IMPLICATIONS OF MEDICAL EDUCATION OF OSTEOPATHS AND ALLOPATHS ON THE APPLICABLE STANDARD OF CARE IN MEDICAL NEGLIGENCE ACTIONS

The law of negligence today animates medical professional liability lawsuits.[1] Osteopathic[2] as well as allopathic[3] physicians are subject to negligence liability.[4] Traditionally, courts considered osteopathic and allopathic physicians as members of different schools of medicine because of their diverse philosophical origins.[5] This classification led courts in most circumstances to hold allopaths and osteopaths to different standards of care.[6] As a result, osteopaths could potentially establish their own, perhaps lower, standard of care enabling them to reduce their exposure to liability.[7]

This note examines the standard of care courts apply in medical negligence actions against allopathic and osteopathic physicians in light of the current education and training of both groups. This note argues

1. Originally, medical liability actions sounded in contract. 1 C. FRANKEL, J. ZIMMERLY & R. PATTERSON, LAWYER'S MEDICAL CYCLOPEDIA OF PERSONAL INJURIES AND ALLIED SPECIALTIES § 2.29 (3d ed. 1981) [hereinafter cited as LAWYER'S MEDICAL CYCLOPEDIA]. Today, a physician may contract to cure a patient or achieve certain results, and is liable for breach of contract for failure to achieve this cure or result. W. PROSSER, THE LAW OF TORTS 162 (4th ed. 1971). Actions in tort, other than negligence, are also maintainable against a physician. *See, e.g.*, Bowers v. Talmage, 159 So.2d 888 (Fla. App. 1963) (misrepresentation or fraud); Bang v. Charles T. Miller Hosp., 251 Minn. 427, 88 N.W.2d 186 (1958) (battery: absence of patient's consent); Pendleton v. Burkhalter, 432 S.W.2d 724 (Tex. Civ. App. 1968) (false imprisonment). For a general discussion of these alternative actions, see Note, *Who's Afraid of Informed Consent? An Affirmative Approach to the Medical Malpractice Crisis*, 44 BROOKLYN L. REV. 241 (1978).

2. Osteopathic physicians receive the degree of D.O. (doctor of osteopathy). Osteopathy is a school of medicine and diagnosis that places emphasis on the relationship of the muscoskeletal system to all other body parts. WEBSTER'S NEW WORLD DICTIONARY 1007 (2d ed. 1979). For a discussion of osteopathic education and practice, see *infra* notes 82-102 and accompanying text. *See generally* Sprafta, Ward & Neff, *What Characterizes an Osteopathic Principle? Selected Responses to an Open Question*, 80 J.Am. OSTEOPATHIC A. 29 (1981).

3. Allopathic physicians are those who receive an M.D. (medical doctor) degree. Strictly defined, allopathy is the external treatment of disease by remedies that produce effects opposite to or different from those the disease produces. WEBSTER'S NEW WORLD DICTIONARY 37 (2d ed. 1979). For a discussion of allopathic medicine, see *infra* notes 64-81 and accompanying text.

4. *See infra* notes 9-60 and accompanying text.

5. *See infra* notes 42-47 & 82-89 and accompanying text.

6. *See infra* notes 42-47 & 82-89 and accompanying text.

7. *See infra* notes 27-30 and accompanying text.

that modern osteopathic education is sufficiently similar to allopathic education to justify holding osteopaths and allopaths to the same standard of care.[8]

I. THE STANDARD OF CARE IN MEDICAL NEGLIGENCE ACTIONS

An individual is not negligent unless the law imposes a duty on that person to adhere to a certain standard of care.[9] In ordinary negligence cases courts usually express this standard as that of the conduct of "the reasonable man of ordinary prudence."[10] When, however, a person possesses knowledge or skill superior to that of the ordinary reasonable person, courts require adherence to a standard of care consistent with the higher level of knowledge and skill.[11]

This higher standard of care for knowledgeable or skilled individuals has obvious implications for medical professionals. Courts require osteopathic and allopathic physicians to possess and use the degree of skill and knowledge normally possessed by members of their profession.[12] A physician is therefore liable for negligent acts which result from a failure to apply the requisite skill and learning.[13] A physician

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8. *See infra* notes 115-133 and accompanying text.

9. W. PROSSER, *supra* note 1, at 143. The elements of a cause of action for negligence are stated in the RESTATEMENT (SECOND) OF TORTS § 281 (1965), which provides as follows:

> The actor is liable for an invasion of an interest of another, if:
> (a) the interest invaded is protected against unintentional invasion, and
> (b) the conduct of the actor is negligent with respect to the other, or a class of persons within which he is included, and
> (c) the other has not so conducted himself as to disable himself from bringing an action for such invasion.

10. W. PROSSER, *supra* note 1, at 150 (quoting Vaughn v. Menlove, 3 Bing. N.C. 457, 132 Eng. Rep. 490 (1837). *See also* McCoid, *The Care Required of Medical Practitioners,* 12 VAND. L. REV. 549, 558 (1959).

11. W. PROSSER, *supra* note 1, at 161. The RESTATEMENT (SECOND) OF TORTS § 289 comment m (1965) addresses itself to this point:

> m. Superior qualities of an actor. The standard of the reasonable man requires only a minimum of attention, perception, memory, knowledge, intelligence, and judgment in order to recognize the existence of the risk. If the actor has in fact more than the minimum of these qualities, he is required to exercise the superior qualities that he has in a manner reasonable under the circumstances. The standard becomes, in other words, that of a reasonable man with such superior attributes.

12. W. PROSSER, *supra* note 1, at 161. *See also* RESTATEMENT (SECOND) OF TORTS § 299A (1965). This statement is the most general articulation of the standard. Jurisdictions throughout the country have defined and qualified this standard through use of the locality and same school rules. *See infra* notes 27-60 and accompanying text.

