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Elliot L. Miller

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COMMENTS

EXPERT TESTIMONY IN MEDICAL MALPRACTICE CASES

What is the standard of care required of a physician? Properly stated, it is ordinary care. It would seem elementary that the person who undertakes to treat human illnesses must exercise the care and skill of the ordinary practitioner under similar circumstances.¹ In ascertaining exactly what those similar circumstances are, the training of the doctor and the locality in which he practices are factors limiting the standard of care expected. These factors limit the liability of the defendant doctor; unless there is evidence that his conduct fell below that which could be expected of the average reasonable practitioner of the same school of treatment in the same locality as the defendant. These are commonly known as the school and locality rules. A question still remains as to whether these limitations are grounded in reason and ought to be retained, or whether they are simply relics of the past, and ought to be disregarded. Two recent decisions of the Florida appellate courts have redefined these areas.^{1a}

The resolution of the question of whether a given act amounts to negligence on the part of a physician is not usually open to observation by jurors of common ordinary experience. Therefore, expert² testimony is needed to establish that negligence.³ The school and locality rules have made it difficult for the plaintiff to present expert evidence that is qualified within those limitations.⁴ Occasionally courts permit circum-

1. *Montgomery v. Stry*, 84 So.2d 34 (Fla. 1955); *Baldor v. Rogers*, 81 So.2d 658 (Fla. 1954); *Hill v. Boughton*, 146 Fla. 505, 1 So.2d 610 (1941); *Saunders v. Lischkoff*, 137 Fla. 826, 188 So. 815 (1939); *Foster v. Thornton*, 113 Fla. 600, 152 So. 667 (1933); *Bir v. Foster*, 123 So.2d 279 (Fla. App. 1960); *Brown v. Swindal*, 121 So.2d 38 (Fla. App. 1960); *Atkins v. Humes*, 107 So.2d 253 (Fla. App. 1958); *Crovella v. Cochrane*, 102 So.2d 307 (Fla. App. 1958). See also, *Ewing v. Goode*, 78 Fed. 442 (C.C.S.D. Ohio 1897); *McNeveins v. Lowe*, 40 Ill. 209 (1866); *Bacon v. Walsh*, 184 Ill. App. 377 (1913); *Edwards v. Uland*, 193 Ind. 376, 140 N.E. 546 (1923); *Clark v. George*, 148 Minn. 52, 180 N.W. 1011 (1921); *PROSSER, TORTS* 133 (2d ed. 1955) (cases cited n.87).

1a. *Cook v. Lichtblau*, 144 So.2d 312 (Fla. App. 1962); *Musachia v. Terry*, 140 So.2d 605 (Fla. App. 1962).

2. FLA. STAT. § 90.23 (1961).

3. *Atkins v. Humes*, 110 So.2d 663 (Fla. 1959); *PROSSER, TORTS* 134 (2d ed. 1955) (cases cited n.97).

4. *Huffman v. Lindquist*, 37 Cal. 2d 465, 234 P.2d 34 (1951) (judicial notice that members of the local medical society are loath to testify against each other).

One plaintiff grew so discouraged at the unanimous refusal of physicians to testify that she unsuccessfully brought suit against the county medical society, alleging a conspiracy. *Agnew v. Parks*, 343 P.2d 118 (Cal. App. 1959), noted in 58 MICH. L. REV. 802 (1960).

Wisconsin has a statute which waives the effect of the locality rule in situations when a plaintiff is unable to secure expert evidence: "[A] medical or osteopathic physician, licensed to practice in another state, may testify as the attending or examining physician or surgeon to the care, treatment, examination or condition of sick or injured persons whom he

stantial evidence,⁵ or text authorities⁶ or even non-physician expert witnesses.⁷

THE SCHOOL RULE

At the time the school rule was first formulated, some seventy years ago,⁸ it was thought it would be unfair to require from a practitioner of a recognized⁹ school of medical thought the same type of treatment¹⁰ as a practitioner of a different school would have rendered in the same circumstances.¹¹ To do so would be for the law to make a choice between the

has treated in the ordinary course of his professional practice for the sickness or injury which is the subject of the judicial inquiry in any action or proceeding in which he is called as a witness." WIS. STAT. § 147.14(2a) (1961). A previous version of this statute was construed in *Paulsen v. Gundersen*, 218 Wis. 578, 260 N.W. 448 (1935).

5. "[N]egligence in a case like this might be inferred from circumstances proven, but . . . when circumstantial evidence is relied on . . . the circumstances should raise a fair presumption of negligence." *Foster v. Thornton*, 125 Fla. 699, 703, 170 So. 459, 461 (1936). See also *Montgomery v. Stary*, 84 So.2d 34 (Fla. 1955); *Walker Hospital v. Pulley*, 74 Ind. App. 659, 127 N.E. 559 (1920) (leaving several yards of gauze imbedded in the wound).

6. Despite reluctance to permit the use of texts, due to the rule against hearsay, there is early case authority supporting their use. *Bowman v. Woods*, 1 Greene 441 (Iowa 1848). MASS. GEN. LAWS ch. 233, § 79C (1959) provides: "A statement of fact or opinion on a subject of science or art contained in a published treatise, periodical, book or pamphlet shall, in the discretion of the court, and if the court finds that it is relevant and that the writer of such statement is recognized in his profession or calling as an expert on the subject, be admissible in actions of contract or tort for malpractice, error or mistake against physicians, surgeons, dentists, optometrists, hospitals and sanitarium, as evidence tending to prove said fact or as opinion evidence; provided, however, that the party intending to offer as evidence any such statement shall, not less than three days before the trial of the action, give the adverse party notice of such intention, stating the name of the writer of the statement and the title of the treatise, periodical, book or pamphlet in which it is contained." (Emphasis added.)

