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A STATEWIDE STANDARD OF CARE IN MEDICAL MALPRACTICE CASES—WE'RE SHOVELING SMOKE

Thomas J. Harlan, Jr.*

I. INTRODUCTION

A month before his death, Judge Learned Hand, in an interview with a young *Life* magazine reporter, was asked how he felt after his long and illustrious career on the bench in which his opinions were adopted by the United States Supreme Court, cited in major law schools throughout the country, hailed as legally incisive and brilliant, and being viewed himself as a trendsetter in legal thinking. Judge Hand replied: "I've spent a lifetime of utter drudgery, shoveling smoke" ¹

In 1977, the Virginia General Assembly first adopted a statewide standard of care,² replacing what was known as the locality rule,³ in medical malpractice cases. The standard of care under the locality rule required the defendant to act as a reasonably prudent physician would act in his community or in a medically similar community.⁴ The locality rule permitted expert testimony of "like

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1. Havemann, *On a Great Judge's Death: A Moving Memoir*, LIFE, Aug. 25, 1961, at 38.

2. VA. CODE ANN. § 8.01-581.12:1 (repealed 1979). The statewide standard is now found in *id.* § 8.01-581.20(A) (Cum. Supp. 1983). The current statute provides that:

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 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 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 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.

Id.

3. For a discussion and history of the locality rule in Virginia, see Note, *Virginia Abolishes Locality Rule in Medical Malpractice*, 13 U. RICH. L. REV. 927 (1979).

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

specialists in good standing, in the same or similar localities" as the defendant in a medical malpractice case.⁵ It was eventually extended to cover various specialties within the medical profession.⁶ Under the locality rule, the plaintiff would obtain a physician familiar with the local standard of care to testify as an expert witness against the defendant physician. In the alternative, a physician from a "similar community" could testify as to his community's standard of care, and the plaintiff would then need a "hiatal witness" to present evidence that medical practice in the two communities was similar.⁷

Concededly, it was difficult, if not impossible, to persuade physicians from the same community to testify against fellow physicians. Unless the acts were truly egregious, the physicians' reluctance to be a witness is understandable. It is conceivable that lawyers might have the same difficulty if asked to testify against one of their brethren in the same bar association. However, in response to the plaintiffs' lawyers' lament that the vestigial "conspiracy of silence" among doctors was aided and abetted by the locality rule, the Virginia General Assembly, enacted a statewide standard of care.⁸ Somehow, the legislature, the courts, and lawyers perceived that all physicians could be measured by such a statewide standard.

Is this a realistic assumption? What is "that degree of skill and diligence practiced by a reasonably prudent practitioner in the field of practice or specialty in this Commonwealth . . .?"⁹ How do we go about measuring it? The statute does allow the defendant's conduct in some instances to be judged against a local standard, but places the burden upon the defendant doctor to "prove by a

5. *Id.* at 131, 96 S.E. at 366 (establishing the initial test for the standard of care in medical malpractice cases). See also *Carroll v. Richardson*, 201 Va. 157, 160-63, 110 S.E.2d 193, 195-97 (1959) (discussing instructions in applying the locality rule to expert testimony); *Reed v. Church*, 175 Va. 284, 293, 8 S.E.2d 285, 288 (1940) (holding expert testimony is required concerning the applicable standard of care); Note, *supra* note 3, at 928 (discussing the history of Virginia Supreme Court decisions on the locality rule).

6. See *White v. United States*, 244 F. Supp. 127 (E.D. Va. 1965) (psychiatrists); *Bly v. Rhoads*, 216 Va. 645, 222 S.E.2d 783 (1976) (gynecologists); *Whitfield v. Whittaker Mem. Hosp.*, 210 Va. 176, 169 S.E.2d 563 (1969) (nurse-anesthetists); *Alexander v. Hill*, 174 Va. 248, 6 S.E.2d 661 (1940) (dentists).

