



1971

Standard of Care for Medical Practitioners-- Abandonment of the Locality Rule

Katherine Randall Bowden
University of Kentucky

Follow this and additional works at: <https://uknowledge.uky.edu/klj>

 Part of the [Torts Commons](#)

Right click to open a feedback form in a new tab to let us know how this document benefits you.

Recommended Citation

Bowden, Katherine Randall (1971) "Standard of Care for Medical Practitioners--Abandonment of the Locality Rule," *Kentucky Law Journal*: Vol. 60 : Iss. 1 , Article 13.

Available at: <https://uknowledge.uky.edu/klj/vol60/iss1/13>

This Comment is brought to you for free and open access by the Law Journals at UKnowledge. It has been accepted for inclusion in Kentucky Law Journal by an authorized editor of UKnowledge. For more information, please contact UKnowledge@sv.uky.edu.

Comments

STANDARD OF CARE FOR MEDICAL PRACTITIONERS—ABANDONMENT OF THE LOCALITY RULE—Clarence Blair severely injured his hand in an industrial accident and was treated for approximately one week by Dr. Kenneth Eblen, a general practitioner in Henderson, Kentucky. When his hand subsequently became infected, Blair requested, and Dr. Eblen arranged for, the services of other physicians. After controlling the infection, orthopedic specialists in Evansville, Indiana, amputated Blair's thumb, index finger, and a portion of his ring finger. A specialist in Louisville then attempted to restore function in his hand. In an action brought against Dr. Eblen for alleged malpractice in the treatment of the hand injury, the trial court instructed the jury that the defendant was obligated to use such reasonable and ordinary knowledge, skill, and care as is exercised by physicians in similar communities. The jury returned a general verdict for the defendant. On appeal, the plaintiff asserted that the language of the applicable standard should not be restricted to "similar communities" but should be expressed as "the state of Kentucky." *Held*: Reversed. The defendant in a medical malpractice case is under a duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances. *Blair v. Eblen*, 461 S.W.2d 370 (Ky. 1970).

The decision to abandon the anachronistic locality rule makes *Blair v. Eblen* a landmark case in Kentucky malpractice law. The locality rule, an unfortunate relic of more provincial times, has become increasingly detrimental to the functioning of those groups which it was established to protect: the medical profession generally and plaintiffs in medical malpractice actions specifically. This comment will relate the history of the rule, the rationale for its adoption and subsequent abolition, and the proposed long-range alternative, the uniform nationwide standard of care.

The standard of care in medical malpractice cases has been defined as follows:

This legal duty requires that the physician undertaking the care of a patient possess and exercise that reasonable and ordinary degree of learning, skill, and care commonly possessed and exercised by reputable physicians practicing in the same locality, or in similar localities, in the care of similar cases; it requires also

that the physician, in caring for the patient, exercise his best judgment at all times.¹

This requirement, concerning the evaluation of the physician in terms of the locality in which he practices, has been denominated the locality rule.

The locality rule is a doctrine peculiar to American law. It has never been suggested in an English case and Lord Nathan indicates that the English courts would reject a contention that the requisite standard may differ from one part of the country to another.²

The original and most narrow construction of the doctrine, the "same locality" rule, requires that a physician adhere only to the standard of care of the specific community in which he practices.³ Although the same locality rule is viable in a number of states today,⁴ it has two practical drawbacks: the possibility of a small group of practitioners establishing an unsatisfactory local standard of care and the difficulty in securing competent local witnesses, *i.e.*, the plaintiff is forced to seek witnesses from among the defendant's colleagues.⁵

The same locality rule was soon superseded by the "similar locality" rule which states that the defendant practitioner

[W]as bound to possess that skill only which physicians and surgeons of ordinary ability and skill, practicing in similar communities, with opportunities for no larger experience, ordinarily possess. . . .⁶

Early opinions and legal writings indicated that the similar locality rule was devised to protect the country and small town practitioner,⁷ theorizing that it would be "manifestly unfair" to require a physician in a small rural community to exercise the same degree of skill as is required of one who practices in a large city.⁸ Courts recognized the expediency of the principle, reasoning that, in comparison with the practitioner in a metropolitan area, the country practitioner did not enjoy the same opportunities of daily observation and practice;⁹ he did not usually make a specialty of surgery and was limited in his

¹ L. REGAN, *DOCTOR AND PATIENT AND THE LAW* 17 (3d ed. 1956).

² NATHAN, *MEDICAL NEGLIGENCE* 21 (1957).

³ See, e.g., *Force v. Gregory*, 27 A. 1116 (Conn. 1893).

