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Negligence - Medical Malpractice - the Locality Rule

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test and direct more verdicts so as to substantially lighten the trial case load will only be answered by the acceptance and application of the new rule at the trial level. Even if the *Pedrick* rule is applied, the time saving factor is still questionable, as the time necessary to pick a jury and present the evidence have not been alleviated. The prospect of less people filing frivolous claims because they know the court will dismiss any claim not having substantial merit is also questionable, for if the person's claim is frivolous he has nothing to lose by filing suit and hoping for a settlement before the judge has a chance to dismiss.

In conclusion, the possible practical benefits of the rule in *Pedrick* concerning directed verdicts are outweighed by the susceptibility to encroachments on our right to a trial by jury. While the actual worth of a jury is a question men may debate, it is not a court's function to pass upon this question, but rather the people's choice via amendment to their state constitution. The long range effects of *Pedrick*, while seemingly harmless in the facts of the case itself, are best summarized by Judge Dempsey in *Mesich v. Austin* where he stated:

> [B]ut we believe the time necessary to complete the case would have been a small price to pay for following the law . . . there is a temptation in a case such as this, where the evidence weighs heavily in one party's favor, to cut through the restraints imposed by those fundamental principles which protect the right of the opposite party to have a jury pass on his case. . . . Although it may appear desirable in a particular case to relax the time honored and hundreds-of-times confirmed principles it cannot be done without undermining them. . . . For a reviewing court to relax the long settled standards of proof in a hard case would encourage further relaxation; it would be an invitation to trial judges to weigh evidence and determine credibility.[33]

Robert Tarnoff

[33] *Supra* note 12 at 343-44, 217 N.E.2d at 547, 578.

NEGLIGENCE—MEDICAL MALPRACTICE—THE LOCALITY RULE

On October 4, 1958, at St. Luke's Hospital in New Bedford, Massachusetts, Mrs. Theresa Brune gave birth to a baby. During the delivery, an anesthesiologist administered a spinal anesthetic to Mrs. Brune containing eight milligrams of Pontocaine.[1] Eleven hours later, attempting to get out of bed, she slipped and fell on the floor. She subsequently complained of numb-

[1] Trademark for preparations of tetracaine. The term tetracaine applies to a preparation used as a local anesthetic. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1564 (24th ed. 1965).

ness and weakness in her left leg, and brought suit against the doctor to recover because of his alleged negligence in administering the spinal anesthetic. During the course of trial it was proved that the dosage of eight milligrams of Pontocaine was excessive, and that good medical practice required a dosage of five milligrams or less. It was also shown, however, that in New Bedford the dosage administered was customary. The court instructed the jury that the defendant:

> [M]ust measure up to the standard of professional care and skill ordinarily possessed by others in his profession in the community, which is New Bedford, and its environs, where he practices, having regard to the current state of advance of the profession. If, in a given case, it were determined by a jury that the ability and skill of the physician in New Bedford were fifty per cent inferior to that which existed in Boston, a defendant in New Bedford would be required to measure up to the standard of skill and competence and ability that is ordinarily found by physicians in New Bedford.[2]

Upon a verdict for the defendant, the court entered judgment accordingly. On appeal to the Supreme Court of Massachusetts the plaintiff argued that the defendant should be held to the standard of skill and care commonly possessed and used by similar specialists in like circumstances; not merely the standard of anesthesiologists practicing in New Bedford. The supreme court reversed the lower court, and, in doing so, abandoned the "locality" rule. *Brune v. Belinkoff*, — Mass. —, 235 N.E.2d 793 (1968).

The *Brune* decision represents an important change in Massachusetts law. The courts of that state had faithfully adhered to the "locality" rule since the year 1880, when *Small v. Howard*[3] was decided. In that case, the defendant, a general practitioner in a country town with a population of 2,500, was consulted by the plaintiff to treat a severe wound which required a considerable degree of surgical skill. In an action against the defendant for malpractice, the court limited the area in which to determine the skill required to that prevailing in similar localities. The court felt that the doctor in the small country village would not usually make a specialty of surgery. He would perform very few, if any, surgical operations, and thus his exposure to this type of work would be minimal. Hence he was not to be held to the standard of skill possessed by those in large cities where surgery was more prevalent. The court held him responsible only to the standard of those in the same or similar localities.[4]

[2] Brune v. Belinkoff, — Mass. —, 235 N.E.2d 793, 795 (1968).

