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Fractured confidence: Origins of American medical malpractice, 1790–1900

De Ville, Kenneth Allen, Ph.D.

Rice University, 1989

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RICE UNIVERSITY

FRACTURED CONFIDENCE: ORIGINS OF AMERICAN MEDICAL MALPRACTICE, 1790-1900

by

KENNETH ALLEN DE VILLE

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE

DOCTOR OF PHILOSOPHY

APPROVED, THESIS COMMITTEE:

Harold M. Hyman, Professor of History, Director

Albert Van Helden, Professor of History

Martin Wiener, Professor of History

Baruch Brody, Professor of Philosophy

Chester R. Burns, Professor of Medical History

Houston, Texas
April, 1989
ABSTRACT

Fractured Confidence: Origins of American Medical Malpractice, 1790-1900

Kenneth Allen De Ville

By the 1840s medical men felt they were in the midst of an unprecedented malpractice epidemic. For the first time, American patients began to sue their physicians on a wide scale. Focusing on mid-century this dissertation describes, explains, and analyzes the origins of American medical malpractice.

Patients sued their physicians in the 1840s because of immediate social, medical, and technological developments. The anti-status, anti-professional sentiment of the Jacksonian period antagonized the lay public. Americans had a long tradition of home remedies and had little patience with doctors who demanded respect and privilege but offered few cures. Intra-professional competition also generated conflict and many medical men incited suits against fellow practitioners. Dramatic advances in several areas of medicine created unrealistic expectations in both physicians and patients and blurred standards of care.

However, these immediate causes would not have engendered widespread suits without fundamental cultural changes. Many Americans changed their views on divine providence in the first half of the nineteenth century. This
transformation allowed individuals to seek earthly causes for their misfortunes, assign blame, and demand compensation. At the same time a variety of forces combined to make Americans dramatically more concerned about their physical well-being. Finally, the erosion of traditional community customs inhibiting litigation and a transformation in individualism allowed patients to attack their physicians in court. These cultural developments did not cause malpractice suits, but without them widespread litigation would not have been possible.

Malpractice law in the early part of the nineteenth century was in flux. American judges and lawyers relied on British precedents but altered them. Many scholars have claimed that legal relationships evolve from status-based responsibilities to contract-based responsibilities. I argue that this process occurred in malpractice law but was ultimately incomplete.

The patterns set in the first half of the century continued through 1900. Many of the inciting causes of the 1840s disappeared. However new technological, social, professional, and legal factors arose to take their place. Most importantly, the underlying cultural trends that made the suits possible continued to develop and provided an increasingly hospitable social environment for malpractice suits.
Acknowledgements

I have always considered myself lucky. On this project I have been fortunate enough to incur a wide range of debts which I take great pleasure in recognizing.

Rice University History department has provided consistent intellectual and financial support for this project and my general academic development. I am sincerely grateful. Vali, Michelle, and Douglas in the Rice University Fondren inter-library loan department performed remarkable feats in acquiring often obscure materials. Inci Bowman of the University of Texas Medical Branch at Galveston, and Beth White of the University of Texas Health Science Center at Houston, also helped me gather research.

A wide range of individuals have offered various types of help at different points of the dissertation. Randy Sparks, Matt Taylor, and Mary Winkler provided regular and essential encouragement. Mark E. Steiner offered general comments and kept me up-to-date on the world of legal anthropology. John Boles, Mary Winkler, and Albert Van Helden contributed insight on many of the points expressed in Chapter 6. Members of the 1988–1989 Rice University Legal History Seminar, including Brian Dirck, Randall Jamail, Charles Robinson, James Schmidt, Patricia Tidwell, and Charles Zelden, read each chapter as it was completed and
provided enormous editorial and intellectual aid. My dissertation committee of Baruch Brody, Chester Burns, Albert Van Helden, Harold Hyman, and Martin Wiener, was both helpful and charitable.

My deepest gratitude and most profound respect are reserved for Harold M. Hyman. Professor Hyman played an integral role in the conception and completion of this project. More importantly, he guided and shaped my general academic and professional development. His example and tutelage have convinced me that opportunity, hard work, and discipline, can yeild undreamed of results and satisfaction.

Finally, I want to thank Chris Moore De Ville (who clearly had better things to do) for her unremitting support and saintly patience with my neurotic work habits.
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Abbreviations

ABFRJ  American Bar Foundation Research Journal
AHR   American Historical Review
AJLH  American Journal of Legal History
AJMS  American Journal of Medical Science
AJP   American Journal of Psychology
AJPH  American Journal of Public Health
AJJS  American Journal of Sociology
ALJ   Albany Law Journal
AMM   American Medical Monthly
AP    American Practitioner
AtM   Atlantic Monthly
BHM   Bulletin of the History of Medicine
BMSJ  Boston Medical and Surgical Journal
BuMJ  Buffalo Medical Journal
BuMJSR Buffalo Medical Journal and Monthly Review
BuMSR Buffalo Medical and Surgical Review
CH    Church History
CM    Connecticut Medicine
CS    Christian Spectator
DPLR  DePaul Law Review
DTMJ  Daniel's Texas Medical Journal
For   Fortune
Gym   Gymnasiom
Har   Harpers
HCR   Hastings Center Report
HTR   Harvard Theological Review
IMH   Indiana Magazine of History
JAAR  Journal of American Academy of Religion
JAH   Journal of American History
JAMA  Journal of the American Medical Society
JISHS Journal of the Illinois State Historical Society
JLH   Journal of Legal History
JLM   Journal of Legal Medicine
JLP   Journal of Legal Pluralism
JMCS  Journal of Medicine and Collateral Sciences
JPH   Journal of Presbyterian History
JSH   Journal of Sports History
JSocH Journal of Social History
JSJ   Justice System Journal
LHR   Law and History Review
LSR   Law and Society Review
MassR Massachusetts Review
MA    Mid-America
MCMS  Medical Communications of the Mass. Medical Society
ME    Medical Examiner
MLR   Modern Law Review
MNL   Medical News and Library
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<td>Medical Reporter</td>
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Preface

A nineteenth century physician commenting on malpractice suits observed that "The remedy for these evils in the profession involves many and grave problems in sociology which I cannot now stop to consider." The writer was correct. The malpractice phenomenon, like other legal issues, is a reflection of social, cultural, and professional trends which have yet to be identified and explained. Neither nineteenth century observers, nor modern scholars in legal, medical, or social history attempted to document and interpret the development of medical malpractice in America. Instead, scholars have made only passing reference to the issue and have failed to exploit what is potentially a rich, and multi-dimensional topic.

The short and meager tradition of malpractice history began with Hubert Winston Smith's lengthy 1941 study in the Journal of the American Medical Association. Smith explained basic legal doctrine to his readers and traced the

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genealogy of a twentieth century American malpractice
decision to its British common law ancestors. Smith's most
valuable contribution to the discussion was his tabulation of
all the American malpractice appellate cases between 1793 and
1940. Other writers have followed Smith's approach and used
state appellate court decisions to understand the history of
malpractice.\(^3\)

The weakness of these studies has been both in their
materials and their approach. Appellate decisions tell only
part of the story. The majority of trial cases never reach
an appellate court. Although useful, the information gleaned
from these higher court decisions is uneven. Appellate
courts deal primarily with legal doctrine, and seldom provide
detailed information about the mechanics of the trial or the
life of the litigants. Moreover, the writers who have used
these materials have tended to treat law and legal
development as an entity divorced from the cultural context
of specific times. Their strictly linear tracing of cases

\(^3\) Andrew Sandor, *JAMA* 163 (February 9, 1957): 459-66; Earl
F. Rose, "Major court decisions that have influenced the
practice of medicine," *TM* 72 (October 1976): 90-6; Victor
Gordon, "The Origin, Basis, and Nature of Medical Malpractice
Liability," *CM* 35 (February 1971): 73-7; Joseph C. Stetler,
"The History of Reported Medical Professional Liability
Cases," *TLO* 30 (1957): 366-83; E.A. Reed, "Understanding Tort
Law: The Historical Basis of Medical Liability," *JLM* 5
has resulted in important omissions and very little insight into the causes and development of malpractice.

Although a few writers have begun to study twentieth century malpractice, professional historians have virtually ignored it.\footnote{Louis B. Harrison, Melvin H. Worth, and Michael A. Carlucci, "The Development of the Principles of Medical Malpractice in the United States," \textit{PRM} 20 (1985): 41-72; Edward J. Larson, "Medicine, Physicians and Malpractice Law," (Paper delivered to the American Association for the History of Medicine, Rochester New York, April 30-May 3, 1986); and Joseph F. Sandusk, "Analysis of Professional Factors in Medical Malpractice Claims," \textit{JAMA} 161 (June 2, 1956): 442-7, discuss malpractice in the twentieth century.} In 1969, Chester Burns recognized the research potential of the topic, identified the 1840s as the first outbreak of malpractice, and issued an implicit call for investigation into its nineteenth century roots.\footnote{Burns, "Malpractice Suits in American Medicine Before the Civil War," \textit{PRM} 43 (1969): 41-56; and Burns, "Medical Malpractice Law and the Public's Health in the United States During the Nineteenth Century," \textit{Actes Proceedings, XXVIIIe Congrès International D'Histoire De La Médecine} 1 (1982): 75-7.} Unfortunately, no one has expanded on Burns' pioneering work. General medical and legal historians may mention increased malpractice, but they provide no systematic discussion or clues to its origins. William Rothstein, for example, suggests that nineteenth century malpractice rates increased as scientific advancements made objective evaluations of
physicians possible.\textsuperscript{6} Rothstein did not embellish or
document his observation, and while the evolution of medical
technology was significant, it only illuminates partially the
complex sources of the suits.

Lack of resources, both primary and secondary, handicap
any attempt to understand fully the history of medical
malpractice. There are no studies that consider trial court
decisions or local peculiarities. Quantitative approaches to
the problem are restricted by the nature of trial court
activity. Nineteenth century trial records have sometimes
disappeared while the surviving ones are often inaccessible,
and seldom in perfect condition. A systematic tabulation of
trial court cases would require a search of hundreds, if not
thousands of locations and would be, according to one writer,
"practically speaking, impossible."\textsuperscript{7} Ultimately, smaller
scale studies of individual states may be warranted but they
will never provide a completely accurate report of the number
of cases in nineteenth century America.

Until recently, the secondary literature in several
fields was not sufficiently developed to support a viable
study of the issues surrounding the topic. Malpractice is

\textsuperscript{6} William Rothstein, \textit{American Physicians in the Nineteenth
Century} (Baltimore: Johns Hopkins Press, 1972), 324.

\textsuperscript{7} Burns, "Malpractice Suits," 42.
neither solely a medical issue nor a legal one. It also has social, political, and religious components. Before the 1970s, medical historians (with some notable exceptions) concentrated on great doctors, major diseases, or specific events. While their work was competent and valuable, they generally did not explore the ways in which medical practice and thought interacted with the cultural and political environment. Similarly, traditional legal historians have tended to emphasize "great cases" and major constitutional changes while ignoring the law's relationship with society, the market, and contemporary intellectual developments.

In the past two decades, however, both legal and medical historians have begun to explore new areas of, and approaches to research. They treat law and medicine not as self-contained disciplines but as part of the society in which they exist. These new works help provide a perspective from which to view the malpractice problem. In addition, the enormous growth in social history and anthropological studies have enhanced our understanding of the nineteenth century world and provided insights that were heretofore unavailable. Because of this prodigious increase in secondary literature

in a wide range of fields, a synthetic study of the origins of medical malpractice is now feasible.

Problems remain, but many can be overcome. When malpractice became a perceptible problem in the 1840s, medical journals published accounts and editorials on scores of malpractice suits. Some of these articles contained portions of trial transcripts, detailed descriptions of the treatment involved, and contemporary commentary. Sometimes physicians or disgruntled patients published pamphlets containing partial or full accounts of trials. Nineteenth century physicians often discussed malpractice in their memoirs, and state medical societies regularly appointed committees to study the problem. By mid-century, medical and legal writers produced entire treatises and compendia on the subject. And, despite their deficiencies, appellate court decisions are a crucial source of information.

I do not intend to provide a comprehensive history of medical malpractice in the nineteenth century. The issues are so numerous and rich, and the country so large and diverse, that a full history is far beyond the reach of any single book. I have occasionally overlooked, or oversimplified, complex legal or medical issues so that I could emphasize their contextual foundations. I often fail to discuss or stress important regional differences. Despite these shortcomings I offer the first in-depth historical
examination of the origins of modern medical malpractice. I am interested in presenting close-up pictures of medical and legal life, but I am equally concerned with identifying and illuminating the fundamental and topical causes of the phenomenon in America.

I hope my work will be useful and look forward to the insight and understanding that scholarly criticism can bring.
In March 1829, Dr. Asabel Humphrey instructed his student to vaccinate Harriet Landon for smallpox. The physician had been hired by the town of Salisbury, Connecticut to vaccinate its citizens. Humphrey's student made two punctures just above Landon's elbow joint. After the treatment Landon found that her lower arm was almost paralyzed. When her condition did not improve, she sued Humphrey for malpractice. After several witnesses, including a medical school professor, testified that the vaccination punctures were in a "very unusual place" and had caused irreparable injury, the jury awarded Landon $400 in damages. In reporting the case for the Boston Medical and Surgical Journal an editorialist "confess[ed]" that he was "somewhat incredulous as to the justice of the decision" and declared that the case should "excite the astonishment of every medical man."1

By the mid-nineteenth century commentators in medical literature rarely expressed incredulity or astonishment when

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1 Landon v. Humphrey 9 Day (Conn.) 209 (1832); BMSJ, (March 21, 1832) 6: 98-9. For an extended discussion of this case also see Chapter 5 below.
a patient sued a physician. They had begun to view the malpractice suit as a ubiquitous, and possibly permanent, fixture of medical practice. Before the late 1830s and early 1840s, however, malpractice cases had been rare in the United States and physicians did not consider law suits a significant threat to their income or status. The social, political, legal, technological, and professional transformations that would eventually incite and nourish the malpractice phenomenon were underway, but they had not yet created the environment conducive to widespread prosecutions. The years from 1790 to 1835 were a period of relative judicial safety for the physician and only isolated cases presaged the menace on the horizon.

While there is no accurate way to calculate the absolute number of malpractice suits in this or any other period, certain legal records, medical literature, and contemporary responses clearly illustrated the relative frequency or infrequency of the litigation. Soon after the American Revolution, individual compilers were publishing reports of all the cases decided in the appellate courts of the respective states. Appellate reports did not record cases decided at the trial level but provided state supreme court rulings on lower court judgments. Appellate decisions were

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accepted elaborations and, occasionally, alterations of the common law and could be used as precedents in subsequent trial and appellate court cases. Therefore, appellate decisions are valuable sources of legal theory and doctrine. Unfortunately, they are less useful as barometers to determine the exact number of malpractice cases at the trial level. A variety of legal, social, financial, and historical factors contributed to the decision to appeal a trial court decision and only a small percentage of trial judgments terminated in appellate court rulings. One writer developed a formula which suggested that there were nine malpractice charges filed at the trial level for each reported appellate decision.3 Another study estimated that the proportion was 100:1.4 The (9:1) ratio is an unreasonably low conjecture.5 The 100:1 figure corresponds with some known nineteenth- and twentieth-century rates and is probably a better estimate. For example an 1860 Ohio medical society committee on

3 Hubert Winston Smith, "Legal Responsibility for Medical Malpractice," JAMA 116 (June 14, 1941): 2670-9 at 2671.


5 Even an incomplete search of antebellum medical journals uncovers a large percentage of the 243 expected suits using the 9:1 ratio [27 appellate decisions X 9 = 243 trial cases], and there were clearly many cases that journals did not report. See bibliography.
malpractice reported that there had been over 200 malpractice cases in the state while the Ohio supreme court had reported two appellate court decisions regarding malpractice.\(^6\) But the vagaries of appellate jurisprudence rob even the 100:1 figure of much of its certitude and utility.

Nevertheless, reported appellate decisions serve as a broad measure of the frequency of malpractice litigation. There were 216 appellate malpractice cases reported between 1790 and 1900. Out of the 216 total, only 5 cases, or 2.3\% were reported before 1835.\(^7\) Despite the uncertainty involved in correlating appellate decisions to trial court judgments, the insignificant number of malpractice cases in the first third of the century contrasted sharply with the acceleration of reported decisions after 1840. Although the rate of increase intensified as the century progressed and continued to soar in the twentieth century, the initial increase in the late 1830s and early 1840s represented a fundamental break

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6 "Prosecutions for Mal-Practice," \textit{OMSJ} 13 (Jan. 1861): 253-60; \textit{Bliss v. Long} 1 Wright's Reports 351 (1833) and \textit{Gindle v. Rush et al.} 7 Ohio 123 (1836).

7 \textit{Drawn from Smith, "Legal Responsibility,"} 2672-3; A decade by decade tally: 1790-1800/1 case; 1800-1810/0 cases; 1810-1820/1 case; 1820-1830/0 cases; 1830-1840/5 cases; 1840-1850/3 cases; 1850-1860/13 cases; 1860-1870/25 cases; 1870-1880/45 cases; 1880-1890/47 cases; 1890-1900/77 cases. For another useful pioneering study, see Chester R. Burns, "Malpractice Suits in American Medicine Before the Civil War," \textit{BHM} 43 (1969): 41-56.
with the past. In the early part of the century malpractice suits were virtually non-existent; after 1840 they became a prominent feature of the medical world.

The contrast between malpractice rates before and after the first third of the century are even more striking when they are compared to population increases. Between 1790 and 1840 the U. S. population grew 334.4% (3,929,214 to 17,069,453). During this period, the number of appellate malpractice decisions remained almost constant. Six appellate decisions were scattered over fifty years. Between 1840 and 1880 the U.S. population increased 194% (17,069,453 to 50,155,783) between 1840 and 1880 but the total number of appellate malpractice decisions jumped 1433%, from 6 cases as of 1840 to 92 cases by 1880.\textsuperscript{8} While the rate of appellate malpractice decisions was seemingly unaffected by a 334% population increase between 1790 and 1840, the rate of reported cases far outstripped population growth over the next forty years. In fact, the interval between 1790 and 1840 has been the only period in American history in which

\textsuperscript{8} Francis A. Walker, \textit{A Compendium of The Ninth Census} (Washington: Government Printing Office, 1872), 8-9 and \textit{Abstract of the Eleventh Census: 1890} (Washington: Government Printing Office, 1894), 3. The number of appellate decisions was calculated from Smith, "Legal Responsibility," 2672-3. Smith cites 7 cases before 1840 and 93 cases before 1880. However, Burns, "Malpractice Suits," 42 note 4, points out that Smith included one case, \textit{Sumner v. Utley} (1828 Conn.), that was actually a slander suit. Consequently I used 6 and 92 as the revised, respective totals for 1840 and 1880.
the proliferation of appellate malpractice decisions failed to surpass the growth rate of the population. These observations demonstrate that the increase in reported suits in the last two-thirds of the nineteenth century was not directly related to population increases and reinforce the conclusion that the late 1830s represented a critical turning point in the history of American medical malpractice.

The low frequency of reports of malpractice in early nineteenth century medical journals corroborate the rarity of suits before 1835. Medical publications allowed physicians to develop their views and communicate their attitudes toward malpractice to other members of the profession. Detailed malpractice reports helped physicians gauge the frequency of litigation, speculate on the causes of the suits, and suggest possible remedies. These commentaries, while virtually absent from early journals, were published at a furious rate beginning in the late 1830s. For example, between 1812 and 1835 the New England Journal of Medicine and Surgery and its successor the Boston Medical and Surgical Journal reported on only 3 malpractice cases. These three cases included one suit each from France, England, and the U.S.⁹ In contrast, between 1835 and 1865 the BMSJ published 48 reports and

editorials on malpractice. Other journals exhibit a similar disparity between the number of suits reported before and after 1840. For example, in New York (the state considered the center of the new malpractice phenomenon in the 1840s) the medical society reported only one malpractice incident before 1835 in its Transactions—and that involved an illegal abortion, not a lawsuit. Similarly, the Medical Examiner was founded in the 1830s but did not report a single malpractice case until the next decade. Publishers did not attempt to provide a comprehensive list of suits but the scores of malpractice reports between 1835 and 1865 reflected the general trend of litigation and the level of professional concern. While these later articles were filled with the medical profession's concerns regarding the frequency of malpractice suits, the few existing reports in the BMSI and other publications between 1790-1835 reflected little anxiety

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10 See bibliography for citations


12 See bibliography for list of citations and for journals that I surveyed.
and treated the cases as regrettable, but isolated, incidents. 13

Although the field of medical jurisprudence blossomed in the early nineteenth century, scholars seldom, if ever, addressed the issue of malpractice before 1835. 14 Two of the most widely circulated works in America were Theodoric Beck's *Elements of Medical Jurisprudence* (1823) and Joseph Chitty's *A Practical Treatise on Medical Jurisprudence* (1834). Neither Chitty, a lawyer, nor Beck, a New York physician, contributed a sentence of advice or information on malpractice. 15 When R. E. Griffith added an American chapter to Michael Ryan's work on medical jurisprudence in 1832, he merely noted that there were three types of malpractice: willful, negligent, and ignorant. He did not cite any cases

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13 While an increase in the number of medical journals may account for some of the increase in reported cases, as many as 74 journals had been founded by 1840. See James H. Cassidy, *Medicine and American Growth 1800-1860* (Madison: Univ. of Wisc. Press, 1986), 66-7 and Henry Burnell Shafer, *The American Medical Profession 1783-1850* (N.Y.N.Y.: AMS Press, 1968), 181-99 for a discussion of early nineteenth century medical journals.


or suggest that the litigation was prevalent. When physicians discussed malpractice in the first third of the century, they were most likely referring to non-licensed practice, ethical violations, or criminal abortion. Civil lawsuits for damages after treatment received scant attention and generated no concern.

When late eighteenth- and early nineteenth-century American lawyers brought malpractice suits against physicians they were able to refer to a slowly expanding body of legal literature for guidance, but no specialized works. Lawyers of the American Revolution had read William Blackstone's or Edward Coke's commentaries, referred to scattered British court decisions, and learned from assisting their preceptors. After independence, Americans published their own law journals, case reports, treatises, and legal handbooks. Despite this relative outpouring of reference material, the essential mechanics of malpractice prosecutions remained


relatively unchanged and lawyers and judges continued to rely on traditional as well as current sources.

American lawyers eagerly bought up Blackstone's commentaries when they first became available in 1769. The first American edition printed in 1771-1772 and the famous St. George Tucker's Blackstone published in 1803 made the commentaries accessible to virtually every lawyer in the country. In fact, for those lawyers who trained in the late 1700s, and practiced into the mid 1830s, Blackstone was the most important legal resource.18

Blackstone categorized *mala practice* not under contract or mercantile law, but under the heading of private wrongs. He defined malpractice as an injury or damage to a person's "vigor or constitution" sustained as a result of "the neglect or unskillful management of [a] physician, surgeon, or apothecary." Blackstone declared that malpractice is an offence because "it breaks the trust which the party placed in his physician." The injured patient possessed a remedy for damages with the special legal action, or writ, of "trespass on the case."19

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The trespass on the case writ was the technical name of the action in a malpractice suit.\textsuperscript{20} This writ served as the common law remedy for all cases in which one person purportedly caused another an injury without the use of force. The scope of trespass on the case included damages sustained as the result of breach of duty, negligence, or carelessness. An attorney had to convince the judge and jury that the accused physician had failed to live up to the common law definition of professional responsibility, and that this lapse had resulted in an injury to the defendant. Judges and lawyers drew on English precedents to form the American malpractice standard. While the law did not demand that physicians implicitly guarantee cures, it required that they exercise "ordinary diligence, care, and skill."\textsuperscript{21} Although the precise wording of the requirement varied, and was occasionally qualified in significant ways, the essential standard remained. Doctors were expected to possess and apply an ordinary and reasonable degree of care, skill, and diligence. Individual physicians' performance would be measured against the therapeutic conventions, or standards of "ordinary" or average members of the profession.

\textsuperscript{20} For an extended and more detailed discussion of the legal aspects and development of malpractice law as well as its English origins see Chapter 7 below.

\textsuperscript{21} This quote is from Landon v. Humphrey 9 Day Conn. 209 (1832).
The common law reserved an important role for the jury in malpractice cases. While trial judges articulated the legal standards by which juries were required to assess physicians, jurors were asked to determine "questions of fact" such as what constituted carelessness and the standards of the profession at large. Although expert medical testimony was required to guide the jury's deliberations, laymen were entrusted with the tremendous power to designate the boundaries of acceptable medical behavior. Since juries made these decisions on a case by case basis, acceptable standards of care, skill, and care were highly sensitive to popular conceptions of the medical profession and medical practice.\textsuperscript{22} Similarly, the use of physicians as medical witnesses provided an official inlet for the personal or professional prejudices of rival medical men. These provisions, contained in the common law, would play a role in the multiplication of suits in the 1840s and 1850s.

There were so few malpractice prosecutions before 1835 that it is difficult to draw many confident generalizations. Still, some trends do appear. The lawsuit was not a common, nor completely acceptable, response to personal misfortune. Generally, only in cases of severe injury or death did

\textsuperscript{22} There was nothing unique in the jury's power to determine "questions of fact" in malpractice cases. This role was routine in other areas of Anglo-American law.
individuals overcome tradition and sue physicians. Patients and their families rarely won in court. Although malpractice suits of all kinds were infrequent before 1835, cases which did not involve death or amputation were especially rare. Fractures which did not result in amputations, the most common source of suits after 1835, were seldom the source of litigation.

For example, in 1767 a physician was accused, but not charged, of malpractice when a patient died as a result of a bloodletting procedure. The earliest reported appellate decision, *Cross v Guthery*, arose in 1794. Doctor Cross, a Connecticut physician, amputated one of Mrs. Guthery's breasts but she died three hours later. Her husband sued the physician asking £1000 for "his costs and expense, and deprivation of the service and company of his wife." Although the jury ruled in favor of Guthery, they awarded him only £40 in damages. In 1825, Michael O'Neil accused Dr. Gerard Banker of infecting his four year old son with a fatal dose of smallpox during a vaccination, and sued for $5000. A New York city jury refused to award the father any

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24 *Cross v Guthery*, 1 Amer. Dec. 61 2 Root 90 (1794).
25 *Cross v Guthery*, 1 Amer. Dec. 61.
damages. 26 A third case from this period which resulted in death occurred in Ohio in the early 1830s. A physician, using a knife and hook, to remove a fetus, injured the mother who subsequently died. The patient's husband sued the physician for malpractice but the trial court judge dismissed the case as a non-suit. 27

Besides cases involving deaths, patients also sued physicians in this early period when they believed that improper treatment had resulted in an amputation or a severe deformity. In a Pennsylvania suit in the late 1820s, a patient accused a physician of improperly treating his broken leg. The limb remained swollen and inflamed for twelve months after the injury until amputation was the only remedy. Although the patient won his case at the trial level, the Pennsylvania state supreme court overturned the judgment. 28 The 1832 Connecticut case Landon v Humphrey involved a physician who reportedly paralyzed a young woman's arm during an improper vaccination procedure.


27 Bliss v Long Wright's Reports 351-3 (1833). A "non-suit" results when a judge dismisses the charges after ruling that the plaintiff has no grounds for prosecution.

28 Bemus against Howard 3 Watts (Penn) 255-8 (1834).
The narrow range of cases prosecuted in the early nineteenth century provide a clue, and a preview, to the subsequent increases in malpractice suits. The suits before 1835 generally involved obstetrical or vaccination cases, or profound deformities such as amputations. Obstetrics and vaccination procedures were viewed by the public as having a mechanical certitude. A judge in 1827 noted that a "physician may mistake the symptoms of a patient; or may misjudge as to the nature of his disease; and even as to the powers of a medicine; and yet his error may be of that pardonable kind, that will do him no essential prejudice." But, the judge observed, while a physician often exercised a profession "beset by great difficulties, the employment of a man midwife and surgeon for the most part, is merely mechanical, and therefore held to a higher standard of performance." 29

Similarly, by the 1820s and 1830s, smallpox vaccination was widely considered a predictable, almost routine, procedure. Statistics from European countries convinced Americans of the value of vaccination and several state legislatures required counties to provide the procedure for

29 Sumner against Utley 7 Conn. Reports 263 at 260. Sumner was a slander case where a patient accused a physician of malpractice but did not file a formal charge.
all citizens.\textsuperscript{30} These attitudes toward particular medical treatments engendered a false sense of certitude and confidence. Both obstetrics and vaccination were still uncertain fields subject to the vagaries of individual patients and practitioners. But, public perception was more important than reality. If a physician did not perform a seemingly mechanistic, simple procedure with success, then he must have been guilty of a lapse in care or skill. The image of the body as a machine and the physician as a mechanic grew out of the triumph of Cartesian thought in the eighteenth century. The mechanistic view of the body and of certain medical practices did not have a major impact on the frequency of malpractice litigation until advancements in medical technology created a reasonable, yet illusory, expectation of success.\textsuperscript{31}

More important, however, the complex of social and professional factors necessary for widespread litigation had not entirely coalesced in the first third of the nineteenth century. An early suit in Maine illustrated the social, medical, and legal environment of this period and suggested


\textsuperscript{31} See Chapter 4, below.
some of the reasons why malpractice suits increased after the first third of the century.

In September 1821, Charles Lowell was riding in the country near the village of Lubec, Maine. Lowell's "young and restive" horse threw him from the saddle and fell across the man's legs. Lowell's companions carried him home and called for Dr. John Faxon. Though Faxon, according to Lowell, was "not a thorough bred physician," he was the only doctor in town and had treated Lowell's family for several years. Faxon examined Lowell and discovered that the man's left hip was dislocated and left leg was twisted at a forty-five degree angle from the right leg. Faxon used a ball, made of a large sheet, as a fulcrum, the dislocated limb as a lever, and attempted to force the hip bone back into the socket. Faxon could not correct the injury, so he sent Jacob Winslow to the nearby village of Eastport to bring Dr. Micajan Hawks.

During the three mile journey from Eastport, Hawks told Winslow that Faxon "was not fit to doctor a sheep or a hog,

32 Lubec is on the extreme northeast coast of the state.

much less a human being." However, when Hawks reached Lowell's house, he was courteous and allowed Faxon to assist him. Hawks directed several men to pull on Lowell's good leg, some others to pull at his arms, and ordered Faxon and three additional men to manipulate the injured leg. Without anaesthesia this was a profoundly painful procedure that Lowell referred to as "torture." Witnesses heard "a kind of a grating" and Hawks declared that the hip was in its proper position. Hawks tied a handkerchief around Lowell's knees and told him to lie still for fourteen days. Hawks said that he would not come back but that he would tell Faxon how to proceed. Hawks spent a total of fifteen minutes with Lowell.34

Lowell repeatedly sent messages to Hawks asking to see him. Hawks refused to visit. Neither Hawks or Faxon were concerned when Lowell discovered a mysterious indentation near his hip joint. Hawks visited Lowell in late October 1821 and though Lowell had reported that the injured leg was very painful and three inches shorter than the other one, the physician refused to examine it. Hawks finally told Lowell that he had "gotten to be a cripple for life and all through Faxon's ignorance and quackery." Even though Lowell had been in bed with his legs bound together, Hawks claimed that Faxon

34 Lowell, Authentic Report, 9-10.
had allowed the patient to reinjure the hip. Now, Lowell was in constant pain and was unable to walk without crutches.\footnote{Lowell, \textit{Authentic Report}, 4.}

In December 1821, about four months after the accident, Lowell traveled two-hundred and fifty miles to Boston aboard a cargo ship to meet with Dr. John Collins Warren. Warren was easily the most distinguished physician in the country. He had studied at schools and hospitals in London, Edinburgh, and Paris. He was an accomplished surgeon, held the chair of anatomy and surgery at Harvard medical school and had founded Massachusetts General Hospital and the \textit{New England Journal of Medicine}. Warren examined Lowell's deformed hip and said that Lowell had suffered a simple dislocation. Since the injury had been left untreated for such a long time, however, nothing could be done. He declared that it "was nonsense for Hawks to say he ever reduced the dislocation and that [Lowell had] displaced the bone again lying in bed." Warren consulted four other physicians at the hospital and they all agreed that Lowell's deformity and handicap was the result of an untreated, simple dislocation. Lowell said that he was "prepared in mind and body for the pain of [an] operation," had a family to support, and convinced Warren and his associates to try and treat the leg. Warren used a series of pulleys, bandages, and cords in an attempt to force Lowell's
leg back into its proper position. He conducted the operation for over two hours in front of one hundred students and surgeons but could not improve the condition of the leg. Lowell declared that "I am aware of the necessity of kissing the rod, and him who hath anointed it; and were it purely an act of God, I would accept it without a murmur."36 But after leaving Boston, he "was satisfied that [his] ruin had been brought on by ignorance, stupidity, and unpardonable neglect."37

Lowell sued doctors Faxon and Hawks for malpractice and asked for $10,000 in damages. In March 1823 a jury for the Court of Common Pleas found Faxon and Hawks guilty of malpractice and awarded Lowell $1,962. The physicians appealed the case in the Supreme Judicial Court of Maine for Washington county. The Supreme Judicial Court had a judge, and a full jury, and possessed the power to entirely retry

36 Lowell, Authentic Report, 18.

the case. The second trial started in July 1823 but was continued to the June 1824 term.  

John Warren and four of his associates from Massachusetts General supplied the most damaging evidence against the defendants. The Boston physicians gave sworn depositions witnessed by Lemuel Shaw, then a representative to the Massachusetts state legislature. Warren repeated his assertion that Lowell's injury was a simple dislocation that could have been corrected with prompt treatment. He said that a physician of "ordinary skill" ought to know that a limb which was three inches shorter than the other was dislocated. Warren also agreed with Lowell's attorney that "common and ordinary attention" would lead to regular examinations, comparisons of the lengths of the patient's legs, and concern over any chronic pain. Warren also contended if "naked hand force" was not sufficient to reset the dislocation, then it was improper treatment to neglect the use of some mechanical means such as pulleys. Warren concluded by stating that he did not believe that physicians of high standing would disagree with his diagnosis or

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38 Lowell, Authentic Report, 6-7; Adams, Report of a Trial, 5.
treatment in the case. Several other doctors testified that dislocations were easy to diagnose and treat. 39

Faxon and Hawk's attorneys countered Warren's testimony by introducing Dr. Nathan Smith. Smith was a well-known New England physician the founder of Dartmouth and Yale medical schools. Warren's father had been instrumental in the establishment of Harvard's medical program. When Smith heard Warren's deposition he called the Boston doctors, "a pack of old grannies." Smith blamed the near unanimity of the evidence against the defendants on Warren. "I suppose Warren said so, and all the rest fell in with his opinions." Smith had examined Lowell's leg in June of 1822. He testified that Lowell did not have a dislocation but had broken the bones of the joint in his fall from the horse. In such an injury, Smith argued, nothing could have been done to cure it. Smith declared that pulleys such as Warren used were not necessary and that they had often been injurious. When Lowell's lawyers cross-examined Smith, the physician admitted that he knew Hawks and that he had once told Lowell that "he had better drop his action [malpractice suit] and

39 Other surgeons were William Spooner, David Townsend, James Mann, Adams, Report of a Trial, 10-30; for Warren's testimony see Adams, Report of a Trial, 12-3, 15, 23-5.
try and get well, which would be better than to try to get damages out of the doctors."40

In his short closing statement, Lowell's attorney declared that it was a "known principle of law" that he "who undertakes any business for another shall conduct that business with ordinary skill." Nothing would be more just, he continued, than "that one man should not suffer of the carelessness of another." According to Lowell and his lawyer, Hawks was negligent because he left a patient in the care of Faxon, a man he did not consider fit to treat a "sheep or a hog." Hawks had been hasty in his treatment of Lowell, careless in not noticing the shortened leg, and negligent in allowing Faxon to treat patients. The lawyer asked the jury to award Lowell damages enough to support the injured man for life.41

John Davies' closing argument for the defendants filled over fifty pages of text. Davies portrayed Hawks as a modest but committed physician. Hawks did not claim the highest powers and honors of his profession but he had used the best means at hand to reduce a difficult dislocation. According to Davies, Hawks did not expect to cure Lowell


completely because he was always "satisfied that there was some interior injury which his art could not reach and which he thought best to be trusted to the healing power of nature." Davies noted that malpractice cases were rare and difficult to adjudicate because "[t]he work of a physician is all tentative and experimental . . . [n]ew observations and discoveries are continually enlarging the field and changing the instruments of professional power." Therefore Davies reasoned:

The same degree of skill cannot be expected in all places nor exacted of all persons. A young physician cannot be equal to an old one, nor a village apothecary set up to rival a college professor.42

After arguing that physicians' skills should be judged on the standard of care in their locality, Davies tried to persuade the jury that quality of medical care in rural Maine was probably preferable to the scientific advances of Boston. According to the lawyer, Hawks and Faxon did not try and adjust Lowell's leg further because they believed that he was beyond help and did not wish to subject him to any more pain. Davies' sarcastic tone throughout the closing argument was designed to create resentment against the pretensions of big city medicine in the small town jury. Davies told the jurors

that John Warren and the "learned faculty of that eminent institution [Massachusetts General]" came together to examine "the case of an unfortunate victim of village quackery."

Davies described the Boston doctors as:

Cradled in the love and honor of our society, nursed in the laps of ease, enjoying the patronage of power and opulence, having walked perhaps one after another the hospitals of Europe . . . a Boston jury would hardly permit the winds of Heaven to visit them too roughly.

In contrast, Hawks' "opportunities" were more limited.\textsuperscript{43}

While "persons of loftier standing" than Hawks might be "a little more adventurous," "it behoove[d] such humble individuals as himself to be cautious and circumspect in their conduct . . . [and] not to perform experiments at random." In Boston, Davies declared, they were less cautious. Warren and his colleagues had argued that Hawks and Faxon should have used mechanical means to treat the dislocation. Davies lampooned the scene in Boston as Warren prepared to treat Lowell. "The rising usefulness of this grand institution [Massachusetts General] was about to be attested by a decisive achievement—and a day of glory was about to dawn upon Massachusetts General Hospital." Davies described how Warren administered powerful cathartics,

nauseating doses of antimony, and bled Lowell as freely as possible.44

Davies compared Warren's use of a pulley on Lowell to seventeenth century torture. He quoted medical books which discouraged the use of mechanical devices. Davies claimed that the treatment was so painful and dangerous that "[t]he wonder is not that the operation was unsuccessful but that the patient survived." Yet, Davies reminded the jury, Hawks and Faxon were being persecuted because they had not used a pulley. Finally, Davies asked the jurors to consider the impact of a guilty verdict on the community since Hawks and Faxon were the only physicians in their respective villages. "What is the consequence of a limb like Lowell's... compared with the usefulness of such a physician as Dr. Hawks, entirely lost to the present scene from his practice?"45

After Davies finished his argument judge Nathan Weston charged the jury. Weston accepted Davies' description of the legal responsibilities of surgeons. Weston declared:

It is not to be expected of a Surgeon or a Physician in a country or obscure village, that he will possess the skill of a surgeon in the city of London, or any large city-this would be unreasonable to expect... all that is required is ordinary skill according to the general state of medical science in the section of the country in which he lives.

44 Adams, Report of a Trial, 97.
45 Adams, Report of a Trial, 86-95, 100-1.
Judge Weston was clearly partisan. He said that he did not think the leg had ever been dislocated. While he believed the Boston physicians had "spoke with too much certainty," he knew of no reason why the jurors should not believe the witnesses for the defence. The Boston physicians testified that Hawks and Faxon should have used a pulley. Weston followed the defence attorney's lead and suggested that mechanical devices might be dangerous. But, according to Weston, even if the pulleys were the most appropriate treatment, "it did not appear that anything of the kind could be had" in Lubec.46

The jury could not decide on a verdict and judge Weston convinced Lowell to accept a non-suit. Lowell later felt that he had been coerced and published a twenty-nine page pamphlet exposing "the official conduct of Judge Weston and the candor and intelligence of the Jurors of this county." A one-hundred and seventeen page account by a friend of the accused physician and a one-hundred and forty-two page report by one of the medical witnesses followed Lowell's publication.47 The volume of literature on this case far


exceeded the literature published on any other suit in the century and underlines the rarity of the litigation. Lowell claimed that Weston had "instructed the jury in the most novel and extraordinary way" and that he agreed to a non-suit because the "excitement and prejudice was so great that there would be no probability of getting an impartial trial." He lamented that "[the trial] doomed me to a miserable existence, through the residue of my mortal life for every step I take, I am reminded of my now irreparable misfortune."48

The 1824 Lowell case was an anomaly in the first third of the century but it foreshadowed the imminent onslaught of suits and helps illustrate some of the factors that would instigate future litigation. By 1824 the social, religious, and political assumptions of colonial society were well on their way to being destroyed. Early America had been characterized by the existence of organic communities in which individuals were bound together by common interests and dependency relationships. The good of the community was placed above the good of the individual and stability and consensus were the order of the day. Most communities were small and emigration was relatively rare. Local issues remained local issues. Since relationships among citizens

were intimate, the power of community opinion to mediate disputes was both a possibility and a necessity. In addition, stability and order were maintained by a network of hierarchical and familial relationships which emphasized deference and compromise over conflict. Especially after 1776, these orderly, closed, communal relationships began to break down under the stresses of economic development, emigration, and the growth of egalitarian ideas. Although social upheaval and fragmentation of communal structures continued unabated after the American Revolution, a decisive break with colonial structures did not occur until the second third of the nineteenth century. Therefore, remnants of many colonial assumptions, though dramatically undermined, persisted into the period embracing the 1824 Lowell lawsuit. At the same time however, several factors in this unusual, transitional case anticipated the foundations of increased malpractice prosecutions later in the century.

Judge Weston had charged the Lowell jury that a physician practicing in an "obscure village" was not required to possess the same degree of medical knowledge as a practitioner in a large city. The jury was asked to compute

a physician's acceptable degree of skill according to the state of local medical practice. This doctrine, which would become known as the "locality rule" in the latter part of the century, reflected the condition of both the medical profession and the nation in the first part of the nineteenth century. Rural practitioners were usually isolated from urban centers of medical progress. In 1824 there were fewer medical schools and journals to disseminate knowledge on a national scale. When juries judged physicians by local standards they reflected the more general commitment to localism and anti-urbanism of the period. Davies, Hawks' attorney, manipulated this strain of local pride in his description of the elite Boston physician who testified for the prosecution. He also argued that malpractice suits were "foreign from the ordinary routine of judicial business" partially because "the work of the physician is all tentative and experimental; it is all as it were underwater."51

50 Most legal writers trace the origins of the locality rule to the 1870s and 1880s but it is clear that the doctrine was employed much earlier. For comments on the locality rule and medical malpractice see: Jon R. Waltz, "The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation," DPLR 17 (1969): 408-21; David D. Armstrong, "Medical Malpractice--The 'Locality Rule' and the 'Conspiracy of Silence'," SCLR 22 (1970): 811-21; Carleton Chapman, Physicians, Ethics, and the Law (N.Y. N.Y.: New York University Press, 1984), 96. See Chapters 2 and 8 for more on the locality rule.

Unfortunately, these sentiments could also work against medical advancement and proper care by putting a low premium on superior skill, protecting incompetent physicians, and discouraging suits. The arguments and result of the Lowell case reflected the country's diverse medical culture and were an explicit legal toleration of lower medical standards.

Three decades later, at mid-century, both the country and the medical profession looked quite different. The assumptions of the judge, defense attorney, and jury were no longer as obviously applicable. In 1860 Stephen Smith argued that while it may have once been proper to gauge the amount of skill required by physicians by the locality in which they lived, it would be "manifestly dangerous" to accept the practice. It was ludicrous, Smith declared, for a physician to plead ignorance of generally recognized knowledge "in our time [1860] when communication is so rapid, and books and periodicals are abundant and cheap." 52 Much of the public shared Smith's beliefs and were willing to hold physicians to a higher standard of accountability after 1835. Physicians' performances were seldom measured only against the standard of care in their own community. Reality, however, did not match perception. While medical care had improved nearly

everywhere by mid-century, it had not developed uniformly. Physicians' and patients' inflated expectations in the wake of specific medical advancements between 1820 and 1840 contributed to dissatisfaction with medical treatment and undermined the development of realistic standards of care.

The defense attorney also asked the jury to consider "What is the consequence of a limb like Lowell's . . . compared with the usefulness of such a physician as Dr. Hawks, entirely lost to the present scene from his practice?" 53 Both Hawks and Faxon were the only physicians in their communities and the prospect of their loss following a successful malpractice prosecution undoubtedly influenced the jury's decision. In the early years of the nineteenth century physicians were scarce in rural areas. 54 As physicians became significantly more plentiful later in the century, patients, juries, and judges could afford to charge and convict malpractice defendants without the fear that the community would be left without a medical man. 55

53 Adams, Report of a Trial, 100.

54 The increased supply of physicians, and its impact on malpractice is discussed in Chapter 3.

55 The word "conviction" now refers to the determination of guilt in a criminal charge. Formerly, "conviction" also referred to a judgment against the defendant in a civil case. See Black's Law Dictionary 5th edition. (St. Paul Minn.: West Publishing Co., 1979), 301. I will use the nineteenth century terminology, of defendant, prosecutor, and verdict, throughout this work.
Finally, Lowell's terse apologia which affirmed the religious necessity of accepting adversity by "kissing the rod and him who hath anointed it," suggested that much of society still believed that misfortunes emanated from the hand of God. The proper response to an act of God was humble acceptance, not a lawsuit. As religious beliefs concerning providence evolved, victims of misfortune were freed to search for temporal causes and blame human actors. Davies, Dr. Hawks' attorney, had observed that:

It is not a very commendable sight anymore than a very customary sight to see a patient prosecuting his physician. It is rather doubtful whether the intensity of moral obligation can be increased in such a case by legal action.

Davies believed, rather, that "public judgment" was the "proper tribunal to regulate this species of responsibility."

In the closed, parochial communities of the late eighteenth and early nineteenth centuries, Davies was probably correct. However, as social, economic, and geographic mobility


57 For a discussion of the transformation of attitudes toward providence and its role in the malpractice epidemic see Chapter 6.

destroyed the basis for communal judgment, disgruntled patients were more likely to turn to courts for satisfaction.
In 1844 a writer for the *Boston Medical and Surgical Journal* warned that qualified physicians were "constantly liable to vexatious suits instituted by ignorant and unprincipled persons."¹ In 1853 the *Western Journal of Medical and Physical Sciences* reported that malpractice suits "occur almost every month in the year and everywhere in our country."² These writers were not exaggerating and their suspicions and fears were well founded. They, and their contemporaries, were witnessing the first symptoms of a professional disease that would plague medical men for the next one hundred and fifty years. Although medical malpractice suits were virtually non-existent between 1790 and 1835, patients then suddenly began to sue their physicians at an increasing and unprecedented rate. As early as the 1840s, the frequency of suits in some parts of the country had filled medical men with a mixture of anger, panic, and confusion. The suits and the alarm increased as the decades passed. Frank Hamilton, a New York physician,

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claimed that between 1833 and 1856 "suits for malpractice were so very frequent in the Northern states," that many men "abandoned the practice of surgery, leaving it to those who, with less skill and experience, had less reputation and property to lose." 3 By 1860 John Elwell, who wrote a book on the subject, could claim that "There can hardly be found a place in the country, where the oldest physicians in it have not, at some periods in their lives, been actually sued or annoyingly threatened." 4

Every available indicator suggested that the doctor-patient relationship was entering a dramatic new phase. Of the 216 reported appellate malpractice decisions in the nineteenth century, only 5 had occurred before 1835. In contrast, state supreme courts ruled on 42 malpractice cases between 1835 and 1870, 45 cases from 1870 to 1880, and 47 cases from 1880 to 1890. 5 Also, the period between 1835 and

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5 See Chapter 1 above. Figures culled from Hubert Winston Smith, "Legal Responsibility for Medical Malpractice," JAMA 116 (June 14, 1941), 2672-3. A decade by decade tally: 1790-1800/1 case; 1800-1810/0 cases; 1810-1820/1 case; 1820-1830/0 cases; 1830-1840/5 cases; 1840-1850/3 cases; 1850-1860/13 cases; 1860-1870/25 cases; 1870-1880/45 cases; 1880-1890/47 cases; 1890-1900/77 cases. For another useful
1870 marked the first time that the increase in appellate malpractice decisions outran the increase in the nation's population. State supreme courts would continue to rule on malpractice cases at a faster rate than the population growth through the twentieth century. Although the numbers of appellate cases represented only a small fraction of the total number of actual prosecutions, they underscored the sudden prevalence of the practice after 1835.

