Chicago-Kent Law Review

Volume 44 | Issue 2 Article 3

October 1967

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"Reasonable Man" Doctrine

Negligent conduct results from a failure of one to conform to a required standard of care.[1] Ordinarily the standard of care demanded is measured by the conduct of the so-called "reasonable man" under the same or similar circumstances. The law assumes basic characteristics attributable to the reasonable man. He is a man of prudence—he looks before proceeding; he thinks before acting. He is a man endowed with certain minimum knowledge gained from his experience, and he must act accordingly. If he has gained knowledge through education, he is thereafter required to utilize this knowledge for his own safety and the safety of others.[2]

Standard of Care for the Physician

What is the standard of conduct required of a physician? To some extent, it is the same standard that is used to judge the conduct of a defendant in an ordinary negligence action. The physician has gained skill and knowledge superior to that of the ordinary man, and the law will demand that he conform his conduct in a manner consistent with this higher knowledge and skill.

The Illinois courts, in instructing the jury as to the standard required of a physician, rely on the following:

> In [treating] [operating upon] a patient, a doctor must possess and apply the knowledge and use the skill and care that is ordinarily used by reasonably well-qualified doctors in the locality in which he practices or in similar localities in similar cases and circumstances.[3]

Some explanation is needed to better understand this instruction.

The standard established for the medical profession does not necessitate that the highest degree of skill be exercised nor, on the other hand, that an average degree of skill be exercised. This proposition was first established in *Holtzman v. Hoy*.[4] In that case, the patient alleged that the physician was negligent in his treatment of the patient's fractured leg. In affirming for the physician, the court explained that the highest degree of care would eliminate all but the best of physicians, while an average degree of care would include the "quacks, the young men who have no practice, the old ones who have dropped out of practice . . . ," which would place the standard too low.[5] Thus, the law excludes those no longer practicing

1 Prosser, Torts § 30 (3d ed. 1964).
2 *Id.* § 32.
3 I.P.I. § 105.01 (1961).
4 118 Ill. 534, 8 N.E. 832 (1886).
5 *Id.* at 536, 8 N.E. at 832 [repeated in Olander v. Johnson, 258 Ill. App. 89, 95 (2d Dist. 1930)].

medicine and those unfit to practice medicine when determining the standard. Instead the law assumes that the standard will be based only on those in good professional standing "and of these [physicians] it is not the middle but the minimum common skill which is to be looked at."[6]

The standard of care that must be exercised by the one who holds himself out as a physician or as a surgeon and, as such, attempts to treat another, is the same as if the person were a physician or a surgeon. For example, in *Williams v. Piontkowski*,[7] the defendant was licensed as a chiropractor but held himself out as being able to practice obstetrics. The court said the would-be doctor in such circumstances must bear the same responsibility as a licensed medical practitioner. When the patient believes the person treating him to be a physician, he must be chargeable as a physician. Likewise in *Matthei v. Wooley*,[8] where a druggist, holding himself out as a doctor, undertook to cure the plaintiff's finger, the court held him liable, imposing the same standards upon him as if he were a doctor.[9]

Standard of Care for the Specialist

What is the standard of care for the specialist in the profession of medicine? The Illinois Supreme Court's Committee for adoption of Jury Instructions has formalized the following instruction as to the skill that must be exercised by a specialist:

> In [treating] [operating upon] a patient, a doctor who holds himself out as a specialist and undertakes service in a particular branch of medical, surgical, or other healing science, must possess and apply the knowledge and use the skill and care which reasonably well-qualified specialists in the same field, practicing in the same locality, or in similar localities, ordinarily would use in similar cases and circumstances.[10]

Although this instruction has been adopted by the Committee, its validity as law has not been fully established in Illinois. In *Schireson v. Walsh*,[11]

6 Prosser, Torts § 32 (3d ed. 1964). William J. Curran, in his article "Professional Negligence—Some General Comments" in *Professional Negligence* (Roady and Anderson, 1960), questions the "minimum common skill" standard which the physician is required to attain. He argues that in ordinary negligence cases the defendant must conduct himself as the "reasonable man" would in the same or similar circumstances. This requires *prudent* conduct—prudent conduct being higher than merely average conduct. However, with regard to the professional man, he argues that "we seem to be satisfied with average or minimum acceptable conduct."