7. "[T]he witness must qualify as having expert knowledge of the correct and proper manner and method of administering the particular treatment . . ." *Foster v. Thornton*, 125 Fla. 699, 706, 170 So. 459, 462 (1936); *Longan v. Weltmer*, 180 Mo. 322, 79 S.W. 655 (1904). "[T]hose who are qualified by training and experience to perform similar services in the community." *Brown v. Swindal*, 121 So.2d 38, 40 (Fla. App. 1960). See generally, 12 U. FLA. L. REV. 121 (1959).

8. *Force v. Gregory*, 63 Conn. 167, 27 Atl. 1116 (1893).

9. A practitioner of an unrecognized school, *i.e.*, a witch-doctor, would not be entitled to the exclusionary protection of the school rule, and simply would be held liable for the standard of care of the ordinary physician. The school must be based upon some scientific principles, and not on arbitrary cultisms. Specific repudiations include: *Nelson v. Harrington*, 72 Wis. 591, 40 N.W. 228 (1888) (spiritualist or clairvoyant physician); *Longan v. Weltmer*, 180 Mo. 322, 79 S.W. 655 (1904) (magnetic healing); *Hansen v. Pock*, 57 Mont. 51, 187 Pac. 282 (1920) (Chinese herb doctor). Schools commonly recognized include allopathic, homeopathic, eclectic, osteopathic, chiropractic, Christian Science and drugless healing (naturopathy).

10. *Force v. Gregory*, 63 Conn. 167, 27 Atl. 1116 (1893); *Bowman v. Woods*, 1 Greene 441 (Iowa 1848); *Patten v. Wiggin*, 51 Me. 594, 81 Am. Dec. 593 (1862); *Bryant v. Biggs*, 331 Mich. 64, 49 N.W.2d 63 (1951); *Janssen v. Mulder*, 232 Mich. 183, 205 N.W. 159 (1925); *Grainger v. Still*, 187 Mo. 197, 85 S.W. 1114 (1905); *Cook v. Moats*, 121 Neb. 769, 238 N.W. 529 (1931); *Porter v. Puryear*, 153 Tex. 82, 262 S.W.2d 933 (1953), *rev'd and remanded*, 153 Tex. 82, 264 S.W. 689 (1954); *Bowles v. Bourdon*, 148 Tex. 1, 219 S.W.2d 779 (1949); PROSSER, TORTS 133 (2d ed. 1955) (cases cited n.90); Annot., 78 A.L.R. 696 (1931).

11. "[I]t was incumbent on him to use reasonable care and skill to ascertain whether the ailments were of the class to which his treatment applied. If not, it was his duty to so advise plaintiff, in order that she might secure the services of one familiar with such

schools, preferring some one single school as the only true school, when the very fact that there are different schools indicates that the minds of reasonable experts differ as to what theories or treatments are proper in identical cases.¹² Thus, the standard of care required of a physician came to be stated as: the customary and usual practice of the ordinarily careful and skilled practitioner of the same school in the community.¹³

In the recent case of *Musachia v. Terry*,¹⁴ the defendant doctor of osteopathy objected to the evidence of plaintiff's expert doctor of medicine on the issue of his standard of care.¹⁵ The trial court sustained this objection, excluded the doctor's evidence, and directed a verdict for the defendant. In reviewing this decision, the appellate court did not reject the school rule out of hand, but rather avoided it, by finding that the facts of the case fell within an exception to the rule. This well recognized exception to the school rule is applicable to those areas of practice where the principles of the schools do, or should concur.¹⁶ This view paves the way for the application of an objective standard, to see if any school can be permitted to remain ignorant of advances discovered by another school.¹⁷ A major area where the principles of the schools ought to

ailments." *Janssen v. Mulder*, 232 Mich. 183, 192, 205 N.W. 159, 162 (1925); *accord*, *Foster v. Thornton*, 125 Fla. 699, 170 So. 459 (1936). But a practitioner of an unrecognized school is not entitled to the protection of the *school* rule. Annot., 78 A.L.R. 696 (1931).

12. *Force v. Gregory*, 63 Conn. 167, 27 Atl. 1116 (1893).

13. Cases collected in Annot., 78 A.L.R. 696 (1931). *But cf.* *Bacon v. Walsh*, 184 Ill. App. 377 (1913). In Illinois, all physicians are licensed by the State "to practice medicine and surgery, and there is no distinction made between different schools of medicine The insertion of the words 'and of the school of which defendant belongs' is erroneous and misleading. It limits the care and skill which he must use, not to the average ordinary care and skill of the physicians and surgeons in good practice in the vicinity, . . . but to the care and skill of some particular sect of physicians and surgeons in that locality." *Id.* at 379, 380.

14. 140 So.2d 605 (Fla. App. 1962).

15. The defendant was called to treat plaintiff's decedent, who had just been severely beaten. After several days in the hospital, the patient was told that he was suffering from nothing more serious than an adynamic ileus, which is a digestive disorder, involving a paralysis of the ileus, or small intestine. Further hospitalization was suggested by the defendant, but in view of the diagnosis made, the patient demanded to be discharged. Upon his release, the patient died the following day. The post-mortem examination disclosed that the immediate cause of death was perforations of the intestine, leading to fecal peritonitis. Decedent had thirteen fractured ribs and generalized peritonitis, in addition to the adynamic ileus. At the trial for wrongful death, under FLA. STAT. § 768 (1961) the plaintiff tendered the evidence of a doctor of medicine on the issue that the defendant was negligent in his diagnosis and treatment of the decedent. The trial court excluded this testimony, on the ground that the witness was of a different school than the defendants, and therefore his evidence as to the standard of care required, and hence their negligence, was inadmissible.

