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John K. Johnson, Jr.

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An Evaluation of Changes in the Medical Standard of Care

I. INTRODUCTION

When a layman is charged with negligence, his conduct is compared with the conduct to be expected from that familiar fictional person—the reasonable and prudent man under the same or similar circumstances.¹ The defendant's special knowledge or skill is only one of the circumstances to be considered; another is the customary practice of those similarly situated. In the field of medical negligence, however, the conduct of other physicians becomes extremely important. The standard of care to which doctors will be held is determined to a large extent by fellow practitioners. The standard of care for medical practitioners has been expressed as follows:

a reasonable . . . or ordinary degree of skill and learning; . . . commonly possessed and exercised by members of the profession . . . who are of the same school or system as the defendant . . . and who practice in the same or similar localities; . . . and exercise of the defendant's good judgment.²

This medical standard, like the reasonable and prudent man standard, is said to be objective. However, subjective elements, such as evaluations of expert opinion and mistake of judgment, are decided by the trier of fact.³

In malpractice cases expert testimony, directed toward the standard of care, is ordinarily required before the negligence issue is allowed to go to the jury.⁴ The expert medical witness requirement is peculiar to the medical malpractice case. Once the requirement is met, the jury is permitted to resolve conflicts of expert opinion and determine the proper standard of conduct.⁵

Although the articulated medical standard of care has remained basically unchanged, many courts have made significant alterations in the application of the standard. The purpose of this Note is to examine some of the existing court rules and their modifications pertaining to the medical standard of care. The areas of concentration are the locality rules, the medical custom standard, and the mistake of judgment defense. All three are particularly viable doctrines in the

1. See W. PROSSER, TORTS § 32, at 153 (3d ed. 1964); McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 558 (1959); RESTATEMENT (SECOND) OF TORTS §§ 295A, 299A (1965).

2. McCoid, *supra* note 1, at 559.

3. See I D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE ¶ 8.04, at 203 (1969).

4. See B. SHARTEL & M. PLANT, THE LAW OF MEDICAL PRACTICE § 3-16, at 130 (1959).

5. See F. HARPER & F. JAMES, TORTS § 17.1, at 968-69 (1956).

medical malpractice arena, and indications of change have appeared with respect to each. Such factors as better and more standardized medical training, advanced means of communication and transportation, and more knowledge of medical affairs on the part of laymen have been the basis for arguments in favor of change.

Although the three elements of the standard of care under consideration are discussed separately, they are interrelated to some extent. For example, a broadening of the locality rule necessarily affects the customary practice rule since the custom might be altered as the geographical boundaries are expanded; determination of whether there is an honest mistake of judgment rather than negligence will be affected by the applicable locality and customary practice rules.

II. LOCALITY RULE

The standard of care owed patients by medical practitioners has been consistently articulated with reference to the geographical area in which the physician practices. The original locality rule which set the standard as that in the practitioner's local community has been broadened in varying degrees.

A. *The Traditional Rule*

Under the original locality rule the physician's actions are measured exclusively by the standard of care evidenced by other physicians in the same locality.⁶ This rule was established by the courts in the early days because of the generally poor and diversified training that doctors received and because the country doctor, due to a lack of efficient means of transportation and communication, could not be expected to keep abreast of medical advances.⁷ The rural physician also lacked the sophisticated equipment available to his city brother. The logical basis of this rule, therefore, was not to require the county practitioner to meet the same standard of care as the city doctor who had access to a metropolitan hospital and its facilities for both treatment and learning. It should be noted that although some of these

6. See generally 1 MEDICAL MALPRACTICE VII-R-8 (S. Schreiber ed. 1967); W. PROSSER, *supra* note 1, at 166-67; RESTATEMENT, *supra* note 1, § 299A, comment g, at 75; McCoid, *supra* note 1, at 569.

7. *E.g.*, *Small v. Howard*, 128 Mass. 131, 35 Am. R. 363 (1880). This often cited case justifies the locality rule on the basis of the rural conditions existing in the 19th century. It was recently overruled in *Brune v. Belinkoff*, 354 Mass. 102, 235 N.E.2d 793 (1968), discussed in text accompanying notes 56-57 *infra*.

same reasons might have been applicable to other professions, the locality rule has been used only with regard to the medical profession.⁸

The significance of the locality rule is apparent during the trial when the standard of care against which the physician's conduct will be measured must be established by another doctor. If the plaintiff is unable to present expert testimony that establishes the local standard from which the defendant's conduct deviated, a verdict will ordinarily be directed against him.⁹ If the case does go to the jury, the judge's instruction will indicate that the locality rule shall be applied.

Application of the "same locality" rule has resulted in two practical difficulties.¹⁰ First, there is the problem of securing physicians from the same locality who are qualified and willing to testify about the local standard of care. Secondly, there is the concern that a small group of doctors can, by their carelessness, establish an inferior local standard of care. Nevertheless, a number of states still follow the "same locality" rule, and the country doctor remains well protected.¹¹

B. Expansion to a Similar Locality

Some courts have indicated that the "same locality" rule is too restrictive. In these jurisdictions, the rule was broadened to one that measures the physician's conduct by the standard practice of physicians in the same or a similar locality or community.¹² Use of the "same or similar locality" rule reduces to some extent the difficulties presented by the "same locality" rule. When the plaintiff can look to other localities for expert witnesses he is more likely to find a physician who is willing to testify as to the standard of care because the expert would

8. With regard to lawyers, the courts usually speak of the ordinary or normal lawyer, and there is little reference to lawyers in a same or similar community. See Wade, *The Attorney's Liability for Negligence*, 12 VAND. L. REV. 755, 762-63 (1959). A reference to locality was made, however, in *Pitt v. Yalden*, 98 Eng. Rep. 74, 75 (K.B. 1767), where Lord Mansfield said that "they were country attorneys; and might not, and probably did not know that this point was settled here above."

See *Pederson v. Dumouchel*, 72 Wash. 2d 73, 431 P.2d 973 (1967), where the locality rule for physicians was specifically abolished. The court said, "Parenthetically, we note that the law of this jurisdiction has never recognized a difference in the professional competency of a lawyer in a small community from that of the professional competency required of a lawyer in a large city." *Id.* at 77, 431 P.2d at 977.

9. See B. SHARTEL & M. PLANT, *supra* note 4.

10. *Pederson v. Dumouchel*, 72 Wash. 2d 73, 77-78, 431 P.2d 973, 977 (1967), discussed in text accompanying notes 31-33 *infra*.

11. See 18 DEPAUL L. REV. 328, 332 n.13 (1968) for a list of states following the "same locality" rule.

12. *E.g.*, *Michael v. Roberts*, 91 N.H. 499, 23 A.2d 361 (1941). See 18 DEPAUL L. REV. 328, 332 n. 14 (1968) for a list of states following the "same or similar locality" rule.

not be testifying against a doctor from his own community. Nevertheless, the plaintiff is still greatly inconvenienced, initially, by having to determine what constitutes a similar locality, and then because there is reason to doubt that many doctors would be willing to testify even against a foreign locality doctor.¹³ The movement to the "same or similar locality" rule cannot be expected to alleviate the problem of low standard of care in small communities because the standard in similar localities is probably about the same. Despite its shortcomings, the "same or similar locality" rule is a slight improvement over the traditional "same locality" rule.

