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THE LAW OF MEDICAL MALPRACTICE IN MARYLAND: A PLAINTIFF'S DILEMMA

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The locality rule in medical malpractice cases has evolved into varied hybrid forms throughout the United States. While the majority of the states has adopted more liberal versions of the rule, Maryland has stood fast in its application of a strict locality rule. The author discusses the history and rationale of the rule in Maryland, contrasts it with the prevailing national trend and propounds reasons for the strict locality rule's abandonment. The subsequent article takes an opposing viewpoint.

It has been argued that a medical malpractice suit should be based on the contractual relationship existing between a physician and his patient. However, Maryland rejects such a theory and grounds medical malpractice litigation in tort.[1] The plaintiff must prove that the defendant-physician's conduct failed to meet the particular standard of care and skill that the jurisdiction in question requires of all physicians and surgeons engaged in the same type of practice as the defendant.[2] To establish the standard and breach, if any, the plaintiff must of necessity use a medical expert who possesses the same special knowledge and skill as the defendant.[3] Thus, a suit brought against a surgeon alleging negligence must result in the plaintiff producing the testimony of an expert in surgery who can state that the injury of which the plaintiff complains resulted from the defendant-surgeon's failure to exercise the usual standards of care in the performance of the surgery in question.

The various jurisdictions have used different rules in medical mal-

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1. Benson v. Mays, 245 Md. 632, 227 A.2d 220 (1967). The court noted:

> While it may be as appellant argues that a physician impliedly contracts with those who employ him that he possesses and will exercise a reasonable degree of care, skill and learning, . . . malpractice is predicated upon the failure to exercise requisite medical skill and, being tortious in nature, general rules of negligence usually apply in determining liability. . . .The great majority of courts that have [also] considered the question have concluded that medical malpractice actions sound in tort and not in contract.

Id. at 637, 227 A.2d at 223.

2. W. PROSSER, TORTS 161–66, (4th ed. 1971).
3. Fink v. Steele, 166 Md. 354, 171 A. 49 (1934). In certain cases, however, the act by the physician itself is of such an exceptional nature that it is negligent per se. An example of such is the case where a surgeon, while operating, negligently drops his scalpel resulting in a puncture of one of the patients organs. In such a situation, the negligence of the physician is recognized by the court without the necessity of presenting an "expert" to testify as to the standard of care, regardless of what the standard may be in that particular locality.

practice actions to evaluate the requisite standard of care and skill required of a physician practicing in a jurisdiction.[4] A medical expert must assert a familiarity with that jurisdiction's rule for judging that standard of care before he will be permitted to offer an opinion about the competence of a fellow practitioner. Because of the various rules or doctrines respecting the standard of care, a practical problem of trial preparation for the attorney may develop when a local medical expert cannot be obtained and it thus becomes necessary to seek the assistance of an expert from a different locality or, indeed, a different state. The out-of-state or out-of-the-locality expert is required to show a familiarity with the rule for judging the standard of care existing in the forum jurisdiction before he is permitted to testify as to the presence or absence of the requisite standard of care. The more restrictive the rule followed in a jurisdiction, the more difficult it is for the plaintiff to prepare and produce medical testimony, notwithstanding the availability of outstanding medical specialists from out of the state.

The most restrictive of these doctrines, the *traditional strict locality* rule, requires that the expert witness be familiar with the standard of care possessed and exercised by physicians and surgeons in the defendant's own community or locality.[5] In addition, under this traditional rule the expert witness not only must be familiar with the local standards, but he must also practice in that locality.[6] The rationale for this traditional rule is that a physician in a small or rural community does not have the opportunity for continuing medical education or the facilities and support systems used by physicians in large metropolitan areas to more accurately diagnose and better treat his patients.[7] It is therefore argued that only physicians from the locality of the defendant-physician are competent to express an opinion as to local standards. Such a contention is an attempt to prevent out-of-state experts from participating in the trial and furnishing the evidence as to the alleged lack of due care, the *sine qua non* of getting the case to a jury.

