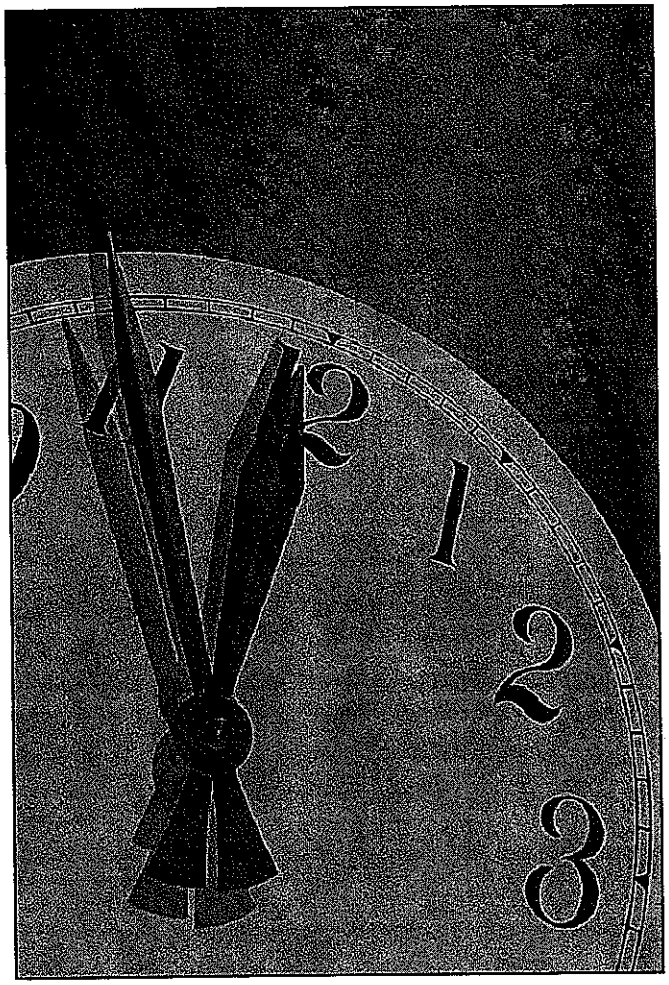
Medical Malpractice

Usurping the Role of the Jury and Turning Back the Hands of Time:

The "Locality Rule" in Medical Malpractice Cases -- Are We Condemned to Repeat History?



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In the landmark case of *Shilkret v. Annapolis Emergency Hospital Association*,[1] the Maryland Court of Appeals established the now-familiar legal standard for judging allegations of medical negligence:

> [We] hold that a physician is under a duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances. Under this standard, advances in the profession, availability of facilities, specialization or general practice, proximity of specialists and special facilities, together with all other relevant considerations, are to be taken into account.[2]

The Court of Appeals has never overruled its decision in that case, nor cited it disapprovingly.

Before reaching its commonsense conclusion, the Court of Appeals carefully considered and rejected arguments in favor of a "locality rule" for health care providers.[3] For 35 years since *Shilkret*, the "locality rule" has been consigned to the dustbin of history.

Over the last several years, however, members of the medical establishment have attempted to resurrect the locality rule in Maryland, claiming that the holding in *Shilkret* was quietly overruled by the General Assembly in 1993. Indeed, anecdotal evidence on the MAJ listserv indicates that health care providers are raising the "locality rule" with increasing frequency, either as an alleged prerequisite to the qualification of an expert witness for the plaintiff, or as an alleged element of the plaintiff's cause of action itself.

The locality rule was an historical artifact in 1975, when the Court of Appeals unanimously rejected it. In an "internet age" of tele-medicine, nationwide certification, standardized training and instantaneous sharing of information worldwide, "locality rule" arguments fail the "smell test" -- to date, no Maryland trial court has granted a defense motion to exclude an expert, or to enter a directed verdict, on the grounds that *Shilkret* has been overruled.

This article will remember the locality rule, so that we

1 276 Md. 187, 349 A.2d 245 (1975).

2 *Shilkret*, 276 Md. at 200-01, 349 A.2d at 253. Accord MPJI 4th 27:1 (2010).

