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The Locality Rule Lives! Why? Using Modern Medicine To Eradicate An "Unhealthy" Law, 61 Drake L. Rev. 321 (2013)

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THE LOCALITY RULE LIVES! WHY? USING MODERN MEDICINE TO ERADICATE AN UNHEALTHY LAW

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ABSTRACT

The "locality rule" places a geographical dimension on the professional standard of care in medical negligence litigation. It requires the measurement of a physician's conduct by a standard focusing on the geographical location of the treatment provided. This Article traces the origin of the locality rule, discusses its related practical problems, focuses on the states in which it exists, suggests that the rule is archaic, and explains how modern medicine (undergraduate medical education, graduate medical education, state medical licensure, board certification, continuing medical education and practice guidelines) is well positioned to eradicate it.

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I. PROLOGUE

On March 24, 1888, the Journal of the American Medical Association published the obituary of Levi Howard, M.D.[1] Dr. Howard attended Bowdoin College and graduated from Dartmouth Medical College.[2] He resided and practiced medicine in Lowell, Massachusetts for many years.[3] In 1875, Dr. Howard was president of the Middlesex North District Medical Society.[4] He was a well-regarded and well-compensated physician.[5]

Dr. Howard's claim to legal fame occurred posthumously.[6] He was sued by a patient in Massachusetts for alleged "malpractice in dressing and caring for a wound upon the [patient's] wrist."[7] This case, *Small v. Howard*,[8] became celebrated as the origin of the "locality rule"[9]—the rule

1. Levi Howard, *Necrology*, 10 JAMA 378 (1888). Dr. Howard actually died on January 23, 1885. WILSON WATERS & HENRY SPAULDING PERHAM, HISTORY OF CHELMSFORD, MASSACHUSETTS 805 (1917).

2. Howard, *supra* note 1.

3. *Id.*

4. FRANCIS H. BROWN, THE MEDICAL REGISTER FOR THE STATE OF MASSACHUSETTS 21 (1875).

5. WATERS & PERHAM, *supra* note 1, at 803–05.

6. *See* Small v. Howard, 128 Mass. 131 (1880), *overruled by* Brune v. Belinkoff, 235 N.E.2d 793, 798 (Mass. 1968).

7. *Id.* at 131.

8. *See Small*, 128 Mass. 131.

9. *See, e.g.*, Reeg v. Shaughnessy, 570 F.2d 309, 313 (10th Cir. 1978) ("The [locality] rule is said to have its origin in the 1880 case of *Small v. Howard* . . . ."); Kent E. Baldauf, *Non-Resident Expert Testimony on Local Hospital Standards*, 18 CLEV.-MARSHALL L. REV. 493, 493 (1969); Michelle Huckaby Lewis et al., *The Locality Rule and the Physician's Dilemma: Local Medical Practices vs the National Standard of Care*, 297 JAMA 2633, 2634 & n.9 (2007); Meghan C. O'Connor, *The Physician–Patient Relationship and the Professional Standard of Care: Reevaluating Medical Negligence Principles to Achieve the Goals of Tort Reform*, 46 TORT TRIAL & INS. PRAC. L.J. 109,

placing a geographical dimension on the professional standard of care in medicine.[10]

Physicians are generally obligated to provide to patients the degree of skill and care that a reasonably well-qualified physician would provide under the same or similar circumstances.[11] That is a basic expression of "the standard of care."[12] Yet, identifying or finding the applicable standard of care is not always a simple task. With the exception of practice guidelines[13] there is no single accessible source to explore. The standard of care is derived from the collective education, training, and experience of physicians over time, as well as from medical literature.[14] The locality rule modifies this expression by injecting geography into the standard of care—requiring physicians to provide to patients the degree of skill and care that a reasonably well-qualified physician, *in the same or similar locality* would provide under the same or similar circumstances.[15] Of course, there is a more drastic version of the locality rule that narrows the geographical dimension to the state or community where the defendant practices.[16] This version of the locality rule is the focus of this Article.

Not all states subscribe to the locality rule in any form.[17] Instead, they opt to measure the conduct of physicians by a national standard of care,[18] based upon assumptions and facts, which will be explored in depth later in

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118 (2010).

10. *See* DAN B. DOBBS, THE LAW OF TORTS § 244, at 635 & n.1 (2000) ("At one time, courts held that the professional standard of care for medical doctors was the standard in the very same locality where the doctor practiced."); MARK A. HALL ET AL., MEDICAL LIABILITY AND TREATMENT RELATIONSHIPS 326 (2d ed. 2008) (discussing the justifications for confining a doctor's standard of care to their immediate locality).

11. *See* Pederson v. Dumouchel, 431 P.2d 973, 978 (Wash. 1967); PROSSER & KEETON ON THE LAW OF TORTS 187 (W. Page Keeton ed., 5th ed. 1984).

12. *See Pederson*, 431 P.2d at 978.

13. *See infra* Part V.F (discussing practice guidelines and noting the existence of such guidelines eliminates the need for the locality rule).

14. *See* Joseph H. King, Jr., *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 VAND. L. REV. 1213, 1241–42 (1975).

15. *See* Small v. Howard, 128 Mass. 131, 136 (1880), *overruled by* Brune v. Belinkoff, 235 N.E.2d 793, 798 (Mass. 1968); DOBBS, *supra* note 10, § 244, at 635 & n.1.

16. *See, e.g.*, Kaiser v. Suburban Transp. Sys., 398 P.2d 14, 16 (Wash. 1965).

17. *See, e.g.*, Spencer v. Seikel, 742 P.2d 1126, 1128 (Okla. 1987) (rejecting the locality rule in favor of a national standard of care).

18. *See, e.g., id.*; Hill v. Medlantic Health Care Grp., 933 A.2d 314, 325 (D.C. 2007); Roberts v. Tardif, 417 A.2d 444, 451–52 (Me. 1980).

this Article.[19] An interesting minority of states, however, are wedded to a strict version of a locality rule, or to a close relative of the strict version.[20] The minority remains, despite predictions of the demise of the locality rule many years ago[21] and more recently.[22]

This Article intends to provide the evidence necessary to convince the strict locality rule states to rid themselves of the rule in any form. In fact, the strict or modified version of the rule is simply obsolete. Although some courts have given lip service to advances in medicine as the reason to discard the locality rule in favor of a national standard,[23] these courts have not utilized available data from the world of modern medicine to emphasize the point. This data relates to undergraduate medical education, graduate medical education, state medical licensure, board certification, continuing medical education, the geographical location of board certified physicians, and national practice guidelines.[24]

The locality rule, a topic of much discussion over many years in legal and medical scholarship,[25] is archaic, anachronistic, and in fact, insulting to

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19. *See infra* Part V.

20. *See infra* Part IV (discussing in detail the "last vestiges" of the strict locality rule).

21. Jon R. Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DEPAUL L. REV. 408, 415 (1969).

22. KENNETH S. ABRAHAM, THE FORMS AND FUNCTIONS OF TORT LAW 84 (4th ed. 2012) ("It is no surprise, therefore, that the rule broke down in a variety of ways and then eventually disintegrated."); MARCIA M. BOUMIL & DAVID J. SHARPE, LIABILITY IN MEDICINE AND PUBLIC HEALTH 203–04 (2004) ("Over the past decade the so-called locality rule has yielded to a national standard of care.").

23. *See, e.g.*, Pederson v. Dumouchel, 431 P.2d 973, 977–78 (Wash. 1967).

24. *See infra* Part V.

25. *See, e.g.*, Page Keeton, *Medical Negligence—The Standard of Care*, 10 TEX. TECH L. REV. 351 (1979); John F. King & Ward B. Coe, III, *The Wisdom of the Strict Locality Rule*, 3 U. BALT. L. REV. 221 (1974); Lewis et al., *supra* note 9; Samuel J. Stoia, Vergara v. Doan*: Modern Medical Technology Consumes the Locality Rule*, 2 J. PHARMACY & L. 107 (1993); David D. Wininger & W. Fletcher Sams, *Medical Malpractice: The Alabama Locality Rule*, 11 CUMB. L. REV. 275 (1980); John C. Drapp III, Note, *The National Standard of Care in Medical Malpractice Actions: Does Small Area Analysis Make It Another Legal Fiction?*, 6 QUINNIPIAC HEALTH L.J. 95 (2003); Richard L. Hartmann, Comment, *Standard of Care for Medical Specialists*, 16 ST. LOUIS U. L.J. 497 (1972); Casey Caroline Hyman, Comment, *Setting the "Bar" in North Carolina Medical Malpractice Litigation: Working with the Standard of Care that Everyone Loves to Hate*, 89 N.C. L. REV. 234 (2010); Swithin S. McGrath, Note, *Standards of Medical Care for General Practitioners in Montana: The* Chapel *Decision and a Move Toward a National Standard*, 53 MONT. L. REV. 119 (1992).

modern medicine. It is time to put this rule to rest.

II. HOW IT BEGAN: THE ORIGIN OF THE LOCALITY RULE

Although the origin of the locality rule is often credited to *Small v. Howard* decided in 1880,[26] its birth may have occurred somewhat earlier. In his text, *Medical Malpractice in Nineteenth Century America*, Kenneth Allen De Ville attributes the locality rule to a series of medical malpractice trials in Maine involving the claim of *Lowell v. Faxon & Hawks*.[27] De Ville reports the following instruction to the jury:

> It is not to be expected of a Surgeon or a Physician in a country or obscure village, that he will possess the skill of a surgeon in the city of London, or any large city—this would be unreasonable to expect . . . all that is required is ordinary skill according to the general state of medical science in the section of the country in which he lives.[28]

It is possible that this instruction was the first recitation of the locality rule about which there is some record.

There is also a series of reported cases predating *Small v. Howard* to which the locality rule might be traced. In 1853, the Superior Court of Judicature of New Hampshire,[29] in *Leighton v. Sargent*, considered an action for "trespass on the case" against a physician in connection with treatment he provided to a plaintiff's injured foot and ankle.[30]

In discussing the "duties and obligations of the professional man,"[31]

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26. *See, e.g.*, Reeg v. Shaughnessy, 570 F.2d 309, 313 (10th Cir. 1978) (stating that the locality rule "is said to have its origin in the 1880 case of *Small v. Howard*").

27. KENNETH ALLEN DE VILLE, MEDICAL MALPRACTICE IN NINETEENTH-CENTURY AMERICA: ORIGINS AND LEGACY 55–58 (1990); Charles Lowell, *An Authentic Report of a Trial Before the Supreme Judicial Court of Maine for the County of Washington, June Term 1824, Charles Lowell v. John Faxon & Micajah Hawks Surgeons and Physicians in an Action of Trespass on the Case for Ignorant and Negligent Treatment with Observations on the Prejudices and Conduct of the Inhabitants of Eastport in Regard to this Cause* (Portland: Printed for the Author, 1826).

28. DE VILLE, *supra* note 27, at 18 (alteration in original).

29. *See About the Supreme Court*, NEW HAMPSHIRE JUD. BRANCH, http://www.courts.state.nh.us/supreme/about.htm (last visited Feb. 1, 2013) (noting that the Superior Court of Judicature of New Hampshire was the state's highest appellate court until 1876).

30. Leighton v. Sargent, 27 N.H. 460, 460–61 (1853) (internal quotation marks omitted).

31. *Id.* at 468.

the court pronounced:

> By our law, a person who offers his services to the community generally, or to any individual, for employment in any professional capacity as a person of skill contracts with his employer,
>
> I. That he possesses that reasonable degree of learning, skill and experience which is ordinarily possessed by the professors of the same art or science, and which is ordinarily regarded by the community . . . to qualify him to engage in such business.[32]

Of course, this statement is not truly a recitation of the locality rule, as the geographical reference of "community" appears in the context of "learning, skill and experience"[33] possessed, not "applied."[34]

In 1870, in *Tefft v. Wilcox*, the Supreme Court of Kansas spoke emphatically about the role of locality in the standard of care applicable to a physician.[35] The court quoted from John Elwell's 1866 treatise titled *Malpractice and Medical Evidence* as follows:

> In large towns and cities, are always found surgeons and physicians of the greatest degree of skill and knowledge. They are held to a corresponding high degree of responsibility. In the smaller towns and country, those who practice medicine and surgery, though often possessing a thorough theoretical knowledge of the highest elements of the profession do not enjoy so great opportunities of daily observation and practical operations, where the elementary studies are brought into every day use, as those who reside in the metropolitan towns, and though just as well informed in the elements and literature of their profession, they should not be expected to exercise that high degree of skill and practical knowledge possessed by those having greater facilities for performing and witnessing operations, and who are, or may be, constantly observing the various accidents and forms of disease.[36]

A close reading of *Tefft*, however, casts doubt on it as the genesis of the

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32. *Id.* at 469.
33. *Id.*
34. *Id.* at 471–72.
35. Tefft v. Wilcox, 6 Kan. 46, 62–64 (1870).
36. *Id.* (alteration in original) (quoting JOHN J. ELWELL, A MEDIO-LEGAL TREATISE ON MALPRACTICE AND MEDICAL EVIDENCE, COMPROMISING THE ELEMENTS OF MEDICAL JURISPRUDENCE 22–23 (1866)).

locality rule. Earlier in its opinion, the court refers to "[t]he standard of ordinary skill which is required of any physician and surgeon"[37] and states that "such physician and surgeon must in general be held to apply in his practice, what is thus settled in his profession."[38] These statements do not refer to locality.[39] Therefore, it is possible that *Tefft* is actually a precursor of a more enlightened version of the standard of care; one that requires a physician to apply the skill and care of a reasonably well-qualified physician, under the same or similar circumstances, with locality counting as a circumstance.[40]

In 1872, in *Smothers v. Hanks*, the Supreme Court of Iowa considered a medical negligence case involving the treatment of a plaintiff's arm and spoke of the applicable standard of care.[41] The court recognized "that the standard of ordinary skill may vary even in the same state, according to the greater or lesser opportunities afforded by the locality, for observation and practice, from which alone the highest degree of skill can be acquired."[42] This pronouncement embraces a locality-based standard of care grounded upon different levels of physician knowledge throughout the state.[43]

If the majority opinion in *Smothers* provides early support for the locality rule, it is the dissenting opinion that is ahead of its time in opposition to the locality rule.[44] The dissent fully recognizes that medical knowledge has greatly advanced and pinpoints a true weakness in the locality rule—an entire locality of physicians may practice beneath the standard of care—when it queried,

> Dare we say that a remedy of yesterday is sufficient, when the progress and experience of [today] have taught the profession that there is something better? May we pronounce surgical operations, done in accordance with the canon of the profession in force fifty years ago,

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37. *Id.* at 62 (quoting ELWELL, *supra* note 36, at 55) (internal quotation marks omitted).

