

NOTES

The Law of Medical Malpractice in Missouri

Medical malpractice has been defined as "the treatment of a disease by a physician or surgeon in an unskilful manner, or in a manner contrary to accepted rules, causing injurious results to the patient."¹ This note will attempt to formulate the Missouri law regulating those who engage in the "art of healing" as it has evolved in civil litigation.² The subject of factual causation will not be included, not because it is unimportant but due to the technical difficulties that are necessarily involved in any discussion of that subject.³ Nor will there be any section devoted to the problem of damages in malpractice.⁴ The scope of this note is to define the duty of the medical practitioner, those acts or omissions that amount to a breach of that duty and the defenses that are available to the practitioner.

The Form of the Action

Malpractice at its inception was inextricably tangled up with the law of implied contract.⁵ The liability of the practitioner was predicated upon the fact that he held himself out as possessing sufficient skill and care for his undertaking.⁶ However, as the action was more closely scrutinized the courts, largely on the basis of public policy, began to recognize that the action sounded in tort.⁷ In *Barnhoff v. Aldridge*,⁸ plaintiff, less than five years and more than two years after injury by the defendant practitioner's alleged malpractice, brought an action on the contract. There was a five year statute of limitations for actions on the contract and a two year statute of limitations for ac-

1. MALOY, MEDICAL DICTIONARY FOR LAWYERS 318 (1942).

2. The criminal law of medical malpractice is beyond the scope of this note which is restricted to problems arising in civil litigation.

3. An intelligent discussion of medical causation requires considerable medical background.

4. Problems of damages are not peculiar to malpractice litigation.

5. For a discussion of the contractual liability of physicians and surgeons see Miller, *The Contractual Liability of Physicians and Surgeons*, 1953 WASH. U.L.Q. 413.

6. See, e.g., *Force v. Gregory*, 63 Conn. 167, 27 Atl. 1116 (1893); *Small v. Howard*, 128 Mass. 131 (1880); *Leighton v. Sargent*, 27 N.H. 460 (1853).

7. In *Hales v. Raines*, 146 Mo. App. 232, 130 S.W. 425 (1910), public policy was the very ground upon which the court refused to limit the practitioner's duty to the scope of his contractual agreement. For a discussion see text accompanying note 11 *infra*.

8. 327 Mo. 767, 38 S.W.2d 1029 (1931).

tions of malpractice. Defendant demurred to the petition and the trial court sustained the demurrer. On appeal the court held, "it would seem very advisable and almost necessary to do what has been done in some jurisdictions, namely recognize the fact that *an action for malpractice is neither a purely tortious or contractual action, but is a hybrid. . .*"⁹ However, it was decided sixteen years later that the action of malpractice sounded in tort. In *Baysinger v. Hanser*¹⁰ plaintiff's wife died after having been operated on by defendant. Plaintiff brought his action eighteen months after the operation and defendant made a motion to dismiss alleging that the petition showed on its face that it was barred by the one year statute of limitations placed on all wrongful death actions. Plaintiff, relying on the *Barnhoff* decision, replied that an action of malpractice was *sui generis* and survived under the two year statute of limitations that applied to malpractice actions. The court in affirming trial court's action in sustaining the motion to dismiss held that *malpractice is a tort action* and as such survives only under the wrongful death statute.

Since it is now generally recognized that the action sounds in tort, it is also well established, perforce, that the duty of the practitioner is one that is imposed upon him as a matter of law and not limited by the contractual nature of the practitioner-patient relationship. However, although the practitioner cannot diminish his duty by contractual agreement, he may expand his duty by entering into a contract to cure.¹¹

As a tort malpractice is a generic term under which may be subsumed actions against medical practitioners for negligence,¹² recklessness¹³ and intentional torts.¹⁴

I. DUTY

If a medical practitioner is held liable in malpractice, it is because the law has imposed upon him a duty with which he has not con-

9. *Id.* at 772, 38 S.W.2d at 1031. (Emphasis added.)

10. 355 Mo. 1042, 199 S.W.2d 644 (1947).

11. *E.g.*, *Vanhooover v. Berghoff*, 90 Mo. 487, 3 S.W. 72 (1887).

12. Negligence forms the basis for the majority of the malpractice litigation.

13. When the selection of the treatment is the issue, it is submitted that before the practitioner can be held liable his breach must approach recklessness. For a discussion of the selection of treatment see text accompanying notes 93-95 *infra*.

14. In *Moore v. Webb*, 345 S.W.2d 289 (Mo. 1961), plaintiff went to defendant who was an extractionist to have several teeth removed. Defendant mistakenly pulled all her teeth. Plaintiff brought her action in malpractice, but it is submitted that a battery action could have been just as successful. See *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905); *but see Hershey v. Peake*, 115 Kan. 562, 223 Pac. 1113 (1924), distinguishing between the intentional and the unintentional excess of authority.

formed. This section will be concerned with when the duty arises, to whom it is owed and the standard by which it is applied. Before embarking upon an extensive analysis of the duty of the medical practitioner, it would be beneficial to survey rather generally for purposes of comparison the duty and the standard of application that is employed in the ordinary negligence case.

The negligent actor is held to a duty of *due care*. In applying this nebulous phrase to the facts of any given case, the jury is told to measure the actor's conduct by the standard of the reasonably prudent man.¹⁵ This fictional character is "a hypothetical person . . . who represents a community ideal of reasonable behavior."¹⁶ Undoubtedly this standard is formulated in the jury's mind partly from its own experience and partly from its concept of what the reasonably prudent man *would* do. No witness is asked what he would have done under the circumstances, nor is the jury asked to determine what it would have done.¹⁷ The jury's final determination must be based not upon what men actually do, but upon what this hypothetical creation would have done. Indeed the key to the question of reasonableness lies not in "what actually happened, but what the reasonably prudent person would have foreseen as likely to happen. . . ."¹⁸ Thus the standard that is applied in measuring the conduct of the negligent actor in the normal negligence case is a conceptualization of reasonable prudence with the focus trained upon the actions of a mythical man. With this as a background the duty of the medical practitioner can be more easily illuminated.

The medical practitioner is held to possess and exercise that degree of skill and care that is possessed and exercised by the average practitioner of the same school practicing in similar localities.

15. TORTS, RESTATEMENT § 283, comment *a* (1934).

The words "reasonable man" denote a person exercising those qualities of attention, knowledge, intelligence and judgment which society requires of its members for the protection of their own interests and the interests of others.

16. PROSSER, TORTS § 31 at 124 (2d ed. 1955). Seavey refers to the standard as a "fictitious personality with whose conduct we compare the actor's. . . ." Seavey, *Negligence—Subjective or Objective?* 41 HARV. L. REV. 1, 10 (1927).

17. Professor Green in his work, JUDGE AND JURY, points out the undesirability of having the jury attempt to measure the conduct of the negligent actor in terms of its own experience or in terms of any mathematical computation. Rather the trial courts in their instructions attempt to objectify the abstractions of reasonableness and prudence. GREEN, JUDGE AND JURY 161-64 (1930).

18. James, *Nature of Negligence*, 3 UTAH L. REV. 275, 281 (1953).

A. *Medical Practitioners*¹⁹

Before deciding the question of who may be liable in malpractice, it is necessary to decide what constitutes the practice of medicine. The friendly neighbor and the corner druggist engage in the practice of medicine when they "advise and prescribe" treatments and cures. Applying this definition literally, it is conceivable that the neighbor and the druggist could be held liable in malpractice. The relevant Missouri statutes shed little light upon the subject, for although they define the individuals who are authorized to practice medicine²⁰ and those individuals who are not authorized to do so, they fail to reveal when one not authorized to do so shall be deemed to be engaging in the practice of medicine.

A workable definition of the practice of medicine was stated by the court in *Longan v. Weltmer*.²¹ It was held that one who holds himself out to be a "healer of diseases"²² may be held liable in malpractice. However, the difficulty with this definition is that it seemingly affords a class of defendants, whom it is intended to comprehend, a ready defense. Since they are being held to have practiced medicine solely because they have held themselves out as healers of disease, it would seem anomalous to hold them liable for compliance with the practice upon which their liability is predicated.²³ Thus, if *D* holds himself out as being able to heal by magnetism, conformity to the art of magnetic healing, although not recognized by the medical profession or the statutes, should logically afford *D* a perfect defense. However, it was held when this defense was urged that one who holds himself out as a healer of diseases, but belongs to no recognized school, shall be held to the standard of the average physician or surgeon.²⁴ This definition has excluded the friendly neighbor and the corner druggist, for although they may advise and even prescribe, they cannot conceivably be said to hold themselves out as healers of disease. It includes a class of possible defendants that

19. 'Medical practitioners' as used in this article is a term of art. It is intended to encompass not only those who deal in dispensing of medicine but also those who may be liable in malpractice.

20. See generally, Mo. REV. STATS. §§ 331.010-.100 (1950) (Chiropractors); Mo. REV. STATS. §§ 332.010-.390 (1959) (Dentists); Mo. REV. STATS. §§ 334.010-.260 (1959) (Physicians and Surgeons).

21. 180 Mo. 322, 79 S.W. 655 (1904).

22. *Id.* at 333, 79 S.W. at 658.

23. This was in fact the defense that was urged in *Weller v. Palapao Lab., Inc.*, 197 Mo. App. 47, 191 S.W. 1056 (1917). See also *Owens v. McCleary*, 313 Mo. 213, 281 S.W. 682 (1926).