7. See *Ives v. Redford*, 219 Va. 838, 843, 252 S.E.2d 315, 318 (1979) (stating that the use of an expert from a *similar* community does not mean the *same* community in which the act occurred).

8. See *supra* note 2 and accompanying text.

9. VA. CODE ANN. § 8.01-581.20(A) (Cum. Supp. 1983).

preponderance of the evidence" that a "local standard of care" is "more appropriate" than the statewide standard.¹⁰ Is this fair? This article will examine the elements involved in determining a standard of care and will conclude that a return to the locality rule is appropriate.

II. THE STANDARD OF CARE: WHAT IS INVOLVED?

A. *Training and Experience*

To understand the elements constituting a standard of care for medical malpractice purposes requires careful analysis. A "standard of care" connotes that a defendant physician has achieved a certain level of training, both academically and through experience.¹¹ Training and experience are common sense guides to evaluating a proposed standard of care. The difficulty lies in the arbitrary determination of these factors in a statewide standard. For example, the standard for a pediatrician who has three years of extensive training in children's illnesses theoretically should be higher than the standard for a family physician. On the other hand, the family practitioner who has kept abreast of pediatric medicine and who may have twenty years of experience in dealing with the diagnosis of children's diseases may, practically speaking, have diagnostic skills superior to that of a newly graduated pediatrician.

B. *Diagnosis*

One must acknowledge that medicine is an inexact science.¹² Medicine, in the diagnostic sense, depends greatly upon the subjective interpretation of the signs and symptoms of the patient, and the symptoms of a particular disease may vary widely from patient

10. *Id.* The statute provides in part that:

[T]he standard of care in the locality or in the 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 . . . give rise to a standard of care *which is more appropriate than a statewide standard.*

Id. (emphasis added).

11. See *Reed v. Church*, 175 Va. 284, 293, 8 S.E.2d 285, 288 (1940) (stating the general proposition that medical personnel hold themselves out to the world in a capacity to furnish skillful treatment and are liable for malpractice due to any deviation from such expertise).

12. *Fitzgerald v. Manning*, 679 F.2d 341, 347 (4th Cir. 1982).

to patient.¹³ The skills of a good diagnostician are based not only on training and experience, but also, to a large measure, on a truly intangible quality — intuition. Similarly, any good lawyer makes daily judgments, particularly in the courtroom, based on intuition. How, then, does one teach intuitive skills to another? How does one articulate what an intuitive judgment is? It cannot be taught. It comes to some and not to others; it can be developed but not created; it can be relied upon but not explained. The experienced lawyer, utilizing well-developed intuitive skills, can breathe life into the law by creating new and imaginative solutions to stodgy problems. In a similar sense, the skills of a medical diagnostician are based upon the art of “intuitively” making the correct diagnosis when, in some cases, the medical facts may point the inexperienced physician in the wrong direction.

Similarly, surgery is to a great extent an art form. A surgeon’s skill depends upon his natural talent, his knowledge and his dexterity which generally become better with increased experience. No two patients respond to surgery in the same way; mental outlook, healing time, anatomical structure, and reaction to medicines vary from patient to patient. In dealing with these human differences, the surgeon, too, must rely upon certain indefinable intuitive skills when encountering a patient who does not “quite fit the mold.”¹⁴ Therefore, if justice is to prevail, all of these variables must be understood and taken into account when assessing the conduct of a physician.

1. Patient History

In medicine, a correct diagnosis depends upon many factors. One of the first and most important of these factors is the ability of a physician to obtain an accurate history of the development of his patient’s disease.¹⁵ To some extent, this is within the control of the physician and to some extent it is within the control of the patient. A child may be unable to describe his complaints. An unconscious

13. *Id.* See also *Easterling v. Walton*, 208 Va. 214, 218, 156 S.E.2d 787, 790 (1967) (holding a physician is not an insurer of a cure).

14. See generally Wecht, *Medical Malpractice—A Bird’s-eye View*, PRACTICING LAW INSTITUTE, COURSE HANDBOOK SERIES NO. 57, MEDICAL MALPRACTICE: A PRACTICAL APPROACH 7 (Neil T. Shayne, Chm. 1973).

