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**Health Law—A Call For the Arkansas General Assembly to Modernize the Standard of Care Requirement in Medical Malpractice Cases. *Broussard v. St. Edward Mercy Health System, Inc.*, 2012 Ark. 14, 386 S.W.3d 385.**

Jarred Kibbey

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HEALTH LAW – A CALL FOR THE ARKANSAS GENERAL ASSEMBLY TO  
MODERNIZE THE STANDARD OF CARE REQUIREMENT IN MEDICAL  
MALPRACTICE CASES. *BROUSSARD V. ST. EDWARD MERCY HEALTH SYSTEM,  
INC.*, 2012 ARK. 14, 386 S.W.3D 385.

I. INTRODUCTION

When a patient goes to a physician's office, she should not have to worry about whether the advice she receives or the procedure performed is considered appropriate by national standards, or simply appropriate by physicians in similar geographic locations. She should expect that the physician she sees is held to the same standard as all physicians across the country. This, however, is not the case in Arkansas.

Arkansas is one of the few states that still uses a locality rule to determine the appropriateness of the standard of care a physician adheres to in medical malpractice cases.<sup>1</sup> Doctors in Arkansas are not held to a national standard; instead, they are examined against the standard of care of physicians in similar localities.<sup>2</sup> In *Broussard v. St. Mercy Health System, Inc.*,<sup>3</sup> the Arkansas Supreme Court found that part of the statute containing the locality rule was unconstitutional.<sup>4</sup> When the state legislature amends the statute, it should change the locality rule to modernize it and bring it in line with the majority of states.

When the locality rule was first introduced during the late nineteenth century, it was designed to protect physicians who practiced in rural settings and who did not have ready access to the most current information in the ever-evolving medical field.<sup>5</sup> While this rule served as a valuable purpose at the time, the free flow of information due to technological advancements, ease of transportation, and requirements of continuing education have rendered the rule outdated and counter-productive in a time when more than 600 medical malpractice claims are filed daily.<sup>6</sup> Additionally, there has been

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1. Michelle Huckaby Lewis et al., *The Locality Rule and the Physician's Dilemma: Local Medical Practices vs the National Standard of Care*, 297 J. AM. MED. ASS'N 2633, 2635 (2007) (listing each state's rule to determine the standard of care in medical malpractice claims).

2. *Id.*

3. 2012 Ark. 14, 386 S.W.3d 385 (holding that ARK. CODE ANN. § 16-114-206 unconstitutionally violated the separation of powers).

4. *Id.*, 386 S.W.3d 385.

5. Tyrone E. May, Note, *Locality and the Standard of Care of Medical Practitioners*, 25 ARK. L. REV. 169, 170–71 (1971).

6. Richard E. Anderson, *Effective Legal Reform and the Malpractice Insurance Crisis*, 5 YALE J. HEALTH POL'Y L. & ETHICS 341, 346 (2005).

encouragement at the federal level to gather data on best practices and disseminate them to the medical community.<sup>7</sup>

Part II of this note will discuss the history of the locality rule throughout the country, followed by a brief history of the rule in Arkansas.<sup>8</sup> Part III will argue that the locality rule promotes less than adequate medical care by protecting physicians who choose not to stay apprised of recent developments in their field.<sup>9</sup> The section will then demonstrate that the locality rule is outdated and that most states have moved away from it because of advancements in communication and technology.<sup>10</sup> The section will conclude by demonstrating that the locality rule violates the most common views of medical ethics.<sup>11</sup>

Finally, Part IV will call on the Arkansas legislature to modify the existing locality statute to treat professional expertise and resource availability separately.<sup>12</sup> Professional expertise should be measured against a national standard of care. However, holding resource availability to a national standard is unreasonable and should include a geographic component.<sup>13</sup>

## II. BACKGROUND

### A. Development of the Locality Rule Nationally

The idea of locality was first recognized in the late 1800s and was strictly applied.<sup>14</sup> The doctrine of strict locality provides that physicians must adhere to a standard of care that is consistent with physicians in the same geographic location in which they practice.<sup>15</sup> Strict locality can be broken down into two different categories.<sup>16</sup> The first is a statewide standard in which the standard of care is compared to other physicians who practice in the same state.<sup>17</sup> Currently there are three states that follow the statewide locality standard.<sup>18</sup> The other, stricter category is the “community standard”

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7. Gail R. Wilensky, *The Policies and Politics of Creating a Comparative Clinical Effectiveness Research Center*, 28 HEALTH AFF. 719, 722–23 (2009).

8. See *infra* Part II.

9. See *infra* Part III.A.

10. See *infra* Part III.B.

11. See *infra* Part III.C.

12. See *infra* Part IV.

13. See *infra* Part IV.

14. See, e.g., *Smothers v. Hanks*, 34 Iowa 286 (1872); *Whitesell v. Hill*, 70 N.W. 750 (Iowa 1897).

15. E. Lee Schlender, *Malpractice and the Idaho Locality Rule: Stuck in the Nineteenth Century*, 44 IDAHO L. REV. 361, 361–362 (2008).

