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THE WISDOM OF THE STRICT LOCALITY RULE

John F. King† and Ward B. Coe, III††

Unlike the preceding article, this article favors the retention of the strict locality rule in medical malpractice cases in Maryland. The authors, after analyzing many of the arguments put forth to liberalize or extinguish Maryland's version of the strict locality rule, discuss the case history that has solidified Maryland's position and demonstrate the justification for the rule's continued application in this jurisdiction.

The locality rule in medical malpractice cases is today a bone of vigorous contention. It has been much maligned by legal writers,¹ abandoned by some courts,² and challenged in others.³ It is a rule of uncertain tradition and seldom pronounced rationale. The lingering question is whether its original justification is relevant today in light of modern medical practice. This article will show that the locality rule has good reasons both legally and medically for its continuing application.

In medical malpractice suits the burden of proof is upon the plaintiff to show that the physician did not maintain the minimum degree of care in the diagnosis or treatment and that this failure of care proximately caused the injury to the plaintiff. This testimony must be elicited from experts who give their opinions as to the proper standard of care.⁴ Therefore, initially, the courts must establish parameters within which the proper standard of care may be determined. The test applied is generally referred to as the locality rule. The rule is established and the proper standard of care may be determined in a jurisdiction once the court decides upon the geographical locale from which to measure the standard.

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1. See McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549 (1959); Note, *Medical Malpractice-Expert Testimony*, 60 NW. L. REV. 834 (1966); Note, *Medical Specialties and the Locality Rule*, 14 STAN. L. REV. 884 (1962).
2. Kronke v. Danielson, 108 Ariz. 400, 499 P.2d 156 (1972) (where the rule was abandoned as to "specialists"); Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968) (where local practice within geographic proximity was reduced to being only one factor to be considered in determining the standard of care); Naccarto v. Grob, 384 Mich. 248, 180 N.W.2d 788 (1970); Carbone v. Warburton, 11 N.J. 418, 94 A.2d 680 (1953); Pederson v. Dumouchel, 72 Wash. 2d 73, 431 P.2d 973 (1967) (where local practice within geographic proximity was recognized as only one factor to be considered in determining the standard of care).
3. Dunham v. Elder, 18 Md. App. 360, 306 A.2d 568 (1973).
4. There are, however, some instances when expert testimony may not be required. See note 51 *infra*.

THE VARIOUS FORMS OF THE RULE

There are basically three variations of the locality test presently used in American courts. The most conservative test is the strict locality rule from which the similar locality rule and the national standard rule have developed.

Under the *strict locality rule*, in order to sufficiently demonstrate medical malpractice the plaintiff must produce testimony that the defendant did not adhere to the standard of care practiced by physicians of his specialty in his own locality.⁵ This rule was apparently first articulated in *Leighton v. Sargent*⁶ in 1853. The court stated that a physician who offers his services to the community contracts with his employer that he possesses that degree of skill, learning, and experience which is ordinarily possessed by other physicians and which is ordinarily regarded by the community as necessary and sufficient to qualify him to engage in such practice.⁷

Today, the *similar locality rule* is followed by a majority of the jurisdictions in this country.⁸ The rule states that the standard to which physicians are held is "that degree of skill and diligence employed by the ordinary, prudent practitioner in his field and community, or in a similar community at the same time."⁹

The leading case embracing the similar locality rule is *Small v. Howard*¹⁰ in which a physician in a small country village allegedly improperly treated a severe cut to the wrist. The jury charge included an instruction that:

The defendant, undertaking to practice as a physician and surgeon in a town of comparatively small population, was bound to possess that skill only which physicians and surgeons