15. See, e.g., Godosky, *Malpractice in Diagnosis, Treatment and Surgical Intervention in Patients with Appendicitis*, PRACTICING LAW INSTITUTE, COURSE HANDBOOK SERIES NO. 128, MEDICAL MALPRACTICE LITIGATION 13-22 (Robert L. Conason, Chm. 1978).

person would be of no assistance. An uneducated or inarticulate patient would pose a different problem entirely.

2. Laboratory Tests

The number, quality, and type of laboratory tests available to the physician in his community or hospital to assist him in making a diagnosis is another factor in determining his ability to deliver care to the patient.¹⁶ Some tests, such as a complete blood count or an X-ray, may be available to almost every physician throughout Virginia. On the other hand, more sophisticated processes and tests costing large sums of money may not be available in every community. Thus, whether or not a community has, for example, a computerized areal tomography (CAT) scanner is significant in evaluating a physician's conduct in relation to the information that would be available to him in a community that does not have a CAT scanner.

If the tests are available to a physician in Virginia, a related question is what is the "turnaround time" that a physician can count on. Does the laboratory remain open twenty-four hours a day? What is the quality of the technicians who conduct the tests? These are further factors touching on the standard of care in many cases. These are matters that an "outsider physician" would be hard pressed to know.

3. Cover

The concept of "cover" of one physician by another also affects the determination of a standard of care. For example, in a group practice of seven orthopedic surgeons, one surgeon might have duty only one night a week due to rotation of work assignments. Each would have the opportunity to take a vacation while being "covered" by his partners. This practice is in contrast to that of a community where there is only one orthopedic surgeon, or none at all.

The solo practitioner in medicine, as well as in law, must work harder at his craft not only in "covering" his patients, but also in keeping abreast of new developments. In a partnership of several physicians, information gleaned by one is usually imparted to the

16. See *Naccash v. Burger*, 223 Va. 406, 290 S.E.2d 825 (1982) (concerning the physicians' liability to a patient in reference to laboratory tests).

group. There is also the ability to corroborate the diagnosis and treatment of complicated cases. Of course, a solo practitioner probably has greater *continuity* of care by being the only physician to see his patients every day. All of this information requires further analysis in determining an appropriate standard of care. Indeed, the standard may vary from group to group within a given community.

C. *Treatment*

Treatment by a physician or surgeon may be done in the office or may require hospitalization. Treatment may consist of purely medical treatment, surgical treatment, or a combination. A patient, for example, may be diagnosed as having an abdominal abscess requiring surgical intervention to drain the abscess and medical treatment thereafter with antibiotics. During the course of such treatment, if the patient's condition should worsen, the admitting physician may need to consult with specialists in another field. However, consultation with a specialist may vary depending upon the degree of specialization among the available specialists within one community as contrasted with another. Thus, the interrelationship between the primary physician and the consulting physician in evaluating the patient's condition and deciding what course of action to follow must be an element taken into account in defining the standard of care.

D. *Teaching versus Non-Teaching Hospitals*

Whether a patient is treated in a teaching or non-teaching hospital may also affect the standard of care. If, for example, a diabetic patient with an infection is admitted by a sole practitioner to a teaching hospital having several residents in training on its staff, the admitting physician takes comfort in the fact that these residents will see this patient daily and will submit reports. The nurses also can call upon the residents, day or night, to see the patient if necessary, and the patient may be treated by the resident for minor changes in his condition. This enables the sole practitioner to avoid unnecessary visits to the patient. However, only a few of the hospitals in Virginia are teaching hospitals, and many have no residents.¹⁷ The sole practitioner in hospitals without resi-

17. AMERICAN HOSPITAL ASSOCIATION GUIDE TO THE HEALTHCARE FIELD (1983) [hereinafter cited as GUIDE].

dents must rely solely upon the nursing staff, who cannot prescribe medications, to make any reports.

