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# WEST VIRGINIA LAW REVIEW

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JURIDICAL TRAUMA AND MEDICAL SHOCK\*  
(A FEW POINTS OF CONTACT BETWEEN LAW AND MEDICINE)

HENRY H. FOSTER, JR.\*\*

*Introduction*

IF MEDICINE is married to science, the law at least is a jealous mistress. And the tie that binds them together is more than mere infatuation. If there are moments of friction, there is also occasional rapport. In any event, the liaison is not a passing fancy, and common areas of interest perpetuate a somewhat ambivalent relation. Although it would take a Kathleen Windsor or a Marcel Proust to relate a complete case history of this romance, perhaps we may briefly examine a few of the points of contact between law and medicine.

First of all, we might observe that we are living in an age of specialization and fragmentation. It used to be that lawyers and doctors were authentic "jacks of all trades." Today our professions are split up into specialties. There seems to be a mania to split things, whether they be hairs, atoms, infinitives, or fees. All too often, what now passes for "higher" education consists of compartmentalized training and the learning of an esoteric vernacular which blocks communication with the outside world. This, I am told, has been diagnosed as the disease of "jargon asphasia." In any event, communication failure leads to misunderstanding or impairs understanding, and over-specialization, I suspect, leads to an intellectual provincialism. To a great extent the friction between our professions arises due to corresponding narrow points of view and a failure to

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\* The substance of this paper was delivered as a lecture before a joint assembly of the Schools of Law and Medicine of West Virginia University, on April 27, 1956, in observance of Medical Education Week.

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understand the problems and perspective of each other's profession. In our quest for technical expertness we may have neglected the art of empathy and have spawned technicians rather than doctors and lawyers.

Infrequently, we do pause long enough in our specializations to examine the implications of a narrow training. Some law faculties tolerate courses in Jurisprudence, and I suppose the general practitioner comes in for some kind words at medical college. But the bulk of legal education, and I imagine a large part of medical education, consists of rather narrow classifications of subject matter into tight little compartments, isolated and secure from exposure to outside influences and ideas. A doctor might regard this as a quarantine, or a lawyer as a sequestration, of knowledge. This "hardening of the categories" is bad enough *inter se*, but when it occasions a loss of contact between the arts and sciences, it is a pernicious malady. We sorely need integration of subject matter and the cross-fertilization of ideas, for both law and medicine comprehend vast areas of knowledge and many skills and techniques.

But the picture may not be so dark as just painted. Fortunately, there is a new awareness that over-specialization may be self-defeating. At least we are talking about it, and in due time, something may be done about it. Many of us have been stimulated by the lively interplay which may occur on an inter-professional level. Civic clubs, societies, and groups, have sponsored joint programs on law and medicine. Medico-legal symposiums or clinics have been held under the auspices of bar and medical associations. Dr. Hubert Winston Smith has staged many such programs throughout the country. The American Bar Association reports that in about half the states, bar associations now maintain some form of direct and continuing liaison with state medical societies for the purpose of considering mutual problems and coordinating their activities in the medico-legal field. An inter-professional code has been developed in Wisconsin. The American Medical Association has established a legal department under the direction of Joseph Stetler which closely follows recent legal developments. Thus, our professions are providing machinery for closer cooperation and continuing inter-relation, and we are acquiring the means for attacking joint problems.

Not only have our professional associations come to recognize that unfamiliarity breeds discontent, but our educators are waking

up too. There is a lot of talk these days about "core curricula" and "integration of subjects." On the professional school level, "released time" is being sought so that other disciplines may be incorporated into professional education. Several law schools now offer courses in medical jurisprudence and the University of Texas, for example, has established a Law-Science Institute which includes a comprehensive curriculum for medico-legal education. The law school at West Reserve University has a similar institute under the able directorship of Professor Oliver Schroeder and it may be predicted that other law schools will launch similar undertakings within the near future.

Legal periodicals are giving increasing attention to medico-legal materials. The current issue of the *Index to Legal Periodicals*, lists two and one-half columns of titles under the heading "Medical Jurisprudence." A check of back issues of the *Index* shows that in the nine year period from 1946 to 1955, there were 18 articles on "Medicine," 4 on "Nurses," and 70 on "Physicians and Surgeons," and 90 on "Medical Jurisprudence," for a total of 182 such articles in legal journals. In the nine year period from 1898 to 1907, there was a total of 15 such articles; in the fifteen year period from 1908-1922, a total of 54; in the nine-year period from 1923-1931 a total of 94. Not only has there been an increase in the number of articles appearing in established journals, but in the past few years several law reviews have devoted entire issues to medical legal matters, and within the past five years at least three new journals have been founded which are directed almost exclusively to forensic science and medico-legal matters. Thus the need for such materials has been appreciated and they are being made available.

Fortunately, lawyers and legal educators are beginning to perceive the realities of modern practice. The significance of medicine in the judicial process becomes apparent when we consider that in about ninety per cent of all civil cases heard by juries, medical testimony is offered, and in over half the cases heard by our appellate courts, medical evidence is part of the record.<sup>1</sup> When we remember that at least since the code of Justinian (530 A. D.) medical opinion has been required by courts in some cases, we realize that the medical expert is not a newcomer to the legal arena. It has been

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<sup>1</sup> Regan, *Medical Legal Problems—The Physician's and Lawyer's Viewpoint*, MEDICO-LEGAL SYMPOSIUMS 11, 13-14 (mimeographed by Law Department, American Medical Association, 1956).

estimated that seven out of ten personal injury cases really hinge on the medical evidence produced rather than upon questions of liability.<sup>2</sup> Despite the importance of such evidence, our law school tradition has been to ignore it and to concentrate on the liability problem. Obviously, in this respect, legal education has been inadequate. On the other hand, the medical student may fare but little better in learning about a doctor's legal rights and duties. Thus, due to deficiencies in education the seeds of suspicion and mistrust may be sown and it may become increasingly difficult to appreciate the problems and the view point of the other profession. In order to serve justice, and in order to serve man, we must discard our blinders and seek understanding so that the great talents of each profession may be more fully utilized for the causes we most surely accept as being our mutual concern.

Since the points of contact and the areas of friction between law and medicine are manifold, the dictates of time require a somewhat arbitrary selection of sub-topics which usually are of interest to both professions. First, we will consider contract law and the doctor; secondly, tort law and the doctor; thirdly, the doctor as a citizen, and; finally, legal control—or governmental regulation—of the doctor and medicine.<sup>3</sup>

### *Contract Law and the Doctor*

The relationship between physician and patient usually is described as "consensual," but it is misleading and inaccurate to think of it wholly in terms of contracts. The relationship involves much more than mere private agreement. The law imposes certain duties and obligations, independent of any private understanding, and hence in some respects the relation is more one of status than contract. However, ordinarily, there is no legal duty to take individual cases nor to serve a particular patient, and theoretically, the doctor has complete freedom of choice in that regard.<sup>4</sup>

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<sup>2</sup> Small, *Personal Injury Law*, 41 A.B.A.J. 693 (1955).

<sup>3</sup> Acknowledgment is made of my indebtedness to Professor Burke Shartel of the University of Michigan whose mimeographed materials on Medical Jurisprudence are most helpful. Moreover, many of the citations are culled from REGAN, *THE DOCTOR AND PATIENT AND THE LAW* (2d ed. 1949).

<sup>4</sup> Query: Suppose an emergency occurs in the physician's presence, does he have any legal duty to render first aid? *Hurley v. Eddingfield*, 156 Ind. 416, 59 N.E. 1058 (1901), holds no legal duty, *sed quaere*.

