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ONE HUNDRED YEARS OF HARMFUL ERROR: THE HISTORICAL JURISPRUDENCE OF MEDICAL MALPRACTICE

THEODORE SILVER*

In this Article, Professor Silver examines the origins of present-day malpractice law. He begins by noting that negligence and medical malpractice as the common law now knows them made their debut in the nineteenth century although their roots lie deep in the turf of trespass and *assumpsit*. He argues, however, that toward the turn of the century several episodes of linguistic laziness purported to produce a separation between negligence and medical malpractice so that the two fields are conventionally thought to rest on separate doctrinal foundations.

According to Professor Silver, historically based scrutiny of medical malpractice and its ties to negligence reveal that any differentiation between the two bodies of law arose solely by accident; the distinction is devoid of rational basis and serves only to confound and confuse. Thus, he concludes, the common law, through its own devices or those of our legislatures, should be forced to renounce it.

*'Twill be recorded for a precedent,
And many an error by the same example
Will rush into the state.*¹

I. INTRODUCTION

A medical malpractice action is identical in all vital respects to any and every suit sounding in negligence. That simple truth, however, has been lost in a maze of judicial mistakes one century in the making. Consequently, most legal minds identify medical malpractice as a discrete body of law and the medical malpractice suit is thought to proceed from its own set of "rules," "doctrines," and "principles."

That fundamental misconception is traceable primarily to nineteenth century courts who built and bequeathed to the common law a host of unfortunate inventions. These include "the professional custom standard," "the locality rule," "the best judgment" principle, the "expert witness" requirement, the "common knowledge exception," and "special rules" concerning the so-called doctrine of *res ipsa loquitur*. All of these doctrines purportedly followed from some rational design, but historical

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1. WILLIAM SHAKESPEARE, *THE MERCHANT OF VENICE* act 4, sc. 4.

and jurisprudential scrutiny reveals that they were sired not by reason, but by a series of conceptual accidents. Hence, these misbegotten creatures are children of failed thought that have generated a plethora of unsound decisions.

The locality rule itself is largely a memory,² although, like the ancient forms of action, it governs from the grave.³ Yet the other named doctrines still thrive and flourish still. The cause of rational jurisprudence requires that each doctrine be understood for the peculiar manner in which it arose and for its failure ever to play a legitimate role in the law of medical malpractice. It next requires that a corrective statute be devised so that medical malpractice law may henceforth proceed from sound premises. Such are the purposes of this article and of the two which will follow it in series.

This first article probes the jurisprudence surrounding the professional custom and locality rules.⁴ The professional custom rule provides that the duty of care physicians owe their patients is measured not by ordinary notions of reasonableness but by customary practice among physicians. Patients do not prevail in a medical malpractice action by establishing negligence in the usual legal sense. Rather, they must establish that the defendant physician's actions contravened customary practice. Unlike any other group of persons or professionals, physicians enjoy the somewhat inexplicable privilege of establishing the legal standard to which they are answerable through their own behavior.⁵ The locality rule, to the extent it still operates, compounds this anomaly by holding physicians liable only if they contravene the custom that prevails among physicians practicing in their geographic community or in communities "similar" to their own. Hence, where the locality rule governs, physicians within one geographic community are peculiarly privileged to fashion, by their own practices, the standard of care they are legally obliged to satisfy.⁶

This article explores the history and jurisprudence surrounding these two improbable doctrines in order to demonstrate that they arose not by plan or purpose but by want of judicial attention to the jurisprudence that underlies medical malpractice and negligence. Section II lays the ground

2. See *infra* note 116 and accompanying text.

3. FREDERIC W. MAITLAND, LECTURES ON THE FORMS OF ACTION AT COMMON LAW 1 (1936) ("The forms of action we have buried, but they still rule us from their graves.").

4. The second article will address the "best judgment" principle, the "expert witness" requirement, and the "common knowledge exception." The third will concern the doctrine of *res ipsa loquitur* and will also suggest a statute designed to correct the flawed jurisprudence to which the entire three-part series pertains.

5. See *infra* notes 58-65 and accompanying text.

6. See *infra* notes 108, 133, 135 and accompanying text.

for subsequent discussion. By exploring the historical roots of medical malpractice suits from the fourteenth through the nineteenth centuries, it demonstrates, conventional wisdom notwithstanding, that a malpractice action always represented the action known today as ordinary negligence. Section III describes the flawed jurisprudence that fostered the "professional custom standard" as well as the problems it creates. Section IV describes the misconceptions that gave rise to the locality rule and the injury it has done the law. Finally, Section V presents an imaginary opinion that would have diverted the late nineteenth century common law from the erroneous path it followed with respect to medical malpractice.

II. MEDICAL MALPRACTICE AS NEGLIGENCE: HISTORY AND JURISPRUDENCE

The words "negligence" and "malpractice" were strangers to fourteenth century common law.⁷ Yet through action on the case,⁸ medieval physicians were held answerable for professional misfeasance, and it is almost inescapable that the rules through which their liability attached grew from the same sociopolitical impulses on which the concept of negligence⁹ as we know it now rests.¹⁰

7. 1 THOMAS A. STREET, *FOUNDATIONS OF LEGAL LIABILITY* 187 (1906). Indeed, they had no significance even to fifteenth, sixteenth, and seventeenth century common law. Percy H. Winfield, *The History of Negligence in the Law of Torts*, 42 L.Q. REV. 184, 194-95 (1926).

8. See *infra* notes 15, 16.

9. The modern American doctrine of negligence rests on the tenet that a tortfeasor is liable when he or she causes injury by conduct falling short of judgment and prudence that would be exercised by a person of ordinary sense and sensibility under similar circumstances. See Henry T. Terry, *Negligence*, 29 HARV. L. REV. 40 (1915) ("[N]egligence is doing what a reasonable and prudent man would not have done or not doing what such a man would have done."); 2 FOWLER V. HARPER & FLEMING JAMES, JR., *THE LAW OF TORTS* 902-20 (1956) (Regarding any particular act under consideration, "[t]he question [is] whether, considering how people generally act and the ordinary exigencies of life, it will generally be reasonable to act in that way. . . . The test of reasonableness is what would be the conduct or judgment of what may be called a standard man in the situation of the person whose conduct is in question."); See also *infra* note 57 and accompanying text.

10. See Robert L. Rabin, *The Historical Development of the Fault Principle: A Reinterpretation*, 15 GA. L. REV. 925 (1981) (discussing the historical and sociopolitical foundations of the negligence and fault principles). See generally Morris S. Arnold, *Accident, Mistake, And Rules of Liability In The Fourteenth-Century Law of Torts*, 128 U. PA. L. REV. 361 (1979); MORTON J. HORWITZ, *THE TRANSFORMATION OF AMERICAN LAW, 1770-1860*, pp. 94-97 (1977); ALBERT K. R. KIRALFY, *THE ACTION ON THE CASE* (1951); Percy H. Winfield & Arthur L. Goodhart, *Trespass and Negligence*, 49 L.Q. REV. 359 (1932); Nathan Isaacs, *Fault and Liability*, 31 HARV. L. REV. 954 (1918); 2 SIMON GREENLEAF, *A TREATISE ON THE LAW OF EVIDENCE* §§ 85-92 (Edward A.

Conceptually, therefore, medical malpractice actions were from their earliest origins no different from ordinary negligence suits.¹¹ That proposition is fundamental to the arguments that follow. However, this proposition is easier to state than prove—it occasions inquiry into jurisprudence of the past. For as Justice Holmes taught, “[i]n law also, doctrine is illuminated by history.”¹²

The reign of Henry IV offers the first reported recovery brought for damage by a physician’s faulty practice.¹³ The decision arose from the burgeoning doctrine requiring persons who practiced a “common calling” (meaning, probably, a skilled profession)¹⁴ to act as would any reasonably competent person practicing under like conditions or be liable for an action in trespass on the case. Conversely, persons selling services not associated with a common calling were liable for flawed performance only if they had breached an “express” agreement to achieve or avoid a given result. The action raised in these cases was not trespass on the case but

Harriman ed., 16th ed. 1899); John H. Wigmore, *Responsibility For Tortious Acts: Its History*, 7 HARV. L. REV. 315 (1894); OLIVER W. HOLMES, *THE COMMON LAW* 77-96, 112 (1881). See also 3 THOMAS STREET, *THE FOUNDATIONS OF LEGAL LIABILITY* 182 (F.B. Rothman ed., 1980); THOMAS BEVIN, *NEGLIGENCE IN LAW* (3rd. ed. 1908).

11. The term “malpractice” apparently did not arise until the early nineteenth century. See *infra* note 32 and accompanying text.

12. *Kovacs v. Cooper*, 336 U.S. 77, 95 (1949).

13. *DeBance*, Mich. 12 Hen. IV, m. 615, Yorks Arch. Soc. Rec., Ser. XVIII, p. 78. It is often reported that the first medical malpractice case arose in 1374 wherein plaintiff alleged that defendant surgeon had negligently treated his hand and thus caused damage. See also Allan H. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 550 (1959); C. Joseph Stetler, *The History of Reported Medical Professional Liability Cases*, 30 TEMP. L.Q. 366, 367 (1957). In the 1374 case the court did indicate that the surgeon would be liable for failure to treat in a competent manner but barred the suit on the ground that it had been pled in trespass on the case and not in trespass vi et armis. Y.B. Hill. 48 Edw. III, f. 6 (1374). That decision derived from a pleading principle that was then near the end of its useful life. See F. W. MAITLAND, *EQUITY; ALSO THE FORMS OF ACTION AT COMMON LAW* (A.H. Chaytor & W.J. Whittaker eds., 1916); FREDERICK G. KEMPIN, *LEGAL HISTORY LAW AND SOCIAL CHANGE*, 71-75 (1963); H. POTTER, *HISTORICAL INTRODUCTION TO ENGLISH LAW AND ITS INSTITUTIONS* 455-65 (A.K.R. Kiralfy ed., 4th ed. 1958). The law had not yet adopted the emerging rule requiring that the practitioner of a common calling deliver competent professional service or be chargeable in trespass on the case. See *infra* notes 15 and 16; see also McCoid, *supra*, at 543.

14. Although the meaning of the phrase “common calling,” as then used, was elusive and equivocal, it probably described a profession that: (1) called for skill, and (2) on the occasion in question was actually practiced by one who regularly held himself out as possessing such skill. Hence, the word “common” bespoke both the notion of skill and the fact that the practitioner held himself out as commonly practicing the profession with the requisite skill. See 3 WILLIAM BLACKSTONE, *COMMENTARIES* 165. See also Winfield, *The History of Negligence in the Law of Torts*, 42 L.Q. REV. 184, 185-89; OLIVER W. HOLMES, *THE COMMON LAW* 183 (1881).

assumpsit on the case.¹⁵ Under early common law, such cases required the plaintiff to establish that the defendant had expressly promised to avoid the alleged damage.¹⁶ With respect to a common calling, however, the practitioner had a legal duty to exercise care and prudence independent of any express agreement.

Hence, in the 1500s, Fitzherbert averred that "[i]f a smith prick my horse with a nail, I shall have my action on the case against him without any warranty by the smith to do it well; for it is the duty of every artificer to exercise his art rightly and truly as he ought."¹⁷ "Such actions," wrote a fourteenth century court, "*go to a matter . . . beyond . . . covenant . . . The plaintiffs have suffered a wrong.*"¹⁸ Medicine,

15. See MATTLAND, *supra* note 13, at 360-63 (regarding the history of *assumpsit* on the case, its historical-jurisprudential relationship to pure *assumpsit* and to trespass on the case, and its relevance to the modern contract action). See also F. B. Ames, *The History of Assumpsit, I: Express Assumpsit*, 2 HARV. L. REV. 1 (1888); F. B. Ames, *The History of Assumpsit, II: Implied Assumpsit*, 2 HARV. L. REV. 53 (1888); George E. Woodbine, *The Origins of the Action of Trespass*, 34 YALE L.J. 343 (1925); C. H. S. FIFOOT, *HISTORY AND SOURCES OF THE COMMON LAW* (1949).

16. See *supra* note 15; see also FREDERICK G. KEMPIN, JR., *LEGAL HISTORY LAW AND SOCIAL CHANGE*, 79-83 (1963); Charles K. Burdick, *The Origin of The Peculiar Duties of Public Service Companies*, 11 COLUM. L. REV. 514, 516 (1911); Norman F. Arterburn, *The Origin And First Test of Public Callings*, 75 U. PA. L. REV. 411, 418 (1927); James B. Ames, *History of Assumpsit*, in SELECT ESSAYS IN ANGLO AMERICAN LEGAL HISTORY 259-65 (Assoc. of American Law Schools ed., 1909).

As a result, substandard treatment of a plaintiff's horse thus imposed no liability on the practitioners who had not held themselves out as skilled veterinarians. Y.B. 19 Hen. VI, f. 49, pl. 5 (1440) ("You have not shown that he is a common surgeon to cure such horses, and so, although he killed your horse by his medicines, you have not action against him without an *assumpsit*."); see also Winfield, *supra* note 7, at 185-89 (1926).

17. Fitz. Nat. Brev. 94 D (1514).

18. 3 WILLIAM HOLDSWORTH, *A HISTORY OF ENGLISH LAW*, 430 (6th ed. 1934) (citing Y.B. 14 Hy. VI. p. 18.; cf. Ames' summary, *Lectures* 130) (emphasis added):

If a carpenter . . . makes a covenant with me to make me a house good and strong and of a certain form, and he makes me a house which is weak and bad and of another form, I shall have an action of trespass *on my case*. So if a smith makes a covenant with me to shoe my horse well and properly, and he shoes him and lames him, I shall have a good action. So if a doctor takes upon himself to cure me of my diseases, and he gives me medicines, but does not cure me, I shall have action *on my case*. So if a man makes a covenant with me to plough my land in seasonable time, and he ploughs in a time which is not seasonable, I shall have action *on my case*. And the cause is in all these cases that there is an undertaking and a matter in fact beyond the matter which sounds merely in covenant . . . In these cases the plaintiffs have suffered a wrong.