24. In *Weller v. Palapao Lab.*, *Supra* note 23, at 60, 79 S.W. at 1060, the court said that "while . . . defendant did not hold itself out as a practicing physician . . . it was . . . under the like obligation of a physician and surgeon."

are commonly called "quacks." However it would seem to bring within its ambit another class of possible defendants: faith healers. Faith healers and Christian Scientists fit the description of people who hold themselves out as healers of disease but belong to no recognized school. The difficulties with holding that these people are practicing medicine, and therefore liable in malpractice are manifest.²⁵ There are no reported cases in Missouri in which a faith healer or Christian Scientist has been sued for malpractice in a civil action; however, there is one criminal case in which a Christian Scientist was charged with unlicensed practice of medicine.²⁶ The court there held that although defendant was holding herself out as a healer of disease, the diseases that she was seeking to cure were the diseases of the soul and not of the body and therefore not within the purview of the statute.²⁷ Thus the practice of medicine may be defined, for purposes of malpractice, as the healing of physical diseases.²⁸

B. Skill and Care

Much of the early effort of the Missouri courts was spent in establishing the distinction between *skill* and *care*. *Skill* was held to be the actual knowledge that the practitioner possessed while *care* referred to the way in which he administered the treatment to his patient. This distinction afforded the malpractice plaintiff a procedural device by which he had two separate and distinct causes of action. In *Vanhoover v. Berghoff*²⁹ the court held that plaintiff was "at liberty to take his position before the jury that defendant was

25. Among other things, this would infringe severely upon religious freedoms.

26. *Kansas City v. Baird*, 92 Mo. App. 204 (1902).

27. Although there are no reported cases in Missouri dealing with the liability in malpractice of a faith healer, it would appear that the *Baird* case would be extended to exempt faith healers from liability. If the faith healer fails to conform to the accepted practices of "faith-healing," *e.g.*, if he attempts to heal a fracture and no other healer of his cult would have attempted it, it is submitted that plaintiff would be wiser to proceed in negligence.

28. An interesting problem is posed by the psychiatrist, for he is not in a strict sense a healer of *physical* diseases. The psychiatrist heals diseases of the mind as distinguished from physical diseases or diseases of the soul and although there are no reported cases in Missouri, it is submitted that a psychiatrist would be liable in malpractice.

It is not necessary that the patient be human for veterinarians may be held liable in malpractice. See *Breece v. Ragan*, 234 Mo. App. 1093, 138 S.W.2d 758 (1940).

29. 90 Mo. 487, 498, 3 S.W. 72, 76 (1887). See also *Sennert v. McKay*, 56 S.W.2d 105 (Mo. 1932); *Rothschild v. Barck*, 324 Mo. 1121, 26 S.W.2d 760 (1930); *Trask v. Dunnigan*, 299 S.W. 116 (Mo. Ct. App. 1927); *Fowler v. Burris*, 186 Mo. App. 347, 171 S.W. 620 (1914); *Gore v. Brockman*, 138 Mo. App. 231, 119 S.W. 1082 (1909); *Robertson v. Wenger*, 131 Mo. App. 224, 110 S.W. 663 (1908).

ignorant and unskillful, or that he was negligent and careless, or . . . that he was both unskillful and negligent.”³⁰

There is one other very cogent reason for the efforts of the Missouri courts to establish this distinction. The action of malpractice as noted above³¹ was born in the law of contract, and, therefore, the duty of the medical practitioner was recognized as being contractual in nature. It would then logically follow that defendant could urge as an unassailable defense that he has only contracted to use the care which he himself possessed. Thus, a practitioner who did not possess requisite skill would be immune from liability merely by exercising his maximum skill while a practitioner who possessed greater skill would be vulnerable to greater liability. To avoid this anomalous result the court established the distinction between skill and care. The practitioner was deemed to have promised that he possessed the requisite skill and would exercise the requisite care, thus subjecting the unskillful practitioner to liability on a contract theory.

At the present time there seems to be no very compelling reason for insisting upon the preservation of this distinction. The law of malpractice has become more sophisticated. The courts have generally recognized that the duty of the medical practitioner, although born in contract, is akin to a tort duty. Thus a practitioner who has attempted to treat a patient without possessing the requisite skill is *negligent*. This approach, therefore, necessarily puts in issue whether the practitioner possessed sufficient skill to have treated the patient and whether he treated the patient with due care. In *Rothschild v. Barck*³² the court held that “the term ‘negligence’ not only covers a lack of care, but the failure to exercise skill which the person possesses, or the attempt to exercise skill which he knows he does not possess.”³³

Some writers³⁴ have expressed concern at the current neglect of this area of the law of medical malpractice. It is submitted that the terminology would not of itself focus attention where it is needed in this area. The terms “skill and care” were invented by the court to fill a gaping breach in the law. This breach has now been filled by re-definition of the action, and this artful language is now but a non-functional vestige of an ancient concept. Although the phrase is still used by many trial courts in their instructions to the jury, no

30. *Vanhoover v. Berghoff*, 90 Mo. 487, 498, 3 S.W. 72, 76 (1887).

31. See text accompanying note 5 *supra*.

32. 324 Mo. 1121, 26 S.W.2d 760 (1930). See also *Sennert v. McKay*, 56 S.W.2d 105 (Mo. 1932) (citing with approval).

33. *Rothschild v. Barck*, 324 Mo. 1121, 1128, 26 S.W.2d 760, 763 (1930).

case has been decided since 1900 in which the distinction was determinative.

C. Average Practitioner

As noted earlier³⁵ the duty of the negligent actor in the ordinary negligence case is due care, and the standard by which it is applied is the mythical reasonably prudent man. The duty that is impressed upon the medical practitioner is considerably less demanding. He does not have to meet any standard of reasonableness nor of prudence. The degree of skill and learning that he must possess and the degree of care that he must exercise is that "which is *ordinarily* possessed and exercised by the members of his profession."³⁶

This provides the malpractice defendant with a significant advantage. He need not attempt to show that the procedure that he pursued in treating his patient was reasonably prudent, but rather he need only establish that it is the procedure employed by other members of his profession. The "negligence" defendant on the other hand has no such defense available to him.³⁷ Hence proof of conformity to the customary treatment employed by his fellow practitioners can be a complete defense for the "malpractice" defendant.³⁸ If there is conflicting testimony as to what the custom for the treatment is, the malpractice defendant is given a further advantage. "[U]nless it be shown that the course pursued was *clearly* against

34. In a book review of PROFESSIONAL NEGLIGENCE, 1961 WASH. U.L.Q. 86, Orville Richardson expressed concern over this area of the law of malpractice and the neglect that the bar and the bench have accorded it. It is suggested that the phrase "skill and care," notwithstanding Mr. Richardson, could be shortened to care without detriment to the law of malpractice.

35. See text accompanying note 15 *supra*.

36. Owens v. McCleary, 313 Mo. 213, 222-23, 281 S.W. 682, 685 (1926). (Emphasis added.) See *e.g.*, Heier v. Funsch, 61 S.W.2d 253 (Mo. Ct. App. 1933); Hales v. Raines, 146 Mo. App. 232, 130 S.W. 425 (1910); Robertson v. Wenger, 131 Mo. App. 224, 110 S.W. 663 (1908).

37. There are three distinct views on the effect of custom in the ordinary negligence case. The majority view is represented by Bimberg v. Northern Pac. Ry., 217 Minn. 187, 14 N.W.2d 410 (1944). The court held that custom was admissible to show due care but that it was merely evidence of due care and the defendant was not entitled to a directed verdict on the strength of it alone. McNally v. Colwell, 91 Mich. 527, 52 N.W. 70 (1892); Jenkins v. Hooper Irr. Co., 13 Utah 100, 44 Pac. 829 (1896) represent a substantial minority holding that custom is not admissible as evidence of due care. Bandekow v. Chicago, B.&Q. Ry., 136 Wis. 341, 117 N.W. 312 (1908) represents the third view holding that custom is controlling. For an excellent discussion see Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147 (1942).

38. It should be noted at this point that there is a class of cases in which custom has the same weight as in the ordinary negligence cases, and within that class of cases it does not therefore afford the malpractice defendant a complete

the course recognized as correct by the profession generally"³⁹ defendant will be entitled to a directed verdict. The negligence defendant in the event of a conflict in the evidence as to his negligence or freedom will go to the jury.

In addition to these advantages the malpractice defendant need not exercise "his best skill and ability if he uses the care and skill which is exercised generally by physicians of ordinary care and skill."⁴⁰ The negligence defendant is held to possess what knowledge the reasonably prudent man would possess and he is also held accountable for any subjective knowledge that he himself actually possesses.⁴¹ Thus if *D* is an ophthalmologist with special experience in the treatment of glaucoma and treats a patient suffering from glaucoma, the fact that he had had special experience would not be admissible against him. In measuring the conduct of the malpractice defendant the jury is not concerned with whether the treatment he selected is reasonable nor are they interested in ascertaining what additional subjective knowledge he possessed. The standard is simply what other members of his profession *do*.

