Catholic University Law Review

Volume 29
Issue 4 *Summer 1980*

Article 19

1980

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Catholic University Law Review

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Recommended Citation

Catholic University Law Review, *Medical Malpractice - National Standard of Care Adopted in the District of Columbia*, 29 Cath. U. L. Rev. 1081 (1980).
Available at: http://scholarship.law.edu/lawreview/vol29/iss4/19

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MEDICAL MALPRACTICE — NATIONAL STANDARD OF CARE ADOPTED IN THE DISTRICT OF COLUMBIA. *Morrison v. MacNamara*, 407 A.2d 555 (D.C. 1979).

Recently, the District of Columbia Court of Appeals adopted a national perspective when it evaluated the standard of care required in a medical malpractice action. In that case, Richard E. Morrison visited the Oscar B. Hunter Memorial Laboratories in the District of Columbia to have a urethral smear test performed. The test was administered while the appellant was in a standing position. Testing stopped after Morrison complained of feeling faint but resumed a few minutes later when he told the administering technician that he felt better. Soon thereafter, the appellant fainted and suffered head injuries which were the basis for the medical malpractice suit filed against the laboratory and its technician in the Superior Court for the District of Columbia.

Expert testimony produced at trial described both the national and local standards for proper administration of the urethral smear test. According to the national standard, the preferred patient posture is a sitting or prone position during administration of the test.[1] In contrast, evidence indicated that under the local standard it is acceptable for the patient to be standing. The court instructed the jury that the appropriate standard of due care is the local standard, and judgment for the defendant followed.[2] On appeal to the District of Columbia Court of Appeals, the decision was vacated and a new trial ordered.[3] In vacating, the court adopted a national stan-

1. When the urethral smear test is administered, a swab is inserted into the tip of the penis resulting in blood rushing from the brain, thus often causing the patient to feel faint. The national standard attempts to alleviate any difficulty by requiring the patient to be sitting or in a prone position. *See* Morrison v. MacNamara, 407 A.2d 555, 559 (D.C. 1979) (Dr. Shargel, a board certified urologist, testified as to the national standard).

2. The jury was instructed that the laboratory and its technician are required to exercise the skill and care employed by similar practitioners in good standing "in the same community." *Id.* at 560.

3. *Id.* at 565. The appeal was based on the superior court's application of the local rather than the national standard. *Id.* at 559, 565. Additionally, the trial court addressed whether the patient assumed the risk when he indicated to the technician that his condition had improved and that he was prepared to continue with the test. The court of appeals ruled, however, that it was improper in this case for the jury to consider the question of assumption of risk because that doctrine requires the patient to know of the danger and voluntarily to expose himself to it. *Id.* at 565-68. *See* W. PROSSER, THE LAW OF TORTS § 68 (4th ed. 1971). The court reasoned that Morrison did not assume the risk when he consented

dard of care for "board certified physicians, hospitals, medical laboratories, and other health care providers."[4]

In medical malpractice actions, the applicable standard of care is that exercised by the average or reasonable practitioner[5] in the defendant's class under the same or similar circumstances.[6] Where the national stan-

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to resumption of the test but rather relied on the technician's expertise to insure that it was safe to continue. 407 A.2d at 568.