3 HOLDSWORTH, *supra* at 430. (all emphasis supplied).

Referring to the fourteenth century, Holmes wrote likewise:

If damage had been done or occasioned by the act or omission of the

of course, was a "common calling,"¹⁹ and careless or inattentive physicians were thus answerable not for breach of agreement, but for a "wrong" per se.²⁰ They were liable in action on the case, and their

defendant in the pursuits of some of the more common callings . . . it seems that the action would be maintained, *without laying an assumpsit* . . . [T]he . . . principle . . . expressed the general obligation of those exercising a public or common business to practise their art on demand, and show skill in it.

HOLMES, *supra* note 14, at 183-84. See also Winfield, *supra* note 7, at 185-89.

19. See Winfield, *supra*, at 187 note 7, n.7 (citing Y.B. Hil. 48 Edw. III, f. 6; Groenvelt's Case, 91 Eng. Rep. 1038 (1697); Slater v. Baker, 95 Eng. Rep. 860 (1767); Seare v. Prentice, 103 Eng. Rep. 376 (1807)).

20. The obligation of care imposed on common callings was said to arise from a contract "implied by law." It was written, by law the professional was party to an implied contract requiring him to practice his profession skillfully, carefully and properly. Blackstone wrote of the early common law "supposition, that every one who undertakes any office, employment, trust, or duty, *contracts* with those who employ or entrust him, to perform it with integrity, diligence, and skill. And, if by his want of either of those qualities any injury accrues to individuals, they have therefore their remedy in damages by a special action *on the case*." 3 BLACKSTONE, *supra* note 14, at 165 (emphasis added). Such contracts "implied by law," however, constitute no more than a perverse legal fiction through which the medieval courts sought to reconcile, in form, a new and novel legal duty with existing legal doctrine and device. In 1893, Keener studied the genesis of the contract "implied in law" (known also as quasi-contract) and wrote, in relation to the early common law,

[I]f the wrong complained of would not sustain an action, either in contract or [trespass] then the plaintiff was without redress The judges attempted, however, by means of fictions, to adapt the old remedies to . . . new rights, with the result usually following the attempt to put new wine into old bottles. . . .

[T]he courts in using a purely contractual remedy to give relief in a class of cases possessing none of the elements of contract . . . resorted to fictions to justify such a course. [T]he insuperable difficulty of proving a promise where none existed was met by the statement that "the law implied a promise.

William A. Keener, *Quasi-Contract, Its Nature And Scope*, 2 HARV. L. REV. 57, 66-67 (1893) (emphasis added).

"The statement that the law imposes the obligation would not have met the difficulties," Keener explained, because it would not have been consonant with any doctrine then known. "The fiction of a promise was adopted then in this class of cases solely that the remedy of a [contract] might be used to cover a class of cases where, in fact, there was no promise." *Id.* See also *infra* note 51 and accompanying text.

There can be no substantive difference between a contract implied by law wherein one is bound to manifest care, prudence, and attention and a forthrightly identified legal duty whereby one is bound to fashion her behavior after those same attributes. Any distinction between the two is misleading. Notwithstanding the references to contract, logic and scrutiny dictate that the obligations attached to the common callings in medieval England were legal duties arising from the law's wish to create them anew. The contract implied in law is a costume designed to disguise that truth.

patients need not have pled *assumpsit*.

Trespass on the case, is often described as the precursor to negligence, but the two actions are not so tightly tied as is often taught.²¹ To elucidate the link between the liability early imposed on the careless physician and today's notions of negligence one must first examine certain of the basic principles from which modern negligence law proceeds and, second, study the medieval common calling rule to ascertain whether it vindicates those principles.

A negligence action proceeds from two oft-stated premises. The first pertains to *duty* and the second to the *circumstances* surrounding the defendant at the time of the allegedly negligent conduct. With respect to

Such, of course, is always the use of legal fictions: they are distortions of language and thought, pressed into service when a court wishes to change nothing while it changes everything. See ROBERT H. JACKSON, *STRUGGLE FOR JUDICIAL SUPREMACY* 293 (1941) (Legal fictions "enable lawyers to use old forms and procedures to gain new ends."); Oliver R. Mitchell, *The Fictions of the Law: Have They Proved Useful or Detrimental To Its Growth?*, 7 HARV. L. REV. 249, 262 (1893) ("A legal fiction is a device which attempts to conceal the fact that a judicial decision is not in harmony with the existing law. The only use and purpose, upon the last analysis, of any legal fiction is to nominally conceal this fact that the law has undergone a change at the hands of the judges."). See also JOHN C. GRAY, *THE NATURE AND SOURCES OF THE LAW* 30 (1909); Jeremy Bentham, *Preface Intended For The Second Edition of the Fragment on Government*, in A COMMENT ON THE COMMENTARIES AND FRAGMENT ON GOVERNMENT 502, 509 (James H. Burns & H.L.A. Hart eds., 1977); Jeremy Bentham, *A Comment on the Commentaries*, in A COMMENT ON THE COMMENTARIES AND FRAGMENT ON GOVERNMENT, *supra*, at 58; Jeremy Bentham, *The Elements of the Art of Packing, as Applied to Special Juries*, in 5 THE WORKS OF JEREMY BENTHAM 61, 92 (John Bowring ed., 1843); Oliver W. Holmes, *Law in Science and Science in Law*, 12 HARV. L. REV. 443, 460 (1899); Louise Harmon, *Falling Off the Vine: Legal Fictions and the Doctrine of Substituted Judgment*, 100 YALE L.J. 1, 2-16 (1990).

21. In 1926, Winfield probed the historical connection between negligence and action on the case by examining, among other sources, the "abridgments" of scholars who, from the fifteenth to nineteenth centuries, sought to catalog, translate, and annotate English decisions. Winfield, *supra* note 7. Referring to the works of Rolle, Sheppard, Bacon, Viner, and Comyns, Winfield wrote that the term negligence as a subject heading generally

does not exist. . . . But under the title, 'Actions upon the case,' there are attempts to classify the heap of unsifted matter of which those remedies had become the nucleus, and there is a misty conception that inadvertent acts and omissions should form a separate class. The idea barely exists in Rolle (1668), but it gets less nebulous with his successors, until it appears as 'action upon the case for negligence' in Comyns (1762).

Winfield, *supra* note 7, at 194-95. Winfield concludes that until the nineteenth century, "the history of negligence is a skein of threads, most of which are fairly distinct, and no matter where we cut the skein we shall get little more than a bundle of frayed ends." *Id.* at 185.

the first premise, defendants must owe a plaintiff a so-called duty of care;²² That is, his relationship with the plaintiff must legally oblige them to meet some specified standard of conduct. Unreasonableness, carelessness, neglect, imprudence, and inattentiveness do not of themselves create liability for damage they cause. They do so only if, with respect to the plaintiff, the defendant has some legal duty to be reasonable, careful, prudent, and attentive. Such has been the rule since scholars first explained the essence of negligence.²³ Whether the courts took their cues from the commentators or the commentators took theirs from the courts is unclear, but in either event the notion of duty as prerequisite to a negligence action took root early among common law judges and holds fast today in Anglo-American jurisprudence.²⁴

22. See Fleming James, Jr., *Scope of Duty in Negligence Cases*, 47 NW. U. L. REV. 778 (1953).

23. See 1 C. G. ADDISON, A TREATISE ON THE LAW OF TORTS 19 (4th ed. 1876) ("But before an action can be maintained, it must of course be clearly proved that the law imposes upon the defendant the duty which he is charged with neglecting."); THOMAS M. COOLEY, A TREATISE ON THE LAW OF TORTS 791-92 (2d ed. 1888) ("The first requisite in establishing negligence is to show the existence of the duty which it is supposed has not been performed. A duty may be general and owing to everybody or it may be particular, and owing to a single person only, by reason of his peculiar position."); 1 THOMAS A. STREET, FOUNDATIONS OF LEGAL LIABILITY 195 n.5 (1906) ("The law of negligence historically starts from the idea of failure in the performance of a determinable provable legal duty."); FOWLER V. HARPER, A TREATISE ON THE LAW OF TORTS 157 (1933) ("Negligence can exist only when the law imposes a duty to employ care."). See also 1 THOMAS BEVEN, NEGLIGENCE IN LAW 7-8 (4th ed. 1928).

24. See, e.g., Degg v. Midland Ry. Co., 156 Eng. Rep. 1413 (1857) ("[T]here is no absolute or intrinsic negligence; it is always relative to some circumstances of time, place or person There can be no action except in respect of a duty infringed."); Heaven v. Pender, 52 L.J.K.B. 702 (1883) ("[W]henver one person is by circumstance placed in such a position with regard to another that every one of ordinary sense who did think would at once recognize that if he did not use ordinary care and skill in his own conduct with regard to those circumstances, he would cause danger of injury to the person or property of the other, a duty arises to use ordinary care and skill to avoid such danger."); Le Lievre v. Gould, 1 Q.B. 491, 497 (1893) ("The question of liability for negligence cannot arise at all until it is established that the man who has been negligent owed some duty to the person who seeks to make him liable for his negligence A man is entitled to be as negligent as he pleases towards the whole world if he owes no duty to them."); Bottomley v. Bannister, 12 K.B. 458, 476 (1932) ("It is a commonplace of the law of negligence that before you can establish liability for negligence you must first show that the law recognizes some duty towards the person who puts forward the claim. . . . English law does not recognize duty in the air, so to speak; that is, a duty to undertake that no one shall suffer from one's carelessness."); Tappen v. Ager, 599 F.2d 376, 379 (10th Cir. 1979) ("Negligence does not exist in the abstract, it contemplates a legal duty owing from one party to another and the violation of that duty by the person owing it.").

Scholars are reminded, however, that "duty" as theoretical concept poses one of the

Where the defendant's duty is established, he is required to exercise the care that would be given by a reasonable person. To the modern legal mind, the importance of "surrounding circumstances" is nearly self-evident, for it means that conduct is reasonable or unreasonable depending on the situation in which it is undertaken. Yet this was not obvious to lawyers of the nineteenth century, and some conscientious courts took trouble to make it plain:

The issues . . . involve [] the question of the exercise of ordinary care and prudence. . . . The solution of these questions depends upon the peculiar facts and circumstances of each case, the state and condition of the parties; the manner in which, and the circumstances under which, the injury was received or inflicted; in short, all the circumstances surrounding the transaction which in any way reflect upon either the *degree of care* or the *manner* in which, in the particular case, it should have been exercised. The circumstances are all relevant, and may be given to the jury. . . . They form, so to speak, a part of the *res gesta* of the transaction; they are the circumstances under which it occurred, and indicate the agencies which caused it. . . .²⁵

more vexing questions to which modern jurisprudence is heir. See, e.g., William L. Prosser, *Palsgraf Revisited*, 52 MICH. L. REV. 1 (1953); W. W. Buckland, *The Duty To Take Care*, 51 L. Q. REV. 637; Leon Green, *The Duty Problem in Negligence Cases*, 28 COLUM. L. REV. 1014 (1928); Leon Green, *The Duty Problem in Negligence Cases: II*, 28 COLUM. L. REV. 1014 (1928).

25. *Cleveland, Columbus & Cincinnati R.R. Co. v. Terry*, 8 Ohio St. 570, 580 (1858).

So what would be reasonable care, in one driving a carriage on an ordinary road, and about to meet another carriage, coming upon another road of the same description, which intersects it might, if that were a railroad on which cars were advancing, be considered gross negligence, in consequence of the velocity with which carriages, on the latter kind of road, are propelled, and the comparative difficulty of controlling them. So, for obvious reasons, it is usually less safe, to drive rapidly in turning the corners or passing the cross-walks of streets, it is usually less safe, to drive rapidly in turning the corners or passing the cross-walks of streets, than where the course is straight, or there are no such walks. Reasonable care requires that, in all cases, the precautions should be proportioned to the probable danger of injury; and the question as to the exercise of such care, is to be determined like other questions of fact.

Id. at 580. See also *Beers v. Housatonic R.R. Co.*, 19 Conn. 566, 577 (1849); *Cayzer v. Taylor*, 76 Mass. (10 Gray) 271, 280 (1883); ("What would be ordinary care in one case may be gross negligence in another."); *Brown v. Kendall*, 60 Mass. (6 Cush.) 292, 293 (1850) (ordinary care varies according to the exigencies); *Fletcher v. Boston & Maine R.R.*, 83 Mass. (1 Allen) 9, 15 (Mass. 1861) ("Ordinary care is a term that has relation

A. "Duty" and the Common Calling Rule

The evolution of negligence doctrine mirrors the evolution of a culture. Hence, the legal duties that each citizen owes all others are fundamentally a function of social development. That fourteenth century common law should have attached a general duty of care and prudence to the "common calling"²⁶ but not to the whole of human activities may reflect the relatively unevolved civic values prevailing at that time. Yet, the fact that fourteenth century law imposed a generalized duty of care on *any* relationship indicates that the negligence principle had begun to operate. Its attendant *duty* was limited, extending only to the skilled professional who had undertaken to sell a service. Nonetheless, the common calling rule indicates that by the fourteenth century negligence doctrine had quietly been born.²⁷ It was, to be sure, an unnamed infant; but it had ascertainable breath and heartbeat and its growth was marked, then as now, by the ever broadening expanse of duty.

to the situation of parties and the business in which they are engaged.").

With respect to the definition of negligence and the matter of prevailing circumstances, "[t]he rule has been repeatedly laid down that no definition is complete or correct which does not embody that element." *Yerkes v. N. Pac. Ry. Co.*, 88 N.W. 33, 36 (Wis. 1901); *see also* *Krieger v. Howell*, 710 P.2d 614, 617 (Idaho 1985) ("Reasonable or due care requires different conduct under different circumstances.").