38. *Id.* (quoting ELWELL, *supra* note 36, at 3) (internal quotation marks omitted).

39. *Id.*

40. *See* DOBBS, *supra* note 10, § 244, at 636 ("Even without a locality rule, the jury could have considered all the circumstances, including limitations on equipment." (footnote omitted)).

41. Smothers v. Hanks, 34 Iowa 286, 289 (1872) (per curiam).

42. *Id.* at 289–90.

43. *See id.*

44. *See id.* at 297–98 (Beck, C.J., dissenting).

> without the instruments and efficient anesthetics of [today], skillfully performed? . . . If not, can we announce as a rule of the law that a physician or surgeon may be five years, one year, or one month behind the progress of his profession?[45]

In 1876, in *Hathorn v. Richmond*, the Supreme Court of Vermont considered the appropriateness of jury instructions in medical negligence litigation and appeared to embrace the locality rule.[46] The instructions given by the trial court included: "The ordinary expression is, *ordinary skill.* That means, such skill as doctors in the same general neighborhood . . . ."[47] Considering the case's particular facts, the trial court asked:

> [D]id Dr. Richmond use ordinary and reasonable care in dressing the leg,—that is, in doing what he did on Saturday, did he set and dress that leg in the manner that doctors like himself in the community would have done the same thing, or are ordinarily accustomed to do the same thing?[48]

The Vermont Supreme Court reversed a jury verdict in favor of the defendant, based upon the impropriety of instructions relating to the successive conduct of two physicians.[49] The supreme court did not appear to disturb the trial court's reference to locality with the standard of care instruction.[50]

The classic and celebrated locality rule case is *Small v. Howard*, which involved wound care provided by the defendant, Dr. Howard.[51] The opinion of the Supreme Judicial Court of Massachusetts reveals that the plaintiff, Mr. Small, suffered a serious injury caused by glass.[52] The wrist wound "extended to the bone, severing all the arteries and tendons."[53] Dr.

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45. *Id.* at 298.
46. Hathorn v. Richmond, 48 Vt. 557, 562 (1876).
47. *Id.* at 558–59.
48. *Id.* at 559.
49. *Id.* at 565.
50. *See id.*
51. Small v. Howard, 128 Mass. 131, 132 (1880), *overruled by* Brune v. Belinkoff, 235 N.E.2d 793, 798 (Mass. 1968).
52. *Id.*
53. *Id.* Additionally, it should be noted that medical literature of the early twentieth century described the severity of the wrist injury and surgical procedure necessary to repair it. Torr Wagner Harmer, *Certain Aspects of Hand Surgery*, 214

Howard was a "country" physician and surgeon, with experience consistent with that status.[54] Allegedly, an "eminent surgeon" was within four miles of Dr. Howard, but Dr. Howard did not advise the plaintiff to see the other surgeon.[55] The court was confronted with the issues of the propriety of Dr. Howard's care and the appropriate standard of care applicable to Dr. Howard.[56]

In *Small*, the plaintiff proposed, and the trial court refused, an instruction suggesting "that the skill required of the defendant was merely the average skill of all practitioners, educated and uneducated, permanent and occasional, regulars and interlopers alike."[57] The Supreme Judicial Court of Massachusetts rejected this form of instruction and uttered the following words, which are often credited as the origin of the locality rule:

> One other point remains to be considered. It is a matter of common knowledge that a physician in a small country village does not usually make a specialty of surgery, and, however well informed he may be in the theory of all parts of his profession, he would, generally speaking, be but seldom called upon as a surgeon to perform difficult operations. He would have but few opportunities of observation and practice in that line such as public hospitals or large cities would afford. The defendant . . . being the practitioner in a small village . . . was bound to possess that skill only which physicians and surgeons of ordinary ability and skill, practi[c]ing in similar localities, with opportunities for no larger experience, ordinarily possess; and he was not bound to possess that high degree of art and skill possessed by eminent surgeons practi[c]ing in large cities, and making a specialty of the practice of surgery.[58]

A point of interest here is that despite the fame of this statement with respect to the locality rule, it truly does not represent the strict locality rule

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NEW ENG. J. MED. 613, 613–14 (1936); Torr Wagner Harmer, *Tendon Suture*, 177 BOSTON MED. & SURGICAL J. 808, 808 (1917); Maurice Culmer O'Shea, *Severed Tendons and Nerves of the Hand and Forearm*, 105 ANNALS OF SURGERY 228, 234 (1937) (noting that in the surgical repair of severed tendons, "great care, perfect surgical [technique] and excellent surgical judgment are required").

54. *Small*, 128 Mass. at 132.
55. *Id.*
56. *Id.*
57. *Id.* at 136.
58. *Id.* (internal quotation marks omitted).

exemplified by the current Idaho approach.[59] In fact, *Small* appears to pronounce a modified locality rule that requires compliance with the standard of care provided in the same or similar locality.[60] This approach is a bit more lenient than the strict locality rule, but as this Article argues, it is also out of date.

Another point, perhaps ironic, is that the Supreme Judicial Court of Massachusetts gave, at least, lip service to modern medicine in its opinion.[61] Frankly, this Article contends that the locality rule is antithetical to modern medicine. The court in *Small* noted that "in judging of this degree of skill in any given case, regard is to be had to the advanced state of the profession at the time."[62] Therefore, it is reasonable to assert that while *Small* is celebrated as the origin of the locality rule, it also contains the seeds of an anti-locality rule effort.

Small retained vitality in Massachusetts until 1968, when it was expressly overruled in *Brune v. Belinkoff*.[63] *Brune* involved a medical negligence claim against an anesthesiologist who administered an anesthetic to the plaintiff–delivering mother during child birth.[64] The plaintiff later attempted to get out of bed, slipped and fell, and suffered "numbness and weakness in her left leg."[65] The court recognized that the locality rule not only concerned the standard of care but also "the qualifications of a medical expert to testify."[66] The *Brune* court repudiated the "Balkaniz[ation]" of medicine through the locality rule[67] and held that the appropriate standard of care encompasses a consideration of the circumstances present when care was provided, such as "the medical resources available to [the physician]."[68]

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59. *See id.*; IDAHO CODE ANN. § 6-1013 (2010) (requiring testimony of a physician's standard of care to be specific to community stardards within the physician's actual practice area).

60. *See Small*, 128 Mass. at 136.

61. *See id.* at 135–36.

62. *Id.* at 135 (citing McCandless v. McWha, 22 Pa. 261 (1853)).

63. Brune v. Belinkoff, 235 N.E.2d 793, 798 (Mass. 1968).

64. *Id.* at 794–95.

65. *Id.* at 795.

66. *Id.* at 796 (citing Sampson v. Veenboer, 234 N.W. 170, 171 (Mich. 1931)).

67. *Brune*, 235 N.E.2d. at 798.

68. *Id.*

III. THE REAL PROBLEM WITH THE LOCALITY RULE

Assuming the locality rule ever had a legitimate purpose, it must have been to define the professional standard of care in a manner designed to help protect physicians from medical negligence claims (or, at least, bolster the defense of claims) by recognizing that physicians in rural and remote areas had limited access to facilities, resources, and knowledge.[69] Therefore, these physicians arguably needed a mechanism with which to resist the application of a standard of care that was a better fit for urban practitioners.

Of course, the protective aspect of the locality rule focuses on the need for expert witnesses in medical negligence litigation since "the plaintiff bears a burden to establish the standard of care through expert witness testimony."[70] "This requirement is based on the simple fact that without expert testimony, jurors, not skilled in the profession, are not equipped to judge the professional's conduct."[71] A deviation from the applicable standard of care must be proved by expert testimony;[72] therefore, the locality rule is interconnected with the standard of care. This was well explained by the Supreme Court of Washington in *Pederson v. Dumouchel*, as follows:

> The original reason for the "locality rule" is apparent. When there was little intercommunity travel, courts required experts who testified to the standard of care that should have been used to have a personal knowledge of the practice of physicians in that particular community where the patient was treated. It was the accepted theory that a doctor in a small community did not have the same opportunities and resources as did a doctor practicing in a large city to keep abreast of advances in his profession; hence, he should not be held to the same standard of care and skill as that employed by doctors in other communities or in larger cities.[73]

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69. *See* DOBBS, *supra* note 10, § 244, at 635–36 ("One theory sometimes advanced for this result was that smalltown doctors might not have the latest equipment or training and should not be liable merely for that reason.").

70. Studt v. Sherman Health Sys., 951 N.E.2d 1131, 1136 (Ill. 2011) (quoting Advincula v. United Blood Servs., 678 N.E.2d 1009 (Ill. 1996)) (internal quotation marks omitted).

71. *Id.* (citations omitted).

72. Hardy v. Cordero, 929 N.E.2d 22, 26 (Ill. App. Ct. 2010).

73. Pederson v. Dumouchel, 431 P.2d 973, 977 (Wash. 1967).

The *Pederson* court went on to explain that the locality rule created

> [T]wo practical difficulties: first, the scarcity of professional [expert witnesses] in the community who were qualified or willing to testify about the local standard of care; and second, the possibility of a small group [of physicians], who, by their laxness or carelessness, could establish a local standard of care that was below that which the law requires.[74]

In my estimation, the second concern voiced in *Pederson* is unlikely to occur. As this Article will explain, modern undergraduate and graduate medical education, licensing and board certification requirements, continuing medical education, and national practice guidelines diminish, if not eradicate, any possibility that physicians in any community, as a group, intentionally or carelessly practice substandard medicine.[75]

The first concern of the *Pederson* court is quite real.[76] Jurisdictions that have adopted the locality rule, particularly those with the strict variety, create a difficult burden for plaintiffs to overcome.[77] Here is the problem: Plaintiff A files a medical negligence lawsuit against Physician B in State X. State X has adopted the locality rule to define the standard of care. State X is a relatively small state without major urban areas and likely without major medical centers. Physicians who practice medicine in State X are not inclined to testify against their colleagues.[78] Physicians who practice medicine outside of State X may be "unqualified" to testify against Physician B insofar as nonresident physicians are unfamiliar with the standard of care in the community within State X where the alleged negligence occurred.[79] Therefore, Plaintiff A is unable to secure an expert witness to testify that Physician B deviated from the standard of care.

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74. *Id.*

75. *See infra* Part V.

76. *See Pederson*, 431 P.2d at 977 (expressing concern about the scarcity of willing and qualified expert witnesses).

77. *See, e.g.*, Suhadolnik v. Pressman, 254 P.3d 11, 22–23 (Idaho 2011) (recognizing the difficulty of finding expert witness under Idaho's strict locality standard); *see also infra* note 97 and accompanying text (outlining the Idaho statute applied in *Suhadolnik*).

78. This disinclination to testify has been referred to as a "conspiracy of silence." *See, e.g.*, BARRY R. FURROW ET AL., HEALTH LAW § 6-2, at 265 (2d ed. 2000); David B. Resnik, *Punishing Medical Experts for Unethical Testimony: A Step in the Right Direction or a Step too Far?*, 4 J. PHIL. SCI. & L. 1, 7 (2004).

79. *See* Resnik, *supra* note 78, at 7.

Physician B is essentially insulated from potential liability due to the likely scarcity of medical experts.[80]

Currently, the strict locality rule appears in statutory form[81] and as a product of case law.[82] Idaho provides an example of the strict locality rule in pure form, but the locality rule (or at least vestiges of it) continues to survive in other jurisdictions as well.[83]

This Article explores the locality rule in its strict form, although the arguments against the strict locality rule are applicable to all versions of this outdated rule. Finally, this Article looks to medical education in the United States, as well as graduate medical education, board certification, medical licensing, continuing medical education, and medical practice guidelines, and suggests the locality rule is simply out of step with modern medicine and should be abandoned in favor of a national standard of care that is flexible enough to consider some legitimate local conditions should they arise.[84]

IV. WHAT REMAINS OF THE STRICT LOCALITY RULE?

The last vestiges of the strict locality rule appear to reside in Idaho,[85] Arizona,[86] Washington,[87] Virginia,[88] New York,[89] and Tennessee.[90] Tennessee's approach—a close relative of the strict locality rule—deserves inclusion here because of the rule's peculiarity[91] and its recent applicable

80. *Cf. Suhadolnik*, 254 P.3d at 22–23 (disqualifying an outside expert who was unable to find local physicians who would cooperate in educating him on local community standards).

81. *See, e.g.*, IDAHO CODE ANN. § 6-1012 (2010).

82. *See, e.g.*, Nestorowich v. Ricotta, 767 N.E.2d 125, 128 (N.Y. 2002) (delineating the common law strict locality rule in New York).

83. *See infra* Part IV.

84. *See infra* Parts V–VI.

85. *See* IDAHO CODE ANN. § 6-1012; *see also Suhadolnik*, 254 P.3d at 16–23 (applying Idaho's strict locality rule).

86. *See* ARIZ. REV. STAT. ANN. § 12-563 (2003 & Supp. 2012).

87. *See* WASH REV. CODE ANN. § 7.70.040 (West 2007 & Supp. 2012).

88. *See* VA. CODE ANN. § 8.01-581.20 (2007 & Supp. 2012).

89. *See* Nestorowich v. Ricotta, 767 N.E.2d 125, 128 (N.Y. 2002) (delineating the common law strict locality rule in New York).

90. *See* TENN. CODE ANN. § 29-26-115 (2012).

91. *See id.* The statute refers to the standard of care "in the community in which the defendant practices or in a similar community." *Id.* § 29-26-115(a)(1). It has been asserted that this "same or similar" standard does not equate with the classic

jurisprudence.[92] Obviously, these states are demographically diverse from one another.[93] For example, there are no medical schools in Idaho, but there are medical schools in the other locality rule states.[94] Within New York, there are thirteen allopathic and two osteopathic medical schools.[95] Therefore, the prevalence of basic, formal undergraduate medical education within a state does not dictate against the locality rule, and the

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locality rule. *See* Lewis et al., *supra* note 9, at 2634. However, it is section (b) of the Tennesee statute that, in my estimation, merits inclusion in the classic locality rule discussion. *See* TENN. CODE ANN. § 29-26-115(b) (requiring medical expert witnesses to be licensed either in Tennessee or a contiguous bordering state).

92. *See* Shipley v. Williams, 350 S.W.3d 527, 536–54 (Tenn. 2011) (finding that a medical expert must first show their "familiarity with the standard of care in the same or similar community as the defendant" before testifying regarding a national standard).