Similarly, medical journals printed hundreds of accounts and comments on malpractice cases between 1835 and 1865. The editorials, rare in the first third of the century, reflected the novelty, and intensity of the phenomenon. Alden March, a prominent New York physician, reported in an 1847 issue of the BMSJ that "Legal prosecutions for mal-practice occur so often that even a respectable surgeon may well fear the results of his surgical practice." A writer for the Medical Examiner in 1851 lamented that "[m]ischievous prosecutions for some years have alarmed medical gentlemen in various parts of the country to such a degree that many have

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6 See Chapter 1 above.

concluded to let all surgical patients go unassisted in their afflictions." Worthington Hooker, the Connecticut doctor who wrote the influential *Physician and Patient* in the 1840s, declared that "the professional reputation of medical men seems to be considered by common consent as fair game for the shafts of all, whether high or low, learned or unlearned. Although the charge of mal-practice is a serious charge . . . it is exceedingly common to hear this charge put forth without any hesitation." Observers believed that the new and dangerous trend began in western New York in the late 1830s and early 1840s and quickly spread both east and west. A writer for the *BMSJ* in 1847 noted that the malpractice "fever" first became popular in western New York "a few years since," and then spread through other eastern states, into Vermont, and even into Canada. Frank Hamilton told the 1843 graduating class of Geneva Medical College that he knew of over twenty malpractice prosecutions against "respectable and eminent"

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New York state surgeons in 1840 and 1841 alone. These writers were probably correct. New York accounted for the lion's share of the publicized cases in the 1840s. One New York case, in 1839, gained national attention and opened a widespread debate in the pages of the major medical journals. When one of the medical witnesses in the trial was subjected to a retaliatory suit two years later, a commentator warned that western New York was the country's hotbed of medical malpractice. In 1844, Dr. James White of Erie county New York treated William Tims who had suffered an oblique fracture of his thigh bone after falling from the roof of a railway depot. When Tims' limb healed, it was crooked and had a bony protuberance at the point of the injury. He sued White for malpractice but the jury refused to reach a verdict. Tims sued White the next year with the same result. Finally, in 1848, a jury decided the case in favor of the physician. During the trial, Dr. Trowbridge, of Buffalo N. Y. who served as one of the medical witnesses, testified that while he had never been sued, the frequency of


malpractice prosecutions in the state had driven him from practice. The editor of the Buffalo Medical Journal congratulated Trowbridge for his "timely and judicious course in laying down the scalpel," and reported that "in this city [Buffalo] there are but a few surgeons of years or reputation in the profession, who have not been latterly crowned with the accompanying honors of a public prosecution for malpractice."\(^{13}\) When Adolphus Gates, a German laborer in Buffalo, was awarded $600 after his fractured wrist healed in a frozen position, an editorialist in the same journal wrote that "the whole system of trials for malpractice is so radically wrong that the defendant must be mulcted in every case where he is not sustained by the entire professional evidence." According to the author:

\[\ldots\text{ evidence of a single man,}\]
\[\ldots\text{ contradicting all surgical experience, and}\]
\[\ldots\text{ evidently based on an egregious error in diagnosis, outweighed the opinions of older and better surgeons, and subjected a poor, hard-working and intelligent practitioner to a judgment and costs heavy enough to sweep away the greater portion of the small earnings of many years.}\(^{14}\)

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\(^{14}\) "Trial for Malpractice," BufMJMR 10 (1854-55): 569-70.
New York physicians became more preoccupied by the phenomenon as the suits multiplied. A reviewer for the *New York Journal of Medicine* in 1853, barely mentioned the two books he was ostensibly reviewing and used the occasion to rail against malpractice in the state. "The disposition to institute legal proceedings against the surgeon for the treatment of fractures has become so strong, that prosecutions have been made where there was not the slightest ground for complaint." "And," he observed, "this spirit of persecution is stimulated and more widely disseminated on every repetition of these trials."\(^{15}\) In less than fifteen years, from 1839 to 1853, malpractice suits in New York went from being rare and unimportant to being common and a major concern to all New York physicians.\(^{16}\)

New York may have been the apparent source of the malpractice "fever" in the 1840s, but the disease did not spread to other states by imitation alone. An outbreak of prosecutions in any region required the existence of specific

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\(^{15}\) "Bibliographic Notices," *NYJM* (Sept. 1853), 272-5.

social and professional conditions. For example, intra-professional rivalry, numerous medical sects, and low public esteem fueled by particularly strong Jacksonian sentiment, made medical men in New York somewhat more vulnerable than their colleagues in other states. However, these factors and others, in slightly diminished intensity, quickly provided the environment necessary for the more frequent prosecution of physicians in other states. While patients and physicians in other regions may have been aware of the growing malpractice epidemic in 1840s New York, the practice could not have spread to other states unless the complex of social and professional factors which favored its existence already existed. When the necessary preconditions for widespread suits were absent, malpractice litigation did not flourish.

By 1850 suits were beginning to appear at an increasing rate in western states such as Ohio. Several malpractice cases surfaced in the state in the 1830s but the prosecutions did not alarm the profession until mid-century. The appearance of suits in some counties for the first time in

17 See chapters 3-6 for an exposition of these social and professional conditions.

18 For example see Gallaher & White v Thompson (1833) in Elwell, Treatise on Malpractice, 115-7; Bliss v Long (1833) in 1 Wright's Reports, 351-3; and Samuel Gindle v Leo Rush et al. (1836) 7 Ohio 123.
the late 1840s heightened physicians' fear. Washington county, Ohio reported its first malpractice case in 1849 when a patient asked for $10,000 in damages after his thigh fracture resulted in a shortened limb (he received only $200). According to the Western Lancet, Meigs county Ohio suffered its first malpractice suit in 1850. During one week in 1855, four cases were tried in four separate Ohio counties. The same year, the Ohio Medical Society created a committee to investigate the sudden onslaught of suits in the state. The committee published accounts of seven cases and called the phenomenon "a standing and cumulative evil bearing with the weight of an incubus upon the profession." 


Ohio Medical and Surgical Journal published numerous accounts between 1850 and 1865, and as in New York, medical men were reportedly leaving the profession because of the frequency of law suits. One editorialist claimed in 1861, that "from first to last there have been over 200 prosecutions in Ohio." While many counties in the state had recorded their first suits as late as 1850, lawsuits were common enough to be considered a major threat as early as a decade later.

Within ten years of the first outbreak of malpractice in 1840s New York, other eastern physicians began to complain of the malady. William Wood, a Pennsylvania physician, warned in 1849 that "the principles of law, intended for the protection of the community, are perverted into powerful instruments of wrong and injustice." Echoing the claims of observers in New York and Ohio, Wood reported that "[s]ome of the most competent young men are driven off, and such as remain refuse to take the responsibility of surgical cases." To illustrate the situation in Pennsylvania, Wood chronicled the plight of Charles Brandes, a young German physician who set up practice in the late 1840s. Almost immediately he was plagued by malpractice suits, and threats of suits. He was charged twice for the improper vaccination of patients, and

once for the unskillful treatment of a thigh fracture.\textsuperscript{22} Like Ohio, local Pennsylvania medical societies established committees to investigate this new threat to the profession.\textsuperscript{23} The malpractice phenomenon reached even isolated states such as New Hampshire and Vermont. Dixi Crosby, a prominent Vermont physician, was sued for $5000 after offering advice to another physician on a thigh fracture in 1853. After the jury awarded the patient $800 in


damages, a judge in New Orleans exclaimed that "a man had better be in any other profession than in the medical."24

Physicians' experience in Massachusetts, more than anywhere else, demonstrated the timing, rapidity, and amplitude of the initial increase in malpractice litigation. A medical writer commenting on an 1842 Vermont malpractice case, regretted that the defendant "could not have had a hearing before an enlightened jury of Massachusetts, where his high attainments in medicine and surgery would have been appreciated."25 The Massachusetts writer's lament reflected his belief that the state was not fruitful ground for the widespread prosecution of physicians. Through most of the 1840s his judgment appeared sound and there were few


lawsuits. As, late as 1847, the BMSJ could confidently assert: "Here in Massachusetts the trick has been attempted on a small scale two or three times, but the result has not been sufficiently encouraging to induce many to embark on it." The writer believed that "there happens to be too much intelligence here, for such degradators to succeed."26

The medical journalist's optimistic certainty that Massachusetts was immune to the "mania" that was sweeping the northeast was unfounded and short-lived. By 1853 the tone of the Massachusetts medical commentators had evolved from sympathy for their colleagues in other states, to concern for their own professional safety. After a spate of cases in the state, the BMSJ warned that "Every surgeon in the community is liable to a lawsuit for damages." Even more ominously, the journal observed that "[j]uries appear to have been particularly sympathizing with plaintiffs."27 Another writer declared in 1853 that:

A fresh disposition to prosecute physicians for alleged [sic] malpractice is manifest in Massachusetts. It is becoming a hazardous enterprise to give surgical assistance in this ancient Commonwealth. It is even worse

in some respects, than in western New York or Vermont.\textsuperscript{28}

A flood of suits struck the state as suddenly, and dramatically, as they had in other areas of the country. Between 1850 and 1856, for example, there were five malpractice suits in Middlesex county Massachusetts alone.\textsuperscript{29}

By the mid-1850s, Massachusetts physicians, like those in New York, Ohio, Pennsylvania, Vermont, and New Hampshire, were being sued in all parts of the state. In fact, malpractice charges had become a recognizable and urgent problem throughout the north, even though they remained rare in the south.\textsuperscript{30} The actual number of lawsuits between 1835-

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\textsuperscript{28} "Mal-practice," BMSJ 49 (Oct. 26, 1853): 204.


\textsuperscript{30} Hamilton, "Suits for Malpractice in Surgery," 98. Chapter 6 below contains a short, speculative comment on the
1865 is impossible to determine without a courthouse-to-courthouse search of every state. It was clear, however, from appellate court reports, medical journals, and contemporary commentaries that these years represented a fundamentally new era in the history of medical malpractice. The rate of prosecutions in this period was probably not as great as in comparable periods later in the century, and certainly not as intense as in the twentieth century, but the initial explosion of litigation in the 1840s represented a basic, fateful, and irrevocable shift in attitudes toward the practice. While a variety of technological, intra-professional, economic, and social changes would push litigation rates to soaring heights over the next century and a half, the profession and the country crossed over the most critical threshold in the 1840s and 1850s.

The types of treatment which engendered lawsuits between 1835–1865 also broke with the patterns of the past. In the first third of the nineteenth century malpractice cases typically involved death, severe deformity, vaccination, or obstetrics. Less severe injuries seldom led to lawsuits. After 1840, patients began to charge physicians for absence of widespread litigation in the nineteenth century south.
malpractice involving a wider range of treatments (See Table 1).

In addition, patients regularly sued physicians for less severe injuries than they had before 1835. For example, a New York man sued his physicians in 1839 when his badly fractured leg healed, but was 1 1/4 inches shorter than his other limb.31 In an 1843 case, John Basset of Independence, New York injured his thigh when his wagon overturned and crushed his leg. Two weeks after the accident, doctors John Collins and Anthony Barney examined Basset and decided, after noting his shortened leg, and outturned toes, that the injury was a dislocated hip. They used ropes and pulleys to adjust the hip to its proper position. When the physicians heard the characteristic "pop" that generally accompanied the relocation of bones, and the leg was restored to its natural length, they dismissed Basset as cured. Within a year his leg was shortened 1 1/2 inches and he charged the physicians with malpractice. After two trials and four years a jury decided in favor of Collins and Barney.32 In 1853 Dixi Crosby, a Vermont physician, was sued and fined $800, for


providing consultation in a fracture case in which the patient's injured leg lost 1/4 inch in length. Although these were undoubtedly traumatic disfigurements for the individuals involved, the cases were significantly less serious than the typical case in the first third of the century.

<table>
<thead>
<tr>
<th>Type</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>fracture</td>
<td><em>BufMJMR</em> 4 (Aug.1848): 131-54</td>
</tr>
<tr>
<td>hernia</td>
<td><em>StLMSJ</em> 3 (May 1846): 529-63</td>
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<tr>
<td>amputation</td>
<td>28 Maine Reports 97-101 (1847)</td>
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<tr>
<td>laceration</td>
<td><em>NWMSJ</em> 5 (1848-9): 536-46</td>
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<tr>
<td>abandonment</td>
<td><em>MNL</em> 6 (May 1848): 60</td>
</tr>
<tr>
<td>obstetric</td>
<td><em>OMSJ</em> 2 (Sept. 1849): 6-10</td>
</tr>
<tr>
<td>dislocation</td>
<td><em>WL</em> 11 (1850): 763-8</td>
</tr>
<tr>
<td>vaccination</td>
<td><em>AJMS</em> 22 (July 1851): 43-50</td>
</tr>
<tr>
<td>calomel</td>
<td><em>WJMPs</em> 24 (1851): 168-70</td>
</tr>
<tr>
<td>aneurism</td>
<td><em>BMSJ</em> 35 (Aug.12,1846): 43-5</td>
</tr>
<tr>
<td>patent medicine</td>
<td><em>OMSJ</em> 6 (Nov. 1853): 182</td>
</tr>
<tr>
<td>death</td>
<td>12 <em>Howard Practice Reports</em> 323 (1855)</td>
</tr>
<tr>
<td>bleeding</td>
<td>Elwell, <em>Treatise</em>, 142-62 (1857)</td>
</tr>
<tr>
<td>misdiagnosis</td>
<td>21 <em>Texas Reports</em> 111 (1858)</td>
</tr>
<tr>
<td>chloroform</td>
<td>Smith, <em>Doctor in Medicine</em>, 277-8</td>
</tr>
<tr>
<td>ocular</td>
<td><em>BMSJ</em> 32 (April 2,1845): 185</td>
</tr>
<tr>
<td>tonsils</td>
<td><em>BMSJ</em> 28 (Feb.15,1843): 29-33</td>
</tr>
</tbody>
</table>

The increased variety in the types of cases brought to trial after 1835, and patients' marked tendency to sue for significantly less severe injuries, were both a product of a transformed attitude toward malpractice. The increased willingness of individuals to sue, and society's accompanying acceptance of the practice, encouraged litigation of all types. Unrealistic public and professional expectations, born of technical advancement in particular areas of medicine, also helped fuel the trend.34 Before 1835, when personal and public reservations concerning malpractice prosecutions dampened the flow of cases through the courts, injuries and complaints generally had to be serious enough to overcome traditional doubts about the practice. Therefore death and amputation cases dominate the small sample of early suits.35 However, as personal doubt and public disapprobation dissipated, patients felt justified in suing physicians for injuries that resulted in minor deformities, pain, or even inconveniences.

After 1835 deformities following fractures and dislocations suddenly became the major source of malpractice

34 This observation is particularly true of the relationship between fracture treatment and the increase in malpractice suits after 1835. See Chapter 4.

35 See Chapter 1.
prosecutions. John Elwell in his 1860 *Treatise on Medical Malpractice* claimed that "nine-tenths of all the cases of malpractice that come before the courts for adjudication arise either from the treatment of amputations, fractures, or dislocations." 36 Although Elwell was correct in noting the predominance of fracture-dislocation cases, his estimated proportion was probably inflated. The wide variety of suits prosecuted after 1835 made it unlikely that fracture-dislocation-amputation cases could account for 90 percent of the suits. Elwell also misled his audience by combining amputation cases with fractures and dislocations. Suits involving amputations were rare after 1835 and lumping them together with other orthopedic injuries masked their insignificant contribution to the total number of cases. Stephen Smith, also writing in 1860, countered Elwell's claim using statistics he had gathered from "several hundred suits for malpractice." He argued that 142, or a "little over two-thirds" of the cases he studied, grew out of amputations, fractures, and dislocations. Of these 142 suits, only eight or about 4 percent of the approximately 213 in his study, originated from amputations. One hundred and two suits grew

out of fractures, and thirty-two suits stemmed from dislocations.37

Smith's figures are in general agreement with the rate that suits were reported in contemporary medical literature. Fracture-dislocation cases accounted for about two-thirds of the malpractice cases between 1835 and 1865, with the rest of the suits represented by the causes listed in Table 1. While fracture-dislocation cases did not account for 90 percent of the litigation as Elwell had claimed, they did constitute a majority of the suits in the nineteenth century. The particular propensity to prosecute physicians for the maltreatment of fractures and dislocations aggravated an atmosphere that was already conducive to widespread litigation, and played a role in making the initial increase in suits more profound. Because they did not have to justify their actions to themselves and their community, individuals felt free to demand monetary remuneration even when their injuries were relatively minor—the type of results that often followed fracture treatment. Therefore, the general

37 Steven Smith, [Review of John Elwell's Treatise on Malpractice], AJMS 40 n.s. (July 1860): 153-66 at 162. Unfortunately Smith did not provide the total number of cases used in his study. However, he noted 142 cases represented a "little over two-thirds" of his total. Therefore his study was drawn from approximately 213 cases. I have used this total in calculating these percentages.
tendency to sue physicians after 1835, and the new found
inclination to sue for fracture type injuries, interacted,
and pushed the climbing malpractice rates higher.\(^{38}\)

When patients received permanent injuries after
treatment for fractures, or other maladies, different factors
precipitated the initial decision to hire a lawyer and begin
a lawsuit. Often, patients acted on their own without any
apparent prodding from friends, lawyers, or other physicians.
For example, after an Ohio man in the mid 1850s suffered a
compound fracture of his lower leg, his family summoned a
physician who set and wrapped the victim’s seriously injured
leg. Within days the leg became inflamed and swollen and the
physician removed all the wrappings from the limb. The
family, believing that the physician was neglecting the
fracture, dismissed the doctor after two weeks. The patient
suffered in bed for almost a year. His first action upon
leaving his bed on crutches was to visit, and hire, an
attorney.\(^{39}\) In a similar case in 1856, Nathan Varner was
riding his sleigh, drunk, about two miles from his home in
Zanesville, Ohio. Varner lost control of the horse, fell

\(^{38}\) These issues will be discussed further, and more fully,
in Chapter 4.

\(^{39}\) "Report on the Difficulties Growing Out of Alleged Mal-
Practice in the Treatment of Fractures," \textit{TOMS}, 11 (1856): 53-
66 at 57-8.
from the sleigh, and broke his lower leg. When Dr. Thaddeus Reamy was treating the injury he told Varner that there was almost always shortening after these types of injuries and asked his patient if his was going to sue if the leg did not heal perfectly. Reamy replied that he would be "damned if he wouldn't," and warned that he would make the physician "pay like hell." Varner believed that his patient was joking. He was not, and when his injured leg healed 1 1/8 inch shorter than normal, Reamy found a lawyer and sued the physician for $3000.  

Although there were many instances in which patients began litigation on their own initiative, outside parties, and the physician himself, often played important roles in the conscious decision to file malpractice charges. When a young New York man's fractured elbow mended, but froze in a rigid position in 1845, his friends convinced him to sue for damages and he won an award of $450.  

In a New York case in the late 1830s, members of the community began a

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subscription drive to raise money to help an injured man sue his doctors.42

Some malpractice suits arose out of cross complaints after a physician sued his patient for fees. A Kentucky patient, in 1850, refused to pay his medical bill claiming that the physician had infected his family with smallpox while treating them for typhus. The physician sued for fees, and the patient, on a cross complaint, sued for malpractice damages.43 In 1858 Dr. William Gautier sued Texas slaveholder William Graham for $187.57 in fees for treating ten slaves who had died. Gautier had treated the slaves for cholera. Graham, however, claimed that the physician had wrongly diagnosed the slaves and caused their deaths and demanded $10,700 for the costs of the slaves.44 Sometimes, patients used the threat of malpractice to intimidate


43 Piper v Menifee 51 Kentucky Reports 465 (1851).

44 Graham v Gautier 21 Texas Reports 111-20 (1858). For examples of other malpractice suits that originated out of suit-for-fees see: Bellinger v Craigue 31 Barbour Reports (NY) 534-40 (1860); [Akin v. Green, N.Y. circa 1850s] Elwell, Treatise on Malpractice, 102-3; and McClallen v Adams 19 Pick (Mass) 33 (1837).
physicians into dropping their claims for fees. Patients who were sued by their physicians for non-payment of fees could effectively use a cross-suit of malpractice because of the loosening of traditional legal pleading rules in the late eighteenth and early nineteenth centuries, and, the civil procedure reforms of the late 1840s and early 1850s.

Even though disputes over fees surfaced regularly in malpractice cases, patients' reluctance to pay medical bills alone cannot explain the sudden appearance of numerous suits in the 1840s. Patients would have been able to file cross-suits well before 1840. Suits for fees did indeed reflect the general popular antipathy that formed part of the environment responsible for engendering malpractice prosecutions. But, disputes over fees provided only the precipitating incident of an occasional suit rather than the cause of the huge increase of litigation. They did not form part of the professional, psychological, and social matrix which sanctioned and even encouraged the prosecution of physicians.


46 Under strict application of the eighteenth century writ system, prospective litigants would be forced to file an entirely separate action for malpractice. For discussion of the writ system see Chapter 7.
Medical fees became an important issue in the nineteenth century malpractice debate because they helped characterize the type of patient who physicians most distrusted. Because so many malpractice plaintiffs had not paid their bills, physicians began to believe that their poorer patients were the most likely to sue. Undoubtedly, many patients refused to pay because they were dissatisfied with their treatment. But, these plaintiffs' poverty was substantiated by the fact that in many cases they could not pay their court costs either. One physician noted that "the class of persons who are most exposed to accidents, and the least responsible, either for the surgeon's bill for professional attendance, or for the costs of a suit for malpractice, seem to require high surgical attainments," and consequently were the biggest malpractice risks. An 1878 survey of malpractice in Maine discovered that the vast majority of malpractice plaintiffs could not pay court costs. Even if indigent patients constituted a majority of malpractice plaintiffs, they were not the "cause" of the Jacksonian malpractice phenomenon.


48 Eugene Sanger, "Report on Malpractice," BMSJ 100 (Jan. 2, 1879): 14-23; and Sanger, "Report on Malpractice," BMSJ 100 (Jan. 9, 1879): 41-50. Sanger did not provide dates but noted that the suits and threats occurred within the "remembrance of the present generation."
Physicians treated poor patients before the outbreak of malpractice fever, and the inability to pay bills did not spark lawsuits on a broad scale. Poorer patients were, however, members of the segment of society that was more likely to hold the beliefs that generated the suits after 1835.

In contrast to many twentieth century physicians' claims that lawyers incite malpractice suits either directly, or indirectly, mid-nineteenth century doctors seemed to believe that attorneys were mostly honorable and were more guilty of misunderstanding than malevolence. Stephen Smith was convinced that:

Could the capable and the conscientious legal adviser clearly understand and be thoroughly impressed with the inherent difficulties in the practice of medicine, he would be slow to counsel prosecutions of medical men; and had the court the same knowledge, we believe that a nonsuit would be the summary termination of many a trial for alleged malpractice.49

Frank Hamilton, a respected New York surgeon, and a nearly perpetual expert witness, felt that while there may have been a few who undertook malpractice suits, "honorable and intelligent lawyers seldom countenance these

49 Smith, [Review of Elwell], 153-66.
prosecutions."\(^{50}\) Joshua Spencer, a New York attorney, explained in 1855 that while he had frequently served as counsel for physicians in malpractice cases, he had never worked for the plaintiff/patient. "My brethren," he noted, "generally, look upon the complaints with suspicion and refuse to meddle with them."\(^{51}\)

Physicians acknowledged that lawyers regularly refused to represent undeserving clients and often withdrew from cases when they discovered the true nature of the injury involved. One physician in 1856 exhorted his colleagues, "[L]et us be thankful that the poor and unenlightened will often find counsellors actuated by higher motives than the paltry profits of a suit, and so honest as to use the influence which they possess over their clients to prevent rather than forward so ill-judged an action."\(^{52}\) A report on malpractice in Ohio recounted suits in which "some difficulty was experienced in finding a lawyer to undertake the case."\(^{53}\)

The *BMSJ* reported an incident in 1860 in which a New York man

\(^{50}\) "Correction," *WMSJ* 32 (1855): 49-50 at 50.

\(^{51}\) "Correction," *WMSJ* 32 (1855): 49-50 at 50.

\(^{52}\) "Trial for Mal-Practice," *BMSJ* 54 (March 27, 1856): 149-56 at 156.

searched his county for a lawyer to sue his son's physician. Despite the physician's treatment for a degenerative hip disease, the boy's hip had frozen in one position. "To the honor of the legal profession," the journal observed, "no attorney in the County could be induced to engage in the suit." However, "[a]n obscure 'limb of the law' was found in an adjoining county," to handle the case.54 Samuel Parkman, a surgeon at Massachusetts General Hospital, examined the physician's relation to the law at mid-century and concluded that "the practitioner of medicine has no cause of complaint against the law or its ministers."55

Elwell, in his Treatise on Medical Malpractice, argued that lawyers were hampered by the lack of relevant medical and legal materials on the topic. "[T]he attorney," he explained, "experiences the greatest difficulty, doubt, and perplexity, in preparing cases involving the question of Malpractice."56 Law journals in the first two thirds of the nineteenth century rarely contained articles or commentary on malpractice, and lawyers had to rely on their own scant


56 Elwell, Treatise on Malpractice, 2.
knowledge of medical issues, and legal authorities scattered, undigested, through appellate law reports. Many writers seemed to believe sincerely that most lawyers would decline, or drop, illegitimate cases once they were apprised of the intricacies and uncertainties of the medical world. One Worcester, Massachusetts lawyer helped a patient sue a physician whose supposedly inept treatment had resulted in a withered and deformed arm after what was allegedly a simple fracture. After listening to several medical witnesses the attorney rose in court and declared that the case would proceed no further. He had mistakenly believed that the injury was a simple fracture, but the evidence had demonstrated that the injury had been compound and was very difficult to treat. He "handsomely" and "honorable," according to one medical journal, praised the physician's treatment and abandoned the suit.57

Despite the general era of good feeling between the professions, some writers foreshadowed the more prevalent attitude of the late nineteenth and twentieth centuries. In 1854, Dr. T.J. Pray observed that in trials for malpractice, "it seems to be the great forte of legal gentlemen to make an

abusive tirade upon the medical profession at large." He warned that:

_Raying and sound argument_ are two different kinds of action, and originate generally not from the same species of animals . . . A man may put on a lion's skin, but too often certain long appendages will peep out from under their concealment, and betray the wearer.58

Pray's observations, however, did not reflect the majority position among physicians. Lawyers did serve as an essential tool of the malpractice plaintiff, but the lowering of state bar association requirements only slightly increased the number of attorneys in practice. Some lawyers used contingency fee arrangements, but physicians did not attack the practice as an evil incitement to litigation. Between 1835-1865 physicians did not believe that lawyers were unredeemable villains but felt that they constituted a misguided, underinformed, "sister" profession.

Medical men usually laid most of the blame for inciting suits on other heads. Physicians believed that irregular practitioners played a role in convincing patients to sue. A variety of alternative healers practiced in America in the nineteenth century. Thomsonians were a self-taught sect that

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used only botanic remedies. Homeopaths stressed the healing powers of nature and ascribed to the theory that "like cures like." They employed infinitesimal doses of remedies that would in theory create the same reactions as the symptoms of the disease. The amounts were so small that the major attraction to these healers was that their treatments were mild. Hydropaths stressed preventative health care and explored the therapeutic uses of water. These practitioners competed with regular practitioners for patients and occasionally incited patients to sue their counterparts. However, most physicians agreed that the real enemy was inside the ranks of regular practitioners. Physicians competed bitterly with their ostensible colleagues. Often, they purposively encouraged patients to sue rivals in order to ruin their reputations and gain patients.59

No matter how a patient made the initial decision to sue his physician, through friends, a lawyer, a rival practitioner, or his own initiative, the path he took afterward followed a fairly standard pattern. True, legal rules of evidence and procedure varied from state to state and from decade to decade. Nevertheless a model of a typical case may be imagined.

59 Competition's role in generating malpractice suits will be discussed in greater length in Chapter 3.
After an injured patient, usually with a fractured or dislocated limb, decided to sue his physician, he hired a lawyer. Women were seldom plaintiffs in early malpractice cases. When women were the victim of supposed medical malpractice, their husbands or fathers generally sued the physician. Sometimes lawyers made contingency arrangements and prosecuted a case for a percentage of the anticipated damage award. In other cases, attorneys merely deferred payment until after the trial, or were paid at the time of their employment.

Until the late 1840s the lawyer and his client filed a writ of "trespass on the case" or "action on the case." 60 After the late 1840s various states abolished the writ system and thereafter all civil offenses, including malpractice, fell under the rubric of a catch-all civil action writ. Law reformers had hoped that this civil procedure reform would simplify the complex, traditional pleading requirements. However, with the exception of abolishing the category of specific writs, most of the pleading requirements remained and the reforms did not significantly alter the broad outlines of malpractice procedure. 61

60 See Chapters 1 and 7 for discussion of common law writs.

61 For some history and impact of the civil procedure reforms, see Joseph H. Koffler and Alison Reppy, Handbook of Common Law Pleading (St. Paul Minn.: West Publishing Co.,
With rare exceptions malpractice cases were heard by a jury in a county court house. In one Michigan case in the late 1840s a jury had granted the plaintiff $300 in damages for injuries that supposedly resulted when a physician failed to immediately diagnose a dislocated arm. A state appellate court judge granted the physician a new trial, but removed the case from the court and referred the complaint to two physician-arbitrators. The arbitrators reported to the chief justice of the state supreme court. They decided that although the dislocation was not discovered, it was a rare injury, and in many cases was untreatable even if diagnosed. They recommended no award with both parties paying their own costs. The judge accepted their recommendation. Although physicians occasionally advised the more frequent use of arbitrators, it was an exceedingly uncommon practice. Jury trials were the almost unalterable rule.62


62 Dan Brainard, "Another Suit for Malpractice," JMCS 3 (Nov. 1846): 406. For another case of the anomalous use of
The common law required that the plaintiff prove that a doctor-patient relationship had existed between him and the physician/defendant. This point was seldom in dispute. Physicians usually admitted treating the patient, and treatment was enough evidence to establish that "a duty-filled" relationship existed. After confirming the existence of a doctor-patient relationship, the court would examine whether the physician was legally liable for the permanent injuries, or pain, of the patient. The physician was always held legally responsible for everything that he explicitly promised to do. For example, if a physician claimed that he could save a patient's badly crushed leg and "make it as good as new," yet was unable to fulfill his promise, the injured man would have a strong case against the practitioner. Such simple situations constituted a very small proportion of the suits against physicians in the nineteenth century. Physicians rarely guaranteed their work, and if they did so orally, the existence of such a promise would be very difficult to prove in court. In fact, liability based on a promise to cure constituted an entirely different type of case from the typical medical malpractice charge. Responsibility based on promises to cure involved an

referees see "Trial for Mal-Practice," BMSJ 51 (Nov. 1854): 345.
explicit, conscious agreement between doctor and patient; an ordinary contract. The theoretical and doctrinal source of most malpractice liability was more ambiguous.63

The more common situation did not involve a physician's promise to cure patients. In such situations the common law did not require a complete cure. In 1833 an Ohio man tried to bring charges against a physician under a writ of assumpsit, or breach of promise, for failing to deliver safely the plaintiff's child. The trial court judge dismissed the case as a non-suit because "the law does not raise from the fact of employment, an implied undertaking to cure."64 When, absent the element of explicit contract to cure, trial court judges held or even implied that physicians guaranteed cures, appellate courts consistently overturned the decisions and granted physician/defendants new trials. For example, an Ohio man charged a physician with malpractice in 1836. In his official declaration to the court, he claimed that he had retained the physician to "manage, take care of, and cure [original emphasis]" his fractured leg. Although the physician "promised" to set and cure his leg, he claimed he lost his limb to amputation

63 See Chapter 7 for a discussion of legal theory and the source of malpractice liability.

64 Bliss v Long 1 Wright's Reports 351-3 at 352.
because of the doctor's failure. The physician asked the trial court judge to tell the jury that the law required proof of the existence of an explicit promise to cure. But, the judge charged the jury that since the defendant had held himself out to the world as a physician, that there was no need to prove an explicit promise to cure; the law assumed the existence of that duty. The jury found the physician guilty of malpractice. The Ohio supreme court summarily reversed the decision and ruled that physicians did not implicitly promise to cure every case and they would not be held responsible for such a promise.65

Few trial court judges ignored the clear common law precedents regarding implied promises to cure, but when they did, state appellate courts invariably reversed the decisions. One rogue Pennsylvania trial judge in 1853 went so far as to tell a jury that the defendant/physician was required to use the skill necessary "to set the leg so as to make it straight and of equal length with the other." The judge even suggested that "if suits were more frequently brought, we would have perhaps fewer practitioners of medicine and surgery not possessing the requisite professional skill and knowledge." Although the jury ruled

65 Samuel Grindle, etc. v Leo Rush et al. 7 Ohio (Charles Hammond Reports 7) part 2, 123-5.
against the physician, the state supreme court overturned the
decision and reiterated the common law precedent that "the
implied contract of a physician is not to cure— to restore a
fractured limb to its natural perfectness— but to treat the
case with care, diligence, and skill." 66

The bulk of the legal arguments, evidence, and testimony
centered not around promises and guarantees to cure, but
rather the meaning and requirements of the terms "care,
diligence, and skill." As mentioned earlier physicians were
required to possess and apply an "ordinary degree of skill,
care, and diligence. Before malpractice juries retired to
make their decisions, trial court judges would instruct them
on the common law requirements. Judges in all parts of the
country drew on virtually the same precedents and the
essential requirement varied little. In 1833 a trial court
judge told a Connecticut jury that "if there was either
carelessness, or a want of ordinary diligence, care, and
skill, then the plaintiff was entitled to recover." 67

66 *Mc Candless versus Mc Wha* 22 Penn (1853) 261-74 at 263-4,
267. *Benjamin Reynold vs. Samuel H. Graves* 3 Wisconsin
Reports 416 (1853) is another of the rare examples in which a
trial judge allowed a defendant/physician to be held
responsible for an implied contract to cure. The decision
against the physician, as with all similar cases, the
appellate court reversed the decision.

67 *Landon against Humphrey* 9 Day Reports 209 at 216 (1832).
Maine supreme court declared in 1848 that "The [malpractice] defendant is not liable for a want of the highest degree of skill, but for ordinary skill. And of course only for the want of ordinary care and judgment." The Illinois supreme court announced one of the clearest and most enduring renderings of the doctrine in an 1860 case in which Abraham Lincoln was an attorney for the patient. Justice Walker wrote:

The principle is plain and of uniform application, that when a person assumes the profession of physician and surgeon, he must, in its exercise, be held to employ a reasonable amount of care and skill. For anything short of that degree of skill in his practice, the law will hold him responsible for any injury that may result from its absence. While he is not required to possess the highest order of qualification, to which some men may attain, still he must possess and exercise that degree of skill which is ordinarily possessed by members of the profession.

The first United States treatise on tort law, published by Francis Hillard in 1859, reinforced the essential permanence of the ordinary skill and care doctrine, as did Amasa

68 Barzillad Howard versus John Grover 28 Maine Reports 97 at 101 (1848).
Redfield's important *Treatise on the Law of Negligence* in 1870.\(^70\)

Legal definitions of standard of care over the first half of the nineteenth century were similar and consistent because trial and appellate judges drew from the same English and state supreme court precedents.\(^71\) When trial court judges plainly abrogated the meaning of the doctrine, state appellate courts readily overturned the decisions. In actual operation, however, the principles of malpractice liability were anything but "plain" and of "uniform application." The unornamented simplicity of the maxim, "ordinary diligence, care, and skill," engendered ambiguity. In addition, the requirements of the trial process and the prerogatives of trial judges complicated the ostensibly simply "ordinary care" standard.

The plaintiff/patient was required to present expert witnesses to prove that his physician had not exercised "ordinary" skill and care. In rebuttal, the defendant/physician could offer testimony from his own expert

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71 Chapter 7 contains a discussion of state courts' use of British precedents.
witnesses. Witnesses testified to both fact and opinion. However, an expert was not allowed to actually make a judgment on whether the treatment constituted malpractice. Expert witnesses were required to give their opinion on whether the plaintiff's injury was permanent, and if the treatment provided by the defendant was standard. They were also asked if the type and the degree of the plaintiff's permanent injury would have occurred after competent medical care. The first question rarely generated much controversy. Permanent injuries were usually readily apparent and admitted by both sides of the dispute. Most of the disagreement among witnesses, and indeed, the central issue in most malpractice cases derived from problems in determining what constituted ordinary care in each instance. Precedents applied only to legal doctrine and not to technical information. Medical practice was evolving. Every injury was ostensibly unique. Therefore, this discovery phase of the trial was unpredictable.

Expert witness complicated the determination of what constituted an ordinary degree of skill and acceptable results. Since medical licensure was mostly a dead letter by the late 1830s, courts allowed any practicing physician, licensed or unlicensed, educated or not, to serve as an expert witness. According to one text, "Extra knowledge on
questions of science, skill, trade, business or other matters requiring special knowledge, qualifi[ed] the person thus informed to give opinions in courts of justice."\textsuperscript{72}

Practitioners from different schools of medicine, regular physicians, homeopaths, hydropaths, and Thomsonians, were allowed to testify interchangeably at each others' trials. This practice was remarkable because, therapeutically, competitively, and socially the various schools of medicine were generally at odds with one another. To complicate the matter further, even though a variety of types of practitioners could testify at a trial, the defendant was only required to exercise ordinary skill according to the standards of his own school of practice.

For example in the late 1840s an Iowa man sued a Thomsonian physician because he had caused the man's wife pain and injury during and after the delivery of a child. The Thomsonian had failed to remove the placenta following the birth and the mother suffered a massive loss of blood and great pain. The after-birth was finally removed by a regular

physician who testified at the malpractice trial. He explained that it was standard practice to remove the placenta at a much earlier period and that a delay was injurious and risked puerperal fever. Several other regular physicians concurred and testified against the defendant.

The Thomsonian physician attempted to prove that his school of medicine considered it improper to remove the placenta until it was expelled by nature. However, the trial judge refused to allow the introduction of the evidence and the jury found the Thomsonian guilty. He appealed the judgment to the Iowa supreme court which overturned the decision. Judge Greene, writing for the majority of the court, explained that since there "is no particular system of medicine established or favored by the laws of Iowa, . . . [t]he people are free to select from the various classes of medical men." "While a regular physician is expected to follow the rules of the old school in the art of curing, the botanic physician must be equally expected to adhere to his adopted method."

Paradoxes multiplied. Courts strictly followed the doctrine that physicians were accountable for injuries

73 Bowman v Woods 1 Iowa Reports 441 at 442-3. Also see Patten v Wiggin 51 Maine 594 (1862) for a ruling which holds that physicians are to be judged by the standards of their school of practice only.
resulting from the failure to supply ordinary skill and care, only according to their respective systems of treating diseases. Yet, they continued to accept any practicing medical man as an expert witness. Regular practitioners appeared to suffer much more than their irregular counterparts. Irregular practitioners were rarely sued. Regular practitioners bore the brunt of the majority of the suits and regularly had to face their hostile counterparts in court. By the early 1860s, states began making changes in the rules of evidence so that physicians from different schools could not testify against one another.

Although testimony from rival schools of medical practice contributed to the confusion and antipathy in the witness-box, evidence presented by regular physicians against regular physicians constituted the majority of the proof in malpractice trials. The same features that characterized irregular practitioners' testimony applied equally to regular physicians' testimony in court. The competition among

74 In an extreme example of this practice, in *Rice v State* 8 Missouri Reports 561 (1844), a Thomsonian had been found guilty of causing the death of a seven and one half month pregnant woman who he was treating for sciatica. He wrapped her in kerosene soaked blankets, treated her with violent cathartics, and fed her cayenne pepper. She died after three days. Regular physicians testified that his treatment was inappropriate and dangerous and he was found guilty. An appellate court overturned the decision because the Thomsonain had acted within the rules of his school.
regular physicians was nearly as vigorous as between regulars and irregulars. Often this contention among regulars carried over into court and physicians found their rivals testifying against them.75

In addition, medical evidence on appropriate treatment for injuries or illnesses was not always consistent even when all the witnesses were regular physicians. Many times the expert witnesses came from radically different areas of the country. Or, expert witnesses sometimes practiced in areas quite different than those of the defendant physician. Elwell recounted the episode of a rural Ohio man who had lost his leg to amputation after crushing it while building a log cabin in a new settlement. Several years later, the man and some friends recovered the bone, cleaned it, and used it as the basis of a suit against the physician who performed the operation. The bone was shipped to Philadelphia, New York, and Washington and physicians examined the bone and provided depositions.76 Although the physician won the several trials related to the case, the incident demonstrated how witnesses were sometimes drawn from diverse community and medical

75 Chapter 3 contains more discussion on the issue of intra-professional rivalry.

76 Elwell, Treatise on Malpractice, 81. For another case where expert witnesses were drawn from Philadelphia, New York, and Boston, see Elwell, 146-62.
surroundings and asked to judge the competency of a medical defendant.

Often, however, defendants had more to fear from local colleagues. Keen competition for patients, or personal animosity, could influence the testimony of local practitioners. When Dr. Sargent was sued by a New Hampshire man for the treatment of his broken leg, the medical witnesses separated into two camps according to their place of practice. The two expert witnesses for the prosecution were local physicians who undoubtedly competed with Dr. Sargent for patients. All the physicians who testified for Sargent came from at least thirty miles away. Sargent lost two trials relating to the case, won on appeal, and finally settled out of court.  

Even when expert witnesses were not competing with the defendant for patients, or practicing in a center of medical excellence, their testimony seldom clearly delineated the acceptable standards of the profession. The unspecific nature of the malpractice doctrine allowed even disinterested medical witnesses to disagree on what constituted ordinary care. The state of medicine between 1835 and 1865 also contributed to the frequent dissension among medical

77 T. J. W. Pray, "A Surgical Case of Malpractice," BMSJ 51 (Nov. 8, 1854): 289-97. This case is discussed in Chapter 7.
witnesses. Attacks from irregular practitioners, the growth of statistical scrutiny of procedures, and universal recognition of the considerable uncertainty in medicine aggravated the difficulty in defining standard practice. As John Elwell noted in 1860:

While the uncertainty of medicine is readily admitted, the reasons of this uncertainty, and the unsolved state of the science, are far from being understood; and not being understood, more blame is often thrown upon the physician or surgeon than if there existed an intelligent knowledge of the real inherent difficulties of his profession.78

Even in fracture treatment, where significant progress had been made in the first third of the century, competing theories and expectations were more prevalent than many practitioners realized.79 A single trial often yielded


79 See Chapter 4 for discussion of fracture treatment.
several opinions on the correct procedure for setting a broken leg.

Both the malicious and the innocent disagreements of medical witnesses extended the already wide latitude of discretion left to the jury. A medical editorialist in 1847 condemned the "glorious uncertainty of legal justice and of medical testimony," and warned that conflicting testimony "bewildered" lay juries.\textsuperscript{80} Jurors were not bound to accept the evidence of expert testimony even when it was unanimous; disagreement among medical witnesses gave jurors even freer rein. As one irate New York doctor reported in 1854, "A single dissenting voice among the surgeons on the stand is enough to turn the scale in favor of the plaintiff, toward whom the sympathies of the jury invariably run."\textsuperscript{81}

Juries frequently ruled against the defendant even when the bulk and quality of the expert testimony supported the physician. The jury's social beliefs and attitudes toward the profession surfaced in many ways. If a juror harbored a general antipathy toward the medical profession at large, as much of society did in the Jacksonian period, he might rule


\textsuperscript{81} "Trial for Malpractice," \textit{BufMJMR} 10 (1854-5): 568-70 at 570.
against the physician regardless of the evidence to the contrary.\textsuperscript{82} If a juror utilized the service of an irregular practitioner, he might have been more likely to believe a homeopathic witness for example, or less likely to rule against a Thomsonian defendant in a malpractice case.

The nature and development of national medical practice further complicated the determination of what constituted an "ordinary" standard of care. In the 1824 \textit{Lowell v Faxon & Hawks} case the trial judge instructed the jury that a physician in an "obscure village" was not required to possess the same degree of skill as his urban counterpart.\textsuperscript{83} Instead he need only possess and exercise the degree of skill that was ordinarily possessed and exercised by other rural practitioners in similar communities. This notion, which became known as the "locality rule" in the late nineteenth century, was a recognition of the decentralized nature of the medical profession and the nation. The locality rule was unknown in English common law, and, until the 1870s, unsupported by any state appellate court decision. In the first third of the century some judges instructed juries to abide by its formula. Other juries, because they understood

\textsuperscript{82} See Chapters 3 and 4 for social and political attitudes and their relevance to the malpractice phenomenon.

\textsuperscript{83} See Chapter 1 above.
and sympathized with the plight of the rural practitioner probably often applied an informal version of the locality rule when they considered the "ordinary" care requirement.

However, the locality rule did not become a general feature of malpractice law until the last third of the nineteenth century. Between 1835-1865, national medical journals multiplied, and transportation and communication improved. As Stephen Smith argued, it would be "manifestly dangerous" to accept the locality rule in 1860, because every physician now had the opportunity and the duty to keep abreast of medical advancement.\textsuperscript{84} Much had changed since the first part of the century. Judges rarely instructed juries to calculate the required medical competency by community standards. Jurors, with less general sympathy for physicians, and under the mistaken impression that the American medical world was becoming homogeneous, were more willing to hold parochial physicians to the standards of their better educated, more practiced, cosmopolitan counterparts. Plaintiffs would summon medical experts from larger cities, other communities, and even other states without regard to the relative standards of practice. In the case of small communities, urban physicians usually served as witnesses to the detriment of the defendant/physician.

\textsuperscript{84} Smith, [Review of Elwell], 159; and Chapter 1.
Medical practice in America, however, had not become homogeneous. Despite the proliferation of medical journals and schools, and the increased interconnectedness of the rest of society and the economy, physicians' skill in different geographic locations and social surroundings varied greatly. Hospital-based physicians or physicians with thriving urban practices, for example, were exposed to a wider range and greater number of injuries and illnesses. Some writers and jurists recognized the still Balkanized nature of American medicine and the need for adjusted standards of care. Elwell contended that it was sometimes difficult to define "ordinary" degree of skill since:

It may vary in the same state or country. There are many neighborhoods, in the West especially, where medical aid is of little attainment; yet cases of disease and surgery are constantly occurring, and they must, of necessity fall into the hands of those who have given the subject but little if any thought.85

Therefore, Elwell believed that the locality rule, or community standard doctrine should be applied in all malpractice cases.

Only a few trial and appellate court judges invoked the locality rule between 1835-1865, and when they did, it was

85 Elwell, Treatise on Malpractice, 22.
not in forums that would set doctrinal precedent. In 1857 a patient sued two Ohio oculists for malpractice after treatment which left him in bed for two months and unable to read for two years. The oculists had bled the patient and dosed him with cathartics for several weeks. The trial court judge instructed the jury that "An absolute necessity requires that the wants of the community be supplied with the best medical knowledge its means and location will command." 86 The jury was unable to reach a verdict. In a similar instance, a patient sued his physician in Massachusetts for a deformity following a severe hip injury. Although the medical witnesses for the defense, and the prosecution, both agreed that the results of the treatment were the best that could be expected, the jury returned a verdict against the physicians for $365. The physician appealed the decision to the state supreme court, which overturned the verdict for being against the weight of the evidence. In writing the opinion for the court, the eminent Massachusetts chief justice Lemuel Shaw, noted that the defendant/physician had "shown a degree of skill beyond what

86 Elwell, Treatise on Malpractice, 162.
is usually expected of surgeons residing in the country." Since Shaw's comment was not clearly articulated, and was incidental to the decision in the case, it was probably considered obiter dictum, and therefore not binding as precedent. At any rate, the decision was ignored by other courts and had no impact on the law of malpractice.

