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Medical Malpractice Standard of Care: The Same or Similar Localities Rule Revisited

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NOTE: MEDICAL MALPRACTICE STANDARD OF CARE: THE SAME OR SIMILAR LOCALITIES RULE REVISITED

Following presurgical administration of anesthetic, plaintiff suffered cardiac and respiratory arrests, resulting in severe, irreversible brain damage. After a lengthy trial, the jury found for the defendant. The Arkansas Supreme Court reversed, holding that the jury instruction¹ defining the standard of care for a physician or surgeon was no longer valid in Arkansas. The instruction described the standard as the degree of skill and learning ordinarily possessed and used by members of the profession in good standing, engaged in the same type of practice or specialty in the same or a similar locality.² With three judges dissenting, the court broadened the standard to the degree of skill and care of the average qualified practitioner, with locally available medical resources to be considered as only one circumstance in determining the degree of skill and care required, and held the modified standard applicable to defendant. On rehearing two months later, the court reversed itself and, in a substituted opinion, reinstated the same or similar localities rule. *Gambill v. Stroud*, 258 Ark. 766, 531 S.W.2d 945 (1976), *rev'g on rehearing*, 258 Ark. Adv. Sh. 766, 529 S.W.2d Adv. Sh. 330 (1975).³

The locality of a physician's practice was first used as one crite-

1. Arkansas Model Jury Instructions Civil 2d, 1501 (1974) [hereinafter cited as AMI 1501].

2. *Id.* The instruction says,

In [diagnosing the condition of] [treating] [operating upon] a patient a [physician] [surgeon] [dentist] must possess, and, using his best judgment, apply with reasonable care the degree of skill and learning ordinarily possessed and used by members of his profession in good standing, engaged in the same [type of practice] [specialty] in the locality in which he practices, or in a similar locality.

A failure to meet this standard is negligence.

When the plaintiff alleges that the physician failed to apply the required degree of skill and learning, an additional instruction should be given as follows: "In deciding whether _____ applied the degree of skill and learning which the law required of him, you may consider only the evidence presented by the (physicians) and (surgeons) (dentists) called as expert witnesses." *Id.*

3. The cases are hereinafter cited as *Gambill II* and *Gambill I*, respectively. *Gambill I*, handed down Nov. 3, 1975, was reported in 258 Ark. Adv. Sh. 766, 529 S.W.2d Adv. Sh. 330. *Gambill II*, handed down Jan. 26, 1976, was printed in the bound volume of Arkansas Reports, 258 Ark. 766, and *Gambill I* was withdrawn from the bound volume of 529 S.W.2d. Both decisions were 4-3. In the first, Justice Smith wrote the majority opinion, with Chief Justice Harris and Justices Fogleman and Holt dissenting. On rehearing, Justice Byrd changed his position, writing a concurring opinion. Justice Fogleman wrote the majority opinion for the second decision, and Justices Smith, Roy, and Jones dissented.

tion in setting the standard of care in *Small v. Howard*.⁴ In that 1880 Massachusetts case, the court held that a general practitioner in a small town was not required to exercise the same surgical skill as a specialist in a large city.⁵ That "same or similar localities" rule has subsequently been interpreted in various jurisdictions as ranging from the standard in the town in which the physician is practicing (the strict locality rule, now apparently all but discarded)⁶ to a broader rule including other towns of about the same size or with the same available medical facilities (the similar localities rule).⁷

In 1968 the Massachusetts court, recognizing modern developments in transportation, communication, and medical education, expressly overruled *Small* and liberalized the rule.⁸ Citing similar holdings in other jurisdictions,⁹ the court held in *Brune v. Belinkoff* that

[t]he proper standard is whether the physician, if a general practitioner, has exercised the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession. In applying this standard it is permissible to consider the medical resources available to the physician as *one* circumstance in determining the skill and care required. Under this standard some allowance is thus made for the type of community in which the physician carries on his practice.

One holding himself out as a specialist should be held to the standard of care and skill of the average member of the profession practising the specialty. And, as in the case of the general practitioner, it is permissible to consider the medical resources available to him.¹⁰

Although jurisdictions vary in their interpretation and application of the localities rule, the general rule in medical malpractice cases is that the standard of care and any finding of negligence must

4. 128 Mass. 131 (1880).

5. *Id.* at 136.