4. *Id.* at 565. Courts have moved away from the strict locality rule, and the majority now apply the same or similar locality rule. *See, e.g.*, Reeg v. Shaughnessy, 570 F.2d 309 (10th Cir. 1978) (physician was not a board certified orthopedic surgeon and court applied same or similar community rule); Koch v. Gorrilla, 552 F.2d 1170 (6th Cir. 1977); Priest v. Lindig, 583 P.2d 173 (Alaska 1978) (national board certified specialist held to similar community standard); Baoust v. Kraut, 377 A.2d 4 (Del. 1977); Schwab v. Tolley, 345 So. 2d 747 (Fla. App. 1977) (neurosurgeon held to standard of the average practitioner in the same or similar community); Conrad v. St. Clair, 599 P.2d 292 (Idaho 1979) (standard of same or like community applied to physician's postoperative treatment); Chandler v. Neosho Memorial Hosp., 223 Kan. 1, 574 P.2d 136 (1977) (physicians and hospitals held to same or similar community standard); Tallbull v. Whitney, 172 Mont. 326, 564 P.2d 162 (1977) (standard of same or similar community within the state applied); Anderson v. Moore, 202 Neb. 452, 275 N.W.2d 842 (1979) ("same neighborhood and in similar communities"); Dickens v. Everhart, 284 N.C. 95, 199 S.E.2d 440 (1973) (general practitioner held to similar community standard); Runyon v. Reid, 510 P.2d 943 (Okla. 1973) (psychiatrist held to similar community standard); Incollingo v. Ewing, 444 Pa. 263, 282 A.2d 206 (1971) (physician who was not a specialist held to standard in same or similar community); Bly v. Rhoads, 216 Va. 645, 222 S.E.2d 783 (1976) (the court noted that there were sound reasons for abandoning the locality rule but stated that the legislature should make the change); Schroeder v. Adkins, 149 W. Va. 400, 141 S.E.2d 352 (1965) (chiropodist held to similar community standard). In addition, a similar locality standard has been enacted by some state legislatures. *See, e.g.*, ALASKA STAT. § 09.55.540 (1973); LA. REV. STAT. ANN. § 9:2794 (West Supp. 1980).

However, a number of courts apply the more liberal national standard. *See, e.g.*, Speed v. State, 240 N.W.2d 901, 908 (Iowa 1976) (locality is one factor to consider); Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 200-01, 349 A.2d 245, 253 (1975) (type and availability of facilities and type of practice are to be considered); Brune v. Belinkoff, 354 Mass. 102, 108-09, 235 N.E.2d 793, 798 (1968) (medical resources are one circumstance used in determining requisite case); Hirschberg v. State, 91 Misc. 2d 590, 597-98, 398 N.Y.S.2d 470, 474-78 (Ct. Cl. 1977) (population and financial resources should be considered); Pederson v. Dumouchel, 72 Wash. 2d 73, 78-79, 431 P.2d 973, 977 (1967) (local practice in community may be considered); Shier v. Freedman, 58 Wis. 2d 269, 283-84, 206 N.W.2d 166, 173 (1973) (size and character of community should be considered).

5. There may be a difference between the average and the reasonable practitioner. The term "average" suggests that although the performance of half of the country's physicians may be reasonable, it will be considered negligent simply because it falls below the professional average. *See* Robbins v. Footer, 553 F.2d 123, 129 n.19 (D.C. Cir. 1977); Priest v. Lindig, 583 P.2d 173, 177 n.11 (Alaska 1978).

6. Proof of the recognized standard of care and of the defendant's departure from that standard are required for a finding of malpractice. *See* Price v. Neyland, 320 F.2d 674, 677 (D.C. Cir. 1963). Generally, negligence by a medical practitioner must be shown by expert testimony indicating that the defendant's conduct fell below the applicable standard of due care. *See* Smith v. Reitman, 389 F.2d 303, 304 (D.C. Cir. 1967); Brown v. Keaveny, 326 F.2d 660, 661 (D.C. Cir. 1963).

dard is employed, the criteria are applied without geographic limitation,[7] and no territorial restrictions are placed on the availability of experts who may testify as to whether the applicable standard has been met.[8] Thus, while the standard is not geographically limited, a practitioner's location may be one factor considered in determining the reasonableness of conduct.[9]

The national standard, however, may be criticized for inhibiting innovation by creating the apprehension of potential malpractice action. Recently, for example, there has been much concern over the use of laetrile as a cancer treatment. If a physician administers laetrile in a community where its use is lawful and the patient later dies, the physician might then be deemed negligent.[10] This result is anamolous since in a national standard jurisdiction, the physician may be negligent although the use of laetrile is medically acceptable in the community where it was used. Thus, while the national standard is becoming increasingly popular, many courts continue to adhere to the locality rule.[11]

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7. The national standard, based on national certification, readily available literature, and common facilities, is restricted by the boundaries of the United States. *See* Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 199, 349 A.2d 245, 252 (1975).

