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Medical Malpractice--The "Locality Rule" and the "Conspiracy of Silence"

David D. Armstrong

COMMENTS

MEDICAL MALPRACTICE—THE "LOCALITY RULE" AND THE "CONSPIRACY OF SILENCE"*

Until recently, it has been extremely difficult for a plaintiff to prove medical malpractice because: (1) a medical practitioner's performance was measured against a local community standard as opposed to a minimum national standard and (2) doctors would not testify against their professional brothers. The decisions which established the local community standard rule are rapidly being undermined, but the second obstacle, the so-called "conspiracy of silence," is still quite viable.

I. INTRODUCTION

> Medicine is of all the Arts most noble; but, owing to the ignorance of those who practice it, and of those who, inconsiderately, form a judgment of them, it is at present far behind all the other arts. Their mistake appears to me to arise principally from this, that in the cities there is no punishment connected with the practice of medicine (and with it alone) except disgrace, and that does not hurt those who are familiar with it. Such persons are like the figures introduced in tragedies, for as they have the shape, and dress, and personal appearance of an actor, but are not actors, so also physicians are many in title but very few in reality.[1]

Hippocrates'[2] observations concerning the legal aspects of medical practice are quite interesting, especially when one realizes that much of this 2400 year old statement is true today. An investigation of recent decisions further reveals that there has been much litigation involving medical practitioners. As students of the legal profession, we are often called upon to represent a patient or an allegedly incompetent physician who does not possess the expertise necessary to provide the aggrieved with the nebulous "minimum standard of care." The bench and bar face the myriad interpretations and rules incident to this pro-

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

1. 10 HIPPOCRATES, GREAT BOOKS OF THE WESTERN WORLD 144 (1952).
2. *Fl.* 400 B.C.

fessional standard. This article deals with two policies which cloud the definition of a "minimum standard of care," that is, the "locality rule" and its ubiquitous companion, the "conspiracy of silence." To further complicate matters, each policy contains numerous refinements and interpretations—all covertly couched under these two shibboleths.

In the 1968 case, *Brune v. Belinkoff*,[3] the same court which had originally enunciated the "locality rule" in 1880 renounced it. Based on this leading case, the "locality rule" appears destined for a restful peace among numerous other legal skeletons. Its demise, however, has been hindered by (1) long factually irrelevant bibliographies of cases which the courts are reluctant to overrule because of reverence for the doctrine of *stare decisis;* (2) defense attorneys who have a "ready-made defense" if they can utilize the "locality rule," which makes it virtually impossible for a plaintiff to prove his allegation of malpractice; (3) an organized medical profession which seeks to eliminate malpractice litigation; (4) malpractice insurance carriers who seem more concerned with their balance sheets than with either the plaintiff's *or the defendant physician's welfare;* and (5) the individual doctors themselves, who, as members of a closely knit professional fraternity, are reluctant to testify against their professional brothers. Notwithstanding these formidable obstacles, the "locality rule" is becoming less viable, and the foundations supporting the "conspiracy of silence" are beginning to crack.

II. The Locality Rule

A. An Historical View: The Rise and Fall of the Locality Rule

In 1853, a Pennsylvania court in *McCandless v. McWha*[4] defined what is generally thought to have been the minimum standard of care for medical practitioners at that time. The court said:

> The law has no allowance for quackery. It demands *qualification* in the profession practised—not extraordinary skill such as belongs only to few men of rare genius and endowments, but that degree which ordinarily characterizes the profession.[5]

The court also stated that a physician should employ "reasonable skill and diligence as are ordinarily exercised in his pro-

3. 354 Mass. 102, 235 N.E.2d 793 (1968).
4. 22 Penn. St. 261 (1853).
5. *Id.* at 269.

fession."[6] The importance of these statements is that there is no mention of, or allusion to, the physician's locality.

