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ADMISSIBILITY OF WRITTEN STANDARDS AS EVIDENCE OF THE STANDARD OF CARE IN MEDICAL AND HOSPITAL NEGLIGENCE ACTIONS IN VIRGINIA

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I. INTRODUCTION

The standard of care in a medical negligence action represents the duty which the defendant physician, nurse, hospital or other health care provider owes to the patient. In Virginia, it is that degree of care and skill possessed by the reasonably prudent practitioner of the same specialty in this state.[1] This standard is an elusive one at best. While learned treatises and journal articles assist in determining the standard, in practice the plaintiff offers experts who state, based on their knowledge, training, and experience that the standard of care requires the defendant to provide a particular type of care which the defendant did not provide. The defendant in turn, offers experts with similar knowledge, training and experience who testify that the standard required a different type of care, which the defendant did in fact provide. The trial becomes a "battle of the experts," a contest where each side attempts to obtain a greater number of more attractive and more convincing experts.

This article discusses an alternative which, while not eliminating the need for expert testimony, will eliminate some of the elusiveness surrounding the standard of care concept. Such an alternative is to allow as evidence written health care standards promulgated under the auspices of (1) national certifying or accrediting organizations such as the Joint Commission on the Accreditation of Hospitals, (2) federal law, (3) state licensing and regulatory boards and (4) individual health care institutions. In addition to aiding the trier of fact, these standards are relevant, material and not subject to any persuasive objections. This article assesses and promotes the admission of written health care standards based on an analy-

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1. VA. CODE ANN. § 8.01-581.20 (Repl. Vol. 1984).

sis of the modern trend towards admitting written standards; the various types of standards and their relationship to federal and state law applicable to health care providers; the Virginia cases which have discussed the admission of various non-health care written standards; and the procedures for implementing the admission of such standards during discovery and at trial.

II. Seminal Cases: Evidence of Custom in the Trade

According to some writers, in the past, the majority rule precluded the admission of codes or standards which did not have the force and effect of law as evidence of negligence per se.[2] Frequently such standards were viewed as hearsay opinions about developing sciences.[3] Those who sought to introduce them attempted to apply one of the evidentiary exceptions to the hearsay rule such as the public record or learned treatise exception in order to obtain their admission. Standards not found in statutes or administrative regulations generally do not have the force of law. This includes standards promulgated by either governmental bodies or voluntary associations. Of these, standards promulgated by voluntary associations are more likely to be admitted into evidence.[4] The modern trend is to admit all types of written standards, along with other evidence, to illustrate the standard of care required of the defendant in a negligence case.[5]

Two cases are frequently cited for the proposition that written standards should be admitted as evidence. The first is the 1964 case of *McComish v. DeSoi*,[6] a products liability case involving an industrial injury where the plaintiff administratrix sued the companies responsible for building, reassembling and installing the machine which caused the decedent's injuries. Following a verdict

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2. S. Baldwin, F. Hare, Jr. & F. McGovern, The Preparation of a Product Liability Case § 3.3.2 (1981); 57 Am. Jur. 2d *Negligence* § 273 (1971).

3. 30 Am. Jur. 2d *Evidence* § 1003 (1967).

4. 29 Am. Jur. 2d *Evidence* § 891 (1967).

5. *See, e.g.*, 61 Am. Jur. 2d *Physicians and Surgeons* § 344 (1981); Yacura, *Inside the PDR*, 20 Trial June 1984, at 64 (discussing the use of drug "inserts" or similar literature which is reproduced in the *Physicians' Desk Reference* (PDR) as evidence of the standard of care in drug therapy cases, particularly when the written standards apply to a doctor's duty to warn); *see also* Philo, *Use of Safety Standards, Codes and Practices in Tort Litigation*, 41 Notre Dame Law. 1 (1965) (dealing with the use of non-medical standards at trial by plaintiffs and defendants in products liability and personal injury cases); Comment, *Admissibility of Safety Codes, Rules and Standards in Negligence Cases*, 37 Tenn. L. Rev. 581 (1970) (discussing the admissibility of safety codes and standards in negligence cases).

6. 42 N.J. 274, 200 A.2d 116 (1964).

for the plaintiff, the defendants appealed, alleging that the court erred in admitting industry safety standards regarding the construction of the machine involved. The court, ruling for the plaintiff, held that the standards were *not* learned treatises and consequently were not hearsay opinion of one expert,[7] excludable as an out-of-court statement not subject to cross examination. Under this decision, treatises are properly used only for impeachment purposes when a witness has recognized a particular treatise as authoritative.[8] The *McComish* court ruled that the standards were not hearsay, but rather were admissible evidence as to the common practice and matured judgment of those with experience in a particular business.[9]

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7. *But cf.* FED. R. EVID. 803 (18) (Learned treatises may be read into evidence, although not admitted as an exhibit, if they are acknowledged by the expert witness upon cross examination or relied upon him in direct examination.).

8. *McComish*, 42 N.J. at ____, 200 A.2d at 120.

9. *Id.* at ____, 200 A.2d at 121-22; *see also* C & M Promotions v. Ryland, 208 Va. 365, 158 S.E.2d 132 (1967) in which the Virginia Supreme Court held that:

> It is well settled in this jurisdiction that general usage of the business in a given situation is admissible as evidence of what is reasonable and proper to be done in that situation, from which, along with other (if there be other) pertinent facts and circumstances, the jury are [sic] to determine the question of negligence. If there is no conflict in the evidence as to the existence of general usage, and nothing tending to show that the usage was not reasonably safe or adequate for its purpose and occasion, such usage is conclusive evidence of the exercise of ordinary care.

Id. at 368, 158 S.E.2d at 134 (citing Andrews v. Appalachian Elec. Power Co., 192 Va. 150, 157, 63 S.E.2d 750, 755 (1951)).

Although there have been no written opinions issued by the Virginia Supreme Court on the admissibility of written standards, Judge Willard I. Walker ruled, in a Richmond Circuit Court case involving an injury caused by a radial arm saw, that the Occupational Safety and Health Association (OSHA) standards requiring a machine guard were admissible. Usher v. Forcade, No. LG-423. Richmond Cir. Ct. Jan. 18, 1984) (A shop class instructor was allegedly negligent for not ensuring that the saw was in proper condition before it was used by students. During the instructor's deposition, he acknowledged that he was familiar with the OSHA standards and had allegedly complied with them.).

In some cases, professional standards should be admissible in negligence actions. For example, in actions brought against attorneys the Code of Professional Responsibility should be admissible to indicate a code violation which might constitute breach of a voluntarily assumed duty. *But cf.* Ortis v. Barrett, 222 Va. 118, 131, 278 S.E.2d 833, 840 (1981) (a negligence action against an attorney wherein DR 5-107(B) was held inadmissible on the grounds of relevancy); Ayyildiz v. Kidd, 220 Va. 1080, 1085-86, 266 S.E.2d 108, 112 (1980) (a negligence action brought against an attorney wherein the Court held that the code provision created neither a private cause of action nor a remedy available to non-clients).

The reasoning behind the admissibility of all written codes is expressed in Burley v. Louisiana Power and Light Co., 319 So. 2d 334, 338 (La. 1975) (Although a code or regulation may not have been adopted by law or ordinance or supported by expert testimony, it is still produced by the combined effort of groups having special knowledge of the subject matter and every reason to adopt wise standards for general safety.).