The specialist presents a slightly different problem. In *McClarín v. Grenzfelder*⁴² the trial court instructed the jury that if defendant who had held himself out as an expert in the cure of hernia had not used "ordinary skill and care," they could then find him guilty of malpractice. The jury returned a verdict for plaintiff which was reversed; the court held that one who holds himself out as an expert is held to the degree of care of those who "devote special study to the treatment of the disease."⁴³ Although it seems that the standard for the specialist is more demanding, the court pointed out that it affords the specialist a wider latitude in selecting a treatment.⁴⁴

defense. This is developed more completely below; see text accompanying notes 96-100 *infra*. Professor Morris in MORRIS, TORTS § 4 at 59-60 (1953) states:

The substantive law rule is that a patient is treated improperly by his physician, surgeon, or dentist only if the defendant has departed from the practice of other reputable practitioners. . . . In suits against railroads, banks, drovers or any defendant other than a medico the plaintiff need not prove that the defendant departed from the ways of his craft. . . . But a doctor accused of malpractice may have excusably made a medical mistake. The conformity test is a rough and ready test of whether mistakes should be excused.

39. *Bailey v. St. Louis S.F. Ry.*, 296 S.W. 477, 479 (Mo. Ct. App. 1927). (Emphasis added.)

40. *Hales v. Raines*, 146 Mo. App. 232, 241, 130 S.W. 425, 428 (1910). See also *Heier v. Funsch*, 61 S.W.2d 253 (Mo. Ct. App. 1933).

41. *E.g.*, RESTATEMENT, TORTS § 290, comment *e* (1934).

42. 147 Mo. App. 478, 126 S.W. 817 (1910). See also *McMurdock v. Kimberlin*, 23 Mo. App. 523 (1886).

43. *McClarín v. Grenzfelder*, 147 Mo. App. 478, 487, 126 S.W. 817, 820 (1910).

44. If the specialist were held to the standard ordinarily exercised in the community by average practitioners, then he would be precluded from employing

D. Same School

The duty of the medical practitioner is reduced further by the requirement that he be held only to the standard of his school or branch of medicine. In evaluating whether the treatment selected by a medical practitioner was proper under the circumstances, neither the jury⁴⁵ nor the medical profession⁴⁶ will be allowed to decide the question. The only practitioners who are qualified to comment upon the propriety of any treatment are those who are members of the same school or branch of medicine as the defendant. In order for the malpractice defendant to be afforded the protection of the same school requirement he must belong to a school that is recognized. This presents two immediate problems; first, what schools are recognized, and second, to what standard are those practitioners held who belong to no recognized school?

The doctrine of *Grainger v. Still*⁴⁷ provides the answer to both of these questions. First, the only schools that are recognized are those that are specifically recognized by statute.⁴⁸ Second, those practitioners who belong to no school that is specifically recognized by statute "must be held to the duty of treating patients with the ordinary skill and knowledge of *physicians* in good standing."⁴⁹

Substantively the effect of this rule is to forbid the jury to question the validity of any school of medicine. The statutory sanction that has been granted by the legislature is conclusive upon the fact finder, and neither the fact finder nor the medical practitioner at large can be allowed to pass upon the propriety of the treatment that any recognized school employs. The practitioner who belongs to no school recognized by statute does not have such shelter. The validity of his treatment may be directly attacked by those who do not subscribe to his methods, and the determination of the jury will be conclusive.

Procedurally the effect of the same school requirement is far

treatments beyond their scope of knowledge but that were in use among other specialists. Thus a specialist could be held liable for employing a treatment that the court would label an 'innovating experiment' when in fact the treatment was well recognized among other specialists.

45. In *Atkinson v. American School of Osteopathy*, 240 Mo. 338, 144 S.W. 816 (1912), the court reversed a verdict for plaintiff because the instructions were so framed as to give "the jury the right to find that osteopathic treatment was not proper treatment." *Id.* at 352, 144 S.W. at 821.

46. See, e.g., *Mann v. Grim-Smith Hospital and Clinic*, 347 Mo. 348, 147 S.W.2d 606 (1941); *Pedigo v. Roseberry*, 340 Mo. 724, 102 S.W.2d 600 (1937); *Reed v. Laughlin*, 332 Mo. 424, 58 S.W.2d 440 (1933); *McDonald v. Crider*, 272 S.W. 980 (Mo. Ct App. 1925); *Atkinson v. American School of Osteopathy*, 240 Mo. 338, 144 S.W. 816 (1912); *Grainger v. Still*, 187 Mo. 197, 85 S.W. 1114 (1905).

47. 187 Mo. 197, 85 S.W. 1114 (1905).

48. See footnote 20, *supra*.

49. *Grainger v. Still*, 187 Mo. 197, 214, 85 S.W. 1114, 1119 (1905).

reaching. As stated above, in cases involving the selection of the proper treatment by a practitioner who belongs to a recognized school, the fact finder is not competent to question the validity of the school's method of treatment. Thus for plaintiff in this type action to make a submissible jury case, he must produce an expert from defendant's school who will testify to the impropriety of defendant's treatment. Practitioners of another school are incompetent to testify to the treatment employed. However, if the issue concerns the *diagnosis* of the disease the rule is quite different:

The disease is the same no matter which school of medicine the attending physician belongs to. . . . They [practitioners of different schools] may differ as to the proper treatment of the disease after its presence is ascertained, but there is no difference as to diagnosis. . . . This being so, there is no sound reason why a physician of any school should not be a competent witness . . . as to any diagnosis of any disease. The bias or prejudice of one school of medicine against another cannot affect the question of diagnosis, however much it might affect the treatment employed by the other school.⁵⁰

Thus, a practitioner who belongs to a school other than defendant's school is incompetent to testify as to treatment employed by defendant but competent to testify as to his diagnosis or to "any scientific fact that is, or ought to be, known to every physician and surgeon of every school or system."⁵¹

The specialist receives slightly different treatment. Only those members of his school who "by special study and experience probably have acquired more accurate knowledge of the right methods of treatment than is possessed by ordinary practitioners of medicine"⁵² are qualified to testify as to the propriety of the specialist's treatment.

The same school requirement serves to insulate the malpractice defendant from having his system of medicine directly attacked. If

50. *Id.* at 225-26, 85 S.W. at 1123. In *Mann v. Grim-Smith Hospital and Clinic*, 347 Mo. 348, 147 S.W.2d 606 (1941) an osteopath testified against an allopath and the court upheld the trial court in allowing him to do so and they cited the following with approval from *Swanson v. Hood*, 99 Wash. 506, 170 Pac. 135 (1918),

The rule is not that a physician of another school is incompetent to testify, but that a defendant's treatment is to be tested by the general doctrine of his own school, which is a very different thing; . . . the standard of exclusion of evidence is not the school of the witness, but the premises of his testimony. *Id.* at 353, 147 S.W.2d at 608 (1941).

See also *Reed v. Lauglin*, 332 Mo. 424, 58 S.W.2d 440 (1933) (M.D. testifying against osteopath); *Cazzell v. Schofield*, 319 Mo. 1169, 8 S.W.2d 580 (1928) (osteopath testifying against M.D.).

51. *Grainger v. Still*, 187 Mo. 197, 85 S.W. 1114 (1905). See also *York v. Daniels*, 259 S.W.2d 109 (Mo. 1953) (Mortician, dentist, pathologist, M.D. testifying against chiropractor).

52. *McClarin v. Grenzfelder*, 147 Mo. App. 478, 487, 126 S.W. 817, 820 (1910).

the system is recognized by statute, then its soundness cannot be questioned. Practically the malpractice plaintiff when attempting to put in issue the selection of treatment by the medical practitioner is faced with the burden of producing practitioners of his own school. This consequence of the 'same school' requirement is often fatal to plaintiff's cause of action.

E. Similar Localities

The rule that the practitioner is held only to the standard of those practicing in the same or similar localities is peculiarly American in its origin.⁵³ Apparently, it is a result of geographical rather than legal forces. During the earlier days of this country when the communication media were not well developed, the dissemination of information was quite slow. Thus it would have been incongruous to hold that a practitioner had constructive knowledge of the latest developments in the nearest large city or in the medical centers of Baltimore, New York or Vienna. Hence the rule at its inception was a device to protect the much revered country doctor. He was not responsible for the latest scientific advances but was liable only for those in use in the same or similar localities. Nor was he responsible for using the latest equipment. These restrictions upon the degree to which a practitioner could be held constructively knowledgeable have carried over into modern Missouri law.⁵⁴

This is, however, decidedly not the rule in England nor has it ever been.⁵⁵ England is of course a much smaller country and the opportunity for communication was always more available. However, if the basis for the rule were merely the geographic conditions and their effect upon communication, is the rule of any value at the present time?

In *Williams v. Chamberlain*⁵⁶ the court said in dicta that the instruction of "in similar communities"⁵⁷ was not necessary as this requirement was created at a time when there was not an equal opportunity for learning. However, they indicated that it was not error to include this requirement in the instructions. The *Williams* case indicates that the Missouri court may in time broaden the opera-

53. Fleming, *Development in the Law of Medical Liability*, 12 VAND. L. REV. 633, 640 (1958).

54. See, e.g., *Owens v. McCleary*, 313 Mo. 213, 281 S.W. 682 (1926); *McDonald v. Crider*, 272 S.W. 980 (Mo. Ct. App. 1925); *Evans v. Clapp*, 231 S.W. 79 (Mo. Ct. App. 1921); *Wojciechowski v. Coryell*, 217 S.W. 638 (Mo. Ct. App. 1920) (under like conditions); *Hales v. Raines*, 146 Mo. App. 232, 130 S.W. 425 (1910); *Robertson v. Wenger*, 131 Mo. App. 224, 110 S.W. 663 (1908).

55. Fleming, *supra* note 53.

56. 316 S.W.2d 505 (1958).