⁴ For a list of states which adhere to the same locality rule, see 18 DE PAUL L. REV. 328, 332 n.13 (1968).

⁵ *Pederson v. Dumouchel*, 431 P.2d 973, 977 (Wash. 1967).

⁶ *Small v. Howard*, 128 Mass. 131, 132, 35 Am. R. 363, 365 (1880).

⁷ This idea was recognized in *Blair v. Eblen*, 461 S.W.2d 370 (Ky. 1970), where the court stated: "In short, we will not perpetuate a rule designed to protect country doctors in 1902. . . ." *Id.* at 373.

⁸ 21 R.C.L. *Physicians & Surgeons* § 30 (1918).

⁹ *Smothers v. Hanks*, 34 Iowa 286, 290 (1872); *Tefft v. Wilcox*, 6 Kan. 46, 64 (1870).

facilities.¹⁰ In addition, the country practitioner did not have the same degree of skill, since the most talented naturally sought the more lucrative fields of employment.¹¹

The first Kentucky case to define locality was *Burk v. Foster*.¹² In a suit to recover damages for alleged careless and negligent treatment of plaintiff's broken and dislocated arm by a small town physician, the trial court instructed the jury that the defendant would be held to the standard of care of the "ordinarily skillful and prudent physicians and surgeons in that vicinity."¹³ The court of appeals rejected the instructions, and hence the same locality rule, holding that the applicable standard of care would be "such as is exercised generally by physicians of ordinary care and skill in similar communities,"¹⁴ citing the similar community standard.¹⁵

For more than thirty years after the *Burk* decision, the Kentucky courts reiterated the similar locality rule, substituting phrases such as the following without noting any perceptible change in meaning: "similar neighborhoods and surroundings,"¹⁶ "where the defendant is stationed and located,"¹⁷ and "that vicinity."¹⁸

The court made its singular departure from the similar locality rule prior to its decision in the *Blair* case in *Tanner v. Sanders*.¹⁹ In an action involving alleged negligence by a Louisville dentist, the court specifically affirmed lower court instructions which limited the standard to "the community of Louisville."²⁰ The court noted that Louisville, being the largest city in the state, has "as high a standard of professional skill as may be found in this country."²¹ After the *Tanner* case the court returned to the similar locality standard, whether such locale be a neighborhood, surrounding, or community.²²

The similar locality rule was not the perfect procedural solution to the so-called "conspiracy of silence."²³ The plaintiff was still re-

¹⁰ *Small v. Howard*, 128 Mass. 131, 136, 35 Am. R. 363, 365 (1880).

¹¹ 21 R.C.L., *supra* note 8.

¹² 69 S.W. 1096 (Ky. 1902).

¹³ *Id.* at 1097.

¹⁴ *Id.*

¹⁵ See note 6 *supra*.

¹⁶ *Stevenson v. Yates*, 208 S.W. 820, 822 (Ky. 1919).

¹⁷ *Hoover v. McCormick*, 247 S.W. 718, 722 (Ky. 1923).

¹⁸ *Knopp v. Thornton*, 250 S.W. 853, 854 (Ky. 1923).

¹⁹ 56 S.W.2d 718 (Ky. 1933).

²⁰ *Id.* at 719.

²¹ *Id.* at 721.

²² See, e.g., *Fields v. Rutledge*, 284 S.W.2d 659 (Ky. 1955); *Stacy v. Williams*, 69 S.W.2d 697 (Ky. 1934); *Van Sant's Adm'r v. Overstreet*, 86 S.W.2d 1008 (Ky. 1935).

²³ See H. R. and M. B. LEWIS, *THE MEDICAL OFFENDERS*, 301 (1st ed. 1970) for a detailed discussion of this problem. The following passage is representative of the many obstacles facing the plaintiff's attorney in medical malpractice cases:

(Continued on next page)

quired to produce the testimony of medical experts; however, the rule did give him a wider area from which to draw. Some courts, realizing the plaintiff's plight, succeeded in diluting the similar locality rule in the following ways: by allowing expert witnesses from other localities, provided such witnesses had knowledge of similar conditions;²⁴ by extending the geographical area involved to encompass "medical locality", *i.e.*, accessibility to medical facilities and experience;²⁵ by distinguishing between quasi-experimental ("teaching institutions") and conservative treatment;²⁶ and by defining community on the basis of various socio-economic factors.²⁷

