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**Hospital Liability in West Virginia**

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HOSPITAL LIABILITY IN WEST VIRGINIA

THOMAS J. HURNEY, JR.*

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I. INTRODUCTION

Since the abolishment of charitable immunity, hospitals in West Virginia have faced exposure to liability in medical malpractice cases notwithstanding the 1986 passage of the Medical Professional Liability Act (MPLA), West Virginia's attempt at tort reform in response to the "medical malpractice crisis." While the MPLA plainly applies to hospitals, it has not, as a practical matter, limited the circumstances under which hospitals can be drawn into medical malpractice actions because of the expanding judicial imposition of vicarious liability to hospitals.

This Article will examine the areas in which a hospital, under West Virginia law, may be found liable for personal injuries to patients and others. This Article will discuss the MPLA and its impact upon existing West Virginia law regarding medical malpractice and hospital liability; the judicial expansion of hospitals' vicarious liability; hospitals' potential liability for failure to adequately screen and monitor the activities of the medical staff; and liability outside of the traditional medical malpractice context.

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1. Excluded from discussion in this Article are suits outside the personal injury context, such as claims by staff physicians against the hospital for failing to grant privileges, etc., see Mahmoodian v. United Hosp. Ctr., Inc., 404 S.E.2d 750 (W. Va. 1991); Jacqueline Oliverio, Comment, Hospital Liability for Defamation of Character During the Peer Review Process: Sticks and Stones May Break My Bones, But Words May Cost Me My Job, 92 W. Va. L. Rev. 739 (1990), and employment related lawsuits, Birthisel v. Tri-Cities Health Servs. Corp., 424 S.E.2d 606 (W. Va. 1992); Graf v. West Virginia Univ., 429 S.E.2d 496 (W. Va. 1992), including actions by employees under the "deliberate intention" exception of the West Virginia Workers' Compensation Act, W. Va. Code § 23-4-2(e)(2) (Supp. 1992) (commonly referred to as Mandolidis actions after the case of Mandolidis v. Elkins Indus., Inc., 246 S.E.2d 907 (W. Va. 1978), where the West Virginia Supreme Court of Appeals significantly broadened the scope of employer liability).

This Article also does not address federal claims for liability for "patient dumping" under the Federal Emergency Treatment and Active Labor Act, 42 U.S.C. § 1395dd (1988), which is an article unto itself and, in fact, has been covered in this journal. James P. McHugh, Comment, Emergency Care for Indigents: All Hospitals Must Provide Stabilizing Treatment or Pay the Price, 93 W. Va. L. Rev. 165 (1990); see also Helene Hoffman, Does COBRA Work? The Problem of Patient Dumping and Possible Solutions, 25 J. HEALTH & HOSP. L. 1 (1992); Ingrid M. Orentas, Making COBRA Work: The Role of the Federal Courts, 25 J. HEALTH & HOSP. L. 15 (1992).
II. HOSPITALS AND THE WEST VIRGINIA MEDICAL PROFESSIONAL LIABILITY ACT

A. Applicability

In 1986, the West Virginia Legislature, responding to a crisis in the availability of medical malpractice insurance,\(^ 2\) passed the MPLA to place limits on liability in cases involving medical malpractice.\(^ 3\) The MPLA applies to injuries sustained after its effective date, June 6, 1986,\(^ 4\) and places limitations upon all medical professional liability actions against health care providers and facilities.\(^ 5\) Since the MPLA

\(^2\) See W. VA. CODE § 55-7B-1 (Supp. 1992) (legislative declaration of purpose). One author traces the medical malpractice crisis to 1974 when “the issue of medical malpractice exploded across America as health care providers saw their medical malpractice liability insurance premiums increase up to 500% virtually overnight.” Larry M. Pollack, Medical Malocurrence Insurance (MMI): A First-Party, No-Fault Insurance Proposal for Resolving the Medical Malpractice Controversy, 23 TORT & INS. L.J. 552, 557 (1988) (citing P. DANZON, MEDICAL MALPRACTICE 85 (1985)). The crisis has been explained by inadequate charging of premiums caused by extreme competition, pressure by medical providers to keep rates down, an increase in malpractice litigation and liberal courts and generous juries. Id. at 558-59. A first crisis abated by 1976; however, “as interest rates dropped sharply in 1984, the continuing severity of premium loss sparked the current round of the medical malpractice crisis.” Id. at 560.


\(^3\) W. VA. CODE § 55-7B-1 to -11 (Supp. 1992) [hereinafter cited as “MPLA § ____”].

\(^4\) MPLA § 10.

\(^5\) The MPLA contains the following definitions:

(b) “Health care facility” means any clinic, hospital, nursing home, or extended care facility in and licensed by the state of West Virginia and any state operated institution or clinic providing health care.
governs all medical professional liability (formerly medical malpractice) actions, knowledge of its provisions is essential to understanding hospital liability in West Virginia for two reasons. First, the MPLA directly affects hospitals because it governs actions against nurses, technicians, and other employees as well as doctors. Second, because judicial decisions have expanded hospitals’ vicarious liability, hospitals now face potential liability for nonemployee physicians. Evaluation of hospital cases, therefore, must occur within the confines of the MPLA.

At the heart of the MPLA is a series of interrelated definitions establishing its application. “Medical professional liability actions” are defined to include “any liability for damages resulting from the death or injury of a person for any tort or breach of contract based on health care services rendered, or which should have been rendered, by a health care provider or health care facility to a patient.”

The MPLA defines “health care” as “any act or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to or on behalf of a patient during the patient’s medical care, treatment or confinement.”

These definitions are consistent with preexisting law that a physician-patient relationship must exist to support a medical malpractice action. In Rand v. Miller, the absence of a physician-patient relationship barred an employee from bringing a malpractice claim against a physician who examined him at the request of his employer. Applying this principle in Sisson v. Seneca Mental Health Center, the

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(c) “Health care provider” means a person, partnership, corporation, facility or institution licensed by, or certified in, this state or another state, to provide health care or professional health care services, including, but not limited to, a physician, osteopathic physician, hospital, dentist, registered or licensed practical nurse, optometrist, podiatrist, chiropractor, physical therapist, or psychologist, or an officer, employee or agent thereof acting in the course and scope of such officer’s, employee’s or agent’s employment.

Id. § 2.

6. Id. § 2(d).

7. Id. § 2(a).


Supreme Court of Appeals of West Virginia affirmed summary judgment for a counselor who became sexually involved with the plaintiff because there was no evidence that a "trust relationship" had arisen.\textsuperscript{11}

The MPLA applies to actions against hospitals, defining both "healthcare provider" and "healthcare facility" to include hospitals\textsuperscript{12} as well as any "officer, employee or agent thereof acting in the course and scope of such officer's, employee's or agent's employment."\textsuperscript{13}

These definitions are significant because they eliminate the suggestion in prior West Virginia cases that actions against hospitals are mere "negligence" actions as opposed to medical malpractice actions.\textsuperscript{14} By defining hospitals, nurses, and their agents as "health care providers," the MPLA places them on the same footing as physicians in its statutory scheme.

The MPLA definitions, however, limit which hospitals qualify. Healthcare providers must be "licensed by, or certified in, this state or another state, to provide health care or professional health care services."\textsuperscript{15} Healthcare facilities—hospitals, nursing homes, or extended care facilities—include those "in and licensed by the state of West Virginia and any state operated institution or clinic providing health care."\textsuperscript{16}

\textsuperscript{11} \textit{Id.} at 429. In a related vein, suits by spouses of patients having sex with a counselor are barred under West Virginia's alienation of affection statute, W. VA. CODE § 56-3-2a (Supp. 1992). Weaver v. Union Carbide, 378 S.E.2d 105 (W. Va. 1989).

\textsuperscript{12} MPLA § 2(b); \textit{see} definitions \textit{supra} note 5.

\textsuperscript{13} MPLA § 2(c); \textit{see} definitions \textit{supra} note 5.


\textsuperscript{15} MPLA § 2(c).

\textsuperscript{16} \textit{Id.} § 2(a)-(c); \textit{see} W. VA. CODE § 16-5B-1 to -12 (1991 & Supp. 1992) (licensing of hospitals); W. VA. CODE § 16-5C-1 (1991) (licensing of nursing and personal care homes); W. VA. CODE § 16-5I-1 (1991) (licensing of hospices). The MPLA can also apply to hospitals located in other states. However, assuming the negligence took place there, West Virginia would apply the other states' substantive law. In \textit{Vest} v. St. Albans Hosp., 387 S.E.2d 282 (W. Va. 1989), a pre-MPLA case, the court found that Virginia substantive law governed the claim since the hospital was located in Virginia and the negligence took place there. However, the court refused to apply Virginia's medical malpractice law which required notification of the defendant and submission to a medical review panel and which required dismissal of any case brought in violation of its provisions. \textit{Id.} at 286.

In addition, it is an open question whether the MPLA applies to federally operated hospitals. Some federal courts have applied state malpractice acts to federal hospitals. \textit{See
Absent an appropriate license, the MPLA might not apply, stripping the facility of its protections.  

The MPLA is limited to actions arising out of care of a "patient" defined as a "natural person who receives or should have received health care from a licensed health care provider under a contract, express or implied." This definition was discussed in Ricottilli v. Summersville Memorial Hospital.  

Ricottilli involved claims for emotional distress damages against a hospital arising out of the autopsy of the plaintiff’s deceased child. The plaintiff argued that the MPLA applied, providing a two-year statute of limitations, making the action timely. However, by finding that the body was not a "patient," the court concluded that the MPLA did not apply.

By definition, the MPLA pertains to liability arising from the provisions of "health care" which is defined as "treatment performed or furnished, or which should have been performed or furnished . . . on behalf of a patient . . . ." W. VA. CODE § 55-7B-2(a). Because the term patient is further defined as a "natural person," a deceased individual is necessarily precluded from qualifying as a patient under the MPLA, and therefore cannot be the basis for a cause of action alleging medical professional liability pursuant to the Act.

Ricottilli provides good news and bad news. Even though it provided a shorter statute of limitations, its restrictive view of the "patient" definition has the absurd result of excluding pathologists from the protections of the MPLA. Certainly, the MPLA was designed to protect all physicians and health care providers—even pathologists. Because of its unusual facts, Ricottilli is best viewed as an application

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17. For example, in Ricottilli v. Summersville Memorial Hosp., 425 S.E.2d 629 (W. Va. 1992), the court held that a dead body was not a "patient" as defined in the MPLA; therefore, it held the MPLA inapplicable. See also Rudemacher v. Tountas, 474 N.W.2d 446 (Minn. Ct. App. 1991).
18. MPLA § 2(e).
20. Id. at 633.
of West Virginia law allowing recovery for emotional distress based on the mishandling of a corpse. Nonetheless, Ricottilli suggests that where its definitions are not met, the MPLA will not apply.