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5. *Riley v. Layton*, 329 F.2d 53 (10th Cir. 1964); *Orange v. Shannon*, 284 Ala. 202, 224 So. 2d 236 (1969); *Wheeler v. Barker*, 92 Cal. App. 2d 776, 208 P.2d 68 (Dist.Ct.App. 1949) (an action for damages for an alleged technical assault arising out of an allegedly unauthorized surgical operation); *Ardoline v. Keegan*, 140 Conn. 552, 102 A.2d 352 (1954); *Geraty v. Kaufman*, 115 Conn. 563, 162 A. 33 (1932); *Dunham v. Elder*, 18 Md. App. 360, 306 A.2d 568 (1973); *Michael v. Roberts*, 91 N.H. 499, 23 A.2d 361 (1941); *Lockart v. Maclean*, 77 Nev. 210, 361 P.2d 670 (1961); *McCay v. Mitchell*, 62 Tenn. App. 424, 463 S.W.2d 710 (1970).
 6. 27 N.H. 460 (1853).
 7. *Id.* at 469. As in many cases in which the locality rule has been stated, the issue did not involve the use of the strict locality rule but, rather, whether more than ordinary care was required of a physician.
 8. See *Murphy v. Dyer*, 409 F.2d 747 (10th Cir. 1969); *Sinz v. Owens*, 33 Cal. 2d 749, 205 P.2d 3 (1944); *DiFilippo v. Preston*, 53 Del. 539, 173 A.2d 333 (1961); *Couch v. Hutchison*, 135 So.2d 18 (Fla. App. 1961); *Iterman v. Baker*, 214 Ind. 308, 15 N.E.2d 365 (1938); *Bartholomew v. Butts*, 232 Iowa 776, 5 N.W.2d 7 (1942); *Avery v. St. Francis Hosp. & School of Nursing, Inc.*, 201 Kan. 687, 442 P.2d 1013 (1968); *Wiggins v. Piver*, 276 N.C. 134, 171 S.E.2d 393 (1970); *Smith v. Yohe*, 412 Pa. 94, 194 A.2d 167 (1963); *Cavallaro v. Sharp*, 84 R.I. 67, 121 A.2d 669 (1956); *Reed v. Church*, 175 Va. 284, 8 S.E.2d 285 (1940); *Hundley v. Martinez*, 151 W.Va. 977, 158 S.E.2d 159 (1967).
 9. *Whitfield v. Whittaker Memorial Hosp.*, 210 Va. 176, 183, 169 S.E.2d 563, 568 (1969), *cit-ing Reed v. Church*, 175 Va. 284, 292, 8 S.E.2d 285, 288 (1940) (emphasis added).
 10. 128 Mass. 131 (1880).

of ordinary ability and skill, *practicing in similar localities*, with opportunities for no larger experience, ordinarily possessed; and he was not bound to possess that high degree of art and skill possessed by eminent surgeons practicing in large cities, and making a specialty of the practice of surgery.¹¹

The defendant, practicing in Chelmsford, Massachusetts, a town of about 2,500, maintained a general practice and performed only minor surgery. The severity of the plaintiff's wound required a high degree of surgical skill. An eminent surgeon resided within four miles. Although treatment lasted ten days, the defendant did not direct the plaintiff to visit this other surgeon. The plaintiff sought to hold the defendant to a higher standard than the average practiced in the Commonwealth.¹²

The court relied on a contract theory in deciding that a surgeon only represents that he possesses that skill "ordinarily possessed by others of his profession."¹³ The court emphasized that it was common knowledge that small country village physicians were not specialists in surgery and that the defendant here, a small-village physician, could not be held to a standard represented by eminent surgeons in large cities.¹⁴

Rejecting these various forms of the locality rule, several courts have recently announced that variations in standards of medical care based on these tests are no longer valid, thereby adopting a *national test*.¹⁵ The rationale of the national standard cases is that with the advancements of modern medicine, communication, and transportation, the time for judging physicians in one area differently from those in others has passed. "The time has come when the medical profession should no longer be Balkanized by the application of varying geographic standards in malpractice cases."¹⁶

The emerging test appears to be simply whether the defendant failed to use that care and skill generally exercised in the profession¹⁷ or that differing local practices become merely a factor for the jury to consider.¹⁸ Some courts have approached the problem piecemeal, indicating that with respect to certain medical procedures¹⁹ or the duty owed by a hospital to a patient,²⁰ national standards have

11. *Id.* at 132.

12. *Id.* Again, the issue was not the application of a locality rule but, rather, whether the standard to be applied was average care or better than average care.

13. *Id.* at 135.

14. *Id.* at 136.

15. See cases cited note 2 *supra*.

16. *Brune v. Belinkoff*, 354 Mass. 102, 108, 235 N.E.2d 793, 798 (1968).

17. See *Carbone v. Warburton*, 11 N.J. 418, 425, 94 A.2d 680, 683 (1953).

18. *Brune v. Belinkoff*, 354 Mass. 102, 109, 235 N.E.2d 793, 798 (1968).

19. See *Couch v. Hutchison*, 135 So. 2d 18 (Fla. Dist. Ct. App. 1961), in which an expert from Philadelphia was competent to testify as to the negligent performance of a laminectomy and spinal disc fusion by a surgeon in Florida, on the basis that the defendant's performance of the operation was in a manner having national recognition and that there was no other physician in Florida of the defendant's specialty.

20. See *Kapuschinsky v. United States*, 248 F. Supp. 732 (D.S.C. 1966), in which a nonlocal expert was permitted to testify as to the cause of a staph infection contracted by an infant in the defendant hospital and the duty of the hospital to prevent such infections.

developed. Others have stated that, at least in urban settings, a national standard for medical malpractice has developed.^{2 1}

THE MARYLAND RULE

In 1973, the Maryland Court of Special Appeals took another look at Maryland's application of the locality rule in *Dunham v. Elder*.^{2 2} The court, noting the long tradition in Maryland for enforcement of the strict locality doctrine, re-affirmed past appellate judicial pronouncements as to its status in Maryland courts.