From the standpoint of contract law, the physician-patient relation begins when the physician responds to the express or implied request that he attend the prospective patient and undertakes to do so. It is only when the patient no longer needs professional services, or when the doctor is otherwise properly relieved of his obligation, that the relation terminates.<sup>5</sup> Usually, the relation endures until the patient recovers or dies, but it may be terminated at any time by either party. However, if the physician withdraws, he should afford the patient reasonable opportunity to acquire another doctor, and if he arbitrarily abandons the patient, there may be liability for harm occasioned by such neglect. The relation also is terminated if the physician becomes incapable of attending the patient. If he wishes, the doctor may limit his undertaking so as to treat only a particular ailment, or to render services only at a particular place or for a particular time.

The contractual undertaking of the physician is usually interpreted as one to render service, not to effect a cure, and there is no implied warranty that the patient will be benefited by the treatment,<sup>6</sup> unless the physician, unwisely, has specifically agreed to effect a cure or to better the condition.<sup>7</sup>

The agreement for medical care may be an express one, one undertaken by an office assistant, or implied from the facts. It need not be formal. The late Dr. Regan, in his valuable book,<sup>8</sup> says that more than one doctor has stopped on the highway to give emergency first aid, not intending to assume any further responsibility, told the injured person to go to a hospital for emergency treatment, and later been sued by the beneficiary of his kindness for allegedly abandoning the care of the patient. In such cases the issue of fact may be resolved against the doctor if the jury feels that the doctor did not do enough under the circumstances.

Note that the relationship is regarded as personal. The patient is contracting for the physician's best judgment, hence the latter cannot delegate functions requiring special skills to another or substitute. To do so may be regarded as abandonment of the patient

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<sup>5</sup> *Lawson v. Conway*, 37 W. Va. 159, 16 S.E. 564 (1892).

<sup>6</sup> *REGAN, op. cit. supra* note 3, at 54.

<sup>7</sup> The Code of Hammurabi, which existed in Babylon from about 2250 B.C., imposed an insurer's liability upon physicians and surgeons, and the penalty for an unsuccessful operation might be death or loss of a hand.

<sup>8</sup> *REGAN, DOCTOR AND PATIENT AND THE LAW* 56-57 (2d ed. 1949).

and malpractice. In *Young v. Jordan*,<sup>9</sup> a physician administered medicine to induce labor, then failed to return within a few hours or to remain where he could be reached as he had promised, and after considerable suffering the patient finally procured another physician for the delivery. The West Virginia court held that there had been a breach of duty and that the doctor was liable for the suffering caused by his neglect.

However, where the physician properly dressed a wound and found it in apparently good condition twenty-four hours later, temporarily absented himself on business, and left the patient in the care of a competent nurse and assistant, the West Virginia court held that there had been no abandonment of the patient.<sup>10</sup> Of course, the basic question in these cases is whether the physician behaved reasonably under the circumstances. On the other hand, the doctor cannot be expected to devote all of his time to one patient, but on the other, he must give each patient proper attention. He may not avoid liability for neglecting a patient on the excuse that he had more patients than he could properly handle,<sup>11</sup> yet the needs of other patients must be considered in the allotment of time.

Much the same reasoning would apply to a doctor's refusal to make a call late at night. We have the word of no less an authority than Lord Macauley that it will hardly be maintained that a surgeon ought to be treated as a murderer for refusing to go from Calcutta to Meerut to perform an operation. There is no legal duty to do so. As previously stated, the physician-patient relationship begins by consent. But once the relationship has been established, the physician is obligated to render reasonable care and treatment and clearly, under some circumstances, it would be unreasonable to fail to respond to an emergency call from a patient regardless of the personal inconvenience to the doctor.

The duty of the physician is not affected by the fact that his services are being given gratuitously, nor by the fact that some third person rather than the patient is paying the fee.<sup>12</sup> Moreover, the patient is liable for any fee he has agreed to pay unless there is some fraud or misrepresentation, except that a contingent fee, based upon the size of the patient's recovery in a personal injury action

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<sup>9</sup> 106 W. Va. 139, 145 S.E. 41 (1928).

<sup>10</sup> *Browning v. Hoffman*, 90 W. Va. 568, 111 S.E. 492 (1922).

<sup>11</sup> *Sinclair v. Brunson*, 212 Mich. 387, 180 N.W. 358 (1920).

<sup>12</sup> *Kershaw v. Tilbury*, 214 Cal. 679, 8 P.2d 109 (1932).

(although proper for legal services) would probably be held an improper basis for a medical fee. In *Early v. Shelter Ice Cream Co.*,<sup>13</sup> the West Virginia court held that a contract to pay a medical witness for testifying, coupled with the condition that the right to compensation was contingent upon winning the suit, was void as contrary to public policy due to the possibility that it might influence the nature of the testimony. However, in a few states, physicians or nurses rendering services to accident victims have liens for their services upon any amount the patient may recover in a law suit for such injuries.

If there is no agreement as to size of the fee, a physician is entitled to a "reasonable fee," and usually it will be a jury question as to what is deemed to be "reasonable." The testimony of colleagues will be important. Such factors as time spent, difficulty and delicacy of the service or operation, customary fees, materials used, the doctor's standing in the profession, and the patient's ability to pay (in some states) will be considered. An infant or insane person may make his assets liable for necessary medical services, and even an unconscious patient treated in an emergency, is liable for a reasonable fee. A fake charity patient is also liable for a fee. A husband, as head of the family has the legal obligation to support, and generally is liable for medical services provided to his wife or children, but he has a right to be consulted in the choice of a doctor, and if he chooses another physician, the wife or child's choice may be unable to collect from him. Usually, a third person is not liable for medical services furnished another, but if he expressly undertakes such responsibility, he may be, and under workmen's compensation statutes a fund or insurance carrier or employer may be liable for medical care given to an injured worker.

Photographs, X-ray plates, records, belong to the doctor subject to the patient's control of their public use. This means that there should be no public use of the patient's likeness or case history without the knowledge and (preferably written) consent of the patient, otherwise the doctor may be liable for the invasion of right of privacy which is recognized as a tort in many states. The first American case which recognized privacy as a legally protected interest was *De May v. Roberts*,<sup>14</sup> decided by the Michigan court in 1881. Recovery was allowed against a physician who unnecessarily permitted

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<sup>13</sup> 108 W. Va. 184, 150 S.E. 539 (1929).

<sup>14</sup> 46 Mich. 160, 9 N.W. 146 (1881).



an unmarried, nonprofessional man to accompany him at childbirth without the patient's knowing his true status. In a recent unreported case, a doctor and a hospital were sued for allowing internes and nurses to be spectators in the delivery room.<sup>15</sup> The responsibility of the doctor goes beyond tolerating trespassing kibitzers, and the cases indicate an implied agreement on his part not to humiliate or embarrass his patient nor to make public confidential or personal matters. In *Feeney v. Young*,<sup>16</sup> the patient recovered in her suit against her doctor where although she had orally consented to the taking of movies of her Caesarian operation for exhibition to medical societies in the interest of science she had not consented to the public exhibition of such pictures in a film entitled "Birth" at regular movie houses. In *Banks v. King Features Syndicate*,<sup>17</sup> the unauthorized newspaper publication of an X-ray picture of a woman's abdomen was held actionable, and presumably the doctor who supplied the X-ray would also have been liable if he had been joined in the suit. In short, there is a legal duty imposed upon doctors to abide by the dictates of good taste and decency and to respect the confidential and personal character of their professional relation to their patients. There is an implied undertaking to this effect.