A New Jersey medical negligence case which prohibited the admission of American Acad-

The second landmark case, decided one year after *McComish*, is *Darling v. Charleston Community Memorial Hospital.*[10] *Darling* provides an in-depth analysis of the use of health care standards in a medical and hospital negligence action. The case involved an appeal from a verdict in which the defendant alleged error in the admission of the state's licensing regulations for hospitals, the defendant hospital's bylaws, and the national standards for hospital accreditation.[11] The court held that all of these standards were admissible as evidence of custom, because a hospital, in reality, "assumes certain responsibilities for the care of the patient" which are separate and distinct from the responsibilities of its individual staff personnel.[12] The court decided that the standards would aid

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emy of Pediatrics Standards supports the proposition that medical standards are different from other safety standards and should be treated differently by the courts. Swank v. Halivopoulos, 108 N.J. Super. 120, 260 A.2d 240 (1969). The pediatrics standards involved in *Swank* contained no specific requirements, but rather general recommendations or guidelines. However the court noted that the standard sought to be introduced against the defendant had been complied with and that other written standards containing the same information had already been admitted without objection. *Id.* at ____, 260 A.2d at 243. The court's ruling implies that if the plaintiff had sought to admit a standard which had not been complied with or which had not already been admitted in another form, the result may have been different. *See also* Annot., 58 A.L.R.3d 148, § 10 (1964) (discussing *Swank* as well as the use of governmental and voluntary association codes applicable to other types of personal injury cases. Such cases involve electrical lines, industrial power equipment, airplanes, vehicles, recreational activities, fires and architectural designs.). For a discussion of the admissibility of codes or rules promulgated by the defendant in personal injury cases involving vehicles, explosives, premises or defective products see Annot., 50 A.L.R.2d 16 (1956). The key to admissibility of these rules is expressed in Current v. Columbia Gas Inc., 383 S.W.2d 139 (Ky. 1964). The court developed the following criteria for admissibility of rules: The rules must be effective before and at pertinent periods involved, known to employees, relevant to the case and created for safety purposes, and there must be no showing that the rules go beyond the standard of ordinary care. *Id.* at 143.

10. 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *aff'g* 50 Ill. App. 2d 253, 200 N.E.2d 149 (1964).

11. These national standards are now commonly referred to as JCAH standards, published yearly by the Joint Commission on the Accreditation of Hospitals (JCAH) to reflect changes in the state of the art. The standards relate to the quality of care in services provided. Compliance with standards has been demonstrated at an existing hospital and is measurable. Standards are created because a need exists to measure and improve care in a particular area. At present there are written standards for the following areas: anesthesia services, dietetic services, emergency services, functional safety and sanitation, governing body, home care services, hospital sponsored ambulatory care services, infection control, management and administrative services, medical record services, medical staff, nursing services, pathology and medical laboratory services, pharmaceutical services, professional library services, quality assurance, radiology services, rehabilitation programs/services, respiratory care services, social work services, special care units, and utilization review. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS, (1983) [hereinafter cited as JCAH STANDARDS]. *See also* S. E. PEGALIS & H. WACHSMAN, 1 AMERICAN LAW OF MEDICAL MALPRACTICE § 3:4 -:38 (1980).

12. *Darling*, 33 Ill. 2d at ____, 211 N.E.2d at 257.

the jury in deciding what the hospital feasibly knew or should have known about its responsibilities for the care of patients.[13]

When the *Darling* case was decided, the national standards for hospital accreditation were labeled by the drafters as "required minimum" standards. The following year the same national standards for hospitals held admissible in *Darling* were amended to reflect hospitals' desire to change the standards from a "required minimum" to those viewed as "optimal."[14] This view has continued to the present. The 1983 version of these standards include as their stated purpose the encouragement of "hospitals to strive for excellence in the provision of patient care."[15] These standards currently appear in the *Accreditation Manual for Hospitals* which is published yearly by the Joint Commission on the Accreditation of Hospitals (JCAH) and reflect changes in applicable standards.

Since JCAH standards are now "optimal," it is argued that they are not reliable indicators of custom in the industry.[16] The better view, however, is that the standards continue to reflect generally recognized healthcare standards. For example, in *Cornfeldt v.*

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13. Other cases, like *Darling*, which have held that written standards are admissible as evidence to show whether the standard of care was violated include: Steeves v. United States, 294 F. Supp. 446, 454-55 (D.S.C. 1968) (Federal Tort Claims negligence action alleging that physicians did not obtain necessary consultation was supported by American Medical Association and JCAH Standards as well as hospital regulations); Fox v. Cohgen, 84 Ill. App. 3d 744, 750, 406 N.E.2d 178, 182 (1980) (A wrongful death action against the physician for medical negligence and against hospital and its employees for destruction or loss of medical records wherein the court admitted evidence as to the hospital's duty to keep records. This duty was established by a statement of the American Hospital Association's Committee on Medical Records, by the American Medical Record Association's Planning and Bylaws Committee, and by the JCAH standards, which provide that one of the purposes of a medical record is to "assist in protecting the legal interests of the patient, hospital and responsible practitioners."); Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, ___, 349 A.2d 245, 254 (1975) (a negligence case where the JCAH standards for hospital accreditation were admitted on the issue of the hospital's negligence, and where other written standards, applicable to practitioners in all states, were admitted on the issue of the physician's negligence); Hunsaker v. Bozeman Deaconess Found., 179 Mont. 305, 588 P.2d 493, 502, 503-04 (1978) (negligence case brought against the hospital and physicians wherein the court held that the plaintiff's expert witness should have been allowed to testify as to the hospital's violation of its own rules since such testimony was within the scope of "scientific, technical, or other specialized knowledge which would aid the trier of fact").

14. JCAH STANDARDS, *supra* note 11, at ix.

15. *Id.* at x.

16. An additional objection to the use of standards is based on policy considerations. For example, if a health care provider is to be judged by a policy which reflects an optimal standard, then those providers will cease to write or aspire to standards of excellence since those written policies may constitute a duty. This potential problem, however, is remedied through the introduction of other persuasive evidence indicative of what the standard of care is and through appropriate jury instructions. *See infra* note 90 and accompanying text.

Tongen,[17] a medical negligence action involving a claim of wrongful death, the court held that the JCAH standards were relevant and material as evidence of accepted medical practice.[18] Once the evidence indicated that the JCAH standards had been adopted by the hospital where the patient was being treated,[19] the standards were declared admissible. The court acted even though the defendants lacked familiarity with the standards, and despite the fact that the standards were national in character, whereas the state subscribed to a local standard.

There are two clear policy reasons for admitting JCAH standards into evidence regarding the standard of care. First, compliance with JCAH standards has, in prior years, formed the basis for hospital accreditation.[20] The reality of the 1980's is that hospitals almost without exception[21] adopt JCAH standards. Hospitals also use the standards as the basis for their own internal manuals. Second, health care providers adopt these standards as the required price for doing business in the health care field. Due to an overriding and legitimate concern for the public welfare and in exchange for payment of a significant percentage of patient bills, the federal

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17. 262 N.W.2d 684 (Minn. 1977).

18. *Id.* at 704.

19. *Id.* at 703-04.

20. The stated purposes of the JCAH Standards are:

> 1. *to establish standards for the operation of hospitals and other health-related facilities and services*;
>
> 2. to conduct survey and accreditation programs that will encourage members of the health professions, hospitals, and other health-related facilities and services voluntarily:
>
> a. to promote high quality of care in all aspects in order to give patients the optimum benefits that medical science has to offer,
>
> b. to apply certain basic principles of physical plant safety and maintenance, and of organization and administration of function for efficient care of the patient, and
>
> c. to maintain the essential services in the facilities through coordinated effort of the organized staffs and the governing bodies of the facilities;
>
> 3. *to recognize compliance with standards by issuance of certificates of accreditation*;
>
> 4. to conduct programs of education and research and publish the results thereof, which will further the other purposes of the corporation, and to accept grants, gifts, bequests, and devices in support of the purposes of the corporation; and
>
> 5. to assume such other responsibilities and to conduct such other activities as are compatible with the operation of such standard-setting, survey and accreditation programs.

JCAH STANDARDS, *supra* note 11, at ix (emphasis added).

21. Ninety-nine of the 108 general hospitals in Virginia are accredited. Div. of Medical and Nursing Facilities Services, Va. Dep't of Health, Health Care Facilities Licensing and Certification Activities Monthly Report 4 (May 31, 1984) [hereinafter cited as Monthly Report].

and state governments regulate the business of health care by utilizing these standards.