6. W. Prosser, *The Law of Torts* § 32 (4th ed. 1971). The strict locality rule has been upheld in *Gandara v. Wilson*, 85 N.M. 161, 509 P.2d 1356 (1973), and *Foreman v. Ver Brugghen*, 81 Nev. 86, 398 P.2d 993 (1965). No other jurisdiction has been found to be now following this rule.

7. W. Prosser, *supra* note 6, § 32; Restatement (Second) of Torts § 299A, Comment g (1965) [hereinafter cited as Restatement].

8. *Brune v. Belinkoff*, 354 Mass. 102, 235 N.E.2d 793 (1968).

9. *Id.* at 107-08, 235 N.E.2d at 797 (citing *McGulpin v. Bessmer*, 241 Iowa 1119, 43 N.W.2d 121 (1950); *Viita v. Dolan*, 132 Minn. 128, 155 N.W. 1077 (1916); *Pederson v. Dumouchel*, 72 Wash. 2d 73, 431 P.2d 973 (1967) (physicians); *Carbone v. Warburton*, 11 N.J. 418, 94 A.2d 680 (1953); *Hundley v. Martinez*, 151 W. Va. 977, 158 S.E.2d 159 (1967) (specialists)).

10. *Brune v. Belinkoff*, 354 Mass. 102, 109, 235 N.E.2d 793, 798 (1968).

be based on expert medical testimony.¹¹ One notable exception is the case in which the physician's lack of skill or care is so obvious that it is within the jury's common knowledge and experience.¹² Therefore, while the surface issue arising out of any form of the localities rule is the parameters of medical standards to which a physician may be held, a significant underlying problem, especially for the plaintiff, lies in determining who can testify as an expert witness. For instance, under the strict locality rule, only doctors familiar with the medical practices in the defendant's own community may testify.¹³ It has often been noted that a "conspiracy of silence" operates to prevent physicians practicing in the same community from testifying to a colleague's incompetence or negligence.¹⁴ However, under the similar localities rule, physicians familiar with medical practices in communities similar to that of the defendant may testify to the standards in all such communities.¹⁵

Prior to the *Gambill* decisions, the Arkansas court had consis-

11. *Jeanes v. Milner*, 428 F.2d 598, 601 (8th Cir. 1970) (applying Arkansas law); *Gambill II*, 258 Ark. 766, 770-B, 531 S.W.2d 945, 949 (1976); W. Prosser, *supra* note 6, § 32; 7 J. Wigmore, *Evidence in Trials at Common Law* § 2090 (3rd ed. 1940).

12. *Lanier v. Trammell*, 207 Ark. 372, 377, 180 S.W.2d 818, 823 (1944) (failure of a physician to sterilize his instruments and wash his hands before performing surgery); *Steele v. Woods*, 327 S.W.2d 187 (Mo. 1959); *Mehigan v. Sheehan*, 94 N.H. 274, 51 A.2d 632 (1947); *Frederickson v. Maw*, 119 Utah 385, 227 P.2d 772 (1951); W. Prosser, *supra* note 6, § 32. Recent Arkansas cases in which the issue has been raised appear to have been decided on a case-by-case basis. *Compare Davis v. Kemp*, 252 Ark. 925, 481 S.W.2d 712 (1972) (patient could not recover without expert testimony that physician's failure to probe wound, find piece of glass, and administer antibiotics in initial treatment was negligent) with *Pry v. Jones*, 253 Ark. 534, 487 S.W.2d 696 (1973) (expert testimony not required to prove that severance of ureter during removal of ovary was negligent) and *Graham v. Sisco*, 248 Ark. 6, 449 S.W.2d 949 (1970) (expert testimony not required to prove injuring unborn child during Caesarean delivery was negligent).

13. *Lockart v. Maclean*, 77 Nev. 210, 361 P.2d 670 (1961); *Gandara v. Wilson*, 85 N.M. 161, 509 P.2d 1356 (1973).