The *Dunham* case arose out of an incident of alleged malpractice in Prince George's County in 1967. The defendant, a general practitioner in Prince George's County, had diagnosed Charles Dunham as having gout, and prescribed a drug named Benemid. The plaintiff later developed a nephrotic syndrome, inflammation of the kidneys, and it was thereafter discovered that he had never been afflicted with gout but was actually suffering from arthritis. Benemid can cause nephrotic syndrome, and, when the drug is used, periodic tests for uric acid crystals and protein in the urine are performed to determine whether there is any kidney effect.^{2 3} The plaintiff alleged that the doctor had fallen below the standard of care for two reasons, namely, negligence in the misdiagnosis of the defendant's initial complaint and negligence in the misuse of Benemid.

The plaintiff produced two experts at trial, a urologist at George Washington University in Washington, D.C., who had never practiced in Maryland, and an orthopedic surgeon from New York who had been a general practitioner in the District of Columbia from 1925 until 1928.^{2 4} Neither of the plaintiff's medical witnesses was allowed to testify at trial as an expert on the standard of care employed by a general practitioner from Prince George's County. The trial court ruled that they lacked the requisite qualifications for testifying as to that standard of care. The Circuit Court for Prince George's County, therefore, directed a verdict for the defendant on the basis that the plaintiff could not establish a standard of care for a general practitioner

21. *Naccarato v. Grob*, 384 Mich. 248, 180 N.W.2d 788 (1970), where specialists from Chicago and Los Angeles were permitted to testify as to the standard of care for pediatricians in Detroit. The court stated:

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. Rather his knowledge is a specialty. He specializes so that he may keep abreast. Any other standard for a specialist would negate the fundamental expectations and purpose of a specialty. The standard of care for a specialist should be that of a reasonable specialist practicing medicine in light of present day scientific knowledge. Therefore, geographical conditions or circumstances control neither the standard of a specialist's care nor the competence of an expert's testimony.

Id. at 253-54, 180 N.W.2d at 791.

22. 18 Md. App. 360, 306 A.2d 568 (1973).

23. Brief for Appellant at 5.

24. 18 Md. App. at 365-66, 306 A.2d at 571-72.

in that county in 1967, against which standard the defendant could be measured.²⁵

In affirming, the Court of Special Appeals indicated some dissatisfaction with the strict locality rule, but accurately interpreted prior Maryland cases as requiring its application.²⁶ The court noted that the strict locality rule was now utilized in only a distinct minority of the states, and that since the dissemination of medical information had become quicker and treatment more uniform, a trend had developed toward allowing experts from other localities to testify as to what standard a defendant should have observed. If the issue had been one of first impression, the court "might have been persuaded to adopt the similar locality rule."²⁷ However, the court correctly recognized that the issue was not one of first impression and reaffirmed the strict locality rule. The opinion is a classic example of the court's proper adherence to *stare decisis*. Besides the historical validity for the *Dunham* decision,²⁸ there is, more importantly, sound medical justification for the decision, as will be demonstrated.

THE HISTORY OF THE RULE IN MARYLAND

The cases are not without exception in representing a tradition of strict locality in Maryland, and the earliest cases display some inconsistency. In *State ex rel. Janney v. Housekeeper*,²⁹ one of the earliest medical malpractice cases in this jurisdiction, the court stated that it was the duty of the physician to exercise "ordinary care and skill."³⁰ The following defendant's prayer was granted: "[T]he degree of care and skill required is that reasonable degree of care and skill which physicians and surgeons ordinarily exercise in the treatment of their patients . . ."³¹ Apparently, the defendant requested this prayer rather than a more restrictive locality prayer. The fact that plaintiff's expert may have been a local Harford County physician may explain the absence of mentioning the locality rule.

As early as 1896 in *Dashiell v. Griffith*,³² a prayer was given which stated the locality rule in terms strikingly similar to those used by the *Dunham* court:

If the jury find . . . that [plaintiff's] finger was subsequently

25. *Id.* at 362, 306 A.2d at 570.

26. *Id.* at 365, 306 A.2d at 571.

27. *Id.*

28. *Id.* at 363-64, 306 A.2d at 570-71, citing *Kruszewski v. Holz*, 265 Md. 434, 290 A.2d 534 (1972); *Nolan v. Dillon*, 261 Md. 516, 276 A.2d 36 (1971); *Johns Hopkins Hosp. v. Genda*, 255 Md. 616, 258 A.2d 595 (1969); *Suburban Hosp. Ass'n v. Mewhinney*, 230 Md. 480, 187 A.2d 671 (1963); *State ex rel. Solomon v. Fishel*, 228 Md. 189, 179 A.2d 349 (1962); *Lane v. Calvert*, 215 Md. 457, 138 A.2d 902 (1958).

29. 70 Md. 162, 16 A. 382 (1889).

30. *Id.* at 171, 16 A. at 384.

31. *Id.* at 172, 16 A. at 384.