III. Standards Applicable to Health Care Providers in Virginia and Governmental Requirements

A. *National Standards*

1. The JCAH Standards

Accredited hospitals, which include almost all Virginia hospitals, must comply with mandatory JCAH standards. These standards apply to hospital departments regardless of their status as independent contractors or employees. A review of the JCAH standards reveals that each separate section contains principles, standards, and interpretations of those standards.[22] Although the methods used to implement the standards may vary from hospital to hospital, the standards do apply to all accredited hospitals and substantial compliance is expected.[23] To illustrate the relevance and materiality of a typical standard, consider the following example. Assume that a patient-plaintiff has alleged an injury that was caused by the failure of the Emergency Department to perform a procedure described in and required by the applicable written standards. In such a case, both the general standard requiring written procedures and the specific standard describing the procedure would be relevant. The defendant would naturally seek to introduce the standards if they had complied with them, and the plaintiff would want to introduce the standards if there had been a failure to comply. The assigned weight given to compliance or noncompliance with a particular standard would be affected by the mandatory or non-mandatory language of the standard. It should be noted that the word "shall" is used by the JCAH to indicate a mandatory standard.

The general JCAH standard[24] applicable to this emergency de-

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22. JCAH Standards, *supra* note 11.

23. *Id.* at xi-xii. The specific language used in the JCAH standards defines certain mandatory requirements. For example, the term *shall* or *must* is used to indicate a mandatory statement, the only acceptable method under the current standards. The term *should* is used in interpretation of a standard to reflect the commonly accepted method, yet it allows for the use of effective alternatives. The term *may* is used in the interpretation of a standard to reflect an acceptable method that is recognized but not necessarily preferred. *Id.* at 209, 211.

24. The standard is that "[e]mergency patient care *shall* be guided by written policies and procedures." The interpretation of the standard is as follows:

partment hypothetical provides that written policies are required for hospital emergency services pertaining to the conduct of patient care and that those policies must be enforced. This particular standard is clearly neither optimal nor optional. Therefore, assuming that this standard is relevant to the patient's injury, evidence that a defendant either complied or did not comply with this mandatory standard would be significant.

As previously noted, in order to obtain accreditation status, hospitals must conform to JCAH standards.[25] Conformity is maintained by inspections and related survey reports conducted at the initial application for certification as well as every three years thereafter.[26] Accreditation by JCAH not only enables a hospital to attract patients by advertising its accredited status, but also enables most hospitals to obtain government funding through Medicare and Medicaid.[27] Evidence of compliance with JCAH standards also enables some Virginia hospitals to secure up to twenty percent reductions in medical malpractice insurance premiums.[28]

2. Medicare and Medicaid

Most hospitals in Virginia participate in Medicare and Medicaid programs[29] which require compliance with written standards. The

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there *shall* be written policies and procedures specifying the scope and conduct of patient care to be rendered in the emergency department/service. Such policies and procedures *must* be approved by the medical staff and hospital administration, and *shall* be reviewed at least annually, revised as necessary, dated to indicate the time of the last review, and *enforced.*

Id. at 28-29 (emphasis added).

25. *See, e.g.*, Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, ____, 349 A.2d 245, 254 (1975); JCAH STANDARDS, *supra* note 11, at ix.

26. JCAH STANDARDS, *supra* note 11, at xxi-xxiv.

27. Medicare pays about 40% of all hospital bills. Haney, *For Profit Hospitals Making Their Mark*, Richmond Times-Dispatch, May 13, 1984, at C3, col. 2.

28. Oulton, *Reducing Risk Through Compliance with Accreditation Standards*, QUALITY REV. BULL., May 1980, at 1, 3 (discussing the experience of the Virginia Hospital Insurance Reciprocal program with hospital liability resulting from "deficiencies in the quality of health care"). The JCAH is regarded as a major ally in risk management because compliance with the JCAH standards is believed to have a positive impact on the quality of care. This, in turn, may decrease the likelihood of patient injury due to negligence. *Id.* at 3. As a result of these findings and as an incentive to comply with JCAH, hospitals that are insured by the Reciprocal may obtain the lowest premiums by compliance in four areas: quality assurance, anesthesia services, critical care equipment, and credentialing staff and delineating staff privileges. *Id.*

29. All 108 general hospitals in Virginia meet the conditions for and participate in the Medicare/Medicaid programs. Monthly Report, *supra* note 21.

Health Insurance for the Aged Act (Medicare)[30] has provided, since its inception, that the Department of Health and Human Services set requirements applicable to the health and safety of patients in participating hospitals. Hospitals accredited by JCAH are deemed to comply with the conditions for participation so long as they also meet the requirements for state licensing.[31]

The Medicaid program,[32] initiated by the federal government and adopted by Virginia in 1966, provides assistance to the medically needy and reimburses hospitals for patient care costs.[33] JCAH accredited hospitals, as under Medicare, are deemed to be in compliance for purposes of reimbursement by the federal government.[34] A JCAH accredited hospital can receive reimbursement under either program by completing a one-page federal form stating that it has complied with JCAH standards.[35] In order to receive Medicaid payments in Virginia, a hospital must additionally complete a state form[36] certifying that it is licensed by the state and is either certified for Medicare participation *or* is accredited by JCAH and has a utilization review program meeting Title XVIII of the Social Security Act (Medicare) standards.[37]

State licensing, together with JCAH accreditation, is a very simple and desirable method for hospitals to meet federal requirements for monetary assistance. If a hospital is *not* accredited by JCAH, or if it loses its accreditation,[38] a hospital may instead meet federal requirements for participation in Medicare or Medicaid by

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30. Pub. L. No. 89-97, § 1861(e)(8), 79 Stat. 286, 315 (1965) (codified as amended at 42 U.S.C. § 1395 (1982)).

31. 42 C.F.R. § 405.1101 (1983). *See generally* Dornette, *The Legal Impact of Voluntary Standards in Civil Actions Against the Health Care Provider*, in HOSPITAL LIABILITY: LAW AND TACTICS 302-07 (1980); S. E. PEGALIS & H. WACHSMAN, *supra* note 11, § 3:4, at 123.

32. Pub. L. No. 89-97, § 121(a), 79 Stat. 206, 343 (1965) (codified as amended at 42 U.S.C. § 1395 (1982)).

33. COMMONWEALTH OF VA., DEP'T OF HEALTH, VIRGINIA MEDICAL ASSISTANCE PROGRAM HOSPITAL MANUAL 35 (1973) [hereinafter cited as HOSPITAL MANUAL].

34. Commonwealth of Va., Dep't of Health, Health Care Financing Administration, Hospital Request for Certification in the Medicare and/or Medicaid Program, HCFA-1514(10-80).

35. *Id.*

36. Commonwealth of Va., Dep't of Health, Medical Assistance Program, Hospital Participation Agreement, Form MAP 100-2/1/69.

37. HOSPITAL MANUAL, *supra* note 33, at 35.

38. Loss of accreditation status initiates an immediate response by surveyors designated by state and federal agencies involving extensive on-site inspection of the facility and its programs. Interview with Esten H. Shomo, Assistant Director of Medical and Nursing Facilities Services, Department of Health, Commonwealth of Virginia (May 2, 1984).

complying with specific requirements promulgated by the federal government which closely track the JCAH standards.[39] The federal requirements on emergency care[40] directly correspond to the JCAH standards for emergency services applicable to our hypothetical patient-plaintiff. Both standards require written policies and procedures whose enforcement is the responsibility of the medical staff. This basic uniformity between the standards of "voluntary" associations and federal government regulations, which have the force of law, demonstrates the error of applying the terms "optimal" or "optional" to JCAH standards. This is especially true where, as in Virginia, a health care provider may avoid complying with a government regulation by virtue of compliance with a voluntary association regulation.

Both sets of standards reflect the input of many qualified persons. JCAH is composed of representatives possessing mature judgment and experience in the business of patient care: the American College of Surgeons, American College of Physicians, American Hospital Association, and American Medical Association.[41]

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39. 42 C.F.R. §§ 405.1020-.1040 (1983).

40. Condition of Participation—Emergency Service or Department, 42 C.F.R. § 405.1033 (1983) provides:

> (a) *Standard; organization and direction . . . .*
>
> (1) There are *written policies which are enforced* to control emergency room procedures.
>
> (2) The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff.

