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THE NURSING STANDARD OF CARE IN ILLINOIS: RETHINKING THE WINGO EXCEPTION IN THE WAKE OF *SULLIVAN V. EDWARD HOSPITAL*

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INTRODUCTION

Medical malpractice cases turn on whether a medical professional's conduct comported with the professional standard of care. Generally, while medical professionals are not liable for any adverse results that occur when their conduct meets or exceeds the minimum standard of care, they are liable when their deviation from that standard causes a patient harm.[1] Accordingly, establishing the standard of care is a crucial element in any medical malpractice lawsuit.

At trial, each party must present expert testimony in order to establish the applicable standard of care.[2] In most areas of law, Illinois courts do not require experts to hold any specific licenses; rather, the attorneys may question expert witnesses about their licensure in order to bolster their credibility or place it in doubt.[3] In medical malpractice cases, however, Illinois courts require medical experts to be licensed in the school of medicine about which they plan to testify.[4] The Illinois Supreme Court articulated this rule in *Purtill v. Hess*, stating that when an expert medical witness seeks to establish the standard of care, "[i]t must be established that the expert is a licensed member of the school

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1. There are certain specified tort theories, such as *res ipsa loquitur*, which do not specifically address whether the defendant's actions breached the standard of care. However, straightforward medical malpractice cases revolve around four basic elements: duty, breach, causation, and damages. If the medical practitioner breached his duty to act within the standard of care, and this breach caused the patient harm, then that practitioner would be liable for the cost of that harm.

2. Walski v. Tiesenga, 381 N.E.2d 279, 282 (Ill. 1978); Borowski v. Von Solbrig, 328 N.E.2d 301, 304-05 (Ill. 1975). *See also* Ill. Pattern Jury Instr.-Civ. 105.01 (2011). These cases state that *expert* testimony, and not just lay opinion testimony, must be used in order to establish the standard of care in medical malpractice cases. In practice, this means that each side must present experts to explain to the jury what they believe the professional standard to be.

3. ILL. R. EVID. 702.

4. Purtill v. Hess, 489 N.E.2d 867, 872 (Ill. 1986).

of medicine about which he proposes to express an opinion, and the expert witness must show that he is familiar with the methods, procedures, and treatments ordinarily observed by other physicians, in either the defendant physician's community or a similar community."[5]

Illinois courts have aptly applied this rule to the nursing profession. When a nurse is a defendant in a medical malpractice case, only a licensed nurse may testify to the nursing standard of care; the testimony of a physician may not establish this standard.[6] In 1997, however, the Illinois Appellate Court carved out an exception to this rule in *Wingo ex rel. Wingo v. Rockford Memorial Hospital*.[7] According to this exception, in the limited situation of establishing the standard of care for communications between nurses and physicians, a physician may testify as to what information a nurse must disclose and how the nurse must convey that information to the physician.[8]

In 2004, the Illinois Supreme Court reaffirmed the *Purtill* licensing requirement for expert medical testimony in *Sullivan v. Edward Hospital*. The *Sullivan* court noted the *Wingo* exception, but neither overruled nor endorsed it. This ruling has created confusion among the lower courts about whether the *Wingo* exception still stands, and if so, in what situations it may apply. It is important that Illinois courts create a single rule to resolve this tension because the different opinions about how *Wingo* and *Sullivan* interact have wildly different implications for how lawyers practice law and how nurses and physicians communicate on the hospital floor. Since the *Sullivan* ruling, however, the districts of the Illinois Appellate Court have proffered three separate views on how to interpret *Wingo* in light of *Sullivan*.

This note first reviews the history of the medical licensing requirement and the policy rationale supporting it. Next, this note examines the three-way split among the appellate districts and analyzes the implications of each rule for nurses and legal practitioners. Finally, this note advocates for a strict application of the original licensing requirement, contending that the best interpretation of *Sullivan* completely overrules the *Wingo* exception and restores the rule that only a nurse may testify to the nursing standard of care.

5. *Id.* (internal citations omitted).
6. *See, e.g.*, Sullivan v. Edward Hosp., 806 N.E.2d 645, 657-58 (Ill. 2004).
7. Wingo *ex rel.* Wingo v. Rockford Mem'l Hosp., 686 N.E.2d 722 (Ill. App. Ct. 1997).
8. *Id.* at 729.

I. BACKGROUND AND HISTORY OF THE *WINGO/SULLIVAN* SPLIT

Over the past quarter-century, Illinois courts have struggled to adopt a unified rule concerning which expert witnesses may testify to the standard of care for medical professionals. This section will highlight and explain three major developments in the rule's evolution: the establishment of licensure requirements in *Dolan*; the *Wingo* exception allowing physicians to testify about the standard of care for nurse-doctor communications; and the *Sullivan* ruling, which may have abolished the *Wingo* exception.

A. The Licensing Requirement

In 1979, the Illinois Supreme Court discussed licensing requirements for experts offering medical testimony in *Dolan v. Galluzzo*.[9] This was an issue of first impression in Illinois.[10] In that case, the plaintiff patient brought a medical malpractice action against the defendant, a podiatrist licensed under Illinois law.[11] The plaintiff claimed that the defendant had negligently performed an osteotomy, a surgical bone cutting, on the plaintiff's left foot.[12] On appeal, the primary issue was whether the plaintiff could offer expert testimony by a non-podiatrist physician or surgeon in order to establish what standard of care the podiatrist owed his patient.[13]

The *Dolan* court ruled that in medical malpractice cases, the parties must establish the appropriate standard of care for a particular professional by offering expert testimony from a licensed member of that professional community.[14] The court looked to state law in reaching this conclusion, explaining that the state has "long recognized podiatrists as a separate and distinct profession of healers who are severely limited in their practice and whose educational requirements are substantially different than those of physicians."[15] The court recognized several distinct categories of medical practices as determined by Illinois regulatory statutes: for example, medicine and surgery,

9. Dolan v. Galluzzo, 396 N.E.2d 13 (Ill. 1979).
10. *Id.* at 15.
11. *Id.* at 14.
12. *Id.*
13. *Id.* at 15.
14. *Id.* at 16.
15. *Id.* at 15.

nursing, pharmacy, dental surgery, and podiatry.[16] The court emphasized that these different medical professions require different training and are guided by different philosophies of care and methods of treatment.[17] Considering fairness, the court also recognized that allowing physicians or surgeons to testify to the podiatry standard of care could unfairly impose a higher standard of care on podiatrists.[18] Therefore, the Illinois Supreme Court held that in malpractice cases, the "defendant has the right to have his competence judged by the standards of his own distinct profession and not by those of any other."[19]

The crux of the *Dolan* decision rests on the fact that science and medicine are constantly evolving and that the standard of care changes in response to new discoveries. If all medical professionals are allowed to testify to any other medical professional's standard of care, this falsely assumes that all schools of thought "have achieved a universal standard of treatment of disease or injury."[20] In the absence of any "universal medical method," courts may only trust a licensed member of a particular group to testify about that group's training, methods, and general standard of care.[21]

Applying the *Dolan* rule, Illinois courts have developed a three-part test to determine whether a health professional may testify to a defendant's standard of care. The expert witness must meet two foundational requirements: (1) she must be a licensed member of the school of medicine about which she plans to testify, and (2) she must be familiar with the methods, procedures, and treatments normally performed in the defendant's professional community.[22] If an expert passes these two tests, the analysis moves to the third step, in which the trial court judge determines whether the proffered expert is competent to testify in the case at hand.[23] This three-part test is called the "*Purtill* foundational test," because the Illinois Supreme Court articulated the first two steps in *Purtill v. Hess*.[24] Today, Illinois courts still

16. *Id.* at 16. *See, e.g.*, 225 ILL. COMP. STAT. ANN. 25 (West 2012) (Illinois Dental Practice Act); 225 ILL. COMP. STAT. ANN. 60 (West 2012) (Medical Practice Act of 1987); 225 ILL. COMP. STAT. ANN. 65 (West 1998) (Nurse Practice Act); 225 ILL. COMP. STAT. ANN. 85 (West 2012) (Pharmacy Practice Act); 225 ILL. COMP. STAT. ANN. 100 (West 2012) (Podiatric Medical Practice Act of 1987).

17. *Dolan*, 396 N.E.2d at 15.

18. *Id.* at 16.

19. *Id.* at 15.

20. *Id.* at 16.

21. *Id.*

22. Purtill v. Hess, 489 N.E.2d 867, 872 (Ill. 1986).

23. Alm v. Loyola Univ. Med. Ctr., 866 N.E.2d 1243, 1247 (Ill. App. Ct. 2007).

24. *Purtill*, 489 N.E.2d at 872-73. *See also* Petryshyn v. Slotky, 902 N.E.2d 709, 715 (Ill. App. Ct. 2008) (using the term "*Purtill* foundational test").

use this test; however, a myriad of exceptions threaten to undermine the foundations of the licensing rule.

B. The Wingo Exception

In 1997, a medical malpractice case in the Second District changed the way Illinois courts perceive the *Dolan* licensing rule. In that case, *Wingo ex rel. Wingo v. Rockford Memorial Hospital*, the plaintiff sued the hospital where she gave birth, claiming that the negligence of the hospital's nursing staff proximately caused her daughter's brain damage.[25]

The facts of *Wingo* are as follows. The plaintiff, who was approximately thirty-five weeks pregnant, went to the hospital at 5:00 a.m. because she was leaking fluid.[26] At the hospital, she continued to leak fluid for several hours, and a physician concluded that her bag of waters was the source of the leak.[27] This continuous leaking was noted on the plaintiff's nursing chart.[28] At 9:30 a.m., Nurse Weldon and Dr. Klink took over the plaintiff's case.[29] Dr. Klink examined the plaintiff, and at the time of the exam, she did not leak any fluid.[30] Dr. Klink left and Nurse Weldon resumed monitoring the plaintiff.[31] The nurse observed that the plaintiff continued to leak intermittently all morning.[32]

At 2:45 p.m., Dr. Klink spoke with Nurse Weldon on the phone.[33] Nurse Weldon later stated that she would have told Dr. Klink that the plaintiff exhibited "no change."[34] Dr. Klink interpreted the statement "no change" to mean that the plaintiff had not leaked fluid since the time that he examined her.[35] However, Nurse Weldon meant to convey that the plaintiff had intermittently leaked fluid since her admission to the hospital several hours earlier.[36] After this exchange, Dr. Klink released the plaintiff from the hospital.[37] When the plaintiff later gave birth, doctors discovered that her bag of waters had become infected

25. Wingo *ex rel.* Wingo v. Rockford Mem'l Hosp., 686 N.E.2d 722, 725 (Ill. App. Ct. 1997).
26. *Id.*
27. *Id.*
28. *Id.*
29. *Id.*
30. *Id.*
31. *Id.*
32. *Id.*
33. *Id.*
34. *Id.*
35. *Id.* at 726.
36. *Id.* at 725.
37. *Id.*

from the leaking rupture, and that this untreated infection caused the plaintiff's baby to suffer severe and irreversible brain damage.[38]