C. Criticism of the Locality Rule

Although the original reasons used to justify the locality rules might have been valid 50 to 100 years ago, there is no longer a lack of training opportunities and means of contact with other parts of the country. The quality of transportation has improved greatly, and there have been significant advances in the communications industry. New techniques and discoveries are available to all doctors within a short period of time through medical journals, closed circuit television presentations, special radio networks for doctors, tape recorded digests of medical literature, and current correspondence courses.¹⁴ Perhaps the most unique means of providing the rural doctor with the latest medical developments at a moment's notice was created this year in Alabama.¹⁵ The Medical College of Alabama in Birmingham created a consultation service, Medical Information Service via Telephone (MIST), which provides a 24-hour switchboard through which the calling doctor can be connected to a staff specialist in the area of inquiry. The country doctor from the most remote corner of the state can now receive free advice from highly qualified specialists. In addition to the advancements in means of communications, the quality of medical schools has been improved;¹⁶ a national accrediting system

13. W. PROSSER, *supra* note 1, at 167 & n.45.

14. See Harris, *Survey of Medical Communication Sources Available for Continuing Physician Education*, 41 J. MED. EDUC. 737 (1966); Orr, *The "Newer" Media for Post-Graduate Education—Their Promises and Problems*, 37 J. MED. EDUC. 137 (1962).

15. TIME, Oct. 10, 1969, at 72.

16. The early medical school curriculum consisted of a course of lectures over a period of 6 months. Sometimes this same course was taken for a second time for a total of 1 year of schooling. This formal education was supplemented by apprenticeships with doctors who had even less formal education. Young, *Medical Education in the United States*, 34 J. MED. EDUC. 802, 803 (1959). In 1910, Abraham Flexner conducted a survey and wrote a report on medical education. A. FLEXNER, *MEDICAL EDUCATION IN THE UNITED STATES AND CANADA: A REPORT TO THE CARNEGIE FOUNDATION FOR THE ADVANCEMENT OF TEACHING* (1910). This work had a

has led to greater standardization of medical schools throughout the country.¹⁷ Furthermore, all licensed physicians, theoretically at least, meet the minimum standards of knowledge and skill required by their respective state licensing boards.¹⁸ In view of these developments, it cannot reasonably be argued that any physician is isolated from centers of medical advancement.

The locality rules present unreasonable practical difficulties for the plaintiff, and the reasons for the rule's creation are no longer significant. Recognizing these deficiencies, some courts have diluted the locality rules and extended the geographical boundaries under certain circumstances. Recently a very few courts have even abandoned the locality rules altogether. A discussion of these steps toward the abolition of the locality rules follows.

D. *Toward Abandonment of the Locality Rules*

1. *Expert Witnesses from other Localities.*—It is well settled that in an action for negligence against a doctor the burden of proof is on the plaintiff to prove by expert testimony the applicable standard of care. Under locality rules this means the standard in the same or similar localities, and an expert from that locality is necessary to establish the standard. A few states, however, have expanded the standard by allowing the testimony of expert witnesses who are not from the same or similar locality. In *Sinz v. Owens*¹⁹ the California Supreme Court permitted the plaintiff's expert witness, who was from a different locality, to testify as to the applicable standard of care. The court indicated that the essential factor qualifying an expert is his knowledge of similar conditions; his geographical proximity to the place of the alleged negligence is just one factor in determining whether he qualifies.²⁰ The Georgia Court of Appeals extended this policy in

terrible effect on medical education, and radical changes were made to improve it. *See generally Medical Education in the United States*, 210 J.A.M.A. 1455 (1969).

17. Accreditation of medical schools in the United States began in 1906 under the AMA Council on Medical Education. Since 1942, accreditation has been controlled by the AMA's Liaison Committee on Medical Education and the Association of American Medical Colleges. In the academic year 1968-69 there were 99 American medical schools of which 85 were fully accredited 4-year schools granting the MD degree; 6 were accredited 2-year schools of basic medical sciences; and 8 were under development. *Medical Education in the United States*, *supra* note 16, at 1460. These figures should be compared with those compiled in 1907 when there were 160 medical schools of which only 82 were graded acceptable. Young, *supra* note 16, at 803.

18. *See Ruhe, Medical Licensure Statistics for 1967*, 204 J.A.M.A. 1067 (1968).

19. 33 Cal. 2d 749, 205 P.2d 3 (1949).

20. *Id.* at 756-57, 205 P.2d at 7. In this case the plaintiff's expert witness came from a smaller town which was within the trade territory of a larger town common to the defendant's locale.

Murphy v. Little,²¹ where the standard for treatment of fractures was held to be general and not local by pointing out the invalidity of the reasoning which underlies requiring local experts.²² Thus, according to these and other cases,²³ the fact that the expert witness does not practice in the same or a similar locality is no longer the significant factor in deciding whether or not he will be permitted to testify. He must show only knowledge of the standard of care that is applicable to the locality and medical problem involved.

It would be desirable if all courts would realize that their only concern should be with the witness's knowledge of the prevailing standard of care either in the defendant doctor's community, as in the *Sinz* case, or in the general practice of medicine, as in the *Murphy* case. There are still a large number of courts that either have not considered the question of the outside expert or have simply refused to weaken the locality rules in any way. They have categorically rejected the testimony of any doctor who comes from a different community.²⁴

There are two situations where the plaintiff's problem of establishing the standard of care by experts has been solved. In some areas the medical and bar associations have taken steps to aid

21. 112 Ga. App. 517, 145 S.E.2d 760 (1965).

22. *Id.* at 522, 145 S.E.2d at 764. It should be noted that Georgia has a statute, GA. CODE ANN. § 84-924 (1955), that prescribes a general standard rather than a local one to medical practitioners. This particular case involved the treatment of a fracture which is considered by some courts to be an elementary medical problem and, therefore, subject to a more general standard of care. *Murphy v. Little* is discussed in text accompanying notes 41-43 *infra*.

Wisconsin has a statute that permits any person who qualifies as a medical expert to testify on medical subjects. WIS. STAT. ANN. § 147.14(2)(b) (1957). In Alabama the common law rule of evidence permits the use of medical textbooks and treatises as a substitute for expert testimony. *Watkins v. Potts*, 219 Ala. 427, 122 So. 416 (1929). Massachusetts and Nevada have statutes to this effect. MASS. ANN. LAWS ch. 233, § 79C (Supp. 1968); NEV. REV. STAT. § 51.040 (1967).

23. In *Riley v. Layton*, 329 F.2d 53 (10th Cir. 1964), the treatment was for a broken arm and a physician from San Francisco qualified to testify as to the standard of care in a small Utah town. In *Montgomery v. Stary*, 84 So. 2d 34 (Fla. 1955), the alleged negligent conduct was that the defendants so severely scalded and burned an infant's hand that the fingers and thumb had to be amputated. Three Chicago doctors were permitted to testify over the objections by the defendants that they were not familiar with the standard in the same or similar localities. In *Teig v. St. John's Hosp.*, 63 Wash. 2d 369, 387 P.2d 527 (1963), another broken bone case, the plaintiff's expert from Portland qualified to testify as to the standard of care in a town 50 miles away. In *Hundley v. Martinez*, 151 W. Va. 977, 158 S.E.2d 159 (1967), a case involving a cataract operation by the specialist defendant, an outside expert was allowed. It should be noted that the fact situations in the above cited cases subject them to broader standards because they deal with elementary medical problems, discussed in text accompanying notes 41-46 *infra*, and specialists, discussed in text accompanying notes 47-55 *infra*. Cf. text accompanying note 24 *infra*.

