Yet upon whose shoulders does the duty fall to ensure that important legislative purposes are not lost in the vast hallways of the federal courts?

Butz signifies a major setback in procedural and substantive review under NEPA. The court exhibited a lax and cursory attitude in both areas of judicial review. In the area of procedural review, *Butz* viewed an environmental impact statement as nothing more than a lengthy document containing a catalogue of information about a project planned by a federal agency. In the past, however, courts have required that an environmental impact statement contain a complete and systematic basis for an environmentally sound project, as well as a comprehensive evaluation of the effects of the project as planned. The standard of procedural review set by *Butz* requires a reviewing court merely to determine whether an environmental impact statement was prepared in good faith, and to ignore blatant inconsistencies and omissions. The ultimate effect of such a holding will be a less rigorous and comprehensive approach by the agency in preparing an environmental impact statement, as a document with little factual support will be approved by a reviewing court. The effect of *Butz* will be most crippling in the area of substantive review. Although the court maintained that review of the merits of an agency decision is a mandate, the brief analysis of the agency decision in issue successfully precludes meaningful substantive review in the future. According to the standard of substantive review set by *Butz*, a court is not required to evaluate, in light of the environmental policy of NEPA, the balance struck by an agency. Instead, a reviewing court will merely determine whether an agency decision is reasonable and supportable. Without taking into consideration the policies espoused by section 101 of NEPA, any decision would arguably be supportable and reasonable. NEPA sought to interject an emphasis upon environmental protection into the agency decision-making process. *Butz*, however, has rendered the environmentally oriented policy of NEPA meaningless, and has made the Act just another means by which the courts can, with minimal effort, rubber-stamp the decisions of federal agencies.

SANDRA LEE BONDY

MEDICAL MALPRACTICE—STANDARD OF CARE WHICH GENERAL MEDICAL PRACTITIONER IS HELD TO IS "SUCH REASONABLE CARE AND SKILL AS IS EXERCISED BY THE ORDINARY PHYSICIAN OF GOOD STANDING UNDER LIKE CIRCUMSTANCES," AND LOCALITY IN QUESTION IS MERELY ONE CIRCUMSTANCE TO BE CONSIDERED, NOT AN ABSOLUTE LIMIT ON THE SKILL REQUIRED.—*Speed v. State* (Iowa 1976).

Plaintiff Speed, a student at the University of Iowa, was inflicted with an upper respiratory infection which had persisted several weeks. He also had several teeth extracted at the Oral Surgery Department of the University Hospitals, and was then sent home. Speed experienced severe headaches and nausea following his oral surgery and was given medication for the pain, although it was determined that the extractions were healing properly. Shortly thereafter, Speed was taken to the University Student Health Infirmary where the examining physician noted that Speed was suffering from cold, headache, nausea, loss of appetite, dehydration, dizziness and inflamed eyelids; however, a definite diagnosis for his illness was not reached. Doctors were called early the following morning and found his eyes beginning to bulge abnormally. Speed was taken to the Neurology Department and was operated on the following day for the removal of ethmoid sinuses. It was determined that an infection, probably originating in the sinus area had caused blood clotting, and while intensive medical care saved Speed's life, he emerged permanently blind. Speed filed suit against the state under the Iowa Tort Claims Act,[1] alleging negligence on the part of the treating physicians at the State University Hospitals. The Johnson County District Court entered judgment for the plaintiff, and the state appealed, alleging *inter alia* that plaintiff's expert witnesses were incompetent to testify as they lacked knowledge of the standard of care applicable in the community. The Supreme Court of Iowa *held*, affirmed. The standard of care which a general medical practitioner is held to is "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 to be considered, not an absolute limit on the skill required. *Speed v. State*, 240 N.W.2d 901 (Iowa 1976).

The central issue in *Speed* was whether Iowa would continue to adhere to the "locality rule," which prior to the case at bar defined the standard of care required of practicing physicians in Iowa. The locality rule itself is an American creation[2] and can be traced to the second half of the nineteenth century. An early statement of the rule appears in the case of *Smothers v. Hanks*.[3]

---

1. IOWA CODE ch. 25A (1973).
2. Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DE PAUL L. REV. 408, 410 (1969) [hereinafter cited as Waltz].
3. 34 Iowa 286 (1872).