32. 84 Md. 363, 35 A. 1094 (1896).

amputated, and said amputation was rendered necessary by the want of reasonable skill, care and diligence in the treatment of said finger and of the said plaintiff, as is usually exercised by physicians and surgeons in good standing *in the defendant's school of practice in this locality*, then their verdict must be for plaintiff.³³

The court stated that permitting expert opinion, contrary to the traditional rule,³⁴ would be less objectionable if strictly construed by inclusion of a local standard charge. Thus, by 1896, strict locality was the recognized rule in this state.

Later cases have sometimes been misread as not being supportive of the strict locality rule, but upon close scrutiny it is discovered that they do not encroach upon the rule's tradition. For example, in *Lane v. Calvert*,³⁵ which described the standard in terms of "the profession," locality was not at issue before the court, plaintiff's expert being from defendant-physician's community. Also, in *Johns Hopkins Hospital v. Genda*,³⁶ which stated the rule in terms of "cases of this kind,"³⁷ the locality rule was specifically set forth in the charge to the jury.³⁸

Five Maryland Court of Appeals cases,³⁹ all recent, have cited the strict locality rule as the standard in Maryland. The reason for the locality rule pronouncement in these cases appears to have been to emphasize that physicians are not required to exercise more than ordinary care in their locality and are not to be held to have the skills of some specialty other than their own. However, occasional lapses in the application of the locality rule have occurred in trial courts in spite of the rule's integrity at the appellate level.

In *State ex rel. Solomon v. Fishel*⁴⁰ the appellees (defendants at trial) argued in their brief that the case should not have gone to the jury despite the fact that the verdict was in their favor because the plaintiff's expert, a New York physician, was not qualified to express an opinion

33. *Id.* at 364 (emphasis added).

34. In earlier cases the rule allowing experts to give opinions was somewhat disfavored as being a departure from the common law tradition of testimonial knowledge. See generally 7 J. WIGMORE, A TREATISE ON THE ANGLO-AMERICAN SYSTEM OF EVIDENCE ON TRIALS AT COMMON LAW § 1917 (3d ed. 1940).

35. 215 Md. 457, 138 A.2d 902 (1958).

36. 255 Md. 616, 258 A.2d 595 (1969).

37. *Id.* at 620, 258 A.2d at 598.

38. Record at 172.

39. *State ex rel. Solomon v. Fishel*, 228 Md. 189, 179 A.2d 349 (1962), the earliest of the five cases, stated that the question was whether or not the defendant failed to exercise the care "generally exercised in the community (the City of Baltimore) [sic] in which he was practicing by doctors engaged in the same field," citing *Lane*. *Nolan v. Dillon*, 261 Md. 516, 276 A.2d 36 (1971) also cites and quotes from *Lane* as to the standard without mentioning locality but goes on to say that plaintiff's expert testified that defendant did not meet the standard in the community (Montgomery County). In a case dealing with malpractice by an optometrist, the court stated that the standard was that "exercised generally in the community." *Tempchin v. Sampson*, 262 Md. 156, 277 A.2d 67 (1971) (emphasis added), citing *Fisel*, *Genda* and *Lane*. See *Kruszewski v. Holz*, 265 Md. 434, 290 A.2d 534 (1972); *Thomas v. Corso*, 265 Md. 84, 288 A.2d 379 (1972), citing *Genda*.

40. 228 Md. 189, 179 A.2d 349 (1962).

on the standard of care in Baltimore.⁴¹ The Court of Appeals found it unnecessary to address itself to the admission of the out-of-state expert's testimony in affirming the decision of the lower court. The court did, however, explicitly state the strict locality rule in its opinion.

In *Nolan v. Dillon*,⁴² there was no locality problem. The alleged malpractice took place in Wheaton, Maryland and the defendant practiced in the general District of Columbia metropolitan area.⁴³ One expert practiced in Bethesda and two others in Silver Spring.⁴⁴ Nevertheless, the court's instruction to the jury included a classic strict locality charge:

You are instructed that the standard of care to which the Defendant physician is required to adhere in the practice of his profession is only that he exercise ordinary and reasonable care and skill in the treatment of patients, that is to say, he is not by law required to exercise any care or skill of a special character which exceeds that ordinarily and customarily . . . employed by physicians *in the same type of practice in the community*, and therefore should you find that the Defendant doctor used ordinary and reasonable care and did not depart from accepted standards and practices of that field in the community . . . you should return a verdict for the Defendant.⁴⁵

The trial judge in *Kruszewski v. Holz*⁴⁶ also referred, in instructions, to the standard of care in the community, Frederick County.⁴⁷ The plaintiff's expert had practiced in Florida for nineteen years and had never practiced in Maryland,⁴⁸ yet he was permitted, over objection, to answer questions about the standard of care.⁴⁹ Nevertheless, the jury returned a verdict in favor of the defendant. Consequently, the locality problem was moot on appeal. It is significant to note, however, that the Court of Appeals elected to consider this matter in dicta. Therein, they stated: "[a]t trial both sides agreed, as they should, that Dr. Holz [defendant] was required to adhere to the same standard of care in treating his patients as was practised by other physicians engaged in the specialty in the community."⁵⁰ The question of the qualification of plaintiff's expert was not raised at the appellate level.