Recalling that "duty" and "circumstance" are underpinnings of the modern negligence suit, scholars might more easily see the direct connection between the "common calling" rule of old and negligence rules of our time. In determining what negligence is . . . we are not to look solely at a man's acts or his failure to act: the term is relative, and its application depends on the situation of the parties, and the degree of care and vigilance which the circumstances reasonably impose All circumstances are to be taken into account when the question involved is one of negligence; for negligence in a legal sense is no more nor less than this: the failure to observe, for the protection of the interests of another person, that degree of care, precaution and vigilance which the *circumstances* justly demand. . . .

RESTATEMENT OF TORTS § 283 (1934).

26. *See supra* note 14.

27. *See, e.g.,* Charles O. Gregory, *Trespass to Negligence to Absolute Liability*, 37 VA. L. REV. 359, 360 (1951) (Negligence "was completely unknown at the time when the action on the case was developing. But something of the sort no doubt operated to furnish the basis for liability during these early times in the absence of the trespassory contact.").

Similarly, referring to the fourteenth century, Winfield writes that "[t]he law has little to say about negligence as a term, but in many directions it has grasped the ideas underlying it; and if we transplanted . . . the 'reasonable man' to [medieval England] we should find him doing very much what he does now . . ." Winfield, *supra* note 27, at 185. Winfield concludes that fourteenth century courts had a subconscious appreciation of negligence. *Id.* at 196.

Over succeeding centuries the duty of due care has grown to cover most of humanity's activities. Yet even now it does not touch them all. In some instances, one may be manifestly careless and imprudent but, for *want of duty*, be immune to liability for damage thus caused.²⁸ Negligence, even as we see it and know it today, continues to evolve as the duty of due care lengthens its reach.

1. "CIRCUMSTANCE" AND THE COMMON CALLING RULE

The matter of circumstance is a second basis on which the common calling rule bespeaks the principles of negligence. In the medieval judicial mind, there probably lurked a sense that one's knowledge bore on the reasonableness of one's acts. Knowledge, after all, is a circumstance that should of logical necessity inform one's conduct and decisionmaking.

Consider a modern setting. One does not act unreasonably by backing a car from an ordinary driveway in the usual way. If a small child, of whom the driver has no reason to know, is playing under the

28. Twentieth-century tort law has not traditionally imposed a duty of ordinary care on the owner of land in favor of trespassers and social guests. See Leon Green, *Landowner v. Intruder, Intruder v. Landowner*, 21 MICH. L. REV. 495 (1923); RESTATEMENT (SECOND) OF TORTS §§ 329-330 (1965); Vitauts M. Gulbis, Annotation, *Modern Status of Rules Conditioning Landowner's Liability Upon Status of Injured Party as Invitee, Licensee, or Trespasser*, 22 A.L.R. 4TH 294 (1983); Younce v. Ferguson, 724 P.2d 991 (Wash. 1986). Twentieth century tort law also fails to impose a duty of ordinary care with reference to the matter of rescue and it is still true, generally, that "no ordinary bystander is under a duty to attempt the rescue of a child from drowning in what he knows to be shallow water." PERCY H. WINFIELD, A TEXT-BOOK OF THE LAW OF TORT 404 (4th ed. 1948). The adult's failure to rescue is not pardoned for any reasonableness, but rather for want of duty. See, e.g., Allen v. Hixson, 36 S.E. 810, 810 (Ga. 1900); Riley v. Gulf, C. & S.F. Ry., 160 S.W. 595, 597 (Tex. 1913); Yania v. Bigan, 155 A.2d 343, 346 (Pa. 1959); McFall v. Shimp, 10 Pa. D. & C.3d 90, 91-92 (1978); RESTATEMENT (SECOND) OF TORTS § 314 (1965); Robert L. Hale, *Prima Facie Torts, Combination, and Non-Feasance*, 46 COLUM. L. REV. 196 (1946).

The reader might take heart to know that pursuant to the urgings of scholarly writers and to an ever-evolving cultural morality, the law has moved, warily, to attach increased duties to landowners. See Gulbis, *supra*; Poulin v. Colby College, 402 A.2d 846 (Me. 1979). Through impetus of like sources, the law has moved somewhat more aggressively to impose on the citizenry a duty of rescue. See, e.g., Francis H. Bohlen, *The Moral Duty to Aid Others as a Basis of Tort Liability*, 56 U. PA. L. REV. 217 (1908); H.D. Minor, *Moral Obligation as a Basis of Liability*, 9 VA. L. REV. 420 (1923); Wallace M. Rudolph, *The Duty to Act: A Proposed Rule*, 44 NEB. L. REV. 499, 499-503, 509 (1965); Alexander W. Rudzinski, *The Duty to Rescue: A Comparative Analysis*, in THE GOOD SAMARITAN AND THE LAW 91, 123 (James M. Ratcliffe ed., 1981); Hutchinson v. Dickie, 162 F.2d 103, 106-107 (6th Cir. 1947); Farwell v. Keaton, 240 N.W.2d 217, 222 (Mich. 1976); MINN. STAT. ANN. § 604.05 (West 1988); VT. STAT. ANN., tit. 12, § 519 (1973).

vehicle, the driver is not liable for negligence despite the injury her act may cause. Yet the driver is surely unreasonable in backing the vehicle if she somehow *does* know of the child, even though a reasonable person ordinarily would not. The driver's knowledge--whether derived from superior vision, extraordinary hearing, or supernal intuition--renders her liable if she backs the car and injures the child. Had she remained ignorant, her act would be reasonable. In light of her superior knowledge, it would be negligent.

Similarly, suppose a railroad engineer sees a pedestrian on the tracks. Having no reason to know the pedestrian is deaf the engineer assumes he will respond to the whistle. The assumption is reasonable and when the train strikes the pedestrian the engineer is not liable.²⁹ Yet if by some fortuity the engineer should know of the pedestrian's impaired condition, even though a reasonable person would not have such knowledge, he is held to act as a reasonable person would once possessed of the knowledge. Armed with such knowledge, a reasonable person would not rely on a whistle to alert the pedestrian of the train's presence. Liability would thus attach.

It follows that when one has more than the ordinary quantum of knowledge or skill in a given situation, one is unreasonable for failing to exercise it.

If the actor possesses special skill he must exercise it . . . whenever he, either as a reasonable man, or as an expert, realizes or should realize that its exercise is necessary to the reasonable safety of others. The superior skill, being the result or aptitude developed by special training and experience, may give to the actor special ability to perceive the existing facts and a special knowledge of other pertinent matters which, separately or together, may enable him to realize a necessity of using his skilled technique which a person of lesser skill would not realize.³⁰

29. Addressing just such a situation, the Ohio Supreme Court wrote, "It is clear, we think, that without such knowledge [of plaintiff deafness] on the part of defendant, the unfortunate condition [of plaintiff] would not impose upon the defendant or its agents any increased degree of care. . . . [S]uch deafness could not enhance the responsibilities of the defendant, unless a knowledge of the fact should be brought home to it." *Cleveland, Columbus & Cincinnati R.R. Co. v. Terry*, 8 Ohio St. 570, 579 (1858).

30. RESTATEMENT (SECOND) OF TORTS § 299, cmt. f (1965). See also Warren A. Seavey, *Negligence—Subjective or Objective?*, 41 HARV. L. REV. 1, 5-7 (1927) (Seavey writes, "it is dangerous to shoot in a place in which people are accustomed to be In determining whether or not it was *dangerous*, we immediately go back to the position of the actor. If we assume that he knew everyone in town had left and no strangers had come in, we would not say his act was risky. If he did not know, we would

Because knowledge is a circumstance affecting reasonableness, it is likely that the duty of care attached to common callings reflected, *sub silentio*, the early common law's recognition that one's training, skill, and experience were simply circumstances that should inform one's conduct. That is probably why the law required more of the experienced professional than it did of the untrained amateur.

It appears that negligence, unseen and innominate, was awake and at work early in the common law day. The doctrine of common callings merely reflected a first conception of "duty" and "circumstance," as those words bear on today's notions of negligence. The medieval physician was liable under the rule of common callings and medieval medical malpractice cases were thus based on negligence and little else.

In the early nineteenth century, negligence remained camouflaged by action on the case.³¹ It had not fully emerged as an independent tort.³² As Anglo-American courts of that period groped toward understanding negligence as an independent concept, they also seemed to recognize, at some semiconscious level, that medical malpractice was actually grounded in negligence, notwithstanding its historic tie to the rules of "common callings" and "contract implied by law."³³

Some courts of that era related the physician's liability to the words "negligence"³⁴ and others to "carelessness," or failure of "ordinary

say it was, although the physical facts would, of course, be the same Risk, then, would seem to include the advertence of someone to the possibility that an event may occur." (emphasis added)); RESTATEMENT OF TORTS § 299, cmt. f (1934).

31. See *supra* notes 18, 20, 21.

32. The term "negligence" had gained recognition, and was featured in the designation "trespass on the case for negligence." See *supra* note 21 and accompanying text. In respect of the physician, the reference to "common callings" seems to have disappeared from the decisions. It was replaced, in some cases, by the designations "professional" and "mal-practice," (the hyphenated form of the word then being in vogue.)

See, e.g., *Seare v. Prentice*, 103 Eng. Rep. 376, 376 (1807) (the opinion describing the suit as an "action on the case . . . against . . . a surgeon, for *negligently*, ignorantly and unskillfully reducing a dislocated elbow" (emphasis added)); *Landon v. Humphrey*, 9 Conn. 209, 210 (1832) (the court described the suit as "an action on the case against the defendant for mal-practice in his profession as a physician and surgeon."); *McCandless v. McWha.*, 22 Pa. 261, 267 (1853) (characterizing the suit as "an action on the case . . . against a respectable physician and surgeon, for malpractice in setting a broken leg of the plaintiff"); *Branner v. Stormont*, 9 Kan. 40, 42 (1876) (describing the suit against a physician, simply, as an "action for malpractice."); *Small v. Howard*, 128 Mass. 131 (1880) (characterizing the suit as "[t]ort against a physician and surgeon for malpractice").

33. See *supra* note 20 and accompanying text.

34. *Seare v. Prentice*, 103 Eng. Rep. 376, 377 (1807) (involving a patient who complained of defendant physician's faulty treatment of an injured arm, wherein the trial court instructed the jury that "the gist of the action was negligence").

care.”³⁵ Some went so far as to characterize the physician’s duty, in substance, as “ordinary care under the circumstances,” a conception which clearly iterates the duties underlying negligence.³⁶

For example, in *Lanphier & Wife v. Phipos*,³⁷ the court ruled that in treating an injured hand a physician was bound to exercise a “proper degree of skill and care.”³⁸ In *Landon v. Humphrey*,³⁹ the trial court charged the jury that if it found “in the operation there was either carelessness, or a want of ordinary diligence, care, and skill, their verdict ought to be for the plaintiff; otherwise for the defendant.”⁴⁰ Defendants objected to the charge,⁴¹ but the supreme court affirmed, noting, once

35. See *infra* notes 39-57 and accompanying text.

36. See *supra* note 10 and accompanying text.

37. 173 Eng. Rep. 581 (1838).

38. *Id.* at 583.

39. 9 Conn. 209 (1832) (concerning defendant’s alleged malpractice in vaccinating plaintiff).

40. *Id.* at 212.

41. The defendant had urged that the law held physicians liable not for a breach of “ordinary care,” but only for “gross negligence.” Physicians, he said, make no promise, except to do as well as they can, and as well as they know how to do. There is nothing like mechanical perfection in the healing art. The only reasonable rule on this subject . . . is, that nothing short of gross ignorance or gross negligence will subject a surgeon to damages What man, even of skill and talents, would undertake to practice in the healing art, if some little failure of ordinary skill, or ordinary diligence, or even some trifling want of carefulness, might sweep him from the whole earnings of a life of toil and drudgery?

Landon 9 Conn. at 214 (citations omitted).

The argument is superficially cogent, but it is nonetheless the product of gross misconception. The defendant erred conceptually in equating the notion of negligence with that of a failure to achieve a cure. A number of nineteenth- and twentieth-century courts have fallen prey to that same conceptual error and thus have befuddled the law with references to “gross negligence” (often called *crassa negligentia*) as the basis of the physician’s liability. For example, in *Sumner v. Utley*, 7 Conn. 257 (1828), the court wrote:

A physician may mistake the symptoms of a patient; or may misjudge as to the nature of his disease, and even as to the powers of a medicine; and yet his error may be of that pardonable kind, that will do him no essential prejudice, because it is rather a proof of human imperfection, than of culpable ignorance or unskillfulness [N]othing short of gross ignorance and want of skill, will authorize a suit against a practicing physician.

Id. at 260, 263 (citations omitted). The *Sumner* court thus suggests that because physicians are not bound to a successful cure, they are therefore liable only for gross negligence.

In 1827, the courts and the bar generally had not fully discovered or articulated the essence of negligence. The *Sumner* court, among others, failed to distinguish between the absence of negligence and an unsuccessful professional outcome. Hence, the court indicated that a failure to cure of itself signified “an error,” a phrase it seemed to equate

with ordinary negligence. The court was sufficiently enlightened to declare that a physician was not necessarily liable for a mere failure to cure which, unfortunately, it termed "an error." It drew the faulty conclusion, however, that an untoward medical result would raise liability only if it constituted *gross negligence*.

What the *Sumner* court likely wished to express, but could not articulate, was that a physician, like any other person, is liable for ordinary negligence but that negligence is not synonymous with a failure to cure. Conceptually, the case is no different from that of a lifeguard who does everything reasonably in her power to rescue a swimmer caught by a powerful undertow, but nonetheless fails to prevent her from drowning. The lifeguard is not negligent simply because the victim died, so long as she did that which a reasonable lifeguard would do under those conditions.