57. *Id.* at 510.

tive area of the similar localities rule. It is doubtful, however, if it will be completely abolished. Although the practitioner has the opportunity to read many medical journals, it would still be impossible for him to stay abreast of all the developments in all the large medical centers of the world and still carry on a successful practice. Similarly, although he may know of the advances in technical machinery, it may be impossible for him to acquire and operate it. The fate of the "similar localities" rule will probably be a modification rather than a complete abrogation.

The practical effect of the rule can be quite harsh upon the malpractice plaintiff. In order to make a submissible case he may be forced to produce a practitioner from the same small town as defendant or from one that is similarly situated both from the standpoint of population and geographical proximity to a larger city.

F. Scope of the Medical Practitioner's Duty

The duty of the medical practitioner arises when the relationship of doctor and patient comes into existence. This relationship cannot be forced upon the practitioner nor upon the patient, for each must give his consent to it.⁵⁸ Although this relationship is consensual in nature, the duty that results from it and the liabilities that attach to it do not rest upon the existence of an express or implied contract.⁵⁹ Thus if *P* comes to *D*'s office to seek treatment from him, no duty arises until *D* agrees to treat *P*. Having agreed to treat *P*, *D*'s duty is not limited by the contractual nature of their agreement.⁶⁰

Once this consensual relationship is formed, the duty that results will endure throughout the treatment. The practitioner cannot unilaterally put an end to his duty. The rule was stated more fully in *Reed v. Laughlin*.⁶¹

[W]hen a surgeon is employed to perform an operation, the relation of physician and patient continues until ended by the mutual consent of the parties, the physician's withdrawal after reasonable notice, the dismissal of the physician or surgeon by the patient or the cessation of the necessity. . . .⁶²

58. See, e.g., *Hurley v. Eddingfield*, 156 Ind. 416, 59 N.E. 1058 (1901).

59. E.g., 41 AM. JUR. *Physicians and Surgeons* § 71 at 193 (1942).

60. *Vanhooover v. Berghoff*, 90 Mo. 487, 3 S.W. 72 (1887); see also *Barnhoff v. Aldridge*, 327 Mo. 767, 38 S.W.2d 1029 (1931), wherein the court held that "malpractice is neither a purely tortious or contractual action, but is a hybrid. . . ." In *Baysinger v. Hanser*, 355 Mo. 1042, 199 S.W.2d 644 (1947), it was held that the action sounded in tort and survived only under the wrongful death statute.

61. 332 Mo. 424, 58 S.W.2d 440 (1933); *Cazzell v. Schofield*, 319 Mo. 1169, 8 S.W.2d 580 (1928); see also *Boyd v. Andrae*, 44 S.W.2d 891 (Mo. Ct. App. 1932).

62. *Reed v. Laughlin*, 332 Mo. 424, 430-31, 58 S.W.2d 440, 442 (1933).

If the practitioner attempts to end the relationship without complying with the above requirements, he is liable in malpractice to the patient that he has abandoned.⁶³

Hence, the relationship that began through the consent of the practitioner cannot be terminated arbitrarily. A termination that does not comply with the standards established by the court will result in the practitioner being liable in malpractice for abandonment.

G. Duty to Warn of Serious Possible Collateral Hazards

In the past three years a new doctrine has arisen in the Missouri law of malpractice. According to the court the seeds came into existence in *Steele v. Woods*⁶⁴ and were germinated in *Mitchell v. Robinson*,⁶⁵ however, an analysis of the cases leads to a different conclusion.

In the *Steele* case plaintiff went to the hospital for a uterus operation. It was performed successfully, and while plaintiff was recuperating, defendant noticed that there were varicose veins in her leg. He recommended an operation for their removal to which plaintiff agreed. After the operation for the removal of the varicose veins, plaintiff suffered severe vascular spasms in her leg. Defendant advised her that an operation called a paravertebral block was necessary to inhibit the spasms. There was a conflict in the evidence concerning whether plaintiff had ever been warned of the necessity of the block operation and the consequences that could ensue from not having it. The result was that plaintiff was not operated on until after gangrene had set in and compelled the amputation of her foot. Plaintiff brought her action in malpractice alleging that she had never been told of the necessity of the paravertebral block. The case was submitted to a jury and the verdict was for the plaintiff. The issue that was submitted was whether or not defendant had advised plaintiff of the necessity of a paravertebral block. It is important to note that defendant did not claim that he was not under a duty to inform plaintiff of the necessity for the operation. Indeed this was admitted as what the average practitioner would have done in the situation.

The Supreme Court in remanding the case said that the facts admitted of a third possibility which the instructions of the trial court failed to frame; that defendant had informed plaintiff of the necessity of the operation but that plaintiff due to her distraught condition was unable to comprehend defendant's advice. Defendant admitted that the average practitioner in this situation would have a duty to go beyond plaintiff herself and seek the consent of her next of kin.

63. See, e.g., *Small v. Wegner*, 267 S.W.2d 26 (Mo. 1954).

64. 327 S.W.2d 187 (Mo. 1959).

65. 334 S.W.2d 11 (Mo. 1960).

This is the decision upon which the doctrine of the *Mitchell* case is bottomed. In the *Mitchell* case plaintiff was suffering from severe emotional disorder and alcoholism. He went to defendant who recommended insulin shock treatment to which plaintiff agreed. As a result of the treatments plaintiff had convulsions and fell from the treatment table fracturing a bone in the process. In his action for malpractice plaintiff offered no expert witnesses and the court held that to support the claim of improper treatment it was necessary that he produce expert witnesses. But the court held defendant was liable as he had a duty to "inform him [plaintiff] generally of the possible serious collateral hazards. . . ."66 In relying upon the *Steele* case, the court recognized that there was no mention in *Steele* of this duty to warn, but they asserted that *Steele* pointed out there was a duty to "communicate the advise of a treatment"67 and that this should have served as warning for defendant under the facts of the present case.68

This doctrine of a duty to warn of serious possible collateral hazards has found its way into the law of several other jurisdictions.69 Although the court found authority for the *Mitchell* decision in the *Steele* case, none in fact exists. In *Steele* the Supreme Court decided only that after proof that the average practitioner would communicate the advice of operation to his patient, defendant's failure to do so was an actionable breach. This was not even contested by defendant. In *Mitchell*, however, no evidence was offered to prove that the average practitioner would inform the patient of the possible collateral hazards of shock treatment, but rather the court manufactured out of whole cloth this new addition to the duty of the medical practitioner.

If the source of this doctrine were the only fault that could be asserted, then it would scarcely be worth attack. There are undoubtedly situations in which a medical practitioner should inform a patient of the serious possible collateral hazards that might attend a proposed treatment, just as there are situations in which it would be thought unwise to inform the patient of all the possible catastrophies that

66. *Id.* at 19.

67. *Id.* at 16.

68. The court in *Salgo v. Leland Stanford, Jr., Univ. Board of Trustees*, 154 Cal. App. 2d 560, 317 P.2d. 170 (1957), pointed out that the issue in this class of cases is whether or not plaintiff has had sufficient information upon which to base an intelligent consent. If the information is not sufficient, then the consent is inoperative. It would then seem to follow that plaintiff could proceed on a battery theory rather than negligence. However, battery does not seem to be an action that is favored by plaintiff's counsel. In *Moore v. Webb*, 345 S.W.2d 239 (Mo. 1961), defendant dentist had been authorized to extract several teeth by a referral card and mistakenly extracted eight of plaintiff's teeth. Plaintiff sued in malpractice and recovered, but it is submitted that the case could have been more easily handled as a simple battery.

69. Annot., 79 A.L.R.2d 1028 (1961).

could befall him.⁷⁰ The problem could be approached in three ways; first, the court could establish a rule that there was no duty to inform of possible serious collateral hazards;⁷¹ second, the court could, as they do in the *Mitchell* case, hold that there is an absolute duty to inform of serious possible collateral hazards. Both of these approaches have obvious flaws. In the one many innocent defendants will be held liable and as a result patients will eventually be informed of matters that it were better for them not to know.⁷² In the other system, culpable defendants will escape liability.

It is submitted that there is a third approach that is more consistent with the Missouri law as a whole. The question of whether or not defendant had a duty to inform the patient of the serious possible collateral hazards should be a question of fact for the jury to decide on the basis of what the average practitioner would do in the circumstances.⁷³ This would measure the practitioner according to the standards that have become fixed in Missouri for the past fifty years, instead of imposing an arbitrary standard of conduct that could lead to unpleasant results for both practitioners and patients.⁷⁴

What the fate of the *Mitchell* case will be cannot be predicted. The Supreme Court has not been confronted with the problem and it may reject or modify the doctrine. The bar, in seeking a solution, may draft a new form to be signed by patients before the practitioner will agree to treat him. The form would include all *possible*⁷⁵ collateral hazards that might arise in the course of treatment and would be given to the patient for his signature with the operative release. Although this seems a rather foolish way of nullifying the result of

70. *Hunt v. Bradshaw*, 242 N.C. 517, 88 S.E.2d 762 (1955).

71. In *Kenny v. Lockwood*, 1 D.L.R. 507 (1932), the court held:

To fasten on a physician or surgeon the obligation to discuss with his patient the possibilities and probabilities of an operation . . . in order that the patient might make an election . . . is in my mind unwarranted.

72. In a letter from Dr. M. A. Cassel to the author, Feb. 5, 1962, Dr. Cassel said:

the practical effect of relating to a patient prior to operation all the *possible* catastrophies that could befall him would either discourage him from the operation or debilitate his mental condition to the point that recuperation would be severely impaired. (Emphasis added.)

