CALL IN HOUDINI: THE TIME HAS COME TO BE RELEASED FROM THE GEOGRAPHIC STRAITJACKET KNOWN AS THE LOCALITY RULE

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I. INTRODUCTION

The locality rule has received considerable judicial and scholarly attention since its first appearance in Kansas1 and conceptualization in a Massachusetts Supreme Judicial Court opinion over a century ago.2 At

1. Tefft v. Wilcox, 6 Kan. 46, 63–64 (1870).
2. Small v. Howard, 128 Mass. 131, 136 (1880). Tefft is the first case to actually consider locality, “[a]lthough Small v. Howard is the case most frequently cited [as] establishing the concept of the ‘locality’ rule.” Bernard Friedland, Managed Care and the Expanding Scope of Primary Care Physicians’ Duties: A Proposal to Redefine
some point in their jurisprudential history, most states have accepted some form of the locality rule,³ but recent courts and scholars have disfavored the rule.⁴

The original formulation of the locality rule “require[d] that a physician or surgeon be held only to that degree of diligence, learning, and skill possessed by physicians and surgeons of the particular locality where he practices.”⁵ This version of the rule has been consistently criticized as having two main drawbacks: “the possibility of a small group of practitioners establishing an unsatisfactory local standard of care and the difficulty in securing competent local witnesses . . . .”⁶

As commentators have excavated gaping holes in the foundation of the locality rule, courts have haphazardly developed numerous offshoots in an attempt to reconcile more sophisticated reasoning and new technologies with stare decisis.⁷ In doing so, various courts have created modified locality rules that expand the doctor’s community to similar communities nearby, across the state, or across the nation.⁸ Other courts permit juries to

Explicitly the Standard of Care, 26 J.L. MED. & ETHICS 100, 110 n.21 (1998).


⁴. See Samuel J. Stoia, Vergara v. Doan: Modern Medical Technology Consumes the Locality Rule, 2 J. PHARMACY & L. 107, 109 (1993) (“[M]any states have adopted standards of care for medical doctors without emphasizing the locality rule.”); see also Plaintiff v. City of Parkersburg, 345 S.E.2d 564, 567 (W. Va. 1986) (in one of the more enthusiastic dismissals of the locality rule, the West Virginia Supreme Court noted “[m]uch has been written about the obsolescence of the locality rule. We have nothing to add to the oceans of ink and forests of paper that have been pressed into service to hasten the rule’s demise.”).

⁵. 61 AM. JUR. 2D Physicians, Surgeons, and Other Healers § 200 (2002).

⁶. Theodore Silver, One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice, 1992 WIS. L. REV. 1193, 1227 n.114 (quoting Katherine R. Bowden, Comment, Standard of Care for Medical Practitioners—Abandonment of the Locality Rule, 60 KY. L.J. 209, 210 (1971)).

⁷. See Siirila v. Barrios, 248 N.W.2d 171, 186 (Mich. 1976) (Williams, J., concurring) (“[T]he [locality] rule has been subjected to both intensive criticism and extensive change, reflecting progress in technology and communication, and changing attitudes of the medical profession itself.”); see also Silver, supra note 6, at 1235 (“[R]ules, once announced, develop lives of their own, and, even if their genesis is clearly erroneous, the law is slow to discard them. The locality rule still operates . . . on the sheer momentum of ‘precedent.’”) (footnote omitted). See generally Pearson, supra note 3, at 1151–57.

⁸. See Pearson, supra note 3, at 1156–57 (courts included in a doctor’s community any “medical centers readily accessible” to them).
consider locality as only one factor in their decision. Yet, the recent trend is to disaffirm any mention of locality in favor of a standard of care analogous to the traditional, reasonable person, negligence standard.

Even Massachusetts—the oft cited birthplace of the locality rule—has abandoned its original formulation of the rule. In its widely cited opinion overruling Small v. Howard, the Massachusetts Supreme Judicial Court quipped: “The time has come when the medical profession should no longer be Balkanized by the application of varying geographic standards in malpractice cases.” Nearly forty years have passed since the Massachusetts decision, but for Iowans, the locality rule continues its stranglehold—the Iowa Supreme Court recently accepted the “Balkanization” by allowing use of the locality rule in Estate of Hagedorn v. Peterson.

Until the Hagedorn decision in 2004, many observers agreed with the plaintiff in Hagedorn that “the locality rule [was] not the law in Iowa.” In
the wake of Hagedorn, however, the state of the locality rule in Iowa has become one of the more confusing and unjust doctrines in the state’s medical malpractice jurisprudence. As such, a more manageable standard of care is required for the sake of predictability and basic fairness.

II. OVERVIEW

The remainder of this Note will examine the state of the locality rule, both around the country and in Iowa. Part III will trace the development of, and the reasons for, the acceptance of the locality rule. Despite the prompt acceptance of the locality rule, critics quickly chipped away at its core, thus Part IV will trace the reasons for the criticism of the rule, the movement away from the strict locality rule, and the standards used in its place. Part V will investigate the history of the locality rule in Iowa from its birth in Smothers v. Hanks in 1872,\(^\text{16}\) to its feigned death in Speed v. State in 1976.\(^\text{17}\)

The resurrection of the locality rule in 2004 with the court’s ruling in Hagedorn will be evaluated in Part VI. After an in-depth analysis of the case, Part VI will discern the standard pronounced by the court, how it conforms to earlier Iowa jurisprudence, and the rule’s limitations. After this discussion, the need for a new rule will be apparent. Part VII will propose a new rule that is not confined by the constraints of geography. Finally, the Conclusion will show how the non-geographically defined standard overcomes the unjust consequences of the locality rule, while remaining flexible enough to be sensitive to the facts of any given case.

III. EXAMINATION OF THE STRICT LOCALITY RULE

The locality rule can only be understood by viewing the historical context that led to its development. Three factors—population density, medical care, and technology—have had a significant impact on the development of the locality rule.\(^\text{18}\) This Part will briefly trace the changes

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\(^\text{16}\) Smothers v. Hanks, 34 Iowa 286 (1872).
\(^\text{17}\) Speed v. State, 240 N.W.2d 901 (Iowa 1976).
\(^\text{18}\) Siirila v. Barrios, 248 N.W.2d 171, 186 (Mich. 1976) (discussing technology and medical care as factors contributing to changes in the locality rule); Hirschberg v. State, 398 N.Y.S.2d 470, 475 (1977) (noting that population density has a bearing on the
in population density and medical advancements, and explain how these changes have influenced the rise and fall of the locality rule.

The period between 1800 and 1900 was a time when the qualifications for doctors were minimal, and many “mountebanks, ignorant pretenders, and impostors” partook in the practice of medicine.\(^{19}\) In fact, licensing laws were largely ineffective, partially because eclecticism and homeopathy were considered no less valid than what one would consider regular medicine today.\(^{20}\) These two sects “successfully competed with regular medicine and were, between 1830 and 1850, in great part responsible for the repeal of medical licensing laws . . . ”\(^{21}\)

When discussing the lack of organization, licensing, and medical school admissions standards, Richard Harrison Shryock, a medical historian, observed:

> The invasion of medical practice by sectarians . . . encouraged the states to ignore or even repeal early licensing laws, so that medical schools of any sort could secure charters and authorize graduates to practice. And since education was cheap (involving only lectures and a few books), even “regulars” formed schools which admitted any literate student and made a “doctor” in less than a year. Although the “M.D.” had originally been viewed with awe, this degree was so cheapened by 1850 that some medical leaders wanted to abandon it altogether.\(^{22}\)

In an attempt to produce standardization, the American Medical Association (AMA) was formed in 1847.\(^{23}\) Unfortunately, while the AMA eventually produced better standards for medical training, practice, and development, it “failed in its immediate objective of reforming education . . . .”\(^{24}\) However, the AMA did succeed in laying the foundation of a forum for critics and in placing unified pressure on the medical

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21. Id.
profession to develop better standards.\textsuperscript{25}

Despite the work of organizations like the AMA, the problems in licensing and educational criteria produced a widely varied standard of medical care.\textsuperscript{26} In fact, the standard of care was wholly dependent on geography because the local medical society developed the medical training program, which was the basis for the standard of care for a particular region.\textsuperscript{27}

These geographically defined standards of care can be validated when one understands the lack of technology and the population dispersion at the time. In 1800, the total land area of the United States was 864,746 square miles.\textsuperscript{28} The United States Census Bureau recorded that approximately 5.3 million people lived in the nation, which made the population density of the United States in 1800 6.1 people per square mile.\textsuperscript{29} Moreover, there was little urban centralization, as 93.9\% of Americans lived in rural areas in 1800.\textsuperscript{30} From these numbers, one can see that pre-\textit{Small v. Howard} America was comprised of small and relatively isolated groups of people. This isolation, along with limited communications technology and deficiencies in the medical community, led to the creation of a geographically dependent standard of care.

