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THE MEDICAL STANDARD OF CARE IN MISSISSIPPI

INTRODUCTION

On February 27, 1985, just over two years after *King v. Murphy,*[1] in which the court expanded the previously applied strict locality rule to a statewide standard, the court again greatly enlarged the standard. As stated in *Hall v. Hilbun,*[2] the standard of care to which a physician in Mississippi must now conform is a national standard, modified only minimally by local factors, most notably with regard to the availability of medical equipment.

A parallel expansion enlarged the pool from which expert witnesses may be drawn. Where a witness lives or practices has no *per se* bearing on his competence. What is required is that the witness in fact be qualified as an expert and that he be "familiarized"[3] with the available resources.

BACKGROUND

Proof of medical malpractice[4] requires evidence as to the recognized standard of medical care and a showing of the physician's negligent departure from that standard.[5] The burden of proof is on the plaintiff to make this showing,[6] which, in most

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1. 424 So. 2d 547 (Miss. 1982).

2. 466 So. 2d 856 (Miss. 1985). The court considered this case on direct appeal on November 9, 1983. Because this opinion was withdrawn and a new opinion substituted, the November 9, 1983, opinion is not officially reported.

3. *See infra* text accompanying note 118.

4. "Basically, medical malpractice is the infliction of injury or death under circumstances where it may be said that the cause thereof is a failure on the part of the defendant medical practitioner to have complied with applicable standards of medical practice." D. HARNEY, MEDICAL MALPRACTICE 88 (1973); *see also* 70 C.J.S. *Physicians and Surgeons* § 40 (1951).

5. Davis v. Virginian Ry. Co., 361 U.S. 354 (1960). *See also* Wale v. Barnes, 278 So. 2d 601 (Fla. 1973), *conformed to* 280 So. 2d 476 (Fla. Dist. Ct. App. 1973); Vertsteeg v. Mowery, 72 Wash. 2d 754, 755, 435 P.2d 540, 541 (1967) ("In order to sustain a judgment against a physician or surgeon, the standard of medical practice in the community must be shown, and, further, that the doctor failed to follow the methods prescribed by that standard." (quoting Richison v. Nunn, 57 Wash. 2d 1, 4, 340 P.2d 793, 795 (1959), *cert. denied*, 364 U.S. 816 (1960))).

6. Davis v. Virginian Ry. Co., 361 U.S. 354 (1960); Harper v. Baptist Medical Center – Princeton, 341 So. 2d 133 (Ala. 1976); Wale v. Barnes, 278 So. 2d 601 (Fla. 1973); Delaughter v. Womack, 250 Miss. 190, 164 So. 2d 762 (1964); Versteeg v. Mowery, 72 Wash. 2d 754, 435 P.2d 540 (1967); Hundley v. Martinez, 151 W. Va. 977, 158 S.E.2d 159 (1967). In Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 349 A.2d 245 (1975), the court held:

> The general principles which ordinarily govern in negligence cases also apply to medical malpractice claims [citations omitted]. Therefore, as in any other case founded upon negligent conduct, the burden of proof rests upon the plaintiff in a medical malpractice case to show a lack of the requisite skill or care on the part of the defendant.

Id. at 190, 349 A.2d at 247. *See generally* Annot., 37 A.L.R. 3d 420 (1971).

cases,[7] must be done through expert testimony.[8] This requirement is often a threshold area of proof for the plaintiff.[9] An expert witness will not be judged competent to testify unless he is familiar with the applicable standard of care,[10] which varies from jurisdiction to jurisdiction.[11] Therefore, the criteria used to determine this standard are often central in negligence actions against physicians.[12]

The "strict locality rule," as applied to a general standard of medical care, limits the obligation of a physician to the level of learning, skill and experience of physicians practicing in their own

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7. Expert testimony is not required if negligence can be determined through the common knowledge of the lay juror. Graham v. Sisco, 248 Ark. 6, 449 S.W.2d 949 (1970); Dazet v. Bass, 254 So. 2d 183 (Miss. 1971); In Hammond v. Grissom, No. 54,794 (Miss. May 29, 1985), the court stated that the situation exhibited "an absence of medical care, rather than the misfeasance of some complex medical diagnosis or treatment." *Id.*, slip op. at 9. (The court noted that the lay observers common-sense observations were strengthened by their having had some medical training, justifying a rare exception to the rule requiring expert testimony); Pharmaseal Laboratories, Inc. v. Goffe, 90 N.M. 753, 548 P.2d 618 (1981). *See generally* 70 C.J.S. *Physicians and Surgeons* § 62(d)(2) (1951) ("Expert evidence is not required where the results of the treatment are of such character as to warrant the inference of want of care from the testimony of laymen or in the light of the knowledge and experience of the jurors themselves . . . .").

8. Ayers v. Barry, 192 F.2d 181 (3d Cir. 1951); Zills v. Brown, 382 So. 2d 528 (Ala. 1980); Sinz v. Owens, 33 Cal. 2d 749, 205 P.2d 3 (1949); Fitzmaurice v. Flynn, 160 Conn. 609, 356 A.2d 887 (1975); Dazet v. Bass, 254 So. 2d 183 (Miss. 1971); Bruni v. Tatsumi, 46 Ohio St. 2d 127, 346 N.E.2d 673 (1976); Hundley v. Martinez, 151 W. Va. 977, 158 S.E.2d 159 (1967). *See generally* 70 C.J.S. *Physicians and Surgeons* § 62(d)(2) (1951). Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DE PAUL L. REV. 408, 409 (1969) ("[T]he technical aspects of his claim will ordinarily be far beyond the competence of the lay jurors whose duty it is to assess the defendant doctor's conduct.").

9. Plaintiff will be nonsuited if this burden is not met.

> Before the plaintiff can recover, she must show by affirmative evidence – first, that defendant was unskillful or negligent; and, second, that his want of skill or care caused injury to the plaintiff. If either element is lacking in her proof, she has presented no case for the consideration of the jury.

Bruni v. Tatsumi, 46 Ohio St. 2d 127, 130, 346 N.E.2d 673, 677 (1976) (quoting Ewing v. Goode, 78 F. 442, 443-44 (C.C.S.D. Ohio 1897)). *See also* Merriman v. Toothaker, 9 Wash. App. 810, 515 P.2d 509, 511 (1973) ("Failure to establish a medical standard applicable to defendant's class of physicians is fatal to a claim of malpractice where the subject matter requires expertise.").

10. Loftus v. Hayden, 391 A.2d 749, 752 (Del. 1978) ("We think that a witness offered to give 'expert medical testimony' should establish that he 'knows' what degree of skill is ordinarily employed here and that he is well acquainted or thoroughly conversant with it."). Regarding what constitutes "familiar," the court states that some cases have required knowledge based on direct occupational or practical experience, and others permit it to be based on observation. *Id.* at 752 n.5. *See also* Bruni v. Tatsumi, 46 Ohio St. 2d 127, 132, 346 N.E.2d 673, 677 (1976) ("[t]his expert must be qualified to express an opinion concerning the specific standard of care that prevails in the medical community in which the alleged malpratice [sic] took place . . . .").

11. Sinz v. Owens, 33 Cal. 2d 749, 205 P.2d 3 (1949). *See also* Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 349 A.2d 245 (1975); Annot., 99 A.L.R. 3d 1133 (1980); Annot., 37 A.L.R. 3d 420 (1971); 70 C.J.S. *Physicians and Surgeons* § 43 (1951).