[3] 128 Mass. 131, 35 Am. Rep. 363 (1880).

[4] *Id.* at 136, 35 Am. Rep. at 364, 365. Subsequent decisions which followed the standard applied by the *Small* court were: Delaney v. Rosenthall, 347 Mass. 143, 196 N.E.2d 878 (1964); Riggs v. Christie, 342 Mass. 402, 173 N.E.2d 610 (1961); Ramsland v. Shaw, 341 Mass. 56, 166 N.E.2d 894 (1960); Berardi v. Menicks, 340 Mass. 396, 164

In counterpoint, the court in *Brune* felt the reason for interring the rule was the change in the environment of the "small-town doctor."

> We are of the opinion that the "locality" rule of *Small v. Howard* which measures a physician's conduct by the Standards of other doctors in similar communities is unsuited to present day conditions. The time has come when the medical profession should no longer be Balkanized by the application of varying geographic standards in malpractice cases. Accordingly, *Small v. Howard* is hereby overruled. . . . The proper standard is whether the physician, if a general practitioner, has exercised the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession. In applying this standard it is permissible to consider the medical resources available to the physician as *one* circumstance in determining the skill and care required. Under this standard some allowance is thus made for the type of community in which the physician carries on his practice.[5]

This case note will examine the "locality" rule as it was first formulated, the manner in which different courts have treated it, and the continuing trend towards its abandonment.

While there have been numerous verbal formulations used to set up the standard of care required of a doctor in the practice of medicine, the following have been found to be the basic elements of the prevailing rule:

(1) a reasonable or ordinary degree of skill and learning
(2) commonly possessed and exercised by members of the profession
(3) who are of the same school or system as the defendant
(4) and who practice in the same or similar localities
(5) and an exercise of the defendant's good judgment.[6]

The fourth element, the "locality" rule, began to appear in various decisions in the latter part of the nineteenth century.[7] The reasoning espoused by the courts in applying this provincial doctrine bore striking similarity. It was held that a country doctor, was, at most, a "country doctor." As such, he did not possess the medical expertise found among his brethren practicing

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N.E.2d 544 (1960); Vigneault v. Dr. Hewson Dental Co., 300 Mass. 223, 15 N.E.2d 185 (1938); Bouffard v. Canby, 292 Mass. 305, 198 N.E. 253 (1935); Ernen v. Crofwell, 272 Mass. 172, 172 N.E. 73 (1930).

[5] *Supra* note 2, at —, 235 N.E.2d at 798.

[6] A. H. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 559 (1959). Another source which is in accord as to the standard determinative of the care required is RESTATEMENT (SECOND) OF TORTS, § 299A, at 73 (1965). (As adopted and promulgated by the American Law Institute at Washington, D. C.). "Unless he represents that he has greater or less skill or knowledge, one who undertakes to render services in the practice of a profession or trade is required to exercise the skill and knowledge normally possessed by members of that profession or trade in good standing in similar communities."

[7] Tefft v. Wilcox, 6 Kan. 33 (1870); Smothers v. Hanks, 34 Iowa 286, 11 Am. Rep. 141 (1872); Gramm v. Boener, 56 Ind. 497 (1877).

in the larger cities where the latest advances in medical facilities and medical knowledge prevailed. Due to a lack of efficient transportation and communication, the country doctor was not kept aware of significant changes in his profession. He did not possess the most advanced and sophisticated equipment. He was, so to speak, limited by his environment.

Times and conditions have changed markedly from what they were when the "locality" rule first was enunciated. Yet this rule has stubbornly stayed with us. The first significant attempt to modify it nearly resulted in its abandonment. In 1916, in the case of *Viita v. Fleming*,[8] the Supreme Court of Minnesota held that a doctor was not to be held merely to the "same or similar" locality standard.