\textbf{A. Early Development of the Locality Rule}

By the time the Massachusetts Supreme Judicial Court wrote the \textit{Small} opinion in 1880,\textsuperscript{31} the population density of Massachusetts was 221.78 people per square mile,\textsuperscript{32} which was nearly sixteen times more dense

\begin{thebibliography}{99}
\bibitem{25} Id.
\bibitem{27} Id.
\bibitem{29} Id.
\bibitem{31} Small v. Howard, 128 Mass. 131 (1880).
\end{thebibliography}
than the country’s average.\textsuperscript{33} Still, the court recognized the reality that the quality of medical care was geographically dependent, and pronounced what would later be termed the “locality rule.”\textsuperscript{34}

The court in \textit{Small} was confronted with a medical malpractice case in which a man who had a severe cut on his wrist visited a rural doctor for care.\textsuperscript{35} The evidence showed that the doctor, Howard, was not skilled in the necessary care, but undertook the treatment of the non-life-threatening wound despite being aware that a qualified surgeon was merely four miles away.\textsuperscript{36} The evidence further revealed that the patient would have been able to travel the distance; nevertheless, Dr. Howard continued to care for the patient.\textsuperscript{37}

As is often the case in medical malpractice cases, the expert testimony clashed over the standard of care.\textsuperscript{38} The appellate court commented that “One of the experts called by the plaintiff testified, that he did not think the average country surgeon would be likely to possess the requisite skill to care for this wound. The evidence of the experts was conflicting, some testifying that the wound was properly treated, others the contrary.”\textsuperscript{39}

Based on the experts’ testimony, the trial court’s construction of the standard of care in the jury instructions was geographically based.\textsuperscript{40} The court instructed the jury that the physician

\begin{quote}
was bound to possess that skill only which physicians and surgeons of ordinary ability and skill, practising [sic] in similar localities, with opportunities for no larger experience, ordinarily possess; and he was not bound to possess that high degree of art and skill possessed by eminent surgeons practising [sic] in large cities, and making a specialty of the practice of surgery.\textsuperscript{41}
\end{quote}

In upholding the defense verdict, the Supreme Judicial Court accepted the

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\textsuperscript{33.} \textsc{U.S. Census Bureau}, 2000 \textsc{Population Count}, \textit{supra} note 28, at 2 tbl.2. The average population density for the entire country was 14.2 people per square mile in 1880. \textit{Id.}
\textsuperscript{34.} \textit{Small}, 128 Mass. at 132.
\textsuperscript{35.} \textit{Id.}
\textsuperscript{36.} \textit{Id.}
\textsuperscript{37.} \textit{Id.}
\textsuperscript{38.} \textit{Id.}
\textsuperscript{39.} \textit{Id.}
\textsuperscript{40.} \textit{Id.}
\textsuperscript{41.} \textit{Id.}
\end{quote}
The court reasoned that it was “common knowledge” that small town practitioners like Dr. Howard had “few[er] opportunities of observation and practice . . . [as] large cities would afford.”43 The lack of evidence in the opinion that supports this conclusion makes it appear probable that the court believed this viewpoint was so permanently grounded in fact that it would be wasteful to spend time and paper to further present proof on the point. Due to limited supporting data, commentators have been left to examine the justifications of the locality rule by looking into the historical context of the rule’s development.44 In diving into the historicity of the locality rule, it is evident that due to the slow and laborious communication and transportation of the late nineteenth century, a rural doctor did not have much of an opportunity to update and refine his capabilities.

When justifying the holding in Small, one commentator noted, “[t]hose were the days of the horse-and-buggy doctor in which medical science, transportation, and communications were primitive by today’s standards.”45 Given these limiting conditions, when a rural doctor was confronted with an emergency life or death scenario, it was still better for the physician to care for the individual than to refuse giving care because the physician had never studied the particular condition in question. Clearly, this “lack of continued training” argument does not justify Dr. Howard’s non-substantive based decision not to send his patient four miles

42. Id. at 136.
43. Id.

Although case opinions are short on supporting data, courts one hundred years ago were probably justified in adopting a presumption that the large city practitioner enjoyed broader experience than his country cousin and greater access to the latest medical knowledge and to the most advanced and elaborate facilities and equipment.

Id. at 411. But see Silver, supra note 6, at 1234 (arguing that the lack of relevant data and support in past opinions was because the locality rule was never justified, stating, “[i]n jurisprudential terms the locality rule never existed. If a ‘rule’ is abandoned not by reason of social enlightenment but because of simple technological advancement then the ‘rule’ never was a rule, but misguided pronouncement”).

down the road, but the court used it nonetheless.46

Regardless of the application in Small, many other jurisdictions accepted the logic of Small and implemented their own versions of the locality rule.47 Most of these early courts required the jury to look at the specific community the doctor was from—using the phrase “same locality” rather than “similar locality” as used in Small.48 This standard, which became known as the strict locality rule, “require[d] that a physician or surgeon be held only to that degree of diligence, learning, and skill possessed by physicians and surgeons of the particular locality where he practices.”49

Northwestern University law professor and legal scholar, Jon R. Waltz, observed that the driving force behind the strict locality rule was “to protect the rural and small town practitioner, who was presumed to be less adequately informed and equipped than his big city brother.”50 This means that two basic assumptions must be accepted for the locality rule to be valid: (1) rural doctors do not have the same opportunity for learning and skill development, and (2) rural doctors do not have access to the same technological resources as their counterparts in the city. The battleground over the standard of care in medical malpractice cases has centered on the acceptance or rejection of these assumptions. Because America has become more interconnected, commentators and courts have agreed that these assumptions are no longer valid.51

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46. See Small, 128 Mass. at 136.
47. See DAN B. DOBBS, THE LAW OF TORTS § 244 n.1 (2001) (highlighting that the court in Small used the similar locality standard—as opposed to the strict locality standard that was adopted by many states—because the court was less concerned with the issue of locality and more concerned with the fact that Dr. Howard was not a surgeon). See generally Pearson, supra note 3, at 1140–48 (detailing the various versions of the locality rule, including “same” or “similar” distinctions, as well as differing definitions of what constitutes a locality).
48. Small, 128 Mass. at 136; see also Waltz, supra note 44, at 410–11 (discussing the use of the strict locality rule and the transition to the similar locality rule).
49. 61 AM. JUR. 2D Physicians, Surgeons, and Other Healers § 200 (2002).
50. Waltz, supra note 44, at 410.
51. See id. for one of the most cited evaluations of the collapse of the locality rule. See also Cohen, supra note 45, at 597–98 (briefly tracing the locality rule’s demise); Stoia, supra note 4, at 109 (pointing out the role of technological advancements in the collapse of the locality rule).
B. Adapting the Locality Rule to an Interconnected America

By the mid-1900s, communications technologies were more developed and widely dispersed, and medical care became nationalized, and Americans continued to migrate to urban centers. These changes created a more interconnected society and required the assumptions of the locality rule to be re-examined. As the nation’s urban centers filled in and as technologies developed, courts began to question what allowances rural doctors should actually be given.

New technologies resulted in two major consequences for the medical standard of care. First, the opportunity for communication increased greatly, which made the exchange of information more pervasive among doctors throughout the nation. Second, the distance between the city and country became much more manageable, allowing people better access to resources.

In 1880, when *Small* was decided, there were only 1.1 telephones per 1,000 people, but this number jumped to 123.9 by 1920, and rose to just over four telephones per person by 1960. Likewise, the number of

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52. See Stoia, *supra* note 4, at 109 (discussing how technology has usurped the locality rule).


54. The U.S. Census Bureau figures for population density show greater numbers of people living per square mile throughout the late 1800s and mid 1900s. U.S. CENSUS BUREAU, 2000 POPULATION COUNT, *supra* note 28, at 2 tbl.2. Also, the Census Bureau figures reveal a steady migration toward the city throughout the late 1800s and mid 1900s. U.S. CENSUS BUREAU, 1990 POPULATION COUNT, *supra* note 30, at 5 tbl.4.

55. *Siirila v. Barrios*, 248 N.W.2d 171, 186 (Mich. 1976) (“[T]he [locality] rule has been subjected to both intensive criticism and extensive change, reflecting progress in technology and communication, and changing attitudes of the medical profession itself.”).


automobiles on the road increased, which greatly reduced the gap between rural and urban communities. In fact, the frontier officially closed in 1890, and America began to fill in more rapidly. By the 1960s, there were approximately 50.6 people per square mile in a country with over 179.3 million people, compared to 14.2 people per square mile in a country with over 50.1 million people in 1880. While 71.8% of Americans lived in rural areas in 1880, the exodus from the country resulted in only 36.9% of Americans living outside of an urban area by 1960.