A significant modification to the traditional strict locality rule has been to relax the requirement that the expert witness be from the same locality as the defendant.[8] Under this *modified strict locality* doctrine, although the expert witness must still profess a familiarity with the local standard he need not practice in that locality. The importance of this modification is that it enables the plaintiff in a medical malpractice action to go outside of the defendant's own locality to obtain experts

4. *See, e.g.*, Ardoline v. Keegan, 140 Conn. 552, 102 A.2d 352 (1954) (general neighborhood rule); Lockart v. Maclean, 77 Nev. 210, 361 P.2d 670 (1961) (traditional strict locality rule); Carbone v. Warburton, 11 N. J. 418, 94 A.2d 680 (1953) (no geographical limitations); Wiggins v. Piver, 276 N. C. 134, 171 S.E.2d 393 (1970) (similar locality rule).
5. Lockart v. Maclean, 77 Nev. 210, 361 P.2d 670 (1961).
6. Johnson, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 733 (1970).
7. Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968), *noted in* 82 HARV. L. REV. 1781 (1969); 34 MO. L. REV. 297 (1969); 18 DEPAUL L. REV. 328 (1968). PROSSER, *supra* note 2, at 164.
8. *See* Teig v. St. John's Hosp., 63 Wash. 2d 369, 387 P.2d 527 (1963). *See generally* Johnson, *supra* note 6, at 733–34.

who are willing to testify as to whether the defendant acted with the requisite skill and care practiced by other physicians in the defendant's own locality. In many cases it is extremely difficult, if not impossible, for a plaintiff to acquire competent local expert testimony as to the standard of care required and the defendant-physician's negligence because of the well known "conspiracy of silence"[9] which may exist in the defendant's own locality.

THE MARYLAND STRICT LOCALITY RULE

A minority of jurisdictions, including Maryland,[10] still adheres to the archaic strict locality rule. Maryland first established the *general* rule regarding the degree of care and skill required to be exercised by a physician and surgeon in the 1889 case of *State* ex rel. *Janney v. Housekeeper.*[11] In that decision, a wrongful death action involving an allegation of medical negligence, the Court of Appeals stated:

> [T]he degree of care and skill required [of physicians] is that reasonable degree of care and skill which physicians and surgeons ordinarily exercise in the treatment of their patients, and that the burden of proof is on the plaintiff to establish the want of such skill and care in the performance of the operation and attendance on the deceased while under treatment.[12]

Housekeeper set forth the standard to evaluate a physician's performance but the court did *not* include a restrictive qualification that testimony regarding the standard of care required must be established by experts from the same community as the defendant. It was not until *State* ex rel. *Solomon v. Fishel*[13] in 1962 that the qualification of the strict locality rule entered the Maryland legal scene. In *Fishel* the Maryland court, for the first time and without explanation, qualified the *Housekeeper* standard of care by injecting a geographical limitation which is commonly found under the strict locality rule. That standard was the "care, skill and diligence as a physician and surgeon which is exercised generally in the community in which he was practicing by doctors engaged in the same field."[14] This qualification to the *House-*

9. *See* pages 214-16 *infra*.
10. Dunham v. Elder, 18 Md. App. 360, 364, 306 A.2d 568, 571 (1973).
11. 70 Md. 162, 16 A. 382 (1889).
12. *Id.* at 172-73, 16 A. at 384.
13. 228 Md. 189, 179 A.2d 349 (1962).
14. *Id.* at 195, 179 A.2d 353. The court cited as authority for this proposition Lane v. Calvert, 215 Md. 457, 138 A.2d 902 (1958). However, in the *Lane* case, the Court of Appeals did not place such a geographical limitation on the evaluation of a defendant-physician's degree of care or skill. Rather the court merely noted that "the amount of care, skill and diligence required is not the highest or greatest, but only such as is ordinarily exercised by others in the profession generally." *Id.* at 462, 138 A.2d at 905. This failure by the *Lane* court to place such a strict locality limitation upon the plaintiff in a medical malpractice suit makes the *Fishel* court's addition to the Maryland medical malpractice standard, allegedly based on *Lane*, of highly dubious validity. *See* Nolan v. Dillion, 261 Md. 516, 276 A.2d 36 (1971).

keeper standard has become stare decisis in Maryland.