24. *Lockhart v. Maclean*, 77 Nev. 210, 361 P.2d 670 (1961). A comment on this case appears in 14 STAN. L. REV. 884 (1962). See also *Ramsland v. Shaw*, 341 Mass. 56, 166 N.E.2d 894 (1960); *Vcrsteeg v. Mowery*, 72 Wash. 2d 754, 435 P.2d 540 (1967).

deserving plaintiffs who are unable to obtain expert witnesses. Under such circumstances a panel of qualified and impartial experts examine the plaintiff's allegations and agree to testify for him if a finding of negligence is made.²⁵ There are other situations where the jury is allowed to infer negligence without the aid of an expert.²⁶ This occurs when the doctor's conduct can be evaluated by the jury because it is thought to be within the common knowledge of laymen.

Our system of compensation for injuries caused by negligence is undermined by doctors who refuse to testify against each other. If an expert is qualified and demonstrates knowledge of the applicable standard, he should not be barred from testifying simply because he happens to live in another community.

2. *Accessibility of Resources.*—Another approach utilized to dilute the locality rules has been to extend the geographical boundaries to include those centers that are readily accessible for appropriate treatment of the patient. This expanded rule has been articulated in terms of a "medical neighborhood" or the "medical locality rule."²⁷

The rationale behind extending the geographical boundaries was expressed in 1940 by the Supreme Court of North Dakota in *Tvedt v. Haugen*,²⁸ a case involving the negligent treatment of a complicated bone fracture by a small-town practitioner whose defense was that he did not have an adequate X-ray machine. The court rejected this defense and pointed out that the defendant was familiar with and had access to more expert advice and facilities located in nearby towns.²⁹ One year later on similar facts in *Flock v. J.C. Palumbo Fruit Co.*,³⁰ the Supreme Court of Idaho followed and quoted the language of *Tvedt*.

25. See SPECIAL COMMITTEE OF THE ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK, IMPARTIAL MEDICAL TESTIMONY (1956).

26. *Id.* For example, the medical practitioner might have cut off the wrong leg, pulled the wrong tooth, or burned an arm while operating on a toe. See *Scardina v. Colletti*, 63 Ill. App. 2d 481, 211 N.E.2d 762 (1965), where the court said: "The so called 'common knowledge' and 'gross negligence' exceptions to the requirement of expert testimony are applicable if the negligence of the physician is so grossly apparent or the treatment is such a common occurrence that a layman would have no difficulty in appraising it." *Id.* at 488, 211 N.E.2d at 766. See also F. HARPER & F. JAMES, TORTS § 17.1, at 968 (1956); Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147, 1165 (1942); Note, *Malpractice and Medical Testimony*, 77 HARV. L. REV. 333 (1963); Comment, *Medical Malpractice—Expert Testimony*, 60 NW. U.L. REV. 834 (1966).

27. *E.g.*, *Geraty v. Kaufman*, 115 Conn. 563, 162 A. 33 (1932). The court held that the medical neighborhood was wide enough to include both New London and New Haven.

28. 70 N.D. 338, 294 N.W. 183 (1940).

29. *Id.* at 349, 294 N.W. at 188.

30. 63 Idaho 220, 238, 118 P.2d 707, 714-15 (1941); *accord*, *Hodgson v. Bigelow*, 335 Pa. 497, 7 A.2d 338 (1939).

In the recent case of *Pederson v. Dumouchel*,³¹ the Supreme Court of Washington abolished the locality rule. The court, holding that instructing the jury that the medical standard of care is based on the practice of other physicians in the same or similar locality was reversible error, declared: "The 'locality rule' has no present-day vitality except that it may be considered as *one* of the elements to determine the degree of care and skill which is to be expected of the average practitioner"³² Thus the Washington court joined the ranks of those that have embraced the medical neighborhood doctrine by stating that the standard of care "is that established in an area coextensive with the medical and professional means available in those centers that are readily accessible for appropriate treatment of the patient."³³

The effect of these decisions is that some courts will not be bound by artificial geographical boundaries but will apply the standard of care of the superior medical locality proven by the plaintiff to be readily accessible. The adoption of this standard entails, of course, the rejection of the antiquated locality rules, a move that is not surprising in light of modern conditions and the general criticism of the locality rules.³⁴ There is, then, an apparent trend to find a suitable substitute for the locality rules that have dominated, and still dominate, the medical negligence scene. Although some cases and commentators indicate that we are headed for a minimum national standard,³⁵ it has been suggested that the medical locality rule provides the proper standard of care.³⁶ The basis for such a view is that the medical locality rule emphasizes access to areas where superior medical skill and knowledge exist and those physicians having access to them should be held to a higher standard of care. By the same token, it does not impose an unreasonable standard upon the most isolated doctor.³⁷

As was pointed out by the *Pederson* court, locality differences in standards of care have never been applied to the legal profession³⁸ or

31. 72 Wash. 2d 73, 431 P.2d 973 (1967). This case is noted in 44 WASH. L. REV. 505 (1969) and 46 N.C.L. REV. 680 (1968).

32. *Pederson v. Dumouchel*, 72 Wash. 2d 73, 79, 431 P.2d 973, 978 (1967).

33. *Id.* The plaintiff's injury was caused by the negligence of a general practitioner in a town 110 miles from Seattle where the plaintiff was ultimately taken.

34. See, e.g., Comment, *Medical Malpractice—Expert Testimony*, 60 NW. U.L. REV. 834, 837-39 (1966); 14 STAN. L. REV. 884 (1962).

35. This proposition is discussed in text accompanying notes 40-60 *infra*.

36. 44 WASH. L. REV. 505, 510 (1969).

37. Nevertheless, a physician practicing in a locality where the standard is low would be knowledgeable enough to advise his patients that better medical care is available elsewhere. 1 D. LOUISELL & H. WILLIAMS, *supra* note 3, ¶ 8.07, at 212.

38. *Pederson v. Dumouchel*, 72 Wash. 2d 73, 431 P.2d 973 (1967); see note 8 *supra*.

other professions. The conduct of other members of the profession is looked to only to show customary practice—one factor to be considered by the jury, but not a conclusive standard.³⁹ The medical profession, however, even under the medical neighborhood rule, still has some of the protection of a conclusive standard based on a specific locality.

3. *Minimum National Standard.*—As mentioned above, there is some evidence that medical standards are approaching national uniformity.⁴⁰ When a court recognizes the disadvantages of the traditional locality rules, the question arises as to what should replace them. The medical locality rule has been suggested and discussed. However, a minimum national standard is a competing alternative that has been applied in special situations.

(a) *Basic medical problem.*—A few courts seem to be willing to hold a physician to a national standard of care for common types of medical operations. For example, in *Murphy v. Little*⁴¹ the plaintiff, an eleven-year-old boy, suffered a fractured forearm. The defendant placed the arm in a plaster cast, but two days later swelling and a dusky color were noticed in the boy's hand. By the time the defendant removed the cast four days after it was applied, the plaintiff had suffered from Volkmann's ischemic contracture, a failure of circulation in the arm resulting in tissue necrosis, loss of use, and deformity. The court held that at least in respect of treatment of fractures the standard is general rather than local.⁴² It should be noted that the court was aided by a Georgia statute⁴³ that sets the standard as the degree of care and skill which is ordinarily employed by the profession generally and not such as is ordinarily employed by the profession in the community.

