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THE LAW OF MEDICAL MALPRACTICE IN WEST VIRGINIA

MICHAEL J. FARRELL*

The preparation and trial of a medical malpractice case is a trial lawyer's delight. The trial arena presents a unique opportunity for the lawyer, physician, patient, and jury to explore the intricacies of a surgical procedure, the maze of a diagnostic puzzle, and the mystery of malpractice causation.

The physician is subjected to intense scrutiny by professional malpractice witnesses; he is compelled to justify every note in his record and every omission in his thought process. The lawyer undertakes the herculean task of learning anatomy, physiology, and the specific medical discipline of the defendant. It is in this context that a review of the law of medical malpractice in West Virginia will be explored with appreciation to those who have blazed the path.¹ This analysis of West Virginia law will demonstrate that the untimely death of a patient or an unexpected complication alone does not make a physician negligent.²

A national study exploring the causes and effects of medical malpractice concludes that no malpractice crisis really exists.³ The study is valuable in ascertaining what areas of medical treatment produce the greatest number of malpractice claims⁴ and indicates

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¹ Posten, Law of Malpractice in West Virginia, 41 W. Va. L.Q. 35 (1934); Foster, Juridical Trauma and Medical Shock, 59 W. Va. L. Rev. 1 (1956); G. Daughters, Medical Man Miscue (1964).
² Most medical procedures have a risk of failure. Failure by a physician to cure as well as to prevent unexpected injury precipitates malpractice actions. The widely accepted indirect stimuli of these actions include deficient or lost rapport with the treating physician and non-verbal criticism by follow-up physicians or nurses. Other contributing factors are collection suits, misleading explanations, and exaggerated prognoses. D. Louiseill & H. Williams, Medical Malpractice §§ 5.01-.11 (1977).
⁴ Id. at 9. Nationally, 57.2% of all claim files closed in 1970 involved surgical procedures. In West Virginia, 17% of all published medical malpractice opinions involved surgical operations.
that the changing patterns of medical practice from family physician to the super-specialist clinic has brought about an increase in malpractice claims.  

The depersonalizing aspects of a patient being hospitalized, operated upon, and released without substantial personal input by the physician creates an unhealthy atmosphere. The prominent role which hospitals have assumed in the dispensing of health care has also made hospitals the primary situs of the alleged malpractice.  

The generic use of the term "malpractice" has severe social and economic connotations. Generally, a physician accused of malpractice can become stigmatized by the public as an incompetent physician. More importantly, a physician found guilty of medical malpractice by a jury can lose his license to practice medicine.

\[5 \text{ Id. at 3.}\]
\[6 \text{ Id. at 9. The 1970 claims figures show that 74\% of all alleged malpractice occurs in hospitals. Among the published West Virginia decisions, hospitals were named defendants in 47.1\% of the cases. Hospitals were the situs of the alleged malpractice in approximately 85\% of the cases.}\]
\[7 \text{ "Malpractice" literally means bad practice. It is generally understood to be a deviation from the standard of care which an ordinary, careful, prudent, and skillful physician or surgeon, practicing in the same or similar locality and practicing in the same field of medicine at or about the same time, would have done under the same or similar circumstances. Kuhn v. Brownfield, 34 W. Va. 252, 12 S.E. 519 (1890). As a historical note, see Sandor, The History of Professional Liability Suits in the United States, 163 J.A.M.A. 459 (1957).}\]
\[8 \text{ A physician may have his license to practice suspended or revoked if he is known to engage in malpractice. W. Va. Code § 30-3-6 (1976 Replacement Vol.) provides:}\]
\[\text{The medical licensing board may refuse to grant a certificate of license to a person who has been found guilty of a felony as decreed by a court of law, or to a person known to indulge in gross immorality, or to a person who is addicted to drunkenness or the habitual use of narcotic drugs, or to a person known to engage in malpractice, or to a person who resorts to fraud in procuring the certificate and may suspend or revoke a certificate for like cause. No such refusal, suspension or revocation shall be ordered by reason of the individual belonging to or practicing in any particular school or system of medicine.}\
\[\text{The statutory variances in West Virginia regarding the effect of professional malpractice is shocking. An attorney may have his license suspended or annulled by a judge who "observes any malpractice." W. Va. Code § 30-2-7 (1976 Replacement Vol.) provides in relevant part:}\]
\[\text{If the supreme court of appeals or any court of record of this State, except the county court, observe any malpractice therein by an attorney, or if}\]
complaint, verified by affidavit, be made to any such court of malpractice by any attorney therein, such court shall order the attorney to be summoned to show cause why his license shall not be suspended or annulled. . . .

The failure to provide a statutory definition of malpractice has been previously criticized. Farrell, Ethics Committee Changes—Enough or Too Much, 4 W. Va. Sr. B.J. 57 (1978). On April 3, 1979, the West Virginia Supreme Court of Appeals approved the deletion of W. Va. State Bar Const. art. VI, § 25, which set forth the procedure for disbarring and suspending attorneys for malpractice. This section modeled W. Va. Code § 30-2-7 (1976 Replacement Vol.). The vagueness of the term “malpractice” was a principal reason for the deletion.

Dental malpractice will not result in the suspension or revocation of the dentist’s license. The license can be revoked for gross ignorance or gross inefficiency in the profession. W. Va. Code § 30-4-7 (1976 Replacement Vol.).

The Board of Examiners for Registered Nurses may suspend or revoke a license upon proof that the nurse is “unfit or incompetent by reason of negligence, habits or other causes.” W. Va. Code § 30-7-11 (1976 Replacement Vol.).

However, a practical nurse can be negligent or commit malpractice without jeopardizing her license. W. Va. Code § 30-7A-10 (1976 Replacement Vol.).

An optometrist who commits “gross malpractice” can have his certificate of registration revoked or suspended. W. Va. Code § 30-9-8 (1976 Replacement Vol.).


A veterinarian’s license can be revoked or suspended after an administrative hearing board finds, by a concurrence of four members, that “incompetence, gross negligence or other malpractice” occurred in the practice of veterinary medicine. W. Va. Code § 30-10-12 (1976 Replacement Vol.).

The only statute to define malpractice pertains to chiropodist-podiatrists. W. Va. Code § 30-11-8 (1976 Replacement Vol.):

The medical licensing board may refuse to grant a license to a person convicted of a felony or guilty of gross immorality or addicted to drunkenness or the habitual use of narcotic drugs, and may by legal proceedings as provided in article one [§30-1-1 et seq.] of this chapter suspend or revoke a license for like cause, or for malpractice, or for fraud in procuring the license, but no such refusal, suspension or revocation shall be ordered by reason of the individual belonging to or practicing in any particular school or system of chiropy or podiatry. Provided, however, that malpractice as herein used means bad, wrong or injudicious treatment of a patient, professionally and in respect to the particular disease or injury, resulting in injury, unnecessary suffering, or death to the patient and proceeding from ignorance, carelessness, want of professional skill, gross disregard of established rules or principles, neglect, or a malicious or criminal intent.

This statutory definition of malpractice is patently absurd. Every practitioner has caused one patient to suffer unnecessarily as a result of bad, wrong, or injudicious treatment.

The vagueness of the term malpractice does not prevent courts from reaching verdicts. Malpractice, like any other negligence based action, is subject to the equation of duty, breach, causation, and damages. Malpractice cases have some unique features such as non-negligence based theories of recovery. Each of these theories as well as the negligence approach also has the unique feature that expert testimony regarding causation is necessary to make a prima facie case.

The protection of medical malpractice victims by court interpretations has been expanding in recent years. The most notable expansion involved the creation of the “discovery rule” which holds that the statute of limitations does not begin to run against a claim until the injured party knows or should have known of the alleged malpractice.

Malpractice defendants usually are physicians, hospitals, and their agents, servants or employees. As defendants, they are liable for primary negligence and the vicarious acts of those whom they control. The business format, partnership or medical corporation, chosen by the physician will determine the personal exposure which a physician has for vicarious liability. A hospital’s vicarious liability can arise from the negligence by commission or omission of its agents, servants, or employees. A hospital’s primary negligence can range from negligent selection of incompetent employees to maintaining an unsafe premises.