3 *Shilkret*, 276 Md. at 198, 349 A.2d at 251 ("Were we to adopt a standard tied to locality for specialists, we would clearly be ignoring the realities of medical life").

-- and the past and future victims of medical negligence in Maryland -- are not condemned to repeat that history. The authors also will address how the defense recently has raised the locality rule, and will review how plaintiffs' counsel, armed with compelling arguments (including those voiced in *Shilkret* itself) can overcome such tactics.

A Brief History of the "Locality Rule"

The rationale underlying the creation of a special "locality rule" for physicians arose from the dismal state of medical science at the turn of the twentieth century and the "manifest inequality [in knowledge and skill] between physicians practicing in large urban centers and those practicing in remote rural areas."[4] Courts accepted as an article of faith that a physician's "knowledge or skill" would vary widely, depending upon whether the physician was a "country doctor" or a "city doctor":

> A country doctor could not be expected to have the equipment, facilities, contacts, opportunities for learning, or experience afforded by large cities.[5]

In the latter half of the twentieth century, however, courts and commentators became more critical of the locality rule. As a practical matter, the locality rule made it more difficult for injured plaintiffs to find experts qualified -- by experience practicing in the community -- to offer standard of care opinions against a local colleague. Another criticism focused on the consequence of the locality rule that, if all of the physicians in a particular community were incompetent, then the standard of care for that community would be incompetence:

> If a town's six doctors all ignored helpful new drugs for treatment of the plaintiff's condition, none of them would be guilty of malpractice for failing to prescribe such a drug when it was needed.[6]

The problem would be compounded if there were just one physician of a particular specialty practicing in a community -- that physician would be effectively immune from liability as no one could criticize his conduct.[7] Indeed, the locality rule actually discourages progress, because even a medically

4 *Shilkret*, 276 Md. at 193, 349 A.2d at 249.

5 W. Page Keeton, et al., Prosser & Keeton on the Law of Torts, § 32, at 187-88 (5th ed. 1984). *Accord Brown v. Tatsumi*, 346 N.E.2d 673, 678 (Ohio 1976) (The basis for [the locality rule] was that a physician at that time in a small town lacked the opportunity to keep abreast of the advances in the medical profession and that he did not have the most modern facilities to provide care and treatment for his patients . . . it would be unfair to hold such a doctor to the same standards of care as doctors who have such opportunities and facilities in larger cities").

6 Dan B. Dobbs, The Law of Torts, § 244, at 635 (2001).

7 *Shilkret*, 276 Md. at 194, 349 A.2d at 249 ("He could be treating bone fractures by the application of wet grape leaves and yet remain beyond the criticism of more enlightened practitioners from other communities" (*quoting* Waltz, The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation, 18 DePaul L. Rev. 408, 411 (1969))).

superior diversion from local practice would be a deviation from the locally-established standard of care.

With that historical context, local defense lawyers openly praised the application of a strict locality rule in Maryland,[8] and Maryland courts applied the locality rule to protect local physicians from allegations of malpractice. In *Dunham v. Elder*,[9] the Court of Special Appeals explicitly affirmed a trial court's decision to disregard expert testimony from physicians who practiced in the District of Columbia, with respect to the standard of care applicable to a physician in Prince George's County.[10]

Dunham's pronouncement on the viability of the locality rule in Maryland was applied by the trial court in *Raitt v. Johns Hopkins Hospital*.[11] As a consequence of an allegedly negligently performed tubal ligation, the plaintiff in *Raitt* suffered a bowel perforation; moreover, she was discharged from the defendant hospital "against her wishes" and despite her complaints of "severe stomach pain."[12] At trial, the plaintiff proffered four (4) experts in the field of obstetrics and gynecology to testify concerning the violations of that applicable standards of care:

> After hearing extensive argument from counsel, the trial court ruled that none of the four medical witnesses tendered by [the plaintiff] was qualified 'to express opinions as to the standards of care in the City of Baltimore in the performance of the surgical procedure which is in question in this case.' It arrived at this conclusion because none of the witnesses had ever practiced in Maryland; had ever enjoyed any hospital privileges in Maryland; or had ever maintained an office in this state.[13]

