The Standard of Care for the Medical Specialist in Ohio: *Bruni v. Tatsumi*

In a medical malpractice action, as in any action for negligence, the plaintiff must show the defendant's failure to exercise the standard of care that the law imposes. Except for those instances in which the alleged negligence of a medical practitioner involves a matter clearly within the comprehension of lay jurors, the standard of care by which the medical malpractice defendant is to be judged must be developed by expert testimony presented by the plaintiff because jurors are generally considered incapable of resolving technical medical issues by themselves.[1] Preliminarily, the plaintiff must demonstrate that his expert witness is in fact competent to testify as to the standard by which the defendant's conduct should be judged. This necessity for competent expert testimony has often proved to be a troublesome area of proof for the medical malpractice plaintiff.

The Supreme Court of Ohio has recently eased the plaintiff's burden in establishing the applicable standard of care and in demonstrating the competency of an expert medical witness. In *Bruni v. Tatsumi*[2] the court held that the standard of care for one engaged in the practice of a "board-certified medical specialty" is that of a reasonable specialist practicing the same specialty, taking into account present scientific knowledge in that area of medicine. Departing from prior Ohio law, the court expressly held that geographical considerations now control neither the applicable standard of care nor the competence of expert testimony.

The holding in *Bruni* is certain to have a significant impact upon medical malpraction litigation in Ohio. This Case Comment will discuss prior Ohio law, the rationality of the new "national" standard, and the effect that its application may have on the medical profession. It will also analyze the ambiguities apparent in the standard as formulated by the Ohio Supreme Court, and the potential application of this national standard to the general medical practitioner.

I. BACKGROUND OF *Bruni*—THE LOCALITY RULES

For many years most jurisdictions[3] adhered to the "strict locality" rule governing the applicable standard of care by which a medical practitioner's conduct was measured. According to this rule, a doctor

1. *See* W. PROSSER, TORTS § 32, at 164-65 (4th ed. 1971).

2. 46 Ohio St. 2d 127, 346 N.E.2d 673 (1976).

3. *See, e.g.*, Woodlawn Infirmary v. Byers, 216 Ala. 210, 112 So. 831 (1927); Burton v. Tribble, 189 Ark. 58, 70 S.W.2d 503 (1934); Phillips v. Powell, 210 Cal. 39, 290 P. 441 (1930); Brown v. Hughes, 94 Colo. 295, 30 P.2d 259 (1934); Slimak v. Foster, 106 Conn. 366, 138 A. 153 (1927); Swanson v. Wasson, 45 Idaho 309, 262 P. 147 (1928); Olander v. Johnson, 258 Ill. App. 89 (1931).

had a duty to his patient to possess and exercise the skill and care employed by a reasonably competent physician in the same geographic locale.[4] The rule was designed to protect the rural and small town physician, who was often less skilled and equipped than the practitioner in the large city. Despite the original appeal and apparent justification for the strict locality rule, it proved to be an unwieldy one that frequently impeded recovery by plaintiffs who actually were victims of medical malpractice. The rule suffered two notable defects that hindered plaintiffs' efforts to provide competent expert testimony. First, it in effect insulated from liability a doctor who happened to be the sole practitioner in his community because he was considered the only one qualified to testify as to the applicable standard. Second, a "conspiracy of silence" among fellow practitioners in a community often precluded the possibility of obtaining the expert testimony necessary for the plaintiff to meet his burden of proof.[5]

Dissatisfaction with the strict locality rule led to its gradual decline,[6] and today many states have embraced the "same or similar locality" rule.[7] This rule is based on the concept that a medical expert is qualified to testify about the applicable standard of care in a malpractice action if his community, or other communities with which he is acquainted, bear sufficient similarity to that in which the alleged tort occurred. As to what constitutes a "similar community," however, jurisdictions have differed. Some have held that the criteria by which similarity is to be determined are such socio-economic factors as population, type of economy, and income level.[8] The better-reasoned

4. *See* Schireson v. Walsh, 354 Ill. 40, 187 N.E. 921 (1934); Hollis v. Ahlquist, 142 Wash. 33, 251 P. 871 (1927). A like standard has been formulated with slight variations depending on the jurisdiction. While some courts refer to a "reasonably competent" physician, a "physician in good standing," or an "average physician," such terminology is not altogether precise. For instance, it is clear from the cases that the use of the word "average" was never meant to suggest a statistical average arrived at by examining the varying qualifications and capabilities of physicians in a jurisdiction ranging from the most to least competent and experienced. Rather, it appears that the term "average physician" is used in a more familiar sense to mean one of ordinary or reasonable education and training. *See, e.g.*, Sim v. Weeks, 7 Cal. App. 2d 28, 45 P.2d 350 (1935); Holtzman v. Hoy, 118 Ill. 534, 8 N.E. 832 (1886); Whitesell v. Hill, 101 Iowa 629, 70 N.W. 750 (1896).