16. *Id.*

17. *Id.*

18. Lewis et al., *supra* note 1, at 2635. Arizona, Virginia, and Washington currently have a statewide locality standard. *Id.* This is a particularly interesting because all three states

in which physicians are judged against the manner that other physicians in the same community practice.<sup>19</sup> Currently only two states adhere to this standard.<sup>20</sup>

The similar locality rule is analogous to the strict locality rule, but instead of confining its examination to a specific geographic region, it includes physicians that are located in a similar location, within any state.<sup>21</sup> There are currently eleven states that apply the similar locality rule,<sup>22</sup> including Arkansas.<sup>23</sup> When determining the similar location of a physician, the court may examine many different elements including geography, population demographics, and even medically similar communities.<sup>24</sup> In Arkansas, to determine the similarity of communities, the court looks not only to the population of areas, “but rather upon their similarity from the standpoint of medical facilities, practices and advantages.”<sup>25</sup>

Over the years, most states have moved to a national standard of care.<sup>26</sup> The national standard of care requires physicians to render the same level of care that patients could expect in any part of the country.<sup>27</sup> Currently, thirty states and the District of Columbia adhere to a national standard.<sup>28</sup>

Not all states have a uniform standard of care. Five states have differing standard of care levels that depend upon whether the physician is a primary care physician or a specialist.<sup>29</sup> Primary care physicians are held to a locality standard, and specialists are held to a national standard of care.<sup>30</sup> This note will discuss this, and the reasons behind it, in more detail.

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have very large metropolitan areas on one side of the state and the other side is primarily rural and a large distance from urban areas with the most modern health care, which could lead to complications in determining the standard of care.

19. Schlender, *supra* note 15, at 369.

20. See Lewis et al., *supra* note 1, at 2635. Idaho and New York are the only two states that still adhere to the same community standard. *Id.*

21. *Id.* at 2634.

22. *Id.* at 2635. The states include Arkansas, Illinois, Kansas, Maryland, Michigan, Minnesota, Nebraska, North Carolina, North Dakota, Oregon, and Tennessee. *Id.*

23. See Dooley v. Cap-Care of Ark. Inc., 338 F. Supp. 2d 962, 966 (E.D. Ark. 2004).

24. Scott A. Behrens, Note, *Call in Houdini: The Time Has Come to be Released from the Geographic Straightjacket Known as the Locality Rule*, 56 *DRAKE L. REV.* 753, 769 (2008).

25. Gambill v. Stroud, 258 Ark. 766, 770, 531 S.W.2d 945, 948 (1976).

26. See Lewis et al., *supra* note 1, at 2634.

27. See Behrens, *supra* note 24, at 770.

28. See Lewis et al., *supra* note 1, at 2635.

29. See *id.* Colorado, Louisiana, Montana, Pennsylvania, and South Dakota have different standards of care for physicians and specialists. *Id.* Specialists are typically held to the heightened national standard of care because of the perceived greater level of knowledge they must maintain. *Id.*

30. *Id.*

## B. Development of the Locality Rule in Arkansas

Recently, the Arkansas Supreme Court declared section 16-114-206 of the Arkansas Code unconstitutional.<sup>31</sup> In *Broussard v. St. Edward Mercy Health System Inc.*,<sup>32</sup> the patient brought a medical malpractice suit against the physicians who treated her after a surgery.<sup>33</sup> The circuit court granted summary judgment to the defendant and Broussard appealed arguing that section 16-114-206 violated section 3 of amendment 80,<sup>34</sup> of the Arkansas Constitution.<sup>35</sup> The court held that the statutory language, “[b]y means of expert testimony provided only by a medical care provider of the same specialty as the defendant” violated the separation of powers doctrine by dictating to the courts what types of witnesses they could hear and ruled that the clause was severable.<sup>36</sup>

The locality rule in Arkansas has been around for almost a century. The first Arkansas case that applied the locality rule was *Dunman v. Raney*.<sup>37</sup>

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31. ARK. CODE ANN. § 16-114-206 (2012) (held unconstitutional in part by *Broussard v. St. Vincent*):

(a) In any action for medical injury, when the asserted negligence does not lie within the jury’s comprehension as a matter of common knowledge, the plaintiff shall have the burden of proving:

(1) By means of expert testimony provided only by a medical care provider of the same specialty as the defendant, the degree of skill and learning ordinarily possessed and used by members of the profession of the medical care provider in good standing, engaged in the same type of practice or specialty in the locality in which he or she practices or in a similar locality

(2) By means of expert testimony provided only by a medical care provider of the same specialty as the defendant that the medical care provider failed to act in accordance with that standard; and

(3) By means of expert testimony provided only by a qualified medical expert that as a proximate result thereof the injured person suffered injuries that would not otherwise have occurred.

*Id.*

32. 2012 Ark. 14, 386 S.W.3d 385.

33. *Id.*

34. ARK. CONST., amend LXXX, § 3 (stating that, “The Supreme Court shall prescribe the rules of pleading, practice and procedure for all courts; provided these rules shall not abridge, enlarge or modify any substantive right and shall preserve the right of trial by jury as declared in this Constitution.”).

35. *Broussard v. St. Edward Mercy Health Sys., Inc.*, 2012 Ark. 14, 386 S.W.3d 385.