Elwell's comment, and the Massachusetts and Ohio cases are important as points of contrast. Most judges and the majority of society were not inclined to measure physicians only against community standards even though geographic location and professional atmosphere could have a profound impact on the intellectual and technical development of individual practitioners. The failure of the locality rule to take hold between 1835-1865 was the result of two developments. First, the public and most judges misunderstood, overestimated, the degree of change in the first half of the century. Despite the substantial development of a more integrated national economy, the establishment of a national medical organization for regular physicians in 1846, and increased communication among national medical practitioners, the profession could still be

characterized as a collection of communities of varying knowledge and skill.

Second, the acceptance of the locality, or community standard, rule would have been out of harmony with developments in other areas of American law. Between 1780 and 1860, state and federal judges transformed many aspects of the traditional common laws in ways that reflected and encouraged the growth of national, economic development. For example, Joseph Story, in his career as a treatise writer and Supreme Court Justice (1811-1843), devoted much of his time to creating and fostering a uniform federal common law to neutralize the pluralistic tendency of the states. He attempted to formulate a uniform national commercial law and worked on schemes to adjudicate conflicts of laws among states.88 The John Marshall court (1801-1836), of which Story was a member, and the Roger Taney court which followed made numerous "nationalizing" decisions which were calculated to facilitate economic integration by extending federal

oversight.\textsuperscript{89} In one of them, \textit{Swift v Tyson} (1842), the Taney court ruled that federal courts were bound to follow state court decisions only in strictly state matters. Other economic issues could be decided by federal courts on the basis of general principles of commercial law.\textsuperscript{90} Although \textit{Swift} remained somewhat of a dead letter, the intent of the ruling was to open the door to national commercial uniformity. Changes in areas of the law such as contract also reflected the same nationalizing tendencies. For example, in the late eighteenth and early nineteenth centuries courts began to scrutinize contracts less by community standards of fairness, and more according to the explicit terms of the agreement. This new view of contractual liability was designed to facilitate long-distance, future-oriented agreements with strangers rather than immediate exchanges between individuals in parochial communities.\textsuperscript{91}

\textsuperscript{89} \textit{Gibbons v Ogden} 9 Wheaton 1 (1824); \textit{Wilson v Blackbird Creek Marsh Co.} 2 Peters 245 (1829); and \textit{Propellor Genessee Chief v Fitzhugh} 12 Howard 443 (1851).

\textsuperscript{90} \textit{Swift v Tyson} 16 Peters 1 (1842).

\textsuperscript{91} Morton J. Horwitz, \textit{The Transformation of American Law, 1788-1860} (Cambridge Mass: Harvard University Press, 1972), 160-211. See also Chapter 7 below.
Story wrote in 1837, "I am myself no friend to the almost indiscriminate habit . . . of setting up particular usages or customs in almost all kinds of business and trade, to control, vary or annul the general liabilities of parties under the common law . . . ."92 The application of the locality rule in malpractice cases was incompatible with this sentiment and with the general context of jurisprudential thought in antebellum America. The locality rule stressed diversity while economic development and law were bolstering national uniformity.

Unfortunately for malpractice defendants, the nationalizing tendency in law arrived long before the medical profession was ready. Physicians in isolated communities could not acquire the same training, education, and experience as physicians in thriving urban centers. The failure of judges and the public to understand, or admit, this fact did not cause the wave of malpractice suits in the 1840s and 1850s, but it clearly aggravated an already oppressive situation. The use of the locality rule between 1835 and 1865 could have softened the blow of the initial increase in suits. Instead, judges continued to allow expert witness from centers of medical excellence to testify at the trials of rural practitioners without instructing juries to

92 Story quoted in Horwitz, Transformation, 196-97.
consider their relative theaters of practice. The confusion which resulted from admitting testimony from a variety of witnesses with differing standards of practice played a role in enhancing the discretion of the jury. The locality rule did not surface as a defensive tool for physicians until 1880 when state appellate courts began to rule that the doctrine set limits on the skill required of medical men.\textsuperscript{93}

It appeared to many physicians that medical men had little chance in a courtroom once they were sued for malpractice. As one physician noted, "the defendant must be mulcted in every case where he is not sustained by the entire professional evidence."\textsuperscript{94} Other writers, however, actually believed that there was no escape from conviction even if all the witnesses supported the defendant. "The fact is," reported an editorialist in 1855, "that sometimes surgeons have been mulcted in damages simply because the jury believed from the united character of the medical testimony that it was a conspiracy and the more conclusive the testimony, the more certain with some jurors is the defendant to suffer."\textsuperscript{95}

\textsuperscript{93} \textit{Small v Howard} 128 Mass 131 (1880) is usually cited as the first appellate decision requiring the use of the locality rule. The acceptance of the locality rule by appellate courts is discussed in Chapter 8.

\textsuperscript{94} "Trial for Malpractice," \textit{BufMJMR} 10 (1854-5): 568-70 at 570.

\textsuperscript{95} "Correction," \textit{WMSJ} 32 (July 1855): 49-50 at 50.
These two opposing viewpoints reflected the prevalent belief among medical men that the "sympathy of a jury of citizens is not generally with the doctor, but rather on the side of the poor, ill-advised, unfortunate victim of incurable injury." 96

These writers exaggerated juries' inclination to rule against physicians. It appears that in at least half the medical malpractice trials reported in the medical literature, juries ruled in favor of the defendant/physician. Some contemporary estimates of acquittal rates are higher. An Ohio physician in 1859 estimated that while the tendency to prosecute physicians was increasing, "[t]his certainly has not originated from the success connected with these prosecutions. In not one instance in twenty as far as my observation extends--have they been successful." 97 While the Ohio writer's estimate was unrealistically optimistic, it provided a counter to the gloomy predictions of other physicians. Even when physicians lost their case in the initial trial they often received favorable verdicts in retrials, or, at the appellate level. State appellate courts overturned trial verdicts against physicians, when the trial


judge had improperly instructed the jury on the "ordinary" care requirement, when juries awarded excess damages, and when evidence was improperly admitted or rejected. Including acquittal verdicts gained by malpractice defendants in retrials and on appeals, physicians probably prevailed in well over half the malpractice suits between 1835-1865. 98 These successes were small consolation to a profession that felt deluged by prosecutions and believed, as did John Elwell, that "Victory in these cases is in one sense, defeat because the disgrace, vexations, and cost are generally ruinous." 99

When judges incorrectly or prejudicially instructed juries, or, juries flagrantly ignored evidence, physicians could either ask the trial judge for a new trial, or they could appeal their case to a higher state court. Indeed, the typical legal battle between a patient and his physician consisted of multiple trials utilizing numerous witnesses and covering several years. For example when Lorenzo Slack sued Dixi Crosby in the spring of 1851, it had been nearly six


99 Elwell, Treatise on Malpractice, 8.
years (two days before the statutory limit) since Crosby had treated the man's broken leg. The first trial, in which Slack asked for $5000 in damages, was delayed until 1853. A Vermont jury awarded Slack $800 plus $300 in costs. A second trial yielded similar results and, it was not until a third trial in 1854 that a jury acquitted Crosby. 100 Another fracture case in New Hampshire began in 1850 and was not concluded until 1855 after a long procession of trials, hearings, and negotiations. At the first trial the patient was awarded $1500 plus court costs. A jury at the second trial only awarded him $525 plus costs. The physician appealed the decision to the New Hampshire supreme court which overturned the decision on the basis of the trial court judge's instructions to the jury. A third jury again ruled against the physician in 1854, but the state supreme court overruled this verdict because some of the jurors had shared a gill of brandy the night before they reported their

decision. Finally, the patient and the physician settled the dispute out of court for an undisclosed sum of money.\textsuperscript{101}

These two cases were the rule, not the exception. The number and length of the trials growing out of each malpractice charge was significant because it subjected the physician to more anxiety, cost, and publicity. The trials of the New Hampshire physician lasted several days each and played to a packed courthouse. One trial employed sixty witnesses. Although the legal costs and attorneys' fees undoubtedly varied greatly, five trials in Massachusetts in the mid-1850s generated $10,000 in trial costs and fees. One of the defendants reportedly paid $2,000 of that total, an enormous sum in the mid-nineteenth century.\textsuperscript{102} This figure was abnormally high, but costs often approached the amount of damages awarded to the patients.

When a jury found a defendant guilty of malpractice it was asked to calculate the monetary value of the damages to the plaintiff. The injured patient could receive money for all the consequences of the injury, past and future. In

\textsuperscript{101} T.J.W. Pray, "A Surgical Case of Malpractice," \textit{BMSJ} 51 (Nov.8, 1854): 289-97; \textit{Leighton v Sargent} 7 Foster's Reports 460-76 (1853); and \textit{Leighton v Sargent} 31 New Hampshire Reports 119-39 (1855). There is a discussion of this case in another context in Chapter 7.

\textsuperscript{102} "Case of Malpractice," \textit{BMSJ} 54 (March 13, 1856): 109-12.
addition, the jury was authorized to take into account the effects of the injury including: pain, personal inconvenience, and decreased income capacity. The award however, could not exceed the amount claimed by the plaintiff at the beginning of the trial.

Patients invariably asked for damage awards of $5,000, $10,000, $20,000, and $25,000. Juries' awards, however, never approached the damage claims of the patients. While there were several awards between 1835-1865 in the $1,000 to $3,000 range, the typical malpractice damage judgments fell between $200 and $800. 103 If an appellate court believed that an award was excessive, it could void the judgment as the Maine supreme court did in 1848. A patient had accused a physician of malpractice because he failed to amputate the plaintiff's leg high enough. Consequently, the man required two more operations to remove progressively more of the stump of the leg. A jury returned a verdict for the plaintiff in

the amount of $2,025. The physician appealed the verdict claiming that it was excessive and against the weight of the evidence. The state supreme court demanded that the patient agree to remit $500 of the judgment because "surgeons should not be deterred from the pursuit of their profession by intemperate and extravagant verdicts." If the patient refused to accept $1,525, the court threatened to grant the physician a new trial. The court justified its decision by explaining that "[t]he compensation to surgeons in the country is small, . . . and an error of judgment is visited with a severe penalty, which takes from one a large share of the surplus earnings of a long life." 104

These awards seem almost insignificant by mid- and late-twentieth century standards. But they shocked nineteenth century physicians. Eight hundred dollars was no inconsequential sum in 1850, even for a physician. Wages were low and the majority of physicians had to pursue sideline occupations to support their families. While a few medical men might have earned more than $8,000 per year, the BMSJ considered $500 normal for the established, full-time physician in 1833. Expenses could have depleted that figure to as low as $350. Many rural doctors earned less, and a

portion of their income usually included payment-in-kind rather than money. Second, nineteenth century physicians were not shielded from malpractice claims by any form of insurance. Malpractice insurance and group defense schemes did not surface until the last decade of the nineteenth century and were not an established feature of medical life until the early twentieth century. Before then, physicians had to fend and pay for themselves.

Finally, the dollar amount of early damage awards was of secondary importance to both antebellum physicians and to the overall development of medical malpractice in America. When a physician was charged with malpractice he felt as if his professional future had been put in jeopardy even if the damage award against him was small, or, even if he won his case. Many malpractice suits were highly visible, local events. After an Ohio suit in 1849 in which the courthouse

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106 See Sandra Cirincione, "The history of medical malpractice in New York State: a perspective from the publications of the Medical Society of the State of New York," *NYSJM* 86 (July 1986): 361-9 at 363-8 for comments on early group defence and insurance plans after 1900.
had been crowded for four days, one observer declared that he
"believed that there has been no case [of any kind] tried
within the county during the last ten years which has
elicited so much attention." Members of the community
could sit and listen to a parade of witnesses testify that
the accused physician was unskillful, incompetent, or
careless. Members of the patient's family, rival or more
accomplished physicians, and the prosecuting attorney could
all join in the attack. In the highly competitive medical
environment of the mid-nineteenth century, and in an era when
public trust of regular physicians was tenuous at best,
attacks on a doctor's competency could have significant
fallout. A writer for the Ohio Medical and Surgical Journal
in 1861 affirmed that "sensible and intelligent physicians
appreciated the "serious character and bearings of
prosecutions for malpractice." The commentator recognized
that a suit was a "grave matter" to both the accused
physician and the profession. As he explained, "The
reputation of the physician is his stock in trade. He
cherishes it beyond all price." A physician could bear the
loss of property, arduous labors, obscurity, and poverty but
the "formal and public attack on his reputation, and the

107 Theodore Nicholos, "Trial for Mal-Practice," OMSJ 2
(Sept. 1849): 6-10 at 10.
concurrency of "twelve disinterested members of the
community," struck at the core of his, and his colleagues',
professional respectability.

It is not very difficult to see that the
event, from its very inception casts a long
shadow upon the future, pregnant with fears,
uncertainties, apprehensions, and future
forbodings.108

The writer's prophetic statement reflected the
profession's well justified impression that the sudden and
dramatic appearance of widespread and frequent malpractice
suits was an augur of things to come and a fundamental threat
to the medical community at large. As he predicted, "The
public knowledge of a verdict for the prosecution will beget
a brood of new cases, in which, quite as likely as otherwise,
the most skillful and diligent of the profession will be the
victims."109

While damage awards were smaller than in later years,
they were not inconsequential. But a focus on the amount of
the awards obscures the more important contemporary and
historical issues. The first malpractice "crisis" of 1835-

108 "Prosecution for Mal-Practice," OMSJ 13 (Jan.1861): 253-
60 at 253.

109 "Prosecution for Mal-Practice," OMSJ 13 (Jan.1861): 253-
60 at 253.
1865 was the genesis of a modern professional epidemic, the first step over a threshold into a new era of American medicine. Many nineteenth century physicians saw it as such and desperately tried to unravel the twisted social and professional motives behind the suits. The questions of the size of the damage awards or who won the majority of the cases are important; but, they are dwarfed by the need to explain why the suits originated in the first place and how the phenomenon's origins continued to generate suits for the next one-hundred and fifty years.
Schools for Scandal

Chapter 3

The increase in malpractice suits, and threats of suits, in the early 1840s was sudden and dramatic. Contemporaries identified several factors as the underlying cause of the phenomenon. Medical society committees on malpractice in Pennsylvania in 1850, Kentucky in 1853, Massachusetts in 1854, and Ohio in 1855, plus scores of individual physicians, joined in a consensus that the profession's status was deteriorating.¹ However ill-defined, a view prevailed that the increase in malpractice suits was inextricably related to this decline in public confidence. In addition, medical men contended that the specific agents of the decline, aspects of medical treatment, competition, and anti-professional sentiment, were the specific causes of the litigation crisis.

These perceptive commentators accurately explained physicians' low status. But they were unable to recognize and interpret the long term cultural trends that created the environment conducive to widespread litigation. Instead, observers in the mid-nineteenth century mistook important, topical, factors for fundamental causes. These immediate factors may have incited suits in the 1840s and 1850s, but they cannot explain why the number of suits continued to increase into the twentieth century. Indeed, frequent malpractice litigation persisted long after the so-called causes identified by mid-nineteenth century physicians had disappeared.

The immediate causes of increased malpractice prosecutions have usually been visible to contemporary observers. Although their social standing in America had never been high, most doctors were painfully aware of the medical profession's abysmal status in the first half of the nineteenth century. At a meeting of the American Medical Association in 1848 Nathan Chapman had noted that the "once revered" and "venerated profession has become corrupt, and degenerative to the forfeiture of its social position."\(^2\)

A physician in 1858 confirmed that the medical profession had "been losing its hold on the respect and confidence of the

\(^2\) [The Status of Physicians], MSR 11 (Jan. 1858): 60-3.
people" for fifty years. Since the early part of the century, the physician lamented, the profession had lost its favored position, when children had been taught to raise their caps, if boys; and drop and courtesy, if girls, in token of respect, when they met their family physician on the street . . . even when that physician was under the influence of intoxicating drink. 3

Alexander Garnett, writing for the Medical and Surgical Reporter, outlined the causes of the profession's meager social standing. According to Garnett by 1854 doctors were held in low public esteem because of "defective medical acquirements," the "want of union and harmony among physicians," and, "the radical and progressive proclivities of the present age." 4 Garnett's three factors deserve closer analysis for they explain physicians' low status, accurately characterize the medical environment of the first half of the

3 Ibid., 62.

nineteenth century, and provide insight into the source of many malpractice suits.

"Defective medical acquirements"

In the late eighteenth century American physicians attempted to reproduce the English institutions that bestowed a distinct social status on physicians. They organized medical schools, founded professional societies, and convinced state legislatures to pass licensure laws. Despite these temporary successes American physicians were unable to make themselves into an elite profession and gain a monopoly over practice.

Physicians' inability to demonstrate the superiority of their treatment methods was one of the central components of this failure.5 Americans had a long tradition of domestic medicine. Although full-time physicians existed, much of the medical practice in the first half of the nineteenth century was dispensed by part-time practitioners and lay persons armed with folk remedies and ubiquitous handbooks on home

health care.⁶ William Buchan's *Domestic Medicine*, for example, was published in one hundred and forty-two separate editions between 1769–1871.⁷ As a result, the public had little patience with pretentious physicians who specialized in ineffective, unpleasant, and sometimes dangerous therapies.

Conventional medical theory in the late eighteenth and early nineteenth century was dominated by the 'heroic' treatments popularized by Benjamin Rush. Rush advocated the copious use of emetics and cathartics to induce vomiting and evacuation, and advised the massive bleeding of patients.⁸ Although the centuries-old system of humoral pathology utilized bleeding and employed agents that induced vomiting,

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diarrhea, and perspiration, heroic practitioners, under Rush's inspiration, disregarded traditional restraints and employed active agents in immense quantities. Often, patients were bled until they fainted. Rush suggested that in some cases four-fifths of all the blood in the body might be removed. Physicians applied similar gargantuan doses of cathartics and emetics. As one nineteenth doctor recalled: "If vomited, they did not come up in gentle puffs and gusts, but the action was cyclonic. If perchance, the stomach was passed the expulsion would be by the rectum and anus, and this would be equal to a regular oil-well gusher." 9 Calomel, a mercury based cathartic, was often prescribed until the gums bled (a sign of mercury poisoning). Heroic therapy won converts in some circles, but it was also the object of widespread derision and one of the main sources of public antipathy toward the profession. A physician in 1835 claimed that the injudicious use of heroic treatments "has produced, does continue, and will perpetuate (unless obviated), the fear, jealousy, and suspicion that exists between ... the community, and the profession at large." 10


10 Quoted in Rothstein, American Physicians, 127.
Physicians also undermined public confidence by their conflicting and inconsistent diagnoses and therapies. Doctors not only utilized depletive therapies like bleeding in varying degrees, but prescribed drugs and tonics such as opium, quinine, antimony, and arsenic in a fickle and unsystematized fashion. Since they did not understand the pharmacological working of their "remedies" and possessed no diagnostic tools except their senses, physicians favored drugs and doses which induced visible results. Remedies would often produce different effects in different patients so medical practice appeared to be unsystematized and erratic. The same remedy prepared by different physicians would usually taste and act differently in various cases. This problem was compounded by a lack of consensus about practice among physicians.


12 Rothstein, American Physicians, 54.

13 For example, see Gert H. Brieger, "Therapeutic Conflicts and the American Medical Profession in the 1860s," BHM 41 (1967): 215-222.
By the 1830s and 1840s physicians had begun to distrust the efficacy of their medical treatments. Empirical statistical studies inspired by Pierre Louis in Paris, demonstrated that heroic treatment regimes were generally useless and sometimes harmful.14 Medical writers began to stress the "uncertainty" of medical practice, the healing powers of nature, "self-limiting" diseases, and the merits of "conservative" treatments.15

The public was unwilling to support a profession that first endorsed harsh heroic therapies and then abandoned them within three decades.16 These therapeutic fluctuations were

14 Shryock, Medicine and Society, 130-2; Edwin Ackernecht, "Elisha Bartlett and the Philosophy of the Paris Clinical School," BHM 24 (1950): 49-60; and Cassedy, American Medicine, passim.


16 John Harley Warner, however, demonstrates that the drift away from heroic theory was slow and subtle. See The Therapeutic Perspective: Medical Practice, Knowledge, and Professional Identity in America, 1820-1885 (Cambridge: Harvard University Press, 1986).
relevant to the malpractice phenomenon in two respects. On one hand, the absence of widespread agreement on the diagnosis and treatment of most maladies precluded the establishment of an "ordinary standard of care." In addition, even when physicians agreed on a remedy, they followed the dictum of "specificity." This theory held that medicines acted differently on different patients.17 Therefore, malpractice suits for purely medical, as opposed to surgical, treatments were rare, and usually unsupportable.

On the other hand, therapeutic inconsistencies subverted physicians' general status as competent public servants and left them more vulnerable to malpractice charges for treatments in which they did claim proficiency, like orthopedics. In 1854 a Kentucky Medical Society committee on the causes of malpractice noted: "During the last half century, the relative position of our profession to the public has undergone a marked change. Implicit confidence, amounting in some instance to blind credulity, has given place to widespread skepticism as to the powers and capabilities of the healing art."18

17 See Warner, Therapeutic Perspective, 58-80.
18 [Proceedings of the Kentucky Medical Society, October 1854], WJMS, 366.
Other professional activities contributed to public fear and distrust. Physicians' and medical students' quests for cadavers for anatomical study helped to brand the profession as unfeeling ghouls. Although the public seemed to accept some post-mortem operations, they were repelled by the use of cadavers for instruction. Some early medical schools obtained their dissection subjects from other states or countries, but many merely retrieved recently buried corpses from the local cemetery or relied on professional grave robbers. Consequently, attempts to introduce dissection into early anatomy classes often met with violent opposition. As example, rioters, believing that William Shippen had robbed graves to acquire teaching aids, attacked his Philadelphia School of Anatomy in 1765. By mid-century, similar riots had occurred in Maryland, New York, Vermont, Massachusetts, Ohio, Illinois, and Connecticut. Three rioters were killed in a Baltimore disturbance and seven in a New York uprising.\(^{19}\)

Violent opposition to "bodysnatching" and dissection continued far into the nineteenth century and encouraged state legislatures to provide penalties for grave robbing and

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criminalize the use of human cadavers for instruction. The
dissection controversies colored the public's perception of
the medical profession at large. For example, a group of
enraged Ohioans in 1845 passed this resolution: "That we most
solemnly believe that those who have no regard for the dead,
can have but little respect for the living, and those who
respect neither the dead nor the living, should never receive
the confidence of the public."\(^{20}\)

The reaction to the study of anatomy damaged the
profession's status and hindered the acquisition of
anatomical knowledge. Medical societies and contemporary
observers argued that physicians would be subject to
malpractice suits if they did not understand the workings of
the human body and yet were being denied the primary source
of that knowledge.\(^{21}\) In one of the rare malpractice cases
decided by arbitrators, an 1844 panel of Michigan physicians
refused to award damages to a plaintiff. They found that the
injury resulted from defective medical knowledge and declared
that it was unfair to hold physicians responsible for
insufficient training when "the study of anatomy essential to

\(^{20}\) Quoted in Edwards, "Resurrection Riots," 178

\(^{21}\) Blake, "Anatomy," 37.
the proper treatment of such cases, is by the laws of the state of Michigan a penitentiary offense."\textsuperscript{22}

Although judges never appeared to consider the lack of access to proper training as a mitigating factor in malpractice cases, physicians often complained. Josiah Trowbridge, a Buffalo, New York physician, reported in 1848 that he abandoned his twenty-five year medical practice in protest because the state legislature criminalized human dissection as a method of teaching anatomy and surgery. Since physicians would be "mulcted with ruinous damages" if they did not possess this knowledge, Trowbridge resolved "not to serve the public on such conditions."\textsuperscript{23} Although several state legislatures passed laws allowing dissections under certain circumstances, most soon repealed these statutes. By 1860 only two states allowed the use of human cadavers.\textsuperscript{24}

Physicians had hoped that they could use improved medical education to increase the ability and the status of the profession. Before 1765 most aspiring American physicians trained as apprentices to established

\textsuperscript{22} "Another Prosecution for Malpractice," JMC\textit{S} 1 (November 1846): 406.


\textsuperscript{24} Blake, "Anatomy," 37-8.
practitioners. These preceptorships varied in quality and length. Some physicians required their trainees to read the important medical texts, but others merely used them as a source of cheap, menial labor. Other physicians were entirely self-trained relying on the many self-help medical books, or on experience. A few wealthy medical students were able to study in the universities of Britain and Europe.25

Earlier reformers had believed that Americans could improve the quality of medical care as well as physicians' social standing by introducing the London guild system to the colonies. Medical practice in London was theoretically regulated through three royally chartered corporations: the Royal College of Physicians of London, the United Company of Barber Surgeons, and the Guild of Apothecaries. Under this scheme, the rights and duties of physicians, surgeons, and apothecaries within a seven mile radius of London were strictly defined.26

In this system the role of a physician was that of an aloof and gentlemanly advisor who did not sully his hands with the manual task of dealing with patients. In fact


physicians were not allowed to do anything but diagnose, 
prognose, and prescribe. Surgeons were not permitted to 
carry out any of these responsibilities and were limited to 
manual treatments. Apothecaries, who were formerly associated 
with the grocer's guild, mixed and sold pharmaceuticals and 
potions. Surgeons and apothecaries were forbidden to act 
without a physician's direction.27

When any member of a group performed a function reserved 
to another, he could be prosecuted. While each of the three 
required specialized training, only physicians were required 
to possess a university education. Physicians could not 
charge, or sue for, fees, but had to accept the payment that 
was offered. This hierarchical arrangement only applied to 
the London area and, even in this setting, was only formal. 
However, this arrangement was important because it 
represented the image of the physician as an elite, 
gentlemanly, public servant who was uninterested in 
commercial gain.28

This system was not transplanted to the American 
colonies. The majority of the immigrants to New England did 
not come from London where at least the ideal existed.


28 Shryock, Medicine, 3-5.
Instead, colonists came from rural farming communities like East Anglia where the highest percentage of practitioners were physicians who diagnosed, prescribed, performed surgery, and mixed drugs. In addition, many of the practitioners in these areas were also engaged in such other enterprises as cobblers, wheelwrights, ministers, and innkeepers. Consequently, most emigrants had no experience with, and saw no reason for the specialized, educated, full-time physician of London.

Virtually all colonial physicians were generalists. They eschewed the distinctions of London because of the type of practitioner common in rural England, because of the scarcity of university educated physicians in the colonies, and because they could make more money by prescribing and preparing medications. It was this image of the physicians that would influence American attitudes toward medicine.29

These prevailing attitudes toward physicians did not stop physicians from attempting to raise the standards and change the image of the profession. John Morgan, born of an upper class Philadelphia family in 1735, served a medical apprenticeship in America, and studied medicine in London and Edinburgh. When he returned to America in 1765 he attempted to organize the medical profession into the hierarchical

guilds he had seen in London. More importantly, he met with the board of trustees of the College of Philadelphia (now the University of Pennsylvania) and convinced them to establish the first medical school in America. The school adopted formidable entrance requirements and demanded four years of study for a doctorate. Morgan also called for strict licensure and separation of medicine from surgery and pharmacy.30

Despite Morgan's stature, his proposals did not have a widespread impact. Some colonies passed licensure laws in the last half of the eighteenth century but they did not effectively limit or proscribe practice.31 Although Morgan promised to eschew all surgery and pharmacy, most physicians could not afford to make that sacrifice and continued to practice all three roles.32

Morgan's campaign to transform medical education also failed. Several schools copied the College of Philadelphia model but the institutions were unable to maintain high standards. By 1789 even the College of Physicians had lowered its entrance requirements and reduced the length of

31 See below for more on licensure in America.
32 Shryock, Medicine, 7.
study to one year. Other schools followed suit. Morgan and his supporters introduced medical schools into America to enhance the status of the profession. Other American physicians had the same idea and by the early nineteenth century, medical schools began to proliferate. In 1834 there were over twenty. By 1850 forty-two schools, as well as many diploma mills, had been established in the United States.\textsuperscript{33} Many of these institutions were proprietary schools and competed for students by low entrance requirements and graduation standards. Even earnest medical administrators were forced to forego enhanced standards. Admission was open to any student who could pay the fees. By 1850 the typical program at American medical schools was comprised of two, identical, four month terms of lectures. At Harvard, one of the better schools in the country, students were only required to pass five of nine, five minute, oral examinations. As late as 1870, perhaps over one-half of Harvard's medical students could not write.\textsuperscript{34}

\textsuperscript{33} In comparison, France had three medical schools in 1850. James H.Cassedy, \textit{Medicine and American Growth 1800-1860} (Madison: University of Wisconsin Press, 1986), 68.

Alfred Stillé, a professor of pathology at the University of Pennsylvania, admitted in 1847 that the medical profession had become "[d]egraded in its position and authority" and forfeited "public confidence" as a result of the state of medical education.

By an extraordinary multiplication of medical schools a vulgar rivalry has arisen in spirit and conduct similar to that displayed in the competitions of steamboats, and railroads, with the same means resorted to for reaching success. Education is cheapened, the period of study abridged, or lightened—no irksome examinations are to be endured, and degrees acquired easily and assuredly. 35

The proliferation of medical schools and diplomas, and the accompanying deterioration of educational standards in the first half of the nineteenth century, affected physicians' status and their vulnerability to malpractice suits in two ways. First, the mediocre education offered at most schools left graduates ill prepared to deal with all the complexities of the human body. Physicians' resulting deficiencies often led to bungled diagnoses and treatments which generated law suits. An editorialist for the Medical Examiner in 1841 admitted that while "malignity and sordid calculation are no infrequent instigators of prosecutions for

mal-practice, it is quite possible for medical men, in these
days of easy graduation and multiplied professorships, to be
guilty of culpable neglect or—in the existing condition of
many medical schools—scarcely blamable neglect." 36 Alden
March, a nationally known specialist in surgery and a
professor at Albany Medical School, agreed. Although he
condemned the wave of malpractice suits that threatened even
"respectable surgeons," he confessed that "too many ignorant
and careless men get into the ranks of our profession, who
are liable to commit errors, for the the consequences of
which, the law holds them responsible. This would seem to
indicate the necessity of higher attainments in our
profession." 37 Individual doctors who were the product of
cursory medical educations, devoid of clinical experience and
anatomical instruction, were more likely to make mistakes and
become defendants in malpractice suits.

Second, the farcical education process debased the
status of the medical profession as a whole. Medical men had
hoped to use education to establish professional credibility
and overcome the multitude of home practitioners, folk

36 [R.C.], "A Report of the Facts and Circumstance relating
to a case of Compound Fracture and Prosecution for

37 Alden March, "Case of Alleged Mal-Practice in Surgery,"
healers, midwives, and irregular practitioners who practiced in the early nineteenth century. Indignation with this attempt arose from contradictory sentiments. The popular democracy of the Jacksonian period was accompanied by a virulent anti-intellectualism which elevated native intelligence over education and common sense over expertise. This feeling informed attitudes toward politics, law, religion, and medicine. Andrew Jackson personified the unschooled, uncorrupted, unassuming wisdom which captured the imagination and hearts of the country.

Jacksonian democrats resented the pretension of physicians who endeavored to place themselves above other practitioners and the common people. Worthington Hooker, a Connecticut doctor who wrote in the 1840s, lamented that "education in the science of medicine is practically despised by quite a large portion of the community." According to

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38 Peter Dobkin Hall discusses this idea in "The Social Foundations of Professional Credibility: Linking the Medical Profession to Higher Education in Connecticut and Massachusetts," in Thomas L. Haskell (ed.), The Authority of Experts: Studies in History and Theory (Bloomington: Indiana University Press, 1984), 107-41. However, Hall does not provide a detailed picture of the profound difficulties faced by these early professionals.

Hooker, many people demonstrated a "readiness to put the quack on a level with the thoroughly-educated physician, or even above him," because they felt that "Many a man has risen to eminence in other professions by his own exertions, without any great amount of education, and why should this not be the case in the practice of medicine?".40

A Pennsylvania physician, William Wood, commented on the phenomenon in 1849 and linked it to the profession's malpractice woes. He explained that physicians had customarily defended medical education despite the facility with which diplomas were granted "on the ground that it is better to provide the people with imperfectly educated physicians, than with those not educated at all." However, the experience of "some few years" had led Wood to change his position. He now believed that in light of many of the malpractice suits:

It is better to be without a diploma; for then besides having the sympathies of the community, the practitioner can say, 'I make no pretensions, I offer no certificate of ability, and only gave my neighbor in his sufferings such aid as I could.41

40 Hooker, Physician and Patient, 223-224.

It is unlikely that the abolition of medical degrees would have immunized the profession from malpractice accusations, but Wood's assertion underscored the public's attitude toward education and the profession. The physician was at greater legal peril because he had undemocratically claimed expertise through education.

Ironically, physicians could be maligned both for possessing a medical education and for possessing a defective medical education. Although Jacksonians resented the ostentation of the medical degree, they were appalled by the insufficient education of most physicians. As Alfred Stillé reported in 1847, the "diploma [M.D.] has lost its value. Everyone knows of its prostitution, and has ceased to regard it as in itself deserving attention."\(^{42}\)

Stillé cited another important product of the burgeoning number of American medical schools. He speculated that "the annual number of graduates, in medicine, is at present probably larger in the United States, than in the whole of the residue of the civilized world."\(^{43}\) Other physicians shared Stillé's concern over the flood of physicians entering practice in the first half of the nineteenth century. One

\(^{42}\) [Stillé and Huston], "Medical Reform," 49.

\(^{43}\) Ibid, 49.
writer reported in 1858 that "Every little hamlet has now two or three physicians, where one physician, forty years ago did the entire practice of half a dozen such hamlets . . . ."  

Most figures suggest that the supply of physicians between 1790 and 1850 grew from scarcity to surfeit. The five existing American medical schools produced less than 250 physicians between 1765 and 1800. Many communities subsisted without the benefit of a formally educated practitioner.  

After the "medical school mania" of the early 1800s, the number of graduates increased dramatically. During the 1830s medical schools granted approximately 6,800 degrees. In the 1850s almost 18,000 physicians received their M.D.s. Although most early estimates are imprecise, the total number of practicing physicians grew from between 3,500 and 4,900 in 1790, to 40,564 in 1850. Some of this increase was a reflection of the medical needs of the growing population. However, the ratio of physicians to inhabitants increased between 1790 and 1850 from between 1 in 800 and 1 in 1,100,  

44 "To what causes are we to attribute the diminishing respectability of the medical profession in the estimation of the American public?" MSR 1 n.s. (1858): 141-3.  


46 These figures include any practitioner, educated or not, who called himself a "physician."
to about 1 in 570.⁴⁷ In some areas of the country the
density of physicians was greater. In 1846 a speaker before
a graduating medical class bemoaned the crowded state of the
profession and argued that the country did not need more than
1 physician for every 2500-3000 inhabitants.⁴⁸ It was said
that in 1845 there was 1 doctor for every 400 persons in
Buffalo; in St. Louis, the proportion reached 1 to 274.⁴⁹

Despite these figures the "surplus" of physicians was
regional and not national, and represented a maldistribution,
rather than an overall excess of practitioners.⁵⁰ For
example, communities on the western frontier continued to
survive without adequate numbers of trained physicians.
Still, physicians in the areas which contained an oversupply
of medical practitioners suffered in several ways. The over-
abundance of physicians had played a major role in
diminishing the respectability and status of the profession
since 1800. One physician who had practiced for forty-seven

⁴⁷ These statistics were drawn from Cassedy, Medicine and
American Growth, 66-8, 232-3.

⁴⁸ Samual Jackson "Critical Analysis," NYMJ 8 (March 1847):
218-22.

⁴⁹ Ibid, 232-3; also see Rothstein, American Physicians,
344-5 for a discussion of the perceived surplus of
physicians.

⁵⁰ Cassedy, Medicine and American Growth, 70.
years, complained in 1858 that the medical profession was "greatly overstocked; and it is a natural consequence, that where there is an excess of a commodity in the market, its value should be proportionally diminished."\textsuperscript{51}

F. Cambell Stewart, a mid-century physician, offered a more subtle interpretation of the relationship between an increase in numbers and the decline in status. He explained that many individual physicians were held in high esteem by their respective communities. The elevated social status of these physicians "excite[d] the ambition of many of the thousand applicants for admission to our ranks, some of whom thus see a road opened for access to a society which it might be much more difficult for them to reach by other more laborious and circuitous routes."\textsuperscript{52} As unworthy social climbers crowded the profession, the overall image of the profession deteriorated. The decline of public trust and confidence emboldened patients and made it easier for them to accuse their physicians of mistreatment.

\textsuperscript{51} "To what causes," 141-3.

\textsuperscript{52} Stewart, "The Actual condition of the medical profession in this country; with a brief account of some of the causes which tend to impede its progress, and interfere with its honors and interests," \textit{NYJM} 6 (1846): 151-71, excerpted and reprinted in Brieger, \textit{Medical America}, 62-74 at 64.
"Want of union and harmony"

The rise in the number of medical practitioners created another pitfall for potential malpractice defendants. In the 1824 Lowell malpractice case, the defense attorney asked the jury to weigh the patient's injury against the two defendants' importance to their communities. "What is the consequence of a limb like Lowell's," the lawyer demanded, "compared with the usefulness of such a physician as Dr. Hawks, entirely lost to the present scene from his practice."53 Hawks and his co-defendant Faxon were the only medical men in their respective towns. The jury could not decide on a verdict and the trial judge issued a non-suit ruling.54 The prospect of losing the sole practitioner in the village may have intimidated the judge and jury and influenced their decision.

If other late eighteenth and early nineteenth century juries were influenced by physicians' value to their


54 See Chapter 1 for a fuller discussion of this case.
communities, as was suggested in the Lowell case, they would be less likely to charge and convict physicians and risk denying their villages medical aid. The alteration of legal rules regarding contract, tort, property, and corporations between 1780 and 1820 encouraged the expansion of commercial enterprises that would presumably serve the public interest. Similarly, the attitudes of juries and judges in medical cases may have represented the socially "instrumental function" of law by protecting, and allowing the development of another resource vital to the welfare of the public—medical care. By 1850 the number of physicians in some areas had increased to the point of a glut. If a malpractice suit destroyed a physician's career, there was always another doctor, or two, ready to take his place. In this situation, juries and judges were less likely to shelter physicians from unhappy litigious patients.

The surplus of physicians in many parts of the country also subverted the medical profession's status and gave rise to malpractice suits by engendering and exacerbating competition among regular practitioners. Competition,

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however, did not arise merely from the excess of medical men. Physicians often fought bitterly over control of local medical societies, and against rival organizations. Other intra-professional disputes centered on issues such as fee bills and consultations.56 Physician owned-and-operated medical schools were also the source of open economic conflict.57

One physician, writing in 1846, admonished his colleagues that they "too often pursued a course in furtherance of their own individual interests which was calculated to impair that of the body [medical profession] generally." If the profession did not stem the tide of dissention, the writer warned, conflict would "lessen the estimation in which [the profession] should be held by the public at large."58

56 Local medical societies set price guidelines for physicians to follow. When practitioners undercut, or overpriced, quarrels ensued. The standard work on the subject is George Rosen, Fees and Fee Bills: Some Economic Aspects of Medical Practice in Nineteenth Century America, Supplement to the Bulletin of the History of Medicine, No. 6 (Baltimore: Johns Hopkins University Press, 1946).


58 Stewart, "The Actual Condition," passim and 69, 71. For other comments on the effect of professional quarrels on professional status, see "Review: Medical Ethics," AJMS 23 (January 1852): 149-78 at 151.
The founders of the American Medical Association recognized that the lack of internal cohesion damaged public confidence in the profession. The first AMA code of ethics in 1847, advised that since:

. . . the feelings of medical men may be painfully assailed in their intercourse with each other, and which cannot be understood or appreciated by the general society, neither the subject matter of such differences nor the adjudication of the arbitrators should be made public, as publicity in a case of this nature may be personally injurious to the individuals concerned, and can hardly fail to bring discredit on the faculty.\(^59\)

These warnings failed to restrain the competition that was seemingly endemic to the profession. Large numbers of physicians streaming out of medical schools in search of patients added to the discord. The competition for patients became so vigorous that a young student was advised in 1836 that the "only way to get practice would be to underbid those already practicing."\(^60\) Conversely, established practitioners considered new physicians trespassers. As one writer

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59 "Code of Medical Ethics adopted by the National Medical Convention in Philadelphia, June 1847), Article VI § 1. See Chester R. Burns, "Medical Ethics in the United States Before the Civil War," (Unpublished Ph.D. Dissertation Johns Hopkins University, 1969), 91-125 for a discussion of how other ethical codes were used to blunt the conflict among physicians.

60 Quoted in Starr, Social Transformation, 64.
confirmed, "any new comer is looked upon as an intruder upon vested rights."61 Many medical men believed that conflict indirectly encouraged malpractice suits by marring the physician's public image. But, they also contended that competition, born of the physician surplus, directly incited suits.

In fact, between 1835-1865, physicians identified intra-professional competition as the primary source of the malpractice affliction more often than any other cause. Alden March claimed in 1847 that "[i]n most of the prosecutions of physicians and surgeons for malpractice, it is fair to presume, from a pretty extended observation, that they originate in, or grow out of an unwarrantable rivalry, or perhaps jealousy, between two neighboring practitioners."62 The 1853 Massachusetts Medical Society committee on malpractice concluded that "the jealous eyes of rivals" was the "most important" cause of the prevalent suits.63 Similarly, in 1854 a writer decried, "We too often find the viper within our own ranks; those who from envy or

rivalry seek to destroy the hard earned fame of one in every way their superior." 64 One of the patriarchs of mid- and late- nineteenth century medicine, Stephen Smith, concurred in 1860 that his "own experience in suits for alleged malpractice has led to the conclusion that both the source of the evil and the remedy lie within the pale of the profession itself. The secret history of the vast majority of these cases reveals the humiliating fact that they were instigated by medical men." 65

Some physicians inadvertently generated suits with offhand remarks while examining patients. Samuel Parkman, a frequent commentator on malpractice, reported that sometimes "a medical man is entrapped into the examination of a case which he afterwards discovers involves a legal investigation." Parkman explained that a patient who believed he had been mistreated by a physician would consult a second practitioner in hope of securing evidence. "The second surgeon soon discovers that he is summoned as a


65 Stephen Smith, [Review of John Elwell's treatise on malpractice], AJMS 40 n.s. (July 1860): 153-166 at 156. For other claims that suits were instigated by rival practitioners, see William M. Wood, "A Statement of two Suits for Malpractice, tried in November and December, 1850, in the Court of Erie County, Pa.," AJMS 22 (July 1851): 43-53.
witness in a trial in which the first surgeon is the defendant and the patient is the plaintiff."\textsuperscript{66}

In one such case, a New York man broke his leg when he was pinned under a falling tree. A local physician set the leg, but since it was planting time the man hobbled about in the field trying to work. About six months later he visited a second doctor who examined the limb and remarked that "the attending physician ought to be ashamed of it; and that he ought to pay him for a year's work. The farmer sued the first physician for malpractice.\textsuperscript{67}

When physicians testified as expert witnesses in court, they attempted to display their medical superiority to the audience, often to the detriment of the defendant. They often claimed or, intimated that their methods of treatment were safer, more advanced, or more effective than the defendant's. As one observer noted, when physicians were "called into court, one is pitted against another, like two roosters in a cock pit."\textsuperscript{68}

\textsuperscript{66} Samuel Parkman, "On the Relations of the Medical Witness with the Law and the Lawyer," \textit{AJMS} 23 (January 1852): 126-34 at 128.

\textsuperscript{67} The jury could not agree on a verdict and the patient withdrew the charges. Both parties paid their own legal fees and court costs. March, "Case of Alleged Mal-Practice," 9-10.

\textsuperscript{68} "Critical Analysis," \textit{NYMJ} 3 (March 1847): 218-22.
Other physicians deliberately used malpractice suits against competitors. They urged patients to sue their professional antagonists in order to ruin their reputations and destroy their practices. Often, the accuser served as an expert witness for the prosecution. Occasionally, these suits inspired retaliatory litigation. Covetous, aspiring, physicians used suits to discredit established practitioners. When Dixi Crosby, a respected New Hampshire physician was sued and convicted for malpractice in 1851, medical editorialists rushed to his defense. One writer reported that "A scheme is imagined to have been devised for breaking down the professor [Crosby] . . . in other words, by driving off an old surgeon, there is a chance of dropping into his place."69

Malpractice suits were also employed by established practitioners to discourage new competitors. A young physician in the 1840s complained that he was plagued by accusations and suits for malpractice as soon as he arrived in Erie, Pennsylvania. The suits, he said, were instigated by local practitioners "who regarded his advent with a jealous eye." The same practitioners who encouraged patients to sue the newcomer, served as expert witnesses for the

prosecution. The strategy worked. After being sued for two small pox vaccinations and one fracture treatment, the doctor "wearied of vexation . . . [and] left his suits, his property, and his family, to seek a more generous home and better rewards, in the golden valleys of California." The physician eventually returned to Erie county to face trial. He was acquitted on two charges, but fined $1,450 in the third trial. 70

Even powerful and famous physicians were vulnerable to suits incited by professional enemies. William Beaumont became world renowned in the 1830s for his historic studies on digestion gained by observations through the chronically unhealed wound in Alexis St. Martins' stomach. 71 In 1844 Beaumont, practicing in Saint Louis, Missouri, took a public position in a dispute between two rival medical schools. The opposing faction convinced two patients to sue Beaumont for malpractice. In one case he was charged, along with a co-defendant, with an incompetent hernia operation that left the young woman patient with a small, open incision. Beaumont neither assisted in the surgery, nor advised the attending physician. Although he was only one of several physicians to


71 Flexner, Doctors on Horseback, 217-64.
view the patient during her long convalescence, his name was added to the suit for $10,000. A local physician claimed that some medical men "resolve to attain practice at any cost, whether of professional principles or of a brother's character." They were willing to use "unholy means" and "calculated success by others' downfall, and by means of detraction will sap the reputation of a professional brother, with the hope of building up a practice in his ruin."