The trial court rejected one of the plaintiff's expert witnesses, even though that physician had spent five years training as an OB/GYN intern and resident at Sinai Hospital.[14] On appeal, however, the Maryland Court of Appeals reversed the judgment of the trial court, holding that the question of whether an expert "had practiced, treated patients, enjoyed hospital privileges or maintained an office in Maryland" was only part of the proper inquiry in determining whether the experts were qualified to offer opinions.[15]

Decided by the Court of Appeals six months after *Raitt*, *Shilkret* went even farther in abolishing the last vestiges of the "locality rule" in Maryland. After distinguishing several earlier cases,[16] the Court of Appeals in *Shilkret* addressed the locality rule in Maryland.[17] After tracing the historical roots of the strict locality rule applied by the trial courts in *Dunham* and *Raitt*, the Court of Appeals also surveyed the advancements in medical specialization, technology, and medical school training that had taken place since ancient times, concluding that, "[w]hatever may have justified the strict locality rule fifty or a hundred years ago, it cannot be reconciled with the realities of medical practice today."[18] Rejecting the locality rule entirely, the Court of Appeals instead announced that the standard of care for physicians must be measured by "that degree of care and skill which is expected of a reasonably competent practitioner" in the same specialty and acting in the same or similar circumstances.[19]

With regard to the standard of care applicable to health care provider defendants in medical malpractice actions, the Court of Appeals adopted a rule of reasonable care, taking into account all relevant and material circumstances:

> [We] hold that a physician is under a duty to use that that degree of care and skill which is expected of a reasonably

8 John F. King and Ward B. Coe, III, "The Wisdom of the Strict Locality Rule," 3 U. Balt. L. Rev. 221 (1974)
9 18 Md. App. 360, 364, 306 A.2d 568, 571 (1973).
10 *Dunham*, 18 Md. App. at 367, 306 A.2d at 572.
11 274 Md. 489, 336 A.2d 90 (1975).
12 *Raitt*, 274 Md. at 491, 336 A.2d at 90.
13 *Raitt*, 274 Md. at 493, 336 A.2d at 92.
14 *Raitt*, 274 Md. at 493, 336 A.2d at 92.
15 *Raitt*, 274 Md. at 500-01, 336 A.2d at 96.
16 *State ex rel. Solomon v. Fishel*, 228 Md. 189, 179 A.2d 349 (1962); *Tempchin v. Sampson*, 262 Md. 156, 277 A.2d 67 (1971); *Kruszewski v. Holz*, 265 Md. 434, 290 A.2d 534 (1972).
17 The Court of Appeals left no doubt that it was addressing a question of first impression. *Shilkret*, 276 Md. at 192, 349 A.2d at 248 ("we now explicitly decide for the first time this question of the standard of care to be applied in medical malpractice cases").
18 *Shilkret*, 276 Md. at 194, 349 A.2d at 249.
19 *Shilkret*, 276 Md. at 200-01, 349 A.2d at 253.

> competent practitioner in the same class to which he belongs, acting in the same or similar circumstances. Under this standard, advances in the profession, availability of facilities, specialization or general practice, proximity of specialists and special facilities, together with all other relevant considerations, are to be taken into account.[20]

The Court of Appeals decided *Shilkret* in 1975, long before the Internet age; medical technology and the standardization of medical education have advanced exponentially in the last 35 years. National Board certifications teach and reinforce a single standard of care to Board-certified physicians nationwide. Medical journals are available online in every corner of our State, and through "telemedicine" and closed-circuit communication, documents and images can be transmitted and interpreted by physicians almost anywhere in the world. Near-instantaneous access to information and training on a variety of procedures is the rule, not the exception. Medical students entering practice are no longer trained that patients are entitled to a lesser standard of care in rural areas (if they were ever trained that way at all). If the locality rule was out of step with the realities of 1975, there can be no dispute that the locality rule has no place in the law today, or in the future.

The "Locality Rule" Strikes Back?