73. This is the approach adopted in *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960).

74. Dr. Cassel asserted that there are surgeons who now refuse to do certain operations because of the exposure to liability if the patient is dissatisfied. Letter from Dr. M. A. Cassel to the author, Feb. 5, 1962.

75. The choice of the word "possible" by the court in the *Mitchell* case could conceivably create a monster that could not be controlled. *Any* poor result that was serious in nature about which the practitioner failed to warn would expose him to liability. The possibilities are unlimited since the bad result itself proves that the hazard was "possible."

the *Mitchell* case, it may be the one to which the bar will resort if the doctrine survives.

Summary of the Duty of the Medical Practitioner

The duty of the malpractice defendant has been considerably diminished from the duty of the negligence defendant. The care that he must exercise is neither *reasonable* nor is it *prudent*. It need not be his "best" care or skill as long as it conforms to the average skill and care that is employed in the community. In establishing the standard, the attention of the fact finder is focused not upon what should or would have been done, but rather it is placed on what *is* done. The "same school" requirement precludes the plaintiff from attacking the system of medicine to which the practitioner adheres and the "similar localities" rule reduces even further the knowledge for which the practitioner can be held accountable. Because of these limitations on the duty of the medical practitioner, he is, to a great extent, insulated from liability. Indeed, the "plaintiff in a malpractice action assumes a very heavy burden."⁷⁶

Why has the law built such a strong protective shell around the practitioner in defining the limits of his duty? There are two extremely compelling reasons; first, the social value of the function that the medical practitioner performs cannot be exaggerated. A society without medical practitioners is inconceivable. However, this fact alone would be inadequate to grant him such great protection. The second reason for limiting the extent of the practitioner's duty is the extremely high degree of risk with which he is faced in the performance of his everyday business. These two facts taken together, the high degree of risk encountered daily which necessitates vast exposure to liability, and the social value of the function that he performs in society are ample reasons for the protection afforded him.⁷⁷

II. BREACH AND PROOF OF BREACH

The duty that the medical practitioner owes to his patient is born of a consensual relationship. This section will be concerned with the

76. *Hopkins v. United States*, 152 F. Supp. 473, 476 (W.D. Mo. 1957).

77. Professor Morris suggests a third reason for confining the liability of the medical practitioner. He urges that

a doctor who loses a malpractice case stands to lose more than the amount of the judgment—he may also lose his professional reputation and his livelihood. These considerations heighten the need for a test of malpractice that will protect doctors against undeserved liability. . . . The reasonably prudent man "test" would enable the ambulance chaser to make a law suit out of any protracted illness.

Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147, 1165 (1942). This provides a rather ready answer to those who would expand the medical practitioner's liability because he is most likely insured and therefore a better loss distributor than the injured patient.

nature and the characteristics of the acts that amount to a breach of that duty and relationship, and the nature and degree of proof that is required to establish that a breach has occurred.

For purposes of analysis it would be beneficial to divide the doctor-patient relationship into two parts: diagnosis and treatment. The nature of the acts that amount to a breach and the characteristics of the proof required to establish a breach vary according to the phase of the doctor-patient relationship during which the breach is alleged to have occurred. Thus if *P* awakes from an operation to find that his leg is paralyzed, the nature of the act or omission that he must allege and the degree of proof which he will be required to produce in order to establish a cause of action in malpractice, will depend upon the phase during which he alleges that the breach occurred.

A. *Diagnosis*

Diagnosis is the recognition of a disease by analysis of symptoms.⁷⁸ Hence when a practitioner examines a patient he initially analyzes the manifested symptoms and decides what the nature of the plaintiff's ailment is. It is this act of diagnosis with which this subsection is concerned.

The general rule was stated by the court in *Trask v. Dunnigan*;⁷⁹ the court concluded that "mistaken diagnosis . . . unless followed by improper treatment . . . would afford no cause of action."⁸⁰ This general rule is subject, however, to several exceptions and numerous qualifications. They can best be illustrated by a series of hypothetical situations.

1. *Improper diagnosis⁸¹ followed by the diagnosing practitioner's proper treatment*

This is in fact the situation involved in the *Trask* case.⁸² A medical practitioner making an improper diagnosis but applying the correct treatment is not liable in malpractice for a bad result.

78. See BLACK, LAW DICTIONARY (4th ed. 1951).

79. 299 S.W. 116 (Mo. Ct. App. 1927). See also, *Sibert v. Boger*, 260 S.W.2d 569 (Mo. 1953); *Gottschall v. Geiger*, 207 Mo. App. 89, 231 S.W. 87 (1921). *Cf.*, *Fausette v. Grim*, 193 Mo. 585, 186 S.W. 1177 (1916).

80. *Trask v. Dunnigan*, 299 S.W. 116, 117 (Mo. Ct. App. 1927).

81. Improper diagnosis means diagnosis in violation of the practitioner's duty. See generally, duty section *supra*.

82. In the *Trask* case plaintiff went to defendant who diagnosed his condition as a sprained arm. Defendant then applied a splint to plaintiff's arm. The arm was in fact broken and the break healed poorly. Defendant proved at the trial that the splint that he applied would have been the proper treatment for the broken arm. Although the court chose to frame the rule that there will be no liability for improper diagnosis unless followed by improper treatment, a simpler ground of decision would have been that defendant's negligence was not a

2. Improper diagnosis followed by the diagnosing practitioner's improper treatment

In this situation the medical practitioner is held liable,⁸³ but the basis of his liability is *not* the improper diagnosis, but rather it is the improper treatment. Thus the rules that would determine the practitioner's liability in this situation are the rules that obtain in the treatment cases.⁸⁴

3. Improper diagnosis followed by improper treatment of another practitioner based upon the former's erroneous diagnosis

The practitioner who made the improper diagnosis should not according to the rule be held liable in malpractice. If, however, he retains control over the practitioner who renders the treatment⁸⁵ or if the diagnosis and treatment are a part of a joint enterprise,⁸⁶ the diagnosing practitioner may be liable.⁸⁷ The physician who improperly treats the patient on the basis of the former practitioner's erroneous diagnosis is held liable in malpractice. As the court noted in *Baird v. National Health Foundation*,⁸⁸ "a physician is liable if he negligently adopts as his own the erroneous diagnosis and treatment of another doctor, if he has opportunity to discover the true facts for himself . . ."⁸⁹ But in this situation the rules that apply in determining liability are the rules for the treatment cases as the improper treatment in reality forms the basis of the liability.

4. Improper diagnosis which because of its very nature precludes the patient from seeking proper treatment

In this situation the practitioner could preclude the patient from taking any further action either by diagnosing the disease as extremely serious or insignificant. In either event the patient might be persuaded by the diagnosis to seek no further treatment and accept the finding of the practitioner. Thus if *P* broke out in large black spots and became severely swollen and *D* diagnosed this as a mild cold, *P* by the force of this diagnosis might be persuaded merely to

cause in fact of plaintiff's injury, i.e., even had defendant properly diagnosed the broken arm, the treatment would have been the same and the result—poor mending—would have still ensued.

83. *Boyd v. Andrae*, 44 S.W.2d 891 (Mo. Ct. App. 1932); *Lewis v. McClellan*, 1 S.W.2d 247 (Mo. Ct. App. 1928).

84. See text accompanying notes 92-95 *infra*.

85. *Noren v. American School of Osteopathy*, 298 S.W. 1061 (Mo. Ct. App. 1927).

86. *Baird v. National Health Foundation*, 235 Mo. App. 594, 144 S.W.2d 850 (1940).

87. The problems of vicarious liability are beyond the scope of this note.

88. 285 Mo. App. 594, 114 S.W.2d 850 (1940).

89. *Id.* at 608, 144 S.W.2d at 857.

go home and rest. If liability is to be imposed on the practitioner in this situation there are two approaches that could be employed. It would be possible to characterize what the practitioner has done as implying that there is no treatment available for the disease. This act⁹⁰ would amount to a 'negative' treatment and would then be evaluated according to the rules that obtain in the treatment cases. A more direct approach would be to hold that the practitioner was liable solely because of his improper diagnosis which has precluded the patient from taking any further action.⁹¹

B. Treatment

The overwhelming majority of the malpractice cases that have been reported in Missouri deal with the treatments that are employed by medical practitioners. This area of the Missouri law has also presented the most confusing doctrines and apparently contradictory cases. It is submitted that the reason for the confusion and the difficulty is the failure of the Missouri Supreme Court to articulate a very important distinction. The Kansas City Court of Appeals announced the doctrine in their decision in *Coffey v. Tiffany*⁹² which was subsequently quashed by the Supreme Court on a point of evidence without any mention of the distinction that the Kansas City Court had drawn. In the *Coffey* case plaintiff had gone to the defendant to have her eyes treated. Defendant placed some drops in them, and plaintiff was caused extreme pain and loss of vision in the eye treated. Plaintiff claimed that defendant had given her the wrong drops. The court held:

In that case [referring to another case] the court properly recognized the distinction between matters of science and those of art. As to the former, an honest error of a legally qualified physician or surgeon cannot afford a cause of action, no matter how injurious it may be to the patient, while in matters of art, i. e., in the performance of surgery, or in the application of remedies, his negligent errors are held to be governed by the ordinary rules of negligence. Thus a physician should not be held liable for erroneously, but honestly, deciding to perform a surgical operation upon a patient, for that would be an error in a matter of science and the law would be too harsh and severe should practitioners of medicine or surgery be held to know at their peril what were best to be done in a given case. But a surgeon who uses an unclean or rusty knife in an operation, or a physician who administers a dose of medicine without knowing what it is, would be

90. See BECHT AND MILLER, *FACTUAL CAUSATION* (1961).

91. In *Baird v. National Health Foundation*, 235 Mo. App. 594, 144 S.W.2d 850 (1940), it is difficult to say what the rationale is that the court employs. They find little difficulty in imposing liability in the case notwithstanding the *Trask* case.