(emphasis added).

41. JCAH STANDARDS, *supra* note 11, at ix-x. For another example of the fact that the documents referred to in this article are the products of group efforts, see the American College of Obstetrician's and Gynecologist's statement concerning the authorship and meaning of their standards:

> Although this revision has been prepared by the ACOG Committee on Professional Standards, it represents the cumulation of opinions, attitudes, experience, and judgments of the College. The recommendations of various ACOG committees, as well as many of the ACOG policy statements, have been incorporated in this volume. Where appropriate, references have been made to technical bulletins and other resources of both the ACOG and NAACOG. The cooperation of the many individuals of special competence who collaborated in the development of the *Standards* is recognized with gratitude.
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> The standards presented here should be achievable in this era of modern medicine and technology. They should not be considered absolute, but rather a summation of some of the best opinions currently available. Subsequent Committees on Professional Standards will continue to monitor developments as they occur. These standards are intended as guidelines that should be adapted to varying situations, taking into account the needs and resources peculiar to the type of practice, the institution, and the locality. Variations and innovations that may improve the quality of care are

The regulations of the Department of Health and Human Services are compiled by a broad range of consultants. The presence of collective input refutes the hearsay objection that these standards represent the opinion of one person who is not present to be cross-examined and highlights the character of the standards as evidence of custom.

B. *State Standards*

1. Medicaid

All states regulate hospitals directly through state imposed Medicaid regulations, which exist concurrently with the Federal Medicaid Conditions for Participation.[42] Virginia requires its participating hospitals to be JCAH accredited or to be in compliance with Medicare regulations.[43] The Virginia legislature has specifically declared that it is "in the public interest and for the protection of the health and welfare of the residents of the Commonwealth" that a medical assistance regulatory program be established[44] allowing the Commonwealth to inspect and audit all records where medical assistance is provided. Consequently, Virginia checks to see that the requirements for participation, such as the promulgation and enforcement of the written policies and procedures for providing patient care are complied with by hospitals accepting state money.

2. Licensing

Written standards for hospital patient care are also required by states through their licensing function. Pursuant to statutory authority,[45] the rules and regulations of the Department of Health provide that no hospital may operate in Virginia without a license.[46] In addition, the rules and regulations exist for the purpose of defining the *minimum* standards required for licensing of Vir-

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encouraged.

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, STANDARDS FOR OBSTETRIC-GYNECOLOGIC SERVICES viii (1982).

42. *See supra* note 36 and accompanying text.

43. HOSPITAL MANUAL, *supra* note 33, at 35.

44. VA. CODE ANN. § 32.1-310 (Cum. Supp. 1984).

45. VA. CODE ANN. § 32.1-123(1) (Repl. Vol. 1979).

46. COMMONWEALTH OF VA., DEP'T OF HEALTH, DIV. OF MEDICAL CARE AND NURSING FACILITY SERVICES, THE RULES AND REGULATIONS FOR THE LICENSURE OF HOSPITALS IN VIRGINIA § 30.1 (1982) [hereinafter cited as RULES AND REGULATIONS].

ginia hospitals.[47] Courts should take judicial notice of pertinent statutes and regulations pertaining to licensing.[48]

The degree of licensing inspection imposed on a hospital and its programs for patient care is reduced for those institutions which are accredited by JCAH or certified to receive Medicare funds.[49] If a hospital is JCAH accredited and provides the state with a copy of the most recent survey results, the hospital is deemed to be in compliance with the rules and regulations.[50] Assuming that a hospital was not accredited or that the JCAH survey revealed deficiencies of concern to the state, then the hospital would have to comply with the state regulations.[51] Virginia has authorized the Board of Health to issue regulations which "shall be in substantial conformity to the standards of health, hygiene, sanitation, construction, and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety."[52]

3. Negligence per se

A hospital or an individual physician, nurse or other similar professional may be negligent per se for violation of a statute or statutorily authorized administrative regulation relating to patient care when such violation is the proximate cause of a patient's injury. A Virginia statute requires that a physician must be on call at all times at each licensed hospital which holds itself out as operating an emergency room.[53] If a relationship between the failure to have a physician on call and the patient's injury is established, then the hospital would be negligent as a matter of law.[54]

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47. *Id.* at § 10.2; VA. CODE ANN. § 32.1-127(B) (Repl. Vol. 1979).

48. *See, e.g.*, VA. CODE ANN. § 32.1-125.1 (Repl. Vol. 1979).

49. RULES AND REGULATIONS, *supra* note 46, § 30.11.1.

50. *Id.* at Part II (providing the specific organization and operation requirements).

51. Part of the annual licensing process includes a determination of whether or not a hospital has complied with written policies and procedures. Interview with William Wakefield, Supervisor, Acute Care Services, Department of Health, Commonwealth of Virginia (May 2, 1984).

52. VA. CODE ANN. § 32.1-127(A) (Repl. Vol. 1979).

53. *Id.* § 32.1-127(C).

54. *See, e.g.*, Stahlin v. Hilton Hotels Corp., 484 F.2d 580 (7th Cir. 1973) (a negligence case involving a nurse practicing without a license in violation of the state Nursing Act); Kapuchinsky v. United States, 248 F. Supp. 732 (D.S.C. 1966) (a federal tort claims negligence case involving a violation of a safety rule designed to promote the safety of hospital patients); RESTATEMENT (SECOND) OF TORTS § 285 (1965). The Restatement sets forth how the standard of conduct is determined:

C. *A Defendant's Own Rules*

A hospital typically has corporate bylaws, medical staff bylaws, and policy and procedure manuals for its various departments. These rules may also be viewed as including JCAH standards when the hospital adopts these standards as its own in order to obtain accreditation status, state licensure, or Medicare/Medicaid reimbursement. When a hospital is required by state or federal law to make and enforce rules, or when the hospital relies on its accreditation status as evidence of compliance with legal standards, then a hospital should be estopped from asserting voluntariness as a defense to the admission of these standards. Since *Darling*, the courts have had no difficulty in admitting the self-imposed standards of hospitals as evidence of the standard of care, and no court has used the argument that such standards were voluntary or self-imposed as a reason for exclusion.[55]

Even if such standards were assumed to be voluntary, they should still be admissible as representing the duty or standard which the hospital has assumed.[56] Furthermore, specifically assumed duties represented by patient care standards are generally uniform throughout the hospital industry and, as such, are imposed on the industry as a whole.[57] For example, virtually every hospital's emergency service has rules about taking vital signs, re-

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The standard of conduct of a reasonable man may be
(a) established by a legislative enactment or administrative regulation which so provides, or
(b) adopted by the court from a legislative enactment or an administrative regulation which does not so provide, or
(c) established by judicial decision, or
(d) applied to the facts of the case by the trial judge or the jury, if there is no such enactment, regulation, or decision.

Comment *i* to this same section, provides:

i. Statutory duties. In so far as the standard to which an actor must conform to avoid being negligent is fixed by a legislative enactment, the fact that the legislature is defining what it regards as the standard conduct of a reasonable man is less obvious. But on analysis it is clear that such is the case. By prohibiting a particular act for the purpose of protecting the interests of some person or class of persons as individuals, the legislative body declares its opinion that the risk involved therein is unreasonable.

55. *See* Dornette, *supra* note 31, at 320 n.61. This principle was applied in Kapuschinsky v. United States, 248 F. Supp. 732, 748 (D.S.C. 1966) (a Federal Tort Claims negligence case which involved a violation of the hospital's own rules. The court found that the rules imposed no higher standard than that which prevailed in the applicable community) (citing Smith v. United States, 336 F.2d 165, 171 (4th Cir. 1964)).

56. RESTATEMENT (SECOND) OF TORTS § 323 (1965).

57. Dornette, *supra* note 31, at 314 n.37.

cording medications given, and transferring patients. The existence of and requirement for conformity with such basic rules are facts capable of proof notwithstanding the existence of differently worded or more extensively developed rules in some hospitals. Failure to comply with these basic rules would be a violation at any hospital under any standard. Moreover, in negligence cases it is usually these common rules which allegedly have been violated.

