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STANDARDS OF MEDICAL CARE FOR GENERAL PRACTITIONERS IN MONTANA: THE *CHAPEL* DECISION AND A MOVE TOWARD A NATIONAL STANDARD

Swithin S. McGrath

I. INTRODUCTION

Since the early 1950s specialists in the medical profession have increasingly replaced family doctors.[1] This trend has added to the medical malpractice epidemic of the last century.[2] In addressing the medical malpractice crisis over the years, the courts have revised and redefined the standards of medical care that traditionally have governed physicians nationwide. As new laws are created, the courts continually strive to "protect the faithful and conscientious practitioner from any loss by reason of matters for which it would be unreasonable to hold him responsible, and at the same time to guard the public against the practice of incompetent persons who hold themselves out as physicians."[3]

In 1990, the Montana Supreme Court in *Chapel v. Allison*[4] addressed the standard of medical care applicable to non-board-certified general practitioners practicing in Montana.[5] This leading case brings Montana law into line with a developing trend of imposing a national standard of medical care for all general practitioners.[6] The supreme court's decision overturned the "same or

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1. Note, *Civil Liability of Physicians and Surgeons For Malpractice*, 35 MINN. L. REV. 186, 186-87 (1951).

2. *Id.*

3. Note, *The Standard of Skill and Care Governing the Civil Liability of Physicians*, 78 U. PA. L. REV. 91, 100 (1929).

4. 241 Mont. 83, 785 P.2d 204 (1990).

5. *Id.* at 89, 785 P.2d at 207. This note will refer to non-board-certified general practitioners simply as "general practitioners."

6. Amicus Brief of the Montana Medical Association at 19, Chapel v. Allison, 241 Mont. 83, 785 P.2d 204 (1990) (No. 88-550) [hereinafter Amicus Brief-MMA]. Because any final judgment on the standards of medical care in Montana undoubtedly would have a substantial impact on the medical community and its patients, the supreme court invited and reviewed amicus briefs from the Montana Trial Lawyers' Association [hereinafter MTLA], the Montana Hospital Association [hereinafter MHA], and the Montana Medical Association [hereinafter MMA].

The MTLA argued for adoption of the national standard of care: "a physician is under a duty to use that degree of skill which is expected of a reasonably competent practitioner in the same class to which it belongs, acting in the same or similar circumstances." *Chapel*, 241 Mont. at 90, 785 P.2d at 208. MTLA argued that all physicians generally receive the same standardized education and have access to modern medical technology and information. *Id.* MTLA also advocated the "same or similar circumstances" clause to account for local factors and conditions. *Id.*

similar locality" rule, recognized in *Tallbull v. Whitney*,[7] as the governing standard, and applied a new national standard of medical care for general practitioners.[8]

The discussion that follows focuses on the Montana Supreme Court's holding in *Chapel v. Allison*. The note first traces the general developments of the standard of medical care for physicians in the United States and the historical development of the standards of medical care for physicians in Montana. Second, the note will discuss the court's reasoning and unanimous decision to expand the locality rule beyond Montana's borders and overrule *Tallbull*. Third, the note analyzes the competing standards of medical care proposed by the litigants and the implications of adopting a new standard. Finally, the note considers the effects of the decision on the standards of medical care for general practitioners in Montana.

II. Standards of Medical Care: A Historical Perspective

The earliest principles governing the standards of medical conduct required that a doctor "exercise a reasonable degree of skill and care . . . usually exercised by ordinarily skillful and careful members of the medical profession."[9] This broad standard worked well until the courts found that city doctors generally displayed greater expertise and skill than did their rural colleagues—"the country doctors."[10] Because the urban areas provided more lucrative employment opportunities, they tended to attract the "more talented of the profession."[11] Likewise, greater access to facilities and resources enabled city doctors to develop

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The MHA argued that the application of the "same locality" rule should continue because rural hospitals face the threat of closure due to a lack of use and money. *Id.* at 91, 785 P.2d at 209. They argued the "rule is needed to keep physicians [in rural areas] providing essential health services and utilizing local rural hospitals." *Id.*

Because the court relied substantially on the arguments posed by the various amicus parties in reaching the *Chapel* decision, this note will make numerous references to the amicus briefs.

7. 172 Mont. 326, 564 P.2d 162 (1977).