Other states, not content with diminution and dilution of a rule they felt to be inadequate and inferior, abandoned the locality rule altogether. In 1916 the Supreme Court of Minnesota, in *Viita v. Dolan*,²⁸ affirmed a lower court instruction that the locality of the defendant physician was "among the circumstances to be considered"²⁹ in evaluating the physician's conduct. Although the *Viita* case has been called a "premature holding"³⁰ and was subsequently modified,³¹ the court's rationale was adopted in two very recent decisions, *Pederson v. Dumouchel*³² and *Brune v. Belinkoff*.³³ The *Brune* case provides a nationwide standard,³⁴ both for the general practitioner ("the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession")³⁵ and for the specialist ("the standard of care and skill of the average member of the profession

(Footnote continued from preceding page)

Medical ethics generally prohibit physicians from airing a colleague's wrongdoing before the laity. In 'embarrassing situations,' a set of A.M.A. principles has stated, 'a physician should seek a personal interview with his fellow.' The code adds that physicians should refrain from making a colleague's errors a matter of public knowledge. 'Questions of conduct should be considered first before proper medical tribunals in executive session.' *Id.* at 302.

²⁴ See, *e.g.*, *Sinz v. Owens*, 33 Cal. 2d 749, 205 P.2d 3 (1949).

²⁵ See, *e.g.*, *Flock v. J. C. Palumbo Fruit Co.*, 118 P.2d 707 (Idaho 1941); *Tvedt v. Haugen*, 294 N.W. 183 (N.D. 1940).

²⁶ McCoid, *The Care Required of Medical Practitioners*, in PROFESSIONAL NEGLIGENCE 13, 37 (T. Roady & W. Anderson ed. 1960).

²⁷ See, *e.g.*, *Morrill v. Komasinski*, 41 N.W.2d 620 (Wis. 1950); *Michael v. Roberts*, 23 A.2d 361 (N.H. 1941).

²⁸ 155 N.W. 1077 (Minn. 1916).

²⁹ *Id.* at 1081.

³⁰ 14 S.D. L. Rev. 349, 351 (1969).

³¹ For a list of relevant decisions, see 18 DE PAUL L. REV. 328, 331 n.10 (1968).

³² 431 P.2d 973 (Wash. 1967).

³³ 235 N.E.2d 793 (Mass. 1968).

³⁴ Note that the court which promulgated the "similar locality" rule in *Small v. Howard*, 128 Mass. 131, 35 Am. R. 363 (1880), here expressly overrules it. The import of the *Brune* case is evidenced by its inclusion in Averbach, *The Ten Leading Malpractice Cases of the Last Decade*, in TRIAL AND TORT TRENDS 5 (M. Belli ed. 1970), and in Gottlieb, *The Locality Rule*, in LEGAL MEDICINE ANNUAL 31 (C. Wecht ed. 1969).

³⁵ *Brune v. Belinkoff*, 235 N.E.2d 793, 798 (Mass. 1968) (dictum).

practicing the specialty, taking into account the advances in the profession").³⁶ The *Pederson* case is more restrictive. The standard therein is "that degree of care and skill which is expected of the average practitioner in the same class to which he belongs, acting in the same or similar circumstances."³⁷

When the Kentucky Court of Appeals finally³⁸ abandoned the locality rule, it defined the new standard of care as follows:

. . . [T]he defendant was under a duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances.

Under the standard just expressed, the evidence may include the elements of locality, availability of facilities, specialization or general practice, proximity of specialists and special facilities as well as other relevant considerations.³⁹

The court in *Blair* declined to record explicitly the law or policy reasons on which it based its decision. One might assume, however, that a study of the court's citations would provide the necessary rationale. Dean Prosser⁴⁰ and the *Lawyers' Medical Cyclopedia*⁴¹ only serve to buttress the court's conclusion as to a trend away from the locality rule. The case of *Pederson v. Dumouchel*⁴² is more useful in extracting the *Blair* court's reasoning. The *Pederson* opinion implies that advances in transportation and communication, availability of new techniques and discoveries, and increased opportunities for medical experience, observation, and consultation today invalidate the reasons which justified the rule one hundred years ago.⁴³

³⁶ *Id.*

³⁷ *Pederson v. Dumouchel*, 431 P.2d 973, 978 (Wash. 1967).

³⁸ The abandonment of the locality rule by Kentucky was suggested in 29 Ky. L.J. 223 (1941) in which the author advocated that locality should simply be one of the circumstances to be considered regarding the standard of care. It was foreshadowed in *Johnson v. Vaughn*, 370 S.W.2d 591, 596 (Ky. 1963), where the court, although adhering to the locality rule, emphasized that to a large degree the standard is dependent upon the nature and circumstances of the particular case.

³⁹ *Blair v. Eblen*, 461 S.W.2d 370, 373 (Ky. 1970).

⁴⁰ W. PROSSER, *LAW OF TORTS* 167 (3d ed. 1964).