Vol.). Chiropractors can lose their license upon a showing of “malpractice.” W. Va. Code § 30-16-8 (1976 Replacement Vol.).

The general absence of due process in these disciplinary statutes is appalling. A call to the legislature for corrective action is hereby made.

The traditional negligence equation generally requires only three elements: (1) a legal duty, (2) breach of the duty, and (3) a proximate cause relationship between the breach and the damages.

Breach of a special contract to cure, lack of informed consent, and abandonment are non-negligence based causes of action.

The expert witness rule is the best evidence of the flexibility of the common law to remedy wrongs with justice to all concerned. See Hinkle v. Martin, 256 S.E.2d 768 (W. Va. 1979).


Vicarious liability attaches without personal fault if the physician’s employee or partner is found liable. Cook v. Coleman, 90 W. Va. 748, 111 S.E. 760 (1922).


This article will canvas the prerequisites to a malpractice action as well as probe the theories of liability, defenses, and immunities.

I. PHYSICIAN-PATIENT RELATIONSHIP

A physician must accept a patient before a duty of care arises. The physician-patient relationship generally is grounded in contract, express or implied.

An express contract to achieve a particular result is termed a "special contract." An implied contract between patient and physician requires the use of ordinary and reasonable care comparable to that possessed by average physicians in a similar community. Beyond the contractual physician-patient relationship, a physician may become a "fiduciary" to the patient which requires that the physician do more than merely meet the medical standard of care.

The existence of a physician-patient relationship is a prerequisite to creating the duty of care. No West Virginia case has held a physician liable to a patient without proof of the physician-patient relationship.

This relationship arises most often when the patient directly employs the physician. The socio-economic roots of West Virginia


15 Kuhn v. Brownfield, 34 W. Va. 252, 12 S.E. 519 (1890). Every patient enters into an implied contract with the physician in which the physician agrees to render proper medical services for the stated remuneration. The performance of the physician is measured by the tort standard of due care. Deviation from this standard is actionable only in tort.


17 A good discussion of this requirement is found in Buttersworth v. Swint, 53 Ga. App. 602, 186 S.E. 770 (1936), where the court held that neither gratuitous medical advice by a physician nor the employer-employee relationship created a physician-patient relationship.

interposed the "company store" concept into the selection of a physician whereby the coal company was responsible for forming the relationship by supplying competent physicians to the miners.\textsuperscript{21} The physicians were sometimes employed directly by the coal company. At other times, they were merely retained. The difference is significant since the employee retained the right to sue his employer directly when the physician retained by the company committed malpractice.\textsuperscript{22}

Parents can also create the necessary physician-patient relationship when they employ the physician on behalf of their child.\textsuperscript{23}

A non-consensual physician-patient relationship can arise when a physician exceeds the scope of his limited authority. For example, a physician-patient relationship is generally not created when a physician performs a physical examination for an employer, insurer, the court, or adverse litigants.\textsuperscript{24} However, if a physician subsequently renders treatment to the patient, with or without authority from the employer or insurer, then the relationship attaches.\textsuperscript{25}


\textsuperscript{22} Ashby v. Davis Coal & Coke Co., 95 W. Va. 372, 121 S.E. 174 (1924); Neil v. Flynn Lumber Co., 71 W. Va. 708, 77 S.E. 324 (1913). In \textit{Ashby}, the coal company charged the plaintiff a fee for medical services to be rendered in a case of injury or illness by competent physicians whom the defendant represented would be employed for that particular purpose. Mr. Ashby believed that he had been the victim of malpractice by an incompetent physician retained by the coal company. The court held that the employee had a direct action against the employer for the malpractice of the physician on the theory of breach of implied contract.

\textsuperscript{23} See Browning v. Hoffman, 86 W. Va. 468, 103 S.E. 484 (1920).


\textsuperscript{25} Tompkins v. Pacific Mut. Life Ins. Co., 53 W. Va. 479, 44 S.E. 439 (1903) (physician-patient relationship did arise where physician altered the status quo of
Hospitals are subject to the same legal principles. The patient will present himself for care and treatment at the hospital through the auspices of a physician. Emergency care patients often arrive at a hospital involuntarily in an unconscious state. Once the hospital undertakes to care for the patient from either source, a duty of care attaches.  

There is no legal requirement that a public or private hospital in West Virginia accept or treat patients presenting themselves at the hospital door. However, several jurisdictions reject this "no duty" rule when the patient is acutely ill. This should be the interpretation accepted in West Virginia since our statute requires mandatory admission of all persons requiring hospital care to state operated emergency hospitals.  

Good Samaritan first aid does not create a physician-patient relationship. However, a Good Samaritan physician may waive

examinee's physical condition and injury resulted from an insurance company examination).


29 W. VA. CODE § 26-8-2 (1976 Replacement Vol.).

30 West Virginia has two Good Samaritan statutes. Neither creates a physician-patient relationship. W. VA. CODE § 55-7-15 (1966) provides:

No person, including a person licensed to practice medicine or dentistry, who in good faith renders emergency care at the scene of an accident, without remuneration, shall be liable for any civil damages as the result of any act or omission in rendering such emergency care.

W. VA. CODE § 30-3B-4 (1976 Replacement Vol.) provides:

No physician or surgeon, who in good faith gives emergency instructions to such paramedic, nor any such paramedic who renders such emergency
this immunity and create a physician-patient relationship if he attempts to charge the patient for the services.\textsuperscript{31} There is no reported West Virginia case interpreting the limits of the immunity.

There is no authority that requires a private physician to accept every patient who seeks his services.\textsuperscript{32} Any other rule would result in socialized medicine.

However, once the physician accepts a sick patient, the relationship continues for the duration of the illness or until it is terminated by mutual consent or revoked by the express dismissal of the physician by the patient.\textsuperscript{33} Neglect or temporary absence from the patient by the treating physician during the treatment phase is actionable upon proof of harm proximately caused by the absence.\textsuperscript{34}

A doctor does not become the prisoner of his patient for life. Following the termination of the illness, he may unilaterally terminate the relationship if he gives the patient reasonable notice of

\textsuperscript{31} Cf. Colby v. Schwartz, 78 Cal. App. 3d 885, 144 Cal. Rptr. 624 (1978). The California Good Samaritan statute does not apply to physicians who render emergency care in a hospital emergency room. Annot., 39 A.L.R.3d 222 (1971); Note, \textit{Good Samaritans and Liability for Medical Malpractice}, 64 COLUM. L. REV. 1301 (1964); 51 CAL. L. REV. 816 (1963); 32 TENN. L. REV. 287 (1965). There is scant authority on this subject which indicates either that there are no good samaritans or no complaining accident victims.

\textsuperscript{32} Physicians who do not intend to accept a patient should maintain a file which shows the name of the patient and the date of rejection. Absent this type of documentation, a patient can create a justiciable issue by swearing that the doctor accepted him or her for treatment.


\textsuperscript{34} Maxwell v. Howell, 114 W. Va. 771, 174 S.E. 553 (1934) (failure to visit patient in hospital for five days on one occasion and eight days on another); Young v. Jordan, 106 W. Va. 139, 145 S.E. 41 (1928) (obstetrician has absolute duty to remain with expectant mother once he has induced labor); cf. Browning v. Hoffman, 90 W. Va. 568, 111 S.E. 492 (1922). In \textit{Browning}, the plaintiff was hospitalized with a broken leg. The defendant had to be out of town during the hospitalization period. During defendant’s absence, the plaintiff developed gangrene which necessitated amputation of the leg. A cause of action was not stated based solely on Dr. Hoffman’s absence since he left a qualified physician in charge and adequate instructions with the nursing staff.
that intention so that the patient may secure a successor physician.\textsuperscript{35}

\section*{II. Duty of Care}

\subsection*{A. Special Contract To Cure}

West Virginia jurisprudence has recognized the validity of a special contract to cure since the first medical malpractice case was decided.\textsuperscript{36} The standard of care in a special contract case is to cure the patient completely.\textsuperscript{37} The special contract can be created by the physician making representations as to his success ratio and the degree of pain to which the patient will be subjected. In \textit{Schroeder},\textsuperscript{38} the plaintiff testified that she told the defendant that she did not want to have bumps on each foot. He asked her to let him remove them and represented to her that he removed such bumps as often as fifteen or twenty-five times each week and that if she did not have the bumps removed, she would likely begin to have corns. In response to her question regarding risks, the chiropodist replied that they were insignificant and that she would be all right. She also testified that she showed her a book which contained a picture and explained the operation for the removal of the bumps. This evidence was sufficient to warrant a jury instruction on a special contract to cure.\textsuperscript{39}