8. *Chapel*, 241 Mont. at 92, 785 P.2d at 210. *Tallbull* held that a licensed general practitioner would be held to the standard of care of a licensed general practitioner practicing in the "same or similar community in Montana." 172 Mont. at 335, 564 P.2d at 166. Prior to *Tallbull* the "strict locality" rule limited the standard of medical care to the same community in which the physician lived. *Id.* at 331, 564 P.2d at 164.

9. Note, *Problems of Negligent Malpractice*, 26 Va. L. Rev. 919, 920 (1940).

10. Gramm v. Boener, 56 Ind. 497, 501 (1877). *See generally*, Notes: *The Standard of Skill and Care Governing the Civil Liability of Physicians*, 78 U. Pa. L. Rev. 91 (1929); *Problems of Negligent Malpractice*, 26 Va. L. Rev. 919 (1940); *Civil Liability of Physicians and Surgeons for Malpractice*, 35 Minn L. Rev. 186 (1951); *Degree of Care and Skill Required of Physicians and Surgeons in Iowa*, 36 Iowa L. Rev. 681 (1951).

11. Burk v. Foster, 114 Ky. 20, 25, 69 S.W. 1096, 1097 (1902).

superior professional skills and knowledge than rural doctors.[12]

The courts found that holding country doctors to the same standard of skill and care of city doctors had two unfortunate effects.[13] The country doctors either left the rural areas and moved into the city, where they too could have access to resources for professional development, or they left the medical profession altogether.[14] This result left many rural communities without adequate medical care and services.[15]

Only in the late nineteenth century, when the courts began to take judicial notice of the "varying degrees of competency" among doctors, did the general standard change to reflect the changing needs of society.[16] In response to the exodus of rural doctors from the countryside, state courts began to attach territorial limitations—"locality" rules—to the general rule of liability.[17]

In 1920, the Montana Supreme Court joined this national trend when it adopted the "strict locality" rule.[18] The strict locality rule requires that a physician's conduct be judged by the standards of reasonable and ordinary skill, care and expertise of physicians "of good standing of the same system or school of practice in the community in which [the physician] resides."[19] The expert witness who testifies under this rule is expected to know those methods, procedures, and treatments prevailing in that community at the time.[20]

Although arguably practical, especially for a rural state like Montana, the rule received increasing public criticism because of a presumption that it tended to "immunize physicians" from their negligent conduct.[21] Specifically, two compelling arguments questioned the legitimacy of the strict locality rule and ultimately led to relaxation of the rule's application.[22]

First, if a community had only two physicians and they were

12. Note, *Problems of Negligent Malpractice*, 26 VA. L. REV. 919, 920 (1940).

13. Note, *The Standard of Skill and Care Governing the Civil Liability of Physicians*, 78 U. PA. L. REV. 91, 96-97 (1929).

14. *Id.*

15. *Id.*

16. *Id.*

17. Pearson v. Crabtree, 70 Cal. App. 52, 232 P. 715 (1924).

18. Hansen v. Pock, 57 Mont. 51, 58-59, 187 P. 282, 284 (1920). The strict locality rule has been characterized as the "same community" or "same locality" rule.

19. *Hansen*, 57 Mont. at 59, 187 P. at 285, *quoted in Chapel*, 241 Mont. at 87, 785 P.2d at 206.

20. Amicus Brief-MMA, *supra* note 6, at 8.

21. Amicus Curiae Brief of the Montana Trial Lawyers' Association at 9, Chapel v. Allison, 241 Mont. 83, 785 P.2d 204 (1990)(No. 88-550)[hereinafter Amicus Brief-MTLA].

22. *Id.*

both incompetent, setting an inferior standard for that town, the courts as a matter of policy could not condone these customary standards.[23] In so doing, the courts in effect were allowing physicians to escape liability.[24] Second, because of the well-known "conspiracy of silence" amongst doctors not to testify against one another, the boundary limitations made it difficult if not impossible for a patient to obtain expert medical testimony.[25] As a response to these policy concerns, the Montana Supreme Court's 1977 *Tallbull* decision abrogated the "strict locality" rule and adopted the "same or similar locality" rule.[26] By the time Montana adopted this expanded locality rule, the national trend had moved away from "locality" standards altogether.[27] Coming almost full circle, many states, including Montana after *Chapel*, have since returned to a national standard of care (without geographical boundaries) which essentially requires a general practitioner "to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances."[28]