⁴¹ 1 *LAWYERS' MEDICAL CYCLOPEDIA* 124 (rev. ed. Frankel ed. 1966).

⁴² 431 P.2d 973 (Wash. 1967). The dependence herein on the *Pederson* case to provide the missing rationale is based on the *Blair* court's adoption of the *Pederson* standard, with the minor qualification that the term "reasonably competent" be substituted for the *Pederson* word "average." *Blair v. Eblen*, 461 S.W.2d 370, 373 (Ky. 1970).

⁴³ The following passage from D. LOUISELL & H. WILLIAMS, *THE PARENCHYMA OF LAW* 182 (1960), part of which was quoted in the *Pederson* case, adds support to the rationale implied above:

. . . Just as new legal concepts have had to be developed—one might say invented—to handle new problems such as those of radio and television broadcasting, aeronautics, and now space travel, so have changes in the relationships between medicine and society as a whole brought about

(Continued on next page)

Three parameters of the *Blair* decision are particularly noteworthy. First, the decision specifically rejects the community standard in favor of a nationwide standard of care for general practitioners.⁴⁴ Second, it allows malpractice claimants to seek medical experts in any geographic area of the United States. Third, it invites the medical profession to rectify the situation.⁴⁵ The unique aspect of the decision is this summons to the medical profession to propose and execute its own standards.

The general malpractice problem has been extensively publicized recently. The President's health message to Congress,⁴⁶ Congressional

(Footnote continued from preceding page)

modifications of the older legal standards by which physicians' conduct is judged. *Courts have begun to reappraise the reasonableness of the traditional rule by which a physician charged with malpractice is judged only according to the medical standards of his own or a similar community in the same general area.* The public and the courts undoubtedly will recognize that in reality medical standards are becoming—if indeed they have not already become—national in scope. Certainly this is already true as to many elements of medical practice, particularly some which are likely to be involved in charges of malpractice.

Can anyone deny, for example, that it is just as much below standard practice to kill a child with excessive ether during an adeno-tonsillectomy in a small town as it is in a large city? Or that a general practitioner who undertakes to pin a hip should be held to a reasonable standard established by specialists in orthopedics if the latter are available? Or that an allergist who injects a dose of the wrong extract should be responsible for the consequences whether he practices in Florida or Oregon?

The comprehensive coverage of the Journal of the American Medical Association, the availability of numerous other journals, the ubiquitous "detail men" of the drug companies, closed circuit television presentations of medical subjects, special radio networks for physicians, tape recorded digests of medical literature, and hundreds of widely available post-graduate courses all serve to keep physicians informed and increasingly to establish nationwide standards. Medicine realizes this, so it is inevitable that the law will do likewise. *Id.* at 182-84 (emphasis added).

⁴⁴ The defendant in the much-heralded *Brune* decision was a specialist; reference was made to the standard for the general practitioner only by way of dictum. The *Pederson* case, in which the defendant was a general practitioner, was more cautious than the *Blair* case, qualifying its standard in terms of accessible medical and professional means.

⁴⁵ *Blair v. Eblen*, 461 S.W.2d 370 (Ky. 1970) wherein the court stated: The point is this: We are convinced that the standard should be established by the medical profession itself and not by the lay courts. *Id.* at 373.

⁴⁶ 7 WEEKLY COMPILATIONS OF PRESIDENTIAL DOCUMENTS 244 (1971). The passage of *The President's Health Message to Congress Proposing a Comprehensive Health Policy for the Seventies* most pertinent to this comment follows:

I am therefore directing—as a first step in dealing with this danger—that the Secretary of Health, Education, and Welfare promptly appoint and convene a *Commission on Medical Malpractice* to undertake an intensive program of research and analysis in this area. The Commission membership should represent the health professions and health institutions, the legal profession, the insurance industry, and the general public. Its report—which should include specific recommendations for dealing with the problem—should be submitted by March 1, 1972. *Id.* at 252 (emphasis added).

committee studies,⁴⁷ reports of medical malpractice conferences,⁴⁸ books,⁴⁹ and magazine articles⁵⁰ have all related the problem with increasing concern.