Insofar as his relation to contract law is concerned, by far the most important problem for the doctor is the legal requirement of consent for operations or treatment. The law, out of regard for the physical integrity of the individual, considers any unpermitted or unprivileged contact with the person of another a battery. In medical cases the question usually is whether or not there was actual or implied consent to the treatment or operation. If there was, the contact was privileged and the doctor is not liable. The general rule is that a physician must obtain the consent of the patient or someone authorized to give it for him. Of course, consent may be inferred from acquiescence when the patient knows what he is doing. However it will not be implied contrary to express prohibitions or conditions of which the physician has knowledge, as where the doctor knows the patient would not agree to what he proposes to do. It is doubtful that the law would imply consent in the face of a known

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<sup>15</sup> See also *Griffin v. Medical Society*, 11 N.Y.S.2d 109 (1939).

<sup>16</sup> 191 App. Div. 501, 181 N.Y. Supp. 481 (1920).

<sup>17</sup> 30 F. Supp. 352 (S.D.N.Y. 1939). See also *Barber v. Time*, 348 Mo. 1199, 159 S.W.2d 291 (1942), where *Time* was held liable for invasion of privacy for printing pictures of plaintiff taken during a humiliating illness and reproducing them under the caption "starving glutton". Presumably, a doctor, supplying such pictures, likewise would be liable.

## JURIDICAL TRAUMA

refusal by a mentally competent adult, even where the medical facts indicate the alternative will be death. Probably, most courts would regard an operation on a known Christian Scientist, undertaken without consent from anyone, as a battery, although consent perhaps might be implied where such a patient is unconscious, it is a life or death matter, and there is no time to contact relatives.

In a recent unreported Ohio case,<sup>18</sup> a patient who had been injured in a fall a year later suffered from unbearable headaches, and the defendant doctor performed a spinal column operation (cervical laminectomy and posterior rhizotomy). After the patient failed to get over his headaches he returned to the hospital for further observation and treatment. He complained that any movement caused him pain. Despite the protests and resistance of the patient and protests from his wife, one of the doctors seized the patient's head, turned it from side to side several times, compelled the patient to get out of bed, forced him to walk out to the hall where he left him while he answered a telephone call. The appellate court held that there had been a technical assault and battery on a sick and weak man with resulting injuries, and that it was question of fact for the jury as to whether or not there was an implied consent to the methods employed. It is to be noted that the plaintiff's theory of liability in this case is based upon unauthorized as distinguished from negligent acts and that the decision of the crucial fact issue was entrusted to the jury, it being the final arbiter as to whether or not the treatment given was so extreme as to exceed the bounds of any actual or implied consent.

An Oklahoma case held that an anesthetist but not the surgeon was liable for a technical assault in giving a patient a spinal block contrary to wishes expressed to the surgeon and noted by him on the hospital chart which the anesthetist read but failed to follow,<sup>19</sup> and the rule is fairly well established in most jurisdictions that a patient's express or implied consent must be obtained for operations.

Ordinarily, consent of an unconscious patient will be implied in emergency situations, or where a surgeon runs into unanticipated difficulties during an operation, but where practicable, the wise surgeon will exercise reasonable and diligent efforts (time permitting) to obtain proper authorization from the appropriate relative.

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<sup>18</sup> Discussed by Morris, *Medical Malpractice a Changing Picture*, 23 INS. COUNSEL J. 23, 27-30 (1956).

<sup>19</sup> *Woodson v. Huey*, 261 P.2d 199 (Okla. 1953).

In order to protect himself, it may be wise to call in consultants so that the emergency character of the situation may be readily established.

In the usual case of scheduled operations, it is standard practice to have an authority for the operation executed in advance, which covers possible contingencies that may develop during the course of the operation, and leaves what should be done to the discretion and judgment of the surgeon. The problem in legal drafting here is to give the doctor the benefit of express consent to cover possible developments but not to make the authority such a blanket coverage as to be meaningless and hence ineffectual.<sup>20</sup> Only the operation specifically consented to may be performed, unless the need for further surgery, essential to the preservation of life or health, develops or becomes apparent during the course of the operation. No separate, unrelated, or entirely different operation is within the bounds of the original consent, and being unconsented to, amounts to a battery. For example, consent to an operation of the right ear does not imply consent to an operation on the left ear,<sup>21</sup> consent to an appendectomy does not imply the same as to removal of Fallopian tubes,<sup>22</sup> authority for a hysterectomy does not cover an appendectomy,<sup>23</sup> an operation on the wrong leg may be actionable,<sup>24</sup> removal of the patient's teeth without consent is actionable,<sup>25</sup> and any operation beyond that which was directed,<sup>26</sup> may result in tort liability unless the court or jury deems that the emergency character of the situation obviates the lack of actual consent and is sufficient to raise an implied consent to what was done. The surgeon has the burden of proving that in fact it was an emergency and that the unanticipated surgery was essential to save the patient's life or health and not merely expedient, and prudence dictates that consultants be called in to establish such facts.

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<sup>20</sup> REGAN, *op. cit. supra* note 8, at 61. In *Valdez v. Percy*, 35 Cal. App. 2d 485, 96 P.2d 142 (1939), the court referred to blanket consent forms and said: "We do not understand such agreement to constitute a consent to perform operations other than the one which the operating surgeons were engaged by the plaintiff to perform unless necessity therefor arose during the authorized operation."

<sup>21</sup> *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905).

<sup>22</sup> Compare *Wells v. Van Nort*, 100 Ohio St. 101, 125 N.E. 910 (1919), and *King v. Carney*, 85 Okla. 62, 204 Pac. 270 (1922).

<sup>23</sup> *Church v. Adler*, 350 Ill. App. 471, 113 N.E.2d 327 (1953).

<sup>24</sup> *Moos v. United States*, 118 F. Supp. 275 (D.C. Minn. 1954).

<sup>25</sup> *Ehlen v. Burrows*, 51 Cal. App.2d 141, 124 P.2d 82 (1942).

<sup>26</sup> *Russell v. Jackson*, 37 Wn.2d 66, 221 P.2d 516 (1950).

Where an operation will or is apt to result in sterility, any spouse of the patient is concerned, and it is desirable to obtain the consent of both husband and wife before such an operation. If an operation is illegal, such as a criminal abortion, consent of the patient will be nugatory in the criminal law, and although the patient's consent may preclude her suit in tort, her parent may have a cause of action against the physician.<sup>27</sup> Where surgery is for nontherapeutic purposes, such as "face lifting", the surgeon may run a risk in some states that such an operation is not warranted where there is no therapeutic necessity, and in any event the surgeon had best be sure that the patient understands the possible dangers as well as the advantages that are involved.

In the case of a patient who lacks legal capacity, such as an infant (usually anyone under twenty-one) or an insane person, consent for operation or treatment should be obtained from one legally competent to give it, such as a parent, guardian, spouse or relative. In the absence of such consent, the doctor runs a risk that he commits an assault and battery, unless he has made diligent effort to get such consent or the emergency is such that the requirement is dispensed with due to exceptional circumstances.<sup>28</sup> Moreover, the doctor assumes a risk that the adult from whom he obtained the consent was legally authorized to bestow it, and in a Texas case it was held that a sister had no such authority to speak for the parents.<sup>29</sup>

Where an operation is made compulsory by law, such as vaccination or sterilization, the law furnishes the consent and the doctor acting in compliance therewith does not commit a battery, unless perhaps when the law is unconstitutional.<sup>30</sup>

It should also be noted that if it is found that the patient's consent was obtained by fraud or misrepresentation, the consent may be disregarded and the surgeon treated as if he operated without any consent whatsoever.<sup>31</sup>

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<sup>27</sup> See W. VA. CODE c. 30, art. 6, § 8 (Michie 1955), and *Billingsley v. Clelland*, 41 W. Va. 234, 23 S.E. 812 (1895).

