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MEDICAL TORT LAW: THE EMERGENCE OF A SPECIALTY STANDARD OF CARE

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I. INTRODUCTION

Medical tort law is a battlefield of social evolution. The conduct of professionals, perhaps more than any other segment of society, reflects changes in societal standards. Tort law, which establishes the lower limits of professional standards of conduct, must stay abreast of a society that is becoming increasingly more professional and specialized.

Anyone who has "been to the doctor" knows that medicine has become a highly specialized profession. Has tort law, as it applies to the medical profession, lagged behind the degree to which medicine has progressed? Has tort law permitted standards of medical conduct to be substandard? Does the standard of care really reflect the manner in which medicine has been standardized in the various specialties? Does relatively static tort law, in contrast to the well-financed dynamics of medical progress, cause patients to suffer an increasing gap between legal standards of medical conduct and medical standards of modern medicine?

This article examines the standard of conduct which must be met by medical professionals. In doing so, the history of the "locality" rule and its expansion, the "same or similar communities" rule, will be traced and commented upon. This article will focus on the emerging "specialty standard of care" rule, urging its adoption nationwide and will conclude by commenting on the ramifications of such a national standard's adoption. Medical tort law ensures minimal medical standards, and adherence to a "specialty standard of conduct" will ensure

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medical responsibility commensurate with the level of training of today's graduating physician.

II. HISTORICAL PERSPECTIVE ON SPECIALTY STANDARDS

A. *Standard of Care—In General*

In an ordinary negligence suit, the defendant's conduct is normally measured against the conduct of a hypothetical, the reasonably-prudent person acting under the same or similar circumstances.[1] The plaintiff must present evidence establishing the applicable standard of care, demonstrating a breach of that standard, and showing actual damage in the form of the harm caused by the breach.[2] This standard of care, which evaluates a defendant's conduct against that conduct which is reasonable under the circumstances, also is applicable in the law of professional negligence.

The law of ordinary negligence generally does not acknowledge differing standards or categories of care, but rather it requires adherence to a uniform standard of conduct: that of reasonable care under the circumstances.[3] In medical negligence matters, however, one of the factors which may be relevant to the determination of what is reasonable care under the circumstances is the special knowledge or skills

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1. The courts have dealt with the standard of conduct by creating a fictitious person, who never has existed on land or sea: the "reasonable man of ordinary prudence." Sometimes he is described as a reasonable man, or a prudent man or a man of average prudence, or a man of ordinary sense using ordinary care and skill. It is evident that all such phrases are intended to mean very much the same thing. The actor is required to do what such an ideal individual would be supposed to do in his place. A model of all proper qualities, with only those human shortcomings and weaknesses which the community will tolerate on the occasion, "this excellent but odious character stands like a monument of our Courts of Justice, vainly appealing to his fellow-citizens to order their lives after his own example."

W. PROSSER, HANDBOOK OF THE LAW OF TORTS, § 32 at 150 (4th ed. 1971) (footnotes omitted).

2. *Id.* § 30 at 143-44.

§ 281. Statement of the Elements of a Cause of Action for Negligence

The actor is liable for an invasion of an interest of another, if:

(a) the interest invaded is protected against unintentional invasion, and

(b) the conduct of the actor is negligent with respect to the other, or a class of persons within which he is included, and

(c) the actor's conduct is a legal cause of the invasion, and

(d) the other has not so conducted himself as to disable himself from bringing an action for such invasion.

RESTATEMENT (SECOND) OF TORTS § 281 (1965).

3. The standard of conduct is measured in terms of what is customary in the commuity in which the conduct occurred. If an actor engages in conduct which every other community member has engaged in, the presumption is that he is conforming to the community's standard of reasonable conduct. W. PROSSER, *supra* note 1, § 33 at 166.

which a defendant physician possesses.[4] The duty of reasonable care requires those with special training and experience to adhere to a standard of conduct commensurate with such attributes. It is this notion of specialized knowledge and skill which differentiates the law of professional negligence from other forms of negligence.[5]

Although the law has imposed a higher standard of care on doctors, it has tempered the impact of that rule by permitting the profession, as a group, to set its own legal standards of reasonable conduct. In an ordinary negligence case, whether a defendant has conformed to a customary practice is evidence of whether he acted as a reasonably prudent person.[6] In a medical negligence case, however, the question of whether the defendant acted in conformity with the common practice within his profession is the essence of the suit. As part of his prima facie case, a malpractice plaintiff must affirmatively prove that the relevant recognized standards of medical care exercised by other physicians were not followed in the treatment of the plaintiff. In almost all cases, the plaintiff must present expert witnesses, since the law recognizes the technical complexity of the facts and issues and usually prevents the jury from determining the appropriate standard of care and whether the defendant's conduct conformed to that standard. Thus, in most medical cases, there cannot be a finding of negligence without supporting expert testimony.[7]

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4. *See generally*, W. PROSSER, *supra* note 1, § 32 at 161-66. "[T]he standard of conduct becomes one of 'good medical practice,' which is to say, what is customary and usual in the profession." *Id.* at 165. RESTATEMENT (SECOND) OF TORTS § 289, comment m (1965) provides:

> If the actor has in fact more than the minimum of these qualities [i.e., attention, perception, memory, knowledge, intelligence, and judgment], he is required to exercise the superior qualities that he has in a manner reasonable under the circumstances. The standard becomes, in other words, that of a reasonable man with such superior attributes.