8. *See generally* Annot., 37 A.L.R.3d 420 (1971). Under the locality rule, courts may consider practitioners from outside the locality incompetent to testify as to the applicable standard of care. *See, e.g.*, Koch v. Gorrilla, 552 F.2d 1170 (6th Cir. 1977) (physician not allowed to testify about the standard of care in a town 100 miles away). However, where the community standard is similar to that applied in other jurisdictions, the court may allow experts representative of those jurisdictions to testify. *See* Dickens v. Everhart, 284 N.C. 95, 199 S.E.2d 440 (1973) (although California physician was unfamiliar with standard of particular North Carolina community, the physician was familiar with the standard in similar communities). *See also* Tallbull v. Whitney, 172 Mont. 326, 335, 564 P.2d 162, 167 (1977) (expert's familiarity with practice in localities similarly located and of comparable size and character from a medical viewpoint made him competent to testify). Furthermore, courts may allow expert testimony where the expert, although unfamiliar with the standard in a particular locality, is familiar with standard procedure used throughout the country. *See* Hundley v. Martinez, 151 W. Va. 977, 993-95, 158 S.E.2d 159, 168-69 (1967).

9. *See, e.g.*, Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 200-01, 349 A.2d 245, 253 (1975) (totality of circumstances including availability of facilities should be considered); Hirschberg v. State, 91 Misc. 2d 590, 597-98, 398 N.Y.S.2d 470, 475 (Ct. Cl. 1977) (population density, territorial expanse, and financial resources should be considered).

10. For a discussion of laetrile and its legal implications, see Note, *Laetrile: Individual Choice For Cancer Patients*, 7 N.Y.U. REV. L. & SOC. CHANGE 313 (1978). The article mentions that laetrile is toxic and could potentially result in a patient's death. *Id.* at 317-18. Thus, the question may arise whether a physician would be liable for administering the drug.

11. *See, e.g.*, Parrish v. Spink, 284 Ala. 263, 267, 224 So. 2d 621, 623 (1969) (oral surgeon held to degree of care exercised in same general neighborhood); Fitzmaurice v. Flynn, 167 Conn. 609, 616-18, 356 A.2d 887, 891-92 (1975) (same general neighborhood); Lockhart v. Maclean, 77 Nev. 210, 215-16, 361 P.2d 670, 673-74 (1961) (under certain circumstances strict locality rule may be relaxed; *Lockhart* overruled as to specialists in Drault v. Miller,

Originally, the locality rule was espoused by nineteenth-century courts largely to protect rural practitioners.[12] In *Small v. Howard*,[13] for example, a Massachusetts court reasoned that a small country physician was bound to exercise the skill and care normally used by practitioners in similar localities. Therefore, this rule clearly expresses the court's concern that rural practitioners may lack the experience, opportunities, and facilities available to the urban practitioner.

The locality rule takes two basic forms: the strict locality, or same community form and the same or similar community form.[14] Under the former, performance is measured against the skill and care ordinarily exercised by practitioners in the same community. The result may be the creation of an abnormally high or low standard of care. A practitioner failing to meet the profession's community standard of care may be absolved from liability where practitioners in the same area customarily perform below the norm. In addition, persons practicing in a single-physician community would be effectively immunized from liability for negligence.[15] Moreover, plaintiffs may be faced with an insurmountable "conspiracy of silence"[16] in attempting to obtain the necessary local expert witnesses for

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595 P.2d 1191 (Nev. 1979)); Gandara v. Wilson, 85 N.M. 161, 163, 509 P.2d 1356, 1358 (1973) (Diplomate of American Board of Surgery held to community standard); Getchell v. Mansfield, 260 Or. 174, 179, 489 P.2d 953, 955 (1971) (reasonable practice in the community).

12. For example, in Tefft v. Wilcox, 6 Kan. 46 (1870), the court commented:

> In the smaller towns and country, those who practice medicine and surgery, though often possessing a thorough theoretical knowledge of the highest elements of the profession, do not enjoy so great opportunities of daily observation and practical operations, where the elementary studies are brought into every-day use, as those have who reside in the metropolitan towns; and, though just as well informed in the elements and literature of their profession, they should not be expected to exercise that high degree of skill and practical knowledge possessed by those having greater facilities. . . .

