute providing immunity for a doctor rendering emergency care for a roadside or highway accident if no established doctor-patient relationship pre-existed such care. No cases have arisen under the law as yet.

VII

CONCLUSION

The trial of a medical malpractice case is essentially little different from the trial of any other personal injury case but the differences that do exist can mean recovery or loss, or a successful or unsuccessful defense. The importance of expert testimony cannot be overemphasized under the present rules and also because the average juror does not expect the physician to be infallible, and is generally quite understanding of the pressures under which the doctor

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11Stetler & Moritz 342; Opinions and Reports of the Judicial Council, American Medical Association 27 (1960).
10Stetler & Moritz 334.
12Ibid; Cal. Bus. & Prof. Code § 2144; Louisell & Williams para. 9.05, n.51. Many authorities consider this problem to be greatly overemphasized since apparently there are no reported cases involving such an action. Averbach, Good Samaritan Laws, 69 Case and Com. 13 (March- April 1964).
13Some question has been raised regarding the constitutionality of such statutes. Stetler & Moritz 335.
14Most of the texts previously cited are excellent practical guides to the trial of such a case with Louisell & Williams being particularly outstanding in the opinion of this writer. A good law review article written by a practitioner experienced in these cases is Ames, Modern Techniques in the Preparation of Trial of a Medical Malpractice Suit, 12 Vand. L. Rev. 649 (1959). This and several other Vanderbilt Law Review articles cited herein are compiled in Roady and Andersen, Professional Negligence (1960). See also Kramer, Medical Malpractice (1962), a pamphlet prepared by the Practicing Law Institute; 7 Am. Jur. Proof of Facts, Malpractice 479-600 (1960); The Defense Research Institute, Inc., Medical Malpractice (1962); Cusumano, Malpractice Law Dissected for Quick Grasping (1963).
works.\textsuperscript{121} There are, of course, two basic problems in this field. The first one is that a suit may be filed for its nuisance value because doctors are naturally quite reluctant to bare the question of their professional competence before a jury and the public.\textsuperscript{122} Second, there is always the danger that a meritorious claim will fail because of the plaintiff's inability to secure expert testimony.\textsuperscript{123}

The \textit{Medical Malpractice Screening Panel} affords a splendid medium for alleviating these problems but it needs greater acceptance throughout the state. There must also be more interchange of ideas on subjects of mutual interest between the professions of law and medicine.\textsuperscript{124} The \textit{Standards of Principles Governing Lawyers and Physicians in the Commonwealth of Virginia}\textsuperscript{125} reflect an attempt to bridge the gap of misunderstanding. With the tremendous rise in personal injury cases the two professions are thrown together more often, and the field of medical jurisprudence has become a full-fledged specialty in both professions. A fuller understanding of the law of medical malpractice on the part of lawyers and doctors may help to eliminate one of the more formidable stumbling blocks to understanding and mutual respect.

\textsuperscript{121}See Power, "After All, Doctors Are Human," 15 Fla. L. Rev. 463 (1963).

\textsuperscript{122}One reason for this reluctance has been the fear that such publicity could affect their practice. An American Medical Association study came up with some interesting conclusions through a survey participated in by forty-one state medical societies. Thirty of these replies indicated that such a suit had little or no effect on the reputation and practice of the physician involved. Of thirty-eight more specific replies, thirty-two felt that the duration of any effect would be a matter of only weeks or months; five felt the effects would last several years; and only one reply stated that the duration of any effects would be about two years. How State Medical Society Executives Size Up Professional Liability, 164 A.M.A. J. 580 (1957).

\textsuperscript{123}A recent text analyzes 123 malpractice cases decided in recent years by various trial courts. Of this number the plaintiff won only 24\% of the cases, which was further broken down into: 1) diagnosis—12\% recovery rate; 2) treatment—25\% recovery rate; 3) operations—30\% recovery rate; and in eighteen cases of dental malpractice the recovery rate was 28\%. Statewide Jury Verdicts: Verdict Expectancies 401-07 (Va. Ed. 1961). It is difficult to say whether these low recovery rates are due primarily to a failure to obtain expert testimony, but this remains the plaintiff's main problem.


\textsuperscript{125}These Standards were adopted by the Virginia State Bar and the Medical Society of Virginia in 1958. They relate primarily to medical reports, physicians as witnesses, and physicians' fees and services. Copies of these Standards in pamphlet form may be obtained from either the State Bar or the Medical Society.