Id.

5. For example, an insurance agent is under a duty to exercise such reasonable care and skill as is expected of an insurance agent acting under similar circumstances. Adkins & Ainley, Inc. v. Busada, 270 A.2d 135, 137 (D.C. 1970). An optometrist must exercise the degree of skill expected of an optometrist acting under the same circumstances. *See*, Evers v. Buxbaum, 253 F.2d 356, 361 (D.C. Cir. 1958). Similarly, a lawyer must exercise that degree of reasonable care, skill and diligence expected of lawyers acting under similar circumstances. *See* Wade, *The Attorney's Liability for Negligence*, 12 VAND. L. REV. 755, 762-63 (1959).

6. See notes 1 and 3 *supra* and accompanying text.

7. W. PROSSER, *supra* note 1, § 32 at 164-65.

> The well known reluctance of doctors to testify against one another, which has been mentioned now and then in the decisions, may make this difficult or impossible to obtain, and so deprive the plaintiff of any remedy for real and grievous wrong. In several cities, medical and bar associations are now cooperating to meet the problem by setting up panels of competent and unbiased experts, who will examine the plaintiff, and agree to testify for him if they find there has been negligence. Where the matter is regarded as within the common knowledge of laymen, as where the surgeon saws off the wrong leg,

B. *The Locality Rule*

To understand the specialty standard of care, a review of the "locality rule"[8] is necessary. The effect of the locality rule is to suppress the minimal standard of care required of the medical community.[9]

The locality rule, which developed prior to accreditation of medical schools by the American Medical Association's Council of Medical Education in 1906,[10] has undergone erosion and, in a few jurisdictions, outright rejection.[11] The specialty standard of care in some cases is an exception to the locality rule, while in other cases, the specialty doctrine completely eliminates the locality rule.[12]

Geographically, the locality rule was first interpreted to limit the

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or there is injury to a part of the body not within the operative field, it has been held that the jury may infer negligence without the aid of any expert.

Id. (foonotes omitted). Expert testimony is not necessary if the doctrine of *res ipsa loquitur* applies. *See* Annot., 82 A.L.R.2d 1262 (1962).

8. The "locality rule" evolved from a fairness concept. For example, a country physician lacking advanced equipment and facilities would not be held to the same standard as a physician at an urban, highly specialized teaching hospital with the latest equipment. Thus, a country physician would be held to the standard of care of the reasonable country physician of the same locale. See notes 12-15 *infra* and accompanying text.

Locality limitation on the standard of care of physicians has never been applied in English courts. *See* H. NATHAN, MEDICAL NEGLIGENCE 21 (1957); Fleming, *Developments in the English Law of Medical Liability*, 12 VAND. L. REV. 633, 640-41 (1959). Numerous articles discussing the locality rule have appeared in periodicals. *See, e.g.*, Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DE PAUL L. REV. 408 (1969); Note, *Law and Medicine—Locality and the Standard of Care of the Medical Practioners*, 25 ARK. L. REV. 169 (1971); Comment, *The Locality Rule in Medical Malpractice Suits*, 5 CAL. W.L. REV. 124 (1968); Note, *Negligence—Medical Malpractice—The Locality Rule*, 18 DE PAUL L. REV. 328 (1968); Note, *The Standard of Care for the Medical Specialist in Ohio*: Bruni v. Tatsumi, 38 OHIO ST. L.J. 203 (1977); Comment, *Standard of Care for Medical Specialists*, 16 ST. LOUIS UNIV. L.J. 497 (1972); Comment, *Medical Specialties and the Locality Rule*, 14 STAN. L. REV. 884 (1962); Comment, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729 (1970).

One of the earliest expressions of the rationale of the locality rule appears in the Kansas case of Tefft v. Wilcox, 6 Kan. 33 (1870). There, the court stated:

> 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.

Id at 43.

9. *See* notes 22-23 *infra* and accompanying text.

10. *See* Siirila v. Barrios, 398 Mich. 576, 615-616, 248 N.W.2d 171, 186 (1976).