The most recent decision at the appellate level in Maryland concerning the strict locality rule is *Dunham v. Elder.*[15] The *Dunham* case arose from an allegation that a physician-defendant had been negligent in the initial diagnosis of his affliction and in the administration of the medication for the incorrectly diagnosed malady.[16]

At the trial the plaintiff called two out-of-state medical witnesses in an effort to establish the standard of care required to be exercised by the defendant. "The first of these expert witnesses, a urologist, testified that he had never practiced, treated patients, enjoyed privileges in any hospital or maintained offices in Maryland."[17] In response to cross-examination by the defendant's counsel the urologist testified that he had no specific knowledge of the standard of care required of a general practitioner in Maryland, although he professed a familiarity with the standard throughout the United States.[18] The trial court ruled that the expert was not qualified to testify as to the standard of care required of a general practitioner in Prince George's County, Maryland.[19] The plaintiff's second expert witness, an orthopedic surgeon, testified only as to the standard of care existing in Maryland thirty-nine years before this incident. He was never qualified as an expert witness at the trial, and his testimony was solely that of an examining physician.[20]

At the conclusion of the case the defendant moved for a directed verdict asserting that the plaintiff failed to meet the burden of proof as to the standard of care in "Prince George's County in 1967."[21] The trial court took the *Dunham* case from the jury and in an oral opinion stated:

> [T]he plaintiff failed to show the standard of care of general practitioners in Prince George's County in 1967 in this type of case. We [sic] have ruled that they have failed to show this to such an extent that it wasn't sufficient in order to submit that particular aspect of it to you members of the jury. If they fail in one of the requirements they have to fail the whole way.[22]

On appeal, the Maryland Court of Special Appeals affirmed the lower court's ruling. In its opinion the court acknowledged that the strict locality rule was still the controlling rule in Maryland. The court concluded:

> We read the Maryland precedents to apply the more strict rule

15. 18 Md. App. 360, 306 A.2d 568 (1973).
16. The plaintiff's affliction had initially been diagnosed as gout. It was later determined that the plaintiff never had gout but was suffering from arthritis. The medication which had been prescribed to combat the gout caused kidney damage. *Id.* at 361-62, 306 A.2d at 569.
17. *Id.* at 365, 306 A.2d 571.
18. Record at 84.
19. *Id.* at 89.
20. 18 Md. App. at 366, 306 A.2d at 572.
21. Record at 292.
22. *Id.* at 296.

> that the plaintiff must show that the defendant-physician failed to exercise "the amount of care, skill and diligence as a physician and surgeon which is exercised generally *in the community . . . in which he was practising . . . .*"[23]

It is apparent that Maryland still adheres to the *modified* strict locality rule, and at least does not support the position of the *traditional* strict locality rule. Nowhere in *Dunham* or any of its predecessor cases do the Maryland courts make reference to the requirement that the expert witness be from the defendant's locality although, of course, the expert must still be familiar with the standard of care in that locality. Nevertheless, Maryland's position has been confused by some lower courts to be that of a traditional strict locality state.