36. *Id.* at 390; Andrew DeMillo, *Arkansas Lawmakers Weigh Competing Tort Reform Ideas*, INS. J. (Feb. 12, 2013), available at <http://www.insurancejournal.com/news/south-central/2013/02/12/280985.htm>. In the most recent Arkansas legislative session, a constitutional amendment was proposed to insert similar language, via constitutional amendment, that was held unconstitutional by the court. *Id.* This ballot measure, if approved, would be placed on the ballot to be ratified by Arkansans in the next statewide election. *Id.*

37. 118 Ark. 337, 176 S.W. 339 (1915).

The patient severely broke his leg and visited a physician, who set it and cared for it on repeated occasions.<sup>38</sup> The plaintiff's leg did not heal correctly and had to be amputated.<sup>39</sup> The facts were disputed as to whether the physician or the patient was at fault for the leg not healing correctly, and thus who was at fault for requiring the amputation.<sup>40</sup> In determining the standard of care that the physician owed to the patient, the court stated:

A physician or surgeon is not required to exercise the highest skill possible. He is only bound to possess and to exercise that degree of skill and learning ordinarily possessed and exercised by members of his profession in good standing, practicing in the same line and in the *same general neighborhood or in similar localities*.<sup>41</sup>

This case set the standard for determining where expert witnesses practice, which is still used in Arkansas medical malpractice cases today.<sup>42</sup>

The locality rule in Arkansas was directly challenged in the 1976 decision of *Gambill v. Stroud*.<sup>43</sup> In *Gambill*, the patient challenged the Arkansas locality rule, arguing the rule was outdated.<sup>44</sup> The defendant practiced in Jonesboro, Arkansas, and the witnesses testified as to the standard of care in Jonesboro, Little Rock, and Memphis.<sup>45</sup> Two of the five witnesses were physicians that had not practiced in Jonesboro, but they testified that they had taught continuing education classes all over the state and that they were familiar with the community and the standards of practice in the area, which were no different than in Little Rock or Memphis, thereby qualifying them as expert witnesses.<sup>46</sup>

The plaintiff argued that the locality rule was no longer applicable, citing small-town physicians' access to the same opportunities and resources as physicians in large cities and ability to stay abreast of advances in the industry.<sup>47</sup> The plaintiff listed advancements such as access to "the availability of the *Journal of the American Medical Association* and other journals, drug company representatives and literature, closed circuit television, special radio networks, tape recorded digests of medical literature, medical

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38. *Id.* at 340–42, 176 S.W. at 339.

39. *Id.*, 176 S.W. at 339.

40. *Id.*, 176 S.W. at 339.

41. *Id.* at 342, 176 S.W. at 339 (emphasis added).

42. *See, e.g.*, *Gambill v. Stroud*, 258 Ark. 766, 770, 531 S.W.2d 945, 952 (1976) (stating in the dissenting opinion that *Dunman v. Raney* established the standard).

43. *Id.*, 531 S.W.2d 945.

44. *Id.* at 769, 531 S.W.2d at 948.

45. *Id.*, 531 S.W.2d at 948.

46. *Id.* at 768–69, 531 S.W.2d at 947–48.

47. *Id.*, 531 S.W.2d at 947–48.

seminars and opportunities,” and opportunities to converse with physicians in larger cities.<sup>48</sup>

The court rejected this argument stating, “[h]owever desirable the attainment of this ideal may be, it remains an ideal.”<sup>49</sup> It reasoned that the time had not been reached when the education, research, and experience was available equally to every physician regardless of their location.<sup>50</sup> The court believed that while transportation and communication advancements had extended beyond the boundaries of the locality rule, they had not eliminated them entirely, therefore, the court upheld the locality rule.<sup>51</sup> The rule in *Gambill* still stands today, and is codified at Ark. Code Ann. section 16-114-206(a)(1).<sup>52</sup>

*Gambill* was not decided unanimously; there was a concurring opinion and two dissenting opinions.<sup>53</sup> The concurring opinion did not find the plaintiff’s argument to be without merit, but instead felt that it was not the court’s place to overturn the law because it was constitutional; instead, altering the law should be the task of the Arkansas General Assembly.<sup>54</sup>

The first dissent argued the locality rule was too restrictive.<sup>55</sup> Instead, it would have advanced a rule that considered the “size and character of the community” as one of many factors in determining whether the standard of care was met.<sup>56</sup> This would allow for variances in medical care to be taken into consideration, but would not constitute an overriding factor as with the current locality rule.<sup>57</sup>

The second dissent argued for the abolition of the locality rule.<sup>58</sup> According to Justice Roy, when the locality rule was conceived, there was little standardization in the education that physicians received and in many locations, “refresher” courses were non-existent.<sup>59</sup> He argued that because “[m]edical science recognizes no geographical boundaries” anymore, then a law that recognized geographical restrictions was outdated as well.<sup>60</sup>

In Arkansas, it has been codified that in any case in which medical malpractice is alleged and does not meet one of the three following enumerated exceptions, expert testimony must be given to demonstrate the standard

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48. *Gambill*, 258 Ark. at 768–69, 531 S.W.2d at 947–48.

49. *Id.* at 769, 531 S.W.2d at 948.

50. *Id.* at 769–770, 531 S.W.2d at 948.

51. *Id.* at 770, 531 S.W.2d at 951–52.

52. ARK. CODE ANN. § 16-114-206(a)(1) (2012).

53. *Gambill*, 258 Ark. at 770, 531 S.W.2d at 949.

