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Virginia Abolishes Locality Rule in Medical Malpractice

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VIRGINIA ABOLISHES LOCALITY RULE IN MEDICAL MALPRACTICE

The Virginia General Assembly, in recognition of a modern medical society, has abolished[1] the presumption which favors the application of a "same or similar"[2] locale standard to determine the requisite care of a health care provider.[3] The "same or similar" standard has been used consistently since 1918[4] in malpractice litigation and, more recently, in proceedings before the medical malpractice review panels in Virginia.[5] This standard was first adopted by statute in 1977,[6] and though it appeared to intend a broader

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1. VA. CODE ANN. § 8.01-581.20 (Cum. Supp. 1979) states as follows:

   A. In any proceeding before a medical malpractice review panel or in any action against a physician, dentist, nurse, hospital or other health care provider to recover damages alleged to have been caused by medical malpractice where the acts or omissions so complained of are alleged to have occurred in this Commonwealth, the standard of care by which the acts of omissions are to be judged shall be that degree of skill and diligence practiced by a reasonably prudent practitioner in the field of practice or specialty in this Commonwealth and the testimony of an expert witness, otherwise qualified, as to such standard of care, shall be admitted, provided, however, that the standard of care in the locality or in similar localities in which the alleged act or omission occurred shall be applied if any party shall prove by a preponderance of the evidence that the health care services and health care facilities available in the locality and the customary practices in such locality or similar localities give rise to a standard of care which is more appropriate than a Statewide standard.

   B. In any action for damages resulting from medical malpractice, any issue as to the standard of care to be applied shall be determined by the jury, or the court trying the case without a jury.

2. *See* notes 13-24 *infra,* and accompanying text.

3. Defined as:

   1. *'Health care provider'* means a person, corporation, facility or institution licensed by this Commonwealth to provide health care or professional services as a physician or hospital, dentist, pharmacist, registered or licensed practical nurse, optometrist, podiatrist, chiropractor, physical therapist, physical therapy assistant, clinical psychologist or a nursing home as defined in § 54-900 of the Code of Virginia except those nursing institutions conducted by and for those who rely upon treatment by spiritual means alone through prayer in accordance with a recognized church or religious denomination, or an officer, employee or agent thereof acting in the course and scope of his employment.

VA. CODE ANN. § 8.01-581.1 (Repl. Vol. 1977).

4. Hunter v. Burroughs, 123 Va. 113, 96 S.E. 360 (1918).

5. VA. CODE ANN. §§ 8.01-581.1 *et seq.* (Repl. Vol. 1977). For an excellent discussion of the medical review board legislation, *see* Harlan, *Virginia's New Medical Malpractice Review Panel and Some Questions It Raises,* 11 U. RICH. L. REV. 51 (1976).

6. VA. CODE ANN. § 8.01-581.12:1 (Repl. Vol. 1977) (repealed by enactment of VA. CODE ANN. § 8.01-581.20 (Cum. Supp. 1979)).

standard than the local standard,[7] it was in fact interpreted as a clear statutory adoption of the Virginia case law rule.[8] The new statute, repealing the 1977 statute, adopts the statewide standard of care[9] as the presumption which now can only be rebutted by a "preponderance of the evidence"[10] that, in consideration of local customs and practice, another standard would be "more appropriate."[11]

In medical malpractice litigation, expert testimony is required concerning the applicable standard of care.[12] The Virginia Supreme Court, in 1918, defined what was to become the test for that particular standard. In *Hunter v. Burroughs,*[13] the court adopted the defendant's contention that the standard to be applied was that of "like specialists in good standing in the same or similar localities as

7. The 1977 statute could have been read as rejecting the presumption calling for the local rule but, in reality, the use of the local rule was inevitable.

> In any action against a physician, dentist, nurse, hospital or other health care provider to recover damages alleged to have been caused by medical malpractice where the acts or omissions so complained of are alleged to have occurred in this Commonwealth, the standard of care by which the acts or omissions are to be judged shall be that degree of skill and diligence practiced by a reasonably prudent practitioner in the field of practice or specialty in this Commonwealth; provided, however, that the standard of care in the locality or in similar localities in which the alleged act or omission occurred may be applied if, after considering the health care services and health care facilities available in such locality and the customary practice in such locality or other similar localities, it is determined that the local standard of care is more appropriate than a statewide standard.

VA. CODE ANN. § 8.01-581.12:1 (Repl. Vol. 1977).

8. *See* 11 U. RICH. L. REV., *supra* at 54.