There, the Iowa court was faced with an appeal from a judgment entered against a physician who allegedly treated plaintiff's injury in a "negligent, ignorant and unskillful"[4] manner. The court held the standard of care applicable to a physician to be that care ordinarily exercised in the profession,[5] but noted that, "[i]t is also doubtless true that 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."[6] From cases such as *Smothers*, the locality rule developed, providing that a physician is bound "to exercise the degree of skill ordinarily employed, under similar circumstances by members of his profession in good standing *in the same community or locality*. . . ."[7]

The rationale behind the locality rule is set forth in a frequently cited case, *Small v. Howard*,[8] wherein a malpractice suit was filed against a small town general practitioner, alleging that he had treated a severe wound, which treatment required a considerable degree of surgical skill, in a negligent manner. The court stated that it was a matter of common knowledge that a physician in a small country village did not generally make a specialty of surgery, and was but seldom called upon to perform difficult operations.[9] Accordingly, the court held a physician "bound to possess that skill only which physicians and surgeons of ordinary ability and skill, practising in similar localities, with opportunities for no larger experience, ordinarily possess; and [that] he [is] not bound to possess that high degree of art and skill possessed by eminent surgeons practising in large cities, and making a specialty of the practice of surgery."[10]

Accordingly, the locality rule was grounded upon practical considerations for which there seems to have existed considerable justification given the attendant circumstances. However, the application of the locality rule has given rise to two significant difficulties. First, it has allowed pockets of inferior medical care to exist free of liability for substandard practices due to a uniformity of practice in those areas.[11] Second, it has created a substantial burden for the plaintiff seeking to secure expert witnesses who are both familiar with community standards and willing to testify against a defendant physician.[12]

---

4. Smothers v. Hanks, 34 Iowa 286, 287 (1872).
5. *Id.* at 289.
6. *Id.* at 289-90. The court further noted that it was not disposed to lower the professional standard of care and diligence, but recognized that the standard must be a practical and attainable one, and not one of theoretical perfection which would necessarily drive from the profession a large number of practitioners. *Id.* at 290.
7. Lemoine v. Bunkie Gen. Hosp., 326 So. 2d 618, 619 (La. App. 1976) (emphasis added).
8. 128 Mass. 131 (1880). The Massachusetts court overruled this decision in Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968).
9. Small v. Howard, 128 Mass. 131, 136 (1880).
10. *Id.*
11. *See* Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 349 A.2d 245 (1975); Pederson v. Dumouchel, 72 Wash. 2d 73, 431 P.2d 973 (1967).
12. This so-called "conspiracy of silence" is frequently referred to. *See, e.g.*, W. PROSSER, LAW OF TORTS 164 (4th ed. 1971) [hereinafter cited as PROSSER]. Other writers have suggested that in fact such a problem is exaggerated. King & Coe, *The Wisdom of the Strict Locality Rule*, 3 U. BALT. L. REV. 221 (1974).

In the face of such difficulties, some jurisdictions have continued to adhere to a strict application of the locality rule,[13] but more commonly, modifications in the locality rule have been effected. The most common modification has been to expand the standard to "similar localities"—instead of "the locality" in fact involved—such as the Iowa court early did in *Whitesell v. Hill*.[14] There the court stated,

> "It will not do . . . to say that, if a surgeon or physician has exercised such a degree of skill as is ordinarily exercised in the particular locality in which he practices, it will be sufficient." . . . [W]e are of the opinion the correct rule is that a physician and surgeon, when employed in his professional capacity, is required to exercise that degree of knowledge, skill, and care which physicians and surgeons practicing *in similar localities* ordinarily possess.[15]

Likewise, in *Viita v. Fleming*,[16] the Minnesota court in a widely followed decision held that a general practitioner was not bound by the standard of the locality, unless that term was correctly interpreted to indicate a wider geographic span than a village or a city.[17] This interpretation of the locality rule as referring to a similar locality is modernly followed by a plurality, if not a majority of the states.[18] The rationale behind such an approach is to remedy the problems identified in a strict application of the locality rule, as is seen in the court's reasoning in the case of *Sampson v. Veenboer*.[19] In that action the court allowed a Chicago physician to testify as to surgery practices in Grand Rapids, Michigan, after he had stated that he was familiar with pracices in similar communities. The *Sampson* court noted that "[a]t times it may become necessary to secure the expert testimony of one who resides some distance from the home of a defendant accused of malpractice, for it may be difficult to obtain a witness to testify against one who bears the very high professional reputation of defendant [physician]."[20]

