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# Evidence--Expert Witness--Qualification of Specialist as Expert Witness in Medical Malpractice

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three provided for in the federal court system.[33] These include representation by private attorneys, attorneys furnished by the bar, or a system containing a combination of both of these. Of course, these solutions would only provide attorneys, not their fees. No one solution appears to be better than others. Whatever the source or funding for the adopted plan, it must be remembered that the right of the individual to adequately defend himself against a possible loss of liberty " . . . is too sacred a right to be sacrificed on the altar of expedience."[34]

*John Charles Lobert*

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**Evidence—Expert Witnesses—Qualification of Specialist as Expert Witness in Medical Malpractice**

*P*, experiencing vision loss in his right eye, consulted *D*, an ophthalmologist. *D* informed *P* that he had a cataract formation on the eye and advised a corrective operation, which was performed in August of 1962. After the operation *P* made periodic visits to the office of *D* where he was told each time that his progress was normal. Though *D* continually assured *P* that he would recover his vision, *P* continued to suffer from vision loss in his right eye. Finally, in May, 1963, *D* told *P* that he had retina trouble in the right eye and that he could do nothing to improve his vision. Subsequently, in February, 1965, *P*, having trouble with his left eye, went to *X*, a different specialist. *X* performed a cataract operation on the left eye in March, 1965, and informed *P* that more than half of the iris of the right eye was missing and that his eye was permanently damaged. In May, 1965, *P* brought a malpractice action in the Court of Common Pleas in Kanawha County, West Virginia. Part of *P's* evidence was the expert testimony by deposition of Z, an ophtalmologist from New York. After *P* rested his case *D* moved for and obtained a directed verdict on the grounds that the cause of action was barred by the pertinent statute of limitations. *P* appealed and the circuit court reversed; but *D* was sustained on his cross assignment of error, the circuit court holding the testimony of *Z* inadmissible. The case was remanded for retrial, but *P* appealed. *Held* the Supreme Court of Appeals reversed in part and remanded.

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[33] The Criminal Justice Act of 1964, 18 U.S.C. § 3006(A)(a) (1964).
[34] State v. Borst, 154 N.W. 2d 888, 895 (Minn. 1967) (dictum).

*Z's* expert testimony was held admissible. In liberalizing to a limited degree the prior "locality rule," the court ruled that *Z*, the New York specialist, was qualified to testify as to the correct manner to perform a cataract operation, because the standard procedure was shown to be the same throughout the country and thus applicable to Charleston, West Virginia. *Hundley v. Martinez,* 158 S.E.2d 159 (W. Va. 1967).

Medical malpractice is a subject about which the layman is greatly unfamiliar and thus is not qualified to give medical opinions.[1] Hence, expert medical witnesses are required in order for plaintiff to produce the medical testimony to support his complaint.[2] Because of the uniqueness of the medical profession, it is allowed to set its own standard of care.[3] The three traditional standards for the degree of care which a physician must meet are (1) the reasonable degree of care and skill exercised by members of the profession in good standing, (2) the school or system of practice which the doctor follows, and (3) the locality in which the doctor practices.[4] From this, the area from which an expert witness can be drawn is defined. The *Hundley* case illustrates a broader definition of "locality" by holding that, when a specialist qualifies as an expert witness by being from the "same or similar locality" as the defendant, the definition of locality is very inclusive, possibly the whole country.

Historically, the locality rule was based on the idea that a country doctor was not to be held to possess the same medical knowledge and thus not held to the same standard of care as the doctor in the city. The reasons where that he did not have access to the facilities in a large city, he usually would not practice a speciality, and he would not come in constant contact with others of their profession, resulting in little exchange of knowledge between country doctors. It was thus stated that a physician or surgeon could be held to no higher standard than others in the same locality.[5] However, with the

[1] This is true except where the negligence is so great as to be obvious to the layman, as illustrated in Buskirk v. Bucklew, 115 W. Va. 424, 176 S.E. 603 (1934), and Howell v. Biggart, 108 W. Va. 560, 152 S.E. 323 (1930).

[2] Riley v. Layton, 329 F.2d 53 (10th Cir. 9164); Schroeder v. Adkins, 149 W. Va. 400, 141 S.E.2d 352 (1965).