Beaumont was ultimately exonerated, but a vicious pamphlet debate continued for many months.72

Medical literature counseled physicians against playing either an accidental or malicious role in inciting litigation. An editorialist in 1847 gently advised that "A difference of opinion between two or more physicians, where the spirit of kindness and courtesy controls the intemperate expressions of vanity and malevolence, may often lead to the best results."73 Another writer commenting on malpractice cases for fractures observed that "These cases should lead members of our profession to be kind, generous, liberal to one another, and not to impute to ignorance or inattention,


73 [Justice], "The Late Suit for Mal-Practice in Delaware Co., N.Y.," BMSJ 37 (August 11, 1847): 35-6 at 35.
that which is the result of a generally incurable accident." 74 Other writers encouraged harsh reprisals against physicians who purposefully instigated litigation. One physician declared in 1854 that "[t]hose puny strife engenderers, who stir up these unnatural suits, deserve the execrations of all classes and conditions." He recommended that "they should be shunned and left to wallow in their own filthiness." 75

"Radical and progressive proclivities"

The medical profession's open competition with itself, as well as its lack of a respected, and distinct social status, reflected the social and political environment of Jacksonian America. The roots of the crisis are somewhat earlier. Between the American Revolution and 1800, the traditional ranks of society rapidly blurred, and social hierarchies became less rigid. Although the stratified nature of society had been under attack since the early

74 T. J. Pray, "A Case of Alleged Mal-Practice," BMSJ 54 (April 24, 1856): 230-42 at 242. For another writer who counseled physicians to be circumspect in judging the work of their peers, see March, "Case of Alleged Malpractice," 9-14.

eighteenth century, the republican rhetoric of 1776 hastened the process. Plain, unlettered men started to believe that they were the equals of men of any rank and began to resent and hate any emblem of hierarchical privilege or status. 76

Professional monopolies reeked of aristocratic privilege and were inconsistent with the growing notion of equality and democracy because they interfered with free and open competition. The late eighteenth century attempts of elite physicians to organize the profession failed because they could not provide efficacious care, and because their reorganization plans mirrored the hierarchical, tripartite arrangement of the London medical profession. Consequently, when physicians lobbied early state legislatures to pass licensure laws they met with limited success. Virtually every state passed some type of licensure statute but they were inclusive rather than exclusive. Many of the statutes did not forbid unlicensed practice but merely provided certificates of legitimacy to "qualified" doctors. In some states unlicensed physicians were only prohibited from suing in court for unpaid fees. Non-licensed physicians in these

jurisdictions could mitigate this handicap by requiring payment in advance.\textsuperscript{77}

Even in states where licensure laws provided penalties for unsanctioned practice, juries generally would not convict violators.\textsuperscript{78} There was little in physicians' education or results to justify the establishment of a medical monopoly. Many Americans, especially in the working classes, believed that a physician's status should be determined by his performance and not by legislation.\textsuperscript{79}

This trend accelerated after 1800. Physicians were continually frustrated in their attempts to retain their social status and to establish a market monopoly by licensure. They lost ground as democratic, anti-status feelings grew. Alexis de Tocqueville concluded that democratic revolutions were generally followed by an attack on symbols of social aristocracy and an increase in individualism.\textsuperscript{80} The old order was changing rapidly. These sentiments glorified the image of a society of common, hard-

\begin{footnotes}
\item[	extsuperscript{77}] Richard Harrison Shryock, \textit{Medical Licensing in America, 1650-1965} (Baltimore: Johns Hopkins Press, 1967), 3-23.
\item[	extsuperscript{78}] Starr, \textit{Transformation}, 44-5.
\item[	extsuperscript{79}] Rosenberg, \textit{Cholera Years}, 70.
\end{footnotes}
working individuals operating without legal or institutional restraints. This philosophy had no room for aristocratic, intellectual, or economic privilege. Jacksonian democrats praised free-trade and competition, and condemned monopolies and chartered corporations. They attacked professional licensure as an injustice as odious as the Monster U.S. Bank. 81

Critics of the profession argued that physicians were no different than merchants or craftsmen. Medical sects such as Thomsonians, homeopaths and hydropaths claimed to embody the free-market, common-man, mentality of the Jacksonians and joined in the attack on the desires of regular physicians for a privileged legal position. An antebellum Ohio newspaperman exemplified the mood of much of the working class when he declared that "We go for free-trade in doctoring." 82

State legislatures responded. Beginning in 1838, jurisdiction after jurisdiction abolished their already weak licensure laws. By 1850, only New Jersey and the District of Columbia retained any effective controls over medical


82 Rosenberg, Cholera Years, 151-72, quote at 161.
practice. There was "free trade in doctoring." These were the "radical and progressive proclivities" that Alexander Garnett believed "induce[d] every street urchin or illiterate mechanic, to entertain the belief that he has not only the unquestionable right to fill, but that he is eminently fitted for any station or position in society." Physicians saw an intimate connection between Jacksonian rhetoric, their decline in status, the abolition of licensure, and the increase in malpractice suits. William Wood noted in 1849 that "the general influences leading to these perversions of justice [malpractice cases] can be readily perceived by all." According to Wood, the efforts to limit the practice of medicine to those who "have the abilities and acquirements essential to its proper understanding" had failed. The public, Wood held, considered the limitation of medical practice to those with "scientific attainments" as an attempt of a sect to monopolize rights and infringe on the greatest liberty." As a result, "ignorant and impudent pretenders, under a great variety of humbugging titles, come before the public with equal rights and a better chance for public favour, than the regular practitioners."

83 Shryock, Medical Licensing, 30-1.
Meanwhile, the medical doctor was forced to pursue his profession "under risks and hazards no prudent man could encounter."\textsuperscript{85}

Stephen Smith drew a direct parallel between the lack of medical licensure in the United States and climbing malpractice rates. Smith pointed out that Britain, France, and Germany had enacted stringent licensure laws that were designed "to develop, foster, and advance true scientific medicine." The physicians in these countries, Smith noted, suffered fewer malpractice suit than their American counterparts.\textsuperscript{86} In the absence of any limitation on medical practice, malpractice became the only way to protect the public from incompetent practice. One writer in 1847 recognized that the lack of effective licensure in most states left "to the common law the task of guarding their citizens by suits for malpractice."\textsuperscript{87}

The use of market forces and individual malpractice cases to oversee the medical profession was a characteristically Jacksonian approach to regulation. Licensure, in the Jacksonian mind, represented regulation

\begin{itemize}
\item \textsuperscript{85} Wood, "Thoughts on Suits for Malpractice," 395-396.
\item \textsuperscript{86} Smith, [Review of Elwell], 154.
\item \textsuperscript{87} [Stillé and Huston], "Medical Reform," 50.
\end{itemize}
from the top down and appeared to benefit the physician by creating an unfair monopoly and relying on artificial measures of merit. Malpractice suits, however, represented regulation from the bottom up. Individual patients could choose which practitioner to patronize, and, individual juries could decide if the medical treatment had been competent. This arrangement was consistent with regulating patterns in other areas of early nineteenth century life. Most regulation was "local and self-sustaining." States made few overarching efforts to enforce existing regulations and if an individual did not initiate a lawsuit, the statute was not enforced.88

While patients increasingly accused regular physicians of malpractice, Thomsonians and homeopaths, who espoused the social and political equalitarianism of the working class, were seldom sued. The Pennsylvania medical society committee on malpractice found that irregular physicians, who "[are] gross and ignorant pretenders, [and] whose whole existence is a continued system of mal-practice, pass unnoticed and unharmed." The committee believed that irregular physicians

avoided law suits because "they act on popular prejudices."\(^{89}\) Other writers agreed "that the chances are all together better for the acquittal of an ignorant, uneducated pretender to medical knowledge, who is really guilty, than that of an intelligent, well-educated surgeon to whom no fault can justly be charged."\(^{90}\)

Malpractice suits offered injured farmers and laborers an outlet for anti-status, anti-professional sentiment. Physicians recognized that they were at greater risk from the poorer segments of society and blamed political and class antipathy for many of the suits and subsequent convictions. A writer in 1847 alleged that "the people, or, at least that class of persons who are most exposed to accidents, and the least responsible, either for the surgeon's bill for professional attendance, or for the costs of a suit for malpractice seem to require high surgical attainments."\(^{91}\) And, as a physician in 1849 claimed, "the interests and prejudices of the whole class are against the acts and doings of the regular practitioner.\(^{92}\)


\(^{90}\) "Prosecutions of Medical Men," WJMS 28 (1853): 346-347.

\(^{91}\) March, "Case of Alleged Malpractice," 13.

\(^{92}\) Wood, "Thoughts on Suits," 395-6.
Prosecuting attorneys sometimes exploited this prejudice in their arguments to juries. In an 1848 New York case, the patient's attorney condemned the medical profession as an "oppressive and aristocratic monopoly." The trial court judge cautioned the jury to disregard the remarks and they returned a verdict for the physician. Other physicians were not so lucky. A writer in 1856 declared that "The trial of a professional man for an alleged malpractice by a jury of laborers is a farce and a disgrace to our country." One layman observed that a

. . . jury of laboring men . . . go into the jury box with feelings excited against the surgeon, because they think his business should produce no better pecuniary returns than his own; the surgeons bill is always deemed exorbitant by them; and he is generally looked upon as almost a swindler, and living luxuriously upon their hard earnings; therefore they are always inclined to render a verdict against your profession, and in favor of one of their own class.


The lay observer also described the reaction of a working-class jury to expert witness testimony. According to the narrator, "after a few questions are answered, they sneer and laugh at you [physicians], and make up their minds long before they leave the box." A medical editorialist verified the characterization and confirmed that "A great number of these trials in various parts of the Union, but especially amongst farmers, are terminated in this way." 96

Corporations and physicians shared resentment and distrust. The Massachusetts Medical Society committee on malpractice concluded that patients "from whom the least remuneration is to be obtained" were responsible for most of the suits. The committee believed that the sympathy of the jury was generally on the side of the plaintiff. According to the study, "this sympathy for the seemingly oppressed and misused has influence in all cases where a corporation, civic or otherwise is the defendant; and it cannot be denied that it is an important element in the patient's decision to bring a suit against his physician." 97 Corporations, specifically railroads, were also suffering through their first wave of lawsuits in the early 1840s and 1850s. In personal injury

96 "The Greenpoint Malpractice Case," 313.

cases against corporations, plaintiffs' attorneys often described the cases as a battle between oppressive, powerful corporations, and virtuous, hardworking laborers.98

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Declining social status of physicians, "defective medical acquirements," the "want of union and harmony," and "radical and progressive proclivities," were central elements in the increase of malpractice suits between 1835-1865. These factors helped generate, directly and indirectly, many of the suits in the period. However, they do not provide the fundamental explanation for the malpractice phenomenon. Instead, poor medical training and therapy, intra-professional competition, and Jacksonian sentiments were immediate causes of the dramatic increase in litigation and help explain why this period contrasted so starkly with the pre-1835 years. As important as these elements were between 1835-1865, their gradual disappearance did not retard the rate of malpractice prosecutions.

Although appellate court decisions are only a crude, and imprecise measure of the frequency of litigation, they demonstrate that malpractice cases multiplied at a rate faster than the population through the early twentieth century (see Table 1).

### TABLE 1

<table>
<thead>
<tr>
<th>Years</th>
<th># of decisions</th>
<th>% increase pop.</th>
<th>% increase cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1790-1830</td>
<td>2</td>
<td>3.37</td>
<td>---</td>
</tr>
<tr>
<td>1830-1860</td>
<td>21</td>
<td>2.44</td>
<td>10.50</td>
</tr>
<tr>
<td>1860-1890</td>
<td>119</td>
<td>2.00</td>
<td>5.66</td>
</tr>
<tr>
<td>1890-1920</td>
<td>485</td>
<td>1.68</td>
<td>4.08</td>
</tr>
<tr>
<td>1920-1950</td>
<td>1143</td>
<td>1.53</td>
<td>2.36</td>
</tr>
</tbody>
</table>


During this time the therapeutic, educational, professional, and social trends that played an important role in promoting suits between 1835-1865 faded and, in some cases, reversed. The malpractice epidemic did not.

In the 1870s medical education started its long trek toward excellence and respectability. Schools such as Harvard, the University of Pennsylvania, the University of
Michigan, and Johns Hopkins raised entrance requirements, enhanced curriculums, and began to place the study of medicine on a "scientific" basis. The medical school programs were longer, required laboratory and clinical study, and employed full-time medical academics. These institutions became the standard by which other schools were measured and by 1920 the low quality proprietary schools disappeared. The new medical school produced more competent physicians and raised the respect of the profession. 99

Much of the competitiveness and divisiveness that had rent the profession in the Jacksonian period dissipated by the first decades of the twentieth century. Statistical revelations and scientific discoveries of the last half of the nineteenth century helped standardize and unify medical beliefs and treatments, as did the standardization of medical educations. Medical societies, which were weak and contentious in the 1840s, settled their differences, increased their membership and successfully promoted professional harmony by 1900. Likewise, the reorganized AMA had a pacific and unifying effect on the profession. 100

99 Ludmerer, Learning, passim; and Starr, Transformation, 123-7.

100 Rothstein, American Physicians, 249-81; and Starr, Transformation, 102-7.
Finally, the Jacksonian antipathy for corporations, monopolies, and professions declined. States instituted effective medical licensure laws in the 1880s and 1890s which helped limit access to the profession. By 1900, the public still distrusted the intellectual, but recognized, and often deferred to, the authority of experts. These developments, the improvements in therapy in many areas of medicine, and the promise of the future significantly raised the status of the medical profession by 1920.\textsuperscript{101}

Malpractice suits continued to rise in spite of the general improvement in the status of the profession and the disappearance of many of elements that incited litigants between 1835-1865. Litigiousness persisted because these factors were only the immediate and topical causes of suits in a specific historic period. Contemporary observers were correct in blaming them for the wave of malpractice suits. However, the existence of these elements did not guarantee runaway litigation.

Southern physicians were also poorly organized and educated. Irregular practitioners, especially Thomsonians, were prevalent and popular. Although many areas of the South

\textsuperscript{101} Rothstein, \textit{American Physicians}, 305-10; and Thomas Haskell, \textit{The Emergence of Professional Social Science} (Urbana Ill.: University of Illinois Press, 1977).
lacked sufficient medical practitioners, some states reported a greater density of physicians than the national average. Southern state legislatures abolished licensure about the same time as their northern counterparts.\textsuperscript{102} Despite the existence of many of the same elements which encouraged litigation in the rest of the country, medical malpractice suits in the South were rare.\textsuperscript{103} Southern society had not yet undergone the cultural transformations that provided the fundamental preconditions for widespread malpractice prosecution. Therefore, even though many of the immediate factors that inspired suits in the North existed, they did not produce the same results.

Suits continued to proliferate in the rest of the country long after the immediate causes of the Jacksonian period dissipated because the social and cultural foundations for the litigation continued to evolve unabated. Immediate factors such as low status, anti-professionalism, and competition were responsible for provoking the first malpractice crisis of the 1840s. Without these elements, medical malpractice rates may have risen more gradually, but

\textsuperscript{102} See Haller, \textit{American Medicine}, 327-31 for the number of physicians in various states; and Rothstein, \textit{American Physicians}, 332-9 for a survey of licensure legislation.

\textsuperscript{103} See above, Chapter 2, and below, Chapter 6, for a discussion of the rarity of malpractice suits in the South.
they cannot completely explain the flood of suits between 1835-1865, nor the unremitting litigation since.
"The Expression of a Well Made Man"
Chapter 4

The expression of a wellmade man appears not only in his face,
It is in his limbs and joints also . . . it is curiously in the joints
of
his hips and wrists,
It is in his walk . . . the carriage of his neck . . . the flex of his
waist and
knees . . .

Walt Whitman (1855), "I Sing the Body Electric"

Malpractice suits arising from the treatment of fractures and dislocations constituted most of the increased litigation after 1835, and continued to be the major complaint through 1916. Lay and professional attitudes toward orthopedic practice and the development of fracture treatment, like physicians' low status, intra-professional rivalry, and Jacksonian sentiment, represented one of the immediate causes of the first dramatic leap in malpractice rates. But, at the same time, the impact of technological developments illustrate an underlying cultural attitude that


helped engender suits into the twentieth century. Malpractice suits were, in part, an expression of a transformed view of the human body and an unprecedented concern for physical well-being.

"The mechanic's hand"

Before 1835 fractures accounted for a small percentage of the total malpractice cases unless they resulted in a severe deformity or amputation. Since malpractice suits were not a common nor an entirely acceptable practice in the first third of the century, patients generally refrained from bringing charges for milder injuries. As the practice of suing physicians became more acceptable and prevalent, patients freely sued on the basis of more moderate physical damage. Fractures and dislocations were the type of injuries that were most likely to result in permanent but not grievous physical results. Patients who suffered fractures and dislocations were probable candidates for shortened or deformed limbs, frozen joints, and long periods of convalescence. These injuries left the prospective plaintiff with a physical manifestation of the defendant/physician's supposed incompetence to display to sympathetic jurors. The

3 See Chapter 1.
long recovery period usually required for orthopedic injuries provoked potential plaintiffs by denying them the ability to work and causing them long-term discomfort.

In addition the protracted healing process sometimes enticed patients out of their beds and into the fields to work before it was safe or sensible. Occasionally, patients would loosen or remove painful or restrictive splints and bandages. Premature activity and interference with the physician's treatment could hamper the healing process, worsen the patient's injury, and distort the results. In these instances, physicians could ostensibly protect themselves in court with the doctrine of contributory negligence by arguing that the patient was the author of the bad results of treatment. 4

In February 1856 an Ohio man was thrown from a sleigh near his home. He severely fractured both bones in his lower leg. A year later, when his leg healed with some shortening and deformity, he sued his physician for malpractice. The defence attorney introduced a parade of witnesses who affirmed that the patient had been careless and did not follow the physician's instructions. One witness testified that he accompanied the patient, still on crutches, on an all-night, whiskey-drinking, coon hunt. Another witness had

4 See Chapter 2.
drunk with the patient until he became "pretty well sprung." Then, the injured man "said he could walk as good as me; jumped over a manure pile by aid of his cane; [and] tried to walk curb stone without [his] cane." According to one witness, the plaintiff admitted that "the leg had been set straight and he had hurt it running about." The jury returned a not guilty verdict after three minutes of deliberation.\(^5\) Unfortunately for physicians, patient complicity was not always so obvious.

Contributory negligence was a "complete defense." If the defendant/physician could demonstrate that the patient was in any way responsible for the failure of the treatment, the case would be dismissed. However, contributory negligence was not always easy to prove and was often ignored by juries. In addition juries may have been hesitant to accept contributory negligence as a defense because it so thoroughly absolved the physician of liability. Therefore, when malpractice suits for all types of injuries increased after 1835, it was not surprising that fracture cases became the predominant subject of litigation. Fractures and dislocations were common in a society dominated by manual labor.\(^6\) They yielded less


\(^{6}\) It appears, in addition, as if fracture injuries were occurring at an increasing rate in the first half of the century because of the increasingly mechanized and dangerous
severe, but often permanent injuries, which, in a society increasingly sympathetic to malpractice charges, were considered as legitimate subjects for litigation.

Fracture and dislocation suits increased after 1835 not only because malpractice cases of all types were more prevalent, but because the relationship between orthopedic treatment and contemporary malpractice rates was interactive. Before 1835 suits fell into two categories: severe injuries, and "mechanical treatments." By the end of the colonial period, and through the first two decades of the nineteenth century, physicians had developed several medically valid procedures. They were able to administer small pox vaccinations, amputate limbs, set simple fractures and dislocations, excise superficial growths and remove foreign objects. Bloodletting was a relatively standardized procedure, and by the third decade of the nineteenth century, male physicians had displaced many midwives by touting their scientific and technical expertise, even though those claims


were tenuous. Physicians claimed technical expertise in these treatments and patients began to expect mechanical, predictable results. As the 1827 judge explained, the physicians often exercised a profession "beset by great difficulties, [but] the employment of a man midwife and surgeon, for the most part, is merely mechanical." These areas, especially vaccination, amputations, and obstetrics accounted for most of the scattered malpractice cases before 1835.

Even though orthopedics was in some respects considered a mechanical enterprise, fractures and dislocations generated very few cases in the early part of the nineteenth century. Physicians were moderately adept at restoring simple fractures, and even when they failed, the resulting deformity would probably be too minor to warrant a suit in an

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9 Sumner against Utley 7 Connecticut Reports pp. 262-3 at 260 (1827). Also quoted and discussed in Chapter 1. Practitioners in America, unlike many of their counterparts in Britain, performed both surgical and medical procedures so the judge was drawing a distinction between surgical practice and medical practice even though both were usually embodied in one practitioner. See Richard Harrision Shryock, Medicine and Society in America, 1660-1860 (New York: New York University Press, 1960), 59-60.
atmosphere that was generally not conducive to malpractice charges. Severe, compound fractures and dislocations, on the other hand, usually required amputation. Benjamin Bell's *System of Surgery*, a widely used textbook in the early part of the century, advised that, "From the difficult treatment and uncertain event of compound fractures practitioners have been very universally disposed to consider the amputation of the fractured limb as necessary."\(^{10}\) Percival Pott in his 1819 treatise on compound fractures noted that a surgeon often "... showed much more rashness in attempting to save a limb, than he would have done in the amputation of it: The amputation would have been the more justifiable practice."\(^ {11}\) Similarly, Samuel Cooper, author of an 1813 handbook on surgery, warned that although "apparently desperate cases [of compound fracture] are sometimes cured, ... every man also


\(^{11}\) Percival Pott, *Treatise on Compound Fractures* Vol. 1 (Phil., 1819), 266.
knows, that such escapes are very rare to admit of being made precedents and the majority of such attempts fail."\textsuperscript{12}

A few early malpractice cases arose out of amputations, but the procedure did not generate a large number of suits. By its nature, amputation complicated the prosecution of a physician. Often, medical experts, juries, and judges could not examine the excised limb to determine if it truly required the operation. Even if the patient died during the procedure, as many did, there were limited legal remedies before the 1850s when state legislatures enacted wrongful death statutes.\textsuperscript{13} Even compound and complicated fractures in which patients kept their limbs yielded very few cases before 1835. Although the profession and the public were beginning to view procedures such as childbirth, vaccination, and

\textsuperscript{12} Samuel Cooper, \textit{A Dictionary of Practical Surgery} (London, 1813), 420. It is important to note that John Jones, as early as 1776, called perfunctory amputation in compound fractures into question. Jones' position, however, was not accepted. John Jones, \textit{Plain Concise Practical Remarks on the Treatment of Wounds and Fractures} (Phil.: Robert Bell, 1776) [Reprint Edition 1971 by Arno Press], 45-46.

\textsuperscript{13} The issue of "wrongful death" actions is complicated. While there was apparently a common law action for wrongful death, many judges in the early nineteenth century held that there was not. Husbands could, however, sue for loss of consortium. In the early nineteenth century consortium was the husband's conjugal rights to his wife's labor and companionship. Women could not sue for loss of consortium until much later in the century. Wex Malone sheds some light on the topic in "The Genesis of Wrongful Death," \textit{Stanford Law Review} 17 (July 1965): 1043-76.
amputation as mechanical and expected mechanical predictability, fracture treatment, especially for complicated injuries, did not inspire the same confidence, and hence, the same demands.

Physicians were made dramatic improvements in the treatment of compound fractures and dislocations between 1820 and 1840 which changed the basis of prognosis for fractures and dislocations, transformed professional and lay attitudes, and provided the raw material for malpractice suits. During this period evidence rapidly accumulated against the desirability of frequent, and perfunctory, amputation.

Astley Cooper, a surgical pioneer, declared in 1835 that:

Formerly, and with my recollection, it was thought expedient for the preservation of life, by many of our best surgeons to amputate the limb in these cases, but from our experience of late years, such advice would in a great majority of instance be now deemed highly injudicious.14

Physicians had developed new techniques, such as excising jagged pieces of exposed bone with saws, and roughing the exposed ends of bones to facilitate union. They also developed new bandaging and splinting procedures that allowed

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them to save both limbs and lives. Although antiseptic practices were not popular until the 1870s and 1880s, antebellum physicians also devised methods to counter the deadly infections that often followed compound fractures. For instance innovative packing procedures ensured that wounds healed from the inside to the outside and diminished the number of severe internal infections. Consequently, during the 1830s and 1840s, journals reported case after case where compound fractures healed with the only bad effect being some shortening or deformity of the patient's limb.\textsuperscript{15} William Walker presented a lengthy paper to the Massachusetts Medical Society in 1845 celebrating the advancements made in the treatment of compound and complicated fractures.\textsuperscript{16} Finally, with the advent of anesthesia and painless surgery in the late 1840s, physicians could work longer and more carefully on patients, and save rather than amputate limbs.\textsuperscript{17}

At the same time, a strong revulsion occurred against amputations on other grounds. American physicians, under the

\textsuperscript{15} For example see several dozen healed cases reported in Walker, "On the Treatments of Complicated and Compound Fractures," i-lvi; and \textit{ME} 3 (1841): 207; and \textit{ME} 5 (1843): 1555.

\textsuperscript{16} See note 7 above.

\textsuperscript{17} Martin S. Pernick, \textit{A Calculus of Suffering: Pain, Professionalism, and Anesthesia in Nineteenth Century America} (N.Y.N.Y.: Columbia University Press, 1985), pp. 30, 82, 83.
influence of foreign clinicians such as Pierre Louis, scrutinized the treatment's efficacy statistically and discovered that the procedure was dreadfully dangerous.\textsuperscript{18} In 1838 George Norris published a statistical appraisal of amputations. He reported that "[t]he endeavors that have been made for many years past, to save limbs under almost desperate circumstances . . . ha[ve] almost imperceptibly produced a great unwillingness with us as to the performance of amputations." Moreover, Norris noted that amputations were hazardous. An 1833 survey of a St. Louis Hospital found 13 fatalities out of 21 amputations. Norris conducted a survey at the Pennsylvania Hospital between 1831 and 1838. He discovered that 21 of 55 amputees died.\textsuperscript{19}

Finally, physicians who embraced the move toward the "conservative medicine" of the late antebellum period were abandoning heroic medical and surgical procedures and placing a greater trust in the healing powers of nature. Austin

\textsuperscript{18} Cassidy, \textit{American Medicine and Statistical Thinking}, pp. 85-7.

Flint wrote in 1862 that the history of surgery in the first third of the century was characterized by the "introduction and frequent performance of numerous formidable operations." But, Flint remarked, "The change that has taken place is marked. We hear now comparatively little of the terrible operations of that sort which is associated with bloody deeds. What would have once been considered as a degree of courage to be admired is now stigmatized as rashness."20 As William Walker recommended, physicians began to "estimate the powers of nature and or art in resisting and surmounting injuries."21

Not surprisingly wholesale amputations had become less acceptable by the 1850s. John Elwell in his 1860 work on malpractice, declared that:

An amputation that would have been justified by the rules of surgery and the operator protected in court, twenty years ago or even less time than that, would now be repudiated by the best authority and the operator justly chargeable with malpractice.22


22 Elwell, Treatise on Medical Malpractice, 56 and 54-8, passim.
Physicians were caught in a double bind. Fracture treatment had improved dramatically over the first half of the century, and they were more often able to save, rather than amputate limbs. However, badly injured limbs, even if spared, usually healed with some shortening or deformity. These less than perfect results following compound fractures and dislocations were the single most common source of malpractice suits in the nineteenth century.\textsuperscript{23} Physicians who exercised the most up-to-date techniques and preserved badly injured limbs often found themselves in greater legal danger than those practitioners who followed the archaic practice of perfunctory amputation.

Patients were willing to sue physicians for treatment which saved profoundly injured limbs, albeit with some accompanying imperfection. In 1853 a New Hampshire man who had suffered a compound fracture-dislocation of his ankle and lower leg, sued his physician after the joint became frozen in an awkward position. Despite testimony from expert witnesses that this type of injury would have previously required amputation and that the patient should have been

\textsuperscript{23} See Chapter 2 above.
"glad to get off with any foot that would do to walk on," the jury found the physician guilty of malpractice.24

The irony of physicians being placed at greater risk because of medical advancements and successes in saving limbs was noted by Abraham Lincoln during his career as a defense attorney. In 1856, Lincoln, a successful lawyer, represented two physicians against a charge of malpractice. An elderly man had badly broken his leg and it had shortened as it healed. Lincoln searched out physicians to coach him on fracture treatment, and used a chicken bone at the trial to demonstrate the comparative brittleness of young and old bones. During his closing address Lincoln chastised the plaintiff: "Well! What I would advise you to do is get down on your knees and thank your heavenly Father, and also these two Doctors that you have any legs to stand on at all."

Lincoln declared that the injury might have easily warranted amputation but the physicians exercised their skill and saved the leg. Lincoln reasoned that "The slight defect that finally resulted, through Nature's methods of aiding the work of surgeons, is nothing compared to the loss of the limb

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altogether." The jury ruled in favor of the physicians and charged the trial costs to the plaintiff.25

Though unnecessary or incompetent amputations were seldom penalized, physicians who saved limbs with compound or complex fractures were regularly sued. In 1856 the Medical News reported a typical case in an article titled "Legal Robbery of a Physician." A man had crushed his leg so badly that "the first question was as to the propriety of primary amputation." A doctor saved the man's leg, but as in other cases, with some deformity. The patient sued for malpractice and won a substantial award.26 Often then, the best treatment for the patient was not necessarily the safest treatment for the surgeon. In fact, physicians were left more vulnerable by medical progress that frequently provided patients with visible, bodily evidence for malpractice prosecutions.

Although physicians continued to practice the new fracture and dislocation procedures, the vagaries of malpractice litigation could have diminished the quality of medical care in individual cases by making it more attractive


to condone amputation than to follow the safer and more effective procedure of saving limbs. After the introduction of ether in 1846, amputations became less horrible and encouraged some physicians to operate indiscriminately. As a physician in 1851 noted, "anesthesia has its drawbacks and evils." Patients were too easily persuaded to submit to the knife of "what are called promising young men who carve their way into practice."\(^{27}\) This small, but not insignificant, problem arose at the same time that methods for saving mangled limbs were improving and malpractice suits were increasing. Irresponsible practitioners had sufficient motivation to avoid the chance of a suit and enhance their image as a heroic physician with a few strokes of an amputating saw. As one writer suggested after observing a dispute between two physicians over treatment, "In the absence of every other motive, one might almost suppose that amputation was desired to get rid of a troublesome case, and the more effectively to conceal a bad piece of surgery."\(^{28}\) In this case, as in other scattered instances, the fear of prosecution may have encouraged the physician to ignore

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improvements in medical practice while more responsible surgeons saved limbs and left themselves open to attacks in ways that would not have been possible before 1830s.

The dramatic advancements in fracture treatment technology of the first third of the nineteenth century contributed to the leap in malpractice rates in another way. Through much of the first third of the century physicians and the public recognized the uncertainty in the treatment of complex injuries and refrained from characterizing the procedures as "mechanical." After the improvements in treatments proliferated, physicians and the public alike began to conceive of orthopedic practice in mechanistic terms. Many physicians were dazzled by recent advancements and seduced into unrealistic expectations.

Regular physicians also used the image of a machine to counter the claims of irregular physician competitors. "Natural bone-setters," members of an early nineteenth century medical sect, for example, claimed to possess an almost inborn ability to repair all orthopedic injuries. Worthington Hooker, a regular practitioner usually stressed that medicine was a mixture of art and science and inherently uncertain, but abandoned this view when discussing orthopedics. Hooker wrote that the public should realize that "the joints of the body are constructed upon mechanical
principles, and that they are to be understood just like any other machine."29

Many physicians and medical writers began to believe that mechanical, standardized treatment yielded consistent, faultless cures. An Ohio medical society committee studying malpractice concluded that the absence of a realistic and accurate standard of success was responsible for the outbreak of fracture related suits. "There is little in our textbooks, or courses of instruction, from which the beginning practitioner would be led to expect anything but perfect results." The committee also explained that medical men called to examine possible instances of malpractice were also often misled by unrealistic expectations of cures. If their colleagues did not attain their ideal standard, they could "by the honest convictions of right," be "drawn into the service of the prosecution."30 An attorney, in an 1850 suit, quoted Samuel Gross' surgery textbook which held that "in such cases [compound fractures], that where shortening [of a limb] took place, it was owing to the carelessness of

29 Worthington Hooker, Physician and Patient, 161.

the surgeon, or the use of improper apparatus, and need not be so in these days, with the modern improvements."\(^{31}\)

As the public began to perceive of the physician as a technician in specific areas of medicine, the range of injuries open to law suits widened. A New Yorker wrote in 1848 that "there is but one method of setting a limb, of taking up an artery, or of extracting a bullet, and upon this method all well-educated surgeons are agreed."\(^{32}\)

Vaccination, obstetrics, and amputation were considered mechanical practices in the first third of the century and therefore dominated the small number of cases before 1835. When the dramatic improvements in severe fracture and dislocation treatment permeated the lay and professional world around the third decade of the century, the image of the physician as a techniciangrew. Accordingly, the expectation of standard treatment and predictable, near perfect results, intensified. For example, a plaintiff's attorney in 1848 confidently told the jury that "A fracture is a simple thing to cure . . . there are not arbitrary rules

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on the subject." Technological advancement, and the accompanying expectations of complete proficiency have always helped fuel significant increases in malpractice rates. The malpractice rate between 1835-1865 was particularly sensitive to the improvements in fracture treatment because they occurred at the same time that social and professional factors were also driving the litigation rates up.

Despite these sentiments from both the public and the profession it is clear that fracture treatment at mid-century was neither standard nor predictable. The point was not lost on contemporary observers. Frank Hamilton, a Buffalo New York physician, served as an expert witness in dozens of malpractice trials. Hamilton believed that the misunderstanding surrounding the results of fracture treatments was the principle cause of the sudden increase in malpractice suits. Hamilton reasoned that lower expectations in both physicians and patients, would curb the seemingly rampant litigation. Using statistical methods he learned in France in the 1840s, he compiled statistics on the treatment and results of hundreds of fracture and dislocation cases. Hamilton carefully measured and recorded imperfect alignment, shortening, or other deformations, and matched the results.

with the treatment each patient had received. He discovered that, despite the claims of many practitioners, perfect restorations were uncommon. For example, one study revealed that forty of fifty fractures of the lower extremities healed with either deformity or shortening. Hamilton began publishing his results in pamphlets, medical journals, and books in the late 1840s, and by 1860 had reached a wide audience.

Defence attorneys and expert witnesses quoted Hamilton's findings. In an 1857 Ohio case in which the plaintiff had broken both bones in his lower leg, Hamilton's figures demonstrated that out of seventy-two similar cases, only thirty-two yielded perfect results. The jury refused to award damages to the patient. Other defendants successfully


36 For example see Hamilton, "Deformities after Fractures," TAMA 8 (1855): 349-54; and Hamilton, Fracture Tables (Buffalo: Jewett, Thomas & Co., 1853), 33 pp.

37 "Suit for Alleged Mal-practice," OMSJ 10 (1857-58): 13-24. There was also strong evidence that the patient himself had contributed to the bad result. See above, this Chapter.
used the fracture tables. Occasionally Hamilton himself would appear at trials to present and explain his findings. Hamilton's approach implicitly suggested that the bulk of malpractice suits were a technological problem which could be cured with a technological solution. He was partially correct. Reasonable expectations of cure would prepare patients for imperfect results. Physicians could consult statistical studies and choose the most effective treatment for the particular class of fractures. However, Hamilton's statistics were not conclusive. No one approach produced regular cures, or regular failures. Quantification of several hundred cases helped guide physicians, but practitioners still had to treat each fracture individually and uncertainty remained. In addition, fracture treatment was still in flux. Physicians continually developed new approaches to fracture treatments. Reliance solely on statistical studies would slow medical progress, and blunt beneficial innovation.

Some medical men contended that the vast number of imperfect cures in statistical studies demonstrated the need for more effective treatments. These practitioners hoped that a technological breakthrough would moderate the litigation. A writer in 1851 declared that "The statistics of dislocations and fractures, display the limping gate of modern surgery, and we are solicitous to do all in our power to remedy the evil." He believed that "if surgeons used the proper means, in the reunion of fractured bones, no justifiable claim for mal-practice would live long before a jury." The physician commended the Jarvis adjuster, a mechanical device with gears which stretched, then compressed, fractured limbs, into their proper position. He claimed that "a correct understanding of its merits, and the use of its powers, would do much toward stopping those suits for malpractice." 39

The writer's hopes were in vain. Within five years the Jarvis adjuster was generating suits instead of preventing them. The AMA condemned the mechanism and Massachusetts General Hospital forbade its use. In 1856, a man sued a physician for breaking his wife's arm. The woman had dislocated her shoulder and the physician had used to a Jarvis adjuster to relocate it. An expert medical witness

claimed that the injury was caused by the machine because
"The power of this adjuster is very great. We have considered it, in the Hospital [Mass. General], as a dangerous instrument, and it has not been used with us for four or five years."40

Confidence in technological solutions, such as Hamilton's tables or Jarvis' adjuster, were unfounded because technology could not stand still. Progress and advancement heightened expectations. Physicians' optimism for finding a technological cure for the profession's malpractice woes was illusory because the roots of the phenomenon were more complex than the development of fracture treatment. The new proclivity to sue physicians between 1835-1865 reflected, in part, the new way that Americans had come to look at their bodies.

"Song of Myself"

A medical writer in 1850 argued that the principle source of malpractice suits was this popular misunderstanding of the nature of medical practice.

From this prevailing ignorance and misconception, the medical practitioner is expected to be the bold controller of nature instead of her vigilant observer, faithful follower and intelligent assistant... The jury is, perhaps told that the work of a mechanic is rejected, unless it comes up to a standard of perfection, so the work of the physician and surgeon must come to a like perfection; and such illustrations are received as parallel and analogical. By such reasoning, the mysteries of vitality, of that machine fearfully and wonderfully made in the image of its Maker, and living by the breath of the Deity, is reduced to a level with inanimate wood, stone, and iron, obedient to the mechanic's hand.  

These sentiments were consistent with the mechanistic mentality which pervaded the first half of the nineteenth century. The tremendous advances in the physical sciences, industry, and transportation transformed the relation between humans and nature. Humans felt a new power over nature and destiny. By 1830 many Americans felt that these material achievements made their society greater than any in the past. In addition, they saw no reason why advancements must stop or even slow. Social commentary in every circle was filled with the enthusiastic expectation of perpetual progress.  

Contemporary observers believed that the democratic society


accentuated and directed these attitudes by emphasizing practical instead of theoretical science. Leo Marx has argued that during the first half of the century "the awe and reverence once revered for the deity and later bestowed on the visible landscape is diverted toward technology or, rather, the technological conquest of matter."

This notion did not mean that humans were separate from nature, but that mechanistic rationality was inherent in nature. Man gained the ability to look at his body as if it were a thing, that could be manipulated and fixed, like any other machine. Mechanistic mentality had its roots at least as early as Descartes and Newton but began to reach its full expression in the early nineteenth century when it yielded practical applications. As Alexis de Tocqueville observed


"In aristocratic ages the chief function of science is to give pleasure to the mind, but in democratic ages to the body." 46

Thomas Carlyle warned that "Men [had] grown mechanical in head and in heart, as well as in hand." Carlyle observed that "it is not longer the moral, religious, spiritual condition of the people that is our concern, but their physical, practical, [and] economic condition . . ." 47 De Tocqueville confirmed that Americans were increasingly concerned with the material world. "Everyone," he noted, "is preoccupied caring for the slightest needs of the body and the trivial conveniences of life." He concluded that "Democracy favors the taste for physical pleasures. This taste, if it becomes excessive, soon disposes men to believe that nothing but matter exists." 48

Not coincidentally, Americans in the 1830s and 1840s became preoccupied, for the first time, with formalized physical fitness programs. 49 The antebellum physical

46 de Tocqueville, Democracy, 462.


48 de Tocqueville, Democracy, 530, 540.

49 Jan Broekhoff, "Physical Education and the Reification of the Human Body," Gym 9 (1972): 4-11; and Charles W. Griffin,
education movement was only one expression of the new materialism. Fitness promoters warned that Americans were suffering from widespread physical degeneracy. In 1830, one observer suggested that the country was becoming a "weakened society" characterized by the "puny arm and shrinking sensibility of dyspepsy." A variety of health reformers, such as Sylvester Graham, William Alcott, and Catherine Beecher echoed this warning and exhorted Americans to revere and care for their bodies.

In the years before the Civil War concern with the body intensified to the point where many people believed that all health, intellectual, spiritual, and moral, began with bodily health. Even writers who concentrated on spiritual and intellectual matters exhibited a heightened concern over the state of the body and physical well-being. William Channing,


a leading Unitarian minister in the 1830s, warned that the
"puny, half-healthy, half diseased state of body is too
common among us," and counseled that "nothing can be gained
by sacrificing the body to the mind." Transcendentalists,
who might be expected to emphasize the spiritual above the
material, were affected by similar sentiments. Emerson
declared that "bodily vigor becomes mental and moral vigor."
Other Transcendentalists concurred. A strong, healthy body was
an important prerequisite to higher consciousness.53

Popular writers agreed. Thomas Higginson, in an article
titled "Saints and their Bodies" explained that "the
mediaeval type of sanctity was a strong soul in a weak body."
Saints in previous eras had emaciated bodies. "But happily,
Higginson wrote, "times change, and saints with them." The
new American image of the saint, he continued, now included a
vigorous and well-developed physique. Higginson declared,
"We distrust the achievements of every saint without a
body."54 Similarly, Walt Whitman filled his 1855 Leaves of

53 Channing and Emerson quoted in Roberta J. Park, "The
Attitudes of Leading New England Trancendentalists Toward
Healthful Exercise, Active Recreations, and Proper Care of
Also, "Embodied Selves: The Rise and Development of Concern

54 Thomas Wentworth Higginson, "Saints and their Bodies,"
Atlm 1 (March 1858): 582-95 at 582-6.
Grass with dozens of paeans to flesh and blood. Lines such as "If life and the soul are sacred the human body is sacred," and, "Who degrades or defiles the human body is cursed" expressed the poet's regard for the physical nature of humankind.55

While none of these writers spoke for the entire population, they represented a broad spectrum of cultural and intellectual life and suggest that materialistic sentiments were becoming increasingly common in antebellum America. The new awareness of, and concern with the body was the result of several interwoven developments surfacing between 1820-1860. The mechanization of the body encouraged physicians and laymen to believe that physical ills were understandable and remediable. Mechanical successes in manufacturing and transportation generated an atmosphere of optimism, and a faith in progress.

Optimism was fortified by evolving religious beliefs in the 1830s and 1840s which supported the idea of a benevolent God. Many northern evangelicals began to believe in both social and individual perfectionism. Individuals felt that they had access to spiritual, and bodily, salvation.56


56 The best discussion of these changes is in Martha H. Verbrugge, *Able Bodied Womanhood: Personal Health and Social Change in Nineteenth Century Boston* (N.Y.N.Y.: Oxford
Reformers argued that good general health was within reach of all Americans who took care of their bodies with proper diet, exercise, and temperance.

These trends made the earliest medical impact in areas such as preventative health, and surgery, especially orthopedics, where physical problems and solutions seemed simplest and most mechanical. Heightened public concern for physical well-being, combined with real progress in fracture treatments created unrealistic expectations and demands. Suits for fracture treatments were uncommon before the late 1830s for three reasons. First, the general unacceptability of malpractice accusations discouraged many prospective plaintiffs. Second, fracture treatment was not developed enough to engender high expectations in either physicians or patients. Finally, America's preoccupation with material well-being was not sufficiently developed to provoke public comment, inspire health and fitness movements, or generate anger over minor bodily deformities. Before then, suits for treatments which resulted in only minor deformities were unsupportable.

University Press, 1988), especially 3-10. Anita Clair Fellman and Michael Fellman, Making Sense of Self: Medical Advice Literature in Late Nineteenth Century America (Phil.: University of Pennsylvania Press, 1981), 5-6 and Green, Fit for America, 11-4 are also good.
The social and cultural factors that focused individual's attention on their bodies did not disappear. Instead, they matured. Secularization, affluence, and the nascent consumer culture continued to evolve and individuals became even more concerned about their health, comfort, and appearance.\textsuperscript{57} As other medical treatments became mechanical and routinized, expectations grew, patient tolerance for imperfection increased, and physicians were sued for a wider variety of medical treatments.

"Western New York [was] becoming dangerous ground for a surgeon" a writer in 1844 complained. According to the observer, qualified physicians were "constantly liable to vexatious suits, instituted by ignorant, unprincipled persons, sometimes urged on, it is presumed, by those who have a private grudge." This editorialist warned, "that unless a better state of things could be brought about, the medical practitioners in that part of the country would unitedly refuse to render any assistance in cases of fractures and dislocations."¹ One physician observed that between 1833 and 1856, "There was scarcely a surgeon in the State of New York, of any respectability, who had not been prosecuted one or more times; and probably not one who had not been often threatened.²

This apparent malpractice epidemic reflected the confused professional and political position of embattled


medical men in Jacksonian America, especially in New York. Irregular practitioners were numerous and popular in the state and they eroded the status and political power of regular physicians. Western New York was a stronghold of Jacksonian sentiment that was incompatible with the type of monopoly privilege represented by medical societies and licensure laws. Competition among regular practitioners and disputes over therapeutic procedures weakened professional solidarity and sabotaged public confidence. Physicians' social status and lack of professional cohesion encouraged disgruntled patients to sue their doctors. Malpractice litigation, once instituted, exposed and exacerbated the fundamental weaknesses of contemporary medical professionalism in the Jacksonian era. Individual physicians, professional journals, and local medical societies were faced with dilemmas they could not solve. No matter how they reacted to the crisis, they contributed to either public distrust, professional competition, or physicians' incompetence. In turn, this suspicion, divisiveness, and medical ineptitude and aggravated the ever increasing wave of malpractice prosecutions.

Doctors and Politics
New York physicians in the early 1840s suffered under even greater debilities than their colleagues in other states. In 1836, the Boston Medical and Surgical Journal reported that New York was filled with "troops of quacks [and] foreign pretenders of all grades, from pill makers to magicians." John Thomson, the son of the founder of the Thomsonian sect, organized the New York opposition to the licensure laws in the state. He forged a temporary alliance between the Thomsonians, Eclectics, Homeopaths, and other irregular practitioners against the regular physicians and helped make the licensure struggle more intense than in any other state. Job Haskell served as the medical sects' spokesman in the New York state assembly. In 1834, he presented the legislature with a petition with forty thousand signatures that called for an end to restrictive medical legislation. Haskell claimed that licensure laws encouraged "privileged physicians" to "depend on their diplomas and legislative enactments to advance them instead of worth and merit." The obvious popularity of irregular practitioners in New York was a reflection of the public's distrust of the regular practitioners.


The political atmosphere in New York also worked against the regular physicians. Thomsonians were natural allies with the Jacksonian Democratic Party and its Loco Foco spin offs. New York was a Democratic state and "served as an acknowledged Democratic tutor for the newer western states." The party's anti-National Bank, anti-monopoly philosophy fit well with Thomsonian goals. The Loco Focos, a radical strain of Jacksonian Democrats, were especially strong in New York. They opposed all privileged or aristocratic pretension and declared that "every profession, business, or trade not hurtful to the community, shall be equally open to the community." It was not surprising that Haskell, the Thomsonian's advocate in the legislature, became a Loco Foco supporter. These forces were successful and the New York legislature repealed the licensure statute in 1844.

Even in the face of these outside threats to the medical profession, the state's physicians failed to put aside their intra-professional battles. In the New York Journal of Medicine, F. Campbell Stewart wrote in 1846 that the New York


medical profession was marked by "a degree of jealousy and unkind feeling which ought nowhere to exist." Doctors fought each other over therapeutic doctrine, fee schedules and the profits and prestige of controlling medical education in the state. To reduce conflict, competition and jealousy among themselves some New York physicians tried to strengthen the influence of medical societies and associations. For example, the state medical society adopted a code of ethics which stressed the need to avoid disputes within the profession. However, these active professional organizations often provided an enlarged and more public forum for dispute. Daniel Calhoun has characterized the unsuccessful efforts to create a united front of physicians in Jacksonian New York as "the clash between community consciousness and individual ambition." Local and state medical societies served as new bases of professional discord and were often used as weapons in the battle of physician against physician.  


8 These observations on the New York medical profession before 1850 were drawn mostly from Daniel Calhoun's study of the physicians in that state. See Chapter 2 of Professional Lives in America: Structure and Aspiration 1750-1850 (Cambridge: Harvard University Press, 1965), especially 24-7, 34-7, 46-58.
New York physicians' tendency toward professional "suicide," as well as their declining social status and embattled political position encouraged dissatisfied patients to seek relief or revenge in court. Many observers believed that New York was the source of the malpractice "fever" in the 1840s that later spread into New Hampshire, Vermont, Pennsylvania, and Massachusetts. Relatively unsensational malpractice cases of little legal doctrinal importance often disrupted professional relations, distorted standards of care, and further damaged physicians' status in society.

**Smith v. Goodyear and Hyde**

One New York malpractice case in the early 1840s demonstrated how destructive litigation could be and how the crisis confused professionals. William Smith was fifty years old, had a "strong and robust constitution," but, by all accounts, was "addicted to intemperance." On July 4, 1839, while working on a house in Cortland, New York, Smith fell from a scaffold and injured his leg. Witnesses sent for Dr. Azariah Booth Shipman who lived several miles away.¹⁰

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⁹ See Chapter 2 above.