In addition to fractures, another area of basic medical practice has been the use of medical X-ray. Since X-ray procedures are relatively

39. The customary practice doctrine is discussed in text accompanying notes 63-95 *infra*.

40. See I D. LOUISELL & H. WILLIAMS, *supra* note 3, ¶ 8.07, at 211.

41. 112 Ga. App. 517, 145 S.E.2d 760 (1965). This case was discussed in connection with expert witnesses; see text accompanying notes 21-22 *supra*. See also cases involving elementary medical problems cited in note 23 *supra*.

42. "There are doubtless areas of medicine where knowledge of proper treatment is limited geographically by prevalence of the disease or by reason of special facilities for study, but the human race has suffered from broken bones for as long as it has been in existence. Hippocrates wrote a treatise 'On Fractures' in the fourth century B.C. in which he observed that a 'blackening of the swelling' of the injured limb might result, among other causes, from the tightness of the bandage." *Murphy v. Little*, 112 Ga. App. 517, 522-23, 145 S.E.2d 760, 764 (1965). See also *Lewis v. Johnson*, 12 Cal. 2d 558, 86 P.2d 99 (1939), where it was said: "Common knowledge, as well as the testimony of the doctors on both sides, tells us that the method used in treating this particular kind of fracture was one in use throughout the world." *Id.* at 561, 86 P.2d at 101.

43. GA. CODE ANN. § 84-924 (1955).

standard throughout the country, it is reasonable to apply a national standard. In *Christian v. Jeter*,⁴⁴ the defendant physician was charged with negligence for failing to make follow-up X-rays that would have shown an improper setting of a dislocated elbow. The plaintiff's expert testified that post-reduction X-rays to determine proper alignment are in common use, and any general practitioner should be qualified to make them. The court remanded the case to the jury for a determination of negligence based on this testimony. In *McElroy v. Frost*,⁴⁵ in which an X-ray was used for therapy, the court stated: "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."⁴⁶ If, then, certain practices and procedures are basic to all physicians, there is no reason not to apply a national standard.

(b) *Specialists*.—It is easier for courts to apply a national standard to specialists, since the practice of medicine by certified specialists within each of the American Medical Association's recognized specialties is similar throughout the country.⁴⁷ Under these circumstances, distinctions based on locality would be senseless.

In *Brune v. Belinkoff*,⁴⁸ where the locality rule was abolished, and in other cases where the courts have come close to abolition,⁴⁹ the defendants were specialists. The *Brune* case was an action in negligence against an anesthesiology specialist who allegedly administered an excessive dosage of a spinal anesthetic. The defense was that in New Bedford, the community in which the defendant practiced, the dosage administered was customary. The Supreme Court of Massachusetts reversed the lower court's judgment for the defendant and specifically abandoned the locality rule that was established in Massachusetts in 1880 when *Small v. Howard*⁵⁰ was decided.

It is interesting to note that the facts in this case—New Bedford

44. 445 S.W.2d 51 (Tex. Civ. App. 1969); see *Giles v. Tyson*, 13 S.W.2d 452 (Tex. Civ. App. 1929).

45. 268 P.2d 273 (Okla. 1954).

46. *Id.* at 279-80.

47. See the results of the medical specialist survey conducted by the board of editors of the *Stanford Law Review*. 14 STAN. L. REV. 884, 887-89 (1962).

48. 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).

49. The other case that specifically abolished the locality rule is *Pederson v. Dumouchel*, which was discussed in connection with the medical neighborhood standard of care in the text accompanying notes 31-33 *supra*. Decisions hinting at abolition are mentioned later in this section.

50. 128 Mass. 131, 35 Am. R. 363 (1880); see note 7 *supra*.

being 50 miles from Boston—make it a suitable candidate for application of the medical neighborhood rule which had already been articulated by several courts.⁵¹ The *Brune* court, however, chose to go a step further and apply minimum national standards to specialists. The standard allows the jury to consider medical resources available, the locality of the defendant's practice, and advances of the profession. *Brune* has removed the locality test in Massachusetts and stands as another landmark in the quest for higher medical standards.

New Jersey appears to have abandoned the locality rules, at least with regard to specialists. Without discussing the locality rules, two New Jersey courts have established the standard as that degree of care, knowledge, and skill ordinarily possessed and exercised in similar situations by the average member of the profession practicing in his field.⁵² In West Virginia, in *Hundley v. Martinez*,⁵³ the court articulated its locality rule rather than a national standard; however, the defendant ophthalmology specialist was held to a standard nationwide procedure for cataract operations.⁵⁴

There is certainly good reason for having nationwide medical standards in cases involving defendants who are medical specialists. One survey, conducted to determine standard nationwide practice among specialists, indicated that the practice of medicine by certified specialists within most medical specialties is similar throughout the country.⁵⁵ This conclusion was based on the existence of standardized requirements for certification, subscriptions to medical specialty journals, medical specialty societies, and statements from American speciality boards. If a national standard is to be established, it is reasonable that the specialists lead the way.

(c) *General practitioners*.—The preceding sections have discussed cases in which a few courts have indicated a willingness to adopt a

51. See notes 25-35 *supra* and accompanying text.

52. *Fernandez v. Baruch*, 96 N.J. Super. 125, 232 A.2d 661 (1967) (psychiatrist); *Schueler v. Strelinger*, 43 N.J. 330, 204 A.2d 577 (1964) (surgeon); see *McGulpin v. Bessmer*, 241 Iowa 1119, 43 N.W.2d 121 (1950); *Josselyn v. Dearborn*, 143 Me. 328, 62 A.2d 174 (1948). Neither case abolished the locality rules but came close by saying that locality was merely one circumstance to be considered.

53. 151 W.Va. 977, 158 S.E.2d 159 (1967). The court's concern in this case was the qualification of an expert witness who testified to knowledge of the uniform standard procedure throughout the county for performing cataract operations.

54. See also *Duling v. Bluefield Sanitarium, Inc.*, 149 W.Va. 567, 142 S.E.2d 754 (1965) where the same court held that standards in respect of nurses responsible for the care of patients in hospitals are general, rather than local, in scope.

55. 14 STAN. L. REV. 884, 887-89 (1962); see ADVISORY BOARD FOR MEDICAL SPECIALISTS, DIRECTORY OF MEDICAL SPECIALISTS 19-22 (1968).

uniform national standard when an elementary medical procedure is negligently performed or when the defendant is a specialist. The reasons for applying a nationwide standard in such cases are stronger than in the case where a small-town general practitioner performs a relatively difficult operation. Nevertheless, two courts have shown that they are ready for a minimum national standard for general practitioners. Both of these courts have specifically abolished the locality rules in their states.

In *Brune v. Belinkoff*⁵⁶ the defendant was an anesthesiology specialist, but the court articulated the standard of care in terms of the general practitioner. The court stated: "The proper standard is whether the physician, if a general practitioner, has exercised the degree of care and skill of the average qualified practitioner, taking into account the advances of the profession."⁵⁷ This language, dictum as to general practitioners, leaves no doubt that the Massachusetts Supreme Court is ready to hold general practitioners to a national standard.