13. W. PROSSER, *supra* note 1, at 162. *See* Ayers v. Parry, 192 F.2d 181 (3d Cir.), *cert. denied,*

also incurs liability if he knew or should have known that his skill and knowledge were insufficient to treat the patient's condition with a reasonable possibility of success.[14] An undesirable result alone, without proof that the physician deviated from the applicable standard of care, is not a sufficient basis for actionable negligence.[15]

In ordinary negligence cases, evidence of custom is one non-conclusive factor in determining whether the defendant adhered to the proper standard of care.[16] In medical negligence cases courts generally hold that custom is conclusive.[17] It is often the sole evidence of the standard of care.[18] Proof that a respectable minority of physicians adhere to a

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343 U.S. 980 (1951); Johnson v. Colp, 211 Minn. 245, 300 N.W. 791 (1941). The determination of whether a physician has properly applied his knowledge and skill normally requires expert testimony. Hopkins v. United States, 152 F. Supp. 473 (E.D. Mo. 1957); Shea v. Phillips, 213 Ga. 269, 98 S.E.2d 552 (1957). *But see* Larsen v. Yelle, 310 Minn. 521, 246 N.W.2d 841 (1976) (increasing lay familiarity with some medical techniques may make expert testimony unnecessary in some cases). In some cases the injury or event leading to the malpractice action is such that a lay person could decide whether the result would have occurred in the absence of negligence. In these cases the jury may infer negligence without expert testimony, using the doctrine of res ipsa loquitur. Evans v. Roberts, 172 Iowa 653, 154 N.W. 923 (1915) (doctor cut off patient's tongue during an adenoid removal operation). *See also* W. PROSSER, *supra* note 1, at 164. The expert testimony requirement may be a result of deference paid by the legal profession to the medical profession. McCoid, *supra* note 10, at 608. For a discussion of the law's unusual deference to custom in medical negligence actions, *see infra* notes 16-26 and accompanying text. *See generally* Morris, *The Role of Expert Testimony in the Trial of Negligence Issues,* 26 TEX. L. REV. 1, 1-10 (1947).

14. *See* Simone v. Sabo, 37 Cal. 2d 253, 231 P.2d 19 (1951); Manion v. Tweedy, 257 Minn. 59, 100 N.W.2d 124 (1959). Courts refer to this requirement as the physician's duty to refer a patient to a specialist.

15. *See, e.g.,* Siirila v. Barrios, 398 Mich. 576, 228 N.W.2d 801 (1975); Montana Deaconess Hosp. v. Gratton, 169 Mont. 185, 545 P.2d 670 (1976). *See generally* Holder, *Trends in Malpractice Litigation,* 53 YALE J. BIOLOGICAL MED. 333, 340-41 (1980); McCoid, *supra* note 10, at 573.

16. W. PROSSER, *supra* note 1, at 166-68; McCoid, *supra* note 10, at 605-606.

17. McCoid, *supra* note 10, at 606. Dean Prosser notes that good medical practice becomes practice which is customary and usual in the profession. W. PROSSER, *supra* note 1, at 165. *See also* King, *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula,* 28 VAND. L. REV. 1213, 1235 (1975).

Commentators offer several explanations for the crucial role of custom in medical malpractice actions. One expert states that most medical decisions regarding methods of treatment and diagnosis are beyond the knowledge of lay people. *See* Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice,* 1975 DUKE L.J. 1375, 1389-1390. Another explanation advances a theory of implied representation. The physician by practicing medicine impliedly represents that he will follow customary methods. W. PROSSER, *supra* note 1, at 165. Prosser also suggests that the respect of the legal profession for the medical profession explains the unusual reliance on custom in medical negligence cases. *Id.* A more innovative explanation, based on the importance of risk factors in negligence law, is that custom indicates the most desirable level of risk avoidance, based on cost and result. Bovbjerg, *supra,* at 1390 (citing R. POSNER, ECONOMIC ANALYSIS OF LAW 69-70 (1973)).

18. *See* authorities cited *supra* note 17.

particular practice is sufficient proof of acceptable custom.[19]

Critics assert, however, that reliance on custom as the standard of care may permit the entire medical industry legitimately to provide substandard care.[20] As a result, the Washington Supreme Court in *Helling v. Carey*[21] stated that adherence to custom is not conclusive proof that a physician's conduct meets the requisite standard of care.[22] The court reasoned that while custom usually is reasonable conduct, it can never be the strict measure of reasonableness.[23] The court held that despite uncontradicted expert testimony that the defendant had adhered to the universal, customary practice of medical doctors in his field, his conduct, under the circumstances, was negligent.[24] Other jurisdictions have adopted this position,[25] holding that evidence of cus-

19. *See* Riddlesperger v. United States, 406 F. Supp. 617 (D. Ala. 1976); Leech v. Bralliar, 275 F. Supp. 897 (D. Ariz. 1967). *See also* King, *supra* note 17, at 1237. This aspect of medical malpractice law would become more important if courts considered osteopaths and allopaths to be members of the same school for purposes of the same school rule. *See infra* notes 42-60 and accompanying text for a discussion of the same school rule. The "respectable minority" rule would allow for cases in which osteopaths and allopaths might prescribe different treatments. As there are over 21,000 osteopathic physicians in the United States today, osteopaths undoubtedly should be considered a respectable minority of the medical profession. *See infra* notes 87 & 128-131 and accompanying text.

20. Bovbjerg, *supra* note 17, at 1390, 1391. *See generally* McCoid, *supra* note 10, at 606; Morris, *Custom and Negligence,* 42 COLUM. L. REV. 1147, 1153-1154 (1942). Customary practice, however, can just as easily set the standard of care at an unnecessarily high level, resulting in higher costs to the patient-consumer and perhaps unnecessary medical tests and treatment. Bovbjerg, *supra* note 17, at 1380-1390.

21. 83 Wash. 2d 514, 519 P.2d 981 (1974).

22. *Id.* at 516, 519 P.2d at 982.

23. *Id.* The court relied on Judge Learned Hand's pronouncement of the law in The T.J. Hooper, 60 F.2d 737 (2d Cir. 1932):

> [I]n most cases reasonable prudence is in fact common prudence; but *strictly* it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It never may set its own tests, however persuasive by its usages. Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission.

Id. at 740.

24. *Helling,* 83 Wash. 2d at 516, 519 P.2d at 982.

