Duquesne Law Review

Volume 7 | Number 2 Article 9

1968

Physicians & Surgeons - Malpractice - Standard of Care

David L. Gilmore

PHYSICIANS & SURGEONS—MALPRACTICE—STANDARD OF CARE—The Supreme Judicial Court of Massachusetts has held that the "locality rule" in regard to the standard of care of physicians and surgeons is no longer applicable.

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

Plaintiff was delivered of a baby at St. Lukes Hospital in New Bedford, Massachusetts, a city of about 100,000 located approximately fifty miles from Boston. During the delivery, defendant, a specialist in anesthesiology practicing in New Bedford, administered a special anesthetic to the plaintiff. Eleven hours after the delivery plaintiff fell while attempting to get out of bed and complained of weakness and numbness in her left leg. She brought an action against the anesthesiologist alleging negligence in the amount of spinal anesthetic administered.[1] Expert testimony showed the dose to be excessive and plaintiff's condition a result thereof.[2]

The gravamen of the appeal concerned the trial court's charge as to the standard of care required of the defendant physician.[3] The lower court charged:

> [The defendant] must 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, of course, where he practices, ... If, in a given case, it were determined by a jury that the ability and skill of the physician in New Bedford were fifty percent 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.[4]

The plaintiff excepted, contending that "distinctions based on geogra-

1. The anesthetic was a mixture of eight milligrams of pontocaine in one cubic centimeter of ten percent solution of glucose.

2. There was some testimony as to the amount of anesthetic used in relation to the differences in obstetrical technique between Boston and New Bedford. The issue was not dealt with by the court. See n.1, at 795 of 235 N.E.2d 793.

3. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 559 (1959). McCoid stated that the common elements to determine the standard of care are:
(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 exercise of the defendant's good judgment.

4. As quoted by the *Brune* court at 795 of 235 N.E.2d 793.

phy are no longer valid in view of modern developments in transportation, communication and medical education. . . ."[5]

The Supreme Judicial Court, after a thorough examination of the background of the rule in Massachusetts and several recent decisions of other jurisdictions, faced the issue squarely, stating: "We are of the opinion that the 'locality rule' . . .. is unsuited to present day conditions."[6] The court felt the rationale and historical basis of the rule were no longer valid.

The holding of the court can be better understood by placing the "locality rule" in its historical perspective. The rule first emerged into our jurisprudence during the latter half of the nineteenth century and from its inception was uniquely American.[7] Although no single case comes forward as *the* first case to follow a community or locality qualification, several jurisdictions in scattered sections began holding their "country doctors" to a lesser standard of skill than physicians in more urban areas.[8] One of the first cases[9] to expound the locality rule was *Small v. Howard,*[10] the case overruled in the instant decision, where the rationale embodied much of the basic reasoning put forth by other courts of the period.

In *Small,* the plaintiff severely cut his wrist on a piece of glass and engaged the defendant, a physician in a town of about 2,500, to care for the injury. When the wound failed to heal properly a malpractice action was lodged against the physician. In affirming the trial court's charge as to the standard of care required of the defendant, the court stated:

> It is a matter of common knowledge that a physician in a small country village does not usually make a specialty of surgery, and, however well informed he may be in the theory of all parts of his profession, he would, generally speaking, be but seldom called upon as a surgeon to perform difficult operations. He would have but few

5. 235 N.E.2d at 796.

6. *Id.* at 798.

7. NATHAN, MEDICAL NEGLIGENCE 21 (1957). Lord Nathan stated that the locality qualification has never existed in England and that English courts would reject the idea that the standard of care should vary from one part of the country to another.

Canada does not have a locality rule, although locality is often considered as a part of the circumstances of a given case. Sherman, *The Standard of Care in Malpractice Cases,* 4 OSGOOD-HALL L.J. 222, 226 (1966).

8. Force v. Gregory, 63 Conn. 167, 27 A. 1116 (1893); Gates v. Fleischer, 67 Wis. 504, 30 N.W. 674 (1886); Wilmot v. Howard, 39 Vt. 447 (1867); Hathorn v. Richmond, 48 Vt. 557 (1876); Tefft v. Wilcox, 6 Kan. 46 (1880); Whitesell v. Hill, 66 N.W. 894 (Iowa 1896); Gramm v. Boener, 56 Ind. 497 (1877); and Smothers v. Hanks, 34 Iowa 286 (1872).

9. The group of cases which are generally cited as the beginning point of the rule used it with nearly identical rationales, without apparent reliance on each other. See note 8, *supra.*

10. 128 Mass. 131 (1880).