In *Douglas v. Bussabarger*,⁵⁸ the plaintiff was partially paralyzed as the result of a spinal anesthetic administered by the defendant general practitioner who performed an operation to repair a stomach ulcer. The court held as erroneous an instruction that led the jury to believe that less stringent standards of medical practice should be applied for general practitioners in one community than those allowed for physicians in more populous areas.⁵⁹

It has often been pointed out that no single group occupies a more favorable position at law than members of the medical profession.⁶⁰ It is refreshing to note that in the *Douglas* opinion, the court talked more about giving relief to the patient, than protecting the doctor. As the court indicated, it would be absurd for a potential patient to have to

56. This case is discussed thoroughly in text accompanying notes 47-51 *supra*.

57. 235 N.E.2d 793, 798 (Mass. 1968).

58. 73 Wash.2d 476, 438 P.2d 829 (1968).

59. "Rural and small-town doctors could not enjoy advantages not given by the law to any other class of rural and small-town tort defendants. When patients considering operations approach doctors in Raymond (Wash.), the doctors do not admit that they can be a little more careless and act with less responsibility than can doctors in Olympia, who can be a little more negligent than doctors in Tacoma, who can be a little more negligent than doctors in Seattle, who can be considerably more negligent than the doctors in New York City. Certainly, if doctors should freely indicate such discrepancies in medical practice, it would not be surprising that there would be a decrease in the number of operations in Tacoma and Olympia—and a greater decrease still in the Raymond area." *Id.* at 490, 438 P.2d at 838.

60. See Steincipher, *Survey of Medical Professional Liability in Washington*, 39 WASH. L. REV. 704, 710 (1964).

consider the size of the town and the character of the medical practice before agreeing to a particular operation or treatment.

Neither of these courts specifically talks about a minimum national standard. Perhaps the use of such terminology is too radical even for these two modern courts. Instead, they make it clear that they are applying a general standard, but most of their discussion is a criticism of the existing locality rules.

E. Locality Rule Summary

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.⁶¹ Whether verbalized as a national standard or not, the effect is to move toward a more standardized practice throughout the country. The doctors will continue to set by customary practice the standard by which they are to be judged, but any increase in geographical boundaries will improve the overall level of practice. One practical solution is to do away with the same or similar locality jury instruction but permit the jury to consider the doctor's opportunity for acquiring knowledge of current medical practice and procedure as one factor.⁶²

III. CUSTOMARY PRACTICE

A. Background

After the applicable locality rule has been determined, it is necessary to analyze the medical malpractice case in terms of the customary practice element of the standard of care. It is at this stage that the defendant doctor's conduct is compared with that of the fellow members of his profession. The applicable locality rules have a direct bearing on the customary practice element since a larger geographical reference area provides a broader custom.

In the ordinary tort case not involving medical malpractice, evidence of customary performance or procedure among an occupational group is generally admissible as one factor—not a conclusive one—in determining the proper standard of conduct by

61. McCoid, *supra* note 1, at 575. *But see, e.g.,* Fiske v. Soland, 8 Ariz. App. 585, 448 P.2d 429 (1969), for the traditional application of the old same locality rule by a modern court.

62. *See* W. PROSSER, *supra* note 1, at 166-67. Consideration of locality as one circumstance was applied by the court in Brune v. Belinkoff, 235 N.E.2d 793, 798 (Mass. 1968).

which to judge the defendant's actions.⁶³ However, in medical negligence cases custom within the profession is, almost exclusively, the standard of care.⁶⁴ Dean Prosser has said: "[T]he standard of conduct becomes one of 'good medical practice,' which is to say, what is customary and usual in the profession."⁶⁵ Expert medical testimony would, of course, be used to establish what is "good medical practice." This gives the medical profession a privilege, unavailable to other groups, of setting their own legal standards of conduct, merely by engaging in certain practices.⁶⁶

The opposing argument is that "customary practice" is not necessarily the same as "good medical practice," and, if compliance with custom is to establish non-liability, it must be proved that the customary practice is in fact reasonable.⁶⁷ Historically, however, the courts have refused to measure the doctor's conduct by the reasonable man standard applied to other groups. This is fortunate for the doctor since in the reasonable man concept the law requires more than average conduct; it requires average prudent conduct.⁶⁸ Since the standard for physicians is average or minimum acceptable conduct, application of the customary practice test rather than the more general reasonable man test affords the medical practitioner somewhat more protection.⁶⁹ The physician is further protected by permitting him to pursue a course followed by a respectable minority of the profession.⁷⁰ Thus if a physician can show by expert testimony that he followed a recognized school of thought, he is protected. The net result is that physicians establish their own standard, and only when there is disagreement among the experts as to whether the conduct complied with a recognized school of thought will the jury be allowed to select the standard.⁷¹

63. See McCoid, *supra* note 1, at 605-06. See also 2 F. HARPER & F. JAMES, TORTS § 17.3, at 977 (1956).

64. *Id.* See also 1 D. LOUISELL & H. WILLIAMS, *supra* note 3, ¶ 8.04, at 200.

65. W. PROSSER, *supra* note 1, at 167-68.

66. *Id.* at 168. See generally Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147 (1942).

67. See McCoid, *supra* note 1, at 606.

68. See Curran, *Professional Negligence—Some General Comments*, 12 VAND. L. REV. 535, 538 (1959).

69. See McCoid, *supra* note 1, at 607 n. 266.

70. See 1 D. LOUISELL & H. WILLIAMS, *supra* note 3, at 204.

71. See Curran, *supra* note 68, at 538-39.

B. Reasons for and against the Customary Practice Test

Several explanations have been offered for reliance on the custom test.⁷² First, it was thought that since physicians held themselves out to the public as having particular knowledge and skill, the custom test was appropriate. Members of other professions, however, hold themselves out and are not judged conclusively by the custom test. Another explanation is the lack of capacity of lay triers of fact to evaluate a physician's conduct against a general reasonable man standard. But laymen have been permitted to judge medical conduct without the aid of expert testimony in X-ray and sponge cases.⁷³ Also, expert testimony could be utilized to enlighten these laymen without allowing conformity to their testimony to become a conclusive defense. Again, members of other professions are privy to difficult concepts and uncommon knowledge that must be evaluated by the lay jury. A third explanation has been that the courts have chosen to bestow a preferred status upon members of the medical profession. This stems from the feeling that doctors should be free to practice medicine without the fear of being judged later by an outsider with after-the-fact knowledge of unfortunate results. Raising the standard to which the physician would be held above the customary practice would result in more malpractice recoveries, each one of which has the effect of branding the doctor as incompetent. Although there might have been only one deviation from the standard, the individual doctor is ruined and public confidence in the medical profession is undermined. It is also argued that it is administratively burdensome if a custom is adjudged negligent and the entire profession must alter its procedures or take the chance that the deciding court was wrong. Another argument is simply that no other standard is practical.⁷⁴

It has been suggested that in protecting the doctor, the injured patient has been forgotten; there is no comfort in failing to recover because the defendant doctor follows a negligent custom. Raising the standard of care would mean more recoveries, and the doctors could meet this new financial obligation by spreading the risk among all patients.⁷⁵ If the customary practice test were not conclusive, a greater measure of care would result as doctors would strive to keep abreast

72. See W. PROSSER, *supra* note 1, at 168; McCoid, *supra* note 1, at 607-08.

73. See W. PROSSER, *supra* note 1, at 168 & n.52; McCoid, *supra* note 1, at 608, 610-14, 575-76.

74. See generally McCoid, *supra* note 1, at 609; Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147, 1163-67 (1942).