Any time a physician guarantees a result or suggests that complete success is an expectation, then a special contract may exist. Neither the \textit{Schroeder} nor \textit{Buskirk}\textsuperscript{40} opinions state that the physician admitted making the special contract. Therefore, the burden of persuasion will depend upon introduction of corroborative evidence supporting the existence of the special contract.\textsuperscript{41} The care-

\textsuperscript{35} Lawson v. Conaway, 37 W. Va. 159, 16 S.E. 564 (1892).
\textsuperscript{36} Kuhn v. Brownfield, 34 W. Va. 252, 12 S.E. 519 (1892).
\textsuperscript{37} Almost every malpractice case decided in West Virginia since \textit{Kuhn} refers to the higher standard of care when a special contract is proven. Only two cases have actually involved a contract to cure. Schroeder v. Adkins, 149 W. Va. 400, 141 S.E.2d 352 (1965); Buskirk v. Bucklew, 115 W. Va. 424, 176 S.E. 603 (1934). A special contract imposes the highest standard of care since it does not allow for failure or honest mistake. Any result less than absolute cure is actionable.
\textsuperscript{38} Schroeder v. Adkins, 149 W. Va. 400, 141 S.E.2d 352 (1965).
\textsuperscript{39} \textit{Id.} at 402-03, 141 S.E.2d at 357.
\textsuperscript{40} Buskirk v. Bucklew, 115 W. Va. 424, 176 S.E. 603 (1934).
\textsuperscript{41} The best source of corroborative evidence is the medical records. Medical records in the typical case consist of the hospital record, office chart, and correspon-
ful physician will outline the prognosis in the medical records so that the existence or non-existence of a special contract will be evident.

B. Implied Contract

Medical-legal jurisprudence has traditionally recognized that the practice of medicine is not an exact science. For this reason, the physician is expected to meet a standard of care based upon time and place as established by expert testimony. The "locality rule" regarding the standard of care is equally applicable to "negligence" and "non-negligence based" actions.

Even though the physician and patient enter into an implied contract, the standard of care is formulated in tort principles.

[T]he physician's duty to his patient is to exercise such skill and diligence as are ordinarily exercised by average members in good standing of the profession in a similar locality and in the same general line of practice, regard being given to the state of medical science at the time.

The "average" physician is the malpractice equivalent to the "reasonably prudent man." No physician can be held to a 100% standard of correctness regarding his diagnosis and treatment. Physicians do make mistakes which are not negligent or action-

dence to referring physicians. In the hospital record, particular attention should be directed to the admission summary, progress notes, physician orders, and discharge summary. If a special contract exists, evidence of it should be found in these records.

42 The time and place factors are better known as the "locality rule." The locality rule derived from a 19th Century view that it was unfair to hold a rural medical practitioner to the same standard of care as the supposedly better-educated physicians practicing in large urban centers. The rule has lost much of its significance because of better medical education being available to all physicians and the establishment of medical specialties and national standards. Notwithstanding these significant changes, West Virginia still adheres to a liberalized locality rule which states that a physician must exercise the reasonable and ordinary skill and diligence that is ordinarily exercised by the average members of the profession in good standing in similar localities and in the same general line of practice with regard being given to the state of medical science at the time. As will be discussed infra, the locality rule has its most significant application when non-specialist physicians are involved. Generally, a specialist will be held to a national standard of care which would be exercised by ordinary and reasonable physicians holding themselves out as a specialist in their particular medical field.

able. Even the combination of a mistake and a bad result does not equal negligence unless the mistake "is so gross as to be inconsistent with that degree of skill which it is the duty of the physician to possess." 45

It is unrealistic to expect all physicians to achieve the highest degree of care and skill. Our law is pragmatic enough not to expect consistent high standards. 46 This approach does substantial justice for both the patient and the physician. A gross mistake or error should be actionable, but public policy demands that honest mistakes not be the basis for a civil action. 47

C. Standard of Care For a Specialist

An exception to the "average" physician rule occurs when the defendant doctor is a specialist. 48 In Hundley v.

46 "In Dye, the court expressly recognized this rule. We think it may be said to be the generally accepted doctrine that a physician is not required to exercise the highest degree of skill and diligence possible, in the treatment of an injury or disease, unless he has by special contract agreed to do."
47 Judge (Chief Justice) Taft observed that few physicians could practice medicine if they would be held accountable for every error or mistake. Ewing v. Goode, 78 F. 442, 443 (C.C.S.D. Ohio 1897). The West Virginia Supreme Court of Appeals adopted this statement of public policy in Vaughan v. Memorial Hosp., 100 W. Va. 290, 294, 130 S.E. 481, 482 (1925). The following year the court stated: "It is a matter of common knowledge that the wisest and most skillful practitioners in medicine and surgery are often mistaken in diagnosis." Meadows v. McCullough, 101 W.Va. 103, 109, 132 S.E. 194, 197 (1926).
48 Hundley v. Martinez, 151 W. Va. 977, 158 S.E.2d 159 (1967). Dr. Martinez was an ophthalmologist, a specialist in the treatment of diseases of the eye. The court recognized that a specialist has taken advanced training which generally includes a residency program of academic studies and clinical experiences. Many specialists take and pass national examinations in their specialties. These physicians are then charged with observing a national standard of care which would be higher than that expected of the "average" physician. Thus, Dr. Martinez was charged with knowledge of the standard procedure for cataract operations throughout the United States.

A distinction may exist in some specialties where there is a "community national standard" and an "academic national standard." An example of this is pathology where pathologists in a community hospital would not recognize a rare
Martinez, Dr. Martinez had performed a cataract operation on the plaintiff. Plaintiff charged the doctor with malpractice after it was discovered that more than half of the iris of the left eye was missing following the operation. Plaintiff’s proof established that Dr. Martinez’s skill in this case did not meet the national standard of care. This proof was offered at trial through the deposition of a New York ophthalmologist. The court permitted the New Yorker to testify regarding the defendant’s deviation from the standard of care.

In rural communities, this exception will have little effect since few specialists practice in these areas. The metropolitan areas have many specialists and few general practitioners; thus, the “specialist standard” should be more prevalent. However, great care should be exercised by the trial judge in accepting proof as to an alleged national standard from a professional witness who travels from state to state peddling his services. This concern for

lesion, but a national center of pathology like the Armed Forces Institute of Pathology would identify the lesion. Even though the community pathologist passed a national board examination, he should not be charged with the standard of care established by a major research center.

151 W. Va. 977, 158 S.E.2d 159 (1967).

20 Plaintiff’s lawyers have contended for years that a “conspiracy of silence” exists, which imposes an impossible burden on the plaintiff to prove his case by expert testimony. See Hundley v. Martinez, 151 W. Va. 977, 992, 158 S.E.2d 159, 167-68 (1967). The Malpractice Commission was unable to find objective evidence that any conspiracy exists. Report, supra note 3, at 36. Circumstantial evidence does suggest that legitimate practicing physicians are reluctant to testify on one or more of these bases:

(1) Reluctance to suffer loss of time and income for court appearances;
(2) Neglect of patients while away in court;
(3) Fear of cross examination by adverse attorney;
(4) Reluctance to injure friends or fellow physicians;
(5) Common belief among doctors that most malpractice cases are without merit.

Report, supra note 3, at 36-37.

As a result, expert witness procurement agencies have developed. One critic has charged that some of the agencies are “flesh peddlers . . . [whose] witnesses are usually marginally competent.” Windrew, The Midas of Medical Practice, 1 Am. Law. 25, 27 (1979).

Some of these services allegedly permit the malpractice plaintiff to “expert shop” until a willing witness is found. One attorney described his foray into the expert marketplace in terms reminiscent of a housewife picking over fruit at the vegetable counter. “The first [doctor] found no negligence. The second said there was a problem, but he wasn’t strong enough. The third one was good. I had to pay fees for each one, for reviewing the file again.” Id. at 28.
legitimate testimony stems from the specter of filling courtrooms with glib and polished "Madison Avenue" experts who are more familiar with the gold standard than the standard of care.