> We think it is plainly correct that the locality in which the physician or surgeon practices must be considered in determining whether he has the requisite skill and learning, but we do not think that he is bound to possess and exercise only that degree of skill and learning possessed by other practitioners in the same locality, if by that is meant the same village or city. If the same general locality is meant, as, for instance, the northwest, or the state, no fault could be found with such a rule. But in these days the physician or surgeon in a village like Cloquet is not hampered by lack of opportunity for advancement. Frequent meetings of medical societies, articles in the medical journals, books by acknowledged authorities, and extensive experience in hospital work put the country doctor on more equal terms with his city brother. He would probably resent an imputation that he possessed less skill than the average physician or surgeon in the large cities, and we are unwilling to hold that he is to be judged only by the qualifications that others in the same village or similar villages possess.[9]

This decision came at a time when a small minority of courts, at best, were even entertaining thoughts of modifying the "locality" rule. Perhaps this fact accounts for subsequent decisions by the same supreme court; decisions which show a retreat back to the old standard.[10]

Despite Minnesota's refusal to follow the reasoning behind the *Viita* decision, a trend towards discarding this restrictive measure of skill has developed. Melvin Belli acknowledges this in his book, *Modern Trials*, where he states:

> In some jurisdictions, the healer is only held to the standards of his own particular locality. Other state courts subject him to a somewhat higher standard, that of physicians of similar communities. Still other courts have held that the locality is only one of the circumstances to consider in finding whether the doctor has

[8] 132 Minn. 128, 155 N.W. 1077 (1916).

[9] *Id.* at 136, 137, 155 N.W. at 1081.

[10] Fritz v. Parke Davis and Company, 277 Minn. 210, 152 N.W.2d 129 (1967); Manion v. Tweedy, 257 Minn. 59, 100 N.W.2d 124 (1959); Johnson v. Colp, 211 Minn. 245, 300 N.W. 791 (1941); Williamson v. Andrews, 198 Minn. 349, 270 N.W. 6 (1936); Yates v. Gamble *et al*, 198 Minn. 7, 268 N.W. 670 (1936).

exercised reasonable care. . . . Some courts of some jurisdictions, in keeping with the growing uniformity of medical education and technical facilities, show a marked tendency to expand the geographical limitations.[11]

Dean Prosser, in his treatise on the law of torts, reaches a similar conclusion. He finds the present tendency to be one which abandons any "locality" rule formula, and treats the locality as merely one factor to be considered in applying the general professional standard.[12]

Of the states, other than Massachusetts and Minnesota, which have dealt with the "locality" rule problem, the most recently reported cases show that thirty-three have yet to announce any noteworthy changes in their thinking. Nineteen hold that a doctor is to be held to that degree of proficiency possessed by the average doctor in his locality.[13] These states espouse the "same locality" rule—the healer is judged by those standards of his local colleagues alone. While this rule seems more strict than the "same or similar localities" rule, the courts following the former have qualified it by including the words "general neighborhood" or "general community," and, thus, there is at best a fine line between the two. A smaller number of states (fourteen) follow the "same or similar localities" rule.[14]

[11] MELVIN BELLI, MODERN TRIALS 731 (1963).

[12] PROSSER, THE LAW OF TORTS, § 32, at 166-167 (3d ed. 1963). *See* McCoid, *supra* note 6, at 571, 575.