11. Blair v. Eblen, 461 S.W.2d 370, 372-73 (Ky. 1970); Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 199, 349 A.2d 245, 252 (1975); Pederson v. Dumouchel, 72 Wash. 2d 73, — 431 P.2d 973, 978 (1967); Shier v. Freedman, 58 Wis. 2d 269, — 206 N.W.2d 166, 174 (1973).

12. Kronke v. Danielson, 108 Ariz. 400, 499 P.2d 156 (1972); Morrison v. McNamara, 407 A.2d 555 (D.C. 1979); Christy v. Saliterman, 288 Minn. 144, 179 N.W.2d 288 (1970).

availability of expert medical witnesses to those physicians who generally practice in the same community as the defendant physician. The policy behind this strict locality rule was to prevent the small town practitioner from being held to the standard of medical practice of the more sophisticated urban practitioner.[13] The courts generally assumed a rural practitioner had less access to the latest medical information and facilities than urban doctors and did not have the benefit of the same breadth of experience.[14] It also was contended that since cities offered a more lucrative practice, they attracted the most talented doctors.[15] Any attempt to hold rural doctors to urban standards would only drive rural practitioners out of practice, leaving small communities without any doctors.[16]

Application of the locality rule[17] has always created a number of practical difficulties. The strict locality rule understandably facilitated the "conspiracy of silence" atmosphere because of the scarcity of medical colleagues in the same community willing to testify against a fellow practitioner.[18] A federal judge in *Brown v. Keaveny*[19] commented in a dissent that:

> The human instinct for self-preservation being what it is, there is often disclosed in the trial of these cases what has been referred to as the conspiracy of silence—the refusal on the part of the members of the profession to testify against one of their own for fear that one day they, too, may be defendants in a malpractice case.[20]

Another practical problem resulting from application of the strict locality rule was the apparent allowance of a local standard of care below that which was generally found to be acceptable.[21] Additionally,

13. *See* Small v. Howard, 128 Mass. 131, 132, 35 Am. Rep. 363, 365 (1880); Note, *Civil Liability of a Physician for Non-wilful Malpractice*, 29 COLUM. L. REV. 985, 987 (1929); Note, *The Standard of Skill and Care Governing the Civil Liability of Physicians*, 78 U. PA. L. REV. 91, 96-97 (1929) [hereinafter cited as *Standard of Skill*].

14. *See* Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DE PAUL L. REV. 408, 411 (1969); *Standard of Skill*, *supra* note 13, at 96-97 and n. 35.

15. Burk v. Foster, 114 Ky. 29, 30, 69 S.W. 1096, 1097 (1902).

16. *See Standard of Skill*, *supra* note 13, at 97.

17. Even as the courts applied the locality rule, it did not go unrecognized that the increasing standardization of medical training significantly undermined the application of geographic limitations to the population from which a qualified expert witness could be drawn to testify as to the required standard of care. *See* Sinz v. Owens, 33 Cal.2d 749, 767, 205 P.2d 3, 13 (1949) (Carter, J., dissenting); Montgomery v. Stary, 84 So. 2d 34, 39-40 (Fla. 1955).

18. See note 7 *supra*.

19. 326 F.2d 660 (D.C. Cir. 1963).

20. *Id.* at 661 (Wright, J., dissenting) (footnote omitted).

21. The absurdity of coupling the standard of care with the doctor's community is aptly illus-

it was soon recognized that strict adherence to the same locality requirement could completely immunize doctors who were the only practitioners in a small community, as well as small groups of local physicians whose generally lax practice fell below that ordinarily practiced in the rural area.[22] Proclaiming the sensible ideal, it has been held that "[n]egligence cannot be excused on the ground that others in the same locality practice the same kind of negligence."[23]

The strict locality rule, rather than encouraging medical practitioners to elevate the quality of care and treatment to the level existing in other communities, may have fostered substandard care by limiting the testing of the conduct of medical professionals to the conduct of other medical professionals in the same medical community.[24] Moreover, medical schools generally do not provide different degrees of instructions dependent upon where one intends to practice.

At the turn of the century, the logic behind the strict locality rule was evident when distances were great and the traveling country doctor had to contend with muddy lanes, swollen streams and impassable mountains; when communication was restricted to handwritten letters; and when medical journals were rare and largely concerned physicians' personalities.[25] The locality rule was conceived when medical school curricula were much less standardized. Medical education then consisted of a course of lectures over a period of six months.[26] This formal education was supplemented by preceptor-apprenticeships with prac-

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trated in Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968), in which the Supreme Judicial Court of Massachusetts overruled its earlier decision in Small v. Howard, 128 Mass. 131, 35 Am. Rep. 363 (1880), containing one of the first enunciations of the similar locality rule. In *Brune*, which involved an act of alleged malpractice in the city of New Bedford, slightly more than 50 miles from Boston, the trial judge had instructed the jury:

> If, in a given case, it were determined by a jury that the ability and skill of the physician in New Bedford were fifty percent inferior to that which existed in Boston, a defendant in New Bedford would be required to measure up to the standard of skill and competence and ability that is ordinarily found by physicians in New Bedford.