75. McCoid, *supra* note 1, at 609.

of new developments.⁷⁶ Finally, it has been suggested that doctors should testify on medical theory since that is their area of expertise; they are not experts on medical reasonableness.⁷⁷

C. *Exceptions to Customary Practice Application*

Although the medical custom standard is firmly entrenched in legal practice and procedure, that standard may not be applied in all cases. Some courts have held that a defendant doctor cannot escape liability by establishing customary practice where the physician acts in such an obviously careless manner while performing a common sense task that any layman could determine whether the doctor has in fact been negligent.⁷⁸ For example, this has been held where an arm was bandaged too tightly⁷⁹ or where the patient was badly burned by a hot water bottle.⁸⁰

An even more common exception to the customary practice rule is illustrated by cases involving sponges (gauze pads) and other foreign objects left in incisions by doctors.⁸¹ The generally accepted methods used to prevent sponges from being left in the body include strings attached to the sponge and protruding from the incision, sponge counts, and sponges with radioactive threads that can be detected by X-rays. Evidence of compliance with these procedures would probably indicate a following of customary practice as well as due care since there is not much more one can do to insure that the sponges are out. However, when it is discovered that a sponge did remain in the body there is a strong implication of negligence because the chances of leaving a sponge after following the approved techniques are slim.

76. In *Fernandi v. Strully*, 35 N.J. 434, 173 A.2d 277 (1961) the court said: "If, as is to be hoped, the resulting jeopardy to defendants produces a greater measure of care in connection with surgical operations, so much the better." *Id.* at 451, 173 A.2d at 286. Professor Morris has said: "Doctors as a class may be more likely to exert their best efforts than drivers, railroads, and merchants; but they are human and subject to the temptations of laziness and unthinking acceptance of traditions." Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147, 1164 (1942).

77. Morris, *supra* note 76.

78. *Id.* at 1165.

79. *Gruginski v. Lane*, 177 Wash. 121, 30 P.2d 970 (1934).

80. *Duke Sanitarium v. Hearn*, 159 Okla. 1, 13 P.2d 183 (1932); *see Scardina v. Colletti*, 63 Ill. App. 2d 481, 211 N.E.2d 762 (1965), where the court said: "The so called 'common knowledge' and 'gross negligence' exceptions to the requirement of expert testimony are applicable if the negligence of the physician is so grossly apparent or the treatment is such a common occurrence that a laymen would have no difficulty in appraising it." *Id.* at 488, 211 N.E.2d at 766.

81. *See generally* W. PROSSER, *supra* note 1, at 168; McCoid, *supra* note 1, at 610-14; Morris, *supra* note 76, at 1166-67.

Since reasonable conduct does not require favorable results every time, it is quite possible that the doctor did act reasonably even though a sponge was left. Nevertheless, in the usual case, the defendant presents evidence of compliance with the approved technique which is weighed against evidence that the sponge was left in the body. Because of the strong implication of negligence the jury usually concludes that the defendant doctor's evidence was either mistaken or false.

The other general exception to the customary practice rule is seen in cases where a doctor fails to use an X-ray for diagnosis of certain ailments or for a post-operative examination to insure that the desired results were obtained.⁸² The most common areas where this problem arises are fractures, dislocations, and suspected foreign matter in the body.⁸³ Proof that he followed customary practice in these cases where an X-ray was not used has not conclusively freed the doctor from liability.

D. *Indications of Change*

There are a few indications that practicing medicine according to the established custom will not necessarily create immunity from tort liability. Forgetting for a moment the policy considerations discussed above, it does not seem unreasonable to hold a physician liable for following a customary practice that is in fact negligent. To arrive at such a holding, it should be shown that the customary practice fails to meet a test of reasonable care and diligence required of the medical profession. There are several cases which illustrate that some courts are beginning to move in this direction, or at least are becoming dissatisfied with the traditional customary practice rule.

In *Lundahl v. Rockford Memorial Hospital Ass'n*⁸⁴ the plaintiff had shown symptoms of constipation, but the doctor gave him an indigestible substance to drink before X-rays were to be taken. Subsequently, serious damage resulted from the plaintiff's efforts to relieve himself. Although the court found no negligence on the part of the doctor, it did recognize that following the customary practice is not a sure defense. The court said: "the fact that the treatment given was 'usual' or 'customary' would not, of itself, preclude the possibility of either negligence or want of skill. It is entirely possible . . . that what

82. See cases cited in text accompanying notes 16-20 *supra*.

83. See *McCoid*, *supra* note 1, at 575-76.

84. 93 Ill. App. 2d 461, 235 N.E.2d 671 (1968). Although an X-ray is involved in the fact situation, the alleged negligence was not the defendant's failure to use an X-ray, which is a typical customary practice exception.

is the usual or customary procedure might itself be negligent."⁸⁵ In *Toth v. Community Hospital*,⁸⁶ the doctor ordered a reduction in oxygen being given to a baby; the order was not carried out; the baby became blind; and the doctor was sued for negligence on the ground that he failed to insure that his orders were followed. The court held that a jury could find negligence even where a customary practice was followed.⁸⁷ The importance of these decisions is that the courts show a willingness to require more of the doctor than mere compliance with customary practices.

In *Favalora v. Aetna Casualty & Surety Co.*⁸⁸ the plaintiff became dizzy during an X-ray session, fainted, and fell to the floor. If the radiologist had seen the plaintiff's medical history, he would have known that she had dizzy spells—one of the reasons for the examination—and could have prevented the injuries. Although it was customary not to furnish medical histories to radiologists prior to taking X-rays, the court held the radiologist liable. The court indicated that it is unreasonable and arbitrary to grant immunity, when there is a failure to take a known precaution, just because others in the profession fail to exercise due care.⁸⁹ Here then is a case where the doctor followed a customary practice but was held liable because reasonable care and diligence dictated that this practice was negligent.⁹⁰ There is a good possibility that we shall see more of this in the near future.

What part should customary practice play where a court does not consider it controlling on the question of negligence? It is submitted that the proper approach was employed in *Morgan v. Sheppard*,⁹¹ where the court said that evidence of conformity can be considered, along with all other circumstances, without being conclusive.⁹² Use of customary medical practice as one of the circumstances to be

85. *Id.* at 465, 235 N.E.2d at 674. This decision was based on *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965).

86. 22 N.Y.2d 255, 239 N.E.2d 368, 292 N.Y.S.2d 440 (1968).

87. *Id.* at 263, 239 N.E.2d at 373, 22 N.Y.S.2d at 447.

88. 144 So. 2d 544 (La. App. 1962). Here again X-ray appears in the facts, but the alleged negligence had to do with not sending the patient's medical history with the patient rather than a failure to make an X-ray.

89. *Id.* at 551-52.

90. See *George v. Travelers Ins. Co.*, 215 F. Supp. 340 (E.D. La. 1963), which followed the *Favalora* case; cf. *Naccarato v. Grob*, 12 Mich. App. 130, 162 N.W.2d 305 (1968).