[3] 1 LAWYERS MEDICAL CYCLOPEDIA § 2.46 (rev. ed. 1966).

[4] *Id.* at § 2.41.

[5] Small v. Howard, 128 Mass. 131, 35 Am. Rep. 363 (1880). The early rule in West Virginia was expressed in terms of a limited locality. "The physician is bound to bestow such reasonable, ordinary care, skill, and diligence as physicians and surgeons in the same neighborhood, in the same general line of practice, ordinarily have and exercise in like cases." Lawson v. Conway, 37 W. Va. 159, 168, 16 S.E. 564, 567 (1892).

advancements which has taken place across the nation in the areas of communication and transportation, the reasons behind the strict rule have been weakened. The increasing number and excellence of medical schools, the accumulation and publication of scientific information, and the awareness of ethical standards have all combined to harmonize medical standards throughout the country.[6] Thus the phrase "same or similar locality" may no longer be confined to the strict interpretation of a confined physical area.[7]

For many years the leading case on the "locality" rule in West Virginia has been *Dye v. Corbin*,[8] which held that a physician "is required to exercise such reasonable and ordinary skill and diligence as are ordinarily possessed and exercised by the average of the members of the profession, in good standing, in similar localities. . . ."[9] Two recent West Virginia cases,[10] although not cited in the opinion of the principal case, appear to have been moving in the same direction as the principal case. One case, although not based on the medical malpractice of a physician but on the negligence of nurses in a hospital, held it would have been proper to admit testimony from a New York doctor because the standards of care for hospitals are the same.[11] The second case held it would have been proper to admit testimony of a surgeon from Cincinnati in a mal-

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[6] Gist v. French, 136 Cal. App.2d 247, 270, 288 P.2d 1003, 1071 (1955). In Montgomery v. Stary, 84 So.2d 34, 39 (Fla. 1956), the court recognized by dictum the qualification of a doctor from Chicago, Illinois, to testify in Orlando, Florida, when the act would not have been acceptable medical practice in any community. The Florida decision was approved in Cook v. Lichtblau, 144 So.2d 312 (Fla. 1962).

[7] This proposition appears to be the trend. In a case similar to the principal case, Riley v. Layton, 329 F.2d 53 (10th Cir. 1964), an expert from California was permitted to testify in Utah because he was familar with the procedure used for putting on a cast which was found to be universal throughout the United States. The California court, in Gist v. French, 136 Cal. App. 2d 247, 271, 288 P.2d 1003, 1018 (1955), conceded that the expert must have knowledge of the standard of care where the negligent act was performed, but held "community" or "locality" means an area unified by the same customs, laws, and sovereignty. In Geraty v. Kaufman, 115 Conn. 563, 573, 574, 162 A. 33, 36 (1932), it was held that there is now less reason than previously that the territorial limitation should be limited to the confines of a town or city in which treatment was rendered; that within the state medical practices are substantially the same. *See* Annot., 8 A.L.R.2d 772 (1949); 5A PERSONAL INJURY--ACTIONS, DEFENSES, DAMAGES PHYSICIANS & SURGEONS §1.01 (1) (e) (M. Bender 1967).

[8] 59 W. Va. 266, 53 S.E. 147 (1906).

[9] *Id* at 270, 53 S.E. at 149.

[10] Schroeder v. Adkins, 149 W. Va. 400, 41 S.E.2d 352 (1965); Duling v. Bluefield Sanitarium, Inc., 149 W. Va. 567, 142 S.E.2d 754 (1965).

[11] Duling v. Bluefield Sanitarium, Inc., 149 W.Va. 567, 142 S.E.2d 754 (1965) *See also* Comment, EXPERT TESTIMONY OF DEFENDANT PHYSICIAN WHEN CALLED AS ADVERSE WITNESS, 69 W. VA. L. REV. 202 (1967).

practice action against a chiropodist in Cabell County because he would have been equally knowledgeable about the particular conduct involved.[12]

The standard of care for a specialist[13] in his field is higher than that of a general practitioner because he has additional education and experience in his more defined field of practice. A specialist is held to exercise that degree of skill and care ordinarily used by similar specialists in like circumstances, having regard to the existing state of knowledge in medicine and surgery.[14] A duty of a specialist to keep abreast of the times is an important contribution to the enlargement of the definition of the term "locality."[15] Since the definition of a specialist's standard of care encompasses more than just a particular locality, there is a much greater area from which an expert may be brought to testify concerning medical malpractice of a specialist.

