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The Locality Rule and the Physician's Dilemma

Local Medical Practices vs the National Standard of Care

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THE PURPOSE OF MEDICAL MALPRACTICE LAW IS TO PROtect patients from substandard medical care and to compensate them for injuries sustained as a result of substandard care. Each medical malpractice case serves an additional function by further delineating the medical care that is legally acceptable in a particular field.

Although medical school training, medical licensing requirements, and board certification requirements are based on national standards, many states rely on local practice standards to determine the applicable standard of care in medical malpractice lawsuits. Jurisdictions that maintain local practice standards may inhibit the incorporation of scientific progress into practice standards. In addition, adherence to the locality rule can create uncertainty for physicians when they must choose between following local practice standards and national, evidence-based standards for care.

How the Legal Standard of Care Is Determined

When a physician assumes care of a patient, he or she undertakes a legal duty to abide by a certain standard of care. The traditional standard of care for physicians is to exercise "the degree of care and skill that a physician or surgeon of the same medical specialty would use under similar circumstances."[1] This legal standard, however, is not defined uniformly throughout the United States. Traditionally, US courts have allowed the medical profession to set its own standards of care by defining the standards according to medical custom. Expert witness testimony is usually necessary to provide evidence of this custom (97% of medical malpractice cases involve expert medical testimony, with an average of 5 witnesses per trial).[2]

In states that maintain a custom-based standard, the role of the jury in a malpractice case is to decide whether the physician's actions were consistent with what other physicians customarily do under similar circumstances.[3] In theory, the customary standard is based on empirical evidence, but expert witnesses are unlikely to know how other physicians practice. Instead, these expert witnesses are likely to base their testimony on what they would have done under the circumstances.[4,5]

Some state courts have taken a normative approach in defining the standard of care. In these states, the legal standard is what a reasonable physician would have done un-

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der the circumstances. Expert witness testimony is used to provide evidence regarding what would have been reasonable, regardless of customary medical practice. The jury's role is to determine whether the physician acted reasonably, not whether he or she conformed to existing customs.[6]

In many states, there is also a geographic, or locality, component to the determination of the standard of care. Although 29 states and the District of Columbia have adopted a national standard, 21 states maintain a version of the locality rule, in which the standard of care by which a physician is judged is the standard of care in a particular locality (BOX).

The Locality Rule

The locality rule arose in the United States in the 1880s.[9] It has been disregarded by a majority of courts, but a significant minority adhere to the rule. The locality rule was based on the premise that rural physicians might not have the same experiences or opportunities for education as their colleagues in larger cities; therefore, it would be unfair to hold them to the same standard of care. Under the strictest form of the locality rule, a patient is required to prove that a physician violated the standard of care in his or her particular community.[10] Only physicians who practice in that community can serve as expert witnesses. As a result, a physician who is the sole practitioner in his or her community could be effectively immunized from liability.[11] Furthermore, in small communities, it could be difficult for patients to find physicians willing to testify against their colleagues.[12]

Some courts have developed expanded versions of the locality rule. Under one version, physicians are held to the same standard as physicians in the "same or similar locality."[13] This distinction has led to uncertainty about the definition of a similar locality. Some courts have defined *similar locality* in terms of the medical resources available to the physician.[14] In some states, the relevant locality is the entire state.[15]

The locality rule has become increasingly difficult to justify. First, the rule may allow physicians who practice substandard care to set local practice standards. The similar locality standard does not alleviate this problem because other small communities may also have low standards.[11] Second, medical education has become standardized under national accreditation and continuing education programs. Third, with the availability of modern technology, rural and urban physicians generally have the same access to information for patient care.

By the 1970s, many states had abandoned the locality rule in favor of national-based standards.[16] A resource-based national standard of care has been adopted by some states in recognition that resources available to physicians practicing in rural as opposed to urban settings may not be comparable. In these states, local circumstances, such as the availability of facilities and the proximity of specialists, may be taken into account, but local practice patterns are no longer a consideration with respect to the skill, learning, and clinical competence of the physician.[17]

Application of the Locality Rule

The locality rule has been invoked in medical malpractice cases in different ways. Typically, the rule is used to exclude the testimony of expert witnesses who are not familiar with the local standards of care.[18] For example, in *Robinson v LeCorps*, a medical malpractice case in Tennessee, the expert testimony of an orthopedic surgeon from Johnson City was excluded because the witness testified about the national standard of care for orthopedic surgeons and did not have actual knowledge of the standard of care in Nashville, the community where the alleged malpractice occurred.[19] Courts have also applied the rule to determine what the applicable standard of care should be, rather than who is qualified to testify about the applicable standard. Applying the rule in this manner has had inconsistent results.