91. 91 Ohio L. Abs. 579, 188 N.E.2d 808 (1963). In this case the defendant was in charge of the patient after a partial gastrectomy but did not visit the patient until twelve hours after receiving notice that the patient was in shock.

92. *Id.* at 593, 188 N.E.2d 816-17.

considered is the same function business custom serves when a layman is on trial for negligence.⁹³

E. Customary Practice Summary

Some writers have expressed general satisfaction with the conventional standard based on customary practice,⁹⁴ and some of the arguments on both sides of the controversy have been mentioned above. There are, however, other considerations. The customary practice rule is closely tied to the locality rule. Where both rules are applied, the defendant doctor can escape liability by showing that his conduct conformed to the customary practice of other practitioners in the applicable locality. As the courts expand the geographical boundaries in applying the locality rule to the doctor, the customary practice rule, in its present form, will not afford doctors the protection it does now. Enlarging the geographical area will generally upgrade the customary practice on which the doctor must model his practice. Therefore, by abolishing or expanding the locality rules the courts necessarily create a higher customary practice standard.

In the section on the locality rules it was pointed out that the policy reason for abolishing the locality rule is that a doctor should not be granted relief from liability merely because the doctors practicing in his locality set a low standard. By analogy, if doctors in general establish a standard of customary practice that is negligent, the doctor who follows it should not automatically escape liability. Assuming that the geographical boundaries at the applicable locality are broadened, if the custom in that larger area is still negligent, the doctor should still be held accountable. If customary practice is made to be one factor to be considered rather than the conclusive consideration, it is likely that there will be more recoveries by injured patients.⁹⁵

IV. MISTAKE OF JUDGMENT

Although there is room for subjective elements to enter into the determination of malpractice, the standard is intended to be objective.⁹⁶

93. See generally Morris, *supra* note 76, at 1147.

94. 1 D. LOUISELL & H. WILLIAMS, *supra* note 3; McCoid, *supra* note 1.

95. It is certain that the doctors will not foot the bill. Insurance will continue to be the immediate paying agent. See B. SHARTEL & M. PLANT, *supra* note 4, § 3-32, at 163. It has been suggested that in addition to the doctors' malpractice insurance we may soon see some type of government insurance plan to cover personal injuries caused by professional negligence. Curran, *supra* note 68, at 546.

96. Curran, *supra* note 68, at 538; 1 D. LOUISELL & H. WILLIAMS, *supra* note 3.

There is, however, an almost totally subjective test—honest mistake of judgment—that is often applied to a physician's conduct which protects him from liability.

A. Application of Mistake of Judgment

Simply stated, a physician is not liable for an honest mistake of judgment, provided he brings to his patient the requisite degree of skill and care.⁹⁷ The law requires the doctor to base his decisions on skill and careful study of the case, but there is no liability for conduct dictated by a bona fide exercise of judgment.⁹⁸ This is especially true when the proper course is open to reasonable doubt, as when different schools of thought advocate different procedures.⁹⁹

An actual fact situation can be utilized at this point to illustrate some of the general principles surrounding mistake of judgment. In *Loudon v. Scott*¹⁰⁰ the patient died from the shock of the anesthetic given in conjunction with an operation. There was no evidence indicating that the defendant doctor did not possess the requisite skill and learning. The evidence did show that he knew the patient's medical history, physical characteristics, drinking habits, and the extent of the present injury. With this background the doctor determined that the patient could withstand the shock of the anesthetic. The court held that the doctor exercised a bona fide judgment for which he could not be liable.

The reason for allowing the doctor to avoid liability for a mistake of judgment is that the practice of medicine necessarily involves the exercise of individual judgment.¹⁰¹ All medical diagnosis and treatment contains some degree of educated speculation, and it is argued that the law should make allowances for reasonable differences of opinion. Otherwise, the doctor would be deterred from using his skill and judgment to provide the patient with good medical care. The fear seems to be that the doctor's conduct will be judged in light of subsequent developments rather than in light of the conditions existing at the time of the decision. These are reasonable concerns not only for doctors but for other professionals. It appears that lawyers, too, are excused from

97. *E.g.*, *Belk v. Schweizer*, 268 N.C. 50, 56, 149 S.E.2d 565, 570 (1966).

98. *See*, J. RICHARDSON, *DOCTORS, LAWYERS, AND THE COURTS*, § 1.11c, at 24 (1965); B. SHARTEL & M. PLANT, *supra* note 4, § 3-08, at 119.

99. *See* W. PROSSER, *supra* note 1, at 165.

100. 58 Mont. 645, 194 P. 488 (1920).

101. *See* I D. LOUISELL & H. WILLIAMS, *supra* note 3, at 204-05; J. RICHARDSON, *supra* note 98.

liability when there is a mistake of judgment.¹⁰² It is submitted that the mistake of judgment concept is useful when applied correctly.

Nevertheless, mistake of judgment is sometimes used too loosely to explain away a bad result.¹⁰³ As with the locality and customary practice rules, the courts must insure that the reasons for the application of the mistake of judgment doctrine are present whenever it is used.

B. Negligence or Error of Judgment

Medical judgment can be exercised at various stages of the physician-patient relationship. For classification purposes most cases involve an alleged error in diagnosis or an error in method of treatment. It is pretty safe to say that there will be no liability for an honest mistake of judgment in either case, but the facts in several cases indicate that perhaps there was negligence rather than an honest mistake of judgment.

1. *Diagnosis*.—An honest mistake of judgment in diagnosing a medical problem should be a valid defense,¹⁰⁴ but only if one of the following factors is present: (1) there is reasonable doubt as to the nature of the physical conditions involved; (2) there is a split of recognized medical authority as to the diagnostic procedure, one of which is followed; or (3) the diagnosis is made after a conscientious effort by the physician to inform himself of the symptoms and physical state of the patient.¹⁰⁵ The physician's conduct in each case must be carefully examined to determine whether there was in fact a bona fide mistake of judgment or some degree of negligence.

In *Oftedal v. Calaway*¹⁰⁶ a malpractice action was brought against a doctor who diagnosed the patient's problem as ptomaine poisoning instead of appendicitis. Subsequently the patient died. The record showed that the doctor examined the patient and questioned him concerning his activities during the past few days. After being told that

102. See, e.g., *Hodges v. Carter*, 239 N.C. 517, 80 S.E.2d 144 (1954). See generally Wade, *The Attorney's Liability For Negligence*, 12 VAND. L. REV. 755, 764-65 (1959).

103. "But often the 'mistake of judgment' notion . . . serves chiefly to deflect attention from the need for precise analysis of the physician's performance, and thus to fortify a natural hesitancy to face up to the possibility of serious error." 1 D. LOUISELL & H. WILLIAMS, *supra* note 3, at 205.

104. See generally L. REGAN, *DOCTOR AND PATIENT AND THE LAW* 312 (4th ed. 1962); J. RICHARDSON, *supra* note 98, § 1.11d, at 25.

105. See *Belk v. Schweizer*, 268 N.C. 50, 149 S.E.2d 565 (1966); *Moulton v. Huckleberry*, 150 Ore. 538, 46 P.2d 589 (1935).