¹⁰ "A Report of the facts and circumstances relating to a case of Compound Fracture, and prosecution for malpractice," *AJMS* 3 n.s. (Jan. 1842): 181-4; some accounts reported that the scaffolding collapsed beneath Smith.
Shipman, who was thirty-six, had, since his late teens, "determinately g[iven] his odd leisure to studying medicine." He later spent two years working under his brother who was a physician. Though he never studied at a medical school, the county medical society granted Shipman a license in 1826. He earned a good reputation for surgery and was called for nearly all the important operations for miles around, including such difficult procedures as the removal of tumors, tracheotomies, and lithotomies. At the time of Smith's accident, Shipman was president of the Cortland County Medical Society.11

Shipman examined Smith two hours after the accident and discovered that Smith had broken both bones in his lower leg about two inches above his ankle. The jagged edge of the fibula had penetrated the skin, puncturing Smith's boot and pants' leg. Despite the severity of the compound fracture, there was little damage to the nerves, blood vessels, or leg muscles. Doctor Shipman cleaned the wound, removed a small piece of bone, and by "extension and counter-extension" was able to place the bones in their proper positions.

"Extension" was the procedure by which physicians would stretch a broken limb, either manually or mechanically, to

make the adjustment of broken bones easier. Smith also prescribed an anodyne of sulfate and morphine for pain. Shipman closed the gash with adhesive plaster, and put three padded splints on Smith's leg.\textsuperscript{12} The next day, July 5, Smith was sent to the county almshouse and put under the care of doctors Goodyear and Hyde.

Miles Goodyear had graduated with the first medical class at Yale in 1816. He moved to Cortlandville and became "a man of large influence in the city." Fredrick Hyde "read medicine" under several private physicians, attended three medical lecture courses in the early 1830s and was granted a county license in 1833. In 1836 he received a diploma from Fairfield medical college in New York. Two years later, he married Miles Goodyear's daughter and joined the older man's established practice. In addition to their private patients, Goodyear and Hyde were responsible for the sick and injured clients of the county poor house.\textsuperscript{13}


Goodyear and Hyde competed with Dr. Shipman for patients and prestige in Cortlandville. Though Goodyear and his partner advertised in the *Cortland Republican & Eagle*, they were careful not to impugn the ability of other local physicians [See Figure]. The partners claimed to specialize in "practical and operative surgery," but they cautiously noted that their "treatment of all surgical cases shall not be inferior to the ordinary practice of this country."\(^{14}\)

By modestly professing to provide only "ordinary" care instead of claiming superior ability, Goodyear and Hyde were attempting to avoid public quarrels with other practitioners. Though competition among regular physicians was a fact of life in the 1830s and 1840s, the profession collectively faced the greater threat of a hostile public, sectarian rivals, and decreasing legal legitimation. Therefore, many physicians strove to portray a united front to the public and downplay professional dissention. Inevitably, individual doctors would break ranks and destroy this artificial professional solidarity. Dr. Shipman was one of these physicians. Through most of the 1830s, his advertisement appeared immediately adjacent to the modest claims of Goodyear and Hyde. Shipman, however, confidently promised that he could provide "the best treatment which the art can

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\(^{14}\) *Cortland Republic & Eagle*, May 17, 1836, 5.
Dr. Goodyear & Hyde,
PHYSICIANS & SURGEONS

HAVING formed a
connection in Professional Business offer a continuance of their services

To the citizen of this vicinity, particularly in those cases which belong to the department of practical and operative Surgery. To those who may be acquainted with their competency and success in professional practice, they will say nothing, but to such as have not this knowledge, they pledge themselves that the treatment of all

SURGICAL CASES,

which may fall under their care, shall not be inferior to the ordinary practice of this country.

If all persons having unsettled accounts with Dr. Goodyear are requested to call and adjust them immediately.

Also, the accounts of Dr. J. Ballard, have been assigned to Miles Goodyear & E. W. Edgemont. Therefore immediate settlement is necessary, which may be had by calling upon either of the assignees.

Cortland Village, April 23, 1833.

DR. A. B. SHIPMAN,
PHYSICIAN & SURGEON,

OFFERS a continuance of his services, to the citizens of Cortland and vicinity, in the line of his profession, particularly in that of

SURGERY.

From his advantages in that particular branch, and his experience and success in the practice of Surgery, he feels a confidence in saying, that all Surgical Diseases and operations shall receive the best treatment which the art can afford at his hands.

Office, 2 doors north of Webb & Bishop's Store.

Cortland Village, June 9, 1833.
afford." His willingness to proclaim his technical superiority, and to compete openly for patients antagonized other physicians and set the stage for more bitter disputes.15

Nine days after the accident on July 13, the superintendent of the almshouse visited Dr. Shipman at his office and asked him to help Goodyear and Hyde amputate Smith's leg. When Shipman arrived, he discovered that the splints and dressings had been removed from the limb. Smith's leg was in a double-inclined plane and his foot was swollen and twisted to one side. A "double-inclined plane" was a device with a joint in the middle which supported the leg in a 45 degree, bent-at-the-knee, position. Worst of all, the broken end of Smith's fibula was again protruding nearly two inches out of the original wound. He was in considerable pain and part of the bone had begun to decay. Smith's general health, however, was fairly good. Part of the wound had healed, there was little pus, his pulse and appetite were normal, and he was free from fever.

Goodyear and Hyde argued that Smith's age and alcoholic habits convinced them that immediate amputation was necessary. In addition, they held that the hot weather might induce a dangerous fever. Shipman disagreed. He contended

15 Courtland Republic & Eagle, May 17, 1836, 5.
that the physicians should remove the dead portion of the bone, close the wound, and replace the splints. Goodyear cursed Shipman and warned, "... don't mention the villain's [Shipman's] name, I have been a father to him."

Nevertheless, Shipman held to his contention that Smith's leg should be saved and declared that "a man would be a ______ fool to propose amputation in this case." Shipman explained later that the abusive language from Goodyear had prompted his strong response. 16 Three local physicians in addition to Goodyear, Hyde, and Shipman joined the debate. Three of the six physicians opposed the amputation, one doctor believed that amputation might be "talked of," and Goodyear and Hyde supported the operation. Shipman refused to assist in the amputation and left the almshouse. 17

The leg remained untreated for ten days until, on July 23, the superintendent of the almshouse allowed Smith to choose his own doctor. Smith dismissed Goodyear and Hyde and sent for Shipman. When Shipman arrived, he found that

16 A. B. Shipman, A Report of the Facts and Circumstances relating to a case of Compound Fracture and prosecution for Malpractice, in which William Smith was Plaintiff, and Drs. Goodyear and Hyde Defendants, at Cortland Village, Cortland County, N. Y. March 1841: Comprising statements of the case by several medical gentlemen, together with Notes and Comments on the Testimony (Cortlandville: Printed at the office of the Courtland Democrat, 1841), 8, 13, 16.

Smith's condition had deteriorated. Following the course of treatment he had recommended ten days before, Shipman removed about an inch of the decaying end of the protruding bone with an amputating saw and set the leg in splints. He also cleaned the wound of pus and maggots and closed it with adhesive plasters. Throughout Smith's recovery Shipman or one of his colleagues visited the almshouse daily to clean and dress the wound and keep the bone in place. Smith's leg healed slowly but steadily and he was able to leave the poorhouse in the spring of 1840. His leg was an inch and a quarter shorter but it was strong and "he walk[ed] without difficulty and without much lameness." 18

During the summer of 1840, local residents collected money to help Smith hire an attorney. 19 In February 1841, Smith sued Goodyear and Hyde for malpractice. Smith asserted that they had been negligent in allowing the bone to become displaced and in failing to keep the wound clean and dressed. They were also negligent, Smith claimed, for refusing to perform the resection of the decayed bone ultimately carried out by Shipman. Shipman was Smith's strongest witness. He and three other physicians testified that Goodyear and Hyde did not regularly attend Smith and that the broken end of the


bone was left untreated until Shipman reset it nearly three weeks after the accident. They also claimed that amputation would not have been the proper treatment.\textsuperscript{20} Dr. Lewis Riggs, a member of the U. S. House of Representatives, had examined Smith in the alms house. Imputing sinister motives to Goodyear and Hyde, Riggs declared that a physician should never "deprive a poor patient of a leg or an arm, or subject him to any other severe and cruel operation, to gain a reputation as an operative surgeon, or to rid [him]self of the trouble, care or expense of a protracted cure."\textsuperscript{21}

Goodyear and Hyde presented a strong defense. Six local physicians, plus James Webster and Frank Hamilton, professors at the Geneva Medical College, testified on their behalf. Webster and Hamilton had long and respected careers. Hamilton's subsequent activities were especially significant. During the late 1840s, he accumulated and tabulated the results of fracture cases. The results of his study led physicians and patients to lower their expectations of complete cures.\textsuperscript{22} In the Smith case, Webster and Hamilton


\textsuperscript{21} Shipman, \textit{A Report of the facts}, \textsuperscript{7}.

\textsuperscript{22} Hamilton published his famous fracture tables between 1849-1855. Though his study appeared too late to influence this case, his work was often cited by defense attorneys in later malpractice cases. See Chapter 4 above.
testified that Shipman's resection of the end of the bone was improper and that an amputation would have been the correct treatment. After the witnesses for both sides testified, Smith's lawyer withdrew the charge and agreed to drop the suit.23

Professional Reaction

This aborted suit from a small town eventually gained national attention. Ironically, Dr. Shipman, the star witness for the prosecution, and not the defendants Goodyear and Hyde, suffered most from negative publicity. Local physicians, who were no doubt already antagonized by Shipman's aggressive advertising campaign, attacked him in the county newspaper both for his medical treatment and for his role in the trial. Anonymous letters published in the Cortland County Whig praised the character of Goodyear and Hyde, questioned Shipman's medical ability, and insinuated that he had encouraged the law suit. During the trial, under cross examination, Shipman admitted that he had remarked to

some of the town's residents that Goodyear and Hyde's treatment constituted malpractice.\textsuperscript{24}

On April 20 1841, about two months after the trial, the Whig published a letter signed by "Justice." The writer explained that Goodyear, a twenty year resident, had raised his family in Cortland and had distinguished his professional life by "faithful, disinterested and laborious service." These attributes gave "him a hold on the affections of the people," which grew stronger with the "lapse of time." The letter characterized Hyde as a young but thoroughly educated and talented physician with a bright future. The author recounted the events leading to the litigation and reported that the trial was a "triumphant vindication of the professional merit and private worth" of Goodyear and Hyde. The pseudonymous observer "Justice," was, however, "indignant at the foul spirit, that instigated the groundless prosecution," and warned that the "vain," "secret machinations" against the defendants would, "return 'to plague the inventor'."\textsuperscript{25}


\textsuperscript{25} The Cortland Democrat, May 4, 1841, 2; Reproductions of the Cortland County Whig for the 1840s are not existant, but the debate may be followed with some success in the Democrat which reprinted several of the letters that appeared initially in the Whig.
One week later a response, signed by "Truth" defended Shipman in the pages of a rival paper, the **Cortland County Democrat**. "Truth" contended that he did not have "any feelings of prejudice against either of the parties," but that the articles which had appeared in the Whig had been "calculated to lead the public mind to erroneous conclusions, and to reflect dishonor upon the professional judgement and practice of the leading surgeons of our country." The editorialist argued that common sense and "successful precedent" supported Shipman's treatment. If Shipman had not removed the diseased part of the bone, then the patient would have been "lying around for months with the bone projecting through the wound waiting for it to rot off before the limb could be straightened and properly adjusted." "Truth" questioned the value of the testimony of the famous medical professors Webster and Hamilton who had spoken in defense of Goodyear and Hyde. The writer for the **Democrat** argued that the newspaper attacks on Shipman had relied on the testimony of the "learned professors" "who were summoned from a distance," and ignored the evidence presented by the intelligent, local physicians who were acquainted with the case and "therefore the most competent to decide." In sparkling Jacksonian rhetoric, "Truth" exclaimed that he was confident that:
. . . our community profess[es] too much intelligence to be awed by titles and induced to hold the mere opinions of such men ["learned professors"] paramount to the actual knowledge of men of equal talents who have lived among and in the community and proved their judgement and skill by their practice.26

The Whig and the Democrat continued the debate through the following year. Shipman may have represented to the editors of the Democrat the prototypical democratic physician. He excelled by his superior abilities, did not rely on conspiratorial professionalism, refused to protect incompetent practitioners, and was willing to engage in "free trade in doctoring." The Democrat consistently supported Shipman, while the Whig reviled him. In April 1842, for example, the editors of the Whig and the Democrat received an anonymous article entitled "Medical Ethics." The editor of the Democrat refused to print the piece because it "was a wanton and malicious attempt to injure Dr. Shipman" written by a "vile" and "low blackguard." The Whig, however, printed the article even though the editor later admitted that it had been "written with an express design to cast ridicule and reproach upon him [Shipman] --to injure his reputation as a citizen, and to impair and ruin his business as a practitioner."27 According to one medical journal the

26 Cortland Democrat, May 4, 1841, 2.

27 Cortland Democrat, May 4, 1841, 2.
case had "been extensively misrepresented in the neighborhood, and rumors circulated in every direction touching the professional character of [Shipman], and the gentlemen associated with him in the treatment." 28

Shipman complained that "The 'miasma' of falsehood ha[d] been permitted to go out in every direction, and as yet no antidote ha[d] been offered." He charged that the accounts of the trial and treatment in local newspapers "abound[ed] in grandiloquent and bombastic bursts of rhapsody, evidently proceeding from the brain of some conceited attorney." 29 To vindicate himself, Shipman had the Cortland Democrat publish a thirty-five page pamphlet chronicling the case and his medical treatment, and sent copies to major medical journals around the country. 30 In his attempt to win a local battle against rival physicians, Shipman escalated the debate to a national level and risked undermining public confidence in the profession as a whole. But Shipman's action was consistent with his willingness to engage in open competition with his local rivals.

30 See note 17 above.
An editorialist for the *Boston Medical and Surgical Journal* was the first to respond to Shipman's pamphlet, in November 1841. The writer attempted to maintain professional solidarity at all costs and took the opportunity to rail against litigious patients. He noted judiciously that all the witnesses were "[s]urgeons of respectability and skill" and they testified ably to the expediency of both modes of treatment. Shipman's pamphlet, the writer believed, presented "sufficient authority . . . for his choice of treatment to prevent any stigma attaching to his reputation as a surgeon." The editorialist was careful to add that " . . . this we say without the least intending to reflect upon the views of the other medical gentlemen concerned [Goodyear and Hyde] ." He noted candidly that "[i]n all trials for mal-practice . . . our sympathies are in the first place enlisted on the side of the defendant." Continuing, he asserted that:

Prosecutions for malpractice are pretty much of a piece with those for a breach of promise of marriage, and are looked upon by the discriminating public in a similar light. They are in general a pretext, and that is all, for sponging, a little money out of someone who has got more than the plaintiff . . . the public good, humanity, benevolence, philanthropy or any other praiseworthy object, is in most cases entirely out of the question.
The writer hoped that Shipman's pamphlet would "have the effect of putting surgeons on their guard against unprincipled patients and their special friends." It was not clear whether "special friends" referred to lawyers, or if it was masked criticism of Shipman and the other physicians who testified against Goodyear and Hyde.

This writer's comments demonstrated the lengths to which some medical men would go to avoid criticizing other physicians. He implied that both modes of treatment were acceptable even though the respective results would have been radically different. He did not question Goodyear's and Hyde's methods though they left Smith's wound open, pus-filled, and maggot-infested with a protruding bone for nearly three weeks. Moreover, he ignored the growing body of medical opinion which increasingly questioned the wisdom of amputations.

But at the same time that the editorialist was doing his best to preserve the dignity and legitimacy of the profession by refusing to disparage other physicians, he was also damaging the profession's image by confirming the prevalent belief that physicians closed ranks to protect their own monopolistic interests. The writer's refusal to

32 See Chapter 4 above.
support one treatment over another was more suspicious in light of an article published in the same journal two months before. A man had suffered an injury identical to Smith's. The two bones in his lower leg were broken about two inches above the ankle and the fibula protruded from a wound in the leg. The physician sawed off about an inch of the bone and set the leg. The patient recovered, as had Smith, with some minor shortening of his leg.\textsuperscript{33}

Other observers were less blindly loyal to the profession. One, identified only as "R.C." criticized Goodyear and Hyde in an 1841 issue of the \textit{Medical Examiner}. He commented that though it was proper that amputation was considered, he was "acquainted with no experienced surgeon in this section of the country who would have ventured to perform it in the then existing state of the constitution." He believed that Shipman's treatment was correct and would have "expected with some confidence to see the necessity of wearing a high-heeled shoe, the worst ultimate consequence of the avoidance of amputation" in this type of case. Though the writer held that "... a difference of opinion on this subject would not be just ground for a charge of ignorance or even censure," he believed that there were "more formidable questions" about the case. He wondered why the bone was

\textsuperscript{33} "Cases of Compound Fracture of the Leg," \textit{BMSJ} 25 (Sept.8, 1841): 73-5.
allowed to become displaced after it had been adjusted following the accident and why the wound was not dressed and cleaned. He did not condemn Goodyear and Hyde but he asked probing questions and made it clear that he opposed amputation.\footnote{R. C.,"A Report of the Facts and Circumstance relating to a case of Compound Fracture and Prosecution for Malpractice," ME 4 (1841): 712-4.}

After reading the whitewashed account of the case that had appeared in the \textit{Boston Medical and Surgical Journal}, "R.C." of the \textit{Medical Examiner}, composed a follow-up response. He believed that his first report a week earlier had been written "in a spirit, perhaps, of too great mildness." While he could "sympathise" with the \textit{Boston Medical and Surgical Journal} author's "leaning toward the profession," he could not "forget that the first professional duty is toward the patient." He said that though "malignity and sordid calculation are no infrequent instigators of prosecutions for mal-practice, it is quite possible for medical men, in these days of easy graduation and multiplied professorships, to be guilty of culpable neglect or--in the existing condition of many medical schools--scarcely blamable ignorance." On reviewing the evidence the author concluded that ". . . had we been the prosecuting party,--not only should we have avoided
requesting the withdrawal of the case, but we would have not permitted it." Shipman's pamphlet, the writer concluded, "as painful as it must be to lovers of professional concord... will have the effect of 'placing surgeons on their guard', as to the necessity of keeping pace with the advance of science."35

This writer's response underlined physicians' and medical societies' dilemma in dealing with local quarrels and public malpractice controversies. By courageously supporting the best medical practices and condemning incompetent physicians, the author helped to publicize what constituted good practice, but he damaged professional solidarity and the profession's public image. Individual physicians, such as Shipman, retained their reputations but the profession was exposed as a factious, sometimes dishonest, group of practitioners possessing an uneven amount of skill and knowledge.

Early in 1842 George W. Norris lamented in the American Journal of Medical Science that:

[commenting] upon the doctrines and practice of members of our profession where malpractice has occurred, is one of the most unpleasant duties of the medical journalist, and would in the present instance be avoided, did we not hold it to be a duty both to our

readers and the cause of truth, to raise our voice in support of sound surgical principles.

Norris stated frankly that Goodyear and Hyde's treatment had been poor. Moreover, he defended Shipman's refusal to accede to an amputation. "Is it the custom of the gentlemen, who recommended and approved such a course [amputation], to doom to amputation every limb affected with fracture and issue of the bone, which is found to be irreducible, without first resorting to other means of relief?" Norris asked. He reminded his readers that amputation was a dangerous operation and that "sound surgical principles, humanity and daily experience teach" that it should never be resorted to until other means had failed. Norris included accounts of several cases similar to Smith's dating as early as 1815 where amputation was avoided and the patient survived with only a shortening of the leg.36

Despite these articles defending proper treatment in the face of blind professional loyalty, physicians in Cortland, New York, still supported Goodyear and Hyde. At their January 1842, meeting, the Cortland County Medical Society, of which Shipman was still president, discussed a new by-law. The rule would have required that before "any member shall

instigate a prosecution against another member of this Society," he must submit the question to the annual meeting of the society and obtain a two-thirds vote of confidence before proceeding. In addition, he must give the accused physician thirty days notice of the charge, or be expelled from the society. It was clear that "there would have been an almost unanimous vote in favor of the resolution." But no vote occurred. Shipman, president of the society, refused to put the question to a vote when it was moved and seconded, and refused to leave the chair when requested to do so.

Though the society tabled the by-law, its members removed Shipman from the presidency and replaced him with Goodyear. The society then passed a resolution stating, "That on review of the facts in relation to the prosecution by Wm. Smith against Drs. Goodyear and Hyde, for mal-practice, we have yet to see nothing [sic] to diminish our confidence in their skill as practical Surgeons." The society published a report of the proceedings in the *Cortland Democrat* and relayed this vote of confidence to the Philadelphia and Boston medical journals.37

After hearing of the activities of the Cortland Medical Society, a writer for the *Medical Examiner* noted that "although it seems a clique of his [Shipman's] professional

brethren in the neighborhood are weak enough to put him down for doing his duty," Dr. Shipman deserved "great praise" for his "manly and successful efforts to save the limb." The medical society's resolutions, the editorialist noted, "besides endorsing bad surgery, have another obvious ill tendency."

They create among the public an impression that physicians are disposed to screen each other from the just consequences of ignorance and incapacity, that they regard their duty to their patients as secondary, and that, as in the present instance, they deem the preservation of limb and life as of little weight in the balance with the observance of a false code of professional etiquette.38

The Aftermath

This editorial was a remarkably clear perspective on the case. In this malpractice episode three arms of the profession, a medical journal, an expert witness, and a local medical society, attempted to close ranks and support solidarity. In doing so, they refused to condone good practice and condemn obsolete procedures. The public, as the editorialist noted, could only believe that members of the

profession were "disposed to screen each other from the just consequences of ignorance and incapacity." The physicians who attacked Goodyear and Hyde and supported modern techniques, however, damaged the profession in other ways. When malpractice debates exposed professional discord and therapeutic uncertainty, physicians' status and legitimacy suffered. The public distrust born of these debates aggravated patients' suspicions and encouraged additional suits.

The Goodyear and Hyde case also demonstrated how malpractice litigation and the profession's reaction to it could discourage medical advancement. In the first two decades of the nineteenth century amputation was still considered the standard treatment for compound fractures. In cases of compound fractures of the tibia and fibula near the ankle joint, the injury suffered by Smith, the leading expert on orthopedic injuries, Astley Cooper, eschewed amputation and recommended the use of a saw to remove the broken and jagged pieces of bone. Goodyear and Hyde, who were sued for their treatment of Smith, advocated amputation and refused to remove the damaged end of the broken bone with a saw. When Shipman took over the case and followed Cooper's advice, Goodyear and Hyde's supporters attacked him at the

trial, and later in newspapers. Shipman cited Cooper in his defense. The members of the Cortland county medical society, two expert witnesses, local physicians, and a few medical commentators, spurned the authority of Cooper and the evidence of almost a decade, condemned Shipman, and defended Goodyear and Hyde.

By ignoring these advancements, Goodyear and Hyde's supporters retarded the acceptance of new and improved treatments and encouraged the discredited alternative of amputation. Indiscriminate amputation also conflicted with the general trend toward "conservative medicine." Physicians were curtailing heroic medical and surgical procedures and placing a greater trust in the healing powers of nature.\textsuperscript{40} For example, one of Shipman's supporters, a writer for a medical journal, claimed that "nature" had pointed out the correct treatment. The same observer could not find a single reason to support amputation and suggested, as had some of the witnesses, that "[i]n the absence of every other motive, one might almost suppose that amputation was desired to get rid of a troublesome case, and the more effectively to conceal a bad piece of surgery."\textsuperscript{41}

\textsuperscript{40} See above, Chapter 3 and 4.

\textsuperscript{41} "A report of the facts," \textit{WJMS}, 5 (1842): 145.
The editorialist's suggestion was not so far fetched. The vagaries of malpractice litigation could have effected treatment decisions by making it more attractive to condone amputation than to follow the safer and more effective procedure of saving limbs. Though unnecessary and incompetent amputations were seldom penalized, physicians who saved limbs with compound fractures were regularly sued. The single most common complaint in nineteenth century malpractice cases was the existence of a shortened limb after a compound fracture or dislocation. In the Goodyear and Hyde case, the patient's leg was one and a quarter inches shorter than its original length.

The professional and personal animosity aggravated by Goodyear and Hyde's prosecution persisted. In the spring of 1842 Henry Brockway fractured his leg and dislocated his ankle when he jumped from a buggy pulled by a runaway horse. Shipman treated the injury until August 1842. Brockway went to work as a millwright and told Shipman that he was pleased with the results of the treatment. Early in 1844 Brockway visited several local physicians who told him that his ankle was dislocated and advised him to sue Shipman for malpractice. The editors of the Boston Medical and Surgical Journal received an anonymous letter informing them of the
suit and "rejoicing" over Shipman's prosecution. The editors refused to print the report but warned that western New York was rife with accusations of malpractice. The writer noted that Shipman had been a witness for the prosecution in a malpractice case three years previously and acknowledged that the suit had probably been instigated by another physician with a private grudge. The following week, the journal reported that a Cortland county jury voted eleven to one to dismiss the charges against Shipman.

Surprisingly, these public battles did not drive Goodyear, Hyde, and Shipman out of Cortland or into professional obscurity. In 1845, Goodyear and Hyde opened a private school of anatomy and surgery. Later, in 1855, Hyde filled the chair of surgery at Geneva Medical College. He was elected president of the state medical society in 1865. When Geneva Medical College joined with Syracuse University in the 1870s, Hyde became the dean of the new faculty. Shipman served eventually as a professor of surgery at Indiana University.


Though the individual physicians survived the ordeal, the profession suffered significant public damage. In an 1846 article F. Campbell Stewart tried to warn his New York colleagues that self-aggrandizement often amounted to professional suicide. Stewart claimed that "many of our body fall into the gross error of considering that their individual success depends on decrying their professional rivals and indirectly leading patients to conclude that they alone, of all others are able and capable of rendering effectual assistance." He believed that this "course [was] calculated both to impair the credit of the general body and lessen the estimation in which it should be held by the public at large" and advised that "all of our faults and our errors should be kept within our own bounds." Malpractice litigation rendered this advice inappropriate and useless.

In malpractice cases, as in disputes over patients, education, and therapy, local medical societies and codes of ethics failed to contain individual ambition. Some doctors were willing to use malpractice accusations as competitive tools. This no-holds-barred, free-market competition was a contributing cause and an aggravating factor in the crisis.

45 Stewart, "Actual Condition of the Medical Profession," 70-1.
Once a physician was accused of malpractice, the charge
damaged the profession and disrupted professional relations
in a variety of ways.

The spectacle of one physician testifying against
another shattered the thin veneer of professional solidarity
that Stewart and other writers recommended. However, when
physicians defended obviously ignorant, incompetent, or
careless colleagues, suspicious lay observers could accuse
them of protecting quacks. Smith v. Goodyear and Hyde also
demonstrated how malpractice litigation could be, in
addition, antagonistic to medical advancement. The medical
profession's fear of the malpractice epidemic and the
desperate efforts to establish a united front sometimes
encouraged physicians to accept substandard performances from
their colleagues and implicitly support outdated and
dangerous treatments. And, especially in the case of
amputations and fractures, the best treatment for the patient
was not necessarily the safest treatment for the physician.

Local medical societies and medical journals which were
founded in part to unify the profession, served instead as
public forums for personal disputes. These professional
institutions failed to devise a completely unobjectionable
response to the flood of malpractice suits. They either
damaged the profession by exposing an incompetent surgeon,
or, they helped perpetuate poor or outdated treatment and
confirmed the claims of their many critics by sheltering substandard practitioners. Finally, malpractice suits in the 1830s–1840s were a self-perpetuating phenomenon. Some cases, like Goodyear and Hyde's, generated retaliatory suits against physicians who testified for the prosecution. Almost all malpractice cases in the period, however, contributed to the public distrust and resentment, and the professional competitiveness and divisiveness that helped engender the suits initially.
Community, Providence, and the Social Construction of Legal Action
Chapter 6

Malpractice litigation flourished for the first time in the Jacksonian period because the social and medical environments were conducive to the frequent prosecution of physicians. Intra-professional rivalry, the decline of the professional and social status of the physician, were contributing causes in the first malpractice "crisis." In addition dramatic technological advancements blurred previous conceptions of standards of care and created unrealistic expectations in both patients and physicians. These immediate causes increased the impact of Americans' long term and growing concern for physical well-being. But these factors alone do not account for the sudden and unprecedented appearance of large numbers of malpractice suits.

In 1824 a defense attorney castigated the plaintiff in front of the jury. The lawyer declared that "it is not a very commendable sight anymore than a very customary sight to see a patient prosecuting his physician." He argued that "public judgment" was the "proper tribunal to regulate this species of responsibility."1 The lawyer's comments

1 James Adams Jr., Report of an Action, Charles Lowell against John Faxon and Micajah Hawks, Doctors of Medicine, Defendants (Portland: Printed for James Adams Jr. by David and Seth Paine, 1825), 52. also see Chapter 1, above.
illustrated that potential litigants are often constrained by more than just legal rules. Cultural and community attitudes shape the way they feel and act. These attitudes are a reflection of habits and customs and define what are socially acceptable ways to respond to grievances and disputes. As a modern legal anthropologist observed, "Before a person can sue, he must have not only a legally justiciable issue and a legal forum, but also a personal conceptualization of conflict that is adversarial in structure and remedial in orientation." Individual action is shaped by community beliefs and informal moral codes as to what type of wrongs warrant legal action. Changing cultural beliefs make recourse to courts either more or less acceptable.

If the medical and social developments discussed in Chapter 3 provoked malpractice suits in the 1840s and 1850s, the initial burst would have not have been possible without complex psychological and cultural developments. The two essential preconditions for the rise of malpractice suits, were the dissolution of community stigmatization of litigation; and the transformation of the concept of providence leading to a general decline in the perception and acceptance of misfortune as divine will. Without these two

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underlying, long term developments, the widespread prosecution of physicians would have been inconceivable.

I.

Community

The nature and notion of community determines the amount of influence that custom will have on individual behavior. Through much of America's early history community custom relegated many types of disputes to extra-legal forums. By the mid-nineteenth century, beliefs, and communities' coercive power had weakened. As a result, plaintiffs were able to bring previously unlitigated forms of conflict before courts. This change in legal culture did not cause malpractice suits. However, without this development, and its subsequent expansion, widespread prosecution of physicians could not have occurred.

Although there is not effective or accurate way to measure the existence of community, seventeenth-century New England towns provide a convenient model. The early settlements were Christian, closed, corporate communities. In the quest to create a "city upon a hill," colonists created integrated, organic, social systems. The demands of economic survival and old world farming patterns encouraged cooperation. The citizens of the town were tightly bound by economic interest, but also by family ties, and religious beliefs. Indeed part of the function of the social unit was to glorify God on earth. Therefore individualism was both socially and religiously condemned.

Social relations in these settlements were dominated by face to face, personal relationships with a finite number of neighbors. Dissension was rare because the interests of the colonists were relatively homogeneous. In an effort to maintain social and spiritual peace, community members discouraged conflict in general, and litigation

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4 The notion of "community" is one of the most contentious and treacherous debates in contemporary historiography. For the best overview of the complex issues see, Thomas Bender, *Community and Social Change in America* (New Brunswick, New Jersey: Rutgers University Press, 1979).

specifically. Scholars have suggested that the "relational distance" between members of a community influence their willingness to rely on legal remedies. When the "distance," is great, law will be relied on more frequently. When people live in tightly knit, closed, kinship-based, corporate communities, the social costs of disrupting the order will be greater and litigation is relied on less frequently.

Colonists were remarkably successful in discouraging disruptive litigation in the first half of the seventeenth century. Disputes were settled more often through arbitration, mediation, and mutual agreements. Often the entire church congregation judged conflicting claims of disputants. The inhabitants of Dedham, a Massachusetts community founded in 1636, were largely able to avoid the use of courts in disputes through the 1680s. By that point, land hunger, population increases, generational conflict, and economic diversification had begun to undermined the homogeneous nature of colonial existence. Consensus weakened, disputes multiplied, and colonists more frequently resorted to courts. Community opinion and collective self-

6 Lockridge, New England Town, passim.

7 Greenhouse, "Nature is to Culture," 18.
interest were no longer strong enough to suppress completely public quarrels. 8

Despite the incipient break-up of communal structures, many patterns remained. Historians have argued that colonists were able to retain a relative degree of uniformity of thought through much of the eighteenth-century. Although litigation was increasingly common, many communities were able to control access to their towns through "warning out" unwanted outsiders. Religious attitudes were changing, but they still stressed "self restraint and selflessness in dealings with others," and encouraged conformity to prevailing social standards. Everyday relations were still dominated by face to face communications. 9 Uniformity and consensus were undermined further by the religious tumult and factionalism of the Great Awakening, increased economic growth and political activity, and ever growing geographic


mobility. Community life in the eighteenth century certainly was not static, but in many cases it remained stable, relatively insular, and maintained many of the prohibitions against the use of courts.

A study of fourteen Massachusetts towns suggests that shared ethical values and a respect for consensus retarded widespread litigation into the early nineteenth century. The people in towns still "shared assumptions about how 'good people' lived . . . These assumptions were prescribed at the level of moral ideal by church doctrine and confirmed at the level of practice by geographic, demographic, and technological realities that precluded most people from adopting styles radically different from the one they knew." In these towns, it was not until 1790-1825 that the seventeenth century methods of accommodation and consensus dispute settlements broke down significantly and yielded increased litigation.11


Although the first signs of the break-up of communal consensus were visible as early as the mid-seventeenth century, the late eighteenth and early nineteenth centuries provided the most profound shocks to old ways of thinking. The change took place at different rates in different communities and regions, but there is a clear overall evolution from the insular communalism of colonial America to Jacksonian individualism and pluralism.

Many historians have observed that the crucial break with colonial communal habits was especially evident in the first third of the nineteenth century. In the early nineteenth century, "the fading of this homogeneity in fact had not yet disturbed the dominance of older patterns of social leadership and socialization—the accepted articulation, rather than the importation, of community of community standards, values, and practices by the social establishment."12 However, the massive geographic dislocation from westward expansion, the growth of a national economy, and advances in transportation severely undercut the insularity of community life. The democratizing effects of

the American Revolution, and the impact of economic
competition helped nurture the growth of individualism.  

It was not so much a matter of the destruction of
community and the creation of individualism that marked the
first third of the century, as a change in their nature.
Recent studies have suggested that the nature of community
and individualism can influence the type and rate of
litigation. In communities more completely dominated by
face-to-face relationships and economically self-sufficient
farmers and merchants, "it was considered inappropriate for
injured persons to transform their misfortune into a demand
for compensation or to view it as an occasion for
interpersonal conflict."  

Contract or defamation of
case, for example, would have been more
acceptable than personal injury suits. Slander suits
reflected the importance of reputation in face-to-face
communities. In this form of cooperative, communal,

13 Rowland Berthoff, *An Unsettled People: Social Order and
Disorder in American History* (N.Y.N.Y.: Harper & Row
Publishers, 1971), 177-234, and David Rothman, *The Discovery
of the Asylum: Social Order and Disorder in the New Republic*

14 Engel, "Oven Bird's Song," 559. I have relied heavily on
Engel for this argument.

15 These suits were common in early communities. See John
Demos, *A Little Commonwealth: Family Life in Plymouth Colony*
individualism, it would have been inappropriate to sue for personal injury suits for three reasons. First, such suits disturbed the peace of the community. Second, they contradicted the notions of self-sufficiency by demanding compensation. Third, they violated other religious-based community strictures against suing for misfortune. Prohibitions against conflicts and certain types of suits were reinforced by the influence and coercive power of living in a close knit community.

By the Jacksonian period much of America had moved toward a different world and a different individualism. On one hand, individuals were less self-sufficient than their predecessors. Farmers and merchants were connected to larger markets, and the economy was becoming more integrated. On the other, migration and social mobility had made individuals less integrated into the traditional organic and hierarchical society, and less bound by ever weakening public mandates. In this form of society, "A rights-oriented individualism is consistent with an aggressive demand for compensation (or other remedies) when important interests are perceived to have been violated." "Rights-oriented individualism" is illustrated in Jacksonian Democratic demands for more access

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16 See below, this chapter.

17 Engel, "Oven Bird's Song," 558.
to the benefits of law. Individuals felt freer to sue for personal misfortune because recourse to law did not contradict their feelings of self-sufficiency. Self-sufficiency was slowly fading into the realities of market economy. Community proscriptions against suing remained, but in attenuated form. More importantly, the power of community opinion lost influence as towns became increasingly heterogeneous and anonymous. This gradual transformation became especially evident in the first third of the century and was a prerequisite for the proliferation of personal injury suits. The shift from cooperative, self-sufficient, individualism to competitive, rights-oriented, individualism continued and allowed a wider scope of litigation as the decades passed.

II.

Rod in the Hand of God?

Relationships between religious change and increased litigation were subtle, not overt. The gradual secularization of American society, combined with a growing confidence in material progress and a glorification of individual will led to a search for the temporal, human agents of misfortune. When God no longer ordained specific social or physical ills, it became acceptable to search for human culprits, assign
responsibility, and demand reform or restitution through the courts.

In the seventeenth and eighteenth centuries doctrines of direct, divine providence were common among America Protestants. The most powerful churches and the majority of the public subscribed to the 1647 Wesminster Confession, which proclaimed that "God the great creator of all things, doth uphold, direct, and dispose, and govern all creatures, actions and things from the greatest even to the least by his most wise and holy Providence."\(^{18}\)

Providence theory reflected the prevalent belief that God both created the world and sustained it from moment to moment. Nothing in heaven or earth occurred by chance.\(^{19}\) Puritan objections to card games, dice, and lotteries were based on the premise that they trivially abused divine providence.\(^{20}\) God might manipulate events to punish sinners

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and reward saints, or he might rain misfortune on the holy to test or teach them. God's will brought lightning, bad crops, earthquakes, epidemics, a sick horse, or the death of a child. John Winthrop, who helped found and govern early seventeenth century Massachusetts, filled his journals with examples of colonists punished or rewarded by "a special providence of God." Individuals suffered, or were spared, the effects of fire, drowning, smallpox, Indian attacks, birth defects, and accidental injury because of the "righteous hand of God." The proper response to God's will was submissive acceptance. Human resignation to providential misfortune was defended on several grounds. Man could not possibly hope to understand God's plan, and faith demanded that men believe that the Lord worked ultimately toward only good ends. More importantly though, suffering and misfortune on earth were often rewarded in heaven.


After the American Revolution many Northerners began perceptibly to shift their view of the impact of providence on human affairs and moved gradually away from their fatalistic forefathers.24 Colonial engineered lotteries in the eighteenth century were a "symptom" of the gradual waning of conventional piety.25 By the beginning of the nineteenth century the belief in direct providential intervention was attacked overtly by Unitarians, deists, and liberal clergymen from various Protestant denominations.26 Still, fatalistic sentiments and the submissive acceptance of misfortune as God's will remained common through the first three decades of the nineteenth century. In 1823 a writer for the orthodox Presbyterian and Congregational magazine, Christian Spectator, claimed that providence "extends to all beings that have existed, or ever will exist; --to all events that have occurred or ever will occur."

The impious scoffer will tell us that all is the result of accident; and he will misname the signal interpositions of heaven by the epithets of 'good fortune' and 'good luck' but the humble Christian

24 See for example Bertram Wyatt-Brown, Southern Honor: Ethics and Behavior in the Old South (Oxford; N.Y.: Oxford University Press, 1982), 30.


will discern in them all the hand of a wise and holy God. 27

Another writer in the same magazine declared the "without [God's] permission, no power can harm, no ill can befall us; and every afflicting stroke is meant for our good . . . ." 28

Extended to medicine all this meant that a "humble Christian" patient who discerned the wise hand of God in his broken leg would be unlikely to sue his physician if the leg healed with a deformity; to do so would be to question God's wisdom. The doctrine of providence turned "tears into gratitude." 29  Similarly, "humble Christian" juries would not be willing to hold physicians responsible for bad results which were most likely ordained by God, either as punishment, or as a test. Through the first three and a half decades of the nineteenth century when a belief in specific providence was still strong, medical journals and state supreme courts reported only a handful of malpractice cases and writers commented on the rarity of the litigation.

The apparent contradiction between man's free agency and God's providential control fueled theological debates in the


29 "The doctrine of providence," 175 ; Cashdollar, Social Implications, 277-8.
1820s and 1830s. The groups who attacked the notion of direct providence claimed that it undermined the responsibility of the individual. Other writers argued that providential ideas left the status quo untouched. 30 During the first half of the nineteenth century those theologians who saw God's direct intervention in every event lost ground to more liberal thinkers and, "the concept of divine providence was increasingly conceived in indefinite rather than specific terms." 31 A growing segment of the population believed that God operated only through universal, natural laws and influenced world events on the grand, historical level. 32 The trend away from a belief in direct or special providence varied from person to person, denomination to denomination, and region to region, but progressively fewer Americans accepted social and physical ills as purely God's will.

Malpractice and God's Will

30 Cashdollar, Social Implications, 268, 275.

31 Cashdollar, Social Implications, 279.

Malpractice suits were rare in this transition period of the 1820s and 1830s before a large proportion of the population began to hold human agents responsible for human misfortune. When patients did sue their physicians, the cases generally involved only severe injuries or death.

One of the infrequent cases before 1835 illustrated the relationship of providential belief to medical malpractice. In 1824 the city dispensary of New York hired Dr. Gerald Bancker to vaccinate for smallpox all the citizens within an assigned urban district. For a $100 fee, Bancker vaccinated 870 patients without incident. In April 1824 the physician vaccinated the four year old son of Michael O'Neil. Eight days after the visit the boy became dreadfully ill. When the symptoms worsened, O'Neil called in another physician who diagnosed the case as small pox. The child's health deteriorated. He went blind, a brown crust covered him, and he began to lose his hair and skin. The boy's lower jaw disintegrated and fell out of his mouth, and he developed an ulcerous hole through his neck and into his throat. Finally, after four months of profound suffering, the child died. O'Neil sued Dr. Bancker for malpractice and demanded $5000 in damages.33

O'Neil's lawyer and several medical witnesses claimed that Dr. Bancker had infected the child with smallpox by inoculating instead of vaccinating him. In a vaccination a physician took material from a cow-pox sore and inserted it into a patient's arm. This process effectively immunized the second patient against smallpox. For an inoculation, an already obsolete practice, material was extracted from a smallpox sore and inserted into the subject's arm. Inoculation was often effective, but patients contracted a form of the disease from the procedure. O'Neil's lawyers argued that Bancker had carelessly and negligently drawn material from a smallpox, instead of a cow-pox, sore and had infected the boy with the dread disease.34

Dr. Bancker's lawyer argued that the O'Neil boy's disease was nothing short of miraculous. The physician had vaccinated scores of patients and none had contracted this seemingly virulent form of the disease. Medical witnesses for Bancker testified that while some of the symptoms resembled smallpox, they knew of no instance from experience or literature in which such ravages followed an inoculation. The disease, though occasionally fatal, did not exhibit features such as the loss of the jaw or the frightful ulcer on the patient's neck. Therefore, the defense attorney

claimed, providence, not the vaccination was responsible for this tragedy. "In a word," Bancker's attorney explained, "we expect to prove the child died of small pox, proceeding from the visitation of God, and not from any negligence or any want of skill on the part of the defendant." The jury retired after the testimony and found the physician innocent.35

The defense attorney's use of a divine explanation of disease to defend his client suggested that much of society accepted the notion of a specific or direct providence. The apparent success of the lawyer's strategy helps confirm this view. O'Neil, the plaintiff, may have had to overcome personal and communal reservations concerning God's will and misfortune before he sued Bancker. Perhaps the horrific nature of the affliction wiped away O'Neil's misgivings, or, maybe he was a representation of the slow drift toward holding humans responsible for human misfortune. Indeed, the majority of the scattered suits before 1835 involved severe injuries or death. Other victims of medical accident or incompetence may have been less willing to question God's visitations and considered malpractice litigation an improper, or irreligious, remedy.

Charles Lowell, who sued his physician in 1823, suffered a severe, permanent hip deformity after an accident, received an initial award of $1962. A jury at a subsequent trial dismissed his case. Lowell published a pamphlet describing the trial. Though Lowell's belief in providence was not strong enough to preclude him from blaming the physician for his injury, he felt uncomfortable enough to justify his action to his community. Lowell explained that, "I am aware of the necessity of kissing the rod and him who hath appointed it; and were it purely an act of God, I could submit to it without a murmur." But since he had suffered this "calamity" only through the "ignorance and unprecedented fraud of the physicians" he could force himself to sue. After losing his case in civil court, Lowell comforted himself that the physicians would "be brought to a higher tribunal than that of their country" in the after life. Lowell's comments suggested that though he had abandoned a strict definition of direct providence, he, like much of society, still felt its influence enough to defend his legal action against religious questions. Over the next


37 Lowell, An Authentic Report, 8. See Chapter 1 for an extended narrative on this case.
two decades many more Americans were able to shake off their nagging doubts and hold other men responsible for their misfortune. 38

Few contemporary observers were able to grasp the underlying changes that were making suits a more acceptable practice. The 1850 Pennsylvania Medical Society committee on malpractice noted that medical science had advanced rapidly in the previous fifty years. However, its report argued that the public, and physicians, must acknowledge that there was a "mysterious agency of vital laws which are hidden by providence from the scrutiny of man." Despite the medical profession's progress in discovering physical laws, "occasionally all the arrangements and protections of science and philosophy vanish before the Diety. . . . It is an ignorance of, or want of reflection upon these principles which forms the foundation for the prevalence of quackery, and of the unjust persecutions which pursue the regular

38 Judges rarely openly revealed their beliefs about divine providence and malpractice. However in explaining why physicians did not implicitly guarantee the results of their work one judge noted that "The event is in the hands of Him who giveth life and not within the physical control of the most skilful [sic] of the profession." See Grindle, et al. v Leo Rush et al., 7 Ohio 123-5 (1836). Even these types of statements were absent from judges' decisions after the 1830s.
practitioner, and display themselves in groundless suits."

The committee's insightful comment on the impact of attitudes toward providence on malpractice rates was unique in nineteenth century medical literature. Most writers concentrated their attention on more immediate, concrete, and presumably more remediable, causes.

The precise moment of the decisive shift in balance against the notion of direct providence, which opened the door to widespread prosecution of physicians, is impossible to pinpoint. However, several factors suggest that a critical transformation occurred in the decade and a half between 1835 and 1850—the same period that bore America's first malpractice "crisis."

This shift resulted from a variety of changes during the Enlightenment and the scientific revolution of the eighteenth and nineteenth centuries.40 American intellectuals and


theologians, especially Unitarians, were influenced by European philosophers of the 1830s and 1840s including John Stuart Mill and Auguste Comte. These writers' conception of God "forced man away from the pietistic or providential to a naturalistic view of social problems, from prayer to human action."\(^{41}\) The providential view of earthly events was inherently conservative; the naturalistic view was unreservedly reformist. The new perspective made it more difficult to claim that poverty, for instance, was a punishment for a sinful life.\(^{42}\) What were before divinely ordained burdens or punishments for sin, became remediable ills.

During this period, roughly 1835-1850, a vast number of broadly humanitarian movements flourished for the first time in history. Anti-slavery, anti-cruelty to animals, child protection, and prison reform, were among the social improvement programs that arose in this period.\(^{43}\)


\(^{42}\) Cashdollar, Social Implications, 283; and Robert Bremner, From the Depths: The Discovery of Poverty in the United States (New York, 1964), 16-45.

Beginning in the late 1830s, contemporary with the outpouring of social reform and the theological debates over the nature of providence, physicians reported a massive, unprecedented, attack of malpractice prosecutions. Scientific and naturalistic explanations of specific phenomena accelerated the decline in the perception and acceptance of different varieties of misfortune as divine will. Medical researchers in the late eighteenth and early nineteenth centuries explored the mechanical aspects of the body and explained more and more functions in biological or physiological terms. In addition, statistical analyses of diseases, treatments, and cures, as well as in other areas of society, began to engender the hope of scientifically predictable medicine. Perceptions of scientists and medical men diverged from the views of theologians and the general public, but the new mind-set slowly permeated much of society.