92. 192 Mo. App. 455, 182 S.W. 495 (1914).

guilty of failing to exercise reasonable care, since an ordinarily careful surgeon or physician would not use an unclean knife, or administer a medicine without knowing what it is.⁹³

Although the terms "art" and "science" could be more aptly described as "administration of the remedy" and "selection of the remedy," this court recognized a distinction that the Missouri courts have consistently followed until the present time.

It recognized that the act of treatment was divided into two phases. First, the practitioner after having ascertained the nature of the disease [diagnosis], decides what remedy to use to cure the disease. Second, the practitioner applies the remedy. The rules for determining liability can *only* be ascertained after having fixed the point at which the alleged breach occurs.

Many decisions of the Missouri Supreme Court and of inferior Missouri courts have recognized that the degree of proof required to make a prima facie case varied depending upon the characteristics of the acts that were proved as the breach.⁹⁴ No court has articulated the distinction, but they have all generally followed it.⁹⁵

93. *Id.* at 470, 182 S.W. at 499.

94. In *Williams v. Chamberlain*, 316 S.W.2d 505 (Mo. 1958), the court clearly recognized that there was a distinction between cases involving foreign objects and other malpractice cases. The court held that "the cases where a physician or surgeon has left foreign objects in operative cavities fall into *an entirely different class.*" *Id.* at 511. (Emphasis added.) However, the court failed to express what that "different class" was.

In *York v. Daniels*, 259 S.W.2d 109, 121 (Mo. Ct. App. 1953), plaintiff used no expert witnesses and the court held that "it is not *always* necessary that failure to use the accepted method in treatment should be proved by expert witnesses." But the court failed to point out *when* it is and when it is not necessary to produce experts in order to make a submissible jury case.

In *Baird v. National Health Foundation*, 235 Mo. App. 594, 144 S.W.2d 850, 855 (1940), defendants appealed from a jury verdict for plaintiff alleging plaintiff had failed to make a submissible case because he failed to produce expert witnesses. They held that "*in a case of this kind* negligence can be proved by non expert witnesses." But once again the court failed to say what kind of case this was.

Pedigo v. Roseberry, 340 Mo. 724, 736, 102 S.W.2d 600, 607 (1937), the court came very close to announcing the rationale when they held that:

Juries should not be thus turned loose and privileged to say, perchance, *the method of treating an injury . . . was negligent notwithstanding, for instance, the uncontradicted competent testimony establish that the uniformly adopted practice of the most skillful surgeons had been followed.* (Emphasis added.)

Although the *Pedigo* case seems to be inconsistent with the holding in the *Baird* and *York* cases, the decision will be justified later when the ramifications of the distinction between "selection" and "administration" are developed herein.

In *Tate v. Tyzzer*, 208 Mo. App. 290, 234 S.W. 1038, 1041 (1921), defendant requested an instruction that if the jury found that defendant had conformed with the customary practice in the community that he should not be held liable. The court held,

Thus when any question arises as to the liability of a practitioner for the treatment that he has given to a patient, it must be decided initially whether the basis of the liability is the improper selection of the remedy or whether it is the maladministration of the remedy. If it is the former, then the rules that obtain in deciding the question are *sui generis*. If the case is classified as the latter, then the rules that apply in the determination of liability are substantially the same as the rules that apply in the determination of an ordinary negligence case.

1. *The Use of Custom*

As discussed above⁹⁶ the use of custom in the ordinary negligence case is by the majority view merely evidence of due care or negligence. However, if the case involves the alleged improper selection of the remedy by the practitioner, the custom of the medical practice becomes the controlling standard. In *Bailey v. St. Louis S. F. Ry.*⁹⁷ plaintiff had sustained a rupture. The treatment prescribed by defendant was rest and observation in a hospital. Plaintiff attempted to prove at the trial that the selection of the treatment was improper. To

This contention cannot be upheld. Without passing upon the question as to whether or not it correctly declares the law *under certain conditions*, this instruction permits the defendant to rely upon a special and local custom to take his case out of the general rules of law.

Thus it can be seen that the Missouri courts have recognized throughout the years that there are cases in which experts are needed and in which they are not needed, cases in which custom is controlling and in which it is not controlling. But they have never taken the time to announce the basis of the distinction.

95. Compare *Williams v. Chamberlain*, *supra* note 94; *Brown v. Scullin Steel*, 260 S.W.2d 513 (Mo. 1953); *Pedigo v. Roseberry*, *supra* note 94; *Atkinson v. American School of Osteopathy*, 240 Mo. 338, 144 S.W. 820 (1912), with *Snyder v. St. Louis Southwestern Ry.*, 228 Mo. App. 626, 72 S.W.2d 504 (1934); *Bailey v. St. Louis S.F. Ry.*, 296 S.W. 477 (Mo. Ct. App. 1927); *McDonald v. Crider*, 272 S.W. 980 (Mo Ct. App. 1925); *Smith v. Mallinckrodt Chemical Works*, 212 Mo. App. 158, 251 S.W. 155 (1923); *Fausette v. Grim*, 193 Mo. App. 585, 186 S.W. 1177 (1916); *Spain v. Burch*, 169 Mo. App. 94, 154 S.W. 172 (1913); *Reed v. Laughlin*, 332 Mo. 424, 58 S.W.2d 440 (1933); *Gates v. Dr. Nichol's Sanatorium*, 331 Mo. 724, 55 S.W.2d 424 (1932); *Rothschild v. Barck*, 324 Mo. 1121, 26 S.W.2d 760 (1930); *York v. Daniels*, 259 S.W.2d 109 (Mo. Ct. App. 1953); *Seewald v. Gentry*, 220 Mo. App. 367, 236 S.W. 445 (1926); *Evans v. Clapp*, 231 S.W. 79 (Mo. Ct. App. 1921); *Tate v. Tyzzer*, *supra* note 94; *Gross v. Robinson*, 203 Mo. App. 118, 218 S.W. 924 (1920); *Reeves v. Lutz*, 179 Mo. App. 61, 162 S.W. 280 (1914); *Waters v. Crites*, 350 Mo. 553, 166 S.W.2d 496 (1942). *But see Shipper v. Dr. C. M. Coe, Inc.*, 174 S.W.2d 887 (Mo. Ct. App. 1943).

96. See text accompanying footnote 37 *infra*.

97. 296 S.W. 477 (Mo. Ct. App. 1927). See *contra*, *Shipper v. Dr. C. M. Coe, Inc.*, 174 S.W.2d 887 (Mo. Ct. App. 1943); *Waters v. Crites*, 350 Mo. 553, 166 S.W.2d 496 (1942); *Gunter v. Whitener*, 75 S.W.2d 588 (Mo. Ct. App. 1934); *Thompson v. Martin*, 127 Mo. App. 24, 106 S.W. 535 (1904). It is submitted that these cases were erroneously decided because of the court's failure to articulate the distinction between application and selection of the remedy.

this end he introduced several expert witnesses who testified that in this situation they would have operated and that that was the accepted method of treating hernia in their community. Defendant introduced several experts who testified that the treatment that defendant employed was entirely proper. The case was submitted to the jury and the judgment was for the plaintiff. In reversing the judgment the court held that plaintiff had failed to establish a submissible jury case even though he had produced *more* expert witnesses than had the defendant. The court held:

Physicians and surgeons must be allowed a wide range in the exercise of their judgment and discretion . . . the law will not hold a physician guilty of negligence as long as he uses his best judgment, even though his judgment may prove erroneous in a given case, *unless it be shown that the course pursued was clearly against the course recognized as correct by the profession generally.*⁹⁸

This case would seem to support the doctrine that custom is a defense for the malpractice defendant. However, in *Tate v. Tyzzer*⁹⁹ defendant offered expert testimony that surgical sponges were accounted for by the nurse and that this was the customary practice among surgeons in this community. Plaintiff offered no countervailing testimony. Defendant requested an instruction that if the jury found that he had used the customary practice that was employed in the community then they should find for defendant. The court held, "this contention cannot be upheld . . . this instruction permits the defendant to rely upon a special and local custom to take this case out of the general rules of law. . . ."¹⁰⁰

Although the cases are on the surface inconsistent, they seem so only because they are dealing with two separate types of actions with the difference not made clear. The *Bailey* case deals with the *selection* of the proper remedy and the *Tate* case is concerned with the improper *administration* of a remedy. The rule then could be stated that in cases involving the selection of the remedy, custom is a complete defense for the practitioner. The plaintiff in the "selection" cases must show by something more than a mere preponderance that the remedy employed by the practitioner was against the course employed by the practice generally. In those cases in which the practitioner is alleged to have administered the treatment improperly, plaintiff need not establish that the administration was not customary in the community. As a corollary to this rule, defendant cannot avoid liability by establishing that the administration of the treatment was in con-

98. *Bailey v. St. Louis S.F. Ry.*, *supra* at 4. 296 S.W. 477, 479 (Mo. Ct. App. 1927). (Emphasis added.)

99. 208 Mo. App. 290, 234 S.W. 1038 (1921).

100. *Id.* at 302, 234 S.W. at 1041.

formity with the administration that is used in the community generally.