106. 135 P.2d 606 (Cal. Dist. Ct. App. 1943).

the patient had eaten moldy bologna the day before, ptomaine poisoning was diagnosed. A subsequent discovery of gas in the abdomen and intestines was a further indication of ptomaine poisoning. This diagnosis was concurred in by another examining physician. The court held no liability because the plaintiff's evidence did not prove that there was a failure to exercise ordinary care, diligence and skill in making the diagnosis. Since there was reasonable doubt as to the nature of the physical conditions involved,¹⁰⁷ this was found to be a mistake in judgment.

The evidence in *Ries v. Reinard*¹⁰⁸ showed that the customary practice of physicians in the defendant's community for diagnosing gonorrhoea is to use either the methylene blue test or the gram negative stain test. The defendant used the blue test to diagnose the plaintiff's condition, and since this is acceptable practice, the court found no liability. The doctor had relied on his judgment to select one of the two accepted diagnostic procedures.

The most likely area in which to find negligence during the diagnostic stage is where the physician fails to exercise reasonable care in the procedures used to discover the patient's condition from physical evidence and symptoms. If there is in fact negligence, the courts should not be permitted to pass it off as a mere error in judgment. For example, in *Moulton v. Huckleberry*¹⁰⁹ the plaintiff severed a tendon in her leg. This condition was not discovered by the doctor who failed to perform the simple and well-known test of having the patient straighten her leg. In holding for the plaintiff, the court noted that often mistake of judgment is broadly applied to relieve the doctor from liability, but this defense is subject to the limiting factors discussed above. Here the doctor was negligent in his failure to inform himself. Perhaps the same conclusion should have been reached in *Domina v. Pratt*¹¹⁰ where the condition of the defendant's diabetic patient was diagnosed as a diabetic coma when in fact it was insulin shock, which is a reaction to an excess of insulin. The defendant compounded the problem by repeated administrations of additional insulin. The court held in favor of the doctor on the grounds of a mere error of judgment.

One source on which the doctor relies to diagnose the patient's

107. See *Engle v. Clarke*, 346 S.W.2d 13 (Ky. 1961).

108. 47 Cal. App. 2d 116, 117 P.2d 386 (1941).

109. 150 Ore. 538, 46 P.2d 589 (1935). See also *Fornter v. Koch*, 272 Mich. 273, 261 N.W. 762 (1935) (defendant's mistake of judgment held to have been due to his failure to use the local customary procedure in diagnosing the plaintiff's condition).

110. 111 Vt. 166, 13 A.2d 198 (1940).

problem is the patient himself or a member of the patient's family.¹¹¹ The question arises as to how much the doctor can rely on such statements. In *Riggs v. Christie*¹¹² the patient developed high temperature and abdominal pains after returning home from the hospital where an appendectomy had been performed. It was held that the doctor was not negligent in failing to visit the patient immediately when called because from the symptoms given over the telephone by the patient's parents, the doctor was unable to diagnose the trouble as peritonitis. In *Foose v. Haymond*¹¹³ an action was brought by a woman against a doctor who failed to diagnose her injured heel as a fracture. The plaintiff alleged negligence on the part of the doctor for not using an X-ray to diagnose the condition of her foot. The doctor's defense was mistake of judgment in that he did not suspect a fracture from the facts given by the patient. On appeal from trial court's judgment for the doctor, the appellate court granted a new trial saying that in order for the mistake of judgment defense to prevail, the evidence must show that the physician used reasonable care in exercising that judgment. The point of these and other cases is that there are many possibilities for negligent error during the diagnostic stage, and the wholesale application of the mistake of judgment defense should be avoided. The physician's conduct should be subjected to careful scrutiny to establish the presence or absence of the factors upon which mistake of judgment must depend.

2. *Treatment*.—As in the diagnostic stage, the possibilities for negligent conduct during treatment are present, but mistake of judgment is widely used to excuse defendant doctors from liability. The validity of the defense should be contingent on the presence of a split in recognized medical authority as to the proper treatment to be used. For example, in *Scott v. McPeters*¹¹⁴ it was alleged that a physician was negligent in the use of metal clamps and forceps incident to the delivery of a child who was seriously injured by this procedure. The court dismissed on another ground but said: "We do not even suggest the defendant in this case is guilty of malpractice. Mere mistakes in the judgment of the physician do not constitute malpractice."¹¹⁵ While the result may be proper in *Scott*, the danger of such an attitude is that

111. In *Oftedal v. Calaway*, 135 P.2d 606 (Cal. Dist. Ct. App. 1943), the doctor was told that the patient had eaten moldy bologna the previous day.

112. 342 Mass. 402, 173 N.E.2d 610 (1961).

113. 135 Colo. 275, 310 P.2d 722 (1957).

114. 33 Cal. App. 2d 629, 92 P.2d 678 (1939).

115. *Id.* at 637, 92 P.2d at 683.

negligent conduct is often overlooked by courts anxious to apply mistake of judgment. There are, of course, cases where there is no negligent treatment and the mistake of judgment defense should protect the doctor. One such case is *Costa v. Regents of University of California*¹¹⁶ where the patient had cancer of the tongue which was treated with X-rays that damaged bone in his mouth. It was alleged that the X-ray treatment was too drastic and the damage could have been avoided if surgery had been used instead. In holding for the doctor the court said that in fighting dangerous conditions, physicians must rely on their judgment and decide what risks are warranted. To hold them liable for unfortunate results may deter the doctor from acting in the way that gives the patient the best chance of survival.¹¹⁷ Had the plaintiff been able to show that good practice dictated a less drastic procedure or that the defendant was negligent in not using a device to protect other areas of the mouth, the outcome would probably have been different.

C. Mistake of Judgment Summary

The physician is allowed a wide range in the reasonable exercise of judgment while dealing with his patients.¹¹⁸ He is not liable for an error in judgment where there is reasonable doubt as to the proper course to be followed, or where good judgments may differ. The reference standard is the accepted medical practice in the applicable geographical area. Although the physician has broad discretionary powers during the diagnosis and treatment process, negligent acts can and do take place. These acts must not be whitewashed with unwarranted use of the mistake of judgment notion. The courts must carefully analyze cases in which the defendant has raised mistake of judgment as a defense. The mistake of judgment element of the medical standard of care is needed, but only if it is applied properly.

V. CONCLUSION

The judiciary plays an important role in the field of medical malpractice. We have seen examples of decisions in the areas of the locality rule, customary practice, and mistake of judgment. More and more courts are recognizing that the original reasons for the locality

116. 116 Cal. App. 2d 445, 254 P.2d 85 (1953).

117. *Id.* at 457, 254 P.2d at 93.

118. *See, e.g.*, *Schueler v. Strelinger*, 43 N.J. 330, 204 A.2d 577 (1964); *Willard v. Hutson*, 234 Ore. 148, 378 P.2d 966 (1963); *Christian v. Galutia*, 236 S.W.2d 177 (Tex. Civ. App. 1951).

rule no longer exist, and they are applying a variety of modified and new reference standards. These standards will still be governed by the practices adopted by the medical profession. We have seen, however, that some courts are making the customary practice standard only one circumstance to be considered rather than the conclusive one. It is also urged that mistake of judgment be utilized only after a close examination of the physician's conduct shows an honest mistake of judgment and not negligence. These changes will militate toward improvement in medical practice throughout the country and toward more equitable treatment of both doctors and patients in the courts of law.

JOHN KIMBROUGH JOHNSON, JR.