Each teaching hospital has a great variety of resident specialists on its staff. There may be cardiologists, neurologist, neuroradiological residents, cardiovascular surgical residents, otolaryngological residents, to name but a few. Thus, the hospital where a patient is placed is an element to be considered when assessing the physician's ability to deliver a particular standard of care. In a teaching hospital funded by state and federal sources, the medical equipment, the medical staff, the residents, the nurses, and the laboratory technicians may be vastly different than in the typical non-teaching hospital. For example, laboratories in teaching hospitals are fully staffed at night; therefore, the turnaround time for a particular set of lab tests requested might be much shorter in a teaching hospital than in a non-teaching hospital.

Similarly, resident specialists¹⁸ staff the hospital at night and are available within minutes if a consultation in their specialty is needed. No such resident is available in most non-teaching hospitals. At the Medical College of Virginia, for example, a highly specialized neuroradiological resident may be available in the hospital and a neurological radiologist is on call at all times,¹⁹ whereas there may not be a neurological radiologist practicing in most areas in Virginia. As an earlier Virginia case, recognizing this difference stated: "Due care in a lumber camp might be gross negligence at Johns Hopkins."²⁰

E. *The Nursing Staff*

Several considerations with regard to the hospital nursing staff affect the standard of care a doctor is capable of providing. The first consideration is whether a nursing school is attached to the hospital. The nursing staff at a teaching hospital is numerically greater than that at a non-teaching hospital due to the presence of nurses in training. A larger nursing staff greatly enhances the care provided to the patients. However, not all Virginia hospitals have a

18. Resident specialists are doctors already licensed to practice but who are taking further training in a specialty.

19. Telephone interview with Maurice Lipper, M.D., Associate Professor and Chief of Neuroradiological Section, Medical College of Virginia, in Richmond (Aug. 10, 1984).

20. *Fox v. Mason*, 139 Va. 667, 671, 124 S.E. 405, 406 (1924) (standard expected depends on the character and condition of care), *rev'd on other grounds*, 160 Va. 303, 168 S.E. 353 (1933). See *Morgan v. Schlanger*, 374 F.2d 235 (4th Cir. 1967).

nursing school attached to the hospital.²¹

In addition, hospitals employ two types of nurses: a registered nurse whose schooling lasts four years, and a licensed practical nurse whose schooling lasts one year.²² Registered nurses, through their extended course of study, gain a high level of expertise. Thus, the ratio of registered nurses to licensed practical nurses in a given hospital, day or night, influences the quality of care the physician is able to deliver at the hospital.

Finally, the physician in a particular community becomes acquainted with certain nurses and comes to rely upon those whose skills have been demonstrated. A physician from a different community would not be familiar with the reliability and qualifications of the nursing staff. This is another aspect to consider in evaluating a standard of care. For instance, in a given hospital, does the surgeon have a nurse who has specialized surgical training? Is the patient anesthetized by a nurse-anesthetist or by an anesthesiologist?

F. *Specialized Hospital Services*

Several questions arise as to hospital services. Does the hospital have an emergency room?²³ Not all hospitals have emergency care. If the hospital does have an emergency room, is it staffed with board-certified or board-eligible emergency room physicians? Is it staffed by residents or by interns?²⁴

The emergency room at the Medical College of Virginia, for example, is organized around four specialty areas, each staffed, not by family practitioners, but by specialists. The emergency room has (a) an obstetrical and gynecological department; (b) a medical department; (c) a surgical department; and (d) a pediatrics department.²⁵ A child brought into the Medical College of Virginia's emergency room at 2:00 a.m. will be seen by a pediatric resident or a pediatrician, whereas in some non-teaching hospitals, the emergency room specialist is essentially a family practitioner who has

21. GUIDE, *supra* note 17.

22. *Id.*

23. For a discussion of some malpractice problems particular to an emergency care facility, see Wecht, *supra* note 14, at 35-36.

