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THE RISE AND GRADUAL FALL OF THE LOCALITY RULE IN MEDICAL MALPRACTICE LITIGATION

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THE LAW'S mill usually grinds slowly. It turns out, often after the passage of much time, a rule that more or less fits the circumstances of the time, or at least of a time only recently gone by, and then—as though it had accomplished its task to perfection and for all time—it may grind to a halt. Until the mill is made to grind again, the law is said to be "certain." This results in a sort of schizophrenic existence for lawyers, who by and large control the levers on the mill, for it is said that they have pigeonhole minds and regard certainty in the law as a positive good. However, the lawyer's business is the representation not of his own interests but of the interests of others. One lawyer will thus advocate the certainty that presently exists, for it favors his side of a litigated matter; but his adversary will advocate a certainty yet to come, since a new rule would favor the interests that he commonly represents. And so, although lawyers may seek certitude in their contending efforts, they make absolutely certain that the law will never have it. The only thing certain about the law is its long-run uncertainty; it is, as the late Felix Frankfurter once remarked, neither fixed nor finished. Lawyers, along with such philosophers as Alfred North Whitehead, know that one art of a free society consists in fearlessness of legal revision, to secure that law which serves those purposes which satisfy an enlightened reason. Lawyers, when the right time comes, are adept at reactivating the mill in order to produce necessary legal revisions.

This process, which I hope I have not described in too pretentious a fashion, can be discerned in the history of a significant legal rule applicable to medical malpractice litigation—the so-called "locality rule." The law's formulation of the generalized standard of care gov-

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erning the physician and surgeon is full of formulae and phrases which, as Justice Holmes observed in another connection, "by their very felicity delay further analysis." The locality rule, tacked on at the end of the generalized standard, is one of these. The law states that a medical man has the obligation to his patient to possess and employ such reasonable skill and care as is commonly had and exercised by reputable, average physicians in the same general system or school of practice *in the same or similar locality*.[1] On a practical level, the locality rule has influenced not only the professional standards demanded of medical men but also the availability of witnesses to establish the physicians' culpable deviation from those standards.

The plaintiff in all but the most self-evident medical malpractice case is required to produce in support of his claim the testimony of qualified medical experts.[2] This is true because the technical aspects of his claim will ordinarily be far beyond the competence of the lay jurors whose duty it is to assess the defendant doctor's conduct. And the plaintiff himself, lacking the training and experience that would qualify him to characterize the defendant's conduct, is incompetent to supply guidance to the jurors. Turning back to the generalized standard of care applicable to the medical doctor, we find an apparent insistence that the physician's performance conform to practices acceptable in his locality or, if his community provides no comparison, in similar localities. This curiously narrow element of the standard of care sets up an important qualification affecting the sort of medical witness who

[1] *See, e.g.*, Adkins v. Ropp, 105 Ind. App. 331, 334, 14 N.E.2d 727, 728 (1938); Nelson v. Nicollett Clinic, 201 Minn. 505, 509, 276 N.W. 801, 803 (1937); Loudon v. Scott, 58 Mont. 645, 654, 194 P. 488, 491 (1920). *See also* McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 558-60 (1959).

The term "average" is employed in the sense of "ordinary" learning and skill; a true "average" would involve an uneasy aggregation of the best and the worst, the experienced and the inexperienced, the quack and the specializing medical doctor. It has never been suggested that the law strikes the average from so diverse a grouping. *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, 66 N.W. 894 (1896).