41. Brief for Appellant at 4, 26.

42. 261 Md. 516, 276 A.2d 36 (1971).

43. Brief for Appellant at 3, 5.

44. Record at 53, 118, 172.

45. *Id.* at 298 (emphasis added).

46. 265 Md. 434, 290 A.2d 534 (1972).

47. Record at 54, 55.

48. *Id.* at 12, 13.

49. *Id.* at 13, 14. The complication in *Kruszewski* was that during a routine hysterectomy, the defendant physician placed a suture through the patient's bladder, later causing a fistula (a passage between one internal cavity and another) and leakage of urine through the vagina. This was not recognized during the primary surgery and required multiple subsequent operative procedures to correct. The plaintiff's expert was allowed to answer questions about what was the standard required as to informing the patient of the risks of surgery and as to recognition and correction of the complication.

50. 265 Md. at 438, 290 A.2d at 537.

Investigation of the records and briefs in other Maryland medical malpractice cases further reveals a faithfulness to the strict locality rule tradition.^{5 1} Thus, Maryland through the years has shown an adherence to the strict locality rule.

PRACTICAL ASPECTS OF THE LOCALITY RULE

In addition to the legal tradition, there are important and vital reasons for the strict locality rule found in the medical profession itself. Since, in Maryland, it is generally necessary to present expert testimony as to what is the standard of care, that defendant failed to adhere to that standard, and that such failure proximately caused plaintiff's injuries,^{5 2} the effect of the locality rule is to require plaintiffs to obtain experts who practice in the defendant's community. The strict locality rule has been used several times since *Dunham* to prevent out-of-state physicians from qualifying to testify as to the standard of care required in the defendant's community.^{5 3}

It has been argued that the locality rule places an undue burden on

51. In *Lane v. Calvert*, 215 Md. 457, 138 A.2d 902 (1958), the plaintiff's expert was one of the treating physicians. There was no reference to local standards since the expert was obviously qualified in the locality. Record at 16-26.

In *Suburban Hosp. Ass'n v. Mewhinney*, 230 Md. 480, 187 A.2d 671 (1963), a local expert was asked first to assume the locality of Montgomery County in a hypothetical question, and then was asked whether the defendant's care in diagnosing a severed tendon adhered to the "accepted methods of practice in this State." Record at 28. The judge's charge to the jury included no reference to locality, no such reference being necessary. The standard enunciated by the judge therein was "such care as ordinarily exercised by others in the profession generally" Record at 52.

The trial court's instructions in *Johns Hopkins Hosp. v. Genda*, 255 Md. 616, 258 A.2d 595 (1969) referred to the locality (Baltimore City). The judge noted in his jury instruction that "if you [the jury] . . . find . . . that in so doing [referring to defendant's actions] he failed to use that degree of care and skill possessed by ordinary skillful surgeons in this locality under similar circumstances; then your verdict should be for the plaintiffs." Record at 172 (emphasis added).

52. See, e.g., *Baulsir v. Sugar*, 266 Md. 390, 293 A.2d 253 (1972); *Johns Hopkins Hosp. v. Genda*, 255 Md. 616, 258 A.2d 595 (1969).

There are a few exceptional cases in which expert testimony may not be required. See generally *Thomas v. Corso*, 265 Md. 84, 97-98, 288 A.2d 379, 387-88 (1972), quoting from *Central Cab Co. v. Clark*, 259 Md. 542, 551-52, 270 A.2d 662, 667-68 (1970), wherein it was noted that such a situation exists when a dentist accidentally pulls a wrong tooth, *McClees v. Cohen*, 158 Md. 60, 148 A.2d 124 (1930), or when a physician should amputate a wrong limb, an obviously negligent act, *Rural Educ. Ass'n v. Bush*, 42 Tenn. App. 34, 298 S.W.2d 761 (1956) and *Fredrickson v. Maw*, 119 Utah 385, 227 P.2d 772 (1951). The rationale for the non-necessity of an expert witness was stated in *Butts v. Watts*, 290 S.W.2d 777, 779 (Ky. 1956) wherein it was held: "There is a limitation on the rule that expert testimony is essential to support a cause of action for malpractice where the common knowledge or experience of laymen is extensive enough to recognize or infer negligence from the facts."