12. Medicine is the only profession to which the courts have applied geographical locality rules as criteria in determining the standard of care. *See* Johnson, *An Evaluation of the Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 730 n.8 (1970). However, regarding attorney malpractice, *see* Dean v. Conn, 419 So. 2d 148, 150 (Miss. 1982) ("Generally, the same standards of professional conduct are applicable to the attorney and physician alike, namely: (1) both are required to use that degree of care, skill and diligence which is commonly possessed and exercised by attorneys/physicians in that locality.").

communities, or localities.[13] The rule was formulated by the courts in this country[14] in the late nineteenth century under the reasoning that it would be unfair to hold rural practitioners to the same standard as their urban counterparts, since they did not have the same education, training, or facilities.[15] Three problems with the strict locality rule soon became apparent. First, sole practitioners in a community were in effect exempt from malpractice liability.[16] Second, the rule was often used simply as an exclusionary rule of evidence; it was frequently impossible for a plaintiff to find local physicians willing to testify as to the local standard of care.[17] Third, it was possible that a group of lax practitioners might settle in the same community, establishing an inferior local standard.[18] This was obviously unacceptable: "Negligence cannot be excused on the ground that others in the same locality practice the same kind of negligence."[19]

In response, many jurisdictions expanded the strict locality rule to a "same or similar locality" rule.[20] Under this criterion, a physician is held to the standard of care of his own locality or that of a similar locality.[21] This broadening somewhat reduced plaintiffs rigors in finding expert witnesses willing to testify.[22] But, since

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13. *See, e.g.*, Teffet v. Wilcox, 6 Kan. 46 (1970).

> In the smaller towns and country, those who practice medicine and surgery, though often possessing a thorough theoretical knowledge of the highest elements of the profession, do not enjoy so great opportunities of daily observation and practical operations . . . as those who reside in the metropolitan towns . . . they should not be expected to exercise that high degree of skill and practical knowledge possessed by those having greater facilities for performing and witnessing operations . . . .

Id. at 63-64.

14. England has never applied a locality rule to medical malpractice suits. *See* Waltz, *supra* note 8, at 410.

15. For discussions of the original reasons for locality rules, *see generally* Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 349 A.2d 245 (1975); Faulkner v. Pezeshki, 44 Ohio App. 2d 186, 337 N.E.2d 158 (1975); King v. Williams, 276 S.C. 478, 279 S.E.2d 618 (1981); Pederson v. Dumouchel, 72 Wash. 2d 73, 431 P.2d 973 (1967); Hundley v. Martinez, 151 W. Va. 977, 158 S.E.2d 159 (1967); Shier v. Freedman, 58 Wis. 2d 269, 206 N.W.2d 166 (1973); Johnson, *supra* note 12, at 730-31; Waltz, *supra* note 8, at 410-11.

16. Waltz, *supra* note 8, at 411 ("He could be treating bone fractures by the application of wet grape leaves and yet remain beyond the criticism of more enlightened practitioners from other communities.").

17. *See, e.g.*, Gambill v. Stroud, 258 Ark. 766, 531 S.W.2d 945 (1976); Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 349 A.2d 245 (1975).

18. *See, e.g.*, Pederson v. Dumouchel, 72 Wash. 2d 73, 431 P.2d 973 (1967); Johnson, *supra* note 12, at 731.

19. *Pederson*, 72 Wash. 2d at 78, 431 P.2d at 977.

20. *Gambill*, 258 Ark. at 770, 531 S.W.2d at 948 ("The standard is not limited to that of a particular locality. Rather, it is that of persons engaged in a similar practice in similar localities . . . ."). An early case applying a similar locality rule is Small v. Howard, 128 Mass. 131, 35 Am. Rep. 363 (1880), *overruled by* Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968).

21. *See, e.g.*, Waltz, *supra* note 8, at 411.

22. *See* Johnson, *supra* note 12, stating that:

> Use of the "same or similar locality" rule reduces to some extent the difficulties presented by the "same

the standard in the "similar" community might also be low, the danger of an inferior standard of care persisted.[23] A new problem, defining what type of community constituted a "similar locality," presented itself.[24] Similarity seems to have been defined in geographical and socioeconomic terms.[25] But clearly the trend, in those jurisdictions applying this standard, is to define a similar community as one with similar medical practices and facilities.[26]

The approach today, however, is increasingly toward formulating a standard of care not defined solely in geographical terms. Legal writers[27] and cases in a number of jurisdictions[28] in-

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> locality" rule. When the plaintiff can look to other localities for expert witnessess he is more likely to find a physician who is willing to testify as to the standard of care because the expert would not be testifying against a doctor from his own community. Nevertheless, the plaintiff is still greatly inconvenienced, initially, by having to determine what constitutes a similar locality, and then because there is reason to doubt that many doctors would be willing to testify against even a foreign locality doctor.

Id. at 731-37. *But see* Gambill v. Stroud, 258 Ark. 766, 770-A, 770-B, 531 S.W.2d 945, 950 (1976) (applying with approval a similar locality rule).

23. *See generally* Pederson v. Dumouchel, 72 Wash. 2d 73, 431 P.2d 973 (1967); Johnson, *supra* note 12, at 732. *See also supra* note 22.

24. *See generally Shilkret*, 276 Md. at 195-96, 349 A.2d at 250; HARNEY, *supra* note 4, at 97.

25. *Shilkret*, 276 Md. at 195-96, 349 A.2d at 250.

26. *Gambill*, 258 Ark. at 270, 531 S.W.2d at 948 ("The similarity of communities should depend not on population or area in a medical malpractice case, but rather upon their similarity from the standpoint of medical facilities, practices and advantages.") Speed v. State, 240 N.W.2d 901, 904 (Iowa 1976); Waltz, *supra* note 8, at 415.

27. HARNEY, *supra* note 4, § 3.3; Johnson, *supra* note 12, at 729; Waltz, *supra* note 8, at 408. *See generally* Annot., 99 A.L.R. 3d 1133 (1980).

28. In Zills v. Brown, the court held that:

> Distinctions in the degree of care and skill to be exercised by physicians in the treatment of patients based upon geography can no longer be justified in the light of the presently existing state of transportation, communications, and medical education and training which results in a standardization of care within the medical profession. There is no tenable policy reason why a physician should not be required to keep abreast of the advancements in the profession.

382 So. 2d 528, 532 (Ala. 1980). *See also* Gist v. French, 136 Cal. App. 2d 247, 270, 288 P.2d 1003, 1017 (Dist. Ct. App. 1955) ("The ubiquity of such knowledge, the popularity of ethical standards in every part of the nation and the uniformity of curricula have combined to create one community of medical practitioners out of the 48 states and the District of Columbia."); Fitzmaurice v. Flynn, 167 Conn. 609, 616-17, 356 A.2d 887, 892 (1975) ("[I]t is no longer true that standards of care and diagnosis will differ substantially from town to town."); Murphy v. Little, 112 Ga. App. 517, 522, 145 S.E.2d 760, 764 (1965) ("Reasons for the more narrow rule which might have obtained in times past, where transportation was difficult, medical schools and hospitals often inaccessible, and doctors licensed to practice with little or no formal training, no longer have any validity."); Blair v. Eblen, 461 S.W.2d 370, 373 (Ky. Ct. App. 1970) ("[W]e will not perpetrate a rule designed to protect country doctors in 1902 . . . ."); Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 194, 349 A.2d 245, 249 (1975) ("Whatever may have justified the strict locality rule fifty or a hundred years ago, it cannot be reconciled with the realities of medical practice today."); Brune v. Belinkoff, 354 Mass. 102, 108, 235 N.E.2d 793, 798 (1968) ("The time has come when the medical profession should no longer be Balkanized by the application of varying geographic standards in malpractice cases."); King v. Williams, 276 S.C. 478, 279 S.E.2d 618 (1981); Pederson v. Dumouchel, 72 Wash. 2d 73, 78, 431 P.2d 973, 977 (1967) ("Now there is no lack of opportunity for a physician or surgeon to keep abreast of the advances made in his profession and to be familiar with the latest methods and practices adopted.") *Cited with approval in* Douglas v. Bussabarger, 73 Wash. 2d 476, 438 P.2d 829 (1968) (en banc); Shier v. Freedman, 58 Wis. 2d 269, 206 N.W.2d 166 (1973).

dicate that the conditions that supported the validity of geographical locality rules have radically changed;[29] today, uniformly required higher education, widespread medical information, and access to modern facilities are the bases for more and more courts' recognition of a minimum national standard of care.[30] There are several approaches toward this abandonment, or severe modification, of geographical locality rules.