Developments in the medical community also drove critics to question the assumptions of the locality rule. One of the driving forces behind the modernization of medicine was the increased activity of the AMA. In 1906, the AMA began evaluating, ranking, and accrediting medical schools. Their first set of curriculum standards was published in 1905, which soon led to wide acceptance.

During this time, the AMA became more active in other medical areas, including publishing a variety of journals, which helped doctors stay in touch with the latest advancements in practice and theory. Importantly, the AMA Council on Medical Education worked with the Advisory Board for Medical Specialties in 1934 to develop a certification

BUREAU, CENSUS OF POPULATION: 1960 NUMBER OF INHABITANTS, CHARACTERISTICS OF POPULATION 2 tbl.1 (1961), http://www2.census.gov/prod2/decennial/documents/10107945v1pAch02.pdf (reported 179,323,175 people in the United States). If one divides the population in 1960 by the number of available household telephones in 1960, the result is roughly 4.3 telephones per person.


63. Nockleby & Curreri, supra note 53, at 1061 (“In the 1960s and 1970s, however, responding not only to the rise of a national market for medicine, but also to the intense criticism of the locality rule, most states overturned the locality rule.”).


65. Id.

process for officially recognizing specialty boards.67

The timing was perfect; the medical profession was becoming more organized and the ability to obtain and transmit information was increasing, which resulted in bringing rural doctors closer to their city counterparts in terms of knowledge.68 The key ingredients were the dispersion of journals69 and the fact that doctors could communicate with one another with relative ease.70 The result of this interconnected medical community was a nationalization of medical care that, in turn, affected the standard of care by which doctors’ conduct is scrutinized.71

IV. CHALLENGES TO THE LOCALITY RULE

Advances in technology, improvements in the medical profession, and population changes all opened the door for attacks on the locality rule.72 No longer were doctors so isolated that they were unable to sharpen or develop new skills. Still, despite the changes in American society, there was credible evidence that revealed a disparity between rural and urban doctors. The rest of this section will evaluate how the aforementioned changes in the American way of life and the effects of the rule’s application encouraged criticism of, and affected the application of, the locality rule across the nation and in Iowa.

A. Critiques of the Locality Rule Evaluated

The changes in the American landscape and the unjust consequences of the rule’s application produced much criticism.73 In fact, critics began to

67. AMA History 1921 to 1940, supra note 66.
69. AMA History 1900 to 1920, supra note 64; AMA History 1921 to 1940, supra note 66.
70. AMA History 1921 to 1940, supra note 66.
73. See, e.g., Cohen, supra note 45, at 593–601 (discussing the difficulty and necessity of obtaining expert testimony in a medical malpractice action and the
dismantle the foundation of the locality rule as soon as it was announced.\textsuperscript{74} The attacks eventually led to a modification of the rule, and more recently resulted in the abandonment of the rule in most jurisdictions.\textsuperscript{75}

The initial critique of the locality rule was directed at the requirement that the standard of care be based on the physician’s “same community.” To determine a physician’s adherence to the standard of care, the initial construction of the locality rule required juries to look no further than the bounds of the actual community where the alleged negligence occurred.\textsuperscript{76} This formulation created two major issues and numerous derivative issues.

First, holding practitioners accountable by looking no further than their most immediate peers produced the dangerous possibility of a group of substandard practitioners developing an inferior standard of care.\textsuperscript{77} Secondly, procuring suitable expert testimony from such a small sample of the medical community was practically impossible.\textsuperscript{78}

The limited availability of information technology and the lack of uniformity in medical training, along with the isolation of medical communities, combined to increase the likelihood of a lower standard of improvements in rural medical care); Nockleby & Curreri, supra note 53, at 1059–61 (discussing the “conspiracy of silence” and courts’ abandonment of the locality rule because of its unjust consequences); Silver, supra note 6, at 1234–35 (finding locality was not a rule, but was at one time a factor of the reasonable person standard); Sokol & Molzen, supra note 68, at 478–86 (describing the diminishment of the locality rule and the emerging standard of care).

\textsuperscript{74} See Smothers v. Hanks, 34 Iowa 286, 299 (1872) (Beck, J., dissenting). The nature of this case is further developed infra Part V.A.

\textsuperscript{75} See Siirila, 248 N.W.2d at 186 (“[T]he [locality] rule has been subjected to both intensive criticism and extensive change, reflecting progress in technology and communication, and changing attitudes of the medical profession itself.”); see also Silver, supra note 6, at 1235 (noting “rules, once announced, develop lives of their own, and, even if their genesis is clearly erroneous, the law is slow to discard them. The locality rule still operates . . . on the sheer momentum of ‘precedent.’”) (footnote omitted). See generally Pearson, supra note 3, at 1151–52, 1159–62.

\textsuperscript{76} See Waltz, supra note 44, at 410 (“In its original formulation . . . the locality rule literally demanded that a medical expert testifying for the plaintiff in a malpractice action must have practiced in the defendant’s community.”).

\textsuperscript{77} See Silver, supra note 6, at 1227 n.114 (the locality rule leads to “the possibility of a small group of practitioners establishing an unsatisfactory local standard of care”).

\textsuperscript{78} See Cohen, supra note 45, at 592 (highlighting the common “refusal by doctors to testify against members of their profession”); Nockleby & Curreri, supra note 53, at 1060–61.
The result was that a practitioner whose unskilled actions produced injury was immune from patient challenges because the practice, despite its illegitimacy, was traditionally undertaken in the community. Not only does the practitioner escape responsibility, but the patients, and those close to them, are also denied justice. As one commentator explains, “[t]he potential result is that a patient who legitimately feels that the treatment received was substandard in light of advanced medical techniques and knowledge may be deprived of his claim as a result of the failure of not only his physician, but also that physician’s local peers . . . .”

The second part of the problem with requiring the physician’s exact locality to be examined is seen in the fact that even if the standard of care is clearly superior to a practitioner’s conduct, the patient is unlikely to have recourse due to the impracticability of finding a suitable expert. The centrality of expert testimony in a medical malpractice case is an essential axiom drilled into the minds of every first year law student. However, in order for an expert to be qualified to testify to the applicable standard of care, the plaintiff’s counsel must establish the expert’s familiarity with the standard of care. When the standard of care is formulated in accordance with the standard that is practiced in a specific locale, an expert must be a member of that community in order to be considered competent.

Clearly, this presents a problem when there are few doctors in the area. There may be no other doctor in the community or all the other local doctors may share a common practice group. On a larger scale, such as a major city, there are many factors that combine to dissuade physicians from becoming plaintiffs’ witnesses. First, the professional bond that unites doctors in a fraternal order discourages doctors from testifying against one another. To further complicate matters, a rift exists between the legal and medical communities, which makes doctors hesitant to join forces with a plaintiff’s lawyer in opposition to another doctor. Physicians are also

79. See Hall v. Hilbun, 466 So. 2d 856, 872 (Miss. 1985).
81. Cohen, supra note 45, at 592.
82. Id. at 593–95.
83. Id. at 594.
84. Id.
85. See, e.g., Ferrell v. Ellis, 105 N.W. 993, 993 (Iowa 1906).
86. Cohen, supra note 45, at 593 (citing Elliott D. Luby, The Physician and the Lawyer: Conflicts in Conceptual and Professional Models, in INTERSECTIONS OF LAW AND MEDICINE 5, 9 (Grant H. Morris & Martin L. Norton eds., 1972)).
87. See id. (citing Thomas F. Sheehan, The Medical Malpractice Crisis in
loathe to be involved in lawsuits because it is seen as a distraction from their real work with patients. Moreover, physicians know that testifying in the adversarial legal process will result in a sharp cross-examination that attempts to discredit and humiliate them. Lastly, whether legitimate or not, many medical practitioners are fearful of “the alleged reluctance of insurance companies to maintain malpractice insurance coverage for doctors who help plaintiffs obtain judgments.”

The issue now becomes clear. The disinclination of practitioners to testify, and the small pool of available expert witnesses, makes it nearly impossible for plaintiffs to make their cases when the strict locality rule is applied. The almost inevitable consequence of being unable to secure an expert is an early dismissal. Loyola of Los Angeles law professor John Nockleby and his research assistant summarized these issues this way:

Obviously, if the legal rule permitted medical practitioners to adhere to such inferior standards of practice, it would be very difficult for injured patients to prevail in malpractice actions against inferior—but locally accepted—medical practices.

Insurance: How It Happened and Some Proposed Solutions, 11 FORUM 80, 86 (1975) (stating that there exists “a measured amount of professional xenophobia harbored against lawyers and their contingency fee system”).