54. *Id.* at 770-D, 531 S.W.2d at 951 (Byrd, J., concurring).

55. *Id.* at 770-E, 531 S.W.2d at 951–52 (Smith, J., dissenting).

56. *Id.*, 531 S.W.2d at 951.

57. *Id.*, 531 S.W.2d at 951.

58. *Id.* at 770-F, 531 S.W.2d at 951–52 (Roy, J., dissenting).

59. *Gambill*, 258 Ark. at 770, 531 S.W.2d at 952.

60. *Id.*, 531 S.W.2d at 952 (Roy, J., dissenting).

of care.<sup>61</sup> The first is *res ipsa loquitur*,<sup>62</sup> followed by information considered common knowledge to the jury,<sup>63</sup> and the last exception is breach of express warranty.<sup>64</sup> If one of these conditions is not met, then expert testimony is required.<sup>65</sup>

### III. ARGUMENT

The next section will discuss the significant societal changes that have occurred since the *Gambill* decision that could lead to a reconsideration of the current locality rule in Arkansas. In addition, the section will discuss how the locality rule could have a negative medical outcome for patients and examine the locality rule against modern views of medical ethics.

Since the *Gambill* decision in 1976, there have been many great changes in education, communication, and technology that allow for the free flow of medical information—the key reasons the Arkansas Supreme Court upheld the locality rule when it was challenged in *Gambill*.<sup>66</sup> The ruling in *Broussard* gives the Arkansas General Assembly the opportunity to modernize Arkansas's standard of care rule because it must pass a bill to amend section 16-114-206. The Arkansas Supreme Court found that the unconstitutional clause is severable; thus lawmakers could simply strike the language.<sup>67</sup> While that is a viable option, it would serve the best interests of the courts, the medical community, and the state if the legislature modernized

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61. ARK. CODE ANN. § 16-114-206 (2012) (held unconstitutional in part by *Broussard v. St. Edward Mercy Health Sys., Inc.*, 2012 Ark. 14, 386 S.W.3d 385) (citations omitted).

62. *See, e.g.*, *Schmidt v. Gibbs*, 305 Ark. 383, 389, 807 S.W.2d 928, 932 (1991) (*Res ipsa loquitur* in Arkansas applies when: 1) a duty of care is owed to the plaintiff; 2) the injury is caused by something or someone in exclusive control of the defendant; 3) the event is something that does not ordinarily occur without negligence; and 4) there is no evidence to the contrary. *Id.* at 387, 807 S.W.2d at 931. If these four elements are met, then the proceedings do not require the testimony of an expert witness. *Id.* at 390–91, 807 S.W.2d at 932–33. If any of the elements are absent, then an expert witness is required. *Id.*, 807 S.W.2d at 932–33.).

63. *See, e.g.*, *Lanier v. Trammell*, 207 Ark. 372, 377–78, 180 S.W.2d 818, 820–21 (1944) (holding that when it is undisputed that specialists necessarily and properly follow routine sterilization procedures, expert testimony is not needed).

64. *See, e.g.*, *Haase v. Starnes*, 323 Ark. 263, 281, 915 S.W.2d 675, 684 (1996) (holding that a physician cannot be held liable in a malpractice suit if he acted with a sufficient standard of care, the treatment was unsuccessful, and the patient subsequently brings a breach of contract suit because the issue is primarily a contract issue, and therefore doesn't require expert testimony).

65. *See Schmidt*, 305 Ark. at 389, 807 S.W.2d at 932.

66. *Gambill v. Stroud*, 258 Ark. 766, 769, 531 S.W.2d 945, 948 (1976).

67. *Broussard v. St. Edward Mercy Health Sys. Inc.*, 2012 Ark. 14, at 8, 386 S.W.3d 385, 390.

the law to join the majority of other states that do not currently have a locality rule for determining the standard of care in medical malpractice cases.<sup>68</sup>

Arkansas could update its locality rule in a way that differentiates between professional expertise and resource availability when determining the standard of care, similar to what other states, including Mississippi, have done.<sup>69</sup> In the alternative, Arkansas could move to a national standard of care for claims of malpractice involving medical expertise.<sup>70</sup> When the claim concerns resource availability, such as availability of tests or specific facilities, then it would be in the best interests of doctors and patients for Arkansas to maintain a locality rule because it may be impractical for a physician to order tests that are unavailable locally, thereby causing extreme hardship for the patient. The legislature should take that into consideration when determining the standard of care as similar to Mississippi.<sup>71</sup> A resource availability argument made by a plaintiff could still require the use of expert testimony from physicians from similar localities to help determine if a particular test or treatment would typically have been ordered. The *Hall* court determined that differentiating between expertise and resource availability was an ideal way to approach the locality rule and supplied the following language for the determination of a standard of care:

The duty of care, as it thus emerges from considerations of reason and fairness, when applied to the facts of the world of medical science and practice takes two forms: (a) a duty to render a quality of care consonant with the level of medical and practical knowledge the physician may reasonably be expected to possess and the medical judgment he may be expected to possess and the medical judgment he may be expected to exercise, and (b) a duty based upon the adept use of such medical facilities, services, equipment and options as are reasonably available.<sup>72</sup>

The Arkansas Legislature could improve the state of healthcare in Arkansas by adopting language similar to Mississippi's, which differentiates between medical expertise and resource availability.<sup>73</sup> This section will first show that the locality rule promotes poor medical outcomes.<sup>74</sup> Next, it will show that there have been significant advancements in education and technology since the *Gambill* decision.<sup>75</sup> Finally, it will show that the locality rule contradicts leading theories of medical ethics.<sup>76</sup>

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68. See *infra* Part III.A–C.