Recently a professor of gynecology from an outstanding, out-of-state medical school, who, it was proffered, was totally familiar with the standards of care in the gynecological community of Maryland by virtue of having treated patients from Maryland, having reviewed hospital records from Maryland hospitals, and having attended meetings with Maryland specialists, nevertheless was not permitted to testify because he did not practice in the locality in which the alleged tort occurred.[24] Thus, the expertise of a witness and the equitable considerations which must prevail in any trial were lost to the maintenance of an unfair and unrealistic minority rule—the traditional strict locality rule. In this episode the trial judge applied the recent *Dunham* decision but interpreted it as not only requiring that the expert have a knowledge of the standards of care in the Maryland community but further requiring that such knowledge of the standard be gained by practicing in the community about which he is testifying.[25]

Dunham offers ill-defined areas for lower courts to follow and has been interpreted in such a narrow way as to distort the true Maryland law. In addition, a perpetuation of the strict locality rule as expressed in the *Dunham* case is a puzzling matter, particularly when the court at the same time stated that its rule is in the minority[26] and that if the case were one of first impression it might be persuaded to rule otherwise. Less antiquated rules of law have been more quickly abolished and modified than the strict locality rule. In *Dunham* the court stated, in dictum:

> Thus, if the issue were one of first impression in Maryland and its resolution was necessary in order to decide this appeal, we might be persuaded to hold that the requisite standard of medical care and skill to which a physician should be held is the standard which applies either in the general neighborhood of Prince George's County or in similar localities . . . . [T]here was

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23. 18 Md. App. at 364, 306 A.2d at 571.
24. Raitt v. Montague, Law No. 37367 (Montgomery County Cir. Ct., Jan. 29, 1974).
25. Transcript at 85, *id.*
26. 18 Md. App. at 364, 306 A.2d at 571.

> no testimony introduced by the appellants to establish what the requisite standard of medical care and skill for a general practitioner was, either in the Prince George's County area, [or any other locality.][27]

It is therefore apparent that *Dunham* was not the proper vehicle for the Court of Special Appeals to abandon the outdated strict locality rule. The court did, however, indicate that the rule should be broadened to encompass one of the two less strict doctrines, the same or similar community rule or the general neighborhood rule.[28]

STRICT LOCALITY RULE OUTDATED

Why did the *Dunham* court, as well as a majority of jurisdictions, feel that the strict locality rule is outdated? The strict locality rule served an important purpose many years ago. Before the modern developments in rapid transportation, communication, and medical education, it was reasonable to hold a local country doctor only to the standard of care as practiced in his local area. Such a doctor seldom was afforded the opportunity to visit facilities in neighboring communities; received little, if any, professional communications to enable him to keep up-to-date on the latest medical developments; and was educated in a manner which did not hold to any national uniformity. Thus, the rationale developed that a physician should only be held to his own local standards.

Today, however, this rationale is no longer valid. The modern development of transportation, communication, and medical education all tend to promote a degree of standardization within the medical profession. With such a standardization the need to qualify expert witnesses based solely on geographical criteria instead of their professional skill and knowledge is reduced, if not entirely eliminated.

Advances in medical communication have been made through the use of "medical journals, closed circuit television presentations, special radio networks for doctors, tape recorded digests of medical literature, and current correspondence courses."[29] One trend setting method that completely eliminates any geographical gap in the availability of the

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27. *Id.* at 365, 306 A.2d at 571. The plaintiff never did introduce testimony establishing the proper standard of care and consequently did not prove all the elements necessary to establish the malpractice. The defendant's motion for a directed verdict was granted. The court noted that the following elements were necessary to prove malpractice:

> In proving a malpractice case in Maryland, a plaintiff has the burden of proving: (1) the standard of medical skill and care ordinarily exercised in the particular locality; (2) a failure to observe that standard on the part of the physician-defendant; and (3) a showing that the defendant's failure to observe the proper standard was a direct cause of the injuries about which his patient complains in the malpractice action.

Id. at 363, 306 A.2d at 570.

28. *Id.* at 363–64, 306 A.2d at 570–71.

29. Johnson, *supra* note 6, at 732 (footnotes omitted).

latest advice on diagnosis or treatment may be found in Alabama. That state has established a 24-hour switchboard through which the calling doctor can be connected to a staff specialist at the Medical College of Alabama located in Birmingham.[30] Now, even the general practioner can instantly be advised by specialists utilizing the latest diagnostic techniques and equipment. In addition, standardization of teaching in the various medical schools,[31] and the uniform requirements for certification by any of the various departments of the American Specialty Boards,[32] indicate the fallacy of the contention that the standard of care in diagnosing and treating a particular illness in New York differs from that in California.