88. Id. at 594 (citing David E. Seidelson, Medical Malpractice and the Reluctant Expert, 16 CATH. U. L. REV. 158 (1966)).

89. Id. (citing R. Morris & A. Moritz, Doctor and Patient and the Law 315–16 (1971)).

90. Id. at 593 (citing Hoffman v. Lindquis, 234 P.2d 34, 46 (1951) (Carter, J., dissenting)); see also Marvin Belli, An Ancient Theory Still Applied: The Silent Medical Treatment, 1 VILL. L. REV. 250, 255 (Cal. 1956). Cohen further explains:

Although professional ostracism of a plaintiff’s witness and cancellation of his malpractice insurance are probably the exception, cases do exist in which doctors have sued to regain membership into medical societies, or to enjoin the cancellation of malpractice insurance on the grounds that the termination of their membership and policies were solely a result of their cooperation with the plaintiff in a malpractice trial.


92. For an ingenious discussion on how plaintiffs’ attorneys can avoid the need for expert testimony through the use of tactics such as res ipsa loquitur, see Belli, supra note 90, at 262–70.
Because the locality rule established the standard of care in a particular community, in order to prevail an injured patient would ordinarily be required to offer expert testimony from other physicians in the community that the substandard care violated local practice and was therefore negligent. But, how would a patient obtain such testimony? Only from other doctors practicing in the same locality. Here is where the “conspiracy of silence” came into play. The local medical establishment, arm-in-arm with malpractice liability insurers, stigmatized and shunned any physician who dared testify against any other doctor. Thus, the locality rule practically barred most claims of medical malpractice, and the conspiracy of silence prevented worthy plaintiffs from obtaining necessary evidence even in egregious cases.93

A geographically based standard of care binds the legitimate plaintiff in a virtual straitjacket, choking off the ability to obtain a much needed recovery.

B. Response to Critiques of the Locality Rule

Once courts recognized the harsh effects of the locality rule, they began to back away from it.94 However, like most common law rules, the progression of the locality rule has exemplified the type of slow, organic change espoused by Edmund Burke95 instead of the swift change that observers desired. As professor Theodore Silver explains, “[R]ules, once announced, develop lives of their own, and, even if their genesis is clearly erroneous, the law is slow to discard them.”96

1. The Similar Locality Rule

In the spirit of American jurisprudence, courts, in an attempt to reconcile the disparity between the locality rule and the world around them, chose to modify the rule rather than renounce it.97 History has

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94. See id. at 1059–60 (“These locality rules were widely followed until the 1960s, when courts recognized that they would have the serious consequence of enabling doctors in rural locales, or outside urban areas, to follow standards of care that might have been outdated or rejected in more progressive or modern medical centers.”).
96. Silver, supra note 6, at 1235.
97. See Cohen, supra note 45, at 595–96 (“The history of the Locality Rule is one more illustration of the prolific attempts of lawyers and judges to revamp outdated legal doctrines in response to the pressures created by changing conditions outside of
proved these modifications to be ineffective in resolving the two-part conundrum created by the original formulation of the rule. In fact, these recapitulations of the strict locality rule have even magnified issues ancillary to the original formulation. Yet, while each modification of the standard of care contains inherent flaws, most are preferable to the rule’s original casting.

In a response to the critiques of the strict rule’s effects, the first modification of the locality rule changed the geographic area in which the accused practitioner’s standard of care was based from the same locality to include one or more similar localities. The apparent logic behind the “same or similar” locality rule was the assumption that, by broadening the geographic area to include other similar communities, a single locality would be penalized for developing a lower standard of care; thus, the pool of practitioners available to testify as experts would increase.

States have defined “similar” in different ways. Some states look only to communities in the same state. Other states broaden their approach and look to communities having equivalent demographic statistics. Finally, others take a broader approach and look to medically similar communities. Regardless of how a state determines what should be accepted as a “similar” community, the workings of the similar locality rule has fidelity with the original strict locality rule. Both rules provide that small town and rural doctors should not be held to the standard of care practiced by their colleagues in the city. Thus, the only difference between the strict locality rule and the similar locality rule is that the latter assumes that, by broadening the geographic area for determining the standard of care, medical communities and the individual doctors who serve them will not be able to escape accountability due to substandard care community-wide or a plaintiff’s inability to obtain an expert witness. Yet, the same features that make the communities similar are likely to make the standard of care similar. In this case, there is no substantive difference between the strict

the courtroom.”). See generally Pearson, supra note 3, at 1143–51.

98. See supra Part IV.A.
99. See Cohen, supra note 45, at 598.
100. See generally Pearson, supra note 3, at 1143–51.
101. Id. at 1147–48.
102. Id. at 1145–48.
103. Id. at 1148–50.
104. See Cohen, supra note 45, at 594.
and similar locality rules.

2. The Development of a National Standard

While some courts continue to hold to the similar locality rule, most courts have come to the realization that this formulation of the locality rule is an ineffective alternative to the strict version. Consequently, a national standard of care has become the popular trend. As one commentator observed, “every law student in recent years has heard in his or her first-year torts class: there is a national standard of care developing in the area of medical malpractice law.” Instead of allowing geography to determine the standard of care, some states have turned to the original negligence formula, which can be found in the Iowa Model Jury Instructions: “A physician must use the degree of skill, care and learning ordinarily possessed and exercised by other physicians in similar circumstances.”

The national standard of care requires any given doctor to provide patients with the same level of care that they could receive anywhere in the nation. In other words, a doctor practicing in Spencer, Iowa, should provide a patient with the same level of care as a doctor practicing in Des Moines, Iowa, or Boston, Massachusetts. Courts and commentators have justified the movement to a national standard of care based on “progress in technology and communication, and changing attitudes of the medical profession itself.”

First, even the most casual observer can recognize that advancements in information and medical technology have produced a better level of

105. See infra Part VI.B.
106. See, e.g., Drapp, supra note 71, at 95.
107. Id.
108. See Blumstein, supra note 10, at 144 (“The apparent move to a ‘reasonable physician’ standard” while discussing important issues that must be incorporated into the physicians’ standard of care in order for it to be effective).
109. Iowa Civil Jury Instruction 1600.2 (2007). The standard jury instruction is similar to the traditional instruction on negligence: “‘Negligence’ is doing something a reasonably careful person would not do under similar circumstances, or failing to do something a reasonably careful person would do under similar circumstances.” Id. at 700.2.
110. See Silver, supra note 6, at 1234 (noting that under such a standard, doctors would be bound by “prevailing national custom”).
medical care across the nation. 112 Technological advancements have been integral in diagnosing and treating patients, but these advancements have also been utilized to make information more readily accessible, allow doctors better opportunities to connect with one another, and provide for quick and efficient patient referrals. 113 Even if each member of the medical community has not and cannot embrace all the technological advancements, the limited amount of technology that practitioners are economically able to utilize appears to create a more uniform standard of care across the country. 114

Second, the very nature of the medical community has come a long way since the locality rule was originally announced. 115 The uniformity in medical education and the accessibility of information has led to greater uniformity in practice. 116 Recognition of the nationalization of the medical community has affected the application of the standard of care. 117 In the more articulate words of the Mississippi Supreme Court:

We would have to put our heads in the sand to ignore the “nationalization” of medical education and training. Medical school admission standards are similar across the country. Curricula are substantially the same. Internship and residency programs for those entering medical specialties have substantially common components. Nationally uniform standards are enforced in the case of certification of specialists. Differences and changes in these areas occur temporally, not geographically.

Physicians are far more mobile than they once were. They frequently attend medical school in one state, do a residency in another, establish a practice in a third and after a period of time

112. See, e.g., Sokol & Molzen, supra note 68, at 449. This article identifies changes in technology as the impetus for the redevelopment of the standard of care in medical malpractice cases. Moreover, it identifies the benefits and problems created by the inevitable changing of the standard of care as physicians begin to use tools created by technological advancements.


114. Id. at 488.

115. See Drapp, supra note 71, at 95; Nockleby & Curreri, supra note 53, at 1061–63.

116. Hall v. Hilbun, 466 So. 2d 856, 870 (Miss. 1985); Drapp, supra note 71, at 95.

117. Drapp, supra note 71, at 95.
relocate to a fourth. All the while they have ready access to professional and scientific journals and seminars for continuing medical education from across the country. Common sense and experience inform us that the laws of medicine do not vary from state to state in anything like the manner our public law does.\(^{118}\)

The movement of nearly all jurisdictions has been to incorporate a national standard of care, and those that have not had the right case arise have continued to loosely apply the similar locality rule.\(^{119}\) Clearly though, the evidence shows that even this softer version of the locality rule “has been abandoned in favor of a national standard.”\(^{120}\) Importantly, in states that have recently examined the locality rule, Iowa is the only state to still reject the application of a broader standard of care.\(^{121}\)

V. THE LOCALITY RULE IN IOWA

A. The Birth and Life of the Locality Rule in Iowa

The tradition of the locality rule in Iowa stretches back further than it does in most states.\(^{122}\) The first time the Iowa Supreme Court applied the locality rule was in *Smothers v. Hanks* in 1872.\(^{123}\) While the majority opinion was one of the first opinions to apply the locality rule, the more interesting part of the opinion was the sharp dissent by Justice Beck. In fact, with a few minor adjustments, the words of the dissent are still pertinent today.