<sup>28</sup> *Tabor v. Scobee*, 254 S.W.2d 474 (Ky. 1951).

<sup>29</sup> *Moss v. Rishworth*, 222 S.W. 225 (Tex. Com. App. 1920).

<sup>30</sup> REGAN, *op. cit. supra* note 8, at 66.

<sup>31</sup> *Birnbaum v. Siegler*, 273 App. Div. 817, 76 N.Y.S.2d 173 (1948); *Fausette v. Grim*, 236 Fed. 681 (8th Cir. 1916); *Zoterell v. Repp*, 187 Mich. 319, 153 N.W. 692 (1915) (consent must be "understandingly" given).

Dr. Regan raises the interesting problem of a postmortem Caesarian section, and concludes that although consent should be obtained from the husband if possible, if he is not available, the operation would be privileged.<sup>32</sup>

Not only must there be express or implied consent to examinations or operations, but the consent of spouse or next of kin usually is essential for an autopsy. In West Virginia, it is a misdemeanor to send a body to an undertaker without first making inquiry as to the wishes of next of kin.<sup>33</sup>

In summary, although the physician-patient relation is consensual, many duties and responsibilities are imposed and implied by law and the private parties are subject to the overriding considerations of public policy. It also should be noted that medical science affects the law of contracts in that the legal conclusion as to capacity to contract usually depends upon medical evidence offered at trial. Where it is alleged that a party to a transaction or a contract was *non compos mentis*, or it is asserted that undue influence or duress was employed, testimony as to the mental and physical condition of the party in question is decisive and thus the medical expert's testimony is the most important part of the case.

### *Tort Law and the Doctor*

The most significant area of contact and friction between law and medicine is that which is called "tort law." The doctor plays a leading role, as witness or as defendant, in most tort cases. He is indispensable as a witness because in order to maintain a case based upon negligence the plaintiff must prove that he was damaged and that ordinarily entails medical proof. Medical testimony also is perhaps the most important part of workmen's compensation proceedings. This is one of the most likely spots for interprofessional cooperation in education. A seminar course for law students, or law and medical students, led by law teachers and doctors, can be an exciting and valuable course. As a minimum, such a course would undertake to inform the law student about some medical terminology, a little about anatomy and the nervous system, how to read

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<sup>32</sup> REGAN, *op. cit. supra* note 8, at 66.

<sup>33</sup> W. VA. CODE c. 30, art. 6, § 8 (Michie 1955). Dr. Regan, *id.*, states: "The consent of the husband or wife or next of kin of the deceased is a prerequisite to the performance of an autopsy, unless the autopsy is performed, in accordance with the law, by the direction of the coroner or other authorized persons."

medical reports and perhaps something about reading X-rays, and the diagnosis and treatment of the particular diseases selected for the study. Also, he might learn the names of standard medical treatises and how to use a medical library. It would be hoped that one by-product of such a seminar would be a better appreciation of the problems of each profession and an understanding of the other profession's viewpoint.

Although I am extremely interested in medicolegal education for the law student, perhaps a brief discussion of malpractice suits would be more provocative. Doctors are greatly concerned over the tremendous increase in such suits. Malpractice cases have doubled since 1946, and in some areas have increased 350 percent.<sup>34</sup> Premiums for malpractice insurance have doubled.<sup>35</sup> This increase has occurred at a time when the standard of medical competence is at its highest level. The prospect of such suits creates fear, misunderstanding, and resentment on the part of doctors, and unquestionably such contingent liability has had serious repercussions on the doctor-patient relationship. It becomes necessary for the doctor to think of protecting himself even while he is caring for the patient. It has been suggested that the wise doctor will exhaust every possible laboratory aid in every case; he will, on the slightest indication bring consultants into the case; and he will prefer to keep the patient a longer rather than a shorter time in the hospital.<sup>36</sup> It is hoped that by these means the hazard to the physician is decreased, although the cost to the patient is increased. It is also recommended that full, complete, and accurate reports be kept by the doctor and that he should carefully check hospital records, and that extraneous or facetious remarks should not be put in medical records. Studies have found that loose talk about colleagues is one of the prime causes of the instigation of malpractice suits and doctors are continually being warned to desist from damaging criticism. Suits for fees may provoke counterclaims for malpractice.

An extreme view is that malpractice suits result from a conspiracy between an ignorant disgruntled patient and a scheming shyster who is stimulated by his contingent fee. Its counterpart is that the medical profession is itself engaged in a gigantic conspiracy to cover up, hide, and protect incompetent quacks who victimize

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<sup>34</sup> REGAN, *supra* note 1 at 11.

<sup>35</sup> *Ibid.*

<sup>36</sup> *Id.* at 17.

helpless patients. Both extremes are untenable and such rancor but adds fuel to the flames of professional misunderstanding. I suspect that neither profession has a corner on the market in honor, competence, or integrity. I also suspect that so long as it is human to err, mistakes will be made by even competent doctors and lawyers.

Rejecting the viewpoint of the extremist, what's the fuss all about? Does the law itself, as distinguished from the machinations of counsel, give rise to this friction? Perhaps a brief look at the malpractice suit may suggest some of the reasons for misunderstanding.

First of all, it should be appreciated that in legal theory the malpractice suit is *sui generis*, in a class by itself, in that there is a modification of the rules which ordinarily pertain in negligence litigation. In the ordinary case, the liability issue centers around the problem of whether or not the defendant behaved reasonably under the circumstances. If he was careless, inattentive, or the accident was caused by his inadvertence, it may be found that he was negligent. It is not necessary that his conduct or failure to act have a connotation of recklessness, wantonness, or gross negligence—he may be liable for a momentary lapse. There is no implication that he is a “bad man” or that he engaged in anti-social conduct, the inference is merely that in a particular instance he failed to measure up to the objective standard of the man of ordinary prudence. Unless it is a flagrant case on the facts, the parties, the court, the jury, and the public appreciate that “there but for the grace of God, go I.” Contrast with this the implication which is drawn whenever a doctor is found guilty of malpractice. When liability is imposed upon a doctor it is not regarded as a momentary lapse of a usually competent physician, rather, the inference is that he engaged in *unprofessional conduct*. The stigma is equivalent to that where a citizen is convicted of criminal or willful and wanton misconduct. At least one reason why this is so in malpractice cases, is that malpractice, by definition, is a breach of professional duty which occasions injury to the patient. It imputes more than mere negligence. Theoretically, the law applies a special standard, reflecting the medical notion of unprofessional conduct, rather than the usual reasonable man test.

This tailor-made standard, in jurisprudential theory, makes it difficult to prove a malpractice case and is a protection for the doctor, yet, paradoxically, what was intended as a dispensation or as deference to medical judgment, may boomerang. This occurs because the issue usually is determined by a jury. A jury may misunderstand

or disregard the court's instructions; a juror naturally may identify himself with the patient or sympathize with him; and perhaps more important, the jury may naively assume that anything short of medical perfection in this scientific age is not to be condoned. In effect then, the jury although instructed in terms of a special standard may actually superimpose a stringent duty of care and a lapse for which an ordinary mortal might be forgiven assumes exaggerated dimensions where a doctor is involved. Let me illustrate. Do you suppose that a jury, regardless of instructions, might impose a much higher standard of care on the driver of a loaded school bus than upon an ordinary driver? Might not there be something comparable here? We are dealing with one of the most personal and intimate of human relations, where typically there is helplessness, trust, and ignorance on one side, and expertness and professed skill on the other. Due to these reasons, among others, the jury might not only reject the special standard but in practice may hold a doctor to a higher accountability than the average defendant.