16. "Further, the rule as contended for, like all others, has its exceptions. It does not exclude the testimony of physicians of other schools or experts in other lines when that testimony bears on a point as to which the principles of the schools do or should concur, such as the dangers incident to the use of X-rays or the existence of a condition that should be recognized by any physician." *Foster v. Thornton*, 125 Fla. 699, 707, 170 So. 459, 463 (1936).

17. A physician is not only held to his school's practice, but he is also charged with the "duty of keeping pace with the progress of professional knowledge, ideas, and dis-

concur lies in the field of diagnosis. The rationale is that there is actually only one disease, and even if the various schools would treat that disorder differently, they all ought to recognize its existence.¹⁸ Similarly, when a situation involves the use of mechanical devices such as X-ray or diathermy machines¹⁹ or the administration of common anesthetics,²⁰ then the principles of the schools are deemed by law to concur, and hence expert testimony from practitioners of the other schools will be admitted. It is easily seen that the area where "the principles of the schools do or should concur . . ."²¹ opens a vast exception to the school rule, and raises the question as to whether there is any longer a valid distinction between any of the schools of treatment of human illnesses, and more particularly the schools of medicine and osteopathy. Do significant differences in the practices of these two schools still obtain?

In 1897, when the principles of osteopathy were laid down by Dr. A. T. Still, a Missouri doctor of medicine, the science of medicine was still partially in its dark ages.²² It had just felt the impact of the revolutionary ideas of Jenner, Pasteur, Koch and Lister, on the theory of disease. The systems of the body were imperfectly understood. No one school had a monopoly on scientific truth.²³ Dr. Still conceived the theory that physical misplacements or dislocations of portions of the musculo-skeletal system would impinge upon blood vessels or nerves, impeding the flow of blood or "vital energy" through them, and resulting in manifestations of disorder at their termini. He called this the "osteopathic lesion," and prescribed manipulative therapy to reduce the impingement. It may well be that due to the relative ignorance of the time, this theory was seized upon improperly as a cure-all, and was mistakenly applied to situations where it could not possibly effect relief. However, there were areas in which osteopathic treatment was effective,²⁴ and where orthodox medicine had provided no relief. Lack of communication between the schools, and the abhorrence of the term "osteopathic lesion," in addition to political

coveries, to the extent that a faithful, conscientious, and competent practitioner, of whatever school, may be reasonably expected . . . to do . . ." *Force v. Gregory*, 63 Conn. 167, 171, 27 Atl. 1116, 1117 (1893).

18. *Grainger v. Still*, 187 Mo. 197, 85 S.W. 1114 (1905); *Cook v. Moats*, 121 Neb. 769, 238 N.W. 529 (1931).

19. "Where the subject of inquiry relates to the manner of use of electrical or mechanical appliances in common use in all fields of practice." *Porter v. Puryear*, 153 Tex. 82, 262 S.W.2d 933, 936 (1953), *rev'd and remanded*, 153 Tex. 82, 264 S.W. 689 (1954); *Grainger v. Still*, 187 Mo. 197, 85 S.W. 1114 (1905).

20. *Porter v. Puryear*, *supra* note 19; Annot., 78 A.L.R. 696 (1931).

21. *Foster v. Thornton*, 125 Fla. 699, 707, 170 So. 459, 463 (1936) quoted in *Musachia v. Terry*, 140 So.2d 605, 607 (Fla. App. 1962).

22. Leeches used to treat glaucoma. *Ewing v. Goode*, 78 Fed. 442 (C.C.S.D. Ohio 1897).

23. The "eclectic" school was organized to follow no single method, but instead to choose the best from the various other schools and to reject the rest as incorrect. Eclectic practitioners were recognized by membership on the Florida Board of Medical Examiners prior to 1941, when this recognition was abolished by Fla. Laws 1941, ch. 20927.

24. *HORLER, I ACCUSE THE DOCTORS* (1941).

problems within the American Medical Association, led to little attention or scientific analysis being directed by organized medicine towards the elements of value in osteopathic theory. More recently, organized medicine has begun to adopt many of the valuable principles of osteopathy, organizing them within a new specialty called "physical medicine" wherein many of the same manipulative techniques practiced by osteopaths are used on the musculo-skeletal system. Contemporaneously, osteopathy has turned from its original rejection of surgery and drugs, towards a wholehearted embrace of all the modern concepts of medicine. Curricula currently taught in the five schools of osteopathy²⁵ exactly duplicates that taught in approved schools of orthodox medicine. The only distinguishing feature is that additional courses devoted to osteopathic manipulative theory and treatment are taught in the schools of osteopathy. Early emphasis on manipulation is being decreased.²⁶

A committee of the AMA recently completed a study in depth of the schools of osteopathy, with a view towards ending all distinctions.²⁷ A recent amendment to the Medical Officer Procurement Act of 1947²⁸

25. Chicago; Des Moines, Iowa; Kansas City, Missouri; Kirksville, Missouri; Philadelphia. The California College of Osteopathy in Los Angeles, recently changed, to become a school of medicine. See n.32 *infra*.

26. See D. O., July 1962, at 38.

27. 158 A.M.A.J. 736 (July 1955). A five man committee of the AMA, assisted by five deans of schools of medicine, made the inspection and investigation. The committee covered the (then) five schools of osteopathy; the Philadelphia school was not examined.

Its findings, in general, were that the sole fundamental difference lies in the degree of emphasis placed upon the study of the musculo-skeletal system and in the use of manipulative therapy that is taught in the osteopathic schools. The emphasis on manipulative therapy is decreasing in osteopathic schools, and is increasing in the orthodox schools. The courses involving the study of the musculo-skeletal systems and manipulation are in addition to all other medical topics taught in schools of osteopathy, and do not interfere with, nor are they incompatible with them.

As to the use of the term "osteopathic lesion," which has been an issue between the schools, the committee said: "Osteopathy teaches that the symptom complex of musculoskeletal lesion exists. Its exact nature is not known. It may be relieved by manipulative therapy, but the mechanism of relief is not understood. The lesion has not been demonstrated to cause organic disease, and its correction alone does not cure organic disease." *Id.* at 740.