9. VA. CODE ANN. § 8.01-581.20 (Cum. Supp. 1979).

10. Defined in Virginia case law as follows:

> The weight or preponderance of evidence is its power to convince the tribunal which has the determination of the fact, of the actual truth of the proposition to be proved. After the evidence has been weighed, that proposition is proved by a preponderance of the evidence if it is made to appear more likely or probable in the sense that actual belief in its truth, derived from the evidence, exists in the mind or minds of the tribunal, not withstanding any doubts that may still linger there.

Northern Virginia Power Co. v. Bailey, 194 Va. 464, 471, 73 S.E.2d 425 (1952) (quoting Sargent v. Massachusetts Accident Co., 307 Mass. 246, 29 N.E.2d 825, 827 (1940)).

11. VA. CODE ANN. § 8.01-581.20 (Cum. Supp. 1979).

12. Reed v. Church, 175 Va. 284, 298, 8 S.E.2d 285, 288 (1940) (citing Hunter v. Burroughs, 123 Va. 113, 96 S.E. 360 (1918)). *See also* Morgan v. Schlanger, 374 F.2d 235 (4th Cir. 1967). For an example of expert testimony and instructions in applying the locality rule, see Carroll v. Richardson, 201 Va. 157, 160-63, 110 S.E.2d 193, 194-97 (1959).

13. 123 Va. 113, 96 S.E. 360 (1918).

[the] defendant."[14] Although the word "specialists" was used in the *Hunter* test, it was not clear until 1924, in *Fox v. Mason*,[15] that the local rule would be the same with regard to specialists.[16] Courts subsequently applied the rule to dentists,[17] psychiatrists,[18] anesthesiologists,[19] and gynecologists.[20] The local standard has evolved into a more clearly defined model over the past century of use. It is clear today that a doctor "impliedly represents that he is keeping abreast of the [latest] literature"[21] and that the quality of his care will be judged as to the "state of medical science at the time."[22] An exception to the rule has been the "school of practice" limitation, which has allowed the particular defendant who adopts a defined theory to be judged only according to the standards applicable to that particular philosophy.[23] The general rule, however, is that stated in *Hunter*, meaning that a doctor cannot be found guilty of malpractice without expert testimony given by a doctor with a similar practice and from the same or a similar community. This standard has also been employed by federal courts when applying Virginia law.[24]

The locality rule was developed when communication within the medical community was very limited. The immediate access to newly published medical journals was restricted primarily to medical personnel in large, urban areas.[25] The quest for protection of

14. *Id.* at 131, 96 S.E. at 366.

15. 139 Va. 667, 124 S.E. 405 (1924), *overruled on other grounds*, 160 Va. 303, 168 S.E. 353 (1933).

16. *Id.* at 671, 124 S.E. at 406.

17. Alexander v. Hill, 174 Va. 248, 6 S.E.2d 661 (1940); United Dentists v. Bryan, 158 Va. 880, 164 S.E. 554 (1932).

18. White v. United States, 244 F. Supp. 127 (E.D. Va. 1965).

19. Whitfield v. Whittaker Mem. Hosp., 210 Va. 176, 169 S.E.2d 563 (1969).

20. Varga v. United States, 314 F. Supp. 671 (E.D. Va. 1969), *aff'd* 422 F.2d 1333 (4th Cir. 1970); Bly v. Rhoads, 216 Va. 645, 222 S.E.2d 783 (1976).

21. Reed v. Church, *supra* at 292, 8 S.E.2d at 288. *See also* Hall v. Ferry, 235 F. Supp. 821, 826-27 (E.D. Va. 1969).

22. Alexander v. Hill, *supra* at 252, 6 S.E.2d at 663.

23. "[A] physician who subscribes to a particular theory, albeit a minority one, will generally be tested against the standards applicable to good practice within that theory." Shepherd, *The Law of Medical Malpractice in Virginia*, 21 W. & L. L. REV. 212, 218-19 (1964) (citing Reed v. Church, 175 Va. 284, 8 S.E.2d 285 (1940)).

24. *See* Clark v. United States, 402 F.2d 950 (4th Cir. 1968); Hicks v. United States, 368 F.2d 626 (4th Cir. 1966); Lawrence v. Nutter, 203 F.2d 540 (4th Cir. 1953); Hall v. Ferry, 235 F. Supp. 821 (E.D. Va. 1969); Trueman v. United States, 180 F. Supp. 172 (E.D. La. 1960).