5. Some courts have taken judicial notice of this so-called "conspiracy of silence." *See, e.g.*, Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957); Steiginga v. Thron, 30 N.J. Super. 423, 105 A.2d 10 (App. Div. 1954). *See also* Markus, *Conspiracy of Silence*, 14 CLEV.-MAR. L. REV. 520 (1965).

6. A few states still follow the "strict locality rule." *See, e.g.*, Levitt v. Etkind, 158 Conn. 567, 265 A.2d 70 (1969); Gandara v. Wilson, 85 N.M. 161, 509 P.2d 1356 (Ct. App. 1973).

7. *See, e.g.*, Kingston v. McGrath, 232 F.2d 495 (9th Cir. 1963) (applying Idaho law); Peters v. Gelb, 30 A.2d 685 (Del. Super. Ct. 1973); Voss v. Bridwell, 188 Kan. 643, 364 P.2d 955 (1961); Jarboe v. Harting, 397 S.W.2d 775 (Ky. 1965); Bailey v. Williams, 189 Neb. 484, 203 N.W.2d 454 (1973); Carrigan v. Sacred Heart Hosp., 104 N.H. 73, 178 A.2d 502 (1962); Benzmiller v. Swanson, 117 N.W.2d 281 (N.D. 1962); Eckleberry v. Kaiser Foundation N. Hosp., 226 Or. 616, 359 P.2d 1090 (1960); Donaldson v. Maffucci, 397 Pa. 584, 156 A.2d 835 (1959); Bessinger v. De Loach, 230 S.C. 1, 94 S.E.2d 3 (1956).

8. *See, e.g.*, Michael v. Roberts, 91 N.H. 499, 23 A.2d 361 (1941); Morrill v. Komasinski, 256 Wis. 417, 41 N.W.2d 620 (1950).

view, espoused by many states that follow the similar locality rule, is that factors more directly related to the practice of medicine should be examined. The focus thus turns to a comparison of such considerations as the number and quality of hospitals and laboratories and the availability of special equipment in the defendant's and the expert's respective communities.[9]

In 1902 Ohio adopted the similar locality rule in *Gillette v. Tucker*.[10] There the Ohio Supreme Court formulated the standard as follows:

> A surgeon and physician, employed to treat a case professionally, is under an obligation, which the law implies from the employment to exercise the average degree of skill, care, and diligence exercised by members of the same profession, practicing in the same or a similar locality, in the light of the present state of medical and surgical science.[11]

The standard set forth in *Gillette* has been applied subsequently in cases involving general practitioners,[12] surgeons,[13] hospital nurses,[14] and even dentists.[15] Surprisingly, neither *Gillette* nor any of these subsequent cases clearly indicated the criteria by which similarity is to be determined. Because the *Gillette* court formulated the standard "in light of the present state of medical and surgical science," it appears that the basis for comparison of communities was intended to consist of medical rather than socio-economic factors.

II. THE FACTS AND HOLDING OF *Bruni*

The Supreme Court of Ohio has now abandoned the similar locality rule for cases in which the defendant is engaged in the practice of a board-certified medical specialty. In *Bruni v. Tatsumi*, plaintiffs Dorothy and Joseph Bruni brought suit against Dr. Tetsuo Tatsumi, a neurosurgeon, and his associate for their alleged malpractice committed while Mrs. Bruni was a patient in a Canton, Ohio hospital. As a part of the plaintiffs' case presented at trial, a neurosurgeon from Columbus, Ohio testified by deposition that certain surgical procedures used upon Mrs. Bruni by Dr. Tatsumi were not accepted medical practice in Columbus. The Columbus neurosurgeon was then asked: "Would your opinion still hold true, Doctor, for any moderately large,

9. *See* Gambill v. Stroud, 531 S.W.2d 945 (Ark. 1976); Cook v. Lichtblau, 144 So. 2d 312 (Fla. Dist. Ct. App. 1962); Cavallaro v. Sharp, 84 R.I. 67, 121 A.2d 669 (1956).

10. 67 Ohio St. 106, 65 N.E. 865 (1902).

11. *Id.* at 106, 65 N.E. at 865.