93. *Compare, e.g.*, *State & County Quick Facts Idaho*, U.S. CENSUS BUREAU, http://quickfacts.census.gov/qfd/states/16000.html (last modified Sept. 18, 2012) (detailing Idaho's demographic makeup), *with State & County Quick Facts New York*, U.S. CENSUS BUREAU, http://quickfacts.census.gov/qfd/states/36000.html (last modified Sept. 18, 2012) (detailing New York's differing demographics).

94. *See, e.g.*, N.Y.U. SCH. OF MED., http://school.med.nyu.edu/ (last visited Feb. 1, 2013); *School of Medicine: School Overview*, U. OF WASH., http://www.washington.edu/students/gencat/academic/school_medicine.html (last visited Feb. 1, 2013); THE U. OF ARIZ: C. OF MED., http://medicine.arizona.edu/ (last visited Feb. 1, 2013); THE U. OF TENN.: GRADUATE SCH. OF MED., http://gsm.utmck.edu/ (last visited Feb. 1, 2013); U. OF VA.: SCH. OF MED., http://www.medicine.virginia.edu/ (last visited Feb. 1, 2013).

95. New York's allopathic medical schools are: Albany Medical College, Albert Einstein College of Medicine of Yeshiva University, Columbia University College of Physicians and Surgeons, Hofstra University North Shore–LIJ School of Medicine, Mount Sinai School of Medicine, New York Medical College, New York University School of Medicine, State University of New York at Stony Brook School of Medicine, State University of New York Upstate Medical University, State University of New York Downstate Medical Center College of Medicine, University at Buffalo–The State University of New York School of Medicine & Biological Sciences, University of Rochester School of Medicine & Dentistry, Weill Cornell/Rockefeller/Sloan-Kettering Tri-Institutional M.D./Ph. D. Program. *See* HOFSTRA N. SHORE–LIJ: SCH. OF MED. AT HOFSTRA U., http://medicine.hofstra.edu/education/md/md_academic_calendar.html (last visited Feb. 1, 2013) (indicating classes at Hofstra Medical School started in August 2012); *MD/PhD Programs by State*, ASS'N. OF AM. MED. CS., https://www.aamc.org/students/research/mdphd/applying_md-phd/61570/mdphd_programs.html (last visited Feb. 1, 2013). New York's osteopathic schools are: New York College of Osteopathic Medicine at the New York Institute of Technology, Touro College of Osteopathic Medicine. *U.S. Colleges of Osteopathic Medicine*, AM. ASS'N. OF CS. OF OSTEOPATHIC MED., http://www.aacom.org/about/colleges/Pages/default.aspx (last visited Feb. 1, 2013).

absence of a medical school within a state does not compel that state to adhere to the locality rule.[96]

This Article will next focus on the strict and functionally strict locality rule states, emphasizing Idaho and Tennessee simply insofar as their applicable legislation and case law are quite interesting. Medical demographics will be discussed as well. Thereafter, this Article will address aspects of modern medical education, credentialing, and treatment that constitute the ammunition to, at long last, eradicate the locality rule.

A. *Idaho: The Ultra Locality Rule State*

The point of departure in Idaho is found in two statutes: Idaho Code section 6-1012, Proof of Community Standard of Health Care Practice in Malpractice Case, and Idaho Code section 6-1013, Testimony of Expert Witness on Community Standard. The statutes provide in relevant part as follows:

> 6-1012. Proof of Community Standard of Health Care Practice in Malpractice Cases. In any case, claim or action for damages due to injury to or death of any person, brought against any physician and surgeon or other provider of health care . . . such claimant or plaintiff must, as an essential part of his or her case in chief, affirmatively prove by direct expert testimony and by a preponderance of all the competent evidence, that such defendant then and there negligently failed to meet the applicable standard of health care practice of the community in which such care allegedly was or should have been provided, as such standard existed at the time and place of the alleged negligence of such physician and surgeon . . . . Such individual providers of health care shall be judged in such cases in comparison with similarly trained and qualified providers of the same class in the same community, taking into account his or her training, experience, and fields of medical specialization, if any. If there be no other like provider in the community and the standard of practice is therefore indeterminable, evidence of such standard in similar Idaho communities at said time may be considered. As used in this act, the term "community" refers to that geographical area ordinarily served

96. Alaska does not have a medical school. Alaska is trending to or has adopted the national standard of care, at least as to physician specialists. *See* ALASKA STAT. § 09.55.540 (2010); Priest v. Lindig, 583 P.2d 173, 177 (Alaska 1978) (discussing the legislature's apparent adoption of the national standard test in response to the courts' trend toward that test).

> by the licensed general hospital at or nearest to which such care was or allegedly should have been provided.[97]
>
> 6-1013. Testimony of Expert Witness on Community Standard. The applicable standard of practice and such a defendant's failure to meet said standard must be established in such cases by such a plaintiff by testimony of one (1) or more knowledgeable, competent expert witnesses, and such expert testimony may only be admitted in evidence if the foundation therefor is first laid, establishing (a) that such an opinion is actually held by the expert witness, (b) that the said opinion can be testified to with reasonable medical certainty, and (c) that such expert witness possesses professional knowledge and expertise coupled with actual knowledge of the applicable said community standard to which his or her expert opinion testimony is addressed; provided, this section shall not be construed to, prohibit or otherwise preclude a competent expert witness who resides elsewhere from adequately familiarizing himself with the standards and practices of (a particular) such area and thereafter giving opinion testimony in such a trial.[98]

The terms of these statutes focus on the practice of medicine in Idaho communities.[99] Therefore, a plaintiff in a medical negligence claim must prove that the Idaho defendant-physician deviated from the standard of care applicable in the specific Idaho community.[100] From a practical standpoint, this statute limits the field of potential expert physicians to those with specific knowledge about the practice of medicine in a specific Idaho community.[101] Realistically, these expert physicians would be Idaho physicians, unless it is possible for a non-Idaho physician to convince an Idaho court that he or she had the requisite familiarity with the local standard of care. To determine how the Idaho statutes operate, it is necessary to examine Idaho jurisprudence.

In 2011, the Supreme Court of Idaho decided *Suhadolnik v. Pressman*, a case that amply demonstrates the ultra-locality rule.[102] In *Suhadolnik*, Dr. Pressman, the defendant-physician, an ophthalmologist,

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97. IDAHO CODE ANN. § 6-1012 (2010).
98. *Id.* § 6-1013.
99. *See id.* §§ 6-1012, 6-1013.
100. *See id.* § 6-1012.
101. *See id.*
102. Suhadolnik v. Pressman, 254 P.3d 11 (Idaho 2011).

was sued following his performance of a cataract operation.[103] The trial court granted summary judgment in favor of Dr. Pressman because plaintiffs' "expert . . . failed to adequately inform himself on the local standard of care."[104]

The lawsuit focused on a claim that Dr. Pressman "failed to adequately inquire about [the plaintiff's] prior use of the prescription drug Flomax, which resulted in increased risks during surgery and a lack of informed consent."[105] During surgery, a complication occurred.[106] The patient required further surgery and was "legally blind in the affected eye."[107]

Dr. Pressman moved for summary judgment and his motion was contested by the affidavit of an expert who was "a board-certified ophthalmologist currently practicing in Beverly Hills, California, with a multitude of experience in ophthalmology and cataract surgeries."[108] The expert was clearly a physician in the "same class"[109] (ophthalmology) as Dr. Pressman, but the state supreme court noted that he was also obligated to "demonstrate knowledge of the local standard of care in order for this testimony to be admissible."[110]

The expert essentially "familiarized himself with the standard of care . . . in Boise by reviewing the deposition of Dr. Pressman."[111] Curiously, Dr. Pressman's position in response to the expert's affidavit was that "the deposition did not provide sufficient information regarding any

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103. *Id.* at 14. There is extensive literature on cataract surgery—it has been frequently performed in the United States, typically in an outpatient setting. Oliver D. Schein et al., *The Value of Routine Preoperative Medical Testing Before Cataract Surgery*, 342 NEW ENG. J. MED. 168, 168 (2000). "The aim of cataract surgery is to improve visual acuity and thereby improve visual function, with the implicit assumption that this will also improve overall quality of life." P. Desai et al., *Gains from Cataract Surgery: Visual Function and Quality of Life*, 80 BRIT. J. OPHTHAMOLOGY 868, 868 (1996). For a basic review of cataract surgery, see Kathryn E. Bollinger & Roger H. S. Langston, *What Can Patients Expect from Cataract Surgery?*, 75 CLEV. CLINICAL J. MED. 193 (2008).

104. *Suhadolnik*, 254 P.3d. at 14.

105. *Id.* (footnote omitted).

106. *Id.* at 14–15.

107. *Id.* at 15 (internal quotation marks omitted).

108. *Id.* at 15, 19.

109. IDAHO CODE ANN. § 6-1012 (2010).

110. *Suhadolnik*, 254 P.3d at 19.

111. *Id.* at 16.

relevant standard of care."[112] The Supreme Court of Idaho agreed and held that the expert could not rely on Dr. Pressman's deposition testimony "to familiarize himself with the local standard of care."[113]

The Supreme Court of Idaho emphasized that a medical negligence expert must demonstrate familiarity "with the *local* standard of care for the relevant timeframe and specialty"[114] and how the expert "became familiar with that standard of care."[115] These requirements yield interesting options under Idaho law.[116] First, a local Idaho physician could simply testify against the defendant Idaho physician. The local physician would need to have practiced medicine in the same field or specialty, within the same community, and by definition, would need to be familiar with the applicable standard of care. It is, of course, intuitively obvious that this is not likely to occur in a relatively small community.

The Supreme Court of Idaho in *Suhadolnik* also discussed the participation of an "out-of-area expert."[117] In Idaho, the out-of-area expert may practice medicine out of state or merely in a different Idaho community.[118] Here, the court suggests that the nonlocal expert may gain personal knowledge of the local standard of care "by inquiring of a local specialist regarding the standard of care."[119] Furthermore, the nonlocal expert may consult with another nonlocal specialist, "so long as that specialist has had sufficient contacts with the area in question to demonstrate personal knowledge of the local standard [of care]."[120] Additionally, an out of area expert may be able to demonstrate that "a local standard of care has been replaced by a statewide or national standard of care, and further demonstrate[] that he or she is familiar with the statewide or national standard."[121] One wonders if these are realistic

112. *Id.*

113. *Id.*

114. *Id.* at 17 (emphasis added).

115. *Id.* (quoting Dulaney v. St. Alphonsus Reg'l Med. Ctr., 45 P.3d 816, 820 (Idaho 2002)) (internal quotation marks omitted).

116. *See* IDAHO CODE ANN. §§ 6-1012, 6-1013 (2010).

117. *Suhadolnik*, 254 P.3d at 17.

118. *See id.*; *see also* IDAHO CODE ANN. § 6-1012 (defining a practitioner's area as "that geographical area ordinarily served by the licensed general hospital at or nearest to which such care was or allegedly should have been provided").

119. *Suhadolnik*, 254 P.3d at 17 (citing *Dulaney*, 45 P.3d at 820).

120. *Id.* (citing Shane v. Blair, 75 P.3d 180, 184 (Idaho 2003)).

121. *Id.* (footnotes omitted).

options. Although the court in *Suhadolnik* referred to case law in which this circuitous route was taken,[122] it appears that three of the four cases the court referenced did not refer to expert testimony by physicians.[123] Furthermore, and of greater significance, this route requires the willingness of a local Idaho physician to assist a nonlocal physician with the prosecution of a medical negligence claim against the local Idaho defendant-physician.[124] A more recent decision of the Supreme Court of Idaho makes clear that under Idaho law, a medical expert must demonstrate how the expert became familiar with the community standard of care, and in doing so, an out-of-area expert would need to disclose the identity of the local Idaho physician consulted.[125] This requirement could have a chilling effect on the participation of local Idaho physicians as consultants for out-of-area medical experts.

This fact has not eluded the Supreme Court of Idaho, which acknowledged as much in *Suhadolnik*.[126] Curiously, the court also noted that "increased communication and availability of medical information has resulted in more standardization of practice between practitioners in urban centers and those in rural communities."[127] This standardization is derived from "governmental regulation, development of regional and national provider organizations, and greater access to the flow of medical information."[128] Not only is this pronouncement contrary to maintaining a community or statewide standard of care, it suggests the philosophy underpinning a national standard of care.[129]

The Idaho locality rule has not escaped substantial criticism within the state.[130] In addition to the state's locality rule, other defense-oriented

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122. The court discussed at length *Hayward v. Jack's Pharmacy, Inc.*, 115 P.3d 713, 719–20 (Idaho 2005); *Grover v. Smith*, 46 P.3d 1105, 1111 (Idaho 2002); *Perry v. Magic Valley Reg'l Med. Ctr.*, 995 P.2d 816, 821–22 (Idaho 2000); *Kozlowski v. Rush*, 828 P.2d 854, 857–58 (Idaho 1992). *Suhadolnik*, 254 P.3d at 17–20.

123. *Hayward*, 115 P.3d at 716 (involving pharmacology); *Grover*, 46 P.3d at 1106 (involving dentistry); *Perry*, 995 P.2d at 819 (involving nursing).

124. *See Suhadolnik*, 254 P.3d at 17 (requiring any out-of-area expert to consult with local physicians).

125. Arregui v. Gallegos-Main, No. 38496, 2012 WL 1557284, at *9 (Idaho May 4, 2012).

126. *Suhadolnik*, 254 P.3d at 22.

127. *Id.*

128. *Id.*

129. *See infra* Part V.

130. *See, e.g.*, Monique C. Lillard, *The Standard of Care for Health Care*

legislation is in place. For example, Idaho has a legislative cap on noneconomic loss.[131] Furthermore, Idaho utilizes the Idaho State Board of Medicine as a mandatory prelitigation hearing panel for medical negligence claims[132] and to render advisory opinions.[133] These legislative provisions might be characterized as virtual tort reform.[134]

Idaho, through its locality rule (and related physician-friendly legislation), has created massive obstacles for plaintiffs to overcome in the presentation of a medical negligence claim. Does Idaho need the locality rule? Is Idaho a place where frontier medicine is practiced such that it is deserving of a rule similar to, if not more strict than, that born in the 1800s? The answer to both questions is "no."