D. Standard of Care for Non-Medical Practitioners

Licensed physicians and surgeons are subject to the standards of care described above. There are additional health care practitioners who appear to be in a standard of care limbo. Chiroprist-podiatrists,51 chiropractors,52 and optometrists53 are not licensed

The objectivity of these hired guns has been questioned because of the contingency fee which the expert witness supplier earns. Id. at 26. It has been reported that some injured plaintiffs have paid as much as 15% of their gross recovery to the expert witness service. Id. In addition, these injured persons have reportedly paid additional expert witness fees of $500 and up for an initial evaluation, $100 per hour for medical consultations or records review by the doctor, $150 per hour to the doctor for deposition testimony, and between $1,000 and $1,500 per day, plus expenses, for trial appearances. Id. at 28.

These payments create an unhealthy atmosphere in which the perversion of justice is a distinct possibility.

Alternatives to this "expert at any price" system do exist. The Malpractice Commission recommended the creation of expert witness pools. REPORT, supra note 3, at 37. Many state and county medical societies have responded by establishing screening committees which guarantee an expert witness to any plaintiff presenting a meritorious claim. New York city hospital physicians will evaluate cases and testify in medical malpractice cases without any compensation. 65 A.B.A.J. 1042 (1979). Ohio, by statute, has set rigid qualifications for expert witnesses in malpractice cases. OHIO REV. CODE ANN. 2743.43 (Cum. Supp. 1978). Among the requirements is that the physician spend 75% of his time in the active clinical practice of medicine or university teaching.


52 Chiropractic is the drugless treatment which attempts to cure through "adjustment" and "manipulation" of the articulations and adjacent tissues of the spinal column. W. VA. CODE § 30-16-2 (1976 Replacement Vol.). For representative chiropractic malpractice cases, see: Salazar v. Ehmann, 505 P.2d 387 (Colo. App. 1972) (failure to diagnose fracture); Ison v. McFall, 400 S.W.2d 243 (Tenn. App. 1964) (paraplegia from spinal cord injury); Malmstrom v. Olsen, 16 Utah 2d 316, 400 P.2d 209 (1965) (ruptured disc, manipulation).

53 Optometry is the treatment of any abnormal condition of the human eye or its appendages by any non-surgical method. Optometrists cannot prescribe injecta-
physicians or surgeons.\textsuperscript{54}

Limbo exists because only one case involving this class of defendants has been decided.\textsuperscript{55} In Schroeder, a chiropodist was sued. An orthopedic surgeon and a chiropodist testified for the plaintiff and two chiropodists testified on behalf of the defendant. Both parties tried the case based upon the "ordinary skill and diligence of the average chiropodist in this [Huntington] community."\textsuperscript{56} The orthopedic surgeon testified that the surgery by Dr. Adkins caused the problem, but he did not testify as to a deviation from the standard of care.

The opinion cites Dye v. Corbin as the standard of care benchmark.\textsuperscript{57} The court did not discuss the competency of a non-chiropodist to testify as to a chiropody standard of care.\textsuperscript{58} The inference is clear that a chiropodist will be required only to perform on the level of the average chiropodist, but not on the level of the average medical doctor.\textsuperscript{59}

III. THEORIES OF LIABILITY

Medical malpractice cases present the skillful practitioner with myriad theories upon which recovery can be based. Breach of the specialized duties owed by a physician to the patient can be couched in both "negligent" and "non-negligent dependent" causes of action.

The most frequently used theory is negligence—the failure by the physician to use reasonable and ordinary care in the diagnosis and treatment of the patient.\textsuperscript{60} Negligence can result from acts of

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\textsuperscript{54} Medical Care, Inc. v. Chiropody Ass'n, 141 W. Va. 741, 93 S.E.2d 38 (1956).

\textsuperscript{55} Schroeder v. Adkins, 149 W. Va. 400, 141 S.E.2d 352 (1965) (chiropodist).

\textsuperscript{56} Id. at 406, 141 S.E. 2d at 355.

\textsuperscript{57} 59 W. Va. 266, 53 S.E. 147 (1906), cited in 149 W. Va. at 406, 141 S.E. 2d at 355.


\textsuperscript{59} 149 W. Va. at 411, 141 S.E.2d at 358.

commission as well as omissions.

A. Negligence—Acts of Commission

The trial lawyer recognizes that it is very difficult to accurately evaluate a potential medical malpractice case during the initial consultation. Many lawyers search endlessly for the blatant acts of commission such as removal of the wrong organ. Acts of commission involve affirmative deviation from a standard of care. A bad result does not necessarily mean that the physician deviated from the standard of care. This rule is necessary because what may appear to be a bad result to a layman can be the expected and accepted medical treatment and healing process.

Result analysis can also be deceiving where the same outcome would have occurred even in the absence of negligence. More West Virginia cases have involved acts of commission in the diagnosis and treatment of fractures than any other category of injury.

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63 C. Kramer, Medical Malpractice 47 (4th ed. 1976); D. LouiseLL & H. Williams, Medical Malpractice § 8.01 (1977).
65 Hinkle v. Martin, 266 S.E.2d 768 (W. Va. 1979). Here, plaintiff was undergoing x-ray treatment for the excision of warts. She complained that following the third x-ray treatment that she had pain, bleeding, and a generally deteriorated condition of her hand. This was exactly the expected skin reaction that was explained to Mrs. Hinkle by Dr. Martin. Thus, the Supreme Court of Appeals, affirmed the directed verdict by the trial judge.
Typically, these cases involved improper casting which resulted in amputations, deformities, and other complications. For example, in *Utter*, plaintiff was admitted to the hospital with a comminuted compound fracture of the right wrist, a posterior dislocation of the right elbow, and a compression fracture of the second lumbar vertebra. After two days in the hospital, the injured arm was black, swollen, edematous, and exuding a foul-smelling drainage. Both the orthopedic surgeon and the hospital were found negligent in the treatment of this arm which was eventually amputated.

Our court has been very protective of patients who are injured by or through the administration of medicine or drugs. Adverse drug reactions or complications should not make the physician strictly liable since the physician is neither a manufacturer nor a retailer. The complexity and sophistication of prescription drug selection negates the usefulness of strict liability. The foreseeability of adverse reactions to the drug is difficult to predict. Recovery must be based upon a showing by expert testimony that the prescription did not meet the standard of care.


Strict liability for defective products was recently adopted. Morningstar v. Black & Decker Mfg. Co., 253 S.E.2d 666, 680 (W. Va. 1979). In New Jersey, the court held that strict liability was not applicable to a dentist's professional service involving a defective product. Plaintiff was required to prove negligence. Magrine v. Spector, 100 N.J. Super. 223, 241 A.2d 637 (1968).

No expert was required by the court in Howell since the principal theory of recovery was abandonment rather than negligence. The physician must consider both intrinsic and extrinsic factors when selecting prescription medicines.

Not all reactions seemingly due to hypersensitivity are caused by factors intrinsic to the patient however. Dosage (by any route of administration), speed of injection, and site of injection can strongly influence the degree of unfavorable reaction manifested by a patient to a drug. Harmful effects of drugs can also be due to errors in prescriptions, failure clearly to explain...side effects or alternatives...choice of the wrong drug...and accidental ingestion or overdosage. (footnotes omitted).

B. Negligence by Omission

The classic case of negligent omission involved the woman who engaged the physician to sterilize her. Following the sterilization operation, she became pregnant. She sued the doctor by alleging that he was negligent in failing to perform as requested.

A physician may be liable for failing to diagnose a condition promptly or properly. Like acts of commission, malpractice by omission must be proven by expert testimony rather than lay conjecture. A plaintiff cannot prevent the physician from treating the condition and later charge the physician with malpractice for his failure to act.

Cases based on negligent omissions can arise when a physician fails to understand his limitations. Lack of communication and candor between physician and patient can also create legal liability. The safest course for a physician is to fully inform the patient and seek consultations with specialists where reasonable diagnostic doubt exists.