[13] Alabama, Watterson v. Conwell, 258 Ala. 180, 61 So. 2d 690 (1952); Arizona, Harris v. Campbell, 2 Ariz. App. 351, 409 P.2d 67 (1965); Colorado, Foose v. Haymood, 135 Col. 278, 310 P.2d 722 (1957); Illinois, Mann v. Sanders, 29 Ill. App. 2d 291, 173 N.E.2d 12 (1961); Indiana, Shirley v. Schlemmer, 230 N.E.2d 534 (1967); Louisiana, Langston v. St. Charles Hospital, 202 So. 2d 386 (1967); Maryland, Solomon v. Fishel, 228 Md. 189, 179 A.2d 349 (1961); Mississippi, DeLaughter v. Womack, 250 Miss. 190, 164 So.2d 762 (1964); Montana, Donathan v. McConnel, 121 Mont. 230, 193 P.2d 819 (1948); Nebraska, In re Johnson's Estate, 145 Neb. 333, 16 N.W.2d 504 (1944); New Mexico, Cervantes v. Forbis, 73 N.M. 445, 389 P.2d 210 (1964); New York, Calhoun v. Gale, 287 N.Y.S.2d 710 (1968); Oklahoma, Eckels v. Traverse, 362 P.2d 680 (Okla. 1961); South Dakota, Hausen v. Isaak, 70 S.D. 529, 19 N.W.2d 521 (1945); Texas, Rose v. Friddell, 423 S.W.2d 658 (1967); Utah, Dickinson v. Mason, 18 Utah 2d 383, 423 P.2d 663 (1967); Vermont, Pepin v. Averill, 113 Vt. 212, 32 A.2d 665 (1943); Virginia, Easterling v. Walton, 208 Va. 214, 156 S.E.2d 787 (1967); Wyoming, Govin v. Hunter, 374 P.2d 421 (Wyo. 1962). The District of Columbia is in accord, Staples v. Washington, 125 A.2d 322 (1956).

[14] Arkansas, Walls v. Boyett, 216 Ark. 541, 226 S.W.2d 552 (1950); Connecticut, Geraty v. Kaufman, 115 Conn. 563, 162 A. 33 (1932); Delaware, Di Filippo v. Preston, 53 Del. 539, 173 A.2d 333 (1961); Kansas, Voss v. Bridwell, 188 Kan. 643, 364 P.2d 955 (1961); Kentucky, Jarboe v. Harting, 397 S.W.2d 775 (Ky. 1965); Michigan, Bradshaw v. Blaine, 1 Mich. App. 50, 134 N.W.2d 386 (1965); Missouri, Hart v. Steele, 416 S.W.2d 927 (Mo. 1967); New Hampshire, Carrigan v. Roman Catholic Bishop, 104 N.H. 73, 178 A.2d 502 (1962); North Carolina, Koury v. Follo, 272 N.C. 366, 158 S.E.2d 548 (1968); Ohio, Richardson v. Doe, 176 Ohio St. 370, 199 N.E.2d 878 (1964); Oregon, Eckleberry v. Kaiser Foundation Northern Hospitals, 226 Ore. 616, 359 P.2d 1090 (1961); Rhode Island, Cavallaro v. Sharp, 84 R.I. 67, 121 A.2d, 669 (1956); Tennessee, Methodist

A few states have pursued the expansion of the standard by allowing the testimony of expert witnesses who are not of the same or a similar community. California did this in 1949 in the case of *Sinz v. Owens*.[15] There the court observed:

> The more recent California cases upon the question of competency of a doctor in one community to testify as to the standard of care at another place, although phrasing the rule in terms of 'same' or 'similar' locality, have shown a clear tendency to depart from the earlier geographical limitations of the rule. . . . The essential factor is knowledge of similarity of conditions; geographical proximity is only one factor to be considered.[16]

That the locality is a factor to be considered does not lessen the effect of the decision reached by this court; the locality must be considered, just as all other circumstances which have a bearing on the case. Thus, the fact that the doctor does not practice in the same or a similar community is no longer significant in relation to whether or not he will be allowed to testify—his degree of expertise is the vital factor to be considered by the court. The West Virginia Supreme Court of Appeals adopted the same policy concerning expert testimony in *Hundley v. Martinez*,[17] emphasizing that expert witnesses are the only ones who can prove negligence or want of professional skill in medical malpractice cases. Georgia and Florida have also reached the same conclusion.[18]

Another approach utilized to modify the rule has been to extend the geographical boundaries. This has been accomplished in three states.[19] The reasoning behind the change effected by these states was well expressed by the Idaho court:

> The duty of a doctor to his patient is measured by conditions as they exist, and not by what they have been in the past or may be in the future. Today, with the rapid methods of transportation and easy means of communication, the horizons have been widened, and the duty of a doctor is not fulfilled merely by utilizing the means at hand in the particular village where he is practicing. So far as

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Hospital v. Ball, 50 Tenn. App. 460, 362 S.W.2d 475 (1961); Wisconsin, McManus v. Donlin, 23 Wis. 2d 289, 127 N.W.2d 22 (1964).