In *Smothers v. Hanks*,[7] the dissenting judge felt that the *McCandless* statement[8] was just and further indicated that the frontier village surgeon should be brought to the side of his professional city brother because, "[i]n this age [1872] of books, professional periodicals, and mails . . . . [w]e may safely say that no respectable surgeon, wherever he may be, is uninformed of the progress and discoveries in his profession."[9] But the *Smothers* majority said that the "whole case [*McCandless*] . . . is . . . remarkable . . . and their [*McCandless*] observations are well calculated to mislead."[10]

Smothers was one of the earlier cases in the development of the "locality rule," but the rule was also in the fetal stage in Kansas[11] and Vermont.[12] Its birthplace, however, is considered to have been in Massachusetts. The Massachusetts court stated the rule in *Small v. Howard*[13]:

> The defendant [country surgeon], undertaking to practise as a physician and surgeon in a town of comparatively small population [2500], was bound to possess that skill only which physicians and surgeons of ordinary ability and skill, practicing in similar localities, with opportunities for no larger experience, ordinarily possess; and he was not bound to possess that high degree of art and skill possessed by eminent surgeons practicing in large cities, and making a specialty of the practice of surgery.[14]

The court, in maintaining its very narrow view posited on specific facts, continued that the country surgeon would have "but few opportunities of observation and practice . . . such as pub-

6. *Id.* at 267. This was essentially the standard of care in Illinois in 1860 when Abraham Lincoln represented a defendant physician. Lincoln lost the case, both at trial and on appeal. *See* Ritchey v. West, 23 Ill. 329, 330 (1860).
7. 34 Iowa 286 (1872).
8. McCandless v. McWha, 22 Penn. St. 261, 269 (1853).
9. Smothers v. Hanks, 34 Iowa 286, 299 (1872).
10. *Id.* at 293-94. It is interesting that the Iowa court should make such an observation, since it got thoroughly mired in semantics while trying to differentiate between doctors of ordinary skill, those with average skill, those thoroughly educated, etc. In undermining *McCandless,* they mustered weak support from *Howard v. Grover,* 28 Me. 97 (1848), *inter alia.*
11. Tefft v. Wilcox, 6 Kan. 46 (1870).
12. Hathorn v. Richmond, 48 Vt. 557 (1876).
13. 128 Mass. 131, 35 Am. Rep. 363 (1880).
14. *Id.* at 132.

lic hospitals or large cities would afford."[15] Even though the stated rule was quite narrow, most courts seemed to adopt it or at least some variation of it.[16] It was applied to all types of medical practitioners, including a Chinese herb doctor "who [held] himself out as a physician or surgeon, whether licensed or not . . . ."[17]

The strict narrowness of the rule as enunciated caused it to come under attack quite early. A 1916 Minnesota court refused to apply the rule because "[f]requent meetings of medical societies, articles in medical journals, books by acknowledged authorities and extensive experience in hospital work put the country doctor on more equal terms with his city brother."[18] The rule ran into further difficulty in Michigan where the court acknowledged that, if the defendant were the only practitioner in the town, "it would be impossible to secure [expert medical] testimony at all."[19] Connecticut broadened the original rule as stated in *Small* by refusing to restrict the rule's territorial limitations to the confines of a city or town.[20] A forward looking North Dakota court said the standard should be "measured by conditions as they exist, and not by what they have been in the past or may be in the future."[21] And a 1956 Rhode Island court, in recognizing the scarcity of expert specialists, broadened the rule and allowed a Philadelphian to testify as to the Providence standard for "mastoidectomies [that] are performed by otologists . . . ."[22]

In 1965 the American Law Institute, in recognition of a more mobile and metropolitan society, adopted the even more liberal standard "of persons engaged in similar practice in similar localities, considering geographical location, size, and the character of the community in general."[23] But the fatal blow was