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74 Id.
75 Meadows v. McCullough, 101 W. Va. 103, 132 S.E. 194 (1926). A father removed his son from the defendant hospital and went to a second hospital where the son's bladder was catheterized. There was no expert testimony that such treatment should have been administered before the son's removal and, therefore, no malpractice.
76 The AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS §8 provides: "A physician should seek consultation upon request, in doubtful and difficult cases, or whenever it appears that the quality of medical service may be enhanced thereby."

If a non-specialist physician undertakes treatment in a field of medicine that requires specialized care and diagnosis, he is inviting trouble. If the treatment adopted will be of no benefit, the physician must inform the patient. Benson v. Dean, 232 N.Y. 52, 133 N.E. 125 (1921). The patient has the right to expect advice as to which other physicians are necessary and properly qualified to assist in the treatment. Batty v. Arizona State Dental Bd., 57 Ariz. 239, 254, 112 P.2d 870, 877 (1941); Manion v. Tweedy, 257 Minn. 59, 100 N.W.2d 124 (1959). See Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); Hagman, The Medical Patient's Right to Know: Report on a Medical-Legal-Ethical, Empirical Study, 17 U.C.L.A. L. Rev. 758, 815 (1970).
77 The failure to inform the patient of his condition and obtain consent for diagnostic tests or surgical procedures will be discussed infra. This theory of liability is known as informed consent.
C. *Res Ipsi Loquitur*

Literally translated, *res ipsa loquitur* means "the thing itself speaks." When applicable in West Virginia, this method of proving liability creates a rebuttable presumption of negligence.\(^6\)

Three criterion must be simultaneously present before the doctrine of *res ipsa loquitur* will apply in West Virginia: (1) the instrumentality which caused the injuries must have been under the exclusive control of the defendant; (2) the injury must be one which would not occur ordinarily in the absence of negligence; (3) the plaintiff must be totally without fault.\(^7\)

Tangible products, automobiles, electricity, and other such commodities are capable of being controlled exclusively. Experience permits informed judgments as to whether or not negligence involving such instrumentalities would occur in the ordinary course of events. This is not the situation with medical malpractice cases. The human body remains a mystery despite centuries of study. The success or failure of any medical treatment requires precise analysis of the individual patient's present condition, medical history, and responsiveness to available remedies. The same disease in two patients will often require different treatments.

The West Virginia Supreme Court of Appeals and the Court of Appeals for the Fourth Circuit, applying West Virginia law, have rejected, without exception, the use of *res ipsa loquitur* in medical malpractice cases.\(^8\) This is an appropriate position for our court to maintain because of the basic unfairness of permitting a plaintiff to show what appears to be an injury and letting that


\(^8\) Moore v. Guthrie Hosp., Inc., 403 F.2d 366 (4th Cir. 1968); Vaughan v. Memorial Hosp., 103 W. Va. 156, 136 S.E. 837 (1927); Vaughan v. Memorial Hosp., 100 W. Va. 290, 130 S.E. 481 (1925). See also Willigerod v. Sharafabadi, 161 W. Va. 995, 158 S.E.2d 175 (1967). For a cursory discussion examining the law of West Virginia regarding *res ipsa loquitur* and how it might apply to medical malpractice cases, see 70 W. Va. L. Rev. 471 (1968). The student author advocates a refinement of the *res ipsa loquitur* doctrine in West Virginia to permit its use in those instances where a physician leaves a foreign object inside the patient's body.
injury create a rebuttable presumption of negligence. As noted earlier, a bad result received in the course of medical treatment does not equal negligence. The potential prejudice to the defendant physician which is certain to follow the use of res ipsa in malpractice cases has been expressly noted and criticized by the Medical Malpractice Commission and commentators.

For a variety of reasons, and principally because of the alleged conspiracy of silence, res ipsa loquitur has become an increasingly important evidentiary device to plaintiffs' attorneys. During the period 1961-1971, 13.4% of all appellate malpractice cases involved res ipsa loquitur as an issue. Prior to 1950, only 6.3% of the appellate malpractice cases involved this doctrine.

There is no breakdown available from the Medical Malpractice Commission as to how many of these cases involved foreign objects left in the body. At first blush, it would seem difficult to dispute the applicability of res ipsa to foreign object cases. The three criteria would seem satisfied since the physician presumably has exclusive control of the foreign object; the plaintiff certainly would not be at fault in permitting the object to remain in his body; and the injury would not occur but for the carelessness of the physician and/or hospital staff in failing to do an accurate instrument count or sponge count. However, as a practical matter, the surgeon relies upon the surgical nurse to do the sponge count and the instrument nurse to do the instrument count. The exclusivity of control might not be vested in one person. There are five reported foreign object cases in West Virginia, three of which involved sponges.

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81 See note 64, supra.
82 Report, supra note 3, at 28-29. The commission expressed great concern over the expansion of the doctrine particularly in the state of California. This expansion has taken place by permitting the doctrine to apply to rare medical accident cases. Compare Seneris v. Haas, 45 Cal. 2d 811, 291 P.2d 915 (1955) and Cavero v. Franklin Gen. Benevolent Soc., 36 Cal. 2d 301, 223 P.2d 471 (1950) with Lambert v. Soltis, 422 Pa. 304, 221 A.2d 173 (1966) and Hale v. Heninger, 97 Idaho 414, 393 P.2d 718 (1964). This expansion is deplorable and was expressly rejected by the Medical Malpractice Commission. Other commentators have also strongly criticized the use of res ipsa loquitur in medical malpractice cases. See, e.g., Adamson, Medical Malpractice—Misuse of Res Ipsa Loquitur, 46 Minn. L. Rev. 1043 (1962); Binder, Res Ipsa Loquitur in Medical Malpractice, 17 CLEV.-MAR. L. Rev. 218 (1968); Hanson & Stromberg, Hospital Liability for Negligence, 21 Hast. L.J. 1 (1969).
83 Report, supra note 3, at 29.
84 Id.
85 Pickett v. Aglinsky, 110 F.2d 628 (4th Cir. 1940) (sponge); Hill v. Clarke, 241
Foreign object cases are susceptible to *res ipsa* usage if the lawyer prepares his case sufficiently to answer the "exclusivity of control" issue.

**D. Abandonment**

Among the non-negligence related bases of liability, abandonment is the easiest to prove for the malpractice victim. The most frequent fact pattern involves a case where a physician begins to treat a patient's disease and then leaves the community or the hospital at a time when the patient requires additional care.

The duty prescribed by law is that the doctor, after being employed, must treat the sickness or medical condition for its duration and that the physician-patient relationship continues unless it is terminated by mutual consent, or revoked by the express discharge of the physician by the patient or notice by the physician to the patient of his intention to discontinue treatment, without prejudice to the patient. Reasonable and ordinary care must be used in making the decision regarding the intention to discontinue treatment so that a replacement physician can be secured or other arrangements made.84

The grossest abandonment case in West Virginia jurisprudence is *Howell v. Biggart.*85 Mrs. Howell was informed by Dr. Biggart that she was in a rundown condition after a miscarriage and that she needed a tonic. The tonic was administered every other day for a period of approximately four weeks. This tonic was given intravenously in increasing quantities as the treatment progressed. The doctor encouraged the patient to "endure the spartan treatment" despite the fact that she was obviously ill with intermittent fever, chilling, vomiting, and a rash. In addition, her finger and toe nails fell off and her body was raw for several days as if she suffered from a severe burn. In the midst of all this, Dr. Biggart left the community without any notice to Mrs. Howell. The outrage of the West Virginia Court at this conduct is manifested by the fact that it did not require the use of expert testimony to present a case for the jury. Two other West Virginia cases regarding abandonment

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84 Lawson v. Conaway, 37 W. Va. 159, 16 S.E. 564 (1892).

present equally stark fact patterns.\textsuperscript{88}

It is not a defense for a doctor to be unavailable to his patient because he is treating other patients.\textsuperscript{89} Moreover, the availability of other physicians to take care of a patient will not relieve the defendant doctor of liability for abandonment unless he made prior arrangements for such substitute care and informed the patient of the identity of the substitute.\textsuperscript{90}

Liability based upon abandonment still requires that the plaintiff sustain his burden of proof by showing that the injury was proximately caused by the absence of the physician at the time and place in question. This includes the necessity of expert testimony on the issue of causation. In \textit{Browning v. Hoffman},\textsuperscript{91} liability based upon abandonment was rejected by the court because of the absence of proof that the physician’s presence would have changed the result and by proof that the physician left a competent assistant monitoring the patient’s care as well as adequate instructions for the nursing staff on duty. Thus, while abandonment is easier to prove than many other malpractice theories, it is still tightly monitored by the proximate cause requirement.