B. Elements of Proof

Section 3 of the MPLA codifies the classic elements of a medical malpractice case: breach of the standard of care, proximate cause, and injury.

The following are necessary elements of proof that an injury or death resulted from the failure of a health care provider to follow the accepted standard of care:

(a) The health care provider failed to exercise that degree of care, skill and learning required or expected of a reasonable, prudent health care provider in the profession or class to which the health care provider belongs acting in the same or similar circumstances; and

(b) Such failure was a proximate case of the injury or death.22

Under the MPLA, once the plaintiff presents appropriate evidence that the defendant breached the standard of care, the issue becomes a jury question. Moreover, the statutory definition of the standard of care does not disturb the application of West Virginia's comparative fault system to MPLA cases.24

1. The Standard of Care

The MPLA definition of the standard of care makes it clear that hospitals, like other healthcare providers, are to be evaluated against

21. See also Bennett v. 3 C Coal Co., 379 S.E.2d 388 (W. Va. 1989).
22. MPLA § 3. The MPLA maintains a “unitary” standard of care, applicable to all patients. One author has suggested that patient resources should be a factor in determining the legal adequacy of care provided. John A. Siliciano, Wealth, Equity and The Unitary Medical Malpractice Standard, 77 Va. L. Rev. 439 (1991).
similar hospitals. For example, a rural community hospital would not be held to the same standards as an urban tertiary care center. Hospital employees such as nurses and technicians must be judged against reasonable and prudent nurses and technicians. This is a subtle change from prior law, under which hospitals were broadly required to provide such reasonable care and attention as required by the patients' mental and physical condition. Under the MPLA, cases against hospitals are elevated to "malpractice" status, requiring proof of the standard of care by expert testimony.

The MPLA leaves standing the principle that hospitals and other health care providers are not required to exercise the highest degree of skill in treatment absent special contract to do so. Errors in judgment are not negligence and injured patients cannot recover damages simply by showing an undesirable outcome. Hospitals are not insurers of patient safety.


27. Dye v. Corbin, 53 S.E.2d 147 (W. Va. 1906). In Davis v. Wang, 400 S.E.2d 230 (W. Va. 1990), the West Virginia Supreme Court held that a "Dye v. Corbin" instruction—that a mistake in judgment is not negligence—was not appropriate where the physician could not recall whether he had ever examined the patient and evidence was presented that he had never reviewed the chart. See also Kinning v. Nelson, 281 N.W.2d 849 (Minn. 1979); Mitchell v. Hadl, 816 S.W.2d 183 (Ky. 1991) (wrong but reasonable opinion not negligence). Compare Jones v. Chidester, 610 A.2d 964 (Pa. 1992) (Pennsylvania's "Two Schools of Thought").


By requiring specific elements, the MPLA is consistent with prior law, under which res ipsa loquitur was sparingly applied in medical malpractice cases:

The doctrine of res ipsa loquitur cannot be invoked where the existence of negligence is wholly a matter of conjecture and the circumstances are not proved, but must themselves be presumed, or when it may be inferred that there was no negligence on the part of the defendant. The doctrine applies only in cases where a defendant’s negligence is the only inference that can reasonably and legitimately be drawn from the circumstances.30

One area where the MPLA changes existing law is informed consent. Because the MPLA now defines the standard of care by reference to reasonably prudent health care providers in the same or similar circumstances, it is different than prior law. In Cross v. Trapp,31 the Supreme Court of Appeals of West Virginia adopted the “patient need” standard, requiring that informed consent be measured by the reasonable patient. The Cross v. Trapp court expressly rejected the “physician disclosure” standard national or community medical disclosure practice.32

Contrary to Cross v. Trapp, the MPLA definition of the standard of care suggests that physician disclosure standards are now the appropriate measure of informed consent and must be established by expert testimony.33 While hospitals are generally not liable for failure of a

30. Farley v. Meadows, 404 S.E.2d 537, 539 (W. Va. 1991) (citing Davidson’s, Inc., v. Scott, 140 S.E.2d 807, syl. pt. 5 (W. Va. 1965)). Farley was a negligent sterilization claim in which the plaintiff relied completely on res ipsa loquitur. The court refused to apply the doctrine, stating:
   It would be entirely reasonable to infer that the band was correctly applied to Ms. Farley’s right fallopian tube, but that it came off soon thereafter—that Ms. Farley was the one out of every three hundred patients for whom the sterilization procedure was destined to fail. Clearly, then, that Dr. Meadows negligently performed the tubal ligation is not the only inference we can draw from the facts.
   Thus, the doctrine of res ipsa loquitur cannot apply to this case.
31. 294 S.E.2d 446 (W. Va. 1982).
32. Id. at 455; see also Adams v. El-Bash, 338 S.E.2d 381, 385 (W. Va. 1985).
33. MPLA § 7; see infra part II.C; see also Savold v. Johnson, 443 N.W.2d 656 (S.D. 1989); Snawder v. Cohen, 804 F. Supp. 910 (W.D. Ky. 1992); Culbertson v. Mernitz,
private physician to gain consent, this distinction is significant because they can be held vicariously liable under West Virginia law in informed consent cases where the physician is an employee or agent of the hospital.\textsuperscript{34}

2. Proximate Cause

Section 3(b) of the MPLA requires that the medical professional negligence be "a proximate cause" of plaintiff's injury.\textsuperscript{35} Since this term is not defined in the MPLA, preexisting law serves to establish its parameters.

The health care provider's negligence must be at least a "substantial factor" in the ultimate outcome.\textsuperscript{36}

Where a plaintiff in a malpractice case has demonstrated that a defendant's acts or omissions have increased the risk of harm to the plaintiff and that such increased risk of harm was a substantial factor in bringing about the ultimate injury to the plaintiff, then the defendant is liable for such ultimate injury.\textsuperscript{37}

The chain of proximate cause is not necessarily broken by the negligence of a subsequent treating health care provider. Where the negligence is foreseeable, the original provider may still be liable.\textsuperscript{38}

Proximate cause must ordinarily be proven by expert testimony establishing a reasonable probability that the defendant's act caused the plaintiff's injuries.\textsuperscript{39}

\begin{footnotesize}
\begin{itemize}
\item 602 N.W.2d 98 (Ind. 1992).
\item 34. See discussion infra part III.B.
\item 35. MPLA § 3(b).
\item 39. See Hicks v. Chevy, 358 S.E.2d 202, 205 (W. Va. 1987); Totten v. Adongay, 337
\end{itemize}
\end{footnotesize}
C. Expert Witnesses

The MPLA attempted to reform the law of medical malpractice by requiring that the standard of care be proven by expert testimony and by providing specific guidelines as to the necessary qualifications of expert witnesses.

1. Proving the Standard of Care

The MPLA requires that medical professional liability be proven by expert testimony: "The applicable standard of care and a defendant's failure to meet said standard, if at issue, shall be established in medical professional liability cases by the plaintiff by testimony of one or more knowledgeable, competent expert witnesses if required by the court." This provision is basically consistent with existing West Virginia law. "It is the general rule that in medical malpractice cases negligence or want of professional skill can be proved only by expert witnesses." The rule was applied in Farley v. Meadows, where the court refused to allow the plaintiff to rely on the doctrine of res ipsa loquitur and proceed without an expert. In Farley, the plaintiff claimed that the defendant physician negligently performed a tubal ligation (placing elastic bands on the fallopian tubes to prevent the passage of eggs from the ovaries into the uterus). The court noted that whether the physician acted negligently was a matter outside the common knowledge of jurors, thus indicating that the case required expert testimony.


40. MPLA § 7.


42. 404 S.E.2d 537 (W. Va. 1991).
Interestingly, the court openly rejected the plaintiff’s claim that a “conspiracy of silence” among doctors prohibited her from obtaining an expert witness:

Ms. Farley had ample time to retain an expert, and failed to do so. She claims that there is a “conspiracy of silence” among medical professionals, and, of course, there is an understandable reluctance among doctors to testify against fellow doctors with whom they must work every day. However, it is obvious from the abundance of medical malpractice cases that go to trial around the United States, and from the profusion of medical experts advertising their services in the back of legal magazines, that many doctors will gladly don their boxing gloves for a reasonable fee and testify about malpractice matters away from their own home towns.  

Despite stating that the standard of care “shall” be proven by expert testimony, the MPLA does not require experts in all cases; experts are required only “if required by the court.” At a status conference required by the MPLA, the plaintiff must certify that an expert has or will be retained to testify as to the applicable standard of care or that no expert is required. If court rules that an expert is necessary, the plaintiff must be given reasonable time to obtain one.  

This language suggests that the MPLA maintains the “common knowledge” exception to pre-MPLA law requiring experts, judicially adopted in Totten v. Adongay. “The essence of this exception is simply that certain medical situations present routine or noncomplex matters which are cognizable under the common knowledge or experience of lay jurors and, therefore, the presence or absence of negligence can be determined without resort to expert testimony.” In Totten, the court applied the rule, finding that whether an x-ray showed a fracture was within the common knowledge of jurors; accordingly, the

43. Id. at 539-40.
44. MPLA § 7.
45. Id. § 6.
47. Totten, 337 S.E.2d at 7.
plaintiff was not required to present expert testimony that failing to diagnose the fracture was malpractice.48

2. Qualifications

The MPLA also contains requirements for the qualification of experts. Before the court allows an expert to testify, the MPLA provides that five factors must be established:

1) the opinion is actually held by the expert;
2) the opinion can be testified to with reasonable medical probability;
3) the expert possesses professional knowledge and expertise coupled with knowledge of the applicable standard of care;
4) the expert is currently licensed in United States; and
5) the expert is engaged or qualified in same or similar field as defendant health care provider.49

By requiring this foundation as to an expert’s qualifications, the MPLA is consistent with the principle that the trial court has the duty to make the preliminary determination of a witness’ qualifications as an expert50 and that matters outside the field of a witness’ expertise are not admissible.51

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48. In Totten, Justice Neely concurred that there was sufficient evidence to allow the jury to determine negligence; however, he stated “it is stupid, to try any malpractice case, no matter how outrageous, without the help of an expert witness.” Id. at 8.

49. MPLA § 7.

50. W. VA. R. EVID. 104(a); FRANKLIN D. CLECKLEY, HANDBOOK ON EVIDENCE FOR WEST VIRGINIA LAWYERS § 1.8(D) (2d ed. 1986). “[I]t is imperative that the Judge carefully consider the witness’ qualifications as an expert, not generally but specifically with respect to the particular opinions the expert will express and the specialized knowledge she will impart.” 2 STEPHEN A. SALTZBURG & MICHAEL M. MARTIN, FEDERAL RULES OF EVIDENCE MANUAL 14 (5th ed. 1990); accord Ventura v. Winegardner, 357 S.E.2d 764, 768 (W. Va. 1987). Absent this critical function, anyone willing to say “I’m an expert” could testify about anything he wanted. See In re Agent Orange Prod. Liab. Litig., 611 F. Supp. 1223, 1239 (E.D.N.Y. 1985) (“Court must have a detailed inquiry into the admissibility of proffered [expert] testimony . . . ”).