46 Numbers and Sawyer, "Medicine and Christianity," passim.
Religious Reform

In the 1830s and 1840s, liberal theology, embodied in ministers such as Horace Bushnell, William Channing, and Charles Grandison Finney began to gain the upper hand in the battle against orthodox, Calvinist, views of providence.47 Finney's career was particularly relevant. A minister from New York, he believed that God was the creator of the world and governor of natural law but contended that the Almighty did not interfere with the day to day life of human beings. Finney's 1835 Lectures on Revivals of Religion, according to one writer, "clearly marks the end of two centuries of Calvinism and the acceptance of pietistic evangelicalism as the predominant faith of the nation."48 Finney explicitly denounced the precepts of the Westminster Confession which supported the notion of specific providence and man's humble acceptance of misfortune.


The appearance of *Lectures on Revivals* in 1835, almost the exact point at which malpractice suits suddenly increased, should not suggest a direct, causal, connection between the work and the frequency of lawsuits. However, Finney's book and career did represent the widespread public acceptance of the religious and social beliefs that were the necessary precondition for intensified litigation. Finney glorified the individual will and reflected an optimistic belief in human progress.⁴⁹ These ideas made it much easier and acceptable to assign human responsibility to earthly ills. They were also compatible and intertwined with the individualistic tenor of Jacksonian democracy. Finney's theology appealed to the so-called working classes, whom physicians were beginning to blame for many of their malpractice ills, by stressing the individual's ability to make his personal peace with God, and hew out his own place in the world.⁵⁰ These sentiments marked a further break-up of the hierarchical and communitarian mindset that had played a role in discouraging early lawsuits.

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⁴⁹ McLoughlin, "Introduction," passim; also, for an interesting commentary on these issues see Major L. Wilson, "Paradox Lost: Order in Evangelical Thought in Mid-Nineteenth-Century America," CH 44 (Sept. 1975): 352-66.

Finney's brand of Protestantism swept through western New York in a series of revivals in the late 1820s and early 1830s. These revivals were so frequent and did so much damage to old ways of thinking that the region became known as the "burned over district." By the early 1840s observers had begun to identify this "burned over district" of western New York as the source of the malpractice "fever" that was sweeping the northeast. Finney's revivalism alone did not make western New York the seedbed of medical malpractice. The political and social elements of Jacksonian democracy were particularly strong in the state, medical sectarians were popular and prevalent, and regular physicians competed and fought continually among themselves. These factors, combined with the transformation of religious attitudes, helped the state to take the early lead in the field of malpractice suits.

Epidemics

American attitudes towards epidemics serve as an additional gauge of the nature and timing of religious changes in the first half of the nineteenth century. For example, in the 1790s Philadelphia suffered a series of

devastating yellow fever epidemics.52 One inhabitant during the 1793 affliction revealed that, "... [m]ost, if not all [of the population] were convinced it was a judgment sent by the immediate hand of God ... ."53 In the 1790s the forces that would eventually shift the majority view were already at work, but deism, science, and the rationalism of the Enlightenment had not yet influenced a broad segment of the population. By the time a yellow fever epidemic hit New York in 1822 public opinion had changed significantly.54 While most of the population of the city probably still viewed the epidemic as moral retribution, the scientific camp had gained many converts. Orthodox ministers still preached jeremiads and called for days of fasting, but other civil leaders demanded clean streets, pure water, strict shipping regulations, and proper disposal of bodies. The yellow fever crisis of 1822 engendered an open debate over "Divine Providence or Miasma?," which, according to one scholar

52 John Duffy, Epidemics in Colonial America (Baton Rouge: Louisiana State University, 1953); J. H. Powell, Bring Out Your Dead (Phil.: University of Pennsylvania Press, 1949).


served "as an intellectual cameo, the miniaturized playing out of a national drama of the mind."55

The reaction to the 1822 New York yellow fever epidemic represents one transition point in the evolution of public attitudes toward divine providence. The majority of Americans had not yet abandoned the notion of direct intervention, but an increasing minority was willing to entertain alternate explanations for malevolent events.

Cholera, which swept through most large cities between 1832 and 1834 was also, according to most ministers and laymen, "a rod in the hand of God."56 Despite the arguments of physicians and various liberal clergymen, who rarely explained epidemics in supernatural terms, the majority of society believed that the disease, like yellow fever, was a punishment for social or individual sins.57

By the time cholera struck the country again in 1849, the notion of specific providence had faded considerably. Orthodox clergymen, trying to hold a conservative line, warned that Americans had "lost sight of nature's divine Author and Governor [sic]."58 Although materialism and

56 Rosenberg, Cholera Years, 43.
57 Rosenberg, Cholera Years, 40-54; also see Numbers and Sawyer, "Medicine and Christianity," 137-40.
58 Rosenberg, Cholera Years, 128,130.
enlightenment rationalism were already eroding piety in 1832 America, they had not seeped into the consciousness of a sufficient proportion of society to affect the predominant view of misfortune. Also, during the 1832 epidemics, the debates among theologians over specific providence were still undecided. By the 1840s, however, a larger percentage of clergymen had abandoned the idea of direct intervention and much of America had accepted a materialistic philosophy which embraced the goals of scientific, economic, and social progress. An 1857 article in Harper's on the "causes and prevention of epidemics" did not mention God, providence, or religion and outlined the secular, scientific, contagion versus infection argument.59

By the time of new epidemics in 1866, the transformation of the public's view of cholera was visible. During the late 1850s, John Snow's demonstration that cholera was transmitted through contaminated water, had encouraged Americans to accept, and work to remedy the scientific and physical causes of the disease.60 Physicians and government officials used statistical surveys to determine that clean streets, ventilated housing, and pure water were more effective health


60 Rosenberg, Cholera Years, 193-6.
measures than prayers and fast days.61 Secular interpretations of specific misfortunes originated with scientists and physicians and influenced other segments of society only when the interaction of religious views, medical interpretations, and effective cures made other explanations untenable.62 This process began in the early eighteenth century and affected different physical events and ailments at different rates, but the scientific and religious developments in the first half of the nineteenth century contributed to a profound shift in public attitudes on a wide variety of subjects.

Pain and Providence

The timing of this transformation, and its relevance to malpractice suits, is also supported by the concurrent shift in public attitudes toward pain and suffering. The secularization of pain was brought about by the same combination of religious, philosophical, and biomedical factors that changed the public perception of various diseases. Through the eighteenth century, pain like other forms of physical misfortune was accepted as divine will and,


as such, was explicable and bearable. There are numerous biblical justifications for the notion that pain was a punishment for original or earthly sins. Paracelsus experimented with ether on animals in the early sixteenth century, but fearing clerical reaction, did not use it on humans. By 1818, scientists had discussed the clinical benefits of hypnotism, nitrous oxide, and ether and yet none of these procedures gained popular acceptance until after 1830. Ether was not "discovered" until 1846. Many writers have claimed that available analgesics were not employed because most individuals accepted pain as a divinely ordained fact of life. They have argued moreover that

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between 1780 and 1845 pain sensitivity had increased.66

According to Nathan Rice, a prominent nineteenth century physician, "[t]he curious ground of opposition to the use of ether[,] that of religious scruples--[was] based on the argument that, as man was condemned by Providence to suffer pain, it was wrong in him to endeavor to palliate the decree." Some patients consulted clergymen before accepting analgesics. Rice offered an anecdote that underlined the transitional, interrelated nature of attitudes toward providence and pain in this period.67 In 1850 Rice was present when a messenger called on a fellow physician and explained that a local farmer had cut an artery in his hand. The physician sent the man back to tell the farmer that a minor operation would be necessary and that he would bring some ether to ease the surgery. While waiting on the physician to arrive the farmer and his wife prayed and decided not to use the ether because they both considered it wrong. The farmer declared that he "would not endeavor to


escape any of that punishment which had been ordained by sin." 68

When the physician arrived the farmer lay down on the kitchen table and his wife left the room. As soon as the physician began the operation however, the man cried out in pain.

Doctor do you think that it would be really wrong to take it; of course you don't. You are a good man and you wouldn't do anything wrong I know; besides if you recommend it to me, the blame ought to fall on you. . . Well wicked or not I guess I'll have the ether.

The farmer's wife came into the room soon after the surgery and began to chastise her husband for his weak faith while the farmer, drunk with ether, staggered around the room and vainly tried to defend himself from the woman's verbal onslaught. 69 His stream of consciousness justification for using ether symbolized the more general shift in society's attitude toward pain and providence. Although this couple ostensibly retained traditional beliefs about the role of providence later than much of the population, their experience illustrated the type and the nature of the transformation in the middle decades of the century. 70

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68 Rice, *Trials*, 125.

69 Rice, *Trials*, 126.

70 Martin Pernick provides an important discussion of the interrelationship of pain, anesthesia, and religious beliefs in *A Calculus of Suffering: Pain, Professionalism and*
As with attitudes toward disease, the changing perception of pain was a product of a popularized concept of Enlightenment rationalism and scientific optimism which secularized most of Western society in the early nineteenth century. Social philosophers such as Jeremy Bentham and John Stuart Mill, in contrast to previous thinkers, portrayed pain as an "inherent evil." This pain was devoid of the concepts of punishment, redemption, and resignation.\textsuperscript{71} In addition, significant advances in anatomy and physiology between 1800 and 1850 illuminated the physical mechanisms of pain to such a degree that physicians and laymen began to view the phenomenon as an essentially biological function which could and should be controlled by any available scientific means.\textsuperscript{72}

Society's new sensibility to pain was reflected in many of the movements which had themselves been inspired by the possibility and advisability of reform. A variety of groups campaigned against cruelty to animals, flogging, capital punishment, vivisection, and blood sports such as bull


\textsuperscript{72} Caton, "Secularization of Pain," 497.
baiting, and cock and dog fighting.\textsuperscript{73} When William Morton effectively publicized the clinical use of ether in 1846 the public and the medical profession were, for the most part, ready to accept the innovation. Still, many physicians and ministers condemned the use of the ether during childbirth on the grounds that delivery pains were a punishment for the sins of Eve.\textsuperscript{74}

\textbf{The Case of the South}

The secularization of public attitudes toward misfortune was an essential precondition, though not necessarily a cause of, the rise of the malpractice suit in the Jacksonian era. However, the change in the popular view of providence, pain, natural disaster, disease, and social reform did not occur throughout the entire country at the same rate—neither did malpractice litigation.

New England and western physicians, assailed by an increasing number of malpractice suits in the 1840s and 1850s, marveled at the apparent rarity of such litigation in the South. Of the 216 state supreme court malpractice

\textsuperscript{73} See Turner, \textit{Reckoning with the Beast}.

\textsuperscript{74} Pernick, \textit{A Calculus of Suffering}, 49-57; and John Duffy, "Anglo-American Reaction to Obstetrical Anesthesia," \textit{BHM} 38 (Jan.-Feb.1964): 32-44.
decisions reported between 1790 and 1900, only eight originated from the eleven states of the Confederacy.\textsuperscript{75} Even considering the relative populations of the North and South, there is a significant difference in the frequency of litigation. The \textit{BMSJ} reported that the first malpractice case in Tennessee did not occur until 1855.\textsuperscript{76} By that time suits were a common occurrence in states such as New York, Pennsylvania, Massachusetts, and Ohio where hundreds of cases had been reported. Frank Hamilton, speaking to the Medico-Legal Society in the 1870s, observed that while "suits for malpractice were so very frequent in the Northern States—they were always less frequent in the Southern States."\textsuperscript{77}

At an American Medical Association conference in 1873 a Pennsylvania physician noted this disparity and asked a Mississippi colleague to explain the phenomenon. The southern physician acknowledged that malpractice suits were not a problem in the South

\begin{footnotes}
\item[(75)] (North Carolina; Alabama; Arkansas; Florida; Georgia; Louisiana; South Carolina; Mississippi; Tennessee; Texas; and Virginia), calculated from Smith, 2672-3.
\item[(76)] "Case of a Trial for Malpractice," \textit{BMSJ} 61 (March 19, 1857): 148.
\end{footnotes}
and that he had never heard of a case in his state. He suggested that strong medical societies had discouraged intra-professional rivalry and prevented suits. While his interpretation was plausible, it is not clear that southern medical societies were better organized than their northern counterparts were. Even if the explanation were valid, it alone could not account for the vast disparity in suits. Most of the factors that incited suits in the North also existed in the South. However, these immediate factors alone were not enough to produce widespread litigation in the South because the region had not undergone the cultural transformations that were the precondition for large numbers of malpractice suits.

Southern culture grew out of hierarchical rural communities that resembled and reinforced the Old World and colonial order. "Personalistic, face-to-face, kin-and-community relationships" dominated social intercourse. In these types of societies, writers have argued, individuals put a premium on the maintenance and defence of their personal honor. Community opinion was much more important

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79 See Chapter 3, above.
than legal action in settling quarrels.\textsuperscript{80} The existence of hierarchical, communal settlements in colonial and late eighteenth century New England had discouraged, to a certain degree, extensive litigation. While the social, economic, and political turmoil of the first three decades of the nineteenth century destroyed this communal base in much of the country, southern culture retained many of its features and continued to distrust legal redress as the most appropriate solution to conflict.\textsuperscript{81} These attitudes may have stemmed the tide of malpractice litigation that swept the rest of the nation.

The relative infrequency of malpractice litigation in the South may also be explained by the absence there of the religious and cultural changes that were a precondition for the malpractice phenomenon in other parts of the country. Southerners retained traditional, eighteenth-century views of divine providence much longer than believers in the North and these beliefs shaped southerners attitudes toward misfortune,


disease, pain, and reform. The antebellum years were probably the most religious period in the history of the South. During the era of the American Revolution the intellectual leaders of the South shared enlightenment ideas about man and society, but these ideas never penetrated much below the upper class. The popular evangelical churches had slowly begun to take root in the decades before the Revolution, but after the Great Revival of 1800 they came to dominate the popular mind of the South. By the third decade of the nineteenth century, for example, even the aristocrats of Virginia had essentially accepted the evangelical ethos with its emphasis on human depravity and belief in the concept of direct providence.82

Conservative religious views which stressed providence were useful in the defence of slavery and encouraged southerners to retain traditional interpretations of providence.83 Unitarianism, Transcendentalism, and other liberal sects that assailed the notion of direct providence

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in the North were virtually non-existent in the South. Southerners believed that their God "watched over the lives of his poor, earthly creatures with such care that He marked the sparrow's fall." They were resigned to the fact that a certain part of life and nature would always remain inscrutable and must be accepted as God's will. In an ultimate sense God's will not human action, determined the timing of one's death, and neither the patient nor the doctor was finally responsible for healing or death.  

The transformation of the concept of providence from specific to general which encouraged society to prevent and remedy earthly ills in the North had virtually no impact in the South. Southern evangelical fervor had a different face. According to C. Vann Woodward, "In that most optimistic of centuries in the most optimistic part of the world, the South remained basically pessimistic in its social outlook." The region was relatively untouched by almost every reform movement of the early nineteenth century: abolitionism;

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feminism; humanitarianism; anti-cruelty to animals; and prison reform.  

The history of the discovery of ether also suggests that people living in a southern culture held a considerably different view of pain and misfortune than most of their northern countrymen. In the early 1840s, before Morton's famous demonstration in 1846, Crawford Long, a Georgian physician, experimented extensively with ether. Despite his moderate successes, he failed to convince patients or other physicians of the value or propriety of his work. Long even noted that his colleagues advised him to abandon his experiments. When Morton demonstrated ether to a group of physicians in Boston just two years later, the northern medical world hailed him as a hero. Long lived and worked in a stronghold of orthodox Protestantism where an eighteenth century view of pain was still prevalent. Morton on the other hand, presented ether to a liberal, progressive society that believed that pain was a biological function that should be remedied. While there were other conditions that contributed to Long's failure and Morton's success, the divergent views of pain may have been an important factor.  


A final barometer of southerners' perception of pain was their continued enjoyment of so-called blood sports such as cock and dog fighting, ring tournaments, and vicious man-to-man battles. It may also have been mirrored in their willingness to discipline their slaves physically.

Southerner's attitudes toward direct providence, natural disaster, reform, and pain suggest that they had fundamentally different response to natural and physical misfortune than most northerners of the same period. Writers from W. J. Cash to Bertram Wyatt-Brown have agreed that the culture of the American South "grew out of a fatalistic world view which assumed that pain and suffering were man's fate." Fatalism formed an integral part of the southern mindset and encouraged individuals to accept society and their lives as they were. This resignation, born of religious conviction, may have played an important role in discouraging malpractice suits in the nineteenth-century South.

Carol Greenhouse's study of a small, predominantly Baptist, community demonstrated that communal and religious sanctions against legal conflict discouraged litigation into

88 For example see Wyatt-Brown, Southern Honor, 165-6, 340, 341, 344-6.

the the 1970s. Residents of the town maintained what they believed was a "community of Christ." Greenhouse explained that local Baptists' aversion to adversarial conflict being adjudicated in civil courts outside the local church community reached back into the first half of the nineteenth century and persisted through the twentieth century. Their substantial rejection of the use of civil courts is based on the notion that God is the judge of mankind and that resorting to an earthly power questioned his wisdom. Consequently, as late as the mid-1970s, residents of the town considered personal injuries, accidents, automobile accidents, and even personal violence as examples of God's will, and community members generally refused to seek legal redress. To do so would have violated both God's will and community customs which emphasized Christian and social


91 Residents relied on such biblical invocations as: "Pray for them which despitefully use you" (Matthew 5:44); "Be not overcome by evil, but overcome evil with good." (Romans 13:21); and "Dearly beloved, avenge not yourself" (Romans 12:19). See Greenhouse, Praying, 80-1.
harmony. While this consensus is probably only possible in small, socially and religiously homogeneous societies, it suggests a reason why malpractice suits in the American South remained relatively rare through the nineteenth century.

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Jacksonian society's secularized, scientific view of general misfortune, disease, and pain was the psychological backdrop for the dramatic increase in malpractice suits in the late 1830s and early 1840s. Moreover, it was the foundation for the continued rise in suits through the twentieth century. Since the 1830s, social and physical misfortune has been perceived more and more as preventable or, at least remediable. While there was an array of complex causes for the initial increase in lawsuits, Americans' faith in the benefits of science and their newfound certainty that God did not intend man to suffer on earth freed them to blame physicians for incomplete cures. Widespread lawsuits would not have been possible without a fundamental shift in public attitudes about divine providence in everyday life. Although the transformation of public belief was gradual, and not

complete by 1865, the threshold point had been reached as early as the 1840s.

Religious attitudes continued to evolve through the nineteenth century as the notion of providence lost its grip on the American mind. Providence was replaced by a secularized, optimistic, view of the merits and promise of material and social progress. Broad-based public confidence, however, was accompanied by higher expectations and increased demands. When these demands were not met, individuals increasingly blamed men and institutions for their personal misfortune. Although the decline in the importance of providence in the public mind paved the way for beneficial and humane reform, it also encouraged the proliferation of lawsuits by removing the possibility of divine intent and highlighting human culpability. This process, beginning in the late eighteenth century and continuing through the present helps explain the perpetual increase of malpractice suits in the face of profound and unceasing medical progress.

93 See for example Martin E. Marty, "From Providence to Progress" in Righteous Empire, 188-98.
In 1956 a North Carolina state supreme court judge declared that when a physician agrees to accept a person as a patient, "it does not create a contract in the sense that the term is ordinarily used." In medical malpractice cases, the judge observed, "it is apt and perhaps more exact to say it [the doctor-patient relationship] creates a status or relation rather than a contract."¹ This observation is consistent with twentieth century judges' tendency to view medical malpractice as a tort of negligence rather than a breach of contract. Twentieth century legal theorists define torts broadly, as private civil wrongs that violate certain duties or responsibilities. According to one writer, "[t]hese duties often are reflective of a social policy in that certain behaviors are thought [and judged] better than others." Modern contract law, by contrast holds that the duty which is owed by the respective parties is theoretically agreed upon by the individuals involved in the contract.²


² Harrison et al. Principles of Medical Malpractice, 42.
One hundred and fifty years ago the picture was less clear. Judges and legal theorists had not yet molded the notions of tort and contract into discrete categories and there was no need or basis on which to classify malpractice under one abstract subject heading or the other. The prevailing writ system designated specific legal actions and procedures for various civil wrongs and obviated much of the need for overarching doctrinal theory. When lawyers brought a suit before a court they selected the appropriate action and cited pertinent case-law precedent. The earliest American malpractice cases relied heavily on English common law procedures and assumptions about the nature of the doctor-patient relationship. However, the political, social, and economic changes of first half of the nineteenth century transformed the public view of the physician's role in society and threatened to alter fundamentally the grounds of his personal and legal responsibility.

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Common Law Origins

Blackstone categorized *mala practice* not under contract or mercantile law, but under private wrongs. He defined malpractice as an injury or damage to a person's "vigor or constitution" sustained as a result of "the neglect or unskilful management of [a] physician, surgeon, or apothecary." Blackstone declared that malpractice was an offence because "it breaks the trust which the party placed in his physician." The injured patient possessed a remedy for damages with the special legal action, or writ, of "trespass on the case."4

According to eighteenth century common lawyers, when a defendant was charged with a civil offence, the court required the plaintiff to designate the specific writ (action) that entitled him to recover damages. There were ten basic writs (actions) and if the purported offence did not fall under one then the plaintiff did not have a legal remedy.5 The writ of trespass was the legal remedy for

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5 The ten actions included: trespass; debt; covenant; account; assumpsit; detinue; trespass on the case; trover; ejectment; and replevin. For a short and clear description of early American pleading see: Mitchell G. Williams, "Pleading Reform in Nineteenth Century America: The Joiner of Actions at Common law under the Codes," *JILH* 6 (1985): 299-335 and William Nelson, *The Americanization of the the Common Law: The Impact of Legal Change on Massachusetts Society,*
damages resulting from direct force to a person or his property. Broken contracts were prosecuted under the writ of assumpsit. The use of trespass on the case, the writ Blackstone designated to prosecute malpractice cases, evolved in the fourteenth and fifteenth centuries.6

When the writ system was established in the late thirteenth century, it did not include the action of trespass on the case. The trespass writ applied exclusively to direct and unauthorized interference with a man's person or property. A plaintiff could not use the trespass writ if he had voluntarily submitted to a physician's care. The writ was also useless in cases where injury or damage was the result of an indirect or careless action by the defendant. Since there was no remedy for an entire class of cases, English courts slowly accepted the notion that injured plaintiffs were entitled to remuneration even where there was no breach of contract (assumpsit), or injury by force (trespass).

In two cases in the 1370s English courts allowed a special trespass writ (which would become known as trespass on the case) to apply against veterinary surgeons who injured


horses instead of curing them. Through the fifteenth century courts accumulated a significant body of precedents in which they allowed the application of the special trespass writ.7 When in 1553 Anthony Fitzherbert published Natura Brevium he declared that individuals were liable for injuries caused by negligent conduct even when there was no breach of contract or actual trespass. This new writ, which had been evolving for one and a half centuries, was called trespass on the case, or action on the case. Fitzherbert asserted that:

... if a [black]smith prick my horse with a nail, I shall have an action upon the case against him [even] without any warranty by the smith to do it well. ... For it is the duty of every artificer to exercise his art rightly and truly as he ought.8

Fitzherbert's remarks were the modern foundation for action on the case. Subsequent writers argued that his statement applied not only to smiths, but also to innkeepers, ferrymen, carpenters, barbers, and physicians.9

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9 Fifoot, History and Sources, 157.
Sixty years later Edward Coke explicitly utilized the trespass on the case writ for damages arising out the doctor-patient relationship. In *Everard v. Hopkins* a man employed a physician who promised to cure his injured servant's leg.\(^\text{10}\) Instead the physician prescribed harmful medicines and delayed the servant's recovery by a year. Coke declared that the master could sue using the writ of assumpsit because the physician had failed to fulfill his part of the contract to cure the servant. If the physician had not promised a cure then the master could not have recovered under the writ of assumpsit. More significantly for modern malpractice law however, Coke ruled that the servant, even though he had not made a contract with the physician, could bring charges against the doctor under the writ of trespass on the case. This ruling was important because it supported the notion that the physician's liability and responsibility for his patient emanated not from a commercial, contractual agreement but from the affirmative act of entering into the doctor-patient relationship.\(^\text{11}\)

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\(^\text{11}\) Smith, "Legal Responsibility for Medical Malpractice," makes a similar point at 2492.
Writing in the late eighteenth century Blackstone drew from this long evolution. Judges adopted this variant of the trespass writ to fill in situations where there had been no remedy. Blackstone explained that the malpractice prosecution allowed a plaintiff "to bring a special action on his own case, by a writ formed according to the particular circumstances of his own particular grievance." The plaintiff's official form of action would be trespass on the case but the whole "cause of complaint [was] set forth at length in the original writ."\(^{12}\)

In 1767 the case of *Slater v. Baker and Stapleton*, involved a man who sued a physician and an apothecary. They allegedly rebroke his partially healed leg and caused it to heal poorly. In addition, the physician had used an experimental steel device with gears to stretch the limb. Employing a special trespass on the case action, Slater declared that he had hired the physician and his assistant to treat his broken leg but that they, "not regarding their promise and undertaking, and the duty of their business and employment, so ignorantly and unskillfully treated" him that his leg was permanently injured. Several other physicians testified that injured limbs should only be rebroken in cases of extreme deformity and that they had neither seen, nor

\(^{12}\) *Commentaries* Vol. 3, 123.
heard of the experimental device. The court agreed with Slater and ruled that the physician had acted "ignorantly and unskilfully contrary to the known rule and usage of surgeons."  

Slater made it clear that a physician would be held liable for unskillful and negligent conduct even if the damage to the patient was unintentional. The accused physician's medical treatment would be measured against the therapeutic conventions, or standards, of the profession. Slater granted juries the important role of determining "questions of fact" such as what constituted carelessness and what were standards and practices of the medical profession at large. 

Early American lawyers and lower court judges used Slater as a guide for how malpractice pleas should be presented to the trial courts and appellate judges cited the case regularly through the first half of the nineteenth century other English cases also shaped early malpractice pleas. In Seare v. Prentice (1807) Lord Ellenborough, the Chief Justice of the King's Bench, declared that a physician

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14 Slater is noted for example in: Landon v. Humphrey 9 Day 209 (1832); Howard v. Grover 15 Maine 97 (1848); and Mc Candless v. Mc Wha 22 Penn 261 (1857).
could be held responsible for either negligence or unskillfulness. Ellenborough stated that:

... an ordinary degree of skill is necessary for a surgeon who undertakes to perform surgical operations ... in the same manner as it is necessary for every other man to have ... common skill at least in his business, and that is implied in his undertaking.15

Ellenborough's ruling confirms that physicians and members of other occupations had special duties that arose out of their calling, or role in society. The judge implicitly warned these men that their status as innkeepers, ferrymen, barbers, blacksmiths, lawyers, and physicians implied that they possessed the "ordinary degree of skill" that was essential for the fulfillment of their respective tasks.

Until the civil procedure reforms of the late 1840s and 1850s, the trespass on the case writ remained the appropriate remedy for malpractice prosecutions. In his plea to the court, the prosecuting attorney adopted the language of Blackstone, Slater and Seare to justify the charge. For example, a Connecticut appellate court in Landon v. Humphrey used these earlier precedents when it ruled that anyone who undertakes "any office, employment, duty, or trust" must "perform it with integrity, diligence and skill." If an individual was injured as a result of the want of any of

15 8 East's Term Rep 347.
these qualities, then the courts would accept an action on
the case.\textsuperscript{16} Prosecuting attorneys used this language in
their initial pleas, judges incorporated it into their
charges to juries, and appellate jurists measured lower court
proceedings against it.

While the basic action of trespass on the case did not
change, its underlying principles and the wording of the
justification evolved as more appropriate precedents
surfaced. \textit{Lamphier and Wife v. Phippos} (1838) was the last
English decision to contribute influential statements of
principle to American malpractice law.\textsuperscript{17} Physician Phippos
failed to diagnose correctly Mrs. Lamphier's broken wrist.
As a result, the woman lost the use of her hand. In
charging the jury, judge Tyndall explained that every person
who entered into "a learned profession undertakes to bring a
fair, reasonable, and competent degree of skill to his
endeavor." Attorneys did not "undertake" to win every case,
surgeons did not "undertake" consistently to cure. Since
some practitioners would always have "higher educations and
greater advantages" than others, no physician was required to
use the profession's highest degree of skill or care.\textsuperscript{18}

\textsuperscript{16} \textit{Landon v. Humphrey} 9 Day 209 (1832) at 216.

\textsuperscript{17} 8 Carr & Payne 475.

\textsuperscript{18} Decision reprinted in Wade, 21-3.
Tyndall's charge did not alter earlier precedents but it provided the clearest and most enduring elaboration of the principles of malpractice. Trial and appellate court judges' use of Tyndall's language made it the standard charge in nineteenth century malpractice charges. Tyndall's formula, like the prescriptions of Blackstone, Slater and Scare, was consistent with the notion that medical men were accountable for their actions because of the public nature of their calling. It did not suggest that physicians incurred responsibilities because they had entered into commercial associations with their patients. By measuring accused physicians' skill and care against the "ordinary" standard set by the rest of the profession, judges demonstrated that doctor's duties arose out of their general status as medical men rather than from their particular one-on-one contracts with their patients.

American Innovations

19 For examples of American judges who incorporated Tyndall's language see: Patten v. Wiggin 51 Maine 549; Leighton v. Sargent 7 N. Hampshire 460 (1853); Reynolds v. Graves 3 Wisc. 416 (1854); Graham v. Gautier 21 Tx Rep. 111 (1858); and Richey v. West 23 Ill. 385 (1860).
While American courts accepted the wording of these malpractice principles, they did not completely adopt the traditional conception of professional relationships. According to English common law the services of lawyers and physicians were considered gratuitous. Blackstone had declared that lawyers could not sue for fees and, since medicine was an "honorary employment," a physician could not recover compensation for his practice but had to take what was voluntarily given him. 20 This doctrine originated in Roman civil law in an era when physicians did not practice medicine as their sole livelihood, and the legal relation of doctor to patient was referred to as a mandate. 21 English common law gradually dropped the idea of a strict mandate, but it retained the assumption that medical and legal services were intrinsically gratuitous and that doctors had a legal right only to an honorarium.

American courts never accepted the concept of honorariums. Nineteenth century judge and treatise writer Gulian Verplank explained that the growing demand for the services of full-time lawyers and physicians "pointed out the injustice, as well as the absurdity, of leaving them, as a


21 Ordronaux, Jurisprudence of Medicine, 10-1.
class remediless for the value of such services as they may render to the public."22 His views reflected the growing belief that physicians did not occupy a special social or legal status in American society. He contended that it was "wholly inconsistent with all our ideas of equality to suppose that" medicine or law, businesses or professions "by which one earns the daily bread of himself or his family, [are] so much more honorable than the business of other members of the community."23 Significantly, Verplank's major contribution to general American law was his Essay on the Doctrine of Contracts (1825) where, according to a specialist historian, he attempted to "adapt contract law to the reality of a market economy" and argued that the law should "assure that each party to a bargain is given "full knowledge of all material facts."24

John Ordronaux argued that the repudiation of the conception of the doctor-patient relationship as an intrinsically gratuitous service "reduce[d] professions to the status of artisanship" and placed them on a par with

22 Ordronaux, Jurisprudence of Medicine, 37.


manual laborers. The unrestricted right of professionals to sue for fees in America brought the legal relationships and liabilities "directly within the pale of consensual agreements based upon sufficient consideration." Therefore, in suits for fees, the legal relationship of doctor to patient shifted from status based responsibilities growing out of a physician's role as a public servant to contract-based responsibilities emanating from bilateral agreements.

Henry Maine's *Ancient Law* (1884) pioneered the contention that in "progressive societies" legal relationships tend to evolve from status-determined duties to contract-determined duties; legal rights, duties, and liabilities derived more from explicit, conscious agreements than from a person's role, position, or status in society. Recent writers such as Grant Gilmore, Lawrence Friedman, Morton Horwitz, and P. S. Atiyah portrayed the specific development of contract law in a similar vein.  


27 Gilmore, *The Death of Contract* (Ohio State University Press, 1974); Horwitz, *Transformation*, passim; Friedman, *Contract Law in America: A Social and Economic Case Study*
that in earlier times legal obligations, including those originating in private agreements between two parties, were often judged by the community's standards of fairness instead of the contracting parties' agreement. Implied obligations often went beyond the responsibilities the parties themselves had chosen to undertake. For example understood obligations existed between master and servant. Horwitz and others claimed that during the eighteenth and especially the nineteenth centuries, these arrangements were replaced by the belief that legal obligations seldom went beyond what the individual parties had specifically agreed to in a contract. The specific agreement represented a so-called "meeting of the minds." The swing away from community-determined standards and the acceptance of the ideas that masters, employers, and vendors owed no special duty beyond the cash-based commercial agreements with their apprentices, employees, and customers, reached its apex by the mid-nineteenth century.\footnote{American repudiation of the notion of honorariums for physicians and lawyers and the recognition of commercial relationships in allowing suits-for-fees illustrated the \textit{...(Madison Wisc.: Univ. of Wisconsin Press, 1965)}; and Atiyah, \textit{The Rise and Fall of Freedom of Contract} (Oxford: Clarendon Press, 1979) esp. 157-8.}

\footnote{Horwitz, \textit{Transformation}, 160-201.}
evolution of status-based to contract-based liabilities. The move from status to contract in malpractice law, however, was subtle, complex, slow, and ultimately incomplete. Initially Americans accepted English malpractice precedents and the technicalities involved in the common law system of writ pleading. The rationale behind the writ system was to present a simple, specific, well-defined issue so that plaintiffs could offer only appropriate evidence for their claim and defendants could respond with suitable rejoinders. In theory, juries would decide a clear, simple issue of fact. The system, was intricate, and technically unforgiving. Judges dismissed charges, for example, when a plaintiff's lawyer failed to state the full name of a party to the suit, misspelled the town or county where the defendant resided, or did not properly state the occupation of both the plaintiff and the defendant. Procedural rules required the plaintiff to choose the correct writ (action) under which he was bringing suit. If a plaintiff sued using a writ of debt when he should have used a writ of ejectment, the judge would dismiss the case and the plaintiff would have to start over and repeat the entire, costly complicated, pre-trial process.

The selection of the correct writ or charge was not simple and required extensive legal training.\textsuperscript{30}

Popular and professional discontent with the intricate writ system led to a gradual abandonment of the technical pleading. Opponents of the system complained that the strict procedural rules often interfered with substantive justice, that specific forms of action such as trespass, trover, and assumpsit, had outgrown their usefulness, and that the rules that defined their applicability did not fit new social circumstances. In the late eighteenth century, American judges began to ignore many common law pleading technicalities. Judges started to demand substantive justice rather than technical exactitude.\textsuperscript{31} Courts were less concerned with specific pleas as answer to specific writs than with the underlying nature of the cause of action.\textsuperscript{32}

The writ system, in its strict form, had served as a substitute for doctrinal classification. Judges and lawyers did not have to think in terms of contract and tort because there were specific writs for specific wrongs. When pleading

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\item Nelson, Americanization, 83.
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became more concerned with substance and less with form, the distinction among writs such as debt, covenant, and assumpsit became blurred and judges allowed them to be applied to a broader array of breach of contract offences. By the early 1800s, lawyers and judges began to segregate informally the wrongs previously covered by specific writs into the categories of tort and contract and searched for general principles that characterized the two areas of law.\textsuperscript{33} Many ancient writs fell readily into one category or the other. Covenant, debt, and assumpsit could be combined under the rubric of contract violations; trespass was a tort violation.

Malpractice and its common law remedy, the writ of trespass on the case, did not fall naturally into these abstract categories. Blackstone explained that when a litigant sued for damages because of a debt or a breach of personal duty, the suit belonged to the broad theoretical class of contract. However, when a man sued complaining of an injury to his person or his property, Blackstone classified the claim as a tort.\textsuperscript{34} Malpractice exhibited characteristics of both categories. It was a breach of duty.

\textsuperscript{33} White, \textit{Tort Law in America}, 9-12; Nelson, \textit{Americanization}, 81.

\textsuperscript{34} Koffler and Reppy, \textit{Common Law Pleading}, 47.
and it resulted in personal injury. This doctrinal ambiguity probably caused few problems in ordinary law practice as long as strict adherence to the writ system made theoretical classification irrelevant. In addition, the language of English malpractice precedents demonstrated that a physician's liability emanated from his status as a public servant and not from his contractual, commercial relationship with his patient.\(^{35}\) As formal pleading rules were more frequently ignored and eventually abandoned, and American society's attitude toward the medical profession changed, malpractice law felt the strong pull of contract.

Early nineteenth century legal handbooks reflected the blurred distinctions among specific writs. The 1812 American edition of Joseph Chitty's *Practical Treatise on Pleading* informed lawyers that they could sue physicians for malpractice using either a writ of assumpsit, which provided for the recovery of damages for the non-performance of a simple contract, or they could use trespass on the case, which offered a remedy for injuries resulting from a breach of duty.\(^{36}\) Other legal handbooks published before the civil procedure reforms of the late 1840s and early 1850s echoed

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\(^{35}\) See above, pp. 5-7.

Chitty's guidelines. John Saunders' 1844 *Law of Pleading and Evidence* advised that physicians were "liable in assumpsit or [trespass on the] case, for ignorance or unskillfulness, and for negligence in the exercise of [their] profession." Citing *Slater* and *Seare*, Saunders explained that the law implied a "duty" on the part of the physician to exercise "due and reasonable skill." The plaintiff, to win his case, had to:

... prove that the defendant was a surgeon or apothecary by profession, or [emphasis added] that he was retained and paid as such by the plaintiff, or [emphasis added] that he especially engaged to cure the plaintiff for reward.

The patient-plaintiff was required to present "persons of skill and experience" as expert witnesses who would offer testimony on the suitability of the defendant's treatment. The patient would have to prove that the physician's treatment had been unskillful and improper and that he caused a "wound or complaint, or increased [the] wound or complaint of the plaintiff."  

The malpractice references in these early nineteenth century handbooks suggested that the law was beginning to reflect the contractual aspects of the doctor-patient relationship.

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relationship as well as the traditional legal duties associated with a common calling. Both Chitty and Saunders declared that malpractice charges could be initiated under the writ of assumpsit (simple contract) or under trespass on the case. None of the eighteenth century English precedents mentioned the use of assumpsit as a remedy for malpractice. They uniformly utilized trespass on the case. The incorporation of assumpsit into the malpractice lawyer's armory underlines the informal loosening of technical requirements. Under Saund'er's criteria, a doctor's legal responsibility arose from his status as a medical man, or his financial contract with a particular patient, or his explicit promise to cure an illness or injury.

Drifting Toward Contract

The commercial aspect of a physician's liability was consistent with American judges' abandonment of the notion of honorariums and their acceptance of physicians' suits-for-fees. The early nineteenth century doctor-patient relationship seemed to drift equivocally between the legal categories of contract and tort. The two legal categories

38 See above.
remained vague and unqualified until at least the middle of the century. As the notion of contract gained more acceptance in society and law, it played a more important role in defining the doctor-patient relationship and in influencing malpractice litigation.

The process was slow because state supreme court judges erected barriers against this growing tendency. As example, in the Connecticut supreme court case *Grannis et ux v. Branden* (1812) a man claimed that he had paid a physician "reasonable compensation" to deliver his wife's child. The infant died during delivery. While removing the dead fetus the physician severely cut and injured the mother. The husband's charge implied that a physician's liability originated in the economic relationship established when the fee was paid. A jury found the physician guilty of malpractice. When the state supreme court reviewed the case, it let the conviction stand but made clear that "the only point in issue between the parties, was whether the defendant had neglected to perform his professional duty." The judges ignored the service-for-pay claim of the husband.40

In another Connecticut case the board of health of Salisbury, Connecticut hired Dr. Asahel Humphrey and three

other physicians to vaccinate all the town's uninoculated citizens against smallpox. Humphrey and his colleagues contracted to carry out their task "in a faithful manner" and "according to our best skill and judgment." The Salisbury board of health agreed to pay the four physicians fifty dollars for the treatment. The doctors divided the town into four districts and assigned each physician one section as his personal responsibility.

Dr. Humphrey, who was ill, hired Rollin Sprague, a young medical student, to vaccinate the residents of his district. The procedure required Sprague to make a small, shallow incision on the upper part of the patient's arm and insert a quill containing the vaccine virus. Sprague apparently vaccinated several residents successfully before he visited twenty year-old Harriet Landon. "[F]rom real or affected modesty," she refused to raise her sleeve, and Sprague made two punctures in her upper arm just above her elbow but about one inch lower than standard practice. According to

41 The local board of health took this action to meet the requirements of a new state law requiring vaccinations. Charles Lee, "Medical Jurisprudence," NYJMC 1 (Nov. 1843): 352-62 at 352.

42 The fifty dollar fee, split among the four physicians, averaged about four cents for each person vaccinated throughout the town. For more on the case see Landon v. Humphrey 5 Connecticut Reports 209 (1832) and "Alleged Malpractice," BMSJ 6 (March 21, 1832): 98-9.
witnesses, she immediately experienced great pain and was unable to use her arm for several weeks.⁴³ Landon and her attorney brought an action on the case against Dr. Humphrey for malpractice. Their plea to the court, to justify the writ, consisted of two separate counts. They first claimed that Humphrey had held "himself out to the world as a skillful practitioner [and] was employed by the plaintiff . . . to inoculate her with kine pox." Humphrey had been paid, but he "unskillfully" and "unfaithfully" treated the patient and "cut a tendon, cord, ligament, and nerve of the patient's arm." Because he vaccinated Landon in "an improper, unusual, and dangerous place," she had been "deprived of the use of her arm, [and] prevented from pursuing her necessary business."⁴⁴

Landon's charge was noteworthy because it accepted without comment that Sprague was Humphrey's direct agent and presumed that a duty-filled relationship existed between Humphrey and Landon even though the two had never met. Humphrey, by virtue of his status as a physician, and his acceptance of the responsibility of inoculating the residents of his district, entered into a relationship with Landon which rendered him liable if he did not act according to

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certain standards. In a second count, to support the action on the case writ, Landon and her attorney argued that the board of health had employed Humphrey to vaccinate the inhabitants of the town in "a skillful and safe manner." Instead, Humphrey had acted with a "negligence and unskillfulness" that resulted in an injury to Landon. In other words Humphrey, through his agent, failed to act with the skill and care that his status as a physician demanded.

Dr. Thomas Hubbard, a professor of surgery at Yale, testified that Landon's affliction could have been caused by damage to the nerve suffered if the medical assistant made the puncture too deep. Several other physicians confirmed that the punctures were in a very unusual place. The physicians who testified for Humphrey agreed that the incisions were not in the place usually selected, but argued that it was perfectly safe to inoculate that portion of the

45 The prosecution was allowed as many counts of wrongdoing as they wished, all the counts had to support the one writ. In this first count, Landon's attorney accused Humphrey of what amounted to misfeasance. Misfeasance was grounds for an action on the case and was the doing of an act in an injurious manner, or the improper performance of an act which might otherwise have been lawfully done. In this instance, Humphrey, acting through his agent, had improperly performed the otherwise legal act of vaccination.

46 In this count Humphrey was being accused of nonfeasance. Nonfeasance occurred when a person failed to perform a duty that was required of him.
arm and that they had not heard of a single case where this type of injury had occurred after a vaccination.47

The trial court judge quoted Blackstone and charged the jury that anyone who undertook "any office, employment, duty, or trust contracts [emphasis added] to perform it with "integrity, diligence and skill." If a physician lacked any of these qualities and injured a patient, the judge continued, the injured party could claim damages by a special action on the case. The judge also charged the jury that a physician who vaccinated patients was "liable for all the consequences if he neglects the usual precautions, or fails to insert the virus in that part of the arm usually selected [original emphasis] for the purpose." The jury ruled in favor of Landon and awarded her five hundred dollars and costs. The total judgement against Humphrey amounted to one thousand dollars.48

Humphrey appealed the verdict to the Connecticut Supreme Court of Errors. He argued that he did not have a contract with Landon and that the written agreement to vaccinate the citizens of Salisbury should not have been accepted into evidence. He maintained that he had contracted with the board of health and that Harriet Landon "had nothing to do


with it personally." Humphrey asserted that physicians should be liable for "nothing short of gross ignorance or gross negligence." Since there was "nothing like mechanical perfection in the healing art," he pleaded, "some little failure" might sweep from [a physician] the whole earning of a life of toil and drudgery." According to Humphrey, even skilled physicians would not be able to avoid prosecution and fewer men would enter the profession.49

The language of both the trial court judge and the physician reflected the influence of contract ideas. The judge told the jury that a physician "contracts" to perform his duty with "integrity, diligence and skill." In addition, he ruled that a physician was required to vaccinate patients in the place "usually selected for the purpose" even if there were more suitable locations. He illustrated this principle by explaining that a man transporting property would be liable for all consequences if he departed from the usual route. Portraying the physician not as a healer with a special status, but as a technician for hire who had to perform in the manner expected of him, the trial judge reinforced the notion that physicians carried contractual responsibilities when he argued that his "contract" was with

the board of health and Landon "had nothing to do with it personally."

The Connecticut supreme court refused to grant the physician a new trial. The majority explained that the written contract between Humphrey and the board of health was not an important part of the evidence against the physician and its inclusion as evidence was, at worst, unnecessary. The court ruled that there was sufficient evidence, without the contract, to prove that Humphrey had accepted the responsibility of inoculating the residents of his district. The contract was merely additional proof that he had undertaken the role of physician in the community. The inclusion of superfluous evidence could not be grounds for a new trial.50

The supreme court's comments and lack of interest in the written contract demonstrated that the origin of Humphrey's liabilities and duties was his status as a medical man and his informal relationship with his patients rather than an explicit agreement. Humphrey had argued that Landon took no part in the agreement, so the contract could not be used against him. The supreme court, however, was only concerned with establishing Humphrey's status in the community as a

50 5 Connecticut Reports 209.
physician, and his relationship to the patient. Explicit, contractual arrangements were irrelevant.

Although the state supreme court eschewed the notion that a physician's liability arose out of a bilateral, exchanged-based relationship, the positions of Dr. Humphrey and the lower court judge suggested that contractual ideas had made significant inroads into American thought. The roots of these attitudes were intertwined with the country's political, social, and economic history. A Lockean version of the social contract had helped justify the colonists' break from the mother country and explained their subsequent reliance on a written constitution to create a new government.\(^\text{51}\) The social unforeseen leveling effect of the new environment and the revolutionary rhetoric of equality, and the failure to transplant old world institutions in America, combined to undermine traditional relationships of status. For example, apprenticeship relationships had been governed by a set of unwritten, mutual responsibilities that were shared and sanctioned by the entire community. The apprentice owed the master work and respect; the master owed his apprentice such things as room, board, training, and

religious instruction. In America, this status based relationship broke down and each party only owed the other what they had mutually agreed to exchange.  

Similarly, the guild system never took hold in the colonies and access to crafts and professions was generally open. In the late eighteenth century elite American physicians attempted to replicate English institutions which gave professional men a special legal and social status. However, the medical schools, professional societies, and licensure laws failed to elevate the physician's image. Professional monopolies were inconsistent with the republican rhetoric of the post-Revolution years. The schools, designed to enhance the physician's status, instead contributed to a backlash against professionalism by producing undertrained and ignorant practitioners. Doctors' ineffective and unpleasant therapies drove patients to home remedies and medical sectarians. Licensure regulations were weak and ignored.