The standards of the various certifying specialty boards applicable to physicians,[58] such as the American College of Pediatrics, American College of Surgeons, and American College of Pathology, should be admissible as evidence of the recognized, customary practice of such specialists.[59] Such standards may qualify as the

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58. For a complete list of the American Colleges and Boards certifying medical experts see 2 AM. JUR. 2D TRIALS, Locating Medical Experts 357 (Supp. 1984).

59. *See* H.B. 6681, 1984 Va. Gen. Assem. which provides for the admission of such standards. This bill has been carried over and will be studied along with other pending bills by a study commission appointed to review matters concerning medical malpractice in Virginia. (H.J. Res. 20).

This Committee reviews the applicable standard of care and the desirability of using a national standard of care at least in certain limited circumstances. The national standards referred to in this article are indicative of the existence of a national standard of care, which has been adopted by a majority of jurisdictions including all those adjacent to Virginia. *See also* MINUTES OF INITIAL MEETING, JOINT SUBCOMMITTEE STUDY OF VIRGINIA'S MEDICAL MALPRACTICE LAWS H.J. Res. 20, June 5, 1984. For jurisdictions which provide for the qualification of non-resident experts based on national standards (for specialists at least) include:

United States—McBride v. United States, 462 F.2d 72 (9th Cir. 1972); Riley v. Layton, 329 F.2d 53 (10th Cir. 1964); Ketchum v. Ward, 422 F. Supp. 934 (W.D.N.Y. 1976), *aff'd with oral opinion*, 556 F.2d 557 (2d Cir. 1977).

Alabama—Lane v. Otts, 412 So. 2d 254 (Ala. 1982); Early v. Noblin, 380 So. 2d 272 (Ala. 1980).

Arkansas—Rickett v. Hayes, 256 Ark. 893, 511 S.W.2d 187 (1974).

Arizona—Gaston v. Hunter, 121 Ariz. 33, 588 P.2d 326 (1978); Pollard v. Goldsmith, 117 Ariz. 363, 572 P.2d 1201 (1977); Kronke v. Danielson, 108 Ariz. 400, 499 P.2d 156 (1972).

District of Columbia—Robbins v. Footer, 179 U.S. App. D.C. 389, 553 F.2d 123 (1977).

Georgia—Summerour v. Saint Joseph's Infirmary, Inc., 160 Ga. App. 187, 286 S.E.2d 508 (1981); Murphy v. Little, 112 Ga. App. 517, 145 S.E.2d 760 (1965).

Iowa—Bryant v. Rankin, 332 F. Supp. 319, *aff'd*, 468 F.2d 510 (8th Cir. 1972) (applying Iowa law); Perin v. Hayne, 210 N.W.2d 609 (Iowa 1973); Grosjean v. Spencer, 258 Iowa 685, 140 N.W.2d 139 (1966); Barnes v. Bovenmyer, 255 Iowa 220, 122 N.W.2d 312 (1963).

Kansas—Chandler v. Neosho Memorial Hosp., 223 Kan. 1, 574 P.2d 136 (1977); Simpson v. Davis, 219 Kan. 584, 549 P.2d 950 (1976); Avery v. St. Francis Hosp. & School of Nursing, Inc., 201 Kan. 687, 442 P.2d 1013 (1968).

Kentucky—Blair v. Eblen, 461 S.W.2d 370 (Ky. 1970).

Louisiana—Pesantes v. United States, 621 F.2d 175 (5th Cir. 1980) (applying Louisiana law); Samuels v. Doctors Hosp., Inc., 588 F.2d 485 (5th Cir. 1979) (applying Louisiana law); Ray v. Ameri-Care Hosp., 400 So. 2d 1127 (La. App.), *cert. denied*, 404 So. 2d 277 (1981); Babin v. St. Paul Fire & Marine Ins. Co., 385 So. 2d 849 (La. Ct. App.), *cert. denied*, 386 So. 2d 358 (La. 1980); Steele v. St. Paul Fire & Marine Ins. Co., 371 So. 2d 843 (La. Ct. App. 1979), *cert. denied*, 374 So. 2d 658 (La. 1979); White v. Edison, 361 So. 2d 1292 (La. Ct.

standard of care applicable to a particular doctor if that physician

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App.), *cert. denied*, 363 So. 2d 915 (La. 1978).

Maine—Roberts v. Tardiff, 417 A.2d 444 (Me. 1980); Cox v. Dela Cruz, 406 A.2d 620 (Me. 1979); Downer v. Veilleux, 322 A.2d 82 (Me. 1974).

Maryland—Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 349 A.2d 245 (1975).

Massachusetts—McCarthy v. Boston City Hosp., 358 Mass. 639, 266 N.E.2d 292 (1971); Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968).

Michigan—Francisco v. Parchment Medical Clinic, P.C., 407 Mich. 325, 285 N.W.2d 39 (1979); Naccarato v. Groub, 384 Mich. 248, 180 N.W.2d 788 (1970); Gilmore v. O'Sullivan, 106 Mich. App. 35, 307 N.W.2d 695 (1981); Patelczyk v. Olson, 95 Mich. App. 281, 289 N.W.2d 910 (1980); McCullough v. Hutzel Hosp., 88 Mich. App. 235, 276 N.W.2d 569 (1979); LeBlanc v. Lentini, 82 Mich. App. 5, 266 N.W.2d 643 (1978); Callahan v. William Beaumont Hosp., 67 Mich. App. 306, 240 N.W.2d 781 (1976), *aff'd on other grounds*, 400 Mich. 177, 254 N.W.2d 31 (1977); Burton v. Smith, 34 Mich. App. 270, 191 N.W.2d 77 (1971).

Minnesota—Christy v. Saliterman, 288 Minn. 144, 179 N.W.2d 288 (1970).

Missouri—Hart v. Steele, 416 S.W.2d 927 (Mo. 1967); Martin v. Barbour, 558 S.W.2d 200 (Mo. Ct. App. 1977).

Nevada—Moon v. United States, 512 F. Supp. 140 (D. Nev. 1981) (applying Nevada law); Orcutt v. Miller, 95 Nev. 408, 595 P.2d 1191 (1979).

New Jersey—Ayers v. Parry, 192 F.2d 181 (3d Cir. 1951), *cert. denied*, 343 U.S. 980 (1952) (applying New Jersey law); Fernandez v. Baruch, 52 N.J. 127, 244 A.2d 109 (1968); Carbone v. Warburton, 11 N.J. 418, 94 A.2d 680 (1953); Tramutola v. Bortone, 118 N.J. Super. 503, 288 A.2d 863 (1972), *modified in part, rev'd in part on other grounds*, 63 N.J. 9, 304 A.2d 197 (1973); Lewis v. Read, 80 N.J. Super. 148, 193 A.2d 255 (1963); Clark v. Wichman, 72 N.J. Super. 486, 179 A.2d 38 (1962).

New York—Hirschberg v. State, 91 Misc. 2d 590, 398 N.Y.S.2d 470 (N.Y. Ct. Cl. 1977).

Ohio—Bruni v. Tatsumi, 46 Ohio St. 2d 127, 346 N.E.2d 673 (1976).

Oklahoma—Karriman v. Orthopedic Clinic, 516 P.2d 534 (Okla. 1973).

Pennsylvania—McPhee v. Reichel, 461 F.2d 947 (3d Cir. 1972) (applying Pennsylvania law); Kubrick v. United States, 435 F. Supp. 166 (E.D. Pa. 1977), *aff'd in part, remanded in part on other grounds*, 581 F.2d 1092 (3d Cir. 1978), *rev'd on other grounds*, 444 U.S. 111 (1979); Harrigan v. United States, 408 F. Supp. 177 (E.D. Pa. 1976) (applying Pennsylvania law); Freed v. Priore, 247 Pa. Super. 418, 372 A.2d 895 (1977).

South Carolina—King v. Williams, 276 S.C. 478, 279 S.E.2d 618 (1981).