[2] *See, e.g.*, Phillips v. Stillwell, 55 Ariz. 147, 99 P.2d 104 (1940); Hogmire v. Voita, 319 Ill. App. 644, 49 N.E.2d 811 (1943); Treptau v. Behrens Spa, Inc., 247 Wis. 438, 20 N.W.2d 108 (1945). *See generally* Morris, *The Role of Expert Testimony in the Trial of Negligence Issues*, 26 TEXAS L. REV. 1 (1947). In genuinely self-evident cases, such as those in which sponges or items of hardware were left within the situs of operation, the res ipsa loquitur principle will avoid the necessity of expertise. *See, e.g.*, Graham v. St. Luke's Hosp., 46 Ill. App. 2d 147, 196 N.E.2d 355 (1964); Grosjean v. Spencer, 258 Iowa 685, 140 N.W.2d 139 (1966). *See also* Comment, *The Application of Res Ipsa Loquitur in Medical Malpractice Cases*, 60 NW. U. L. REV. 852 (1966).

is free to testify in a malpractice action. The medical expert must be shown to be conversant with the methods, procedures, and treatments commonly utilized in the locality in which the defendant doctor practices. Short of that, he must at least be familiar with acceptable practices in geographic areas sufficiently similar to the defendant's to serve as a fair and adequate guide.

The plain fact is that the locality rule possessed a semblance of certainty for only a short time. It has been put through the mill, so to speak, and has in the process been significantly revised and refined. Moreover, it is about to disappear almost completely. Felicity of phraseology and the cumbersome nature of the law's machinery has slowed, but not halted, perceptive analysis of the locality rule.

ORIGINAL FORMULATION OF THE LOCALITY RULE

The locality rule was a product of the United States;[3] the English courts never developed such a principle.[4] In its original formulation, which took shape in the late nineteenth century, the locality rule literally demanded that a medical expert testifying for the plaintiff in a malpractice action must have practiced in the defendant's community.[5] The rule, in its early form, was demonstrably calculated to protect the rural and small town practitioner, who was presumed to be less adequately informed and equipped than his big city brother. As was noted in *Small v. Howard*, a case involving a general practitioner in a village of 2,500, the defendant "was not bound to possess that high degree of art and skill possessed by eminent surgeons practicing in larger cities."[6]

[3] For three of the earlest formulations of the rule, *see* Smothers v. Hanks, 34 Iowa 286 (1872); Tefft v. Wilcox, 6 Kan. 46 (1870); and Hathorn v. Richmond, 48 Vt. 557 (1876).

[4] *See* NATHAN, MEDICAL NEGLIGENCE 21 (1957).

[5] *See, e.g.*, Force v. Gregory, 63 Conn. 167, 27 A. 1116 (1893); Burk v. Foster, 114 Ky. 20, 69 S.W. 1096 (1902). Surprisingly, a few recent decisions adhere to this early and most restrictive formulation. *See, e.g.*, Horton v. Vickers, 142 Conn. 105, 111 A.2d 675 (1955); Lockhart v. Maclean, 77 Nev. 210, 361 P.2d 670 (1961); Huttner v. MacKay, 48 Wash. 2d 378, 293 P.2d 766 (1956). The *Huttner* case, involving an especially myopic application of the locality rule, is impliedly ovreruled by *Pederson v. Dumouchel*, 431 P.2d 973 (Wash. 1967), to be discussed later in this article.

[6] 128 MASS. 131, 132, 35 AM. R. 363, 365 (1880). *See also* Smothers v. Hanks, 34 Iowa 286 (1872); Tefft v. Wilcox, 6 Kan. 46 (1870); *cf.* Williams v. Chamberlain, 316 S.W.2d 505, 510 (Mo. 1958). Consideration for the "isolated" practitioner has lingering force. *See, e.g.*, Stallcup v. Coscarat, 79 Ariz. 42, 282 P.2d 791 (1955) (Phoenix, Arizona oral surgeon; misguided decision); Josselyn v. Dearborn, 143 Me. 328, 62 A.2d 174 (1948) (where general practitioner in small Maine town 130 miles from hospital and lab-

This early locality rule was an expedient principle. Although case opinions are short on supporting data, courts one hundred years ago were probably justified in adopting a presumption that the large city practitioner enjoyed broader experience than his country cousin and greater access to the latest medical knowledge and to the most advanced and elaborate facilities and equipment. If plaintiff's expert did not come from the defendant's town, he did not have the proper experience for testifying against the defendant: the witness and the defendant functioned in different worlds.