Other Montana decisions revised the standards of medical care for a board-certified orthopedic specialist and a board-certified family practitioner.[29] In 1985, the Montana Supreme Court in *Aasheim v. Humberger*[30] modified the *Tallbull* rule with respect to orthopedic surgeons.[31] The court found that if the defendant in a medical malpractice action was a board-certified specialist, his or her skill and learning "would be measured by the skill and learning possessed by other doctors in good standing, practicing in the same specialty and who hold the same national board certification."[32] The court stated that all board-certified specialists, by virtue of their national certification, possess the same credible standard of skill, training and expertise.[33] Therefore, it made sense to hold them to a national standard.[34]

Similarly, in 1988 in *Glover v. Ballhagen*,[35] the court ad-

23. Tallbull v. Whitney, 172 Mont. 326, 333, 564, P.2d 162, 165-66 (1977).
24. *Id.* at 333-34, 564 P.2d at 166.
25. *Id.* at 334, 564 P.2d at 166.
26. *Id.* at 335, 564 P.2d at 166.
27. Amicus Brief-MTLA, *supra* note 21, at 9.
28. *Id.* at 11.
29. *Chapel*, 241 Mont. at 88, 785 P.2d at 207.
30. 215 Mont. 127, 695 P.2d 824 (1985).
31. *Aasheim* at 131, 695 P.2d at 827.
32. *Id.* at 130, 695 P.2d at 826.
33. *Id.* at 131, 695 P.2d at 827.
34. *Id.*
35. 232 Mont. 427, 756 P.2d 1166 (1988).

dressed standards of medical care for board-certified specialists, specifically board-certified family practitioners.[36] Following the same reasoning as in *Aasheim*, the court found that a board-certified family practitioner would be held to "that skill and learning possessed by other doctors in good standing practicing with the same national board certification."[37] Both cases provide an important, well reasoned transition from the localized standards which have historically characterized rural states like Montana, and adjust the standards to a developing national standard.

III. The *Chapel* Decision

A. *Factual History*

Chapel suffered a severe leg injury while breaking a filly on February 18, 1983.[38] His son took him to the emergency room at Livingston Memorial Hospital where Chapel came under the immediate care and treatment of Dr. James G. Allison (Allison), his physician of nearly 20 years.[39] From the x-rays, Allison diagnosed the fracture as a "comminuted undisplaced fracture of the . . . left tibia," and applied a long leg cast covering Chapel's left leg and foot.[40]

Soon after his release from the hospital on February 21, 1983, Chapel complained of pain at the fracture spot on his left leg.[41] He mentioned to Allison that the cast appeared "crooked in that it angled his left leg below the knee inward to a 'bow-legged' position."[42] On May 2, 1983, Chapel's cast was removed.[43] Chapel's leg displayed a "bow-leggedness" that required corrective surgery.[44] On September 19, 1984 at St. Vincent's Hospital in Billings, Montana, Dr. Richard Snider performed the surgery, removing a piece of broken bone from Chapel's leg.[45]

B. *Procedural History*

After surgery, Chapel brought a medical malpractice action

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36. *Id.* at 429, 756 P.2d at 1168.
37. *Id.* at 430, 756 P.2d at 1168.
38. Brief of Plaintiff/Appellant at 2, Chapel v. Allison, 241 Mont. 83, 785 P.2d 204 (1990)(No. 88-550)[hereinafter Brief-Appellant].
39. Brief for Respondent at 4, Chapel v. Allison, 241 Mont. 83, 785 P.2d 204 (1990)(No. 88-550)[hereinafter Brief-Respondent].
40. *Chapel*, 241 Mont. at 84, 785 P.2d at 204.
41. Brief-Appellant, *supra* note 38, at 5.
42. *Id.*
43. *Chapel*, 241 Mont. at 84, 785 P.2d at 205.
44. *Id.*
45. *Id.*

against Allison to recover damages for the negligent care and treatment of Chapel's orthopedic injury.[46] After plaintiff's case in chief, Allison moved for a directed verdict on the issue of liability.[47] The district court granted the motion on the grounds that Chapel failed to offer sufficient evidence to prove that Allison did not meet the standard of care he owed to Chapel.[48] Thereafter, Chapel appealed the directed verdict ruling.[49]

C. *The Holding: Broadening Montana's Boundaries*

In *Chapel*, the Montana Supreme Court overturned the *Tallbull* rule and held that "a non-board-certified general practitioner is held to the standard of care of a 'reasonably competent general practitioner acting in the same or similar community in the United States in the same or similar circumstances.' "[50] "Same or similar" means a "locality of similar geographical location, size and character in a medical context."[51] The decision applies only to non-board-certified general practitioners, and expands the standard of medical care from a same or similar community in Montana to a broader national standard.