In a New York malpractice case, for example, a pediatrician cited local custom to defend the prolonged use of oxygen to treat preterm infants despite evidence that suggested this practice might be harmful.[20] The Court of Appeals of New York held that because the pediatrician had superior knowledge of the increased risks associated with the administration of excess oxygen, reliance on local custom was no defense.[20] The Court further held that a physician "should at all times use his own best judgment."[20] The Court recognized that this requirement may conflict with the community standard of care and noted that in those cases, "fairness . . . would seem to require that the physician not be held liable for exercising his best judgment."[20]

A jury in a Virginia case, however, came to the opposite conclusion when it found that a family practice resident had failed to meet the Virginia standard of care when he discussed the risks and benefits of prostate-specific antigen (PSA) testing with a patient (who refused the test and was subsequently diagnosed with prostate cancer), because other Virginia physicians ordered the test as a matter of routine for men older than 50 years.[21,22] Under Virginia law, the standard of care for physicians is the degree of skill practiced by physicians in the entire state.[23] Although the medical knowledge available at the time did not support routine PSA screening, the jury's conclusion was consistent with Virginia law regarding the applicable standard of care. These cases demonstrate how the application of the locality rule can lead to uncertainty for physicians.

Implications of the Locality Rule

The persistence of the locality rule has serious implications for physicians. Although originally designed to protect physicians, the rule imposes additional duties and legal risk on physicians. Not only must they remain aware of

Box. Interpretation and Categorization of State Statutes and Case Law on Standard of Care*

National Standard†

Alabama: Ala Code §6-5-548 (2005)

Alaska: Alaska Stat §09.55.540 (2006)

California: *Barris v County of Los Angeles*, 20 Cal 4th 101, 972 P2d 966, 83 Cal Rptr 145 (1999)

Connecticut: Conn Gen Stat §52-184c (2006)

Delaware: Del Code Ann, tit 18, §6801 (2006)

Florida: Fla Stat §766.102 (2006)

Georgia: *McDaniel v Hendrix*, 260 Ga 857, 401 SE2d 260 (1991)

Hawaii: *Hirahara v Tanaka*, 87 Haw 460, 959 P2d 830 (1998)

Indiana: *Vergara v Doan*, 593 NE2d 185 (Ind 1992)

Iowa: *Estate of Hagedorn ex rel Hagedorn v Peterson*, 690 NW2d 84 (Iowa 2004)

Kentucky: *Branham v Nazar*, 2004 Ky App LEXIS 312

Maine: *Downer v Veilleux*, 322 A2d 82 (Me 1974)

Massachusetts: *Brune v Belinkoff*, 354 Mass 102, 235 NE2d 793 (1968)

Mississippi: *Hall v Hilbun*, 466 S2d 856 (Miss 1985)

Missouri: Mo Rev Stat §538.225 (2006)

Nevada: Nev Rev Stat Ann §41A.009 (2006)

New Hampshire: NH Rev Stat Ann §507-C:2 (2006)

New Jersey: *Velazquez v Portadin*, 163 NJ 677, 751 A2d 102 (2000)

New Mexico: *Pharmaseal Laboratories Inc v Goffe*, 90 NM 753, 568 P2d 589 (1977)

Ohio: *Bruni v Tatsumi*, 46 Ohio St 2d 127, 346 NE2d 673 (1976)

Oklahoma: Okla Stat tit 76, §20.1 (2005)

Rhode Island: *Sheeley v Memorial Hospital*, 710 A2d 161 (RI 1998)

South Carolina: *Durham v Vinson*, 360 SC 639, 602 SE2d 760 (2004)

Texas: *Am Transitional Care Centers of Tex Inc v Palacios*, 44 Tex Sup Ct J 720, 46 SW3d 873 (2001)

Utah: *Dalley v Utah Valley Regional Medical Center*, 791 P2d 193 (Utah 1993)

Vermont: Vt Stat Ann tit 12, §1908 (2006)

Washington, DC: *Morrison v MacNamara*, 407 A2d 555 (DC 1979)

West Virginia: W Va Code §55-7B-3 (2006)

Wisconsin: *Phelps v Physicians Ins Co of Wis Inc*, 282 Wis2d 69, 698 NW2d 643 (2005)

Wyoming: Wyo Stat Ann §1-12-601 (2006)

Statewide Standard‡

Arizona: Ariz Rev Stat §12-563 (2005)