53. *Royster v. Beck*, C.A. No. 70-1478-N (D. Md., Oct 23, 1973); *Shilkret v. Monias*, Law No. C-5479 (Anne Arundel County Cir. Ct., Oct. 9, 1973); *Waters v. Smith*, 90/43/77005 (Baltimore County Cir. Ct., Oct. 30, 1973) (mistrial upon anticipation of *Dunham* being applied); *Estep v. Tadalán*, C-4378/63/153 (Howard County Cir. Ct., Nov. 1, 1973); *Raitt v. Montague*, Law No. 37367 (Montgomery County Cir. Ct., Jan 31, 1974).

plaintiffs for at least two reasons: (1) that there is "a conspiracy of silence" on the part of doctors in the same community not to testify against one another, thus forcing plaintiffs to go out of the community in order to find a physician willing to testify;⁵⁴ and (2) that the locality rule may perpetuate a substandard practice simply because it is generally accepted in the area.

Competent physicians today, however, still differ greatly as to what they consider to be proper care and treatment of various medical conditions, injuries, and sicknesses, just as legal experts may differ greatly on issues of importance to the legal community.⁵⁵ Some courts have recognized this characteristic of the medical profession and have held that as long as there is an honest dispute as to the proper course of treatment, and the defendant chooses one of the disputed courses, he cannot be held liable for a bad result therefrom.⁵⁶ This proposition, of course, is well established in general tort law,⁵⁷ and the medical profession should not be excepted from its consistent application.

Consider the physician's dilemma upon being presented with the following controversy over the use of Chloramphenicol in the treatment

54. Some courts have mistakenly paid lip service to the "conspiracy of silence" contention. See *L'Orange v. Medical Protective Co.*, 394 F.2d 57 (6th Cir. 1968); *Christie v. Callahan*, 124 F.2d 825 (D.C. Cir. 1941); *Kapuckinsky v. United States*, 248 F. Supp. 732 (D.S.C. 1966); *Sampson v. Veenboer*, 252 Mich. 660, 234 N.W. 170 (1931); *Johnson v. Winston*, 68 Neb. 425, 94 N.W. 607 (1903); *Carbone v. Warburton*, 11 N.J. 418, 94 A.2d 680 (1953). See generally *Belli, Ready For the Plaintiff*, 30 TEMP. L.Q. 408 (1957); *Belli, An Ancient Therapy Still Applied: The Silent Medical Treatment*, 1 VILL. L. REV. 250 (1956).

Experience in Maryland indicates no such conspiracy exists. Numerous cases have been presented to juries with support for the plaintiff from local physicians. See, e.g., *Balsir v. Sugar*, 266 Md. 390, 293 A.2d 253 (1972); *Itwin v. Dorman*, 1-089079-106-74 (Baltimore City Ct., May 18, 1972); *Edge v. Reinhoff*, 80221/93/75 (Baltimore County Cir. Ct., May 6, 1971) (the "Bailey Goss" case).

The allegation by plaintiff's counsel of a "conspiracy of silence" is really an indication that they have no case. Not every medical complication is the product of negligence. The lip service paid such a contention by the courts is tantamount to holding that every red light case should have an independent witness *on each side* or that there is a conspiracy going on to defeat plaintiffs in red light cases. We have never seen a meritorious case against a physician want for a local expert.

55. See *In re Subpoena to Nixon*, 360 F. Supp. 1 (D.D.C. 1973), in which two prominent legal scholars argued the opposing sides of constitutional separation of powers.

56. *Haase v. Garfinkel*, 418 S.W.2d 108 (Mo. 1968); *Ball v. Mallinkrodt Chem. Works*, 53 Tenn. App. 218, 381 S.W.2d 563 (1964). In *Ball*, the plaintiff had chronic high blood pressure for which she was hospitalized for nearly six months without a successful determination of the cause. She then submitted to the performance of a translumbar aortogram by the defendant physician, in which procedure a dye-like agent (here Urokon 70) is injected into the aorta, permitting the taking of X-rays of the arteries to locate possible obstructions. The patient experienced immediate pain and, later, partial paralysis caused by some of the solution escaping outside the aorta. Defendants testified that in five to ten percent of the cases, in spite of the utmost care, some of the solution escapes, rarely causing permanent damage. Urokon 70 was known to have a toxic effect, but was used by about 50 percent of the physicians performing aortograms and provided better X-rays than less toxic agents. The court found that the defendant physician's choice of Urokon 70, combined with the fact that the procedure was only used in extreme cases where all else failed, was not negligent.