At trial, the plaintiff presented three physicians to testify about Nurse Weldon's standard of care in communicating the plaintiff's condition to Dr. Klink.[39] All three physicians concluded that the nurse had breached the standard of care because they would have taken "no change" to mean no change since the physician's last examination of the plaintiff.[40] The defendant hospital, however, presented the expert testimony of two nurses, both of whom testified that Nurse Weldon appropriately reported the situation given the nursing standard of care.[41] The hospital objected to the physicians' testimony regarding the nursing standard. Invoking *Dolan*, the hospital argued that a physician who was not also a licensed nurse was unqualified to testify about practices in the nursing field of medicine.[42]

Rather than barring the physicians' testimony, the appellate court carved out a limited exception to the *Dolan* rule: when the standard of care in question governs the communications between a nurse and a physician, a physician may testify about the applicable standard of care.[43] To justify this exception to the rule, the court noted that the concerns at issue in *Dolan* did not apply to the case at hand. First, the *Dolan* licensing requirement prevents courts from unfairly imposing higher standards of care on professional defendants.[44] Second, the *Dolan* rule ensures that expert witnesses are familiar with the training, procedures, and treatment philosophies of the relevant medical school.[45] The *Wingo* court reasoned that the current case did not implicate either of these policy concerns.[46] The allegedly negligent conduct was not a nursing procedure, but rather a required communication from nurse to physician. As such, the court concluded, "the allegations of negligence do not concern an area of medicine about which there would be a different standard between physician and another school of medicine."[47] Therefore, since the communication involves both parties, the *Wingo* court reasoned that (1) physicians

38. *Id.*
39. *Id.* at 727.
40. *Id.*
41. *Id.* at 726.
42. *Id.* at 727.
43. *Id.* at 729.
44. *Id. See also* Dolan v. Galluzzo, 396 N.E.2d 13, 16 (Ill. 1979).
45. *Wingo*, 686 N.E.2d at 729. *See also Dolan*, 396 N.E.2d at 15.
46. *Wingo*, 686 N.E.2d at 729.
47. *Id.*

would not impose unfairly high standards on nurses, and (2) physicians are familiar with the nursing procedures regarding nurse-doctor communications.[48]

In sum, the *Wingo* exception states that when the alleged negligence involves a misunderstood communication from a nurse to a physician, the parties may present expert testimony from physicians, without input from nurses, to establish whether that communication met the standard of care. Specifically, physicians may instruct the jury as to what information nurses are required to disclose to them and may specify the manner in which nurses must disclose this information in order for physicians to properly understand, regardless of whether these opinions diverge from the nursing profession's standard of care for communications.

C. *The Sullivan Ruling*

In 2004, the Illinois Supreme Court decided *Sullivan v. Edward Hospital*, the crux of which was a phone communication between a nurse and a physician.[49] In that case, the plaintiff was a stroke patient.[50] The plaintiff had been instructed not to leave his hospital bed, but the nurse on duty, Nurse Lewis, observed that the plaintiff attempted to get up and walk several times.[51] The plaintiff seemed agitated and was not able to follow the nurse's instructions to stay in bed.[52] Concerned, Nurse Lewis phoned the plaintiff's physician, Dr. Conte-Russian, and asked her to order a "posey vest" to restrain the plaintiff to his bed.[53] Dr. Conte-Russian advised that a restraining device might further agitate the plaintiff, and she instead prescribed a calming drug to help the plaintiff sleep.[54] After Nurse Lewis administered the drug, she later found the plaintiff lying on the floor of his hospital room with a pool of blood surrounding his head.[55]

At trial, the plaintiff alleged that both Dr. Conte-Russian and Nurse Lewis failed to meet their respective standards of care. The plaintiff called a physician witness, Dr. Barnhart, to testify that Nurse Lewis was negligent in not properly communicating the plaintiff's condition

48. *Id.*
49. Sullivan v. Edward Hosp., 806 N.E.2d 645, 650 (Ill. 2004).
50. *Id.* at 648.
51. *Id.* at 648-49.
52. *Id.* at 649.
53. *Id.*
54. *Id.*
55. *Id.*

to the physician over the phone when requesting the posey vest.[56] However, since the plaintiff did not properly disclose this aspect of Dr. Barnhart's testimony in pretrial discovery, Illinois Supreme Court Rule 213 precluded Dr. Barnhart from offering his opinion on the nursing standard of care for communicating a patient's condition.[57] The Illinois Supreme Court thus declined to rule specifically on the validity of the *Wingo* exception, stating, "the appellate court did not discuss the merits of *Wingo*, and neither do we."[58]

For other allegations concerning Nurse Lewis's negligence, the Illinois Supreme Court followed the *Dolan* licensing rule. The court thus refused to allow physician testimony about standard nursing procedures and methods, and instead required the parties to establish the nursing standard of care through the testimony of nurse expert witnesses.[59]

After re-affirming the *Dolan* rule, the *Sullivan* court bolstered its position by explaining the policy rationale for maintaining strict licensing requirements. The core of this policy argument was that the diverse schools of medicine have not yet reached a universal understanding of treatment.[60] Given this premise, the court acknowledged that both the Illinois Supreme Court and the Illinois legislature have recognized nursing as a profession that is distinct from, and not subordinate to, that of physicians. The court further emphasized that nurses are not merely physicians' assistants. It rejected the contention made in the *amicus* brief by the Trial Lawyers' Association that "[t]here is nothing which a nurse can do which a doctor cannot do."[61] Not only did that assertion wrongly assume that the medical fields have reached a universal understanding, but it also reflected ignorance of the modern state of the nursing profession.

Quoting a scholarly article, the *Sullivan* court stated, "nursing, as a profession, has moved beyond its former dependence on the physician, and into a realm where it must and can legally account for its own professional practices."[62] The court noted that physicians rarely teach in nursing programs or write the content in nursing texts, both of which

56. *Id.* at 649-50.
57. *Id.* at 652.
58. *Id.* at 657.
59. *Id.* 657-58.
60. *Id.* at 658.
61. *Id.* at 659.
62. *Id.* (quoting Carole F. Kehoe, *Contemporary Nursing Roles and Legal Accountability: The Challenge of Nursing Malpractice for the Law Librarian*, 79 LAW LIBR. J. 419, 428 (1987)).

heavily influence nurses' understanding of their profession's standard of care.[63] Quoting another scholarly journal, the court wrote, "In many situations, a physician would not be familiar with the standard of care or with nursing policies and procedures which govern the standard of care."[64] The *Sullivan* court thus re-established the rule that physicians may not testify to the nursing standard of care because doing so would falsely assume that nurses and physicians have reached a common understanding of the methods, procedures, and science of patient treatment.

Most notably, although the *Sullivan* court stated that it would not address the merits of *Wingo*, one statement in its policy analysis indicates that there is no room for the *Wingo* exception in the post-*Sullivan* world. Quoting the American Association of Nurse Attorneys (TAANA), the court stated that a nurse could *not* testify "that, in her experience, when she calls a physician, he/she usually responds in a certain manner. Such testimony would be, essentially, expert testimony as to the standard of medical care."[65]

This statement contains two distinct assertions that place the *Sullivan* ruling in tension with the *Wingo* exception. First, it asserts that communications made as part of a medical professional's job fall within that professional's standard of care. Therefore, when nurses convey information to physicians, this communication would fall within the nursing standard of care and would not be governed by a different standard as the *Wingo* exception allows. Second, this statement declares that it would be improper for a nurse to testify that, when she calls a physician, the physician usually responds in a certain manner. Since nurses and physicians are equal but distinct professions under the licensing rule, the inverse should also be true: it would be improper for a physician to testify that a nurse usually relays information to him in a certain manner. Yet, this prohibited testimony is precisely what the *Wingo* exception allows.

Despite these strong implications that *Sullivan* should be read to overturn *Wingo*, the lower courts have reached different conclusions about whether *Wingo* is still good law, and if so, in which situations it

63. *Sullivan*, 806 N.E.2d at 658-59 (quoting Elizabeth Webb Beyer & Pamela W. Popp, *Nursing Standard of Care in Medical Malpractice Litigation: The Role of the Nurse Expert Witness*, 23 J. HEALTH & HOSP. L. 363, 365 (1990)).

64. *Id.* at 659.

65. *Sullivan*, 806 N.E.2d at 658 (quoting Amicus Curiae Br. for the American Association of Nurse Attorneys (TAANA) in Support of Defendant/Respondent Edward Hospital, No. 95409 (2002) (hereinafter Sullivan Amicus Brief)).

applies. As a result, there is currently no clear rule in Illinois regarding expert testimony for nurse-doctor communications. Instead, the districts of the Illinois Appellate Court have put forth three contradictory rulings on the *Wingo/Sullivan* rule.[66]

II. THE NATURE OF THE CIRCUIT SPLIT

In the wake of *Sullivan*, Illinois courts have struggled to reconcile the *Wingo* exception with the *Sullivan* court's renewed endorsement of the strict licensing requirements. There are three prominent theories on how to interpret the intersection of the *Wingo* and *Sullivan* rules. First, a lenient application of *Sullivan* not only preserves the *Wingo* exception, but also extends it. Under this approach, a doctor may testify to the nursing standard of care as long as that doctor is familiar with normal nursing procedures. For example, a doctor may testify about nursing procedures that are performed as part of a surgical team in which doctors and nurses collaborate.[67] Second, on the opposite end of the spectrum, proponents of a strict application of *Sullivan* reason that, in endorsing the *Dolan* licensing requirement, the *Sullivan* court overruled the *Wingo* exception. Under this approach, each party must present a licensed nurse to establish the standard of care for all nursing procedures, including nurse-doctor communications.[68] This approach endorses the view that since required communications are an integral part of nursing procedure, and since physicians' expectations may differ from nurses' requirements, only a licensed nurse can properly instruct the jury on a nurse's proper method of communication. Finally, a moderate application of *Sullivan* would preserve *Wingo* but decline to extend the exception any further. Under this approach, doctors may testify to the nursing standard only as it relates to information that a nurse is required to disclose to a doctor.[69] This section will analyze each approach, focusing specifically on how each one balances the dual interests of protecting patients and ensuring that nurse defendants are judged fairly in court.

66. For the first interpretation ("the lenient approach"), *see* Petryshyn v. Slotky, 902 N.E.2d 709 (Ill. App. Ct. 2008). For the second interpretation ("the moderate approach"), *see* Petre v. Cardiovascular Consultants, 871 N.E.2d 780 (Ill. App. Ct. 2007). For the third interpretation ("the strict approach"), *see* Garley v. Columbia LaGrange Mem'l Hosp., 13 N.E.2d 1030 (Ill. App. Ct. 2004).