Virginia: Va Code Ann §8.01-581.20 (2006)

Washington: Wash Rev Code §7.70.040 (2006)

Same Community Standard§

Idaho: Idaho Code §6-1012 (2006)

New York: *Nestorowich v Ricotta*, 97 NY2d 393, 767 NE2d 125 (2005)||

Same or Similar Community Standard¶

Arkansas: Ark Code Ann §16-114-206 (2006)

Illinois: *Jinkins v Lee*, 209 Ill2d 320, 282 Ill Dec 787, 807 NE2d 411 (2004)

Kansas: *Tompkins v Bise*, 259 Kan 39, 910 P2d 185 (1996)

Maryland: Md Code Ann, [Cts & Jud Proc] §3-2A-02(c) (2006)

Michigan: Mich Comp Laws Serv §600.2169 (2006)

Minnesota: *Lundgren v Eustermann*, 370 NW2d 877 (Minn 1985)

Nebraska: Neb Rev Stat §44-2810 (2006)

North Carolina: NC Gen Stat §90-21.12 (2006)

North Dakota: *Winkjer v Herr*, 277 NW2d 579 (ND 1979)

Oregon: Or Rev Stat §677.095 (2006)

Tennessee: Tenn Code Ann §29-26-115 (2005)

Similar Community Standard for General Practitioners/National Standard for Specialists#

Colorado: *Jordan v Bogner*, 844 P2d 664 (Colo 1993)

Louisiana: La Rev Stat Ann §9:2794 (2006)

Montana: *Chapel v Allison*, 241 Mont 83, 785 P2d 204 (1990)

Pennsylvania: *Joyce v Boulevard Physical Therapy & Rehabilitation Ctr PC*, 694 A2d 648 (Pa 1997)**

South Dakota: *Shamburger v Behrens*, 418 NW2d 299 (SD 1988)

*A LEXIS search was performed to identify state statutes that define the legal standard of care for physicians. If there was no relevant statute, a LEXIS search was performed to find case law that governs the standard of care for physicians in that state. Interpretation and categorization of statutes and case law represent the opinions of the authors and should not be considered definitive.

†States are in this category if (1) the statute or case law specifically states that physicians should be held to a national standard; (2) the definition of the standard of care does not contain a geographic limitation and a national standard can be inferred; or (3) the applicable standard is that of physicians acting in similar circumstances, and standards of practice in the same or similar communities can be one consideration but are not conclusive.

‡States are in this category if the statute specifies that the acceptable standard of care is that of health care practitioners in the entire state.

§States are in this category if the statute or case law specifies that practice in the local community determines the standard of care.

||Although the locality rule still applies, New York courts may deviate from applying the locality rule and instead apply a minimum statewide standard of care or even a nationwide standard.[7]

¶States are in this category if the statute or case law holds physicians to the standard of care practiced by physicians in the "same or similar communities."

#States are in this category if the statute or case law specifies different standards of care for non–board certified general practitioners and specialists.

**Although this case has not been overruled, it is the opinion of a subcommittee appointed by the Pennsylvania Supreme Court that a national standard of care applies to all physicians who practice in Pennsylvania.[8]

advances in their specialty, physicians must also be aware of the standard of care in their locality, whether or not that standard is considered substandard at the national level. In Virginia, for example, there is a statutory presumption that each physician knows the standard of care in the state, although it is unclear how a physician may be expected to obtain this knowledge.[23]

The locality rule may cause additional difficulties for a physician who practices in multiple states. If the standards of care are different in the various jurisdictions, the physician may be at legal risk for exercising his or her own best judgment rather than conforming to local practice standards. Furthermore, the practice of evidence-based medicine may not be acceptable if this practice is inconsistent with the local standard of care. Adherence to the locality rule thus could delay the incorporation of new scientific knowledge into the practice of medicine in some communities.

Ethical Implications

The persistence of the locality rule also is troubling from an ethical perspective. In jurisdictions that maintain the locality rule, basic principles of justice may not be met for patients who have been harmed as a result of suboptimal local care standards. In medical malpractice lawsuits, the patient must prove that the physician who provided care failed to meet the requisite standard of care. This usually requires that the patient find an expert witness whose testimony will establish this fact. The difficulty of this burden of proof should be based on the merits of the claim, not on the ability of the patient to find a physician willing to testify against a colleague. In jurisdictions that maintain the strict locality rule, the patient must find another physician from the same community to testify that his or her physician violated the community standard of care. If no other physician is willing to provide this testimony, the merits of the patient's claim may never be assessed.