15. *Id.* at 136, 35 Am. Rep. at 365. *See also* 31 JATLJ L.J. 133 (1968).
16. *See generally* 70 C.J.S. *Physicians and Surgeons* §§ 42, 43 (1951) and 41 AM. JUR. *Physicians and Surgeons* §§ 86,87 (1942).
17. Hanson v. Pock, 57 Mont. 51, 187 P. 282 (1920).
18. Viita v. Dolan, 132 Minn. 128, 135-37, 155 N.W. 1077, 1081, 1916D L.R.A. 644. This statement immediately reminds one of the dissent in *Smothers v. Hanks,* 34 Iowa 286, 299 (1872). *See* text at note 9 *supra.*
19. Sampson v. Veenboer, 252 Mich. 660, 667, 234 N.W. 170, 172 (1931).
20. Geraty v. Kaufman, 115 Conn. 563, 573-74, 162 A. 33, 36 (1932).
21. Tvedt v. Haugen, 70 N.D. 338, 349, 294 N.W. 183, 188 (1940), 132 A.L.R. 379, 386 (1941).
22. Cavallaro v. Sharp, 84 R.I. 67, 72, 121 A.2d 669, 672 (1956).
23. RESTATEMENT (SECOND) OF TORTS § 299A, comment *g* (1965). *See also* W. PROSSER, HANDBOOK OF THE LAW OF TORTS 166-67 (3d ed. 1964).

struck by the Massachusetts court in *Brune v. Belinkoff*[24] where "[t]he rule was abrogated by the court which promulgated it."[25]

B. The Rule Today

In overruling *Small*,[26] the *Brune*[27] court completely reversed the *Small* court by saying:

> [T]he medical profession should no longer be Balkanized by . . . varying geographic standards in malpractice cases . . . .
>
> 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 in the profession.[28]

Needless to say, *Brune* and the factually similar case of *Pederson v. Dumouchel*,[29] a 1967 Washington case, have been the source of much commentary. Perhaps the best critique of the two cases was made by Professor Waltz[30] when he said:

> *Brune* suggests a nationwide standard for both specialists and general practitioners . . . *Pederson*[31] is more cautious [as it only holds] the medical man to that degree of care and skill established in areas accessible to him . . . .[32]

Recognizing the two major problems caused by the locality rule —(1) the shallow pool of available expertise from which a plaintiff can draw a witness, and (2) the fact that the mini-

24. 354 Mass. 102, 235 N.E.2d 793 (1968).
25. Avey v. St. Francis Hospital and School of Nursing, Inc., 201 Kan. 687, 696, 442 P.2d 1013, 1020 (1968).
26. Small v. Howard, 128 Mass. 131, 35 Am. Rep. 363 (1880).
27. Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968). *See* Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DEPAUL L. REV. 408 (1969); Note, *Standard of Care for Medical Practitioners—The Locality Rule*, 14 S.D.L. REV. 349 (1969); Comment, *A Review of the Locality Rule*, 1969 U. ILL. L.F. 96 (1969). *Cf.* 20 S.C.L. REV. 872 (1968) and 82 HARV. L. REV. 1781 (1969).
28. 354 Mass. at 108, 235 N.E.2d at 798. *See also* TRIAL, Aug.-Sept., 1969 at 48.
29. 72 Wash. 2d 73, 79, 431 P.2d 973, 978 (1967). "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 . . . ."
The court also "note[d] 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.
30. Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DEPAUL L. REV. 408 (1969).
31. Pederson v. Dumouchel, 72 Wash. 2d 73, 431 P.2d 973 (1967).
32. Waltz, *supra* note 30, at 418.

mally proficient practitioners have been allowed by default to set community standards—Professor Waltz speculates that "[t]he locality rule will pass unlamented by all but a handful of lawyers and a few substandard medical practitioners."[33] Whether or not the prognosis will prove accurate is moot; however, several courts have already mitigated the harshness of the "locality rule" by often ingenious means,[34] and several have adopted *Brune*.[35]

As opposed to the general practitioner, the standard of skill required of specialists has been less dependent on the specialist's locality,[36] and more dependent on the "state of the art."[37] The reason is patently obvious. A community may have several general practitioners; therefore, it is at least arguable that a community standard does in fact exist. But specialists are usually located either in the larger metropolitan areas or in defined geographic regions. Thus, to talk in terms of a community

33. *Id.* at 420.