EXPANSION OF THE RULE TO INCLUDE SIMILAR LOCALITIES

The early and most restrictive form of the locality rule was soon relaxed in many jurisdictions,[7] if only because it posed a predictable problem. It effectively immunized from malpractice liability any doctor who happened to be the sole practitioner in his community. He could be treating bone fractures by the application of wet grape leaves and yet remain beyond the criticism of more enlightened practitioners from other communities.

Instead of a "same locality" rule, today the law usually applies a "same or similar" locality rule.[8] Furthermore, the definition of "locality" may be an expansive one. In a 1916 case, involving practitioners in a small village, the Minnesota Supreme Court, fifty years ahead of its time, suggested that the relevant locality was the entire state.[9] To this day few courts have expressly gone so far, but it is clear that the current stress is on similarity of locality and medical practice rather than on geographical proximity. For example, the Iowa Supreme Court in 1950 allowed testimony by physicians from Evanston, Illinois against physi-

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oratory facilities treated a rare disease). *Cf.* Moeller v. Hauser, 237 Minn. 368, 54 N.W.2d 639 (1952) (where plaintiff, in action against St. Paul practitioner, relied on experts from Mayo Clinic at Rochester; the court warned that their level of skill was not conclusive).

[7] *See, e.g.*, Pelky v. Palmer, 109 Mich. 561, 67 N.W. 561 (1896); McCracken v. Smathers, 122 N.C. 799, 29 S.E. 354 (1898); Bigney v. Fisher, 26 R.I. 402, 59 A. 72 (1904).

[8] *See, e.g.*, Weintraub v. Rosen, 93 F.2d 544 (7th Cir. 1937); Lewis v. Johnson, 12 Cal. 2d 558, 86 P.2d 99 (1939); Bourgeois v. Dade County, 99 So. 2d 575 (Fla. 1956); Kirchner v. Dorsey, 226 Iowa 283, 284 N.W. 171 (1939); Hodgson v. Bigelow, 335 Pa. 497, 7 A.2d 338 (1939); Stafford v. Hunter, 66 Wash. 2d 269, 401 P.2d 986 (1965). For significant statutory changes in the rule, *see* GA. CODE § 84-924 (1955) (as interpreted in, *e.g.*, Murphy v. Little, 112 Ga. App. 517, 145 S.E.2d 760 (1965)) and WIS. STAT. § 147.14(2)(a) (1961).

[9] Viita v. Fleming, 132 Minn. 128, 155 N.W. 1077 (1916).

cians practicing in Davenport, Iowa.[10] The court concluded that the practice in and around Chicago was essentially comparable to the practice in Davenport. In a still more recent case, a Florida appellate court was adverting to the locality rule when it commented that "Miami is at least a community *similar* to West Palm Beach."[11] It concluded that plaintiff's witness, "though from Miami, was a competent medical expert on the ordinary care required of a doctor in West Palm Beach. . . ."[12] In a Washington case, the state's supreme court upheld the receipt in evidence of expert testimony from a Portland, Oregon doctor in a malpractice action that arose in Longview, Washington, 50 miles away.[13] The two communities were hardly similar, but the court perceived that this circumstance and the geographic facts were virtually irrelevant because the Portland doctor had testified that he was familiar with the standards of medical practice in Longview.[14]

The Supreme Court of California settled California "locality" law after two appellate courts went off in seemingly different directions. In *Warnock v. Kraft*, the lower court approved the admission of testimony by Los Angeles doctors in a malpractice suit against a Pasadena surgeon.[15] The decision was a logical result; Los Angeles was a larger city than Pasadena, but they were both in the same county and, at the time, shared the same general hospital. However, two years after *Warnock* another California appellate court, in *McNamara v. Emmons*, rejected testimony from San Bernardino doctors in a malpractice action against an Ontario physician. (The two communities were in geographic proximity, but San Bernardino had a population of 50,000 while Ontario's was 15,000.)[16]

Subsequently, nine years after *McNamara*, the California Supreme Court, in *Sinz v. Owens*, reached a somewhat timid compromise.[17]

[10] McGulpin v. Bessmer, 241 Iowa 1119, 43 N.W.2d 121 (1950).