Given Montana's rural character, the court adopted the Maryland Court of Appeals' "same or similar circumstance" clause to allow the finder of fact to consider appropriate local factors and circumstances which may influence the "ordinary standard of care."[52] Local factors include "the knowledge and experience of the general practitioner, commensurate with the skill of other competent physicians of similar training and experience, with respect to the type of illness he confronts and the resources, facilities and options available to him at the time."[53]

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46. *Id.*
47. *Id.*
48. *Id.*
49. *Id.*
50. *Id.* at 92-93, 785 P.2d at 210.
51. *Id.* at 88, 785 P.2d at 207 (quoting *Tallbull*, 172 Mont. at 335, 564 P.2d at 166).
52. *Id.* at 92-93, 785 P.2d at 210 (citing Shilkret v. Annapolis Emergency Hospital Ass'n, 276 Md. 187, 349 A.2d 245 (1975)).
53. *Id.* at 93, 785 P.2d at 210. Local factors and circumstances include:

> (a) the expertise of and means available to the doctor; (b) the health of the patient; (c) the state of medical knowledge and the standards of care as they existed at the time of the incident; (d) the availability of medical facilities either directly or through referral or on a consultation basis; (e) access to communication and transportation; (f) weather conditions; (g) reasonable medical judgment under the circumstances, thus allowing for a broad range of therapeutic and diagnostic alternatives recognized as legitimate by the profession; (h) with the standards expressly not imposing liability simply because of a poor result; (i) recognizes explicitly that a physicians should not be liable for harm that results from a patient's

The supreme court also decided that a change in Montana law of this importance should be prospective only.[54] Because important judicial decisions of this nature impose a distinct change in the standards of care for general practitioners, the court decided that the medical community needed due notice before being held to the new standard.[55]

The supreme court declined to adopt Chapel's argument for a national specialist standard, because the standard requires that general practitioners, who only have a general medical education and limited training, be held to the strict standards of a specialist when treatment falls in a specialist area.[56] The court also rejected Allison's proposal to retain the "same locality" rule in part because the rule is "outdated," and also because of a need for increased availability of expert witnesses.[57]

IV. Competing Standards And The Search For A Reasonable Solution

In *Chapel*, Justice Sheehy acknowledged that the lower court had applied the correct rule of law expressed in *Tallbull*, with respect to the standard of care required of a general practitioner in Montana.[58] However, the compelling trend to nationalize standards of medical care led the supreme court to re-examine the medical standards governing general practitioners in Montana.

The supreme court was presented with dual issues. One, should "a non-board-certified general practitioner, practicing in a Montana community, who treats a patient for an injury of a kind which would ordinarily fall within an area of practice of an orthopedic surgeon be held to the degree of care, knowledge and skill of the specialist?"[59] Or, two, should the practitioner be "held to that degree of care, knowledge and skill of a general practitioner practicing in the same or similar communities in Montana?"[60]

After reviewing the arguments of both parties and amicus curiae, the court adopted (with slight modification) the position proposed by the MMA.[61] The court's position requires that non-

refusal to accept treatment.
Amicus Brief-MMA, *supra* note 6, at 8-9.

54. *Id.* at 93, 785 P.2d at 210.
55. *Id.*
56. *Id.* at 91-92, 785 P.2d at 209.
57. *Id.* at 90-92, 785 P.2d at 208-09.
58. *Id.* at 87, 785 P.2d at 206.
59. *Id.* at 89, 785 P.2d at 207.
60. *Id.*
61. *Id.* at 92, 785 P.2d at 209. *See infra* notes 62-96 and accompanying text for a

board-certified general practitioners be held to "the standard of care of a 'reasonably competent general practitioner acting in the same or similar community in the United States in the same or similar circumstances.' "[62] Justice Sheehy's opinion articulates well the arguments and important policy considerations that underlie the various issues involved in determining the current medical standards applied in *Chapel.*