A physician, like any other professional, is:

responsible for the want of [ordinary] care and diligence Many decisions deny the liability of professional men even to this extent, since they decide that the surgeon . . . shall not be held responsible except for *lata culpa* or *crassa negligentia*, manifest fault or gross negligence. *Perhaps nothing more is designed to be expressed in these cases than that the defendant is only liable for the want of ordinary care.*

Leighton v. Sargent, 27 N.H. 460, 471 (1853) (emphasis added; citations omitted).

Unfortunately, the *Leighton* court, seeking to dispel the myth that gross negligence was the essence of medical malpractice unwittingly lay the groundwork for that which later became known as the "error in judgment" or "best judgment" rule. Observing that the physician is not, through his undertaking, obliged to deliver a cure but rather to exercise ordinary care, the court wrote that:

[I]n stipulating to exert his skill, and apply his diligence and care, the medical and other professional men contract to use their *best judgment*. Few cases can be supposed where but a single course of measures alone can be adopted, and many must occur, where great differences of opinion may exist as to the best course to be taken. In most cases judgment and discretion are required to be exercised. *Freedom from errors of judgment* is never contracted for by . . . the physician.

Id. at 472 (emphasis added). See *supra* note 20, regarding the significance of the reference to "contract."

In referring to "best judgment" and "errors of judgment," the *Leighton* court surely meant to say only that the physician is not liable for untoward or undesirable results unless they are the product of ordinary negligence. However, it is apparently on the basis of the *Leighton* opinion that the phrases "error in judgment" and "best judgment" gained an undeserved, undesirable, independent significance that endures even today. As I will discuss in the second article of this series, see *supra* note 4 and accompanying text, these terms have caused faulty jurisprudence and inconsistent judicial decisions within medical malpractice law.

In *McCandless v. McWha.*, 22 Pa. 261 (1853), concerning a physician who had treated a broken limb, the trial court instructed the jury:

[T]he defendant was bound to *bring to his aid the skill necessary* for a surgeon to set the leg so as to make it straight and of equal length with the other when healed, and if he did not, he was accountable in damages, just as a stone-mason or brick-layer would be in building a wall of poor materials, and the wall fell down; or if they built a chimney, and it would smoke by reason of a want of skill in its construction

again, that a physician is liable for "a want of *ordinary* diligence, care and skill . . . or for *carelessness*" ⁴² Similarly, in *Rich v. Pierpont*,⁴³ the court noted that if a jury should think "there had been culpable neglect or want of due care or competent skill, let them find for the plaintiff; if otherwise, for the defendant."⁴⁴ In *Heath v. Glisan*⁴⁵ the court charged the jury that:

A physician or surgeon is . . . responsible for ordinary care and skill, and for the exercise of his best judgment.⁴⁶ The words ordinary skill⁴⁷ and ordinary care, are here used in their common acceptation and meaning, and they should be so understood and construed by you If, under the circumstances of this case, the nature of the plaintiff's injuries could have been ascertained by ordinary skill, and by the exercise of ordinary care and diligence and the defendants, either for want of ordinary care, or of ordinary skill, mistook the character of the injury, and thereby failed to make a perfect cure, which otherwise might have been made, they are liable. But if they possessed ordinary skill, and use ordinary care, they are not

Id. at 263.

Commenting on the charge, and making no reference to gross negligence or *crassa negligentia*, the court wrote: "It is impossible to sustain [the charge] The implied contract of a physician or surgeon is not to cure—to restore a fractured limb to its natural perfectness—but to treat the case with diligence and skill For less than this he is responsible in damages" *Id.* at 267-68. Separately concurring, Judge Lewis wrote with reference to the jury instruction:

[I]t seems to be thought that the [trial] Court, in giving this instruction, held the surgeon bound under all circumstances to cure the fractured leg I do not so understand the language of the judge. He only held the surgeon bound to '*bring to his aid*' the skill necessary for the purpose. If the fracture in question was one which might have been restored by the exercise of ordinary skill, there was no error in requiring its exercise from one who held himself out as possessing it We are therefore brought back to the main question in the cause: . . . Did the surgeon exercise ordinary skill and care in his treatment of the patient? If he did, he is not liable. If he did not, he is.

Id. at 270, 272-73. See also *Parker v. Rolls*, 139 Eng. Rep. 284 (1854).

42. *Landon*, 9 Conn. at 216.

43. 176 Eng. Rep. 16, 16 (1862).

44. *Id.* at 16.

45. 3 Or. 64 (1869).

46. *Id.* at 66.

47. It is interesting to note that the earlier nineteenth century decisions, cited *supra* note 41, make a fairly clear distinction between the physician's supposed duties to possess such skill as is normally possessed by others of his calling and to exercise "ordinary care," a phrase those decisions initially did not relate to customary practice within the profession.

liable for an error in judgement,⁴⁸ committed in a case presenting ground for doubt or uncertainty.⁴⁹

In *Leighton v. Sargent*⁵⁰ Judge Bell averred that the physician is obliged to have a "reasonable, fair degree of skill," and to use

reasonable and ordinary care and diligence in the exertion of his skill and the application of his knowledge, to accomplish the purpose for which he is employed He agrees to exert such care and diligence in his employment as men of common care and common prudence usually exert in their own business of a similar kind.⁵¹

48. See *infra* notes 78-79 and accompanying text. The matter will be more thoroughly addressed in the second article of this series.

49. *Heath*, 3 Or. at 66.

50. 27 N.H. (7 Foster) 460 (1853) (holding a surgeon liable for faulty treatment of fractured bone):

51. *Id.* at 470-71. This court, and a great many others of the nineteenth century, refer to the physician's obligation thus described as arising through a "contract implied by the law." *Id.* at 468. The reference to contract is surely a legacy of legal fiction hatched and handed down by the medieval courts as basis on which to bind the "common callings" to a duty of reasonable care and prudence. See *supra* note 20; see also *Landon v. Humphrey*, 9 Conn. 209, 216 (1832); *Branner v. Stormont*, 9 Kan. 40, 42-43 (1872); *Small v. Howard*, 128 Mass. 131, 132 (1880).

It is virtually provable that the courts did not conceive the supposed contract truly as a contract, because as early as 1838 an English court ruled that a wife might recover for injuries sustained through a surgeon's failure of "proper care and skill," notwithstanding the fact that her husband had employed the physician. *Lanphier & Wife v. Phipos*, 173 Eng. Rep. 581, 583 (1838). At such time in history, one who would now be dubbed a "third-party beneficiary" had no claim on a contract to which she was not party. See Anthony J. Waters, *The Property in the Promise: A Study of the Third Party Beneficiary Rule*, 98 HARV. L. REV. 1109 (1985); A. W. B. SIMPSON, A HISTORY OF THE COMMON LAW OF CONTRACT 475-85 (1975); 4 ARTHUR L. CORBIN, CORBIN ON CONTRACTS §§ 826-835 (1951). Similarly, in 1833, the Supreme Court of Ohio allowed a wife to recover for faulty medical treatment although it was her husband who had formed the contract with the defendant physician. See *Gallaher & Wife v. Thompson*, 1 Wright 466 (Ohio 1833).

In 1853, a Pennsylvania court ruled that when a person "applies to a surgeon and he treats him improperly, he is liable to an action even though he undertook *gratis* to attend the patient, because his situation implies skill in surgery." *McCandless v. McWha.*, 22 Pa. 261, 269 (1853) (emphasis added). See also *Shiells v. Blackburn*, 126 Eng. Rep. 94 (1789); *Thorne v. Deas*, 4 Johns. 84 (N.Y. 1809) (If the physician's duty to treat properly should arise even without consideration on the patient's part then clearly it does not arise from contract since a contract, even in 1853, required consideration.); W. S. Holdsworth, *Debt, Assumpsit and Consideration*, 11 MICH. L. REV. 347 (1913); C. H. S. FIFOOT, HISTORY AND SOURCES OF THE COMMON LAW: TORT AND CONTRACTS 397-400 (1949).

Judge Bell seemed to appreciate that circumstance bore precisely the same importance to medical misfeasance as it did to negligence:

[I]t might be made a question, whether a medical man is not bound to apply extraordinary care, because his charge relates to the lives and health of his patients . . . [B]ut there is no pretense that the physician is bound by any other rule in this respect, than that which governs all classes of employed men in works or services requiring skill; the rule of ordinary care and diligence.

There is, of course, a difference in different cases as to what constitutes ordinary care, dependent upon the importance and delicacy or difficulty of the thing to be done.⁵² Quoting authority, Judge Bell declared:

Different things may require different care. The care required in building a common doorway is quite different from that required in raising a marble pillar; but both come under the description of ordinary care.⁵³ Such differences must exist among the cases requiring medical attention. *But the common rule still applies, which requires such care and diligence as men in general, of common prudence and ordinary attention, usually apply in similar cases.*⁵⁴

Although not clearly articulated, it is virtually incontrovertible that Judge Bell and the other nineteenth century courts just mentioned viewed medical malpractice as resting on precisely the same standard of care that governed negligence actions.⁵⁵

Judge Bell decided *Leighton* in 1853, and in 1858 Judge Peck decided *Cleveland, Columbus & Cincinnati Railroad v. Terry*.⁵⁶ The reader is invited to compare Judge Bell's language, as set forth above, concerning a doctor and patient with Judge Peck's language, as set forth below, relating to a pedestrian and railroad:

52. *Leighton*, 27 N.H. (7 Foster) at 472.

53. *Id.*, citing JOSEPH STORY, COMMENTARIES ON THE LAW OF BAILMENTS § 429, at 445-47 (5th ed. 1851).

54. *Leighton*, 27 N.H. (7 Foster) at 472 (emphasis added).

55. The notion of like circumstance which the *Leighton* court expresses via the phrase "in similar cases" is also indispensable to modern-day negligence law. See *supra* note 25. Incomplete understanding of "like circumstances," however, subsequently gave rise to the ill-advised locality rule. See *infra* Section IV.

56. 8 Ohio St. 570 (1858).

Ordinary care is . . . well known to mean that degree of care which persons of ordinary care and prudence are accustomed to use and employ, under the same or similar circumstances . . . If called into exercise under circumstances of peculiar peril, a greater amount of care is required than where the circumstances are less perilous; because prudent and careful persons, having in view the object to be attained, and the just rights of others, are, in such cases, accustomed to exercise more care than in cases less perilous. The amount of care is indeed increased, but the standard is still the same. It is still nothing more than ordinary care under the circumstances of that particular case. The circumstances, then, are to be regarded in determining whether ordinary care has been exercised.⁵⁷

The comparison plainly shows that the physician and the railroad were held to identical standards. Each was obliged to exercise such care and prudence as would be exercised by an ordinary person of common sense laboring under analogous circumstances. Like the medieval common law that preceded it, early nineteenth century law held the physician to the standard that was destined to become the foundation of negligence. The courts of that day did not consider that it should be otherwise, nor was there any reason they should have.

III. THE EMERGENCE OF ERRONEOUS JURISPRUDENCE: "PROFESSIONAL CUSTOM"

The nineteenth century courts just cited held a physician liable as any other person for a failure to exercise ordinary care. They provided no basis for a rule that would hold a doctor harmless simply because his or her conduct conformed to custom.⁵⁸

57. *Id.* at 581.

58. This matter will be addressed in the second article of this series. *See supra* note 4 and accompanying text. As noted, the cases cited *supra* note 41, did refer to the average or ordinary physician with reference to the *skill* the physician was obliged to bring to his assignment, but not with reference to the care he was obliged to use in completing that assignment.

With respect to the physician's obligation of ordinary care, early nineteenth century law held evidence of custom and conformity admissible, but not conclusive—a notion generally in force today for all endeavors other than medicine. *See supra* note 41 and accompanying text. In *Seare v. Prentice*, 103 Eng. Rep. 376, 377 (1807), the court sustained a jury charge to the effect that "the gist of the action was negligence; of which direct evidence might be given; or it *might be inferred* by the jury if the defendant had proceeded without any regard to the common ordinary rules of his profession." *Id.* (emphasis added).

Yet, subject to a few curiously reasoned "exceptions," the common law has since purported to provide that a physician's duty is not measured by the ordinary rule of reasonableness, but rather by professional custom. The doctor is bound to do no more than follow ordinary practice within the profession.⁵⁹ (If there should be more than one prevailing custom, the physician is said to be free of liability so long as he follows one of

Similarly, in *Patten v. Wiggin*, 51 Me. 594 (1862) the court instructed the jury that: The law requires . . . that when a physician undertakes professional charge of a patient, he will use *reasonable and ordinary care and diligence* in the treatment of the cases If the case is such that no physician of ordinary knowledge or skill would doubt or hesitate, and but one course of treatment would by such professional men be suggested, then any other course of treatment *might be evidence* of a want of ordinary knowledge or skill, or care and attention. . . .

Id. at 596-97 (emphasis added). As of 1862, therefore, the common law seems to have provided that common care and prudence furnished the duty by which physicians were bound and that custom was no more than admissible evidence as to the matter of the breach of common care and prudence.