67. For a discussion of the lenient approach, *see infra* pp. 255-58.

68. For a discussion of the strict approach, *see infra* pp. 258-62.

69. For a discussion of the moderate approach, *see infra* pp. 262-66.

A. The Lenient Approach

The most lenient application of *Sullivan* adopted by the lower courts allows physicians to testify to the nursing standard of care when the defendant nurse worked on a surgical team. The physician's testimony need not be related to communications. Rather, if a team of physicians and nurses has worked on a patient during surgery, a physician may testify to the standard of care of any nursing procedure typically performed during that surgery. Therefore, this lenient approach not only leaves the *Wingo* exception intact, but also expands its breadth to cover any nursing procedure performed in a setting where physicians and nurses would usually communicate.

This approach abandons the first foundational requirement of the *Dolan* licensing test (that the expert must be a licensed member of the relevant school of medicine), as long as the second foundational requirement is met (that the expert is familiar with the methods, procedures, and treatments of the relevant school). While this rule likely preserves the goals of tort law, it places an unfair burden on surgical team nurses to act in accordance with what surgeons, rather than other nurses, consider to be the nursing standard of care. Since nurses have no way of knowing what surgeons consider the nursing standard to be, this rule imposes on nurses a request that is nearly impossible to meet.

The Fourth District has endorsed this lenient approach in *Petryshyn v. Slotky*.[70] In that case, the plaintiff brought a medical malpractice action against her obstetrician and hospital when she discovered 11.3 centimeters of an intrauterine pressure catheter (IUPC)[71] left inside her body several months after having a Cesarean section (C-section).[72]

At trial, the plaintiff's expert witness explained that during C-sections, surgical teams of physicians and nurses work together and perform different necessary tasks.[73] Normally, the nurses would remove the IUPC from the patient's birth canal before the start of the C-

70. 902 N.E.2d 709 (Ill. App. Ct. 2008).

71. IUPCs are used to monitor the progression of labor and uterine contractions. *Id.* at 711. For more detail, *see* Robin Elise Weiss, *Intrauterine Pressure Catheter (IUPC)*, ABOUT.COM PREGNANCY & CHILDBIRTH, http://pregnancy.about.com/od/laborglossary/g/iupc.htm (last visited Feb. 3, 2012). When contractions do not progress normally, a doctor may order a C-section. *Petryshyn*, 902 N.E.2d at 710.

72. *Petryshyn*, 902 N.E.2d at 710.

73. *Id.* at 716.

section.[74] In this case, the nurses did not do so, and the IUPC was cut in half while the doctor made the abdominal incision to remove the child.[75] Expert testimony also showed that if the nurses had not previously removed the IUPC, they would normally do so right after the C-section during the postoperative "sponge and instrument count" and would check to make sure that the entire device was removed.[76] In this case, the nurses did remove part of the IUPC, but since it had been cut during the surgery, another part of the IUPC remained in the patient.[77] The nurses did not report to the doctor that the discarded IUPC was not intact.[78] Expert testimony also showed that at the end of the procedure, the physician standard of care requires the physician who performed the C-section to examine the patient's birth canal to ensure that the nurses properly removed all of the surgical equipment.[79] In this case, the physician failed to check the birth canal.[80]

The *Petryshyn* court ruled that a physician expert witness may testify to the standard of care for every medical professional on the surgical team.[81] The court reasoned that the *Wingo* exception should be expanded to cover the situation at hand in the case: "*Wingo* relieves a party of satisfying the licensing prong of the *Purtill* foundational test[82] when the allegations of negligence concern communications between members of different schools of medicine acting as part of the same team."[83] The court emphasized, however, that *Wingo* only relieves the expert of satisfying the licensing prong.[84] The expert must still prove that she is familiar with the responsibilities, training, and methods of the school of medicine for which she seeks to offer testimony.[85]

Most importantly, the *Petryshyn* court proposed that Illinois courts use a "providing-medical-care continuum" to guide their rulings on medical testimony in future cases.[86] According to this analysis, *Dolan* represents one extreme of the continuum, in which a practitioner,

74. *Id.* at 711.
75. *Id.*
76. *Id.* at 716.
77. *Id.* at 711.
78. *Id.* at 711-12.
79. *Id.* at 711.
80. *Id.*
81. *Id.* at 716-17.
82. *See supra* pp. 245-46 (explaining the three-part Purtill foundation test).
83. *Petryshyn*, 902 N.E.2d at 715 (quoting Petre v. Cardiovascular Consultants, 871 N.E.2d 780, 792 (Ill. App. Ct. 2007) (internal quotations omitted).
84. *Id.* at 715.
85. *Id.*
86. *Id.* at 715-16.

unlicensed in podiatry and without any knowledge of that school's methods and training, sought to offer expert testimony about the podiatry standard of care. This type of testimony, *Petryshyn* conceded, should still be prohibited.[87] However, the court reasoned that the *Petryshyn* case represented the opposite extreme of the spectrum, in which an expert is intimately familiar with the methods and requirements of another school of medicine because that expert has worked in a team setting with and among members of that school. According to this analysis, a surgical team is a complete organism, and any member of the team may testify to the responsibilities of any other team member. In fact, the *Petryshyn* court insisted that it was even more reasonable for the court to admit differently-licensed expert testimony in a team setting than in the communications setting presented in *Wingo*.[88]

The lenient approach succeeds in promoting the tort law goal of deterring potential tortfeasors. In jurisdictions applying this approach, medical professionals working in a team setting would be aware that their competence could be judged by any other category of licensed professional on that team. Therefore, all of the professionals involved would be more likely to ensure that every team member understood and accurately communicated every action taken. A new standard of care might emerge in which each team member checks the work of every other person, so that a team truly does function as a complete organism. For example, in the *Petryshyn* scenario, the physician might have been required to ask the nurses if they had removed the entire IUPC, and the nurses might have been required to ask the physician if he had checked the birth canal after the operation. In this way, team members would be deterred from remaining silent in the face of unclear information and would have affirmative incentives to check the work of other team members, possibly reducing the number of injuries in the future.

However, any team cohesion enhanced by the lenient approach comes at a high price for nurse defendants in terms of fairness. Illinois courts and legislatures have long recognized nursing as a profession completely separate from that of physicians. To assume that a physician is familiar with the methods, procedures, and treatments of nurses simply by virtue of working alongside them is akin to assuming that anyone who has closely observed a medical professional's work in a team setting may testify to that professional's standard of care. Assum-

87. *Id.* at 715.
88. *Id.* at 716.

ing, as the courts and legislatures have, that nurses are separate, but not inferior to, physicians, this standard would allow operating room nurses to testify to surgeons' standards of care. The implications of such a ruling border on the absurd. Could a doula[89] who attends a birth establish the standard of care of a licensed nurse midwife or obstetrician? Could a doctor's unlicensed assistant, or even a frequent patient, testify to that doctor's standard simply because of close observation? In short, the lenient approach sacrifices fairness for nurse defendants by assuming, without supporting data, that close observation in a team setting is sufficient to satisfy the licensing prong of the *Purtill* foundational test.

B. The Strict Approach

Under a strict application of *Sullivan*, courts would interpret the *Sullivan* ruling to completely abolish the *Wingo* exception and restore the *Dolan* licensing requirements to their original status. This approach defers to the policy rationale in *Dolan* by recognizing that allowing differently-licensed medical professionals to testify about standards of care could result in courts holding professional defendants to unfairly high standards. The strict approach therefore only allows licensed professionals to establish the standard of care for their own professions, regardless of whether the standard at issue pertains to a procedure or a method of communication. Unfortunately, plaintiffs would not be compensated if their injuries resulted from ineffective nurse-doctor communications where both the nurses and physicians met their respective minimum standards of care. However, if these situations arise, the appropriate response is to revise the standard of care in order to close these communication gaps. It is *not* appropriate for physicians, at trial, to hold nurses to a standard of care that is more rigorous than the standard governing those nurses' training and practice. Such a rule is especially unfair because the reverse would not be true — nurse experts would not be allowed to testify that the physician's understanding of the nurse's oral report fell below the physician standard of care. Accordingly, a strict application of *Sullivan* is the only approach that safeguards fairness for professional defendants while

89. Doulas are birthing coaches. WebMD states, "A doula . . . [is] not a doctor, not a nurse, not a midwife. Indeed, a doula (a Greek word meaning 'women supporting women') is not a medical professional at all. Rather, she provides support and encouragement throughout labor and delivery, and often, after the baby is born, as well." Star Lawrence, *Doulas: Easing Birth*, WEBMD, http://www.webmd.com/baby/features/doulas-easing-birth (last visited Nov. 16, 2012).

still allowing plaintiffs to recover where defendants have breached their true standards of care.

In *Garley v. Columbia LaGrange Memorial Hospital*, the First District embraced this strict application of *Sullivan*.[90] The facts of that case began when Pauline Garley went to the hospital for several abdominal surgeries.[91] When the surgeries were completed at 1:30 p.m. on April 28, her treating physician mandated that she be "ambulated with assistance" to decrease the likelihood of developing a deep vein thrombosis (DVT).[92] Later that afternoon, a nurse attempted to ambulate Ms. Garley, but Ms. Garley could not tolerate it.[93] The next day, beginning at 11 a.m., Ms. Garley walked three short distances of about ten feet each.[94] The following day, when a nurse attempted to help Ms. Garley ambulate, she collapsed and subsequently died.[95] A medical examiner later concluded that Ms. Garley had died from a pulmonary embolism caused by a DVT.[96]

Ms. Garley's husband brought a wrongful death suit against the hospital. At trial, the court instructed the jury on five theories of negligence against the hospital's nursing staff.[97] Three of these theories alleged improper nurse-doctor communications: "[1] failing to notify her physicians of her complaints of pain... [2] failing to notify her physicians of her lack of ambulation... [and 3] failing to suggest the use of anticlotting devices during surgery."[98]

At trial, the plaintiff called three expert witnesses to establish the nursing standard of care. All three of these experts were physicians

90. Garley v. Columbia LaGrange Mem'l Hosp., 813 N.E.2d 1030 (Ill. App. Ct. 2004). Note that the First District overturned this ruling in Petre v. Cardiovascular Consultants, 871 N.E.2d 780 (Ill. App. Ct. 2007).

91. *Garley*, 813 N.E.2d at 1032.

92. *Id.* at 1032-33. WebMD states the following information about DVT: "Deep vein thrombosis (DVT) occurs when a blood clot forms in a vein deep inside a muscle in your body. It usually happens in the legs, but can also develop in your arms, chest, or other areas of your body. And though DVT is common, it can be dangerous. The blood clot can block your circulation or lodge in a blood vessel in your lungs, brain, heart, or other area. The clot can cause severe organ damage and even death — within hours." *Causes of Deep Vein Thrombosis (DVT)*, WEBMD, http://www.webmd.com/dvt/deep-vein-thrombosis-causes-are-you-risk-dvt (last visited Nov. 16, 2012).

93. *Garley*, 813 N.E.2d at 1033.