57. W. PROSSER, *TORTS* 168-70 (4th ed. 1971).

of a patient with an infection.^{5 8} The opinions of experts vary from the view that the drug should never be used^{5 9} to the view that it can be used quite safely.^{6 0}

Assume that X, suffering from a gunshot wound to the stomach and acute peritonitis,^{6 1} an infection of the abdominal membrane enclosing the intestines, is brought to the emergency room of a local hospital where Chloramphenicol is used. Chloramphenicol is administered, and the infection is controlled. Aplastic anemia, failure of the bone marrow to manufacture blood cells, later develops, causing the death of X. X's family then sues the treating physician presenting at trial an out-of-state expert who testifies that the standard of care is that Chloramphenicol has been known to have the dangerous side effect of causing aplastic anemia and that it should not be used at all. The defendants present testimony from local experts who contend that no causal relationship has been established between the use of Chloramphenicol and aplastic anemia, and that the local standard of care required the administration of Chloramphenicol to control X's acute peritonitis. A jury of laymen would pass judgment on this esoteric medical controversy.^{6 2}

This example demonstrates the intolerable burden placed on the individual physician by any rule other than strict locality. In considering whether to administer Chloramphenicol he must consider not only the drug itself, its possible complications, and its appropriateness for the particular case, but also the effect of his acts before a jury. If he does not use Chloramphenicol, local experts might testify against him if the peritonitis is not controlled; if he does use the drug, non-local experts might testify as to the drug's potential harmful effects.

The Massachusetts case which abandoned that state's locality rule^{6 3} further demonstrates the physician's dilemma. There, the defendant was delivering a baby in a hospital in New Bedford, Massachusetts in accordance with the method used in that community.^{6 4} An 8 mg. dose of spinal anesthesia, the standard dosage in New Bedford for this

58. See AMA DRUG EVALUATIONS 551 (2d ed. 1973); Bloom & Grillo, *The Influence of Tetracycline and Chloramphenicol on the Healing of Cutaneous Wounds*, 10 J. SURG. RES. 1 (1970); Caulfield & Burke, *Inhibition of Wound Healing by Chloramphenicol*, 92 ARCH. PATHOL. 119 (1971); Wallenstein, Conduit, Kasper, Brown & Morrison, *Statewide Study of Chloramphenicol Therapy and Fatal Aplastic Anemia*, 208 J.A.M.A. 2045 (1969); *Special Report: Should Chloramphenicol Be Used at All?*, 1 MED. J. AUST. 928 (1971).

59. *Special Report*, *supra* note 58, concludes, based on a statistical study of the increase in occurrence of fatal aplastic anemia (failure of the bone marrow to produce blood) among people to whom chloramphenicol had been administered, that the drug should not be prescribed for the treatment of undiagnosed severe infections.

60. Bloom, *supra* note 58, concludes that chloramphenicol may be safely used on surgical patients without adversely affecting the healing of wounds.

61. Acute peritonitis is frequently caused by a penetrating wound to the intestine. It can be fatal in a matter of hours.

62. For a local case involving the use of chloramphenicol, see *Leonig v. Parke, Davis*, Law No. 2759 (Calvert County Cir. Co., Jan. 21, 1972) (dismissed) (subsequently settled).

63. *Brune v. Belinkoff*, 354 Mass. 102, 235 N.E.2d 793 (1968).

64. "Suprafundi pressure" or pressure applied to the uterus during delivery.

method of delivery was administered. Eleven hours later, while attempting to get out of bed the plaintiff slipped and fell as a result of the numbness and weakness in her left leg. The testimony indicated that the 8 mg. dose caused the leg condition which persisted for some time thereafter.

Experts from New York and Boston testified that only 5 mg. of anesthesia was the proper dosage and should be the standard in such a case. The trial court, adhering to the Massachusetts same or similar locality rule, betrayed some disdain for it in stating that even if the standard in New Bedford were 50% inferior to that in Boston, nevertheless, the defendant's actions would have to be measured against the New Bedford standard. The suggestion that the locality rule allowed an inferior practice to continue may have been an invitation to Massachusetts' highest court to overturn the rule. The result for the doctor was the worst possible. If he had used 5 mg. of anesthesia, the non-local dosage, and the plaintiff had experienced considerable pain or other complications, local experts would have assured his liability under the Massachusetts locality rule. Having complied with the local standards, and existing legal doctrine, he was still found liable on the basis of non-local or "non-similar" community testimony. The result is that the individual doctors act at their own peril in areas of medical controversy, leaving to the whims of juries the highly sophisticated decision of which practice is best for the patient.

The rationale advanced for dispensing with the locality rule by the Massachusetts court was that the rule allowed "Balkanization" of the medical profession.⁶⁵ This rationale is based on an assumption, demonstrably false, that the medical profession does not diligently pursue solutions to its own controversies,⁶⁶ and that allowing juries to decide what standard of care is applicable will somehow nationally elevate the standards of the medical profession. Allowing non-local or "non-similar" community testimony could just as easily have the opposite effect. There being geographical deviations in medical practice, the non-local or "non-similar" community testimony may in some cases represent inferior practice. Confusion on the part of doctors as to which standards will be applied to them, and the unfairness of exposing them to liability whatever standard they choose, could be the only result. That the medical profession diligently pursues its own betterment, and that it is more competent at doing so than juries of laymen, is unquestionable.

The strict locality rule, by no means, makes it unduly burdensome for plaintiffs to present expert testimony in medical malpractice cases. The "localities" to which the standards have been applied in Maryland have always been large enough to include numerous physicians of the

65. 354 Mass. at 108, 235 N.E.2d at 798.