12. Dietsch v. Mayberry, 70 Ohio App. 527, 47 N.E.2d 404 (1942).

13. Ault v. Hall, 119 Ohio St. 422, 164 N.E. 518 (1928).

14. Richardson v. Doe, 176 Ohio St. 370, 199 N.E.2d 878 (1964).

15. Cox v. Cartwright, 96 Ohio App. 245, 121 N.E.2d 673 (1953).

or large metropolitan area in which neurosurgery is practiced throughout this country," to which he replied, "I believe it would."[16]

The plaintiffs contended that this answer established the standard of care in Canton, where Mrs. Bruni was treated, notwithstanding that in earlier testimony the neurosurgeon had admitted his lack of specific knowledge concerning medical practices in Canton and Cleveland. When the plaintiffs' medical expert was asked "whether [the defendant-doctor] is using accepted and good medical technique and procedure," he responded, "Well, I do not have an opinion about anything that goes on in Canton."[17] Additionally, when asked if his opinion concerning the proper standard of care and good medical practice would also be applicable to the Cleveland vicinity, he replied, "I do not know how they do cases like this in Cleveland."[18]

At the conclusion of all the evidence the trial court sustained a motion for a directed verdict in favor of both defendants, stating that these statements by the plaintiffs' expert about his lack of specific knowledge of medical practice in Canton and Cleveland "nullified" his other testimony that his methods of procedure were followed in "metropolitan areas." Because the plaintiffs introduced no other testimony, the trial court held that the standard of care had not been established and that this failure "is fatal to the presentation of a prima facie case of malpractice by the plaintiff."[19]

Although the Court of Appeals for Stark County affirmed the judgment, the Supreme Court of Ohio reversed, holding that it was error to have directed a verdict for the defendants. Upon examining the origin and development of the similar locality rule, the court found the rule's original justification no longer applicable. At one point the court stated:

> Admittedly there was ample justification for a local-standard rule then and for many years following. But in this modern era means of transportation facilitate opportunities for physicians and surgeons from small communities to attend up-to-date medical seminars; the general circulation of medical journals makes new developments readily available to them and they can easily communicate with the most advanced medical centers in the country.
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> . . . [T]he locality rule has been increasingly eroded as being antiquated and unrealistic especially in the medical specialties field.[20]

Finding the credentials of the plaintiffs' expert to be "flawless," the Ohio Supreme Court decided that a question of fact existed which

16. 46 Ohio St. 2d at 129, 346 N.E.2d at 676.

17. *Id.*

18. *Id.*

19. *Id.* at 133, 346 N.E.2d at 678 (quoting Finley v. United States, 314 F. Supp. 905, 911 (N.D. Ohio 1970)).

20. *Id.* at 133-34, 346 N.E.2d at 679.

should have been presented to the jury.[21] In formulating the new standard that would supplant the locality rule for medical specialists, the supreme court held:

> The standard of care for a physician or surgeon in the practice of a board-certified medical or surgical specialty should be that of a reasonable specialist practicing medicine or surgery in that same specialty in the light of present day scientific knowledge in that specialty field; *therefore, geographical considerations or circumstances control neither the standard of the specialist's care nor the competence of the testimony of an expert in that specialty.*[22]

By adopting a standard of care that, unlike the locality rules, is not entrenched in geographical considerations, the supreme court has substantially altered the criteria by which the standard of care is determined. Furthermore, it is readily apparent that a plaintiff's ability to present a prima facie case is greatly enhanced by the holding in *Bruni* since his difficulty in demonstrating that his expert is qualified to testify about the applicable standard has been reduced. *Bruni* is thus certain to have a significant impact upon malpractice litigation in Ohio.

III. THE AMERICAN SPECIALTY BOARDS

Before the holding in *Bruni* can be properly assessed, it is necessary to understand the American medical profession's internal certification system, which the Ohio Supreme Court suggested may affect the development of standards of care in the medical profession. For many years all that one needed in order to practice medicine legally was a degree from a recognized medical school. Now, however, all states require prospective practitioners to pass an examination developed by representatives of state medical associations, and thirty-nine states also require successful completion of a year of internship.[23] In recent years, more uniform medical standards have resulted from the nationwide acceptance of examinations produced by the Federation of State Medical Boards.[24]

The origin of formal medical specialties occurred as specialists developed competence in narrow areas of medical practice that

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21. *Id.* at 135, 346 N.E.2d at 679.

22. *Id.* at 127, 346 N.E.2d at 675 (emphasis added).

23. Holden, *Specialty Board Certification as a Measure of Professional Competence*, 213 J. AM. MED. A. 1016, 1016 (1970).