59. See JON R. WALTZ & FRED. E. INBAU, *MEDICAL JURISPRUDENCE* 42 (1971) (The nearly universal rule in this country is that a physician will not be liable for negligence in a medical malpractice case unless he fails "to possess and employ such reasonable skill and care as are commonly had and exercised by reputable, average physicians in the same general system or school of practice."); Richard Pearson, *The Role of Custom in Medical Malpractice Cases*, 51 IND. L. J. 528, 528 (1976) (noting that the medical profession establishes its own standard of care, and that a physician's conduct is measured against medical custom rather than standards of reasonableness determined by judges and juries). See also John K. Johnson, Jr., *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 742 (1970) (noting that the medical profession establishes its own standard of care, and that a physician's conduct is measured against medical custom rather than standards of reasonableness determined by judges and juries); Allen H. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 560 (1959) ("[T]he physician . . . is not only to be held to the standard of practice generally accepted by his branch of the profession but is to be protected by this standard since compliance with accepted practice is generally taken as conclusive evidence of due care."); Welch v. Whitaker, 317 S.E.2d 758, 763 (S.C. 1984) (citing 61 AM. JUR. 2D at 337-38 (1981) ("The failure by a physician to exercise 'that degree of care and skill which is ordinarily employed by the profession generally, under similar conditions and in like surrounding circumstances' constitutes medical malpractice.")); Hurlock v. Park Lane Med. Ctr. Inc., 709 S.W.2d 872, 882-83 (Mo. 1985) (noting that the standard of care in medical malpractice cases is the degree of skill and learning ordinarily used under similar circumstances by others in the profession); Maxwell v. Soileau, 561 So.2d 1378, 1386 (La. 1990) (noting that the medical profession establishes its own standard of care, and that a physician's conduct is measured against medical custom rather than standards of reasonableness determined by judges and juries). See also Joseph H. King, Jr., *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 VAND. L. REV. 1213, 1234-36 (1975); Allen J. Peizer, *Physicians and Surgeons—Malpractice—Court Disregard for the Standard of the Profession The Legislative Response—Helling v. Carey*, 51 WASH. L. REV. 167, 169-72 (1975).

them.)⁶⁰ Although in negligence law generally, evidence of conformity to custom is relevant and admissible,⁶¹ medical malpractice supposedly is governed by a different rule: "[I]n medical malpractice cases failure to establish non-conformity is fatal to the plaintiff, and the defendant who establishes conformity is entitled to a directed verdict."⁶²

With professional custom as the standard, the nation's physicians may lawfully adopt and follow practices that are patently negligent and unreasonable under the standard of ordinary care to which all others are held. The medical community is answerable not for want of care but for want of conformity. It is thus recognized that the medical profession has the curious advantage of establishing, on its own, the standard of care to which it is legally obliged. As Professor Pearson wrote, "Under this rule, the medical profession is able to establish its own standard of care. Thus, it is medical custom, rather than standards of reasonableness determined by judges and juries, against which the conduct of a physician is measured."⁶³ In recent decades, this troubling phenomenon has led some modern courts to criticize the professional custom rule.⁶⁴ Yet,

60. See, e.g., *Trent v. Trotman*, 508 A.2d 580, 584 (Pa. 1986) ("[A] physician will not be held liable merely for exercising his judgment in applying a course of treatment supported by a reputable and respected body of medical experts, even if another body of expert medical opinion would favor a different course of treatment.").

61. See 2 FOWLER HARPER & FLEMING JAMES, JR., *THE LAW OF TORTS* 977-82 (1956); Clarence Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147, 1147-53 (1942); Fleming James, Jr., & David K. Sigerson, *Particularizing Standards Of Conduct In Negligence Trials*, 5 VAND. L. REV. 697, 710 (1952).

62. Morris, *supra* note 61, at 1159.

63. Richard N. Pearson, *The Role of Custom in Medical Malpractice Cases*, 51 IND. L.J. 528, 528 (1976).

64. In the celebrated case of *Helling v. Carey*, 519 P.2d 981 (1974), evidence established that when the plaintiff was 24 years old she visited the defendant ophthalmologists for routine eye care, and seven years later returned with a complaint that suggested the possibility of glaucoma. The defendants then tested for glaucoma and discovered that plaintiff was afflicted with the disease, and had in fact been afflicted with the disease for approximately 10 years, but had shown no symptoms. She alleged that her ophthalmologists malpracticed by failing to test her when she first visited them at age 24. *Id.* at 982.

At trial, uncontroverted expert testimony established that custom among ophthalmologists was to administer glaucoma testing routinely to all patients over the age of 40, but not to patients under the age of 40 because the incidence of the disease among the younger population is exceedingly low (one in 25,000). *Id.* at 981-82. The defendants testified that they had not tested the plaintiff during her first visit because they were following professional custom. Because the plaintiff had introduced no evidence of defendants' nonconformity to custom, the trial court did not submit to the jury the question of malpractice for failure to administer glaucoma testing. Judgment was for the defendant.

The plaintiff contended on appeal that the trial court should have allowed the jury to find the defendants liable notwithstanding their adherence to professional custom.

most continue to adhere to it.⁶⁵ Consequently, one who is injured by a physician's unreasonable professional conduct may not recover unless that conduct happens to contravene prevailing medical custom.

Courts do not frequently offer a rationale for the professional custom rule. A few have suggested that medicine is too complex and the human body too temperamental to allow that a doctor be held to the simple

Although the appellate opinion is not entirely clear, it does indicate that the trial court submitted the case to the jurors with instructions that forbade it to find liability for failure to administer glaucoma testing. The plaintiff had alleged malpractice in connection with other aspects of her care and these, presumably, were the matters submitted for jury consideration. *Id.* at 982.

The court created a veritable shock wave by ruling that professional custom should not govern a physician's duty of care and that the failure to administer glaucoma testing to persons under 40 constituted malpractice as a matter of law:

The precaution of giving this test to detect the incidence of glaucoma to patients under 40 years of age is so imperative that irrespective of its disregard by the standards of the ophthalmology profession, it is the duty of the courts to say what is required to protect patients under 40 from the damaging results of glaucoma We therefore hold, as a matter of law, that . . . in failing to [administer the test], the defendants were negligent. . . .

Id. at 983.

The court reasoned that the diagnostic test was safe and inexpensive, and proper practice required that it be made routinely available to all patients, notwithstanding the relatively low incidence of glaucoma among younger persons:

The incidence of glaucoma in one out of 25,000 persons under the age of 40 may appear quite minimal. However, that one person, the plaintiff in this instance, is entitled to the same protection, as afforded persons over 40, essential for timely detection of the evidence of glaucoma where it can be arrested to avoid the grave and devastating result of this disease. The test is a simple pressure test, relatively inexpensive.

Id.

The *Helling* decision was followed by the enactment of a statute evidently designed to restore the professional custom standard. WASH. REV. CODE § 7.70.040 (1975) provides that a health care provider is liable for failure to follow the accepted standard only if the health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent provider at the time in the professional class to which he belongs, in the state of Washington, acting in the same or similar circumstances. . . . The Supreme Court of Washington, however, has so construed the statute as not to undermine its decision in *Helling*. See, e.g., *Gates v. Jensen*, 595 P.2d 919 (Wash. 1979); *Harris v. Groth*, 663 P.2d 113 (Wash. 1983). See also *Brown v. Dahl*, 705 P.2d 781 (Wash. Ct. App. 1985).

Other courts have in one way or another criticized the professional custom rule. See, e.g., *Morgan v. Sheppard* 188 N.E.2d 808 (Ohio 1963); *Favalora v. Aetna Casualty & Sur. Co.*, 144 So.2d 544 (La. 1962); *Darling v. Charleston Comm'ty Mem. Hosp.*, 211 N.E.2d 253 (Ill. 1965); *Incollingo v. Ewing*, 282 A.2d 206 (Pa. 1971).

65. B. FURROW ET AL., HEALTH LAW 104 (1987).

standard of reasonableness.⁶⁶ Others have written that medical practice, being highly complex, is not susceptible to evaluation through ordinary common sense and must instead be assessed pursuant to the customs of those with experience.⁶⁷

66. See, e.g., *Mullinax v. Hord*, 94 S.E. 426, 428 (N.C. 1917) ("[T]he law does not require of a physician or surgeon absolute accuracy, either in his practice or in his judgment. It does not hold physicians and surgeons to the standard of infallibility, nor does it require of them the utmost degree of care and skill of which the human mind is capable, but that, while in the practice of their vocation, they shall exercise that degree of knowledge and skill ordinarily possessed by members of their profession."); *Maxwell v. Soileau*, 561 So.2d 1378, 1386 (La. 1990) ("Neither a general practitioner nor a specialist is held to a standard of perfection or evaluated with the benefit of hindsight. A general physician is not required to exercise the highest degree of care possible.").

67. See, e.g., *Pedigo v. Roseberry*, 102 S.W.2d 600, 607 (Mo. 1932) ("Jurics should not be . . . turned loose and privileged to say, perchance, the method of treating an injury . . . was negligent notwithstanding . . . [testimony establishing] . . . that the uniformly adopted practice of the most skillful surgeons had been followed."); *Haase v. Garfinkle*, 418 S.W.2d 108, 113 (Mo. 1967) ("Whether [a physician's course of conduct is appropriate] is a question beyond the knowledge and competence of lay jurors."). See also *Fisher v. Wilkinson*, 382 S.W.2d, 627, 632 (Mo. 1964); *Hart v. Steele*, 416 S.W.2d 927, 932 (Mo. 1967) (the Missouri Supreme Court, like many courts, tended erroneously to unite the issue pertaining to the standard of care with that of the frequent need for expert testimony in establishing its breach).

Without citation to judicial authority, McCoid has suggested yet an additional rationale for the professional custom rule. The professional custom standard, he writes, appropriately affords physicians a "preferred status" in tort law in order that they be free in pursuit of their important calling to exercise judgment and hard-won skill without fear of penalty:

The qualified practitioner of medicine has undertaken long years of study to acquire knowledge of man, his body and its illnesses and the means of combating such ailments, coupled with an intensive training of the senses and mind of the physician to respond to stimuli in a manner best described as "the healing art." A large measure of judgment enters into the practice of this art. That judgment should be free to operate in the best interests of the patient. If the "judge" is himself to be judged by some outsider who relies on after-acquired knowledge of unsatisfactory results or unfortunate consequences in reaching a decision as to liability, the medical judgement may be hampered and the doctor may become hesitant to rely upon his developed instinct in diagnosis and treatment. If, on the other hand, the doctor knows that his conduct is to be evaluated in terms of what other highly trained medical practitioners would have done or would accept as competent medical practice, he is more likely to pursue his own judgment when he is confident of the diagnosis and line of treatment, and is more likely to provide good medical service for his patient.

Allan H. McCoid, *The Care Required of Medical Practitioners*, 12 VAND L. REV. 549, 608 (1959).

In partial response, I, as a law professor who also carries a license to practice medicine and surgery, respectfully express my observations that:

(1) medical students pursue their study by *choice*, in contemplation of the varied

Such explanations might at first seem sensible, but sensible they surely are not. First, medicine is no more complex than scores of other professional undertakings. Does the law seriously contend that the pediatrician who treats an ear infection for the one-thousandth time undertakes more a complex assignment than the author of a battle plan, a peace treaty, or an international trade policy? Organ transplantation is glamorous, but surely it is no more complicated or unpredictable in outcome than taming wild animals, designing a nation-wide marketing plan, or evaluating a new corporate security. All these pursuits are prey to the unknown and unknowable, and all demand expertise of a high order. With regard to medicine, complexity and uncertainty provides no greater reason for fashioning a standard of care after custom than they would in any other professional endeavor.

Second, if the law truly trained its sights on the meaning of negligence, then no matter how complex the activity at issue, it would never find need or excuse to remove the determination of its existence from the lay decisionmaker (court or jury). Negligence is nothing more nor less than a failure to do what a reasonable person would under the prevailing circumstance. From a more refined perspective it is a failure

rewards it offers not the least of which is financial,

(2) each of the years in which one studies medicine is 12 months long and no longer, and McCoid's reference to "long years" is therefore bewildering,

(3) the judgment required of the conscientious physician is not one whit more subtle than that demanded of a conscientious lawyer, teacher, writer, engineer or probably, any other person pursuing a skilled calling,

(4) many if not most medical practitioners, think mechanically (like many if not most legal practitioners) and do not seriously appreciate the need or nature of judgment, and, most important,

(5) *judgment* is, perhaps, the very hinge-pin on which negligence turns. To justify a "preferred status" for physicians on the basis that medical practice requires judgment is to ignore the fact that most human activity requires judgment—day to day and minute to minute. The judgments one must exercise in handling a carving knife, crossing the street, or walking a dog may seriously affect the lives and fortunes of others. Indeed, were this not so there would be no need of the creature we know as negligence law. Medical practice is not unusual for the fact that it calls for judgment. In *Vaughan v. Menlove*, 132 Eng. Rep. 490 (1837) (in which the defendant was sued for negligent construction and maintenance when a hay-rick on his property but located close to the home of a neighbor, caught fire and burned the neighbor's cottage as well), the court rejected the notion that the defendant should be exculpated simply because he had:

acted honestly and bona fide to the best of his own judgment. . . .

Instead . . . of saying that the liability for negligence should be coextensive with the judgment of each individual which might be as variable as the length of the foot of each individual, we ought rather to adhere to a rule, which requires in all cases a regard to caution such as a man of ordinary prudence would observe.

Id. at 493 (Tindall, C.J.)

to assess reasonably the costs and benefits associated with a given course of conduct, and thus to decide on its advisability. As Justice Learned Hand explained:

The degree of care demanded of a person by an occasion is the resultant of three factors: the likelihood that his conduct will injure others, taken with the seriousness of the injury if it happens, and balanced against the interest which he must sacrifice to avoid the risk. All these are practically not susceptible of any quantitative estimate, and the second two are generally not so, even theoretically. For this reason a solution always involves some preference, or choice between incommensurables, and it is consigned to a jury because their decision is thought most likely to accord with commonly accepted standards, real or fancied.⁶⁸

Indeed, Hand reduced the matter to quasi-mathematical terms, creating the famed Hand calculus: "Possibly it serves to bring this notion into relief to state in algebraic terms: if the probability be called P ; the injury, L ; and the burden, B ; liability depends upon whether B is less than L multiplied by P : i.e., whether $B < PL$."⁶⁹

The complexity of any technical field, medicine included, may well disable a lay juror who seeks independently to assess the relative risks and benefits attending a given course of conduct. That, however, only means that the juror needs advice from experts (genuine experts)⁷⁰ who can identify the risks and benefits at issue. Thus informed, there is no reason that a juror cannot and should not pass on the appropriateness of anyone's conduct, including a physician's.