69. See *Hall v. Hilbun*, 466 So.2d 856, 872 (Miss. 1985).

70. See *id.*

71. *Id.*

72. *Id.*

73. *Id.*

74. See *infra* Part II.A.

75. See *infra* Part II.B.

76. See *infra* Part II.C.

### A. Improved Medical Outcomes

Physicians are uniquely positioned to determine what is acceptable medical care and what is not.<sup>77</sup> The ability to determine what is acceptable medical care, paired with differing locality rules, allows for multiple standards of care across different regions of the country or even within individual states.<sup>78</sup> This has been said to create a “Balkaniz[ation]” of the medical profession.<sup>79</sup> At the time of its inception, the locality rule served an important purpose, however, the advancements in communication, technology, transportation, and continuing education requirements have since rendered the rule out of date and in need of modernization.<sup>80</sup> This argument first appeared as early as 1968 in *Douglas v. Bussabarger*,<sup>81</sup> where the Washington Supreme Court cited ease of transportation, seminars, and ease of communication in concluding that “there is no longer any basis in fact for the ‘locality rule’”.<sup>82</sup>

Protecting doctors from the threat of malpractice suits when they do not use the most diligent standard of care is bad public policy.<sup>83</sup> If a physician holds herself out as an expert in her field, she should actively seek out the newest and best treatments for her patients, but not all physicians do.<sup>84</sup> Moving to a national standard of care gives physicians an additional incentive to provide the best and most up-to-date care for their patients by decreasing the protections created by the locality rule.<sup>85</sup>

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77. Franklin D. Cleckley & Govind Hariharan, *A Free Market Analysis of the Effects of Medical Malpractice Damage Cap Statutes: Can We Afford to Live with Inefficient Doctors?*, 94 W. VA. L. REV. 11, 66–68 (1991).

78. See James F. Blumstein, *The Legal Liability Regime: How Well Is It Doing in Assuring Quality, Accounting for Costs, and Coping with an Evolving Reality in the Health Care Marketplace?*, 11 ANNALS HEALTH L. 125, 135 (2002).

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

80. *Id.* at 796.

81. 438 P.2d 829, 837–38 (Wash. 1968). The court reasoned that:

Modern means of transportation permit country doctors to attend up-to-date medical seminars; the general circulation of medical journals makes new developments readily available to them, and they can easily and quickly communicate with the most modern and up-to-date medical centers in cities throughout the United States. As has been pointed out, today’s rural practitioner can and does give and receive advice transmitted thousands of miles over the telephone, and he is expected to keep himself apprised of recent developments as they are regularly published in medical journals.

*Id.* at 837 (citing F. Spies, *Arkansas Model Jury Instructions: Malpractice*, 20 ARK. L. REV. 86 (1966)).

82. *Id.* at 838.

83. See Lewis et al., *supra* note 1, at 2634–36.

84. *Id.*

85. *Id.*

Conversely, the locality rule could also make the physician vulnerable to unnecessary malpractice actions if the standard of care used in the locality is more rigorous than the national standard of care.<sup>86</sup> If a physician practices in different regions, then she makes herself vulnerable to potential legal risks for exercising her best judgment rather than conforming to local practices.<sup>87</sup> In such a case, a physician could potentially be punished for using a consistent standard of care if she travels to another location where the standard of care is different, even if the patient's symptoms and condition mirror patients that she has treated elsewhere.<sup>88</sup>

Over the last fifteen years, there has been a movement to promote outcomes research through evidence based medicine and create systems to distribute the information to physicians to improve their practices.<sup>89</sup> When the 2008 stimulus bill was passed, \$1.1 billion was earmarked to further medical outcomes systems.<sup>90</sup> Prior to the stimulus bill, two pieces of legislation were passed to help advance comparative research: the Comparative Effectiveness Research Act and the Children's Health and Medical Protection Act.<sup>91</sup> The purpose of these measures was to create a center to gather information concerning healthcare practices and interventions throughout the country and to house them in one system.<sup>92</sup> There the information could be analyzed and then disseminated to the medical community.<sup>93</sup>

Medical outcomes could be improved in Arkansas if the Arkansas General Assembly would consider adopting the national locality rule. Physicians would have an additional incentive to remain current in their fields. This goal has become much more attainable with additional federal programs, as well as the numerous technological advancements as discussed in the next section.

## B. Educational and Technological Advancements

When the locality rule was first introduced, there was little to no uniformity in the education that physicians received.<sup>94</sup> In some instances, one could become a physician with little education past high school, subsequently practice in an area with little continuing contact with the medical com-

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86. *Id.* at 2636.

87. *Id.*

88. *Id.*

89. *See* Wilensky, *supra* note 7, at 722.

90. *Id.* at 719.

91. *Id.* at 722.