Laissez-faire sentiment toward medical licensure developed at the same time as reliance on status in other

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legal relationships declined. From his travels in early nineteenth century America Alexis de Tocqueville concluded that democratic revolutions are generally followed by an attack on symbols of social aristocracy and an increase in individualism. He observed that "Each citizen of an aristocratic society has his fixed station, one above another, so that there is always someone above him whose protection he needs and someone below him whose help he may require." In short, many rights and duties were a result of social or professional status. During the first half of the nineteenth century this system disintegrated in America. A society filled with men who praised equality and individualism took its place. Especially between 1800 and 1860, economic development, transportation improvements, and massive migration helped break up the localism that provided the context for status relationships and responsibilities. These forces contributed to the anti-privilege, anti-

monopoly, anti-professional philosophy of the Jacksonian period.55

Free-trade, laissez-faire ideas, individualism, and the breakdown of status relationships all served as the underpinning of the so-called "golden age of contract." The "will theory of contract" was a model that suggested that legal responsibilities were the consequence of a "meeting of the minds" of two, presumably equal, bargainers. According to one writer, the "will theory of contracts carried the republican impulse to the smallest unit of society--two individuals, who in concert formed a microlegislature and made law."56 Under this concept, which gained prominence between 1750 and 1850, the law more frequently disregarded traditional community standards of fairness and protected only the explicit expectations of the bargaining parties as expressed in their private agreements.57 This notion of


57 Horwitz, Transformation, 173-210. Horwitz's thesis is not universally applicable and has come under considerable attack. For example see A. W. B. Simpson, Legal Theory and Legal History: Essays on the Common Law (London: Hambledon Press, 1987). While much of the criticism of Horwitz is
contract seeped into many areas of law and altered traditional liability. Employers abandoned their status based, paternalistic, hierarchical relationships with their employees and customers and relied on written agreements to define respective rights and liabilities. Just price and fair wage standards were out; caveat emptor ("let the buyer beware") was in. The fellow servant rule was replaced by respondeat superior. Common carriers such as trains and steamboats frequently asked their customers to sign waivers and "contract away" their rights to sue for damages in case of accidents. Virtually every area of law felt the impact of this movement.\textsuperscript{58}

The rise of contract mentality in the 1830s, 1840s, and 1850s contributed to the already declining professional status of the physician. Medical sectarians who claimed to embody free-market Jacksonian sentiment called for an end to restrictive licensing, and praised open competition. By 1850 only two states retained licensure statutes and the medical world became characterized by "free trade in doctoring."\textsuperscript{59}

\textsuperscript{58} Horwitz, \textit{Transformation}, 201-10.

\textsuperscript{59} For more on the Jacksonian antipathy toward regular practitioners see above, Chapter 3.
Physicians' changing legal and social status and the rise of contract mentality in other areas of law spilled over into malpractice prosecutions. Although the technical legal forms did not change, the language and implications of many malpractice cases reflected the growing predilection to treat physicians like ordinary businessmen. In Grannis et ux v. Branden (1812), Landon v. Humphrey (1832) and other cases, doctors, patients, or trial lawyers attempted to define physicians' liabilities in contractual terms. The appellate court judges, however, had refused to refer to the doctor-patient relationship as contractual. Instead, state supreme court judges, drawing on the guidance of English precedents, usually agreed that physicians' professional responsibilities emanated from their status as members of a common calling.60

In the 1840s and 1850s physicians, lawyers, and judges more frequently referred to the relationship as contractual and began to apply general legal doctrines, drawn from the growing category of contract law, in malpractice cases. Malpractice law was drifting from status to contract.

The 1848 Iowa case, Bowman v. Woods, exhibited the impact of contractual doctrine on malpractice liability. Bowman, a Thomsonian or botanic doctor, delivered Woods' child, but failed to remove the after-birth. Thomsonians believed that

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60 See above, this Chapter.
the placenta should remain in the uterus until expelled by
nature. Although Mrs. Woods survived, her husband sued Bowman
for malpractice. A jury agreed and awarded Woods fifty
dollars.61

The Iowa supreme court overturned the conviction. The
majority decision explained that since Iowa had no licensure
laws, no particular system of medicine was legally supported
or prohibited. While the appellate court judges clearly
preferred regular practitioners to medical sectarians, such
as homeopaths or Thomsonians, they ruled that regular
physicians were not the exclusive standard or test by which
the other systems were to be judged. "A person professing to
follow one system of medical treatment, cannot be expected by
his employer [emphasis added] to practice any other," the
court noted. Though the law required physicians to use an
"ordinary degree of care and skill," it did not require a man
"to accomplish more than he undertook, nor in a manner
different from what the profess[ed]." The wording of the
majority decision implied that this doctor-patient
relationship resembled the model of a contract. There had
been a "meeting of the minds" between Bowman and Woods.

61 Bowman v. Woods 1 G. Greene (Iowa) 441 at 442. See
Chapter 2 for a discussion of another aspect of this case.
Bowman had been hired as a Thomsonian, so he only needed to perform like a Thomsonian.\textsuperscript{62}

Since physicians possessed no special status in law or society, the idea of contractual responsibilities became more important. The \textit{Bowman v Woods} decision constructed a clear analogy between the doctor-patient relationship and the commercial marketplace. "If a person will knowingly employ a common mat maker to weave or embroider a fine carpet, he may impute the bad workmanship to his own folly." Therefore, the court reasoned, if a patient chose the wrong type of physician to treat him, "in all such cases, the employer ought properly to attribute loss or injury to his own negligence and mismanagement." The court recognized that the country was filled with quacks, "novices," and "empirics," but lamented that "these are evils which courts of justice possess no adequate power to remedy."\textsuperscript{63}

According to \textit{Bowman v Woods}, the medical world was a free market where physicians and patients met to bargain. The watchword was caveat emptor. If patients were careless when hiring physicians, then the courts would not protect them. This doctrine could have easily been used to diminish physicians' liability especially in a country where the

\textsuperscript{62} \textit{Bowman v Woods} 1 G. Greene (Iowa) 441 at 442-3.

\textsuperscript{63} \textit{Bowman v Woods} 1 G. Greene (Iowa) 441 at 443-4.
elimination of licensing had denied physicians official status and eliminated official standards. Though judges in the 1840s and 1850s did not abandon basic legal forms, or the common law prescription that physicians had to perform with "ordinary skill and care," the growing reliance on doctrines associated with contract signalled a significant shift in judicial emphasis.

Although many courts at the trial and appellate levels began to view the doctor-patient relationship in at least quasi-contractual terms, they still recognized that much of a physician's liability arose from his status as a member of a common calling.64 After witnessing a malpractice trial in 1860, a physician noted that "our Judiciary look upon the relation of Physician and Patient as that of a CONTRACT [original emphasis]." At the same time, however, he explained that the "contract" required physicians to act with the "ordinary amount of skill, care, and attention that pertain[ed] to the profession of which he is a member."65 A quasi-contractual view did not automatically alter a

64 For cases that exhibited some contractual language see: Piper v Menifee 51 Ky 465 (1851); Alder v Buckley 1 Swan (Tenn) 69 (1851); Moody v Sabin 63 Mass 505 (1852).

physician's liability. But if local and appellate courts allowed defense attorneys to apply contractual doctrines such as caveat emptor and "contracting away" to medical relationships, then physicians' traditional liability would be modified. **Leighton v Sargent** (1853) provided one of the most frank examples of contractual language in malpractice cases and demonstrated the practical ramifications of this doctrinal drift.

**Leighton v Sargent**

In September 1850, Joseph Leighton injured his ankle and leg when he lost his balance and fell from a moving carriage in Strafford, New Hampshire. Friends of Leighton sent for Dr. Sargent who lived in Barnstead six miles away. After examining the injury, Sargent discovered that Leighton had dislocated his ankle and fractured and partially shattered his lower leg. Sargent wrapped Leighton's inflamed and swollen limb in a starched bandage and immobilized the entire leg in a homemade fracture box. Leighton's injury, known

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67 T. J. W. Pray, "A Surgical Case of Malpractice," *BMSJ* 51 (Nov. 8, 1854): 289-97 at 289-90. During Leighton's long convalescence, he suffered "feverish excitement," coughs, and "had to resort to stimulation to withstand the prostrating effects of the disease." "Stimulation" generally referred to brandy, port, or some other alcoholic beverage.
as a compound fracture was profound. The starch dressings irritated Leighton's leg and his foot became "greatly inflamed" and covered with a "mass of gathering putrid sores." Doctor Sargent attended Leighton from 1 September 1850 until 12 January 1851. During this time, he visited and treated Leighton sixty-two times, or an average of once every two days.\textsuperscript{68} Though Sargent did not see his patient after January 1851, Leighton continued to suffer from his injury. Pus-filled sores periodically formed on his ankle and slivers of bone occasionally oozed from the ulcerations.

By the spring of 1852, Leighton's foot had healed but his ankle joint was frozen in an unusual position so that the toes of his foot were permanently pointed downward and three to five inches lower than his heel. Leighton was unable to work and could not walk without the use of a cane or crutches.\textsuperscript{69}

Leighton and his lawyer charged Dr. Sargent with malpractice complaining that the physician's starch wrapping and the setting of his leg had resulted in a "greatly inflamed, virulent, corrupt and festering . . . mass of gathering an putrid sores which caused him great bodily pain

\textsuperscript{68} Pray, "A Surgical Case," 289-90.

\textsuperscript{69} Pray, "A Surgical Case," 289-91.
and caused the ankle to heal in a deformed position.\footnote{70}

Medical witnesses from both sides immediately undermined Leighton's case. They testified that the swelling, inflammation, and sores that plagued Leighton for so many months were a "necessary and unavoidable consequence of the severe injury" he had received and would "accompany even the best possible surgical and medical treatment." Since Leighton had linked the inflammation to the fixed joint, his claim lost its credibility.\footnote{71}

Seeing his case destroyed by his own expert witnesses, Leighton changed his charge in the middle of the trial. Ignoring the objections of Sargent's lawyer, the trial court judge allowed Leighton to enter his new charge. He now claimed that he had "employed [Sargent] for a reasonable reward" to treat, set, and cure his right ankle and foot. Instead, Leighton claimed, Sargent behaved "negligently, carelessly, and unskillfully" and allowed the foot to become deformed and useless. Leighton produced a new parade of witnesses who testified that the deformed position of his foot was identical to its position when it was first placed

\footnote{70} Leighton's lawyer used a "trespass on the case writ."

in the fracture-box by Dr. Sargent. They recalled that they had brought the unnatural position of the foot to the physician's attention on many occasions but that Sargent answered that the angle of the joint was correct and that the toes should be dropped "to get the spring of the foot."\textsuperscript{72}

Only two medical men testified for the prosecution. They testified that though Leighton's injury was severe, there was "no difficulty in fixing the foot in any position desired, " and that he had never seen an instance where it could not be maintained in that [the correct] position."\textsuperscript{73}

Twenty witnesses for Dr. Sargent, testified that they frequently saw a three-quarter inch book behind the foot-board of the fracture box. Defense lawyers claimed that the book would have positioned the foot at nearly a right angle with the leg. They argued therefore, that Leighton's foot had become deformed for some other reason than its position in the fracture-box. Other medical witnesses told the jury that compound dislocations were very severe injuries and often resulted in amputations. "The best treatment," one testified, "cannot make a good limb . . . and the patient and doctor should be glad to get off with any foot that will do

\textsuperscript{72} 7 Foster's Reports 460 at 465; RMSJ 51: 290.

\textsuperscript{73} Fry, "A Surgical Case," 290.
to walk on." In his charge to the Strafford county jury, judge Minot stated that a physician must possess "a reasonable degree of skill, such as is ordinarily possessed by his profession," and he must "exercise that skill with reasonable care and diligence." Although the "legal gentlemen of the Strafford bar" believed that the jury would exonerate Sargent, the jury declared that the physician was guilty and awarded Leighton $1500.

Sargent appealed the verdict to the New Hampshire supreme court in 1853. The court ruled that the trial court judge should have not have allowed Leighton to change his charge in the middle of the trial, overturned the jury's decision, and granted the physician a new trial. Judge Bell, who wrote the opinion for the New Hampshire supreme court noted, however, that the principles of malpractice were of "great consequence to all classes of professional men" and should be "settled and well understood." "At the present moment," he observed, "it is to be feared there is a tendency to impose some perilous obligations beyond the requirements of the law on some professional men." Bell declared that while doctors did not implicitly guarantee the results of their work, they were required to possess a "reasonable, [Footnote 74 Pray, "A Surgical Case," 291.]

[Footnote 75 7 Foster's Reports 460 at 464-6.]
fair, and competent degree of skill" and exercise this skill with "ordinary care and diligence." Supreme court judge Bell's definition of professional responsibility was no different in substance from the trial court judge's charge to the jury or the common law precedents articulated in previous appellate decisions. Bell's description of the legal relationship between doctor and patient, while it resembled the ruling in *Bowman v Woods*, varied significantly from the opinions of his early nineteenth century counterparts.

Bell stated that when a physician "offers his services to the community generally, or to any individual, for employment in any professional capacity, [he] contracts with his employer." Judge Bell's use of the term contract in his decision was not a harmless and meaningless abstraction. The judge was concerned that medical men were suffering under "some perilous obligations" and he was going to give them a judicial remedy. Bell ruled that while physicians must exercise "ordinary good judgement," the risk from "mere errors and mistakes is upon the employer [patient] alone."

The judge continued:

> He [the patient] too has judgement to exercise in the selection of the physician of the lawyer whom he will employ, and if he makes a bad selection, if he fails to choose a man of the

76 7 Foster's Reports 460 at 468, 469, 471, 472.
best judgement, the result is fairly attributed to his own mistake. 77

Judge Bell's decision, like the majority ruling in Bowman v Woods, viewed the doctor-patient relationship through the lens of contract. Two years later in Cater v. Fernald a New Hampshire trial court judge used this medical version of caveat emptor to charge a jury in a malpractice case. He reminded them that the "employer has to exercise judgment too in the employment of a professional man." 78

The Connecticut supreme court judge in the 1832 Landon v Humphrey ruling had dismissed the importance of a contract in adjudicating malpractice cases. In the Bowman, Leighton, and Cater decisions, however, the judges specifically referred to the doctor and his patient as "employee" and "employer." The

77 7 Foster's Reports 460 at 472. After losing his award in the state supreme court, Leighton again charged Dr. Sargent with malpractice in the Strafford county court. The jury again sided with Leighton and fined Sargent $525 plus the cost of both trials. Sargent appealed to the state supreme court in 1855 claiming that three jurors at the second trial had shared a "gill" of brandy the night before they agreed on the guilty verdict. On these grounds, the supreme court set aside the verdict and called for a third trial. Finally, after five years of litigation, Leighton and Sargent agreed to an undisclosed, out-of-court settlement. Leighton v Sargent 11 Foster's Reports 119 at 130, 138; and Milo McClelland, Civil Malpractice (N.Y. Hurd and Houghton Co., 1873), 210.

78 "Case of Alleged Malpractice," BMSJ 54 (April 24, 1856): 229-42 at 239.
decisions assumed that the medical world was merely an
alogue of the commercial marketplace and should operate by
many of the same rules. The judges embraced contract
doctrines and provided physicians with a defensive legal
weapon by constructing a medical malpractice version of
caveat emptor. Treating malpractice as a type of contract
could affect potential financial awards to injured patients
in other ways. If malpractice were considered purely under
the rubric of tort law, as it eventually was, pain and
suffering, as well as damages, could be used as grounds for
remuneration. If malpractice was treated as a contract case,
the law generally provided only that the plaintiff be placed
in the same position he would be in if the contract had been
properly performed.79

Contracting Away

If the doctor-patient relationship was truly a "meeting
of the minds," the doctor should have also been able to
contract for less liability. Despite the efforts of some
corporations, state courts had of the 1830s and 1840s refused
to allow common carriers to "contract away" their common law
liability. But the abstract notion of freedom of contract,

79 Harrison et al., "Development of the Principles of
Medical Malpractice," 42, 44, 45.
and a desire by state court judges to encourage economic expansion, broke down old barriers. In 1850 New York judges allowed common carriers to restrict their liability by special agreement with their customers. By 1853, corporations could limit lawsuits even for gross negligence. Despite these decisions, treatise writers remained tentative in their support of contractual protection from lawsuits.  

Physicians began to seek the same right. They attempted to force their patients to "contract away" liability in two ways. Many doctors asked prospective patients to sign a bond agreements which stipulated a monetary penalty in event of a malpractice charge. Patients could still sue for malpractice, but they would presumably lose more than they would gain.

As early as 1847 an editorialist advised Ohio physicians to use bonds to slow the "endless vexations and pecuniary losses" of malpractice suits. By the early 1850s the practice had become common. The 1851 Medical Examiner advised that "It would perhaps be the course of prudence for surgeons among us to keep blank bonds on hand." A New York

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80 Horwitz, Transformation, 206.


physician reported that he refused to treat the fractures and dislocations of working class patients, perceived as the group most likely to sue, without first receiving an indemnity bond. He warned his colleagues, "Surgeons! Take an indemnity bond or never treat a poor patient." In 1854 an editorialist for the *Boston Medical and Surgical Journal* lamented that:

> It is almost a wonder that any surgeon, now-a-days, can be found . . . to remedy a deformity, or treat a case of injury, without a bond from the patient or legal guardian that he shall not be subjected to a suit for damages as whole and perfect as he was when he came from the hands of the creator.  

The injuries generally convinced patients to sign bonds and, the penalties were usually high enough to discourage them from violating the agreements. Dr. Horace Nelson, a New York physician, recounted his use of bonds. In December 1855, Louisa Bovee brought the physician her two year-old child, who had fractured and dislocated his right arm.

83 "Important Case of Alleged Malpractice," *Scal* 9 (April 1857): pp. 54-7 at 56.

Nelson informed the woman that he would not treat the child unless she signed a bond agreement guaranteeing not to sue for malpractice. Bovee declined and the physician refused to treat the child. After conferring with her friends, the woman returned, and signed the bond agreeing to pay the physician two thousand dollars if she attempted to sue him for malpractice. In Nelson's words, "We are now safe, let the result be what it may." Nelson published a copy of the bond as a model and promised that it was good in any state of the Union (see reproduction).

The careful, legalistic exactness of Nelson's bond mocked Blackstone's notion that medical men held a position of public trust, or that they were honored public servants with a special legal and social status. Instead the written pre-treatment agreement resembled, more than anything else, a carefully framed labor or commercial contract. Moreover, the bonds reinforced the Jacksonian contention that physicians were no different than mechanics or merchants, and ran counter to the elite physicians' position that medicine was a profession and not a trade.

The use of bonds was probably the surest method of discouraging litigation by contract. Physicians also experimented with contracts that completely immunized them

STATE OF NEW YORK,
Clinton County

KNOW all men by these presents, that I, Louisa Bovee, the wife of
Orrey Bovee am held and firmly bound to Doctor Horace Nelson,
practicing surgeon, of the town of Plattsburg, in the county of
Clinton, in the sum of two thousand dollars, lawful money of the
United States, to be paid to the said Doctor Horace Nelson, his
executors, administrators, or assigns; for which payment, well and
truly to be made bind myself and each of my heirs, executors, and
administrators, jointly and severally firmly be these presents.
Sealed with my seal. Dated this 28th day of December, 1855.

Whereas the above bounden has this day applied to, and
requested the said Horace Nelson, surgeon aforesaid, to set and
reduce a fracture and dislocation of the right elbow joint of Charles
Leonard Perry, and infant, and now child by adoption of the above
bounden, the wife of Orrey Bovee, of Plattsburg.

Now therefore, the condition of this obligation is such, that
if the above bounden Louisa Bovee, shall well and truly keep and bear
harmless, and indemnify the said Horace Nelson, surgeon aforesaid,
his executors, administrators and assigns, and every other person or
persons aiding and assisting him in the premises, of and from all
harm, let, trouble, damages, costs, suits, actions, judgments, and
executions that shall be brought against them, or any of them, as
well for the setting of said arm, as for the inconvenience and damage
arising therefrom. Then this obligation to be void, else to remain
in full force and virtue.

[L.S.]

Louisa Bovee

Sealed and delivered in presence of F.L.C.
Sailly, Justice of the Peace.
from lawsuits. These agreements were identical to the court supported liability waivers of common carriers. And, it was in the shadow of the 1850s rulings that some physicians attempted to mimic the corporations. The legal status of these arrangements, however, was ambiguous. Apparently absolute waivers of liability were used only infrequently.

In 1861 an Ohio man caught his leg in the flywheel of a sawmill. Physician G.W. Butler examined the injured leg and discovered a compound fracture and crushed bone. The doctor warned the patient that the injury was severe and dangerous, and declared: "I will not treat your case at all unless you clear me of all responsibility for results." According to witnesses, the injured man replied: I will clear you of all responsibility. Go on and treat my case. I would rather have you than anyone else." Butler placed the leg in a bandage and splint but after eight days, the injury required amputation.86

The patient sued for malpractice claiming that the physician cut off the circulation by bandaging the limb too tightly. The defence attorney argued that the physician had made a "special contract" with the patient absolving him of all liability. The patient's attorney

... quoted legal decisions to show that Dr. Butler could not make a special contract with the patient, by the terms of which he obligated himself to render to the patient anything less that the ordinary amount of "skill, care and attention," [and] that such a rule would do away with all standards of comparison and prove positively injurious to the interests of society.87

Ignoring the arguments of the defence attorney, the trial court judge accepted the validity of the pre-treatment agreement. "This contract," the judge ruled, "the defendant had the right to make." If the jury believed that an agreement existed, then Butler was not liable for the loss of the leg. The jury retired, and after a "short absence," decided in favor of the physician. A jubilant editorialist declared that if other physicians and courts used contractual immunity that "damages in favor of the plaintiff could not in one case in a hundred be obtained."88

Despite this isolated case, there was no simple solution to the malpractice problem. The use of agreements to contract away liability was rare. No specific case ruling on special contracts and malpractice existed. However, the near


consensus of both legal and medical writers suggested that absolute abrogation of medical liability never completely took hold, and was discredited by the 1860s. Similarly, judges' use of contractual language in defining the origin of physicians' malpractice liability declined in the late 1850s.

The Road not Taken

Medical men refuted the notion of contractual relationships with patients because it distorted the image of the physician as a public servant with a distinct social status. Most physicians maintained this position even though some contractual doctrines, such as waivers and caveat emptor, could have mitigated verdicts in malpractice cases. Worthington Hooker warned the profession that "The relation of a physician to his employers is not shut up within the narrow limits of mere pecuniary considerations. There is a sacredness in it, which should forbid its being subjected to the changes incident to the common relations of trade and commerce among men." 89 Valentine Mott, an eminent surgeon, advised physicians to "Condemn with relentless severity the slightest deviation from professional honor. Find no excuse

89 Worthington Hooker, Physician and Patient, 410.
for anyone who is induced to lower our noble art to the condition of a trade." 90

A Massachusetts medical society committee on malpractice agreed that the doctor-patient relationship was different from purely economic arrangements.

[T]he peculiar relations always existing between physician and patient and the fact of one of the parties always being more or less incapacitated by his condition, have put out of sight the idea of a bargain, as in other engagements between man and man. 91

The committee concluded that "It cannot be conducive to the interests of the patient that his relation with his physician should be reduced to a mere business transaction, to be judged as a contract, to which the employer strictly holds the employed." 92

Medical and legal writers also attacked the use of bonds, and the practice of contracting away liability. Joel Parker, constitutional commentator, one time Massachusetts supreme court judge, and professor of medical jurisprudence

90 "Valentine Mott on Medical Ethics; He Throws a Medical Boomerang," Scal 9 (July 1857): 125-6.


at Dartmouth, deflated the hopes of those physicians who believed that bonds and contracts could protect them from malpractice suits. In an 1855 lecture he explained that while there was no specific ruling on the issue, there was "very grave doubt whether it [contracting away] could have any legal operation to exempt the physician from any responsibility." Since contracting for exemption from liability remained a controversial practice in other areas of law, Parker felt that the best a physician could hope for, was that the agreement, despite its feeble legitimacy, might discourage the disgruntled patient from instituting a suit. 93 Physicians undoubtedly recognized the legal weakness of contracting away, but most opposed it on other grounds.

One physician argued that while some of his colleagues required bonds or contracts before treatment, he objected on the grounds that "in the first course, such refusals would be considered inhuman; and in the second, it is undignified [original emphasis] for a well qualified profession to resort to such expedients." 94 Both John Elwell, in his Medico-Legal Treatise on Malpractice (1860) and John Ordronaux, in The

93 Joel Parker, "Extract from a Lecture," 218.

Jurisprudence of Medicine (1869) agreed that physicians could not use special contracts to protect themselves. According to Ordronaux, "With or without such a bond he may still be prosecuted for malpractice. And certainly, it is a derogation of his dignity, and an attempt on his part to pervert the equitable streams of jurisprudence."  

Ordronaux, a physician and a lawyer, was one of the leading nineteenth century experts on medical jurisprudence. He declared unequivocally that "the duty of professing skill and exhibiting correctness in prescribing is not created by contract, but by law." Drawing on the status of physicians in Roman law, Ordronaux explained that "the very nature of the relation between patron and client raised it [the doctor-patient relationship] above all taint of a mercenary character." Professional responsibility had its origins in "the character publicly assumed by him who undertakes to render such services." Liability did not flow from the financial arrangement between doctor and patient, but from the practitioner's public assertion that he was a physician.

95 Ordronaux, The Jurisprudence of Medicine, 104; and Elwell, A Medico-Legal Treatise on Malpractice and Medical Evidence (N.Y.N.Y.: John Voorhis, 1860). Courts accepted special contracts from common carriers until 1873 when the United States Supreme Court in N.Y. Central R.R. v Lockwood 84 U.S. 357 ruled against them.

96 Ordronaux, Jurisprudence of Medicine, 11, 71, 73, and 96.
Ordronaux shared the assumptions of the the majority of judges in the late 1850s and 1860s. Although some earlier courts had referred to the doctor-patient relationship as contractual, most judges objected. A Massachusetts judge observed that medical relationships were fundamentally different from purely commercial contracts. He noted that "In ordinary cases the employer governs or directs the employed; but in surgery the case is reversed. The surgeon controls the patient." In an 1854 case, the plaintiff's attorney declared that the physician had agreed to treat his client "for a reasonable reward and compensation." The trial court judge, in his charge to the jury, however, stressed that

[This] is not an action on a contract, although the declaration alleges what the law would make a contract . . . still the action is not for a breach of contract but, it is not for the defendant's [sic] not doing what he agreed to do, but for doing what he did agree to do in a careless, unskillful and negligent manner as to injure the patient.

To replace the void left by the decaying and abandoned writ system, mid-century treatise writers segregated legal

97 "Trial for Alleged Malpractice," *BMSJ* 50 (March 8, 1854), 120-1.

duties into the broad categories of tort and contract. Lawyers and judges yearned for rationalized, general, legal principles on which to base legal duties. Traditional, status based responsibilities were generally classified as torts.99 Francis Hillard wrote the first American treatise on torts in 1859. He divided all legal actions into contracts, torts, and crimes. Contracts were based on "agreements, express or implied;" torts were "injuries of omission or commission, done to individuals;" and crimes were "injuries done to the public or the state."100 Hillard included malpractice actions under the heading of tort because the offence was a breach of public duty.101 Amasa Redfield and Thomas Sherman's important 1870 treatise on negligence also reflected the non-commercial basis of physicians' liability. Redfield noted that: "The peculiar nature of the services which a medical man undertakes to render, often makes it his duty to continue them long after he would gladly cease to do so . . . Even if his services are

99 White, Tort Law in America, 10-12, 40.


gratuitous, he must continue them until reasonable time has been given to procure other attendance." 102

Appellate court judges in the 1850s and 1860s reinforced the notion that a physician's responsibility emanated from his status as a professional instead of from the relationship created by a contract. They only resurrected the contractual language of *Bowman*, *Leighton*, and *Cater* when the suit involved a conflict over fees, or an explicit promise to cure. 103

In *Smith v Overby* the Georgia supreme court sanctioned a jury charge which explained that "the profession of physician is one of the learned professions . . . as in all professions in which learning and skill are required, the rule of law is, that every person who enters into a learned profession undertakes to bring to the exercise of his profession, a reasonable degree of care and skill." 104 The Illinois supreme court in *Ritchey v West* affirmed that "when a person assumes the profession of a surgeon, he must in its exercise,


103 See for example *Piper v Menifee* 51 Ky. 465 (1851); and *Alden v Buckley* 1 Swann (Tenn.) R. 69 (1851).

104 *Smith v Overby* 30 Ga. 241 (1860).
be held to employ a reasonable amount of care and skill." 105

Finally, the majority in *McNevins v Lowe* ruled that:

If a person holds himself out to the public
as a physician he must be held to ordinary
care and skill in every case of which he
assumes the charge, whether in the particular
case he has received fees or not. But if he
does not profess to be a physician nor
practice as such, and is merely asked his
advice as a friend or neighbor, he does not
incur any professional responsibility. 106

*Overby, Ritchey,* and *McNevins* were characteristic
annunciations of malpractice case law in the mid 1860s. In
contrast to some of the rulings of the late 1840s and early
1850s, they banished contractual language from the doctrine
of physicians' liability. A doctor was liable for his
actions, not because he treated a patient for pay, but
because he held a special status in society: the public
servant, the professional.

Malpractice law's mid-century flirtation with
contractual language and doctrine, and its eventual
abandonment of the notion, reflected the paradoxical legal
and social position of the American medical profession. The
English precedents which informed early malpractice law were
based on the assumption that physicians' liability arose from

105 *Powers Ritchey v Keziah West* 23 Ill 329 at 330 (1860).

106 *Benedict McNevins v Cyrus Lowe* 40 Ill 209 at 210 (1866).
their special status as public servants. English common law prohibitions on suits for fees reinforced the non-commercial nature of the doctor-patient relationship. American courts never accepted the idea of honorarium pay for physicians, but initially followed the malpractice rulings which implied status based responsibility.

By the late 1840s the contractual view of society was strong enough to threaten the status based foundations of malpractice law. The Lockean, contractual character of a written constitution, and the ideals of individualism and free-trade in the Jacksonian era provided a fertile environment for contractual interpretations. Jacksonian commentators condemned traditional professional groups as anti-democratic and aristocratic. Other status based relationships were being undermined. Master-servant doctrine, aspects of family law, and the responsibility of common carriers all reflected the influence of contract mentality. In suits for fees, the legal relationship of doctor and patient had already evolved from status based responsibility to contract based liability. Jacksonian Americans refused to grant physicians either legal status through licensure, or social status through respect. Therefore, it was not surprising that some judges, attorneys, and physicians began to integrate market oriented principles into malpractice law.
Ultimately judges and treatise writers turned away from contractual views of the doctor-patient relationship because the medical world was not analogous to the commercial world. Physicians retained remnants of the idea of the medical man as public servant and wanted to raise the profession above the position of a wage earner. The contractual model of two presumably equal bargainers engaging in a "meeting of the minds" does not accurately describe medical relationships. Patients who have injuries cannot freely consent to treatment in the same way a merchant freely decides to purchase commercial goods. Laymen approach the doctor-patient relationship with less knowledge about their illness, their probability of recovery, and the various treatments and medical alternatives than the physicians with whom they deal. Therefore, notions such as caveat emptor are not appropriate or effective safeguards on the "medical market."\textsuperscript{107}

The banishment of the will theory of contract from mainstream malpractice law had ethical and practical consequences. It was an implicit recognition that physicians

filled an extraordinary role in society that severed the doctor-patient relationship, legally, ethically, and economically from the principles that usually governed the exchange of goods and services in a laissez-faire economy. In the late twentieth century, medical practice, institutions, and organization have increasingly taken on the appearance of commercial enterprises. Consequently, a growing segment of the population and the profession, have again begun to view physicians as businessmen and medical ethicists debate the viability of contract as a source of professional responsibility. Some of the debates surrounding twentieth century malpractice reform have suggested the use of contract as a basis for defining physicians' liability. Society, the courts, and the profession may have to decide again the way in which the doctor-patient relationship is different from a commercial contract.


Medical malpractice suits continued to plague physicians through the last third of the nineteenth century. Although the suits and professional responses changed in several important respects, the trends and patterns which surfaced between 1835-1865 endured. The rate of suits and size of the awards climbed slowly and undramatically. Physicians blamed many of the same factors they had earlier for the litigation, but changes in the legal and medical professions altered the ways in which they interpreted and dealt with the suits. Appellate courts modified traditional legal doctrines but the central tenets of malpractice law remained unchanged.

The evolution of medical practice and organization generated new suits and new issues. Ceaseless medical innovations inspired new litigations in the same way as the improvement in fracture treatment engendered suits in the first half of the century. Physicians' experience with malpractice between 1865-1900 followed a course set earlier in the century. At the same time, the suits, response, and the law reacted to the modernizing medical environment and represented a prelude to the twentieth century.
Rates

Physicians were relieved that malpractice rates abated somewhat during the tumultuous 1860s. Editorials and reports of cases appeared less frequently in medical journals. One observer at the end of the decade remarked that the problem was "not so urgent as it was a dozen years ago, when the number of actions for malpractice brought against respectable practitioners caused a good deal of excitement in the medical profession." ¹

The respite, if it occurred, did not last long. By the early 1870s, patients were suing physicians with renewed vigor. In 1872 the president of a New York medical society commented that while suits were "rarely found" in previous years, "of late they have become frequent. At nearly every setting of the court one or two of such cases are on the calendar." ² An 1875 writer remembered that "suits were prominent between 1833 and 1861 in New York and also in the Eastern and Western states." He lamented that "Latterly the danger to the profession has been revived." ³ Another

physician echoed the writer's concern the following year and reported that "the increase in the number of suits for malpractice has again become a topic of remark in medical circles."4

After suffering two suits in the 1870s, Eugene Sanger produced a detailed report of malpractice in Maine. Sanger's study, published in 1879, surveyed the approximately six hundred regular physicians practicing in the state, and yielded the most evocative picture of the phenomenon in the nineteenth century. Of the one hundred and fourteen doctors who responded to Sanger's query, only fifty-eight had escaped prosecutions, threats of suits, or "the payment of smart money." Seventy of the one hundred and fourteen physicians had actually been sued for malpractice. Sanger argued that the true total for the state was undoubtedly higher since many physicians, "from modesty and disinclination to advertise their contributions to the patients and attorneys, who follow us as the shark does the emigrant ship, have failed to report."5

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Through the remainder of the century, physicians and other observers claimed that medical men were subjected to an ever-increasing burden of litigation. Not only did suits continue without relief, but most writers believed that each decade was more litigious than the last. The problem was evident enough for an 1880 editorialist in *Popular Science Monthly* (then a serious effort to popularize science) to complain that "So jealously does the law guard the lives and persons of the people, that every time the physician writes a prescription, or the surgeon makes an incision, he takes his purse, his liberty, or, perhaps, his life in his hand." A physician in 1882 warned that "The increasing frequency of the allegations of malpractice in surgery makes the subject one of great interest to nearly every physician." In a paper read before the Chicago Medical Society in 1886, a local doctor declared that "It is undoubtedly a fact that such suits against physicians are on the increase. The New York *Medical Record* has reported a large number in the course of the past year, and a glance over the Court-record in this

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city will prove the correctness of my assertion, as far as Chicago is concerned."\(^8\) A San Francisco physician in 1889 revealed that "the majority of physicians who have attained prominence and a reputation for ability to pay, have been obligated to defend suits of this character."\(^9\) The following year a Michigan physician informed the state medical society that "There is scarcely a surgeon of any great experience in this State who has not either been prosecuted or many times threatened."\(^10\) By the turn of the century the *Colorado Medical Journal* reported that "The malpractice fad is upon us."\(^11\)

Although appellate decisions are an uncertain measure of trial court litigation rates, they tend to confirm physicians' impressions that malpractice suits were a growing problem. State appellate courts handled a gradual but clearly increasing stream of cases as the decades passed:

\(^8\) E. J. Doering, "Mutual Protection Against Blackmail," *JAMA* 6 (1886): 114-7 at 114.

\(^9\) "Malpractice Suits," *MSR* 61 (September 21, 1889): 326.


1860-70, 25; 1870-80, 45; 1880-90, 47; 1890-1900, 77; 1900-
1910, 116.12 While figures on the absolute number of cases
remain elusive, appellate rates and contemporary commentary
demonstrate that frequent malpractice suits were a persistent
phenomenon from the late 1830s through 1900. Malpractice in
the last third of the century was a natural continuation of
the course and patterns set in antebellum America.

Awards

While immense monetary penalties did not become popular
until much later, damage awards slowly climbed between 1865
and 1900. Before 1865, the typical malpractice judgment was
between $200 and $800, with a few isolated verdicts reaching
$1,000 to $3,000.13 In contrast, 37 sample malpractice awards
between 1870 and 1900 averaged $2,627. Twenty of those
judgments were over $2,000, and only twelve were $1,000 or
lower.14 Some of the larger awards included: $3,000 to a

12 Hubert Winston Smith, "Legal Responsibility for Medical
Malpractice," JAMA 116 (June 14, 1941): 2670-9 at 2672-3; and
Charles J. Weigel II, "Medical Malpractice in America's

13 See Chapter 2, above.

14 See Appendix A.
woman who lost her nose in 1876, allegedly to cancer
treatment; $4,000 for a fracture case in 1872; $4,500 for a
man who lost the use of his legs in 1882; $7,000 for a
fracture case in 1885; $12,000 for a fracture case in 1894;
and $5,000 for a destroyed penis in 1895. Other studies
suggest a similar range in the judgments. Physicians' 
average income in this period probably ranged from about
$1,000-$1,500 per year when the average income for all non-
farm occupations averaged about $500. Appellate courts
refused to overturn the gradually increasing malpractice
judgment as excessive. The increases are significant but

15 Musser v Chase 29 Ohio St. 577, 1876 [lost nose $3,000];
W. F. Hutchinson, "A Recent Suit for Malpractice," BufMSJ 12
(1872-3): 290-1 [$4,000, fracture]; Kelsey v. Hey 84 Indiana
189, 1882 [$4,500, damage to legs]; "Some Recent Malpractice
Suits," MR 28 (December 19, 1885): 690-1 [$7,000, fracture];
"Verdict Against Physician," MR 47 (January 12, 1895): 64
[$12,000, fracture] and Jackson v. Burnham 20 Colorado 533,
1895 [$5,000, lost penis. Some of these awards, as well as
the judgments rendered in the 37 sample cases were reduced on
retrial.

16 Weigel's study, based on appellate decisions between
1860-1915, uncovered awards in 34 cases: 5 awards were less
than $100; 4 awards were less than $500; 22 awards were
between $1,000-$5,000; and 3 awards were between $6,000-
$10,000. Weigel, "Medical Malpractice," 194, 195.

17 Paul Starr, The Social Transformation of American

18 For example, appellate courts in Kelsey v. Hay 84 Indiana
189 (1882) [$4,500]; Brooke v. Clarke 57 Texas 1905 (1882)
[$5,500]; and Cayford v. Wilbur 86 Maine 414 (1894) [$2,075],
refused to reduce or overturn damage awards.
not dramatic. They help to underscore the continuity with the first two-thirds of the century.

"Impecunious clients of desperate lawyers"

Medical spokesmen reiterated many prewar assumptions. In the early 1870s and 1880s, physicians continued to blame their colleagues for many of the suits. Writers complained of "traitorous" and careless medical men. Stephen Smith declared in 1872 that "the origin of nearly every trial for alleged malpractice may be traced to the reckless criticisms which rival practitioners pass upon the works of one another."19 Sanger's 1878 report warned of "the dangers from jealous rivals, tricky lawyers, [and] impecunious and ignorant patients."20

As the profession became less contentious and more solidified, both socially and organizationally, there were progressively fewer charges of physician complicity in


malpractice suits. By 1900, editorials rarely cited intra-professional competition as a major source of the suits. The development of professional solidarity and the threat of suit encouraged physicians to close ranks.

While medical men ceased blaming their fellow physicians for their malpractice woes, the profession reaffirmed its conviction that the poor and laboring classes were their chief tormentors.21 The contention that base greed and status and class resentment generated suits, remained central in malpractice editorials. In the 1840s New York physicians lived in fear of malpractice juries filled with "anti-rent communists" and anti-professional Jacksonian Democrats.22 In the 1870s physicians still claimed that suits and convictions were generated by "an ill-feeling toward the 'class to which the defendants belong'." This prejudice, a physician explained in 1872,

... is simply the same idea which led to the robberies and murders of the [1871] Paris Commune, and which is subversive of justice everywhere. For it represents simply the jealousy and hate which unsuccessful and poor men bear those who have been, through greater industry and care, more fortunate than they in amassing wealth ... What is it but robbery to adjudge against all evidence, the equalization

21 See Chapter 3, above for discussion of working class and the poor's role in malpractice litigation.

22 Wey, "Medical Responsibility," 87.
of property between the doctor and his patient.\textsuperscript{23}

The Paris Commune ballooned anxieties of American elites. Antebellum, upper-class fears of egalitarian farmers and workers evolved into late nineteenth-century alarm over social unrest, labor agitation, and Granger, Alliance, and Populist political organization. Frightened social and political elites in the late 1800s decried the common man's declining respect for property and authority.\textsuperscript{24} Physicians in the 1840s had believed that excessive democracy engendered antipathy against regular practitioners and helped incite malpractice suits. By the 1890s, doctors were even more convinced that their malpractice problems originated in one class of patients and jurors. As one writer explained, "the evil is in the imperfection and prejudices of the twelve specimens of human nature, in the jury box."\textsuperscript{25} Physicians felt that working class juries were particularly susceptible

\textsuperscript{23} W. F. Hutchinson, "A Recent Suit for Malpractice," \textit{BufMSJ} 12 (1872-3): 290-9 at 297.


\textsuperscript{25} Blake, "Suits against Surgeons," 316.
to the lawyer who "alluded to the poor laboring man and [the] rich doctor."

Although class and status resentment existed against medicos, its was a profession whose average income placed its members in the middle class. Probably, much of the antipathy emanated from the physicians' quests and demands for the social standing and prestige of learned professionals. Jacksonians were repelled by the quasi-aristocratic, gentlemanly ideals espoused by early nineteenth century physicians. Many later patients resented the pretension and affected dignity of medical men. But the impulse behind the hostility of some segments of the population had clearly begun to shift. In the early nineteenth century antagonism was status-based and emanated from anti-aristocratic, democratic sentiments. By the late nineteenth century when physicians' income had begun to rise, status-based antagonism remained. But, hostile attitudes toward physicians, where they existed, were increasingly grounded in class-based resentment. Physicians hoped to translate their enhanced status into both honor and gold, but they had yet to complete the process.

In the meantime, professional advice literature advised physicians to maintain a social distance from their patients.

to inspire respect. Intimacy and familiarity had a "levelling effect and divests the physician of his proper prestige." Dressing or acting poorly in public, according to a professional etiquette guide, would "show weakness, diminish your prestige, detract from your dignity, and lessen public esteem, by forcing on everybody the conclusion that you are, after all, but an ordinary person."27

Editorialists continued to maintain, as they had before the war, that "Physicians and corporations are too often regarded as fair game by the impecunious clients of desperate lawyers." The young physician, they argued, soon had "his ardor dampened, his interest cooled, [and] his humanity chilled by the hardness of the material with which he comes in contact . . . [H]e is gradually brought to regard a certain class of his patients as seeking to enrich themselves."28 As example, Sanger's study of malpractice in Maine seemed to confirm the profession's informal profile of the typical plaintiff. Out of the seventy malpractice charges he investigated, only eight plaintiffs were able to pay the costs of the trials and, allegedly "very many of them were


28 "Civil Malpractice," *BMSJ* 96 (April 19, 1877): 470-3 at 470.
drunken and shiftless persons." 29  Most physicians agreed that "nine times out of ten the plaintiff is a pauper who has received the gratuitous service of the man who he prosecutes." 30  Sanger warned that physicians would have to give up surgery entirely, select among reliable patients cases which promise favorable results, or, "... leave the afflicted poor, as barbaric tribes do, to perish by the wayside." In disgust and anger, he drafted a proposal to the Maine Medical Association: "Resolved, that with the existing laws on civil malpractice, it is unsafe to practice surgery among the poor." The medical society approved the resolution. 31

In the first half of the century physicians seldom accused lawyers of fomenting malpractice suits. They considered lawyers a sometimes ill-informed, but "noble sister profession." 32  Although change was already underway, physicians and lawyers earlier in the century were often drawn from the same social class. Both groups suffered under

29 Sanger quoted in "Medical Notes [Summary of Sanger's study]," RMSJ 99 (July 18, 1878): 91.


the anti-professional Jacksonian sentiment of the 1830s and 1840s. Perhaps this common ground, both socially and politically, bred sympathy.

But beginning in the 1870s physicians began to revile lawyers for their alliances with poor plaintiffs. By the 1880s the composition of the bar was more socially diverse, more lawyers came from the working classes, and the two professions lost some of their natural social affinity. In addition, the number of lawyers in the country increased in the last half of the century, from about 22,000 in 1850, to 60,000 in 1880, to 114,000 in 1900. Per capita estimates increased from 1 lawyer to 947 inhabitants in 1870, to 1 lawyer for every 662 inhabitants in 1900. This increase put financial and competitive pressures on American lawyers and may have driven some to create business in previously objectionable ways.

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By 1877 a physician exclaimed that "A surplus of cheap and briefless lawyers fosters the spirit of litigation, which is too common among certain classes of all large cities."\(^{36}\) Another complained that "Every large city is overrun with petty lawyers, who have little or nothing to do, and are always willing to undertake any suit whether there is the least prospect of getting something out of the defendant."\(^{37}\)

The variety of pejorative titles and metaphors physicians dreamed up for plaintiff's attorneys reflected the depth of the medical profession's new fears. Physicians called malpractice lawyers "legal adventurers," "pettifogging attorneys," "human vampires," "sharks," "jackals," and "shysters."\(^{38}\) An Illinois physician in 1882 claimed that unethical lawyers played the central role in inciting unwarranted suits. He warned his colleagues to beware of the "wily machinations of that most despicable of

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37 Doering, "Mutual Protection," 114.

creatures (excepting only the quack doctors)—the shyster lawyer like the vulture hovering near his prey, he quietly watches for his opportunity to pounce upon the purse of the unwary surgeon." 39 Theoretically, the common law offenses of barratry and maintenance prohibited lawyers from inciting suits. Unfortunately for physicians many states required a succession of abuses before charges could be filed, and the remedies were rarely invoked. 40

While lawyers were an important component in the prosecution of malpractice cases, they did not constitute the chief cause of increased litigation. Their relative contribution has yet to be unravelled but the social and cultural factors behind patients' proclivity to sue are surely involved in the more fundamental explanation. Lawyers were, at most, a match to a fuse; another immediate, aggravating cause of the late century suits.

Physicians denounced the increased use of contingency fees. The no award—no fee arrangements were not unknown in the first half of the century. However, contingency arrangements were probably a more informal, and less visible aspect of legal practice. Physicians rarely mentioned contingency arrangements in conjunction with malpractice

40 Weist, "Civil Malpractice," 165.
suits. In the last third of the century, they became a common, if incompletely accepted, legal practice. Lawyers who employed them charged no initial fee and generally received fifty percent of the damage award if victorious. Defendants could not benefit from the contingency fee's new popularity, and defendant physicians felt that they were at an immediate disadvantage. Physician-defendants would have to pay for their legal help and expert witnesses whether they won or not. In addition, doctors believed that contingency fees, by giving the attorney an interest in the case, tended to increase the amount of damage awards. William Wey, president of the New York State Medical Society, argued that attorneys who encouraged suits and then represented patients under contingency fee arrangements were "mischief makers" and "professional pirates" who were themselves guilty of the "most flagrant malpractice."[41] The Medical Times editorialized "that respectable members of the legal profession do not usually accept contingent fees from poor people."[42]

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41 Wey, "Medical Responsibility," 83.

The editorialist's comment reflected the profession's persistent belief that malpractice suits were a subtle form of class and status conflict. It also strengthened the overt and underlying connections between physicians and other personal injury defendants, especially corporations. Like physicians, corporations, mainly railroads, became the frequent object of damage claims beginning in the late 1830s. By the last third of the century, railroads and other corporations were suffering an intensified rate of personal injury litigation.