25. *See e.g.,* Morgan v. Shepard, 91 Ohio L. Abs. 579, 188 N.E.2d 808 (1963). The *Morgan* court stated that methods customarily employed by physicians do not furnish a test which is controlling on the question of negligence. *Id.* at 593, 188 N.E.2d at 816. *Accord* Lundahl v. Rockford Memorial Hosp. Ass'n, 93 Ill. App. 2d 461, 235 N.E.2d 671 (1968). In Toth v. Community Hosp., 22 N.Y.2d 255, 239 N.E.2d 368, 292 N.Y.S.2d 440 (1967), the New York Court of Appeals articulated a standard slightly different than custom. The *Toth* court held that the standard of care to which defendant-physicians must adhere is measured not by compliance with *custom* but by compliance with *accepted* medical practice. One critic has argued, however, that the *Toth* court did not base its decision on the newly articulated standard, but on the defendant's actual knowledge

tom may be unacceptable because it is inadequate in light of the knowledge possessed by the profession concerning the risks involved in a procedure or in light of improved techniques promising greater success than the customary technique.[26]

A further qualification on the standard of care calculus is the locality rule. Courts employ the locality rule to limit the geographic area from which witnesses may show evidence of custom. In its original form the locality rule provided that a court can hold a physician only to that degree of skill and care possessed and exercised by other physicians practicing in the same area.[27] Courts reasoned that doctors in small rural communities did not have the same resources and educational opportunities as doctors in metropolitan areas and thus that it was unfair to hold all doctors to the same standard of care.[28]

From its inception, strict usage of the locality rule engendered problems. Doctors in the same community were hesitant to testify against one another. A conspiracy of silence was created.[29] Moreover, the rule enabled a small group of physicians in one area to establish an inferior standard of care.[30] The development of advanced communication and transportation devices, however, led to the eventual decline of

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that the (customary) treatment administered to the patient was at best questionable and probably unsafe. King, *supra* note 17, at 1236-37.

Although the Washington state legislature passed a statute purporting to overrule the decision in *Helling v. Carey*, *see* WASH. REV. CODE § 4-24-290 (Supp. 1982), the Washington Supreme Court in Gates v. Jensen, 92 Wash. 2d 246, 595 P.2d 919 (1979) reaffirmed *Helling* stating that "reasonable prudence may require a . . . standard of care [higher] than that exercised by the relevant professional group." *Id.* at 253, 595 P.2d at 924.

26. *See* King, *supra* note 17, at 1248.

27. *See e.g.*, Small v. Howard, 128 Mass. 131 (1888), *overruled in* Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968). *See also* Loftus v. Layden, 391 A.2d 749 (Del. Super. Ct. 1978); Tefft v. Wilcox, 6 Kan. 46 (1870). To obtain evidence of the local standard of care, courts require that only experts from the same locality as the defendant serve as witnesses. *See* Force v. Gregory, 63 Conn. 167, 27 A. 1116 (1893); Burk v. Foster, 114 Ky. 20, 69 S.W. 1096 (1902).

28. Pederson v. Dumouchel, 72 Wash. 2d 73, 77, 431 P.2d 973, 977 (1967). *See* McCoid, *supra* note 10, at 569; Note, *An Evaluation of Changes in Medical Standard of Care,* 23 VAND. L. REV. 729, 731-33 (1970). At the time of the development of the locality rule, there were many medical schools in America. Only about half of these were accredited. Medical education standards varied tremendously from one location to the next. *Id.* at 733 n.17. Although the reasons behind the locality rule are applicable to other professions, courts traditionally applied the rule only to doctors. *Id.* at 731. *See* Wade, *The Attorney's Liability for Negligence,* 12 VAND. L. REV. 755, 762, 763 (1959).

29. Pederson v. Dumouchel, 72 Wash. 2d 73, 78, 431 P.2d 973, 977 (1967). *See* W. PROSSER, *supra* note 1, at 164; Note, *supra* note 28, at 731.

30. *See* authorities cited *supra* note 29.

the rule.[31] These advances facilitated the standardization of medical training and created more opportunities for continuing medical education through travel to major medical facilities and access to professional medical journals or local medical seminars.[32]

Recognizing these changes, some courts gradually replaced the original "same" locality rule with a "similar" locality rule.[33] Under this version of the locality rule a physician's conduct is measured against the standard of care exercised by physicians practicing in an area with educational opportunities similar to those in defendant's area.[34] Other courts hold that locality is merely one factor to consider in determining the appropriate standard of care.[35] A few courts have advanced a "same class" standard which holds that it is not the physician's locality which determines the applicable standard of care but rather the de-

31. *See* Harris, *Survey of Medical Communication Sources Available for Continuing Physician Education,* 41 J. MED. EDUC. 737 (May-July 1966).

32. Since 1942, the American Medical Association (AMA) has accredited medical schools on a national basis. Note, *supra* note 28, at 733 n.17. Some states require evidence of continuing medical education as a prerequisite to reregistration of a physician's medical license. *The Impact of Mandatory Continuing Medical Education,* 239 J. A.M.A. 2663, 2663-2666 (1978). *See also infra* notes 64-66 & 77-80 and accompanying text.

33. *See, e.g.,* Borowski v. Von Solbrig, 14 Ill. App. 3d 672, 303 N.E.2d 146 (1973) *aff'd,* 60 Ill. 2d 418, 328 N.E.2d 301 (1975) (standard of care was that of physician in same or similar community or hospital). For other jurisdictions in which the similar locality rule is in effect, see Annot., 99 A.L.R. 3d 1133 (1981). In some states the legislature has modified or abolished the locality rule. *See, e.g.,* WIS. STAT. § 147-14(2)(a) (1955). The "similar" locality rule eliminates the problem of doctors' unwillingness to testify against fellow physicians in their community. Note, *Overcoming the "Conspiracy of Silence": Statutory and Common Law Innovations,* 45 MINN. L. REV. 1019, 1043-1045 (1961).

34. *See, e.g.,* Geraty v. Kaufman, 115 Conn. 563, 162 A. 33 (1932); Flock v. J.C. Palumbo Fruit Co., 63 Idaho 220, 118 P.2d 707 (1941); Tvedt v. Haugen, 70 N.D. 338, 294 N.W. 183 (1940); Hadgson v. Bigelow, 335 Pa. 497, 7 A.2d 338 (1939). In *Tvedt,* a small-town practitioner defending a malpractice claim argued that he did not have adequate x-ray facilities to examine the plaintiff's fracture properly. The court held that the defendant had access to better x-ray facilities in nearby towns and should have used those facilities. *Tvedt,* 70 N.D. 338, 349, 294 N.W. 183, 188 (1940).