The American Specialty Boards, which includes the fields of anesthesiology, neurological surgery, and urology[33] require that any specialist seeking certification in his particular field pass certain tests and conform to certain standards. The tests are given on a nationwide basis and do not vary from state to state.[34] These various certifying boards of the medical specialties have existed for over fifty years.[35] Prior to 1923 the practice of medicine in the United States did not enjoy the qualitative policing of care as it does today. Similarly, before the creation of the various boards of the medical specialties no journals existed dealing with common problems by which members of a specalty could gain insight by regular and prompt receipt of such publications. Also, the various medical education seminars and specialty meetings which are held at the national, regional, and local levels keep the busy practitioner aware of new trends in medical care and afford a uniformity of knowledge regardless of where in the nation the physician practices.

There is no greater evidence of the uniformity of medical care which prevails in the United States today than the recently enacted federal statute[36] which created a Professional Standards Review Organization (PSRO). This statute empowers the Secretary of Health, Education and

30. *Id.*
31. *Medical Education in the United States*, 210 J.A.M.A. 1445 (1969).
32. 14 MARQUIS—WHO'S WHO, INC., DIRECTORY OF MEDICAL SPECIALISTS (13th ed. 1968). The functions and purposes of specialty boards as stated in the introduction of the DIRECTORY OF MEDICAL SPECIALISTS are:

    The primary functions of approved boards are (1) to determine the competence of candidates who appear voluntarily for examination and to certify as diplomates those who are qualified and (2) to improve the general standards of graduate medical education and facilities for specialty training. The objective of these activities is to promote the public's welfare and improve medical care.

    Id. at 20.
33. *Id.* at 22.
34. *Id.* at 17-22. The American Board of Internal Medicine, composed of physicians from throughout the country, conducts and approves certification of all physicians so applying. In addition to the prerequisite that one seeking certification as an expert in a particular field be a graduate of an approved medical school, there is the further requirement of residency and post-graduate studies which have a national, rather than a local, application.
35. *Id.* at 19.
36. 42 U.S.C.A. § 1320(c) (Supp. 1973).

Welfare to organize regional medical districts which will implement and oversee the quality of medical and hospital care in the particular PSRO area involved. HEW is granting to the various medical communities sufficient time to issue directives to the medical profession so that various physicians and specialists adhere to standards which are uniform. It is interesting to note that the implication of this regulation of HEW is that the medical profession is being given until January 1, 1976, to establish its peer review boards whose review would be based on uniform standards—the alternative being that the federal government would implement such controls itself.

PRACTICAL PROBLEMS OF STRICT LOCALITY

One of the major obstacles which must be overcome by a plaintiff in a jurisdiction which still employs the strict locality rule is the problem of obtaining local practitioners to testify against a local colleague. That this is a very real and practical problem is evidenced by a recent study conducted by a special committee formed by the Secretary of Health, Education and Welfare to investigate the total impact of malpractice generally on the medical, legal, and lay community.[37] This study, beginning in September, 1971, and lasting sixteen months, involved a nationwide survey of physicians. The study culminated in a report that emphasized the antagonism which local physicians have toward malpractice suits being filed in their community. The commission cited a number of reasons why physicians might be reluctant to testify in malpractice cases:

> 1. The reluctance to suffer loss of time and income from practice that may be involved in court appearance;
> 2. The inability to provide care to patients while away in court;
> 3. The fear and resentment of physicians regarding cross-examination under the adversary legal system;
> 4. The natural reluctance to injure friends and fellow craftsmen, coupled with the feeling that "there but for the grace of God go I"; and
> 5. The common belief that most malpractice claims are without sound basis.[38]

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37. HEW, REPORT OF THE SECRETARY'S COMMISSION OF MEDICAL MALPRACTICE (1973).