24. An intern is a senior medical student who is not licensed to practice medicine.

25. Telephone interview with Deborah Kelso, Nursing Coordinator of Emergency Department, Medical College of Virginia, in Richmond (June 26, 1984). The emergency room also has a non-acute area for general practice-type problems. *Id.*

branched into emergency medicine. How then can it be said that there is a statewide standard of care for emergency room practice unless there is a recognition that several levels of emergency room care can be obtained in Virginia.

The same view holds for intensive care units. Does the hospital have an intensive care unit? Does the hospital have a pediatric intensive care nursery? Some hospitals have both, some have neither.

G. *The Available Medical Community*

The variety of specialists available for consultation within the community affects the standard of care. The availability of such specialists as nephrologists, urologists, or board-certified neurosurgeons directly influences the quality of care that a physician is capable of providing his patient.

The availability of specialized operations also affects the standard of care. In Norfolk, for example, a micro-neurosurgical team can replace an amputated hand, under certain conditions, in a special surgical unit. The procedure may last up to twelve hours, with surgeons utilizing microscopes to sew severed nerves with sutures infinitesimally finer than human hair. At the present, such a unit is unavailable anywhere else in Virginia. Similarly, kidney transplants, heart transplants, and other specialized organ transplants can only be done in a few cities. Thus, the availability of both specialists and equipment becomes a major issue in determining a standard of care.

H. *Individual Experience*

The standard of care is also sometimes affected by individual experience. For example, although it may be standard practice to give a child an injection in the upper outer quadrant of his buttock, a physician experiencing a child who has suffered sciatic nerve injury with subsequent paralysis, might very well alter his method of giving shots and give the shot in a higher more lateral aspect. Through discussions among local practitioners, this thinking might ultimately pervade a community. The thinking, however, might not reach a statewide level because the particular problem has not yet been experienced by the rest of the state. Such an analogy might be expanded so that fifty percent of the doctors in the state are modifying the manner in which they give shots. Suppose seventy-five percent modified the way they gave such shots, would

the remaining twenty-five percent be considered to have automatically deviated from accepted practice? What happens if a case is brought during the transitional period of thinking? Would it be fair for a physician from one camp to testify against a physician in the other for failing to adhere to the recently adopted change?

III. A RETURN TO THE LOCALITY RULE

With all these factors in mind, how then can any one physician take the stand and testify that he *knows* the statewide standard of care? Does it not seem reasonable to require that the physician be familiar with the capabilities of what a particular hospital can deliver in terms of services? Does it not seem reasonable to require that the physician know various levels of specialties available in a particular community? How can any physician generalize and say that he knows the statewide standard of care?

As discussed earlier,²⁶ a physician, surgeon, or specialist was required under the locality rule to "exercise that degree of skill, care, knowledge, and attention ordinarily possessed and exercised by members of the profession in his community under like circumstances" ²⁷ This standard was established by expert testimony.²⁸ The expert had to "show familiarity with the degree of skill and care employed by the ordinary, prudent practitioner" in the relevant field and community.²⁹ Whether the witness was qualified to render an opinion was left to the discretion of the trial court.³⁰ For example, in *Noll v. Rahal*,³¹ the Virginia Supreme Court held that the trial court did not abuse its discretion by re-

26. See *supra* notes 4-7 and accompanying text.

27. *Easterling v. Walton*, 208 Va. 214, 218, 156 S.E.2d 787, 790 (1967). See also *Maxwell v. McCaffrey*, 219 Va. 909, 912, 252 S.E.2d 342, 345 (1979) (a witness, to qualify as a competent expert, must show familiarity with "the degree of skill and care" of a practitioner in the relevant field and community). Cf. *Noll v. Rahal*, 219 Va. 795, 250 S.E.2d 741 (1979) (Fairfax physician was not qualified to testify as to standard of practice in Richmond even though he was familiar with practice through journals, meetings, and acquaintances).