A method still using geographical terminology to expand the range of the required standard of care is the "same general neighborhood rule."[31] Although some jurisdictions, including Mississippi,[32] appeared to have equated "same general neighborhood" with the community of the defendant physician (in effect a strict locality rule), Connecticut has defined "neighborhood" as including the entire state, thus holding physicians throughout Connecticut to a uniform standard of care.[33] Alabama, construing a state statute,[34] has extended the definition of "neighborhood" to near its outer limit, holding that the "same general neighborhood" is a "*national medical neighborhood* or *national medical community,* of reasonably competent physicians acting in the same or similar circumstances."[35]

Another standard, the "medical neighborhood rule," also retains some vestiges of geographical factors in its formulation. Under this rule, the boundaries of the area establishing the standard of care are extended to include "medical and professional means available in those centers that are readily accessible to appropriate treatment of the patient."[36] The physician cannot use only the facilities and means available locally if transfer to an accessible

29. In fact, a 1916 Minnesota case, Viita v. Dolen, held that:

> 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 . . . .

132 Minn. 128, 137, 155 N.W. 1077, 1081 (1916).

30. *See* cases cited *supra* note 28.

31. *See generally* Annot., 37 A.L.R. 3d 420, 430-32 (1971).

32. Copeland v. Robertson, 236 Miss. 95, 112 So. 2d 236 (1959). *But see* Zills v. Brown, 382 So. 2d 528, 530 (Ala. 1980) (stating that there is a "significant distinction between the 'strict locality rule' and the 'same general neighborhood' rule, inasmuch as the latter is a liberalization of the former." However, the dissenting opinion defined "same general neighborhood" as the defendant's "community." *Id.* at 535).

33. Fitzmaurice v. Flynn, 167 Conn. 609, 356 A.2d 887 (1975).

34. ALA. CODE § 6-5-484(a) (1975).

35. *Zills*, 382 So. 2d at 532.

36. *Pederson*, 76 Wash. 2d at 79, 431 P.2d at 978.

center is indicated due to a deficiency in local training or facilities.[37] The standard expands or contracts according to the circumstances of each case.[38] The rule is considered to have "paved the way for the national standard."[39]

A minimum national standard of care is required in some jurisdictions for "basic medical problems."[40] These cases hold that the minimum acceptable standards for such common treatments and procedures as bone-setting[41] and X-rays[42] are basic, would not vary from locality to locality, and justify the application of a uniform national standard.

Several jurisdictions also hold specialists[43] to a national standard of care. A specialist, in representing himself as possessing special skill and knowledge, is held to a higher standard than a general practitioner.[44] A national survey[45] indicated: "On the basis

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37. *See* Sinz v. Owens holding that:

> [T]he duty of a doctor is not fulfilled merely by utilizing the means at hand in the particular village where he is practicing . . . . [T]he borders of the locality and 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 limited facilities or training, is unable to give.

33 Cal. 2d 749, 755, 205 P.2d 3, 6 (1949) (quoting Tevdt v. Haugen, 70 N.D. 338, 349, 294 N.W. 183, 188 (1940)). *See also* Meeks v. Marx, 15 Wash. App. 571, 550 P.2d 1158 (1976). *But see* Gambill v. Stroud, 258 Ark. 766, 770-C, 531 S.W.2d 945, 950 (1976), arguing that a small town doctor should not be penalized when transfer to a medical center "is not practicable."

38. Meeks v. Marx, 15 Wash. App. 571, 576, 550 P.2d 1158, 1162 (1976) ("The very value of the *Pederson* rule lies in its amenability to contraction or expansion in each case depending on the proofs adduced. We therefore decline any invitation to define the area in geographical terms, be they broad or narrow.").

39. *Shilkret*, 276 Md. at 196, 349 A.2d at 250.

40. *See generally* Johnson, *supra* note 12, at 737-38.

41. Murphy v. Little, 122 Ga. App. 517, 145 S.E.2d 760 (1965).

42. McElroy v. Frost, 268 P.2d 273, 279-80 (Okla. 1954) ("It is a matter of common understanding that a proper method of treating human ailments by x-ray would not vary from place to place or state to state. What is the best practice in one place would be the best in another.").

43. "The question of when a physician becomes a specialist has been held to be not one of law, but of fact, primarily for his own determination." 70 C.J.S. *Physicians and Surgeons* § 41 (1951).

44. *See* Ardoin v. Hartford Accident and Indem. Co., 360 So. 2d 1331 (La. 1978) (cardiovascular surgeon) (In construing LA. REV. STAT. ANN. § 9:2794 (West 1974) to mean that specialists are not to be judged by a standard tied to locality, the court held that "[t]he various medical specialties have established uniform requirements for certification. The national boards dictate the length of residency training, subjects to be covered, and the examinations given to the candidates for certification. Thus the medical profession itself recognizes national standards for specialists that are not determined by geography." *Id.* at 1337); Naccarato v. Grob, 384 Mich. 248, 253-54, 180 N.W.2d 788, 791 (1970) (pediatricians) held that:

> [c]alling a specialist parochial or bucolic is hardly appropriate. The reliance of the public upon the skills of a specialist and the wealth and sources of his knowledge are not limited to the geographic area in which he practices . . . . Therefore, geographical conditions or circumstances control neither the standard of a specialist's care nor the competence of an expert's testimony.

See also 70 C.J.S. *Physicians and Surgeons* § 41 (1951).

45. Note, *Medical Specialties and the Locality Rule*, 14 STAN. L. REV. 884 (1962). *See also* Johnson, *supra* note 12, at 738-39; Note, 40 FORDHAM L. REV. 435 (1971). RESTATEMENT (SECOND) OF TORTS § 299A (1965) applies a national standard to specialists and a same or similar standard to general practitioners. "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." *Id.*

of the existence of standardized requirements for certification, subscriptions to medical specialty journals, medical specialty societies, and statements from American Specialty Boards, it is concluded that the practice of medicine by certified specialists within most medical specialties is similar throughout the country."[46] In applying a national standard to specialists, the law is seen to reflect medical realities, "[s]ince the medical profession itself recognizes national standards for specialists that are not determined by geography . . . ."[47]

Other jurisdictions have held that a national standard of care exists for, and is applicable to, general practitioners as well as specialists.[48] However, evidence showing justifiable circumstances for not adhering to the national standard is admissible and may include "elements of locality, availability of facilities, specialization of general practice, proximity of specialists and special facilities as well as other relevant considerations."[49] This "assures that the local practitioner need not run the risk of being judged by a national standard that may be abstractly unaffected by local conditions."[50] But locality is not the determinative factor in establishing the standard of care. Instead, local limitations are a factor – and only a factor – that may be considered in determining, in each circumstance, whether adherence to a national standard of care is to be required.[51]

THE STANDARD OF MEDICAL CARE IN MISSISSIPPI

Prior to the holding in *King v. Murphy*,[52] a line of Mississippi

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46. Note, *Medical Specialties and the Locality Rule*, 14 STAN. L. REV. 884, 887-89 (1962).

47. *Shilkret*, 276 Md. at 198, 349 A.2d at 251.