[11] Cook v. Lichtblau, 144 So. 2d 312, 316 (Fla. App. 1962).

[12] *Id.* at 317.

[13] Teig v. St. John's Hospital, 63 Wash. 2d 369, 387 P.2d 527 (1963).

[14] *See also* Riley v. Layton, 329 F.2d 53, 57 (10th Cir. 1964), in which a San Francisco practitioner was permitted to testify against a physician practicing in a small Utah town after having testified that, ". . . through his experience, reading, lectures and travels [he] was familiar with the practice in small towns throughout the United States with regard to the treatment of . . . fractures [of the type involved in the case]."

[15] 30 Cal. App. 2d 1, 85 P.2d 505 (1938).

[16] 36 Cal. App. 2d 199, 97 P.2d 503 (1940).

[17] 33 Cal. 2d 749, 205 P.2d 3 (1949).

Plaintiff Sinz had charged the defendant general practitioner with malpractice in his treatment of a double comminuted leg fracture. An expert called by the plaintiff testified that "the standard practice *in California*" was to use skeletal traction in double comminuted fracture cases, a procedure that had been omitted by the defendant physician.[18] A verdict for plaintiff resulted. On appeal the defendant contended that plaintiff's expert had not been properly qualified to testify. The contention pushed the locality rule to something of an extreme, since the community from which plaintiff's expert hailed was smaller than the town in which the defendant practiced. The California Supreme Court, rejecting defendant's argument, stated: "The essential factor is knowledge of similarity of conditions; geographical proximity is only one factor to be considered."[19] But the court insisted that plaintiff's contention that the entire San Joaquin Valley was the relevant geographic area was "beyond permissible bounds."[20] Dissenting, one justice asserted that, "the qualifications of a physician and surgeon to practice in California does [*sic*] not depend upon the locality in which he is engaged in practice, but upon the education and training which he has received in institutions in which the method and scope of instruction and the technique in training are substantially uniform."[21] The dissenting judge would have held that a physician licensed to practice medicine in California was qualified to testify as an expert in any part of the state. The level of equipment and facilities available to the defendant in his particular locality would simply be a factor which the jurors could take into account in assessing the propriety of his conduct.

The dissenting justice in *Sinz* partially comprehended the real reasons for a lessening of the locality rule's rigidity. These reasons are to be found in nationwide advances in medical training and improvement in communications and transportation. Today's doctor begins his practice, wherever it may be, with a stronger base of training than was generally true in the late nineteenth century. The proliferation of medical literature, attendance at seminars and conferences, and reasonably speedy mail service enhances and updates the knowledge of

[18] *Id.* at 752, 205 P.2d at 4.

[19] *Id.* at 756, 205 P.2d at 7.

[20] *Id.* at 755, 205 P.2d at 6.