28. *Easterling v. Walton*, 208 Va. at 218, 156 S.E.2d at 790. This method of establishing the standard, and any breach, was originally established by the Virginia Supreme Court in *Hunter v. Burroughs*, 123 Va. 113, 131, 96 S.E. 360, 366 (1918). For a discussion of the history of the locality rule, see *Fitzgerald v. Manning*, 679 F.2d 341, 347-48 (4th Cir. 1982); Note, *supra* note 3, at 928-30.

29. *Easterling v. Walton*, 208 Va. at 218, 156 S.E.2d at 790. See also *Bly v. Rhoads*, 216 Va. 645, 652, 222 S.E.2d 783, 789 (1976) (stating that the locality standard is embedded in the history of Virginia litigation).

30. *Maxwell v. McCaffrey*, 219 Va. at 912, 252 S.E.2d at 344; *Noll v. Rahal*, 219 Va. at 800, 250 S.E.2d at 744.

31. 219 Va. 795, 250 S.E.2d 741 (1979).

fusing to admit testimony of a Northern Virginia pediatrician concerning the incorrect diagnosis by two Richmond pediatricians of an eleven year old boy who had contracted Rocky Mountain spotted fever.³² The trial court ruled that the proffered witness was not familiar with the local standards in Richmond notwithstanding the fact that he had practiced in Richmond for ten months.³³ Similar decisions were made concerning chiropractic practices,³⁴ obstetrics and gynecology,³⁵ and internal medicine.³⁶

In 1976, the Virginia General Assembly enacted a series of statutes creating a "medical malpractice review panel" for evaluating medical malpractice cases and rendering opinions, admissible in court, as to whether or not a defendant doctor is guilty of malpractice.³⁷ The medical malpractice review panel, with some modification, could be impaneled with three local physicians to judge the conduct of the defendant. These physicians would not only understand the local standard of care, but also, by being appointed by the Chief Justice of the Supreme Court, would have the approval of the Commonwealth and the medical community to render such an opinion. It would not only eliminate the so-called "conspiracy of silence," but would also ensure that the defendant physician was being judged by an appropriate standard.

Today, the plaintiff in most Virginia medical malpractice cases must produce a medical witness to testify to the following three points: (a) that he knows the standard of care as practiced by a "reasonably prudent practitioner in the field of practice or specialty in this Commonwealth;"³⁸ (b) that the defendant doctor failed to comport with that statewide standard of care; and (c) that such failure was a proximate (or the sole proximate) cause of the plaintiff's injury.³⁹ The theory behind the legislative change to a

32. *Id.* at 800-01, 250 S.E.2d at 743-45.

33. *Id.*

34. *Maxwell v. McCaffrey*, 219 Va. 909, 252 S.E.2d 342 (1979).

35. *Bly v. Rhoads*, 216 Va. at 653, 222 S.E.2d at 789 (Abington, Pennsylvania is not similar in practice to Prince William County).

36. *Little v. Cross*, 217 Va. 71, 74, 225 S.E.2d 387, 390 (1976) (ear specialist from Washington, D.C. does not know the skills and practices of the Norfolk, Va. area). See also *Fitzgerald v. Manning*, 679 F.2d at 347-48 (relating further applications of the locality rule to expert witnesses).

37. VA. CODE ANN. § 8.01-581.1 to .20 (Repl. Vol. 1977 & Cum. Supp. 1983). For a 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).

38. VA. CODE ANN. § 8.01-581.20(A) (Cum. Supp. 1983).

39. *Id.* Proximate cause, while an important factor in determining a medical malpractice

statewide standard of care was obviously to make it easier for the plaintiff to obtain an expert witness. However, it has led to the creation of an artificial "statewide standard of care" which probably does not exist, but in whose existence every medical expert can be cajoled into believing.

IV. CONCLUSION

With the many factors involved in determining a standard of care, it is difficult to believe that any one physician can testify that he knows the "statewide standard of care." Reason dictates that this physician should be familiar with the capabilities of a particular hospital in terms of services, with the training and experience of the physicians in the community, and with the tests and equipment available in the medical community. It seems reasonable to require that the testifying physician *know* the various aspects of medical care available in a particular community.