A. *Increased Accountability: The Specialist Standard*

On appeal, Chapel challenged the settled rule of law governing general practitioners in Montana. He favored abrogating the *Tallbull* standard and asserted that the national standard of board-certified orthopedists should be applied to general practitioners "who voluntarily undertake treatment normally performed by a specialist in the orthopedic branch of medicine."[63]

Although this standard proposed a considerable change in the law, Chapel justified the change by pointing to the increasing trend toward specialty practice among physicians nationwide.[64] He contended that such a trend obliges the general practitioner to refer any patient who needs specialized treatment to the appropriate specialist.[65] Chapel also argued that general practitioners have a duty to inform their patients of all the alternatives for proper care and if such physicians lack the expertise or facilities to address the patients' desired method of treatment, they have a responsibility to refer patients to a physician who does.[66] Finally, Chapel indicated that in an emergency situation that requires immediate specialized treatment, the standard should be less stringent than the requisite national specialty standard.[67] Heeding Montana's rural character, and the status of general practitioners in Montana, the court rejected Chapel's argument by concluding that a national specialist standard exceeded what would be a fair result in the case at bar, and in future cases. The standard of care Chapel sought to impose reflects a common position of many plaintiffs in medical malpractice actions. The plaintiff seeks a higher duty of care to help establish a breach in the context of a negligence action. As

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discussion of MMA's position.

62. *Chapel*, 241 Mont. at 92-93, 785 P.2d at 210.

63. Additional Brief of Plaintiff/Appellant on the Issue of the Applicable Standard of Medical Care at 2, Chapel v. Allison, 241 Mont 83, 785 P.2d 204 (1990)(No. 88-550)[hereinafter Brief of Plaintiff-Standards].

64. *Chapel*, 241 Mont. at 89, 785 P.2d at 208.

65. *Id.*

66. *Id.* at 89-90, 785 P.2d at 208.

67. *Id.* at 90, 785 P.2d at 208.

long as medicine involves highly technical, complicated procedures, however, unfortunate results will occur absent negligence. The court needed to create standards that are fair and reasonable for both doctor and patient.

The supreme court agreed with the MMA's middle-of-the-road position on the issue, and the court's reasoning reflects the realities of Montana's specific medical needs.[68] The MMA and the court rejected the national specialist standard for the following reasons:

> (1) The loss of general practice or family practice medical services in Montana communities, including rural areas; (2) the lack of specialty care in or near the rural communities, to which to refer patients; (3) the fact that the general practitioner, though competent to act in areas which overlap with specialists' areas, is not necessarily as skilled as the specialist . . . .[69]

The national specialist standard requires that a general practitioner have the same knowledge, skill and training as a national specialist, so as to perform competently in an overlapping area of treatment.[70] Therefore, general practitioners "qualified to treat an injury or illness conceivably could be held to the standard of care of an orthopedic surgeon, dermatologist, neurologist, cardiologist, internist, obstetrician, gynecologist, etc."[71]

The nationally uniform standard makes sense for specialists who hold board-certification, because certification insures that specialists are properly educated, trained and experienced in their respective specialties.[72] No equivalent national uniformity exists, however, for general practitioners.[73] They typically do not hold board-certification, have not undergone a three-year residency as a specialist, and in general have the least training and education of any group of practitioners in the medical profession.[74] The court found the disparity in education and training and the nature of the general practitioners' broad-ranging practice made it unrealistic and unreasonable to expect or require a general practitioner to be as qualified as a specialist.[75]

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68. *Id.* at 91, 785 P.2d at 209.
69. Amicus Brief-MMA, *supra* note 6, at 5.
70. *Chapel*, 241 Mont. at 92, 785 P.2d at 209.
71. Brief of Respondent on the issue of the Applicable Medical Standard of Care at 16, Chapel v. Allison, 241 Mont. 83, 785 P.2d 204 (1990) (No. 88-550) [hereinafter Brief of Respondent-Standards].
72. *Aasheim*, 215 Mont. at 131, 695 P.2d at 827.
73. Brief of Respondent-Standards, *supra* note 71, at 13.
74. *Id.* General practitioners receive a "general education with limited experience in multiple disciplines gained through a one-year rotation." *Id.* at 13-14.
75. *Chapel*, 241 Mont. at 92, 785 P.2d at 209.