It further commented that if the lesion is *not* accompanied by manifestation of disease, then it may be treated by manipulation. If disease is indicated, then the osteopathic practice would be treatment by medication, surgery and other etiological or pathological methods, in accord with common medical practice. X-ray is used freely as a diagnostic tool as it is in medical practice. The committee's conclusions were:

(1) Educational requirements for admission to schools of osteopathy are the same as for schools of medicine.

(2) The full basic science and clinical curriculum found in schools of medicine is taught in schools of osteopathy.

(3) The faint aura of cultism which clings to osteopathic teaching arises out of the past. It does not result from the present beliefs, teachings and practices of the vast majority of faculty members of colleges of osteopathy. "The teaching in present-day colleges of osteopathy does not constitute the teachings of cultist healing." *Id.* at 741.

This report failed of passage, by a vote of 101 to 81, when presented to the AMA.

28. 10 U.S.C. § 3294 (1958), as amended by Act of Sept. 2, 1958, ch. 85-861, § 1 (77), 72 Stat. 1467.

led to a thorough hearing as to the advisability of appointing osteopaths as medical officers in the armed forces. Despite opposition of the AMA²⁹ the amendments were approved, abolishing all distinctions between the schools, for purposes of appointment to and service in the armed forces.

The California Osteopathic Society recently voted to merge with the California Medical Association and eliminate all distinctions between the schools of osteopathy and medicine. The first step was the accreditation by the AMA of the California College of Osteopathy,³⁰ now renamed the Los Angeles College of Medicine. This school has recently been awarding M.D. degrees to almost all of the 2742 practicing doctors of osteopathy.³¹ Hereafter all osteopaths will continue to practice, but now as doctors of medicine under the same regulations as other doctors of medicine. In November 1962 the voters of California approved a constitutional amendment abolishing the special licensing of osteopaths.³²

Illinois has recently taken the position that the qualifications of a graduate of the Chicago College of Osteopathy do not differ from those of graduates of recognized colleges of medicine, and its supreme court has required that doctors of osteopathy be permitted to take the exami-

29. Dr. James R. McVay, a trustee of the AMA, testified that in his opinion the standards of osteopathy are as yet inferior to medicine, and therefore doctors of osteopathy in the armed services would render inferior medical care to the troops.

There was other testimony, by the surgeon general, expressing the fear that if the proposed amendment were passed, and osteopaths were appointed, then their practice in service hospitals would constitute the practice of cultist medicine in those hospitals, and result in withdrawal of their AMA accreditation. If such accreditation were withdrawn, then no intern could use the time spent in these hospitals in fulfillment of his internship requirements. It was argued that this might jeopardize the internship training program whereby the services attract new medical graduates to enter the services immediately and complete their internship requirements by service in military hospitals. It was said that problems might arise when osteopaths are promoted to positions where they may exercise command functions over doctors of medicine. *Hearings on H.R. 483 Before a Subcommittee of the Senate Armed Services Committee*, 84th Cong., 2d Sess. (1956); H.R. REP. NO. 1140, 84th Cong., 1st Sess. (1956); S. REP. NO. 1869, 84th Cong., 2d Sess. (1956); H.R. REP. NO. 2702, 84th Cong., 2d Sess. (1956) (conference report).

30. Accredited by AMA Council on Medical Education and Hospitals, and by Association of American Medical Colleges, effective Feb. 15, 1962. It had been founded as a school of osteopathy in 1914.

31. *California's \$65 Trade: M.D. for D.O. Degree*. D.O., June 1962 at 30.

32. Proposition No. 22, a proposed amendment to the California Constitution was approved in the November 1962 general election, 3,200,000 for, and 1,400,000 against.

This abolition of separate licenses was violently opposed by the American Osteopathic Association, which fears a loss of identity and of the philosophical backgrounds of osteopathy. The Association had raised a \$250,000 "war chest," by special assessment of its membership, to fight this and other potential abolitions. D.O., April 1962, p. 10 (Editorial by C. L. Naylor, President of the American Osteopathic Association).

Recent feelers have been put out by organized medicine in Pennsylvania. The AMA News for October 29, 1962, carried the following note:

The Pennsylvania Medical Society's House of Delegates voted to establish a procedure whereby qualified osteopaths in the state may become members of the society. PMS proposes that the Philadelphia College of Osteopathy apply for accreditation as a medical college and seek authorization to confer medical degrees to its current students, as well as to osteopaths who are fully licensed in the state and whom the college deems properly qualified.

nation for the Illinois license to practice medicine, instead of the previously restricted license to practice only osteopathy.³³

In Florida, separate licenses to practice medicine and osteopathy are granted to graduates of the different schools. These are administered by different regulatory boards,³⁴ but it is implied that the standard of excellence, training and skill demanded of graduates of either school is the same.³⁵

In the *Musachia* case, the court used two major exceptions to the school rule. It found that the negligence involved pertained to diagnosis,³⁶ where concurrence is presumed, and also found it error for the trial court to exclude the testimony of the plaintiff's medical doctor witness as to the propriety of the treatment rendered, without first ascertaining whether the principles of the schools do concur as to such treatment.

The exceptions to the school rule involving diagnosis, concurrent thought, machines, anesthetics, have all but engulfed it. There is apparently no longer any valid difference between practices in the schools of osteopathy and medicine.³⁷ Thus, it seems that the need for the exclusionary school rule between these two schools is obsolete. As to other

33. *Chicago College of Osteopathy v. Puffer*, 51 Ill. 2d 441, 126 N.E.2d 26 (1955).