In *Smothers*, the court was reviewing a trial court decision based on a

\(^{118}\) Hall, 466 So. 2d at 870, superseded by statute, MISS. CODE ANN. § 85-5-7 (1999).

\(^{119}\) Sam A. McConkey, IV, Note, *Simplifying the Law in Medical Malpractice: The Use of Practice Guidelines as the Standard of Care in Medical Malpractice Litigation*, 97 W. VA. L. REV. 491, 498 n.35 (1995) (“The modern trend of most jurisdictions is to abandon the ‘strict locality rule’ in favor of a broader version . . . .”).


\(^{121}\) Estate of Hagedorn v. Peterson, 690 N.W.2d 84, 89 (Iowa 2004).

\(^{122}\) Recall that the original formulation of the locality rule in Kansas came in 1870. *Tefft v. Wilcox*, 6 Kan. 46, 63–64 (1870). The Massachusetts case of *Small v. Howard*, which is most often regarded as the unofficial beginning of the locality rule, was decided in 1880. *Small v. Howard*, 128 Mass. 131, 136 (1880). The official declaration of the locality rule in Iowa, however, occurred in 1872, only two years after *Tefft*, and eight years prior to *Small*.

\(^{123}\) Smothers v. Hanks, 34 Iowa 286, 290 (1872).
doctor’s alleged negligence in the treatment of a patient’s broken wrist.124 After losing at the trial court level, the defendant doctor appealed, arguing that the standard of care applied by the trial court was too burdensome.125 The jury instruction required the doctor to use “such reasonable skill and diligence as are ordinarily exercised in the profession by thoroughly-educated surgeons, having regard to the improvements and advanced state of the profession at the time.”126

The court focused on the requirement that surgeons be “thoroughly educated.”127 In the majority’s view, a practitioner should not be held to such a high standard, nor to a standard that examined the average surgeon.128 Rather, he should be held to a standard “exercised by some defined or undefined portion of the profession, or in other words, more than mere ordinary skill.”129 The court clarified this confusing statement by accepting the locality rule, saying, “the standard of ordinary skill may vary even in the same state, according to the greater or lesser opportunities afforded by the locality, for observation and practice, from which alone the highest degree of skill can be acquired.”130

Despite this argument, one justice was content with the trial court’s formulation of the standard of care.131 Justice Beck’s dissent argued that allowing practitioners who are not current in their understanding of the profession to factor into the standard of care diminishes the standard, which negatively affects society.132 He argued that “[t]he education required must be in the profession in its present state, with all its improvements, the fruits of experience and progress—in the science of today, not of the past.”133 The thrust of his argument can be found in his closing remarks:

But it is said that the instruction is erroneous, because it places the surgeon of the frontier village on a level with the experienced practitioner of the cities and seats of learning. As we have seen, tests

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124. *Id.* at 287.
125. *Id.*
126. *Id.* at 289 (emphasis added).
127. *Id.*
128. *Id.*
129. *Id.* (emphasis omitted).
130. *Id.* at 289–90.
131. *Id.* at 294 (Beck, J., dissenting).
132. *Id.* at 296.
133. *Id.*
of experience and practice are not within the scope of the instruction. But, it is shown, that the frontier surgeon, as to theoretical knowledge, is brought by the side of his professional brother of the city. And why should he not stand there? He may in vain plead, or rather it may in vain be urged in his behalf, for, I know, frontier men of no profession will seek such protection, that his opportunities for the acquisition of professional knowledge are more limited than those of a city. In this age of books, professional periodicals, and mails, the position wants the support of facts. We may safely say that no respectable surgeon, wherever he may be, is uninformed of the progress and discoveries in his profession.134

One can see that this argument is in accord with the critique of the locality rule today. By changing the word “frontier” to “rural” and including the Internet along with “books, professional periodicals, and mails,” Justice Beck’s argument undermines the ongoing assumption of the locality rule—that rural physicians are justified in not being as informed as their city brethren.135 Thus, even as early as 1872, there were some who understood that the technological advancements of that day—“books, professional periodicals, and mails”—allowed rural and urban doctors access to the same level of medical knowledge.136

Beck’s position in opposition to the locality rule was not heard again for some time in Iowa. In 1896, the Iowa Supreme Court modified the pronouncement of the standard of care as developed in Smothers.137 While the ruling modified the specific language—officially incorporating the similar locality rule rather than the strict version—the viability of the locality rule in the state did not change.138 The court explained, “we are of the opinion that the correct rule is that a physician . . . is required to exercise that degree of knowledge, skill, and care which physicians . . . practicing in similar localities ordinarily possess.”139

The use of the “similar locality” rule became a stumbling block for the court in Ferrell v. Ellis in 1906.140 The doctor in this case was from Powersville, Missouri, which sits just across the Iowa-Missouri border and

134. Id. at 299.
135. See supra Part III.A.
136. Smothers, 34 Iowa at 299 (Beck, J., dissenting).
137. Whitesell v. Hill, 70 N.W. 750, 751 (Iowa 1897).
138. Id.
139. Id.
140. Ferrell v. Ellis, 105 N.W. 993, 993 (Iowa 1906).
had a population that was too small to be mentioned in the federal census.\footnote{141} Unsurprisingly, the doctor was the only physician in the town—making it impossible for the plaintiff to procure an expert from that locality.\footnote{142} Despite the fact that the plaintiff’s expert witnesses were numerous “[s]urgeons of more or less experience” from four other towns ranging in population of 690 to 5,000 residents, the court determined that insufficient evidence existed to rebut the standard of care in Powersville as testified to by the defendant himself.\footnote{143} As a result, a single doctor was able to set his own standard of care.

It was not until 1950 in McGulpin v. Bessmer that the Iowa Supreme Court began to reconsider the application of the locality rule.\footnote{144} In this malpractice action, the court explained that “[t]here seems to be sound basis for holding a physician to such reasonable care and skill as is exercised by the ordinary physician of good standing under like circumstances. And the locality in question is merely one circumstance, not an absolute limit upon the skill required.”\footnote{145} However, the McGulpin court’s apparent denial of the locality rule was short-lived.

In the 1962 case of Lagerpusch v. Lindley, the Iowa Supreme Court again made reference to similar localities when announcing a physician’s standard of care.\footnote{146} However, change was soon to come. In 1970, the court in Dickinson v. Mailliard refused to apply the locality rule to hospitals, saying, “It is doubtful today if there is any substantial difference from one locality to another in the type of hospital services rendered.”\footnote{147} The court continues to apply this standard to hospitals despite the fact that many rural hospitals across the state and nation have much smaller budgets than city hospitals.\footnote{148} The court went on to reject arguments in favor of the locality rule by citing McGulpin, saying, “[w]e have brushed aside many of
these same arguments in connection with the skill to be exercised by a
doctor in attending his patient, and we have long compelled him to abide
by the rules of good practice followed generally under similar
circumstances."\footnote{Dickinson, 175 N.W.2d at 596 (citing McGulpin, 43 N.W.2d at 128);
Grosjean v. Spencer, 140 N.W.2d 139, 143 (Iowa 1966).}

Notwithstanding the discussions in McGulpin and Dickinson, the
court again affirmed the application of the locality rule in the 1971 case of
Sinkey v. Surgical Associates.\footnote{Sinkey v. Surgical Assocs., 186 N.W.2d 658, 660 (Iowa 1971) (citations
omitted).} The court explained that “[a] patient is
entitled to a thorough and careful examination such as his condition and
attending circumstances will permit, with such diligence and methods of
diagnosis as are usually approved and practiced by physicians of ordinary
skill and learning under like circumstances and in like localities.”\footnote{Id. (emphasis added) (citations omitted).}