[21] *Id.* at 767, 205 P.2d at 13.

practitioners in small communities as well as large. The Supreme Court of Florida, in *dicta*, recognized this reality:

> This rule [*i.e.*, the locality rule] was originally formulated when communications were slow or virtually non-existent, and . . . it has lost much of its significance today with the increasing number and excellence of medical schools, the free interchange of scientific information, and the consequent tendency to harmonize medical standards throughout the country.[22]

That the Florida court's suggestion is realistic is further demonstrated by Louisell's and Williams' more complete listing of the modern day doctor's learning aids, which include:

> The comprehensive coverage of the *Journal of the American Medical Association*, the availability of numerous other journals, the ubiquitous "detail men" of the drug companies, closed circuit television presentations of medical subjects, special radio networks for physicians, tape recorded digests of medical literature, and hundreds of widely available postgraduate courses.[23]

Eight years ago, when the list was compiled, Louisell and Williams insisted that the medical profession was then rapidly establishing nationwide standards of proficiency and that, "Medicine realizes this, so it is inevitable that the law will do likewise."[24]

Furthermore, in an era of fast transportation it may be proper practice in the smallest and most remote community to send a patient with a complex malady to a specialist in a metropolitan area that has better medical facilities. In *Tvedt v. Haugen*, a North Dakota court, refusing to limit the pertinent locality to a small town, said:

> Today, with rapid methods of transportation and easy means of communication, the horizons have been widened, and the duty of a doctor is not fulfilled merely by utilizing the means at hand in the particular village where he is practicing. So far as medical treatment is concerned, the borders of the locality or community have, in effect, been extended so as to include those centers readily accessible where appropriate treatment may be had which the local physician, because of limited facilities or training, is unable to give.[25]

The quoted language states a double-barrelled proposition: (1) acceptable practice in an ill-equipped community may involve sending the patient to an accessible metropolitan area for treatment if time permits;

[22] Montgomery v. Stary, 84 So. 2d 34 (Fla. 1955).

[23] LOUISELL & WILLIAMS, THE PARENCHYMA OF LAW 183 (1960). *See also* Kolesar v. United States, 198 F. Supp. 517, 521 (S.D. Fla. 1961); Douglas v. Bussabarger, 438 P.2d 829, 837 (Wash. 1968).

[24] LOUISELL & WILLIAMS, *supra* note 23.

[25] 70 N.D. 338, 349, 294 N.W. 183, 188 (1940).

and, (2) a physician from a metropolitan area might be allowed to testify against a rural practitioner regarding an applicable procedure. The former has to do with the physician's standard of care, while the latter has to do with the sort of expert who can testify to it.

The modern view of a majority of courts is that a medical expert is free to testify in a malpractice case if his community or other communities with which he is familiar bear sufficient similarity to that of the defendant. And in determining similarity the courts will not now look to such socio-economic facts as population, type of economy, and income level but to factors more directly relating to the practice of medicine. In the main, an expert practicing in a locality having medical facilities comparable to those existing in the defendant's community is permitted to testify concerning the standard of care governing the defendant. The number and quality of hospitals, laboratories and medical schools are typical considerations. Of course, the nature of the community in which the witness currently practices is irrelevant if he happens also to possess familiarity with standards in the defendant's locale or in areas sufficiently similar to it. The law has focused on the witness' place of practice on the assumption that a medical man will be knowledgeable only about standards in his immediate vicinity, but this assumption is not invariably valid.[26]

THE IMPENDING DISAPPEARANCE OF THE LOCALITY RULE

It is safe prognostication of the law's future direction to say that the locality rule, long in the process of shrinking, will gradually disappear almost completely. Four years ago, Dean Prosser discerned a "tendency. . .to abandon any such formula [*i.e.*, the locality rule], and [to] treat the size and character of the community, in instructing the jury, as merely one factor to be taken into account in applying the general professional standard."[27] Cases are beginning to bear out Prosser's observation. In the 1968 case of *Brune v. Belinkoff*,[28] Massachu-

[26] *See, e.g.*, Riley v. Layton, *supra* note 14; Teig v. St. John's Hospital, *supra* note 13; and text at *supra* note 14.

[27] PROSSER, TORTS 166-67 (3d ed. 1964).