Another modification of the strict locality rule employed by some courts has been to expand the geographical boundaries of the locality to include those

---

13. *E.g.*, Gandara v. Wilson, 85 N.M. 161, 509 P.2d 1356 (1973); Collins v. Itoh, 503 P.2d 36 (Mont. 1972); Getchell v. Mansfield, 489 P.2d 953 (Ore. 1971).
14. 101 Iowa 629, 70 N.W. 750 (1897).
15. Whitesell v. Hill, 101 Iowa 629, 636-37, 70 N.W. 750, 751 (1897) (emphasis added and citations omitted).
16. 132 Minn. 128, 155 N.W. 1077 (1916).
17. Viita v. Fleming, 132 Minn. 128, 137, 155 N.W. 1077, 1081 (1916).
18. Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, —, 349 A.2d 245, 250 (1975); *accord*, Pegram v. Sisco, 406 F. Supp. 776 (W.D. Ark. 1976) (same or similar locality); Callahan v. William Beaumont Hosp., 67 Mich. App. 306, 240 N.W.2d 781 (1976) (similar community); Kortus v. Jensen, 195 Neb. 261, 237 N.W.2d 845 (1976) (same neighborhood or similar community). Alaska has enacted a statute setting forth the required standard of care in terms of similar communities, which the court in Poulin v. Zartman, 542 P.2d 251 (Alas. 1975), held could not be judicially expanded upon. The determination of what is a similar community for those jurisdictions following the similar locality rule does not necessarily hinge upon geographic similarity, but rather considers medical similarity of facilities, as is pointed out in the case of Gambill v. Stroud, 531 S.W.2d 945 (Ark. 1976).
19. 252 Mich. 660, 234 N.W. 170 (1931).
20. Sampson v. Veenboer, 252 Mich. 660, 667, 234 N.W. 170, 172 (1931).

centers that are readily accessible for appropriate treatment. For example, in *Tvedt v. Haugen*,[21] a North Dakota case, the court noted that "the borders of the locality and community have, in effect, been extended so as to include those centers readily accessible where appropriate treatment may be had which the local physician, because of limited facilities or training, is unable to give."[22] This method of liberalizing the strict locality rule thus looks to what is termed the medical locality or the "same medical community."[23]

A third major response to the locality rule has been to abandon it and hold that the locality of the practitioner is merely one factor to be considered in determining the applicable standard of care, rather than finding the local standard to be an absolute limit upon the skill required.[24] In adopting this position in *Speed*, the Iowa court placed reliance upon commentators in the field, past Iowa decisions, and the trend discerned in other jurisdictions regarding the standard of care required of practicing physicians.

In examining the present viability of the locality rule, the court in *Speed* correctly noted that commentators have frequently criticized the existence of the rule under modern conditions. Dean Prosser has espoused the view that "[i]mproved facilities of communication, available medical literature, consultation and the like, led gradually to the abandonment of any fixed rule, and to treating the community as merely one factor to be taken into account in applying the general professional standard."[25] Nations and Surgent, two noteworthy commentators who have examined the rule's modern applicability, conclude that while the locality rule is still the rule followed by the majority of the states,[26] recognition by the courts of advances within the medical profession are definitely leading to a new standard wherein the nature of the practice within the community of the defendant physician will only be one consideration in testing

---

21. 70 N.D. 338, 294 N.W. 183 (1940).

22. Tvedt v. Haugen, 70 N.D. 338, 349, 249 N.W. 183, 188 (1940).

23. Finley v. United States, 314 F. Supp. 905 (N.D. Ohio 1970). For a general discussion of the term "medical locality," see 18 DE PAUL L. REV. 328 (1968).