Such concern is most appropriate when one considers the role of the courts to date. There has long been a nationwide standard for specialists;⁵¹ in fact, a survey⁵² of the American Specialty Boards, the American Medical Association, and the American Hospital Association concluded that the practice of medicine by certified specialists is similar throughout the country.⁵³ The courts, however, have lagged in recognizing the dimensions of the dilemma with reference to the non-specialist. To date physicians have been held to a nationwide standard in only three areas—radiation therapy⁵⁴ and the treatment of fractures⁵⁵ and cataracts.⁵⁶

Even if the courts were inclined to do so, it would be an arduous task, in the absence of specific criteria, to devise comprehensive standards for a group as diverse and dynamic as the medical profession. Realizing this, commentators have proposed a new standard:

It is anomalous enough that in this area [medical malpractice], unlike most, the custom and practice of an occupational group conclusively determines the applicable standard of care. It is more than merely anomalous that so progressive a profession, with its unmatched educational facilities, should not be held, in the law's eyes, to a uniform medical standard of care.⁵⁷

⁴⁷ STAFF OF SENATE SUBCOMMITTEE ON EXECUTIVE REORGANIZATION, 91ST CONG., 24 SESS., *MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN* (Comm. Print 1969).

⁴⁸ AMERICAN OSTEOPATHIC ASSOCIATION, REPORT; FIRST NATIONAL CONFERENCE ON MEDICAL MALPRACTICE, February 7-8, 1970, Chicago, Illinois (1970).

⁴⁹ H. LEWIS & M. LEWIS, *THE MEDICAL OFFENDERS* (1970).

⁵⁰ *Suing the Doctor: A Rising Problem*, U.S. NEWS & WORLD REPORT, March 8, 1971, at 70.

⁵¹ The cases are collected in Annot., 21 A.L.R.3d 953 (1968).

⁵² 14 STAN. L. REV. 884 (1962).

⁵³ The conclusion was based on the existence of standardized requirements for certification, subscriptions to medical specialty journals, medical specialty societies, and statements from American Specialty Boards. The conclusion did not pertain to the practice of internal medicine, preventive medicine, psychiatry, neurology, or surgery, but was applicable to the other nineteen recognized specialties. *Id.* at 887-89.

⁵⁴ Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 737-8 (1970).

⁵⁵ *Murphy v. Little*, 145 S.E.2d 760 (Ga. 1965):

There are doubtless areas of medicine where knowledge of proper treatment is limited geographically . . . but the human race has suffered from broken bones for as long as it has been in existence. *Id.* at 764.

⁵⁶ *Hundley v. Martinez*, 153 S.W.2d 159 (W. Va. 1967):

As a specialist, with the advantage of additional training and a higher degree of skill, the defendant is charged with knowledge of the standard procedure for cataract operations throughout the country. *Id.* at 169.

⁵⁷ *Waltz, The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DE PAUL L. REV. 408, 419-20 (1969).

At present, the uniform nationwide standard of care is only an abstraction in the most progressive medical and legal minds. In an attempt to arrest the growing public criticism,⁵⁸ the medical profession has acted to improve both its practice of medicine and its relationship with the legal profession. To improve the practice of medicine, the profession has established numerous continuing education programs; it has been suggested that such programs might be more effective if attendance and a terminal examination were mandatory.⁵⁹ To improve its relationship with the legal profession, the medical profession, through local medical societies, has joined with bar associations to provide expert testimony for the injured patients.⁶⁰ Other mitigating activities include benefit schedules similar to workmen's compensation schedules; interim payment by insurers to injured patients, without admission of liability; and the use of arbitration.⁶¹

As noted above, the medical profession has taken concrete, although preliminary, steps toward a solution. The ideal, however, is still the uniform nationwide standard of care. Such standard should be an integral part of the "uniform national code of malpractice evidence and standards" requested by the First National Conference on Medical Malpractice.⁶² It is hoped that the President's Commission on Medical Malpractice,⁶³ the single group with power delegated to act affirmatively and immediately, will delineate the standard so vital to renewed excellence in medical treatment.

Regardless of the solution ultimately reached, the Kentucky court's progressive decision in *Blair v. Eblen* may be viewed as a timely invitation to the medical profession to resolve the malpractice problem.

Katherine Randall Bowden

FEDERAL INJUNCTIVE RELIEF: WHAT REMAINS AFTER *YOUNGER v. HARRIS*?—Historically, the equitable remedy of injunction has been subjected to extensive limitations. Few legal maxims are as often referred to as "equity will not grant specific relief where there exists an adequate remedy at law." In application of this principle the courts have not

⁵⁸ See notes 45-49 *supra*, and accompanying text.

⁵⁹ AMERICAN OSTEOPATHIC ASSOCIATION, *supra* note 48, at 30.

⁶⁰ For a discussion of the use of panels of experts by California, Arizona, Nevada, New Jersey, Indiana, and Wisconsin, see R. LONG, *THE PHYSICIAN AND THE LAW* 79 (1968).

⁶¹ AMERICAN OSTEOPATHIC ASSOCIATION, *supra* note 48 at 28.

⁶² *Id.* at 38.

⁶³ See note 46 *supra*.