

Evidence - Torts - Standard of Care Required of Physician Testifying as an Expert Witness

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the specific purpose of rape statutes is to proscribe the punishment for the offender, not to protect the female; and the penalty for the violation of such a statute is often a large fine and lengthy imprisonment in the penitentiary,²⁸ which results in loss of reputation. Since statutory rape is not a regulatory offense,²⁹ a mens rea must be required. Consequently, a reasonable mistake of age, inasmuch as it negates a criminal intent, should be a defense as allowed by the *Hernandez* case.³⁰

The above analysis has pointed out that past decisions have eliminated the element of criminal intent resulting in gross injustices, and that to disallow the defense of mistake of age is inconstant with the present trend in the law. The defense of mistake of fact has been created by case law and statute in the analogous crime of bigamy. From all indications, it appears that the *Hernandez* case may be the beginning of a similar trend for statutory rape.

Sandy Kahn

²⁸ PA. STAT. tit. 18, § 4721 (1939), which provides a fine of not more than \$7000, or imprisonment for not more than 15 years, or both.

²⁹ See Sayre, *Public Welfare Offenses*, 33 COLO. L. REV. 55 (1933).

³⁰ *People v. Hernandez*, *supra* note 4.

EVIDENCE—TORTS—STANDARD OF CARE REQUIRED OF PHYSICIAN TESTIFYING AS AN EXPERT WITNESS

A nine year old child, who broke her arm while playing, was given emergency treatment in a hospital operated by the defendants. After the course of treatment was completed, the plaintiff brought this action contending that due to improper medical attention her right arm had to be amputated. Among other allegations, the plaintiff claimed that the physician who treated her improperly reduced the fracture in her arm, and was subsequently negligent in not removing the cast despite severe pain and swelling. In the trial court, Dr. Major, a practicing physician in San Francisco, California, was called as an expert medical witness on behalf of the plaintiff, and was allowed to testify over the defendant's objections¹ Dr. Major's testimony tended to prove the plaintiff's allegations of negligence.

¹ *Riley v. Layton*, 329 F.2d 53 (10th Cir. 1964), in reference to the witnesses' experience. Dr. Major was a graduate of Baylor University School of Medicine, and had been engaged in the general practice of medicine for six and a half years in San Francisco, California. Prior to that time he practiced with his two brothers in a small Texas town where they operated a twenty bed hospital. Dr. Major had casted between 120 and 150 fractures similar to the one in question and through his experience, reading, lectures and travels said that he was familiar with the practice in small towns with regard to the treatment of fractures.

The trial court returned a verdict for the plaintiff and the defendants appealed on the grounds that the lower court erred in admitting the testimony of Dr. Major because he was not familiar with the standard of medical care prevailing in the small rural community of Kanab, Utah, where the action arose. The U.S. Court of Appeals affirmed the lower court's decision. *Riley v. Layton*, 329 F.2d 53 (10th Cir. 1964).

Since the expert, in order to give opinion evidence, must be qualified to discuss any part of the field of interest to which the opinion will relate, by induction, a change in the required qualifications of the expert will correspondingly indicate a change in the substance of this field of interest. As related to the principal case, the following questions have arisen: Should a physician who practices in the city with its vast medical facilities for learning and skill be permitted to testify as to the standard of care expected and required from a physician who practices in a small rural community which lacks these facilities? Ultimately, is the small town physician required to 'exercise the same degree of care as his counterpart in the city, in accordance with the so called "universal standard of care"? The *Riley* case represents the growing trend towards answering these questions in the affirmative.