The year after *Shilkret* was decided, the Maryland General Assembly enacted the Maryland Health Care Malpractice Claims Act,[21] establishing mandatory arbitration and enacting other tort reforms in response to a perceived "crisis" in medical malpractice insurance. The MHCMA codified the holding in *Shilkret* with regard to the applicable standard of care, enacting into law the rule of reasonable care under all of the relevant and material circumstances. In its current form, the statute provides:

> In any action...the health care provider is not liable... unless it is established that the care given by the health care provider is not is accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged act giving rise to the cause of action. [22]

Self-evidently, the statutory language tracks the language of the Court of Appeals in the *Shilkret* decision itself.[23] As defined in *Shilkret*, a physician's standard of practice is "that degree of care or skill expected of a reasonably competent practitioner in the same class...acting in the same or similar circumstances," which also includes consideration of the "availability of facilities [and] proximity of specialists and special facilities," as well as other relevant considerations.[24]

In recent years, some members of the malpractice defense bar have contended that, by enacting § 3-2A-02(c)(1) in its current form, the General Assembly superseded *Shilkret* by statute and "returned Maryland to a locality standard as set forth in" cases such as *Dunham v. Elder*.[25] The essential basis for the argument focuses on a 1993 amendment to § 3-2A-02(c)(1), that added "situated in the same or similar communities" to the sub-paragraph; such language -- the argument goes -- necessarily rejected the holding of the Court of Appeals in *Shilkret*.[26]

To date, although raised with increasing frequency, the argument has not yet persuaded any trial court to hold that *Shilkret* was overruled. At least one appeal raising the issue was resolved after oral argument but before a written opinion

20 *Shilkret*, 276 Md. at 200-01, 349 A.2d at 253. Accord MPJI 4th 27:1 (2010).

21 Md. Cts. & Jud. Procs. Code Ann. §§ 3-2A-01, *et seq.* ("MHCMA").

22 Md. Cts. & Jud. Procs. Code Ann. § 3-2A-02(c)(1) (2010).

23 *Shilkret*, 276 Md. at 200-01, 349 A.2d at 253. Accord MPJI 4th 27:1 (2010).

24 *Shilkret*, 276 Md. at 200-01, 349 A.2d at 253. Accord MPJI 4th 27:1 (2010).

25 Brief of Appellant, Ira Papel, M.D., in *Cyrus v. Papel*, CSA No. 2007-2734, at 15. Similar arguments have been made in other cases as well.

26 Although no trial or appellate court has accepted the argument that Shilkret has been overruled by § 3-2A-02(c)(1), a comment to Maryland Pattern Jury Instruction 27:1 cites Dunham (a case that had been overruled in both *Raitt* and *Shilkret*) and claims that § 3-2A-02(c)(1) establishes a locality rule in Maryland. Contrast *Dingle v. Belin*, 358 Md. 354, 368, 749 A.2d 157, 164 (2000) (citing *Shilkret* and § 3-2A-02(c)(1) in the same paragraph, both with approval, implying that the latter codified the former).

was issued.[27] The issue is currently on appeal in another pending case.[28]

Dealing with Locality Rule Arguments

Until such time as appellate precedent confirms the continuing viability of the holding in *Shilkret*, diligent plaintiffs' counsel in medical malpractice cases must be prepared for the argument to be raised in nearly every case. Ideal preparation will begin in discovery, because the health care provider defendant often can provide the best evidence against the application of any "locality rule" argument.

For example, evidence that a defendant surgeon completed medical education in several states, or has practiced in multiple hospitals, can lead to questions about whether the standards of practice are lower in Maryland (or in one of its counties, or in one of its hospitals) than elsewhere. Evidence that a physician serves on a medical school faculty, or travels to other cities to lecture, can give rise to similar questions. Expert witnesses also provide fertile ground for generating a similar record.

Such questions (and the inevitable answers) can be powerful tools to defeat the locality rule, because they expose the fiction of the locality rule in modern times, with admissions from the defendant physician that -- as the Court in *Shilkret* recognized more than thirty-five years ago -- standards of practice and reasonable care are essentially the same everywhere.[29] These arguments define the relevant "same or similar communities" in an individual case as having no geographic borders -- if the standards or practice are the "same or similar" in every community, then every community fits within that "same or similar" label.