7 337 Ill. App. 101, 84 N.E.2d 843 (3d Dist. 1949) (Abst.).

8 69 Ill. App. 654 (1st Dist. 1897). *Accord*, Prout v. G. Gordon Martin, Inc., 160 Ill. App. 11 (1st Dist. 1911); (unprofessional treatment by defendant, a corporation practicing dentistry).

9 It should be noted that a person who does not profess to be a doctor but merely gives gratuitous advice on a remedy for an injury or a disease will not be held to the same standard of a physician. McNevins v. Lowe, 40 Ill. 209 (1866).

10 I.P.I. § 105.02 (1961).

11 354 Ill. 40, 187 N.E. 921 (1933).

the only case in Illinois discussing the question of the standard of care to be exercised by a specialist, the Illinois Supreme Court indicated as dictum that the standard to be followed was *contra* to the above-quoted instruction. In the *Schireson* case, the Illinois Supreme Court determined that the Department of Registration and Education had applied an incorrect rule of law in revoking the license of the plaintiff-doctor on grounds of gross malpractice. The Department argued that ". . . when a physician . . . proclaims himself one of the greatest and most skillful plastic surgeons in the world, . . . the law demands a much higher degree of skill and ability than is expected of the average physician."[12] The court, however, said,

> Under this proposition of law . . . specialists in treating a patient professionally might do or omit to do some act the doing or omission of which would constitute malpractice or gross malpractice on his part which would not even be deemed negligence on the part of the average, ordinary physician or surgeon in the same community. Under the rule adopted by the commission . . . the degree of professional skill required on the part of a physician . . . might be made to depend upon the extravagance or boastfulness of his statements as to his skill and ability as a physician or surgeon. We do not believe it can be seriously contended that such is the law of this State.[13]

Although the Illinois court would not accept the Department's analysis of the law, it appears that the Department was in accord with the majority of decisions discussing standard of care for a specialist.[14] The Committee drafting the Illinois Pattern Jury Instructions in refusing to follow the dictum in the *Schireson* case assumed that Illinois law would follow the majority rule and thus drafted the instruction accordingly.

The Same or Similar Locality Provision

Both the instructions denoting standard of care for the physician and standard of care that must be exercised by the specialist mention "practice in locality or in similar localities."[15] Earlier medical malpractice cases did not limit the standard of care to the same locality. Instead the standard was the skill exercised by the "profession"[16]—a much wider standard. Not until *Bacon v. Walsh*[17] did Illinois courts set the rule as to how broad the physician's knowledge on particular medical skills and practices would

[12] *Id.* at 56, 187 N.E. at 927.

[13] *Id.* at 56-57, 187 N.E. at 927.

[14] See McGulpin v. Bessmer, 241 Iowa 1119, 43 N.W.2d 121 (1950); Carbone v. Warburton, 22 N.J. Super. 5, 91 A.2d 518 (1952), *aff'd*, 11 N.J. 418, 94 A.2d 680 (1953); Malila v. Meacham, 187 Or. 330, 211 P.2d 747 (1949).

[15] *Supra* notes 4 and 7.

[16] Ritchey v. West, 23 Ill. 385 (1860).

[17] 184 Ill. App. 377 (3d Dist. 1913). It should be noted in that case that the jury was instructed on care and skill that must be exercised by the defendant in terms of the school to which the defendant belongs. This is a different concept entirely from the "same or similar locality" provision which the Illinois Supreme Court in that case finally established. For a detailed analysis on this subject, see 70 C.J.S. *Physicians and Surgeons* § 44 (1951) and p. 114 of this symposium.

have to be. In that case, the court narrowed the standard to encompass only "that degree of professional knowledge, skill and care which the average physician and surgeon in good practice would ordinarily bring to a similar case under like circumstances in that locality."[18]