The court obviously understands the realities of medical practice; one physician cannot be available at all times to all of his patients. Group practice and coverage arrangements are common among all practicing physicians. In essence, the duty of care owed by the original physician can be delegated so long as the substitute physician is competent and has adequate information to treat the patient in the event of an emergency. This duty can also be delegated to a nursing staff for short periods of time when competent physicians are available for consultation.

\textsuperscript{88} Young v. Jordan, 106 W. Va. 139, 145 S.E. 41 (1928). In \textit{Young}, the court held that once an obstetrician gives a pregnant woman drugs to induce labor, he has an absolute duty to stay with her until delivery is accomplished. \textit{See also Buskirk v. Bucklew}, 115 W. Va. 424, 176 S.E. 603 (1934). This case mixes the theories of special contract, abandonment, and gross negligence in the use of x-ray therapy. Following severe burns of the arm, the doctor advised her not to return for additional treatment or care since he was going to Baltimore. She was compelled to seek other medical care.

\textsuperscript{89} This broad statement is made in Young v. Jordan, 106 W. Va. 139, 145 S.E. 41 (1928) in the context of an impending pregnancy. It is doubtful that this would be an absolute rule.


\textsuperscript{91} 90 W. Va. 568, 111 S.E. 492 (1922).
In *Maxwell v. Howell*, the court recognized that temporary abandonment or neglect can constitute a deviation from the standard of care and can be actionable. In that case, there was proof that the operating surgeon neglected to visit the patient post-operatively for as many as five days at one time and eight days at another. The court required expert testimony that the failure of the doctor to visit the patient deviated from the standard of care and proximately resulted in harm to the patient.

*Maxwell* is the most recent of the abandonment cases decided in West Virginia and reinforces the view that abandonment must be proved by expert testimony. The court implicitly recognizes a sliding scale of responsibility from the physician to the patient depending upon the physical condition of the patient and the length of the absence.

E. Informed Consent

The most fundamental right of every person in this society is that of determining what shall be done with his body. The common law and the First Amendment to the United States Constitution have afforded protection to the individual's right of self-determination regarding his body.

Surgery has always been recognized as an accepted and necessary medical procedure. Surgery necessarily involves intervention of the body cavity. Thus, the common law has developed a doctrine known as informed consent which requires that a physician obtain the consent of the patient prior to any disturbance of the physical security and integrity of the body. West Virginia recognizes this principle.

In *Browning II*, the language of the court is dictum since there was no informed consent issue raised. However, the strength of the court's pronouncement on informed consent would indicate that West Virginia is in accord with the majority of jurisdictions. "Except in very extreme cases, a surgeon has no legal right to operate upon a patient without his consent, nor upon a child without the consent of its parent or guardian."

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114 W. Va. 771, 174 S.E. 553 (1934).

id. at 581, 111 S.E. at 497.
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The emergency exception carved out in *Browning II* is necessary and consistent with good medical practice. In those circumstances where the patient is unable to give consent and delay will cause irreversible consequences, the physician must be permitted to act without fear of reprisal.96

One of the critical issues in most informed consent cases involves the scope of the disclosure rather than the absence of consent.97 Most courts have been hesitant to set specific disclosure requirements and have opted instead for a balancing test since all medical procedures have an inherent risk of failure.98 Each proce-

96 Jackovach v. Yocum, 212 Iowa 914, 237 N.W. 444 (1931) (plaintiff, a minor, was injured as a result of a fall from a freight train; defendant physician amputated his arm without parental consent after unsuccessful efforts were made to locate the parents for the purpose of obtaining consent); Wells v. McGehee, 39 So. 2d 196 (La. App. 1949) (plaintiff, a minor, sustained a wrist fracture and was taken to defendant's medical office for treatment; she was anesthetized with chloroform and death ensued within five minutes; search for parents to obtain consent was described as half-hearted; defendant was held not liable on the grounds of emergency).

97 Louisell and Williams suggest that comprehensive informed consent, where circumstances permit, should include the following: "(1) the diagnosis, (2) the general nature of the contemplated procedure, (3) the risks involved, (4) the prospects of success, (5) the prognosis if the procedure is not performed and (6) alternative methods of treatment, if any." D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE §22.01 (1977).

98 For example, a balanced approach was originally adopted by a California District Court of Appeal in Salgo v. Leland Stanford Junior Univ. Bd. of Trustees, 164 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957):

A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact a minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.
dure is unique to the extent that the risk of failure or adverse result fluctuates, depending on the physical condition of the patient.

The consent obtained is only as effective as the ability of the physician to establish that it was actually "informed." The physician's explanation of the procedure must be in such words and phrases that the patient can intellectually grasp what is being said. For example, a patient who signed a consent for the performance of a mastectomy, but did not understand that this meant removal of her breast, successfully asserted a claim for lack of informed consent.39

Liability arising from a surgical procedure where informed consent is missing presents the plaintiff with one of two available theories of recovery: battery or negligence.100

Even though informed consent is a non-negligence based theory of recovery, the plaintiff must sustain his burden of proof that the injury proximately resulted from the failure of the physician to inform the patient properly and obtain consent for the medical procedure. There is a subjective decision that a patient must make regarding whether or not to undergo a particular medical procedure. However, it would be patently unfair to permit an obviously disgruntled patient to sustain his burden of proof on informed consent by merely testifying that he would not have undergone the treatment had he been advised of all the risks. The patient's testimony can certainly be considered by the jury, but it is never conclusive.

California has abandoned this balanced approach for the ultra-liberal patient-focused standard which requires disclosure of all risks which would be material to the patient's decision.


100 Battery is appropriate where a physician obtains no consent or obtains a consent for the performance of a particular procedure but performs a different procedure for which consent was not obtained. See, e.g., Zoterell v. Repp, 187 Mich. 319, 153 N.W. 692 (1915) (consent for a hernia operation but physician also removed both ovaries); Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905) (consent for operation on right ear and physician operated on the left ear); Darrah v. Kite, 32 App. Div. 2d 208, 301 N.Y.S.2d 286 (1969) (consent for routine brain test and a complete workup but no consent for a ventriculogram which necessitated the drilling of holes in the head of a nine year old child).

Negligence is the appropriate theory when injury results due to an undisclosed risk inherent in the procedure. See, e.g., Salgo v. Leland Stanford Junior Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957) (paralysis of lower extremities following an aortographic examination); Aiken v. Clary, 396 S.W.2d 668 (Mo. 1965) (brain damage following insulin shock therapy).
For that reason, proof of the standard of care regarding the extent of disclosure necessary to "inform" can be accomplished three ways. The first system, and the one probably applicable in West Virginia, establishes the duty of the physician by the ordinary and reasonable disclosure practices of the average physician practicing in the same field in the same or similar communities. The plaintiff must establish both the customary disclosure practices and the physician's deviation by the use of expert testimony.

The second system discards the locality rule in favor of measuring the standard of care by what a reasonable physician would disclose under the same or similar circumstances. This system would substitute a national standard of reasonable and ordinary care for the traditional locality standard.

The third approach focuses upon the patient's state of mind rather than the mind of the physician. This system holds that the duty of the physician will be measured by the patient's need for information which is material to the patient's decision whether or not to accept or reject the proposed treatment. This minority approach developed because of a dissatisfaction with granting unlimited discretion to physicians as to what information to disclose.

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As many as ten exceptions or defenses are available to the requirement of informed consent. These defenses include "but for situations,"104 "unexpected risks,"105 "ignorance is bliss,"106 "emergencies,"107 "peace of mind,"108 "commonly known dangers,"109 "discovered dangers,"110 "non-material dangers,"111 "improper performance of a proper procedure,"112 and "extreme rarity of a non-serious risk."113

West Virginia’s development of the law of informed consent should follow our traditional formula of evaluating the physician’s disclosure requirement by the standards of his community or a similar community.