Section 7 of the MPLA is significant to hospitals because qualified experts must be used to prove the liability of nurses, technicians, and other hospital employees rendering healthcare treatment. Often, experts in medical malpractice cases focus on physicians, but also express opinions as to the nurses and other nonphysicians. Under the MPLA, an appropriate foundation must be established before such testimony is admissible. Using the nurse as an example, the MPLA requires an expert in nursing and nursing standards.

On its face, the MPLA places more particular requirements on the admissibility of expert testimony than the West Virginia Rules of Evidence, which have been liberally interpreted by the Supreme Court of Appeals of West Virginia. Applying Rule 702, the court has allowed testimony of experts with any level of knowledge helpful to the jury, inferring that any deficiencies will affect the weight of testimony rather than its admissibility. "The key test is whether the witness has specialized knowledge that will assist the trier of fact."

In the face of this preexisting case law, the problem addressed by the MPLA was how to exclude the "hired gun" or general purpose medical expert willing to testify, regardless of the specialty of medicine involved in a particular action. Two decisions interpreting sec-


54. See Ventura v. Winegardner, 357 S.E.2d 764, 768 (W. Va. 1987); Jones v. Ganes, 395 S.E.2d 548 (W. Va. 1990). Of course, without proper qualifications—specialized knowledge or skill or education not in the possession of the jurors—"it is difficult to see how anyone could qualify as an expert." 2 SALTZBURG & MARTIN, supra note 50, at 13. The court's inquiry, therefore, is "[d]oes this particular expert have sufficient specialized knowledge to assist the jury in this case?" J. B. WEINSTEIN & MARGARET A. BERGER, WEINSTEIN'S EVIDENCE 702, 707 (1981).

55. Simply allowing someone to testify as an expert gives them credence with juries. See United States v. Addison, 498 F.2d 741, 744 (D.C. Cir. 1974); United States v. McDonald, 485 F. Supp. 1087, 1096 (E.D.N.C. 1986). Indeed, a recent study suggests that juries are highly influenced by experts, Expert Witnesses Found Credible by Most Jurors,
tion 7 of the MPLA, Gilman v. Choi\(^{56}\) and Fortney v. Al-Hajj,\(^{57}\) however, indicate that the court will not interpret the MPLA as placing more particularized requirements on experts than was required under prior West Virginia law.

In Gilman v. Choi, the trial court precluded plaintiff's expert orthopedic surgeon from testifying against two defendants, an internist and an emergency room physician, because he was not engaged in the "same or substantially similar" medical field as required by section 7(e) of the MPLA. The trial court certified to the supreme court the question whether section 7 was in conflict with Rule 702 of the West Virginia Rules of Evidence.

The court found no conflict, stating that section 7(e) of the MPLA was "concerned primarily with competency of expert testimony" unlike Rule 702, "which is concerned primarily with relevancy."\(^{58}\)

The court discussed several "common law principles" applicable to both the MPLA and Rule 702, and stated:

A medical expert, otherwise qualified, is *not* barred from testifying merely because he or she is not *engaged in practice* as a specialist in the field about which his or her testimony is offered; on the other hand, it is clear that a medical expert may not testify about any medical subject without limitation.\(^{59}\)

Discussing the MPLA, the court stated that "the party offering the witness must establish that the witness has more than a casual familiarity with the standard of care and treatment commonly practiced by

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\(^{57}\) 425 S.E.2d 264 (W. Va. 1992)

\(^{58}\) Id. at 202.

\(^{59}\) Id. at 204 (emphasis added).
physicians engaged in the defendant’s specialty” and suggested that sufficient knowledge can be acquired through “practical experience, recent formal training and study or a combination of these factors.”

Accordingly, under Rule 702 of the West Virginia Rules of Evidence or under W. VA. CODE, 55-7B-7 [1986], a proper assessment of the competency of an expert medical witness, and the relevancy of that witness’ testimony, require the trial court to focus specifically on the act of medical malpractice which is alleged; and, while there are circumstances in which, for example, a generalist may testify as to the standard of care of a defendant specialist, there are also circumstances in which a generalist or a specialist in another field may not testify as to the standard of care of a defendant specialist.

The court remanded the case for the trial court to “apply the foregoing principles in exercising sound discretion” in ruling whether the plaintiff’s expert was qualified, warning that it would be an abuse of discretion to require that an expert be board certified in the same specialty as the defendant because that requirement is not included in the MPLA.

Justices Neely and Brotherton dissented, finding that the MPLA was plainly intended to change the existing law of evidence by providing more stringent requirements than Rule 702.

For clause (e) to have any meaning, it must require something in addition to what the previous clauses require. Recognizing this fact, and given that the purpose of the [MPLA] is to alleviate the medical malpractice insurance crisis, “qualified” must mean more than “possessing professional knowledge and expertise coupled with knowledge of the applicable standard of care” [the requirements of clause (e)].

... Precisely because of the liberality with which many courts treat expert testimony in medical malpractice cases, physicians, hospitals, and

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60. Id.
61. Id. A similar result was reached in a Louisiana case examining that state’s medical malpractice statute where the court found that the expert did not have to actively practice to qualify. Piazza v. Behrman Chiropractic Clinic, 601 So. 2d 1378 (La. 1992); see also Stackhouse v. Scanlon, 576 N.E.2d 635 (Ind. Ct. App. 1991) (chiropractor not qualified to testify against physician); Joyce-Couch v. Desilva, 602 N.E.2d 286 (Ohio Ct. App. 1991) (weaknesses in knowledge go to weight, not admissibility).
insurance companies worked hard to get the legislature to impose by statute a stricter standard than that of Rule 702.62

Section 7 of the MPLA was discussed again in *Fortney v. Al-Hajj.*63 The plaintiff went to a hospital emergency room, complaining that a piece of chicken was stuck in his throat. The emergency room physician ordered a barium swallow64 which allegedly caused a perforation of the plaintiff’s esophagus. The plaintiff sued the emergency room doctor, the hospital, and his treating physicians. The hospital settled and the case was tried against the physicians, resulting in a $350,000 verdict against the emergency room physician and a defense verdict for the two subsequent treating physicians.

On appeal, the defendant argued that the plaintiff’s expert, a general surgeon, was not qualified under the MPLA because he “had not worked in an emergency room other than to perform surgeries when requested by emergency medical physicians.”65 Rejecting this argument, the court stated:

While [the defendant] was indeed practicing in the emergency room, it must be acknowledged that the medical subject we are concerned with is not simply the general practice of medicine, but rather the specific issue of treatment of patients with blockages of the nature of that suffered by the Appellee. Consequently, the emphasis must be on whether the proffered expert . . . had the requisite experience to testify with regard to that latter issue. While [he] only practiced in an emergency room setting when specifically needed for surgery, he had handled many impacted food cases during his career.

... A physician’s experience may qualify him to testify regarding areas other than his board certified specialty. The fact that a testifying expert physician may not have precisely the same specialty as a physician defendant does not disqualify that testifying physician as an expert regarding the standard of care to be employed by the physician defendant. By emphasizing the fact that [plaintiff’s expert] had not actually practiced

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62. *Id.* at 205.
64. A barium swallow is a procedure where the patient drinks contrast material (barium) while being x-rayed. In *Fortney,* it was ordered to determine whether the plaintiff had an obstruction in his throat. *Id.* at 266.
65. *Id.* at 267.
emergency medicine, [the defendant] is hedging the issue slightly. The salient inquiry is to what extent [the expert] is qualified under West Virginia Code § 55-7B-7 to testify as an expert on the issue of [the defendant's] standard of care in treating a patient suffering an impacted food blockage. Based upon the foregoing, we conclude that [the expert] was qualified to provide expert testimony on the issue of the standard of a physician rendering assistance to a patient suffering from an impacted food blockage. Any shortcomings which the Appellant believed existed in [plaintiff's expert's] credentials could have properly been the subject of cross-examination.66

Despite the legislature's efforts, Gilman and Fortney demonstrate that the West Virginia Supreme Court will not apply the MPLA requirements for qualifications of expert witnesses. While recognizing that the MPLA was a valid way to change the law of expert qualifications, the court effectively ignored the statute and told trial courts they may ignore it, especially subsection 7(e), and not be reversed under the abuse of discretion standard.67 This was perversely applied in Gilman, where the proffered expert had been refused by the trial court. In Fortney, the court ignored the MPLA by focusing not on whether the defendant's actions complied with a "reasonable, prudent health care provider in the same profession or class . . . acting in same or similar circumstances" but on the medical condition treated. Thus, an expert with "treatment experience" and not "emergency room experience" was permitted to testify on the standard of care of an emergency room physician.

After Gilman and Fortney, the status of section 7 of the MPLA as placing more stringent requirements on experts is at best unclear and at worst ineffective. Perhaps the only clear statement from Gilman and Fortney is that board certification is not a prerequisite to the admission of expert testimony. Otherwise, the court has simply left the statute to

66. Id. at 270-71.

67. The court's interpretation of MPLA § 7 effectively ignores the "spirit and intent" of the legislature to tighten up expert qualifications in MPLA actions. This is reminiscent of the court's statement that W. VA. CODE § 23-4-2 lessened the standard in Mandolidis cases when the preamble to the statute states it was intended to tighten the standard. Compare W. VA. CODE § 23-4-2 with Mayles v. Shoney's, Inc., 405 S.E.2d 15 (W. Va. 1990).
be developed on a case-by-case basis through trial litigation, with the benefit of the doubt going to admissibility.

D. Statute of Limitations


The MPLA codifies the statute of limitations, stating:

A cause of action for injury to a person alleging medical professional liability against a health care provider arises as of the date of the injury, except as provided in subsection (b) of this section [relating to minors], and must be commenced within two years of the date of such injury, or within two years of the date when such person discovers, or with the exercise of reasonable diligence should have discovered such injury, whichever last occurs: Provided, that in no event shall any such action be commenced more than ten years after the date of injury.68

The MPLA statute of limitations is consistent with the general two-year statute of limitations for tort actions.69 By including in the definition of medical professional liability "any liability . . . for any tort or breach of contract based on health care services rendered, or which should have been rendered," the MPLA is also consistent with existing law that actions for personal injuries, even if framed as breach of contract claims, take a two-year statute of limitations and not the longer period applicable to contract cases.70 Thus, all MPLA actions71 are subject to a two-year statute of limitations, except those involving some minors.