Without expert assistance a lay juror cannot determine whether it is negligent to discharge a particular cardiac patient from the hospital without prescribing anticoagulants.⁷¹ Yet, to make the determination, the juror requires only that an expert explain how the omission affects the matter of risks and benefits. An expert might explain that, according to standard medical wisdom, anticoagulants present a variety of risks and adverse effects, and, to the extent competent information allows, he might provide estimates of such risks in quantitative terms. The expert could

68. *United States v. Carroll Towing Co.*, 159 F.2d 169, 173 (2nd Cir. 1947). See also 2 HARPER & JAMES, *supra* note 9, at 930-36.

69. *Conway v. O'Brien*, 111 F.2d 611, 612 (2nd Cir. 1940).

70. The common law also purports to require that a plaintiff present an expert witness to establish malpractice. The expert, however, is asked to testify simply to professional custom, not to the risks and benefits on which negligence properly depends.

71. See *Haase v. Garfinkle*, 418 S.W.2d 108 (Mo. 1967).

then explain that, according to standard medical insight, the anticoagulants would afford the patient in question particular benefits and quantify the benefit to the extent that credible research permits. Armed with this knowledge, the jury would be competent to determine, as it does in any other negligence suit, whether the defendant physician had acted with reasonable care. Under the supposedly prevailing rule of professional custom, however, such a risk/benefit analysis is not even the sort of testimony that the expert is asked to provide; he is asked to testify only to custom.

Consider an idealized and slightly oversimplified case. A child is brought to a physician shaking, thrashing, and quivering. The physician correctly diagnoses a "febrile seizure," a condition that frequently affects children experiencing high fever.⁷² The physician medicates the child appropriately, the seizure subsides, and the parents are advised that no further treatment is indicated for the seizure, although the fever must be studied and addressed. The physician studies the fever, ascertains its cause, and treats it appropriately.

One year later, the child experiences a second febrile seizure and dies. A malpractice action is brought wherein the plaintiff alleges that the physician was negligent for failing to prescribe an ongoing course of anticonvulsant medication immediately upon diagnosing the first febrile seizure. Pursuant to current jurisprudential practice, plaintiff and defendant would each present a so-called expert witness. The plaintiff's expert would testify, in substance, that the physician's decision not to prescribe the anticonvulsant did not comply with professional custom. The defendant's witness would testify that it did. Issues of causation and damage aside,⁷³ the jury would be instructed to determine whether the defendant's failure to prescribe the medication did or did not comport with custom. In respect of the defendant's alleged breach of duty, the jury would thus be asked, in essence, to pass on little more than the experts' relative credibility.

However, there is no reason that the jury should not pass on the issue of negligence in medical malpractice cases as it does in all others. It would only require that "experts" testify with regard to matters in which they are (or should be) truly expert. For example, rather than

72. See M. LENNOX-BUCHTHAL, FEBRILE CONVULSIONS: A REAPPRAISAL 221 (1973); WOODBURY ET AL., ANTIEPILEPTIC DRUGS 108 (1972).

73. Elaborate notice is unnecessary here to make the point that negligence liability requires a showing not only of duty and breach—which together constitute negligence—but also of damage and causal links between the damage and the negligence. The links normally carry the designations "cause in fact" and "proximate cause." The question of cause has provoked no small scholarly debate. See H.L.A. HART & TONY HONORE, CAUSATION IN THE LAW (2d. ed. 1985).

testifying that the physician's omission was a breach of custom, the plaintiff's expert might state that:

- (1) a child who experiences one febrile seizure has an 8% chance of experiencing another;
- (2) in 3% of cases, febrile seizures are fatal;
- (3) in 80% of cases, regular barbiturate therapy prevents the recurrence of febrile seizures;
- (4) barbiturates thus administered carry approximately a 4% risk of causing severe mental damage to developing children and that they also produce, in approximately 50% of cases, a psychological and physical dependence; and
- (5) the psychological and physical dependence (but not the mental damage) is reversible in 75% of patients.

The defendant's witness would, in turn, express his or her view of such factual matters, all of which bear on the relative risks and benefits associated with the defendant's failure to prescribe the anticonvulsant. If, as is usual, the medical matters at issue did not facilitate precise numerical description, the expert would refer not to numbers, but qualitatively to a "very serious risk," or "significant chance," or "slight chance," or "negligible risk."

Thus possessed of expert testimony as to potential risk and benefit—the essence of negligence—the jury would be well equipped to apply Hand's calculus to determine whether the defendant's failure to prescribe the anti-convulsants reflected an unreasonable decision. Hence, the expert's function would be to provide the jury with relevant knowledge of risks and benefits so that they could competently assess the reasonableness of the physician's act or omission. There is no good reason that law or procedure should ever have been otherwise. The proffered explanations for the professional custom rule are unscholarly, unimpressive, and notably devoid of authoritative support.⁷⁴

How then did the professional custom rule arise? The limited existing record indicates that it arose through conceptual confusion, compounded by the law's propensity toward "lazy repetition."⁷⁵

74. See *supra* notes 66-67 and accompanying text.

75. See *Tiller v. Atl. Coast Line R.R.*, 318 U.S. 54, 68 (1942) (Frankfurter, J., concurring) (referring specifically to the phrase "assumption of the risk": "[U]ncritical use of words bedevils the law. A phrase begins life as a literary expression; its felicity leads to its lazy repetition; and repetition soon establishes it as a legal formula, indiscriminately used to express different and sometimes contradictory ideas.").

*A. Creation of the Professional Custom Standard:
Conceptual Confusion*

During the early nineteenth century, decisions typically described the physician's duty as a two-tier entity: (1) doctors were bound to come to their patients with the skill that would be possessed by an ordinarily competent and qualified physician, and⁷⁶ (2) in actually treating patients, they were bound to use "ordinary care."⁷⁷ The courts distinguished plainly and repeatedly between the matter of skill and the matter of care used in exercising that skill. They ruled that the physician was bound by "contract"⁷⁸ to have such skill as would be had by other physicians in good standing, and thus referred the phrase "ordinary skill" to those faculties normally held by other physicians. Yet the courts made no such reference in respect to ordinary care, by which, as explained above,⁷⁹ they meant to signify the sense and prudence generally exercised by reasonable persons. Hence, the early nineteenth century courts obliged the physician to have such skill as his colleagues normally possess but to use such care as would be exercised by all reasonable persons under like circumstances.

In *Leighton v. Sargent*,⁸⁰ the court wrote that a professional contracts with his employer:

[t]hat he possesses that reasonable degree of learning, skill and experience which is ordinarily possessed by the professors of the same art of science, and which is ordinarily regarded by the community, and by those conversant with that employment, as necessary and sufficient to qualify him to engage in his business.⁸¹

In respect of care, the court wrote,

the professional man contracts that he will use reasonable and ordinary care and diligence in the exertion of his skill and the application of his knowledge to accomplish the purpose for which he is employed. He agrees to exert such care and diligence as men in general, of common prudence and ordinary attention, usually apply in similar cases . . .⁸²

76. See *supra* note 47.

77. *Id.*

78. See *supra* note 20.

79. See *supra* notes 39-57 and accompanying text.

80. 27 N.H. (7 Foster) 460 (1853).

81. *Id.* at 469.

82. *Id.* See also *West v. Martin*, 31 Mo. 375, 378 (1862) (physician's liability dependent on whether "he has treated the case skillfully or has exercised such reasonable skill and diligence as is ordinarily exercised in his profession").

Similarly, in *Patten v. Wigger*⁸³ the court sustained this jury charge:

[T]he law requires that [a physician or surgeon] be possessed of that reasonable degree of learning, skill, and experience which is ordinarily possessed by others of his profession and the law implies as a part of the contract that when a physician takes professional charge of a patient, he will use reasonable and ordinary care and diligence in the treatment of the case.⁸⁴

The court explicitly related the matter of skill to professional custom, but it made no such reference with respect to the physician's exercise of ordinary care.

Likewise, in *Heath v. Glisan*⁸⁵ the court referred to both ordinary skill and ordinary care as components of the physician's obligation. It wrote, "By ordinary skill, is meant such degree of skill as is commonly possessed by men engaged in the same profession."⁸⁶ Yet it offered no such definition with respect to ordinary care. The phrase "ordinary care" stands apart from professional habit or custom. In *Branner v. Stormont*,⁸⁷ the trial court charged the jury: "The law required the defendants to possess and employ that degree of skill which ordinarily characterized the profession at the time they treated [plaintiff]; and if you find that . . . injuries resulted from want of such skill the defendants are liable."⁸⁸ However, according to the plaintiff's attorney at any rate, the court also advised that the defendant, in exercising his skill, was to give proper care and attention, a phrase it defined as "[c]ommon prudence and care, exercised by common-sense men, such as are usually exercised where all are alike interested."⁸⁹ The appellate court affirmed, proclaiming that the physician's obligation was to possess "that reasonable degree of learning, skill, and experience which is ordinarily possessed by others of his profession; that he will use reasonable and ordinary care and diligence in the treatment of the case which he undertakes"⁹⁰ In *Small v. Howard*,⁹¹ the appellate court sustained a jury charge that thus described the physician's duty:

His contract, as implied by law is: 1. That he possesses that reasonable degree of learning, skill and experience which is

83. 51 Me. 594 (1862).

84. *Id.* at 595-96.

85. 3 Or. 64 (1872).

86. *Id.* at 66.

87. 9 Kan. 40 (1872).

88. *Id.* at 42.

89. *Id.* at 41.

90. *Id.* at 42-43 (quoting *Tefft v. Wilcox*, 6 Kan. 46, 61 (1870)).

91. 128 Mass. 131 (1880).

ordinarily possessed by others of his profession, having regard to the present advanced state of the science of surgery. 2. That he will use reasonable and ordinary care and diligence in the treatment of the case committed to him.⁹²

In *Pike v. Honsinger*,⁹³ the court ruled that:

[A] physician and surgeon, by taking charge of a case, impliedly represents that he possesses, and the law places upon him the duty of possessing, that reasonable degree of learning and skill that is ordinarily possessed by physicians and surgeons. . . . Upon consenting to treat a patient, it becomes his duty to use reasonable care and diligence in the exercise of his skill. . . .⁹⁴

B. The Confusion Emerges

Toward the end of the last century, some courts began carelessly to overlook the distinction between (1) the skill with which a physician was obliged to approach his task, and (2) the care that he was obliged to give it. They thus began blindly to blend the two very different concepts to form one misguided idea: that the physician's duty was that of ordinary skill and care which meant the skill and care that would be manifest generally in the profession. (Thus confused, these same courts further misled themselves by misreading the articulated rule that rendered custom *relevant* to the matter of ordinary care as one that made custom *equivalent* to ordinary care.) It was this confusion—and nothing more—that created this rule—now lazily, lamentably, and repeatedly proclaimed: In a given situation one physician is bound to do that which would generally have been done by others.

In the 1860 case of *Ritchey v. West*,⁹⁵ the Illinois court ruled that a physician was required to “possess and exercise that degree of skill which is ordinarily possessed by members of the profession. And whether the injury results from a want of skill, or the want of its application, he will, in either case, be equally liable.”⁹⁶ The court cited no authority for its formulation of the physician's duty and, initial impressions notwithstanding, the “rule” is substantially different from that set forth in *Leighton*, *Patten*, *Heath*, *Branner*, *Small*, and *Pike* discussed

92. *Id.* at 132.

93. 49 N.E. 760 (Ct. App. N.Y. 1898).

94. *Id.* at 762. Early courts, and even some in the twentieth century, describe the physician's duty in like terms. See *Bigney v. Fisher*, 59 A. 72, 73 (R.I. 1904).

95. 23 Ill. 329 (1860). The report indicates that defendant physician was represented by one A. Lincoln.

96. *Id.* at 330.

above.⁹⁷ The *Ritchey* formulation provided simply that the physician was obliged to possess and exercise customary skill. It did not articulate a standard through which the skill was to be exercised. The court did not, for example, state that in exercising his skill the physician was to show "ordinary care and prudence," or the "care that would be shown of a common sense person possessed of such skill." It is one thing to write, as did the several courts cited above, that a physician must possess customary skill and then, in using it, exercise ordinary care. It is another to state that the physician is merely obliged to possess and exercise customary skill. Indeed, the latter statement does not truly set forth two separate requirements. It provides only this one: In treating a patient physicians are obliged to bring their skill to bear. The statement is legally incomplete, failing to articulate a standard of behavior to which physicians are answerable.

The hasty reader, however, might easily miss the conceptual flaws inherent in the *Ritchey* formulation and subject it instead to either of two alternative constructions. One reader might think it means simply that physicians are bound to possess the skill their colleagues possess and, in exercising it, proceed with ordinary care and caution. This understanding would be in accord with the prevailing opinion of the era. Another might think the *Ritchey* formulation means that physicians are obliged only to possess skill equivalent to that of their colleagues and behave as would their colleagues. *Ritchey* supports neither of these interpretations, because it fails to refer to the standard by which physicians are to exercise their skill.⁹⁸

In *Barnes v. Means*,⁹⁹ the court cited *Ritchey* alone as authority for the proposition that "[a] surgeon, in order to relieve himself of responsibility, must not only possess, but, *in the practice of the profession*, must use ordinary skill."¹⁰⁰ To a hasty reader, the *Barnes* opinion would likely encourage the second of the two alternative readings described above. The phrase "but in the practice of the profession," which did not appear in the *Ritchey* decision, might lead one to conclude that the phrase

97. See *supra* notes 80-94 and accompanying text.

98. Like the other nineteenth century courts already discussed, the *Ritchey* court itself seemed to believe that the physician's behavior was to be judged according to ordinary standards of negligence. In sustaining the verdict and judgment against the defendant, the court wrote that "from this evidence it would seem that there must have been a want of ordinary skill, or great negligence in the treatment of the case . . ." *Ritchey*, 23 Ill. at 386. Such language suggests that there was in the court's mind a difference between the possession of ordinary skill and negligent behavior. Nonetheless, the notion that a physician is bound to possess and exercise ordinary skill does not, of itself, acknowledge that distinction.