2. *The Expert Witness*

Use of the expert witness in malpractice cases and the rules as to his competency are discussed above.¹⁰¹ However, the question of when an expert witness is necessary will be treated in this section.

In *Pedigo v. Roseberry*¹⁰² the practitioner used a "box cast" on the patient's broken leg. Patient at the trial complained of this method of treatment. Defendant offered experts who testified as to the propriety of the treatment that defendant employed. The case was submitted to the jury and the judgment was for plaintiff. In reversing the judgment the court held:

Juries should not be thus turned loose and privileged to say, perchance, the method of treating an injury . . . was negligent notwithstanding . . . uncontradicted competent testimony. . . .¹⁰³

In *Sontag v. Ude*¹⁰⁴ defendant failed to anchor a drain tube to the infant patient and it slipped within the patient's chest. Plaintiff offered no expert witnesses to prove that defendant's administration of the remedy was negligent. The court held that,

We do not believe that on such facts any jury would say that the acts of defendant did not constitute negligence, no matter how many expert professional gentlemen might have testified to the contrary.¹⁰⁵

The *Pedigo* case seems to stand for the proposition that expert testimony is indispensable to the plaintiff's cause of action, while the *Sontag* case indicates that it is not only not indispensable, but that it cannot afford the defendant any protection as a defense. Although the decisions seem contradictory, this again is because they are dealing with two distinctly different types of actions without indicating the difference.

The *Pedigo* case involves the *selection* of the proper remedy, while the allegation in the *Sontag* case is concerned with *maladministration* of the remedy. The rule then may be stated that in cases in which the issue is the proper selection of the remedy, plaintiff *must* produce expert witnesses in order to make a submissible jury case. As a corollary to this rule the defendant if he produces sufficient countervailing experts will be entitled to a directed verdict.¹⁰⁶ In cases in

101. See text accompanying notes 49-50 *supra*.

102. 340 Mo. 724, 102 S.W.2d 600 (1937).

103. *Id.* at 736, 102 S.W.2d at 607.

104. 191 Mo. App. 617, 177 S.W. 659 (1915).

105. *Id.* at 626, 177 S.W. at 661-62.

106. See, *e.g.*, *Brown v. Scullin Steel*, 260 S.W.2d 513 (Mo. 1953); *Pedigo v. Roseberry*, 340 Mo. 724, 102 S.W.2d 600 (1937); *Snyder v. St. Louis S.W. Ry. Co.*, 228 Mo. App. 626, 72 S.W.2d 504 (1934); *Bailey v. St. Louis S.F. Ry. Co.*,

which the issue is the propriety of the administration of the remedy plaintiff need not produce experts to make a submissible jury case nor will defendant be entitled to directed verdict on the strength of expert testimony.¹⁰⁷

3. *Inferential Evidence*

Due to the peculiar nature of malpractice actions, plaintiff will often find himself in a situation in which he has no information about the way in which he was injured. If the law of malpractice precluded plaintiff from using circumstantial evidence to establish his prima facie case, many plaintiffs would find themselves with an insurmountable task. In every phase of malpractice, plaintiff is allowed to establish his case with the aid of circumstantial evidence. The degree to which he may use such evidence and the situations in which he may rely upon it exclusively, vary depending upon whether the action is predicated upon the improper selection of the remedy or whether it is predicated upon the maladministration of the remedy.

In *Eicholz v. Poe*¹⁰⁸ plaintiff went to the hospital for an operation. While she was recuperating, she reported a toothache and her doctor recommended that the tooth be extracted. A dentist was called in, and in the process of pulling the tooth he broke plaintiff's jaw. Plaintiff pleaded only that the result of a broken jaw implied negligence and the court held:

[W]e think the extraction of the tooth, being under the management and control of defendants was sufficiently out of the ordinary course of that which usually happens where ordinary care and skill is employed, in the absence of explanation by defendants to warrant the jury in finding that the tooth was negligently extracted. . . .¹⁰⁹

The court without expressly denominating it as such is applying the doctrine of *res ipsa loquitur*. They find little difficulty in applying it to the facts of the *Eicholz* case.

However, five years later in *Cardinale v. Kemp*¹¹⁰ defendant practi-

296, S.W. 477 (Mo. Ct. App. 1927); Fausette v. Grim, 193 Mo. App. 585, 186 S.W. 1177 (1916).

107. See, e.g., York v. Daniels, 259 S.W.2d 109 (Mo. Ct. App. 1953); Baird v. National Health Foundation, 144 S.W.2d 850 (Mo. Ct. App. 1940); Seewald v. Gentry, 220 Mo. App. 367, 286 S.W. 445 (1926); Tate v. Tyzzer, 208 Mo. App. 290, 234 S.W. 1038 (1921); Gottschall v. Geiger, 207 Mo. App. 89, 231 S.W. 87 (1921).

108. 217 S.W. 282 (Mo. 1920). See also, Williams v. Chamberlain, 316 S.W.2d 505 (Mo. 1958); State ex rel. American School of Osteopathy v. Daves, 323 Mo. 411, 18 S.W.2d 487 (1929); Cardinale v. Kemp, 309 Mo. 241, 274 S.W. 437 (1925); Pate v. Dumbauld, 298 Mo. 45, 250 S.W. 49 (1923); Mitchell v. Poole, 299 Mo. App. 1, 68 S.W.2d 833 (1934); Hill v. Jackson, 218 Mo. App. 210, 265 S.W. 859 (1924); Wilt v. McCallum, 214 Mo. App. 321, 253 S.W. 156 (1923); Connelly v. Cone, 205 Mo. App. 395, 224 S.W. 1011 (1920).

109. Eicholz v. Poe, 217 S.W. 282, 285 (Mo. 1920).

110. 309 Mo. 241, 274 S.W. 437 (1925).

tioner had removed a cyst from plaintiff's eyelid. Defendant had chosen to remove it by turning the lid back and removing it from the inside of the lid. Plaintiff's eyeball grew to the lid and he lost his vision in that eye. Plaintiff attempted to introduce testimony of experts that this was not the sort of thing that happened in the normal course of events and that the selection of the operation was improper. Trial court excluded the evidence and directed a verdict for defendant.¹¹¹ On appeal the directed verdict for defendant was affirmed, the court holding that plaintiff had failed to make a prima facie case.

The *Eicholz* decision and the decision in the *Cardinale* case hardly seem consonant. In the former, the court finds no difficulty in freely applying the doctrine of *res ipsa loquitur* while in the latter they refuse even to accept evidence that might tend to establish the probability postulate. However, the cases can be justified on the basis of the distinction between selection and administration of the remedy. The attorney in the *Eicholz* case chose to plead the act of defendant as maladministration, while the attorney for plaintiff in the *Cardinale* case couched his action in improper selection of the remedy. It is submitted that a different result might have been achieved in the *Cardinale* case had the attorney for the plaintiff attempted to characterize the act of defendant as maladministration of treatment. For the rule may be stated that the doctrine of *res ipsa loquitur* will be applied in those cases which involve the administration of the treatment when the postulates are fulfilled, and it will not be applied in those cases in which the issue involves selection of the remedy, even if it appears that the postulates are satisfied.¹¹²

Although plaintiff may rely upon the doctrine of *res ipsa loquitur* in those cases which involve the administration of the treatment, the probability postulate is often quite difficult to satisfy. In *Hill v. Jackson*¹¹³ decided four years after *Eicholz v. Poe*, plaintiff went to defendant dentist to have a tooth extracted. In the course of the extraction defendant dislocated plaintiff's jaw. The court held that plaintiff had failed to make a prima facie case as they were not convinced that dislocation does not occur even when the dentist exercises due care. The court has held that the postulate was satisfied, however, when an osteopath partially dislocated a patient's neck.¹¹⁴ As a general rule, it is clear that the probability postulate will be more difficult to satisfy in a malpractice action than in an ordinary negli-

111. Plaintiff's counsel failed to make an offer of proof at the trial, but the court indicated that it would not have been willing to reverse even had a proper offer been made.

112. See, e.g., *Cardinale v. Kemp*, 309 Mo. 241, 274 S.W. 437 (1925).

113. 218 Mo. App. 210, 265 S.W. 859 (1924).

114. *York v. Daniels*, 259 S.W.2d 109 (Mo. Ct. App. 1953).

gence case.¹¹⁵ Plaintiff will also be precluded from relying upon the doctrine if specific negligence is alleged.¹¹⁶

If the theory employed by plaintiff is that defendant's selection of the remedy was negligent, the proof that plaintiff offers must of necessity be direct. There are no presumptions of which he may avail himself. If plaintiff's theory sounds rather in the maladministration of the remedy, there are several situations in which he may avail himself of the benefit of a presumption. Cases in which foreign bodies are left within operative cavities provide an excellent example.

In *Sontag v. Ude*¹¹⁷ defendant practitioner inserted a tube in plaintiff's decedent's chest to drain an abscess. The drain was improperly anchored and fell within the operative cavity. Plaintiff produced only two witnesses, neither of whom was an expert. Defendant put on no evidence and appealed from a jury verdict for plaintiff. The court held that experts were not necessary to plaintiff's cause of action. Further, even had the defendant produced many experts to testify as to the propriety of the treatment, plaintiff would still have made a submissible jury case.¹¹⁸ The *Sontag* case held that proof of a foreign object left within an operative cavity establishes a presumption of breach that cannot be dispelled even by expert evidence.