Despite having no medical schools,[135] Idaho presumably has highly

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Providers in Idaho, 44 IDAHO L. REV. 295, 324–47 (2008) (discussing the concerns about how the rule is implemented, whether it provides incentives to the medical and legal professions, and the concept that the local standard of care is the only acceptable standard); E. Lee Schlender, *Malpractice and the Idaho Locality Rule: Stuck in the Nineteenth Century*, 44 IDAHO L. REV. 361, 375–77 (2008) (calling for a national standard of care); Kelley Ann Porter, Casenote, Dulaney v. Saint Alphonsus Regional Medical Center*: Reconstructive Surgery for Plaintiffs' Medical Nightmare—A Call for Reform of the Local Standard of Care*, 38 IDAHO L. REV. 597, 630 (2002) (recommending a national standard of care); Debra D. Young, Comment, *The Idaho Standard of Care in Medical Malpractice Cases*, 25 IDAHO L. REV. 415, 419 (1988–1989) (recommending a national standard of care for board certified physicians).

131. IDAHO CODE ANN. § 6-1603 (2010); Lillard, *supra* note 130, at 299.

132. IDAHO CODE ANN. § 6-1001; Elliott v. Verska, 271 P.3d 678, 687 (Idaho 2012).

133. *Elliott*, 271 P.3d at 687.

134. The Idaho legislation can be compared with the well-known, failed efforts in Illinois to achieve tort reform. *See* Lebron v. Gottlieb Mem'l Hosp., 930 N.E.2d 895, 902–05 (Ill. 2010) (finding Illinois statutes instituting caps on noneconomic damages unconstitutional); Best v. Taylor Mach. Works, 689 N.E.2d 1057 (Ill. 1997) (invalidating reform measures on medical review panels, medical insurance, and damage caps); Wright v. Central Du Page Hosp. Ass'n., 347 N.E.2d 736, 738–43 (Ill. 1976) (invalidating newly enacting statutory provisions for medical review panels and procedures); *see also* David M. Goldhaber & David J. Grycz, *Three Strikes and You're Out: Illinois Supreme Court Invalidates Damage Cap*, 24 CHI. B. ASS'N REC. 30 (2010) (discussing the Illinois Supreme Court's repeated invalidation of medical damage caps).

135. In 2007, a Medical Education Study Final Report was submitted to the Medical Education Study Committee, Idaho State Board of Education. MGT OF AM., INC., MEDICAL EDUCATION STUDY FINAL REPORT (2007), *available at* http://www.boardofed.idaho.gov/board_members/documents/medical_ed/med_ed_study_rpt_final.pdf. The focus of the study was on "the feasibility and viability of offering a

qualified physicians within its borders. In 2009, data published by the Association of American Medical Colleges revealed that in 2008 there were more than 2,700 active physicians in Idaho.[136] Statistics published by the American Board of Medical Specialties (ABMS)[137] in 2010 revealed that there were more than 2,500 board certified physicians in Idaho.[138] There are twenty-four member-boards of the ABMS: Allergy and Immunology, Anesthesiology, Colon and Rectal Surgery, Dermatology, Emergency Medicine, Family Medicine, Internal Medicine, Medical Genetics, Neurological Surgery, Nuclear Medicine, Obstetrics and Gynecology, Ophthalmology, Orthopaedic Surgery, Otolaryngology, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Plastic Surgery, Preventive Medicine, Psychiatry and Neurology, Radiology, Surgery, Thoracic Surgery, and Urology.[139] As of 2010, Idaho had board certified physicians in each of these specialties, except for Medical Genetics.[140] Although the ABMS member-boards have certified a large percentage of licensed United States physicians,[141] board certification "requires between 3 and 6 years of training in an accredited training program and a passing score on a rigorous cognitive examination."[142]

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medical degree." *Id.* at i (quoting S.B. 1210) (internal quotation marks omitted). The study revealed that "Idaho has been one of the fastest growing states in the nation in recent years," but ranked forty-ninth out of the fifty states in "its ratio of physicians per capita." *Id.* at 1-10. The study identified Idaho as "the most populous state in the nation that does not operate its own medical school." *Id.* at 3-13. Among the alternatives proposed by the study was the establishment of a medical school in Idaho. *Id.* at 5-2. To date, this has not occurred.

136. CTR. FOR WORKFORCE STUDIES, ASS'N OF AM. MED. COLLS., 2009 STATE PHYSICIAN WORKFORCE DATA BOOK 9 tbl.1 (2009), *available at* https://www.aamc.org/download/47340/data/statedata2009.pdf.

137. The ABMS "is a not-for-profit organization of 24 medical specialty Member Boards which work in collaboration to develop and implement professional standards, custom-tailored to each specialty, for Board Certification and the ABMS Maintenance of Certification (ABMS MOC) program." AM. BD. OF MED. SPECIALTIES, 2010 ABMS CERTIFICATE STATISTICS 1 (2010).

138. *Id.* at 24.

139. *See About ABMS Member Boards*, AM. BOARD OF MED. SPECIALTIES, http://www.abms.org/About_ABMS/member_boards.aspx (last visited Feb. 1, 2013).

140. AM. BD. OF MED. SPECIALTIES, *supra* note 137, at 24 tbl.3C.

141. Lisa K. Sharp et al., *Specialty Board Certification and Clinical Outcomes: The Missing Link*, 77 ACAD. MED. 534, 534 (2002) (stating that the ABMS has certified approximately 87% of U.S. licensed physicians as of 1998).

142. Troyen A. Brennan et al., *The Role of Physician Specialty Board Certification Status in the Quality Movement*, 292 JAMA 1038, 1040 (2004).

Furthermore, member-boards may "require satisfactory program director evaluations on 6 competencies . . . oral examinations, audits of medical records, review of case logs, or observed performance on real or standardized patients."[143] Although the vitality of board certification has been the subject of discussion,[144] it is highly likely that board certification will remain a significant credential.[145] Thus, Idaho physicians have achieved this distinction.

The board certification process is *not* a state-based process; rather, it is a national process.[146] Idaho physicians' achievement of board certification and recertification (called Maintenance of Certification)[147] reveals that Idaho physicians are quite capable of practicing medicine consistent with a national standard of care.

B. *Tennessee*

The Tennessee locality rule has been the recent subject of intense judicial scrutiny.[148] It provides, in relevant part, as follows:

> 29-26-115. Burden of proof; expert witnesses
>
> (a) In a health care liability action, the claimant shall have the burden of proving by evidence as provided by subsection (b):
>
> (1) The recognized standard of acceptable professional practice in the profession and the specialty thereof, if any, that the defendant practices in the community in which the defendant practices or in a similar community at the time the alleged injury or wrongful action occurred;

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143. *Id.* (footnote omitted).

144. *See* Robert Steinbrook, *Renewing Board Certification,* 353 NEW ENG. J. MED. 1994, 1994 (2005) (discussing the changes to recertification and renewal requirements); Kevin B. Weiss, *Future of Board Certification in a New Era of Public Accountability*, 23 J. AM. BOARD FAM. MED. S32, S36–S38 (2010) (discussing the future of voluntary certification in light of market demands).

145. Charles M. Kilo, *Maintenance of Certification: Moving Forward: Comment on "Maintenance of Certification in Internal Medicine"*, 171 ARCHIVES INTERNAL MED. 176, 176 (2011); Weiss, *supra* note 144, at S37.

146. *See infra* Part V.D.

147. *See* AM. BD. OF MED. SPECIALTIES, ABMS GUIDE TO MEDICAL SPECIALTIES 42 (2010).

148. *See* Shipley v. Williams, 350 S.W.3d 527, 539 (Tenn. 2011) (discussing the inconsistent application of the locality rule).

> (2) That the defendant acted with less than or failed to act with ordinary and reasonable care in accordance with such standard; and
>
> (3) As a proximate result of the defendant's negligent act or omission, the plaintiff suffered injuries which would not otherwise have occurred.
>
> (b) No person in a health care profession requiring licensure under the laws of this state shall be competent to testify in any court of law to establish the facts required to be established by subsection (a), unless the person was licensed to practice in the state or a contiguous bordering state a profession or specialty which would make the person's expert testimony relevant to the issues in the case and had practiced this profession or specialty in one (1) of these states during the year preceding the date that the alleged injury or wrongful act occurred. This rule shall apply to expert witnesses testifying for the defendant as rebuttal witnesses. The court may waive this subsection (b) when it determines that the appropriate witnesses otherwise would not be available.[149]

Tennessee's rule, which applies to defense experts as well as experts called by the plaintiff,[150] focuses the standard of care "in the community in which the defendant practices or in a similar community,"[151] which is arguably not the harshest variant of the rule. What is interesting, however, is the requirement that an expert medical witness is competent[152] to testify as to the applicable standard of care only if the expert is licensed to practice medicine in Tennessee or in "a contiguous bordering state,"[153] unless waived by the court.[154] Therefore, the Tennessee locality rule places a geographical dimension on both the standard of care and the state of licensure of the medical expert witness, requiring that the witness hold a

149. TENN. CODE ANN. § 29-26-115(a)–(b) (2012).

150. *See id.* § 29-26-115(b).

151. *Id.* § 29-26-115(a)(1).

152. For an explanation of the "competency" requirement, see KENNETH S. BROUN ET AL., MCCORMICK ON EVIDENCE 116 (6th ed. 2006) ("[C]ompetency rules address the threshold question of whether a prospective witness is qualified to give any testimony at all in the case. For the most part, the competency standards relate to the prospective witness's status and personal capacities rather than the content of the testimony the witness is prepared to give.").

153. TENN. CODE ANN. § 29-26-115(b).

154. *Id.*; McDonald v. Shea, No. W2010-02317-COA-R3-CV, 2012 WL 504510, at *7 (Tenn. Ct. App. Feb. 16, 2012).

medical license in Tennessee, Kentucky, Missouri, Arkansas, Mississippi, Alabama, Georgia, North Carolina, or Virginia. This statutory curiosity becomes thought provoking when one considers that some of these contiguous states adhere to a national standard of care.[155]

In *Shipley v. Williams*, the Supreme Court of Tennessee addressed the Tennessee locality rule in painstaking detail.[156] *Shipley* involved a medical negligence claim following an abdominal surgery performed by the defendant surgeon.[157] The patient unsuccessfully sought follow-up care with the defendant surgeon and had an unfortunate post-operation course, including "acute sepsis, pneumonia, hypotension, acute renal failure, and abdominal pain."[158] Eventually, the patient "suffered a debilitating stroke and other alleged permanent damage."[159]

A lawsuit was filed and the plaintiff's proffered medical experts included "a board-certified general surgeon who practices in Asheville, North Carolina, and . . . a physician board-certified in emergency medicine who practices in the Montgomery, Alabama, area."[160] The trial court disqualified these experts because they did not satisfy Tennessee Code section 29-26-115; the surgical expert "did not demonstrate familiarity with the standard of care for general surgeons in Nashville . . . Nor did he demonstrate that Asheville, North Carolina is a similar community to Nashville, Tennessee."[161] As to the emergency medicine physician, the trial court found this specialty irrelevant "to the standard of care issues in this

155. *See, e.g.*, Patton v. Thompson, 958 So. 2d 303, 308 (Ala. 2006) (explaining the plaintiff's obligation to prove that a defendant-physician "breached his duty to exercise such reasonable care, diligence, and skill as reasonably competent physicians in the national medical community ordinarily would in the same or similar circumstances" (citations omitted)); McDaniel v. Hendrix, 401 S.E.2d 260, 262 (Ga. 1991) (applying a general, rather than a local, standard of care); McAllister v. Franklin Cnty. Mem'l Hosp., 910 So. 2d 1205, 1209 (Miss. Ct. App. 2005) ("Mississippi physicians are bound by nationally-recognized standards of care . . . ." (quoting Palmer v. Biloxi Reg'l Med. Ctr., Inc., 564 So. 2d 1346, 1354 (Miss. 1990)) (internal quotation marks omitted)).

156. Shipley v. Williams, 350 S.W.3d 527, 536–54 (Tenn. 2011).

157. *Id.* at 533.

158. *Id.*

159. *Id.*

160. *Id.*

161. *Id.* at 534 (alteration in original) (quoting the trial court) (internal quotation marks omitted).

case."[162] The court of appeals upheld the disqualification of the plaintiff's experts.[163] The state supreme court "granted permission to appeal in order to address and clarify the standards a Tennessee court should use in determining whether a medical expert is qualified to testify as an expert witness in a medical negligence case."[164]

The state supreme court noted the enactment of Tennessee's locality rule in 1975[165] and laboriously reviewed Tennessee's jurisprudence pertaining to the rule.[166] The court concluded that the trial court's gatekeeping function requires it "to determine (1) whether the witness meets the competency requirements of [the Tennessee Code] and, (2) whether the witness' testimony meets the admissibility requirements [of the Tennessee rules of evidence]."[167] The court made clear that Tennessee's locality rule does not authorize a trial court "to decide how much weight is to be given to the witness' testimony."[168] Weighing evidence is, of course, a jury function.[169]

Tennessee's locality rule shares with Idaho the out-of-area expert's burden of familiarity with the applicable community standard of care.[170] In *Shipley*, the court enumerated how "a medical expert must demonstrate a modicum of familiarity with the medical community in which the defendant practices or a similar community"[171] as follows:

- Review and become "familiar with pertinent statistical information

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162. *Id.* (quoting the trial court) (internal quotation marks omitted).

163. Shipley v. Williams, No. M2007-01217-COA-R3-CV, 2009 WL 2486199, at *5 (Tenn. Ct. App. Aug. 14, 2009).

164. *Shipley*, 350 S.W.3d at 535.

165. *Id.* at 532.

166. *Id.* at 536–54.

167. *Id.* at 551.

168. *Id.*

169. *See, e.g.*, FEDERAL CIVIL JURY INSTRUCTIONS OF THE SEVENTH CIRCUIT § 1.11 (2009), *available at* http://www.ca7.uscourts.gov/pattern_jury_instr/7th_civ_instruc_2009.pdf ("You should use common sense in weighing the evidence and consider the evidence in light of your own observations in life."); Langwell v. Albemarle Family Practice, PLLC, 692 S.E.2d 476, 480 (N.C. Ct. App. 2010) (noting that "[i]t is well settled that [i]t is the jury's function to weigh the evidence and to determine the credibility of witnesses" (alteration in original) (quoting Anderson v. Hollifield, 480 S.E.2d 661, 664 (N.C. 1997) (internal quotation marks omitted)).

170. *Compare* Suhadolnik v. Pressman, 254 P.3d 11, 17 (Idaho 2011), *with Shipley*, 350 S.W.3d at 554.