68. MPLA § 4(a).
71. This applies even to a claim of breach of "a special contract to heal." Michael J. Farrell, The Law of Medical Malpractice in West Virginia, 82 W. VA. L. REV. 251 (1979). "The standard of care in a special contract to cure case is to cure the patient completely . . . . Any time a physician guarantees a result or suggests that complete success is an expectation, then a special contract may exist . . . ." Id. at 259 (citations omitted).
2. Minors

The MPLA contains a significant limitation related to minors not found in pre-MPLA statutes or case law. The MPLA shortens the statute of limitations for actions for injuries to minors under ten years old, requiring that they be brought within two years of injury or prior to the minor's twelfth birthday, whichever is longer.\footnote{Prior law allowed such actions to be brought by the representative of a minor up to the age of majority and by the minor within two years of reaching "full age" except no case could be brought more than twenty years after the injury.} Prior law allowed such actions to be brought by the representative of a minor up to the age of majority and by the minor within two years of reaching "full age" except no case could be brought more than twenty years after the injury.\footnote{W. VA. CODE § 55-2-17 (1981).}

3. Tolling Doctrines

The MPLA codifies the discovery rule\footnote{See Hill v. Clark, 241 S.E.2d 572 (W. Va. 1978); Morgan v. Grace Hosp., 144 S.E.2d 156 (W. Va. 1965); Harrison v. Seltzer, 158 S.E.2d 159 (W. Va. 1967).} and fraudulent concealment\footnote{See W. VA. CODE § 55-2-17 (1981); Hundley v. Martinez, 158 S.E.2d 159 (W. Va. 1967); Sattler v. Bailey, 400 S.E.2d 220 (W. Va. 1990).} as tolling doctrines. It tolls the running of the statute until the person "discovers, or with the exercise of reasonable diligence should have discovered" the injury.\footnote{MPLA § 4.} The MPLA also states "[t]he periods of limitation set forth in this section shall be tolled for any period during which the health care provider or its representative has committed fraud or collusion by concealing or misrepresenting material facts about the injury."\footnote{Id. § 4(c). Fraudulent concealment requires a showing (1) that the dependent fraudulently concealed facts which are the basis of plaintiff's claim; (2) plaintiff failed to discover them within the statute of limitations; and (3) plaintiff exercised due diligence. Pocahontas Supreme Coal Co. v. Bethlehem Steel, 828 F.2d 211, 218 (4th Cir. 1987). Ignorance alone is not enough. Id.; see also Jones v. Philpott, 713 F. Supp. 844 (W.D. Pa. 1989).}
The MPLA tolling provisions were discussed in Miller v. Romero, where the plaintiff relied on the "discovery rule" to allow the filing of a wrongful death action more than two years after the death of her daughter. The supreme court rejected this argument, finding that the discovery rule did not apply in wrongful death cases under section 55-7-6(d) of the West Virginia Code.

Despite holding that the MPLA did not apply since the death occurred before its effective date, the court stated that the MPLA statute of limitation applied only to injuries, not to deaths. "The omission of the word 'death' from West Virginia Code § 55-7B-4 must mean that the section applies only to injury cases and the legislature intended West Virginia Code § 55-7-6 to remain the applicable provision for limitations of actions involving wrongful death." Nonetheless, the court held that wrongful death actions are subject to tolling under the doctrine of fraudulent concealment.

A situation where a decedent's representative is barred from filing suit against a malfeasor because that person fraudulently concealed the malpractice, and the representative did not discover the negligence until after the two-year period had run, violates the strong public policy of this State.

The court was careful to limit this holding, stating "the only portion of West Virginia Code § 55-7-6 which we find to be against the public policy of this state, and thus not limited by the two-year filing period, is when fraud or concealment of material facts surrounding the death is involved." The court further stated:

We must extend a note of caution to those who read this opinion. It is not sufficient for a plaintiff to complain that he didn't understand what he was told, or that he did not know enough to do research. If situations such as those were allowed to extend the two-year filing period, then virtually every layperson could claim fraud, misrepresentation, or concealment. Again, the purpose of the statute to act as a time constraint would be destroyed. Instead, only cases where evidence of fraud, misrepresentation, or concealment of material facts is presented will be sufficient to permit

78. 413 S.E.2d 178 (W. Va. 1991).
79. Id. at 182.
80. Id.
an extension. On a practical note, cases filed beyond the statutory two-year time period need only undergo limited discovery on the issue of fraud before a summary judgment motion can be entertained. If it survives summary judgment, then the case proceeds and the issues of fraud and negligence become questions for the jury. 81

Thus, under the MPLA, fraudulent concealment tolls the two-year limitation for wrongful death actions while the “discovery rule” does not apply to wrongful death actions.

After the enactment of the MPLA, the West Virginia Supreme Court held that the “discovery rule” applies to all tort actions. In Cart v. Hager, 82 the defendant began timbering plaintiff’s property under an oral agreement, but refused to sign a written contract. When the plaintiff kicked him off the property until the contract was signed, the defendant absconded with the timber. Since the plaintiff filed suit more than two years later, the circuit court dismissed the case.

On appeal, the Supreme Court recognized that the statute of limitations ordinarily begins to run when the injury is inflicted. 83 To mitigate the harshness of the rule, the discovery rule tolls the statute until the plaintiff knows or by reasonable diligence should know that he has been injured and who is responsible. Noting that the rule had been expanded to all types of cases, 84 the court created a bright-line rule:

81. Id. at 183.
83. Id. at 646-47 (citing Jones v. Trustees of Bethany College, 351 S.E.2d 183, syl. pt. 1 (W. Va. 1986)).
84. Id. After reviewing the application of the discovery rule in medical malpractice cases, the court cited an example of an appropriate application of the rule:

For example, if a surgeon leaves a surgical sponge inside of a patient, and the patient discovers it five years later and immediately brings suit, that would fit under the discovery rule. However, if the patient (with health insurance) bore noticeable stomach pains for two more years before having a doctor examine him, then he did not act with reasonable diligence and the “discovery rule” would not protect the patient.

[W]e hold today that the “discovery rule” is generally applicable to all
torts, unless there is a clear statutory prohibition of its application. Howev-
er, by declaring the existence of a “discovery rule” we do not eviscerate
the statute of limitations: the statute of limitations will apply unless the
handicaps to discovery at the time of the injury are great and are largely
the product of the defendant’s conduct in concealing either the tort or the
wrongdoer’s identity.

The “discovery rule,” then, is to be applied with great circumspection
on a case-by-case basis only where there is a strong showing by the plain-
tiff that he was prevented from knowing of the claim at the time of the
injury. The general rule is that mere ignorance of the existence of a cause
of action or of the identity of the wrongdoer does not prevent the running
of a statute of limitations. In order to benefit from the rule, a plaintiff
must make a strong showing of fraudulent concealment, inability to com-
prehend the injury, or other extreme hardship. 85

In a footnote, the court explained that “[f]raudulent concealment
would include concealment of the injury itself or the identity of the
tortfeasor.” 86 Inability to comprehend the injury would include leaving
a piece of surgical equipment in a patient or exposure to hazardous
chemicals where the effects were only detectable at a later time. 87
Applying the discovery rule, the court found that the plaintiff should
have known that defendant took his wood at the time of the conver-
sion. 88 Accordingly, the plaintiff

suffered from none of the disabilities that a beneficiary of the “discovery
rule” must show in order to free himself from the demands of the statute
of limitations . . . . A reasonably diligent investigation would have turned
up the identities of [the defendants] sooner; indeed, [the plaintiff] still had
nearly a year after he discovered the identities of [the defendants] to bring
suit, yet he failed to do so. No hardship prevented [the plaintiff] from
discovering his injury or the identities of [the defendants]. 89

liability)).

85. Id. at 648 (footnotes omitted).
86. Id. at 648 n.13.
87. Id. at 648 n.14.
88. Id. at 649.
89. Id. at 649. The court noted that one of the defendants, who had actually abscond-
ed with the money, had never been located. As to this defendant, the court indicated in a
footnote that because he had gone into hiding, “it is quite possible that a suit against [him]
would be successful.” Id.
More recently, the court discussed the MPLA statute of limitations and discovery rule in *Findo v. Hamilton*.\(^{90}\) In *Findo*, the plaintiff alleged that the defendant-physician committed malpractice in treating her for diverticulitis and perforation of the colon during a hospitalization which ended on September 23, 1986. Claiming damages for treatment required over the next five years, the plaintiff filed a complaint alleging medical malpractice on January 8, 1991.\(^{91}\)

The circuit court granted the defendant's motion for summary judgment, finding that the plaintiff had discovered the alleged malpractice in October 1987 and therefore had not filed her complaint within the two-year MPLA statute of limitations.\(^{92}\) The plaintiff appealed, arguing that a question of fact existed as to the date on which the statute of limitations should have begun, asserting that the statute should not begin to run "until the Plaintiff becomes aware that the action in question constituted malpractice."\(^{93}\) In this regard, the plaintiff argued that it was "possible to discover an injury without recognizing that malpractice was committed."\(^{94}\) The court agreed with the plaintiff's theory, but stated:

[T]he statute did not begin to run when she merely discovered that additional treatment could possibly have been provided or that Dr. Hamilton could have treated her more aggressively. Rather, as in *Renner*, the statute began to run when the Appellant affirmatively recognized that malpractice had been committed.\(^{95}\)

In the face of this testimony, the plaintiff argued that since she could not recall exactly what the physician told her about the malpractice, "this uncertainty raises an issue of material facts precluding summary judgment and requiring the taking of additional evidence."\(^{96}\) The court replied:

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91. *Id.* at 780.
92. *Id.* at 780-81.
93. *Id.* at 781.
94. *Id.*
95. *Id.* (referring to *Renner v. Asli*, 280 S.E.2d 240 (W. Va. 1981)).
96. *Id.*
A review of the Appellant’s testimony leads to the inescapable conclusion that she was informed by Dr. Tyre in October 1987 that [the defendant’s] actions constituted malpractice. While some excerpts from the transcript do indicate the Appellant’s confusion about particular aspects of her discussions regarding [the defendant’s] treatment, she repeatedly answers in the affirmative when questioned as to whether she was told in October 1987 that [the defendant’s] actions constituted malpractice.77

Noting that “[t]he principles requiring presentation to the jury need not be stretched to the absurdity,”8 the court found “that the Appellant’s own testimony rendered it impossible to conclude that the Appellant had filed her claim within the statute of limitations.”99

Despite the strong language in Cart, a confusing treatment of the statute of limitations was seen in Ricottilli v. Summersville Memorial Hospital.100 There, the court found that a claim for outrageous conduct or negligent infliction of emotional distress was governed by a one-year statute of limitations.101 Although rejecting plaintiff’s argument that the hospital’s refusal to provide a complete autopsy report was a continuing tort,102 the court found that the statute did not begin to run until the hospital filed a brief admitting that tissue analysis, the basis for the plaintiff’s assertion that the autopsy report was incomplete, could not be performed because the body had been embalmed prior to the autopsy. Despite Cart, nowhere in Ricottilli does the court analyze what actions the plaintiffs took to discover that the autopsy could not be completed or whether the hospital actively concealed facts from the plaintiffs.