Initially, the courts held that the standard of care required of a physician was that of the average or ordinarily skilled practitioner *in the same locality*, being called the "strict locality rule."² A corollary or outgrowth of this rule is the evidentiary rule, which may be stated as follows:

To qualify as such expert medical witness in a malpractice case against a physician, the witness must not only show himself to possess learning and knowledge of the subject of inquiry, sufficient to qualify him to speak with authority on the subject, *but also a familiarity with the treatment and degree of care and skill of other practitioners in the locality in question, sufficient to qualify him to say whether or not the defendant's treatment was consistent with what other practitioners in the exercise of reasonable care might do under similar circumstances.*³

The weaknesses of the "strict locality rule" are quite apparent. For example, the establishing of a standard of care required of a defendant physician in a malpractice action becomes unrealistic if there is only one physician in the locality or if the only physicians in the locality are directly responsible for the low standards in the community. Most of the courts have liberalized the "strict locality rule," taking the position that the standard of care required of a physician is that of the ordinary average practitioner in the

² *Edwards v. Clark*, 96 Utah 121, 83 P.2d 1021 (1938); *Anderson v. Nixon*, 104 Utah 262, 139 P.2d 216 (1943).

³ *Rasmussen v. Shickle*, 4 Cal. App. 2d 426, 430, 41 P.2d 184, 186 (1935). (Emphasis added.)

same or similar locality.⁴ Thus, the corollary to this liberalized locality rule allows the showing of competency of a medical expert to be made by showing that he has a familiarity with the standards prevailing in a particular locality or in a similar locality.⁵

In *Lockart v. Maclean*,⁶ the court held that the physician was not qualified as an expert medical witness because he had obtained all his experience in California, whereas the defendant was a Nevada physician. There is an important distinction between the noted case and *Lockart*, as in the latter, the medical procedure involved in the malpractice action was a very complicated one with varying standards of care all over the U.S. However, in the noted case, the medical procedure was one which was uniformly established throughout the country. No special equipment or facilities were needed which were not available in the small rural town of Kanab, Utah. In the trial court the defendant admitted in his testimony that: "the standard of general practice in Kanab and Salt Lake City is comparable, and that the standard of practice for a general practitioner is approximately the same in Salt Lake City and San Francisco." In addition the record clearly shows that the treatment of fractures is universally the same throughout the medical community.⁷

As contrasted with the *Lockart* case, an expert medical witness from the city was permitted in another case to testify in regard to the general practice in the state for the application and treatment of plaster casts, even though he had never practiced where the action arose. The court said that the standard of practice in such a matter does not materially differ in the various areas of the state.⁸

Is this liberalized locality rule all important, or is it but one factor to be considered? "The essential factor is knowledge of similarity of conditions—geographical proximity being only one factor to be considered."⁹ Also note that the "locality in question is merely one of the circumstances, not an absolute limit upon skill required."¹⁰ When the locality rule was established it was sound in reason. The physician in a small community did not have the same opportunities and resources for keeping abreast of the advances in his profession, and it seemed just that he should not be

⁴ *Hoover v. Goss*, 2 Wash. 2d 237, 97 P.2d 689 (1940); *Reed v. Church*, 175 Va. 284, 8 S.E. 2d 285 (1940).

⁵ *Sinz v. Owens*, 33 Cal. 2d 749, 205 P.2d 3 (1949).

⁶ 77 Nev. 210, 361 P.2d 670 (1961).

⁷ *Riley v. Layton*, 329 F.2d 53, 57 (10th Cir. 1964).

⁸ *Geraty v. Kaufman*, 115 Conn. 563, 162 Atl. 33 (1932).

⁹ See *supra* note 5.

¹⁰ *McGulpin v. Bessmer*, 241 Iowa 1119, 1131, 45 N.W.2d 121, 128 (1950).

held to the same standard of skill and care as the city physician or surgeon.¹¹

"Today with the rapid methods of transportation and easy means of communication, the horizons have been widened, and the duty of a doctor is not fulfilled merely by utilizing the means at hand in the particular village where he is practicing."¹² Thus, the court has recognized that the physician now has opportunities to keep abreast of advancements in his profession that were not available before. Accordingly, the country physician should not be judged only by the qualifications that other physicians in the same or similar village possess.¹³ It has been pointed out that the small town physician is on a more equal basis with his city brother as a result of frequent meetings of medical societies, articles in medical journals, books by acknowledged authorities and extensive experience in hospital work. In one case the court instructed the jury that:

the defendant was required to exercise such reasonable care and skill as an ordinary physician or surgeon in good standing would exercise in like circumstances and that one of the circumstances to be considered was the locality where the action arose.¹⁴