171. *Shipley*, 350 S.W.3d at 552.

such as community size, hospital size, the number and type of medical facilities in the community, and medical services or specialized practices available in the area."[172]

- "[D]iscuss[] with other medical providers in the pertinent community or a neighboring one regarding the applicable standard of care relevant to the issues presented,"[173] or "visit[] the community or hospital where the defendant practices."[174]

This list is not included in the locality rule statute,[175] and the statute does not define the "community" similar to that in which the defendant-physician practices.[176]

An interesting aspect of *Shipley* is that the Supreme Court of Tennessee is familiar with the concept of a national standard of care, acknowledges that Tennessee courts have embraced it "or a standard pertinent to a broad geographic area," but the court refuses to adopt the national standard of care model.[177] As a result, the court went to great lengths to explain how a medical expert may self-educate on a community standard of care and endeavor to assert the application of a national standard of care.[178] In short, the *Shipley* court attempts to preserve the Tennessee locality rule while recognizing that it may be anachronistic.

Even though a medical expert in Tennessee may urge an applicable national standard of care, the "expert may not rely solely on a bare assertion of the existence of an applicable national standard of care."[179] The medical expert must explain "why the national standard applies under the circumstances."[180] Of course, there is no guarantee that a trial court would accept the explanation, which is the pitfall of the approach adopted in *Shipley*.[181]

A recent article in the *Tennessee Bar Journal* recommends that the

172. *Id.*
173. *Id.*
174. *Id.*
175. *See* TENN. CODE ANN. § 29-26-115 (2012).
176. *Shipley*, 350 S.W.3d at 532.
177. *Id.* at 553.
178. *See id.* at 550–54.
179. *Id.* at 553.
180. *Id.*
181. *See id.*

state legislature consider the national standard of care in lieu of the locality rule.[182] Additionally, another reason supports the position that the locality rule is out of place in Tennessee. The state is the home of four allopathic medical schools,[183] and all of Tennessee's adjacent states are home to allopathic medical schools as well.[184] Thus, the geographical region referred to in Tennessee's locality rule[185] offers a plethora of modern medical education.[186]

This Article previously discussed board certification in the context of the Idaho locality rule.[187] As of 2008, Tennessee was home to more than 14,000 active physicians,[188] and by 2010, there were more than 14,000 board certified physicians in Tennessee, with certification of every ABMS member-board.[189] This evidence, at least, places doubt on the need for the locality rule.

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182. *See* Donald F. Paine, *Medical Experts: Is There a National Standard of Care?*, 48 TENN. B.J., May 2012, at 28.

183. *See MD/PhD Programs by State*, ASS'N. OF AM. MED. COLLS., *supra* note 95. Tennessee's schools are: East Tennessee State University James H. Quillen College of Medicine, Meharry Medical College School of Medicine, University of Tennessee Memphis College of Medicine, and Vanderbilt University School of Medicine. *Id.*

184. *See id.* Kentucky: University of Kentucky College of Medicine, University of Louisville School of Medicine; Missouri: Saint Louis University School of Medicine, University of Missouri–Columbia School of Medicine, University of Missouri–Kansas City School of Medicine, Washington University in St. Louis School of Medicine; Arkansas: University of Arkansas College of Medicine; Mississippi: University of Mississippi School of Medicine; Alabama: University of Alabama School of Medicine, University of South Alabama College of Medicine; Georgia: Emory University School of Medicine, Medical College of Georgia, Mercer University School of Medicine, Morehouse School of Medicine; North Carolina: East Carolina University Brody School of Medicine, Duke University School of Medicine, University of North Carolina at Chapel Hill School of Medicine, Wake Forest University School of Medicine; Virginia: Eastern Virginia Medical School, University of Virginia School of Medicine, Virginia Commonwealth University School of Medicine. *Id.*; MERCER U. SCH. OF MED., http://medicine.mercer.edu/ (last visited Feb. 1, 2013).

185. TENN. CODE ANN. § 29-26-115(b) (2012) (requiring relevant expert testimony be offered from others practicing "in the state or a contiguous bordering state a profession or specialty which would make the person's expert testimony relevant to the issues in the case").

186. *See infra* Part V.A–B (discussing why available, advanced medical education eliminates the justification for a strict locality rule).

187. *See supra* Part IV.A.

188. CTR. FOR WORKFORCE STUDIES, *supra* note 136, at 9 tbl.1.

189. AM. BD. OF MED. SPECIALTIES, *supra* note 137, at 25 tbl.3C.

C. *New York*

New York's locality rule jurisprudence is interesting and implicates a discussion of semantics. Its locality rule has its origin in *Pike v. Honsiger*, in which the Court of Appeals of New York pronounced: "A physician and surgeon, by taking charge of a case, impliedly represents that he possesses, and the law places upon him the duty of possessing, that reasonable degree of learning and skill that is ordinarily possessed by physicians and surgeons in the locality where he practices . . . ."[190] This statement does not technically use locality to describe the provision of medical care, but it describes the duty to *possess* a degree of knowledge and skill and not the duty to *apply* it.[191] There is a difference.

In 1988, an intermediate appellate court in New York cast doubt on the locality rule.[192] In *Riley v. Wieman*, the court noted:

> Although the rule is still extant, the standards upon which it is based are no longer the same as articulated in *Pike v. Honsiger*. In *Toth v. Community Hosp. at Glen Cove*, the Court of Appeals in discussing the locality rule observed that "conform[ing] to accepted community standards of practice usually insulates [the doctors] from tort liability." However, the court then applied the locality rule as a minimum standard, inserting the further requirement that doctors use their "best judgment and whatever superior knowledge, skill and intelligence [they have]. Thus, a specialist may be held liable where a general practitioner may not." The resulting two-tiered standard preserves the benefits of the locality rule while compelling doctors to use available methods that may exceed local standards.[193]

Despite this commentary, the original New York locality rule was apparently vindicated in 2002 by the Court of Appeals of New York in *Nestorowich v. Ricotta*.[194] In *Nestorowich*, the court recognized that the *Pike* locality rule, "[t]he prevailing standard of care governing the conduct of medical professionals[,] has been a fixed part of our common law for more than a century."[195] Significantly, the court placed *Pike* in the context

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190. Pike v. Honsinger, 49 N.E. 760, 762 (N.Y. 1898).
191. *See id.*
192. *See* Riley v. Wieman, 528 N.Y.S.2d 925, 928 (App. Div. 1988).
193. *Id.* (alteration in original) (citations omitted).
194. Nestorowich v. Ricotta, 767 N.E.2d 125, 128 (N.Y. 2002).
195. *Id.* (citing *Pike*, 49 N.E. 760).

of exercising or providing care, not simply possessing knowledge.[196] The *Nestorowich* court recognized evolving medical negligence jurisprudence and "advances in medicine," but it confirmed the "*Pike* standard"[197] and, in a footnote, the court noted that it would not "pass[] on the 'locality' issue in this appeal."[198] It is, therefore, fair to state the locality rule remains a part of New York jurisprudence. Again, as with the other featured states, it is fair to ask, "Why?"

New York state is no stranger to modern medical education. It is the home of many medical schools,[199] and by 2008, there were more than 67,000 active physicians in New York.[200] By 2010, there were more than 61,000 board certified physicians in the state, representing all of the ABMS member-boards.[201] For this reason alone, the locality rule should be abandoned in New York.

D. *Virginia*

Virginia's locality rule is found in section 8.01-581.20 of the Virginia Code and states:

> A. In any . . . action against a physician . . . to recover damages alleged to have been caused by medical malpractice where the acts or omissions so complained of are alleged to have occurred in this Commonwealth, the standard of care by which the acts or omissions are to be judged shall be that degree of skill and diligence practiced by a reasonably prudent practitioner in the field of practice or specialty in this Commonwealth and the testimony of an expert witness, otherwise qualified, as to such standard of care, shall be admitted; provided, however, that the standard of care in the locality or in similar localities in which the alleged act or omission occurred shall be applied if any party shall prove by a preponderance of the evidence that the health care services and health care facilities available in the locality and the customary practices in such locality or similar localities give rise to a standard of care which is more appropriate than a statewide standard. Any physician . . . who is licensed to practice in Virginia shall be

196. *Id.*
197. *Id.*
198. *Id.* at 128 n.3 (citing 1A N.Y. PJI3d 703–04 (2001)).
199. New York has thirteen allopathic and two osteopathic medical schools. *See MD/PhD Programs by State*, *supra* note 95.
200. CTR. FOR WORKFORCE STUDIES, *supra* note 136, at 9 tbl.1.
201. AM. BD. OF MED. SPECIALTIES, *supra* note 137, at 25 tbl.3C.

> presumed to know the statewide standard of care in the specialty or field of medicine in which he is qualified and certified. This presumption shall also apply to any physician who is licensed in some other state of the United States and meets the educational and examination requirements for licensure in Virginia.... An expert witness who is familiar with the statewide standard of care shall not have his testimony excluded on the ground that he does not practice in this Commonwealth. A witness shall be qualified to testify as an expert on the standard of care if he demonstrates expert knowledge of the standards of the defendant's specialty and of what conduct conforms or fails to conform to those standards and if he has had active clinical practice in either the defendant's specialty or a related field of medicine within one year of the date of the alleged act or omission forming the basis of the action.
>
> ....
>
> B. In any action for damages resulting from medical malpractice, any issue as to the standard of care to be applied shall be determined by the jury, or the court trying the case without a jury.[202]

The statute provides a statewide standard of care unless a more specific, local standard of care "is more appropriate than a statewide standard."[203] The party desiring the use of a local standard of care must prove its application "by a preponderance of the evidence."[204] How that proof is evidenced is a problem. If competing experts suggest different standards of care (statewide versus local), does the jury simply receive the testimony, deliberate, determine which standard of care is applicable, and then render a verdict? Or must the trial court determine which standard of care will apply? The Virginia Code provides: "In any action for damages resulting from medical malpractice, any issue as to the standard of care to be applied shall be determined by the jury, or the court trying the case without a jury."[205] Does the statute suggest a default application of the statewide standard of care in the event an effort to provide the application of a more

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202. VA. CODE ANN. § 8.01-581.20(A)–(B) (2007 & Supp. 2012).

203. *Id.* § 8.01-581.20(A); *see also* Dunston v. Huang, 709 F. Supp. 2d 421, 425–26 n.4 (E.D. Va. 2010) (noting that a party may prove by a preponderance of the evidence that application of a local standard of care is more appropriate); Smith v. Irving, 604 S.E.2d 62, 65 (Va. 2004) (finding that a Virginia physician is presumed to know the statewide standard of care).

204. VA. CODE ANN. § 8.01-581.20(A).

205. *Id.* § 8.01-581.20(B).

specific local standard of care is unsuccessful? Virginia jurisprudence helps to focus on an issue not typically highlighted in a discussion of the locality rule. Certainly, the locality rule is thought to create a harsh evidentiary burden for plaintiffs for the reasons discussed earlier in this Article.[206] However, there are implications for defendants as well, as addressed by the Supreme Court of Virginia in *Rhoades v. Painter*.[207]

In *Rhoades*, the trial of a medical negligence action resulted in a verdict for the defense.[208] Various medical expert witnesses testified for the defense "to prove the standard of medical care in the Fredericksburg area."[209] As a result, the jury was instructed "that they could apply a local standard of care if they found that the defendant has proved by the greater weight of the evidence that the health care services and customary practices in the locality where the treatment took place make a local standard of care more appropriate than a statewide standard."[210] Because the defense experts' proof was insufficient, the supreme court reversed the verdict and remanded the case for a new trial.[211] *Rhoades* demonstrates another pitfall of the locality rule: the need for a retrial when appellate review demonstrates that the trial court erred in substituting a local community standard of care for the statewide standard of care.[212] This problem would not arise with the use of a modern national standard of care.

Virginia is the home of three allopathic medical schools.[213] As of 2008, there were more than 19,000 active physicians in the state,[214] and by 2010, there were more than 19,000 board certified physicians in Virginia, covering every ABMS member-board.[215] The practice of modern medicine

206. *See supra* notes 73–80 (discussing the difficulty in locating cooperative local physicians, either to testify or to inform out-of-area experts on local standards of care).

207. Rhoades v. Painter, 360 S.E.2d 174, 176 (Va. 1987).

208. *Id.* at 175.

209. *Id.*

210. *Id.* (quoting the jury instructions) (internal quotation marks omitted).

211. *Id.* at 176.

212. *See id.*

213. *See MD/PhD Programs by State*, *supra* note 95. Virginia's schools are: Eastern Virginia Medical School, University of Virginia School of Medicine, Virginia Commonwealth University School of Medicine. *Id.*

214. CTR. FOR WORKFORCE STUDIES, *supra* note 136, at 9 tbl.1.

215. AM. BD. OF MED. SPECIALTIES, *supra* note 137, at 26 tbl.3C.

has been present in Virginia for many years. The locality rule is out of place in Virginia.

E. *Arizona*

Arizona utilizes a statewide, statutory-based, standard of care as follows:

> 12-563. Necessary elements of proof.
>
> Both of the following shall be necessary elements of proof that injury resulted from the failure of a health care provider to follow the accepted standard of care:
>
> 1. The health care provider failed to exercise that degree of care, skill and learning expected of a reasonable, prudent health care provider in the profession or class to which he belongs within the state acting in the same or similar circumstances.
>
> 2. Such failure was a proximate cause of the injury.[216]

The statewide standard of care clearly applies to all physicians in Arizona,[217] although Arizona jurisprudence may have embraced the concept of a "national minimal standard [that] establishes the minimal degree of care . . . expected" of a physician in the state.[218] It is difficult to conjure the meaning of a national minimal standard (i.e., whether it is higher or lower than the Arizona state standard).[219] This is simply another reason to supplant a local standard of care with a national (not national minimal) standard of care.

Recently, in *Smethers v. Campion*, the Court of Appeals of Arizona recognized that a "national specialty standard of care" may apply to "physicians practicing in a discrete specialty" in Arizona.[220] The enlightened court of appeals generally referred to:

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216. ARIZ. REV. STAT. ANN. § 12-563 (2003 & Supp. 2012).

217. *See* McGuire v. DeFrancesco, 811 P.2d 340, 343 (Ariz. Ct. App. 1990) (indicating that even specialists must be held to a statewide standard of care).

218. *Id.* at 344 (quoting ARIZ. REV. STAT. ANN. § 12-563) (internal quotation marks omitted).

219. *See generally id.* (discussing the potential complications depending on whether the national or state standard is more rigorous).

220. Smethers v. Campion, 108 P.3d 946, 950 (Ariz. Ct. App. 2005) (internal quotation marks omitted).

> The advent of specialty residency programs, the use of standard textbooks and reference to specialty-oriented medical literature, the use of national testing and certification for such specialty, and the creation of and membership in specialty professional organizations are intended to create a consensus and to encourage uniformity in the diagnosis and treatment of a disease or condition.[221]

Although the *Smethers* court should be applauded for its recognition of the trappings of modern medicine, its pronouncement suggests a limited variety of discrete specialties.[222] In fact, physicians who practice family medicine and internal medicine—often referred to as general medical practitioners—are likely board certified by the American Board of Family Medicine or the American Board of Internal Medicine.[223] Therefore, family medicine and internal medicine are discrete specialties as well.