94. *Id.*

95. *Id.*

96. *Id.* (the medical examiner explained that Ms. Garley had developed a DVT, which had "dislodged and traveled through her bloodstream, blocking her pulmonary arteries"). For more information on DVT, *see supra*, note 92.

97. *Id.* at 1035.

98. *Id.* at 1035-36.

without nursing licenses.[99] First, Dr. Charles Bird testified that his experience working with nurses made him familiar with "the standard of care applicable to nurses who perform postoperative care on patients who have undergone [similar] surgeries."[100] He testified that the nurses in this case should have ambulated Ms. Garley within 12 hours of surgery, and that their failure to do so contributed to her death.[101] Second, Dr. Fred Duboe testified that he was familiar with the nursing profession because he had taught nurses, married a nurse, and occasionally read *Nursing Spectrums*, a nursing periodical.[102] Dr. Duboe testified that the nurses in this case should have ambulated Ms. Garley within 12 to 18 hours of surgery, for a distance of about 60 feet, and that if they could not accomplish this, they should have called Ms. Garley's treating physician for further instructions.[103] He asserted that the nurses' failure to do any of this was a deviation from the nursing standard of care.[104] Finally, Dr. Richard Vasquez testified that he had taught nurses and worked with nursing personnel "in the formation of guides as to what nurses are supposed to do."[105] He stated that, in this case, the operating room nurse deviated from the nursing standard of care by failing to advise Ms. Garley's surgeon to use anticlotting devices during the operation.[106] The surgeon's subsequent failure to use anticlotting devices, he testified, "set the ball rolling toward [the development of a] DVT and pulmonary embolus."[107]

The hospital, in contrast, presented a registered nurse as their expert witness to establish the nursing standard of care.[108] This nurse expert, Jacqueline Medland, stated that Ms. Garley should have been ambulated "as soon as she was able to tolerate it, but no later than 24 hours after surgery."[109] She concluded that the nurses on duty had met the standard of care by walking Ms. Garley to the chair in her hospital room at 11 a.m. on April 29.[110] Since these nurses had met the stand-

99. *Id.* at 1034.
100. *Id.*
101. *Id.*
102. *Id.*
103. *Id.* at 1034-35.
104. *Id.*
105. *Id.* at 1035.
106. *Id.*
107. *Id.*
108. *Id.*
109. *Id.*
110. *Id.*

ard of care, they would not have needed to contact Ms. Garley's treating physician for alternate instructions.

The *Garley* court ultimately decided that only a nurse can establish the nursing standard of care. The plaintiff bears the burden of proving the applicable standard of care in medical malpractice cases. Since the plaintiff in *Garley* had not offered a nurse's testimony to establish the standard of care, he lost the case by failing to prove this element of the tort.

In reaching its decision, the court made no distinction between the plaintiff's claims based on nursing procedures and his claims based on failed nurse-doctor communications; rather, the court held that all of the claims required the expert testimony of a licensed nurse. The court stated, "It is undisputed that, in this case, plaintiff's experts were well-qualified physicians, whose professional experience and accomplishments were beyond reproach. Equally undisputed, however, is that none of plaintiff's experts were licensed in the school of nursing."[111] The court further emphasized that a court should only consider the second prong of the *Purtill* foundational test (the familiarity prong) once the first prong (the licensing prong) has been met. So, in *Garley*, the expert physicians' familiarity with nursing practice was inconsequential: "[a]n expert physician who is not licensed in the particular school of medicine about which he intends to testify is automatically incompetent; his knowledge, experience, and level of expertise, no matter how extensive, are simply irrelevant."[112] Since nursing is a distinctly licensed medical profession, and the plaintiff did not offer a nurse's testimony to set the standard of care, the plaintiff failed to present a complete case to the jury.

The *Garley* court based its analysis on both the text of the *Sullivan* opinion and enduring policy considerations. First, it reasoned that the Illinois Supreme Court had unequivocally restored the *Dolan* licensing requirements: "the court in *Sullivan* reiterated the requirement that, in order to provide competent standard of care testimony, the plaintiff's proffered expert physician must be licensed in the defendant's given school of medicine."[113] The *Garley* court reasoned that, since *Sullivan* had reaffirmed the same-license requirement across the board, the *Wingo* exception no longer applied. The court wrote, "[a]s our supreme court has made clear, '[w]e expressly reaffirm the license requirement

111. *Id.* at 1038.
112. *Id.* at 1042 (citing Sullivan v. Edward Hosp., 806 N.E.2d 645, 653 (Ill. 2004)).
113. *Garley*, 813 N.E.2d at 1037 (citing *Sullivan*, 806 N.E.2d at 653-54).

of Dolan and its progeny and decline plaintiff's invitation to deviate therefrom.'"[114] Therefore, invoking *stare decisis*, the court determined that it must affirm the *Sullivan* and *Dolan* licensing requirements without exception.[115]

Next, the *Garley* court began its policy analysis by acknowledging that both the Illinois Supreme Court and the state legislature have recognized nursing as a distinct school of medicine.[116] Since these schools are unique, allowing a doctor to testify to the nursing standard of care would improperly assume that doctors and nurses have reached a universal standard of treatment.[117] The *Sullivan* court itself rejected the idea that "[t]here is nothing which a nurse can do which a doctor cannot do" because it presumes the fantasy of a universal standard.[118] Therefore, since a nurse-doctor communication is a communication spanning two distinct professions, it would be unfair to allow one of those professions to dictate the required terms of the interaction. In short, the *Garley* court concluded that *Sullivan* had already answered any remaining doubts about expert testimony — a nurse expert is always required to establish the nursing standard of care.

C. The Moderate Approach

A moderate application of the *Sullivan* ruling recognizes the *Wingo* exception as it relates to nurse-doctor communications, but refuses to extend the exception to any other scenarios, such as the surgical team scenario presented in *Petryshyn*. Under this approach, courts must follow the three-part *Purtill* foundational test in every situation except when dealing with communications covered by the limited *Wingo* exception. Courts that have adopted this approach reason that a nurse-doctor communication is not a nursing procedure, and therefore the

114. *Id.* at 1040 (quoting *Sullivan*, 806 N.E.2d at 660).

115. *Id.* ("[r]igid and formalistic though this rule may be, it is fundamental to our judicial system that once our supreme court has declared the law on any point, this court must follow that law, as only the supreme court has authority to overrule or modify its own decisions") (citing Schiffner v. Motorola, Inc., 697 N.E.2d 868, 871 (Ill. App. Ct. 1998) ("the doctrine of *stare decisis* requires courts to follow the decisions of higher courts")).

116. *Id.* at 1038-39. *See also* Nursing and Advanced Practice Nursing Act, 225 ILL. COMP. STAT. 65/5-1 (2000) (establishes a distinct licensing and regulatory scheme for the nursing profession).

117. Dolan v. Galluzzo, 396 N.E.2d 13, 16 (Ill. 1979) ("to [allow surgeons to testify to the standard of care of podiatrists] would not only be unfair to podiatrists . . . but it would also assume that science and medicine have achieved a universal standard of treatment of disease or injury").

118. *Sullivan*, 806 N.E.2d at 658.

policy interests behind the medical licensing requirement do not apply in these cases.

In *Petre v. Cardiovascular Consultants*, the First District adopted this moderate approach, invalidating the strict approach endorsed in *Garley*.[119] The facts of that case began when James Petre had coronary bypass surgery on November 26, 1996.[120] Mr. Petre developed an infection while under the care of his treating physician, but it went unnoticed and the physician released Mr. Petre from the hospital on December 2.[121] Over a month later, Mr. Petre underwent a second surgery to cure the infection, which resulted in the loss of his sternum, which in turn necessitated plastic surgery to reconstruct the shape of his chest.[122]

At trial, Mr. Petre's treating physician, Dr. Kucich, testified that a culture was taken from the fluid from Mr. Petre's incision shortly after the first operation.[123] However, Dr. Kucich only learned of the culture result, which was positive for a bacterial infection, much later, which indicates that there was a missed communication between a nurse or staff member and Dr. Kucich.[124] Dr. Kucich testified that "[i]f my office knew and didn't tell someone, then yeah, there's a breach of standard of care."[125] Thus, this case concerned the required communications between a nurse or staff member and the patient's treating physician, falling "squarely within the exception to the licensing requirement articulated in *Wingo*."[126]

By adopting a moderate application of *Sullivan* and endorsing the *Wingo* exception, the First District in *Petre* explicitly overturned *Garley*, which had adopted a strict application of *Sullivan*.[127] The court based its decision to overturn *Garley* on its own interpretation of the *Sullivan* holding: "*Sullivan* very clearly distinguished *Wingo* because it found that the 'precise factual scenario' of communications between a nurse and a physician was not present in that case."[128] Therefore, the *Petre*

119. Petre v. Cardiovascular Consultants, 871 N.E.2d 780 (Ill. App. Ct. 2007).
120. *Id.* at 784.
121. *Id.*
122. *Id.*
123. *Id.* at 786.
124. *Id.*
125. *Id.* at 787.
126. *Id.* at 793.
127. *Id.* at 792 ("We therefore disagree with Justice Quinn's opinion in *Garley* on this point and find *Wingo* to remain appropriate precedent for this court to follow"). For an analysis of the *Garley* opinion, *see infra* pp. 259-62.
128. *Petre*, 871 N.E.2d at 792.

court reasoned that *Sullivan* intended to leave the *Wingo* exception intact.

However, it was improper for the *Petre* court to base its decision on the factual differences between *Wingo* and *Sullivan*. Although the factual situation of nurse-doctor communications was not presented at trial in *Sullivan*, it does not follow that the *Sullivan* court was silent on this issue. In fact, the *Sullivan* court was not silent. In its extensive policy analysis of the importance of the original licensing requirements, the *Sullivan* court explained that a nurse could not testify that when she calls a physician, the physician usually responds in a certain way.[129] Such testimony would be inadmissible because it would amount to a nurse determining the physician's standard of care for nurse-doctor communications.[130] At the very least, this analysis shows that a physician's communications to a nurse fall under the purview of a physician's standard of care. Moreover, since the *Sullivan* court emphasized that nursing is a distinct, yet equal profession, it would follow that the court believed that the reverse is also true: a nurse's communication to a physician is a nursing procedure governed by the nursing standard of care. The *Petre* court's dismissive account of *Sullivan* failed to recognize the *Sullivan* court's implication that strict licensing requirements would nullify the *Wingo* exception.

After dismissing this implication and explaining that it would adopt a moderate interpretation of *Sullivan*, the *Petre* court began its analysis of the case at hand. The court structured its analysis around the *Purtill* foundational test. First, regarding the licensing requirements, the court stated, "*Wingo* relieves a party of satisfying the licensing prong of the *Purtill* foundational test where the allegations of negligence concern communications between members of different schools of medicine acting as part of the same team."[131] Therefore, since the allegation of negligence in this case concerned what a nurse or staff member should have told Dr. Kucich about Petre's culture, the "plaintiff is relieved of satisfying the licensing requirement of the *Purtill* foundational test."[132]

While discussing the policy implications of its decision, the *Petre* court stated that licensing requirements need not apply in cases con-

129. Sullivan v. Edward Hosp., 806 N.E.2d 645, 658 (Ill. 2004) (Sullivan Amicus Br., *supra* note 65).

130. *Id.*

131. *Petre*, 871 N.E.2d at 792 (citing Wingo *ex rel.* Wingo v. Rockford Mem'l Hosp., 686 N.E.2d 722, 729 (Ill. App. Ct. 1997)).