It has been argued that the locality provision imposes too low a requirement upon physicians and surgeons. One student author suggests that the "locality rule should not be a shield used to protect a physician who, perhaps because of a self-imposed isolation, has blinded himself to the progress of his profession and thus established for himself a defense to a malpractice action."[19] Indeed, Dean Prosser has recognized that an increasing number of jurisdictions have abandoned the formula of "locality or similar locality," thus recognizing that medical standards are approaching a nation-wide uniformity.[20] The Committee that drafted the Illinois Pattern Jury Instructions contends that the locality rule in Illinois today merely will be applied where the physician of a small community is faced with an emergency situation.[21] That physician will be relieved from the use of appliances and treatment used by the physician in the larger community.

Proof of A Bad Result

Proof by the patient that the treatment given by the physician was not favorable—that he still suffers from the same condition or illness—does not of itself indicate that the physician failed to use the acceptable standard of conduct. Similarly, proof that the physician had made a mere error in judgment on the best method of treatment of itself will not indicate the physician failed to use the acceptable standard of conduct. In *Scardina v. Colletti*,[22] it was alleged by the administrator of the decedent's estate that the surgeon negligently failed to ligate a severed blood vessel, which resulted in profuse internal bleeding, requiring further operation. There was testimony in behalf of the defendant by another surgeon who reported that it was possible that the ligature may have slipped off, but that this was one of the normal risks of surgery. The court, in holding for the defendant, stated that the plaintiff failed to sustain his burden of proof as he failed to show that the defendant was unskillful or negligent. "It is not enough to prove that he made a mistake or that this treatment harmed plaintiff."[23] The court went on to say that "proof of a bad result or mishap is no evidence of lack of skill or negligence."[24]

18 *Id.* at 379.

19 See 14 DePaul L.R. 453, 456 (1965).

20 For an examination of some of the jurisdictions that have abandoned the locality formula, see Prosser, Torts § 32 at 167, n.43, (3d ed. 1964).

21 I.P.I. § 105.01 (1961). See Annot., 8 A.L.R.2d 772 (1949).

22 63 Ill App. 2d 481, 211 N.E.2d 762 (1st Dist. 1965).

23 *Id.* at 488, 211 N.E.2d at 765.

24 *Ibid.*

Similarly, in *Quinn v. Donovan*,[25] the court declared:

> If appellant possessed, and in the treatment of appellee's arm used, reasonable skill, he could not be held responsible, although the result of the treatment was not as favorable as appellee expected or might of anticipated . . . . A physician cannot be regarded as an insurer of a successful result of all cases.[26]

In *Sims v. Parker*,[27] the court held:

> No man, skilled or unskilled, undertakes that he shall be successful; he undertakes for good faith and integrity but not for infallibility and he is liable for negligent bad faith or dishonesty but not lapses consequent upon mere errors of judgment.[28]

The physician in the *Sims* case prescribed treatment for a hernia where, in fact, no hernia existed. The treatment necessitated the plaintiff to wear a truss, which caused an abscess at the point where the bulb of the truss pressed. The mere proof that the physician was mistaken as to the existence of the rupture or proof that the abscess was caused by the pressure of the truss was not enough to entitle plaintiff to a verdict; for the plaintiff failed to show that the defendant had not followed a standard of conduct which other physicians in the locality would have used in the same or similar circumstances.

The physician also will not be liable if he uses a different method of treatment than other doctors in the community, if the method he uses is a recognized one for that specific malady or injury. In *Wade v. Ravenswood Hosp. Ass'n*,[29] the plaintiff charged *inter alia*, that the examining physician failed to take X-rays or spinal punctures and failed to provide prompt immobilization and traction subsequent to a diagnosis of a cervical fracture and cord injury. Plaintiff was moved to Hines Hospital two days later, where these procedures were followed. The physician testified that no X-rays were taken for fear of moving the patient. The court said that the physician was not negligent for selecting one of the different methods of treatment, even though it later developed that his choice was not the best.