34. FLA. STAT. § 458 (Physicians), § 459 (Osteopaths) (1961).

35. Florida Statutes previously provided the following examination topics for the professions of medicine and osteopathy:

Physicians

Anatomy
Chemistry
Diagnosis
Gynecology
Hygiene
Medical Jurisprudence
Obstetrics
Pathology
Pediatrics
Physiology
Surgery
Surgical Pathology
Therapeutics
Practice of Medicine

Osteopaths

Anatomy
Chemistry
Diagnosis
Gynecology
Hygiene
Materia medica
Medical Jurisprudence
Obstetrics
Pathology
Pharmacodynamics
Pharmacology
Physiology
Surgery
Therapeutics
Practice of Osteopathic Medicine
Toxicology

FLA. STAT. § 458.09 (1959), amended to eliminate specific examination topics, Fla. Laws 1961, ch. 61-243, § 6.

FLA. STAT. § 459.09 (1955), amended to eliminate specific examination topics, Fla. Laws 1957, ch. 57-241.

36. *Grainger v. Still*, 187 Me. 197, 85 S.W. 1114 (1905).

37. There are still significant differences among other recognized schools for treating human illnesses, such as Christian Science, naturopathy, and chiropractic. As to osteopathy, ten states permit doctors of osteopathy to hold their license as physicians, including Illinois and New York. Approximately twenty five other states, including Florida, permit practitioners of osteopathy to practice under special licensing statutes. See also *Welch v. Shaver*, 351 S.W.2d 588 (Tex. Civ. App. 1961); see note 27 *supra*.

schools, like chiropractic, it would seem that protection of the public³⁸ would require that the practitioner be held responsible for the best possible standard of medical treatment and care, and ought not be permitted to hide behind the exclusionary effect of the school rule.

THE LOCALITY RULE

The rule restricting the standard of care of the doctor to that prevalent in the locality, was a logical outgrowth of the poor communications that existed in the early days of the country.³⁹ Doctors outside of large centers remained relatively unaware of medical advances. In addition to the initial handicap of minimal training, the average physician outside of metropolitan areas labored under large case loads. Initially, the courts refused to hold the defendant to the standard of care of the average practitioner in the country, but instead limited the standard to that of the average or ordinarily skilled practitioner in the *same* locality.⁴⁰ The intent of this rule, sound at the time, was not to require of a backwoods practitioner the same standard of care as would be expected of a city doctor, who had at hand all the facilities for both treatment and learning of the metropolitan hospital.

This is the essence of the *strict* locality rule. Its inherent weakness is demonstrable by assuming that there is but one physician in that locality, and that physician is the defendant.⁴¹ How then can a plaintiff secure an expert to establish the standard of care required of the defendant? In the face of so obvious an anomaly, the courts liberalized this very strict use of the locality rule, taking the position that the standard required of the physician is that of the ordinary practitioner in the same *or similar* localities.⁴² This position relieved the impossibility of securing expert testimony in a case against the single practitioner in a small isolated community, but it developed a morass of interpretation problems as to just what a *similar* locality is. The intent doubtless was to require similarity concerning medical standards and practices. A minority took the view that geographical contiguity was at least part of

38. Bacon v. Walsh, 184 Ill. App. 377 (1913). The practice of chiropractic healing, which seems to the author to occupy much the same position today as did osteopathy sixty years ago, is specifically regulated. FLA. STAT. § 460 (1961).

39. Couch v. Hutchison, 135 So.2d 18 (Fla. App. 1961). See generally Annot., 8 A.L.R.2d 772 (1949).

40. Force v. Gregory, 63 Conn. 167, 27 Atl. 1116 (1893).

41. Gramm v. Boener, 56 Ind. 497 (1877); Burk v. Foster, 114 Ky. 20, 69 S.W. 1096 (1902); Small v. Howard, 128 Mass. 131, 35 Am. Rep. 363 (1880).

42. Hill v. Boughton, 146 Fla. 505, 1 So.2d 610 (1941); *accord*, Weintraub v. Rosen, 93 F.2d 544 (7th Cir. 1937); Sinz v. Owens, 33 Cal. 2d 749, 205 P.2d 3 (1949); Gist v. French, 136 Cal. App. 2d 247, 288 P.2d 1003 (1955); Bourgeois v. Dade County, 99 So.2d 575 (Fla. 1957); Montgomery v. Stary, 84 So.2d 34 (Fla. 1955); Baldor v. Rogers, 81 So.2d 658 (Fla. 1954); McGulpin v. Bessmer, 241 Iowa 1119, 43 N.W.2d 121 (1950); Norton v. Argonaut Ins. Co., 144 So.2d 249 (La. App. 1962); Lockart v. Maclean, 361 P.2d 670 (Nev. 1961); Cavallaro v. Sharp, 121 A.2d 669 (R. I. 1956); Morrill v. Komaskinski, 256 Wis. 417, 41 N.W.2d 620 (1950).

the test of similarity.⁴³ The plaintiff's expert had to show that his practice was nearby to that of the defendant, and also in a town of the same size. This view avoided the situation of a plaintiff calling his expert witness from a small town in Maine, to testify as to the standard of care that might be expected of defendant, who is a practitioner in a town of the same size in Nevada.⁴⁴ It failed to establish limits short of that absurdity. Typical interpretation problems that have arisen relate to whether Chicago is *similar* to Davenport, Iowa,⁴⁵ or Grand Rapids, Michigan,⁴⁶ and the attempt to compare Los Angeles with San Luis Obispo, California,⁴⁷ and Philadelphia with Providence, Rhode Island.⁴⁸ The interpretations have not been overly liberal, and a court has held that Rochester, New Hampshire, is dissimilar to Boston.⁴⁹

In analyzing the similarity referred to, it becomes apparent that the court is simply requiring a foundation for testimony from the plaintiff's expert as to the standard of care that would be employed in essentially similar circumstances. He must be familiar with the medical practices in the locality in which the defendant practiced before he can testify as to the standard of care expected of the defendant. This familiarity or foundation can be shown in several ways. The witness may have come from the same locality,⁵⁰ or from localities with equivalent facilities.⁵¹ He may have trained at the same school as the defendant,⁵² or he may show that even though he does not practice in that community, he has knowledge⁵³ of the practices employed there. In extreme cases, the witness may testify that the practices of the defendant would be unacceptable in *any* community.⁵⁴ It should be noted that the emphasis of the rule is essentially exclusionary.