34. *See generally* 70 C.J.S. *Physicians and Surgeons* § 42, 43 (1951) and 41 AM. JUR. *Physician and Surgeons* § 86, 87 (1942). For a state tally of the locality rule as of 1969, *see* Alexander, *The Standard of Care*, MEDICAL & DENTAL MALPRACTICE 9 (I. Cohen ed. 1969).

35. *See, e.g.*, Avey v. St. Francis Hospital and School of Nursing, Inc., 201 Kan. 687, 442 P.2d 1013 (1968); King v. Flamm, 442 S.W.2d 679 (Tex. 1969), *rev'g* 434 S.W.2d 197 (Tex. 1968). For the latest statement of Texas law, *see* Christian v. Jeter, 445 S.W.2d 51 (Tex. 1969), which quotes 8 A.L.R.2d 773 (1949).

Brune was decided by the Massachusetts Supreme Judicial Court on April 3, 1968. But the "locality rule" question was also under discussion in the federal courts of Massachusetts. *Alexandridis v. Jewett*, 388 F.2d 829 (1st Cir. 1968), which was decided on January 24, 1968, presents a tragic fact situation. During parturition, the defendant physician performed an episiotomy (incision) in the perineum to allow more room for delivery. The anal sphincter subsequently ruptured, and the defendant attempted repair. The original incision (which was totally unnecessary according to expert testimony) and the attempted repair became infected when the sutures parted. Two subsequent operations to correct the plaintiff's condition also failed, and she has since been left with chronic rectal incontinence.

The court, which granted the plaintiff a new trial, avoided the "locality rule" by saying that the plaintiff had contracted for the care of two specialists and instead she received the service of a first-year obstetric resident. Therefore, the care provided for was less than that contracted for.

A federal court in Colorado was apparently unable to find a way to bypass the state "locality rule" when it reluctantly followed the doctrine as set forth in *Erie Railroad v. Tompkins*, 304 U.S. 64 (1938). The Colorado court, in citing *Brune* said, "Certainly the similar locality test has been subjected to persuasive, scholarly criticism and has recently been rejected . . . . But in the diversity suit we are, of course, bound by the Colorado rule." Murphy v. Dyer, 409 F.2d 747, 749 (D. Colo. 1969).

One cannot help but question the merits of *Erie* when viewed in light of *Murphy, supra*. When faced with an unclear rule or an "antiquated" rule, one can readily see the merits of choosing the state forum when litigating such a question.

36. *See generally* 21 A.L.R.3d 953 (1968).

37. *E.g.*, Cavallaro v. Sharp, 84 R.I. 67, 121 A.2d 669 (1956).

standard is absurd. The best standard for the specialist is perhaps regional or hopefully national. Several courts have specifically abandoned the "locality rule" as applied to specialists.[38]

C. The Locality Rule in South Carolina

South Carolina has had relatively few malpractice cases, and of these cases fewer yet involving the "locality rule."[39] The latest statement by the South Carolina Supreme Court was in *Bessinger v. DeLoach*.[40] The case involved a dentist whose competence was questionable. In stating the standard, the court said that the dentist is

> only bound to possess and exercise that degree of skill and learning which is ordinarily possessed and exercised by members of his profession in good standing in the same general neighborhood or in similar localities. Failure to perform his duty in either of these respects is malpractice.[41]

As is often the case, a rule stated in one forum is interpreted by another. In *Kapuschinsky v. United States*[42] the Federal District Court for South Carolina said:

> From South Carolina authority [*Bessinger*] it can be inferred that at least the "community" standard [for hospitals] would obtain . . . . [I]t would seem that the "community" is not necessarily restricted to the geographical area in proximity to the alleged tortfeasor, but would extend to other locales similarly situated.[43]