14. *McGulpin v. Bessmer*, 241 Iowa 1119, 1130, 43 N.W.2d 121, 127 (1950); *Sampson v. Veenboer*, 252 Mich. 660, 667, 234 N.W. 170, 172 (1930); *Pederson v. Dumouchel*, 72 Wash. 2d 73, 77-78, 431 P.2d 973, 977 (1967); Belli, *An Ancient Therapy Still Applied: The Silent Medical Treatment*, 1 Vill. L. Rev. 250 (1956); Markus, *Conspiracy of Silence*, 14 Clev.-Mar. L. Rev. 520, 522 (1965); Seidelson, *Medical Malpractice Cases and the Reluctant Expert*, 16 Cath. U.L. Rev. 158 (1966); 77 Harv. L. Rev. 333, 336-38 (1963). For an extreme example of a court's reaction to refusal of medical personnel to testify about the cause of an injury alleged to have occurred in surgery, see *Ybarra v. Spangard*, 25 Cal. 2d 486, 154 P.2d 687 (1944), in which the court held multiple defendants liable under the doctrine of *res ipsa loquitur* because the plaintiff "would be entirely unable to recover unless the doctors and nurses in attendance voluntarily chose to disclose the identity of the negligent person and the facts establishing liability." *Id.* at 490, 154 P.2d at 689.

15. *Murphy v. Dyer*, 409 F.2d 747 (10th Cir. 1969) (applying Colorado law); *DiFilippo v. Preston*, 53 Del. 539, 173 A.2d 333 (1961); *Cook v. Lichtblau*, 144 So.2d 312 (Fla. App. 1962); *Michael v. Roberts*, 91 N.H. 499, 23 A.2d 361 (1941). See generally Annot., 37 A.L.R.3d 420 (1971); Annot., 8 A.L.R.2d 772 (1949).

tently held that the standard of care for physicians was based partially on locality, but it had never clearly defined the scope of the geographical area to be considered. The similar localities rule was first adopted in Arkansas in 1915 in *Dunman v. Raney*,¹⁶ in which the court held that the standard was that of the skill and care of practitioners "in the same general neighborhood or in similar localities."¹⁷ Applying the rule in 1933 in *Gray v. McDermott*,¹⁸ the court used only the term "neighborhood"¹⁹ and omitted "similar localities," although it cited *Dunman* and did not indicate an intent to narrow the *Dunman* rule. A year later, in *Burton v. Tribble*,²⁰ the court cited *Gray* but substituted the word "community" for "neighborhood."²¹ In *Walls v. Boyett*²² the court cited both *Dunman* and *Gray* for the proposition that the standard was well settled.²³ No recognition was given to the fact that *Dunman* prescribed the similar localities rule, while *Gray* appears to prescribe the strict locality rule.

In *Gambill I*, citing only AMI 1501 and with no reference to Arkansas case law,²⁴ the court clearly rejected the conventional similar localities rule and adopted verbatim the *Brune*²⁵ standard as "so much the best of the alternative [localities] rules" for both general practitioners and specialists.²⁶ The court noted that both the strict locality and similar localities rules have been rejected in a number of jurisdictions²⁷ and found further authority for the abandonment

16. 118 Ark. 337, 176 S.W. 339 (1915).

17. *Id.* at 346, 176 S.W. at 342. The entire *Dunman* rule is,

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. He must use reasonable care in the exercise of his skill and learning, and act according to his best judgment in the treatment of his patients.

Id.

18. 188 Ark. 1, 64 S.W.2d 94 (1933).

19. *Id.* at 3, 64 S.W.2d at 95-96. The court's reasoning in *Gray* included the following statement:

It may be that some outstanding surgeon could have or would have done something . . . that was not done by these physicians, but this is purely speculative Moreover, this is not the test to be applied in cases of this kind. Reasonable care, skill and learning is all this [*sic*] is required.

Id. at 6, 64 S.W.2d at 96.

20. 189 Ark. 58, 70 S.W.2d 503 (1934).

21. *Id.* at 60, 70 S.W.2d at 504.

22. 216 Ark. 541, 226 S.W.2d 552 (1950).

23. *Id.* at 547, 226 S.W.2d at 556.

24. *Gambill I*, 258 Ark. Adv. Sh. 766, 767, 529 S.W.2d Adv. Sh. 330, 331 (1975).

25. *Brune v. Belinkoff*, 354 Mass. 102, 235 N.E.2d 793 (1968).

26. *Gambill I*, 258 Ark. Adv. Sh. 766, 768, 529 S.W.2d Adv. Sh. 330, 332 (1975).