[15] 33 Cal. 2d 749, 205 P.2d 3 (1949).

[16] Sinz v. Owens, *supra* note 15, at 756, 757, 205 P.2d at 7.

[17] 158 S.E.2d 159 (W. Va. 1967).

[18] Murphy v. Little, 112 Ga. App. 517, 145 S.E.2d 760 (1965); Montgomery v. Stary, 84 So. 2d 34 (Fla., 1955). Three Chicago doctors were permitted to testify as to the standard of care, over objections of appellant that they were familiar neither with the same locality nor similar localities.

[19] Idaho, Flock v. J. C. Palumbo Fruit Co., 63 Idaho 220, 118 P.2d 707 (1941); North Dakota, Tvedt v. Haugen, 70 N.D. 338, 294 N.W. 183 (1940); Pennsylvania, Hodgson v. Bigelow, 335 Pa. 497, 7 A.2d 338 (1939).

medical treatment is concerned, the borders of the locality and community have, in effect, been extended so as to include those centers readily accessible where the appropriate treatment may be had which the local physician, because of limited facilities or training is unable to give.[20]

These states have recognized that the physician practicing in a small town is no longer isolated from the many advances in the medical profession. The latest in sophisticated equipment is as readily accessible to him as it is to his counterpart in the large city. While these states have not expressly abandoned the "locality" rule, they are on the brink of doing so. As they broaden the bounds within which the standard of skill is determined, they necessarily extend the ambits of prior case law.

The states of Maine and Iowa have not announced that the old standard is no more, yet the decisions in *Josselyn v. Dearborn*[21] and *McGulpin v. Bessmer*,[22] respectively, are food for thought along that line. In the *Josselyn* case, the high court of Maine upheld the refusal of the presiding justice to instruct that the locality was important in determining the degree of skill and care required. The court held that the justice's instruction that the physician is held to that degree of care and skill ordinarily possessed by other physicians under like conditions was sufficient, and that from this the jury would consider the locality as one of the circumstances to be properly taken into account. The court in *McGulpin* said:

> There seems to be sound basis for holding a physician to such reasonable care and skill as is exercised by the ordinary physician of good standing under like circumstances. And the locality in question is merely one circumstance, not an absolute limit upon the skill required.[23]

These states are but one step away from a complete abandonment of the "locality" rule. Their language is extremely similar to the *Brune* decision, as well as the two cases which will be discussed below.

Aside from Massachusetts, two other states have done away with the "locality" rule. In the case of *Pederson v. Dumouchel*[24] the Supreme Court of Washington, foreshadowing the *Brune* decision, found that "[t]he 'locality rule' has no present-day vitality except that it may be considered as *one* of the elements to determine the degree of care and skill which is to be expected of the average practitioner of the class to which he belongs. . . .

[20] Flock v. J. C. Palumbo Fruit Co., *supra* note 19, at 238, 118 P.2d at 714, 715.

[21] 143 Me. Rep. 328, 62 A.2d 174 (1948).

[22] 241 Iowa 1119, 43 N.W.2d 121 (1950).

[23] McGulpin v. Bessmer, *supra* note 22, at 1131, 43 N.W.2d at 128.

[24] 72 Wash. Dec. 2d 73, 431 P.2d 973 (1967). *Accord*, Versteeg v. Mowery, 435 P.2d 540 (1967).

In other words, local practice within geographic proximity is one, but not the only factor to be considered."[25] The state of New Jersey has reached the same conclusion.[26]