This may be but a phase of the current lapse from the traditional negligence formula in personal injury litigation. A number of observers have noted that negligence is rapidly losing, if it has not entirely lost, its character as a branch of "fault" liability, and that persons who actually cause harm are being saddled with the loss even though there was no blameworthiness.<sup>37</sup> Unquestionably, there has been an increasing tendency in personal injury suits for courts to defer to the jury's sense of justice and it is believed that usually a jury assumes that the defendant carries insurance and hence a verdict in the plaintiff's favor averts the calamity of having the loss placed on any one person's shoulders, since the institution of insurance will diffuse the cost.

If there is any substance to this rationale, it would appear that doctors are being caught on the escalator which goes to more and larger plaintiff's recoveries, and in addition may be taken for the ride because a jury frequently assumes a good doctor makes no mistakes and that in any event the doctor is insured or better able than the patient to pay for the harm done. If such are the realities of the moment, what are the alternatives? One possibility would be to

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<sup>37</sup> PROSSER, *TORTS* 316 (2d ed. 1955); EHRENZWEIG, *NEGLIGENCE WITHOUT FAULT* (1951); Leflar, *Negligence in Name Only*, 27 N.Y.U.L. REV. 564 (1952); McNiece and Thornton, *Is the Law of Negligence Obsolete?* 26 ST. JOHN'S L. REV. 255 (1952); James, *Accident Proneness and Accident Law*, 63 HARV. L. REV. 769 (1950).



frankly abandon what now may be a pretense of a special standard and to avowedly make the doctor, like the lawyer, merchant and chief, liable for mere negligence in his professional life as he already is in his personal life. If the trend continues, the doctor then would become a virtual insurer as to his professional expertness as he already is as to his driving skill. Insurance companies would pay the verdicts, premiums would go up, and fees would be hiked to pay the increased cost of the premiums. No logical basis would be left for any imputation of gross incompetence merely because the patient collected. Whether we like it or not, realistically, we may predict that this probably will be the "law in action" in many states, and the minimum that may be salvaged is an awareness that liability does not connote fault.

Opposing this trend, many strong judges may retain a taut check on malpractice suits and tighten and batten down the hatches of legal procedure so that a malpractice case will not reach the jury unless there is substantial evidence of professional incompetence. Adherence to this traditional approach depends in large measure upon the personality and philosophy of the particular court and its theory as to division of labor between court and jury. As previously stated, the trend, rightly or wrongly, is to show deference for the jury, perhaps on the theory that it reflects the sentiment of the community.

A very remote possibility, which I imagine would find acceptance only within the medical profession, would be to require a finding of incompetence by a panel or medical board on the malpractice issue and to take that fact question out of the hands of the court and jury. I hope that this will not be construed as a jeremiad, but frankly I foresee no hope of any lessening of responsibility. An increasing liability appears inevitable. I only hope that there will be a corresponding decrease in the opprobrium now attached to malpractice liability.

We have spoken of a special standard in malpractice cases which differs from that of the ordinary prudent man. Perhaps we should look at it a little more closely. In the usual case, in effect, a defendant may be held liable for acting unreasonable under the circumstances. Reasonableness is determined by such considerations as the foreseeability of harm, magnitude and kind or risk, and the utility of the defendant's action or forbearance. But a tradition or custom of doing things in a certain way is not conclusive. For

example, in *The T. J. Hooper*,<sup>38</sup> Judge Learned Hand held that a jury properly might find negligence where a coastal vessel, per custom, failed to have a radio aboard to receive storm warnings, if in their opinion a reasonable skipper would have his vessel so equipped. The fact that other vessels operated without radios was not determinative. In the case of the medical practitioner, however, the standard of care theoretically is particularized and anchored in custom in that the physician or surgeon merely undertakes to exercise that degree of care and skill commonly possessed and exercised by reputable practitioners in the same or similar localities in similar cases. The custom of the vicinage sets the standard. What local doctors would have done is the criterion.

This means, in theory, that neither the highest, nor even a high degree of care and skill is required of a physician undertaking the care of a patient.<sup>39</sup> He is not required to exercise the highest degree of care and skill and diligence possible in the treatment of an injury or a disease unless by special contract he has assumed to do so, but he may be liable for a mistake or error so gross as to be inconsistent with the degree of skill it is his duty to possess.<sup>40</sup> Of course, if the defendant-doctor is a specialist, a greater degree of skill is required, and he is judged by the degree of skill which is ordinarily exercised by specialists in the same field of practice in the same or similar localities.<sup>41</sup> Theoretically, the individual doctor has his competence or incompetence in the particular instance measured by the average in the profession, not by its geniuses, and the jury will be so instructed. However, it may be doubted that this sinks through to many juries which may assume that even an average doctor simply does not make mistakes.

In flagrant cases, there really is no problem of degree of skill and care. Thus, where a nearsighted or careless doctor tied a ligature about the child's penis instead of around the umbilical cord,<sup>42</sup> or left a four inch rubber tube in a patient's body,<sup>43</sup> made a spinal puncture upon the wrong patient,<sup>44</sup> failed to administer insulin to a diabetic

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<sup>38</sup> 60 F.2d 737 (2d Cir. 1932).

<sup>39</sup> *Dye v. Corbin*, 59 W. Va. 266, 53 S.E. 147 (1906).

<sup>40</sup> *Vaughan v. Memorial Hospital*, 100 W. Va. 290, 130 S.E. 481 (1925).

<sup>41</sup> *REGAN, op. cit. supra* note 8, at 56.

<sup>42</sup> *Brooke v. Clark*, 57 Tex. 105 (1882).

<sup>43</sup> *Saucier v. Ross*, 197 Ala. 603, 73 So. 40 (1915).

<sup>44</sup> *Gill v. Selling*, 125 Ore. 587, 267 Pac. 812 (1928).

before and after an operation,<sup>45</sup> left forceps in the abdomen,<sup>46</sup> failed to put silver nitrate in the eyes of a new born child,<sup>47</sup> failed to X-ray a fractured leg,<sup>48</sup> or used non-sterile instruments,<sup>49</sup> it is idle to speak of degrees of care because under almost any standard there was negligence. In these cases there was a failure to follow good practice. Dr. Regan, from his study of the cases, concludes that the physician must:

1. Not neglect nor abandon his patient.
2. Give his patient sufficient attention.
3. Not experiment.
4. Proceed diligently, without unnecessary delay.
5. Follow good practice, common practice, in diagnosis and treatment.
6. Find or anticipate any condition reasonably determinable or reasonably to develop.
7. Utilize indicated diagnostic aids.
8. Obtain legal consent to operate and for autopsy.
9. Give proper instructions for the care of patients and for the protection of those coming in contact with the patient.
10. And must fulfill the terms of a special contract if he makes one.<sup>50</sup>

In effect, the individual diagnosis and treatment must be in line with the requirements of good medical practice. Good medical practice is presumed to be average care and skill practiced in the community, and if a particular doctor fails to meet such standard, due to negligence, ignorance, willful departure from standard practice, or breaks the law (as by operating without consent) he may be held liable for malpractice.<sup>51</sup>

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<sup>45</sup> *Greenstein v. Fornell*, 143 Misc. 880, 257 N.Y. Supp. 673 (1932).

<sup>46</sup> *McGrady v. Brink*, 195 Wash. 626, 81 P.2d 800 (1938).