48. May v. Moore, 424 So. 2d 596 (Ala. 1982); Fain v. Moore, 155 Ga. App. 209, 270 S.E.2d 375 (1980); Blair v. Eblen, 461 S.W.2d 370 (Ky. 1970); Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 200, 349 A.2d 249, 252 (1975) ("[T]here is no valid basis for distinguishing between general practitioners and specialists in applying standards of care."); Brune v. Belinkoff, 354 Mass. 102, 109, 235 N.E.2d 793, 798 (1968) ("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."); King v. Williams, 276 S.C. 478, 279 S.E.2d 618 (1981); Pederson v. Dumouchel, 72 Wash. 2d 73, 79, 431 P.2d 973, 978 (1967) (calling for physicians to exercise the "care and skill which is expected of the average practitioner in the class to which he belongs . . . ."). The Maryland court in *Shilkret* eschews the term "average" used in the *Brune* and *Pederson* standards and substitutes "reasonably competent," aligning itself with the Kentucky court in *Blair*. *See also* Shier v. Freedman, 58 Wis. 2d 269, 206 N.W.2d 166 (1973).

49. Blair v. Eblen, 461 S.W.2d 370, 373 (Ky. 1970).

50. Drs. Lane, Bryant, Eubanks & Dulaney v. Otts, 412 So. 2d 254, 258 (Ala. 1982).

51. Cases applying this standard include Drs. Lane, Bryant, Eubanks & Dulaney v. Otts, 412 So. 2d 254 (Ala. 1982); Mull v. Emory University, Inc., 114 Ga. 63, 150 S.E.2d 276 (1966); Speed v. State, 240 N.W.2d 901 (Iowa 1976); Blair v. Eblen, 461 S.W.2d 370 (Ky. 1970); Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 349 A.2d 245 (1975); Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968); Pharmaseal Laboratories v. Goffe, 90 N.M. 753, 568 P.2d 589 (1981); King v. Williams, 276 S.C. 478, 279 S.E.2d 618 (1981); Pederson v. Dumouchel, 72 Wash. 2d 73, 431 P.2d 973 (1967).

52. 424 So. 2d 547 (Miss. 1982).

Supreme Court cases established what was in effect a strict locality rule in Mississippi. In *Copeland v. Robertson*[53] the court quoted the rule from *American Jurisprudence* and expressed its accord with it:

> It is the universal rule that a physician is liable to his patient for a failure to exercise requisite skill and care. By that it is meant that a physician must possess that reasonable degree of learning, skill and experience which ordinarily is possessed by others of his profession, and that he must exercise reasonable and ordinary care and diligence in the exertion of his skill and the application of his knowledge, and exert his best judgment as to the treatment of the case intrusted to him - *in short a physician is bound to bestow such reasonable and ordinary care, skill, and diligence as physicians and surgeons in good standing in the same neighborhood, in the same general line of practice, ordinarily have and exercise in like cases.* The terms "physician" and "surgeon" here are used interchangeably, the courts making apparently no attempt, so far as this point is concerned, to distinguish their respective liabilities; and the practitioner is equally responsible in either case, whether the injury results from want of skill or want of care.[54]

The same standard was again quoted, with apparent approval, in other Mississippi cases. However, in none of them was the exclusion of a non-local witness in issue.[55]

It was not until *Dazet v. Bass*[56] that excluded testimony became an issue. The trial court had peremptorily instructed the jury to find for the defendants, specialists in obstetrics and gynecology in the Jackson area. All physicians who testified stated that the defendants "possessed and exercised the standard of care ordinarily possessed and exercised by gynecologists in the Jackson area."[57] The court held that, absent medical testimony of malpractice, all that was shown was that an undesired result occurred and that physicians are not warrantors against bad results.[58] However, the trial court refused to admit the testimony of a New Orleans physician because he was unfamiliar with the standard of medical skill exercised in the Jackson area. The court stated:

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53. 236 Miss. 95, 112 So. 2d 236 (1959).

54. *Copeland*, 236 Miss. at 110, 112 So. 2d at 241 (quoting 41 AM. JUR. *Physicians and Surgeons* § 82 (1938)) (experts testified as to the local standard of care regarding gynecological treatment in Jackson, the locality of the defendant physician).

55. Delaughter v. Womack, 250 Miss. 190, 164 So. 2d 762 (1964) (the court rejected arguments that plaintiff had failed to establish a standard of skill and care to be exercised); Hill v. Stewart, 209 So. 2d 809 (Miss. 1968) (expert testified as to the general standards of skill of general medical practitioners on the Gulf Coast, the locality of defendant physician); Hawkins v. Osborn, 383 F. Supp. 1389 (N.D. Miss. 1974) (tried in United States District Court due to diversity of citizenship, applied the same standard expressed in *Copeland*; plaintiff's expert testimony that defendant physician had not exercised reasonable care and skill raised an issue of fact which was rebutted by other medical witnesses). *See also* Sanders v. Smith, 200 Miss. 551, 27 So. 2d 889 (1946).

56. 254 So. 2d 183 (Miss. 1971).

57. *Id.* at 186-87.

58. *Id.* at 187. *See also* Sanders v. Smith, 200 Miss. 551, 27 So. 2d 889 (1946).

> Plaintiff contends with a great deal of force that the so-called "locality rule" is no longer valid for the reason that physicians now attend the same colleges, receive the same post graduate courses in their specialities, and go to the same seminars; that the standards of care for a specialist should be and are the same throughout the country, and that geographical conditions or circumstances are no longer valid as controlling the standards of a specialist's care or competence. Conceding that there is considerable force in the argument on this question, we are not convinced that the "locality rule" should be entirely abolished . . . .[59]

But because the expert had been dismissed from the stand without testimony, the court could not determine if the exclusion was prejudicial, and the court was unable to address the issue.

King v. Murphy

In *King v. Murphy*,[60] the court modified and enlarged its previous locality (or neighborhood) rule so that physicians and surgeons in Mississippi were held to a statewide standard of care.[61] From the wording of the holding, the standard applied both to specialists and general practitioners.

> We are of the opinion that the locality rule in Mississippi should not be abolished, but it should be extended and expanded. Therefore, we hold that the standard of care by which the acts or omissions of physicians, surgeons, or specialists are to be judged shall be that degree of care, skill and diligence practiced by a reasonably careful, skillful, diligent and prudent practitioner in such field of practice or specialty in this state, and for a reasonable distance adjacent to state boundaries. An expert witness who is knowledgeable of, and familiar with, the statewide standard of care shall not have his testimony excluded on the ground that he does not practice in the state.[62]

The trial court in *King* had permitted the plaintiff's expert witness to testify by expanding the previously applied strict locality rule to a similar locality rule, "although expressing some doubt as to whether or not Dr. Gardner qualified."[63] The witness, Dr. Richard Gardner, had practiced at a major military hospital, in Boston, Massachusetts, and in Ft. Myers, Florida, population approximately 162,000 to 180,000.[64] Iuka, where Murphy was treated, had a population of 2,846; Tishomingo County's population was 18,434.[65] Since Dr. Gardner had never practiced in Mississippi the supreme court held that he did not qualify under the previous

59. *Dazet*, 254 So. 2d at 187.

60. 424 So. 2d 547 (Miss. 1982).

61. A judicially created statewide standard of care is not unique to Mississippi. A "same general neighborhood" standard was defined as including the entire state of Connecticut in Fitzmaurice v. Flynn, 160 Conn. 609, 356 A.2d 887 (1975). The Delaware court, interpreting a statute, appears to apply a statewide standard in Loftus v. Hayden, 391 A.2d 749 (Del. 1978).

62. *King*, 424 So. 2d at 550.

63. *See id.* at 551.

64. *See id.* at 550.