Similarly, if the medical standards are too high, rural general practitioners tend to leave the profession because they cannot meet, or fear they will not be able to meet, the higher standards.[76] The court and the MMA point out that rural communities in Montana already face a serious shortage of physicians and cannot afford to lose more due to a higher specialty standard of care.[77]

The MMA and Chapel also recommended that the "national specialist standard . . . be applied to any physician who holds himself or herself out as a specialist."[78] It appears the supreme court impliedly rejected this provision in part because of a "lack of specialty care in and of the rural communities for referral of patients."[79] Here the court's reasoning—that a lack of available referral services provides a good rationale for rejecting the specialist standard—falls short on several important points. Although specialty services are limited in rural areas of Montana, today's communication technology and sophisticated medical transportation (e.g. helicopter service to and from urban hospitals) make it rare that a rural doctor could not refer a patient for treatment by a qualified specialist in a nearby area. Expenses and inclement weather appear to be the only limiting factors and as such could fall within the emergency exclusion; as Chapel conceded, if rural doctors must perform an emergency operation and cannot afford the luxury of referral services, the specialty standard should not apply.[80]

Referral services may provide a realistic option for today's practitioners who cannot adequately treat a specialty case. Consequently, practitioners should have a responsibility to refer the case, or to make clear the risks involved if they nevertheless chose to treat the patient. If physicians know they cannot competently treat the patient, and do so anyway, without referral or notice of the risks, they should be answerable for negligent conduct.

Chapel raised legitimate and persuasive issues and arguments. The national specialist standard, however, would require a considerable change and a higher duty of care for general practitioners. The Montana Supreme Court was not ready to adopt changes of this magnitude.

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76. *Id.*
77. *Id.*
78. *Id.* at 91-92, 785 P.2d at 209.
79. *Id.* at 92, 785 P.2d at 209.
80. *Id.* at 89-90, 785 P.2d at 208.

B. The Locality Rule: Are the Boundaries Still Necessary?

Allison argued for the continued viability and application of the "locality"/*Tallbull* rule as an appropriate standard for a rural state like Montana.[81] The defense rejected a national specialist standard because of its impractical effects.[82] A specialist, orthopedic or otherwise, is an apparent minority in a rural Montana community.[83] Unlike their urban counterparts, rural communities typically only receive medical services from a longstanding general practitioner who has experience with a variety of medical cases.[84]

Rural general practitioners have treated a much broader range of illness and injury than a general practitioner in a large metropolitan area.[85] Thus, they hold an advantage over their urban colleagues who "devote much of their practice to initial diagnoses with referral to a specialist for anything beyond routine care."[86] Allison testified that he treated 15 injuries like Chapel's in his career, which indicates a level of experience unique to general practitioners in rural areas.[87] He advocated the pragmatism of the locality rule as it implicitly accounts for "the need for general practitioners to treat orthopedic injuries because of the unavailability of orthopedic surgeons in small towns in Montana."[88] Finally, Allison referred to the Restatement (Second) of Torts, § 299A comment g (1965), as authority for sustaining the "locality" rule.[89]

The supreme court rejected Allison's arguments and found a middle ground between the more stringent national specialist standard, and the regional *Tallbull* rule. The court's decision does not

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81. *Id.* at 90, 785 P.2d at 208.

82. *Id. See supra* notes 62-79 and accompanying text for discussion of Chapel's argument.

83. Brief of Respondent-Standards, *supra* note 71, at 12.

84. *Id.*

85. *Id.*

86. *Chapel*, 241 Mont. at 90, 785 P.2d at 208.

87. *Id.*

88. Brief of Respondent-Standards, *supra* note 71, at 13.

89. *Chapel*, 241 Mont. at 90, 785 P.2d at 208. Comment g states:

> Allowance must be made also for the type of community in which the actor carries on his practice. A country doctor cannot be expected to have the equipment, facilities, experience, knowledge or opportunity to obtain it, afforded him by a large city. The standard is not, however, that of the particular locality. If there are only three physicians in a small town, and all three are highly incompetent, they cannot be permitted to set a standard of utter inferiority for a fourth who comes to town. The standard is rather that of persons engaged in similar practice in similar localities, considering geographical location, size, and the character of the community in general.

Restatement (Second) of Torts, § 299A comment g (1965).

substantially change the current standard for general practitioners; it merely expands the existing locality beyond the boundaries of Montana, while giving proper deference to important local factors. By adopting the MMA's position, as modified, the court reached a fair and reasonable result.