24. The rationale underlying the decisions in those jurisdictions where the locality rule has been abrogated is perhaps most succinctly set forth in Shilkret v. Annapolis Emergency Hospital Association, 276 Md. 187, 349 A.2d 245 (1975), a decision not cited in *Speed*. In *Shilkret*, the court stated:

> [J]ustification for the locality rules no longer exists. The modern physician bears little resemblance to his predecessors. As we have indicated at length, the medical schools of yesterday could not possibly compare with the accredited institutions of today, many of which are associated with teaching hospitals. But the contrast merely begins at that point in the medical career: vastly superior postgraduate training, the dynamic impact of modern communications and transportation, the proliferation of medical literature, frequent seminars and conferences on a variety of professional subjects, and the growing availability of modern clinical facilities are but some of the developments in the medical profession which combine to produce contemporary standards that are not only much higher than they were just a few short years ago, but also are national in scope.
>
> In sum, the traditional locality rules no longer fit the present-day medical malpractice case.

Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, —, 349 A.2d 245, 252 (1975).

25. PROSSER, *supra* note 12.

26. For an illuminative, though now dated, breakdown as to respective jurisdictional adherences at that time see 18 DE PAUL L. REV. 328, 332 (1968).

the qualifications of a witness to testify as to the medical malpractice of another physician.[27] Waltz, a frequently cited author, has also concluded that the locality rule has long been in the process of shrinking and will gradually disappear almost completely.[28] Lawyers Medical Cyclopedia notes the trend away from the locality rule;[29] the *Restatement of Torts* likewise does not adhere to a strict application of the rule, but rather requires a general practitioner to exercise the skill and knowledge normally possessed by members of that profession in good standing in similar communities.[30] Thus, it can be seen that the view of most commentators is often to discourage a strict application of the rule and to recognize a general trend away from its continued use. However, it should be noted that the rule is not without its defenders.[31]

In reaching the decision to abandon the locality rule in Iowa, the court in *Speed* also placed great reliance upon the past Iowa decisions. Indeed, the court seemed not so much to engage in a present reasoning process as it did to look to and draw upon the reasoning of past related cases in a cumulative assembly and incorporation process.

In *Ruden v. Hansen*,[32] the Iowa court addressed itself to the standard of care applicable to practitioners of veterinary medicine. The court held that it no longer approved of locality limitations as they applied to veterinarians, but rather that the standard of care practiced in a particular locality was but one element for consideration, and not conclusive as to the care owed.[33] Likewise, the standard of care applicable to specialists was held, in the Iowa case of *Grosjean v. Spencer*,[34] to be that degree of skill and care ordinarily used by similar specialists in like circumstances without reference to the locality in question.[35]

---

27. Nations & Surgent, *Medical Malpractice and the Locality Rule*, 14 S. TEXAS L.J. 129 (1973).

28. Waltz, *supra* note 2, at 415.

29. LAWYERS MEDICAL CYCLOPEDIA § 2.45 (1966).

30. RESTATEMENT (SECOND) OF TORTS § 299A (1965). For general notations of this trend also see Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729 (1970); 25 ARK. L. REV. 169 (1971); 18 DEPAUL L. REV. 328 (1968).

31. King & Coe, *The Wisdom of the Strict Locality Rule*, 3 U. BALT. L. REV. 221 (1974); *see* note 9 *supra*.

32. 206 N.W.2d 713, 716 (Iowa 1973).

33. Ruden v. Hansen, 206 N.W.2d 713, 716 (Iowa 1973).

34. 258 Iowa 685, 140 N.W.2d 139 (1966).

35. Grosjean v. Spencer, 258 Iowa 685, 691, 140 N.W.2d 139, 143 (1966). The *Grosjean* holding had no application to general practitioners, though, for as was held in *Barnes v. Bovenmyer*, a higher degree of competence is required of specialists than that usually exercised by general practitioners. Barnes v. Bovenmyer, 255 Iowa 220, 228, 122 N.W.2d 312, 316 (1963).

The rationale behind the Iowa court's decision as to the skill required of specialists may be seen more clearly by looking to the holdings of foreign jurisdictions. In *Naccarato v. Grob*, for example, the Michigan court stated that public reliance upon the skills and knowledge of a specialist are not limited by the geographic area in which he practices. Naccarato v. Grob, 384 Mich. 248, 253-54, 180 N.W.2d 788, 791 (1970). His knowledge is a specialty and this specialization enables him to keep abreast of scientific advances in his field of medicine. *Id.* The court indicated that to qualify this on the basis of the locality in which he practices would be to frustrate public expectations. *Id.*