92. *Id.*

93. *Id.*

94. *See* Behrens, *supra* note 24, at 757.

munity, and have very few opportunities to ever learn new techniques.<sup>95</sup> This could lead to major differences in practice from area to area, even from town to town.<sup>96</sup> Over time, there have been efforts by the American Medical Association to standardize education requirements throughout the country, including stipulations such as attending continuing education classes.<sup>97</sup>

Technology has also advanced tremendously since the locality rule was enacted in Arkansas. When many states migrated to a national standard of care in the 1970s, many cited the increase of technology as a leading principle.<sup>98</sup> This was before personal computing, the Internet, or electronic health records were ever imagined, which allow physicians to better retrieve information to make correct diagnoses, to treat patients, and to communicate with other medical professionals.<sup>99</sup>

In 1976, computers were still items that seemed closer to science fiction than personal use.<sup>100</sup> Today computers are in virtually every physician's office in the nation, and each physician is likely to have a phone in her pocket that has more computing power than many super computers that once took up entire rooms.<sup>101</sup>

Due to the abundance of smartphones and the prevalence of the Internet, physicians have access to a seemingly endless supply of medical journals, research information, and other forms of medical expertise.<sup>102</sup> No longer is a physician left on an intellectual island to make a decision. Medical information is so easily accessible that many patients have already researched their symptoms and self-diagnosed their illnesses before they step foot into a doctor's office.<sup>103</sup>

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95. *Id.*

96. *See* Gambill v. Stroud, 258 Ark. 766, 770, 531 S.W.2d 945, 948 (1976).

97. *See* Behrens, *supra* note 24, at 757–58.

98. *See* Schlender, *supra* note 15, at 367–72.

99. *See* Behrens, *supra* note 24, at 770–71.

100. *See Exhibits*, COMPUTER HIST. MUSEUM, <http://www.computerhistory.org/timeline/?year=1976> (last visited Nov. 26, 2012).

101. *See* Nancy Gibbs, *Your Life is Fully Mobile*, TIME MAG. (Aug. 16, 2012), available at <http://techland.time.com/2012/08/16/your-life-is-fully-mobile/> (noting that nine out of ten adults carry a cell phone and that a single smart phone has more computational power than the entire Apollo 11 space mission that successfully landed humans on the moon); *Exhibits*, COMPUTER HIST. MUSEUM, <http://www.computerhistory.org/timeline/?year=1976> (last visited Nov. 26, 2012) (noting that the fastest computer of the day took up 58 cubic feet and weighed 5,300 pounds).

102. *See* Adrian Lee, *40 Years of the Mobile Phone: Top 20 Facts*, EXPRESS (Apr. 3, 2013) <http://www.express.co.uk/news/science-technology/388974/40-years-of-the-mobile-phone-Top-20-facts>.

103. Matthew I. Trotter & David W. Morgan, *Patients' Use of the Internet for Health Related Matters: A Study of Internet Usage in 2000 and 2006*, 14 HEALTH INFORMATICS J. 175 (2008) (finding that the number of patients that used the internet to look up health information increased in the author's clinic from 43% in 2000 to 70% in 2006, a very significant increase in just six years).

Recently, the use of telemedicine has also increased in Arkansas.<sup>104</sup> Currently in Arkansas, there are over 400 telemedicine<sup>105</sup> units around the state.<sup>106</sup> These units allow patients to go to a unit located near them and communicate with a physician in another part of the state or even outside of the state.<sup>107</sup> This type of technology was unimaginable in its current form when *Gambill* was decided in 1976.<sup>108</sup>

The use of telemedicine presents new challenges to the locality rule. If there is a claim of medical malpractice, whose location is used to determine the appropriate standard of care? Will the location where the patient was seen be used or will the location where the physician is located be used? These issues have not been addressed by a court that still adheres to the locality rule, and it is unclear how a court would address these questions.

### C. Medical Ethics Concerns

The current locality rule in Arkansas does not coincide with the major theories in medical ethics because it fails to promote the best physician behavior.<sup>109</sup> This section will examine some of the most prevalent views in bioethics—the Morality View, Utilitarianism, Kantian Moral Imperative, and Principlism—and illustrate how the locality rule conflicts with all of them.

At its most basic level, the Morality View applies only to a person's behavior toward others.<sup>110</sup> The Morality View defines what is right by creating a duty between actors.<sup>111</sup> The underlying foundation of this duty is mutual respect.<sup>112</sup> The duty is created by the valid expectations that others have

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104. See Carol Bynum, *UAMS Rural Hospital Program Reaching out through Telemedicine*, ONLINE NEWSL. FOR ARK. DISTANCE LEARNING (Spring 2009), available at <http://ardla.org/Newsletter/1-2/1-2--Bynum.htm>.

105. *What is Telemedicine?*, AM. TELEMED. ASS'N, [http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.VD\\_q81ZVCik](http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.VD_q81ZVCik) (last visited Feb. 22, 2012). Telemedicine is the exchange of medical information electronically between medical personnel and the patient. *Id.* While it can take many forms, the fastest emerging and most efficient method is a two way conference between the physician and the patient. *Id.* This can be accomplished via smart phones or other internet communication methods such as Skype. *Id.* This allows patients in rural settings to get medical advice from professionals from across the country that the patient ordinarily would not have access to. *Id.*

106. ARK. TELEMED., <http://arkansastelemedicine.com> (last visited Nov. 26, 2012).

107. *Id.*

108. *Id.*

109. See Lewis et al., *supra* note 1, at 2636 (explaining that the locality rule may violate basic ethical principles).

110. BERNARD GERT ET AL., *BIOETHICS: A SYSTEMATIC APPROACH* 21–22 (2d ed. 2006).

111. *Id.* at 21.