[28] 235 N.E.2d 793 (Mass. 1968). *See also, e.g.*, McGulpin v. Bessmer, *supra* note 10; Sampson v. Veenboer, 252 Mich. 660, 234 N.W. 170 (1931); Carbone v. Warburton, 11 N.J. 418, 94 A.2d 680 (1953); Cavallaro v. Sharp, 84 R.I. 67, 121 A.2d 669 (1956); Hundley v. Martinez, 158 S.E.2d 159 (W. Va. 1967).

This abandonment of the locality rule stems from the fact that the practice of medi-

setts' Supreme Judicial Court announced that it is abandoning the last vestiges of the locality rule. The sweep of this statement is limited only by the fact that *Brune* involved as the defendant a medical specialist, and it is arguable that the locality rule has long since lost vitality in specialist cases.

The *Brune* case involved an action against a specialist in anesthesiology to recover for injuries caused by his alleged negligence in administering an excessive injection of spinal anesthetic (pontocaine) when the plaintiff gave birth to a baby in a New Bedford, Massachusetts hospital. The defendant practiced in New Bedford, a city of 100,000 population, slightly more than 50 miles from Boston. Plaintiff complained of persistent post-delivery numbness and weakness in her left leg. The evidence showed that the anesthetic given her contained eight milligrams of pontocaine in one cubic centimeter of ten percent glucose solution. Plaintiff's evidence also tended to prove that good medical practice called for a dosage of five milligrams or less. Defendant's evidence, including his own testimony, revealed that an eight milligram dosage was customary in New Bedford in vaginal deliveries. The plaintiff objected to the trial judge's giving to the jury the following instruction on the governing law:

> [The defendant] must measure up to the standard of professional care and skill ordinarily possessed by others in his profession in the community, which is New Bedford, and its environs, of course, where he practices, having regard to the current state of advance of the profession. If, in a given case, it were determined by a jury that the ability and skill of the physician in New Bedford were fifty percent inferior to that which existed in Boston, a defendant in New Bedford would be required to measure up to the standard of skill and competence and ability that is ordinarily found by physicians in New Bedford.[29]

The jury in *Brune* found for the defendant anesthesiologist, and the plaintiff appealed, winning a reversal and a new trial. The core of the higher court's reasoning is found in the following portions of its opinion:

> We are of the opinion that the "locality" rule . . . which measures a physician's conduct by the standards of other doctors in similar communities, is unsuited to present day conditions. The time has come when the medical profession should no

cine by certified specialists within each of the American Medical Association's nineteen specialty branches is, obviously, substantially similar throughout the country. *See* Comment, *Medical Malpractice—Expert Testimony*, 60 NW. U.L. REV. 834, 838-39 (1965); Note, *Medical Specialties and the Locality Rule*, 14 STAN. L. REV. 884, 887-88 (1962).

[29] Brune v. Belinkoff, 235 N.E.2d 793, 795 (Mass. 1968). This charge to the jury was a typical expression of the locality rule as it pertains to the standard of care.

longer be Balkanized by the application of varying geographic standards in malpractice cases. . . . The present case affords a good illustration of the inappropriateness of the "locality" rule to existing conditions.[30]

the court observed that New Bedford was close to Boston, "one of the medical centers of the nation, if not the world," and that a practitioner in New Bedford was "a far cry from the country doctor."[31] The trial judge, said the court, may well have carried the locality rule to its logical conclusion, "but it is, we submit, a *reductio ad absurdum* of the rule."[32] The court went on to expound what it viewed as the proper approach:

The proper standard is whether the physician, if a general practitioner, has exercised the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession. 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. . . . One holding himself out as a specialist should be held to the standard of skill of the average member of the profession practicing the specialty, taking into account the advances in the profession. And, as in the case of the general practitioner, it is permissible to consider the medical resources available to him.[33]

There were harbingers of *Brune* in a 1967 Washington case. *Pederson v. Dumouchel* involved a malpractice action against an Aberdeen, Washington medical doctor, dentist, and hospital in which the trial court had charged the jury that the standard of care applicable to the defendants "was set by the learning, skill, care and diligence ordinarily possessed and practiced by others in the same profession in good standing, engaged in like practice, in the same locality or in similar localities."[34] The Supreme Court of Washington rejected the locality rule as a binding principle. It stated that, "local practice within geographic proximity is one, but not the only factor to be considered."[35] Pointing to expanded means for the dissemination of medical knowledge, the court declared: "No longer is it proper to limit the definition of the standard of care. . . to the practice or custom of a particular locality,

[30] *Id.* at 798.