24. *Medical Licensure* 1971, 220 J. AM. MED. A., 1605, 1606 (1972). As of 1972, forty-one states have adopted these examinations for use by their licensing boards. The examinations are produced by the Federation of State Medical Boards to be used for qualification toward licensure. They are administered by the participating states under their own statutes, rules, and regulations. The test scores are reported so that all candidates' grades will be comparable from one state to another; however, each state may decide its own passing level based on these standard scores, thus allowing for state autonomy while providing a uniform standard for measuring achievement. R. STEVENS, AMERICAN MEDICINE AND THE PUBLIC INTEREST 534 n.8 (1972).

exceeded the capabilities of generalists and as it became apparent that a standardized mechanism for recognition of that competence was desirable. The movement toward formal recognition of the medical specialties ultimately resulted in the American Board of Medical Specialties, a nonprofit organization under the direction of the American Medical Association, which represents the twenty-two approved American Specialty Boards.[25] Ostensibly, the general aim of the boards is to improve the quality of health care provided to the public by medical specialists.[26] To achieve this goal, each approved specialty board determines the competence of candidates who appear voluntarily for examination. To that end, specialty boards decide whether candidates have received adequate preparation in accordance with established educational standards, provide comprehensive examinations to determine the competence of candidates, and certify the competence of those physicians who have satisfied the requirements.[27]

Although the various specialty boards disclaim any real power to control specialists[28]—possibly to avoid antitrust implications[29]—hospitals tend to offer more responsible positions to board-certified physicians. Consequently, an increasing proportion of medical specialists are becoming board-certified. Since 1947, the Veterans Administration has required its many medical specialists to be certified.[30] Because certain employment advantages are thus enjoyed by certified specialists, the specialty boards seem to have more power than they officially claim. To the extent that specialty board certification has achieved acceptance among those in positions of making hiring and retention decisions, certification, although not required by law in any state as a condition to practice, has become a de facto requirement for the specialist. The *Bruni* decision seems to have increased the significance of the

25. Following is a list of the American Specialty Boards and year of their approval: allergy and immunology (1971); anesthesiology (1941); colon and rectal surgery (1949); dermatology (1933); family practice (1969); internal medicine (1936); neurological surgery (1940); nuclear medicine (1971); obstetrics and gynecology (1933); opthamology (1933); orthopedic surgery (1935); otolaryngology (1933); pathology (1936); pediatrics (1933); physical medicine and rehabilitation (1947); plastic surgery (1941); preventive medicine (1949); psychiatry and neurology (1935); radiology (1935); surgery (1937); thoracic surgery (1970); and urology (1935). MARQUIS WHO'S-WHO, DIRECTORY OF MEDICAL SPECIALISTS xxii (17th ed. 1975-1976).

26. *Id.* at xviii.

27. *Id.* at xx.

28. The American Medical Association's *Directory of Approved Internships and Residencies*, in listing the requirements for certification, makes the disclaimer that:

> The boards are in no sense educational institutions, and the certificate of a board is not to be considered a degree. It does not confer on any person legal qualifications, privileges, nor a license to practice medicine or a specialty. The boards do not in any way interfere with or limit the professional activities of a licensed physician, nor do they desire to interfere in the regular or legitimate duties of any practitioners of medicine.

H. LERNER, MANPOWER ISSUES AND VOLUNTARY REGULATION IN THE MEDICAL SOCIETY SYSTEM 123 (1974).

29. *Id.*

30. F. Moore, *Freedom and Organization*, 176 ANNALS OF SURGERY 1 (1972).

American Specialty Boards even further; by confining the new national standard to the board-certified specialties, the court has extended the consequences of the medical profession's certification system to the legal arena.

IV. THE COURT'S RATIONALE

Given the present systems of licensure and certification, the Ohio Supreme Court's decision in *Bruni* is a rational one. To the extent that procedures and practices in the medical specialties have become standardized throughout the United States, a rule that refuses to give great weight to geographical considerations is sound. The present state of the medical profession is such that "[n]ew techniques and discoveries are available to all doctors within a short period of time through journals, closed circuit television presentations, special radio networks for doctors, tape recorded digests of medical literature, and current correspondence courses."[31]

Although specialty boards are not themselves responsible for the establishment of national standards of medical care, they appear to make a national "standard of care" in the legal sense more operable. By attesting to the competence of practitioners in a given specialty by the mechanism of certification, the specialty boards have established national requirements for certification that may be called "standards." But these standards are in no way standards of medical care, *i.e.*, recognized methods of procedure and practice. Rather, these standards take the form of educational and training requirements, such as subjects to be covered and length of residency training, which indicate to the practitioner the steps he should take to achieve what the specialty boards perceive as a desired level of proficiency. In meeting the requirements, the specialist can better ensure that he is sufficiently apprised of those practices and procedures that provide the foundation for a national standard of care in the legal sense. It does not necessarily follow that meeting the requirements of certification is an adequate means of informing oneself of national standards; however, to the extent that the certification system facilitates the ability of all practitioners to inform themselves of the present state of their specialties, the imposition of a national standard is less objectionable.