112. H. TRISTRAM ENGELHARDT, *THE FOUNDATIONS OF BIOETHICS* 117 (2d ed. 1996).

come to count on in the medical profession.<sup>113</sup> The Morality View is most concerned with achieving what is good for the individual person.<sup>114</sup> When a patient sees a physician she expects to receive medical care that is of the highest quality.<sup>115</sup> This relationship between the physician and the patient creates a duty that the doctor will provide a certain standard of care.<sup>116</sup> To provide anything less than that standard of care, the physician will have breached his duty, therefore violating the Morality View.<sup>117</sup>

Utilitarianism, one of the earlier medical ethical frameworks states that “[a]ctions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness.”<sup>118</sup> Every person is valued the same, so the right action is one that produces the most happiness for the largest group of people.<sup>119</sup> In the context of medical decision making, this note proposes that the word “happiness” can be replaced with “health benefit.” Simply put, utilitarianism is acting in a way that furthers the best interests of a community.<sup>120</sup> The community can be society as a whole, a more localized community such as the community in which a person is physically located, or the medical community.<sup>121</sup>

When a physician does not keep up with the best practices in her field, she does not further the best interest of her communities and may in fact cause harm.<sup>122</sup> The medical field is ever-evolving, and it is the physician’s duty to stay up to date with its practices.<sup>123</sup> If a physician is negligent in doing so, she causes harm to her physical community because she does not provide the best medical care she can.<sup>124</sup> This lack of care could potentially hurt the individual, which will possibly make her less productive for her family and society. Physicians also hurt the overall medical community by failing to remain current and failing to work to advance the best practices as determined by the medical community as a whole.<sup>125</sup> A physician also has a

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113. GERT ET AL., *supra* note 110, at 91.

114. See ENGELHARDT, *supra* note 112, at 117.

115. See Lewis et al., *supra* note 1, at 2636.

116. GERT ET AL., *supra* note 110, at 90.

117. *Id.* at 91.

118. RONALD MUNSON, INTERVENTION AND REFLECTION: BASIC ISSUES IN MEDICAL ETHICS 743 (8th ed. 2006) (quoting JOHN STUART MILL, UTILITARIANISM (1863)).

119. *Id.*

120. See *id.* at 743–50.

121. *Id.* at 744

122. *Declaration of Professional Responsibility: Medicine’s Social Contract with Humanity*, AM. MED. ASS’N (2001), available at <http://www.ama-assn.org/resources/doc/ethics/decoprofessional.pdf> (indicating that it is the physician’s role to “[w]ork freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being”).

123. *Id.*

124. *Id.*

125. *Id.*

duty to try to advance her profession.<sup>126</sup> By failing to keep up with recent developments in the field and apply contemporary practices, a physician holds the profession back by continuing to practice on an outdated knowledge base.<sup>127</sup>

The third ethical viewpoint, the Kantian Moral Imperative, states that for an act to be considered moral, one should act only in a way that the individual would will to be universal law, in other words, only act in a way you would want everyone else to behave in the same circumstance.<sup>128</sup> Immanuel Kant argues that an action is given moral worth if it is done for the sake of duty.<sup>129</sup> In the legal sense, using Kant's reasoning, Arkansas physicians potentially act in a way that violates their duty if they do not show due diligence in keeping up with the best practices in their field.<sup>130</sup> This violation of duty goes against the categorical imperative because they are not acting in a way they would want all other physicians to act.<sup>131</sup>

Principlism is one of the most well-known and respected theoretical models of bioethics in which there are four main principles of medical ethics, and all four should be considered and weighed against each other when making a decision.<sup>132</sup> The first principle is respect for autonomy.<sup>133</sup> Beauchamp and Childress define autonomy as "self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice."<sup>134</sup>

The locality rule could impose a significant burden on a patient's autonomy by restricting their options. Physicians should be able to inform patients what the options are when treating their maladies.<sup>135</sup> If the physician has not done her duty to stay current with the changing medical field, she may not be able to accurately represent to her patient what all the options are.<sup>136</sup> This could lead to a patient agreeing to a procedure that is not the best

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126. *Id.*

127. *Id.*

128. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 348–53 (5th ed. 2001).

129. Lawrence M. Hinman, *A Pluralistic Approach to Moral Issues*, in *MEDICAL ETHICS: APPLYING THEORIES AND PRINCIPLES TO THE PATIENT ENCOUNTER* 23, 31 (Matt Weinberg ed., 1st ed. 2001).

130. *See id.*

131. *Id.* at 31–32 (generally stating that one should act in a way that would be universally acceptable by all in the same position).

132. *See generally* BEAUCHAMP & CHILDRESS, *supra* note 128.

133. *Id.* at 58.

134. *Id.*

135. *See* Lewis et al., *supra* note 1, at 2636 (explaining that physicians may be forced to make decisions for their patients based on what is acceptable in the location, instead of presenting the patient with options or doing what is considered best nationally).