[31] *Id.*

[32] *Id.*

[33] *Id.*

[34] 431 P.2d 973, 976 (Wash. 1967). *Accord*, Douglas v. Bussabarger, 438 P.2d 829(Wash. 1968); Versteeg v. Mowery, 435 P.2d 540 (1967).

[35] Pederson v. Dumouchel, 431 P.2d 973, 978 (Wash. 1967).

a similar locality, or a geographic area."[36] But the court, seemingly on the verge of adopting a nationwide standard, appeared to backtrack, stating that the standard of care applicable to medical men is that level of proficiency "established in an area coextensive with the medical and professional means available in those centers that are readily accessible for appropriate treatment of the patient."[37] It can be demonstrated, however, that the Washington court's apparent hedging reflected a necessary exception to the concept of a national standard of care in medical malpractice cases.[38]

THE SIGNIFICANCE OF THE *Brune* AND *Pederson* DECISIONS

The *Brune* and *Pederson* decisions herald an important shift at two levels of the law of medical malpractice. At one level, the shift is in the relevant standard of care. *Brune* suggests a nationwide standard for both specialists and general practitioners: the general practitioner must adhere to "the degree of care and skill of the average qualified [general] practitioner. . .," while the specialist must adhere "to the standard of skill of the average member of the profession practicing the specialty. . . ."[39] *Pederson* is more cautious, and correctly so. By holding the medical man to that degree of care and skill established in areas accessible to him, the Washington court took into account the possible unavailability in some cases of special facilities, equipment or devices. It would not do to suggest that a physician could rationally be found guilty of malpractice for failing to employ, for example, an artificial kidney machine if that equipment were unavailable in his community and not accessible elsewhere in time to save his patient's life. If *Brune* is read to mean that the absolute unavailability of essential "medical resources" is merely a "permissible" consideration for which a jury could make "some allowance," it goes too far. Such a situation would constitute the basis not for "some allowance" but rather for summary judgment or a directed verdict in favor of the defendant doctor. The law of medical malpractice, akin with diplomacy,

[36] *Id.*

[37] *Id.*

[38] That the basic teaching of *Pederson* is considered clear in Washington is attested by *Douglas v. Bussabarger, supra* note 34, at 837-38, in which that state's Supreme Court, citing *Pederson*, declared that, ". . . there is no longer any basis in fact for the 'locality rule.'" *See also* Versteeg v. Mowery, *supra* note 34.

[39] *Supra* note 29, at 798.

is an aspect of the art of the possible. If, on the other hand, *Brune* is read to mean that "some allowance" could properly be made where essential resources were unavailable locally (*e.g.*, in New Bedford) but readily accessible elsewhere (*e.g.*, in Boston, a fast 50 miles away), it perhaps does not go far enough. In the latter situation it can rightly be said, as a matter of law, that the defendant doctor had a duty to remove his patient to the accessible medical facility where crucial resources and medical specialists were available. This proposition is the inferential teaching of the more carefully worded *Pederson* opinion and the express teaching of the forward-looking 1940 opinion in *Tvedt v. Haugen*.[40] Finally, putting aside cases involving crucial medical facilities, equipment, devices, and the like, *Brune* and *Pederson* are consistent. In cases involving general professional skill, uncomplicated by any question of available special resources, both strongly suggest the demise of the locality rule as binding consideration.