F. Vicarious Liability

A physician is liable for injuries proximately caused by his negligence and the negligence of his partners and employees.114 The

109 Butler v. Berkeley, 25 N.C. App. 325, 213 S.E.2d 571 (1975) (the physician has no obligation to communicate commonly known dangers such as infection when the patient is of average sophistication and should be aware of the risks).
110 Id.
111 Id.
112 Mallett v. Pirkey, 171 Colo. 271, 466 P.2d 466 (1970) (the physician does not have a duty to disclose the risks of his negligence in performing the medical procedure for which consent has been obtained).
114 West Virginia has adopted the Uniform Partnership Act which provides: Where, by any wrongful act or omissions of any partner acting in the ordinary course of the business of the partnership or with the authority of its co-partners, loss or injury is caused to any person, not being a partner in the partnership, or any penalty is incurred, the partnership is liable therefor to the same extent as the partner so acting or omitting the act.
context of vicarious liability usually arises where numerous physicians and/or hospital personnel have been involved in the diagnostic or treatment phase of the patient’s care. Most plaintiff’s attorneys choose to file “shotgun” actions which name every doctor or hospital that has been involved in the case and effectively shift the pre-trial burden to each defendant to prove that he is not responsible for the alleged negligence. This “weeding out” of defendants usually involves substantial discovery.

Recently, physicians have begun to engage in non-traditional business forms of medical practice. For example, partnerships are not being formed as readily as they were in the past since the present trend favors office-sharing arrangements or medical clinics. In either situation, an individual physician will rent office space and maintain his own patients but share in the common expense of communal services such as reception, secretarial, accounting, and administration.15 These arrangements should not form any legal basis for suit against a non-treating physician who happens to also practice in the medical office or clinic.

Some debate exists in the trial courts of West Virginia regarding the scope and effect of the Medical Corporation Act.16 Prior to

W. Va. Code § 47-8A 13 (1976 Replacement Vol.). It is axiomatic that a physician would be liable for the torts of his employee based on agency principles.

15 See Graddy v. New York Medical College, 19 App. Div. 2d 426, 243 N.Y.S.2d 940 (1963). In this case, a patient came into the care of Dr. Edward Bell, an otolaryngologist, who shared one medical office complete with secretary, professional equipment, and office supplies with a second physician, Dr. Alvin M. Street. The plaintiff was originally the patient of Dr. Street but came under the care of Dr. Bell exclusively prior to the alleged negligence. Graddy sued both doctors. Dr. Street was held vicariously liable at trial. The appellate court reversed, holding that where there is neither legal nor actual control of the treating physician by another physician, the mere relationship of sharing office space or an agreement to service each others’ patients will not create vicarious liability.

16 W. Va. Code § 30-3-4c (1976 Replacement Vol.) provides in relevant part: A medical corporation may practice medicine and surgery only through individual physicians and surgeons duly licensed to practice medicine or surgery in the State of West Virginia, but such physicians and surgeons may be employees rather than shareholders of such corporation, and nothing herein contained shall be construed to require a license for or other legal authorization of any individual employed by such corporation to perform services for which no license or other legal authorization is otherwise required. Nothing contained in this article is meant or intended to change in any way the rights, duties, privileges, responsibilities and liabilities incident to the physician-patient relationship nor is it meant
its enactment, the law was clear that a non-treating physician could be held vicariously liable only if he was in a legal partnership subject to the Uniform Partnership Act.\textsuperscript{17} It would seem equally consistent that the Medical Corporation Act would insulate a physician who is merely a shareholder or employee of a medical corporation from vicarious liability when he did not personally treat or otherwise affect the health care rendered to that patient. The language of the statute is consistent with this interpretation.

West Virginia has never adopted the "Captain of the Ship" doctrine which holds an operating surgeon liable for the negligence of all participants in the surgical arena.\textsuperscript{18} The Captain of the Ship doctrine is basically unfair in its attempt to make the physician the watchdog of persons beyond his control. For example, a physician normally does not control the work of the anesthesiologist or anesthetist in the surgical procedure. However, in West Virginia, a modified Captain of the Ship doctrine may exist when an anesthetist is administering anesthesia and the surgeon is the only medical doctor present.\textsuperscript{19}

\textsuperscript{17} W. VA. Code § 47-8A-1 to 45 (1976 Replacement Vol.).


\textsuperscript{19} An anesthesiologist is a medical doctor who is generally certified by a national examination as a specialist in the administration and treatment of anesthesia-related cases. An anesthetist is a nurse who has received specialized training and is licensed by the State of West Virginia as an anesthetist.

In the four or five largest cities in West Virginia, there is a shortage of anesthesiologists. Thus, nurse anesthetists are employed to administer the anesthesia. The nurse anesthetists are the ones actually in surgery and the anesthesiologists are generally on call at the hospital in case of emergency. In these circumstances, the anesthetist theoretically is subject to the control of the operating surgeon and the operating surgeon may be responsible for the negligence of the anesthetist. W. VA. Code § 30-7-15 (1976 Replacement Vol.) provides:

In any case where it is lawful for a duly licensed physician or dentist practicing medicine or dentistry under the laws of this State to administer anesthetics, such anesthetics may lawfully be given and administered by any person (a) who has been licensed to practice registered professional nursing under this article, and (b) who holds a diploma or certificate evidencing his or her successful completion of the educational program of a school of anesthesia duly accredited by the American association of nurse anesthetists: Provided, that such anesthesia is administered by such person in the presence and under the supervision of such physician or dentist.

In most rural West Virginia hospitals, no anesthesiologist is available. The operating surgeon will be responsible for supervising the anesthetist.
An additional vicarious liability situation exists in West Virginia. Hospitals are vicariously liable for the acts and omissions of their agents, servants, or employees.\textsuperscript{120} For many years, our court created a legal fiction to avoid charitable immunity which permitted liability only upon a showing that the charitable hospital negligently employed incompetent persons.\textsuperscript{121}

The law of vicarious liability is very broad. West Virginia's exposure to this doctrine has been limited in medical malpractice cases. The public policy reasons for spreading the risk among as many financially responsible individuals as possible are appropriate when the individuals charged have the capability of preventing the negligence. However, West Virginia should be very cautious in extending vicarious liability too far. For example, the adoption of a rule which makes a hospital vicariously liable for the torts of the independent contractor physicians utilizing the hospital would be destructive to the health care system.\textsuperscript{122}

IV. DEFENSES

Medical malpractice cases are not exempt from the standard common law defenses available in any negligence action. With the adoption of comparative negligence, a plaintiff cannot recover if his negligence is equal to or greater than the combined negligence of the defendants.\textsuperscript{123}

A. Contributory Negligence

Contributory negligence has always been a defense in medical malpractice cases.\textsuperscript{124} However, the court has confused the concept


\textsuperscript{121} The first case discussing this legal fiction was Roberts v. Ohio Valley Gen. Hosp., 98 W. Va. 476, 127 S.E. 318 (1925). Legal fiction may be a harsh description, but it certainly seems that our court imposed it as a pretext so that charitable hospitals would not be absolutely immune. Of course, charitable immunity has been abolished. Adkins v. St. Francis Hosp., 149 W. Va. 705, 143 S.E.2d 154 (1965).

\textsuperscript{122} The historic case of Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965) held that a hospital has a duty to supervise the physicians who practice therein. A few jurisdictions have followed the lead of Darling, but most have wisely rejected its thesis as unworkable and unrealistic.


\textsuperscript{124} Lawson v. Conaway, 37 W. Va. 159, 16 S.E. 564 (1892).
of contributory negligence with the concept of mitigation of damages.\textsuperscript{125}

The nature of medical malpractice cases generally precludes actual contributory negligence by the plaintiff since the patient is generally being acted upon by the physician. Subsequent conduct which should reduce any award to a plaintiff would include failure to continue prescribed treatment, failure to take prescribed drugs, or failure to submit to corrective procedures designed to undo the original malpractice.\textsuperscript{128}

\textbf{B. Assumption of Risk}

The West Virginia Court has not addressed assumption of risk in a medical malpractice situation. Examples of the application of the doctrine include situations where the plaintiff knew that the physician was incompetent or that the course of treatment de-

\textsuperscript{125} Jenkins v. Charleston Gen. Hosp. & Training School, 90 W. Va. 230, 110 S.E. 560 (1922). In that case, the court stated:.manifestly the plaintiff was guilty of contributory negligence, as matter of law, but not until after the negligence of the defendant had inflicted some injury upon him. The original negligence, committed within the period of employment continuing until the plaintiff's negligence occurred, was the detriment suffered between the dates of the two acts of negligence. In other words, the proximate cause of the injury complained of was nontreatment. In the first instance non-treatment was imputable to the defendant alone and later, to both it and the defendant. . . .