38. *Id.* at 36-37. Illustrative of the uniformity of the medical profession's opposition and hostility to participate as an expert witness in a lawsuit against a fellow physician of their locality is the recent case of Capobianco v. Gordon, 19 Md. App. 662, 313 A.2d 517 (1974). This case demonstrates the readiness of the Medical and Chirurgical Faculty, ostensibly a quasi governmental bureau of the Medical Examiner's office, *see* MD. ANN. CODE art. 43, § 130 (1970), writing through their counsel to a physician defendant and offering gratuitously by virtue of the defendant-physician's membership in the medical society a "panel of experts" to help in the defense of the case.

November 3, 1972

Dear Dr. Gordon:

I confirm the referral by Med-Chi to this office of your defense pursuant to its By Laws.

Based on the survey, the commission recommended that "organized medicine and osteopathy establish an official policy encouraging members of their professions to cooperate fully in medical malpractice actions so that justice will be assured for all parties; and, the Commission encourages the establishment of pools from which expert witnesses can be drawn."[38] [39]

Within the boundaries of the modified strict locality rule as enunciated in *Dunham*, this writer has been able to establish the requisite foundation and to qualify out-of-state medical experts by eliciting the following statements in testimony:

1. That the particular medical expert is qualified in his field by receiving his medical degree at a recognized and approved medical school.
2. That following his graduation he pursued residency in a particular specialty of medicine.
3. That following his residency he actively engaged in the practice of that specialty.
4. That in a particular year he applied for, was tested, and certified as a specialist by his particular specialty board.
5. That since his certification he has received various medical journals dealing with the practice of medicine throughout the country including Maryland.
6. That he has had contact at medical meetings with Maryland physicians where ideas were exchanged, as were case histories involving the treatment of particular ailments.
7. That he has in the past read papers by medical specialists from Maryland dealing with the practice of medicine here and the management of a particular medical problem.
8. That he has treated patients who formerly were treated in Maryland, thus necessitating the obtention of medical charts and hospital charts from Maryland which revealed how the patient's medical problem was handled in Maryland.
9. That he has in the past had professional contact with Maryland physicians regarding the treatment of a patient who has since moved out of Maryland.
10. That as a result of all of the above, he is familiar with the standard of care in the community and finds no difference between that standard and the standard of his own state.

I should appreciate your insurance carrier and its counsel advising me of such time, if any, as it would consider a panel of doctors to be of assistance in this matter.

In the meantime, you are cautioned to restrict communication on this subject to authorized representatives of your carrier, its counsel and this office.

Very truly yours,
/s/ John F. King
John F. King

Id. at 664, 313 A.2d at 518.

Such panels are not available to plaintiffs. The individual participation on behalf of a plaintiff of a local practitioner who is a member of the Medical and Chirurgical Faculty can readily be appreciated as an act which would engender the displeasure of his peers.

39. *Id.* at 37.

A second obstacle created by the adherence to the strict locality rule concerns the fear that a small group of physicians can, by their carelessness, establish an inferior local standard of care. As an example of the application of the locality rule, a renowned professor from an outstanding medical school, who also practices within a large city community, would be effectively prevented from commenting upon a departure from the standard of medical care in a local community merely because he is not familiar with the standard of care established in that local community.[40] This could be so even if such violation were a basic omission of minimal standards of care. Thus, the disturbing practical effect of the continuing adherence to the strict locality rule results in giving more consideration to artificial geographical boundaries and less to the expertise and qualifications of the expert sought to be introduced.