<sup>47</sup> *Walden v. Jones*, 289 Ky. 395, 158 S.W.2d 609 (1942).

<sup>48</sup> *Stoll v. Balazs*, 32 Ohio App. 117, 167 N.E. 522 (1929).

<sup>49</sup> *Clemens v. Smith*, 170 Ore. 400, 134 P.2d 424 (1943).

<sup>50</sup> *REGAN, op. cit. supra* note 8, at 26.

<sup>51</sup> *Ibid.*

For our purposes, the significant thing is that malpractice is coming more and more to be synonymous with negligence and is losing its original connotation of gross professional incompetence. If the departure from good practice is willful, due to ignorance, or carelessness, there may be liability if damage results. From the doctor's standpoint, only professional incompetence of a serious nature should be actionable, but from the attorney's and jury's point of view, doctors should be liable for their negligence, whether slight or gross. This, I believe, is the basis for professional misunderstanding because not only has the favorable special standard of care become illusory but in addition the invidious connotation of malpractice remains. Insult is added to injury.

It is important to appreciate that the doctor's resentment of malpractice suits is not a squeal because he has been hit in his pocketbook. The fact that most doctors carry malpractice insurance affords scant comfort. It is not the contingency of financial liability that is disturbing so much as the irreparable harm such litigation may cause to professional reputation. Truly, he who robs a doctor of his good name, makes him poor indeed. Moreover, the doctor, like other professional men, is hypersensitive to criticism and quick to resent aspersions.

Further antagonism between the professions is occasioned by rules of evidence which in most jurisdictions require the plaintiff to prove his case by expert witnesses unless the facts are within the common knowledge and experience of laymen or obvious to the non-expert.<sup>52</sup> For years many lawyers complained that they had difficulty in obtaining such testimony due to an understandable reluctance on the part of colleagues to stigmatize a doctor as guilty of malpractice or negligence. I understand that this is no longer a substantial problem for plaintiff's lawyers in urban areas but may still be a barrier to a merited recovery in rural sections. I suppose that if we assume a case of gross incompetence most of us would agree that there is a substantial miscarriage of justice if a patient entitled to reparation is denied recovery because of the unwillingness of doctors to testify as to the facts. On the other hand, we might understand the reluctance to testify if it was merely a momentary lapse by a reputable physician. The doctor has a great deal at stake. Unfortunately, the patient may be hurt just as badly in either case. The increasing use of the doctrine of *res ipsa loquitur* is counter-

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<sup>52</sup> Howell v. Bigart, 108 W. Va. 560, 152 S.E. 323 (1930).

acting the usual requirement of expert testimony and where adopted tends to place the doctor on the same footing as the ordinary citizen in negligence cases.

I agree with my doctor friends that perhaps we expect too much of them and that it is a serious thing to impose liability for professional negligence. There is little solace in the thought that one reason for exacting such liability is the myth of medical omnipotence and that perversely the profession is being paid a compliment by the idea that it is composed largely of supermen. We expect miracles to be the standard order of procedure. We forget that medicine still is more of an art than a science. And we often fail to recognize that good judgment is the fortunate alternative that hindsight confirms. I think that the doctor may be caught in a squeeze between legal theory and practice and that perhaps the only practicable remedy may be to abandon the theoretically protective standard, to frankly make him liable for mere negligence (as juries are doing anyway) and to thus remove the unfortunate stigma that now is implicit in the term malpractice.

### *The Doctor as a Citizen*

The Hippocratic Oath contains the vow that a doctor "will keep pure and holy" both his life and his art, that he "will abstain from all intentional wrongdoing and harm." The Principles of Medical Ethics promulgated by the American Medical Association, specify that a physician should be "an upright man, instructed in the art of healing," and that "he must keep himself pure in character and be diligent and conscientious in caring for the sick."<sup>53</sup> Further, the Principles of Ethics cites with approval Hippocrates' admonition that "he should also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life."

This glowing description, for the law student, may call to mind A. P. Herbert's characterization of the mythical "reasonable man" in the law of torts:

"this excellent but odious character stands like a monument in our Courts of Justice, vainly appealing to his fellow-citizens to order their lives after his own example. He is an ideal, a stand-

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<sup>53</sup> Principles of Medical Ethics c. 1, § 1.

ard, the embodiment of all those qualities which we demand of the good citizen . . . He is one who invariably looks where he is going, and is careful to examine the immediate foreground before he executes a leap or a bound; who neither star-gazes nor is lost in meditation when approaching trapdoors or the margin of a dock; . . . who will inform himself of the history and habits of a dog before administering a caress; . . . who never drives his ball until those in front of him have definitely vacated the putting-green which is his own objective; who never from one year's end to another makes an excessive demand upon his wife, his neighbors, his ox, or his ass; . . . who never swears, gambles, or loses his temper; who uses nothing except in moderation, and even while he flogs his child is meditating on the golden mean . . .<sup>54</sup>

Thus, out of the whole cloth, the law has created the reasonable man who will serve as the perfect patient for the ideal doctor of Hippocrates. Utopia is at hand! But seriously, we expect more of doctors and lawyers than of other men. And it is always something of a shock when they prove all too human. As professional men we are dedicated to careers of public service, assume a fiduciary duty to those we serve, and relegate the profit motive to a place of secondary importance. To the extent that law or medicine takes on an aspect of business and financial gain becomes a matter of primary importance, professional identity is lost, and all the gray flannel men from Madison Avenue can't put it together again.

In addition to the responsibilities of good citizenship and the high standards of moral character which are imposed upon the doctor, due to the Principles of Ethics, he is specifically obligated to "observe the laws regulating the practice of medicine" and not to assist others to evade such laws,<sup>55</sup> and it is his public duty to help enforce the laws of his community and to help sustain institutions which advance the cause of humanity.<sup>56</sup> In other words, there is a professional obligation that a physician be a law-abiding citizen and observe the spirit as well as the letter of the law.

In general, the physician, if he has the time, enjoys the rights and privileges of citizenship and is saddled with its obligations, although the nature of his profession may occasion some modification. In West Virginia, for example, a quick look at your *Code* reveals that practicing physicians and dentists are exempt but not disquali-

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<sup>54</sup> HERBERT, MISLEADING CASES IN THE COMMON LAW 12-16 (1930).

<sup>55</sup> Principles of Medical Ethics c. 1, § 11.

<sup>56</sup> *Id.* c. 8, § 1.

fied from jury service;<sup>57</sup> ferrymen have a duty to give them prompt service;<sup>58</sup> some of the provisions of the liquor control act are inapplicable,<sup>59</sup> but due to the Hippocratic admonition to stay sober that's of little help; a doctor may be summoned to assist at a coroner's inquest;<sup>60</sup> and most interesting is the monopoly granted for the use of the prefix "Dr."<sup>61</sup> It may come as something of a shock to academic doctors to learn that the use of the title "doctor" (without using the appropriate letters to designate their degree), in any letter, business card, or advertisement, is a misdemeanor.

One of the most important public duties of physicians is to assist the law in determining issues of responsibility. Although, ultimately, the concept of responsibility is a philosophic one, which the courts are as well equipped to answer as medical practitioners, nonetheless the basis for the moral judgment may hinge upon the expert's estimate as to the mental condition of the alleged offender. Today, enlightened jurisdictions are not relying upon the prosecution or defense to produce such evidence but the court upon its motion may require a medical examination of the accused. In Pittsburgh, the Behavior Clinic is available for the criminal courts, and a judge may, and usually does, refer an accused to the clinic where there is any issue as to his mental condition at the time of the alleged offense or at the time of trial. Although the findings and conclusions of the clinic are not obligatory on the court, they are usually accepted and the trial may proceed or be continued according to the nature of the report. The practical effect of the expert's opinion is to cause a dismissal where the accused is deemed to have been incompetent at the time of the crime, or to occasion a continuance where he later became incompetent and is unable to stand trial, the alleged offender being subject to a later trial when and if his condition improves.