Adhering to a standard whereby one is held to the degree of care expected of a reasonably competent practitioner in the same specialty, as opposed to some narrower standard based on geography, does not preclude consideration of such other factors as the availability of facilities or the extent to which new techniques and practices have gained general acceptance. For a plaintiff's witness to qualify as an

31. *See* Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729 (1970).

expert on the standard of care for the medical specialty in which the defendant-doctor practices, it should suffice under the holding in *Bruni* that the party offering the witness establish the familiarity of the witness with the standard of care and treatment commonly practiced by physicians engaged in the same specialty as the defendant. That a witness is not familiar with medical practice in the defendant's community should be of no consequence because here the standard of care owed to patients is not tied to the defendant's locality. To the extent that particular circumstances confronting the defendant or geographical factors peculiar to the defendant's community can fairly be said to affect what a reasonable specialist in the field might have done, the opportunity remains open to the defendant to introduce such evidence for the jury's consideration.[32]

V. UNRESOLVED ISSUES

Despite its apparent rationale, however, the holding in *Bruni* raises some interesting questions. It is noteworthy first that the type of practice in question, neurosurgery, is generally accepted as a specialized area of medicine and is represented by a recognized specialty board. Furthermore, both the plaintiffs' expert medical witness and one of the defendants were certified by that board. As noted above, the Ohio Supreme Court held the applicable standard of care for one engaged in the practice of a board-certified specialty to be that practiced by a reasonable specialist. The court appeared to rest its decision heavily on the finding that the practice of most medical specialties by *certified* specialists is similar throughout the country.[33] One unresolved issue is whether a defendant who is not certified, but is nevertheless engaged in the practice of a board-certified specialty, should be held to the national standard set forth in *Bruni*. Another question is whether *Bruni* should be read as requiring a plaintiff's expert medical witness to be certified in the defendant's specialty, irrespective of whether the defendant is certified. Finally, the potential issue remains of whether the rule in *Bruni* should be applied to those areas of medicine traditionally considered areas of general practice, but which the medical profession has denoted as specialties, and for which specialty boards have been established.

32. *See, e.g.*, Brune v. Belinkoff, 354 Mass. 102, 109, 235 N.E.2d 793, 798 (1968) in which the Supreme Judicial Court of Massachusetts in adopting a national standard of care whereby a practitioner is held to the degree of care of the average qualified practitioner stated: "In applying this standard it is permissible to consider the medical resources available to the physician as *one* circumstance in determining the skill and care required. Under this standard some allowance is thus made for the type of community in which the physician carries on his practice." *See also* Shier v. Friedman, 58 Wis. 2d 269, 284, 206 N.W.2d 166, 174 (1973), in which the Supreme Court of Wisconsin, adopting a national standard, held: "Geographical area and its attendant lack of facilities are circumstances that can be considered if appropriate."

33. 46 Ohio St. 2d at 134, 346 N.E.2d at 679.

A. *Defendant's Certification*

Whether a noncertified specialist should be held to a national standard of care and proficiency is not clearly resolved by the court's opinion in *Bruni*. The court's language in *Bruni*, however, does suggest that such a specialist will be held to the standard. The case syllabus characterizes the national standard as being applicable to a physician "in the practice of a board-certified medical or surgical specialty . . . ."[34] This indicates that a practitioner will be held to a national standard so long as he is engaged in the practice of a specialty for which there has been established a certifying board, regardless of whether the defendant himself has been so certified.

The court's opinion, however, casts some doubt on whether this interpretation is the one it intended. Justice Corrigan, writing for a unanimous court expressly stated that an "important consideration in this case is that . . . both the defendant and [plaintiffs'] expert witness were *board-certified* neurosurgeons."[35] Additionally, to support its finding that the similar locality rule no longer reflects the state of the medical profession, the court cited a survey that concluded that the practice of medicine by *certified* specialists within most medical specialties is similar throughout the country.[36]

Nevertheless, the ambiguous opinion also gives reason to believe that, notwithstanding the references to certification, the court did not perceive national certification as the *foundation* for a national standard, but rather as *evidence* that procedures and techniques have become fairly standardized. In particular, Justice Corrigan stressed that, aside from certification, contemporary "means of transportation facilitate opportunities for physicians and surgeons from small communities to attend up-to-date seminars; the general circulation of medical journals makes new developments readily available to them and they can easily communicate with the most advanced medical centers in the country."[37]

It is also noteworthy that throughout its discussion of the applicable standard of care the Ohio Supreme Court rarely modified the words "physician" and "specialist" with the adjectives "certified" or "board-certified." In the portion of the opinion that corresponds to the syllabus paragraph in which the national standard is formulated, the court concluded by stating that the defendant is "obligated to bring to the discharge of his duty that degree of skill and knowledge possessed by physicians who are *specialists*. . . ."[38] Thus, "the stand-

34. *Id.* at 127, 346 N.E.2d at 675.
35. *Id.* at 132, 346 N.E.2d at 678 (emphasis added).
36. *Id.* at 134, 346 N.E.2d at 679.
37. *Id.*
38. *Id.*

ard of care in this case is that owed to a patient by the *community of neurosurgeons.*"[39] In neither instance was it implied that only certified specialists or neurosurgeons are referred to.