Actually there should be very little difference throughout the United States for the standard of care required of a specialist in a certain field of medicine.[16] In the principal case the expert on ophthalmology testified that the standard way of performing the cataract operation was the same throughout the country.[17] More particularly, the manner in which the defendant described the operation was the same procedure outlined by the expert.[18]

Therefore, it would seem that, for a specialist in a malpractice action, the "community" or "locality" in which he practices is very large, possibly the entire country. Or, from another point of view,

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[12] Schroeder v. Adkins, 149 W. Va. 400, 141 S.E.2d 352 (1965).

[13] The test to determine whether one is a specialist or general practitioner is that one who holds himself out as a specialist is judged as a specialist. Ayers v. Parry, 192 F.2d 181, 184 (3d Cir. 1951); Rule v. Chessman, 181 Kan. 957, 965, 317 P.2d 472, 478 (1958).

[14] Grossjean v. Spencer, 140 N.W.2d 139, 143 (Iowa 1966); McGulpin v. Bessmer, 241 Iowa 1119, 1132, 43 N.W.2d 121, 128 (1950); Wood v. Vroman, 215 Mich. 449, 465-66, 184 N.W. 520, 525 (1921); Carbone v. Warburton, 11 N.J. 418, 426, 94 A.2d 680, 683 (1953); 41 AM. JUR. PHYSICIANS & SURGEONS § 90 (1942); 7 AM. JUR. PROOF OF FACTS, *Malpractice* 79 (Supp. 1967).

[15] In Flock v. J. C. Palumbo Fruit Co., 63 Idaho 220, 236, 118 P.2d 707, 714 (1941) the court said, "Physicians are required to keep abreast of and use best modern methods of treatment, and in so doing they may not unduly and narrowly restrict or confine their responsibility to the immediate place where they are practicing." Accord, Worster v. Cayler, 231 Ind. 625, 630, 110 N.E. 2d 337, 339 (1953); Stone v. Goodman, 271 N.Y.S. 500, 507 (1934).

[16] Although no case was found directly on this point, it would seem to be the logical continuance of the present trend.

[17] Hundley v. Martinez, 518 S.E.2d 159, 168 (W. Va. 1967).

[18] *Id.*

it could be said that for the specialist the locality rule has been abandoned. The principal case would appear to support this observation. Yet, the court was careful not to abrogate the locality rule entirely. Each case must be considered on its own facts. The court seemed to say that the locality rule applies to specialists and general practitioners, but the definition of locality for the specialist embraces more area.[19] The diminishing importance of the locality rule can be seen by one expressed view that the size and character of the community is just one factor to be taken into account in determining the applicable general professional standard.[20]

The general rule as to the standard of care established for a doctor in a medical malpractice action, imposing the requirements of the same or similar locality, still prevails. However, with improved communications and transportation, the area of inclusion within a "locality" has been enlarged. The West Virginia Supreme Court of Appeals seems fully warranted in holding that the locality to which the standard is applied for a specialist in a medical malpractice action in West Virginia is large enough to encompass the testimony of a specialist from New York.

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**Future Interests—Transmissibility and Survivorship Characteristics of Reminders**

*T* died in 1908, leaving a will which devised her property to *X* in trust for the benefit of *A* for life, and in case *A* should die leaving "child or children" surviving her *then* to such "child or children." If *A* should died without issue *then* to *T's* brothers and sisters in equal shares, with the share of any brother or sister who died leaving children to those children. *T* had eight brothers and sisters, three of whom predeceased *T*, and the remaining five predeceased *A*, who died without issue in 1965. The trial court found that *T* intended her property to go to her brothers and sisters or their direct descendents per stirpes, without lapse, with the interests vesting at

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[19] This is not to say that the locality rule for the general practitioner has not been expanded, but only that the expansion for the specialist has been greater.

[20] McGulpin v. Bessmer, 241 Iowa 1119, 1131, 43 N.W.2d 121, 128 (1950); W. PROSSER, THE LAW OF TORTS § 32 (3d ed. 1964).