B. The “Death” of the Locality Rule in Iowa

In 1976, however, the court’s opinion in Speed v. State appeared to be
the end of the locality rule in Iowa.\footnote{Speed v. State, 240 N.W.2d 901 (Iowa 1976).} The court concluded “that the
statement of a physician’s duty found in Sinkey v. Surgical Associates,
insofar as it assumes the locality rule is the law in Iowa, is not in step with
the trend of our decisions, while the statement from McGulpin reflects the
view of this court.”\footnote{Id. at 908.} In other words, the standard of care used in McGulpin,\footnote{McGulpin, 43 N.W.2d at 128.} which did not incorporate the locality rule, was to apply in
place of the standard of care used in Sinkey,\footnote{Sinkey, 186 N.W.2d at 660 (citations omitted).} which did apply the locality
rule.\footnote{Recall that the court in Sinkey relied on Wilson to support its use of the locality rule, even though McGulpin was released mere months after Wilson. Thus, the reliance on the locality rule in Sinkey would have been error because it did not follow precedent.}

From the ruling in Speed until the ruling in Hagedorn nearly forty
years later, Iowa courts did not apply the locality rule. In 1999, the Iowa
Supreme Court refrained from using locality in developing the standard of
care, saying, “A physician owes a duty to his patient to exercise the
ordinary knowledge and skill of his or her profession in a reasonable and
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careful manner when undertaking the care and treatment of a patient.”¹⁵⁷ Moreover, during this time period, the Iowa Court of Appeals used a standard of care that did not mention locality, stating, “[d]octors are held to such reasonable care and skill as is exercised by the ordinary physician of good standing under like circumstances.”¹⁵⁸

Commentators also understood the locality rule to be extinct in Iowa.¹⁵⁹ While one commentator did conclude that Iowa still allowed locality to be one factor in determining “similar circumstances,”¹⁶⁰ the bulk of commentators were under the impression that the locality rule did not apply in Iowa. In an American Law Reports annotation, Iowa was categorized as one of the states that did not refer to locality in its standard of care.¹⁶¹ One commentator cited Speed in stating “many states have adopted standards of care ... without emphasizing the locality rule.”¹⁶² As recently as 2006, one note cited McGulpin for the proposition that Iowa had abandoned the locality rule.¹⁶³

Thus, it is not surprising that the plaintiffs and commentators believed the court’s review in Hagedorn would deal the final blow to the locality rule in Iowa. Instead, the court decided the locality rule deserved another try.¹⁶⁴


¹⁵⁹. Lee, supra note 15, at 142 n.23 (listing Iowa among the states “abandoning [the] locality rule and holding physician to degree of skill of physician in like circumstances” (citing McGulpin, 43 N.W.2d at 127–28)); Pearson, supra note 3, at 1151 (prior to Hagedorn, Iowa was in the group of states that did not refer to locality); Stoia, supra note 4, at 109 n.8 (referencing Iowa by stating, “many states have adopted standards of care ... without emphasizing the locality rule” (citing Speed v. State, 240 N.W.2d 901 (Iowa 1976))). But see Cook, supra note 15, at 221 (“The Iowa Supreme Court now holds that the locality in which a physician practices is merely one circumstance to be considered in determining the standard of care applicable to that physician.” (citing Speed, 240 N.W.2d at 908)).

¹⁶⁰. Cook, supra note 15, at 221.

¹⁶¹. Pearson, supra note 3, at 1151.

¹⁶². Stoia, supra note 4, at 109 (citing Speed, 240 N.W.2d at 901).

¹⁶³. Lee, supra note 15, at 142 n.23 (“[A]bandoning [the] locality rule and holding physician to degree of skill of physician in like circumstances.” (citing McGulpin, 43 N.W.2d at 127–28)).

VI. THE RESURRECTION OF THE LOCALITY RULE IN IOWA WITH ESTATE OF HAGEDORN V. PETERSON

After nearly forty years of holding physicians to a standard of care that did not reference locality, the court resurrected the locality rule in Hagedorn. By the time Hagedorn was decided, Iowa, as well as the entire country, was a long way from the horse and buggy days of Tefft, Smothers, and Small. As the new millennium came, America’s population continued to grow. The country’s population was almost 282 million people, and the population density was 79.6 people per square mile. By this time, the urban-rural split was heavily in favor of the urban areas, with 79.0% of Americans being urbanites. Yet, the Iowa Supreme Court was still under the impression that the locality rule was justified.

A. The Facts Behind the Case

On March 6, 1999, Dawn Hagedorn, who was in her thirty-third week of pregnancy, experienced dangerous levels of bleeding. Quickly, Hagedorn rushed to Spencer Municipal Hospital to ensure that no harm would come to her or the child she was carrying. At the hospital, the on-call physician, Jeffry Peterson, took Hagedorn under his care.

Dr. Peterson quickly deduced that Hagedorn was suffering a dangerous condition known as placental abruption, which is a maternal hemorrhage that poses serious risks to both the child and the mother. Hagedorn was stable when she presented, but Dr. Peterson was fully aware that if the abruption progressed, it would cut off the oxygen supply to the child, resulting in permanent injury if the child was not delivered by cesarean section (C-section) within fifteen minutes.

Because Dr. Peterson was not capable of performing a C-section, he
alerted the on-call staff that was capable of performing such a procedure. However, this alert was not a call to mobilization, but simply a forewarning of a possible mobilization. After some time, Dr. Peterson began to arrange for Hagedorn to be transferred to Sioux Falls, South Dakota. However, while on the phone, the fears of Hagedorn and her doctor were realized when her condition dramatically worsened. At this point it was clear that an emergency C-section was required. Unfortunately for Hagedorn and her son, Bryson, Dr. Peterson’s failure to actually mobilize the on-call surgical staff resulted in a thirty-minute delay before the surgery could be performed—twice as long as Dr. Peterson knew he had in this situation. As a result of the injuries suffered during this delay, Bryson Hagedorn died shortly after birth.

B. Does Hagedorn Conform to Previous Jurisprudence?

Naturally, the plaintiff’s experts were critical of the care Hagedorn received from Dr. Peterson. The negligence in question was the doctor’s failure to assemble the already on-call surgical staff prior to the time that Hagedorn’s condition worsened. In defending his conduct, Dr. Peterson and other defense experts argued that it was standard practice in the small town of Spencer not to call in a surgical team until surgery was actually needed. They argued that financial and convenience considerations made it justifiable to summon on-call personnel only when the surgery was absolutely necessary.

A jury found for the defendant, and the plaintiffs objected to a

177. Id.
178. Id.
179. Id.
180. Id.
181. Id.
182. Id.
183. Id.
184. Id. at 87.
185. Id.
187. Hagedorn, 690 N.W.2d at 87.
188. Id.
number of jury instructions.\textsuperscript{189} Of seminal importance was the trial court’s instruction that “[a] physician must use the degree of skill, care, and learning ordinarily possessed and exercised by other physicians in similar circumstances. \textit{The locality of practice in question is one circumstance to take into consideration} but is not an absolute limit upon the skill required.”\textsuperscript{190}

Upon review, the Iowa Supreme Court also ruled in favor of the defendant.\textsuperscript{191} The court briefly reviewed the reasons for the original acceptance of the locality rule.\textsuperscript{192} The court went on to admit that locality was not to be used to limit the skill and care required by a physician.\textsuperscript{193} Further, the court stated that the locality in question was “one circumstance to be considered in determining whether” a physician exercised reasonable care.\textsuperscript{194} Importantly, the court concluded that “the facilities, personnel, services, and equipment reasonably available to a physician continue to be circumstances relevant to the appropriateness of the care rendered by the physician to the patient.”\textsuperscript{195}

After laying out this rule, and rejecting “the plaintiffs’ contention that the locality rule [was] not the law in Iowa,” the court cast the case as one involving limited medical personnel.\textsuperscript{196} The court framed the issue as: “whether, given the limited medical personnel available in the community, a physician of ordinary skill and learning would have assembled a surgical team on a standby basis.”\textsuperscript{197} Admitting that it was completely possible for Dr. Peterson to do so, the court concluded that his failure to do so did not constitute negligence.\textsuperscript{198}

The court’s conclusion hinged on accepting that personnel was a relevant factor to be considered when locality affects the standard of care.\textsuperscript{199} However, the court did not show how this conclusion was tied to any of the justifications it gave for the rule. In justifying the locality rule,
the court said the rule in Iowa was developed to “equitably account for differences in physicians’ ability to develop skill in their profession due to ‘the greater or lesser opportunities afforded by the locality, for observation and practice.’” \textsuperscript{200} However, this justification for the locality rule does not validate the rule’s application in \textit{Hagedorn}, because the physician’s knowledge and skill was not in question.

The court, without citing any Iowa precedent, also claimed that the rule in Iowa was “‘to protect rural practitioners presumed to be less adequately informed than their colleagues in the city.’” \textsuperscript{201} Again, this justification is not persuasive because the physician’s knowledge was not in issue. Moreover, it is questionable why the court accepted this presumption without analysis. The court presented one last justification for the locality rule, but again, did not cite to an Iowa case, stating the rule “allowed the fact finder to take into account differences in physicians’ ‘access to the latest technology.’” \textsuperscript{202} Here, it is difficult to say that there was an issue in regard to the access to technology. Even if one disputes whether Dr. Peterson had access to the surgical team, it is indisputable that a surgical team is not “the latest technology.”