354 Mass. at —, 235 N.E.2d at 795.

22. *See* Gramm v. Boener, 56 Ind. 497 (1877), quoted in Burk v. Foster, 114 Ky. 25, —, 69 S.W. 1096, 1097 (1902).

23. Pederson v. Dumouchel, 72 Wash. 2d 73, 78, 431 P.2d 973, 977 (1967).

24. Morrison v. MacNamara, 407 A.2d 555, 563 (D.C. 1979).

25. *See* Grist v. French, 136 Cal. App. 2d 247—, 288 P.2d 1003, 1017 (1955). The Supreme Court of Florida stated:

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

Montgomery v. Stary, 84 So.2d 34, 39-40 (Fla. 1955).

26. *See* Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 732-33 n.16 (1970).

ticing physicians who had acquired even less formal education.[27]

C. *Same or Similar Communities*

The rigidity of the strict locality rule was not relaxed to reflect the technological progress of medicine until the expansion of the geographical reference group. With this expansion, "same or similar communities"[28] became the term of art defining the relevant geographic standard of care. Similarity of communities, however, should not depend on population, but rather on the similarity of medical facilities, practices and advantages.[29] The existence of research and laboratory facilities in the communities and the availability of other medical resources to serve the physician have a significant bearing on the appropriate standards of practice.

Many courts have criticized this "same or similar communities" approach in defining who is competent to testify as an expert.[30] Difficulty arises when a court must determine whether two communities are similar. The similar communities rule answers some of the criticisms directed at the strict locality standard by expanding the geographical area in which the expert witness may testify as to a medical opinion. The similar community standard, however, is not sufficient when the requisite standard of care is geographically determined. A minimal standard of care may be similarly minimal in a similar community. "Substandard practice is substandard whether it is followed in the same or in a similar community."[31]

Even the most liberal application of the "similar community" rule implies that some characteristics of a geographic area justify a different and perhaps lower standard of care in the exercise of medical judgment than the standard followed in other localities.[32] In nineteenth century

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27. *Id.*

28. For cases applying the "similar communities" test, *see* Annot., 37 A.L.R.3d 420 (1971). *See also* McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549 (1959); Note, *Medical Specialties and the Locality Rule*, 14 STAN. L. REV. 884 (1962). For a discussion of the phrase "or similar communities" stated in the general rule in malpractice cases, *see* Yeates v. Harms, 193 Kan. 320, 393 P.2d 982 (1964); Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093, *clarified*, 187 Kan. 186, 354 P.2d 670 (1960).

29. *See* Gambill v. Stroud, 258 Ark. 766, — 531 S.W.2d 945, 948 (1976), *followed*, White v. Mitchell, 263 Ark. 787, 568 S.W.2d 216 (1978).

30. *See generally*, Note, *Torts—Medical Malpractice—Michigan Abandons "Locality Rule" With Regard to Specialists*, 40 FORDHAM L. REV. 435, 439 (1971); Note, *Medical Malpractice—Expert Testimony*, 60 NW. U.L. REV. 834, 838 (1966); Note, *Medical Specialties and the Locality Rule*, 14 STAN. L. REV. 884, 890 (1962).

31. Morrison v. MacNamara, 407 A.2d 555, 565 (D.C. 1979).

32. See Robbins v. Footer, 553 F.2d 123, 128 (D.C. Cir. 1977).

America, the validity of this assumption may have been obvious enough for courts to accept unquestionably.[33]

The assumption of its continuing validity in our age of ubiquitous national communication networks, both within and outside the medical profession, is extremely doubtful.[34] "Modern medical education and postgraduate training [have] been nationalized. Scientific information flows freely among medical institutions throughout the country. Professional journals and numerous other means of continuing education are national in scope."[35] All licensed physicians meet minimum standards required by all state licensing boards.[36] The increasing excellence of medical schools and the free interchange of scientific information tend to harmonize medical standards throughout the country.[37] The current trend toward uniform and improved levels of medical practice will inevitably result from encouraging continuing medical education,[38] as well as "the prevalence of regional medical centers, standardization and excellence of modern medical schools and training, the dissemination of [journal] reports, and instant communication

33. *Id.*

34. *Id.*

35. *Id.*

36. Each state's licensing system, on behalf of the public, is dependent on the schools of medicine and teaching hospitals to provide the educational experience that will foster the development of the knowledge, abilities and skills required for the practice of medicine. The medical schools and hospitals, in turn, rely on the state medical boards to evaluate the capabilities of their graduates to assume responsibility for the care of patients. 303 NEW ENGLAND J. MED. 1357 (1980).