Florida courts have approved the locality rule in dicta.⁵⁵ In one

43. Warnock v. Kraft, 30 Cal. App. 2d 1, 85 P.2d 505 (1938).

44. Although today this could probably be done, provided that there was a showing that the standards, training, facilities and practices in both towns were the same.

45. McGulpin v. Bessmer, 241 Iowa 1119, 43 N.W.2d 121 (1950).

46. Sampson v. Veenboer, 252 Mich. 660, 234 N.W. 170 (1931).

47. Gist v. French, 136 Cal. App. 2d 247, 288 P.2d 1003 (1955).

48. Cavallaro v. Sharp, 121 A.2d 669 (R.I. 1956).

49. Michael v. Roberts, 91 N.H. 499, 23 A.2d 361 (1941).

50. Musachia v. Terry, 140 So.2d 605 (Fla. App. 1962).

51. Cook v. Lichtblau, 144 So.2d 312 (Fla. App. 1962). See notes 45-48 *supra*.

52. Gist v. French, 136 Cal. App. 2d 247, 288 P.2d 1003 (1955).

53. Huffman v. Lindquist, 37 Cal. 2d 465, 234 P.2d 34 (1951); Ardoline v. Keegan, 140 Conn. 552, 102 A.2d 352 (1954); Carbone v. Warburton, 11 N.J. 418, 94 A.2d 680 (1953); Morrill v. Komasiński, 256 Wis. 417, 41 N.W.2d 620 (1950).

54. Montgomery v. Stary, 84 So.2d 34 (Fla. 1955); Cook v. Lichtblau, 144 So.2d 312 (Fla. App. 1962); Lockart v. Maclean, 361 P.2d 670 (Nev. 1961).

55. Bourgeois v. Dade County, 90 So.2d 575 (Fla. 1957); Montgomery v. Stary, 84 So.2d 34 (Fla. 1955); Baldor v. Rogers, 81 So.2d 658 (Fla. 1954); Hill v. Boughton, 146 Fla. 505, 1 So.2d 610 (1941); Olschefsky v. Fischer, 123 So.2d 751 (Fla. App. 1960); Brown v. Swindal, 121 So.2d 38 (Fla. App. 1960); Crovella v. Cochrane, 102 So.2d 307 (Fla. App. 1958).

case⁵⁶ the Florida Supreme Court criticized the exclusionary effect of the locality rule. Its criticism did not extend to a repudiation of the locality rule. The court avoided the question by permitting the evidence of plaintiff's witnesses, who were not of the same locality, on the view that the conduct of the defendant would be unacceptable in *any* community.⁵⁷ In a subsequent case where the issue on appeal was the standard of care, the court indicated approval of the liberal locality rule⁵⁸ but again it was not directly in issue, as the conduct of the defendant was found to have been negligent when tested by the evidence of the standards prevailing within the same community. A ruling almost on point occurred in the 1961 case of *Couch v. Hutchison*,⁵⁹ in which an interesting interplay of both the school and locality rules was involved. The defendant, an osteopath in St. Petersburg, sought to establish his proper treatment of the plaintiff. The defendant tendered supporting evidence of other osteopaths, trained in the same school as the defendant, who practiced in Philadelphia. The plaintiff tendered evidence of medical doctors who practiced in St. Petersburg. In this case it was the defendant who sought to use the testimony of a physician outside the immediate locality in order to establish his own reasonable care. Strangely enough, the defendant was the *only* osteopathic orthopedic surgeon practicing on the west coast of Florida. The exclusionary effect of the locality rule would have been fatal to his case. The court held that the primary consideration must be to test the conduct of the defendant doctor by the standards of his own school.⁶⁰ If there is no way to establish those standards by evidence of the theories and practices of members of that school in the same locality, then it is proper to establish the standards of that school from without the locality.⁶¹ This case would seem to have set the locality rule to rest in Florida. In addition to the holding, which clearly disregarded the locality rule *in that posture*, the case contained a host of critical dicta suggesting limitations on or total discard of the locality rule.⁶² The court summed up: "The rule has, of course, an appropriate

56. *Montgomery v. Stary*, 84 So.2d 34 (Fla. 1955).

57. "The jury could have found, as a matter of their own common knowledge and experience, and independent of expert testimony as to acceptable medical practice, that the fingers and thumb of a premature infant were needlessly burned off and that this could not be considered acceptable medical practice in any community." *Id.* at 40.

58. *Bourgeois v. Dade County*, 99 So.2d 575 (Fla. 1957) (same or similar communities or localities).

59. 135 So.2d 18 (Fla. App. 1961).

60. *Foster v. Thornton*, 125 Fla. 699, 170 So. 459 (1936); see generally cases collected in Annot., 78 A.L.R. 696 (1931).

61. The case took a different posture from usual school rule cases on appeal. Usually, if all the evidence that the plaintiff has is from an expert of another school than the defendant, the trial court will exclude such evidence and direct a verdict for the defendant. In the *Couch* case, the trial court permitted the *non-school* evidence of the plaintiff to make a prima facie case for the plaintiff. It then refused to admit the *non-local* evidence for the defendant. This resulted in the appealed-from verdict for the plaintiff.