35. Pederson v. Dumouchel, 72 Wash. 2d 73, 431 P.2d 973 (1967). In *Pederson* the court stated that the locality rule had lost all current viability. The court stated that "negligence cannot be excused on the ground that others in the same locality practice the same kind of negligence." *Id.* at 78, 431 P.2d at 977. For a listing of jurisdictions following the *Pederson* approach, see Annot., 99 A.L.R. 3d 1133 (1981).

Courts take an approach similar to that in *Pederson* in cases involving a treatment that is universally the same. In these cases courts do not take locality into account. *See, e.g.,* Riley v. Layton, 329 F.2d 53 (10th Cir. 1964). In *Riley,* a case involving a fractured arm, the court permitted a San Francisco doctor to testify as to the standard of care required of a doctor in a small Utah town. *Id.* at 57. *See also* Teig v. St. Johns Hosp., 63 Wash. 2d 369, 387 P.2d 527 (1963).

fendant's class as a physician.[36]

The "same class" standard is a national approach to standard of care determination. Almost all courts employ this standard in determining the requisite standard of care for the medical specialist.[37] Courts require specialists to exercise a standard of care commensurate with the knowledge and skill possessed by like specialists.[38] The policy behind this exception to the locality rule is that the education of specialists across the nation is approximately uniform.[39] The American Medical Association (AMA) and affiliated specialty boards certify specialists on a national basis.[40] Further, recognized medical specialties have specific training requirements.[41] These requirements assure minimum standards of education, knowledge, and skill for specialists across the country, rendering the locality rule as applied to specialists a useless anachronism.

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36. Blair v. Eblen, 461 S.W.2d 370 (Ky. 1970); Farrow v. Health Services Corp., 604 P.2d 474 (Utah 1979).

37. *See* Belk v. Schweizer, 268 N.Y. 350, 149 N.E.2d 565 (1966). The minority approach holds specialists to a standard of care of specialists in the same or similar locality. *See, e.g.,* Crovella v. Cochrane, 102 So. 2d 307, 311 (Fla. App. 1958).

Medical specialists are usually defined as physicians who apply themselves to the study of a particular disease, organ, or injury of the body. B. OPPENHEIMER, A TREATISE ON MEDICAL JURISPRUDENCE 32 (1935). A medical speciality board need not certify a physician to subject that physician to a specialist's standard of care. *See* Simpson v. Davis, 219 Kan. 584, 549 P.2d 950 (1976) (physician subject to specialist standard when he holds himself out as a specialist). *See generally* LAWYER'S MEDICAL CYCLOPEDIA, *supra* note 1, § 240. If a defendant has represented himself as having less skill and knowledge than the average member of the profession, and the patient accepts treatment on that basis, the standard of care will be modified accordingly. W. PROSSER, *supra* note 1, at 163. In a trial against a specialist, however, another specialist need not testify as to the standard of care. A general practitioner can testify against a specialist if the plaintiff shows that the witness-practitioner has knowledge of the standard of care customary for the particular treatment at issue. *See, e.g.,* Carbone v. Warburton, 11 N.J. 418, 94 A.2d 680 (1953).

38. *See, e.g.,* Naccaroto v. Grob, 384 Mich. 248, 254, 180 N.W.2d 788, 791 (1970). *See* RESTATEMENT (SECOND) TORTS § 299A comment d (1965); W. PROSSER, *supra* note 1, at 163; LAWYER'S MEDICAL CYCLOPEDIA, *supra* note 1, at § 240.

39. *See infra* note 40.

40. *Future Directions for Medical Education—Report on the Council on Medical Education, Adopted June 15, 1982, by the American Medical Association House of Delegates,* 248 J. A.M.A. 3225, 3226-3232 (1982) [hereinafter cited as *Medical Education*]. Physicians are "board eligible" when they have completed the training requirements (residency and practice requirements) of their chosen specialties. Physicians become "board certified" when they pass the national examination given by the American Board of Medical Specialties and satisfy practice and continuing education requirements. *Id. See* LAWYER'S MEDICAL CYCLOPEDIA, *supra* note 1, § 240. *See also infra* notes 76-80 and accompanying text.

41. *Medical Education, supra* note 40, at 3225.

A final qualification on standard of care determination is the same school rule. Like the locality rule, the same school rule limits those who can testify against a defendant physician. The rule states that a court should judge physicians according to the principles of the school of medicine that they follow.[42] A school of medicine must be recognized, with legitimate, definite principles[43] to come within the ambit of the same school rule. Under a strict form of the rule a physician's conduct is not negligent unless the plaintiff proves, by testimony of a member of the physician's own school, that the conduct was below the proper level of care[44] as defined by practitioners of that school.

The origins of the same school rule are similar to those of the locality rule. It arose when medical education was neither standardized nor formal.[45] The field of medicine included practitioners who had a variety of theoretical approaches to the treatment of disease.[46] Courts believed that a jury would be unable to make valid judgments about the advantages or disadvantages of a particular school's method of treatment.[47]

Many jurisdictions have adopted a modified version of the same school rule that allows practitioners of different schools to testify if the physician testifying has knowledge or expertise of the other school's practices.[48] To determine what constitutes knowledge or expertise for this purpose, courts compare the nature of the witness's and the defendant's medical practice, and the witness's knowledge and experience outside his practice.[49]

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42. Force v. Gregory, 63 Conn. 167, 27 A. 1116 (1893); Patten v. Wiggin, 51 Me. 594 (1862). *See* RESTATEMENT (SECOND) TORTS § 299A comment f (1965); W. PROSSER, *supra* note 1, at 162.

43. W. PROSSER, *supra* note 1, at 163. According to Dean Prosser, "no quack, charlatan or crackpot can set himself up as a 'school' and so apply his individual ideas." *Id.* Courts have discretion to recognize or not recognize schools of medicine, but when a school has legislative recognition the statute requires the court to accept that school as a legitimate one. W. PROSSER, *supra* note 1, at 162; McCoid, *supra* note 10, at 563. *See also* Cummins v. Donley, 173 Kan. 463, 249 P.2d 695 (1952) (osteopathy legislatively recognized and therefore a school).

44. *See* Hopkins v. United States, 152 F. Supp. 473 (E.D. Mo. 1957). *See also* authorities cited *infra* note 50.

45. *See supra* notes 28-32 and accompanying text.