37. Cook v. Lichtblau, 144 So. 2d 312, 315 (Fla. 1962), quoting Montgomery v. Stary, 84 So.2d 34, 39 (Fla. 1955).

38. Continuing medical education is one way which physicians may remain abreast of the advances of medicine. An early reference to continuing medical education is found in a report by the Commission on Medical Education of the American Association of Medical Colleges, where it stated:

> In discussing the problems of an adequate program of medical care for a community and in visualizing the individual medical needs to be met, emphasis was placed upon the necessity of competent physicians who are familiar with current knowledge regarding the diagnosis, treatment and prevention of disease, and upon the importance of every physician continuing to be a student through his professional life. * * * The time may come when every physician may be required, in the public interest, to take continuation courses to insure that his practice will be kept abreast of current methods of diagnosis, treatment and prevention. *Postgraduate Medical Education*, Final Report of the Commission on Medical Education, American Association of Medical Colleges, 122-40 (1932)
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> As of June 1, 1978, the following states had enacted legislation or created regulations providing for a Commission on Medical Education (CME) requirement for reregistration of the license to practice medicine: Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Illinois, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, New Hampshire, New Mexico, Ohio, Pennsylvania, Puerto Rico, Rhode Island, Utah, Washington and Wisconsin. *See, e.g.*, KAN. STAT. ANN. § 65-2809 at 220 (1980).

devices."[39] Medical textbooks in use today are national textbooks. The required examination is a national exam, evaluated by a body of examiners selected to eliminate regional peculiarities. After certification,[40] specialists[41] keep abreast of developments in their field through medi-

39. Siirila v. Barrios, 398 Mich. 576, —, 248 N.W.2d 171, 187 (1976).

40. The recognition of the need for continuing medical education is perhaps best exhibited by the medical community through certification of specialists. Certification of specialists, such as the licensing of a physician, requires the ability to exhibit necessary expertise and experience at the time of testing. The maintenance of the necessary expertise and experience, however, requires continuous medical education which can only be tested by periodic recertification examinations. Recognition of the need for recertification was reported by the Advisory Board for Medical Specialists. The report stated "many persons argue that certification of a specialist indicates that he is up to date and competent at the time of examination, but this does not prove that he continues indefinitely thereafter to be competent and aware of all important new knowledge in his field." Specialty Boards, Report of the Commission on Graduate Medical Education, Evanston, Ill., Advisory Board of Medical Specialties, 203-23 (1940).

Periodic recertification is intended to have the physician specialist maintain the current knowledge and capabilities as the science and technology of medicine advances. Periodic recertification of physicians dictates continuing education as a categorical imperative of contemporary medicine. *A National Program to Conquer Heart Disease, Cancer, and Stroke; Report to the President*, President's Commission on Heart Disease, Cancer and Stroke (1964). The acceptance of this philosophy was evident by 1978 when 19 specialty boards had established commitments to recertification. *"Why Certification?"* 115 ARCHIVES OF SURGERY 11-14 (1980). Periodic recertification is a significant mechanism within the profession insuring the maintenance of a high level of professional competence.

41. For a comprehensive compilation of requirements for certification, statistics on numbers of specialists, names and addresses of the various specialty boards, names and addresses of hospitals with approved residency training programs for the various specialties, and other details pertaining to postgraduate medical education, consult the issue of the *Journal of the American Medical Association* which contains each year's annual report of the Council on Medical Education and Hospitals. *The Directory of Medical Specialists* gives biographical information on physicians certified by the various specialty boards.

Certification requirements are as follows: *Dermatology*—the American Board of Dermatology requires three years' training beyond internship; *Internal Medicine*—the American Board of Internal Medicine requires three years' training beyond internship when a formal residency program is followed, but several alternate plans are offered; *Neurology*—the American Board of Psychiatry and Neurology requires three years' training beyond internship; *Pathology*—the American Board of Pathology requires four years' training beyond internship; *Pediatrics*—the American Board of Pediatrics requires two years' training beyond internship and two additional years' training for certification in the subspecialty of pediatric allergy; *Physical Medicine and Rehabilitation*—the American Board of Physical Medicine and Rehabilitation requires three years' training beyond internship; *Preventive Medicine*—the American Board of Preventive Medicine requires three years' training beyond internship for public health, four years' training beyond internship for aviation medicine, and three years' training beyond internship for occupational medicine; *Psychiatry*—the American Board of Psychiatry and Neurology requires three years' training beyond internship; *Radiology*—the American Board of Radiology requires three years' training beyond internship for the categories of radiology (that branch of medicine which deals with the diagnostic and therapeutic application of radiant energy including roentgen, i.e. x-rays, radium and radioisotopes), diagnosticroentgenology (that branch of radiology which deals with the therapeutic application of roentgen rays, radium and radioactive isotopes); *Anesthesiology*—the American Board of Anesthesiology requires a minimum of two years' training beyond intership; *General Surgery*—the American Board of Surgery requires a minimum of three years' training beyond internship; *Neurological Surgery*—the American Board of Neurological Surgery requires a minimum of four years' training beyond internship; *Obstetrics and Gynecology*—the American Board of Obstetrics

cal specialty journals[42] disseminated throughout the nation, and through meetings of medical specialty societies with national and international memberships.

