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Torts -- Medical Malpractice -- Rejection of "Locality" Rule

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authority and usurped the legislative function of the Congress.[36] The three dissenting justices are of the opinion that the regulation has been shown to be an invalid interpretation of the statutory language.[37]

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Torts—Medical Malpractice—Rejection of "Locality" Rule

In *Pederson v. Dumouchel*,[1] plaintiff brought a malpractice action against a physician, dentist, and hospital to recover for brain damage allegedly sustained as a result of an operation.[2] He had suffered a broken jaw and was placed under the care of Dr. Dumouchel, who associated a dentist to reduce the fracture. The operation was performed between 10:20 a.m. and noon the following day. The dentist had no working knowledge of the use of a general anesthetic, which was administered by a hospital nurse. No medical doctor was present during the operation; it was Dr. Dumouchel's afternoon off and he had left the hospital before the operation commenced. Plaintiff suffered convulsive seizures in the recovery room. About 1:30 p.m. another doctor was located who suspected brain damage, consulted a neurosurgeon in Seattle, 110 miles away, and arranged to have plaintiff taken there. He remained unconscious for a month. Expert testimony supported the finding that plaintiff suffered severe brain damage caused by the administration of the anesthetic. Dr. Dumouchel was charged with negligently failing to assume the responsibility for the patient's medical care while in surgery. The trial judge instructed the jury that the standard of care to be applied was "the learning, skill, care, and diligence ordi-

[36] United States v. Correll, 36 U.S.L.W. 4055, 4057 (U.S. Dec. 11, 1967).
[37] *Id.*

[1] —— Wash. 2d ——, 431 P.2d 973 (1967).

[2] The scope of this note is limited to a discussion of the standard of care applied to physicians and surgeons. Generally, the standard for dentists is the same as that applied to doctors.

Much that is said herein about the locality rule is applicable to hospitals as well as physicians. However, hospital liability for negligence necessarily involves additional factors such as administrative supervision, ANNOT., 14 A.L.R.3d 873 (1967), agency principles when plaintiff seeks to establish hospital liability for the negligence of a physician, ANNOT., 69 A.L.R.2d 305 (1960) and the physical facilities of the hospital. *See* 43 N.C.L. REV. 469 (1965). The *Pederson* court held that plaintiff's case against the hospital was sufficient to go to the jury on the doctrine of res ipsa loquitur. *See* ANNOT., 173 A.L.R. 535 (1948); ANNOT., 9 A.L.R.3d 1315 (1966).

narily possessed and practiced by others in the same profession . . . *in the same or in similar localities* . . . ."[3] In holding this instruction to be reversible error, the Washington Supreme Court took the position that the degree of care required is that of an average competent practitioner acting in the same or similar circumstances, and that local practice within geographic proximity is only one factor to be considered. The court set forth the following rule:

> A qualified medical . . . practitioner should be subject to liability, in an action for negligence, if he fails to exercise that degree of care and skill which is expected of the average practitioner in the class to which he belongs, acting in the same or similar circumstances. This standard of care is that established in an area coextensive with the medical and professional means available in those centers that are readily accessible for appropriate treatment of the patient.[4]

Although the opinion is somewhat ambiguous, it appears that this court has discarded the "locality" rule and has set forth a standard of care based on the conduct of a reasonable practitioner acting under the same or similar circumstances. If so, the court has taken a major step in conforming the law of malpractice to the conditions of medical practice as they exist today.

The courts have long encountered difficulty in stating a general rule by which to measure the standard of care for physicians and surgeons. Generally, the physician is required to possess and exercise that degree of skill and care ordinarily possessed and exercised by physicians under similar circumstances.[5] The early cases imposed a narrow qualification on the standard by requiring that it be determined by reference to the "same" locality or community in which the defendant-doctor practices.[6] The locality rule is based on the premise that a doctor in a small community does not have the same opportunities and resources as do urban doctors to keep abreast of developments in his profession, and therefore can not

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[3] —— Wash. 2d ——, , 431 P.2d 973, 976 (1967).

[4] *Id.* at ——, 431 P.2d at 978.

[5] RESTATEMENT (SECOND) OF TORTS § 283 (1965).