No effort was made in the course of the trial to apply the legal principle requiring apportionment or limitation of damages in conformity with the bases of liability, as here defined. In attempting to prove his case the plaintiff imputed all of the injury and damages to the defendant, notwithstanding the obvious lack of right to recover for so much of the damages as were occasioned by the combined negligence of both, if apportionment thereof by the jury was possible. Nor was the attention of the jury directed to their power and duty to make the apportionment, if practicable, and limit their verdict to the damages accrued before the date of the plaintiff's contribution to the negligence of the defendant. If a proper inquiry had been made, it might had been shown that the effect of the defendant's negligence was slight and of little consequence, and that substantially all of the injury complained of was the result of the concurrent negligence.

\textit{Id}. at 243-44, 110 S.E. at 565-66.

\textsuperscript{128} Thackery v. Helfrich, 123 Ohio St. 334, 175 N.E. 449 (1931) (plaintiff refused to submit to corrective surgery designed to remedy a faulty union of bone fragments following the original negligent treatment).
viated from the standard of care and, notwithstanding this knowledge, plaintiff continued in the care of the physician.\textsuperscript{127}

C. Emergencies

The only other substantive defense is emergency. West Virginia has implicitly recognized this defense by dictum in \textit{Foster v. Memorial Hospital Association of Charleston}.\textsuperscript{128} West Virginia would, in the appropriate case, certainly embrace the concept of emergency as a complete defense to a claim of no informed consent.

D. Statute of Limitations

Medical malpractice cases have reshaped the heretofore clear and unambiguous language of West Virginia's statute of limitations.\textsuperscript{129} Prior to 1965, the Supreme Court of Appeals had held that the statute of limitations began to run in a medical malpractice case at the time of the alleged negligence "in the absence of actual knowledge, fraud, or concealment on the part of the defendant."\textsuperscript{130} Moreover, the physician's silence was held not to constitute fraud which would toll the running of the statute.\textsuperscript{131}

However, these cases have been expressly overruled by

\textsuperscript{127} See, e.g., Champs v. Stone, 74 Ohio App. 344, 58 N.E.2d 803 (1944); Gramm v. Boener, 56 Ind. 497 (1877); Kirschner v. Keller, 70 Ohio App. 111, 42 N.E.2d 463 (1942).

\textsuperscript{128} 219 S.E.2d 916, 921 (W. Va. 1975). In discussing an emergency situation regarding blood donors and blood supply, the court suggested that the standard of care will be adjusted in an emergency situation.

Obviously under circumstances such as this the degree of "reasonable care" necessary to protect the hospital from liability must be lower than in other circumstances because the exigencies of the situation demand speed, and the time necessary for the performance of tests is not available. Otherwise the hospital leaves the healing business and enters the insurance business.

Similarly, while the giving of inherently dangerous experimental drugs may be 'reasonable' in a 'last-ditch' effort to save a patient who would inevitably die in spite of all known treatment, the giving of the same drugs to a mildly ill patient who could be cured by more conservative procedures is far less 'reasonable'. An action in tort against the doctor would test the reasonable care in the doctor's over-all treatment in fact situations such as these.

\textsuperscript{129} W. Va. Code § 55-2-12 (1956).

\textsuperscript{130} Gray v. Wright, 142 W. Va. 490, 500, 96 S.E.2d 671, 676 (1957).

\textsuperscript{131} Baker v. Hendrix, 126 W. Va. 37, 27 S.E.2d 275 (1943).
Morgan v. Grace Hospital, Inc. Morgan introduced the "discovery rule" which holds that the statute of limitations does not begin to run until the patient either learns of the negligence or by the exercise of reasonable diligence should have learned of it.

The issue of plaintiff's actual knowledge or constructive knowledge of the defendant's negligence is one of fact, not law, and, therefore, must be resolved by the jury.

E. Hospital Immunity and Liability

There is no longer any distinction in West Virginia between the liability of a private (for profit) hospital and a charitable hospital. Both are vicariously liable for the negligence of their employees under the doctrine of respondeat superior. Hospitals may be liable for injuries which proximately result from the negligence of a nurse, an intern, or a staff radiologist.

In West Virginia jurisprudence, better than 85% of all the appellate malpractice cases involve claims arising at a hospital. Thus, the exposure of a hospital to claims is significant. Many of these claims involved alleged tortious conduct by independent contractor physicians. West Virginia generally recognizes the rule that a hospital is not liable for the torts of an independent contractor. Hospitals can also be guilty of primary negligence when they fail to observe the proper standard of care in the selection of competent employees.

There have been a number of direct negligence suits against

132 149 W. Va. 783, 144 S.E.2d 156 (1965).
134 Id. at 573. See also: Annot., 70 A.L.R.3d 7 (1976).
139 Vaughan v. Memorial Hosp., 100 W. Va. 290, 130 S.E. 481 (1925) (dicta).
hospitals for maintaining unsafe premises.\textsuperscript{141} The duty of care which a hospital owes to a patient for maintaining a safe environment is very important since many patients have impaired capacity due to their sickness or medications.\textsuperscript{142}

Governmental immunity for certain hospitals may persist in West Virginia.\textsuperscript{143} Yet, the doctrine of immunity is not absolute. A public institution may plead the defense of sovereign immunity if it can establish that its function is "governmental" rather than "proprietary."\textsuperscript{144} A rebuttable presumption exists that governmental bodies do act in their "governmental" capacity.\textsuperscript{145} Shaffer appears to be a shaky but existing precedent for public hospital immunity. The definition of public hospital appears to be limited to West Virginia State Hospitals and those wholly owned and operated by a county.\textsuperscript{146}

**CONCLUSION**

The law of medical malpractice in West Virginia has developed slowly and, in general, consistently. The new horizon of informed consent remains uncharted. The wisdom and necessity of the expert witness rule is firmly entrenched. Yet, there is an uneasiness in some quarters regarding our system of resolving medical malpractice cases.

Mandatory arbitration statutes have risen and fallen and risen again across the country. Statutory limitations on verdicts have generally proved to be unconstitutional.

The concern to be addressed is the protection of the injured patient’s rights without a premature destruction of the medical doctor’s career. The stigma of being sued for malpractice is real. Like an indictment, a malpractice suit publicized in a newspaper can have dire consequences.

\begin{footnotes}
\item[142] Hogan v. Clarksburg Hosp., 63 W. Va. 84, 59 S.E. 943 (1907).
\item[146] W. Va. Const. art. 6, § 35; Boggs v. Board of Educ., 244 S.E.2d 799 (W. Va. 1978).
\end{footnotes}
The frequency of malpractice cases being filed without benefit of a prelitigation expert report in support of the plaintiff's claim is appalling. Our courts have responded correctly to this situation by granting summary judgment to defendants unless the plaintiff can produce an expert witness within a reasonable time after the filing of the suit and opportunity for discovery.

There is no call for limiting the access of alleged malpractice victims to the courts of this state. On the contrary, the purpose and thrust of this article has been to synthesize the law of malpractice in West Virginia. Hopefully, doctors will not be sued unless there is probable cause to believe that they were negligent and lawyers will not take medical malpractice cases without a legitimate belief that a successful verdict can be obtained as the development and trial of a medical malpractice case is a very expensive proposition both in terms of money advanced for expert opinions and legal time.

The legal profession owes it to itself to eliminate the unfounded suits against physicians, to prosecute meritorious claims against physicians, and to develop a system of continuing legal education or specialization to achieve these goals. West Virginia is capable of developing a legal education program which will create malpractice specialists statewide who can competently evaluate, prepare, and try medical malpractice cases. This must be our commitment.