Cart, Miller, and Findo shed considerable light on how tolling doctrines are to apply in West Virginia. The burden upon the plaintiff

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77. Id. at 783.
78. Id.
81. Id. at 630.
82. “A wrongful act with consequential continuing damages is not a continuing tort.” Id. at 632 (citing Spahr v. Preston County Bd. of Educ., 391 S.E.2d 739, 742 (W. Va. 1990)).
to claim relief under the discovery rule includes not only the failure to discover, but proving that "some action by the defendant prevented the plaintiff from knowing of the wrong at the time of the injury." The discovery rule will still apply to the classic foreign object case, unless the plaintiff waits too long in the face of evidence of a problem. Plainly eliminated by Cart is the argument that the plaintiff did not know he could sue, usually until he or she obtained a lawyer.103 Due to its unique facts, Ricottilli's discussion of the statute of limitations issues probably has little precedential value. Indeed, since the court found that the action was filed within one year of CAMC's admission that the autopsy could not be completed, the statute of limitations discussion in Ricottilli is dicta.104

E. Statute of Repose

A new twist added by the MPLA is a statute of repose, requiring that all actions must be brought within ten years of the injury.105 This type of limitation has been held constitutional in similar statutes and has been applied as an absolute bar to actions filed beyond the period of repose.106 Given the Miller v. Romero court's interpretation of section 4 of the MPLA as applying only to "injury" actions, the ten-year limit probably does not apply to wrongful death cases which continue to be governed by a two-year limitation absent proof of fraudulent concealment.107

103. This could be termed "the theory of undiscovered intelligence." More accurate than "discovery" of the injury, this might be described as discovery of a lawyer.

104. Given the court's application of a tolling doctrine—whether discovery or fraudulent concealment is unclear—it was unnecessary to discuss whether the MPLA, one-, or two-year statute of limitations applied.

105. MPLA § 4.


107. Given the Miller court's reliance upon public policy as the basis for engraving the fraudulent concealment rule onto West Virginia's wrongful death statute, it is an open question whether a provision eliminating the doctrine in wrongful death cases would survive judicial scrutiny.
F. Procedural Requirements

To encourage "prompt resolution," the MPLA states that a "mandatory" status conference be held between nine and twelve months after the filing of answers. The MPLA directs the parties to inform the court of the progress of the case, any contested issues of fact, and the nature of anticipated discovery. The plaintiff must also certify that an expert has or will be retained to testify as to the applicable standard of care or that no expert is required. If court rules that an expert is necessary, the plaintiff must be given reasonable time to obtain one.

The MPLA status conference is supposed to ensure that MPLA actions are kept moving with judicial supervision. By requiring identification of experts by the plaintiff and allowing for sanctions, the MPLA attempts to "weed out" baseless or frivolous claims within one year of filing.

As a practical matter, the MPLA imposes no more restrictions than could be applied under the West Virginia Rules of Civil Procedure. Rule 16 provides for both discovery and scheduling conferences. Expert designation can be handled under Rule 16, a motion to compel designation of experts under Rule 26(b)(4), or a motion for summary judgment under Rule 56 based on the absence of necessary expert testimony. Indeed, while the plaintiff can be required to designate an expert within a reasonable time, the MPLA does not expressly provide for dismissal for noncompliance. Dismissal can be accomplished by summary judgment under Rule 56, a dismissal

108. MPLA § 6(a).
109. Id. § 6(a)(1).
110. Id. § 6(a)(2).
under Rule 37 for failure to comply with a discovery order,\textsuperscript{114} or failure to prosecute under Rule 41.

By stating that the status conference be held no less than nine months after the filing of answers, a question arises as to whether a case can be dismissed for lack of an expert prior to the nine-month period. Rule 56 allows the filing of a motion at any time. To avoid summary judgment, the plaintiff would have to respond (1) with an expert affidavit,\textsuperscript{115} (2) that an expert is not required,\textsuperscript{116} or (3) that discovery is not complete and an expert cannot be named.\textsuperscript{117}

As suggested in \textit{Gilman v. Choi}, the relationship between the MPLA and the West Rules of Civil Procedure is probably one of peaceful coexistence.\textsuperscript{118} The MPLA, therefore, would not as a matter of law forbid dismissal of a case before the nine-month status conference. In practice, judges are reluctant to grant summary judgment anyway, particularly if the case is new, the plaintiff needs discovery, or the plaintiff needs time to name an expert.

Moreover, subsection 6(a) of the MPLA should not be interpreted to forbid a Rule 16 scheduling or discovery conference before nine months. The language of section 6 of the MPLA envisions discovery in progress and, as a practical matter, most cases are moving along within nine months. Particularly where there is a statute of limitations issue, an early conference should be held to schedule limited discovery on the issue before the parties delve into liability and damages.\textsuperscript{119} Most other cases could benefit from early scheduling of expert, discovery, and motion deadlines. At the nine-month mark, the court can still hold the MPLA status conference. As more state courts move towards entering early scheduling orders (like the West Virginia federal district courts), this may become the normal course of events in MPLA cases.

\textsuperscript{117} W. Va. R. CIV. P. 56(f); cf. Hulmes v. Catterson, 388 S.E.2d 313 (W. Va. 1989).
Indeed, the West Virginia Supreme Court has mandated that all cases, except very complex ones, be brought to trial within eighteen months.120

The MPLA also grants circuit courts limited power to impose sanctions on any party pursuing a frivolous or dilatory claim or defense "for which there is no reasonable basis in fact or at law prior to trial."121 The court may direct, in its final judgment, that the prevailing party recover reasonable litigation expenses, excluding attorney’s fees and expenses.

The MPLA sanction provision tracks some of the language of Rule 11 of the West Virginia Rules of Civil Procedure, which provides for sanctions, including award of attorneys’ fees and costs for frivolous litigation.122 While Rule 11 applies only to pleadings, motions, and other papers, the MPLA contains no such limitation; this grants broader powers to judges, who can sanction the "pursuit" of frivolous claims. The MPLA sanctions, however, are more limited than Rule 11, as they do not include attorneys’ fees, providing only for "reasonable litigation expenses." Rule 11 is broader, allowing an appropriate sanction ranging from reprimand to attorneys fees to dismissal. Relationship is probably one of peaceful coexistence.123

G. Limits on Noneconomic Damages

The MPLA “caps” damages for noneconomic loss at one million dollars per occurrence. Noneconomic loss is defined as “losses including, but not limited to, pain, suffering, mental anguish and grief.”124 Noneconomic loss does not include pecuniary damages such as past

120. Administrative Order, Supreme Court of Appeals of West Virginia, Rule on Time Standards for Processing Circuit Court Cases 2 (June 30, 1992).
121. MPLA § 6(b).
124. MPLA § 2(g).
and future medical bills, lost earnings, and other calculable or out of pocket damages.\textsuperscript{125}

The MPLA cap was held constitutional by the West Virginia Supreme Court of Appeals in Robinson v. Charleston Area Medical Center, Inc.\textsuperscript{126} In Robinson, the defendant obstetrician was found negligent in delivering the plaintiff’s son who suffered severe brain damage. The jury awarded damages totalling $15.25 million, including $10 million for future medical care, $750,000 for lost future earnings, $2.5 million for past, present, and future loss of enjoyment of life and other noneconomic damages to the infant, and $1 million to each parent for noneconomic damages. The Robinson court found that the MPLA cap applied “per occurrence”; in other words, for each injury, only a million dollars could be awarded, regardless of the number of persons claiming damages as a result of the injury. The cap “applies as one overall limit to the aggregated claims of all plaintiffs against a health care provider, rather than applying to each plaintiff separately.”\textsuperscript{127}

\textsuperscript{125} For example, in Robinson v. Charleston Area MedicalCtr., Inc., 414 S.E.2d 877 (W. Va. 1991), a ten million dollar award consisting of lost future medical bills was affirmed. See infra table 1. Lost future damages, including medical bills, must be proven to a reasonable certainty, Jordan v. Bero, 210 S.E.2d 618 (W. Va. 1974), and must be reduced to present value. Adkins v. Foster, 421 S.E.2d 271 (W. Va. 1992). Only medical bills related to the injury may be recovered. Abdulla v. Pittsburgh & Weirton Bus Co., 213 S.E.2d 810 (W.Va. 1975); see also Lester v. S.J. Alexander, 193 S.E.2d 860 (Ga. Ct. App. 1972). Medical bills must also be reasonable and necessary. Long v. City of Weirton, 214 S.E.2d 832 (W. Va. 1975); W. Va. CODE § 57-5-4j (Supp. 1992) (proof that bills were incurred because of illness is prima facie evidence they were reasonable and necessary).

\textsuperscript{126} 414 S.E.2d 877 (W. Va. 1991). Other states’ caps have also been upheld. Adams v. Children’s Mercy Hosp., 832 S.W.2d 898 (Mo. 1992) (Missouri $430,000 cap); Etheridge v. Medical Ctr. Hosp., 376 S.E.2d 525 (Va. 1989) (Virginia $750,000 cap). Rose v. Doctors Hosp., 801 S.W.2d 841 (Tex. 1990) (limit in wrongful death cases constitutional). But see Morris v. Savoy, 576 N.E.2d 765 (Ohio 1991) (Ohio $200,000 cap unconstitutional). See generally Karin A. Olson, Survey of Constitutional Arguments in Medical Malpractice Award Limit Cases, 23 J. HEALTH & HOSP. L. 328 (1990). Nonetheless, some authors are highly critical of caps as not really beneficially affecting insurance or health care costs. Franklin D. Cleckley & Govind Hariharan, A Free Market Analysis of the Effects of Medical Malpractice Damage Caps: Can We Afford to Live with Inefficient Doctors?, 94 W. Va. L. REV. 11 (1991). It is suggested caps are more likely due to good lobbying than solid facts. Id. at 70-71. Indeed, in Robinson, the West Virginia court hinted that any reduction in the amount of the cap might render it unconstitutional.

\textsuperscript{127} Robinson, 414 S.E.2d at 888.
Applying the cap, the court stated that awards in excess of the limit should be reduced by “eliminating awards to secondary claimants, such as for consortium, prior to eliminating any excessive amount for the noneconomic loss incurred by the physically injured person.” Accordingly, the court eliminated the awards to the parents and reduced the child’s award to $1 million.

TABLE 1
APPLICATION OF MPLA CAP IN
ROBINSON V. CHARLESTON AREA MEDICAL CENTER, INC.