99. 82 Ill. 379 (1876).

100. *Id.* at 384 (emphasis added).

"use ordinary skill" suggests conformity to customary practices.¹⁰¹ The *Ritchey* and *Barnes* formulations were echoed in other decisions of the era, and somewhat thoughtlessly in standard treatises of the day. Hence, toward the latter part of the nineteenth century a line of decisions and commentary repeatedly ruled that the physician was obliged to "have and to exercise ordinary skill."¹⁰² That linguistic construction diverted the

101. *Barnes* concerned a physician's alleged failure to "extend" a fractured bone, and thus to assure its proper placement on healing. The trial court charged the jury that the defendant was liable if he had, by "the want of skill or by negligence of appellants suffered the broken fragment to become displaced." *Id.* at 384. Like the *Ritchey* court, this trial court appears to have believed that possession of skill was a matter separate from negligence. Yet the formulation that the appellate court used in sustaining this charge takes no account of the distinction. Compare *Ritchey*, *supra* note 98.

102. See *Cayford v. Wilbur*, 29 A. 1117 (Me. 1894); *Peck v. Hutchinson*, 55 N.W. 511 (1893); *Hewitt v. Eisenbart*, 55 N.W. 252 (Neb. 1893); *Wood v. Clapp*, 36 Tenn. 65 (1856). In 1895, Jaggard wrote that "[t]he implied contract of a physician or surgeon is . . . to possess and employ in the treatment of a case such reasonable skill and diligence as are ordinarily exercised in his profession by thoroughly educated physicians. . . ." 2 EDWIN AMES JAGGARD, *HAND-BOOK OF THE LAW OF TORTS* 911-12 (1895). Jaggard thus repeated, in substance, that which had been written by the *Ritchey* and *Barnes* courts. In essence, he stated only that the physician's duty was to possess the skill customarily possessed by physicians and then, in treating his patients, to use it.

In 1907, Bigelow described the physician's duty in somewhat poorly chosen terms which, if read carefully (as they probably were not), refer to common care and prudence. But, if read hastily (as they probably were), Bigelow's words might seem to set custom as the standard:

To render a doctor of medicine liable for negligence, there must . . . appear to have been a failure to exercise such diligence or skill as a prudent practitioner of fair ability would have exercised under the same circumstances. The degree of diligence required will be proportionate to the nature of the case; and, in some cases, nothing short of the highest degree of diligence can satisfy the law.

MELVILLE M. BIGELOW, *THE LAW OF TORTS* 127 (8th ed. 1907) (citations omitted).

Bigelow presents the phrase "prudent practitioner," as opposed to "prudent person." Yet, if carefully considered, that phrase can only mean a *prudent person* who happens to be possessed of the skills commonly possessed by a physician. Thus, Bigelow actually intended to state that a doctor would be liable for negligence if he failed to do that which a reasonable person would have done under the circumstances. His manner of expressing that notion, however, and in particular his use of the phrase "prudent practitioner" tends to confuse rather than clarify. An uncritical reader might easily conclude that the professor had described a standard of professional custom, but it is not at all clear that Bigelow himself knew what it was he had described.

The English courts also demonstrated varied degrees of confusion during this period. See, e.g., *Rich v. Pierpont*, 176 Eng. Rep. 16, 18-19 (1862) (appellate court sustained a jury charge, reasoning that:

[a] medical man was certainly not answerable merely because some other practitioner might possibly have shown greater skill and knowledge; but he was bound to have that degree of skill which could not be defined, but which, in the opinion of the jury, was a competent degree of skill and knowledge.).

law from its proper and original course. Then, in 1876, the Vermont Court made a sharp but unnoticed turn in the wrong direction.

*Hawthorn v. Richmond*¹⁰³ concerned a doctor's alleged failure properly to treat a fracture. Drawing, apparently, on the "have and exercise" construction propounded in *Ritchey* and *Barnes*, the trial court issued this jury instruction charge regarding the performance to which a physician was bound:

[T]he question is, how much skill is he bound to have and to exercise in order that he should not be liable for a disastrous result? It is a little difficult to define it—you can only describe it or illustrate it. The ordinary expression is, "ordinary skill." That means, such skill as doctors . . . ordinarily have and exercise in like cases. If a doctor does in a case what the average class of doctors are accustomed to do and would do in such a case, then he exercises what is meant by ordinary skill in a given case. . . . If he exercises such skill, then he is not liable. . . .¹⁰⁴

Citing no authority and giving little attention to the text's meaning, the appellate court sustained the charge:

We think the rule as laid down by the court is substantially correct, and in accordance with the well-settled law on the subject. There are certain expressions used in the charge which, taken by themselves, might seem to indicate a lower degree of skill than the law requires; but when the whole charge is taken together, it clearly gives the true rule. . . .¹⁰⁵

Thus, it seems, the professional custom rule was born, not by reason, but by linguistic and conceptual mutation—unintended, unplanned, and, at the very time of its birth, unseen. The *Hawthorn* case was much cited at the end of the nineteenth century and at the beginning of the twentieth.¹⁰⁶ During those years, for want of judicial watchfulness, the professional custom rule became entrenched.¹⁰⁷

103. 48 Vt. 557 (1876).

104. *Id.* at 558-59 (emphasis added).

105. *Id.* at 562.

106. See, e.g., *Force v. Gregory*, 27 A. 1116 (Conn. 1893); *Whitcress v. Hill*, 70 N.W. 750, 751 (Iowa 1897); *Vaughan v. Mem. Hosp.*, 130 S.E. 481, 482 (W. Va. 1925); *Krinar v. Westerman*, 216 S.W. 938, 941 (Mo. 1919).

107. See, e.g., *Dorris v. Warford*, 100 S.W. 312, 313 (Ky. 1907). ("The rule is that a physician must use that care and skill which is exercised generally by physicians of ordinary care. . . ."); *Long v. Austin*, 69 S.E. 500, 501 (N.C. 1910) ("[The physician] must exercise that reasonable skill, care, and proficiency in . . . the treatment of his patient which a member of his profession of ordinary care and prudence should use under

IV. ERROR COMPOUNDED: "THE LOCALITY RULE"

Historically the professional custom rule has furnished only one-half of the standard to which the common law holds physicians. The other half inheres in the so-called locality rule which, as any dutiful first-year law student knows, obliges physicians to treat their patients with such care and skill as would be furnished by a reasonably competent practitioner operating in the *same community*.¹⁰⁸ Firmly affixed to the doctrine was a traditional apologia now tantamount to a familiar refrain: The locality rule was devised to "protect" rural practitioners by assuring that they would not be held to medical standards prevailing among urban practitioners with better training and resources.¹⁰⁹ Moreover, some say, the rule served to attract physicians to remote and needy provincial settings by allowing them a relaxed standard of professional conduct.¹¹⁰

Conventional wisdom further teaches that the locality rule, once sound and serviceable, underwent reevaluation, revision, and de facto

the circumstances."); *Booth v. Andrus*, 137 N.W. 884, 893 (Neb. 1912) ("[T]he physician's duty is measured by] the degree of skill and diligence which other physicians. . . ordinarily have and practice.").

108. See *Shelton v. Hacelip*, 51 So. 937, 937 (Ala. 1910) ("The reasonable and ordinary care, skill and diligence which the law requires of physicians and surgeons is such as physicians and surgeons in the same general neighborhood, in the same general line of practice ordinarily have and exercise in like cases."); *Slimak v. Foster*, 138 A. 153, 154 (Conn. 1927) ("In determining what constitutes the reasonable and ordinary care, skill and diligence which a physician . . . is required [sic] to exercise, the test is that care, skill and diligence which practitioners in the same general neighborhood . . . exercise in like cases."); *McCurdy v. Hatfield*, 183 P.2d 269, 271 (Cal. 1947) ("A physician is required to have the degree of learning and skill possessed by physicians of good standing practicing in the same locality"); *Riggs v. Christie*, 173 N.E.2d 610, 613 (Mass. 1961) ("[T]he undertaking of a physician as implied by law is that he possesses and will use the reasonable degree of learning, skill, and experience which is ordinarily possessed by others of his profession in the community where he practises [sic]. . .").

109. See Jon R. Waltz, *The Rise and Gradual Fall of the Locality Rule In Medical Malpractice Litigation*, 18 DEPAUL L. REV. 408, 410 (1969) ("The [locality] rule, in its early form, was demonstrably calculated to protect the rural and small town practitioner, who was presumed to be less adequately informed and equipped than his big city brother."); *Hall v. Hilbun*, 466 So.2d 856, 868 (Miss. 1985) (holding that:

No doubt there was a time when all states embraced what has been simplistically denominated "the locality rule." Formulated over a hundred years ago to protect the rural and small town practitioner presumed to be less adequately informed and equipped than his colleague in the city, the rule gradually came to hold sway throughout the country.).

110. The locality rule has been viewed as a subsidy for rural areas—one of the bundle of incentives to attract doctors to areas that they won't otherwise find attractive. Considering the relevance of the locality rule to the shortage of physicians in rural areas, two commentators write that "[a]ny attempt to impose a higher standard . . . may exacerbate an already serious problem." Henry C. Karlson & Roger D. Erwin, *Medical Malpractice: Informed Consent to the Locality Rule*, 12 IND. L. REV. 653, 666 (1979).

repeal over the course of this century and has become largely obsolete.¹¹¹ This last lesson, too, comes equipped with a set of explanatory platitudes, and attentive law students thus record in their notebooks these five insights:

- (1) as corollary to the locality rule, medical malpractice law required that a plaintiff produce, as an expert witness, a physician practicing in the defendant's community, but plaintiff was frequently unable to secure her expert because medical colleagues protected one another through an evidentiary "conspiracy of silence;"¹¹²
- (2) furthermore, the locality rule, if strictly applied, wrought an anomaly whereby physicians who served as their communities' only doctor could never be held to a standard higher than their own, however shoddy their practices;¹¹³
- (3) for the two reasons just cited, the common law relaxed the locality rule during the early part of the twentieth century and bound physicians to standards prevailing not in their own communities exclusively, but in localities "similar" to their own, thus opening the witness box to experts who hailed from communities removed from the defendant's;¹¹⁴

111. See *infra* note 116 and accompanying text.

112. See *infra* notes 114 and 115.

113. See *infra* note 115.

114. See Waltz, *supra* note 109, at 411:

The early and most restrictive form of the locality rule . . . effectively immunized from malpractice liability any doctor who happened to be the sole practitioner in his community. He could be treating bone fractures by the application of wet grape leaves and yet remain beyond the criticism of more enlightened practitioners from other communities.

See also Katherine R. Bowden, Comment, *Standard of Care for Medical Practitioners—Abandonment of the Locality Rule*, 60 KY. L.J. 209, 210 (1971) ("[The locality rule] has two practical drawbacks: the possibility of a small group of practitioners establishing an unsatisfactory local standard of care and the difficulty in securing competent local witnesses, i.e., the plaintiff is forced to seek witnesses from among the defendant's colleagues."); *Jolinson v. Winston*, 94 N.W. 607, 609 (Neb. 1903) (ruling that trial court had improperly sustained objections raised by defendant during plaintiff's examination of medical expert, the court wrote: "We cannot overlook the well-known fact that in [medical malpractice actions] it is always difficult to obtain professional testimony at all."); *Sampson v. Veenboer*, 234 N.W. 170, 172 (Mich. 1931) (holding that plaintiff's expert was qualified to testify notwithstanding his location outside the immediate community in which defendant practiced:

At times it may become necessary to secure the expert testimony of one who resides some distance from the home of a defendant accused of malpractice, for it may be difficult to obtain a witness to testify against one who bears the very high professional reputation of defendant. If it would always be necessary to secure an expert from the vicinity of the home of a defendant

(4) as the century progressed, advanced teaching and communication technologies afforded rurally based doctors much the same learning as is available in urban settings, obituating even the "similar" locality rule;¹¹⁵ and

(5) in the modern era, therefore, the locality rule is fast fading in all its forms and physicians are, by and large, held to a

who might be the only practitioner there, it would be impossible to secure such testimony at all.);

Carbone v. Warburton, 91 A.2d 518, 522 (N.J. 1952) (deciding that a physician licensed in New York State and not in New Jersey was competent to serve as plaintiff's expert, the court wrote:

We find in the decisions throughout the country in medical malpractice actions frequent references to the difficulties of proof faced by a tortiously injured patient, and to the "well known" reluctance of the members of the medical profession to testify for such a patient.);

Huffman v. Lindquist, 234 P.2d 34, 46 (Cal. 1951) (Carter, J., dissenting):

Anyone familiar with [medical malpractice cases] knows that the so-called ethical practitioner will not testify on behalf of a plaintiff regardless of the merits of his case. This is largely due to the pressure exerted by medical societies and public liability insurance companies which issue policies of liability insurance to physicians covering malpractice claims [P]hysicians who are members of medical societies flock to the defense of their fellow member charged with malpractice and the plaintiff is relegated, for his expert testimony, to the occasional lone wolf or heroic soul, who for the sake of truth and justice has the courage to run the risk of ostracism by his fellow practitioners and the cancellation of his public liability insurance policy.

See also Melvin M. Belli, *An Ancient Therapy Still Applied: The Silent Treatment*, 1 VILL. L. REV. 250 (1956) (discussing plaintiffs' difficulty in obtaining expert testimony to support claim of medical malpractice); Note, *Overcoming the Conspiracy of Silence: Statutory and Common-Law Innovations*, 45 MINN. L. REV. 1019 (1961); Richard M. Marcus, *Conspiracy of Silence*, 14 CLEV.-MAR. L. REV. 520 (1965); Joseph Kelner, *The Silent Doctors—The Conspiracy of Silence*, 5 U. RICH. L. REV. 119 (1970).