In *Dickenson v. Mailliard*,[36] the Iowa court was faced with the question of the standard of care applicable to hospitals. The court noted that the locality rule as applied to hospitals had come under criticism, and stated that the reason for its early adoption no longer seemed to exist, as it was doubtful that there was any substantial difference from one locality to another in the type of hospital services rendered.[37] The court concluded that it was no longer justifiable to limit a hospital's liability to that degree of care which was customarily practiced in its own community, and held that the correct standard of care to which hospitals should be held was that which obtained in hospitals generally under similar circumstances.[38] It was held that in the determination of what constituted similar circumstances, local practices could be considered, but only as one element and not as the conclusive standard.[39]

Interestingly, the Iowa court in *Mailliard* also indicated that it had previously brushed aside similar arguments as they applied to the skill required of doctors in treating patients and had long held doctors to abide by the rules of good practice generally followed under similar circumstances,[40] citing to the case of *McGulpin v. Bessmer*.[41] In that case, in a very progressive statement for 1950, the Iowa court noted that there seemed to exist a sound basis for holding a general practitioner to such reasonable skill and care as was exercised by ordinary practitioners under like circumstances, and that the locality was merely one circumstance in the determination and not an absolute limit on the skill required.[42] However, in *McGulpin* plaintiff's expert witness was competent under the locality rule; therefore, this language constituted mere dicta, as the court did not find it necessary to expressly abrogate the locality rule in Iowa.[43]

In the instant case, the state undoubtedly relied upon the Iowa court's previous formulation of the locality rule in *Sinkey v. Surgical Associates*.[44] In *Sinkey*, the court, relying on the previously announced "similar locality" rule, held the standard of care applicable to physicians to be 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*."[45] The state on appeal contended that plaintiff Speed's expert witnesses were incompentent to

---

36. 175 N.W.2d 588 (Iowa 1970).
37. Dickinson v. Mailliard, 175 N.W.2d 588, 596 (Iowa 1970).
38. *Id.*
39. *Id.* at 597. *See also* Kastler v. Iowa Methodist Hosp., 193 N.W.2d 98 (Iowa 1971).
40. Dickinson v. Mailliard, 175 N.W.2d 588, 596 (Iowa 1970).
41. 241 Iowa 1119, 43 N.W.2d 121 (1950).
42. McGulpin v. Bessmer, 241 Iowa 1119, 1131, 43 N.W.2d 121, 128 (1950).
43. *Id.*
44. 186 N.W.2d 658 (Iowa 1971).
45. Sinkey v. Surgical Associates, 186 N.W.2d 658, 660 (Iowa 1971) (emphasis added).

testify as they lacked sufficient knowledge of the standard of care applicable to physicians in the Iowa City community.[46]

These several cases presented the Iowa court with a clear trend departing from an adherence to the locality rule. The rule had already been abandoned in Iowa in relation to the standard of care applicable to hospitals, veterinarians, and specialists. As to its application to general physicians, however, the locality rule rested in somewhat of an intermediate state. Although the court in *Dickinson v. Mailliard*[47] paid lip service to the forward-looking language in *McGulpin v. Bessmer*,[48] the locality rule was nevertheless reiterated a year later in *Sinkey v. Surgical Associates*.[49] The *Speed* decision reflects what is theoretically a logical extension of these earlier holdings, yet it remains more than a natural conclusion to those decisions, as the earlier cases are factually distinguishable. In making the last required step to the abrogation of the rule in regard to general practitioners, the court was required to make the basic assumption underlying the rule's abrogation—that it was no longer required for general practitioners given the state of medical and scientific advances. In this determination, the court apparently looked to and relied heavily upon the trend in other jurisdictions which had considered the issue.

One of the earliest foreign jurisdictions which had addressed itself to this question was the state of Washington in the case of *Pederson v. Dumouchel*.[50] Moving away from simply trying to correct the difficulties in the application of the locality rule, the court looked at it on a more fundamental level and concluded that the rule had no present vitality.[51] The Washington court expressed the view that "[n]ow there is no lack of opportunity for a physician or surgeon to keep abreast of the advances made in his profession and to be familiar with the latest methods and practices adopted."[52] The Washington court reannounced its position a year later in *Douglas v. Bussabarger*,[53] holding that there was no longer any basis in fact for the locality rule and that rural and small town physicians should not enjoy advantages not given by the law to any other class of small town defendants.[54]