132. *Id.*

cerning nurse-doctor communications because "the problem of imposing a higher standard of care on a defendant is not present where there is no different standard between the proffered expert's school of medicine and the school of medicine to which the defendant belongs."[133] However, the court failed to explain why the physician standard of care would always match the nursing standard of care in cases involving a communication. To the contrary, the case law indicates that nurses and doctors can disagree about the communication standard of care. To illustrate, even the *Garley* case that *Petre* overturned presented a difference of opinion between the two schools of medicine: the physician experts testified that the nurses should have contacted the physician if they could not ambulate the patient within 12 to 18 hours of surgery, whereas the nurse expert testified that the nurses need not contact the physician until 24 hours had passed.[134] Therefore, the *Petre* court's conclusory policy analysis failed to explain why nurses and physicians should share a common communication standard of care in court, given that they do not do so in practice.

Further, in applying the *Wingo* exception to the facts of this case, the *Petre* court overlooked a subtle yet important factual difference between *Wingo*, on the one hand, and *Petre* and *Garley*, on the other. In *Wingo*, the nurse had most likely talked to the physician about the patient's leaking bag of waters, and the controversy concerned the nurse's failure to communicate the message in a manner the physician understood.[135] In *Petre* and *Garley*, no communication occurred at all, whether effective or not.[136] In other words, the central question in *Petre* and *Garley* was, "When should a nurse summon the doctor?" whereas the central question in *Wingo* was, "How should a nurse communicate information to the doctor?" Thus, the question presented in *Petre* and *Garley* pertains to nursing procedures even more so than the question in *Wingo*. While the method of communication between nurses and physicians could conceivably fall within either professional's standard of care, the procedure for determining *when* to call the physician is plainly a nursing procedure governed by the nursing standard of care. For example, in *Petre*, what if the nursing standard of care only required the nurse to record the culture test results in Mr. Petre's chart, under the expectation that the physician standard of care

133. *Id.* at 793.
134. *See Garley*, 813 N.E.2d at 1034-35.
135. *See Wingo*, 686 N.E.2d at 725-27.
136. *See Petre*, 871 N.E.2d at 790, 793; *Garley*, 813 N.E.2d at 1033-34.

required Dr. Kucich to check the chart daily? If this were true, then it would be grossly unfair for a physician to testify that the nursing standard of care required the nurse to communicate that information orally when the nurse's own training informed her that recording it in the chart was sufficient.

Ultimately, in the *Petre* case, Dr. Kucich did not have the opportunity to testify as such because his proposed testimony did not pass the second prong of the *Purtill* foundational test, which requires the expert to be familiar with the methods of the defendant's professional community.[137] The *Petre* court emphasized that, although *Wingo* allows experts to bypass the licensing prong of the test, the expert "must still satisfy the second prong of the *Purtill* test by establishing that the allegations of negligence were within that expert's knowledge and experience."[138] In a "sharp contrast" to *Wingo*, in which the physician expert witnesses had taught obstetric nurses and worked with nurses in team settings, Dr. Kucich "never established that he was familiar with the methods, procedures, and treatments ordinarily observed by other staff or employees."[139] Thus, since Dr. Kucich failed to meet the second prong of the *Purtill* foundational test, he could not testify to the standard of care for nurses or other staff members.

Therefore, while the *Petre* case embodies a moderate application of *Sullivan*, it ultimately fails to resolve the tension between *Sullivan*'s endorsement of licensing requirements and *Wingo*'s disregard for those requirements in the limited sphere of nurse-doctor communications. In short, *Petre* states its conclusion without explaining why the important policy concerns that gave rise to the licensing requirements are irrelevant when analyzing the communications between nurses and physicians.

III. ARGUMENT

Of the three possible interpretations of the *Sullivan* case, the First District's ruling in *Garley* is the only one that preserves the goals of tort law while ensuring that nurse defendants are granted a fair trial. This section first discusses the history of medical standards of care and explores the rationale for allowing the medical profession to set its

137. *Petre*, 871 N.E.2d at 793. *See also* Purtill v. Hess, 489 N.E.2d 867, 872-73 (Ill. 1986) (establishing the *Purtill* foundation test).

138. *Petre*, 871 N.E.2d at 792 (citing Wingo *ex rel.* Wingo v. Rockford Mem'l Hosp., 686 N.E.2d 722, 729 (Ill. App. Ct. 1997)).

139. *Id.* at 793.

own standards. Second, this section explains why the original *Dolan* licensing requirements are necessary in the area of nursing malpractice. Third, it explains that the text of the *Sullivan* opinion strongly supports abolishing the *Wingo* exception as the First District did in *Garley*. Fourth, this section analyzes the policy implications of the three possible approaches in the wake of *Sullivan*, and concludes that a strict application of *Sullivan* is the best compromise between ensuring fairness for nurse defendants and promoting the two goals of tort law, compensation and deterrence. Finally, this section argues that liability for failed nurse-doctor communications should ultimately fall on the physician as the least-cost avoider.

A. The History of Medical Standards of Care

Medical professionals have the unique benefit in tort law of setting their own legal standards of care. In ordinary negligence cases, the jury must decide whether the defendant acted like a reasonable person: "Arguably, any lay person can apply this standard and assess whether a defendant's conduct was what a reasonable person would or should have done."[140] In medical malpractice cases, however, the jury's task is to assess whether the medical professional acted in compliance with a specific standard of care, which is based on "customary and usual practices within the profession."[141] Since these standards of care are not intuitive to laypeople, medical experts must educate the jury about the custom and practice in the defendant's professional medical community. Then, the jury must decide, based on these experts' testimony, whether the defendant's conduct met the standard of care. In short, the medical community may set its own "reasonable person" standard based on what professionals usually do in a given situation, regardless of whether that custom is objectively reasonable. The jury generally may not substitute its own understanding of reasonableness for the standard of care offered in expert testimony.[142]

140. Amy Jurevic Sokol & Christopher J. Molzen, *The Changing Standard of Care in Medicine*, 23 J. LEGAL MED. 449, 471 (2002).

141. Paul M. Coltoff et al., *Professional Standard of Care or Conduct*, 65 C.J.S. NEGLIGENCE § 163 (2011).

142. *Id.* There are two main exceptions where the jury *can* substitute its own judgment for that of the experts: "[1] custom and practice are not controlling in negligence cases in which a layperson can infer negligence by a professional without any expert testimony and [2] where the profession has lagged behind in adopting reasonable safety procedures, adherence to a professional custom is not conclusive on the issue of negligence." *Id.* To use the first exception, the professional's negligence must be "so grossly apparent that a layman would have no difficulty recognizing it." Matson v. Naifeh, 595 P.2d 38, 40 (Ariz. 1979).

This different standard for medical professionals reflects both the historical development of medical malpractice law and the modern difficulty of forcing lay jurors to rule on the reasonableness of complex medical procedures. Historically, the relaxed standard of care for medical professionals arose from society's reverence for healers and compassion for country doctors without access to the latest scientific knowledge. In today's world of standardized medical education and complicated medical procedures requiring great expertise, the professional standard acknowledges that what is reasonable in medicine is outside most jurors' ken.

Historians can trace the relationship of medicine and law to the Middle Ages. Before the Black Plague swept through England in the 1300s, physicians enjoyed an "absolute" occupational privilege "protecting them against any liability for negligent injury or death."[143] During the Plague epidemic, physicians' liability changed to reflect the nature of the public emergency. Physicians who refused to treat patients could be liable for nonfeasance (not performing a required act).[144] However, since society desperately needed treatment, it refused to hold physicians liable for misfeasance (performing an act improperly).[145]

By the early 1400s, the English legal system began to draw distinctions between contract and tort law.[146] Contract cases were based on nonfeasance, while tort cases were based on misfeasance, which relied on a variation of the reasonable person standard.[147] A separate category of cases, "action[s] upon the case for negligence," applied to people who breached specific duties "imposed by law" or based upon "customs of the realm."[148] The law did not hold a skilled professional liable for misfeasance, since ordinary people could not determine what conduct was reasonable for a skilled professional.[149] Therefore, injured patients had to rely on the doctrine of negligence to hold physicians accountable, even though there were few regulatory standards in place at that time.[150]

143. Charles Markowitz, M.D., *Medical Standard of Care Jurisprudence as Evolutionary Process: Implications Under Managed Care*, 2 YALE J. HEALTH POL'Y, L. & ETHICS 59, 61 (2001).

144. *Id.*

145. *Id.*

146. *Id.* at 62.

147. *Id.*

148. *Id.*

149. *Id.*

150. *Id.*

In 1518, King Henry VIII founded the Royal College of Physicians and Surgeons.[151] The purpose of the Royal College was to allow the medical profession to police itself.[152] It granted licenses to qualified physicians and punished unqualified ones, and it could fine or imprison professionals who violated the college's regulations.[153] Board members acted as both police officers and judges: they could both investigate physician and pharmacist malpractice and punish offenders.[154] This self-regulatory privilege was a sign of elevated social status.[155]

Yet, recorded medical malpractice lawsuits remained scarce until the nineteenth century.[156] Perhaps due to a sustained reverence for healers, these nineteenth century cases deferred to the medical professions by allowing them to establish their own standards of care. In *Lanphier v. Phipos*, the court held that a professional's reasonable skill is "not [the] highest possible degree of skill."[157] The *Rich v. Pierpont* court was even more deferential, holding that "[t]here must have been a want of competent and ordinary care and skill, and to such a degree as to have led to a bad result."[158]

In the United States, nineteenth century medical malpractice law also deferred to the professions' customs in determining standards of care. In *McCandless v. McWha*, the court defined the standard of care as the obligation "to treat the case with diligence and skill . . . such reasonable skill and diligence, as are *ordinarily* exercised in [the] profession . . . such as thoroughly educated surgeons *ordinarily* employ."[159] American courts were especially deferential to custom because the westward migration across the continent "brought with it significant discrepancies in resources and skill between urban and rural providers."[160] Hence, the "locality rule" was born.[161] This rule held that in medical malpractice cases, the defendant's conduct should not be compared to that of a reasonable person, but rather the customs and prac-

151. *Id.*
152. *Id.* at 62-63.
153. *Id.*
154. *Id.* at 63.
155. *Id.* at 63.
156. *Id.* at 64.
157. *Id.*
158. *Id.*
159. 22 Pa. 261, 267-68 (Pa. 1853) (emphasis added). *See also* Allan H. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 550 (1959).
160. Sokol & Molzen, *supra* note 140, at 474.
161. *Id.* at 476.

tices of other medical professionals in the same community.[162] Thus, in order to avoid liability, rural doctors with poor skills and little equipment only needed to practice medicine as well as other rural doctors with the same limitations.