[6] *E.g.*, Smothers v. Hanks, 34 Iowa 286 (1872). The cases are collected in McCoid, *The Care Required of Medical Practitioners,* 12 VAND. L. REV. 549, 569 (1959).

Many courts impose various combinations of additional qualifications on the standard of care such as an "average" physician "in good standing" engaged in "the same general line of practice." RESTATEMENT (SECOND) OF TORTS § 299A (1963).

be held to the same standard. Since laymen are generally considered unqualified to pass judgment on medical questions, courts consistently hold that there can be no finding of negligence without the aid of expert testimony.[7] It follows that the competence of an expert to testify depends upon his familiarity with the customary practice in the locality. This narrow limitation, coupled with the reluctance of any doctor in the community to testify against another,[8] makes it virtually impossible for a plaintiff to make out a malpractice case in jurisdictions applying the "same" locality rule.

Most courts have realized that the "same" locality is too narrow, and have extended the rule to include "same or similar" localities.[9] This liberalization makes it somewhat easier for a plaintiff to obtain experts willing to testify favorably, but it does not alleviate the possibility that a few local doctors can set a standard below that required by law. A few courts operating under a "similar" localities rule have not been content to determine similarity on the basis of population, and have attempted to compare similar "medical localities."[10] Recent decisions indicate that the courts are becoming much more liberal in finding similarity,[11] admitting expert testimony and taking judicial notice that two localities are similar[12] or

[7] Sinz v. Owens, 33 Cal. 2d 749, 205 P.2d 3 (1949); Graham v. St. Luke's Hosp., 46 Ill. App. 2d 147, 196 N.E.2d 355 (1964); Berardi v. Menicks, 340 Mass. 396, 164 N.E.2d 544 (1960); Miller v. Raaen, 273 Minn. 109, 139 N.W.2d 877 (1966); Hunt v. Bradshaw, 242 N.C. 517, 88 S.E.2d 762 (1955); Schroeder v. Adkins, 149 W.Va. 400, 141 S.E.2d 352 (1965). Expert testimony is not required, however, if the negligence is so grossly apparent or treatment of such common occurrence that a layman would be able to appraise it. Graham v. St. Luke's Hosp., 46 Ill. App. 2d 147, 196 N.E.2d 355 (1964); Grosjean v. Spencer, 258 Iowa 685, 140 N.W.2d 139 (1966); Hammer v. Rosen, 198 N.Y.S.2d 65, 165 N.E.2d 756 (1960).

[8] W. PROSSER, LAW OF TORTS, 167 (3d ed. 1964); Seidelson, *Medical Malpractice and the Reluctant Expert,* 16 CATH. U.L. REV. 158 (1966).

[9] Engle v. Clarke, 346 S.W.2d 13 (Ky. 1961); Small v. Howard, 128 Mass. 131, 35 Am. Rep. 363 (1880); Bradshaw v. Blaine, 1 Mich. App. 50, 134 N.W.2d 386 (1965); Nance v. Hitch, 238 N.C. 1, 76 S.E.2d 461 (1953); Teig v. St. John's Hosp., 63 Wash. 2d 369, 387 P.2d 527 (1963).

[10] Geraty v. Kaufman, 115 Conn. 563, 162 A. 33 (1932); Sampson v. Veenboer, 252 Mich. 660, 234 N.W. 170 (1931); Cavellaro v. Sharpe 84 R.I. 67, 121 A.2d 669 (1956).

[11] Christopher v. United States, 237 F. Supp. 787 (E.D. Pa. 1965) (a Philadelphia surgeon permitted to testify in Baltimore); Riley v. Layton, 329 F.2d 53 (10th Cir. 1964) (California physician familiar with small-town practice qualified to testify in Utah town); Couch v. Hutchison, 135 So. 2d 18 (Fla. App. 1961) (Florida surgeon allowed to testify on teachings of a Philadelphia medical school).