---

46. The state on appeal also alleged as error an insufficiency of evidence to support the trial court's finding. Further, the state alleged that hypothetical questions were improperly posed, in that they went to the ultimate issue, looked to facts outside the record, and failed to include material facts. The *Speed* court concluded there was sufficient evidence to support the trial court's finding. In regard to the hypothetical questions, the court held that the expert opinion was not impermissible as going to the ultimate issue; that facts outside the record were not used; and that material facts were probably not excluded from the questions. Even if such facts had been excluded, the court indicated that it would not have held that the trial court had abused its discretion, as a hypothetical question need not contain all facts shown in evidence. Speed v. State, 240 N.W.2d 901 (Iowa 1976).
47. 175 N.W.2d 588 (Iowa 1970).
48. 241 Iowa 1119, 43 N.W.2d 121 (1950).
49. 186 N.W.2d 658 (Iowa 1971).
50. 72 Wash. 2d 73, 431 P.2d 973 (1967).
51. Pederson v. Dumouchel, 72 Wash. 2d 73, 79, 431 P.2d 973, 978 (1967).
52. *Id.* at 78, 431 P.2d at 977.
53. 73 Wash. 2d 476, 438 P.2d 829 (1968).
54. Douglas v. Busabarger, 73 Wash. 2d 476, 490, 438 P.2d 829, 838 (1968).

In *Brune v. Belinkoff*,[55] the Massachusetts court likewise concluded that the locality rule lacked modern applicability and that the time had come when the medical profession should no longer be Balkanized by the application of varying geographic standards in malpractice cases.[56] Rather, the court held that locality was merely one factor to be considered in determining whether a defendant physician had exercised the required standard of care, and not an absolute limit upon that standard.[57]

In *Blair v. Eblen*,[58] the Kentucky court concluded that it was in agreement with the Washington court that the proper standard of care for a physician should not be expressed to the jury in terms of community practice, and held it would not perpetrate a rule designed to protect country doctors in 1902.[59] The reasoning of the Washington court also proved influential in *Shier v. Freedman*,[60] wherein the Wisconsin court abrogated the locality rule in that jurisdiction as to general practitioners. The court held the reasoning of the Washington court applied with equal logic and persuasion in Wisconsin and that geographic areas were merely circumstances to be considered if they were appropriate.[61]

The Iowa court in the instant case, in addition to examining these key decisions, also looked to recent cases such as *Callahan v. William Beaumont Hostal*[62] and *Gambill v. Stroud*[63] wherein other jurisdictions had reached contrary results in this determination. In *Callahan*, the Michigan court decided that general practitioners would remain subject to the dictates of the locality rule.[64] The Arkansas court in *Gambill* addressed itself squarely to the issue and determined a uniform national standard could not be discerned such as was necessary to support an abrogation of the locality rule.[65]

After carefully considering these authorities, the Iowa court in *Speed* decided it would abandon the locality rule. Expressly rejecting the standard set forth in *Sinkey*, it incorporated its language from *McGulpin* as reflecting the view of the court. Thus, in Iowa a general practitioner is held to such reasonable care and skill as is exercised by the ordinary physician of good standing under like circumstances.[66] The locality involved will be merely one such cir-

---

55. 354 Mass. 102, 235 N.E.2d 793 (1968).
56. Brune v. Belinkoff, 354 Mass. 102, 108, 235 N.E.2d 793, 798 (1968).
57. *Id.* at 109, 235 N.E.2d at 798. *See also* Silberstein v. Berwald, 460 S.W.2d 707 (Mo. 1970); and Germann v. Matriss, 55 N.J. 193, 260 A.2d 825 (1970).
58. 461 S.W.2d 370 (Ky. 1970).
59. Blair v. Eblen, 461 S.W.2d 370, 373 (Ky. 1970).
60. 58 Wis. 2d 269, 206 N.W.2d 166, *modified on other grounds*, 208 N.W.2d 328 (1973).
61. Shier v. Freedman, 58 Wis. 2d 269, 283-84, 206 N.W.2d 166, 173-74 (1973).
62. 67 Mich. App. 306, 240 N.W.2d 781 (1976).
63. 531 S.W.2d 945 (Ark. 1976).
64. Callahan v. William Beaumont Hosp., 67 Mich. App. 306, 240 N.W.2d 781, 783 (1976).
65. Gambill v. Stroud, 531 S.W.2d 945, 949 (Ark. 1976). The court noted that: "However desirable the attainment of this ideal may be, it remains an ideal. It was not shown in this case, and we are not convinced, that we have reached the time when the same postgraduate medical education, research and experience is equally available to all physicians, regardless of the community in which they practice." *Id.* at 948.
66. Speed v. State, 240 N.W.2d 901, 908 (Iowa 1976). While a uniform standard

cumstance to be considered, and will not be an absolute limit on the skill required.[67]