At a second level, the *Brune* and *Pederson* decisions are significant precedents for malpractice claimants to seek their medical experts in any geographic area in the United States, or perhaps even beyond,[41] so long as such experts are equipped to describe "the degree of care and skill of the average qualified [general or specializing] practitioner."[42]

CONCLUSION

The collapse of the locality rule is a welcome example of the law's processes of self-refinement. If the rule were ever justifiable, it clearly is not now. It is anomalous enough that in this area, unlike most, the custom and practice of an occupational group conclusively determines the applicable standard of care.[43] It is more than merely anomalous

[40] *See* text, at *supra* note 25. *See also* Simone v. Sabo, 37 Cal. 2d 253, 231 P.2d 19 (1951); Josselyn v. Dearborn, 143 Me. 328, 62 A.2d 174 (1948); Derr v. Bonney, 38 Wash. 2d 678, 231 P.2d 637 (1951); Myers, *The Surgeon, the General Practitioner, and Medical Ethics*, 45 BULL. AMER. COLL. OF SURGEONS 473, 500 (1960).

[41] *Cf.* Meiselman v. Crown Heights Hosp., Inc., 285 N.Y. 389, 34 N.E.2d 367 (1941) (German-trained physican witness who had not been practicing in the United States at or before the time of defendant doctor's challenged conduct); Ramsland v. Shaw, 341 Mass. 56, 166 N.E.2d 894 (1960) (proffer of English anesthesia treatise under Massachusetts statute permitting receipt in evidence of authoritative medical treatises).

[42] *Supra* note 29, at 798.

[43] The usual role assigned to custom and practice by the law of torts is evidentiary only: "What usually is done may be evidence of what ought to be done, but what ought

that so progressive a profession, with its unmatched educational facilities, should not be held, in the law's eyes, to a uniform medical standard of care. One is compelled almost inexorably to the conclusion that the locality rule's patchwork approach is more a child of the legal profession than of the medical, a tactically advantageous principle to be clung to apologetically by one segment of the trial bar until the courts, sensing that it is no longer rooted in reality, take it away. Surely there could be found today few physicians who would defend the notion that their brothers in some parts of the country are, or should be permitted to be, less competent than those in other regions, based not on impermissibly variant education and training but on some inexplicably depressing force of geography alone.

The locality rule has exerted two interrelated and unfortunate influences. It has rendered all the more shallow the pool of available expertise in legitimate malpractice litigation. And, at least in times past, it has permitted geographic pockets of inferior health service to flourish unchallenged for no better reason than that one or more less than minimally proficient practitioners have been allowed, by the law's default, to set the standard of a community. The fall of the locality rule will exert pressure for uniformly adequate health services, a goal to which both law and medicine are surely united.

The locality rule will pass unlamented by all but a handful of lawyers and a few substandard medical practitioners. For some time the medical specialist has neither had nor wanted the rule. The general practitioner, whether in a large city or small town, must soon confront a nationwide standard of competence. But nothing in what has been said here suggests that the general practitioner must now conform to standards set by medical specialists. The general practitioner must adhere only to those minimum standards of unspecialized practice for which his educational resources have equipped him. It is still good law to say, as did Connecticut's highest court fifteen years ago, that, "A country general practitioner should not be expected to use the high degree of skill possessed by eminent surgeons living in large cities specializing in various branches of medicine."[44]

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to be done is fixed by a standard of prudence, whether it usually is complied with or not." Texas & Pacific Ry. v. Behymer, 189 U.S. 468, 470 (1903). *See also* Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147 (1942).

[44] Marchlewski v. Casella, 141 Conn. 377, 381, 106 A.2d 466, 468 (1954). *See also, e.g.*, Ayers v. Parry, 192 F.2d 181 (3rd Cir. 1951); Worster v. Caylor, 231 Ind. 625, 110 N.E.2d 337 (1953); Rule v. Cheeseman, 181 Kan. 957, 317 P.2d 472 (1957).