It is evident the medical profession has adopted a national standard for membership in most of its certified specialties.[43] Geographic conditions or circumstances, therefore, should neither control the standard of a specialist's care nor the admissibility of an expert's testimony. If the law with regard to medical specialists remains tied to a locality or community standard, it ignores the realities of modern medicine in favor of a medical philosophy that served us poorly fifty and one hundred years ago.[44]

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and Gynecology requires three years' training beyond internship; *Ophthalmology*—the American Board of Ophthalmology requires three years' training beyond internship; *Orthopedic Surgery*—the American Board of Orthopaedic Surgery requires four years' training beyond internship; *Otolaryngology*—the American Board of Otolaryngology requires three years' training beyond internship, or four years' training beyond internship if certification includes eye diseases; *Proctology*—the American Board of Proctology requires five years' training beyond internship (three years in general surgery, plus two years in proctology); *Thoracic Surgery*—the Board of Thoracic Surgery (an affiliate of the American Board of Surgery) requires certification by the American Board of Surgery plus two years' additional training in thoracic surgery; *Urology*—the American Board of Urology requires four years' training beyond internship.

42. Some of the leading journals in each specialty field are: *Dermatology*—ARCHIVES OF DERMATOLOGY; *Internal Medicine*—ARCHIVES OF INTERNAL MEDICINE; ANNALS OF INTERNAL MEDICINE, MEDICAL CLINICS OF NORTH AMERICA; *Neurology*—ARCHIVES OF NEUROLOGY AND PSYCHIATRY; JOURNAL OF NERVOUS AND MENTAL DISEASES; NEUROLOGY; *Pathology*—ARCHIVES OF PATHOLOGY; AMERICAN JOURNAL OF CLINICAL PATHOLOGY; *Pediatrics*—JOURNAL OF DISEASES OF CHILDREN; JOURNAL OF PEDIATRICS; PEDIATRICS; PEDIATRIC CLINICS OF NORTH AMERICA; *Physical Medicine and Rehabilitation*—AMERICAN JOURNAL OF PHYSICAL MEDICINE; JOURNAL OF REHABILITATION; *Preventive Medicine*—ARCHIVES OF INDUSTRIAL HEALTH; AMERICAN JOURNAL OF PUBLIC HEALTH; *Psychiatry*—ARCHIVES OF NEUROLOGY AND PSYCHIATRY; AMERICAN JOURNAL OF PSYCHIATRY; PSYCHIATRY; PSYCHIATRIC QUARTERLY; RADIUM THERAPY AND NUCLEAR MEDICINE; RADIOLOGY; *Anesthesiology*—ANESTHESIOLOGY; *General Surgery*—ARCHIVES OF SURGERY; AMERICAN JOURNAL OF SURGERY; ANNALS OF SURGERY; SURGERY; SURGERY, GYNECOLOGY AND OBSTETRICS; SURGICAL CLINICS OF NORTH AMERICA; *Neurological Surgery*—JOURNAL OF NEUROSURGERY; *Obstetrics and Gynecology*—AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY; OBSTETRICS AND GYNECOLOGY; SURGERY, GYNECOLOGY AND OBSTETRICS; *Ophthalmology*—ARCHIVES OF OPHTHALMOLOGY; AMERICAN JOURNAL OF OPHTHALMOLOGY; *Orthopedic Surgery*—JOURNAL OF BONE AND JOINT SURGERY; *Otolaryngology*—ARCHIVES OF OTOLARYNGOLOGY; ANNALS OF OTOLOGY, RHINOLOGY AND LARYNGOLOGY; *Plastic Surgery*—PLASTIC AND RECONSTRUCTIVE SURGERY; *Proctology*—see journals in general surgery; *Thoracic Surgery*—JOURNAL OF THORACIC SURGERY; *Urology*—Journal of Urology.

43. In 1962, the Board of Editors of the STAN. L. REV. conducted a survey of the American Specialty Boards, the American Medical Association, the American Hospital Association, and publishers of medical specialty journals and medical specialty societies to determine the similarity of practice throughout the country within each recognized medical specialty. The results indicated that the practice within most specialties was similar nationwide. *See* Note, *Medical Specialties and the Locality Rule*, 14 STAN. L. REV. 884, 887-89 & nn.17-23 (1962).