62. "It takes a strange sense of logic to hold that local practice rules out all other evidence on the central issue of reasonable care on such a widely pervasive subject."

relation to the admissibility of evidence; but persuasive argument can be made for not regarding the locality rule as a rule absolute describing *the* definitive means of measuring reasonable care in cases of alleged malpractice"⁶³ Due to the posture, which involved the school rule as well, the case did not squarely reject the locality rule, but it restricted the use of the rule as merely one circumstance relative to the reasonable care of the defendant.

Apparently the abusive potential of the locality rule has not been laid to rest, for in the recent case of *Cook v. Lichtblau*,⁶⁴ the defendant was able to convince the trial judge that the evidence of the plaintiff's Miami expert was inadmissible under the exclusionary locality rule on the issue of the standard of care required of the defendant, a practitioner⁶⁵ in West Palm Beach. The trial court apparently took the view that under the locality rule, it is the burden of the plaintiff⁶⁶ to show that the locality in which his expert practiced was substantially similar to the locality in which the defendant practiced. Rejecting this view, the appellate court commented, "The circumstances attendant to the instant case did not justify restrictive imposition of the 'locality rule.' Moreover, any reasons in logic and law which compel retention of this rule, in whatever form, were not present in this case."⁶⁷ The net result is a heavy disapproval of the restrictive results of the locality rule. The wording of the liberal locality rule⁶⁸ implies the question: Just what is "similar"? The *Cook* case answered the question: "[T]his court's awareness that up-to-date medical facilities and techniques are at the disposal of almost any modern city in this country, leads us to judicially notice that, insofar as the practice of medicine is concerned, Miami is at least a community

Couch v. Hutchison, 135 So.2d 18, 23 (Fla. App. 1961). The court also approved critical comments from Annot., 8 A.L.R.2d 772 (1949); and 12 U. FLA. L. REV. 121 (1959).

63. *Couch v. Hutchison*, 135 So.2d 18, 23 (Fla. App. 1961).

64. 144 So.2d 312 (Fla. App. 1962).

65. The defendant doctor in the *Cook* case was actually a specialist, being an orthopedic surgeon, and he was not a general practitioner. Evidence of a general practitioner would be admissible on the standard of care expected of a specialist, any objections as to the expertise of this kind of witness will go only to the weight to be given his evidence, and not to its admissibility. *Carbone v. Warburton*, 11 N.J. 418, 94 A.2d 680 (1953). "[O]ne who holds himself out as a specialist must employ not merely the skill of a general practitioner, but also that special degree of skill normally possessed by the average physician who devotes special study and attention to the particular organ or disease or injury involved, having regard to the present state of scientific knowledge." *Carbone v. Warburton*, 22 N.J. Super. 5, 9, 91 A.2d 518, 520 (1952).

66. Query: Might not it be better, if the locality rule is to be retained at all, to reverse this burden, and require a defendant to show, as part of his burden, that the tendered expert is incompetent, due to lack of familiarity with conditions in the locality in which the defendant practiced? This view would restrict the attack of the defendant to the weight to be given to plaintiff's expert testimony, rather than to its admissibility. Thus the exclusionary effect of the locality rule might be avoided.

67. *Cook v. Lichtblau*, 144 So.2d 312, 316 (Fla. App. 1962).

68. Same or similar communities (or localities). *Sinz v. Owens*, 33 Cal. 2d 749, 205 P.2d 3 (1949).

similar to West Palm Beach.⁶⁹ Thus, the question remaining for ultimate examination is whether there is, or ought to be any true distinction between the standards of medical care which can be obtained in any community in the nation.

CAN THE SCHOOL AND LOCALITY RULES BE ELIMINATED?

The rationales for fixing liability upon a physician are:

- (1) The express terms of the contract between the parties;
- (2) Terms implied by law from the contract;
- (3) Standards of care required by law, entirely apart from the contract between the parties.

Early rationales of both the school and locality rules rested heavily upon the contract between the parties.⁷⁰ This view assumed that the parties contemplated the standard of care to be exercised. The unreality of this is apparent, when one questions whether in fact the patient actually understands⁷¹ and approves of the distinctions in theory between the schools of osteopathy and of medicine, or whether the patient understands that the small-town doctor knows less medicine or is more careless than his large-city cousin. While it may be tidy to base the liability of the physician upon the contract between the parties,⁷² it does not answer the entire problem.

The second possible basis of fixing liability, the terms of the contract implied by law, results in imposing the standard of reasonable care upon the physician.⁷³ This is the view which initially generated the school and locality rules, to aid in the definition of just what that reasonable care⁷⁴ under similar circumstances ought to be. The harsh results engendered by too enthusiastic applications of those rules have, of necessity, resulted in exceptions to both rules. These exceptions now seem

69. *Cook v. Lichtblau*, 144 So.2d 312, 316 (Fla. App. 1962).

70. *Force v. Gregory*, 63 Conn. 167, 27 Atl. 1116 (1893); *Bowman v. Woods*, 1 Greene 441 (Iowa 1848); *Patten v. Wiggin*, 51 Me. 594, 81 Am. Dec. 593 (1862); *Bryant v. Biggs*, 331 Mich. 64, 49 N.W.2d 63 (1951).

71. Does the patient know that he is consulting an osteopath, and not a "regular" doctor? Florida requires each practitioner of the healing arts to advertise his "school" on his professional sign, and in lettering not less than two and one half inches high by one inch wide. FLA. STAT. § 458.14 (1961).

72. Close analysis of the early cases upon which the contractual rationale of the school rule is based, will disclose a strong reliance upon presumed actual consent by the patient to being treated according to the standards of the physician's school. "A person professing to follow one system of medical treatment, cannot be expected by his employer to practice any other." *Bowman v. Woods*, 1 Greene 441 (Iowa 1848). "A physician of one . . . school . . . is to be tested by the general doctrines of his school, and not by those of other schools. It is to be presumed that both parties so understand it." *Patten v. Wiggin*, 51 Me. 594, 81 Am. Dec. 593 (1862).