In the text *Trial of Medical Malpractice Cases*,¹⁵ the authors indicate that in the United States today there seldom arises a question of variation of medical standards, except when an urban area is contrasted with the standards of an area which is very rural in nature, and these authors conclude that even this contrast is of diminishing significance. The truth seems to be that the courts are becoming increasingly aware of the reality that medical standards are approaching nationwide uniformity. It would seem the rule requiring a physician to meet up to only the standards of his locality or a similar locality is a relic of the past. Certainly the remoteness of the locale must be taken into consideration in determining whether a physician's actions were negligent, but the locality rule should not be a shield used to protect a physician who, perhaps because of a self-imposed isolation, has blinded himself to the progress of his profession and thus established for himself a defense in a malpractice action. If a physician practices in an area which lacks the facilities regarded as standard in other areas, he should be knowledgeable enough to advise his patients, when necessary, that superior medical talent and facilities are in existence elsewhere.¹⁶

¹¹ Warnock v. Kraft, 85 P.2d 505 (Cal. 1938).

¹² Tvedt v. Haugen, 70 N.D. 338, 349, 294 N.W. 183, 188 (1940).

¹³ Vita v. Dolan, 132 Minn. 128, 155 N.W. 1077 (1916).

¹⁴ *Id.* at 1081, 155 N.W. at 1077.

¹⁵ LOUISELL AND WILLIAMS, *TRIAL OF MEDICAL MALPRACTICE CASES*: 806.

¹⁶ *Ibid.*

If the standard of care can be properly induced, the *Riley* case represents the growing trend towards a realistic viewpoint of what standard of care and skill is required of a physician and surgeon in the U.S. today. A physician today should not be required to meet only the standard set by other physicians in his locality—but should be required to have such skill as capable members of the profession ordinarily possess under similar circumstances, and one of these circumstances is his locality and the opportunities it affords for keeping abreast of advances in medical knowledge and science. Accordingly, the requirements of a physician to act as an expert witness should be similarly established.

Richard Spiwak

FAIR TRADE—VALIDITY OF DELEGATION OF LEGISLATIVE POWER TO PRIVATE PERSONS

The proponents of the fair trade laws lost another round in Pennsylvania. The Pennsylvania Supreme Court reversed a lower court, overturning one of its own previous opinions,¹ by holding invalid the non-signer provision of the fair trade law. The plaintiff manufacturer had sought to enjoin a retailer from cutting the price of the manufacturer's trademarked product, basing its case on a price maintenance contract which the plaintiff had obtained from another retailer. Under the non-signer provision,² all retailers are compelled to charge the minimum price specified in the fair trade contract, even though not parties to the contract. The court ruled that the injunction should not be issued because the non-signer provision delegates legislative power to private persons, in violation of the state constitution.³ Thus Pennsylvania became the twenty-third state to hold the non-signer provision unconstitutional.⁴

¹ *Burche Co. v. General Electric Co.*, 382 Pa. 369, 115 A.2d 361 (1955).

² Pennsylvania Fair Trade Act, PA. STAT. tit. 73, § 8 (1935): "Wilfully and knowingly advertising, offering for sale, or selling any commodity at less than the price stipulated in any contract entered into pursuant to the provisions of section one of this act, whether the person so advertising, offering for sale, or selling is, or is not, a party to such contract, is unfair competition and is actionable at the suit of such vendor, buyer or purchaser of such commodity."

³ PA. CONST. art. II, § 1: "The legislative power of this Commonwealth shall be vested in a General Assembly, which shall consist of a Senate and a House of Representatives."

⁴ See U. PA. L. REV. 539 (1961). See also *Bulova Watch Co. v. Robinson Wholesale Co.*, 252 Iowa 740, 108 N.W.2d 365 (1961); *Union Carbide and Carbon Corp. v. Skaggs Drug Center, Inc.*, 139 Mont 15, 359 P.2d 644 (1961); *American Home Products Corp. v. Benny Homsey & Assoc.*, 361 P.2d 297 (Okla. 1961); *Bulova Watch Co. v. Zale Jewelry Co.*, 371 P.2d 409 (Wyo. 1962).