Tennessee—McCay v. Mitchell, 463 S.W.2d 710 (Tenn. Ct. App. 1970).

Texas—Karp v. Cooley, 493 F.2d 408 (5th Cir.), *reh'g denied*, 496 F.2d 878, *cert. denied*, 419 U.S. 845 (1974) (applying Texas law); Christian v. Jeter, 445 S.W.2d 51 (Tex. Civ. App. 1969).

Utah—Farrow v. Health Serv. Corp., 604 P.2d 474 (Utah 1979); Swan v. Lamb, 584 P.2d 814 (Utah 1978).

Washington—Pederson v. Dumouchel, 72 Wash. 2d 73, 431 P.2d 973 (1967); Morrison v. McKillop, 17 Wash. App. 396, 563 P.2d 220 (1977).

West Virginia—Hundley v. Martinez, 151 W. Va. 977, 158 S.E.2d 159 (1967); Duling v. Bluefield Sanitarium, 149 W. Va. 567, 142 S.E.2d 754 (1965).

Wisconsin—Trogun v. Fruchtman, 58 Wis. 2d 596, 207 N.W.2d 297 (1973); Shier v. Freedman, 58 Wis. 2d 269, 206 N.W.2d 166, *modified on other grounds, reh'g denied*, 208 N.W.2d 328 (1973); Froh v. Milwaukee Medical Clinic, S.C., 85 Wis. 2d 308, 270 N.W.2d 83 (Wis. Ct. App. 1978).

Jurisdictions which allow qualification of non-resident experts based on identical or similar standards include:

Alaska—Priest v. Lindig, 583 P.2d 173 (Alaska 1978).

California—Evans v. Ohanesian, 39 Cal. App. 3d 121, 112 Cal. Rptr. 236 (1974).

has adopted the rules in order to obtain certification.[60] There are several reasons for this conclusion. A specialist who voluntarily agrees to become certified, increases his prestige, his clientele, and his income by advertising that he is so specialized. The commit-

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Delaware—Peters v. Gelb, 303 A.2d 685 (Del. Super. Ct. 1973).

Indiana—Worster v. Caylor, 231 Ind. 625, 110 N.E.2d 337 (1953).

Montanta—Tallbull v. Whitney, 172 Mont. 326, 564 P.2d 162 (1977).

Nebraska—Kortus v. Jensen, 195 Neb. 261, 237 N.W.2d 845 (1976).

New Mexico—Patterson v. Van Wiel, 91 N.M. 100, 570 P.2d 931, *cert. denied*, 569 P.2d 413 (1977); Pharmaseal Laboratories, Inc. v. Goffee, 90 N.M. 753, 568 P.2d 589 (1977).

North Carolina—Rucker v. High Point Memorial Hosp., Inc., 285 N.C. 519, 206 S.E.2d 196 (1974); Dickens v. Everhart, 284 N.C. 95, 199 S.E.2d 440 (1973); Wiggins v. Piver, 276 N.C. 134, 171 S.E.2d 393 (1970); Howard v. Piver, 53 N.C. App. 46, 279 S.E.2d 876 (1981).

Rhode Island—Schenck v. Roger Williams Gen. Hosp., 119 R.I. 510, 382 A.2d 514 (1977); Cavallaro v. Sharp, 84 R.I. 67, 121 A.2d 669 (1956).

Virginia—Sawyer v. United States, 465 F. Supp. 282 (E.D. Va. 1978) (applying Virginia law); Ives v. Redford, 219 Va. 838, 252 S.E.2d 315 (1979).

60. The American College of Surgeons requires those who apply for fellowship status to take the following pledge:

> In making application for Fellowship in the American College of Surgeons, I agree to abide by the Bylaws of the College, and by such rules and regulations as may be enacted from time to time, and subscribe to the Fellowship pledge as follows:
>
> FELLOWSHIP PLEDGE
>
> Recognizing that the American College of Surgeons seeks to exemplify and develop the highest traditions of our profession, I hereby pledge myself, as a condition of Fellowship in the College, to live in strict accordance with all its principles and regulations.
>
> I pledge myself to pursue the practice of surgery with scientific honesty and to place the welfare of my patients above all else; to advance constantly in knowledge; and to render willing help to my colleagues, regard their professional interests, and seek their counsel when in doubt as to my own judgment.
>
> Upon my honor I hereby declare that I will not practice the division of fees, either directly or indirectly. I further promise to make my fees commensurate with the services rendered and with the patient's rights. Moreover, I promise to deal with each patient as I would wish to be dealt with were I in his position.
>
> Finally, I pledge myself to cooperate in advancing and extending the ideals and principles of the American College of Surgeons.

AMERICAN COLLEGE OF SURGEONS, STATEMENTS ON PRINCIPLES 2 (1981).

The American Board of Pediatrics describes its function relative to pediatricians across the country in drafting the following competency evaluation document: "[t]o provide definitions and examples of those abilities, which are expected of competent physicians, and to show how these abilities relate to the tasks which pediatricians must accomplish in providing optimal health care to children." THE AMERICAN BOARD OF PEDIATRICS, INC., FOUNDATION FOR EVALUATING THE COMPETENCY OF PEDIATRICIANS 71 (1983).

The Board also identifies the standard with which Board certified pediatricians are expected to comply:

> Pediatricians are responsible for identifying, with accuracy, the nature of problems that may cause ill health in children, for determining methods of resolving or alleviating the problems, for using their skills or those of others to carry out management plans, and for assessing the continued effectiveness of management. They further accept the responsibility for maintaining an optimum level of patient care.

Id. at 2.

ment to adhere to certain standards of practice is the specialist's *quid pro quo* for these benefits.

Certification is the preferred qualification for positions held by physicians[61] and for medical services provided within hospitals. Some hospitals, for example, require their laboratories to be accredited. The American College of Pathology[62] believes that pathology services are "essential to patient care," and consequently requires specific credentials for a laboratory director. Such standards could be relevant evidence in a case where a hospital is alleged to be negligent for the acts of its laboratory director. The relevance exists if, in performing a procedure which caused injury to a patient, it could be shown that the director would have known the proper procedure if he had had the training necessary to obtain the required credentials.

Apart from certification programs, many health care professionals voluntarily join other professional organizations which promulgate their own standards. Nurses, for example, may be members of the American Nurses Association (ANA), Association of Operating Room Nurses (AORN), and the Nurses Association of the American College of Obstetricians and Gynecologists, all of which generate codes or standards for practice.

IV. Virginia Cases Pertinent to the Admission of Written Standards

There is no case law in Virginia on the admissibility of medical and hospital standards. The Virginia Supreme Court in *Bly v. Rhoads*[63] considered the lower court's failure to admit bylaws and accreditation rules, but declined to rule on that issue. The court noted that the need for expert testimony would not be altered by the admission of the standards.[64] Other Virginia decisions have stated that bylaws and accreditation rules do not technically have the force of law and, therefore, would only be some evidence of the

61. See the Rules and Regulations of one local Richmond, Virginia hospital's Department of Obstetrics and Gynecology which require that all members of the division be either Board certified by the American College of Obstetricians and Gynecologists or have completed a residency program making them Board eligible. These same Rules and Regulations provide that all consulting members of the division must be Board certified.

62. American College of Pathology, Standards for Laboratory Accreditation (2d ed. 1982).

63. 216 Va. 645, 222 S.E.2d 783 (1976).