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<tr>
<th>JURY AWARD</th>
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<td>CHILD</td>
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<td>(Future</td>
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<td>earnings)</td>
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<td></td>
<td>$4,500,000</td>
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The significance of the MPLA cap is somewhat overshadowed by the large award for actual loss ($11.75 million) affirmed in Robinson. Compared to Robinson, it is ironic that in Roberts v. Stevens Clin-

128. Id. at 889 n.11; see also Federal Kemper Ins. Co. v. Karlet, 428 S.E.2d 60 (W. Va. 1993) (children’s claims for loss of consortium are derivative; therefore, they are not separate claims for purposes of insurance coverage).
ic, a pre-MPLA case, a ten million dollar award was reduced to three million dollars by the West Virginia Supreme Court. However, in cases involving lower actual losses, the cap can have a more profound effect on the amount of damages awarded, since nonpecuniary damages are often the bulk of awards to plaintiffs. The cap has also gained significance since the supreme court has recently moved away from its traditional disdain for emotional distress awards, suggesting that plaintiffs may recover such damages resulting from negligence in some circumstances.

As to claimants other than the injured party, the Robinson “triage” of claims—trimming the noninjured party’s awards first—is highly significant given the expansion of liability in West Virginia for loss of consortium by children and emotional distress for close family member “bystanders.”

129. 345 S.E.2d 791 (W. Va. 1986).
130. Id. at 793.
H. Joint & Several Liability

The MPLA changes West Virginia law regarding joint and several liability. Like other actions, the jury must allocate fault among all parties who may be at fault.134 Any MPLA defendant bearing more than twenty-five percent of the liability attributable to all defendants is to be held jointly and severally liable.135 Any MPLA defendant with less than twenty-five percent is only severally liable.136 While the MPLA joint and several defendants are “liable to each plaintiff for all or any part of the total dollar amount awarded regardless of the percentage of negligence attributed to him,”137 the MPLA several defendants pay only their proportionate share of any verdict.138 This provision changes prior law, under which each defendant would have been jointly and severally liable to the plaintiff, retaining rights of contribution among defendants.139

I. Contribution, Indemnity & Settlement

The MPLA codifies the rights of contribution and indemnity among defendants in MPLA actions:

A right of contribution exists in favor of each defendant who has paid to a plaintiff more than the percentage of the total dollar amount awarded attributable to him relative to the percentage of negligence attributable to him. The total amount of recovery for contribution is limited to the amount paid by the defendant to a plaintiff in excess of the percentage of the total dollar amount awarded attributable to him.140

135. MPLA § 9(b).
136. Id. § 9(b)-(c).
137. Id. § 9(c).
138. See id.
140. MPLA § 9(c).
This provision is consistent with prior West Virginia law which maintained the right of contribution for any defendant paying more than the *pro rata* share of liability assigned by the jury since the adoption of comparative fault.\(^41\)

The MPLA also codifies the "good faith settlement" rule: "No right of contribution exists against any defendant who entered into a good faith settlement with the plaintiff prior to the jury's report of its findings to the court or the court's findings as to the total dollar amount awarded as to damages."\(^42\) In *Smith v. Monongahela Power Co.*,\(^43\) the West Virginia Supreme Court of Appeals defined a good faith settlement. While *Smith* is not an MPLA case, it is instructive as to how the court would most likely construe the MPLA's adoption of the good faith settlement rule.

Settlements are presumptively made in good faith. A defendant seeking to establish that a settlement made by a plaintiff and a joint tortfeasor lacks good faith has the burden of doing so by clear and convincing evidence. Because the primary consideration is whether the settlement arrangement substantially impairs the ability of remaining defendants to receive a fair trial, a settlement lacks good faith only upon a showing of corrupt intent by the settling plaintiff and joint tortfeasor, in that the settlement involved collusion, dishonesty, fraud or other tortious conduct.\(^44\)

*Smith* places in circuit courts the sound discretion to determine whether a settlement has been made in good faith. The court directed that the trial court should focus not on whether the settlement fell within a reasonable range of the settling tortfeasor's proportional share of fault, "but whether the circumstances indicate that the nonsettling tortfeasor was substantially deprived of a fair trial because of corrupt

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\(^{42}\) MPLA § 9(c); see Board of Educ. of McDowell County *v.* Zando, Martin & Milstead, Inc., 390 S.E.2d 796 (W. Va. 1990); Cook *v.* Stansell, 411 S.E.2d 844 (W. Va. 1991); Cline *v.* White, 393 S.E.2d 923 (W. Va. 1990).

\(^{43}\) 429 S.E.2d 643 (W. Va. 1993).

\(^{44}\) Id. at 651-52.
behavior on the part of the plaintiff and the settling tortfeasor or tortfeasors.\textsuperscript{145} The court highlighted several factors relevant to a determination of whether a settlement lacks good faith:

1. the amount of the settlement in comparison to the potential liability of the settling tortfeasor at the time of settlement, in view of such considerations as (a) a recognition that a tortfeasor should pay less in settlement than after an unfavorable trial verdict, (b) the expense of litigation, (c) the probability that the plaintiff would win at trial, and (d) the insurance limits and solvency of all joint tortfeasors; (2) whether the settlement is supported by consideration; (3) whether the motivation of the settling plaintiff and settling tortfeasor was to single out a non-settling defendant or defendants for wrongful tactical gain; and (4) whether there exists a relationship, such as family ties or an employer-employee relationship, naturally conducive to collusion.\textsuperscript{146}

The Supreme Court gave the trial court broad discretion as to what evidence to consider, stating that a review of discovery documents and affidavits should be sufficient; however, “[t]he trial court may, in its discretion, conduct a hearing on the issue, but it is not required to do so.”\textsuperscript{147} Finally, pretrial settlements by parties under the MPLA are handled in the same manner as under existing West Virginia law, leaving considerable discretion to the trial court as to what information is transmitted to the jury.\textsuperscript{148}

III. HOSPITALS AND VICARIOUS LIABILITY

While the MPLA restricts the liability of hospitals, its provisions do not appear to change the law of agency, the basis of most hospital cases. The MPLA extends its protection to officers, employees or agents of healthcare providers acting in the course and scope of their duties. While the MPLA defines “healthcare providers,” it does not define officers, employees, or agents, leaving these terms to be inter-

\begin{itemize}
  \item \textsuperscript{145} Id. at 652.
  \item \textsuperscript{146} Id.
  \item \textsuperscript{147} Id.
\end{itemize}
interpreted consistent with existing law. Existing law, therefore, governs agency questions.

A. Employees

Hospitals are liable for negligent acts of their employees (nurses, technicians, and other nonphysician health providers) under the doctrine of respondeat superior.149 West Virginia law is replete with cases describing the liability of hospitals for the negligent acts of its employees. For example, nurses have a duty to follow orders,150 to question improper orders,151 and to monitor and report condition of patient.152 A fairly common claim against nurses occurs when an elderly or incompetent patient is injured falling out of bed.153 Other employees, such as radiologic technicians, must also perform their work in a reasonably prudent manner as required by the MPLA.154

B. Agents

1. General Rule

Generally, nonemployee physicians are treated as independent contractors for whom the hospital is not liable. "[I]n most cases doc-


152. Utter, 236 S.E.2d at 214, 216; see also Hiatt v. Groce, 523 P.2d 320 (Kan. 1974).


tors with hospital privileges are not employees of the hospital, but rather independent contractors who must be granted permission to admit patients and make use of the hospital’s resources.”155 “The fact that a physician is a member of the medical staff of the hospital is not determinative of the physician’s status as an agent or servant of the hospital.”156

Historically, physicians and nurses were considered to be independent contractors for whose acts hospitals were not responsible because the courts perceived the hospital as merely furnishing the location where patients could receive care and treatment from their private physicians. The courts reasoned that a layman could not control a physician due to the inherent skill and judgment needed in the practice of medicine. Due to this lack of control, the courts found that the hospital could not be held liable for the physician’s actions.157

Applying this principle, the Supreme Court of Appeals of West Virginia has indicated that hospitals are generally not liable where the plaintiff claims lack of informed consent by a privately retained physician who is a member of the medical staff.158 In Cross v. Trapp, the court held:

When a patient asserts that a particular method of medical treatment, such as surgery, was performed by the patient’s privately retained physician without the patient’s consent, the hospital where that treatment was performed will ordinarily not be held liable to the patient upon the consent

155. Oliverio, supra note 1, at 739 (citing Timothy S. Jost, The Necessary and Proper Role of Regulation to Assure the Quality of Health Care, 25 Hous. L. Rev. 525, 553 (1988)). Oliverio suggests that “[g]enerally, hospitals are responsible for the negligence of their staff members.” Id. at 745. As to the physicians on the medical staff, this is not true unless agency is established or liability is imposed via a theory of negligent screening or credentialing.


issue, where the physician involved was not an agent or employee of the hospital during the period in question.\textsuperscript{159}

Recently, in Belcher v. Charleston Area Medical Center, Inc.\textsuperscript{160} the court refused to move away from Cross v. Trapp, stating:

In this case, the record is clear that the employees of the hospital were aware of the discussions between Dr. Ayoubi and Larry’s parents, and that it was apparent that Larry’s parents consented to the treatment given. Furthermore, there is no dispute that the appellee Ayoubi was privately retained, and the appellants could have chose to not seek his treatment for Larry.\textsuperscript{161}

This general rule, however, does not absolve hospitals from vicarious liability where a physician who is the hospital’s agent fails to obtain informed consent. It is in the area of ostensible or apparent agency where West Virginia has judicially expanded the vicarious liability of hospitals for physicians who are members of its medical staff.

2. Ostensible or Apparent Agency

If a physician is found to be an agent, the hospital may be vicariously liable for his or her negligence.\textsuperscript{162} Applying the doctrine of ostensible agency, the West Virginia Supreme Court has imposed vicari-

\textsuperscript{159} 294 S.E.2d at 447. Under pre-MPLA West Virginia law, physicians had to disclose risks involved with treatment, alternative treatment methods, risks of alternatives, and results of going untreated. West Virginia applied the patient-need standard, under which disclosure is governed by information required by the reasonable patient to make decisions regarding treatment. Adams v. El-Bash, 338 S.E.2d 381 (W. Va. 1985); Cross v. Trapp, 294 S.E.2d 446 (W. Va. 1982).

\textsuperscript{160} 422 S.E.2d 827 (W. Va. 1992). In Belcher, the court expanded the doctrine of informed consent to require physicians to obtain consent from “mature minors.” Even though the decedent in Belcher was seventeen and his parents consented to a “DO NOT RESUSCITATE” order, the court found a question of fact as to whether consent should have been obtained from the minor decedent. Id. at 446.