The holding in *Sontag* is subject, however, to proof of the fact that it was defendant who left the foreign object within the cavity. This rule was established in *Boner v. Nicholson*.¹¹⁹ Defendant in the *Boner* case offered expert evidence that the injury of which plaintiff complained could not possibly have been caused by the sponge that defendant had allegedly left within the cavity and that the sponge could not have been left within the operative cavity by defendant.

115. Denying *res ipsa loquitur*: *Williams v. Chamberlain*, 316 S.W.2d 505 (Mo. 1958) (broken needle); *Mitchell v. Poole*, 229 Mo. App. 1, 68 S.W.2d 833 (1934) (broken needle); *Hill v. Jackson*, 218 Mo. App. 210, 265 S.W. 859 (1924) (dislocated jaw); *Wilt v. McCallum*, 214 Mo. App. 321, 253 S.W. 156 (1923) (doctrine does not apply to complicated machinery); *Connelly v. Cone*, 205 Mo. App. 395, 224 S.W. 1011 (1920) (setting broken bone). *But see* *Evans v. Clapp*, 231 S.W. 79 (Mo. Ct. App. 1921); *Hales v. Raines*, 146 Mo. App. 232, 130 S.W. 425 (1910) holding the postulate satisfied when plaintiff sustained x-ray burns.

116. See, e.g., *Telaneus v. Simpson*, 321 Mo. 724, 12 S.W.2d 920 (1928); *Owens v. McCleary*, 313 Mo. 213, 281 S.W. 682 (1926); *Pate v. Dumbauld*, 298 Mo. 435, 250 S.W. 49 (1923).

117. 191 Mo. App. 617, 177 S.W. 659 (1915); See also, *Null v. Stewart*, 78 S.W.2d 75 (Mo. 1934); *Hilton v. Mudd*, 174 S.W.2d 31 (Mo. Ct. App. 1943); *Ingram v. Poston*, 260 S.W. 773 (Mo. Ct. App. 1924); *Tate v. Tyzzer*, 208 Mo. App. 290, 234 S.W. 1038 (1921); *Reeves v. Lutz*, 179 Mo. App. 61, 162 S.W. 280 (1914). *But see*, *Williams v. Chamberlain*, 316 S.W.2d 505 (Mo. 1958) (broken needle); *Boner v. Nicholson*, 179 Mo. App. 146, 161 S.W. 309 (1913).

118. *Sontag v. Ude*, 191 Mo. App. 617, 626, 177 S.W. 659, 661 (1915).

119. 179 Mo. App. 146, 161 S.W. 309 (1913).

However, the doctrine in the *Boner* case was limited to its unusual facts in a subsequent decision.¹²⁰

In *Null v. Stewart*¹²¹ the court modified the statement in *Sontag* and asserted with clarity that proof of a foreign body left within an operative cavity "makes a prima [facie] case of negligence, and all that plaintiff need do in order to make a prima facie case is to prove that such foreign substance was in fact left inside the patient's body."¹²² A prima facie case of negligence is raised by proof of a foreign body left within an operative cavity. However, this case can be rebutted by defendant if he chooses to come forward with countervailing proof. In *Hilton v. Mudd*¹²³ defendant appealed from a jury verdict for plaintiff alleging an improper instruction as error. The court had instructed the jury that if it found that defendant had left a sponge within plaintiff, then it would hold defendant liable in damages. The court held that:

The trouble with this view is that an instruction which directs a verdict without requiring a finding of negligence is not sufficient in submitting facts merely making a prima facie case. It must submit facts making a case as a matter of law.¹²⁴

There are other presumptions of which plaintiff may avail himself if he alleges maladministration of the remedy.¹²⁵

Thus, if plaintiff alleges that defendant has improperly selected the remedy he will be unable to employ presumptions in proving his case. Plaintiff in an action for the improper selection of the remedy will be bound by rather narrow, unwavering rules. There is an absolute necessity for expert witnesses and the burden of proof approaches the equity burden of "clear and convincing." Custom will afford the practitioner a perfect defense in the "selection" cases. But when the action is characterized as maladministration of the remedy, plaintiff may proceed according to rules that are very similar to the rules that obtain in the normal negligence case. There are no special defenses available to defendant. No case that is reported in Missouri has answered the question who decides whether the issue is improper selection of the remedy or whether it is maladministration. It is patent that plaintiff's counsel should attempt to characterize the act of the practitioner as maladministration, while defendant should attempt to characterize the allegation as improper selection. There are situations that admit of both possibilities.¹²⁶ It

120. *Ingram v. Poston*, 260 S.W. 773 (Mo. Ct. App. 1924).

121. 78 S.W.2d 75 (Mo. 1934)

122. *Id.* at 79.

123. 174 S.W.2d 31 (Mo. Ct. App. 1943).

124. *Id.* at 37.

125. *Id.* at 36.

126. See text accompanying notes 110-112 *supra*.

is submitted that this characterization is essentially a court function.¹²⁷

The distinction between the two classes of cases may seem at first to be arbitrary. However, the necessity for such a doctrine becomes obvious upon closer inspection. This doctrine is both a shield and a sword, protecting the medical practitioner where he needs protection and affording him no special privileges where he needs none. It is essential that the medical practitioner be protected in the exercise of his judgment when he is selecting the proper remedy to apply to a patient's symptoms. This is necessary not only to immunize the practitioner from undeserved liability, but it is also mandatory for the public,¹²⁸ for if the practitioner must exercise his judgment and discretion at his peril, medical science would come to a screaming halt.

On the other hand, there is no very compelling reason for affording the medical practitioner a shield in the administration of the remedy. The law need not shelter the practitioner who is careless in his technique. Nor will he be sheltered from liability because he alone possesses the ultimate facts that are essential to establishing his negligence. Indeed, if the practitioner were granted the same protections in the administration of the remedy as he is in the selection, the law would foster truly deleterious developments in the practice of medicine. Thus, the Missouri law of malpractice has established a doctrine that has the peculiar attributes of allowing the practice of medicine to flourish by not interfering with its essential elements of judgment and discretion. These elements are judged and sanctioned only by the standards that the medical profession itself establishes.¹²⁹ However, the distinction that the Missouri courts have established stunts those practices that are harmful to the medical profession as well as to the general public.

III. DEFENSES

The defense of conformity to the custom of practice employed in the community has been discussed above.¹³⁰

A. Assumption of Risk

The Missouri courts have specifically rejected the defense of assumption of risk whenever a malpractice defendant has chosen to

127. Although the issue has never been presented to a court, this would appear to be a typical court function.

128. See note 74, *supra*.

129. See text accompanying notes 93-95 *supra*.

130. See text accompanying notes 96-100 *supra*.

offer it.¹³¹ In *Hales v. Raines*¹³² plaintiff went to defendant seeking treatment for a red spot on his hand. Defendant before treating plaintiff with x-rays warned him of the dangers of x-ray treatment. Plaintiff was explicitly warned "that there was always peril"¹³³ in this sort of treatment. Defendant interposed a defense that amounted to assumption of risk to which the St. Louis Court of Appeals replied,

We deem it to be contrary to the precepts of public policy to declare such agreement valid in the full measure of its scope and entail upon plaintiff, as within it, the consequences of defendant's negligence . . . ; for consent concerning such matters avails nothing, unless due care and skill is employed by the physician.¹³⁴

Defendant's problem with such a defense lies in a misconception of the action of malpractice. Although the duty that defendant owes to plaintiff arises due to a consensual relationship, that duty cannot be diminished by contractual agreement, although it may be expanded.¹³⁵ The duty is one that is impressed upon the practitioner as a matter of law.¹³⁶

B. Contributory Negligence

The defense of contributory negligence can be a complete bar to plaintiff's recovery in malpractice.¹³⁷ However, where the alleged negligence of the patient is subsequent to the practitioner's negligence and merely aggravated the injury, the patient's negligence will go only to the issue of damages.¹³⁸ Thus if *P* is treated negligently by *D* but subsequent to *D*'s negligent treatment *P* acts negligently, *P* will not be barred from recovery but his damages will be limited to "any increased injury and pain of body and mind . . . occasioned by defendant's negligence in treating same."¹³⁹

131. *E.g.*, *Longan v. Weltmer*, 180 Mo. 322, 79 S.W. 655 (1904); *Weller v. Palapao Lab. Inc.*, 197 Mo. App. 47, 191 S.W. 1056 (1917).

132. 162 Mo. App. 46, 141 S.W. 918 (1911).

133. *Id.* at 66, 141 S.W. at 923.

134. *Id.* at 63, 141 S.W. at 922.

135. *E.g.*, *Vanhooover v. Berghoff*, 90 Mo. 487, 3 S.W. 72 (1887). It is possible for the practitioner to make an absolute contract to cure which would be binding on him. Such agreement is, however, extremely unlikely. It is clear on the other hand that the practitioner cannot contract away his tort liability.

136. See text accompanying note 11 *supra*.

137. *Summers v. Tarpley*, 208 S.W. 266 (Mo. Ct. App. 1919).

138. *Fowler v. Burris*, 186 Mo. App. 347, 171 S.W. 620 (1914). 41 AM. JUR. *Physicians and Surgeons* § 80 (1942).

139. *Fowler v. Burris*, *supra* note 138.

CONCLUSION

If a model malpractice code were to be drafted, its procedural framework would undoubtedly be quite different from the existing Missouri law. However, it is difficult to imagine that any code, no matter how well drafted, could accomplish more effectively what the Missouri law of malpractice accomplishes. It is a law that weeds out unhealthy elements in the medical practice while sedulously fostering medical progress. It is, therefore, all the more lamentable that the Supreme Court has never clearly announced the rationale of its decisions.