Instead of using Iowa case law, the court cited cases from Arkansas,\textsuperscript{203} Texas,\textsuperscript{204} and Mississippi \textsuperscript{205} to substantiate its use of the locality rule.\textsuperscript{206} Whether these cases actually support the court’s conclusion is another matter. What is important is that the court did not find support for its version of the locality rule in Iowa jurisprudence.

\textbf{C. The Hagedorn Rule and Its Limitations}

The rule, as developed by the court in \textit{Hagedorn}, only allows the jury to consider locality when there is a question regarding the availability of facilities, equipment, personnel, and services.\textsuperscript{207} However, this is different from the strict locality rule, the same locality rule, and the instruction given

\textsuperscript{200} Id. at 89 (quoting Smothers v. Hanks, 34 Iowa 286, 289–90 (1872)).
\textsuperscript{201} Id. (quoting Sokol & Molzen, \textit{supra} note 68, at 476).
\textsuperscript{202} Id. (quoting Sokol & Molzen, \textit{supra} note 68, at 474).
\textsuperscript{203} Gambill v. Stroud, 531 S.W.2d 945, 948 (Ark. 1976).
\textsuperscript{204} Birchfield v. Texarkana Mem'l Hosp., 747 S.W.2d 361, 366 (Tex. 1987).
\textsuperscript{205} Hall v. Hilbun, 466 So. 2d 856, 868, 872–73 (Miss. 1985). This opinion is most often cited for its attack of the locality rule. In fact, it is one of the most cited cases for its negative treatment of the rule and the court’s unwillingness to accept any argument in consideration of the rule.
\textsuperscript{206} \textit{Hagedorn}, 690 N.W.2d at 89.
\textsuperscript{207} Id.
by the district court. Moreover, the Hagedorn rule is open to the same attack as the other formulations of the rule.

Unlike the strict locality rule and the similar locality rule, which allow locality to be considered when there is a question of skill or resources, the Hagedorn rule only applies the locality rule when there is a question of resources.208 This suggests that the court accepts the premise that modern society has developed such that the rural physician is at the side of the city physician when care, skill, and learning are at issue. However, the court accepted the instruction that allowed the jury to consider locality as one factor in determining the level of skill required.209 By accepting this statement of the law, the court confusingly implies that the locality of practice is relevant when skill, care, and learning are at issue.

Whether the Hagedorn rule accepts both of the assumptions underlying the locality rule is left for another case. Whatever the exact nature of the rule, the traditional arguments against the rule still apply.210 But as the rule stands, it is a clear victory for defense counsel because the court appears sympathetic to doctors’ financial and time constraints.211

It is difficult to understand how cost and convenience make it reasonable not to summon a surgical team when that team knows it is on-call in a small town. It has always been costly and inconvenient for people and businesses to conform their conduct to the rules of negligence. Negligence law has historically required stores to protect their invitees at their own expense because, in the eyes of the law, a person who invites the public onto his property for a business purpose should not create a dangerous condition for them.212 Negligence law has caused drivers the inconvenience of following sometimes archaic rules of the road because members of society believe the roadways should be safe.213 The list of negligence laws that affect costs and convenience is too long to address here, but the point is that negligence law does not allow an individual’s own customs, financial considerations, and conveniences to control the case—even if the individual went to medical school.

This does not mean that a physician must have all lifesaving

208. Id.
209. Id. at 88.
210. See supra Part IV.A.
211. Hagedorn, 690 N.W.2d at 89.
technologies in his office. Rather, negligence law stands for the proposition that the physician who has that resource readily available cannot avoid using it out of concerns for cost and convenience when the use of that resource is prudent.\textsuperscript{214} Similarly, cost and convenience do not justify the failure to utilize personnel that have intentionally signed up for a position that regularly leaves them on-call. If a physician is not going to actually summon those who are on-call, then the physician’s assurance to the community that there are on-call physicians is misleading.

The doctor who holds himself out to the community as a safe harbor, but does not utilize the available tools is like the company delivery driver who undertakes the responsibility of transporting a sick employee back to her street, but forces her to walk the distance to her house because the road is too difficult to travel.\textsuperscript{215}

The law recognizes that a rescuer is liable for giving another a false sense of security and failing to be reasonable in producing that security.\textsuperscript{216} Similarly, a doctor who gives a patient a sense of security should be responsible for effectuating that security. To conclude otherwise would be similar to saying that a patient who seeks treatment from a rural doctor is assuming the risk that the rural practitioner will not utilize available resources due to cost and convenience. While it may be reasonable to say a

\textsuperscript{214} See Hall v. Hilbun, 466 So. 2d 856, 873 (Miss. 1985) (holding each physician’s duty of care is to use “such reasonable diligence, skill, competence, and prudence as [is] practiced by minimally competent physicians in the same specialty or general field of practice throughout the United States, who have available to them the same general facilities, services, equipment and options.”).

\textsuperscript{215} RESTATEMENT (FIRST) OF TORTS: NEGLIGENT PERFORMANCE AND TERMINATION OF GRATUITOUS SERVICES § 323 illus.1 (1934). The Restatement provision reads:

(1) One who gratuitously renders services to another, otherwise than by taking charge of him when helpless, is subject to liability for bodily harm caused to the other by his failure, while so doing, to exercise with reasonable care such competence and skill as he possesses or leads the other reasonably to believe that he possesses.

(2) One who gratuitously renders services to another, otherwise than by taking charge of him when helpless, is not subject to liability for discontinuing the services if he does not thereby leave the other in a worse position than he was in when the services were begun.

\textit{Id.}

\textsuperscript{216} \textit{Id.} For more information on the “Good Samaritan rule,” see 57A AM. JUR. 2D NEGLIGENCE § 106 (2004).
patient assumes the risk that a rural doctor will not have access to a lifesaving piece of equipment, is it really reasonable to say that if the piece of equipment is available it is not negligent for the doctor to fail to use it in an emergency situation? Even if it is costly to use the machine or if the situation requires another doctor to come in, the possibility of saving a life with the available resources strongly outweighs other concerns.

Moreover, a crafty defense attorney would always be able to put the availability of facilities, services, equipment, or personnel of the particular locality into issue, especially when the plaintiff’s experts are from other localities. Should a physician at Iowa City Hospitals, the largest hospital in Iowa, get a jury instruction that requires the jury to consider the fact that what is reasonably available for Iowa City Hospitals differs from what is available at the Mayo Clinic when a physician from Mayo testifies for the plaintiff? Moreover, at what point is a city “rural enough” to justify using the locality rule?

VII. PROPOSAL OF A NEW RULE

It appears that the rest of the country has determined that it is time for a new rule. It is time that Iowa follows suit. The use of locality in jury instructions requires jurors to take as fact information that they are supposed to determine. In order to prevent this confusion, a medical malpractice standard that does not reference geography is necessary. The most appropriate formulation of this standard is already found in the Iowa Model Jury Instructions: “A physician must use the degree of skill, care and learning ordinarily possessed and exercised by other physicians in similar circumstances.” This two-part duty should apply to all medical malpractice cases because it adequately considers the physician’s knowledge, skill, and the availability of facilities, personnel, services, and equipment in a fair manner. The remainder of this Part will consider the application of the reasonable physician standard in medical malpractice cases.

The first portion of the Iowa Model Jury Instructions regarding a duty of a physician, section 1600.2, expresses the first duty of the negligence standard as, “A physician must use the degree of skill, care and learning ordinarily possessed and exercised by other physicians . . . .” Based on this duty, the jury is to determine if the physician in question possessed and
used reasonable skill, care, and learning. The second duty is observed in the “in similar circumstances” language of the instruction.\textsuperscript{220} This is where the jury is to determine whether the physician in question made use of the resources he had available. The Mississippi Supreme Court explained the bifurcated aspect of this determination by stating the jury should consider that the physician has:

(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 exercise, and (b) a duty based upon the adept use of such medical facilities, services, equipment and options as are reasonably available.\textsuperscript{221}

The first part of the duty is universal, and can be determined without reference to technology, personnel, or locality. Again the Mississippi Supreme Court puts it best:

Regarding the basic matter of the learning, skill and competence a physician may bring to bear in the treatment of a given patient, state lines are largely irrelevant. That a patient’s temperature is 105 degrees means the same in New York as in Mississippi. Bones break and heal in Washington the same as in Florida, in Minnesota the same as in Texas. An abnormal blood sugar count should be interpreted in California as in Illinois as in Tennessee. A patient’s physiological response to an exploratory laparotomy and needs regarding post-operative care following such surgery do not vary from Ohio to Mississippi. A pulse rate of 140 per minute provides a danger signal in Pascagoula, Mississippi, the same as it does in Cleveland, Ohio. Bacteria, physiology and the life process itself know little of geography and nothing of political boundaries.