As in malpractice suits, a growing number of plaintiff's attorneys accepted contingency fees when attacking corporate defendants. Although the United States Supreme Court upheld the legitimacy of contingency arrangements, elite legal professions condemned them. Supreme Court Justice Joseph Bradley declared that the fee "degrad[ed]" the profession and encouraged "[s]tale or doubtful claims, which would have never been put in suit." Finally, Bradley felt that "the peace of society is disturbed by litigation fomented by those

who are not concerned with it."44 Thomas McIntyre Cooley, one of the most influential constitutional theorists of the century, claimed that the fees produced "a feeling of antagonism between aggregated capital on the one side and the community in general on the other."45

Observers like Bradley and Cooley feared the social unrest and class disquiet of the late nineteenth century and believed that contingency fees gave poor, resentful plaintiffs the means to attack innocent targets. Granger and Populist groups harassed propertied interests in state legislatures while individuals sued corporations for personal injuries. Poor patients were able and willing to sue physicians, the representations of status and privilege, and gradually increasing income.

Although conservative critics overstated the threats of irresponsible democracy, it is easy to see how physicians believed that corporations and medical men were the working class' common victims. During the Jacksonian period, popular feeling ran against banks and physicians. By the 1870s, railroads had replaced financial corporations as the focus of


popular resentment, but physicians remained villains through both periods.

**Remedies**

Physicians in the late nineteenth century proposed remedies and strategies to discourage malpractice suits. Antebellum doctors were concerned with the problem, but their solutions were fewer, less sophisticated, and generally useless. Physicians at mid-century had regularly threatened to shun complex fracture cases if the danger of lawsuits did not diminish, but apparently only a few physicians actually resorted to this tactic. Most physicians probably felt that turning away injured patients would violate the humanitarian foundation of medical practice. The large number of regular and irregular practitioners in Jacksonian America also undermined the effectiveness of this remedy. If one physician abandoned fracture treatment a competitor was always waiting to take his business. Finally, avoiding dangerous cases was an inappropriate response to the malpractice "crisis" because only a small minority of patients sued their physicians. By refusing to treat a whole class of cases, a physician turned his back on many deserving patients and their fees.
Editorialists in the 1840s and 1850s had also believed that raising educational standards and reinstituting licensure would raise the profession's status and blunt the malpractice threat. By 1900 the profession was well on its way to accomplishing those goals. A new model medical school was in place and proprietary institutions were rapidly closing their doors. Similarly, almost all the states which required licensure before 1850s had reestablished them before the turn of the century. Neither of these successes appeared to have any impact on patients' propensity to sue.

While it is difficult to determine how much late nineteenth century proposals influenced litigation rates, physicians developed additional and more comprehensive remedies than their mid-century counterparts. Most solutions were designed to stem the tide of suits without undermining the profession's dignity, or blunting their boldness in practice.

In a bizarre 1871 anecdote, a fracture patient told his physician that he was going to sue for his badly healed leg. The physician asked the man to his office and offered to operate on the limb and repair the deformity. When the

patient refused, the doctor knocked him down, chloroformed him, and operated on the unconscious man's leg. The patient recovered and dropped all charges against the physician. A medical journal praised the physician for having "the courage that many surgeons lack, to take the responsibility to act, and look up the law afterward."47 Such approaches to the malpractice problem were rare.

Some physicians believed that charging fees to all patients would discourage litigation. D.W. Cathell, who published The Physician Himself in 1882, continued the refrain that poor patients were not to be trusted. He counselled his colleagues that ". . . you should not induce people to let you involve yourself for their benefit without being paid for your risk and responsibility." Cathell believed that physicians should "send [their] bill promptly to dissatisfied patients who are threatening to sue for malpractice. . . .[S]ending your bill," he reasoned, "gives you a better position before the public, and raises an issue that checkmates theirs. Do not fail to charge the full amount in all such cases [original emphasis]."48


A writer for the New York Medical Journal also believed that immediate payment of fees was "the best possible safeguard" against suits for malpractice.49 Such commentators reasoned that patients, having paid for the services, would be less tempted to escape the charges by a claim of malpractice. Moreover, they hoped that a paid fee implied satisfaction and would be a good defensive weapon in court. Despite the internal logic of this tactic, the realities of medical practice rendered it unfeasible. As part of their self-image and public posture, physicians were expected to perform a certain amount of charity practice and could never completely eliminate non-paying patients.

Late nineteenth century physicians seldom blamed their colleagues for instituting suits because strengthened professional organizations were able to soften the competitive medical market of the 1840s.50 Local and state medical societies with enhanced moral and professional authority discouraged physician complicity in malpractice suits. Stephen Smith advised that the class of physicians who incited litigation "should be stricken from the membership of every medical organization."51 During the late 1870s medical

49 "Remarks on suits for Malpractice," NYJM 65 (May 15, 1897): 676-8 at 678.
51 Smith, Doctor in Medicine, 156.
societies condemned "ill advised" remarks against "brother practitioners," and ostracized members who willingly supported unjustified suits. The Baltimore Medical and Surgical Society encouraged its members to "be on the safe side by actively discouraging all such suits." By the 1880s attorneys and the public believed that members of the medical profession invariably supported the malpractice defendant. Physicians, however, responded that "This is as it should be because we can always give the benefit of the doubt to the right side."53

As frequent malpractice prosecutions became a permanent feature of American medical practice, advice literature became more prevalent. "It would seem," a speaker told the Medico-Legal Society of New York in 1876, "that the most efficient means of prevention (and consequently self-protection) is enlightenment—the knowledge of medical men of their legal duties and liabilities, the knowledge among courts of law and the general public of the possibilities of surgical skill."54 Medical jurisprudence was not a standard


part of medical school curriculums in the 1870s and interested physicians had to rely on handbooks and professional journals for practical guidance.\textsuperscript{55} John Elwell's 1860 treatise on malpractice was reprinted three times before 1881, John Ordronaux published his erudite *Jurisprudence of Medicine* in 1869, and Milo McClelland added a huge compendium, *Civil Malpractice: A Treatise on Surgical Jurisprudence*, in 1877. McClelland reprinted extensive samples of Frank Hamilton's fracture table and representative court decisions that "are inaccessible to medical and legal practitioners."\textsuperscript{56} His commentary explained the various legal dangers of medical practice.

Physicians turned to professional periodical literature for more practical advice and strategies. One article counselled that the prospective defendant, "instead of spending the best of his time in vehement vituperation

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1878 (N.Y.N.Y.: The Medico-Legal Society, 1886), 286-305 at 305.


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against 'ungrateful patients,' [and] 'rascally lawyers' . . . should select one or more good lawyers, and go to work, for a malpractice suit means business." The defendants should coach their attorneys on the medical and anatomical aspects of the case. They should also interview their expert witnesses, with their attorneys, before the trial. Juries, according to the article, "are partial to print [so] It is better to have six recorded cases similar to the one under trial, than the testimony of six experts." Medical journals also instructed defendants in finer points of trial tactics. Writers warned defendants to avoid continuations of trials from one term to another because valuable evidence could be lost. They also cautioned physicians "not [to] reveal to the outside world what you propose to use as evidence." Plaintiffs' depositions, a potential source of defense evidence, should be taken as early as possible. Some writers suggested that physicians could best avoid and defend suits by practicing more "ethical" medicine. According to McClelland:

To avoid the annoyance of such suits, surgeons should above all be honest with their patients,

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58 "Actions for Malpractice," NYMJ 68 (December 24, 1898): 940.
apprising them of the difficulties of the case and the uncertainties of perfect results . . . They should be candid in regard to their deficiencies, claiming no more than they can perform, no more knowledge than they possess.59

Other writers advised physicians to drink moderately, or not at all, and to "[b]e careful in profession deportment" and diligent in their studies, keeping up with every advance. Cautious physicians warned patients, "in the presence of a brother practitioner [of] all the possible contingencies which may result from the operation—be they ever so remote." One writer claimed that the reputation of a good, safe, physician "will make imputations of malpractice too improbable to be feared."60

Most observers doubted that ethical and careful medical practice, alone, immunized physicians against malpractice charges. Medical men claimed that most suits and threats of suits were only "blackmail" ruses to extort money from reputation-conscious medical men. They argued that most plaintiffs and lawyers did not intend for their cases to reach the courtroom but hoped to settle out of court. The generally low quality of the plaintiff's expert witnesses and evidence, and estimates of acquittal rates that sometimes

59 McClelland, Civil Malpractice, 528.

reached nine out of ten, lent credibility to physicians' claims. Many physicians, according to one journal, would have been "unwilling to face the annoyance and publicity which a trial necessarily entail[ed]." When John Reese, an expert on medical jurisprudence, faced a malpractice case, he "might have easily avoided [it] by listening to the base proposals of the plaintiff's counsel to pay blackmail." Instead he decided, in his words, "fearlessly [to] meet this lawsuit."61 Lewis Sayer and Samuel Gross, two renowned surgeons, were also sued in the early 1870s. Plaintiffs' attorneys attempted to settle the cases out of court but both men declined. Gross, "scornfully refused . . . deeming it but just to himself and to the profession to defy the threats of the plaintiff."62 When Reese, Sayer, and Gross decided to face public trials, their prosecutors were left with embarrassingly weak cases and lost.63 After the trials, the Medical Record entreated, "Let us hope that the manly conduct


of Professors Gross and Reese . . . as well as the results of
the suits . . . has convinced the legal fraternity that
members of our profession, one and all intend to resist all
attempts to levy blackmail upon them."64

The message was clear. Most charges were unwarranted
and indefensible. Lawyers' established strategy, and best
hope, was to coerce the payment of "smart money." When the
physician refused, he won his case and was congratulated in
the pages of medical journals. Wealthy surgeons, especially
preferred to pay off plaintiffs, but editorialists argued
that this was a "mistaken policy, and has a tendency to
propagate an evil which in the end reacts with terrible force
upon the poorer surgeon."65 McClelland, in his commentary on
malpractice, declared that "Under no circumstances should
suits be compromised." After performing their duty, surgeons
"owe it to their professional brethren to let the matter be
tried by the letter of the law."66

64 "The Suit against Professor Gross," MT 1 (May 1871): 281.

65 "Blackmailing of Surgeons and Malpractice Suits," MR 13
(April 20, 1878): 315-6. Also see, "The Proper Steps in Suits

66 McClelland, Civil Malpractice, 528.
Mutual Protection

Physicians slowly realized that profound problems were involved in fighting every case in court. Besides risking their reputations, legal fees and court costs were often prohibitive. One doctor, a defendant in two trials in the 1870s, reported that he paid eleven hundred dollars to lawyers and witnesses, and for other court costs.67

The threat of suits, financial realities, and the commitment to fight all charges of malpractice inspired the innovation of group defence organizations. In 1886, a speaker before the Chicago Medical Society proposed the creation of an association of local physicians. Each physician, after screening by the society, would contribute five dollars a year to the legal defense fund. The association would hire a prominent law firm to defend any suit arising against a member physician. According to the speaker, "Let it be known that the individual physician is backed by the financial and moral support of a few hundred of the best physicians, and aided by the best legal talent available, and he will be let severely alone by the dregs of society who constitute, almost without exception, the blackmailing element in our professional life."68

68 Doering, "Mutual Protection," 114.
Although some critics believed that a mutual defense association would "prejudice the jury against the defendant, just as corporations do," the notion gained many converts in the 1880s. In 1887 a writer for the Boston Medical and Surgical Journal agreed that physicians should combine to protect themselves from the "ever impending risk of actions for malpractice." Since the litigations were expensive in time, money, and anxiety, "there are few [physicians] who can afford to engage in defending a suit[,] an easy and honorable way of avoiding it is afforded."69 By the first decade of the twentieth century medical-society-sponsored legal defense associations had become popular in many areas including, Massachusetts, New York, Chicago, Cleveland, and Detroit. Local medical societies embraced the innovation with enthusiastic, but ultimately unfounded, optimism. In 1902 the New York State Journal of Medicine predicted that "through the publicity given to a suit or two, the blackmailing variety of malpractice suits will cease. This class constitutes 97% of all such suits brought."70


The medical defense leagues were closely linked with the rejuvenated professional organizations of the late nineteenth and twentieth centuries. Physicians became increasingly confident that they could slow malpractice rates by group concert. Group defense associations could promote medical malpractice insurance, and societies could castigate or even expel members who instigated or participated in suits. As medical societies gained control over licensure, access to hospital practice, and referrals, they could increasingly dictate individual physicians' behavior.  

Organized physicians were also becoming a more potent political force, and many medical societies began to investigate legislative remedies to malpractice suits. As an 1882 writer contended, the "medical profession surely is entitled to, and I believe possess, sufficient influence if we would exert it, to have framed and passed by our legislative bodies such laws as we are justly entitled for our protection."  

Medical societies drafted prospective legislation that would retain the jury trial but institute a system by which the court, and not the parties to the suit

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72 Powell, "Surgical Malpractice," 236.
would select the expert witnesses who would be paid by the county.

Sponsors believed that this provision would decrease contradictory, and interested testimony, and protect defendants. Other proposals included recommendations that prospective plaintiffs be forced to post bonds to cover the costs of the trials. Physicians designed this alteration with the litigious poor patient in mind, but they held little hope of getting it passed in state legislatures because it clearly prevented legitimate claims from being brought by destitute patients. Some proposals merely asked for the legitimation of "contracting away," while others petitioned for the complete abolition of the jury trial. The Ohio Medical Association, for example, sent a draft to the legislature to introduce trial by arbitrators to the state. The three man board would consist of three physicians: one chosen by the plaintiff, one by the defendant; and the third by the other two arbitrators. The spate of proposals in the


last two decades of the century were not fruitful. State legislatures did not institute any significant changes in the malpractice trial procedure and the process remained essentially unchanged.

The Law

Despite the significant leap in appellate decisions between 1865-1900, the basic requirement that physicians " . . . must possess and exercise that degree of skill ordinarily possessed by members of the profession" proved durable and the doctrine governing malpractice law remained essentially unchanged. Courts reaffirmed the pre-war doctrine that physicians did not automatically guarantee cures, but were only responsible for failures if they specifically promised success.76 Most of the many appellate cases in the late century dealt with important, but mechanical, procedural, pleading, or administrative issues, or questions of fact relating only to individual cases.77 State appellate judges ruled on the proper role of expert testimony. Witnesses could offer, or comment, on hypothetical examples to

76 Ritchey v. West 23 Illinois 329 (1860).

illustrate a case, but they could not draw conclusions on the facts of the case. When witnesses crossed this indistinct line, appellate judges usually overturned the lower court decision.78

Appellate courts also reversed decisions in which the verdict seemed to be unjustified by the evidence. For example, an 1875 jury ignored the overwhelming evidence that a physician had properly set a plaintiff's broken arm and awarded $4,000. The Minnesota supreme court reversed the decision and granted a new trial because "the jury did not accept and weigh as they should have done, the testimony of the experts, but must have acted independently of it."79 Appellate judges also reversed decisions when trial judges made inappropriate conclusions on the facts when defining the legal issues for (charging) the jury.80

These rulings were important, occasionally significant as precedents, but they did not set a basic common law

78 Hoener v. Koch 84 Illinois 408 (1877); and Weigel, "Medical Malpractice," 199.

79 Gerchell v. Hill et al. 21 Minnesota 464 (1875). Also see Fisher et al. v. Niccolls 2 Illinois Appeals 484 (1877); Gores v. Graff 77 Wisconsin 174 (1890); Stevenson v. Gelsthorpe 10 Montana 563 (1891); Feeney v. Spalding 89 Maine 111 (1896); and Richards v. Willard 176 Penn St 181 (1896) for samples of cases overturned for verdicts rendered against the weight of the evidence.

80 Lillie E. Spalding v. Lyman W. Bliss and Eugene W. Davis 83 Michigan 31 (1890).
doctrine of malpractice. Courts were frequently asked to rule on trial judges' variations of "ordinary standard of skill and care" requirement. Appellate courts overturned convictions in cases in which trial judges required the skill of a "... thoroughly educated physician." State supreme court judges also rejected trial definitions which demanded that the physician possess and exercise "full skill," or, be liable for "any want of skill." These definitions set too high a standard for medical practitioners.\(^{81}\) When a trial court announced that a physician must take advantage of the "most accredited sources of knowledge," an Iowa supreme court overturned the judgment because it demanded a too high standard of education.\(^{82}\) An appellate court also reversed a decision in which the trial judge instructed the jury that if the physician "could have learned the nature of the injury, and applied the proper remedy, and failed, he is liable."\(^{83}\) And, in 1873, the Indiana supreme court overturned a conviction in which the judge stated that a physician is "required to exercise care and skill proportionate to the

\(^{81}\) Weigel, "Medical Malpractice," 195-6; McNeivins v. Lowe 40 Illinois Rep 209 (1866); and Smothers v. Hanks 34 Iowa 286 (1872).

\(^{82}\) Almond v. Nugent 34 Iowa 300 (1872).

\(^{83}\) Quinn v. Donovan 85 Illinois 194 (1877).
character of the injury he treats." Courts rarely held that the degree of care and skill set by the trial court was too low.

Although rulings varied slightly from state to state, courts in the late nineteenth century accepted a variety of substitutes for the term "ordinary" in the description of the physician's responsibilities. Appellate judges generally agreed that terms such as "average skill," "fair knowledge and skill," "adequate care," and "reasonable skill," were legitimate synonyms for "ordinary." These modifications did not materially alter the doctrine and judges continued to use mid-century precedents to frame the basic charge to malpractice juries. Late nineteenth century treatises on malpractice and tort reflected this continuity. Elwell's work on malpractice remained essentially unchanged through four editions. Thomas Cooley's 1906 Law of Torts held that a physician must "possess ordinary skill, [and] that he will use ordinary care."

84 Utley v. Burns 700 Illinois 162 (1873).

85 Kendall v. Brown 74 Illinois 232 (1874); Jones v. Angell 95 Indiana 376 (1883); and Carpenter v. Blake 60 N.Y. 12 (1878). See David McAdam, Malpractice with Reference to the Legal and Medical Professions (1893), 13.

The organizational structure of medical practice changed considerably between 1865-1900. The absolute dominance of the solo practitioner began to wane and physicians joined with other physicians, clinics, and hospitals. The increasing importance of technology, and access to new techniques encouraged hospital practice. Most hospitals in the first two-thirds of the century were charity institutions. As hospitals became increasingly important in the delivery of medical care, they also became targets of malpractice charges.

These developments required additions to, but no significant alteration of the common law. The legal doctrine concerning charity hospitals was clear and unequivocal. Although physicians who practiced at the institutions were liable for their conduct under the standard rules of law, the hospital was virtually immune from prosecution. If the charity hospital had "exercised due care in the selection of

Medical Jurisprudence for the Use of Students at Law and of Medicine (Boston: Little, Brown, & Company, 1887), 282-3.

its agents, it [was] not liable for injury to a patient caused by their negligence."\textsuperscript{88}

Group practices, like the Mayo Clinic, and for profit hospitals also proliferated. As malpractice plaintiffs brought these institutions before courts, judges held them responsible only for exercising "due diligence in securing skillful and careful medical men for the treatment of its patients."\textsuperscript{89} Some railroad companies organized hospitals or clinics to provide free care for their employees. Courts generally gave the railroad company the benefit of the doctrine that applied to other medical institutions.\textsuperscript{90} Judges and juries ruled that the doctrine of respondeat superior did not apply to hospitals and clinics.\textsuperscript{91} This

\textsuperscript{88} McDonald \textit{v.} Massachusetts General Hospital 120 Mass 432 (1876). Also see: Downes \textit{v.} The Harper Hospital 101 Michigan 555 (1894); and Hearns \textit{v.} Waterbury Hospital 66 Connecticut 93 (1895).


\textsuperscript{90} Union Pacific \textit{RY Co. v. Artist} 60 Fed. Rep. 365 (1894); and Eighmy \textit{v.} Union Pacific Railway Company 93 Iowa 538 (1895).

\textsuperscript{91} Respondeat superior held that employers were liable for the actions of their employees. During the first half of the century many jurisdictions relaxed this requirements, but by
generous doctrine allowed most medical institutions to escape payment of damages in the nineteenth century.

The last third of the century brought other notable changes to the law of malpractice. In antebellum America, if a patient contributed in any way to his injury, the physician could not be held liable for malpractice. The doctrine rarely influenced verdicts in the first half of the century, perhaps because it was a harsh, complete, defense and entirely absolved the defendant-physicians.\textsuperscript{92} Courts continued to accept a strict interpretation of contributory negligence in malpractice cases through the end of the century. In 1883, the Indiana supreme court ruled that "a party seeking to recover for an injury must not have contributed to it in any degree, either by his negligence or the disregard of a duty imposed upon him by his physician."\textsuperscript{93}

Appellate judges, however, fashioned exceptions to the strict doctrine of contributory negligence. In \textit{Carpenter v. Blake} (1878), a physician's attorney asked a trial judge to instruct the jury that if the patient had contributed in any degree to his injuries, then the physician was not

\begin{itemize}

\item the late nineteenth century, courts had again begun to hold employers responsible for the actions of their workers.

\item See Chapter 2, above.

\item \textit{Jones v. Angell} 95 Indiana 376 (1883). Also see, \textit{Hibbard v. Thomson} 109 Mass. 286 (1872); and \textit{Potter v. Warner} 91 Penn St. 362 (1879).

\end{itemize}
responsible even if he too was negligent. The judge refused, and the jury found the physician guilty of malpractice. The physician claimed that he had not received the full benefit of the contributory negligence defense. The New York state supreme court, however, ruled that once the physician had negligently caused an injury, "The most that could be claimed on account of any subsequent negligence would be that it should mitigate damages."94

An Albany Law Journal writer explained in 1881 that while irresponsibility and complicity of patients usually absolved the physician from all liability, the doctrine could have limits if the respective responsibilities could be "separated."95 This version of contributory negligence was especially important in cases in which patients refused to follow the instructions of their physicians. In Dubois v. Decker (1891), a physician failed to leave enough tissue to cover the protruding bone on the stump of a patient's amputated leg. Consequently, the leg took an inordinately long time to heal, and the patient was left with protruding


bone. The physician argued that the patient had refused to leave the leg in the prescribed position, declined to take medicine, and eventually left the physician's care without permission. The jury found the physician guilty of malpractice and he appealed the decision to the New York supreme court. Citing *Carpenter v. Blake*, the court ruled that even though the patient's actions may have aggravated his injury, the physician was clearly liable for the initial malpractice. Therefore, the patient's actions could only mitigate, and not preclude the damage award he would receive from the physician.  

It is difficult to gauge the effect of contributory negligence on malpractice cases. Each state developed variant patterns and bodies of case law, but a clear softening of the doctrine occurred in most jurisdictions. In the first half of the century when the doctrine was in its strict form, judges and juries seemed to avoid its use in malpractice cases because it completely indemnified physicians from liability. Even though the softened version of contributory negligence threatened physicians because it abandoned absolute immunity, it may have indirectly helped them by forcing juries and judges to reduce damage awards.  

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96 *Dubois v. Decker* 130 N.Y. 331 (1891).

97 The full history of the doctrine and application of contributory negligence has yet to be written. The best introduction is Wex S. Malone, "The Formative Era of
Locality Rule

Another late innovation in malpractice law bestowed unambiguous advantage to the defendant-physician. Through the first two-thirds of the century physicians, and scattered trial court judges, held that malpractice defendants should be measured against the "ordinary" practitioners in the locality in which they practiced. These physicians and jurists argued that physicians' skill, education, and experience differed greatly in different geographic locations and social surroundings. It was unrealistic and unfair for a jury to require the same degree of skill from a small town, rural practitioner as from a hospital-based physician with a thriving urban practice. Notwithstanding these arguments, trial judges only rarely instructed juries to calculate medical competence by community standards and appellate courts never made the notion part of malpractice doctrine.98


98 See Chapter 2, below.
Despite appellate judges' mid-century indifference toward the locality rule, physicians and treatise writers continued to campaign for its inclusion into case law. Elwell supported community standards in 1860, as did Ordronaux in 1869.\textsuperscript{99} Redfield in his important 1870 treatise on negligence cited no precedential support, but asserted that "the standard of skill may vary according to circumstances, and may be different even in the same state or country." He explained that in "country towns, and in unsettled portions of the country remote from cities, physicians, though well informed in theory, are but seldom called upon to perform difficult operations in surgery, and do not enjoy the greater opportunities of daily observation and practice which large cities afford." Therefore, he declared that it would be unreasonable to expect the same degree of skill from both classes of physicians.\textsuperscript{100}

In the wake of these writings, the idea became more visible both in trial and appellate courts. William Wey called for the universal use of the locality rule in 1872. He noted that "This estimate of skill has undoubtably been considered by courts in holding physicians to account for

\textsuperscript{99} Elwell, \textit{Treatise on Malpractice}, 22.

alleged malpractice, and in this way we are enabled to reconcile the otherwise conflicting character of the principles of law by which such cases have been governed."101 Appellate judges began to discuss the community standard rule in their judicial opinions. The Kansas supreme court in *Teft v. Wilcox* (1870) quoted Elwell, and stated that "The opportunities by reason of locality, or other circumstances, on one portion [of the profession], may be many times more favorable than those of another; and the responsibilities resting upon them would be correspondingly greater."102 However, the court reversed the physician's conviction on other grounds. Therefore, the comments were probably obiter dictum and did not have the precedential legitimacy of an explicit ruling on the issue.

In *Smothers v. Hanks* (1872) the locality rule continued to work its way into malpractice law. The Iowa supreme court overturned a malpractice conviction because the trial judge's charge to the jury required that the defendant be a "thoroughly educated" physician. In addition the majority decision, citing Redfield, and noted that "It is also doubtless true that the standard of ordinary skill may vary even in the same state, according to the greater or lesser

101 Wey, "Medical Responsibility," 72, 73.
102 *Teft v. Wilcox* 6 Kansas 46 (1870), at 63, 64.
opportunities afforded the locality for observation and practice."103 Like *Teft v. Wilcox*, *Smothers*' discussion of the community standard was superfluous to the central issue of the appeal and its comments were probably not binding as precedent.

The locality rule did not yet command universal approbation. A dissenting judge in *Smothers* argued against the locality rule because "[i]n this age [1872] of books, professional periodicals, and mails . . . [w]e may safely say that no respectable surgeon, wherever he may be, is uninformed of the the progress and discoveries in his profession."104 The Vermont supreme court accepted a trial court charge to a jury which incorporated the rule in 1876 without comment. The following year, the Indiana supreme court refused to overturn a conviction on the grounds that the trial judges did not invoke the community standard.105

The Massachusetts supreme court provided the definitive precedent in support of the locality rule in 1880. A small town man sued his physician for unsuccessfully treating a

103 *Smothers v. Hanks* 34 Iowa 286 (1872).


105 *Hawthorn v. Richmond* 48 Vermont 557 (1876); and *Gramm v. Boener* 56 Indiana 497 (1877).
severe and complicated injury. Over the objection of the patient, the trial judge instructed the jury that the physician was "bound to possess that skill only which physicians and surgeons of ordinary ability and skill, practicing in similar localities . . . ordinarily possess."
The jury found for the physician, and the patient appealed the case to the state supreme court claiming that the community standard rule lowered the standard of care required of a physician. In Small v. Howard (1880) the appellate court ruled that it was a matter of common knowledge that physicians in small country towns and villages could not possess the same degree of skill as their big city counterparts who had more opportunities to observe practice.106

Small v. Howard ushered in an almost universal, one-hundred year, acceptance of the locality rule. The doctrine was a powerful defensive weapon for defendants. It explicitly lowered the standard of skill courts required of some physicians. In its strictest form, it limited the pool of expert witnesses to those physicians who practiced in the same community as the defendant. As professional opposition to malpractice suits solidified and local medical societies gained coercive power over their members it was sometimes

106 George S. Small v. Levi Howard 128 Massachusetts 131 (1880) at 131, 136.
difficult for plaintiffs to secure qualified expert testimony. Physicians who were the sole practitioners in their communities could likewise escape prosecution by asserting that they set the standard of care for their location, or by claiming that there existed no legitimate expert witnesses to participate in the trial.

Judges soon recognized the difficulties of narrow applications of the locality rule and modified the doctrine. Appellate courts ruled that physicians should not be protected merely because they were the only practitioner in a particular community. They altered the locality rule so that physicians were required to exercise the skill and care of medical men in "similar," or "like," surroundings. This adjustment in the doctrine made it easier to prosecute isolated practitioners and to secure expert testimony in communities where physicians had established a united front against malpractice prosecutions.


108 Pelkey v. Palmer 109 Mich 561 (1896); and Whitesell v. Hill 101 Iowa 630 (1897). Progressively more exceptions were made to the locality rule until 1868 when states began to eliminate it outright. See, Waitz, "The Rise and Gradual Fall," passim.
New Treatments, New Suits

Treatment for fractures and dislocations continued to generate the vast majority of malpractice suits through the beginning of the twentieth century. A writer in 1884 estimate that nine-tenths of all suits were the result of orthopedic treatment. This figure was undoubtedly inflated. Fracture and dislocation cases probably constituted between two-thirds and three-quarters of the litigation.

Some physicians claimed that fracture cases remained common because those injuries plagued manual laborers, "... the poorer and more ignorant classes ... precisely the class to be influenced, by their necessities, to be open to the golden dreams of plenty which a crafty and unscrupulous lawyer knows how to awaken." The explanation is somewhat more complicated. The first rise in suits had been fueled in part by the rapid advances in fracture treatment between 1820-1850, and the accompanying, exaggerated, expectations. Frank Hamilton and his supporters had believed that his 1850s fracture tables would

110 Weigel, "Medical Malpractice," 193.
111 Hodges, "Malpractice," 155.
112 See Chapter 4, above.
stifle suits for this class of treatment. They reasoned that statistical demonstrations of standard treatments and standard results would lower the expectations of both physician and patient and provide evidence of what constituted competent practice.

Despite their popularity and wide dissemination, Hamilton's tables, and other similar strategies could not suppress suits. The device was ultimately ineffectual because it could not take account of perpetual, and rapid, medical technological advancement. By the mid-1870s, the profound advances of antebellum fracture treatment had been superseded. For example, in the 1870s, plaster of Paris dressings for fractures became "the rage, and, he who neglected to employ it was an 'old fogey' or was not up in progress." The initial reports of plaster of Paris recalled the early responses to the advances of the pre-war years. Enthusiasts claimed perfect cures with no shortening or deformity. The innovation brought about a "revolution" in fracture treatment. Older methods were "thrown out as relic[s] of barbarianism." However, results did not always meet expectations and less proficient physicians did not always achieve optimum results. Consequently, the
"revolution" of plaster of Paris engendered suits, just as the advancements of the first half of the century.\textsuperscript{113}

In fractures, as well as other areas of medical treatment, innovation often ran through the cycle of advancement, inflated expectations, limited successes, and lawsuits. By the 1890s fracture treatment had undergone yet another "revolution," provoked in part by the advances in aseptic surgery, and physicians predicted total cures. One writer in 1893 reported that "So great and rapid have been the advances in the treatment of compound fracture within the last two decades that, when properly managed, now many lives and limbs are spared which were formerly sacrificed, distortions obviated, inflammation, necrosis, tetanus, and mortification prevented." Recent advances had brought "the treatment of compound fractures to well-nigh a state of perfection.\textsuperscript{114} Despite the steady advancement, suits for fractures continued.

Although fracture cases dominated malpractice, new classes of suits arose out of new and improved practice.

Ophthalmology, after the invention of the ophthalmoscope in 1851, made rapid and dramatic advancements in the last half

\textsuperscript{113} Thomas Manley, "The Medico-Legal Aspects of Fractures of the Bones of the Extremities, and Others," \textit{NYMJ} 58 (September 9, 1893): 281-90 at 288-9; and Heavy Damages in a Malpractice Suit," \textit{MR} 41 (January 30, 1892) 131.

\textsuperscript{114} Maley, "Medico-Legal Aspects," 290.
of the century. Accompanying this progress, suits against physicians for eye damage became more common between 1880-1900. With the advent of antiseptic and aseptic practice, the knowledge of anatomy, and new instruments, body cavity surgery became a viable and attractive frontier for physicians. Obstetric and gynecological surgery especially flourished between 1880-1900. Surgeons performed a variety of new and often unjustified operations on women's reproductive organs from clitoridectomies to hysterectomies. These cases contributed to the rising, and increasingly diverse body of suits. Women sued

115 Fielding H. Garrison, An Introduction to the History of Medicine (Phil.: W.B.Saunders Company, 1914): 548-55. For example of suits see: Jones v. Vroom et al. 8 Colorado 143 (1896); "Some recent Malpractice Suits," MR 28 (December 19, 1885): 690-1; Feeney v. Spalding 89 Maine 111 (1896); and Peck v. Hutchinson 88 Iowa 320 (1893). If a physician portrayed himself as a "specialist," such as an ophthalmologist, the ordinary skill and care test was modified to "the degree of skill and diligence which other physicians in the same general neighborhood and in the same general line of practice ordinarily have and practice." See Force v. Gregory 63 Connecticut 167 (1893).

116 Although Joseph Lister began to popularize his theories on antiseptic surgery in the late 1860s, his ideas were not perfected and accepted on a wide scale in America until the mid-to late 1880s.

physicians, beginning in the 1880s, for removing their ovaries unnecessarily, or without their consent. They also accused physicians of malpractice for complications following obstetrical surgery. By the 1890s surgical techniques and equipment had become sophisticated enough to justify regular forays into the abdominal cavity. And, by the first decade of the twentieth century, patients were suing their physicians for surgically related offenses such as leaving sponges, broken needles, or drainage tubes in patients' bodies. However, general surgery cases would not surpass orthopedics as the most common source of malpractice suits until the 1940s.

The speed of medical innovation created opportunities, dilemmas, and dangers for physicians. Medical men who attempted new, non-standard, procedures did so at their own peril. A physician who practiced in the late nineteenth century noted in his memoirs that "The surgeon who is

118 "Some Recent Malpractice Suits," MR 28 (December 19, 1885): 690-1

119 Langford v. Jones 18 Oregon 307 (1890); and Kansas v. Reynolds 42 Kansas 320 (1889); and Lewis v. Dwinell 84 Maine 497 (1892).

120 Rothstein, American Medicine, 258.

advancing his profession with new work stands at all times with the muzzle of a loaded gun hoping that no lawyer will come along to pull the trigger.\textsuperscript{122} At the same time, new procedures surfaced and were accepted faster than many physicians could assimilate them. In 1886 a physician used chloroform to sedate a young girl on whom he was performing eye surgery. During the operation, the patient flinched, and the surgeon's knife blinded her. The girl's parents sued claiming that standard practice demanded the use of cocaine as a local anesthetic in similar operations. The physician had consulted an 1880 treatise on eye surgery which prescribed chloroform. But by 1886, cocaine had superceded general anesthetic as the accepted analgesic in such operations.\textsuperscript{123}

Wilhelm Röentgen discovered the power of x-rays in November 1895. The inexpensive, and simple construction of the device put it in the hands of many of American physicians within weeks. Besides its intrinsic interests, physicians, as well as the public, immediately realized its diagnostic and jurisprudential potential.\textsuperscript{124} One optimistic writer


\textsuperscript{123} \textit{Peck v. Hutchinson} 88 Iowa 320 (1893).

declared that "The courts can show endless histories of grave errors committed, to the detriment of poor patients and not the less of poor practitioners; but the discovery of William Conrad Röentgen has come to do away with all of this."

Another observer in early 1896 predicted that x-rays would play a leading role in "cases where surgeons are charged with having overlooked a fracture, or dislocation, where no such injury is present." Many writers recommended its use in every orthopedic case.125

X-ray technology proved a mixed blessing for malpractice defendants. By 1896, less than a year after its discovery, patients were suing physicians for failing to take x-rays before fracture treatment.126 Other patients and their attorneys secured x-rays as evidence of a physician's incompetence. As a writer in 1899 claimed, "Ever since its discovery, especially in the last year, every malicious person who can scrape up enough money for a shadow-graph [x-ray] is having one taken for the purpose of bringing a damage suit for personal injuries or malpractice."127


126 Shikes, Rocky Mountain Medicine, 118-9; and "Report to the Committee," passim.

127 Quoted in "Report of the Committee," 32.
results, especially from the early equipment, were often
distorted, inconclusive, and vulnerable to subjective
interpretation by "innovative attorneys." Primitive
machines, rudimentary knowledge, and inexperienced operators
led to burned patients, and yet another source of malpractice
suits.128 In less than five years after its discovery, x-ray
technology evolved from a promising medical and legal tool,
to a source of suits when physicians failed to use it, to a
cause of suits when it injured patients. X-rays, and other
more sophisticated technology would played a much larger role
in malpractice litigation in the twentieth century.

Malpractice suits between 1865 and 1900 invoked the same
legal doctrine, followed the same patterns, and provoked many
of the same responses as they had in the pre-war years.
Appellate judges fine-tuned traditional common law doctrine
to create a standard that would last into the next century.
Technological advancement and professional relations had
begun to change the character of the phenomenon. Physicians
still blamed poor, resentful patients for their woes, but
they discovered a new villain, the lawyer. More tightly
organized medical societies, with the newly ratified locality

128 "Report to the Committee," 21, 25, 26; F. Boyd, "X-Ray
dermatitis; suit for damages," JAMA 30 (1898): 381; and Ruth
and Edward Brecher, The Rays: A History of Radiology in
America (Baltimore: The William and Wilkens Company, 1969),
106.
rule, were able to limit the use of malpractice litigation as an intra-professional, competitive weapon. By the 1890s American medicine was on the eve of modernization. As the scope of medical practice widened, the type of suits changed, hinted at the future, and provided a preview of the twentieth century.
Appendix A
Representative Malpractice Awards, 1865-1900

_Teft v. Wilcox_ 6 Kansas 460 (1870)/$2,900

John J. Reese, "Case of Alleged Malpractice," _MT_ 1 (Dec.1, 1870):73-4/$1,359.70

W. F. Hutchinson, "A Recent suit for Malpractice," _BufMSJ_ 12 (1872-73): 290-9/$4,000

_Smoters v. Hanks_ 34 Iowa 287 (1872)/$2,000

_Almond v. Nugent_ 34 Iowa 300 (1872)/$2,000

_Kendall v. Brown_ 74 Illinois 232 (1874)/$1,375.17

_Getchell v. Hill et al._ 21 Minn 464 (1875)/4,000

_Weger v. Calder_ 78 Illinois 275 (1975)/$1,500

_Musser v. Chase_ 29 Ohio St. 577 (1876)/$3,000

_McKeeho v. Hall_ (pre-1877), McClelland, _Civil Malpractice_, 261-9/$800

_Young v. Fullerton_ (pre-1877), McClelland, _Civil Malpractice_, 253-6/$1,000

_Means v. Hallam & Barns_ (pre-1877), McClelland, _Civil Malpractice_, 176-180/$1,000


_Brooke v. Clarke_ 57 Texas 1905 (1882)/$5,000

_Kelsey v. Hey_ 84 Indiana 189 (1882)/$4,000

"Some Recent Malpractice Suits," _MR_ 28 (Dec. 19, 1885): 690-1/$7,000

_Quinn v. Higgins_ 63 Wisc. 664 (1885)/$1,600

_Hyrne v. Erwin et al._ 23 S.C. 226 (1885)/$1,000
E.J. Doering, "Mutual Protection against Blackmail," JAMA 6 (1886): 114-7/$4,480

**Gates v. Fleisher** 67 Wisc. 504 (1886)/$350

**Holtzman v. Hoy** 118 Illinois 534 (1886)/$2,500

**Reber v. Herring** 115 Penn St 599 (1887)/$900

**Graves v. Santway** 6 N.Y. Supp. 892 (1889)/$500

**Josephine Sanderson v. Holland** 39 Missouri App. Reports 233 (1889)/ $1,000

**Jennie Langford v. Henry Jones** 18 Oregon 307 (1890)/$1,000

**Stevenson v. Gelsthorpe** 10 Montana 563 (1891)/$500

**Link v. Sheldon et al.** 136 NY App 1 (1892)/$4,000

**Lewis v. Dwinell** 84 Maine 497 (1892)/$450

**Peck v. Hutchinson** 88 Iowa 321 (1893)/$2,500

**Carpenter v. McDavid & Cottingham** 53 Missouri App 393 (1893)/$2,000

**Cayford v. Wilbur** 86 Maine 414 (1894)/$2,075

**Jackson v. Burnham** 20 Colorado 533 (1895)/$5,000

"Verdict Against a Physician," MT 47 (January 12, 1895): 64/$12,000

**Hedin v. Minneapolis Medical & Surgical Inst. et al.** 62 Minn. 146 (1895) $500

**Riognum v. Union Pacific Railway Company** 93 Iowa 538 (1895)/$1,500

**Gores v. Graff** 77 Wisc. 174 (1896)/$2,500
Malpractice suits became a prominent and permanent feature of American medical life in the 1840s. A combination of immediate, short-term causes, and underlying, long-term developments explain the first dramatic increase in the litigation. Although the short-term, inciting factors disappeared, new technological, social, professional and legal factors arose to take their place in generating suits. Moreover, the long-term cultural preconditions for the suits matured, allowed and even encouraged a broader range of society to sue for a wider range of misfortunes.

Physicians' declining status in the first half of the century provided the context for the initial malpractice "crisis." Poor, uneven, and disorganized medical education left physicians ill-prepared to deal with the complexities of the human body. The notoriously low quality of medical training aggravated the profession's declining status. Ironically, segments of the public in Jacksonian America distrusted physicians both for their poor education and for possessing any education at all. The prevailing spirit of the period glorified the virtues of native intelligence and common sense and derided formal education and the authority of experts. These sentiments formed the basis for the anti-
professional feeling that pervaded the age. In the increasing socially and politically egalitarian country, the public resented any quasi-aristocratic trappings of economic or social privilege. Physicians who had hoped to rely on licensure to improve the state of the profession antagonized large segments of the population who believed in the merits and morality of free and open competition.

Competition among regular physicians also played a central role in the initial increase in litigation. The weak, and ultimately non-existent, medical licensure laws of the Jacksonian period swelled the ranks of medical men. Dozens of medical schools with low educational standards graduated thousands of practitioners to compete for patients and fees. Intra-professional competition engendered suits in two ways. Individual physicians were willing to denigrate the therapeutic practices of their medical competitors to improve their own position. Open criticism often encouraged patients to sue their physicians. When physicians appeared as expert witnesses in malpractice trials, they often exaggerated their own abilities and results of their treatments while implicitly demeaning the defendant's performance. Other physicians used malpractice suits as a competitive weapon against potential competitors. They explicitly encouraged patients to sue rivals. Occasionally these attacks generated retaliatory suits. When rival
practitioners testified as expert witnesses, they were in a particularly strategic position to attack their competitors. Although local, state, and national medical societies existed at mid-century, they did not have sufficient influence or coercive power to effectively limit physician complicity in malpractice prosecutions.

Dramatic technological advances contributed to the rise in malpractice litigation. At the beginning of the nineteenth century amputation served as the standard treatment for severe fractures and dislocations. These cases generated few malpractice suits in the first third of the century. By 1840 physicians had learned to save seriously injured limbs that would have previously been amputated. These improvements inspired inflated expectations in both physicians and patients. Many professionals and laymen characterized orthopedic practice as a mechanical task with predictable, standard results. However, badly injured limbs, though saved, seldom healed perfectly. These cases constituted the bulk of the malpractice suits in the nineteenth century.

Anti-professional sentiment, low educational standards, intra-professional rivalry were central components in the increase of suits in the Jacksonian period. However, the mere existence of these factors would not have generated suits without the accompanying appearance of three,
interrelated cultural preconditions. Although community life had been evolving for at least a century, traditional community customs inhibiting litigation weakened in many parts of the country. This change occurred in different parts of the country at different rates, but by the mid-nineteenth century, allowed a larger number of individuals to resort to courts for redress of personal injuries. Americans also began to change their attitudes toward divine providence and misfortune. While many individuals retained the notion of God working through history, they abandoned the idea of special or direct providence. Progressively fewer individuals believed that God willed every event that occurred on earth. An absolute belief that God ordained every event precluded a search for earthly causes and earthly culprits. By the 1840s a large number of Americans had shifted their beliefs and were free to look for remedies in reforms and in courts. General secularizing trends, perfectionist impulses of northern evangelicals, and advancements in industry, transportation, and science combined to give society a new faith in the possibility and probability of progress. An increasingly mechanistic, interventionist view of the world along with various social changes, engendered a new view of the body. Individuals from a wide spectrum of society became conscious of their bodies as "things" and grew progressively more concerned with
pursuing physical well-being. Consequently, as optimism and expectations grew, patient intolerance for imperfect results increased. And, patients sued physicians for more, and less severe injuries.

Transformed attitudes toward the body, progress, providence, and the community were the result of long-term, continuous developments and are the preconditions of modern medical malpractice. These factors allowed more frequent litigation, but they did not directly cause the dramatic increase in the early 1840s. If the immediate causes of anti-professional sentiment, low educational standards, and intra-professional competition had not existed in Jacksonian America, malpractice suits would have increased slowly as a result of the underlying cultural developments. The immediate causes were a match to a fuse. They account for the dramatic jump in rates, but not for the widespread acceptability of suing for personal injuries. In areas of the country like the antebellum South where the immediate factors existed, but the cultural preconditions did not, suits remained rare.

In the last half of the century and beyond, many of the inciting agents present in the Jacksonian period disappeared. Medical education improved, state legislatures reinstituted licensure, and medical societies were able to blunt the malevolent effects of intra-professional competition. But
suits continued. Now aggravating factors arose to provoke litigation. As Americans lost some of their antipathy toward professionals, a class-based resentment toward physicians gradually replaced the status-based resentment that had characterized the first half of the century. A slowly increasing population of lawyers and more frequent use of contingency fee arrangements gave a greater number of dissatisfied patients access to legal remedies. Rapidly advancing medical technology routinized more treatments, raised expectations and demands, and provided the basis for more suits.

The cultural developments that had made suits more acceptable in the Jacksonian period did not disappear or remain static. Instead they ripened. Relatively homogeneous, stable, community environments continued to slow the use of law to settle conflicts into the twentieth century. But shared communal values and the strength of public opinion on individual action decreased as the decades passed. It is impossible and unnecessary to identify one period as the fundamental break with communal life and cohesive, integrated, homogeneous social structures. There has been a long process moving from insular communities to individualism and pluralism, and it has occurred in different areas and regions at different rates. David Engel and Carol Greenhouse have demonstrated how homogeneous, stable
environments have inhibited personal injury lawsuits into the 1970s. However most cities and towns have gradually lost the consensus and structures that slowed suits in the eighteenth and early nineteenth centuries.

Similarly, American attitudes toward the role of God in the world have continued to evolve. By the late nineteenth century more Americans were replacing their acceptance of "providence" with a faith in "progress." Consequently, Americans have become more materialistic and concerned with physical well-being. By the late nineteenth century preoccupation with the condition of the body had increased dramatically. Progressively more individuals viewed the human form as a mechanical entity susceptible to manipulation and alteration. Religious transformations, scientific and material progress, and the comforts of a growing consumer society have engendered what some authors have described as a "therapeutic ethos"—a "fretful preoccupation with preserving


secular well-being." While most eighteenth and early nineteenth century Americans worried first about the soundness of their soul, progressively more people have put a higher premium on physical and psychic health and pleasure. Indeed in the twentieth century Americans' pursuit of comfort, pleasure, and physical well-being has often been characterized by a quasi-religious dedication.

The continuation and intensification of the trends first clearly visible in the early nineteenth century help explain the persistent expansion in the range and number of malpractice suits in modern America. A legal system which provides access and availability to virtually every inhabitant and a medical system that constantly promises grander achievements and better health have influenced twentieth century rates. While Americans may devise methods to slow or discourage suits, it is unlikely that they wish to blunt the medical advancement or legal traditions that have contributed to the litigation. And, no reform, no matter how ingenious,

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can reverse the underlying cultural trends that are the preconditions for the suits.
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