Id. at 63-64. *See also* Force v. Gregory, 63 Conn. 167, 169 (1893); Gramm v. Boener, 56 Ind. 497, 500 (1877); Small v. Howard, 128 Mass. 131, 136 (1880).

13. 128 Mass. 131 (1880).

14. For cases in which the two forms of the locality rule have been applied, see notes 4 & 11 *supra*.

15. *See* Gramm v. Boener, 56 Ind. 497 (1877). The *Gramm* court stated that in any given community there might be few practitioners "all of whom might be quacks, ignorant pretenders to knowledge not possessed by them, and it would not do to say, that, because one possessed and exercised as much skill as the others, he could not be chargeable with the want of reasonable skill." *Id.* at 501. *See generally* Waltz, *The Rise And Gradual Fall Of The Locality Rule In Medical Malpractice Litigation*, 18 DE PAUL L. REV. 408, 411 (1968). In the hypothetical single-physician community or in the community where practitioners do not act reasonably, the practitioner would be effectively free from liability.

16. *See* Brown v. Keaveny, 326 F.2d 660, 661 (D.C. Cir. 1961) (Wright, J., dissenting) (practitioners may refuse to testify for fear that one day they too may be defendants in a

trial.

The problems associated with the strict locality rule can be partially alleviated by expansively interpreting the term "community."[17] Alternatively, the same or similar community standard can be used to mitigate some of the strict locality's more aberrant and anomalous results. Because professional competence is measured against that exercised by practitioners in the same or similar community, practitioners may not be absolved from liability for performing below the norm. Furthermore, since this rule allows practitioners from similar communities to testify as to the applicable standard, it may alleviate the conspiracy of silence problem.[18] Although some of the strict locality problems are corrected by this approach, the inevitable difficulty of defining the functional boundaries of the similar community remain.[19] Moreover, the rule has been criticized for providing a safe harbor unique to the medical profession. Nonetheless, the majority of courts continue to adhere to the same or similar community rule in spite of a modern movement toward the national standard.[20]

Prior to *Morrison v. MacNamara*,[21] the District of Columbia courts applied a variety of standards in medical malpractice actions. The strict locality[22] and the same or similar community rules,[23] as well as the standard

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malpractice action). *See generally* Belli, *An Ancient Therapy Still Applied: The Silent Medical Treatment*, 1 VILL. L. REV. 250, 259 (1956); Seidelson, *Medical Malpractice Cases and the Reluctant Expert*, 16 CATH. U.L. REV. 158 (1966). *See also* RESTATEMENT (SECOND) OF TORTS § 299A (1965). Faced with the "conspiracy of silence," the plaintiff may fail to satisfy the burden of proof. *See* note 6 *supra*.

17. *See* Fitzmaurice v. Flynn, 167 Conn. 609, 356 A.2d 887 (1975) (court defined locality to include the whole state of Connecticut).

18. *See* RESTATEMENT (SECOND) OF TORTS § 299A (1965).

19. In Koch v. Gorrilla, 552 F.2d 1170, 1173 (6th Cir. 1977), the question of same or similar community was addressed. There, the court rejected the argument that Duluth, Minnesota, and Ironwood, Michigan were the same or similar communities although they were located only 100 miles apart and referrals from Ironwood to Duluth medical facilities were regularly made. The court noted that Ironwood was a smaller and distinct community with its own medical needs. *Id. See also* Robbins v. Footer, 553 F.2d 123, 128 (D.C. Cir. 1977) (medical education and training are nationalized); Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. at 196 n.5, 349 A.2d at 250 n.5 (courts may consider geographic proximity, socioeconomic factors, or medical factors in defining similar community).

20. Many courts which still adhere to the strict locality rule for general practitioners apply the national standard for specialists. *See, e.g.*, Kronke v. Danielson, 108 Ariz. 400, 499 P.2d 156 (1972); Drault v. Miller, 595 P.2d 1191 (Nev. 1979) (court rejected the locality rule for specialists). The Restatement has adopted the national standard only for specialists. *See* RESTATEMENT (SECOND) OF TORTS § 299A, comment d (1965).