64. *Id.* at 653, 222 S.E.2d at 789.

standard of care rather than evidence sufficient in and of itself to establish negligence or the absence of negligence.[65]

The *Bly* court noted as relevant *Virginia Railway and Power Company v. Godsey*.[66] This street car passenger injury case should be considered with the 1983 decision of *Pullen v. Nickens*,[67] an automobile accident case. *Godsey* held that in a personal injury action a defendant's private rules cannot be introduced either by the plaintiff to show conduct required, or by the defendant to prove freedom from negligence. The opinion noted that if such admissions were permitted, a person could, "by the adoption of private rules, fix the standard of his duties to others,"[68] rather than the law properly fixing the standard. The rules would also amount to a party admission that reasonable care requires adherence to "all the precautions therein prescribed."[69] The court noted that the plaintiff did not know about the rules, and therefore was not "influenced" by them. As a matter of policy, the court stated that admitting the company rules would discourage a company from having any rules at all or from setting a higher standard for itself than that required by law.[70]

In following *Godsey*, *Pullen* cited the following as reasons for prohibiting the admission of standards: (1) the plaintiff's ignorance of the "guidelines," (2) the defendant's employees' lack of familiarity with the guidelines, and (3) the fact that the action was based on a violation of law rather than a violation of rules, which rules were in fact inapplicable to the work being performed by the defendant's employees just prior to the injury.[71] Based on the preceding analysis, the *Godsey* and *Pullen* decisions are distinguishable, and patient care standards can be admitted into evidence without necessitating a reversal of the positions adopted by the court.

Patient care standards which do not have the force of law do not ultimately define the defendant's duty. That duty is always what is reasonable under all the circumstances unless the law, by creating a statutory standard, has predetermined what is reasonable. The

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65. Norfolk S. Ry. v. Rayburn, 213 Va. 812, 195 S.E.2d 860 (1973). *Cf.* Mackey v. Miller, 221 Va. 715, 273 S.E.2d 550 (1981) (airplane crash case in which court declined to decide whether violation of F.A.A. regulations was neglience per se).

66. 117 Va. 167, 83 S.E. 1072 (1915). *See also* Annot., 50 A.L.R.2d 16, 68 n.17 (1956).

67. 226 Va. 342, 310 S.E.2d 452 (1983).

68. 117 Va. at 168, 83 S.E. at 1073.

69. *Id.* at 169, 83 S.E. at 1073.

70. *Id.* at 169-70, 83 S.E. at 1073.

71. 226 Va. 342, 310 S.E.2d 452 (1983).

standards, along with learned treatises and expert witnesses, simply represent some concrete evidence of that duty and assist the trier of fact in determining the relevant standard of care. Health care standards are neither private nor voluntarily adopted regardless of whether an individual patient-plaintiff is specifically aware of them. Invariably, a defendant hospital's employees admit under oath that knowledge of relevant standards and substantial compliance with them is a basic part of their orientation training and a required part of their job descriptions.[72] Physicians sign agreements to abide by the Hospital Bylaws and Medical Staff rules and regulations in order to obtain staff privileges.[73] Patients are indeed "influenced" by the fact that a hospital is licensed or accredited and patients generally know that *something* is required in order to obtain such a certificate even if the specifics are not known. Patients are also parties to these standards as members of the public, represented by government agencies which require and enforce health care standards for "the public welfare."[74]

The incentive to promulgate hospital department rules will not disappear when courts allow the admission of standards as evidence. Hospitals are required by state and federal law to promulgate such rules, and compliance with these laws is ultimately associated with a hospital's financial success. If a hospital adopts a higher standard than that required by law, then the test of negligence will be that which the reasonably prudent hospital would employ in like circumstances. In some situations, a high standard of care may be required of all health care providers if custom in the industry[75] and reasonableness so dictate. In other less well defined situations, the standard may be lower or more variable. Nevertheless, the point is that health care providers are now regulated, and the regulations include standards adopted for the benefit of the public. For the courts to prohibit the introduction of these standards in medical negligence actions would derogate the rights

72. *See, e.g.*, the internal rules of a typical hospital located in Richmond, Virginia. The rules state that every member of the nursing department staff shall be expected to know and be aware of the polices and procedures that apply to the area in which he or she works.

73. *See* JCAH STANDARDS, *supra* note 11, at 93.

74. *See supra* notes 42-52 and accompanying text.

75. *See* C & M Promotions v. Ryland, 208 Va. 158, 164 S.E.2d 132 (1967). *See generally* Young v. Merritt, 182 Va. 605, 29 S.E.2d 834 (1944) (action for unlawful arrest and false imprisonment in which the court took judicial notice that a large majority of servicemen are highly moral); Branch v. Burnley, 5 Va. (1 Call) 147 (1797) (action involving the collection of a debt by an attorney in which the court took judicial notice of the general practice of attorneys in collecting debts for their clients).

of patients, ignore advances in health technology, and contradict the legislative mandates of this particular industry and its intended beneficiaries.

Several Virginia cases outside the medical and hospital negligence areas of law illustrate how written policies and rules are used as evidence. The denial of unemployment compensation benefits was affirmed based partly on the employee's failure to comply with the company policy against garnishment resulting in his dismissal.[76] Federal Employees' Liability Act (FELA) claims of injured railroad employees have been decided in part on evidence of the employer's safety rules which were properly introduced by both plaintiffs and defendants.[77] Safety policies adopted by a defendant and used as a basis for its instructions to its employees have been held to be admissible evidence of the defendant's knowledge of potential danger.[78] Furthermore, it has been held to be reversible error to exclude written material showing that the defendant *should* have done what it failed to do even though a defendant was willing to stipulate that it failed to do the act in question.[79] The rule is generally "that a litigant is entitled to introduce *all* competent, material and relevant evidence which tends to prove or disprove any material issue raised. Defendant's alleged negligence was a material issue and the exclusion of the [instructions] was error."[80]

The Fourth Circuit Court of Appeals has already indicated its willingness to consider such standards as evidence of the applicable standard of care in medical negligence cases. In *Pelphrey v. United States*,[81] the court affirmed an Eastern District of Virginia

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76. Branch v. Virginia Employment Comm'n, 219 Va. 609, 245 S.E.2d 180 (1978); *see also*, Peanut City Iron & Metal Co. v. Jenkins, 207 Va. 399, 150 S.E.2d 120 (1966).

77. Seaboard Coast Line R.R. v. Ward, 214 Va. 543, 202 S.E.2d 877 (1974); Norfolk S. Ry. v. Rayburg, 213 Va. 812, 195 S.E.2d 860 (1973).

78. New Bay Shore Corp. v. Lewis, 193 Va. 400, 69 S.E.2d 320 (1952).

79. Barnette v. Dickens, 205 Va. 12, 135 S.E.2d 109 (1964).

80. *Id.* at 15, 135 S.E.2d at 112 (emphasis added) (citing Hepler v. Hepler, 195 Va. 611, 620, 79 S.E.2d 652, 657 (1954)).

81. 674 F.2d 243 (4th Cir. 1982). *See also* Graves v. Gulmatico, No. CA 83-0679-R (E.D. Va. Sept. 4, 1984) (Judge D. Dortch Warriner ruled that the HOSPITAL AND MEDICAL STAFF BYLAWS were not only admissible exhibits in a case against a physician, but represented some of the best evidence of the applicable standard of care). *Contra*, Graves v. Community Memorial Hosp., No. 1721 (Cir. Ct. of Mecklenburg County Mar. 9, 1984) (Judge Charles L. McCormick ruled that the EMERGENCY ROOM MANUAL was not admissible against the hospital); Layne v. Christie, No. LG-1725 (Richmond Cir. Ct. Oct. 3, 1984) (Judge William E. Spain ruled that the MEDICAL STAFF BYLAWS and AMERICAN COLLEGE OF SURGEONS BYLAWS were not admissible against a physician. Ruling was based on the unpublished holding in Strayer v. Halterman, No. 82-1673 (4th Cir. Oct. 5, 1983), finding no error in the

opinion granting summary judgment to the defendant in a Federal Torts Claims Act hospital negligence action. In its opinion, the court noted that the defendant's affidavits showed that the recruitment of physicians was "in accord with specific statutory and regulatory standards"; the doctor's qualification exceeded the "minimum standard"; and that the hospital was "fully accredited by the Joint Commission on Accreditation of Hospitals."[82] In summarizing this evidence, the court held that the affidavits were not "opinion," and stated "we are at a loss to say what other informed sources the government could have called upon to demonstrate that it had met its duty of care in physician selection and hospital administration."[83]

V. Procedural Steps Leading to the Admission of Standards and Their Consideration by Juries

In pretrial discovery, a plaintiff in a medical negligence case needs to request production of all written rules which may pertain to the allegations of negligence. Furthermore, the plaintiff should submit interrogatories, requesting all information concerning the defendant's licenses, accreditations, certifications, and eligibility for Medicare/Medicaid reimbursement at the time of the plaintiff's injury. Once obtained, the information should be recast in the form of requests for admission so as to avoid authenticity or timeliness objections at trial. Likewise, defendants should review the same information and request admissions if appropriate. All applicable information gathered should be provided to a party's experts.