The court substantiated its conclusion by citing a ninth circuit opinion which held that " 'the essential factor is knowledge of similarity of conditions; geographical proximity is only one factor to be considered.' "[44] The Federal District Court for

38. Carbone v. Warburton, 11 N.J. 418, 94 A.2d 680 (1953); Hundley v. Martinez, 151 W. Va. 977, 158 S.E.2d 159 (1967).

39. The practitioner's biggest problem in relation to the "locality rule" is keeping abreast of the latest developments and techniques. A physician in a rural community does not have the same degree of exposure as the physician fortunate enough to be associated with a clinic or hospital in a technically progressive area. It is interesting to note that the South Carolina branch of the American College of Surgeons' Committee on Trauma is presently trying to alleviate the problem by coordinating a training program for rural practicing physicians. *See, Aid to the Injured: The South Carolina Concept,* JOURNAL OF AMERICAN INSURANCE, May-June 1970, at 2.

40. 230 S.C. 1, 94 S.E.2d 3 (1956).

41. *Id.* at 7, 94 S.E.2d at 6.

42. 248 F. Supp. 732 (D.S.C. 1966).

43. *Id.* at 743.

44. United States v. Canon, 217 F.2d 70, 73 (9th Cir. 1954).

South Carolina continued: "The argument for application of a 'national standard' has efficacy here because [the Naval Hospital] was accredited by the Joint Commission of Accreditation of Hospitals."[45] At least one commentator[46] seems to believe that, via *Kapuschinsky*, South Carolina has enunciated and follows a minimum national standard for doctors similar to that suggested in *Brune*.[47]

The South Carolina position, however, is at best confused. The latest interpretation of South Carolina's position came in *Steeves v. United States*,[48] where Judge Hemphill essentially reiterated his *Kapuschinsky* views. He held that a practitioner must "only possess and exercise that degree of skill and learning which is ordinarily possessed and exercised by members of his profession who are in good standing and live in a general neighborhood or in a similar locality."[49]

Although *Kapuschinsky* leaves little doubt that the "hospital locality rule" has virtually no place within the federal courts in South Carolina, a valid question remains as to what degree the "locality rule" has been abrogated in the South Carolina state courts. The variations of the rule stated in *Bessinger* are not as clear, nor as broad, as stated in *Kapuschinsky*. But neither is the rule as stated in *Bessinger* as narrow as that in *Small*. Perhaps when appropriate facts present themselves, the Supreme Court of South Carolina will make a clearer statement of what the South Carolina position is.

III. The "Conspiracy of Silence"

While the "locality rule" precludes numerous suits, the "conspiracy of silence" terminates a far greater number because it makes it extremely difficult for the plaintiff to acquire the expert testimony necessary to carry his burden of proof. Such a "conspiracy" is kept active by formal and informal medical associations. But perhaps the biggest "conspiracy" supporter is the malpractice insurance carrier which Melvin M. Belli affectionately refers to as the "Mount Everest Holy Grail Insurance

45. Kapuschinsky v. United States, 248 F. Supp. 732, 744 (D.S.C. 1966). *See* Note, *Non-Resident Expert Testimony on Local Hospital Standards,* 18 Clev. St. L. Rev. 493, 501 (1969).
46. Alexander, *The Standard of Care,* Medical & Dental Malpractice 9, 14 (I. Cohen ed. 1969).
47. Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968).
48. 294 F. Supp. 446 (D.S.C. 1968).
49. *Id.* at 453.

Company, Inc., of Nebraska or whatever."[50] He states that the "physician's pride in his profession has been transcended by his sense of duty to the . . ."[51] insurance company which "wield[s] the whip that keeps medical men silent and in line."[52]

A cursory investigation of legal history shows how medical insurance carriers came into existence and explains their relative popularity. " 'The oldest code of laws in the world' of which we are aware, promulgated by Hammurabi, King of Babylon B.C. 2285-2242" established liability for the malpractitioner.[53] Alexander went a bit further and "condemned the doctor to death for breach of professional duty."[54] Needless to say, the doctors sought to mitigate the consequences of malpractice, so *inter alia* the "locality rule" was devised along with malpractice insurance and silence outside of the medical fraternity.[55] In *Kapuschinsky*, the court said:

> The Court recognizes the difficulty plaintiff had in obtaining local specialists to testify. Judicial notice will be taken of the well recognized reluctance of members of the medical profession to testify in cases of this

50. Belli, *An Ancient Therapy Still Applied: The Silent Medical Treatment,* 1 VILL. L. REV. 250, 257 (1956).

51. *Id.*

52. *Id.* at 253.