When the 'locality' rule was originally applied, it might well have been apropos. The courts felt it unfair to impose liability on a doctor on the basis of a comparison of his expertise with that possessed by others in different parts of our country, or even in other sections of the defendant's own state or county. From the time that this standard first appeared there have been significant changes in our population pattern, particularly, the shift from rural to urban areas. There has been a marked increase in the quality of our transportation. With the significant advances in the communications media, radio, television, and the printing industry, news of improvement in the medical profession is available to any doctor in the country. In addition to these advances, the quality of medical education has vastly improved. In 1906 there were 162 medical schools in the United States. Nearly all of them were scantily equipped, had no hospitals, and few, if any, had expert teachers. The course of education then, was two annual sessions of six months each, with the general requirement for admission to school being a high school education. Realizing that improvements in the training of doctors were desperately needed, committees were formed which investigated the schools. In 1910 a comprehensive study was published which classed the schools according to degree of excellence as either A, B, or C. With this publication many of the schools, out of embarrassment or disgrace, were forced to either terminate activities or merge with a class A school. In 1923 there were only 80 medical schools, and these were far advanced from any of those of 1906.[27] The size of medical endowments had increased, new buildings and better laboratories were constructed, and better trained teachers, with more efficient methods of instruction, were attracted.

In the academic year 1966-1967 there were 89 medical schools in active operation, all of whose course of education runs four years. Of these, 87 were fully accredited,[28] with the remaining two being classed as schools in develop-

[25] Pederson v. Dumouchel, *supra* note 24, at 78, 431 P.2d at 978.

[26] Fernandez v. Baruch, 96 N.J. Super. 125, 232 A.2d 661 (1967). The high court said, "It is incumbent upon the treating physician to utilize only that degree of care, knowledge, and skill ordinarily possessed and exercised in similar situatons by the average member of the practicing profession in that field." *Id.* at 135, 232 A.2d at 666. *Accord*, Schueler v. Strelinger, 43 N.J. 330, 204 A.2d 577 (1964).

[27] 15 ENCYCLOPAEDIA BRITANNICA 177-178 (1944). *See also*, A. FLEXNER, UNIVERSITIES, AMERICAN, ENGLISH, GERMAN 85-96 (1930).

[28] The standards of accreditation are set by the Liaison Committee on Medical Education, composed of the Council on Medical Education and the Association of American Medical Colleges. This committee also does the actual accrediting of United States medical schools.

ment.[29] In contrast to the requirement of a high school education for entrance in the beginning of this century, today all medical students are college graduates. The great majority of them demonstrated superior academic skill while in college. A recent survey found it to be the consensus among college deans and admission committees that the quality and background training of medical applicants is definitely on the increase.[30]

In line with this self-policing within the profession, the states have "toughened up" their requirements for obtaining a license to practice medicine. All states require that the graduate of a recognized medical school pass a comprehensive written exam. Twenty-three require a Basic Science Certificate, and 41 require an endorsement from the National Board. In addition to these, 39 state examining boards require some form of internship, with 35 of them making an internship period of at least one year mandatory.[31] With the four years of medical school, internship, residency, and successful completion of all state licensing requirements taken care of, many doctors continue their medical education. The number of those who do is increasing, as is the amount of courses offered in advanced learning.[32]

In view of these noteworthy advances it is hardly proper that an outdated, provincial standard of skill should be applied in order to determine liability, or the lack of it.[33] The quality of medical aid is more uniform throughout the country; the factors used to measure this quality should also be uniform. While the majority of our states have not changed their "locality" rule thinking, the number of those which have is significant, and their reasoning is cogent. The trend towards abandonment of the old standard is here, and will continue to grow. The future of the "locality" rule is not a bright one, and eventually this ancient doctrine will likely be abandoned. This is merely keeping pace with our modern, changing society, and the advantages inherent in this speak for themselves.

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[29] *Medical Education in the United States*, 202 J.A.M.A. 725, 729 (1967).

[30] *Id.* at 753, 754.

[31] COUNCIL ON MEDICAL EDUCATION OF THE AMERICAN MEDICAL ASSOCIATION, MEDICAL LICENSURE STATISTICS FOR 1967, at 1079, 1080.

[32] *Supra* note 29, at 793.

[33] For a general discussion as to criticism of the "locality" rule, *see* Note, 60 NW. U.L. REV. 834, 837-839 (1966); Note, 14 STAN. L. REV. 884 (1962); Comment, 36 MARQ. L. REV. 392 (1953); Note, 36 IOWA L. REV. 681, 688-693 (1951); Note, 35 MINN. L. REV. 186 (1951).