46. McCoid, *supra* note 10, at 562.

47. Force v. Gregory, 63 Conn. 167, 171, 27 A. 1116, 1117 (1893).

48. *See* Siirila v. Barrios, 398 Mich. 576, 248 N.W.2d 1711 (1976); Grainger v. Still, 187 Mo. 197, 85 S.W. 1114 (1905).

49. *See, e.g.,* Haisenleder v. Reeder, 114 Mich. App. 258, 318 N.W.2d 634 (1982). The *Haisenleder* court held that an allopathic medical specialist in pediatrics, epidemiology, and communicable diseases was competent to testify against an osteopath emergency room physician,

A number of courts have adopted what has become known as the treatment exception to the same school rule.[50] This exception permits the testimony of a physician of a school different from defendant's when the testimony relates to a method of treatment, care, or diagnosis for which the principles of the different schools are, or should be, the same.[51] In a recent case employing this exception, *Bivens v. Detroit Osteopathic Hospital*,[52] the Michigan Court of Appeals held that when certain physiological practices usually result in death, a witness-practitioner is competent to testify about these practices even if from a school other than that of the defendant.[53] The court reasoned that if such practices would be likely to result in death, it must be assumed that the standard of all schools would be to avoid such activities.[54]

Few courts offer any concrete guidance for application of the treatment exception. When a certain medical practice is well established and standardized, such as the treatment of fractures, courts will not invoke the same school rule.[55] Practices which trigger this exception include cataract operations, the use of x-rays, diagnosis of disease or injury, and post-operative care of a patient.[56] The Missouri Supreme

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where the plaintiff proved that the allopathic doctor had emergency room experience and that he knew of the standard of care for osteopathic emergency room doctors. *Id.* at 263-265, 318 N.W.2d at 637-38. Although the court did not explicitly state the basis for its ruling, the opinion suggests that when certain treatments are universally regarded as proper, a practitioner of one school may testify against a practitioner of another school. The allopathic physician in *Haisenleder* stated that the emergency room standard of care was the same for medical osteopathic doctors. *Id.* at 263, 318 N.W.2d 637. *Haisenleder* represents the "treatment" exception to the same school rule. *See infra* notes 50-60 and accompanying text.

50. Riley v. Layton, 329 F.2d 53 (10th Cir. 1964); Musachia v. Terry, 140 So. 2d 605 (Fla. App. 1962); Grainger v. Still, 187 Mo. 197, 85 S.W. 1114 (1905).

51. *See supra* note 49.

52. 77 Mich. App. 478, 258 N.W.2d 527 (1977), *rev'd on other grounds,* 403 Mich. 820, 282 N.W.2d 926 (1978).

53. *Id.* at 483, 258 N.W.2d at 530.

54. *Id.*

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

56. *See, e.g.,* Musachia v. Terry, 140 So. 2d 605, 607 (Fla. App. 1962) (diagnosis); Foster v. Thornton, 125 Fla. 699, 706-07, 170 So. 459, 462-63 (1936) (x-rays); Hundley v. Martinez, 151 W. Va. 977, 995, 158 S.E.2d 159, 169 (1967) (cataract operation). In *Musachia,* the court permitted an allopathic physician to testify against an osteopathic physician. The court stated as follows:

> [W]ith reference to internal injuries including fractured ribs, perforated intestines and generalized peritonitis, which resulted from a severe beating, the principles of the two schools should concur as to diagnosis. The same is applicable to the treatment since it was not made to appear that the schools to which the witness and the defendants belonged required and employed different treatment for those conditions.

140 So. 2d at 607. *See also* Reed v.Laughlin, 332 Mo. 424, 58 S.W.2d 440 (1933).

Court in *Grainger v. Still*,[57] identified at least one situation requiring the invocation of the treatment exception. In *Grainger*, the court allowed an allopathic physician to testify against an osteopathic physician in a hip injury case when the plaintiff proved that allopathic and osteopathic schools used the same textbooks.[58] The court held that when osteopaths and allopaths are educated with the same books, the same school rule is not applicable because "the rules and practices of both are the same."[59] In broad terms the court's holding means that if members of traditionally different schools receive the same education, courts presume that diagnosis and treatment are sufficiently similar for the members of different schools to testify against each other concerning the proper standard of care.[60]

II. THE STATE OF MEDICAL EDUCATION: ALLOPATHIC AND OSTEOPATHIC PHYSICIANS

Assumptions about a physician's education, training, knowledge, and skill underlie the two most significant qualifications of the general standard of care applicable in medical malpractice actions, the locality and same school rules.[61] Both rules first appeared when medical education was poorly organized.[62] As medical education has become stan-

57. 187 Mo. 197, 85 S.W. 1114 (1905). *Grainger* is still good law, and is one of the most frequently cited references for the treatment exception to the same school rule.

58. *Id.* at 224-25, 85 S.W. at 1123.

59. *Id.* The court's exact language is as follows:

> If it be true that osteopaths teach the same textbooks as other schools of medicine, then there can be no reason why a physician of any other school is not a competent witness to express an opinion as to the correctness of the diagnosis and treatment of hip disease by an osteopath, because *pro hac vice* the rules and practices of both are the same.

Id. The court provided no reason why it limited its holding "*pro hac vice*" (for this one particular occasion).

60. *Id.* Increasing numbers of courts are holding that osteopaths and allopaths are competent to testify for, or against, each other. *See* Note, *Medical Malpractice—Expert Testimony*, 60 NW. U.L. REV. 834, 840 (1966).

61. Courts developed the locality rule to protect small town rural doctors, who had little access to opportunities for education and advanced treatment facilities, from being judged by the standards of the urban doctor, who was assumed to have better opportunities to keep up with the state of the art in medicine. *See supra* notes 28-32 and accompanying text. The same school rule arose during a time when a variety of medical philosophies were in common usage. *See supra* note 46 and accompanying text. Only in the twentieth century has allopathic medicine become dominant. *See* McCoid, *supra* note 10, at 562. Courts designed the rule to allow practitioners with a given set of medical principles to be judged by their own standards. *See supra* notes 45-47 and accompanying text.

62. *See supra* notes 28 & 45 and accompanying text.

dardized, the number of cases falling within the exceptions to these rules has increased.[63] The changes in the locality and same school rules during the twentieth century reflect judicial recognition of the diminished utility of these rules in light of the nature of today's medical education and practice.