Arizona is the home of an allopathic medical school at the University of Arizona,[224] and Mayo Medical School (an allopathic medical school in Rochester, Minnesota) has plans to open a medical school in collaboration with Arizona State University.[225] As of 2008, there were almost 14,000 active physicians in Arizona,[226] and by 2010 there were more than 12,000 board certified physicians in the state, covering all of the AMBS member-boards.[227] This data suggests that modern medicine is practiced in Arizona and that the locality rule is out of place.

F. *Washington*

The Washington state locality rule is codified at Washington Revised Code section 7.70.040:

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221. *Id.* (footnote omitted).

222. *See id.*

223. *See About ABFM*, AM. BOARD OF FAM. MED., https://www.theabfm.org/about/index.aspx (last visited Feb. 1, 2013) ("The American Board of Family Medicine (ABFM) is the second largest medical specialty board in the United States."); *About ABIM*, AM. BOARD OF INTERNAL MED., http://www.abim.org/about/ (last visited Feb. 1, 2013) (indicating that one out of every four practicing physicians in the United States is certified by the American Board of Internal Medicine).

224. *See MD/PhD Programs by State*, *supra* note 95.

225. Skip Derra, *New ASU-Mayo Clinic Initiative Helps Redefine Field of Medical Education*, ASU NEWS (Sept. 27, 2011), http://asunews.asu.edu/20110927_mayomedicalschool.

226. CTR. FOR WORKFORCE STUDIES, *supra* note 136, at 9 tbl.1.

227. AMERICAN BD. OF MED. SPECIALTIES, *supra* note 137, at 23 tbl.3C.

> The following shall be necessary elements of proof that injury resulted from the failure of the health care provider to follow the accepted standard of care:
>
> (1) The health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the state of Washington, acting in the same or similar circumstances;
>
> (2) Such failure was a proximate cause of the injury complained of.[228]

This locality rule has been acknowledged as the "accepted standard of care" by the Supreme Court of Washington.[229]

The Washington statute places the standard of care in the context of what is "*expected* of a reasonably prudent health care provider . . . in the state of Washington."[230] The Court of Appeals of Washington has determined "that *both* the medical profession and society play a role in establishing what is expected of a medical provider."[231] How society may play a direct role in establishing the standard of care is unclear. "The standard requires physicians to be knowledgeable of, and to use, advancements in medicine for patients' benefits,"[232] but a jury in medical negligence litigation is informed of the standard of care by expert witnesses.[233] In a professional negligence trial, the jury cannot rely only on its own collective experience to determine liability.

That curiosity aside, Washington state is the home of one allopathic medical school.[234] As of 2008, there were almost 17,000 active physicians in the state.[235] By 2010, there were more than 17,000 board certified physicians in the state, covering all of the ABMS member-boards.[236] The

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228. WASH. REV. CODE ANN. § 7.70.040 (West 2007 & Supp. 2012).

229. Berger v. Sonneland, 26 P.3d 257, 268 (Wash. 2001).

230. WASH. REV. CODE ANN. § 7.70.040(1) (emphasis added).

231. Adair v. Weinberg, 901 P.2d 340, 343 (Wash Ct. App. 1995).

232. Jalayne J. Arias, *Becoming the Standard: How Innovative Procedures Benefitting Public Health Are Incorporated into the Standard of Care*, 39 J.L. MED. & ETHICS 102, 103 (2011) (footnote omitted).

233. *Id.*

234. *MD/PhD Programs by State*, *supra* note 95. Washington's school is the University of Washington School of Medicine. *Id.*

235. CTR. FOR WORKFORCE STUDIES, *supra* note 136, at 9 tbl.1.

236. AM. BD. OF MED. SPECIALTIES, *supra* note 137, at 26 tbl.3C.

locality rule is out of place in Washington as well.

This Article has now examined the states that adhere to strict or semi-strict locality rules. And, the argument has been made that the presence of medical schools, ABMS board certified physicians, or both, makes the locality rule archaic in these states. Now, this Article turns to an evaluation of additional aspects of modern medicine and a re-examination of ABMS certification in order to complete the recipe needed to successfully argue in favor of eradicating the locality rule.

V. HOW TO ERADICATE THE LOCALITY RULE

A. *Undergraduate Medical Education*

Medical education in the United States has been the subject of scholarly discussion and debate for many years.[237] Modern medical education has received its share of criticism.[238] However, for the purposes of this Article, it is important to note that undergraduate medical education in the United States is standardized,[239] suggesting a common approach to medical education across the country.[240] Standardization of

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237. *See, e.g.*, ABRAHAM FLEXNER, MEDICAL EDUCATION IN THE UNITED STATES AND CANADA: A REPORT TO THE CARNEGIE FOUNDATION FOR THE ADVANCEMENT OF TEACHING (1910), *reprinted in* 80 BULL. WORLD HEALTH ORG. 594 (2002), *available at* http://www.who.int/bulletin/archives/80(7)594.pdf (providing "accurate and detailed information as to the facilities, resources, and methods of instruction" for the nation's medical schools); Molly Cooke et al., *American Medical Education 100 Years After the Flexner Report*, 355 NEW ENG. J. MED. 1339 (2006) (discussing the development of medical education in the twenty-first century).

238. *See, e.g.*, Ezekiel J. Emanuel & Victor R. Fuchs, *Shortening Medical Training by 30%*, 307 JAMA 1143 (2012) (contending there is unnecessary waste of time and money in the training and teaching of new physicians); Herbert L. Fred, *Medical Education on the Brink: 62 Years of Front-Line Observations and Opinions*, 39 TEX. HEART INST. J. 322, 326–28 (2012) (criticizing new curriculums and work-hour limitations); David M. Irby et al., *Calls for Reform of Medical Education by the Carnegie Foundation for the Advancement of Teaching: 1910 and 2010*, 85 ACAD. MED. 220 (2010).

239. *See* Karyn D. Baum & Sara Axtell, *Trends in North American Medical Education*, 54 KEIO J. MED. 22, 25 (2005); Andrew H. Beck, *The Flexner Report and the Standardization of American Medical Education*, 291 JAMA 2139, 2139 (2004); Irby et al., *supra* note 238, at 224 ("Medical education has historically standardized accreditation standards on the length and structure of the curriculum . . . .").

240. *See* Baum & Axtell, *supra* note 239, at 24; Beck, *supra* note 239; Irby et al., *supra* note 238, at 224.

modern medical education militates against the locality rule to the extent that the rule sought to protect physicians who lacked access to basic medical knowledge.

Accreditation of United States allopathic medical schools is granted by the Liaison Committee on Medical Education (LCME).[241] LCME accreditation of a medical school is important insofar as:

- "Accreditation by the [LCME] establishes eligibility for selected federal grants and programs . . . ."[242]
- "Most state boards of licensure require that U.S. medical schools be accredited by the LCME, as a condition for licensure of their graduates."[243]
- "Eligibility of U.S. students to take the United States Medical Licensing Examination (USMLE) requires LCME accreditation of their school."[244]
- "Graduates of LCME-accredited schools are eligible for residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME)."[245]
- "The Department of Education recognizes the LCME for the accreditation of programs of medical education leading to the M.D. degree in institutions that are themselves accredited by regional accrediting associations."[246]

The LCME publishes *Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree*[247] and *LCME Accreditation Guidelines for New and Developing Medical Schools*.[248] These materials make clear that

241. *See Overview: Accreditation and the LCME*, LIAISON COMMITTEE ON MED. EDUC., http://www.lcme.org/overview.htm (last visited Feb. 1, 2013).

242. *Id.*

243. *Id.*; *see, e.g.*, Colo. State Bd. of Med. Exam'rs v. Johnson, 68 P.3d 500, 502 (Colo. App. 2002).

244. *Overview: Accreditation and the LCME*, *supra* note 241.

245. *Id.*

246. *Id.*

247. LIAISON COMM. ON MED. EDUC., FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL: STANDARDS FOR ACCREDITATION OF MEDICAL EDUCATION PROGRAMS LEADING TO THE M.D. DEGREE (2012).

248. LIAISON COMM. ON MED. EDUC., LCME ACCREDITATION GUIDELINES

accreditation of medical schools occurs only by compliance with "nationally accepted standards of educational quality."[249]

In addition to the LCME, undergraduate medical education in the United States is also represented by the Association of American Medical Colleges (AAMC), a "not-for-profit association representing all medical schools in the United States . . . that grant the M.D. degree and are accredited by the Liaison Committee on Medical Education."[250] The AAMC also has a national vision regarding medical education.[251] It "represents the interests of the nation's medical schools and teaching hospitals before Congress, federal regulatory agencies, and the executive branch on a wide range of issues."[252]

Modern medical school education in the United States has a standardized, national focus.[253] The shortcomings of medical education that existed much earlier in our history[254] no longer exist. Modern undergraduate medical education is simply incongruent with the locality rule.

B. *Graduate Medical Education*

The Accreditation Council for Graduate Medical Education (ACGME), "perhaps the most important regulatory organization in medicine,"[255] "is responsible for accrediting all U.S. clinical residency and fellowship programs."[256] Although ACGME accreditation is voluntary,[257]

FOR NEW AND DEVELOPING MEDICAL SCHOOLS (2006).

249. LIAISON COMM. ON MED. EDUC., *supra* note 247, at 1.

250. ASS'N OF AM. MED. COLLS., LEARN, SERVE, LEAD: THE MISSION, VISION, AND STRATEGIC PRIORITIES OF THE AAMC 1 (2010), *available at* https://members.aamc.org/eweb/upload/Learn%20serve%20Lead.pdf.

251. *See The Strategic Imperative: Leading Change to Improve Health*, ASS'N. OF AM. MED. CS., https://www.aamc.org/about/strategicpriorities (last visited Feb. 1, 2013).

252. *Id.*

253. *See* LIAISON COMM. ON MED. EDUC., *supra* note 247, at 1.

254. *See* DE VILLE, *supra* note 27, at 65–77 (discussing the problems in medical education in the 1800s that led to widespread medical malpractice claims).

255. Kenneth M. Ludmerer & Michael M. E. Johns, *Reforming Graduate Medical Education*, 294 JAMA 1083, 1086 (2005).

256. Stephen J. Lurie et al., *Measurement of the General Competencies of the Accreditation Council for Graduate Medical Education: A Systematic Review*, 84 ACAD. MED. 301, 301 (2009); *see also* Golek v. Saint Mary's Hosp., Inc., 34 A.3d 452, 456 (Conn. App. Ct. 2012) (referring to the ACGME as "a national accrediting body that

"[r]esidency programs must be ACGME-accredited to receive government funding in support of GME and to enable their graduates to qualify for specialty certification."[258] In 2011, it was estimated "that there were 111,586 active residents in ACGME-accredited programs during the 2010–2011 academic year."[259]

The ACGME has been involved in refocusing graduate medical education. It has developed the following competencies to which graduate medical education should be directed: knowledge, patient care, professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice.[260] These competencies apply to all medical residencies and are not limited by the geographical location of the residency program.[261] They are "general competencies for physicians in training."[262]

To the extent that graduate medical education programs are focused on the development of competencies applicable to all physicians and are nationally accredited, such programs demonstrate a national, rather than local emphasis. If the locality rule was designed to protect physicians due to uneven access to medical knowledge in rural, remote, or other areas of the United States, the reason for that protection has long since ceased to exist.

C. *State Medical Licensure*

The licensing of physicians is a state law function "through the states' authority under the police power to protect the health, safety and general welfare of the community."[263] The history of medical licensing is well reported in literature.[264]

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supervises residency programs in the United States and Canada").

257. *ACGME Fact Sheet*, ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., http://www.acgme.org/acgmeweb/About/Newsroom/FactSheet.aspx (last visited Feb. 1, 2013).

258. Paul Batalden et al., *General Competencies and Accreditation in Graduate Medical Education*, 21 HEALTH AFF., Sept.–Oct. 2002, at 103, 109.

259. Sarah E. Brotherton & Sylvia I. Etzel, *Graduate Medical Education, 2010–2011*, 306 JAMA 1015, 1051 (2011).

260. Richard M. Satava, *The Revolution in Medical Education—The Role of Simulation*, J. GRADUATE MED. EDUC., Dec. 2009, at 172, 173 box 1.

261. *See* Batalden et al., *supra* note 258, at 105–06.

262. *Id.* at 105.

263. FURROW ET AL., *supra* note 78, § 3-1, at 59.

264. *See, e.g.*, Henry E. Sigerist, *The History of Medical Licensure*, 104 JAMA

Despite the state-based medical licensing system, licensing is clearly connected to a nationally focused medical education system. A United States medical school graduate "must have graduated from a school accredited by either the Liaison Committee on Medical Education or the American Osteopathic Association's Commission on Osteopathic College Accreditation" to qualify for a medical license.[265] The applicant "must have successfully completed training in a postgraduate residency program accredited by either the American Council of Graduate Medical Education (ACGME) or the American Osteopathic Association."[266] Furthermore, the "applicant must have successfully passed all three steps of the United States Medical Licensing Examination (USMLE)."[267] "The USMLE provides [state licensing authorities] with a common evaluation system for applicants for medical licensure."[268] "[The USMLE] is designed to assess a physician's ability to apply knowledge, concepts, and principles, and to demonstrate fundamental patient-centered skills, that are important in health and disease and that constitute the basis of safe and effective patient care."[269]

The case has been made for federal medical licensure due to physician mobility, technology, and the commonality of medical practice across the United States.[270] Even without federal licensure, the path to state licensure includes nationally accredited undergraduate medical education, nationally accredited graduate medical education, and a national licensing examination. This path is at odds with the locality rule and its geographic focus on the standard of care.

1057 (1935); Gregory Dolin, Note, *Licensing Health Care Professionals: Has the United States Outlived the Need for Medical Licensure?*, 2 GEO. J.L. & PUB. POL'Y 315, 316–20 (2004).

265. James N. Thompson, *The Future of Medical Licensure in the United States*, 81 ACAD. MED. 536, 536 (2006); *see also* Colo. State Bd. of Med. Exam'rs v. Johnson, 68 P.3d 500, 502 (Colo. App. 2002) (stating that state licensure is predicated on a graduate's medical school receiving LCME approval).