25. *Medical Malpractice—Status of the Locality Rule*, 23 DEF. L.J. 178, 181 (1974).

rural doctors, in light of the great need for their services led to the rule's development. Some authorities contend, perhaps with some justification, that rural communities attract lower caliber physicians, with less training and experience.[26] In Virginia courts, though, the general justification is that the care and skill required is directly related to the conditions surrounding the particular treatment. "Due care in a lumber camp might be gross negligence at Johns Hopkins."[27] Despite the advent of modern transportation and communication systems, it is not inconceivable that a doctor in a remote part of Virginia may not have access to sophisticated and extremely expensive equipment that is common place in metropolitan areas.[28] The Virginia Supreme Court, in more recent cases, acknowledged that the reasons for the locality rule are outdated, but indicated that a long tradition of acceptance and reliance justified its continued recognition.[29] Though the local standard was never seriously questioned, in practice it has led to some inconsistent results.[30] The courts have consistently invalidated testimony by out-of-state experts[31] while applying a similar locality standard which has ranged from what appears to be a national,[32] or large regional area,[33] to a truly local standard.

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26. 40 FORDHAM L. REV. 435, 438 (1971) (citing Small v. Howard, 128 Mass. 131, 136 (1880), *overruled by* Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968)).

27. Fox v. Mason, *supra* at 671, 124 S.E. at 406.

28. *See generally* 23 DEF. L.J., *supra* at 185.

29. The Virginia 'same or similar community' standard is imbedded in the jurisprudential law of this Commonwealth; it has been long relied upon by lower courts, the legal and medical professions, and the public. If for no other reason, we reject the challenge for change because basic concepts of *stare decisis* dictate maintenance of the established law.

Bly v. Rhoads, 216 Va. 645, 652, 222 S.E.2d 783, 789 (1976). For a case showing Virginia's strict adherence to the local rule in a separate area, see Price v. Commonwealth, 214 Va. 490, 201 S.E.2d 798 (1974), *cert. den.* 419 U.S. 902 (1974) (applying a local standard for obscenity).

30. In a 1948 case, the Virginia Supreme Court upheld a doctor's conviction based upon a general practitioner's testimony, in which he acknowledged inexperience in the questioned area; even though an eminent surgeon testified favorably for the defendant. This result effectuated a vigorous dissent. Vann v. Harden, 187 Va. 555, 47 S.E.2d 314 (1948).

31. It appears extremely difficult for an out-of-state expert to prove that his community is "similar" to the defendant's without having practiced in the defendant's own community. *See generally* Little v. Cross, 217 Va. 71, 225 S.E.2d 387 (1976); Bly v. Rhoads, 216 Va. 645, 222 S.E.2d 783 (1976).

32. *See* Whitfield v. Whittaker Mem. Hosp., 210 Va. 176, 180, 169 S.E.2d 563, 566 (1969). The standard applied was considered the standard applicable "in any community."

33. *See* Carroll v. Richardson, 201 Va. 157, 110 S.E.2d 193 (1959) (Tidewater area).

The substantial change in society since the innovation of the rule has been recognized by the Virginia court, but the court felt that any major change in such a well-established rule "should not be accomplished by the mere brush of the judicial pen."[34] Today, medical journals are widely circulated and every doctor is expected to subscribe to his particular specialty's publications.[35] With the abundance of modern transportation, a doctor may easily attend any number of the seminars put on by medical societies throughout the country.[36] Medical schools are now required to have standardized curricula and the licensing of medical personnel is similarly standardized,[37] making it less likely that a doctor in a rural area would have lesser skills or qualifications than his counterpart in the metropolitan area. Moreover the medical profession, through research, discovers new medications and techniques requiring an ever increasing educational burden upon all physicians to remain informed.[38]

The local standard has generated its own peculiar problems. There has been, and will continue to be, a "notorious unwillingness" by doctors to testify in a proceeding against a fellow doctor.[39] This situation has been termed the "conspiracy of silence."[40] The obvious peer pressure invoked in the medical community, accompanied by the "scare tactics of malpractice insurance carriers and medical societies," have put an excessive burden upon the plaintiff-victim who is required to furnish expert testimony.[41] The added disadvantage is that if an expert is found to testify to the local standard, it would be extremely hard for him to be impartial.[42] The geographical

34. Bly v. Rhoads, *supra* at 652, 222 S.E.2d at 789. *See also* note 29, *supra.*

35. 23 DEF. L.J., *supra* at 181.

36. *Id.*

37. *Id.* at 184.

38. *Id.* at 185.

39. 35 ATLA L.J. 60, 60 (1974).

40. 23 DEF. L.J., *supra* at 186.

41. 35 ATLA L.J., *supra* at 60.