A. Allopathic Education

Only in the twentieth century did a formal system of allopathic medical education develop. During the eighteenth and nineteenth centuries most physicians had only a high school education, followed possibly by an additional year attending lectures and demonstrations at a medical school or apprenticed to a practicing physician.[64] In the late nineteenth century, John Hopkins University School of Medicine established medical education as a post-graduate discipline, creating the system that exists today.[65] A national system for accrediting medical schools did not come into existence until 1942.[66]

Currently, allopathic medical education is exclusively post-graduate. Although admissions requirements vary slightly among medical schools, most schools require undergraduate preparation in biology, inorganic and organic chemistry, and physics.[67] Medical school itself consists of four years of study. The first two years center around the study of basic medical sciences, such as anatomy, physiology, biochemistry, microbiology, and pharmacology.[68] Toward the end of the second year, most schools offer courses in physical diagnosis, medicine, surgery, and pediatrics.[69] The purpose of the first two years is to provide an education in general history, diagnosis, and management of common diseases.[70] The third and fourth years provide students with clinical experience.[71] Usually these years consist of clerkships in medicine, obstetrics and gynecology, surgery, pediatrics, and psychia-

63. *See supra* notes 33-41 & 48-60 and accompanying text.

64. LAWYER'S MEDICAL CYCLOPEDIA, *supra* note 1, § 1.1.

65. LAYWER'S MEDICAL CYCLOPEDIA, *supra* note 1, § 1.1.

66. Note, *supra* note 28, at 733 n.17.

67. *Medical Education, supra* note 40, at 3226-27. For a description of each medical school's requirements and curriculum, see ASSOCIATION OF AMERICAN MEDICAL COLLEGES, 1980-1981 MEDICAL SCHOOL ADMISSION REQUIREMENTS AND CURRICULUM DIRECTORY (1981).

68. *See* LAWYER'S MEDICAL CYCLOPEDIA, *supra* note 1, § 1.2; *Medical Education, supra* note 40, at 3228.

69. *See* authorities cited *supra* note 68.

70. *Medical Education, supra* note 40, at 3230.

71. *Id.*

try.[72] The Liaison Committee on Medical Education (LCME) is responsible for accrediting the medical school curriculum.[73]

Twenty-three residency review committees, jointly sponsored by the AMA and various medical specialty boards, evaluate and, in certain instances accredit, internships, residencies, and other programs of graduate medical education.[74] Almost all United States medical school graduates enter residency programs ranging in duration from four to seven years.[75]

The American Board of Medical Specialties currently recognizes fifty-seven areas of general or special certification.[76] Well over half of all United States medical school graduates receive Specialty Board certification.[77] Many specialty boards require doctors to receive continuing medical education in order to retain their certificate.[78] Some state boards have similar requirements for renewal of general medical licenses.[79] The Accreditation Council for Continuing Medical Education accredits continuing medical education programs.[80] Thus, over the past century medical education and training has become lengthier, more competitive, highly standardized, and significantly more specialized.[81]

B. Osteopathic Education

Osteopathic medicine originated in the late nineteenth century. Dr. Andrew Taylor Still, a physician trained at the Kansas City College of Physicians and Surgeons,[82] became disillusioned with traditional medicine and began further inquiry into the causes of disease. He developed new principles and practices and in 1892 he established the

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72. *Id.*

73. *Id.* at 3237-3238.

74. *Id.*

75. *Id.* at 3232. Increasingly, medical professionals view internships simply as part of a residency designed to train a doctor as a specialist. *Id.* at 3230.

76. *Id.* at 3225.

77. *Id.* at 3237-3238.

78. *The Impact of Mandatory Continuing Medical Education, supra* note 32, at 2666-67.

79. *Id.*

80. *Id.* The American Medical Association, the American Hospital Association, the Association for Hospital Medical Education and the Federation of State Medical Boards of the United States jointly sponsor this group.

81. *See supra* notes 64-80 and accompanying text.

82. L. WEISS & A. SPENCE, *Osteopathic Medicine,* in A GUIDE TO THE HEALTH PROFESSIONS 4 (1973).

first osteopathic medical college.[83]

Although osteopathy began as a medical reform movement, today it is an accepted school of medicine.[84] In all fifty states osteopaths are eligible for licenses for unlimited practice of medicine and surgery.[85] Further, osteopathic medicine is the fastest growing health care profession in the United States.[86] In 1970 there were 13,500 doctors of osteopathy actively practicing in the United States, representing approximately five percent of the medical profession;[87] by November 1983, this number had increased to 21,578.[88]

The nature of osteopathic medicine, and consequently the nature of osteopathic education, has changed during this century. Today osteopathic education incorporates traditional medical science as well as osteopathic principles.[89] The American Osteopathic Association (AOA) currently accredits fourteen osteopathic colleges of medicine.[90] Today, 6,133 osteopathic students attend these schools.[91] Experts expect the number of students to grow as the number of osteopathic colleges continues to increase.[92]

Like allopathic medical education, osteopathic education is postgraduate.[93] Admission to a college of osteopathic medicine requires

83. *Id.* at 4, 12. Established medical schools refused to teach Still's methods. For more information about the history of osteopathic medicine, see G. NORTHRUP, OSTEOPATHIC MEDICINE: AN AMERICAN REFORMATION (1972); A. STILL, AUTOBIOGRAPHY (1897).

84. *See infra* notes 89-98 and accompanying text.

85. *Fact Sheet: Dec. 1982,* D.O. 1, 98 (Dec. 1982). This was not always the case. For many years some states limited the practice of osteopathy by prohibiting osteopaths from prescribing drugs or performing surgery. L. WEISS & A. SPENCE, *supra* note 82, at 4.

86. LAWYER'S MEDICAL CYCLOPEDIA, *supra* note 1, § 1.19.

87. L. WEISS & A. SPENCE, *supra* note 82, at 5.

88. *Fact Sheet: Dec. 1983,* D.O. 1, 109 (Dec. 1983).

89. *Fact Sheet: Dec. 1983, supra* note 88, at 109 (Dec. 1983). The modern definition of the osteopathic principle is that the body is a self-regulating unit, with structure and function interrelated. Sprafka, Ward & Neff, *supra* note 2, at 29. For a slightly outdated definition, see McCoid, *supra* note 10, at 560.