Medical examinations may also occur after conviction when the issue is what disposition should be made in the particular case. In California, a state board (adult authority) determines, in most cases, where a particular convicted person should be institutionalized, and in Pennsylvania, a classification center makes a similar determina-

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<sup>57</sup> W. VA. CODE c. 52, art. 1, § 2 (Michie 1955).

<sup>58</sup> *Id.* c. 17, art. 18, § 13.

<sup>59</sup> *Id.* c. 60, art. 6, § 5.

<sup>60</sup> *Id.* c. 61, art. 12, § 9.

<sup>61</sup> *Id.* c. 61, art. 10, § 21.

tion. The nature and character of the criminal as well as his crime is considered by such boards. This is but an interesting phase of the current trend towards personalized treatment of offenders and an emphasis upon rehabilitation rather than punishment. From the standpoint of the relation of law and medicine, this is one of the areas where there is increasing cooperation and teamplay.

Constitutional problems are raised, however, if the issue of responsibility is taken away from the court and jury and committed solely to the judgment of a board or panel, however expert it may be.<sup>62</sup> For this reason, a board or clinic's conclusions cannot be made mandatory.

Furthermore, contrary to military tradition, the selective service act recognizes the special ability of doctors and accords them special treatment. Some ordinances or statutes extend a privilege to ignore speed laws when answering emergency calls, some offices may be filled only by physicians, and in some states medical tools and instruments are exempt from the attachment of creditors.

These, then, are some of the professional responsibilities and privileges imposed on doctors. If we had the time, we might explore the problem of actual or apparant conflict between a doctor's duty to his patient and his duty to assist law enforcement, but we had best move on to our final topic.<sup>63</sup>

### *The Legal Control of the Doctor and Medicine*

Alfred North Whitehead has emphasized freedom of association and self-regulation as important attributes of a democratic society. That philosopher believes that an ideal free society may emerge when it is composed of independent, semi-autonomous units, taking orders from no one and enforcing their own discipline in view of their distinctive functions.<sup>64</sup> He visualizes institutional self-determination for "voluntary association." This would result in private law or nonjudicial control.

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<sup>62</sup> See *State v. Lange*, 168 La. 958, 123 So. 639, 4 TUL. L. REV. 319 (1929) (holding unconstitutional a statute which withdrew insanity issue from the court and placed it in hands of a commission).

<sup>63</sup> It would seem that there may be such a conflict, where, as in West Virginia, communications between patient and doctor are not recognized as privileged by law but the doctor's ethical duty to his patient warrants silence. Again, police authorities may demand that a patient be available for questioning at a time when medical judgment opposes such interference.

<sup>64</sup> See Whitehead's essay, *Aspects of Freedom*, in ANSHEN, FREEDOM: ITS MEANING 42-67 (1940).



Granted that law is but one means of social control, there is little evidence that Whitehead's Utopia is likely to come to pass. The tendency, after some hesitation, is in the opposite direction. For example, an arbitrary exclusion or wrongful expulsion from a trade union will be reviewed by the courts.<sup>65</sup> The law regards one's interest in pursuing a trade or a profession as a "property right", and teachers, lawyers, and others may not be arbitrarily deprived of the chance to earn their livelihoods. Procedural due process may be imposed. But how far should the law go in regulating the internal affairs of a profession?

In *Bernstein v. Alameda-Contra Costa Medical Ass'n*<sup>66</sup> a doctor made a workmen's compensation report which contained derogatory statements about a colleague's examination of the claimant's decedent. Since the report was received into evidence, Dr. Bernstein had the status of a witness. His local medical association, believing that his statements constituted a violation of medical ethics, commenced disciplinary proceedings. The California court enjoined such action on the ground that it would hamper due administration of justice and because the legal privilege of witnesses, which frees them from liability for slander, precluded such punitive action.

In another recent case, *Boswell v. Board of Medical Examiners*,<sup>67</sup> a Nevada physician, in private conversation, referred to one of his fellow doctors as the "city drunk," said that the second was "nothing but a lousy midwife who had probably killed more patients . . . than she had ever helped," and that the only other doctor in the town was incapable of handling medical work expected of him. The physician also said of the second doctor that she had never performed operations but treated appendicitis with a hot enema and had left a large percentage of the women of the county with their "insides hanging out" due to the butchery to which they were exposed under her care, and that she had bled the people of her community of all the money possible. The legal question was whether these statements constitute "conduct unbecoming a person licensed to practice medicine or detrimental to the best interests of the public" within a statute authorizing the state board to revoke medical licenses for unprofessional conduct.

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<sup>65</sup> See *Steele v. Louisville & Nashville R. Co.*, 323 U.S. 192 (1944); *Sanders v. International Ass'n Bridge Workers*, 130 F. Supp. 253 (W.D. Ky. 1955).

<sup>66</sup> 293 P.2d 832 (Cal. 1956).

<sup>67</sup> 293 P.2d 424 (Nev. 1956).

The Nevada court held that Dr. Boswell's license could not be revoked because of his abusive language and enjoined the proceedings of the medical board. It rejected the board's argument that such criticism caused patients to lose confidence in the medical profession and that the use of such language demonstrated that the doctor was unfit to practice medicine, saying "It has never been held that the public health, safety, or morals requires protection through the suppression of criticism of the medical profession as a whole, no matter how harsh the terms in which such criticism is expressed. The common sense and sound judgment of the public in its reaction to unwarranted or unjust criticism of individual doctors or of the medical profession accords a far better protection than the one sought here by the board of medical examiners." The court felt that such charges would result in public resentment against the critic, and in conclusion stated, "Neither the right of individual practitioners to protect themselves nor the right of the medical profession to protect itself may be promoted under the provisions of a statute whose sole purpose is the protection of the public, and whose sole justification lies in the police power of the state exercised to that end."

Now one would not have to be a Samuel Johnson to take issue with this Boswell or the decision or logic of the court. Here, as distinguished from the California case, there is no direct or indirect interference with the judicial process. True, the law affords a remedy to the slandered colleagues if a private suit for defamation were brought, but over and beyond the private interests of any of the parties there is a serious question of the public interest in the maintenance of high professional standards. Does the decision promote medical ethics? Would the same result be reached if a medical society undertook to discipline the offending doctor? Should the judiciary presume to pass upon such matters? Would it not be intermeddling if courts undertook to do more than insure fair procedure? Isn't the medical profession better equipped to promulgate standards of conduct and to define what constitutes "unprofessional conduct"?

The problem of governmental control of the medical profession is too large a topic for present consideration. In general, state laws undertake to prescribe statutory grounds for admission, licensing, suspension, and revocation. In West Virginia, the term "practice of medicine and surgery" is defined to mean "the treatment of any

human ailment or infirmity by any method.<sup>68</sup> Graduates of Class A medical schools who have had a minimum of two years pre-medical education, may be able to take written and oral examinations "covering all essential branches of the science of medicine and surgery." The state board may refuse a license to a person guilty of a felony or gross immorality, or one addicted to drunkenness or habitual use or narcotics, and malpractice or fraud in procuring a license. Licenses may be revoked for the same causes.<sup>69</sup> Practicing without a license is a misdemeanor and the use of a false diploma is a felony.<sup>70</sup> Exceptions are made as to the admission of foreign trained physicians and medics in the armed services. Note that under the West Virginia statutes, both criminal penalties and administrative procedure are provided for in certain instances.