27. *Id.* at 767, 529 S.W.2d at 331.

of the similar localities rule in Dean Prosser's treatise on torts.²⁸ Under the *Brune* rule, apparently any physician who otherwise qualifies as a medical expert may testify about the general (presumably national) standard for the particular medical practice at issue.²⁹

In reversing *Gambill I*, the court in *Gambill II* reinstated the similar localities rule as stated in AMI 1501, noting that it might well be the majority rule and stating that it does not unduly restrict the plaintiff's introduction of evidence.³⁰ The court also cited cases from other jurisdictions in which the rule had recently been upheld.³¹

Although the court did not refer in *Gambill II* to the holdings or reasoning of either *Gambill I* or *Brune*, it specifically rejected the theory that advances in education and the increased availability of medical literature, in-service training programs, and seminars have eliminated the differences between the resources of small town prac-

28. The court quoted this passage from W. Prosser, *supra* note 6, § 32: "Formerly it was generally held that allowance must be made for the type of community in which the physician carries on his practice, and for the fact, for example, that a country doctor could not be expected to have the equipment, facilities, libraries, contacts, opportunities for learning, or experience afforded by large cities. Since the standard of the 'same locality' was obviously too narrow, this was commonly stated as that of 'similar localities,' thus including other towns of the same general type. Improved facilities of communication, available medical literature, consultation and the like, led gradually to the abandonment of any fixed rule, and to treating the community as merely one factor to be taken into account in applying the general professional standard. In a few jurisdictions the 'locality rule' has been entirely discarded, and the general standard applied in all cases."

Id. at 767-68, 529 S.W.2d at 331-32.

29. *Carbone v. Warburton*, 11 N.J. 418, 94 A.2d 680 (1953); *Meiselman v. Crown Heights Hosp.*, 285 N.Y. 389, 34 N.E.2d 367 (1941); *McElroy v. Frost*, 268 P.2d 273 (Okla. 1954) (standard for X-ray treatment does not vary with locality); *Paulsen v. Gundersen*, 218 Wis. 578, 260 N.W. 448 (1935) (under subsequently repealed statute, if bona fide attempt made to obtain testimony from Wisconsin physicians first). *See generally* Annot., 37 A.L.R.3d 420 (1971).

30. *Gambill II*, 258 Ark. 766, 769, 531 S.W.2d 945, 948 (1976).

31. *Id.* (citing *McBride v. United States*, 462 F.2d 72 (9th Cir. 1972); *Goedecke v. Price*, 19 Ariz. App. 320, 506 P.2d 1105 (1973); *Peters v. Gelb*, 303 A.2d 685 (Del. Super. Ct. 1973); *Karrigan v. Nazareth Convent & Academy, Inc.*, 212 Kan. 44, 510 P.2d 190 (1973); *Burton v. Smith*, 34 Mich. App. 270, 191 N.W.2d 77 (1971); *Bailey v. Williams*, 189 Neb. 484, 203 N.W.2d 454 (1973)). *See also* *Poulin v. Zartman*, 542 P.2d 251 (Alaska 1975) (statutory localities rule applied); *Avey v. St. Francis Hosp. & School of Nursing, Inc.*, 201 Kan. 687, 442 P.2d 1013 (1968) (localities rule applied to hospitals); *Chapman v. Argonaut-Southwest Ins. Co.*, 290 So.2d 779 (La. Ct. App. 1974); *Incollingo v. Ewing*, 444 Pa. 263, 282 A.2d 206 (1971); *Bly v. Rhoads*, 216 Va. 645, 222 S.E.2d 783 (1976). *But see* *Shilkret v. Annapolis Emergency Hosp. Ass'n*, 276 Md. 187, 349 A.2d 245 (1975) (localities rule abolished); *Gridley v. Johnson*, 476 S.W.2d 475 (Mo. 1972) (dictum urged review of localities rule as applied in jury instructions).

tioners and those of their colleagues in larger cities.³² However, the court stated that the availability of such resources is a question of fact for the jury.³³ Denying that it could take judicial notice of any established national standard for the practice of medicine, the court added that for those procedures for which such a standard exists, it could be proved and applied to a particular fact situation under the similar localities rule.³⁴

The court went to great lengths to define "similar localities." Population and size are not solely determinative; other criteria include geographical location, the character of the community, and the similarities of medical facilities, practices, and advantages.³⁵ The extent of the geographical area to be considered as part of the locality and the similarity of localities are to be proved as matters of fact.³⁶

Stating that a given locality is not necessarily restricted to a particular city or community,³⁷ the court noted that the North Dakota Supreme Court has held that the proper standard of care "may require" that a doctor with limited medical facilities or training refer patients to larger, better-equipped "centers" nearby when necessary.³⁸ In the case to which the court made reference, the North Dakota court stated that

a doctor does not perform his duty to his patient when he fails to employ available and well known means of diagnosis such as the taking of X-ray photographs, even though no X-ray machine is available in the village where he is practicing, but where one is available at some point within easy access.³⁹

32. *Gambill II*, 258 Ark. 766, 769-70, 531 S.W.2d 948, 950 (1976).