90. *Fact Sheet: Dec. 1982, supra* note 85, at 98. A fifteenth osteopathic college is in the accreditation process. The American Osteopathic Association (A.O.A.) has had standards for approving osteopathic colleges since 1902. For a list of these A.O.A. accredited schools, see LAWYER'S MEDICAL CYCLOPEDIA, *supra* note 1, § 1.19.

91. *Fact Sheet: Dec. 1983, supra* note 88, at 109.

92. Greenman, *Osteopathic Medicine—Origins and Outlook,* 68 POSTGRADUATE MED. 31, 33 (1980). From 1982 to 1983 the number of students enrolled in osteopathic schools increased from 5,811 to 6,133. *Fact Sheet: Dec. 1983, supra* note 88, at 109.

93. Although some osteopathic colleges admit students with only three years of preprofessional training, 97% of all osteopathic students have a bachelor's degree. *Fact Sheet: Dec. 1982, supra* note 87, at 97.

undergraduate study of physics, biology, inorganic and organic chemistry, and English. For two years students study anatomy, physiology, chemistry, pathology, microbiology, immunology, and pharmacology. Students spend the next two years studying clinical subjects, including surgery, pediatrics, obstetrics and gynecology, and emergency care.[94] Schools incorporate osteopathic principles into the general study program.[95] The AOA requires a twelve-month internship following the regular four year course of study.[96] Further, the AOA supports continuing medical education and fosters it through its practice affiliates in over twenty fields.[97] Osteopathic physicians can become certified specialists, but approximately seventy-five percent are involved in the practice of family medicine.[98]

In the past, allopathic hospitals have denied hospital privileges to osteopathic physicians.[99] This is still true in certain areas. Many courts have upheld the right of both public and private hospitals to deny staff privileges to doctors of osteopathy solely because they are not medical doctors. Other courts have held that a denial on that basis alone is impermissible.[100] Denial of hospital privileges to osteopathic doctors is significant because only 152 AOA accredited osteopathic hospitals exist in the entire United States.[101] A denial of hospital privileges makes it

94. *Id. See* Powell & Feinstein, *An Alternative to the 1-Year Rotating Internship in the Osteopathic Profession,* 81 J.A. OSTEOPATHIC A. 31, 38 (1982).

95. *Fact Sheet: Dec. 1982, supra* note 85, at 97.

96. Powell & Feinstein, *supra* note 94, at 38.

97. *Fact Sheet: Dec. 1982, supra* note 85, at 98.

98. L. WEISS & A. SPENCE, *supra* note 82, at 5.

99. Blackstone, *The A.M.A. and the Osteopaths: A Study of the Power of Organized Medicine,* 22 ANTITRUST BULL. 405, 414 (1977). Increasingly, allopathic hospitals are beginning to allow osteopaths to participate in A.M.A. approved internship and residency programs. In 1980 there were 787 graduates of osteopathic medical schools enrolled in A.M.A. approved graduate medical education programs. By 1982 this number had increased to 1,040. Crowley, *Graduate Medical Education in the United States,* 250 J.A.M.A. 1541, 1545 (1983). The number of graduates of osteopathic medical schools in 1983 was 1,317. *Fact Sheet: Dec. 1983, supra* note 88, at 109.

100. For cases involving hospital privileges at public hospitals, see Richardson v. City of Miami, 144 Fla. 294, 198 So. 51 (1940) (requirement that public hospital staff members be graduates of an A.M.A. approved medical school not improper). *But cf.* Stribling v. Jolley, 241 Mo. App. 1123, 253 S.W.2d 519 (1952) (hospital cannot exclude a physician from use of public hospital facilities based upon unreasonable, arbitrary or discriminatory rules). For cases involving private hospitals, see Berman v. Florida Medical Center, Inc., 600 F.2d 466 (5th Cir. 1979) (requirement that physicians complete A.M.A. residency programs before appointment to staff held valid). *But cf.* Greisman v. Newcomb Hosp., 40 N.J. 389, 192 A.2d 817 (1963) (where private hospital was the only hospital in the area it could not deny staff privileges to a doctor of osteopathy on the sole grounds that he had not graduated from an A.M.A. approved medical school).

101. *Fact Sheet: Dec. 1983, supra* note 88, at 109.

difficult for osteopaths to offer complete medical services.[102] In addition, denial forecloses to the osteopath the educational advantages that may come from working with fellow physicians.

C. *The Relationship Between Allopathic and Osteopathic Medicine Today*

The AMA and the AOA are separate and distinct entities. Professional relations between the two groups have not always been harmonious.[103] For many years, allopathic medical doctors viewed osteopathics as cult practitioners.[104] The opening to osteopaths of internships and residencies in AMA accredited hospitals has helped osteopaths gain legitimacy as physicians.[105] As early as 1955 a committee of the AMA, along with five medical school deans, made a study of osteopathic schools.[106] This committee concluded that the educational requirements for admission to osteopathic schools were the same as those for allopathic schools and the curriculum at osteopathic schools, including both basic science and clinical training, was substantially similar to that of allopathic schools.[107]

Indications exist that allopathic medical professionals believe that osteopaths are sufficiently competent to be classified with allopathic doctors. In 1966 the Secretary to the Texas Board of Medical Examiners stated that no difference exists in the medical and surgical ability of osteopathic and allopathic physicians.[108] In 1962 California gave osteopaths the opportunity to exchange their D.O. (doctor of osteopathy) suffix for an M.D. (medical doctor) suffix.[109] At the same time Califor-

102. Blackstone, *supra* note 99, at 414. This explains why so many osteopathic physicians are engaged in family practice, in which the need for complex hospital facilities and equipment is less imperative than in other medical specialties. *See supra* note 98 and accompanying text.