[12] Cook v. Lichtblau, 144 So. 2d 312 (Fla. App. 1962).

that the witness was familiar with general practice in the community.[13]

In furtherence of the tendency to liberalize the area qualification of the standard, the courts have devised additional ways to minimize or circumvent the effect of the locality rule. First, the conduct of a general practitioner is tested by (1) the degree of skill and knowledge *possessed* by the other physicians in the same or similar locality, and (2) the degree of care and diligence *exercised* by those physicians in applying their skill.[14] Malpractice liability may result either through lack of skill and knowledge or neglect to apply it, if possessed.[15] In *Williams v. Chamberlain*,[16] a physician was charged only with failure to exercise the necessary "care." The Missouri Supreme Court, by strong dictum, stated that the original reasons for the locality rule pertain to the inability of a rural physician to possess the skill and knowledge of urban physicians; that where a physician is charged only with failure to exercise due "care," the locality should make no difference and there should be a national standard. While the distinction is perhaps theoretically sound, as a practical matter it may not mean very much. Can the courts really tell whether a physician's conduct was a failure to exercise "care" or a failure to possess knowledge to exercise it?

Second, as the courts learn more about medical practices, they are beginning to formulate with specificity what is required of the reasonable physician in certain circumstances, rather than depending upon experts to formulate it. For example, once the doctor-patient relationship is established, a doctor has a duty to examine the patient,[17] not to abandon the patient until the relationship terminates,[18] to disclose any abnormal risks in the treatment,[19]

[13] Teig v. St. John's Hosp., 63 Wash. 2d 369, 387 P.2d 527 (1963).

[14] D. LOUISELL & H. WILLIAMS, TRIAL OF MEDICAL MALPRACTICE CASES, § 8.04 (1966).

[15] DeLaughter v. Womack, 250 Miss. 190, 164 So. 2d 762 (1964); Newport v. Hyde, 244 Miss. 870, 147 So. 2d 113 (1962); Williams v. Chamberlain, 316 S.W.2d 505 (Mo. 1958); Mehigan v. Sheehan, 94 N.H. 274, 51 A.2d 632 (1947).

[16] 316 S.W.2d 505 (Mo. 1958).

[17] *E.g.*, Stephens v. Williams, 226 Ala. 534, 147 So. 608 (1933); Wheatley v. Heideman, 251 Iowa 695, 102 N.W.2d 343 (1960).

[18] *E.g.*, Capps v. Valk, 189 Kan. 287, 369 P.2d 238 (1962); O'Neil v. Montefiore Hospital, 11 A.2d 132, 202 N.Y.S.2d 436 (1960); see ANNOT., 57 A.L.R.2d 432 (1958).

[19] Williams v. Menehan, 191 Kan. 6, 379 P.2d 292 (1963); Woods v. Brumlop, 71 N.M. 221, 377 P.2d 520 (1962); Watson v. Clutts, 262 N.C.

to instruct patients how to carry out treatment (especially drugs),[20] and to follow the progress of treatment.[21] If the facts of a particular case reveal a clear breach of such a duty, the court may permit a jury to find negligence without the aid of expert testimony,[22] the result being to minimize or remove the effect of the locality rule.

Third, the court may simply disregard the locality rule. In *Koury v. Follo,*[23] a Greensboro, North Carolina physician was charged with prescribing an injection of a drug containing streptomycin for plaintiff's nine-month old baby for treatment of a cold and bronchitis; afterward the child became deaf. The label on the drug container stated "Not for Pediatric Use," accompanied by a warning against use for children. The plaintiff's expert witness testified that deafness was a known hazard, and, in effect, that such use was dangerous. The opinion does not reveal whether or not the expert was familiar with the practice in Greensboro. The defendant testified that other pediatricians in Greensboro were then using the drug in like dosages for children as young as nine months of age. Nevertheless, the court held that plaintiff's evidence was sufficient to justify a finding by the jury that the defendant was negligent. By disregarding the locality rule, it appears that the court found plaintiff's evidence sufficient to prove that defendant's conduct subjected the child to an unreasonable risk of harm, notwithstanding the fact that such conduct was customary in Greensboro.

Most writers generally agree that today the locality of practice is of diminishing importance.[24] As early as 1916, in *Viita v. Flemming,*[25] the Minnesota Supreme Court rejected the concept that the

153, 136 S.E.2d 617 (1964); Hunt v. Bradshaw, 242 N.C. 517, 88 S.E.2d 762 (1955).