33. *Id.* at 770, 531 S.W.2d at 949.

34. *Id.* at 770-A, 531 S.W.2d at 949 (citing *Peters v. Gelb*, 303 A.2d 685 (Del. Super. Ct. 1973); *Rucker v. High Point Memorial Hosp., Inc.*, 285 N.C. 519, 206 S.E.2d 196 (1974); *Hundley v. Martinez*, 151 W. Va. 977, 158 S.E.2d 159 (1967); *Annot.*, 37 A.L.R.3d 420, 425 (1971)).

35. *Gambill II*, 258 Ark. 766, 770, 531 S.W.2d 945, 948 (1976) (citing *Sinz v. Owens*, 33 Cal. 2d 749, 205 P.2d 3 (1949)).

36. *Gambill II*, 258 Ark. 766, 770, 531 S.W.2d 945, 949 (1976) (citing *Sinz v. Owens*, 33 Cal. 2d 749, 205 P.2d 3 (1949); *Tvedt v. Haugen*, 70 N.D. 338, 294 N.W. 183 (1940)).

37. *Gambill II*, 258 Ark. 766, 770-C, 531 S.W.2d 945, 950 (1976) (citing *Lewis v. Johnson*, 12 Cal. 2d 558, 86 P.2d 99 (1939)). The court cited *Warnock v. Kraft*, 30 Cal. App. 2d 1, 85 P.2d 505 (1938) and *Kirchner v. Dorsey*, 226 Iowa 283, 284 N.W. 171 (1939) for the proposition that the locality may include a larger district or area.

38. *Gambill II*, 258 Ark. 766, 770-B to 770-C, 531 S.W.2d 945, 950 (1976) (citing *Tvedt v. Haugen*, 70 N.D. 338, 294 N.W. 183 (1940)). *See also* *Pederson v. Dumouchel*, 72 Wash. 73, 431 P.2d 973 (1967).

39. *Tvedt v. Haugen*, 70 N.D. 338, 349, 294 N.W. 183, 188 (1940) (citing *Whitson v. Hillis*, 55 N.D. 797, 215 N.W. 480 (1927)).

It has been noted that Arkansas has never adopted a "duty-to-refer" standard of care,⁴⁰ and the court did not expressly do so in *Gambill II*, stating that if more advanced facilities are not "reasonably available" and such a transfer is "not practicable," the physician should not be penalized for failure to secure more sophisticated medical treatment. Whether advanced treatment is reasonably available is also a fact question under the similar localities rule.⁴¹ Thus, while the court raised a question about the duty to refer, stating that "the appropriate community standard of care may require" transfer or referral,⁴² the court failed to give any guidelines about the criteria to be applied in such cases.

In articulating the criteria for expert testimony under the Arkansas rule, the court distinguished the strict locality rule, calling it a "rigid, exclusionary rule of evidence, rather than a definition of a standard of care required of a physician."⁴³ The similar localities rule, on the other hand, makes it possible for the plaintiff to present testimony of witnesses who have neither practiced in the defendant's community nor are familiar with the medical practices there.⁴⁴ The plaintiff must only prove the standard of medical practices in a similar locality, either by direct testimony of witnesses familiar with such a standard or by other evidence which would prove the similarity of localities.⁴⁵ The court also noted that the

40. Spies, *Arkansas Model Jury Instructions: Malpractice*, 20 Ark. L. Rev. 86, 87 (1966). For the protection of patients whose physicians "hoard their practice without consideration of their patients' welfare," Professor Spies advocates the development of a duty-to-refer standard of care, noting that Arkansas has no cases on point and has not drafted a jury instruction to cover the situation, although he believes AMI 1501, *supra* note 1, is presently adequate for that purpose. Spies, *supra*, at 87-88. He also notes a suggestion that "selection of an inadequately equipped hospital for certain procedures may violate the standard of care." *Id.* at 87 n.2.

41. *Gambill II*, 258 Ark. 766, 770-B to 770-C, 531 S.W.2d 945, 950 (1976).

42. *Id.*

43. *Id.* at 770-B, 531 S.W.2d at 949-50 (citing *Couch v. Hutchison*, 135 So.2d 18 (Fla. Dist. Ct. App. 1961)).