It is absurd to think that a physician examining a patient in his or her office would, by reference to genuine health care needs of the patient, say: Because I practice in Mississippi (or the Deep South), I will make this diagnosis and prescribe this medication and course of treatment, but if I were in Iowa, I would do otherwise.\textsuperscript{222}

The \textit{Hagedorn} court evidenced its agreement with this principle by stating that locality can only be a factor when the availability of facilities,
personnel, services, and equipment affect the level of care. If it is true that the only time locality is in question in Iowa is in the availability of facilities, personnel, services, and equipment, then the court agrees that the locality rule’s assumption—that the rural doctor does not have the same opportunity for learning and skill development—is invalid. If this is the court’s position, then Hagedorn has effectively eliminated half of the locality rule. Therefore, relying on the first part of the reasonable physician standard of care for physicians would not change anything.

It is the second portion of the reasonable physician standard—“similar circumstances”—where abandonment of the locality would have an impact. Whenever a jury tries to determine what constitutes similar circumstances, they would be looking at things like the nature of the facilities, the availability of personnel, services, technology, and other aspects that made up the given situation. This is due to the fundamental idea that it is the jury’s duty to decide what constitutes “similar circumstances.” However, when examining whether there were similar circumstances, the use of locality in a jury instruction muddies the waters for jurors.

While the phrase “similar circumstances” incorporates all aspects of a physician’s circumstances, it specifically directs the jury to consider the availability of facilities, personnel, services, and equipment; in doing so, it inherently legitimizes local practice. For the locality rule jury instruction to be given it requires a judge to first determine that the availability of facilities, personnel, services, or equipment is at issue. Then, the jury instruction tells the jurors that because the availability of facilities, personnel, services, or equipment is in issue, the law requires them to consider this in determining the standard of care owed to the plaintiff. This determination will necessarily cut in favor of the defendant every time, for these aspects will only be at issue because the defendant will claim that he is being held to too high of a standard. Thus, the court’s instruction of the law gives a defendant an undue advantage.

224. See supra Part VI.B.
226. It is important to note that the same legitimization occurs whenever a reference is made to locality whether in the form of the strict locality rule, the similar locality rule, or mentioning that locality is to be considered as a factor.
227. See IOWA CIVIL JURY INSTRUCTION 1600.2 cmt. (2007) (citing Hagedorn, 690 N.W.2d at 84).
228. Hagedorn, 690 N.W.2d at 88.
Moreover, issuing a geographically determined instruction leaves the jurors to define locality in the way that they see fit. Commonly, the term locality means “[a] definite region; vicinity; neighborhood; community.” Thus, the average juror would be left to assume that the standard as developed in the defendant’s specific community is the standard by which to judge him. In other words, if the defendant’s community has developed a poor custom, that physician’s adherence to the custom is unassailable even if the custom is clearly erroneous. This is the same problem that contributed to the demise of the strict locality rule in the first place.

Merely adding the word “similar” changes little. As one commentator explained:

Allowing evidence of the medical standard in a “similar,” rather than “same,” community may alleviate the problem, but certainly will not excise it, since the Restatement’s guideposts of location and character are too broad and unqualified to provide a clear picture of what a similar community is. Additionally, even if a similar community can be defined and discovered, those very qualifications which make it similar, such as geographic proximity and likeness in character, are apt to mean that such a community would be located near that of the defendant. The result is that expert witnesses would still be familiar with, and sympathetic towards, the defendant.

Even if the testifying doctors are not from the same general geographic zone, the very fact that makes the towns similar would likely make their customs similar.

Problems further arise when using locality as one factor as the district court did in *Hagedorn*. This formulation does not alleviate the prejudice to the plaintiff because it impliedly requires jurors to compare the locality in question with the localities of the experts, giving weight to the locality in question.

By encouraging a jury to consider locality through any type of geographically based jury instruction, the court is serving the jurors a dinner of red herring. Negligence law is based on the foundation that “normative values should be applied to the standard of care and that the question of negligence is what ought to be done rather than what is done in

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229. BLACK’S LAW DICTIONARY 957 (8th ed. 2004).
230. See supra Part IV.A.
231. Cohen, supra note 45, at 594.
232. Hagedorn, 690 N.W.2d at 89.
similar circumstances by most people.” 233 When courts focus on locality they are paying too much attention to what is actually done. Locality forces jurors to look at whether the defendant’s conduct conforms to the locality’s actual custom without questioning the validity of that custom. This is not a normative claim of what ought to be, but a descriptive claim of what is—in other words, it is not negligence law as traditionally viewed in American jurisprudence.

This practice of allowing a custom to determine the standard of care is far removed from the traditional understanding of negligence. 234 Justice Oliver Wendell Holmes noted that customary practices are only a beginning by stating, “What usually is done may be evidence of what ought to be done, but what ought to be done is fixed by a standard of reasonable prudence, whether it usually is complied with or not.” 235 The question of what is reasonable is the precise issue to be determined by the jury. 236

The jury, from its knowledge of how persons of reasonable prudence usually deport themselves in relation to their surroundings, decides the specific standard of care—whether the defendant’s conduct in the particular case is below the general standard of care, including whether in the particular case the risk of harm created by the defendant’s conduct is or is not reasonable. Thus, where not only the facts constituting the conduct of the parties, but also the standard of care that they should have exercised, are to be determined, the case is entirely one of fact to be decided by the jury. 237

It must be conceded that there are legitimate differences in rural and city communities; however, that is where the role of the jury and the “similar circumstances” language of the reasonable physician standard of care become important. This language is what allows the jury to make an unbiased factual determination regarding the availability of facilities, personnel, services, or equipment. 238 By limiting the jury instruction to whether a physician used the degree of skill, care, and learning ordinarily

237. Id. (footnotes omitted).
238. IOWA CIVIL JURY INSTRUCTION 1600.2 cmt. (2007).
possessed and exercised by other physicians in similar circumstances, the court will allow the jury to make this factual determination rather than encouraging the jury to sympathize with the rural physician.

A crucial aspect of the reasonable physician standard is that it allows defense counsel to argue questions of facilities, personnel, services, or equipment, and that as a result of these circumstances, the plaintiff’s characterization of what ought to have been done is unreasonable. In allowing counsel to argue the point rather than declaring it as law, the court does not unduly burden the jury or usurp its duties; rather, the jury is able to recognize the argument as a defense position and determine whether the preponderance of the evidence lies with the plaintiff’s characterization of the evidence or the defense’s characterization. Instead of assuming that a rural physician is justified in possessing or using facilities, personnel, services, or equipment, by using the reasonable physician standard of care without reference to geography, the jury is allowed to hear evidence from both litigants and to make this important factual determination based on the specific case before them.

VIII. CONCLUSION

The locality rule has been the object of much criticism. As a result, the vast majority of states have moved toward a national standard of care. Despite multiple Iowa decisions that appeared to abolish the locality rule in Iowa, the Iowa Supreme Court accepted the rule’s validity in *Hagedorn*.

Evidence abounds that casts doubt on the validity of the locality rule. Standardized medical training and the availability of information and technology has leveled the playing field between city and rural doctors. Thus, we no longer need to assume that rural doctors are necessarily going to be less knowledgeable, skillful, or equipped than their counterparts in the city.

The court in *Hagedorn* ruled that locality can be considered as one factor in determining the standard of care. However, this language is deceptive and too imprecise for a lay jury to appreciate. Instead, the better rule is the reasonable physician standard of care, which requires a physician to use the “degree of skill, care and learning ordinarily possessed and exercised by other physicians in similar circumstances.”

239. *Id.* at 1600.2.
arguments to a jury that can then make a determination on the facts of the case.

In a given situation, gaps may exist in the amount of technology that rural practitioners can utilize compared to what practitioners in the city are able to have at their disposal. But this is not always the case. The locality rule—whether it is the strict, similar, or Iowa version—assumes there is always a difference between rural and urban doctors, while the ordinary negligence standard requires defense counsel to actually prove that difference.

This ordinary negligence standard is preferable because it covers the concerns that surrounded the development of the locality rule, while recognizing that the interconnected and technologically advanced society we live in no longer needs to accept assumptions that allow rural physicians to undertake a lesser duty than urban physicians. Each area of practice will have different benefits and drawbacks, but it is the jury’s job to determine whether these characteristics affect the standard of care.240 It is not the court’s role to rely on outdated assumptions in making a blanket rule that protects rural physicians and unduly binds patients merely because of geography.

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