65. BUREAU OF THE CENSUS, U.S. DEPARTMENT OF COMMERCE, 1980 CENSUS OF HOUSING at 26-18 and 26-113 (1982).

locality rule, the trial court's similar locality rule, or the new statewide rule.[66] Therefore, his testimony had been erroneously admitted, and the case was reversed and remanded.[67]

The court traced the previous application of the locality rule in Mississippi and noted that in *Dazet v. Bass*[68] the court had conceded "considerable force"[69] in plaintiff's arguments for extending the rule. The court also considered decisions and statutes of other states. Although no out-of-state cases were cited in the majority opinion, Virginia[70] and Arizona[71] statutes were considered. Justice Hawkins, joined by Justice Bowling, on petition for rehearing concurred in part and dissented in part.[72] Concurring because the long application of locality rules in Mississippi indicated a need for prospective application of a new approach, the dissent argued for the abolition of locality rules in medical malpractice actions in Mississippi. While small town practitioners should not be unfairly penalized, the dissent contended that limiting witness competency under locality rules is the "wrong medicine"[73] to ensure their equitable treatment. The dissent further argued that limiting witness competence on the basis of locality is inconsistent with what several decisions[74] indicate is the court's liberality regarding competency in nonmedical cases.

Moreover, according to the dissent, the approach was subject to serious flaws. The dissent supported this argument with a

66. *King*, 424 So. 2d at 550.

67. *Id.* at 551.

68. 254 So. 2d 183 (Miss. 1971).

69. *Id.* at 187.

70. VA. CODE § 8.01-581.20 (1979) ("[T]he standard of care by which the acts or omissions are to be judged shall be that degree of skill and diligence practiced by a reasonably prudent practitioner in the field of practice or specialty in this Commonwealth . . . ."). The testimony of an expert witness familiar with that standard will be admissible. A same locality standard or similar locality standard, if circumstances indicate this to be more appropriate, may be applied instead of the statewide standard. The statute has been referred to in several recent cases. However, none of them applied the statewide standard because the causes of action arose before the statute's adoption. In these cases the standard of care which the plaintiff was required to establish was the previous locality or similar locality standard, applicable both to specialists and general practitioners. *See* Fitzgerald v. Manning, 679 F.2d 341 (4th Cir. 1982); Noll v. Rahal, 219 Va. 795, 259 S.E.2d 741 (1979); Ives v. Redford, 219 Va. 838, 252 S.E.2d 315 (1979); Maxwell v. McCaffrey, 219 Va. 909, 252 S.E.2d 342 (1979).

71. ARIZ. REV. STAT. ANN. § 12-563 (1976). The Arizona statute also holds medical practitioners to a statewide standard, which applies both to general practitioners and specialists. Prior to enactment of the statute, Arizona applied a same or similiar standard to general practitioners and a national standard to specialists. Kronke v. Daniel, 108 Ariz. 400, 499 P.2d 156 (1972). Gaston v. Hunter, 121 Ariz. 33, 588 P.2d 326 (1978) applied the previous national standard to specialists because the action was pending at the time of the statute's enactment. However, the court stated: "Arizona's new medical malpractice legislation would hold the specialist to a statewide standard of care." *Id.* at 346 n.21. Thus, the statute actually narrows the standard to be applied to a specialist in Arizona. Musa v. Adrian, 130 Ariz. 326, 636 P.2d 104 (1981) applied the statute to a specialist.

72. *King*, 424 So. 2d at 551 (Hawkins, J., dissenting).

73. *Id.* at 551 n.1.

74. Capitol Transport Co. v. Segrest, 254 Miss. 168, 181 So. 2d 111 (1965); Glenn Falls Insurance Co. v. Linwood Elevator, 241 Miss. 400, 130 So. 2d 262 (1961); King v. King, 161 Miss. 51, 134 So. 827 (1931).

lengthy quotation from *Pederson v. Dumouchel.*[75] The quote reviewed the original rationale for locality rules and argued that today, with post-graduate training and global village communications, there is ample opportunity for physicians, irrespective of locality, to keep abreast of medical advancements,[76] creating what is increasingly a national standard of medical care. Therefore,

> [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 . . . . No longer is it proper to limit the definition of the standard of care which a medical doctor or dentist must meet solely to the practice or custom of a particular locality, a similar locality, or a geographic area.[77]

Physicians, the dissent argued, should be held to the degree of competence of the average practitioner in their class. But this has no relation to a rule excluding an expert's testimony "unless he first determines how medicine is practiced in the same or 'similar' localities where the lawsuit arose . . . ."[78] The dissent further stated:

> In lawsuits our search should be for accuracy and truth. It seems incongruous to me that a medical specialist from the Mayo Clinic, the Ochsner Clinic, the Menninger Foundation, or the Sloan-Kettering Institute could not express opinions within his field of knowledge on what constitutes good medical practice in any court in the United States, or this entire planet, for that matter.
>
> It is my belief, and certainly my hope, that inevitably all courts will reach this view of the matter. In my opinion, our present rule will result in considerable confusion.[79]

The first post-*King* decision to apply the *King* standard was *Pharr v. Anderson.*[80] The witness was qualified as an expert in family medicine. Although he had trained outside Mississippi, he had practiced in Jackson for thirty years. The court held that his testimony was competent under the *King* standard that "an expert witness whose knowledge of, and familiarity with, the statewide standard of care shall not have his testimony excluded."[81]

On November 9, 1983, the original *Hall v. Hilbun*[82] decision was handed down. The court applied the pre-*King* strict locality rule, apparently because the case arose in the trial court before

75. 72 Wash. 2d 73, 431 P.2d 973 (1967).

76. *But see Gambill*, 258 Ark. at 769, 531 S.W.2d at 948 ("However desirable the attainment of this ideal may be, it remains an ideal.").

77. *King*, 424 So. 2d at 552-53 (Hawkins, J., concurring in part and dissenting in part) (quoting *Pederson*, 72 Wash. 2d at 79, 431 P.2d at 978).

78. *King*, 424 So. 2d at 552 (Hawkins, J., concurring in part and dissenting in part).

79. *Id.*

80. 436 So. 2d 1357 (Miss. 1983).

81. *Id.* at 1359 (quoting King v. Murphy, 424 So. 2d 547 (Miss. 1982)).

82. *See supra* note 2.

the *King* decision. No mention was made of *King* or the statewide standard of care.

In *Reikes v. Martin*,[83] the court again applied the pre-*King* strict locality rule, since the case was tried prior to *King*.[84] Appealing the lower court verdict for plaintiffs, appellant physicians assigned, among other errors, the admission of expert testimony of a British physician who moved to America in 1977 and had three times failed the American licensing test. The court reversed, holding that the physician was not qualified to testify, since the applicable standard of care was the strict locality rule, and "[c]learly Dr. Brown was not knowledgeable of or familiar with the practice of medicine in Hattiesburg in 1975."[85] But on May 22, 1985, after *Hall v. Hilbun* on remand, the original opinion was withdrawn and replaced.[86] Applying *Hall*, the court stated that the expert's testimony "cannot be excluded simply because he was not familiar with the practice of medicine in Hattiesburg."[87]

In *Holmes v. Elliott*,[88] the plaintiff's witness was licensed in Oklahoma and Georgia and currently practiced in Oklahoma. He trained in Georgia, and practiced at Bethesda Naval Hospital in Guam, and in Georgia. The court noted that his "testimony did not show that he was familiar with or knowledgeable of any standards of medical practice at Lumberton or south Mississippi, or of any particular locality within the state of Mississippi or any adjacent state."[89] Thus, he was not qualified to give his opinion regarding compliance with "any local or statewide standards of care in Mississippi."[90] The court likened the situation to that in *King* in which "the expert has had no contact with Mississippi, outside of participation in a malpractice trial."[91] Although a witness need not practice in Mississippi, "the expert must nevertheless have some knowledge of, or familiarity with, the statewide standard."[92]

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83. No. 53,915 (Miss. Jan. 25, 1984) (original opinion). *See infra* notes 84-86.

84. In dealing with *Reikes'* prospective application of *King*, the *Hall* court stated:

> It is true that *Reikes v. Martin* [citation omitted] states that *King v. Murphy* shall be applied prospectively only. *Reikes* is pending before this Court on petition for rehearing. Consistent with the implications of *Pharr*, the holding of *Holmes*, and what we have said above, the statement in *Reikes* is seen as incorrect.