Contemporary medical realities justify eliminating the Montana boundary restriction, and the sound policy reasons cited in *Tallbull* for overturning the "strict locality" rule are equally persuasive for revising the "same locality" rule here.[90]

> [T]he accessibility of medical literature, the frequency and availability of national, regional and state medical meetings, advances in communication of medical knowledge, transportation advances, and the opportunity for rural community doctors to gain medical knowledge in the same manner as doctors in more populous regions in the state, all made the "strict locality rule" outdated.[91]

The "same locality" rule no longer serves its historical practical function. In fact, because of the well-known "conspiracy of silence," the "same locality" limitation had created a major shortage of available expert witnesses.[92] An expanded locality rule will correlatively increase available medical experts, a principal reason for expanding the locality rule.[93]

The court acknowledged the benefit to the plaintiff of having increased access to expert witnesses to ensure the injured party's rights to compensation. The court explained that an abundance of unqualified expert testimony may also threaten the physician's right to due process and a fair hearing.[94] The supreme court found that in order to ensure the parties' respective rights, a potential witness must "possess solid practical experience in the type of practice at issue" before qualifying as an expert witness.[95]

Qualified expert witnesses' testimony provides the jury with information to determine "whether the physician had and used such skill, care, and diligence as is ordinarily had and used by the professional in the same or similar localities and under the same circumstances."[96] Because the experts' testimony often carries decisive weight, the court found that the expert's qualifications must substantiate their experience, which should help to ensure that the

90. *Id.* at 83, 785 P.2d at 207.
91. *Id.*
92. Amicus Brief-MMA, *supra* note 6, at 28.
93. *Chapel*, 241 Mont. at 92, 785 P.2d at 209.
94. *Id.*
95. *Id.*
96. Nelson v. Sandell, 202 Iowa 109, 209 N.W. 440, 441 (1926).

testimony given accurately reflects the practices of the specific medical community at issue.[97]

V. After *Chapel*

The supreme court in *Chapel* took a progressive, but not radical, step in overturning the "same locality" rule. In effect, the "same locality" rule was merely expanded to include other locales in the United States having the same or similar character as the Montana community where the general practitioner practices. By considering variables through the "same or similar circumstances" requirement, the rule in effect remains localized. Likewise, local considerations ensure that the rural/urban distinctions remain operative. Practically, because the rule provides for the consideration of Montana's rural character, with the exception of increased availability of expert witnesses, the standards of care for a general practitioner will not significantly change.

The change in the duty of care standard does not negatively affect the standards of care for doctors in Montana. However, the supreme court failed to adequately address several issues which have a negative impact on the patient. The court left unresolved the issue involving general practitioners who explicitly hold themselves out as specialists. To minimize malpractice, the court should require that a physician claiming specialty competence hold the same qualifications as a specialist in the overlapping area of treatment.

Furthermore, practitioners have no duty to refer a patient who needs specialty care, or to make known the specific risks of being treated by a non-specialist. Nor do practitioners have a duty to perform the specialty treatment as competently as a specialist. The decision effectively places risks on the patient who chooses specialist treatment from a general practitioner.

Nonetheless, certain definitive advantages did arise from the decision. The supreme court adopted, almost in its entirety, the MMA's recommendations and in so doing did not alienate the medical community by imposing unreasonable or unfair standards, and neither did it immunize them from wrongful conduct. The new rule created another advantage by increasing available expert testimony. Finally, the "same or similar circumstance" requirement allows judges and juries in medical malpractice suits to consider on a case-by-case basis whether the doctor violated the duty of care. This process takes into account Montana's rural nature and result-

97. Amicus Brief-MMA, *supra* note 6, at 6.

ing medical needs.

VI. Conclusion

In deciding *Chapel v. Allison*, the Montana Supreme Court provided for the unique problems the medical community in Montana faces. At the same time, it aligned Montana with a progressive jurisdictional trend to nationalize the standards of care for general practitioners. By rejecting a national specialist standard, the court acknowledged the need to maintain a reasonable standard of care that will ensure that Montana's rural communities retain their general practitioners and thus provide adequate and necessary medical services. The elimination of the Montana boundary limitation minimally changes the actual standard of care, yet its expansion provides access to much needed expert testimony. Finally, the supreme court acted wisely in adopting the MMA's recommendations as the MMA clearly knows and understands the implications of changing medical standards of care.