266. Thompson, *supra* note 265, at 536.

267. *Id.*

268. U.S. MED. LICENSING EXAMINATION, 2012 BULLETIN OF INFORMATION 1 (2012). For a more detailed discussion of the USMLE, see AM. MED. ASS'N, STATE MEDICAL LICENSURE REQUIREMENTS AND STATISTICS, 101–06 (2012).

269. AM. MED. ASS'N, *supra* note 268, at 101.

270. *See* Michael S. Young & Rachel K. Alexander, *Recognizing the Nature of American Medical Practice: An Argument for Adopting Federal Medical Licensure*, 13 DEPAUL J. HEALTH CARE L. 145, 186–96 (2010).

D. *Board Certification: The American Board of Medical Specialists*

The examination necessary to achieve board certification has been characterized as "a rite of passage for physicians."[271] There are twenty-four member-boards of the American Board of Medical Specialties,[272] and their identities merit repeating here to demonstrate their extensive coverage of medical practice:

- The American Board of Allergy and Immunology
- The American Board of Anesthesiology
- The American Board of Colon and Rectal Surgery
- The American Board of Dermatology
- The American Board of Emergency Medicine
- The American Board of Family Medicine
- The American Board of Internal Medicine
- The American Board of Medical Genetics
- The American Board of Neurological Surgery
- The American Board of Nuclear Medicine
- The American Board of Obstetrics and Gynecology
- The American Board of Ophthalmology
- The American Board of Orthopedic Surgery
- The American Board of Otolaryngology
- The American Board of Pathology
- The American Board of Pediatrics
- The American Board of Physical Medicine and Rehabilitation
- The American Board of Plastic Surgery
- The American Board of Preventive Medicine
- The American Board of Psychiatry and Neurology
- The American Board of Radiology

271. Steinbrook, *supra* note 144, at 1994.
272. *About ABMS Member Boards*, *supra* note 139.

- The American Board of Surgery
- The American Board of Thoracic Surgery
- The American Board of Urology[273]

In addition, subspecialty certification is available through ABMS member-boards.[274]

The board certification process is challenging and has been described as such in literature.[275] One of the qualifications for board certification is "training in an accredited training program."[276] This type of training program—the accreditation for which has been previously discussed—is part of the physician's path through a national (not local) training process. Board certification examinations are administered by the ABMS specialty boards.[277] The certifications are, therefore, national in scope and do not focus on the local practice of medicine.

In 2010, it was estimated that "more than 750,000 U.S. physicians currently hold one or more certificates from ABMS member-boards."[278] Attaining board certification is significant as it may be a prerequisite for hospital staff privileges[279] and for physician participation in "managed care organizations, and health insurance plans [that] require board certification for physicians wishing to obtain clinical privileges and join provider panels."[280] Board certification also plays a role in medical school evaluation of physician faculty.[281]

Board certification status resonates with the public.[282] It "has been associated with increased medical knowledge, superior training, and certain

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273. *Id.*

274. AM. BD. OF MED. SPECIALTIES, *supra* note 147, at 17–63.

275. *See* Brennan et al., *supra* note 142, at 1040.

276. *Id.*

277. *See* AM. BD. OF MED. SPECIALTIES, *supra* note 147, at 5.

278. Weiss, *supra* note 144, at S32.

279. *Id.*

280. Sharp et al., *supra* note 141, at 534.

281. Donna B. Jeffe & Dorothy A. Andriole, *Factors Associated with American Board of Medical Specialties Member Board Certification Among US Medical School Graduates*, 306 JAMA 961, 961 (2011).

282. *See id.* (stating that board certification "is associated with the quality of medical care that physicians deliver to their patients" (footnotes omitted)); Edmund R. Becker et al., *Impact of Board Certification on Physician Practice Characteristics*, 60 J. MED. EDUC. 9, 9 (1985).

aspects of patient care," as well as "positive clinical outcomes."[283] Physicians disciplined by state medical boards are "less likely . . . to be board certified."[284] It is a status achieved as a result of modern, not locally, focused medicine.

At least one court has recognized the national status of board certification. In *Roberts v. Tardif*, the Supreme Judicial Court of Maine aptly considered the dignity of board certification and its relationship to the standard of care when it stated:

> A medical specialist should be held to national standards of care and treatment appropriate to the specialty. Since he may hold himself out as a specialist only after certification by a national board on the basis of national examinations, his patients should have a right to expect that his performance will meet national standards. A doctor who is nationally certified and who represents himself as a specialist in a particular field of medical expertise is held to the standard of skill and knowledge normally possessed by other practitioners engaged in the same specialty.[285]

Of course, even the language distinguishing the specialist from the non-specialist is a bit misplaced. The public might view internal medicine and family physicians as non-specialists, but these physicians are likely board certified by the American Board of Internal Medicine and the American Board of Family Medicine.[286] Therefore, they are considered specialists based upon their education, training, and board certification.

E. *Continuing Medical Education*

Continuing medical education (CME)—the physician's requirement of "lifelong learning"[287]—can be necessary for medical licensure,[288] for

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283. Sharp et al., *supra* note 141, at 537 (footnotes omitted).

284. James Morrison & Peter Wickersham, *Physicians Disciplined by a State Medical Board*, 279 JAMA 1889, 1892 (1998).

285. Roberts v. Tardif, 417 A.2d 444, 452 (Me. 1980) (citations omitted).

286. *See About ABMS Member Boards*, *supra* note 139 (including areas of internal medicine and family medicine as recognized and supported board certifications).

287. Janet M. Torpy, *Continuing Medical Education*, 302 JAMA 1386, 1386 (2009), *available at* http://jama.jamanetwork.com/data/Journals/JAMA/4481/jpg0923_1386_1386.pdf.

288. *Id.*; D. Scott Jones, *Physician Performance Improvement Continuing Medical Education: New Tools for Compliance and Quality*, 11 J. HEALTH CARE

maintenance of board certification,[289] or "for medical staff membership or [professional liability] insurance renewal."[290] "The 3 main types of CME providers are physician member organizations, publishing and education companies, and medical schools."[291]

For the purposes of this Article, it is significant to note a national dimension of CME. The Accreditation Council for Continuing Medical Education (ACCME) is "a national organization which engages in the voluntary accreditation of sponsors of continuing medical education."[292] The ACCME defines its mission as "to identify, develop, and promote rigorous national standards for quality CME that improves physician performance and medical care for patients and their communities."[293] State licensing boards may require physicians to obtain CME credits from ACCME accredited organizations.[294]

The ACCME accredits "approximately 700 organizations across the United States"[295] to provide CME "primarily to national or international audiences of physicians."[296] The ACCME refers to this function as the "National Accreditation System."[297] There is an "Intrastate Accreditation System" arm of the ACCME as well.[298]

A physician has an ethical obligation to participate in continuing

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COMPLIANCE 49, 50 (2009).

289. Jones, *supra* note 288, at 50.

290. *Id.*

291. Robert Steinbrook, *Financial Support of Continuing Medical Education*, 299 JAMA 1060, 1060 (2008), *available at* http://www.ohsu.edu/xd/about/services/integrity/coi/gifts/upload/Financial-Support-of-Continuing-Medical-Education.pdf.

292. Med. CME Assocs. v. Accreditation Council for Continuing Med. Educ., No. 88 C 3023, 1990 WL 160075, at *1 (N.D. Ill. Sept. 13, 1990).

293. THE ACCREDITATION COUNCIL FOR CONTINUING MED. EDUC., THE ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION AT WORK: ACCREDITATION, RECOGNITION, EDUCATION, OPERATIONS, AND GOVERNANCE 5 (2011) *available at* http://www.accme.org/sites/default/files/ACCME%20at%20Work.pdf.

294. Marc A. Rodwin, *Drug Advertising, Continuing Medical Education, and Physician Prescribing: A Historical Review and Reform Proposal*, 38 J.L. MED. & ETHICS 807, 809 (2010).

295. THE ACCREDITATION COUNCIL FOR CONTINUING MED. EDUC., *supra* note 293, at 14.

296. *Id.*

297. *Id.*

298. *Id.* at 31.

medical education.[299] CME is an extension of the largely national focus on modern medical education.[300] Therefore, it is fair to suggest that modern CME is also incongruous with the locality rule.

F. *Practice Guidelines*

Physicians in the United States maintain memberships in professional medical associations, of which there are many.[301] These professional medical associations are voluntary associations—membership is not required.[302] They do not grant degrees, licenses, or board certification. It has been asserted that "[i]n a properly conceived professional medical organization, physicians should associate to improve the care of the sick, to advance the health of the public" so as "to ensure that physicians are competent practitioners," and to "help to advance medical knowledge [and] establish and maintain standards of performance and education."[303] Despite their voluntary status, these professional medical associations are influential and represent large constituencies of physicians in various specialties.[304]

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299. AM. MED. ASS'N, COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS: CURRENT OPINION WITH ANNOTATIONS § 9.110, at 310 (2010–2011 ed. 2010).

300. *See* THE ACCREDITATION COUNCIL FOR CONTINUING MED. EDUC., *supra* note 293, at 14, 26.

301. *See, e.g.*, AM. ACAD. OF NEUROLOGY, http://www.aan.com/ (last visited Feb. 1, 2013); AM. BOARD OF OBSTETRICS & GYNECOLOGY, http://www.abog.org/ (last visited Feb. 1, 2013); AM. C. OF CARDIOLOGY, http://www.cardiosource.org/acc (last visited Feb. 1, 2013); AM. C. OF PHYSICIANS, http://www.acponline.org/ (last visited Feb. 1, 2013); AM. C. OF RADIOLOGY, http://www.acr.org/ (last visited Feb. 1, 2013); AM. C. OF SURGEONS, http://www.facs.org/ (last visited Feb. 1, 2013).

302. *See* Virgin v. Am. Coll. of Surgeons, 192 N.E.2d 414, 415, 422 (Ill. App. Ct. 1963) (discussing remedies after expulsion from the American College of Surgeons, which is referred to as a voluntary medical association); John Frieden, Note, *Judicial Review of Expulsion Actions in Voluntary Associations*, 6 WASHBURN L.J. 160, 160–61 (1966).

303. Edmund D. Pellegrino & Arnold S. Relman, *Professional Medical Associations: Ethical and Practical Guidelines*, 282 JAMA 984, 984–85 (1999).

304. For example, the American College of Physicians "is the largest medical-specialty organization and second-largest physician group in the United States. Its membership of 133,000 includes internists, internal medicine subspecialists, and medical students, residents, and fellows." *Who We Are*, AM. C. OF PHYSICIANS, http://www.acponline.org/about_acp/who_we_are/ (last visited Feb. 1, 2013). The American College of Radiology has more than 36,000 members, including "radiologists, radiation oncologists" and "nuclear medicine physicians, and allied

Another function of professional medical associations is the promulgation of practice guidelines.[305] Practice guidelines derive from a recognition of the need for evidence-based medicine, defined as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients."[306]

Both evidence-based medicine and practice guidelines have been the subject of great debate in medical literature.[307] Legal scholarship has addressed these topics as well.[308] To be fair, the use of practice guidelines as the standard of care or evidence of the standard of care in medical negligence litigation has been criticized.[309] Specific criticisms include guideline inconsistency due to "bias on the part of guidelines issuers,"[310] "personal conflicts of interest,"[311] "the lack of impartial funding for their creation,"[312] "the lack of scientific evidence backing up the recommendations,"[313] "[t]he illusion that broad guidelines can cover

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health professionals." *About Us*, AM. C. OF RADIOLOGY, http://www.acr.org/About-Us (last visited Feb. 1, 2013).

305. *See* David J. Rothman et al., *Professional Medical Associations and Their Relationships with Industry: A Proposal for Controlling Conflict of Interest*, 301 JAMA 1367, 1367 (2009).

306. Stefan Timmermans & Aaron Mauck, *The Promises and Pitfalls of Evidence-Based Medicine*, 24 HEALTH AFFAIRS 18, 18 (2005) (quoting D.L. Sackett et al., *Evidence-Based Medicine: What It Is and What It Isn't*, 312 BRIT. MED. J. 71, 71–72 (1996)) (internal quotation marks omitted).

307. *See, e.g.*, Michael D. Cabana et al., *Why Don't Physicians Follow Clinical Practice Guidelines?: A Framework for Improvement*, 282 JAMA 1458 (1999); Allan D. Sniderman & Curt D. Furberg, *Why Guideline-Making Requires Reform*, 301 JAMA 429 (2009); Timmermans & Mauck, *supra* note 306.

308. *See* Arnold J. Rosoff, *The Role of Clinical Practice Guidelines in Healthcare Reform: An Update*, 21 ANNALS HEALTH L. 21 (2012); Carter L.Williams, *Evidence-Based Medicine in the Law Beyond Clinical Practice Guidelines: What Effect Will EBM Have on the Standard of Care?*, 61 WASH. & LEE L. REV. 479 (2004).

309. *See, e.g.*, Maxwell J. Mehlman, *Medical Practice Guidelines as Malpractice Safe Harbors: Illusion or Deceit?*, 40 J.L. MED. & ETHICS 286 (2012).

310. *Id.* at 292 (citations omitted).

311. *Id.*

312. *Id.*

313. *Id.* at 293. A lack of supporting scientific evidence could be an impediment to a trial court taking judicial notice of practice guidelines. For a discussion of judicial notice and medical practice guidelines, see Richard E. Leahy, Comment, *Rational Health Policy and the Legal Standard of Care: A Call for Judicial Deference to Medical Practice Guidelines*, 77 CALIF. L. REV. 1483, 1522–27 (1989).

specific patients,"[314] and invalidity of a guidelines due to the passage of time.[315] Nevertheless, medical expert witnesses do rely on practice guidelines to support their standard of care opinions.[316] For the purposes of this Article, it is important to address the proliferation of practice guidelines and how they are incongruous with the locality rule.

Good examples of practice guidelines promulgated by an influential professional medical association are the guidelines of the American College of Radiology (ACR).[317] The ACR has issued practice guidelines on the following topics: General Diagnostic Radiology, Abdomen/Gastrointestinal Imaging, Chest Imaging, Genitourinary Imaging, Musculoskeletal Imaging, Neuroradiology, Vascular Imaging, Computed Tomagraphy, Magnetic Resonance Imaging, Breast Imaging and Intervention, Interventional Radiology, Nuclear Medicine, Radiation Oncology, Ultrasound, Medical Physics, as well as pediatric guidelines.[318] These guidelines recommend, if not instruct, how radiology should be practiced.[319] Some examples are worthy of mention.

The ACR guideline for general radiography provides detailed information on the "qualifications and responsibilities" of radiologists and "specifications of the examination," focusing on imaging technique.[320] The ACR guideline for communication of findings provides the specific details of imaging reporting and how final, nonfinal, unusual, and emergency reports are to be communicated.[321]

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314. Mehlman, *supra* note 309, at 295.