103. *See generally* Blackstone, *supra* note 99, at 410-414. Blackstone posits that the A.M.A. resents the intrusion of osteopaths into the virtual monopoly allopaths maintain in the health care field. *Id.*

104. *Id.*

105. Crowley, *supra* note 99, at 1545.

106. Comment, *Expert Testimony in Medical Malpractice Cases,* 17 U. MIAMI L. REV. 182, 186 n.27 (1962) (citing *Proceedings of the Atlantic City Meeting, Report of Reference Committee on Sections and Section Work,* 158 J.A.M.A. 735 (1955)). The A.M.A. membership did not approve this report. *Id.*

107. *Id.*

108. Epstein, *Limitations on the Scope of Practice of Osteopathic Physicians,* 32 MO. L. REV. 354, 372 (1967).

109. CAL. BUS. & PROF. CODE § 2396 (Deering 1975). Other states have taken similar action. *See Update,* 73 J. A. OSTEOPATHIC A. 790, 792 (1974). Washington established a "medical col-

nia denied full licensure to any osteopathic doctors not already licensed.[110] In 1974, however, the California Supreme Court required the state to restore osteopathic licensing.[111]

In 1968 the AMA itself proposed a merger with the AOA. The AOA, however, opposed the merger.[112] While allopathic physicians may be interested in asserting control, via merger, over an increasingly strong competitor, osteopathic physicians are interested in preserving professional identity and heritage. Osteopathy today still stresses its philosophy of medicine.[113]

III. CONCLUSIONS

Courts, pursuant to the same school rule, generally must hold osteopaths to that standard of care possessed by practioners of osteopathic medicine.[114] The treatment exception to this rule arises when the medical treatment advocated by one school is, or should be, the same as that of another.[115] Over the years courts have held that many common medical practices and treatments fall within this exception to the same school rule.[116]

Today, allopathic and osteopathic medical students receive virtually identical medical science and clinical medicine training.[117] Internships and residencies in allopathic hospitals are open to osteopathic and allopathic medical school graduates, although acceptance into these programs may be more difficult for osteopathic school graduates.[118] Access to hospital facilities may also be more limited to the osteopathic physician.[119] Both the AMA and AOA support continuing medical education.[120] Basic admissions requirements for allopathic and osteo-

lege" for doctors of osteopathy at which, after a short spell of study, the D.O.'s received M.D. degrees. *See* Blackstone, *supra* note 99, at 421.

110. *See* CAL. BUS. & PROF. CODE § 2396 (Deering 1975).

111. D'Amico v. Board of Medical Examiners, 11 Cal. 3d 1, 520 P.2d 10, 112 Cal. Rptr. 786 (1974).

112. *Editorial,* 68 J. A. OSTEOPATHIC A., 445-47 (1969). *See* Epstein, *supra* note 108, at 370 n.115.

113. *See supra* notes 89 & 103 and accompanying text.

114. *See supra* notes 42-47 & 82-89 and accompanying text.

115. *See supra* notes 50-60 and accompanying text.

116. *See supra* notes 55-56 and accompanying text.

117. *See supra* notes 68-72, 93-97 & 107 and accompanying text.

118. *See supra* note 105 and accompanying text.

119. *See supra* notes 99-102 and accompanying text.

120. *See supra* notes 78-80 & 97 and accompanying text.

pathic medical schools are the same,[121] and both have become significantly more standardized since the beginning of this century.[122] Currently there is little substantive difference between allopathic and osteopathic education. Though osteopathic schools do teach osteopathic principles, these principles comprise only three to four percent of the curriculum.[123]

It is questionable whether the small differences existing between allopathic and osteopathic medical education are sufficient to sustain osteopathic medicine as a school distinct from allopathic medicine for purposes of medical negligence litigation. If the standard of care in negligence cases is based on the knowledge and skill of the actor, then courts should hold schools that possess the same knowledge and skill to the same standard of care. The education and experience of allopathic and osteopathic physicians is so substantially similar today that holding them to different standards of care serves no valid purpose.[124] Although perhaps at the beginning of the century requiring osteopaths to exercise the degree of care required of allopaths was unfair,[125] current curricula, which eliminates most of the distinctions between the schools, demand that result.[126] To hold otherwise may enable osteopaths, through a conspiracy of silence, to establish a lower standard of care for their profession.[127]

Placing osteopaths and allopaths under one roof for purposes of medical negligence litigation would not sound the death knell to those

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121. *See supra* notes 67 & 93 and accompanying text.

122. *See supra* notes 81 & 89-90 and accompanying text.

123. *See* Powell & Feinstein, *supra* note 94, at 38.

124. *See infra* notes 125-127 and accompanying text. Today, considering allopaths and osteopaths as members of different schools for purposes of the same school rule is logically inconsistent with the theoretical basis of the rule. *See supra* notes 41-46 and accompanying text.

125. *See supra* notes 42-47 & 83-84 and accompanying text.

126. *See supra* notes 42-47 & 83-84 and accompanying text. Further, the Federal Rules of Evidence support the notion that courts should allow osteopaths and allopaths to testify against each other concerning the applicable standard of care. Federal Rule of Evidence 702 provides as follows:

> If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, *a witness qualified as an expert by knowledge, skill, experience, training, or education* may testify thereto in the form of an opinion or otherwise.

FED. R. EVID. 702 (emphasis added). The rule suggests that if osteopaths and allopaths are similarly qualified because of their similar education, training, experience, knowledge, and skill, that they are from different "schools" does not bar them from serving against each other as expert witnesses in malpratice actions.

127. *See supra* notes 29-30 and accompanying text.

osteopathic principles which could evidence themselves in some type of medical treatment. Although customary medical practice generally is conclusive evidence of the proper standard of care, alternative medical practices accepted by a respectable minority of the profession also suffice as evidence of due care.[128] Osteopathic physicians constitute a small but rapidly growing percentage of all medical practitioners.[129] If osteopaths are considered a respectable minority of the medical profession, osteopathic practices followed by them, even if not the custom of the allopathic medical profession, would be acceptable under the law.[130] Thus, the integrity of osteopathic principles would survive but the same school rule, which has no conceptual foundation when applied to modern osteopaths and allopaths, would be streamlined.

Historically, the same school rule is not the only aspect of the medical negligence standard of care influenced by changes in medical education.[131] The modification of the locality rule resulted primarily from the standardization of education and the greater availability of educational opportunities.[132] The rule judging specialists by their own standards, and not by general standards influenced by locality or school, is also a result of increasing uniformity and regulation of specialty education.[133] Classifying allopathic and osteopathic physicians as one school for purposes of medical negligence law would be a recognition of the current state of osteopathic education in accordance with this trend.

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128. *See supra* note 19 and accompanying text.
129. *See supra* notes 85-87 and accompanying text.
130. *See supra* notes 19 & 128-129 and accompanying text.
131. *See supra* notes 45-48 and accompanying text.
132. *See supra* notes 31-34 and accompanying text.
133. *See supra* notes 37-41 and accompanying text.