Thus, the proof of a bad result, mishap or mistake in judgment of treatment is not of itself proof of negligence. However, such proof may be considered by the jury along with all other evidence, and thus may lead to an inference of negligence. In *Doyle v. Owens*,[30] the defendant physician had been negligent. However, there was subsequently a failure by the plaintiff to follow the defendant's direction for treatment of the injury. The combination of defendant's wrong and plaintiff's wrong caused the bad

25 85 Ill. 194 (1877).
26 *Id.* at 195.
27 41 Ill. App. 284 (1st Dist. 1891).
28 *Id.* at 286.
29 3 Ill. App. 2d 102, 120 N.E.2d 345 (1st Dist. 1954).
30 150 Ill. App. 415, 417 (2d Dist. 1909).

result. The court held that it was incorrect to instruct the jury that they should not take into consideration the evidence of a bad result.

The reason that the physician is not liable merely because of bad results is that malpractice liability rests ordinarily on the theory of tort and as such no warranties, either expressed or implied, exist. Although the relationship between the parties would allow the patient to sue the physician in an action sounding in either tort or contract, there have been no cases in Illinois that have held that a doctor may be held liable for an agreement made by the doctor with the patient that an operation would cure the condition which the plaintiff was suffering.[31] As was stated in *Gault v. Sideman*, "The application of the ordinary rules dealing with mercantile contracts to a contract entered into between a physician and a patient in our opinion is not justified."[32]

It can be argued that for public policy reasons the courts fear imposing contract liability upon doctors. The courts realize that medicine is not an exact science and that the doctor knows he cannot warrant his treatment. The courts also wish to protect the physician from the claims of the fraudulent minded.[33]

Special Applications of the Standard of Conduct

What duty is imposed upon the physician who may have lesser knowledge in certain areas of medicine or lack the facilities to adequately treat the patient? Will he fall below the required standard of care for use of the skills and facilities he has without referring the patient to a specialist in the field? The Illinois Pattern Jury Instruction on the duty of the physician to refer a patient to a specialist is as follows:

> If in the treatment of a patient, a doctor realizes, or if, in the exercise of that care and skill which a reasonably well-qualified doctor would ordinarily use in the locality in which he practices, or in similar localities, should realize that the nature of the patient's illness [condition] requires services of a [physician] [surgeon] [dentist] skilled in a special branch of [medical] [surgical] [dental] science, then the [doctor] [dentist] is under a duty to [advise the patient to consult a specialist] [refer the patient to a specialist].[34]

There have been no Illinois cases on the duty of a physician to refer a patient to a specialist. The Illinois Pattern Jury Instruction is based on a New York case, *Benson v. Dean*,[35] where a physician was found negligent by his failure to refer his patient to a rectal specialist to remove a needle

31 Gault v. Sideman, 42 Ill. App. 2d 96, 107, 191 N.E.2d 436, 442 (1st Dist. 1963).

32 *Id.* at 109, 191 N.E.2d at 443.

33 See Zostautas v. St. Anthony DePadua Hosp., 23 Ill. 2d 326, 178 N.E.2d 303 (1961); Miller, *Contractual Liability of Physician and Surgeon*, Wash U.L.Q. 413 (1953).

34 I.P.I. § 105.03 (1961). Last bracketed phrase used if patient is incapacitated to act.

35 232 N.Y. 52, 133 N.E. 125 (1921).

which the defendant physician had left in a wound. Thus, the Illinois law would seem to be that there is a duty to advise the patient to see one who is more qualified in the profession, when the physician's knowledge of, or facilities for treatment are inadequate.

The courts have not answered the question whether or not it is the duty of the physician to keep informed of new drugs, treatment and techniques commonly used in the profession. It is true that there is "no obligation to use drugs or procedures which at the time of treatment were still in the experimental stage, and in fact such novel treatment might lay the groundwork for a valid malpractice suit."[36] However, it may be that in the future it will be the physician's duty to keep abreast of the medical advances and if the physician fails to do so and the patient suffers, then the physician will not have come up to the standard of conduct required and liability will be fixed.[37]

With medical science moving so rapidly, is not each patient entitled to the benefits of these advances? In turn, does not each physician have a duty to see to it that his patient is treated in a manner consistent with advancing medicine? The lawyer would be negligent by relying in his brief on an overruled case. The doctor should be held liable for use of an outmoded medicine or procedure when information on the newer medicine or procedure is as close as the recent medical digests.