136. *Id.*

for her symptoms because she is uninformed about other potentially available options.<sup>137</sup>

The second element of Principlism, beneficence, can simply be defined as “do good.”<sup>138</sup> Beneficence is rooted firmly in the Hippocratic Oath that physicians will “come for the benefit of the sick,” and will administer treatments “for the benefit of the sick according to [their] ability and judgment” and “will keep [patients] from harm and injustice.”<sup>139</sup> The idea of beneficence is framed through mutual understandings between particular groups, in this case patient and physician.<sup>140</sup> It has a quasi-contractual element to it; the patient submits herself to the care of the physician to receive a benefit from the medical profession, which she assumes is the best medical care.<sup>141</sup> While a physician that has not performed her duty to stay informed on advancements in her field may still be “doing good” when she treats a patient, she does not maximize the good for society or her profession when she does not treat a patient that is to the best of her and her profession’s ability, which is required by the American Medical Association Professional Responsibility Requirements.<sup>142</sup>

The third principle is non-maleficence, which “asserts an obligation not to inflict harm on others . . . [and] it has been associated with the maxim *Primum non nocere*: ‘above all do not harm.’”<sup>143</sup> Harm can occur without malicious or harmful intent.<sup>144</sup> In many cases, physicians can be causally responsible even if they were unaware that they caused harm.<sup>145</sup> Both intentional and unintentional negligence is usually considered blameworthy.<sup>146</sup> Some ethicists argue that this obligation of non-maleficence is stronger than that of beneficence.<sup>147</sup>

A physician has the duty to remain up to date with the most beneficial treatments, but adherence to the Arkansas locality rule allows her to ignore most beneficial treatments, either intentionally or unintentionally, because it is not what is used in the locality.<sup>148</sup> Instead of focusing on what the devel-

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137. *Id.*

138. See BEAUCHAMP & CHILDRESS, *supra* note 128, at 165–75.

139. *Id.* at 173 (quoting THE HIPPOCRATIC OATH).

140. See ENGELHARDT, *supra* note 112, at 112.

141. *Id.* at 128.

142. See *Declaration of Professional Responsibility*, *supra* note 122.

143. See BEAUCHAMP & CHILDRESS, *supra* note 128, at 113.

144. *Id.* at 117.

145. *Id.*

146. *Id.*

147. See ENGELHARDT, *supra* note 112, at 110.

148. See, e.g., *Broussard v. St. Edward Mercy Health Sys., Inc.*, 2012 Ark. 14, 386 S.W.3d 385.

opments are nationally, Arkansas physicians must abide by what is being used in similar localities.<sup>149</sup>

This raises an interesting question: how does the standard of care ever evolve under the locality rule? If a standard of care is established in a similar locality, if a physician ever adopts a new procedure that differs from the standard, then she could be potentially liable for malpractice if an action is brought against her, even if her treatment has been shown to be more beneficial. To prove that the standard of care was appropriate, the doctor would have to find a physician in a similar locality, which would likely have to be in a different state that adheres to a national standard of care since the majority of states now adhere to a national standard.

The final principle, justice, is that which is considered fair, equitable, and appropriate treatment of what is due or owed to a person.<sup>150</sup> At the heart of the principle of justice is that “[s]imilar cases ought to be treated in similar ways.”<sup>151</sup> At its essence, the locality rule violates the justice principle because similar medical cases can be treated differently, based on the simple fact that their geographic location somehow makes their medical condition different.<sup>152</sup>

Arkansas’s current use of the locality rule is not consistent with the most prevalent views of medical ethics. The Arkansas General Assembly should correct this issue by ratifying the more modern national standard of care for medical expertise.

#### IV. CONCLUSION

When the Arkansas Legislature amends section 16-114-206 to remove the unconstitutional provision, it should change the law to bring Arkansas’s malpractice standard of care statute in line with the majority of the country. The educational, transportation, communication, and technological advancements have increased significantly since *Dunman* in 1915.<sup>153</sup> There have even been significant increases since *Gambill* was decided in 1976.<sup>154</sup>

The ruling in *Broussard* gives the Arkansas General Assembly a great opportunity to make these changes and modernize Arkansas law.<sup>155</sup> Doing so will promote better medical outcomes by having a consistent standard of

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149. See, e.g., *id.*

150. See BEAUCHAMP & CHILDRESS, *supra* note 128, at 226.

151. See MUNSON, *supra* note 118, at 775.

152. See Lewis et al., *supra* note 1, at 2636.

153. See *supra*, Part III.B.

154. See *supra*, Part III.B.

155. See *Broussard v. St. Edward Mercy Health Sys., Inc.*, 2012 Ark. 14, 386 S.W.3d 385.

care. Lastly, modernizing the law will bring the Arkansas statute in line with modern views of medical ethics.

*Jarred Kibbey\**

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\* J.D. expected December 2014, University of Arkansas at Little Rock, William H. Bowen School of Law; Masters in Public Health expected December 2014, University of Arkansas for Medical Sciences; Certificate in Bioethics and Health Policy, Loyola University Chicago, 2008; Bachelor of Science in Political Science, University of Central Arkansas, 2006. The author would like to thank his wife, Paige, for her support during this entire note-writing process.