Hall v. Hilbun, 466 So. 2d at 877 n.13.

85. *Reikes*, No. 53,915, slip op. at 14.

86. Reikes v. Martin, 471 So. 2d 385 (Miss. 1985).

87. *Id.*, at 393.

88. 443 So. 2d 825 (Miss. 1983).

89. *Id.* at 829.

90. *Id.*

91. *Id.* at 830.

92. *Id.*

The court rejected the argument that a uniform operative procedure for a hysterectomy establishes a national standard of care. Even if it did,

> [t]he test of *King v. Murphy* has not been met. Reiterating, *King* held that an expert who is knowledgeable of, or familiar with, the statewide standard of care shall be allowed to testify as an expert. Thus, even if a national standard exists, it still must be shown the applicable standard is the same. In order to do this, the expert must have knowledge of the statewide or local or similar locality standard. In the instant case, expert Dr. Daniel was not shown to have the requisite knowledge of, or familiarity with, the statewide or Lumberton area or similar locality standard of care . . . .[93]

Hall v. Hilbun:[94] Original Opinion

On May 20, 1978, at the Singing River Hospital in Jackson County, Mississippi, Dr. Glyn R. Hilbun performed an exploratory laparotomy on Mrs. Terry Hall to relieve an obstruction of the small bowel. Following surgery, Mrs. Hall was moved to a recovery room, where Dr. Hilbun remained in attendance with her. With Mrs. Hall alert and communicating and all vital signs stable, she was moved to a private room.

According to the record, Dr. Hilbun made no post-operative contacts with the patient or inquiries concerning her progress after she was moved from the recovery room to a private room. The nursing staff did not communicate with Dr. Hilbun, who was on call that weekend, about Mrs. Hall's condition. Dr. Hilbun's next contact with the patient was after the patient's husband, Glenn Hall, alarmed at his wife's difficulty in breathing, called Dr. Hilbun. He came immediately, but by the time he had arrived Mrs. Hall had died from cardio-respiratory failure.

On May 19, 1980, Glenn Hall brought a wrongful death action based on the post-operative care provided by Dr. Hilbun. Suggested liability was predicated on Dr. Hilbun's failure to make follow-up inquiry and alleged failure to give the nursing staff appropriate post-operative instructions.

At trial, plaintiff called a Cleveland, Ohio physician to establish the existence of a national standard of surgical care to which Dr. Hilbun was obligated to adhere. The expert stated that he did not know the standard of care practiced by Pascagoula surgeons, but that "he did know what the standard should have been."[95] The trial

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93. *Id.*

94. *See supra* note 2.

95. Hall v. Hilbun, 466 So. 2d 856, 864 (Miss. 1985).

court ruled that the expert was not qualified to testify regarding whether Dr. Hilbun had departed from the standard of care. Another expert, also from Cleveland, was called. He too was unfamiliar with the Pascagoula standard of care and also was not permitted to testify.

The defendant's expert from Cleveland had moved to Pascagoula one month before the trial and had practiced at the Singing River Hospital. He testified that there was a great difference between Cleveland and Pascagoula in the medical standard, notably regarding personnel and equipment. With his experts excluded, the plaintiff failed to establish a prima facie case, and defendant's motion for a directed verdict was granted.

The Mississippi Supreme Court affirmed relying on *Dazet v. Bass* which it stated was the latest expression of this court on the local standard of care. There was no mention of the statewide standard of care that had been established by *King*.

Justice Hawkins, joined by Justice Robertson, specially concurred, noting:

> In this case, neither the majority nor dissenting opinion cite *King* . . . . I believe *King* is squarely applicable to this case, and under our holding in *King* the circuit judge was clearly correct in ruling the testimony of the eminent physicians incompetent. I still have my hope the majority may some day agree any so-called "locality" or "similar locality" rule on the *competency* of renowned physicians is anachronistic, unrealistic, and tantamount to a due process violation in preventing parties from having a fair trial. To keep this kind of evidence from a jury's determination is, to me, blatantly unjust.[96]

Hall v. Hilbun: CONTROLLING OPINION

A. Introduction

On February 27, 1985, the Mississippi Supreme Court granted the plaintiff's petition for rehearing. The November 9, 1983, formal opinion was withdrawn and the trial court decision reversed and remanded for a new trial.[97]

By way of introduction, the court discussed the two prongs of the "locality rule" as traditionally applied in medical malpractice actions. The first prong was a rule of substantive law: that the physician must perform according to the standard of care in his locality. The second aspect was a rule of evidence: that an expert could not testify unless he had practiced in the locality in question and was familiar with the local standard of care.

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96. *Id.*, slip op. at 13 (Hawkins, J., specially concurring).

97. The court stated that the standard announced in the case should be applied retroactively upon retrial. *Hall*, 466 So. 2d at 875-77.

Reviewing *King v. Murphy,* the court stated that *King* had enlarged both concepts. The substantive rule regarding standard of care was expanded from a single locality to include "at least *the entire state of Mississippi plus 'a reasonable distance adjacent to state boundaries.'*"[98] Regarding the evidentiary rule, the court stated that *King* removed geographical limits. Under *King,* "an expert witness who is knowledgeable of, and familiar with, the statewide standard of care *shall not have his testimony excluded on the ground that he does not practice in this state.*"[99] The court interpreted this language to mean that

> [u]nder *King* an otherwise competent medical expert, say, from New York, would be eligible to testify if he had, prior to taking the witness stand, substantially familiarized himself with the standard of care in the (greatly enlarged) "locality or neighborhood."[100]

The court stated that *King* established a satisfactory framework for analysis in its distinction between the substantive rule regarding standard of care and the evidentiary rule concerning expert witnesses.

B. Substantive Law: The Standard of Care

In *Hall v. Hilbun* the court established in Mississippi a competence-based national standard of care. The court deemed this inevitable because of the increasing nationalization of medical training, the mobility of physicians, and the opportunity for continuing medical research. In addition, "[r]egarding the basic matter of the learning, skill and competence a physician may bring to bear in the treatment of a given patient, state lines are largely irrelevant."[101] The court stated the physician's duty is

> to possess or have reasonable access to such medical knowledge as is commonly possessed or reasonably available to minimally competent physicians in the same specialty or general field of practice throughout the United States . . . . [The physician is also required] to have a practical working knowledge of the facilities, equipment, resources (including personnel in health related fields and their general level of knowledge and competence), and options (including what specialized services or facilities may be available in larger communities, e.g., Memphis, Birmingham, Jackson, New Orleans, etc.) reasonably available to him or her as well as the practical limitations on same. In the care and treatment of each patient, each physician has a non-delegable duty to render professional services consistent with that objectively ascertained minimally acceptable level of competence he may be expected to apply given the qualifications and level of expertise he holds himself out as possessing . . . .[102]

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98. *Hall*, 466 So. 2d at 867 (quoting King v. Murphy, 424 So. 2d 547, 550 (Miss. 1982)).
99. *Id.*
100. *Id.*
101. *Id.* at 870.
102. *Id.* at 871.

Three components are implicit in this standard: the physician's knowledge and skill; his exercise of medical judgment in the course of treating the patient; and his employment of medical resources. The court differentiated the effect of locality among these components.[103]

Locality is not a factor in determining the standard of care with regard to the physician's knowledge and skill. "Each physician may with reason and fairness be expected to possess or have reasonable access to such medical knowledge as is commonly possessed or reasonably available to minimally competent physicians in the same specialty or general field of practice throughout the United States . . . ."[104] The court stressed that "objectively reasonable expectations regarding the physician's knowledge, skill, capacity for sound medical judgment and general competence are, consistent with his field of practice and the facts and circumstances in which the patient may be found, *the same everywhere.*"[105]

With regard to the second component, the exercise of medical judgment, the effect of the locality is minimal. Local custom might be evidence of compliance with the duty of care, but it is not conclusive of it. "The content of the duty of care may be informed by local medical custom but never subsumed by it."[106] But with regard to the physician's knowledge and skill, locality is not a factor.