While it is by no means clear from *Bruni* whether it should apply to noncertified practitioners, this construction is desirable. To hold otherwise would allow a practitioner to insulate himself from a national standard simply by foregoing certification. This is perhaps the reason why no other jurisdiction that has abandoned the locality rule in favor of a national standard has applied the newer standard solely to certified practitioners. Instead, they have held the national standard to apply either to all physicians,[40] or at least to all specialists, whether or not certified.[41] Even if not intended by the Ohio Supreme Court, that interpretation is defensible on the ground that the existence of uniform procedures nationwide—resulting in part from the improved means of disseminating the most current medical developments, and not solely because of the specialty boards—furnishes the real justification for a national standard of care. The irrationality of allowing certification to determine the applicability of the national standard is demonstrated by the fact that, although as of 1972, 62.3%[42] of all specialists were board-certified, a substantial number of those not certified were "board eligible";[43] they had met such prerequisites for taking the certification exam as residency and training, but had not actually taken the examination. Because the opportunity to inform oneself of the most current medical developments in one's specialty does not appear to be substantially affected by certification, it would be difficult to justify applying different standards of care to the board-certified and the "board eligible" practitioner.

Nevertheless, because certification is regarded as evidence that one is qualified in his specialty,[44] the fact that a defendant is not board-certified could affect the jury's assessment of the applicable standard of care, especially if the plaintiff's witness is certified. To the extent that noncertification affects perceptions of a defendant's ability to follow proper medical procedure, the *Bruni* decision will provide another inducement to become certified in addition to those incentives already provided by the medical profession itself.

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39. *Id.* (emphasis added).

40. *See, e.g.*, Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 349 A.2d 245 (1975); Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968).

41. *See, e.g.*, Kronke v. Danielson, 108 Ariz. 400, 499 P.2d 156 (1972); Nacarrato v. Grob, 384 Mich. 248, 180 N.W.2d 788 (1970).

42. H. LERNER, *supra* note 28, at 169.

43. *Id.* at 124.

44. Holden, *supra* note 23, at 1018.

B. *Certification of the Testifying Expert*

Another issue that *Bruni* raises is whether the expert witness must be a certified specialist engaged in the practice of a board-certified specialty. A negative answer is likely in future cases. In *Bruni* the court held that the applicable standard of care should be that of a "reasonable specialist practicing medicine or surgery in that same specialty in the light of present day scientific knowledge in that specialty field."[45] Furthermore, in its earlier discussion of the need for expert testimony to show medical malpractice, the court stated that the expert "must be qualified to express an opinion concerning the specific standard of care that prevails in the medical community in which the alleged malpractice took place . . . ."[46] Thus, the competency of an expert will probably hinge not on whether he is board-certified but on whether he is sufficiently acquainted with proper procedures of reasonable specialists. Nowhere does the court suggest that certification is a requisite to knowing what is reasonable. Rather, a determination of competency requires a consideration of the same factors that the *Bruni* court used to justify a national standard; that is, it should be incumbent upon the plaintiff to show that his witness has availed himself of the opportunities open to him through such means as journals and seminars to familiarize himself with the current state of the profession. Certification is not irrelevant to the determination of his competency to testify; to the extent that certification is evidence of his professional qualifications and of his familiarity with the applicable standard, certification is a significant factor to be considered by the court. The fact that one is *not* certified, however, should not preclude him from otherwise demonstrating his competence to testify.

Courts in several states that adhere to the "strict" or "same or similar" locality rule have held that a physician or surgeon is not incompetent to testify merely because he is not a specialist in the particular branch of medicine involved in the case.[47] Prior to *Bruni*, when all practitioners were subject to the similar locality rule, an Ohio court of appeals held in *Faulkner v. Pezeshki*[48] that a general practitioner was competent to testify in a malpractice action against a specialist. The court stated: "We are of the view that the witnesses had, by education, training, and experience, sufficient expertise to aid the jury in its task of determining whether defendant was negligent. Admittedly

45. 46 Ohio St. 2d at 127, 346 N.E.2d at 675.

46. *Id.* at 132, 346 N.E.2d at 677.

47. *See, e.g.*, Fitzmaurice v. Flynn, 167 Conn. 609, 356 A.2d 887 (1975); Hanberry v. Fitzgerald, 72 N.M. 383, 384 P.2d 256 (1963); Simpson v. Glenn, 537 S.W.2d 114 (Tex. Ct. App. 1976).