44. Louisell and Williams commented in this regard that:

> The comprehensive coverage of the Journal of the American Medical Association, the availability of numerous other journals, the ubiquitous "detail men" of the drug compa-

III. AN EMERGING NATIONAL STANDARD OF CARE

Medical standards solely dictated by geographic considerations have evidenced erosion through the courts' recognition of the increasing emphasis on medical specialization. Concomitantly, the emergence of a national standard of medicine has enabled the requisite standard of care to mirror the practice of modern medicine. Labeled the "specialty standard of care" by most courts, the national standard is[45] based upon professional proficiency rather than geographic proximity. As such, it establishes a medical-legal principle consistent with the realities of contemporary medical knowledge and practice.

In theory, the national uniform standard of medicine may be difficult for some commentators, including jurists, to accept. In reality, however, most aspects of the practice of medicine are, or should be, so universally known and followed that they are accepted as standards throughout the profession regardless of whether the physician is located in a metropolitan area or a rural area. Therefore, the conflict between national and local standards is largely illusory. Although different treatment methods may be expressed by various medical experts who testify, very seldom will those methods be geographically oriented. Few medical malpractice cases are pursued and even fewer are successfully concluded when the absence of specialized medical facilities or techniques is at issue and when the general methods of diagnosis and treatment of the injury in question would be different in a rural community than in a large metropolitan center. As an example, "the standard of care [practiced by] any [physician] or surgeon in the inspection and detection of post-surgical wound infections cannot, on any rational basis, vary from one part of the country to another."[46]

A "cry of wolf" may be heard from voices in the medical community regarding the imposition of national standards on small town gen-

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nies, closed circuit television presentations of medical subjects, special radio networks for physicians, tape recorded digests of medical literature, and hundreds of widely available postgraduate courses all serve to keep physicians informed and increasingly to establish nationwide standards. Medicine realizes this, so it is likely that the law will do likewise.

D. LOUISELL and H. WILLIAMS, THE PARENCHYMA OF LAW 182 183 (1960).

The Michigan Supreme Court states:

> The reliance of the public upon the skills of a specialist and the wealth and sources of his knowledge are not limited to the geographic area in which he practices. Rather his knowledge is a specialty. He specializes so that he may keep abreast. Any [non-national] standard for a specialist would negate the fundamental expectations and purpose of a specialty.

Naccarato v. Grob, 384 Mich. 248, —, 180 N.W.2d 788, 791 (1970).

45. Hirschberg v. New York, 91 Misc. 2d 590, —, 398 N.Y.S.2d 470, 475 (Ct. Cl. 1977).

46. Priest v. Lindig, 583 P.2d 173, 179 (Alaska, 1978).

eral practitioners. The argument may be heard that national standards of medicine require small town general practitioners to perform triple cardiac bypass surgeries in order to conform to the standard reflected in the major metropolitan cardiovascular surgical centers in the nation. The fallacy, however, with this reasoning is the elemental medical philosophy instilled in the minds of medical students during medical school: physicians should refer the patient when they know or should know they are not in a position to administer successfully the needed treatment and that a better medical facility is available.[47] Thus, the small town general practitioner may have a duty not to operate, but rather to refer.

In adopting the national standard of care, the particular circumstances of the community where the physician practices may be relevant. The availability of certain medical facilities, the accessibility of professional consultation, and the communication and transportation systems of the area should be factors for the jury to consider. Obviously, a physician cannot depart from standard medical practices for failing to employ medical equipment that is not available, when there is no time to procure such equipment from another community, nor time to refer the patient. Medicine is the art of the possible, and each physician owes the duty to care optimally and treat by making the best resources available even if he referred the patient elsewhere. The specialty standard may be inapplicable if the patient fully understands that a specialist is available, but opts against referral to that specialist. The adoption of a national standard of care and the availability of the skills of a specialist should increase the number of patient referrals. But whenever a physician refers a patient, the physician runs the risk that the patient may never return for aftercare or subsequent unrelated care. Increased referrals are incompatible with the practice of retaining patients whose problems the physician is marginally competent to deal with. It is the patient who benefits from the adherence to this greater degree of care.

The national standard of care has been applied throughout the country in a non-uniform manner.[48] Several courts have followed the

47. Swan v. Lamb, 584 P.2d 814, 817 (Utah, 1978).

48. Even where the courts have not repudiated the similar communities test in so many words, they have tended to change the definition of "similarity" to one which increases the focus on medical variables which might impinge upon the defendant physicians' capacity to provide services. Descriptions of this trend, and of the increased standardization of training and access to medical facilities, can be found in Robbins v. Footer, 553 F.2d 123, 128-29 (D.C. Cir. 1977); Shilkret v. Annapolis Emergency Hosp. Ass'n., 276 Md. 187, 349 A.2d 245 (1975).