In maintaining the standard of conduct required, is it necessary for the physician to warn the patient of the possible dangerous consequences of treatment? In *Hall v. United States*,[38] the plaintiff entered Great Lakes Naval Training Center Hospital to receive prenatal care. Subsequent to her child's birth, she was given a spinal anesthetic. The plaintiff, thereafter, had no control of her legs, lower back, bladder or bowels. She alleged *inter alia*, that the anesthetic was improperly administered and charged that the defendant's agents failed to inform and warn her in advance of the possibility of disastrous results. There was testimony on behalf of the defendant that most patients are in a state of high nervous tension and anxiety when preparing for delivery, and it would be a bad practice to warn them that they might die or become paralyzed as a result of receiving anesthetics. The court, in applying Illinois law, agreed with the testifying physicians that there was no duty to warn of possible consequences of a specific regularly practiced medical procedure, unless the patient requested such information beforehand.

The court in the *Hall* case may have reached its decision because of the nature of psychological stress on an expectant mother. However, the same

[36] Murphy, *Medical Malpractice*, 7 Defense L.J. 3, 12 (1960). See also Julien v. Barker, 75 Idaho 413, 272 P.2d 718 (1954), Salgo v. Leland Stanford, Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957).

[37] Murphy, *Medical Malpractice*, 7 Defense L.J. 3, 12 (1960).

[38] 136 F. Supp. 187 (W.D. La. 1955).

decision may not be reached in all cases. There may be a duty to inform the patient of the consequences of a particular procedure if alternative procedures are possible, thus allowing the patient to make a choice.[39] There may also be a duty to inform the patient if the consequences of the proposed procedure to be used are substantially certain to occur.[40] Hence, the duty upon the physician to inform is conditioned on the type of treatment which is necessary, the danger of that treatment and the psychological stability of the patient.

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SPECIALISTS

The standard of care, in most jurisdictions, has been modified to require a greater degree of skill from specialists than ordinary general practitioners.[1] The rationale for imposing this greater duty is that specialists are sought out and greater confidence is placed in them by patients because of the expertise they profess.[2]

Illinois courts, however, have not changed the ordinary standard of care[3] in dealing with specialists. In *Schierson v. Walsh*,[4] the defendant-physician had claimed to be one of the greatest and most skillful surgeons in the world. The plaintiff, through the State Department of Registration and Education, sought to have the defendant's license revoked. The medical committee of the Department held the defendant to his assertions of expertise. Thus, his acts of negligence became gross neglect because of the higher standard of care that was imposed on him. This showing of gross malpractice met statutory requirements for license revocation.[5]

On appeal, the Illinois Supreme Court reinstated the defendant's license. The court, in holding that an imposition of a higher standard of care on the defendant was improper, stated that the test of "reasonable skill . . . such as physicians in good practice ordinarily use and would bring to a similar case in that locality" was ". . . safe for both public and profession."[6]

39 *Cf.*, Bang v. Charles T Miller Hosp., 251 Minn. 427, 88 N.W.2d 186 (1958).

40 See Salgo v. Leland Stanford, Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957).

1 See, *e.g.*, Worster v. Caylor, 231 Ind. 625, 110 N.E.2d 337 (1953); Rayburn v. Day, 126 Or. 135, 286 Pac. 1002 (1928).

2 Baker v. Hancock, 29 Ind. App. 456, 63 N.E. 323 (1902).

3 Ritchey v. West, 23 Ill. 385 (1860).

4 354 Ill. 40, 187 N.E. 921 (1933).

5 Ill. Rev. Stat. ch. 91 § 16a(3), Medical Practice Act (1959 as amended 1961, 1963, and 1965).

The section provides that license revocation can be based on a showing of gross malpractice or gross negligence. Ordinary negligence, sufficient to establish a prima facie case of malpractice, would not be adequate.

6 *Supra* note 4, at 49, 187 N.E. at 927 (1933).