Throughout the second half of the twentieth century, both the need for the locality rule and society's reverence for physicians faded,[163] but a different rationale for the self-policing of medical standards arose: the complexity of medical science. This complexity has two sources. First, evaluating the reasonableness of most medical procedures requires a degree of scientific knowledge that is beyond laypeople's understanding. Second, the urgent nature of emergency care renders the reasonableness standard flexible and relative. For example, the standard of care might require a young resident surgeon to perform an emergency surgery if there is no attending surgeon on call, even if it would be negligent for the resident surgeon to attempt the surgery under normal circumstances.[164] These two factors — the scientific complexity of medicine and the quick decision-making of emergency care — render the "reasonableness" of any medical professional's actions unknowable without expert testimony.

In medical malpractice cases today, Illinois courts usually defer to the standards of care set by the medical professions. When the conduct in question is governed by uniform standards of medical practice, then any medical expert may testify to the standard of care as long as that expert holds the same license as the defendant. However, if the facilities themselves are relevant to determining whether the defendant acted reasonably, than an expert may only testify to the standard of care if that expert is "acquainted with accepted standards of care under similar circumstances."[165] Finally, one Illinois court has held that the jury may substitute its own standard of care if the standard established by the medical profession is deficient.[166] In those rare situations, the

162. *Id.*

163. *Id.* at 477 (The modern standard of care "evaluat[es] physician conduct... based on the unquestioned assumption that access to information technology is relatively uniform and that national customs of practice actually exist"); Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 196 (2000) ("Since 1966, the Roper Center for Public Opinion Research has tracked how confident Americans are about leaders in various fields. In the initial year of the survey, Americans had a 73% level of confidence in medicine, well above the average for other fields (40%). However, the confidence level in medicine has decreased fairly steadily ever since and in 1993 was at an all time low of 22%.").

164. Steven E. Pegalis, *Physician and Surgeon Liability: Standard of care, generally*, 1 AM. LAW MED. MALP. § 3:3 (2011).

165. *Id.*

166. Lundahl v. Rockford Mem'l Hosp. Ass'n, 235 N.E.2d 671, 763 (Ill. App. Ct. 1968).

court held that "although a treatment was usual or customary, a defendant would not be absolved of liability on that basis alone where the customary practice itself might be negligent."[167] However, unless the entire profession is clearly acting carelessly or recklessly, the court should not interpose its own standard of care on the medical community.[168]

While the medical professions do have the privilege of setting their own standards of care, it is not clear that these standards are in fact different from the reasonable person standard. Both the ordinary and professional standards impose "the obligation to provide due care commensurate with the risk posed by the conduct, taking into consideration all relevant circumstances, with the amount of care deemed reasonable varying and depending upon the particular case."[169] Accordingly, "[t]he word 'reasonable' permeates any discussion of... professional liability"; a physician is judged against the "degree of knowledge and concomitant medical or surgical skill that a physician under the same or similar circumstances should 'reasonably' possess."[170] The nursing profession is bound by a similar "reasonableness" standard: a nurse is required "to possess that *reasonable* degree of learning, skill, and experience ordinarily possessed by others of the profession, and to exercise *reasonable* and ordinary care and diligence in the exertion of her skill and the application of her knowledge, and to exert her best judgment as to the treatment of the case entrusted to her."[171] The standard of care, then, simply requires professionals to reasonably apply their skills to the facts at hand.

The only difference between the ordinary and professional standards lies in the jury's ability to determine what is reasonable. Because the medical professions rely on scientific knowledge and must make informed decisions in emergency settings, those professions must educate the jury on what constitutes reasonable action in a given situation. Further, since each medical profession relies on different scientific training and plays a different role in caring for patients, only a person licensed in a certain school of medicine may educate the jury on that school's standards of care.[172] These rules for setting the standard of

167. *Id.*

168. *Locality Rule*, 22 ILL. PRAC., THE LAW OF MEDICAL PRACTICE IN ILLINOIS § 23:7 (3d ed.).

169. Coltoff, *supra* note 141.

170. Pegalis, *supra* note 164.

171. David R. Gee, *Nurse's Failure to Give Physician Timely Notice of Patient's Condition*, 25 AM. JUR. PROOF OF FACTS 2D 411 § 5 (1981).

172. Purtill v. Hess, 489 N.E.2d 867, 872 (Ill. 1986).

care enable juries to make informed decisions about whether a medical professional's conduct was reasonable in light of scientific advances and limitations.

B. *The Necessity of Licensing Requirements in Nursing Malpractice*

Before examining the specifics of how licensing requirements should apply in the limited arena of cross-discipline communications, it is important to discuss why licensing requirements were an appropriate development in the first place. Medical malpractice is the only area in Illinois law where an expert's licensure goes to the admissibility of the testimony rather than merely its weight. Additionally, Illinois is one of the only states that has a same-license requirement for medical expert testimony. The Illinois Supreme Court in *Dolan* presented a comprehensive policy analysis for why licensing requirements are necessary in medical malpractice generally.[173] More specifically, though, it is crucial for Illinois courts to maintain separate licensing requirements for physicians and nurses in recognition of nursing as a distinct profession.

First, it is well established by Illinois courts, the state legislature, and the nursing profession itself that nursing is a distinct profession with unique responsibilities and treatment philosophies. For instance, the Journal of Nursing has tracked the evolution of the profession from subordinancy to independence: in the past, nurses simply provided care and comfort, but the modern nurse "is a client advocate, educator, and manager."[174] Yet, the antiquated public perception of nurses as lowly doctors' assistants could undermine the credibility of nurse expert witnesses in court.[175] Jurors might improperly grant a physician's testimony more weight than a nurse's, even though the nurse would have a more accurate working knowledge of the nursing standard of care.

Unfavorable or inaccurate perceptions of nurses are well documented both among physicians and in society at large. Among physi-

173. Dolan v. Galluzzo, 396 N.E.2d 13, 16 (Ill. 1979).

174. American Society of Registered Nurses, *The Real Public Perception of Nurses*, J. OF NURSING, Dec. 1, 2007, http://www.asrn.org/journal-nursing/249-the-real-public-perception-of-nurses.html (last visited Feb. 5, 2012).

175. Sandy Summers, *The Image of Nursing: The Handmaiden*, NURSING TIMES, Oct. 7, 2010, http://www.nursingtimes.net/nursing-practice/clinical-specialisms/management/the-image-of-nursing-the-handmaiden/5020163.article (last visited Feb. 5, 2012) ("the popular media. . .still tends to present nurses as the lowly assistants of physicians who direct all important health care").

cians, one of the latest battles is the effort to reclaim exclusive control of the honorific "doctor," even though a growing number of nurses are earning doctorate degrees in nursing. This degree is an attractive option for nurses because it can "help them land a top administrative job at a hospital, improve their standing at a university and win them more respect from colleagues and patients."[176] Physicians, however, are pushing back. Laws in Arizona and Delaware prevent Ph.D. nurses from using the "doctor" title unless they immediately identify themselves as nurses, and the New York Senate is currently considering a similar law.[177] Another struggle is over who should see patients first. Physicians argue that their extensive training grants them the exclusive right to diagnose illnesses; however, studies prove that nurses "are perfectly capable of recognizing a vast majority of patient problems."[178] While physicians and nurses often cooperate on patient care, not all physicians are willing to accept that nurses "train, manage, and regulate themselves . . . [and] have independent legal and ethical duties to patients."[179]

Likewise, lay jurors are probably influenced by negative stereotypes of the nursing profession. In its series of articles on the image of nursing, Nursing Times examines the television meme of physicians making bold orders and nurses meekly responding, "[Y]es, doctor!"[180] This stereotypical interaction has significant implications for the *Wingo* rule because it is the only type of nurse-doctor communication with which many jurors are familiar. Nursing Times writes, "[t]he vast majority of nurse appearances [on television] involve a character popping up out of nowhere to absorb a physician command, usually in silence; compliance is assumed."[181] The article additionally asserts that this "handmaiden" stereotype has polluted real healthcare workplaces.[182] Not only do physicians wield more social and economic power than nurses, but nurses also suffer "disproportionately high levels of violence and psychological abuse by patients."[183]

176. Gardiner Harris, *When the Nurse Wants to Be Called 'Doctor'*, THE NEW YORK TIMES, Oct. 1, 2011, *available at* http://www.nytimes.com/2011/10/02/health/policy/02docs.html?_r=1&scp=1&sq=PhD%20nursing&st=cse (last visited Feb. 5, 2012).

177. *Id.*

178. *Id.*

179. Summers, *supra* note 175.

180. *Id.*

181. *Id.*

182. *Id.*

183. *Id.*

The Hollywood portrayal of nursing allows one to reasonably theorize that the public could have adopted these negative stereotypes, and the record of nurse abuse by patients demonstrates a true negative perception, whether influenced by Hollywood or not. Because juries of laypeople judge nurse defendants in court, the *Dolan* licensing requirements are necessary to ensure that nurses receive fair trials. Even if jurors do not view nurses unfavorably, the public perception of nurses as physicians' subordinates might make jurors more inclined to trust a physician's testimony than a nurse's, even when the testimony is used to establish the *nursing* standard of care. Furthermore, since jurors may imagine nurse-doctor communications as a one-way street of commands and acquiescence, they may be disinclined to trust a nurse's opinion that the failure of communication originated with the physician. The licensing requirements are necessary to ensure that jurors base their decisions on the credibility of the testimony rather than on misplaced notions of physician superiority. In short, these requirements could help reduce the structural disadvantages that nurse defendants face in court.

Furthermore, the *Dolan* licensing requirements are a necessary safeguard against physicians dishonestly shifting blame onto nurses. In many cases concerning a flawed nurse-doctor communication, either the nurse or the physician is to blame.[184] However, physicians are generally reluctant to testify against each other; in fact, this phenomenon is so prevalent that courts have dubbed it the "conspiracy of silence."[185] In 1970, the Arkansas Supreme Court wrote, "It is a matter of common knowledge ... that the plaintiff in a medical malpractice case is unable to find a medical expert willing to testify against a fellow physician ... [which] poses the possibility of great miscarriage of justice."[186] Fortunately, this conspiracy of silence has greatly receded

184. Consider several of the Illinois cases cited in this article — *Wingo*, *Sullivan*, *Petryshyn*, *Petre*, and *Garley*. In each of these cases, a nurse and a physician were pitted against each other because one of these professionals was likely the source of negligent conduct.