53. Perhaps the lawyer's most accessible source of relevant segments of the *Hammurabic Code* is in *Hughes v. State Board of Medical Examiners,* 162 Ga. 246, 262, 134 S.E. 42, 49 (1926). A typical clause is: "If a doctor has treated a gentlemen for a severe wound with a lancet of bronze and has caused the gentleman to die, or has opened an abscess of the eye for a gentleman with the bronze lancet and has caused the loss of the gentleman's eye, one shall cut off his hands."

54. 3 M. BELLI, MODERN TRIALS 1975 (1954). For an excellent discussion on suing a doctor for malpractice, the history of medical responsibilities, and quantum of care required, *see respectively* 3 M. BELLI, MODERN TRIALS §§ 327, 328, 329 (1954).

55. Consider Justice Carter's interesting and often quoted dissent in *Huffman v. Lindquist,* 37 Cal. 2d 465, 484, 234 P.2d 34, 46 (1951).

> Anyone familiar with cases of this character knows that the so-called ethical practitioner will not testify on behalf of a plaintiff regardless of the merits of his case. This is largely due to the pressure exerted by medical societies and public liability insurance companies which issue policies of liability insurance to physicians covering malpractice claims. While court records show that some of these claims may be questionable, many have substantial merit and ethical considerations are generally with the plaintiff's side of the case. But regardless of the merits of the plaintiff's case, physicians who are members of medical societies flock to the defense of their fellow member charged with malpractice and the plaintiff is relegated, for his expert testimony, to the occasional lone wolf or heroic soul, who for the sake of truth and justice has the courage to run the risk of ostracism by his fellow practitioners and the cancellation of his public liability insurance policy.

See also 31 JATLJ L.J. 128 (1968).

> style . . . . Some plaintiffs' lawyers call this a "conspiracy of silence," though that characterization seems a bit strong.[56]

Whether the characterization is strong or weak is somewhat academic. The fact remains that citizens, who seek legal redress against an alleged malpractitioner, are seriously hampered by the physicians' individual and collective actions and the actions of their insurance carriers. One can plausibly argue that such actions effectively take the administration of justice out of the judicial organs, as they deny a plaintiff his constitutionally quaranteed right of a trial by jury.[57]

The question is how does the plaintiff's attorney fight this "conspiracy." Since practitioners cannot be forced to testify against their fellow practitioners, several techniques have been developed. One, which is not particularly popular, is the implied contractual obligation and its consequential breach.[58] Here, the lawyer must prove a contract from complex facts and then show that the contract was breached. This in itself will cause all but the most proficient lawyers to turn to tort actions, but another major reason for avoiding an action for breach of contract is that damages have been historically limited to real damages.

The two most popular tort theories in malpractice litigation are: (1) res ipsa loquitur and (2) battery. The advantage of both of these legal theories is that the plaintiff does not have to produce an expert practitioner to prove his case. However, their application is limited to "some medical and surgical errors on which any layman is competent to pass judgment and con-