During depositions, factual witnesses who provide care or who are administratively or vicariously responsible for patient care should be questioned. Their familiarity with written standards should be discerned, as well as their knowledge as to whether com-

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exclusion of an emergency room manual. However, note that such unpublished opinions are of questionable precedential value. Fed. R. App. P. 18 (4th Cir.)).

82. *Pelphrey*, 674 F.2d at 247.

83. *Id. See also* Just, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B.C.L. Rev. 835, 914 n.559 (1983). The section entitled of Inadequate Standards and Inspections through Tort Law," cites additional cases where the defendants' verdicts were supported in part by evidence of compliance with written standards of care. *See, e.g.*, Moreaux v. Argonaut Ins. Co., 350 So. 2d 240, 246 (La. Ct. App.), *cert. denied*, 351 So. 2d 776 (La. 1977) (wrongful death medical malpractice action wherein compliance with requirements of JCAH Standards as reflected in repeated JCAH inspections was evidence in support of the verdict in favor of the defendant hospital).

pliance is an employment criteria, an institution requirement, or a certification, accreditation, licensing or reimbursement requirement. Expert witnesses should also be asked whether the standards applicable to a particular institution are the same or similar to those of other institutions with which the expert is familiar, whether compliance is generally required, and whether their opinion regarding negligence is based in part on conformity to or deviation from such standards.

A. *Documentary Evidence*

Either party may request that written standards be directly admitted by judicial notice,[84] stipulation, or introduction through a proper person who can authenticate a standard and its applicability to the health care provider. Such appropriate persons include hospital administrators, chiefs of medical staffs, directors of nursing, and representatives of state licensing agencies and federal reimbursement programs. Alternatively, written standards may be introduced through requests for admissions once their genuineness and timeliness have been admitted. A less desirable method of introducing the information contained in the standards is through the use of interrogatories and answers, or requests for admission and answers, pertaining to the standards themselves.

It is best for the party seeking the admission of standards to introduce the standards or portions of them as early as possible in the trial, and refer to them in the examination of as many witnesses as appropriate so as to enhance their significance and increase the chances that they will be remembered for the duration of the medical or hospital negligence trial. If the standard's relevance to the facts in issue is questioned after the standard is authenticated, then there are several alternatives. First, the attorney can offer to explain, either verbally or in a trial brief, the relevancy of the standard. Secondly, the document can later be introduced through a witness who is familiar with its specific relevance to the facts in issue. Such witnesses include factual witnesses who are health care providers and who use the standards themselves[85] or expert medical witnesses who use the same or similar standards,

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84. VA. CODE ANN. §§ 8.01-386 to -388 (Repl. Vol. 1984); C. FRIEND, THE LAW OF EVIDENCE IN VIRGINIA §§ 275, 282 (2d ed. 1983); *see also* cases cited *supra* note 75.

85. *See* C. Friend, *supra* note 84, § 253 (stating that if a hospital takes a position at trial contrary to that which is stated in one of its own rules and which is both material and relevant, the rule may be admissible alternatively as a party admission).

and have reviewed the document containing the standard in conjunction with giving an expert opinion.[86]

B. *Testimonial Evidence*

Witnesses may read to the jury portions of documents as part of their testimony on direct or cross examination. Based on the relative effectiveness of demonstrative as compared with spoken evidence, this method is probably less effective than introducing materials which the jury can see. Therefore, it is preferable that the attorney attempt to introduce the standard as an exhibit, and only have the contents read if the judge refuses admission. If testimony comes in first, the standards themselves may be viewed as cumulative evidence. Cases have held that the exclusion of standards is not reversible error when experts had already testified to the information contained therein.[87] If a standard must be read, then a blowup of the pertinent material can still be used as a demonstrative aid during closing argument to focus the jury's attention on the standard.

C. *The Court's Discretion*

Although the standards are found to be authentic and relevant, they will still be subject to the discretionary power of the court. Judges may allow a party to exclude nonrelevant parts with prejudicial impact or include additional parts or material which serve to explain or qualify a standard.[88] The scope of discretion regarding admission was explained by the *McComish* court in 1964.

> Whether the entire code [standard] or just the pertinent portion should go to the jury (removed from the document, or copies or photostated), or whether the pertinent portion should simply be read to the jury, must remain in [the judge's] hands, and an appellate tribunal will not interfere unless abuse of discretion is manifest.[89]

While there may be no apparent reason to exclude the standards, attorneys trying cases where standards are applicable should first determine the most effective manner of admission, and then be

86. VA. CODE ANN. § 8.01-401.1 (Repl. Vol. 1984).
87. Cornfeldt v. Tonsen, 262 N.W.2d 684, 704 (Minn. 1977).
88. McComish v. Desui, 42 N.J. 274, ____, 200 A.2d 116, 123 (1964).
89. 42 N.J. at ____, 200 A.2d at 122.

prepared to utilize alternatives.

D. *Jury Instructions*

Once the standards have been admitted into evidence, the attorney who sought their admission should make certain that the meaning of that evidence is clearly made to the jury to in order avoid inadvertent misconceptions. The following sample instruction is recommended for that purpose:

> In determining the nature of any duty owed the plaintiff by the defendant, you should take into consideration the provisions of the evidence in this case on the subject of the rules and regulations of the [Licensing Act of Virginia; Joint Commission on the Accreditation of Hospitals; Policies and Procedures of Any Department of Any Hospital; By-laws of Any Hospital; By-laws of the Medical Staff of Any Hospital; Federal Medicare and Medicaid Regulations, Standards of the American College of _____] and weigh these provisions along with all the other evidence in the case in determining that duties were imposed upon the defendant.[90]

VI. Conclusion

Virginia courts should allow written standards pertaining to patient care proffered by plaintiffs and defendants to be admitted as evidence provided that those standards are properly authenticated and relevant to the specific allegations of negligence at issue. Such standards would assist the trier of fact in its determination of the standard of care in a given situation. Written standards, especially those which predate a lawsuit, are more reliable in many respects than are the divergent opinions of experts employed by the opposing parties. These standards are composed and approved by health care providers with varied educations and practices who are collectively familiar with the pertinent health care literature. Because these standards represent the combined wisdom of many, this consensus opinion becomes evidence of industry custom and is not objectionable hearsay.

Those standards written pursuant to state licensing and Medicare and Medicaid requirements exist to benefit public safety and

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90. Darling v. Charleston Community Memorial Hosp., 50 Ill. App. 2d 253, ____, 200 N.E.2d 149, 189 (1964), *cert. denied*, 383 U.S. 946 (1966).

welfare, and therefore are not objectionable on the grounds that they are private or voluntary. Decisions of other jurisdictions are examples of proper factual situations and procedures for the admission of written standards on behalf of both plaintiffs and defendants. There are significant Virginia cases where non-medical written standards were permissibly introduced at trial in civil litigation by plaintiff as evidence of defendant's negligence, duty and knowledge of danger. The previous Virginia Supreme Court decisions, which prohibited the admission of standards, *Virginia Railway and Power v. Godsey* and *Pullen v. Nickens* are clearly distinguishable since neither case involved health care providers, nor patient care standards, nor the present realities of essentially uniform standards in the health care industry. There exist no policy reasons for excluding the standards.

The standard to be applied in a given case will still be that of reasonable care under all the circumstances unless, reasonableness has already been defined by statute or a related regulation. Admission of these reliable documents as an aid to the trier of fact would increase the likelihood of just and informed decisions in the developing and complicated area of medical and hospital negligence, as well as remove some of the elusiveness surrounding the standard of care.