lead of the medical profession and have established a national standard of care for all physicians, completely abandoning any locality limitations.[49] Other courts limit the application of the national standard to specialists.[50] The Court of Appeals for the District of Columbia has further restricted national specialty standards to board certified specialists.[51] The Supreme Judicial Court of Massachusetts in *Brune v. Belinkoff*[52] articulated the national standard as the "average member of the professional practising the specialty."[53] Similarly, the Supreme Court of Washington in *Pederson v. Dumouchel*,[54] framed its standard in terms of "an average, competent practitioner,"[55] and the Maryland Court of Appeals in *Shilkret v. Annapolis Emergency Hospital Ass'n*[56] as the "reasonably competent practitioner in the same class in which he belongs . . . ."[57]

Perhaps there is no substantive difference in the verbal distinction between *average* and *reasonably competent* medical practitioner. Those courts which use the word "average" may well intend it in the sense of "ordinary" or "commonly possessed." The term "average," however, can have other meanings which should not be incorporated into a standard of care for negligence. It could be taken to refer to an "aggregation of the best and the worst, the experienced and the inexperienced."[58] "Half of the physicians of America do not automatically become negligent . . . because their skill is less than the professional average."[59] To the extent the two formulations of the standard differ, "reasonably competent" should be preferred because of the potential misinterpretation of the term "average."

What constitutes a specialist is significant if a medical specialist is

49. Blair v. Eblen, 461 S.W.2d 370, 372-73 (Ky. 1970); Shilkret v. Annapolis Emergency Hosp. Ass'n., 276 Md. 187, 199, 349 A.2d 245, 252 (1975); Pederson v. Dumouchel, 72 Wash. 2d 73, —, 431 P.2d 973, 978 (1967); Shier v. Freedman, 58 Wash.2d 269, —, 206 N.W.2d 166, 174 (1973).

50. *E.g.*, Kronke v. Danielson, 108 Ariz. 400, 499 P.2d 156 (1972), *followed*, Matson v. Naifeh, 122 Ariz. 360, 595 P.2d 38 (1979).

51. *See* Morrison v. MacNamara, 407 A.2d 555 (D.C. 1979).

52. 235 N.E.2d 793 (Mass. 1968).

53. *Id.* at 798.

54. 72 Wash.2d 73, 431 P.2d 973 (1967).

55. *Id.* Similar or identical rules have been adopted in at least the following cases: Landeros v. Flood, 17 Cal. 3d 399, 551 P.2d 389, 392-93 (1976), 131 Cal. Rptr. 69, 72-73; Blair v. Eblen, 461 S.W.2d 370, 373 (Ky. 1970).

56. 276 Md. 187, 349 A.2d 245 (1975).

57. *Id.* at ——, 349 A.2d at 253.

58. *See* Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DE PAUL L. REV. 408, 409 n.1 (1969).

59. RESTATEMENT (SECOND) OF TORTS, § 299A, comment e (1965).

held to a national standard. A physician may become a specialist on the basis of education and certification.[60] A physician also is considered a specialist if he holds himself out as such, as is one "who confines his practice to specific diseases or disabilities."[61] Since the public rarely knows the extent of the physician's education and any specialty certification, the patient's perspective of the physician's capabilities should be relevant. Regardless of the degree of education of a specialist and any specialty certification, if a physician undertakes care and treatment that falls within the purview of a specialist, the law should judge the care and treatment based upon a specialty standard of care.[62]

IV. CONCLUSION

While the law is slow to change, medical progress is rapid and accelerating. It is no longer conscionable to allow small town physicians to continue substandard practices because of archaic "locality" legal concepts dating from the horse-and-buggy era. Physicians of limited training should not be insulated from medical misadventures that could be avoided through consultation and referral. The economic apprehensions and the personal needs of the physician cannot excuse a breach of the duty to refer. "Every-doctor-would-have-to-be-a-brain-surgeon" is, in reality, a smokescreen. A national standard of care is the medical-legal counterpart to national sources of readily available training for both medical students and established practitioners.

Tort law is the mechanism by which society reconciles conflict. We must expect the body of tort law to evolve in the direction of enforcing greater medical responsibility if today's physicians are to have responsibility commensurate with their opportunity to practice acceptable medicine. Medical tort law, although it deals with unfortunate consequences, has the net effect in our complex legal system of ensuring minimal medical standards for the benefit of the patient.

60. Roberts v. Tardif, 417 A.2d 444, 452 (Me. 1980).

61. BALLENTINE'S LAW DICTIONARY 1199 (3d ed. 1969).

62. The specialty standard of care is recognized by the following states: Alaska, Arizona, Arkansas, California, Connecticut, Florida, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Missouri, Nebraska, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, Vermont, Virginia, Washington, West Virginia. *See* Annot., 21 A.L.R.3d 953, 954-55 (1968 & Supp. 1980).