SOLUTIONS TO THE STRICT LOCALITY RULE PROBLEMS

Due to these problems created by following a strict locality rule and the antiquated reasons given for its support, most jurisdictions have abandoned it in favor of the two more liberal rules: the *similar locality*[41] rule, and the *general neighborhood* rule.[42]

The similar locality rule requires that the defendant be held to the standard of care ordinarily exercised by medical professionals either in the defendant's own locality *or* in a similar locality.[43] The expert witness does not have to profess a familiarity with the practices in the defendant's specific locality, as is required by the *modified* strict locality rule, if he expresses a familiarity with the practices in a locality considered to be similar to that of the defendant.

The obvious drawback to this approach is the problem still present for the court in determining not the competency of the expert witness but rather the definition of a "similar" locality. However, this seems to be less of a difficulty than the problem of determining the familiarity of the nonlocal experts with the local standards as presented under the strict locality rule.

The *general neighborhood* rule requires the defendant to conform to the standards in the general neighborhood of his locality,[44] the expert witness need only be familiar with that standard. The general neighbor-

40. *See* Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968).
41. *See* Dunham v. Elder, 18 Md. App. 360, 363-64, 306 A.2d 568, 570-71 (1973); Wiggins v. Piver, 276 N.C. 134, 178 S.E.2d 393 (1970).
42. *See* Ardoline v. Keegan, 140 Conn. 552, 102 A.2d 352 (1954); Dunham v. Elder, 18 Md. App. 360, 363-64, 306 A.2d 568, 570-71 (1973).
43. 18 Md. App. at 363-64, 306 A.2d at 570-71; DiFilippo v. Preston, 53 Del. 539, 173 A.2d 333 (1961); Smith v. Yohe, 412 Pa. 94, 194 A.2d 167 (1963); Henley v. Mason, 154 Va. 381, 153 S.E. 653 (1930).
44. 18 Md. App. at 364, 306 A.2d at 571. *See, e.g.*, Ardoline v. Keegan, 140 Conn. 552, 102 A.2d 352 (1954).

hood has been defined by one court to encompass that "area coextensive with the medical and professional means available in those centers that are readily accessible for appropriate treatment of the patient."[45]

The general neighborhood rule readily satisfies one important criteria set by the proponents of the strict locality rule—accessibility. Those proponents argue that the local doctor should be held only to a standard of care that is practiced in areas which are accessible to him. In effect, the more enlightened jurisdictions have simply considered this argument in light of recent advances in communications and transportation and have considered that the accessibility concept has been broadened. A local doctor can now easily travel to areas surrounding him and obtain advice and education from doctors of similar specialties. There is no reason why the local doctor today should not be held to the standards exercised by doctors in surrounding neighborhoods in addition to his own locality.

This rule's most potent attack on the difficulties created by the strict locality rule is that it lessens the chance of a lower standard being applied simply because a few doctors in a small area may be less than competent.

The importance of the similar locality approach, as well as the general neighborhood approach, is that the practical problems created by the strict locality rule are eliminated. This is due to the availability of nonlocal experts and the abandonment of isolated standards as the only criteria for judging medical negligence. These rules are more in accordance with the modern developments that have rendered the strict locality rule obsolete. The reasoning behind extending the geographical boundary was aptly noted by the Supreme Court of North Dakota in *Tvedt v. Haugen*.[46] That court recognized:

> Today, with the rapid methods of transportation and easy means of communication, the horizons have been widened, and the duty of a doctor is not fulfilled merely by utilizing the means at hand in the particular village where he is practicing. So far as medical treatment is concerned, the borders of the locality 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.[47]

Maryland is in the minority by perpetuating a form of the strict locality rule. The need for a change in this rule is evidenced by the abandonment of the strict locality rule in all of the states adjoining Maryland. The enlightened similar locality approach has been followed

45. Pederson v. Dumouchel, 72 Wash. 2d 73, 79, 431 P.2d 973, 978 (1967).
46. 70 N. D. 338, 294 N.W. 183 (1940).
47. *Id.* at 349, 294 N.W. at 188.