> opportunities of observation and practice in that line such as public hospitals or large cities would afford. The defendant was applied to, being the practitioner in a small village, and we think it was correct to rule that 'he was bound to possess that skill only which physicians and surgeons of ordinary ability and skill, practicing in similar localities, with opportunities for no larger experience, ordinarily possess; . . .'[11]

Other courts placed emphasis on the limited opportunity for practice and observation[12] and the lack of modern facilities[13] which rural physicians, generally speaking, lacked. To resolve a practical problem the courts sought a practical remedy to bridge the gap between urban and rural physicians, so that a "country doctor" in a rapidly expanding nation would not be confronted with a standard of conduct he could not maintain. The practical necessity of the problem was commented on by a writer of that period:

> It [the skill of physicians] may vary in the same state or country. There are many neighborhoods, in the West especially, where medical aid is of difficult attainment; yet cases of disease and surgery are constantly occurring, and they must of necessity, fall into the hands of those who have given to the subject but little, if any, thought. Thus the inexperienced and unlearned attend the surgery or it is not attended to at all.[14]

The response to such a problem by the courts was the implementation of a dual standard which measured a physician's conduct by the yardstick of the same or similar locality.

From its birthplace in the nineteenth century the "locality rule" emerged into the twentieth century a vibrant and almost universal doctrine in medical malpractice law.[15] It quickly expanded to include dentists,[16] chiropractors[17] and kindred medical fields.[18] As pointed out

---

11. *Id.* at 136.
12. Smothers v. Hanks, 34 Iowa 286 (1872).
13. Gramm v. Boener, 56 Ind. 497 (1877).
14. McQuillen, *Civil Liability of Physicians & Surgeons for Negligence*, 20 AM. L. REV. 84 (1886).
15. One notable exception to expanding use of the "locality rule" was Vita v. Dolan, 132 Minn. 128, 155 N.W. 1077 (1916), where the court stated at 1081 of 155 N.W. 1077:
> 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 . . . .

16. Ernen v. Crofwell, 272 Mass. 176, 172 N.E. 73 (1930); Dolan v. O'Rourke, 56 N.D. 416, 217 N.W. 666 (1928).
17. Howe v. McCoy, 113 Cal. App. 468, 298 P. 530 (1931).
18. Oculists, Black v. Bearden, 167 Ark. 455, 268 S.W. 27 (1925); X-ray technicians, George v. Shannon, 92 Kan. 801, 142 P. 967 (1914), and Sauers v. Smits, 49 Wash. 557,

above, the rule was designed to inject a medium of flexibility into the standard of skill and care thus providing a buffer between rural and urban physicians. At its inception the rule encompassed a broad area, grouping rural and small town doctors under the heading of the same or similar locality.[19] During the twentieth century, however, many courts applied the rule to only the locality or community in which the defendant physician practiced.[20] In an action against a dentist one court noted that the doctor would not be liable "if in the exercise of his judgment he followed the course of treatment advocated by a considerable number of his professional brethern in good standing in his community . . . ."[21] Instead of being a buffer between the standard required of urban and rural physicians it became a wall dividing each community, town or city into a locality to measure the standard of care of physicians who practiced within it.

The rule, as a result, was being molded to fit changes in society. Often the decisions seemed inimical to the original sheme of the rule. The courts, however, sensing the need for a variable standard to deal with differences in skill and care modified the rule to meet existing circumstances. Many courts broadened what may be included under the term locality or community. In *Tvedt v. Haugen*[22] the court stated that "the borders of the locality or community have, in effect, been extended so as to include those centers rapidly accessible where appropriate treatment may be had. . . ."[23] Thus communities close to large cities or contiguous communities may be considered as one locality in determining the standard of care required.[24] Other courts have taken specialists out of the purview of the rule, reasoning that one who holds himself out to be a specialist will be held to the same standard as all others who hold themselves out as having the same skill.[25]

95 P. 1097 (1908). For a general collection of cases dealing with the "locality rule" and medical fields other than physicians see 41 AM. JUR. *Physicians and Surgeons* §§ 87, 88 (1942); 70 C.J.S. *Physicians and Surgeons* § 43 (1951).

19. Gramm v. Boener, 56 Ind. 497 (1877). There the court placed emphasis on the "similar locality" of the rule, reasoning that all doctors in a particular locality may be grossly negligent, which result the rule was not intended to protect.

20. Moore v. Smith, 215 Ala. 592, 111 So. 918 (1927); Bouffard v. Canby, 292 Mass. 305, 198 N.E. 253 (1935); Coon v. Shields, 88 Utah 76, 39 P.2d 348 (1934).

21. Moscicki v. Shor, 107 Pa. Super. 192, 201, 163 A. 341, 344 (1932).

22. 70 N.D. 338, 294 N.W. 183 (1940).

23. 294 N.W. at 188.

24. Vigneault v. Dr. Hewson Dental Co., 300 Mass. 223, 15 N.E.2d 185 (1938), where the county was considered the locality. Warnock v. Kraft, 30 Cal. App. 2d 1, 85 P.2d 505 (1938), where Los Angeles and Pasadena were considered contiguous. *See also,* McCoid, *supra* note 3, at 571, 572.