185. DIETER GIESEN, INTERNATIONAL MEDICAL-MALPRACTICE LAW 513 (1988). *See, e.g.*, Salgo v. Leland Stanford Bd. Trustees, 317 P.2d. 170 (Cal. Dist. Ct. App. 1957) (calling the phenomenon a "conspiracy of silence"); Morris v. Metriyakool, 309 N.W.2d. 810 (Mich. Ct. App. 1981) (same). Various courts have also dubbed this phenomenon the "community of silence," Crain v. Allison, 445 A.2d 558, 561-62 (D.C. 1982); Sard v. Hardy, 379 A.2d 1014, 1021-22 (Md. 1977); Wilkinson v. Vesey, 295 A.2d 676, 687 (R.I. 1972), the "well recognized fraternal comradeship in the medical profession", Application of Weiss, 147 N.Y.S.2d. 455, 456 (N.Y. Sup. Ct. 1955), and "an affirmative custom to maintain silence," Canterbury v. Spence, 464 F.2d. 772, 783-84 (D.C. Cir. 1972).

186. Graham v. Sisco, 449 S.W.2d 949, 951 (Ark. 1970). *See also* Faulkner v. Pezeshki, 337 N.E.2d 158, 164 (Ohio Ct. App. 1975) ("Locating an expert to testify for the plaintiff in a malpractice action is known to be a very difficult task, mainly because in most cases, one doctor is reluctant and unwilling to testify against another doctor. Although doctors may complain privately to

because the creation of national medical standards means that physicians no longer need to testify against their local colleagues.

However, a South Carolina Law Review article written before these reforms noted that, although nurses and physicians often worked together, there was no conspiracy of silence protecting the nursing profession.[187] At that time, physicians often supplied the expert testimony to establish the nursing standard of care. Despite the conspiracy of silence shrouding the physician community, there was no shortage of physician experts willing to testify against nurses.[188] This trend shows that if given the choice today, physicians are probably much more likely to testify against nurses than fellow physicians. In cases concerning failed communications, where nurses are pitted against physicians, nurses may find it more difficult to obtain a physician witness willing to testify that she followed the nursing standard of care. This unwillingness of physicians to defend nurses, combined with jurors' inclination to trust physicians, could lead to the unfair result of physicians pinning liability on nurses simply because they are in a better position to procure a fellow physician's expert testimony.

The *Dolan* licensing requirements eliminate all of these structural disadvantages against nurse defendants by requiring physicians to establish the physician standard of care and nurses to establish the nursing standard of care. This rule is the only result that adequately ensures that nursing is treated fairly in court as a distinctly valuable profession.

C. *The Neglected Text of Sullivan*

The text of the *Sullivan* opinion strongly indicates that the Illinois Supreme Court intended to abolish the *Wingo* exception. Although the *Sullivan* court did not expressly rule on the standard of care for nurse-doctor communications, one passage in the opinion actually does speak to this factual situation. However, no lower court opinion in the wake of *Sullivan* has identified this passage when discussing *Sullivan*'s effect on the *Wingo* exception.

After reaffirming the *Dolan* licensing requirements, the *Sullivan* court acknowledged that nursing is a distinct and unique medical pro-

each other about the incompetence of other doctors, they are extremely reluctant to air the matter publicly.").

187. Victoria L. Miller, *Court Rejects Fixed Locality Rule for Nurses, Adopts National Standard of Care*, 46 S.C. L. REV. 177, 182 (Autumn, 1994).

188. *Id.*

fession.[189] The court also emphasized that allowing doctors to testify about nursing would improperly assume that the diverse medical professions have reached a universal understanding.[190] Then, quoting The American Association of Nurse Attorneys (TAANA), the *Sullivan* court stated:

> Certainly, nurses are not permitted to offer expert testimony against a physician based on their observances of physicians or their familiarity with the procedures involved. An operating room nurse, who stands shoulder to shoulder with surgeons every day, would not be permitted to testify as to the standard of care of a surgeon . . . A labor and delivery nurse would not be permitted to offer expert, opinion testimony as to the standard of care for an obstetrician or even a midwife. *Nor would a nurse be permitted to testify that, in her experience, when she calls a physician, he/she usually responds in a certain manner. Such testimony would be, essentially, expert testimony as to the standard of medical care.*[191]

This quote first implies that required communications fall within a medical professional's standard of care and should not be held to a different standard than any other job-related procedure. Next, the quote states that nurses cannot testify that physicians usually respond a certain way during cross-discipline communications. Since Illinois courts recognize physicians and nurses as distinct professions, the converse of all of this quotation's examples should be true: physicians cannot testify to nursing procedures just as nurses cannot testify to physician procedures.

Following directly from this logic, a physician should not be allowed to testify that when he asks a nurse to convey some vital communication, she should respond in a certain manner. This interpretation of the quoted text, fully recognizing the uniqueness of the nursing profession, leaves no room for the *Wingo* exception. Indeed, such an exception could only be founded in logic if one believed that nurses were simply inferior physicians' assistants rather than members of a separate profession with unique methods and philosophies of treatment. Such an interpretation has no place in the *Sullivan* decision, and the TAANA quotation indicates that the *Wingo* exception has no place in the post-*Sullivan* era, either.

189. Sullivan v. Edward Hosp., 806 N.E.2d 645, 658 (Ill. 2004).
190. *Id.* at 654, 658.
191. *Id.* at 658 (Sullivan Amicus Br., *supra* note 65 (emphasis added)).

D. *Balancing Compensation and Deterrence*

Legal scholars have long recognized two major goals of the tort system, compensation and deterrence. The compensation goal focuses on the plaintiff: "[t]he function of compensation is to reimburse a victim for her losses from the tortious act, and to restore her to the condition before the act."[192] This is sometimes described as making the plaintiff whole again. The deterrence goal, on the other hand, focuses on the defendant and other potential tortfeasors: "[d]eterrence is the function of tort law by which the law creates incentives that induce people to avoid inappropriately dangerous activities."[193] Often expressed in economic game theory terms, deterrence theories "assume that rational potential tortfeasors weigh the costs and benefits of their actions, and that they take only actions whose benefits exceed the costs."[194] Each of the three applications of *Sullivan* would create different results with respect to these two goals of tort law. For purposes of the below analysis, it is assumed that physician expert witnesses would establish a higher and more rigorous nursing standard of care than nurse experts would.

Under the lenient approach endorsed in *Petryshyn*, the patient may receive a higher compensation award, but not because of any true difference in liability. In cases where medical professionals, working in a team setting, injure a patient, one or more of those medical professionals may have been negligent. This was the case, for example, in the *Petryshyn* case itself, where both the nurses and the surgeon were likely negligent for failing to remove the IUPC from the patient's birth canal. If physicians are allowed to testify to the nursing standard of care in these situations, imposing a higher standard of care on the nurse defendants after the fact, this could ultimately shift responsibility away from the physicians and onto the hospital that employs the nurses.[195]

This blame-shifting could allow plaintiffs to obtain higher compensation awards. Data shows that, on average, plaintiffs receive high-

192. Joanna M. Shepherd, *Tort Reforms' Winners and Losers: The Competing Effects of Care and Activity Levels*, 55 UCLA L. REV. 905, 910 (2008).

193. *Id.*

194. *Id.*

195. Richard J. Kohlman, *Hospital Liability for Nursing Medication Errors*, 29 AM. JUR. TRIALS 591 § 11 (1982) ("There is little doubt today that the professional negligence of an employed nurse will subject the nurse's hospital-employer to vicarious liability for his or her malpractice under the doctrine of respondeat superior.")

er damage awards from hospitals than from individual physicians.[196] Studies also indicate that, even where injuries are substantially the same, juries are more willing to award higher damages against hospitals than against physicians.[197] Therefore, if the lenient approach allows physicians to shift liability to nurses who are hospital employees, this could result in greater compensation for plaintiffs.

However, although injured plaintiffs may obtain higher compensation awards from hospitals via nurse defendants under the lenient approach, this does not indicate that nurse defendants were actually more liable in causing plaintiffs' injuries. The fact that physicians may use societal advantages to shift responsibility onto nurse defendants has no bearing on whether a nurse's manner of conveying information comported with that nurse's training. It is quite possible that even when a physician's misunderstanding was the sole source of the breach, physician expert witnesses could convince the jury that the nurse was at fault. This, in turn, would allow negligent physicians to continue practicing with a clean record, while nurses who followed their standards of care would be held liable. Therefore, although plaintiffs may receive higher awards under this lenient approach, these higher awards do not represent an actual shift in liability, but rather manipulation by physician defendants avoiding responsibility.

This lenient approach would certainly influence potential tortfeasors' behavior, but probably not in a way that would improve patient care. The lenient approach would not actually raise the standard of care of the negligent party. Rather, since nurses could be judged in court against physicians' expectations, hospitals would likely force nurses to take precautionary measures to ensure that their conduct

196. A study of Texas medical malpractice verdicts between 1988 and 2003 illustrates this phenomenon. David A. Hyman et al., *Do Defendants Pay What Juries Award? Post-Verdict Haircuts in Texas Medical Malpractice Cases, 1988-2003*, 4 J. EMPIRICAL LEGAL STUD. 3, 27 (2007). Comparing cases where a plaintiff either sued one hospital or one physician, the data revealed that the mean damage award was 45 percent higher, the mean adjusted verdict was 56 percent higher, and the actual payout was 81 percent higher where the plaintiff sued the hospital. *Id.* Furthermore, comparing cases where plaintiffs sued two or more physicians with cases where plaintiffs sued a physician and a hospital, the mean damage award was 71 percent higher, the mean adjusted verdict was 62 percent higher, and the mean actual payout was 113 percent higher where a hospital was a named defendant. *Id.*

197. In an experiment, 147 jury members were asked to award damages in three hypothetical cases involving a broken femur. Neil Vidmar, *Empirical Evidence on the Deep Pockets Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases*, 43 DUKE L.J. 217, 241 (1993). In the first scenario, the plaintiff sued one anesthesiologist. *Id.* at 244-45. In the second, she sued both an anesthesiologist and a surgeon. *Id.* at 245. In the third, she sued the hospital for the negligence of its orderlies. *Id.* The mean damage award against the anesthesiologist was $99,950, against the two physicians, $67,709, and against the hospital, $114,339. *Id.* at 247.

could not be misunderstood. Rather than enhancing patient care, these precautionary measures could simply increase bureaucracy and interrupt the atmosphere of cooperation governing teams. For example, nurses might take time away from patient care to explain each of their actions to the team physicians, take detailed records of every action, and follow up to ensure that the physicians read the charts and logs. Rather than reducing the number of mistakes made, these precautions would merely be measures to reduce the hospital's liability if an injury occurred. Compiling such detailed records would take a significant amount of time—time that could have been spent on patient care. Further, even if these precautions have the effect of reducing mistakes, this is not a fair way to accomplish the deterrence goal because only the nursing standard of care would be raised, not the standard of every professional team member. This increase in the nursing standard would be especially unfair because nurses were not necessarily more prone to act negligently than the physicians on their teams. Therefore, any gains in patient care are negated by the increased bureaucracy and unfairness to nurses created by this rule.