66. A cursory perusal of *Index Medicus*, the medical equivalent of the *Index to Legal Periodicals* would be enough to dispel any thought that there are not a multitude of controversies in many areas of medical care which are vigorously pursued throughout medical literature.

defendant's specialty.⁶⁷ The "conspiracy of silence" has not prevented plaintiffs from obtaining local expert testimony in numerous Maryland cases.⁶⁸

The argument has been made that with the great advancements in communications and transportation, standards of medical care are uniform throughout the country so that there is no reason for the application of the strict locality rule.⁶⁹ If indeed the standards are national, there then should be no difficulty in proving that standard through testimony from local physicians. The wisdom of the locality rule is that where there are no such national standards, as indeed is often the case, a physician will not be injured by being required to make the Hobson's choice, either one of which may expose him to liability, but only one of which would be pursuant to accepted standards of practice in his community. The contention that National Boards and Board Certification is evidence of a national standard is an inappropriate application of Board Certification to standard of care. The various specialty boards were created by the medical profession for the purpose of *advancing* the standards of medical care, not for *establishing* those standards. One is Board Certified for the purposes of qualifying to set a standard. It is the physician operating in his specialty, in his own community, who sets the standard, not the National Boards.

There is also the danger to the consumer public that an application of some fictitious national standard will further aggravate the cost of medical care by the practice of defensive medicine. A few physicians today do certain tests and carry on certain diagnostic studies not because they really deem it essential to the best interest of the patient, but because they deem it essential to their protection against a potential malpractice suit.⁷⁰ If such defensive medicine is to be

67. See, e.g., *Nolan v. Dillon*, 261 Md. 516, 276 A.2d 36 (1971); *State ex rel. Solomon v. Fischel*, 228 Md. 189, 177 A.2d 349 (1962). Several early cases rejected the strict locality rule where there was only one doctor in the locality. See *Pelkey v. Palmer*, 109 Mich. 561, 67 N.W. 561 (1896); *McCracken v. Smathers*, 122 N.C. 799, 29 S.E. 354 (1898); *Bigney v. Fisher*, 26 R.I. 402, 59 A. 72 (1904). In today's highly urbanized setting, particularly in this jurisdiction, the likelihood of such a situation reoccurring is quite small.

68. See, e.g., *Baulsir v. Sugar*, 266 Md. 390, 293 A.2d 253 (1972); *Suburban Hosp. Ass'n v. Mewhinney*, 230 Md. 480, 187 A.2d 671 (1963); *Lane v. Calvert*, 215 Md. 457, 138 A.2d 902 (1958).

69. See *Brune v. Belinkoff*, 354 Mass. 102, 235 N.E.2d 793 (1968).

70. See *N.Y. Times*, Jan. 27, 1974, at 20, col. 3:

Defensive medicine is the ordering by a physician of many extra, expensive X-rays and other laboratory tests that doctors generally consider unnecessary except for legal self-protection. The practice also includes the refusal to treat high-risk patients.

. . . .

Doctors in such sensitive specialties as orthopedics, open heart surgery, brain surgery, neurology and plastic surgery whose work is subject to a high degree of criticism are paying up to \$20,000 a year for malpractice insurance [in California].

See generally HEW, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, HEW PUBLICATION NO. 73-88, ch. 2, which shows that medical malpractice claims in Maryland increased in 1970 by 22.8%, more than all other states except Tennessee and California. See also *Project: The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939.

proliferated by physicians being called on to adhere to some national standard, it is not unreasonable to visualize a physician doing many more tests and studies so that the cost of medical care becomes even more prohibitive. The thought that medical care should be nationalized in terms of its standards is an entirely stultifying concept. Advancements in medical science occur by virtue of isolated local achievements and studies and research. The validity of these studies is tested locally and it is not until they have recognition in their locality that they may later achieve adoption and a following elsewhere. In the presence of some national standard, it is possible that such local advancements will be discouraged for fear that to step in such a direction, away from the national standard, would subject the physician to a claim of malpractice. To conclude that National Boards create national standards, which clearly is not intended by the profession, would fetter medical practice rather than promote it.

CONCLUSION

There is adequate precedent for the Maryland courts to continue to apply the strict locality rule as was done in *Dunham* which is an exquisite example of judicial discipline. Also, besides the legal tradition, there is overwhelming justification for the locality rule within the medical profession. Plaintiffs have not been burdened in obtaining local experts when local standards of care are violated. The attempt to improve medical practices by the use of medical malpractice suits unjustifiably assumes that the medical profession does not diligently pursue its own improvement. Litigation is an ill-conceived substitute for the traditional scientific methods of improving the medical profession. Finally, the unfairness to physicians in subjecting them to possible liability under more than one standard or requiring them to choose among various methods of practice has a deleterious effect on the cost and quality of medical care.

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