Over and beyond such statutory provisions, certain standards and ethics are subject to private enforcement. A doctor may be subjected to such private sanctions as being barred from admission to a medical society or a hospital staff, or expelled therefrom or denied privileges. As we saw in the California case, and as is shown by *American Medical Ass'n v. United States*,<sup>71</sup> such private sanctions are subject to judicial review.

Moreover, certain reports are required of doctors. He may be required to report gunshot or knife wounds; to submit a report on serological tests of pregnant women to the state laboratory;<sup>72</sup> to keep detailed records and to make reports regarding narcotics;<sup>73</sup> to report venereal disease<sup>74</sup> and communicable diseases;<sup>75</sup> and vital statistics concerning birth and death.<sup>76</sup> Perhaps I should add the obligation of keeping proper records for the Bureau of Internal Revenue.

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<sup>68</sup> W. VA. CODE c. 30, art. 3, § 1 (Michie 1955).

<sup>69</sup> See *Mingo County Med. Soc'y v. Simon*, 124 W. Va. 493, 20 S.E.2d 807 (1942) (evidence of malpractice and that physician testified falsely before Public Health Council respecting his citizenship, that he had got another physician to make a false affidavit, and had proposed fee-splitting, warranted revocation of license for "gross immorality").

<sup>70</sup> W. VA. CODE c. 30, art. 3, § 9 (Michie 1955).

<sup>71</sup> 317 U.S. 519 (1943).

<sup>72</sup> W. VA. CODE c. 16, art. 4, § 26 (Michie 1955).

<sup>73</sup> *Id.* c. 16, art. 8A, § 1, and the federal Harrison Act, 26 U.S.C.A. 2550 *et seq.* (1955).

<sup>74</sup> *Id.* c. 16, art. 4, § 6.

<sup>75</sup> *Id.* c. 16, art. 2, § 1.

<sup>76</sup> *Id.* c. 16, art. 5, § 6.

Fee splitting is not only a violation of the Principles of Medical Ethics<sup>77</sup> but is also proscribed by statute in West Virginia as a misdemeanor.<sup>78</sup>

One of the more interesting and debatable areas of governmental regulation of medicine is with regard to confidential communications between patient and doctor. At common law there is no legal recognition of a privilege to withhold such communications from a court. The Hippocratic Oath, however, provides "And whatsoever I shall see or hear in the course of my profession, as well as outside my profession, in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets." The Principles of Medical Ethics<sup>79</sup> provide that such confidences should not be revealed "unless their revelation is required by the laws of the state." In West Virginia, the common law is in effect except in proceedings before justices or constables, and no privilege is recognized.<sup>80</sup> In about half the states, statutes have accorded a complete privilege so that unless waived by the client, a doctor may not testify as to any communications he received in a confidential capacity. In still other states, such as Pennsylvania, there is a limited privilege in that a doctor may not testify in a civil case without his patient's consent but can be compelled to do so in a criminal prosecution. It has been observed that although such statutes were designed to reflect medical ethics, the privilege usually has been invoked to protect from disclosure matters which have not been kept secret from friends and neighbors and which the court should know about. The American Bar Association has proposed that disclosure should be a matter of discretion for the trial judge.<sup>81</sup>

A discussion on the topic of law and medicine would not be complete without some reference to the role of the doctor as an expert witness. It has been observed that there is an almost unreasoning fear on the part of many doctors to taking the witness stand. A legal expert on such matters, Irving Goldstein, asserts that the key to the problem is keeping proper and complete medical records, and claims that if this is done nine out of ten cases will be

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<sup>77</sup> C. 1, § 6.

<sup>78</sup> W. VA. CODE c. 30, art. 3, § 8 (Michie 1955).

<sup>79</sup> C. 2, § 2.

<sup>80</sup> See W. VA. CODE c. 50, art. 16, § 10 (Michie 1955); and *Mohr v. Mohr*, 119 W. Va. 253, 193 S.E. 121 (1937).

<sup>81</sup> See Chafee, *Privileged Communications*, 52 YALE L.J. 607 (1943).

settled and never reach trial.<sup>82</sup> In the cases that do reach the litigation stage, a well prepared doctor who testifies truthfully and without exaggeration has but little to fear from cross-examination. However, if the doctor is unprepared, or if he varies from the normal and standard procedure, he may anticipate a direct attack upon his testimony during cross-examination. It is important to spend considerable time with counsel before appearing as a witness and to be careful not to get out on a limb. Opposing counsel may be a tree surgeon. A considerate counsel may anticipate the cross-examiner if permitted to do so, by asking on direct examination whether the case had previously been discussed, whether the doctor has testified in similar cases before, and on which side, and what arrangements have been made for his compensation.<sup>83</sup> The standard tactics of impeachment are thus anticipated. Finally, humility is most becoming a doctor or any expert, and it is well to remember that "the Godly trust not their own righteousness." In matters of judgment it is best not to deal in absolutes.

Unquestionably, the "battle of experts" which frequently occurs in criminal or civil cases has had a serious effect upon the prestige of the medical profession. It is a prime cause of cynicism among lawyers. Various ideas have been proposed to deal with this problem. The so-called Minnesota plan contemplates an investigation by the profession itself whenever perjury is suspected or unprofessional opinions are expressed from the witness stand by doctors. A recent New York study reaffirms the old recommendation of panels of impartial experts to assist the court. It would seem that there are at least two factors which have contributed to confusion and irreconcilable testimony. In the first place, often we are dealing with opinion rather than fact, and there is a sound basis for differences in judgment. Experts may be reasonable in reaching opposite conclusions. In the second place, where the issue is insanity, a legal rather than a medical term, the expert is being asked an opinion as to a legal conclusion rather than a medical fact, and although the medical experts agree on the medical facts they may disagree as to the legal conclusion to be drawn therefrom, particularly when there is ambiguity in the terms used. Moreover, conflicting opinions may be predicted on different sets of facts. Over and beyond this, however, there has been an unhealthy tendency

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<sup>82</sup> Goldstein, *Medical Expert Testimony*, PROCEEDINGS MEDICOLEGAL SYMPOSIUMS 51 (1956).

<sup>83</sup> Halpern, *Medico-Legal Problems*, 17 U. PITT. L. REV. 57, 65 (1955).

on the part of a few doctors to be partisan and to identify themselves too intimately with either plaintiff or defendant's counsel to the extent that a neutral observer would not regard them as unbiased.

### *Conclusion*

We have examined, in a superficial way, a few of the problems that are the mutual concern of doctors and lawyers. We have few answers for any of these problems. But we do not regard any of them as insurmountable nor as susceptible to an easy solution. Professional education can and must do more to lay a foundation for better understanding; there is a bond between our professions; and we must learn the other fellow's viewpoint. If we understand one another better one source of hostility will be eliminated. It is not too much to ask our educational institutions to do more than has been done in the past to bring about an intercommunication between our professions and to reduce the barriers which have existed all too long as impediments to understanding. In 1928, Mr. Justice Cardozo delivered an address to the New York Academy of Medicine in which he reminded the doctors present of the old belief that the earliest physician was the priest, just as the earliest judge was the ruler who uttered the divine command and was the king and priest combined. From ancient times there has been a close inter-relationship between law and medicine and the closer we work together the better the chance that our combined efforts will help to solve some of the pressing problems of our times. Law and medicine are intertwined so closely that a failure to work together amounts to working at cross-purposes. *Absit invidia.*