\textsuperscript{161} Id. at 834; see also Jane Greenlaw, Should Hospitals Be Responsible for Informed Consent?, 11 L. MED. & HEALTH CARE, Sept. 1983, at 173.

ous liability on hospitals for the negligence of nonemployee physicians where the hospital provides the physician and leaves the patient with no choice as to whether to hire the physician, and where the hospital holds the physician out as an employee.

Liability for physicians not "chosen" by the patient was applied in Thomas v. Raleigh General Hospital, an anesthesia malpractice case where the plaintiff sued the hospital, the anesthesiologist, and the surgeon. After the trial court granted summary judgment, the plaintiff appealed.

The Supreme Court affirmed summary judgment for the surgeon, finding that he "had nothing to do with the anesthesia procedure... [and] exercised no control whatsoever over [the anesthesiologist or his employee]." The court stated:

We reject the captain of the ship doctrine. The trend toward specialization in medicine has created situations where surgeons do not always have the right to control all personnel within the operating room... An assignment of liability based on a theory of actual control more realistically reflects the actual relationship which exists in a modern operating room.

The court, however, found that the hospital could be held vicariously liable for the negligence of the anesthesiologist. "Where a patient goes to a hospital seeking medical services and is forced to rely on the hospital's choice of physician to render those services, the hospital may be found vicariously liable for the physician's negligence." Since the anesthesiologist had an exclusive contract with the hospital, all patients having surgery had to use him for anesthesia. Based on this lack of choice, the court found a question of fact as to whether the hospital was vicariously liable.

164. Id. at 224.
The Raleigh General rule was confirmed in a footnote in a later case, Belcher v. Charleston Area Medical Center, Inc.,\textsuperscript{167} where the court succinctly stated “Liability may be imposed on a hospital where the patient did not choose the treating doctor, but is forced to rely on the hospital’s choice.”\textsuperscript{168}

Vicarious liability for nonemployee physicians was further expanded in Torrence v. Kusminsky.\textsuperscript{169} In Torrence, after arriving at the emergency room complaining of severe abdominal pain, the plaintiff was admitted as a surgical service patient because she did not have her own surgeon.\textsuperscript{170} Two residents diagnosed appendicitis and notified the defendant physician who immediately came to the hospital to assist in surgery.\textsuperscript{171} The plaintiff alleged that the doctors negligently misdiagnosed and treated her. A jury awarded a verdict against the hospital and the physician.

The hospital appealed, arguing that it was not vicariously liable because the physician was an independent contractor who was an employee of West Virginia University, received no compensation from the hospital, whose billing was handled by WVU Health Service, and because the plaintiff chose him as her surgeon. The plaintiff countered that “she did not select [the defendant] as her physician, but had no choice but to accept his services.”

The court held that the hospital was liable for the doctor’s negligence under the doctrine of ostensible agency:

First, the changing role of the hospital in society creates a likelihood that patients will look to the institution rather than the individual physician for care . . . . In today’s world, a patient may frequently go to the hospital seeking a wide range of services rather than personal treatment by a particular physician. The second factor justifying a finding of “ostensible

\textsuperscript{167} 422 S.E.2d 827 (W. Va. 1992).
\textsuperscript{168} Id. at 834 n.8.
\textsuperscript{169} 408 S.E.2d 684 (W. Va. 1991).
\textsuperscript{170} Surgical service was a teaching service for residents at the hospital. Under this program residents gain experience and training while working on emergency room patients. The program had several physicians, including the defendant Dr. Kusminsky, who supervised these residents on a daily basis. Moreover, the supervising physicians had to be on-call for the emergency room on a rotational basis. Id. at 688-89.
\textsuperscript{171} Id. at 689.
agency" relationship between hospital and physician exists where the hospital "holds out" the physician as its employee. A "holding out" occurs when the hospital acts or omits to act in some way which leads the patient to a reasonable belief he is being treated by the hospital or one of its employees.

Applying this rule to the relationship between the defendant physician and the hospital, the court stated:

We find the application of ostensible agency particularly compelling when a patient seeks services from an emergency room. In such circumstances, there is often no time to arrange for the services of a private physician, and, in effect, the patient has no other choice but the emergency room. Frequently, the situation is tense, with the patient's family and friends in an emotional state. To hold that the hospital, after offering emergency services, should avoid any subsequent liability by claiming that those who render such assistance are not the hospital's employees defies the logical and reasonable expectations of those who seek such services.

Therefore, we hold that where a hospital makes emergency room treatment available to serve the public as an integral part of its facilities, the hospital is estopped to deny that the physicians and other medical personnel on duty providing treatment are its agents. Regardless of any contractual arrangements with so-called independent contractors, the hospital is liable to the injured patient for acts of malpractice committed in its emergency room, so long as the requisite proximate cause and damages are present.

[The defendant] was an ostensible agent of [the hospital] under the circumstances of this case. [The plaintiff] went to the emergency room at [the hospital] because she was seeking the services of that institution rather than a particular doctor. After she arrived, because she did not have her own surgeon, she was assigned as a surgical service patient. As this type of patient, [the plaintiff] received her initial care from two residents who were undeniably agents of the hospital. When the two residents felt that [the plaintiff] needed an operation, they called their supervisor, [the defendant], the physician who was on call for the emergency room that particular evening. Had [the plaintiff] come to the hospital some other night, she might have been operated on by a different surgeon. Moreover, [the defendant] used the staff, facilities, and supplies of [the hospital] during the surgical procedure. Finally, there is no evidence in the record that [the hospital] did anything that would lead [the plaintiff] to believe that [the

172. Id. at 691-92.
defendant] was an independent contractor and not an employee of the hospital. 173

Torrence, like Raleigh General, also suggested that hospitals may be liable for physicians they supply, such as pathologists, radiologists, and anesthesiologists, “all of whom share the common characteristic of being supplied through the hospital rather than being selected by the patient.”174

The concept of liability for physicians “held out” as employees had previously been mentioned in Raleigh General. The court suggested that hospitals could be liable for “managers,” and found a factual question as to whether the physician was a “manager” of anesthesiology at the hospital because he was Director of Respiratory Services and Chief of Anesthesiology and was given an office and a stipend for the performance of these duties. “A hospital cannot absolve itself from liability of a treating physician where that physician was a ‘manager’ of the hospital.”175

The court cited Vaughn v. Memorial Hospital176 as support for the “manager” theory. In Vaughn, the hospital argued it was “not responsible for any default on the part of physicians . . . they being independent agents.”177 The court stated:

A hospital incorporated and conducted for private gain, for the benefit of its stockholders, is liable in damages to its patients for the negligence or misconduct of its officers and employees . . . . The purely private character of the defendant is practically admitted; the certificate of incorporation under the laws of West Virginia being in evidence in the case. The capital invested is like capital invested in any other corporation conducted for profit. In its contract it stands upon the same basis as any other contractor,


174. Torrence, 408 S.E.2d at 691 (citing Paintsville Hosp. Co. v. Rose, 683 S.W.2d 255 (Ky. 1985)).

175. Id. at 225 (citing Vaughn v. Memorial Hosp., 130 S.E. 481, 482 (W. Va.), later appeal, 136 S.E. 837 (W. Va. 1925)).

176. 130 S.E.2d 481 (W. Va. 1925).

177. Id. at 481.
and, as to employees and third persons, it is subject to the same general rule, respondeat superior.

It appeared in evidence that said doctors are the managers of the defendant hospital; that the x-ray machine used in the hospital for examination of this plaintiff's injury was the property of the institution. Under these conditions, the authorities cited hold that the said defendant cannot absolve itself from the obligation it owed to the patient to furnish him proper treatment, on the claim that the physicians who treated him, at its instance, were independent contractors.\textsuperscript{178}

The court also found that the defendant hospital had a contract with the plaintiff's employer, a coal company, to treat its injured employees and that the expenses were paid from the Workers' Compensation Fund.\textsuperscript{179}

Both \textit{Raleigh General} and \textit{Vaughn} are sketchy as to the definition of a "manager" of a hospital. Indeed, \textit{Vaughn} suggests that the doctors involved were, in fact, owners or stockholders of the for-profit hospital and merely used equipment owned by the hospital. The focus in \textit{Vaughn}, therefore, was on the private, for-profit nature of the hospital and more likely an effort to avoid charitable immunity than to establish the broad proposition for which it was cited in \textit{Raleigh General}. Indeed, because of the contractual relationship between the hospital and the coal company to provide medical care, \textit{Vaughn} really stands more for imposing liability where the patient had no choice in selecting the physician.

West Virginia's brand of ostensible agency, as applied in \textit{Raleigh General} and \textit{Torrence}, has resulted in a somewhat fuzzy delineation of just who a hospital is liable for. Employed physicians are easy—respondeat superior controls. \textit{Raleigh General} reflects an inconsistent shifting of liability. While on one hand rejecting the "captain of the ship" doctrine as not reflecting the way things really work in operating rooms, the court expanded the liability of hospitals to encompass acts of physicians whose medical practice they do not control. The concept

\textsuperscript{178} Id. at 482.
\textsuperscript{179} Id.
that a patient is deemed not to "choose" a physician necessarily assumes that patients are never cognizant of who is providing treatment and why. Indeed, unlike the application of ostensible agency in other contexts, the court ignores the requirement of actual reliance by the patient in the hospital scenario.\footnote{See Paintsville Hosp. Co. v. Rose, 683 S.W.2d 255, 258 (Ky. 1985) (Vance, J., dissenting); Brown v. Coastal Emergency Servs., Inc., 354 S.E.2d 632 (Ga. Ct. App. 1987) (ostensible agency); Hardy v. Brantley, 471 So. 2d 358 (Miss. 1985); see generally \textsc{David W. Louisell \& Harold Williams, Medical Malpractice \textsection\textsection{15.07[1]} (1992).}}

This makes the most sense in the context of the emergency room, where the patient is taken or seeks treatment on an emergency basis from the hospital, even though the emergency room may be staffed by a group of doctors with a contract to provide emergency services to the hospital or by members of the medical staff who provide emergency room coverage on a rotating basis. \textit{Torrence}, however, seems to stretch the concept to its limit—not only can the hospital be liable for emergency room doctors, it may also be liable for the negligence of other physicians who received specialty referrals.\footnote{Indeed, in Rine v. Irisari, 420 S.E.2d 541 (W. Va. 1992), the court held that "a negligent physician is liable for the aggravation of injuries resulting from subsequent negligent medical treatment, if foreseeable, where that subsequent medical treatment is undertaken to mitigate the harm caused by the physician's own negligence." \textit{Id.} at syl. pt. 2.} \textit{Torrence}, however, is best understood as an extension of \textit{Raleigh General}: Where the patient cannot choose a physician other than one designated by the hospital, vicarious liability will lie. Neither \textit{Torrence} nor \textit{Raleigh General} dictates vicarious liability for referrals, even from the emergency room, to private specialty physicians not designated by the hospital through an exclusive contract or special arrangement. Moreover, prior contact with the physician by the patient, or referrals made by the patients' personal physician should not impose liability upon the hospital.\footnote{See \textsc{Stanley S. Schwartz \& Norman D. Tucker, Handling Birth Trauma Cases \textsection\textsection{2.13} (1992).}