[20] *E.g.,* Beck v. The German Klinik, 78 Iowa 696, 43 N.W. 617 (1889); McKenzie v. Siegel, 261 Minn. 299, 112 N.W.2d 353 (1961).

[21] Revels v. Pohle, 101 Ariz. 208, 418 P.2d 364 (1966); Sinz v. Owens, 33 Cal. 2d 749, 205 P.2d 3 (1949); Willard v. Hutson, 234 Or. 148, 378 P.2d 966 (1963).

[22] Revels v. Pohle, 101 Ariz. 208, 418 P.2d 364 (1966). "[L]aymen can say that in all cases where there are continual complaints of pain from a patient over a substantial period of time, that it is a departure from standard medical practice for the doctor to fail to examine the patient in any manner." *Id.* at ——, 418 P.2d at 367. Capps v. Valk, 189 Kan. 287, 369 P.2d 238 (1962); Engle v. Clarke, 346 S.W.2d 13 (Ky. 1961).

[23] 272 N.C. 366, 158 S.E.2d 548 (1968).

[24] D. LOUISELL & H. WILLIAMS, TRIAL OF MEDICAL MALPRACTICE CASES, § 8.06 (1966); McCOID, *The Care Required of Medical Practitioners,* 12 VAND. L. REV. 549 (1959); W. PROSSER, LAW OF TORTS 167 (3d ed. 1964); 14 STAN. L. REV. 884 (1962).

[25] 132 Minn. 128, 155 N.W. 1077 (1916).

locality is an overall qualification of the standard. That court stated, in effect, that the standard of care should be expressed in terms of "like circumstances," and the locality should be considered only as one of the circumstances. Since 1916, this development has gained judicial support,[26] some of which has been by word rather than by deed.[27] If this rule is applied as stated, an expert otherwise qualified would not be required to possess personal knowledge of the standards in the same or in a similar locality. He would be permitted to testify to standards of care possessed by the profession generally, and if any evidence concerning local practice is before the court, the jury could consider it in determining the weight to be given the expert's testimony. This rule greatly increases a plaintiff's ability to find favorable expert witnesses as well as easing his overall burden of proof. In *Murphy v. Little*,[28] the Georgia Supreme Court applied this concept of a national standard of care operating under a statute which requires a physician or surgeon to exercise a reasonable degree of care and skill.

The compelling interpretation of the *Pederson* case is that the court reached the same result as the *Murphy* case without the aid of a statute, and thus effectively discarded the locality rule.[29] Superficially, the case is subject to the criticism that by its definition of

[26] Flock v. J. C. Palumbo Fruit Co., 63 Idaho 220, 118 P.2d 707 (1941); McGulpin v. Bessemer, 241 Iowa 1119, 43 N.W.2d 121 (1950); Carbonne v. Warburton, 11 N.J. 418, 94 A.2d 680 (1953); Hodgson v. Bigelow, 335 Pa. 497, 7 A.2d 338 (1939).

[27] Sinz v. Owens, 33 Cal. 2d 749, 205 P.2d 3 (1949). The California Supreme Court said "The essential factor is knowledge of similarity of conditions; geographical proximity is only one factor to be considered." *Id.* at 756, 205 P.2d at 7. However, when plaintiff argued that the area for determination of the standard should be the San Joaquin Valley, containing two cities of over 50,000 people and smaller towns including the community of defendant-doctor's practice, the court balked, saying that plaintiff "seeks to advance this development beyond permissible bounds." *Id.* at 755, 205 P.2d at 6.

[28] 112 Ga. App. 517, 145 S.E.2d 760 (1965).