21. 407 A.2d 555 (D.C. 1979).

22. *See, e.g.*, Garfield Memorial Hosp. v. Marshall, 204 F.2d 721, 725 (D.C. Cir. 1953) (private hospital held to standard of other hospitals "in the community"); Hohenthal v. Smith, 114 F.2d 494, 497 (D.C. Cir. 1940) ("in the same locality"); Wilson v. Borden, 62 F.2d 866, 869 (D.C. Cir. 1932) ("in the District of Columbia").

of the reasonable practitioner,[24] were used. More recently, in *Robbins v. Footer*,[25] the Court of Appeals for the District of Columbia Circuit rejected geographically limited standards for nationally certified medical specialists and instead applied the national standard. The federal court reasoned that the medical profession is national in scope since national medical educational requirements must be satisfied for certification and that specialty medical information is easily disseminated nationwide.[26] Thus, the fears expressed by the court in *Small v. Howard*[27] are misplaced in malpractice actions involving specialists.

The *Morrison* court, however, did not rely on the groundwork laid by the *Robbins* court for the abrogation of the locality rule.[28] Rather, the *Morrison* court accented the potential for inequity since the locality rule essentially protects the rural practitioner and accordingly has no appropriate foundation in the urban setting. In the District's sophisticated medical community, many educational and research facilities allow practioners to give quality treatment. Furthermore, patient care is enhanced by the information disseminated through medical societies, journals, and consultations with other qualified practitioners.[29] Clearly, the District is not the isolated community contemplated by nineteenth-century courts that applied the locality rule.

Moreover, continued use of the locality rule in the District could have fostered substandard care in the medical profession[30] as *Morrison* demonstrated.[31] Conversely, in some circumstances the locality rule could result in hardship to the average practitioner by requiring greater care and skill when a person practices in a community where practitioners routinely excel.[32]

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23. *See, e.g.*, Brown v. Keaveny, 326 F.2d 660, 661 (D.C. Cir. 1963) ("similar localities"); Quick v. Thurston, 290 F.2d 360, 362 (D.C. Cir. 1961) ("his own or similar localities").

24. *See* Harris v. Cafritz Memorial Hosp., 364 A.2d 135, 137 n.2 (D.C. 1976). This standard was applied without discussion of geographically limited standards.

25. 553 F.2d 123 (D.C. Cir. 1977).

26. *Id.* at 126-29. While the *Robbins* court applied the national standard to specialists, it did not discuss the numerous preceding malpractice cases in the District of Columbia which had not applied the national standard.

27. 128 Mass. 131, 136 (1880).

28. The *Morrison* court relegated *Robbins* to a footnote and failed to discuss it. *See* 407 A.2d at 562 n.5.

29. *Id.* at 562-63. See notes 12-13 and accompanying text *supra* for discussion of the rationale behind the locality rule.

30. *See* note 15 *supra*.

31. *See* note 1 *supra* and accompanying text.

32. *See* Tallbull v. Whitney, 172 Mont. 326, 334-35, 564 P.2d 162, 166 (1977) (limitation of the applicable standard to the locality rule removes incentive for improvement).

Additionally, the national standard of care places medical professionals on the same level with professionals in other fields in the District of Columbia.[33] In *Noble v. Worthy*,[34] the District of Columbia Court of Appeals held architects to a standard of care commensurate with the average practitioner in the profession. The court reasoned that persons come to professionals expecting to receive some minimum level of care. This expectation, therefore, is reinforced in the medical profession by national board certification and the ease in obtaining specialty information.

The *Morrison* court's rejection of the locality rule in the District of Columbia suggests that the locality rule may be obsolete in modern cities. Moreover, the change will likely result in an easing of the complications inherent in malpractice litigation. In particular, the new national standard will eliminate the burdensome ambiguities of defining a similar locality and reduce the customary frustrations of locating a suitable local expert witness.

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33. *See, e.g.*, Niosi v. Aiello, 69 A.2d 57, 60 (D.C. 1949) (no geographic limits applied in holding attorney to standard of reasonable duty).

34. 378 A.2d 674, 676 (D.C. 1977).