Finally, when medical advances have not been adopted in their community, physicians may face the choice to do either what they believe is best for their patients or what they believe is in their own best interests by abiding by the local standard of care to minimize their legal risk. Although it may be reasonable to believe that most physicians would act in their patients' best interests rather than their own, it is unclear to what extent the fear of litigation might influence physician behavior.

Conclusions

The locality rule originated in a time when rural and urban physicians may have had vastly different experiences with respect to their education, training, and ability to obtain the latest information relating to diagnosis and treatment. These differences necessitated the development of local standards to govern medical malpractice lawsuits.

Today, however, rural and urban physicians have access to the same information and have the same opportunities to stay current in their specialty. Thus, the locality rule has become an anachronism, but one that persists in some jurisdictions.

The persistence of this rule may serve to promote the practice of substandard medicine. Patients seeking medical care should be able to expect a certain level of competency and skill from their physicians, no matter where the patient lives or where the physician practices. The standards by which physicians are measured should be the same throughout the country and should not depend on the location of the physician's practice. Location should only be considered in relation to the availability of diagnostic facilities or services, or access to subspecialist physicians, not with respect to the knowledge or skill of the treating physician.

The practice of medicine is an artful science, not an exact science, and practice patterns vary throughout the country.[24] Nevertheless, when scientific evidence is sufficient to support a medical practice, physicians should be able to rely on that evidence in their clinical decision making without fear of legal liability.

To enable medical malpractice cases to become more evidence-based, a resource-based, nationwide standard of care should be adopted in all jurisdictions. This type of standard would better enable plaintiffs to find experts willing to testify and further promote justice for all parties. In the meantime, it is incumbent on physicians to become knowledgeable about the standard of care applicable in all jurisdictions in which they practice. If they do not, they risk being held to the same standard as their colleagues in their community, even if that standard is not evidence-based and is considered substandard nationally.

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EDITORIAL

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Modeling Genetic Risk of Breast Cancer

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STARTING EVEN BEFORE THE IDENTIFICATION OF THE *BRCA1* and *BRCA2* cancer susceptibility genes, several models were well established as predictors of a woman's risk of inherited breast cancer.[1] During the past decade, these models have been refined not only to predict breast cancer risk, but also to predict the likelihood that an individual carries a deleterious mutation in one of these genes. Such models have been used as criteria for offering genetic testing,[2] for determining eligibility for screening and prevention trials,[3] and, increasingly, for assessing appropriateness of participation in incremental risk-reduction strategies.[4,5] Illustrating the influence modeling is having on clinical practice, the American Cancer Society recently issued guidelines for offering screening breast magnetic resonance imaging, which, among other criteria, stated that women with a lifetime risk of breast cancer of "20-25% or greater, as determined by BRCAPRO or other models that are largely dependent on family history," should be offered annual breast magnetic resonance imaging beginning at age 30 years.[4]

In this issue of *JAMA*, Weitzel and colleagues[6] present results of a study that details an important limitation of genetic risk assessment modeling. In this study, the authors evaluated the performance of 3 commonly used risk assessment models in 306 women who were diagnosed as having breast cancer prior to age 50 years and had no first- or second-degree relatives with breast or ovarian cancer. This study cohort represents an important fraction of individuals presenting for genetic counseling and testing and accounted for 19.8% of the 1543 individuals presenting to the study center in a 10-year period. In this cohort of women with apparently sporadic, early onset breast cancer, 9.5% of study participants had a deleterious *BRCA1* or *BRCA2* mutation detected on germline screening.

The authors hypothesized that given the strongly sex-limited penetrance of mutations in *BRCA1* and *BRCA2*, current risk assessment models might not adequately predict mutation probability in these nonhereditary-appearing cases. Such a hypothesis recognizes that a dominant susceptibility trait, such as observed with *BRCA1*- and *BRCA2*-linked breast cancer, may be obscured because of a paucity of female relatives in either the maternal or paternal lineage. The authors found that limited family structure (≥1 lineage with <2 first- or second-degree female relatives older than 45 years), compared with adequate family structure (≥2 first- or second-degree female relatives older than 45 years in both the maternal and paternal lineage), was strongly associated with the presence of a deleterious mutation (odds ratio, 2.8; 95% confidence interval, 1.19-6.73; $P=.02$). Despite this, none of the models evaluated (Myriad,[7] Couch,[8] or BRCAPRO[9]) demonstrated significantly different mean pretest mutation probabilities when

See also p 2587.

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