However, with regard to the last component, the facilities and resources available to the physician, "there remains a core of validity to the premises of the old locality rule."[107] Noting that resources may vary from community to community, the court established a "resources-based component"[108] to the national standard of care:

> [G]iven the circumstances of each patient, each physician has a duty to use his or her knowledge and therewith treat through maximum medical recovery, each patient, with such reasonable diligence, skill, competence, and prudence as are practiced by minimally competent physicians in the same specialty or general field of practice throughout the United States, who have available to them the same general facilities, services, equipment and options.[109]

103. The defendant's expert testified about the differences in medical practice between Cleveland, Ohio, and the Singing River Hospital. The court noted that these differences related solely to the resources available to the physician and had no bearing on "the regimen of post-operative care a minimally competent surgeon should have prescribed for a patient . . . ." *Hall*, 466 So. 2d at 878.

104. *Id.* at 871.

105. *Id.* at 872.

106. *Id.*

107. *Id.*

108. *Id.* at 873.

109. *Id.*

Thus, a physician cannot be faulted for not employing facilities that were not reasonably available.[110] The court stated that this recognition was a practical addition to *King*: "[T]he physician's duty of care must take into consideration the quality and kind of facilities, services, equipment and other resources available."[111]

An additional consideration would exist in cases where a resource was not locally available but was reasonably accessible in a neighboring medical center. The question here would be whether the duty of care was met by the physician's actions in deciding whether or not to transfer the patient, taking into account the medical risk as well as economic considerations.

The court noted that the *Hall* standard of care was not a departure from *King* but merely a logical extrapolation from it. The *King* standard was determined by the level of medical competence throughout Mississippi "'and for a reasonable distance adjacent to state boundaries.'"[112] Since this adjacency would necessarily include Mobile, Memphis, and New Orleans, and since, including Jackson, the standard in these cities was equal to that available anywhere in the United States, "it may be seen that for all practical purposes *King* has embraced what many call the 'national standard of care.'"[113]

C. Evidentiary Rule: Expert Testimony

Under the *Hall* standard, where an expert lives or practices has no *per se* bearing on his qualification as a witness. The court quoted *King*: "An expert witness . . . shall not have his testimony excluded on the ground that he does not practice in this state."[114] The court noted two misinterpretations of this language: that those who do not reside in Mississippi and adjacent to it are excluded; and that the expert must possess intimate knowledge of the practice in the particular medical facility. Neither of these is a correct interpretation. The residence of the physician is irrelevant, and the expert must be familiar with the minimum legal standard of the state, not the practice in the facility or communi-

110. *Id.* at 878. This would appear to apply to physical equipment rather than to support personnel. In its discussion of the facts of the instant case, the court noted that the only possible basis for defendant's contention that relevant differences existed between Pascagoula, Mississippi, and Cleveland, Ohio, where the expert resided, was in the area of nursing personnel. But "[b]y establishing the inadequacy of the nursing and personnel resources available to him in Pascagoula, Mississippi, Dr. Hilbun only increases his own responsibility. Where a physician is working with medical personnel of known modest competence, his duty of instruction and control is increased." *Id.* at 879.

111. *Id.* at 873.

112. *Id.* (quoting King v. Murphy, 424 So. 2d 547, 550 (Miss. 1982)).

113. *Hall*, 466 So. 2d at 873.

114. *Id.* (quoting *King*, 424 So. 2d at 550).

ty. Medical experts are to be treated in the same manner as experts in other fields: "There is no valid basis in judicial reason for *not* treating 'the question of the competency of the testimony of physicians the same as any other expert.'"[115]

The court delineated two subject areas of testimony and what was necessary to qualify an expert to testify regarding them. First, to testify about the conclusions and diagnoses that a minimally competent physician would draw or the actions he should take, the physician may base his testimony on "information reasonably available to the physician, i.e., symptoms, history, test results, results of the doctor's own physical examination, X-rays, vital signs, etc. . . ."[116] Second, to testify about the duty of care that the defendant physician owed and whether his acts were in compliance with that duty, the expert must be

> familiarized with the facilities, resources, services and options available. This may be done in any number of ways. The witness may prior to trial have visited the facilities, etc. He may have sat in the courtroom and listened as other witnesses described the facilities. He may have known and over the years interacted with physicians in the area. There are no doubt many other ways in which this could be done, but, significantly, we should allow the witness to be made familiar with the facilities (and customs) of the medical community in question via a properly predicated and phrased hypothetical question.[117]

Thus, instead of requiring that the expert be *familiar* with the local facility, it is sufficient that he merely be *familiarized* with it.[118]

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115. *Id.* at 874 (quoting Holmes v. Elliott, 443 So. 2d 825, 833 (Miss. 1983)) (Hawkins, J., specially concurring).

116. *Hall*, 466 So. 2d at 874.

117. *Id.* at 875.

118. Applying *Hall*, the court in Trapp v. Cayson, 471 So. 2d 375 (Miss. 1985) *reh'g denied*, July 10, 1985, rejected the appellant's contention that plaintiff's expert who was held to be qualified by the trial court should have been excluded under *King v. Murphy*. The expert was board-certified in diagnostic radiology and was a professor of radiology at Louisiana State University in New Orleans. The court held that the expert was qualified regardless of the fact that he had never been to Tupelo or the hospital in question, until the trial.

> [H]e stated that from his experience and training, knowledge of standards of practice of radiologists in general, and from reading the deposition of Dr. Trapp [the defendant] and examining the medical records in the case, he is familiar with, and knows, what the case and practice should be, and is, in Tupelo, Mississippi.

Id. at 380. The court stated that under *Hall*, "the law of Mississippi in malpractice cases, as now stated, is based upon a national standard of care." *Id.*

The same day *Hall* was also applied in Hardy v. Brantley, 471 So. 2d 358 (Miss. 1985) *reh'g denied*, July 10, 1985. The trial court, relying on *King*, had excluded the testimony of a specialist in emergency medicine from Birmingham, Alabama. Reversing, the court held that the lower court erred and applied the *Hall* criteria to the expert's testimony regarding various aspects of the treatment of the patient. As to patient history, since what history should be obtained is within the realm of general medical knowledge, a qualified expert may qualify "without more . . . ." *Id.* at 367. Similarly, the physical examination is "a matter with respect to which physicians are expected to be competent without regard to the availability of facilities or equipment." *Id.* Regarding diagnostic testing, the court noted that, under *Hall*, liability does not attach for failure to perform tests if the necessary equipment is not reasonably available, but here such equipment was almost certainly accessible; and as to the diagnosis, noting that the basis of the suit was failure to diagnose a perforated ulcer, the court stated that to the extent the testimony was excluded because the expert practiced in Birmingham or was supposedly

The court discussed "hired guns," experts who testify for a price. The court rejected the use of a locality rule to exclude these experts: "The instrument with which they would have us afford this protection is too blunt."[119] The court noted that the trial judge must determine whether the potential witness is in fact an expert and that "[l]iberal cross-examination regarding bias, interest and previous experience as an expert in medical malpractice cases should be allowed both on voir dire and when the witness' testimony is being presented to the jury."[120]

ANALYSIS AND CONCLUSION

It is clear that the Mississippi Supreme Court reached an inevitable result in *Hall v. Hilbun* on petition. With widespread standardization of medical training, geographically determined standards of care have little basis.[121] Thus, a physician's skill and treatment are expected to meet minimum national standards.