25. Carbone v. Warburton, 11 N.J. 418, 94 A.2d 680 (1953); Hundley v. Martinez, 158 S.E.2d 159 (W. Va. 1967).

Another area where the locality rule has been molded to fit changing circumstances is in the use of expert testimony. Negligence in medical malpractice must be proven by the testimony offered by other physicians and surgeons.[26] As the locality rule emerged so also did the requirement that the expert testimony was limited to experts from the same community or locality as the defendant.[27] Very often a plaintiff, because of the "conspiracy of silence" among doctors in a community, would have great difficulty in obtaining expert testimony.[28] Recently, a number of courts have broadened this base to permit witnesses from other communities, often major medical centers, to testify if they have a knowledge of the medical practice in the particular locality in question.[29]

The "locality rule" is followed by most jurisdictions today, although usually with one or more of the modifications outlined above. The essence of the rule, as applied by the courts, is spelled out by the *Restatement (Second) of Torts*,[30] using rationale similar to that of the early cases which first expounded the rule. It states that some consideration must be given to the geographic vicinity where the physician practices. The *Restatement* is emphatic in pointing out, however, that the rule is the *same or similar locality*, not the same locality.[31] This is indicative of the current trend away from the strict application the courts had been using, toward the more flexible standard of the original rule.

The court in *Brune* could have chosen several of the modifications

---

26. 7 J. WIGMORE, EVIDENCE § 2090(a) (3d ed. 1940). The exceptions to this general rule are where a common layman could understand the nature of the act, and in rare instances res ipsa loquitur. See McCoid, *supra* note 3, at 614, 631.

27. Tanner v. Sanders, 247 Ky. 90, 56 S.W.2d 718 (1933). The court there held that in a city of 350,000 the defendant dentist was to be judged only by doctors from within the city.

28. The "conspiracy of silence" among doctors was taken judicial notice of in the case of Salgo v. Leland Stanford Univ., 154 Cal. App. 2d 560, 317 P.2d 170 (1957). *See also*, Ames, *Modern Techniques In The Preparation and Trial of a Medical Malpractice Suit*, 12 VAND. L. REV. 649 (1959).

29. Sinz v. Owens, 33 Cal.2d 749, 205 P.2d 3 (1949), Annot., 8 A.L.R.2d 772 (1949); Michael v. Roberts, 91 N.H. 499, 23 A.2d 361 (1941); McGulpin v. Bessmer, 241 Iowa 1119, 43 N.W.2d 121 (1950).

30. RESTATEMENT (SECOND) OF TORTS § 299A (1965).

31. *Id.*, comment *g*, which states:

Type of Community.

Allowance must be made also for the type of community in which the actor carries on his practice. A country doctor cannot be expected to have the equipment, facilities, experience, knowledge or opportunity to obtain it, afforded him by a large city. The standard is not, however, that of a particular locality. If there are only three physicians in a small town, and all three are highly incompetent, they cannot be permitted to set a standard of utter inferiority. . . . The standard is rather that of persons engaged in similar practice in similar localities, considering geographical location, size, and character of the community in general.

previously mentioned and reached a result favorable to the appellants.[32] They chose, however, to break new ground and discard locality as a determining criterion in the standard of care. The court viewed the current trend[33] as a movement away from the *Restatement* and the majority of courts toward that advocated by Professor Prosser, who stated:

> The present tendency is to abandon any such formula, and treat the size and character of the community, in instructing the jury, as merely one factor to be taken into account in applying the general professional standard.[34]

The rationale, simply stated, is that due to modernization in transportation, communication, and medical education, geographic distinctions are becoming nonexistent. The geographic setting of a particular case deserves only to be considered as part of the circumstances rather than a determining factor.

The immediate ramifications of the Massachusetts decision are, broadly speaking, twofold. First, it adds strength and precedent to the movement away from the "locality rule." Secondly, as the "locality rule" is abandoned so will restrictions as to who is qualified to be an expert witness. This should obviate any remaining obstacles due to the "conspiracy of silence".

It is submitted that the instant decision is following the historical evolution of the rule. When the rule was first enunciated the nation was easily divided into two classes, as the nation grew, however, the gap between urban and rural was not easily distinguishable. Instead of a movement from the city to the small town or country side there appeared towns and cities of various sizes. Due to the inherent flexibility of the rule, it was easily molded to provide a separate standard for each community. Modern developments in communication and tranportation have closed this gap and the courts shifted toward an implementation which reflected this progress. The Massachusetts court views its decision as the next logical step in the evolution of the rule. In the last analysis, amortization is the very end the rule seeks to achieve.

David L. Gilmore

32. The defendant was a specialist not a general practitioner, thus the court could have discarded the "locality rule" only in regard to specialists. New Bedford is close enough to Boston for the two to be considered contiguous for the purposes of medical skill and care.

33. Pederson v. Dumochel, 431 P.2d 973 (Wash. 1967); Hundley v. Martinez, 158 S.E.2d 159 (W. Va. 1967); Carbone v. Warburton, 11 N.J. 418, 94 A.2d 680 (1953); Tvedt v. Haugen, 70 N.D. 338, 294 N.W. 183 (1940).

34. W. PROSSER, LAW OF TORTS 167 (3d ed. 1964).