Obviously there are certain aspects of medical care that are so universal in their application that there may indeed be a "statewide" standard of care. But surely the mere reading of medical journals alone cannot give the reader *knowledge* of the actual standard of care. Even a verbal exchange of information between members of different medical communities concerning major aspects of care is inadequate to educate a prospective expert witness about the totality of the medical picture in the defendant physician's community. Indeed, the Virginia Supreme Court agreed that Judge Hening had not abused his discretion in *Noll v. Rahal*⁴⁰ when he disqualified the testimony of a pediatrician as to the standard of care in the Richmond area. The physician, in attempting to demonstrate that he should be permitted to testify, established that he

- (1) was a member of the Medical Society of Virginia;
- (2) regularly read the Society's publication, "The Virginia Monthly," which had articles on pediatrics;
- (3) had reviewed current articles in national publications about the disease in question (Rocky Mountain spotted fever);

claim, is beyond the scope of this article. For a discussion on proximate cause, see *Fitzgerald v. Manning*, 679 F.2d 341, 348-51 (4th Cir. 1982).

40. 219 Va. 795, 250 S.E.2d 741 (1979).

(4) claimed that the national articles indicated that the standard of medical practice for this disease seemed fairly uniform throughout the country;

(5) had been teaching pediatrics at the Fairfax Hospital to residents of Richmond's Medical College of Virginia;

(6) had "discourse" on pediatric medicine with the physicians in charge of the teaching program at that college; and

(7) had practiced in Virginia for ten months.⁴¹

This author submits that Judge Hening's discretion was properly exercised and, even though we now have a supposed "statewide standard of care," should be applicable today. Judge Hening's analysis of the expert's ability to testify should apply where physicians from other states, or indeed from within this Commonwealth, attempt to qualify themselves as having *knowledge* of a statewide standard of care which may well be based on conjecture.

The expert witness is now dictating the outcome of many cases in both the medical malpractice and products liability fields.⁴² The plaintiff's bar is pushing for a national standard of care so that witnesses from all over the United States can pour into Virginia to testify against the physician who has had an unfortunate outcome in the care of a patient. This may represent the death knell for the medical profession.

Being an expert witness is a lucrative business. Depending upon his involvement, an expert can average between \$4,000 and \$6,000 a case. He can come in from out-of-state to supplement his medical income. Why is this necessary? If he is retired, the witness fee could provide a trip to Europe. But has his retirement caused him to slip behind in his medical knowledge?

One would expect advertisements of medical doctors holding themselves out to testify against other medical practitioners in *Trial*, the magazine of the American Trial Lawyers Association. But these doctors are even advertising their services in the *Ameri-*

41. *Id.* at 799, 250 S.E.2d at 743-44.

42. See Patterson, *Rule-Making Power of Expert Witnesses, Part I*, 23 FOR DEF. 10 (Oct. 1981) and Patterson, *Rule-Making Power of Expert Witnesses, Part II*, 23 FOR DEF. 11 (Nov. 1981) for a discussion of problems which can develop at trial when the expert is permitted to testify in ultimate fact language incorporating a standard which he has developed and which may not comport with the legal standard. Although the author speaks of experts in products liability cases, his concerns are equally applicable to medical malpractice cases.

can Bar Association Journal. The Bar Association should have some very real concern over this. The effect could be to drive the cost of medical malpractice insurance beyond the reach of physicians and leave us with socialized medicine in the near future. Indeed, this type of cannibalism of the medical profession may well set a pattern by which we lawyers may devour ourselves.

In a medical malpractice case, the trial judge may hear from the lips of the expert that he is knowledgeable as to the statewide standard of care in Virginia, but, this author submits, he ought to be scrupulously careful to delve beneath this self-serving opinion and see what the witness' opinion is based upon. It is hoped that some of the points in this article will be the subject of careful analysis by trial judges in medical malpractice cases.