The present ruling eliminates the confusion inherent in *King*'s description of the standard of care as being "that degree of care, skill and diligence practiced . . . in this state, and for a reasonable distance adjacent to state boundaries."[122] Unclear aspects included whether a small-town physician would be held to the standard of care of a regional medical center such as Jackson on the basis of his presence within the political boundaries of the state; what constituted a reasonable adjacency to state borders; and the effect, if any, of a facility's lack of medical resources.

Hall also reduces the potential for confusion as to what the geographical limits of witness competency might be. Under *King*, it was unclear whether a "reasonable distance adjacent to state boundaries"[123] indicated that a New Orleans physician might testify regarding conditions in Biloxi or in Iuka. Did it mean that a Mont-

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not familiar with the standard of care in Jackson, in Hinds County or in the hospital in question, the lower court erred.

In Hammond v. Grissom, 470 So. 2d 1049 (Miss. 1985), an expert who had walked through a hospital emergency room, but had not studied the procedures employed by that hospital, was held to be qualified as an expert. The expert met the qualifications of Hall v. Hilbun, 466 So. 2d 856 (Miss. 1985) and Hardy v. Brantley, 471 So. 2d 358 (Miss. 1985), based on his professional qualifications and experience and his knowledge of the standard of care for emergency room doctors in Jackson, Mississippi, and in other cities throughout the United States.

119. *Hall*, 466 So. 2d at 875.

120. *Id.*

121. *See* cases cited *supra* note 28.

122. *King*, 424 So. 2d at 550.

123. *Id.*

gomery, Alabama physician was competent to testify regarding conditions in Meridian or Vicksburg?

In *King*, a physician from Ft. Myers, Florida, was adjudged incompetent to testify because he had neither practiced in Mississippi, nor examined or treated a patient there. *Holmes v. Elliott*,[124] applying *King*, excluded an Oklahoma expert because "his testimony did not show that he was familiar with or knowledgeable of any standards of medical practice at Lumberton or south Mississippi, or of any particular locality within the state of Mississippi or any adjacent state."[125]

Under *King* and *Holmes*, the possibility existed that plaintiff would face inordinate difficulty in procuring medical testimony. Extensive judicial as well as scholarly notice has been taken of the unwillingness of physicians to testify against one another in malpractice trials.[126] Since expert testimony is required in all but self-evident malpractice cases,[127] the inability to procure expert testimony poses the problem that the plaintiff might be deprived of a remedy for an actual injury. Cases abandoning geographically-based standards of care have noted this problem.[128] The *Hall* standard of witness competency, of course, clears the way for "professional experts" and "hired guns" from throughout the nation. But witness competency does not assure witness credibility, and nothing in *Hall* precludes impeachment of the expert by the defendant.[129]

Thus, while it is clear that *Hall* reached a correct result, less obvious is the validity of its insistence that it does nothing more

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124. 443 So. 2d 825 (Miss. 1983).

125. *Id.* at 829.

126. Graham v. Sisco, 248 Ark. 6, 449 S.W.2d 949 (1970) holds that:

> It is a matter of common knowledge, often mentioned in judicial opinions and other authorities that the plaintiff in a medical malpractice case is often unable to find a medical expert willing to testify against a fellow physician . . . . It goes without saying that the plaintiff's inability to obtain favorable expert testimony poses the possibility of great miscarriages of justice.

Id. at 10, 449 S.W.2d at 951. Salgo v. Leland Stanford Board of Trustees, 154 Cal. App. 2d 560, 568, 317 P.2d 170, 175 (1957); Naccarato v. Grob, 384 Mich. 248, 180 N.W.2d 788 (1970); Sampson v. Veenboer, 252 Mich. 660, 234 N.W. 170 (1931); Carbone v. Warburton, 11 N.J. 418, 94 A.2d 680 (1953); Faulkner v. Pezeshki, 44 Ohio App. 2d 186, 337 N.E.2d 158 (1975); King v. Williams, 276 S.C. 478, 279 S.E.2d 618 (1981); Douglas v. Bussabarger, 73 Wash. 2d 476, 438 P.2d 829 (1968); Hundley v. Martinez, 151 W. Va. 977, 158 S.E.2d 159 (1967); D. LOUISELL & H. WILLIAMS, I MEDICAL MALPRACTICE § 14.01[5] ("There is doubtless a natural hesitancy to criticize another physician with whom there must be frequent or even daily contacts on a hospital staff, in a medical society, or in relationship to mutual patients."); Belli, *An Ancient Therapy Still Applied: The Silent Medical Treatment*, 1 VILL. L. REV. 250 (1956). *Cf.* Note, *Medical Malpractice - Expert Testimony*, 60 NW. U.L. REV. 834, 837 (1966) (discussion of the reasons for the reluctance of physicians to testify and possible alternatives to expert testimony).

127. *See supra* note 7.

128. King v. Williams, 279 S.E.2d 618 (S.C. 1981); Douglas v. Bussabarger, 73 Wash. 2d 476, 438 P.2d 829 (1968).

129. *Hall*, 466 So. 2d at 879.

than "smooth some of *King's* rough edges."[130] Rather than a "refinement"[131] of *King*, *Hall* appears to be a complete reformulation of the standard of care and medical expert competency in Mississippi.

In defining the standard of care the *Hall* court stated that because the *King* standard included not only Mississippi but a reasonable area adjacent, including Memphis, Mobile, and New Orleans, and because with the addition of Jackson the level of medical care is equal to that available anywhere in the United States, then "for all practical purposes *King* has embraced what many call the 'national standard of care.'"[132] While this syllogism may indicate that such a result may be reached, the plain language of the *King* standard, "in this state and for a reasonable distance adjacent to state boundaries,"[133] coupled with the holding in *King* itself excluding a Ft. Myers, Florida physician, indicates a more obvious reading of *King*: that it established not a national but a statewide standard, somehow modified by the standards of an undefined adjacent area. Had *King*'s goal been to establish a national standard, the reasonable conclusion is that it would not have done so in such an obscure manner. Instead of attempting, by inference, to reason that *Hall* is nothing more than an explicit statement of what was implicit in *King*, it would seem that the credibility of the decision would have been better served by a forthright repudiation of *King*.[134]

A similar problem exists in the *Hall* court's interpretation of *King* regarding expert witness competence. *King* stated: "An expert witness who is knowledgeable of, and familiar with, the statewide standard of care shall not have his testimony excluded on the ground that he does not practice in this state."[135] *Hall* interpreted this to mean that geographical restrictions on the pool of available expert witnesses had been removed by *King*:

> Under *King* an otherwise competent medical expert, say, from New York, would be eligible to testify if he had, prior to taking the witness stand, substantially familiarized himself with the standard of care in the (greatly enlarged) "locality or neighborhood."[136]

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130. *Id.* at 877.

131. *Id.* at 876.

132. *Id.* at 873.

133. *King*, 424 So. 2d at 550.

134. The closest *Hall* comes to a repudiation of *King* is in a footnote:

> To the extent they may announce or proceed on the assumption of the existence of rules of law in conflict with those set forth here, *King v. Murphy, Holmes v. Elliott* [citations omitted] and all of our other prior medical malpractice cases shall from and after this day stand modified or overruled as may be appropriate.

Hall, 466 So. 2d at 873 n.7.

135. *King*, 424 So. 2d at 550.

136. *Hall*, 466 So. 2d at 867.

While nothing in *King per se* precludes this reading, this interpolation appears strained, if not Delphic. Again, the better approach would have been to establish the new rule without attempting to support it on the slender reed of *King*.

Irrespective of its treatment of *King, Hall v. Hilbun* establishes a standard that comports both with present-day medical realities and with the need for fairness, predictability, and clarity in medical malpractice suits. This standard affords the defendant the protection of showing the limitations of available physical resources. But the skill and knowledge required of him are not geographically limited. Since locality is not a determinative factor of witness competency, this approach prevents the standard of medical care from becoming nothing more than an exclusionary rule of evidence.

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