[29] In a more recent Washington case, Versteeg v. Mowery, —— Wash. 2d ——, 435, P.2d 540 (1967), the Supreme Court cited *Pederson* with approval. At first blush, the language of the court seems to indicate that the court has retained the locality rule. However, the plaintiff totally failed to establish any standard of care at all. The expert testimony merely offered evidence that each surgeon uses different surgical methods when inserting a plastic implant into female breasts. The court said that a jury is not capable of choosing between conflicting standards of the various expert witnesses. "[T]he medical standard or the minimal standard may be the same here that it is in Beverly Hills or New York or some place else, *but nobody has said so*." 435 P.2d at 543-44.

geographic proximity[30] it adds confusion to an already confused area of the law. Such phrases as "coextensive with the means available," and "readily accessible" mean very little in themselves without further judicial interpretation. The real significance of the case, however, lies in what the court intended by defining geographic proximity in this manner. One possible interpretation is that the court has retained a "similar" locality qualification on the standard, and has defined a "medical locality" making the "similar locality" a broader concept. This would be entirely inconsistent with the court's statement that the standard of care is to be expressed in terms of "the same or similar circumstances," and that locality is to be only one of the circumstances. It seems probable, upon analysis of the entire opinion, that the court did not intend to retain any concept of geographic qualification, especially since it stated that it is no longer proper "to limit the definition of the standard of care . . . to the practice or custom of . . . a geographical area."[31] The more tenable interpretation is that the standard of care is that required of a reasonable physician acting under the same or similar circumstances. The geographic proximity remains important, but only to the extent that it is necessary to determine what the reasonable doctor would have done in the same or similar situation. An expert, witness, unfamiliar with customary practice and the local level of knowledge and skill, would be competent to give his opinion of what is required of the profession generally. If the local practice differs from the expert testimony from the plaintiff's side, then it rests with defendant's counsel to bring such evidence before the court. Then, under proper instruction, it is the province of the jury to determine what is required of the average physician under these circumstances.

This is a most welcome decision. Most courts are operating under standards of care encumbered with rigid qualifications to the point that it is often difficult to discern that the malpractice action is grounded in negligence. The *Pederson* court recognized that the controlling question should be whether or not the conduct of the physician subjects the patient to an unreasonable risk of harm, and not what is the practice in the particular locality. It becomes ever more apparent that the original reasons employed to justify the lo-

[30] Note 4, *supra*, and accompanying text.

[31] Pederson v. Dumouchel, —— Wash. 2d ——, ——, 431 P.2d 973, 978 (1967).

cality rule no longer exist.[32] In *Pederson* the court reasoned "Now there is no lack of opportunity for a physician or surgeon to keep abreast of the advances in his profession . . . ."[33] The standards required by state medical licensing boards, the comprehensive coverage of medical journals, the "detail men" of drug companies, and post graduate courses serve to keep physicians abreast of national standards.[34] It is not contended that the facilities in smaller communities are now equal to those in larger towns and cities, nor that the ability and methods of treatment are everywhere the same. It is contended, however, that the older barriers no longer exist that would prevent any competent physician from knowing the extent of his ability and the capabilities of his facilities. There is nothing to prevent the doctor from knowing what skills and facilities are readily accessible for the proper treatment of the patient. "Increasingly realistic judges . . . will acknowledge that the legal rule ceases when the reasons for it cease."[35]

HAROLD N. BYNUM

Wills—Ademption by Trustee of Incompetent Testator in North Carolina—Adoption of the Intent Rule

In *Grant v. Banks*[1] the North Carolina Supreme Court held that the sale by a trustee of property specifically devised by his ward prior to incapacitation did not adeem the devise and that proceeds from the sale still remaining in the estate were recoverable under

[32] In 1940, in Tevdt v. Haugen, 70 N.D. 338, 349, 294 N.W. 183, 188 (1940), the North Dakota Supreme Court stated:

"The duty of a doctor to his patient is measured by conditions as they exist, and not what they have been in the past or may be in the future. Today, with 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 medical treatment is concerned, the borders of the locality or community have, in effect, been extended so as to include those centers readily accessible where appropriate treatment may be had which the local physician, because of his limited facilities or training is unable to give."

[33] Pederson v. Dumouchel, —— Wash. 2d ——, ——, 431 P.2d 973, 977 (1967).

[34] *Id.* at ——, 431 P.2d at 977.

[35] D. LOUISELL & H. WILLIAMS, TRIAL OF MEDICAL MALPRACTICE CASES, § 8.06 (1966).

[1] 270 N.C. 473, 155 S.E.2d 87 (1967).