in West Virginia,[48] Delaware,[49] Pennsylvania[50] and Virginia[51] in place of the more archaic strict locality rule. A slightly more remote state, Connecticut, has ventured a step beyond the similar locality rule and based its standard on the general neighborhood rule. In *Ardoline v. Keegan*[52] the Supreme Court of Errors of Connecticut noted:

> To recover in a malpractice action against a physician the plaintiff must prove that the defendant failed to exercise that degree of care, skill or diligence ordinarily had and exercised by physicians engaged in the same line of practice in the *general neighborhood* where the treatment complained of was administered.[53]

New Jersey adheres to a very liberal interpretation of the locality rule and has abandoned geographical limitations altogether. In *Carbone v. Warburton*[54] the Supreme Court of New Jersey chose to base a witness' expertise upon ones "knowledge and experience in the same profession to know and state whether in the given circumstances of a particular case the physician or surgeon had failed to exercise that degree of knowledge and skill which usually pertains to other members of the profession."[55] The court reasoned that a witness' qualification to testify hinges upon his "knowledge and experience in the care and treatment of the illness or injury."[56]

CONCLUSION

Maryland is alone among the mid-Atlantic states in upholding what the surrounding jurisdictions have recognized as an outdated rule. Of some hope to a plaintiff in Maryland is the inference that can be drawn

48. White v. Moore, 139 W. Va. 806, 62 S.E.2d 122 (1950).
49. DiFilippo v. Preston, 53 Del. 539, 173 A.2d 333 (1961).
50. Smith v. Yohe, 412 Pa. 94, 194 A.2d 167 (1963).
51. Henley v. Mason, 154 Va. 381, 153 S.E. 653 (1930).
52. 140 Conn. 552, 102 A.2d 352 (1963).
53. *Id.* at 556, 102 A.2d at 355 (emphasis added).
54. 11 N.J. 418, 94 A.2d 680 (1953).
55. *Id.* at 424, 94 A.2d at 683. This logic has been applied in jurisdictions throughout the nation. *See, e.g.*, McElroy v. Frost, 268 P.2d 273 (Okla. 1954) wherein the plaintiff brought suit alleging that the defendant doctor, while treating the plaintiff for a skin disorder, negligently administered x-ray treatments resulting in severe burns "about the groin, scrotum and genitals" which "rendered the plaintiff impotent and sterile" and further caused "radiodermatitis, constant pain and discomfort and potential cancer." The plaintiff's experts, although not from the same community as the defendant, were allowed to testify at trial. The Supreme Court of Oklahoma affirmed that decision noting:
    > It is true the witnesses were not from the same community but, with one exception, the medical evidence in plaintiff's behalf came from specialists in their particular field. 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 likewise would be the best in another.

    Id. at 279-80.
56. 11 N. J. at 425, 94 A.2d at 683.

from the dicta in *Dunham* which indicates that this jurisdiction may soon abandon the strict locality rule.

The time has long since passed for the Maryland courts to abandon the strict locality rule and recognize the reality of the more liberal approaches applied in the majority of jurisdictions. If Maryland continues to persist in adhering to stare decisis in regards to the archaic requirements necessary to establish a standard of care in a medical malpractice suit, then the legislature should take it upon itself to reduce the onerous burden upon the injured party.

The need for change in this area is amplified in an article entitled *An Evaluation of Changes in the Medical Standard of Care.*[57] The author there notes:

> The courts that are deemphasizing or abolishing the locality rules are moving away from a reliance upon geographic location and toward an emphasis on the doctor's opportunities for acquiring information concerning current medical practice and procedure. Whether verbalized as a national standard or not, the effect is to move toward a more standardized practice throughout the country.[58]

The strict locality rule exists today solely for the benefit of the defense. It prevents the testimony of otherwise competent, experienced specialists whose only disqualification is that they do not practice in the community involved. Since the rule no longer has any justification, the Maryland courts should abandon it as a requirement governing the admissibility of a proposed expert witness' testimony.

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57. Johnson, *supra*, note 6.
58. *Id.* at 741 (footnotes omitted).