The practical problem presented by the loose application of ostensible agency is that hospitals are simply named as defendants based on broad allegations of "agency." Since \textit{Raleigh General} and \textit{Torrence} suggest that the question is one for the jury, early summary judgment
is not likely, leaving the hospital with the choice of spending legal fees or settling, even where its only liability is solely vicarious. In this circumstance, hospitals are named as a sort of "excess insurer" in large damage cases.¹⁸³ A settlement with the physician in this circumstance should release the hospital.¹⁸⁴

IV. LIABILITY FOR NEGLIGENT GRANTING OF PRIVILEGES OR SUPERVISION

Hospitals must exercise reasonable care in evaluating the qualifications of persons who seek privileges to perform medical services in the hospital and review the treatment rendered by such persons.¹⁸⁵ The failure to carry out this duty may lead to liability for negligence when injury results.¹⁸⁶

Hospitals have been held liable when the failure to properly scrutinize a physician's application results in unreasonable risk of harm to its patients.¹⁸⁷ In Johnson v. Misericordia Community Hospital,¹⁸⁸ the plaintiff claimed the hospital knew or should have known that the physician was not qualified to perform orthopedic surgery. The court held the hospital to the standard of care exercised in similar situations by other hospitals¹⁸⁹ and outlined the steps that a hospital should take when selecting medical staff and granting specialized privileges:

The credentials committee (or committee of the whole) must investigate the qualifications of applicants . . . . [A] hospital should, at a minimum,

¹⁸³. Id. § 2.2.
¹⁸⁶. Holton, 410 N.E.2d at 973.
¹⁸⁸. 301 N.W.2d 156 (Wis. 1981).
¹⁸⁹. Id. at 171 (citing Mossey v. St. Luke's Hosp., 218 N.W.2d 514 (Wis. 1974)).
require completion of the application and verify the accuracy of the applicant's statements, especially in regard to his medical education, training and experience. Additionally, it should: (1) solicit information from the applicant's peers, including those not referenced in his application, who are knowledgeable about his education, training, experience, health, competence and ethical character; (2) determine if the applicant is currently licensed to practice in this state and if his licensure or registration has been or is currently being challenged; and (3) inquire whether the applicant has been involved in any adverse malpractice action and whether he has experienced a loss of medical organization membership or medical privileges or membership at any other hospital.190

The plaintiff must also prove causation: that but for the hospital's lack of care in selecting the physician, the physician would not have been granted staff privileges and the plaintiff would not have been injured.191 Actual knowledge by the hospital of the incompetency of a physician is not necessary; rather, the hospital will be charged with knowledge of information available through a reasonable inquiry into the physician's qualifications and background.192

It is not enough that the hospital failed to adequately verify the physician's credentials; instead, it must be shown that had the hospital made adequate inquiry, it would have denied the physician's application for privileges.193 In Ferguson v. Gonyaw,194 the court found that the hospital did not act in a reasonably prudent manner in checking a physician's qualifications to be a staff member at the hospital. However, the court determined that even if the hospital had checked the physician's qualifications, it would have found him to be a qualified osteopathic surgeon. Consequently, the court affirmed a directed verdict for the hospital.

190. Id. at 174.
192. Johnson, 301 N.W.2d at 173.
Hospitals, therefore, are not insurers of the competence of their medical staff. "A physician’s negligence does not automatically mean that the hospital is liable, and does not raise a presumption that the hospital was negligent in granting the physician staff privileges."\textsuperscript{195}

Hospitals are under no duty to constantly supervise and second guess the activities of physicians, other than the duty to remove physicians known to be incompetent.\textsuperscript{196} Once a physician has been granted staff privileges, the hospital will not be held liable unless it had reason to know that malpractice would likely take place.\textsuperscript{197} Where a previously competent physician with staff privileges develops a pattern of incompetence, which the hospital should become aware of through its peer review process, the hospital may be held liable.\textsuperscript{198} In *Albain,* the court determined that the plaintiff failed to prove that but for the defendant hospital’s lack of care in reviewing the treating physician’s credentials, it would have denied the physician’s staff privileges.

There are no West Virginia cases which fully explore the liability of hospitals for negligence in granting privileges or policing their medical staffs. The court briefly discussed the issue in *Roberts v. Stevens Clinic Hospital, Inc.,*\textsuperscript{199} a medical malpractice action in which the jury awarded $10 million, finding the defendant-physician 82 percent negligent and the defendant-hospital 18 percent negligent. Rejecting the hospital’s assertion that the trial court erred in failing to direct a verdict in its favor, the supreme court pointed out:

> [T]he plaintiff also introduced evidence that the hospital was negligent in granting Dr. Magnus full surgical privileges in light of the fact that before coming to Stevens Clinic Hospital he had been primarily a family practitioner and had never previously been granted full surgical privileges.\textsuperscript{200}

\textsuperscript{196} Albain, 553 N.E.2d at 1046.
\textsuperscript{197} Id. at 1045.
\textsuperscript{198} Id.
\textsuperscript{199} 345 S.E.2d 791 (W. Va. 1986).
\textsuperscript{200} Id. at 798.
The issue was also mentioned in *Rine v. Irisari*, where the court indicated that there was a claim that one of the physicians who treated the infant did not have privileges to care for premature infants experiencing complications. However, since the physician reached a settlement with the plaintiff, the issue was not discussed by the court.

Under the MPLA, the hospital’s duty to screen and monitor physicians will be judged by similar hospitals in the same or similar circumstance. Absent a “common knowledge” argument, the plaintiff will be required to prove the case by qualified expert testimony. These cases are difficult to prosecute. The privilege granted to hospital credentialing committees shields from discovery the hospital’s decision making process in granting credentials. Only documents not covered by the privilege are discoverable. Second, the plaintiff must prove not only negligence by the doctor, but that it was foreseeable in the credentialing process.

V. LIABILITY OUTSIDE THE MPLA

Discussions of hospital liability are generally restricted to the traditional medical malpractice case, now governed by the MPLA. However, suits by persons who are not patients are not covered by the MPLA and are governed by traditional common law principles. Hospitals, like other property owners, owe duties to the general public, or persons other than patients, to maintain a reasonably safe facility.

202. *Id.* at 543.
203. *Id.*
204. MPLA § 7.
Two significant decisions in West Virginia raised questions as to the liability of hospitals for injuries outside the context of the MPLA. A shocking verdict came when a hospital was held liable for negligent infliction of emotional distress where a nonemployee security guard was bitten by a patient with AIDS. In Johnson v. WVU Hospitals, Inc., the court affirmed a two million dollar verdict, finding that the hospital was negligent in failing to warn the guard of the danger when he was called in to restrain the patient, notwithstanding the statutory confidentiality afforded to HIV test results. The court expressly noted that the hospital violated its own rules by failing to post a warning that the patient was infectious.

In another case, Funeral Services by Gregory, Inc. v. Bluefield Community Hospital, the plaintiff, a mortician, claimed exposure to the AIDS virus during the embalming of a body sent to the mortuary from the defendant hospital without any warning that the patient had been infected with AIDS at the time of his death. The plaintiff claimed that he sustained severe emotional distress due to the fear of contracting the AIDS virus.

The court did not discuss whether the hospital or other defendants were negligent in releasing the body to the plaintiffs without warning of the AIDS virus. Instead, it focused on the fact that the plaintiff claimed emotional distress damages without any showing of physical

208. 413 S.E.2d 889 (W. Va. 1991)
210. Johnson is distinct from a claim that AIDS was spread by a health care worker, which would be governed by the MPLA. See Bruce L. Ottley & Marguerite Nye Corboy, A Reasonable Probability of Substantial Harm? Health Care Workers, AIDS, and the Duty to Disclose, 25 HEALTH & HOSP. L.J. 65 (March 1992); see generally Cindy Berry, AIDS and Hospital Liability, FOR THE DEFENSE, Dec. 1990, at 6. It is reminiscent of the duty to warn placed upon psychiatrists. Smith v. Fishkill Health-Related Ctr., 572 N.Y.S.2d 762 (App. Div.), appeal denied, 586 N.E.2d 61 (N.Y. 1991) (psychiatrist not responsible for third party harmed by patient unless faulty treatment was more than mere error in judgment).
211. 413 S.E.2d 79 (W. Va. 1991).
injury. The court found no evidence of actual exposure to the AIDS virus, unlike Johnson v. WVU Hospitals, and stated:

We conclude that if a suit for damages is based solely upon the plaintiff's fear of contracting AIDS, but there is no evidence of an actual exposure to the virus, the fear is unreasonable, and this court will not recognize a legally compensable injury.\(^\text{212}\)

The court further noted that West Virginia did not recognize the tort of negligent infliction of emotional distress.\(^\text{213}\) And since the plaintiff did not allege a physical injury, the court found that the case was barred by the one-year statute of limitations applicable to intentional infliction of emotional distress.

Johnson and Funeral Services create the spectre of liability for hospitals for failure to warn nonpatients of the dangers of the infected patients and comparable dangers. This liability is somewhat similar to that recognized in the psychiatric field, beginning with Tarasof v. Regents of the University of California,\(^\text{214}\) where the court found that a therapist could have a duty to warn foreseeable victims of the violent intentions of patients. The duty to warn occurs when the therapist determines under reasonable professional standards that a patient poses a serious threat to another.\(^\text{215}\) As suggested in Funeral Services, the court will not extend liability for fear of AIDS beyond the context of Johnson, where there was actual exposure to the virus.

\(^{212}\) Id. at 84. Compare Faya v. Almaraz (suit against HIV infected surgeon does not require actual transmission).

\(^{213}\) It is questionable whether this is still true, see supra note 130.


\(^{215}\) See Peck v. Counseling Servs. of Addison County, Inc., 499 A.2d 422 (Vt. 1985) (counselor under duty to warn parents that their son, his patient, threatened to burn down their barn); In re Estate of Votteler, 327 N.W.2d 759 (Iowa 1982); Curry v. United States, 836 F.2d 209 (4th Cir. 1987); Sellers v. United States, 870 P.2d 1098 (6th Cir. 1989).
VI. CONCLUSION

The MPLA benefitted West Virginia hospitals by defining the standard of care and elevating actions against hospitals to malpractice status, requiring expert testimony to establish a *prima facie* case of liability. Despite these and other protections afforded by the MPLA, hospitals continue to face liability in several other areas, particularly as a result of the expansion of vicarious liability for nonemployee physicians. Unfortunately, this judicial expansion of liability will continue to negate, to some extent, the benefits of the MPLA to hospitals, particularly when named as defendants on pure vicarious liability theories.