The moderate approach endorsed by *Petre* entails the same effects on compensation as the lenient approach. In most cases where a nurse-doctor communication failure caused an injury, either the nurse or the physician was negligent. Allowing physicians to establish the nursing standard would simply make it easier for the court to find nurses liable, thus potentially shifting the plaintiff's source of compensation from the true negligent party to the nurse. If both parties met their respective standards of care and the communication still failed, the correct solution is to change the standard of care, not to hold liable a nurse who followed correct procedure.

In terms of deterrence, the moderate approach actually creates perverse incentives for physicians to claim that they did not understand the nurses who communicated with them. If the nursing standard of care for communications requires the nurse to relay information in a way that the physician prefers, this is the equivalent of declaring that if the physician did not understand, then the nurse breached the standard of care. To avoid liability, hospitals would place the onus on their nurses to ensure that every physician understands them correctly and completely. While this could have the positive effect of requiring nurses to verify physicians' understanding, it still creates an incentive for physicians to claim after the fact that they did not understand in order to avoid liability.

The strict application, which the *Garley* court endorsed, is the best approach regarding both deterrence and fairness to nurse defendants. Since physicians could not use structural advantages to artificially shift liability onto nurses, more physicians would likely be held accountable for misunderstandings that amounted to breaches of the physician standard of care. While it is true that plaintiffs generally receive lower damage awards from physicians than hospitals, the higher awards they could potentially gain from the other two approaches are not based on actual liability, but rather artificially shifted blame. In terms of deterrence, the strict application would properly deter physicians from placing the blame of a communication failure on nurses who had followed proper procedure. It would also eliminate the perverse incentives present in the other two approaches for physicians to claim that they did not understand communications. The strict approach would not create perverse incentives or unfair advantages for nurses, in contrast to the advantages that the other two approaches create for physicians. Rather, the outcome would be fair, since both parties would be judged by their peers.

E. The Physician as Least-Cost Avoider

If a failed nurse-doctor communication causes a patient harm, but both the nurse and the physician followed their respective standards of care, modern medical malpractice law offers the plaintiff no relief. The correct solution to this problem is not to place liability on the nurse because it is easy to mischaracterize her standard of care through physician expert testimony. Rather, the correct solution is to change the standard of care. This section argues that the physician standard of care should require physicians to affirmatively correct miscommunications because physicians, rather than nurses, are in the best position to do so.

The liability for a failed nurse-doctor communication should fall on the physician because he is the least-cost avoider. This conclusion arises from the efficiency model of tort law. This model, proposed by scholars in the field of law and economics, reasons that civil liability should fall with the "least-cost avoider,"[198] the party who is in the best position to discover and remedy a hazardous situation.[199] The case law shows that there are two main types of failed nurse-doctor communi-

198. The least-cost avoider is sometimes called the "cheapest cost avoider."

199. M. Stuart Madden, *Selected Federal Tort Reform and Restatement Proposals Through the Lenses of Corrective Justice and Efficiency*, 32 GA. L. REV. 1017, 1047 (1998).

cations: (1) cases of miscommunication and (2) cases of failed communication. In both of these factual scenarios, the physician is the least-cost avoider. Accordingly, the standard of care for nurse-doctor communications should reflect this.

1. Cases of Miscommunication

The least-cost avoider is "the party best able to control a situation."[200] In the arena of patient care, this party is almost always the patient's treating physician. The treating physician creates a care plan for each patient and issues directives consistent with this care plan to the nurses and other hospital staff.[201] Therefore, physicians and nurses have different roles when caring for a common patient: the physician acts as an expert on that particular patient's needs and treatment goals, whereas the nurse focuses on performing specific procedures for a wide variety of patients under her watch.

Law and economics scholars Guido Calabresi and A. Douglas Melamed have asserted that economic efficiency requires placing the costs of accidents "on the party or activity which can most cheaply avoid them."[202] Likewise, Judge Richard A. Posner has reasoned, "we do not want both tortfeasors to take precautions; we want the lower-cost accident avoider to do so."[203]

An example of least-cost avoider application in modern tort law is the exception of the learned intermediary in products liability law. While companies are usually required to provide warnings for the dangerous products that they sell, pharmaceutical companies are relieved of that burden for most prescription drugs.[204] Since the physician who prescribes these drugs is in a better position than the pharmaceutical company to decide whether a drug would benefit a particular patient, and since that physician knows the patient's medical history, allergies, and usage of other prescription drugs, the physician bears the responsibility of explaining the drug warnings to the patient.[205] Therefore, "[i]ndividual patients within the class for whom the pharmaceutical is prescribed benefit therapeutically, and pharmaceu-

200. Scott Hershovitz, *Two Models of Tort (and Takings)*, 92 VA. L. REV. 1147, 1152 (2006).

201. Barbara R. Benninger, Note, *Nursing Malpractice — The Nurse's Duty to Follow Orders*, 90 W. VA. L. REV. 1291, 1300 (1987-88).

202. Guido Calabresi & A. Douglas Melamed, *Property Rules, Liability Rules and Inalienability: One View of the Cathedral*, 85 HARV. L. REV. 1089, 1096-97 (1972).

203. RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW 189 (4th ed. 1992).

204. Madden, *supra* note 199, at 1049.

205. *Id.*

tical companies benefit by avoiding the miring inefficiencies . . . of protracted civil litigation."[206]

The relationship between pharmaceutical companies and physicians mirrors the relationship between physicians and nurses when analyzing instances of miscommunication. Unlike the pharmaceutical company or the nurse, who interact with multiple clients, the patient's treating physician is an expert on that particular patient. When a nurse communicates information to a physician in a manner that the physician finds ambiguous, the physician is the least-cost avoider in resolving the ambiguity. Since the physician is an expert on that patient's history, the physician is in the best position to ask appropriate clarifying questions in order to apply the new information to the patient's overall care plan. For example, if a nurse tells a physician that Mr. Smith has been asleep since two, the physician is in the best position to know whether it matters if the nurse meant two in the morning or two in the afternoon. If that detail would be important, then the physician should have an affirmative duty to clarify the nurse's communication and direct the patient's care accordingly.

Using this framework, only a licensed nurse may testify to the nursing standard of care for communications. The nursing standard would dictate whether the nurse defendant's communication was truly so ambiguous that it fell below the standard of care. Physicians should not be able to testify to this standard based only upon whether they would have considered the nurse's communication to be ambiguous. In fact, if a physician determines that the communication was ambiguous, this should not be evidence that the nurse deviated from the standard of care; rather, it should indicate that the physician was negligent in failing to clarify, fulfilling his proper role as least-cost avoider.

2. Cases of Failed Communication

The physician is also the least-cost avoider in situations where a nurse failed to communicate information to a physician. The nursing standard of care requires the nurse to contact a patient's treating physician upon the occurrence of certain events. For example, the nurse may be required to update the physician of the patient's condition after a certain number of hours, or she may be required to inform the physician when some event occurs, such as the dilation of a pregnant patient's cervix or a deterioration in a patient's vital signs. However, a

206. *Id.*

physician can change the nursing standard of care for when to call the physician by instructing the nurse to call him at a specified time or event. In other words, when deciding when to call the physician, the nursing standard of care acts as a default standard in the absence of alternate instructions. If the physician instructs the nurse to call him at a certain time or upon the occurrence of a certain event, this instruction trumps the default-nursing standard of care.

Although nursing has evolved into an independent profession, physicians, as the experts on specific patients, often direct nurses to perform tasks that a patient's care plan requires. Generally, nurses have a legal duty to execute a physician's directive, and "failure to carry out a physician's order, as a general rule, is a form of nursing negligence or malpractice."[207] Nevertheless, there are exceptions to this nursing duty, and "the law may require more than blind, rigid, obedience to a physician's order."[208] For example, a nurse would not be shielded from liability if she obeyed a physician's order knowing that doing so could harm the patient.[209] In certain situations, the law imposes duties on nurses "to refrain from carrying out a physician's order, to question the order, and at times to actually disobey a physician's order."[210] In the absence of these extraordinary circumstances, however, the nursing standard of care requires nurses to follow physician's instructions on patient care.

In the limited arena of failed nurse-doctor communications, it is difficult to imagine a situation where a nurse must disobey the physician's instructions due to safety. For example, if the default-nursing standard indicates that a nurse should update the doctor on a patient's condition every six hours, but given the patient's critical condition, the treating physician directs the nurse to update him every two hours, this additional responsibility to communicate could not harm the patient. Thus, when a physician directs a nurse to contact him at a specific time, this instruction becomes that nurse's standard of care for communications.

In instances of failed nurse-doctor communications, the physician is the least-cost avoider because he effectively has the power to control the nursing standard of care. The strict approach recognizes this. In

207. Frank J. Cavico & Nancy M. Cavico, *The Nursing Profession in the 1990's: Negligence and Malpractice Liability*, 43 CLEV. ST. L. REV. 557, 613 (1995).

208. *Id.* at 614.

209. *Id.* at 615.

210. *Id.* at 614-15.

cases where injury may have resulted from a failed nurse-doctor communication, such as *Garley*, only a licensed nurse should be allowed to testify to the nursing standard of care. If the patient's treating physician did not give alternate instructions for when to contact him, then the default-nursing standard of care should control. On the other hand, if the physician had directed the nurse to call him at a different time, the nursing standard of care, as articulated by a nurse expert witness, would recognize the physician's instruction as controlling. If a nurse correctly follows the default-nursing standard of care, but an injury occurs, that nurse should not be held to a different standard at the time of trial. Rather, if a physician should have directed a nurse to contact him sooner than the default-nursing standard would indicate, and the physician's failure to do so resulted in harm, then the liability for that negligence should fall on the physician as the least-cost avoider.

CONCLUSION

A strict application of the *Sullivan* ruling which abolishes the *Wingo* exception is the only approach that promotes the goals of tort law while also ensuring that nurse defendants receive a fair trial. The underlying logic of the *Wingo* exception — that there is no difference between the nurse's required disclosures and the physician's expectations — is fundamentally flawed. Since nursing is a distinct profession and not merely a doctoring profession with lower standards, the assumption that nurses' and physicians' expectations will align regarding every communication improperly assumes that the diverse medical fields have reached a "universal understanding."[211] Unfortunately, this assumption could place a nurse defendant in an unfair position if she followed the true nursing standard of care, but the physician's failure to understand the nurse's communication caused an adverse result. A truly fair result for both plaintiffs and defendants can only be reached if every party is judged by its own peers. Therefore, Illinois courts should recognize *Garley* as the best and most accurate interpretation of *Sullivan*, and legal practitioners should advocate for strict licensing rules that rightfully recognize nursing as a distinct medical profession.

211. Dolan v. Galluzzo, 396 N.E.2d 13, 16 (Ill. 1979) ("to [allow surgeons to testify to the standard of care of podiatrists] would not only be unfair to podiatrists . . . but it would also assume that science and medicine have achieved a universal standard of treatment of disease or injury").