44. *Gambill II*, 258 Ark. 766, 770-B, 531 S.W.2d 945, 950 (1976).

45. *Id.* Cases cited by the court in which expert witnesses from other localities were held competent to testify and their testimony held admissible under a rule similar to that adopted in *Gambill II* are *Riley v. Layton*, 329 F.2d 53 (10th Cir. 1964) (applying Utah law); *Sinz v. Owens*, 33 Cal. 2d 749, 205 P.2d 3 (1949); *Sales v. Bacigalupi*, 47 Cal. App. 2d 82, 117 P.2d 399 (1941); *Interman v. Baker*, 214 Ind. 308, 15 N.E.2d 365 (1938); *Kirchner v. Dorsey*, 226 Iowa 283, 284 N.W. 171 (1939); *Dunham v. Elder*, 18 Md. App. 360, 306 A.2d 568 (1973); *Dickens v. Everhart*, 284 N.C. 95, 199 S.E.2d 440 (1973). *But see* the following cases in which such witnesses were held incompetent to testify: *Murphy v. Dyer*, 409 F.2d 747 (10th Cir. 1969) (applying Colorado law) (defendant from Colorado Springs, witness from Seattle); *Wheeler v. Baker*, 92 Cal. App. 2d 776, 208 P.2d 68 (1949) (defendant from Ventura, witness from Los Angeles); *McNamara v. Emmons*, 36 Cal. App. 2d 199, 97 P.2d 503 (1939) (defendant from Ontario, Cal., witness from San Bernardino, Cal.); *Naccarrato v. Grob*, 12 Mich. App. 130, 162 N.W.2d 305 (1968) (defendant from Detroit, witness from Los Angeles); *Mi-*

plaintiff in *Gambill* was allowed to present testimony of several expert witnesses,⁴⁶ at least one of whom testified that he had not practiced and was not familiar with the actual practice of medicine in the town in which the defendant practiced.⁴⁷

Commenting on the standards set by the similar localities rule, the court said that it does not permit doctors in one area to be more negligent than those in other areas, but prohibits incompetent physicians from setting an inferior standard of medical practice in one area.⁴⁸ More specifically, the court rejected the standard of the average qualified practitioner adopted in *Brune* and *Gambill I* and said that such a standard would automatically make about half of all practicing physicians guilty of malpractice.⁴⁹ The court preferred "minimum common skill" as the determinative standard, citing other authorities,⁵⁰ but providing no definition or clarification of the term.

As to the standard for specialists, the court in *Gambill II* did not acknowledge that other jurisdictions have specifically declined to apply the similar localities rule to specialists and have held that the standard for those who hold themselves out as specialists is that of the average physician practicing that specialty. The court did, however, cite authority which supports that proposition.⁵¹ This position is supported by many authorities,⁵² and the court noted that the standard is "more likely" to be the same nationwide for specialists than for general practitioners.⁵³ The court, however, did not adopt a general rather than a local standard for specialists, and it appar-

chael v. Roberts, 91 N.H. 499, 23 A.2d 361 (1941) (defendant from Rochester, N.Y., witness from Revere, Mass., but practiced in Boston).

46. *Gambill II*, 258 Ark. 766, 768, 531 S.W.2d 945, 947 (1976).

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

48. *Id.* at 770-A, 531 S.W.2d at 949 (citing Restatement, *supra* note 7, § 299A, Comment e; 3 T. Shearman & A. Redfield, *Negligence* § 617 (1941)). *Contra*, Pederson v. Dumouchel, 72 Wash. 2d 73, 77-78, 431 P.2d 973, 977 (1967).

49. *Gambill II*, 258 Ark. 766, 770-C, 531 S.W.2d 945, 950 (1976). *Contra*, Restatement, *supra* note 7, § 299A, Comment e.

50. *Gambill II*, 258 Ark. 766, 770-C, 531 S.W.2d 945, 950 (1976) (citing W. Prosser, *supra* note 6, § 32; Restatement, *supra* note 7, § 299A, Comment e).

51. *Gambill II*, 258 Ark. 766, 770-A to 770-B, 531 S.W.2d 945, 949 (1976) (citing McGulpin v. Bessmer, 241 Iowa 1119, 43 N.W.2d 121 (1950); Naccarrato v. Grob, 384 Mich. 258, 180 N.W.2d 788 (1970) (which both held that the similar localities rule would no longer be applied to specialists); W. Prosser, *supra* note 6, § 32).