Far from defining the standard of care, however, some defense counsel attempt to use the "locality rule" as a tool for blocking testimony from plaintiffs' expert witnesses, on the grounds that an expert witness must be "familiar with" the defendant's particular community before being allowed to offer opinion testimony. According to this argument, expert witnesses from foreign jurisdictions (including other Maryland counties) should not be recognized by the trial court as competent to testify, unless they first demonstrate an expertise and knowledge in demography.[30] Importantly, none of the topics related to demographics have any impact on the standard of care owed by a defendant physician to their patient. According to anecdotal accounts, it is in this manner that some defense counsels raise the question of the locality rule for the very first time in litigation -- as an ambush.[31]

In response to such surprise attacks, the preparation of counsel is again critically important. Knowing that a "locality rule" attack might be raised at any time allows plaintiffs' counsel to prepare the response -- indeed, as noted above, some disclosures elicited from a defendant physician during a discovery deposition might be enough to eliminate any real concern about the locality rule at all. Requests for Admissions and Answers to Interrogatories are also helpful and can be used to rebut the defense tactic. All of these are helpful in convincing a judge to disallow any inquiry into the locality rule.

Until the appellate courts settle the issue, the legal response to the locality rule relies on an understanding of the statutory scheme, as well as the decisions of the Court of Appeals in *Shilkret* and *Raitt*.

First, there is no indication that the General Assembly in 1993 ever intended to overrule *Shilkret* or to reinstate an outdated and discredited locality rule. The amendment of § 3-2A-02(c)(1) was occasioned by little to no notice whatsoever, and the *status quo* has remained unchanged for more than fifteen years. Indeed, when the General Assembly in 2004 created a new set of criteria for the qualification of experts testifying with regard to the standard of care, nothing about a "same or similar communities" requirement was considered, even in any of the *draft* legislation.[32]

27 *Cyrus v. Papel*, CSA No. 2007-2734 (2007).

28 *Daee v. Lucas*, CSA No. 2009-2485.

29 The defendant surgeon in *Cyrus* was educated in Boston, served a fellowship in San Francisco, taught medicine at Johns Hopkins University and lectured at conferences internationally. On appeal, the plaintiff highlighted the anachronistic absurdity of such a physician seeking the protections of a century-old legal doctrine designed to protect technologically disadvantaged and geographically isolated country doctors. Brief of Appellee, Brian Cyrus, in *Cyrus v. Papel*, CSA No. 2007-2734, at 29. Similar arguments can be effective in a variety of trial settings, where a record of a defendant's geographically diverse education and sophistication has been developed.

30 Some defense counsel permitted leeway at trial to "explore" the issue frequently ask questions about the population of a particular town (or county), or the number of beds at a hospital -- almost anything, it seems, no matter how trivial, and without any preliminary showing that the questions bear relevance to the applicable standard of care. In that regard, the authors have never yet found a health care provider who claimed in modern times that the applicable standard of care for surgery, *e.g.*, was different depending upon the population of the town (or county) where the surgery was performed.

31 Another example of the "ambush" technique was employed in *Daee v. Lucas*, supra, in which the locality rule was not even mentioned at trial until a motion for judgment at the end of the plaintiff's case. The denial of that motion for judgment is the basis for a pending appeal.

32 Md. Cts. & Jud. Procs. Code Ann. § 3-2a-02(c)(2) provides:

> 1. In addition to any other qualifications, a health care provider who attests in a certificate of a qualified expert or testifies in relation to a proceeding before a panel or court *concerning a defendant's compliance with or departure from standard of care:*

Moreover, the "locality rule" provides no logical or legal basis for excluding the opinion testimony of otherwise competent expert witnesses. The Court of Appeals in *Raitt* held explicitly that expert witnesses need not have practiced in the local jurisdiction of the defendant in order to be competent to testify at trial, even assuming hypothetically that a strict locality rule were to apply.[33] To the extent that the defense bar argues that the locality rule was reinstated, then the holding in *Raitt* should negate any contention that an expert witness must have practiced or resided in Maryland, or must possess an encyclopedic knowledge of local demographic data. Indeed, the court's decision in *Raitt* can be used to show the trial court that the definition of what constitutes a "locality" is very difficult to define. An argument can be made that it certainly is not a small geographic area given the technology of today.