Accordingly, twenty-six years after its statement in *McGulpin v. Bessmer*[68] that no sound basis existed to support the locality rule, the Iowa court in *Speed v. State*[69] definitively clarified its position in abrogating the rule. Such a decision represents a well-reasoned and forward-looking choice, which is, as the court noted, in theoretical accord with past Iowa decisions, supported by commentators, and in line with the developing trend in other jurisdictions which have addressed themselves to the question. As to other jurisdictions, adherence to the locality rule seems most likely to continue to decline, with the strict form of the doctrine disappearing with time, although a few jurisdictions may continue to adhere to the "similar locality" rule.[70] Given the state of modern advances in the fields of medicine and communications, the Iowa position adopted in *Speed*, which allows a consideration of local circumstances without predicating itself solely upon them, represents the most desirable as well as the most reasonable position.

DAVID D. DIXON

---

is recognized by various courts in abrogating their locality rules, the standard has been variously phrased. As is seen in *Speed*, the standard is termed that of the ordinary physician of good standing. In Pederson v. Dumouchel, 72 Wash. 2d 73, 79, 431 P.2d 973, 978 (1967), it was termed that of the "average, competent practitioner"; in Brune v. Belinkoff, 354 Mass. 102, 109, 235 N.E.2d 793, 798 (1968), the term average was also used; in Blair v. Eblen, 461 S.W.2d 370, 373 (Ky. 1970), it was termed that of a "reasonably competent" physician; in Silberstein v. Berwald, 460 S.W.2d 707, 709 (Mo. 1970), it was termed that of an "ordinary, skillful, careful and prudent" physician; in Germann v. Matriss, 55 N.J. 193, 208, 260 A.2d 825, 833 (1970), a dentist was held to the care of the "average member of the profession"; in Shier v. Freedman, 58 Wis. 2d 269, 283, 206 N.W.2d 166, 174, *modified on other grounds* 208 N.W.2d 328 (1973), it was termed that of the average practitioner, and in Shilkret v. Annapolis Emergency Hospital Association, 276 Md. 187, —, 394 A.2d 245, 253 (1975), the court, after carefully analyzing these distinctions, phrased its standard in terms of the "reasonably competent practitioner", following the position of the Kentucky court.

It is also noteworthy that such a standard places a limitation on the skill required of a physician. This idea is expressed in the case of *Lemoine v. Bunkie General Hospital*, where the court stated: "It is well settled that a physician or surgeon is not required to exercise the highest degree of skill and care possible. As a general rule it is his duty to exercise the degree of skill ordinarily employed, under similar circumstances by members of his profession in good standing in the same community or locality. . . ." Lemoine v. Bunkie Gen. Hosp., 326 So. 2d 618, 619 (La. App. 1976).

67. Speed v. State, 240 N.W.2d 901, 908 (Iowa 1976).

68. 241 Iowa 1119, 43 N.W.2d 121 (1950).

69. 240 N.W.2d 901 (Iowa 1976).

70. It also bears noting that the "similar locality rule" is not without attendant difficulties. As has been noted, the locality rule generally creates a problem in that it allows pockets of inferior medical care to exist and creates difficulties for the plaintiff seeking to secure expert medical witnesses who are both competent and willing to testify against a defendant physician. While the similar locality rule precludes single isolated areas of substandard care, it nonetheless allows substandard care to exist where similar localities practice such. Likewise, although the pool of prospective witnesses is broadened, new problems arise for the plaintiff seeking to establish that the locality his medical expert came from is indeed a "similar locality." In this regard see Shilkret v. Annapolis Emergency Hospital Association, 276 Md. 187, —, 349 A.2d 245, 250 (1975).