52. *Carbone v. Warburton*, 11 N.J. 418, 94 A.2d 680 (1953); *Hundley v. Martinez*, 151 W. Va. 977, 158 S.E.2d 159 (1967); Restatement, *supra* note 7, § 299A, Comment d.

53. *Gambill II*, 258 Ark. 766, 770-B, 531 S.W.2d 945, 949 (1976). The comment to AMI 1501, *supra* note 1, states that "[a]ll practitioners of the kindred branches of the healing art, including specialists, are apparently subject to the same duty However, the treatment is tested by that of others engaged in the same type of practice or speciality."

ently acknowledged the validity of AMI 1501⁵⁴ as applied to such physicians.⁵⁵ While, as the court emphasized, any existing national standard of practice can be proved under the similar localities rule,⁵⁶ the plaintiff's burden in doing so is heavier than under the *Brune* rule.⁵⁷

Justice Smith, who wrote the majority opinion in *Gambill I*, dissented in *Gambill II*. In his dissent he insisted that the similar localities rule makes it difficult for the plaintiff to obtain expert witnesses from outside the defendant-physician's locality whose testimony cannot be seriously weakened on cross-examination because they are not personally familiar with the standard of practice in the locality in question. According to Justice Smith, the wording of AMI 1501 enabled the defense to "make a devastating jury argument" regarding an expert's testimony at the *Gambill* trial and generally gives the local physician an obviously unfair advantage at trial.⁵⁸ The plaintiff's difficulty in obtaining credible expert witnesses was also recognized in a 1970 Arkansas case⁵⁹ and is noted by other authorities.⁶⁰

While the majority acknowledged that both the strict and the similar localities rules "necessarily have a relationship to the admissibility of evidence,"⁶¹ it maintained that the similar localities rule "is not necessarily so restrictive."⁶² The majority seemed to discount the plaintiff's difficulty by citing cases from other jurisdictions in

54. *Supra* note 1.

55. *Gambill II*, 258 Ark. 766, 769, 531 S.W.2d 948, 949 (1976). An article on the drafting of the Arkansas malpractice jury instructions notes that "the Arkansas court has not distinguished between general and specialty practice" and says that while other states hold specialists to a higher standard, the similar localities rule will continue to be applied to specialists in Arkansas "until a supreme court decision recognizes that a practitioner in orthopedic medicine must have and use the skill of other orthopedists irrespective of where they practice." Spies, *supra* note 40, at 86-87 & 87 n.1.

56. *Gambill II*, 258 Ark. 766, 770-A, 531 S.W.2d 945, 950 (1976).

57. Further confusing the problem of the rule for specialists is *Rickett v. Hayes*, 256 Ark. 893, 511 S.W.2d 187 (1974), in which jury instructions based on AMI 1501, *supra* note 1, were at issue. The court upheld the challenged instructions, which set the standard of care for a specialist as that of other members of his profession in good standing engaged in the same type of practice or specialty and omitted any reference to locality. By failing to mention the locality issue in its lengthy discussion of the standard, the court left its position open to the inference that the locality standard had been abandoned, if not specifically modified.

58. *Gambill II*, 258 Ark. 766, 770-E, 531 S.W.2d 945, 951 (1976) (Smith, J., dissenting). This advantage noted by Justice Smith may be compounded by the "understandable tendency" of both lawyers and juries "to sympathize with the overworked popular local doctor." Spies, *supra* note 40, at 87.

59. *Graham v. Sisco*, 248 Ark. 6, 10-11, 449 S.W.2d 949, 951 (1970).

60. See generally cases and other authorities cited note 14 *supra*. See also *Couch v. Hutchison*, 135 So.2d 18, 22 (Fla. Dist. Ct. App. 1961); *W. Posser*, *supra* note 6, § 32.

61. *Gambill II*, 258 Ark. 766, 770-B, 531 S.W.2d 945, 949-50 (1976).