73. Any person who holds himself out to diagnose or treat human disease is practicing medicine. FLA. STAT. § 458.13(1) (1961).

74. See note 17 *supra* and accompanying text.

fully large enough to engulf the rule, and leave the standard of care to be simply expressed as reasonable care under the circumstances.⁷⁵

However, the third possible basis, that of fixing the duty of the doctor by law, entirely apart from the contract between the parties, offers the most promising standard regulating the care required.

The state has undertaken to regulate and license⁷⁶ physicians, to insure that anyone who holds himself out as competent to treat human illnesses will have at least a minimal technical competency to so practice.⁷⁷ If the law can require minimal standards of training, why can it not impose additional requirements? Should it not require the physician to keep abreast of the latest advances in medical science, by technical manuals, post-graduate refresher training,⁷⁸ or any other common media? This requirement can be imposed simply by judicial elimination of the judicially created school and locality rules. Indeed, the very wording

75. The physician's duty is "to use ordinary skill and diligence and to apply the means and methods ordinarily and generally used by physicians of ordinary skill and learning in the practice of his profession to determine the nature of the ailment and to act upon his honest opinion and conclusion." *Hill v. Boughton*, 146 Fla. 505, 511, 1 So.2d 610, 613 (1941). *Accord*, *Edwards v. Uland*, 193 Ind. 376, 140 N.E. 546 (1923); *Clark v. George*, 148 Minn. 52, 180 N.W. 1011 (1921).

76. First Florida licensing for physicians in 1889 (separate boards for practitioners of medicine and homeopathy). See FLA. STAT. §§ 458, 459, 460 (1961).

77. See note 9 *supra*. When a person who is not licensed by the state to treat human illnesses undertakes to do so, he will be required to live up to the standards of care established by the licensed practitioners of the healing arts. *Whipple v. Grandchamp*, 261 Mass. 40, 158 N.E. 270 (1927); *Epstein v. Hirschon*, 33 N.Y.S.2d 83 (Sup. Ct. 1942).

78. Florida Statutes require practitioners of Osteopathy and Chiropractic to attend annual refresher courses or their equivalent, as a prerequisite to renewal of licenses to practice. No such requirement is made for practitioners of medicine. FLA. STAT. §§ 459.19 (Osteopaths), 460.27 (Chiropractic) (1961).

The physician's refuge behind the locality rule is subject to attack on the basis of the physician's duty to keep abreast of practices in other localities: "But the contention of [the defendant] is archaic. It was not without merit in former days when distances were great and the mode of travel was in keeping with muddy lanes, swollen streams and impassable mountains; when the means of communication were restricted to handwritten letters; when medical journals were rare and their contents were largely concerning personalities. Today the discoveries of insulin, iron, quinine, strychnine or the antibiotics is [*sic*] instantly heralded throughout the civilized world and as speedily communicated are the methods of administering them and the symptoms for which they are to be applied. Every great hospital in the land maintains systems for preserving statistical information relative to the treatments of diseases and injuries, much of which is published to the medical world in attractive journals, whereby practitioners are equipped immediately to utilize the new remedies. The same is true with respect to all new methods and devices of the surgical art. The ubiquity of such knowledge, the popularity of ethical standards in every part of the nation and the uniformity of curricula in medical schools have combined to create one community of medical practitioners out of the 48 states and the District of Columbia. Surely, a surgeon in San Luis Obispo has acquired practically the same knowledge of surgery that is practiced in both San Francisco and Los Angeles. [The defendant] was educated in the same schools of medicine with [the plaintiff's expert] who has enjoyed a contemporary practice in California communities *similar to* San Luis Obispo. If a surgeon in a coast town does not maintain the same ethical standards as do surgeons of the two more populous cities, it is not because the standards have not been established there, but rather *because of his lack of interest in his work, or he is negligent in performance.*" *Gist v. French*, 136 Cal. App. 2d 247, 269, 288 P.2d 1003, 1017 (1955). (Emphasis added.)

of the major exception to the school rule, "where the principles of the schools do *or should* concur,"⁷⁹ opens the door for the imposition of a *duty* upon the practitioners of one school to keep abreast of, and adopt advances made by the other schools. Entirely distinctly, and in addition to the other duty, the physician can be held to a duty equivalent to that of great care to call in a specialist in situations which he recognizes are beyond his capacity.⁸⁰ This would render a physician liable for his unreasonable failure to seek special aid in all situations of doubt, in order that the patient, whose benefit and protection are the ultimate aims of state regulation, may have the best possible care.

The medical profession has undertaken the burden of the Hippocratic oath, "The regimen I adopt shall be for the *benefit of my patients* according to my ability and judgment, and *not for their hurt or for any wrong.*" Can the law permit any less?

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79. Thus, a defendant doctor is held not only to the competent practice of the theorems of his own school, but in addition he is charged with a duty "of keeping pace with the progress of professional knowledge, ideas, and discoveries, to the extent that a faithful, conscientious, and competent practitioner, of whatever school, may be reasonably expected . . . to do . . ." *Force v. Gregory*, 63 Conn. 167, 171, 27 Atl. 1116, 1117 (1893); see generally later cases collected in Annot., 78 A.L.R. 696 (1932).

80. This theory has been applied to situations other than the usual duty of a general practitioner to call on a specialist in serious cases. It has been extended to a duty to cross school lines in situations where the treatment of the school of the defendant would be unable to aid the patient. "[I]t was incumbent on him to use reasonable care and skill to ascertain whether the ailments were of the class to which his treatment applied. If not, it was his duty to so advise plaintiff, in order that she might secure the services of one familiar with such ailments." *Janssen v. Mulder*, 232 Mich. 183, 189, 205 N.W. 159, 162 (1925).