42. 11 U. RICH. L. REV., *supra* at 51. Several suggestions have been drafted that would allow courts to circumvent the "conspiracy of silence." Examples include: 1) relaxation of locality rule, 2) relax rules of evidence so as to place burden on defendant doctor as to standard of care, 3) relax evidentiary rules as to admitting medical treatises, 4) establishing negligence through use of defendant's own admissions, 5) expand doctrine of *res ipsa loquitur,* and 6) invoking theory of informed consent. 35 ATLA L.J., *supra* at 61 (cited authorities omitted). For an explanation of Virginia law on admittance of medical treatises, *see* Lawrence v.

limitations imposed upon the selection of expert witnesses, by the local rule, is clearly loosened by Virginia's adoption of the statewide standard. However, there are valid arguments that a national standard would not only do away with needless boundaries, but would also be more consistent with the standard of care in ordinary negligence cases—the reasonable prudent man under the same circumstances.[43] The Virginia legislature's adoption of the statewide standard, however, is not without some justification in view of the broad national standard. Many states have significant variances in their laws concerning drug control, "good Samaritan" situations, insurance coverage, medical licensing, and malpractice, which possibly justifies the more limited standard.[44] In fact, the broader area encompassed by the statewide standard will, in all probability, provide a sufficient pool for plaintiff's selection and result in a standard of care equal to the national standard.[45]

The new statute will require judicial interpretation in the future. There is no precedent as to requirements of a preponderance of the evidence in medical malpractice cases.[46] It may eventually result in a restatement of all the reasons for the old rule in attempts to invoke its use. If this results in summarily allowing a local standard of care to be applied, the legislature may be required to repeal the proviso to the statute, allowing local customs and practices to be considered only in determining the actual statewide standard. It is not clear what effect the statute will have upon the "forgotten sponge" cases that invoke the application of *res ipsa loquitur*,[47] but it would appear to have little or no effect. The "school of practice" test, found in some Virginia cases,[48] is not mentioned in the new statute, and serious questions may arise as to the standard to be applied when there are two different theories relating to the same treatment. Should a doctor be penalized because he adheres to a new, innova-

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Nutter, 203 F.2d 540, 543 (4th Cir. 1953); 21 W. & L. L. REV., *supra* at 229. For an explanation of Virginia law on *res ipsa loquitur*, the "forgotten sponge" cases, *see*, Dietze v. King, 184 F. Supp. 944 (E.D. Va. 1960); Easterly v. Walton, 208 Va. 214, 156 S.E.2d 787 (1967); Henley v. Mason, 154 Va. 381, 153 S.E. 653 (1930); 21 W. & L. L. REV., *supra* at 225.

43. Comment, 7 U.S.F.L. REV. 163, 174-75 (1972).

44. *Id.* at 174.

45. *Id.*

46. *See* note 10, *supra*.

47. *See* cases cited in note 42, *supra*.

48. *See* note 23, *supra*.

tive school of thought that may in fact be the national standard, when Virginia doctors use a more outdated, but well-tested practice? The statute can be interpreted so as to not totally bar the national standard. The proviso with regard to the local standard merely requires that after consideration of local practice, a standard of care "more appropriate" than the statewide standard may be used. If it is concluded that a national standard is "more appropriate," then it may similarly be used, even if in conflict with statewide practice.

One final problem will have to be cleared up, either judicially or by statute. The original House bill provided that the expert witness, "who is familiar with the standard of care within the Commonwealth in the field of practice or specialty at issue shall be admissible to prove *whether or not the acts or omissions complained of occurred*" and the standard of care to be applied.[49] In the Senate-approved bill, and in the report of the conferees which resulted in the final bill, the provision with respect to expert testimony was deleted.[50] Whether the deletion was intended to continue existing practice, or to allow the requisite proof by other than expert testimony, is at the moment unanswered.

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49. Amendment in the Nature of a Substitute for House Bill No. 1985 (Proposed by the House Committee for Courts of Justice) (emphasis not in original). The House agreed to the committee substitute and passed the bill on February 7, 1979 by a vote of 92-4.

50. The Senate passed the bill with its own amendments on February 22, 1979 by a vote of 36-3. On February 23, 1979 the Senate amendments were rejected by the House unanimously and subsequently unanimously insisted upon by the Senate. The Senate proposal was similar to the final bill with the wording, between "or specialty in this Commonwealth" and "provided, however," being deleted. (*See* note 1, *supra*). On February 24 the conference report was approved by the House, 83-0 and the Senate, 32-3. The bill was signed by the Governor on March 21, 1979.