48. 44 Ohio App. 2d 186, 337 N.E.2d 158 (1975).

better witnesses may exist, but such fact should not have barred the testimony of the witness produced."[49]

This rule of evidence has been accepted by at least one state supreme court in the context of a national standard of care. In *Carbone v. Warburton*, a 1953 case, the Supreme Court of New Jersey held that the applicable standard for a specialist was a national one.[50] The court also held that the key qualifications of a medical expert are his knowledge and experience in treatment of the illness or injury involved. Upon inquiry into those qualifications, the trial judge can determine whether the witness has sufficient acquaintance with the standards recognized by the medical profession in the situation under investigation to justify his testifying as an expert.[51] Applying this test, the New Jersey court found that a retired general practitioner was qualified to testify about the standard of care applicable to an orthopedic specialist because the witness possessed an extensive medical education and had kept abreast of medical and surgical developments.[52] If an expert witness need not be a specialist in the same area of medicine as the defendant in order to be held competent, a fortiori he need not be a *certified* specialist in that field.

Thus, certification is just one factor among several to be considered in assessing the witness' familiarity with the applicable standard. Nevertheless, as in the case of the defendant, certification is a factor that might be considered by the jury in its evaluation of an expert's testimony.

C. *Applicability of* Bruni *to the General Practitioner*

The Ohio Supreme Court may not have been aware in reaching its holding in *Bruni* that several certification boards exist for "specialties" that are not generally thought of as such by the general public. At least two other jurisdictions that have limited the applicability of a national standard to specialties have given specialties a rather narrow meaning.[53] The *Bruni* decision thus raises the issue whether the scope of its holding should be limited to this narrower category of specialties or instead should encompass all board-certified specialties, including those that are considered by many to be generalized areas of practice.

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49. *Id.* at 193, 337 N.E.2d at 164.

50. 11 N.J. 418, 94 A.2d 680 (1953). There the court held:

> [O]ne who holds himself out as specialist must employ not merely the skill of a general practitioner but also that special degree of skill normally possessed by the average physician who devotes special study and attention to the particular organ or disease or injury involved, having regard to the present state of scientific knowledge.

Id. at 426, 94 A.2d at 683.

51. *Id.*

52. *Id.* at 426-27, 94 A.2d at 684.

53. *See* Kronke v. Danielson, 108 Ariz. 400, 499 P.2d 156 (1972); Naccarato v. Grob, 384 Mich. 248, 180 N.W.2d 788 (1970).

By contrasting the Ohio Supreme Court's rationale to that expressed in a recent line of Michigan decisions that exempted such nontraditional specialties from a national standard, a reasonable inference may be made that they are *not* to be so excluded in Ohio courts.

In *Naccarato v. Grob*[54] the Supreme Court of Michigan held that specialists should be held to a national standard. While the defendants in that case were board-certified pediatricians, the court did not view certification as a decisive factor in concluding that a national standard was appropriate for specialists. Rather, the court based its holding on the inherent nature of a specialty:

> The reliance of the public upon the skills of a specialist and the wealth and sources of his knowledge are not limited to the geographic area in which he practices. Rather his knowledge is a specialty. He specializes so that he may keep abreast. Any other standard for a specialist would negate the fundamental expectations and purpose of a specialty. The standard of care for a specialist should be that of a reasonable specialist practicing medicine in the light of present day scientific knowledge. Therefore, geographical conditions or circumstances control neither the standard of a specialist's care nor the competence of an expert's testimony.[55]

The *Naccarato* court declined to extend its holding to general practitioners, stating that "[w]hatever the considerations were that allowed the area practice to set the standard for the county general practitioner—they are not relevant to a metropolitan specialist."[56]

In *Callahan v. William Beaumont Hospital*[57] a Michigan court of appeals expressly held that general practitioners were still to be held to the similar locality rule and were not affected by the holding in *Naccarato*, which was "grounded to a large degree on the reliance and expectations of the public with respect to the skills possessed by a specialist."[58] Apparently in an effort to clarify the distinction made by the *Naccarato* court between general practitioners and specialists, the court stated that by becoming a specialist, a practitioner "thereby represents to the public that he has special knowledge and skills not possessed by a general practitioner and that he also keeps abreast with the advances in his specialty."[59]

In *Abbe v. Woman's Hospital Association*[60] another Michigan court of appeals raised a further question concerning the applicability of *Naccarato*. The court decided that the defendant, a general surgeon, should be held to the similar community rule, not to a national

54. 384 Mich. 248, 180 N.W.2d 788 (1970).
55. *Id.* at 253-54, 180 N.W.2d at 791.
56. *Id.* at 253, 180 N.W.2d at 791.
57. 67 Mich. App. 306, 240 N.W.2d 781 (1976).
58. *Id.* at 310, 240 N.W.2d at 782-83.
59. *Id.* at 310, 240 N.W.2d at 783.
60. 35 Mich. App. 429, 192 N.W.2d 691 (1971).

standard: "He is what may be designated as a general surgeon. He does not fall within the category which must be judged by the standard of specialists in specific areas of the practice of medicine."[61]

The significance of these Michigan cases becomes apparent when they are considered together. *Naccarato* made it fairly clear that the national standard was applicable only to specialists, specifically omitting general practitioners from the ambit of the holding. It is less clear that the Michigan Supreme Court intended to exclude general surgeons from the national standard. In any event, *Abbe* interpreted the generic term "specialists" to mean doctors engaged in a narrowly defined area of practice, and consequently held general surgeons not to be specialists.