315. *Id.*

316. *See* Frakes v. Cardiology Consultants, P.C., No. 01-A-01-9702-CV-00069, 1997 WL 536949, at *6 (Tenn. Ct. App. Aug. 29, 1997) (determining practice guidelines can "materially assist" the fact-finder and "should be admitted as substantive evidence if introduced through a witness who can lay a proper foundation").

317. *See* AM. C. OF RADIOLOGY, *supra* note 301.

318. *See Practice Guidelines and Technical Standards*, AM. C. OF RADIOLOGY, http://www.acr.org/Quality-Safety/Standards-Guidelines (last visited Feb. 1, 2013).

319. *See id.* ("Practice Guidelines describe recommended conduct in specific areas of clinical practice.").

320. AM. COLL. OF RADIOLOGY, ACR-SPR PRACTICE GUIDELINE FOR GENERAL RADIOGRAPHY 2–3 (Rev. 2008).

321. AM. COLL. OF RADIOLOGY, ACR PRACTICE GUIDELINE FOR COMMUNICATION OF DIAGNOSTIC IMAGING FINDINGS (Rev. 2010); *see also* Marc D. Ginsberg, *Beyond the Viewbox: The Radiologist's Duty to Communicate Findings*, 35 J. MARSHALL L. REV. 359 (2002) (explaining the radiologist's duty of communication before and after the ACR's practical guidelines).

The intent of the ACR guidelines must be derived from confusing language contained on each guideline, appearing in a box before the title and in the preamble.[322] Consider these statements:

> Each practice guideline and technical standard, representing a policy statement by the College, has undergone a thorough consensus process in which it has been subjected to extensive review, requiring the approval of the Committee on Quality and Safety as well as the ACR Board of Chancellors, the ACR Council Steering Committee, and the ACR Council. The practice guidelines and technical standards recognize that the safe and effective use of diagnostic and therapeutic radiology requires specific training, skills, and techniques, as described in each document.
>
> PREAMBLE
>
> These guidelines are an educational tool designed to assist practitioners in providing appropriate radiologic care for patients. They are not inflexible rules or requirements of practice and are not intended, nor should they be used, to establish a legal standard of care. For these reasons and those set forth below, the American College of Radiology cautions against the use of these guidelines in litigation in which the clinical decisions of a practitioner are called into question.
>
> The ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the physician or medical physicist in light of all the circumstances presented. Thus, an approach that differs from the guidelines, standing alone, does not necessarily imply that the approach was below the standard of care. To the contrary, a conscientious practitioner may responsibly adopt a course of action different from that set forth in the guidelines when, in the reasonable judgment of the practitioner, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology subsequent to publication of the guidelines. However, a practitioner who employs an approach substantially different from these guidelines is advised to document in the patient record information sufficient to explain the approach taken.
>
> The practice of medicine involves not only the science, but also the art

322. *See, e.g.*, AM. COLL. OF RADIOLOGY, *supra* note 320.

> of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment. Therefore, it should be recognized that adherence to these guidelines will not assure an accurate diagnosis or a successful outcome. All that should be expected is that the practitioner will follow a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care. The sole purpose of these guidelines is to assist practitioners in achieving this objective.[323]

The aforementioned language makes clear that ACR practice guidelines represent radiology best practices.[324] They are directed to all radiologists, irrespective of their geographical locations.[325] To the extent that the ACR does not intend any of its practice guidelines to constitute the standard of care in a specific area of radiology, that intention is likely misplaced.[326]

Another prominent professional medical association that promulgates practice guidelines is the American College of Cardiology (ACC).[327] The ACC publishes many practice guidelines, which are generally described by the ACC as follows:

> [P]ractice guidelines are developed through a rigorous methodological approach that mandates the review and consideration of the available medical literature. Practice guidelines define the role of specific diagnostic and therapeutic modalities, including noninvasive and invasive procedures, in the diagnosis and management of patients with various cardiovascular diseases. These evidence-based guidelines are intended to assist physicians in clinical decision making by describing a range of generally acceptable approaches for the diagnosis, management, or prevention of specific diseases or conditions. They attempt to define practices that meet the needs of most patients in most circumstances by categorizing the recommendations into a classification system. The development of practice guidelines are the domain of the ACCF/AHA Task Force on Practice Guidelines and are

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323. *Id.*
324. *See id.*
325. *See id.*
326. *See* Ginsberg, *supra* note 321, at 374–77.
327. *See* AM. C. OF CARDIOLOGY, *supra* note 301.

published in JACC and Circulation.[328]

The aforementioned language clearly states that ACC guidelines provide "generally acceptable approaches" and will "meet the needs of most patients in most circumstances."[329] This inclusive language speaks to the national practice of modern medicine. ACC guidelines are likely evidence of the standard of care.[330] Therefore, it is fair to suggest that practice guidelines (1) generally apply to all physicians practicing within a specialty whose professional medical association promulgates practice guidelines[331] and (2) constitute or evidence the applicable standard of care within that specialty.[332] Practice guidelines simply create a landscape in which the locality rule has no place.

VI. THE PREFERRED APPROACH TO THE STANDARD OF CARE: THE LOCALITY RULE NO MORE

Modern medicine does not require the locality rule. If the locality rule once had a legitimate purpose, surely that time is gone.[333] The standard of care applicable to physicians in the United States should be a national standard, unencumbered by geography. That is not to suggest that physicians practicing medicine in rural or remote areas always have

328. *Clinical Statement Definitions*, AM. C. OF CARDIOLOGY, CARDIOSOURCE (Sept. 10, 2010), http://www.cardiosource.org/science-and-quality/practice-guidelines-and-quality-standards/clinical-statement-definitions.aspx.

329. *Id.*

330. *See, e.g.*, Scally v. Veterans Admin., No. 03 CV 4208 JPG, 2006 WL 294789, at *4 (S.D. Ill. Feb. 2, 2006) (relying on expert medical testimony that utilized "authoritative" ACC joint practice guidelines); Bond v. United States, No. 06-1652-JO, 2008 WL 655609, at *5 (D. Or. Mar. 10, 2008) (discussing the validity of expert testimony based on outdated ACC joint practice guidelines); Hinlicky v. Dreyfuss, 848 N.E.2d 1285, 1287, 1289 (N.Y. 2006) (upholding admission of ACC joint practice guidelines into evidence for the standard of care).

331. This, of course, raises a potentially interesting issue. Because professional medical associations are voluntary, some specialists may choose not to join the association. *See* Frieden, *supra* note 302, at 160–61. Are those nonmember physicians bound to follow the practice guidelines of associations they have not joined?

332. *See, e.g.*, Patricia R. Recupero, *Clinical Practice Guidelines as Learned Treatises: Understanding Their Use as Evidence in the Courtroom*, 36 J. AM. ACAD. PSYCHIATRY & L. 290, 290 (2008) (stating that clinical practice guidelines are shaping the standards of care both in the courtroom and in medical practice).

333. *See generally* DOBBS, *supra* note 10, § 244, at 635–36 (explaining the main justification for the locality rule is to protect rural physicians without access to more advanced medical knowledge from liability).

immediate access to the resources available to urban practitioners. The national standard of care would take these differences into account as "circumstances" to be considered by the jury when determining if a defendant–physician complied with or deviated from the applicable standard of care.[334]

Courts repudiating the locality rule in its strict or modified (same or similar locality) version in favor of a national standard of care have provided relevant commentary to support their decisions.[335] Comments include the following:

- The locality rule "reduce[s] the pool of qualified experts to its lowest common denominator."[336]
- The "similar locality analysis [is] no longer applicable in view of the present-day realities of the medical profession."[337]
- Board certification is achieved "on the basis of national examinations."[338]
- Patients of board certified physicians expect that these physicians will practice in accordance with national standards.[339]

Again, modern medicine is specialized and has developed nationally, not pursuant to local standards.[340]

How then, after the locality rule is discarded, would a state posture its standard of care? Consider the example of Oklahoma. By statute, Oklahoma provides as follows:

> § 76.20.1 Healing Arts—Standard Of Care

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334. *See, e.g.*, NEV. REV. STAT. § 41A.009 (2011) (detailing a national standard in which the circumstances of the physician are taken into consideration).

335. *See, e.g.*, Roberts v. Tardif, 417 A.2d 444, 451–52 (Me. 1980); Sheeley v. Mem'l Hosp., 710 A.2d 161, 166–67 (R.I. 1998).

336. *Sheeley*, 710 A.2d at 166.

337. *Id.* (internal quotation marks omitted) (referring to the association of medical schools with teaching hospitals, "vastly superior postgraduate training, the dynamic impact of modern communications and transportation, the proliferation of medical literature, frequent seminars and conferences on a variety of professional subjects and the growing availability of modern clinical facilities").

338. *Roberts*, 417 A.2d at 452.

339. *Id.*

340. *See supra* Part V.

> The standard of care required of those engaging in the practice of the healing arts within the State of Oklahoma shall be measured by national standards.[341]

This simple yet direct statement informs physicians and courts that a national standard of care applies.

Oklahoma has standard of care jury instructions applicable in medical negligence litigation, as follows:

> Instruction No. 14.1
>
> STANDARD OF CARE—NON-SPECIALIST
>
> In [(diagnosing the condition of)/treating/(operating upon)] a patient, a physician must use [his/her] best judgment and apply with ordinary care and diligence the knowledge and skill that is possessed and used by members of [his/her] profession in good standing engaged in the same field of practice at that time. A physician's standard of care is measured by national standards. A physician does not guarantee a cure and is not responsible for the lack of success, unless that lack results from [his/her] failure to exercise ordinary care or from [his/her] lack of that degree of knowledge and skill possessed by physicians in the same field of practice.[342]
>
> Instruction No. 14.2
>
> STANDARD OF CARE—SPECIALIST
>
> In [(diagnosing the condition of)/treating/(operating upon)] a patient, a specialist must use [his/her] best judgment and apply with ordinary care and diligence the knowledge and skill that is possessed and used by other specialists in good standing engaged in the same special field of practice at that time. This is a higher degree of knowledge and skill than that of a general practitioner. A specialist does not guarantee a cure and is not responsible for the lack of success unless that lack results from [his/her] failure to exercise ordinary care or from [his/her] lack of knowledge and

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341. OKLA. STAT. ANN. tit. 76, § 20.1 (West 2002 & Supp. 2012); *see also* Spencer v. Seikel, 742 P.2d 1126, 1128 (Okla. 1987) (finding it an error for an Oklahoma trial court to instruct on the local, rather than the national, standard of care).

342. OKLAHOMA UNIFORM JURY INSTRUCTIONS CIVIL § 14.1 (2009).

> skill possessed by other specialists in good standing in the same field.[343]

The Oklahoma statute makes clear that the "standard of care is measured by national standards."[344] The national standard is incorporated into the jury instruction pertaining to the non-specialist physician[345] and should be specifically incorporated into the jury instruction applicable to specialists.[346] As previously mentioned, specialty board certification is available to internists and family physicians who may be referred to as "general practitioners."[347]

Illinois provides another example of a viable, albeit clumsy approach. The Illinois civil jury instruction for professional negligence suggests that Illinois is a "same or similar localit[y]" jurisdiction.[348] However, caselaw suggests that courts in Illinois are to "read the 'similar locality' rule broadly"[349] due to "relatively uniform standards for the education and licensing of all physicians."[350] The aforementioned Illinois jury instruction's notes on use state that "[t]he locality rule has largely faded from current practice. If there is no issue of an applicable local standard of care, the locality language should be deleted."[351] Therefore, the Illinois approach reflects an evolved position; one in which a national standard of care will apply.

Another method available is to adopt the following simple definition of the standard of care: a physician must exercise that degree of care and skill required of a reasonably well-qualified physician under the same or similar circumstances.[352] This standard is not modified by geography, yet it

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343. *Id.* § 14.2.

344. OKLA. STAT. ANN. tit. 76, § 20.1.

345. *See* OKLAHOMA UNIFORM JURY INSTRUCTIONS CIVIL § 14.1.

346. *See id.* § 14.2.

347. *See supra* note 286 and accompanying text.

348. ILLINOIS PATTERN JURY INSTRUCTIONS CIVIL § 105.01 (2011).

349. Wilbourn v. Cavalenes, 923 N.E.2d 937, 953 (Ill. App. Ct. 2010).

350. *Id.* (quoting Purtill v. Hess, 489 N.E.2d 867, 874 (Ill. 1986)) (internal quotation marks omitted).

351. ILLINOIS PATTERN JURY INSTRUCTIONS CIVIL § 105.01 (citations omitted).

352. *See* NEV. REV. STAT. § 41A.009 (2011) ("Medical malpractice means the failure of a physician, hospital or employee of a hospital, in rendering services, to use the reasonable care, skill or knowledge ordinarily used under similar circumstances." (internal quotation marks omitted)); FURROW ET AL., *supra* note 78, § 6-2, at 264.

allows for proof of geographical or other obstacles to a physician's care of a patient as a "circumstance[]."[353] This definition of the standard of care will be easier for a jury to understand, and more importantly, it will remove the need for a court to screen expert testimony to determine if a medical expert is knowledgeable of a local standard. This approach should allow for more trials of defendant-physicians to be determined on the merits.

VII. CONCLUSION

This Article has demonstrated that the locality rule is archaic, incongruous with, and insulting to modern medicine. The jurisprudence of states that recognize the locality rule is often tedious. By focusing on modern undergraduate medical education, graduate medical education, medical licensing, board certification, continuing medical education, and practice guidelines, the national scope of medicine and the standard of care is revealed.

The locality rule protects physicians from medical negligence claims by creating obstacles to the retention and presentation of expert witness physicians at trial. Trial courts should not engage in a screening process and disqualify medical expert witnesses due to unfamiliarity with a supposed local standard of care. A trial court may disqualify an expert or limit expert testimony for valid reasons; however, a jury should weigh the credibility of witnesses, including expert witnesses. A jury may have a reason to take into consideration the home locale of an expert witness, but a trial court should not simply preclude the out-of-area expert from testifying because the court subjectively believes the expert cannot appreciate a local standard of care.

In 1969, Professor Waltz predicted "[t]he impending disappearance of the locality rule."[354] He prognosticated that it "will gradually disappear almost completely."[355] More than forty years later, the locality rule lives on. Why?

353. *See* NEV. REV. STAT. § 41A.009.
354. Waltz, *supra* note 21, at 415.
355. *Id.*


DRAKE UNIVERSITY
1865
LAW SCHOOL