62. *Id.* at 770-B, 531 S.W.2d at 950.

which such expert witnesses have been held competent⁶³ and by pointing out that all the expert witnesses offered by the plaintiff in *Gambill* were allowed to testify.⁶⁴

However, the problem is not solved simply because the plaintiff is allowed under the similar localities rule to present qualified witnesses. The extent and similarity of localities are questions of fact, which the jury must presumably reach before outside witnesses' testimony can be given credibility. As Justice Smith pointed out, the effectiveness of the witness' testimony can be impaired on cross-examination and destroyed in closing argument by the suggestion that an otherwise qualified witness is incapable of describing a standard of care applicable to a particular locality if he is not actually familiar with the locality.⁶⁵

Justice Roy also dissented in *Gambill II*, concluding that the similar localities rule has outlived its original purpose because of advances in medical training and licensing procedures. She also took issue with the court's use of the term "minimum common skill" and denied that it is or ever has been the standard in Arkansas. She suggested retaining AMI 1501 with the elimination of the reference to locality and the inclusion of availability of medical resources as one factor to be considered in determining the standard of care.⁶⁶ Although neither dissent mentioned either *Brune* or *Gambill I*, Justice Roy's proposed modification of the jury instruction is essentially the rule adopted in those cases.

In *Gambill II* the court reinstated in Arkansas what is still the apparent majority rule for a physician's standard of care in malpractice litigation.⁶⁷ Although the court did not completely justify a retreat from its position in *Gambill I* and its contention that the similar localities rule is falling into disfavor, at least it provided some clarity on how the rule is to be applied in Arkansas.

Gambill II does not, however, resolve all the weaknesses of the similar localities rule raised by the court, much less the weaknesses intrinsic in the rule itself.⁶⁸ Practitioners in Arkansas will probably

63. *Id.*; see also cases cited note 45 *supra*.

64. *Id.* at 768, 531 S.W.2d at 947-48.

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

66. *Id.* at 770-E to 770-G, 531 S.W.2d at 951-52 (Roy, J., dissenting).

67. See cases cited note 31 *supra*; W. Prosser, *supra* note 6, § 32; Restatement, *supra* note 7, § 299a.

68. These intrinsic weaknesses involve the fact-finding process. The jury must make several distinct, but confusingly interrelated, findings of fact before it can determine the applicable standard of care. Some of these issues are included under AMI 1501, *supra* note 1, but several were added by the court in *Gambill II*. Under *Gambill II* the jury must find, if applicable, (a) the extent of the geographical area to be considered as part of the locality;

continue to face difficulties in determining a physician's duties in two significant areas: whether a specialist will be held to a local or a more general (national) standard of care and under what circumstances a physician with limited medical facilities or training has a duty to refer. In addition, the plaintiff will continue to face a dilemma in securing credible expert witnesses: local physicians may be unwilling to testify against a colleague and physicians from outside the defendant's locality may not have actual knowledge of the medical practices employed there.

However, the greatest weakness of the rule is that physicians in rural areas or small towns may be excused from keeping abreast of current medical techniques. As one authority on medical malpractice has stated,

Even conscientious specialists are hard pressed to assimilate the fantastic volume of medical knowledge constantly springing up in their own fields. What of the jack-of-all-medical-trades, the general practitioner, who often complains of patients laying siege on his office? The result is that many general practitioners in the course of several years' practice acquire more patients and income than comprehension of scientific medical developments. Yet there is an understandable tendency on the part of lawyers—and juries, certainly—to sympathize with the overworked popular local doctor.⁶⁹

The court in *Gambill II* attempted to justify reinstating the similar localities rule by noting that its abolition would increase the difficulties experienced by small towns and rural areas in attracting qualified physicians.⁷⁰ However, the similar localities rule carries with it the ever-present prospect that provincial and perhaps out-

(b) what medical resources were available to the defendant; and (c) whether advanced medical treatment was necessary and reasonably available. A required finding about the similarity of localities is inherent, if not articulated, in AMI 1501, *supra*.

Under AMI 1501, *supra*, the jury must also consider whether the defendant used his best judgment in applying his skill and learning with reasonable care. The level of skill required, as interpreted by the court in *Gambill II*, is the "minimum common skill" of his colleagues.

The jury's difficulty in weighing the evidence on these issues is obvious. The terms "similar," "reasonably available," "best judgment," "reasonable care," and "minimum common skill" are ambiguous and subjective, and the more objectively determined factors outlined in *Gambill II* are not even indirectly mentioned in the jury instruction.

Still another problem with the rule is that when a jury returns a general verdict, neither the standard of care nor the complicated fact-finding process by which it is determined is articulated. This leaves the appellate court only to speculate about what specific findings led to the verdict and whether the verdict conforms to the evidence presented.

69. Spies, *supra* note 40, at 87.

70. *Gambill II*, 258 Ark. 766, 770-C n.3, 531 S.W.2d 945, 950 n.3 (1976).

dated medical practices may be found by a jury to be the applicable standard of care in any given community.

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