It does not appear that *Bruni v. Tatsumi* should be given such limited applicability in light of the rationale articulated by the Supreme Court of Ohio in reaching its decision. Had the court expressed a rationale similar to that given by the Supreme Court of Michigan—"[t]he reliance of the public upon the skills of a specialist," and the "fundamental expectations" of a specialty—then a rule confined to the "traditional" specialties would be justifiable in Ohio. The Supreme Court of Ohio, however, focused in *Bruni* not on the public's expectations but on the medical profession itself. From that viewpoint the court found that increased mobility and contemporary modes of disseminating information had resulted in improved accessibility to advanced medical centers and to the latest medical developments. Furthermore, the Ohio Supreme Court acknowledged the American Specialty Boards, their standard requirements for certification, and a survey that concluded that the practice of a medical specialty by certified specialists is similar throughout the country.

At present there are specialty boards for twenty-two areas of medical practice. One, the American Board of Surgery, certifies physicians engaged in the practice of general surgery and pediatric surgery.[62] Much of the impetus for the establishment of this board arose from the fact that physicians engaged in general surgery had been excluded from other specialty surgical boards.[63] Since its establishment in 1937, specialty boards in other surgical specialties such as neurological surgery, thoracic surgery, and colon and rectal surgery have also been approved. Nevertheless, the American Board of Surgery and the American Board of Medical Specialists recognize general surgery as a specialty in itself. Of perhaps even greater importance is the fact that in 1969 a specialty board entitled "The American Board of Family Practice" was approved by the American Medical

61. *Id.* at 433-34, 192 N.W.2d at 693.

62. DIRECTORY OF MEDICAL SPECIALISTS, *supra* note 25, at xxii.

63. R. STEVENS, *supra* note 24, at 236.

Association. That board recognizes the area of general practice as a medical specialty.

Despite the establishment of the American Board of Surgery and the American Board of Family Practice, the public has not yet accepted the general surgeon and the general practitioner as being specialists of the same level of expertise as those in the traditional specialties.[64] Thus the public's expectations of a general surgeon or general practitioner are likely to be lower than its expectations of the sophisticated specialist. If the public's expectations are viewed as the major justification for denoting an area of medicine a specialty to which a national standard should be applied—as they are viewed by the Michigan Supreme Court—excluding the general surgeon or practitioner from the application of a national standard is defensible.

Nevertheless, because the rationale of the Ohio Supreme Court in *Bruni* focused on the medical profession itself rather than on reliance by the public upon the skills of a specialist, the public's reluctance to recognize the general surgeon or general practitioner as a specialist should not preclude the applicability of a national standard to such practitioners in Ohio. Assuming the national uniformity of practices as the rationale for the holding in *Bruni*, it appears that in the future the Ohio Supreme Court will not regard the American Specialty Boards as delimiting the scope of the national standard of care, and will apply the standard to all areas of practice in which uniformity of practice can be shown.

VI. CONCLUSION

The *Bruni* decision will have a significant and beneficial effect upon medical malpractice litigation. During a time when practices and procedures are attaining levels of national uniformity, a standard of care that is coextensive with this standardization is welcome.

As noted above, the *Bruni* decision raises several questions concerning its scope. In view of the rationale articulated by the Ohio Supreme Court, the factor of American Specialty Board certification should not be viewed as the fundamental justification for a nationally defined standard of care even though it may have played a part in the decision. The actual justification for a national standard lies in the increasing uniformity of medical practice nationwide, not in the existence of the national certification boards. Unquestionably, the boards play an important role in establishing and administering standards by which competence is to be judged. As noted earlier, however, these are not the equivalent of a national standard of care. Consequently, *Bruni* should be applied to specialties such as family practice and

64. *See generally id.*, ch. 14.

general surgery, for which certification boards do exist but which the public does not commonly recognize as specialized areas of medical practice. For the same reason, *Bruni* should be read as requiring the application of a national standard of care without regard to whether the defendant is himself certified, and should not be seen as imposing certification of a plaintiff's witness as a prerequisite to his competency.

Dale P. Shrallow