In cases where a proper groundwork has been laid, cautious plaintiffs' counsel might raise the issue affirmatively with the trial court, in a memorandum of law or motion *in limine*. Taking the initiative in this manner might allow plaintiffs' counsel to define the terms of the debate, and to educate a busy trial judge who otherwise might be unfamiliar with the history and complexities of the locality rule. Quoting from the oral deposition testimony of the defendant health care provider, such an affirmative pleading could discredit the "locality rule" argument in a particular case, even before it has been made; in any event, the likelihood of an "ambush" would be diminished.

Additional steps could be taken to prepare ones' own expert witnesses for the possibility of a locality rule attack. Some plaintiffs' counsel prepare so-called "locality rule" binders of demographic data on a given community and provide that data to their experts for their use. Armed with that data -- upon which the expert witness may rely in order to answer questions directed more towards demography than medicine -- an expert witness may testify confidently about such trivialities as the number of people living in a particular county or the number of beds in a particular hospital.

A. Shall have had clinical experience, provided consultation relating to clinical practice, or taught medicine in the defendant's specialty or a related field of health care, or in the field of health care in which the defendant provided care or treatment to the plaintiff, within 5 years of the date of the alleged act or omission giving rise to the cause of action; and

B. Except as provided in item 2 of this subparagraph, if the defendant is board certified in a specialty, shall be board certified in the same or a related specialty as the defendant.

2. Item (ii) 1.B. of this subparagraph does not apply if:

A. The defendant was providing care or treatment to the plaintiff unrelated to the area in which the defendant is board certified; or

B. The health care provider taught medicine in the defendant's specialty or a related field of health care.

It is striking that the General Assembly placed these requirements in the very same statutory sub-section as the language upon which the defense relies for its claim that the locality rule was reinstated in 1993.

33 "Even assuming *arguendo* that the 'strict locality' rule is to be followed, the expert witness need only possess such knowledge of the applicable standard of care as will enable him to render an informed opinion. There is no absolute requirement that he practice or reside in the defendant-physician's community." *Raitt*, 274 Md. at 500, 336 A.2d at 36.

Conclusion

More than thirty-five years age, the Court of Appeals in *Shilkret* rejected the so-called "locality rule" -- a doctrine created by courts more than a century ago to protect small-town country doctors who were both technologically disadvantaged and geographically isolated from their "big-city' brethren.

With increasing frequency, however, defense counsels are raising arguments concerning the locality rule. Being prepared for those arguments -- and the potential ambush at trial -- is the key to protecting your case, and your clients, from this discarded and discredited artifact of Maryland law.

Lost in this discussion is the fact that the application of a locality rule would result in a significant deterioration in the care being provided to patients. Confusion would reign and patient care would suffer. As trial attorneys, we represent individuals but our actions make the medical system safer for others. The locality rule has the potential to make the medical system more dangerous and, accordingly, the locality rule must be resisted. ■

Biography

Karl J. Protil's practice consists of personal injury litigation, with an emphasis on medical malpractice and claims against the federal government. He has extensive experience before federal courts through the United States and in state trial courts in Maryland, Virginia and the District of Columbia. He is particularly active in cases involving brain damage to infants during birth. Prior to joining Shulman, Rogers, Gandal, Pordy & Ecker, P.A., Mr. Protil spent six years in the Army Judge Advocate General's Corps and a year with Medical Mutual Liability Insurance Society of Maryland.

George S. Tolley, III (Dugan, Babij & Tolley, LLC) received his J.D. from New York University School of Law in 1991. Before entering private practice, he served for two years as law clerk to the Hon. Herbert F. Murray of the United States District Court for the District of Maryland. He is a member of the MAJ's President's Club, as an Eagle. A member of the Bar in Maryland, West Virginia and the District of Columbia, Mr. Tolley has litigated complex medical malpractice and personal injury cases in state and federal courts in those jurisdictions, as well as in the courts of Delaware, Pennsylvania, North Carolina, South Carolina and Georgia. In addition to MAJ, he is a member of the Association of Trial Lawyers of America, the West Virginia Trial Lawyers Association, the Pennsylvania Trial Lawyers Association, the American Bar Association, the Federal Bar Association, the West Virginia Bar Association, the District of Columbia Bar, and the Bar Associations of several local jurisdictions in Maryland. His practice is focused on medical malpractice, wrongful death, and catastrophic personal injury matters.