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JOURNAL DISCUSSION
A Resource-Based Locality Rule
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Lewis MK, Gohagan JK, Merenstein DJ. The locality rule and the physician's dilemma. *JAMA*. 2007;297:2633-2637.

Some physicians may find the semantics of the medico-legal world a bore. However, "The Locality Rule and the Physician's Dilemma," by Lewis and colleagues [1], really caught our attention. We consider the locality rule from the point of view of a practicing emergency physician (EP).

The locality rule, once widely applied in the United States and abroad, was designed to protect rural physicians from having to uphold the same standard of care as that provided in the academic health science centers and modern clinics of the city. Initially this was a matter of training, research, and resources; rural practitioners not only lacked the equipment of the urban centers but also did not benefit from the latest advances in science and practice that emanated from medical research conducted at urban center hospitals [2]. Most courts now hold, however, that this argument is not valid in an era of seamless electronic communication, national standards in medical training and lifelong education, and the flow of scientific information among medical institutions throughout the country [3].

Lewis et al. argue convincingly for the abolition of the rule, still in force in some states either by statute or case law. One of their strongest arguments is that the locality rule might actually promote substandard care by preventing practitioners from adopting newer or more evidence-based practices for fear of breaching a local "standard" that is actually inferior [1].

But completely eliminating the locality rule may not be the answer. Instead of defining "locality" as geography, the courts' traditional approach [4-6], we believe that the determination of the standard of care should be based on the resources available to the physicians in that area. This was the approach the court advocated in *Hall v. Hilbun*, redefining the standard of care as follows:

> [G]iven the circumstances of each patient, each physician has a duty to use his or her knowledge and therewith treat through maximum reasonable medical recovery, each patient, with such reasonable diligence, skill, competence and prudence as are 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* (emphasis added) [7].

This view was reaffirmed in *Palmer v. Biloxi Regional Medical Center, Inc.* [8]. The Supreme Court of Mississippi upheld the trial court's decision to dismiss the plaintiff's charge of negligence against the medical center, partly because the plaintiff's medical "expert" had not familiarized himself with the facilities available to the defendant doctor or in the general area of the state. The court held that it is necessary and acceptable to consider the medical resources available in determining the standard of care required by the practitioner [9].

A resource-based approach, while broadly applicable, is especially appropriate for the practice of emergency medicine. Medical management decisions—often critically important ones—may hinge on the availability of resources at a given facility, in a given community, on a given day of the week and time of day. Even within a given community, a small hospital emergency department with minimal staffing and a limited specialist call panel may be just down the street from a major tertiary receiving center with specialists available in-house around the clock. Because of the considerable overlap in the scope of practice and actual practice of EPs and various medical and surgical specialists, EPs often perform procedures that medical and surgical specialists would perform in nonemergency circumstances.

One example is the variation in the performance of a resuscitative thoracotomy: a highly invasive and resource-intensive procedure that is sometimes performed on moribund victims of trauma at urban academic trauma centers. Despite a very low survival rate, the procedure nonetheless has some neurologically intact survivors [10]. EPs are trained in resuscitative thoracotomy but may decide not to apply the skill in practice because it doesn't make sense in their environments; without the immediate availability of an appropriately trained and prepared trauma team, patients are unlikely to survive beyond initial resuscitation. Thus, the availability of resources, especially human resources, is and should be intimately tied to medical decision making and therefore the standard of care.

A more commonly encountered example involves the drainage of abscesses in the emergency department. If an abscess is extremely deep and likely to involve vital structures, a decision may be made to defer drainage to a consultant surgeon, who is better prepared to deal with complications in the controlled setting of the operating room. However, things are not always that simple for EPs. A surgeon may not always be on hand. Even in hospitals with robust call panels, a consultant may not always be able to respond in a timely manner to an emergency if, for example, he or she is already in the operating room with another patient. In the event that an appropriate surgical specialist is not immediately available, the risk of complications may be outweighed by risk of delay in care. Ultimately, EPs are trained and willing to act in such circumstances, even if their experience with the procedure in question is less than the specialist's. Many patients who would benefit from care in settings with more resources by more specialized personnel receive emergency treatment by

EPs when this risk-benefit ratio passes a critical threshold. And that threshold varies with the resources available. So should the EP be held to a general "standard" or that of a similarly situated EP with similar resources?

A resources-oriented locality rule is implicit in the California requirement that testimony in the context of medical malpractice cases against EPs in that state be limited to other EPs, i.e., that it be specialty-specific [11]. EPs in other states do not enjoy this protection. In *Sami v. Varn* [12], for example, an obstetrician-gynecologist was qualified to give expert testimony on the standard of care for a pelvic examination performed by an EP. When resources and urgency are not taken into account, we risk holding EPs to an unrealistic standard.

Lewis et al. argue for the incorporation of evidence to the determination of the standard of care. While it is difficult to take issue with this approach, very few malpractice cases hinge solely on medical evidence, even when such evidence exists. The majority of modern medical practice remains unproven by modern scientific standards, and applying evidence to individual cases remains a matter of judgment. Thus, it continues to be necessary to rely on the expertise of practicing physicians to determine the standard in each individual case. Experts testify as to "the degree of care and skill that a physician or surgeon of the same medical specialty would use under similar circumstances" [13], not on a simple factual question.

We agree that the locality rule as originally designed is somewhat outdated. However, the underlying principle should still apply: each case should be viewed in its own context. A resources-based "locality rule," if adopted nationwide, might protect clinicians from being held to an impractical standard of care that does not consider the totality of the circumstances under which they acted.

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