56. Kapuschinsky v. United States, 248 F. Supp. 732, 744 n.15 (D.S.C. 1966).

57. U.S. CONST. amend. VII, *as construed in* Capital Traction v. Hof, 174 U.S. 1, 23 (1899). *See also* TRIAL, Feb.-Mar. 1970 at 18. Much attention has been devoted to the medical profession and its various legal problems as related to the "conspiracy of silence." A partial bibliography of relevant topics is herein included: Wasmuth, *The Conspiracy of Silence: Physician's View* 15 CLEV.-MAR. L. REV. 85 (1966); Trout, *Medical Witness' Treatment by Courts,* 17 CLEV.-MAR. L. REV. 213 (1968); Franklin, *What Should Be in a Malpractice Insurance Policy,* 14 CLEV.-MAR. L. REV. 478 (1965); Note, *The Physician as a Witness,* 16 CLEV.-MAR. L. REV. 494 (1967); Belli, *An Ancient Therapy Still Applied: The Silent Medical Treatment,* 1 VILL. L. REV. 250 (1956). *See also* Currin, *A Symposium of Professional Negligence,* 12 VAND. L. REV. 535 *et seq.* (1959). In particular *see* Hirsh, *Insuring Against Medical Professional Liability,* 12 VAND. L. REV. 667 (1959). South Carolinians should be particularly interested in: George Savage King, *Liability for Negligence of Pharmacists,* 12 VAND. L. REV. 695 (1959). *See also* Note, *Malpractice and Medical Testimony,* 77 HARV. L. REV. 333 (1964).

58. *See* Alexandridis v. Jewett, 388 F.2d 829 (1st Cir. 1968), which is discussed in note 35, *supra.*

clude from common experience that such things do not happen if there has been proper skill and care."[59]

South Carolina, though it purports to reject res ipsa loquitur by name, nevertheless accepts it in fact.[60] To prove injury by res ipsa loquitur, three elements must be proven:

> (1) [T]he event must be of a kind which ordinarily does not occur in the absence of someone's negligence; (2) it must be caused by an agency or instrumentality within the exclusive control of the defendant; [and] (3) it must not have been due to any voluntary action or contribution on the part of the plaintiff.[61]

The other tort action which is often employed is battery. Battery in malpractice suits can be summarized by saying:

> Every individual has a right to the inviolability of his person which forbids a surgeon or physician to invade the bodily integrity of his person. Whenever a surgeon or physician, *without* the patient's permission, performs an operation or renders medical treatment, he prima facie commits a battery.[62]

Res ipsa loquitur and battery are nothing more than tort theories, which may be employed to enable a plaintiff to avoid producing an expert witness. Unless the plaintiff is able to employ one of these strategies, he is compelled to produce a medical expert who can carry his burden of proof. Should he be unable to get an expert, the plaintiff is virtually precluded from recovery.

IV. Conclusion

In addition to the various attacks that are being directed at the "locality rule" by the legal profession, it is interesting to note that it is also under attack by the medical profession.[63]

59. W. Prosser, Handbook of the Law of Torts 231 (3d ed. 1964).
60. *Torts, 1969 Survey of South Carolina Law,* 21 S.C.L. Rev. 659, 663 (1969).
61. W. Prosser, Handbook of the Law of Torts 218 (3d ed. 1964). *See also* Binder, *Res Ipsa Loquitur in Medical Malpractice,* 17 Clev.-Mar. L. Rev. 218 (1968).
62. McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment,* 41 Minn. L. Rev. 381, 392 (1957) (emphasis added). *See also* Smith, *Battery in Medical Torts,* 16 Clev.-Mar. L. Rev. 22 (1967).
63. *See generally* Trial, Oct.-Nov. 1969 at 50 and *Aid to the Injured: The South Carolina Concept,* Journal of American Insurance, May-June 1970 at 1.

Perhaps the rule's lack of popularity stems from social changes which have changed our society from a largely agrarian one posited on provincial ideals, to one which is relatively well-educated, highly mobile, and rather cosmopolitan.

Similarly, the "conspiracy of silence" is being attacked by both the legal and medical communities. But the "conspiracy" has not been mitigated to the extent that the "locality rule" has been. Based on the imminent changes our society will experience, it necessarily follows that the bench and the bar will respond by seeking to overrule the highly technical rules which have little justification in today's social structure.

DAVID D. ARMSTRONG