115. See, e.g., *Shilkret v. Annapolis Emergency Hosp. Assoc.*, 349 A.2d 245, 249 (Md. 1975) ("Whatever may have justified the strict locality rule fifty or a hundred years ago, it cannot be reconciled with the realities of medical practice today."); see also John K. Johnson, Jr., Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 732 (1970) (discussing the standard of care applicable to practicing physicians:

Although the original reasons used to justify the locality rules might have been valid 50 to 100 years ago, there is no longer a lack of training opportunities and means of contact with other parts of the country. The quality of transportation has improved greatly, and there have been significant advances in the communications industry.).

“national” standard of care.¹¹⁶

This five-point explication is appealing for its apparent sense and simplicity. Its only shortcoming is inaccuracy. The locality rule, like the professional custom standard, arose through jurisprudential accident during the nineteenth century, when negligence law was in its formative period. Turning as it does on the notion of surrounding circumstances,¹¹⁷ negligence doctrine should naturally take account of locality to the extent that locality would inform a reasonable person’s judgments and behaviors. In this regard, consider two scenarios unrelated to medicine. In 1915 many American buildings had telephones but many did not. If in that year a night watchman noticed a fire erupting on his employer’s premises and failed immediately to telephone the fire department, his liability for negligence would depend largely on whether the building was equipped with a telephone. The law would not expect that the night watchman re-invent the telephone in one minute, wire his employer’s premises for service in the next, and then, with telephone service in place, contact the fire department. No reasonable person could or would undertake such an enterprise. The law would expect, however, that the watchman use a telephone if one was available to him, for that is what a reasonable person would do.

Similarly, in 1925, America’s urban inns were commonly equipped with electricity but its rural inns frequently were not. Suppose in that year an inn-keeper’s guest awoke in the night complaining that an animal had invaded his room, that the inn-keeper arrived on the scene but failed to turn on an electric light, and that the animal subsequently injured the guest. If the plaintiff proved that a 60-watt electric bulb would have allowed the inn-keeper and guest to trap the animal and prevent the injury, the inn-keeper’s liability would depend simply on whether the inn had been equipped with electric lighting or, more precisely, whether it might have been so equipped with reasonable effort. If the inn were so situated as to make electric service unavailable, liability would not attach, because the absence of electricity would not reflect unreasonableness on the inn-keeper’s part. If, on the other hand, the inn had been equipped with electric lights or might easily have been so equipped, liability would attach because the failure to have or use electric lights would be unreasonable.

116. See, e.g., *Shilkret v. Annapolis Emergency Hosp. Assoc.*, 349 A.2d 245, 252 (Md. 1975); *Logan v. Greenwich Hosp. Assoc.*, 465 A.2d 294 (Conn. 1983); *Cleveland v. Wong*, 701 P.2d 1301 (Kan. 1985); *Paintiff v. City of Parkersburg*, 345 S.E.2d 564, 567 (W. Va. 1986) (wherein a poetic West Virginia court wrote:

Much has been written about the obsolescence of the locality rule. We have nothing to add to the oceans of ink and forests of paper that have been pressed into service to hasten the rule’s demise. We will only add that the locality rule is abolished in West Virginia, and we shall not miss it.).

117. See *supra* note 25 and accompanying text.

In each situation just discussed, locality would figure in the finding of negligence because it bore on the defendants' opportunity to take remedial action. Refining that perspective one might recognize that opportunity is relevant to negligence because it is a circumstance under which one labors in any given situation. To distill the matter further, one might realize that the circumstance created by opportunity bears on the "burden" or "cost" factor at work in the Hand calculus.¹¹⁸ The nightwatchman could not make a telephone call in a building without a telephone; the cost would have been infinitely high. Had the building had a telephone, the cost or burden of placing the call would have been minimal. The inn-keeper located where electricity was not available would not have been expected to light the guest's room with an electric bulb; again, the cost would have been infinitely high. If, on the other hand, the inn had been equipped with electric lights or electricity was readily available in the region, the cost would have been relatively low.

In the cases just imagined, therefore, locality affected opportunity. Opportunity, in turn, was relevant to negligence because it bore on the "cost" and would thus affect a reasonable person's judgment, decisionmaking, and behavior. Nineteenth century negligence law might thus have identified a "locality rule" with respect to night watchmen and inn-keepers. The rule would have provided that an inn-keeper or night-watchman was bound to do that which would be done by a reasonable night-watchman or inn-keeper working in the same locality. Fortunately, it did not. Such a rule would have been only a specialized redundancy of the general principle on which negligence rests: one is bound to behave reasonably under the circumstances. With reference to a great many undertakings, locality may impair or enhance opportunity, and opportunity is a circumstance that affects a reasonable person's conduct. In any negligence action, therefore, a defendant's *locality is one relevant circumstance*—no more and no less. With this in mind the reader is asked to consider the nineteenth century physician.

The community in which a physician worked clearly constituted a circumstance under which he practiced. In the nineteenth century, it was a circumstance that bore significantly on his access to knowledge and technology. The physician was thus no different from the night watchman or inn-keeper discussed above. The so-called locality rule was no more necessary or meaningful in the case of the physician than it would be in the case of any person pursuing any activity.

The historical record plainly indicates that when nineteenth century courts first referred to a physician's locality they understood it to represent, simply, one circumstance relevant to his or her opportunity for learning, and, hence, to the issue of negligence. The developing common law never intended locality to have importance beyond that of any other circumstance likely to affect the acts and decisions of reasonable persons.

118. See *supra* notes 68-69 and accompanying text.

The so-called locality rule arose, as did the professional custom standard, through a kind of linguistic and conceptual mutation.

In the United States, reference to a physician's locality¹¹⁹ seems to first appear in *Teft v. Wilcox*.¹²⁰ The court mentioned the matter only to indicate that locality was a circumstance relevant to opportunity which, in turn, was relevant to the meaning of "ordinary care." After noting that a physician is obliged to equip himself with such knowledge and skill as is "within his reach," the court wrote:

Regard also is to be had to the circumstances by which the different portions of any one profession may be surrounded, as affecting the question of their proficiency in, and knowledge of advances which may be made in their particular line, and the obligation to be up to such advance. The opportunities by reason of locality, or other circumstance, of one portion, may be many times more favorable than those of another; and the responsibilities resting upon them would be correspondingly greater.¹²¹

In *Smothers v. Hanks*,¹²² the court discussed the duty of care imposed on physicians and reasoned that, "[i]t is . . . doubtless true that the standard of ordinary skill may vary even in the same state, according to the greater or lesser opportunities afforded by the locality, for observation and practice, from which alone the highest degree of skill can be acquired."¹²³

In *Small v. Howard*,¹²⁴ the court evinced the reasoning underlying the *Teft* decision but, unfortunately, issued a statement that tended toward the creation of a veritable locality rule. The court wrote:

It is a matter of common knowledge that a physician in a small country village does not usually make a specialty of surgery, and, however well informed he may in the theory of all parts of his profession, he would, generally speaking, be but seldom

119. In England, the first reference to locality seems to appear in *Seare v. Prentice*, 103 Eng. Rep. 376 (1897). The court instructed the jury that the defendant physician would be liable if he had shown negligence, but "he was at a loss to state to the jury what degree of skill ought to be required of a village surgeon." The court thus seemed to recognize, at some level, that the circumstance of locality had relevance to the matter of negligence, simply because it was a circumstance. Notwithstanding the reference to locality in this case, the English common law never developed anything akin to the locality rule. See *infra* note 141.

120. 6 Kan. 46 (1870).

121. *Id.* at 63 (emphasis added).

122. 34 Iowa 287 (1872).

123. *Id.* at 289-90 (citation omitted).

124. 128 Mass. 131 (1880).

called upon as a surgeon to perform difficult operations. He would have but few opportunities of observation and practice in that line such as public hospitals or large cities would afford. The defendant was applied to, being the practitioner in a small village, and we think it was correct to rule that he was bound to possess that skill only which physicians and surgeons of ordinary ability and skill, practicing in similar localities, with opportunities for no larger experience, ordinarily possess; and he was not bound to possess that high degree of art and skill possessed by eminent surgeons practicing in large cities, and making a specialty of the practice of surgery.¹²⁵

In *Burk v. Foster*,¹²⁶ the court expressly adopted the reasoning advanced in *Small*, but interpreted it in language tending further toward the establishment of an independent locality rule:

[T]hose living in a sparsely settled neighborhood will not have, in any probability, the experience, the opportunity for acquiring skill by practice . . . that comes to the practitioner of medicine and surgery in the city. . . . As the physician engages to bring to bear upon the case only such skill and care as is ordinarily practiced by others of the same profession in like situation, his liability should be measured by that standard. We think the . . . rule is, not . . . that the physician's skill and degree of attention should be measured by those of his community, but by such as is exercised generally by physicians of ordinary care and skill in similar communities.¹²⁷

All four of these courts understood locality as a circumstance that might affect the physician's reasonable opportunity to acquire proficiency. In essence, each unwittingly likened the rural physician to the night watchman or inn-keeper hypothesized above. None of them intended to establish a locality rule; neither would their reasoning ever warrant the pronouncement of such a rule.¹²⁸ Yet only a small quantum of conceptual carelessness would convert the statements made in those cases into a veritable doctrine with a life and identity of its own.

125. *Id.* at 136.

126. 69 S.W. 1096 (Ky. 1902).

127. *Id.* at 1097.

128. Moreover, history belies any thought that the locality rule was designed to "protect" the rural practitioner or to encourage rurally based medicine any more than the ordinary rules of negligence would serve to "protect" the rural inn-keeper of 1915 or encourage the maintenance of rurally based inns. Such rationales were likely little more than professorial musings. Indeed, those proposing them have not backed them with judicial authority. See *supra* notes 109-10 and accompanying text.

Such carelessness was manifest in *Hawthorn v. Richmond*.¹²⁹ The trial court had charged the jury that the defendant physician was obliged to have

exercised ordinary skill That being so, did Dr. Richmond use ordinary and reasonable care in [treating the patient]—that is, in doing what he did . . . did he [provide treatment] in the manner that doctors like himself in the community would have done the same thing, or are ordinarily accustomed to the same thing?¹³⁰

As noted above in connection with the professional custom standard,¹³¹ the appellate court sustained the charge. Paying little attention to the text, the court proclaimed that “when the whole charge is taken together, it clearly gives the true rule”¹³² Hence, the locality rule drew its first breath. Over the course of the century, it joined forces with the professional custom standard to create the twentieth century’s well-known doctrine: A physician was bound to conform his conduct to professional custom prevailing in his community.¹³³ (Many twentieth century courts have spoken not of the physician’s own community, but of “similar communities.”)¹³⁴

129. 48 Vt. 557 (1876).

130. *Id.* at 559.

131. See *supra* notes 104-05 and accompanying text.

132. *Hawthorn*, 48 Vt. at 562.

133. See, e.g., *Swanson v. Wasson*, 262 P. 147, 147 (Wash. 1927) (stating that physicians are bound to exercise the degree of care, skill, or diligence as other physicians practicing in the same locality). See also *Johnson v. Clarke*, 276 P. 1052, 1053 (Cal. 1929); *Knopp v. Thornton*, 250 S.W. 853, 853-54 (Ky. 1923); *Thaggard v. Vafes*, 119 So. 647, 649 (Ala. 1929); *Bartholomew v. Butts*, 5 N.W.2d 7, 9 (Iowa 1942); *McHugh v. Auyudet*, 72 F. Supp. 394, 399 (M.D. Pa. 1943); *Church v. Bloch*, 182 P.2d 241, 245 (Cal. 1947); *Wells v. McGehee*, 39 So. 2d 196, 199 (La. 1949); *Wilson v. Corbin*, 41 N.W.2d 702, 705 (Iowa 1950); *Stottlemire v. Cawood*, 213 F. Supp. 897, 898 (D.D.C. 1963); *Moon v. United States*, 512 F. Supp. 140, 144 (D. Nev. 1981); *Wilson v. United States*, 594 F. Supp. 843, 850 (N.D. Ala. 1984) (citing ALA. CODE §6-5-484a (1975)); *Mariano v. Tanner*, 497 So. 2d 1066, 1069 (La. 1986); *Marchlewski v. Casella*, 106 A.2d 466, 467 (Conn. 1954); *Levett v. Etkind*, 265 A. 2d 70, 73 (Conn. 1969); *Warnock v. Kraft*, 85 P. 2d 505, 506 (Cal. 1939).

134. Since the locality rule was first propounded, a number of jurisdictions referred the physician’s duty not to custom prevailing in the “same” locality but to that prevailing in “similar” localities. The predictably articulated reasons, *supra* note 114, were that poor practice ought not in effect be legalized in a given community where poor practice is the norm. See *McCracken v. Smathers*, 29 S.E. 354 (N.C. 1898); *Lewis v. Johnson*, 86 P.2d 99 (Cal. 1939); *Stafford v. Hunter*, 401 P.2d 986 (Wash. 1965); *Poulin v. Zartman*, 542 P.2d 251 (Alaska 1975); *Hansborough v. Kosyak*, 490 N.E.2d 181 (Ill. 1986). The reasoning is not impressive, because the combined work of the professional custom and locality rules by its nature legalizes that which happens to be prevailing

Since the 1960s, conventional wisdom has characterized the locality rule as an obsolete doctrine, and many of the nation's courts have purported to modify or renounce it. Some writers claim that a few jurisdictions continue to honor the locality rule in its strictest form, that some abide by a rule of "similar locality," and that others have abandoned the rule entirely, adopting a so-called national standard wherein physicians are bound by prevailing national custom. In all of these respects, other writers have ably described the locality rule's failing strength and status,¹³⁵ noting, repeatedly, that improved communications have rendered the locality rule anachronistic.¹³⁶

It is entirely unacceptable, however, that we should leave it at that. In jurisprudential terms the locality rule never existed. If a "rule" is abandoned not by reason of social enlightenment but because of simple technological advancement then the "rule" never was a rule; but misguided pronouncement.

Suppose, for example, that the United States Constitution referred not to "commerce among the several states"¹³⁷ but instead to "interstate business and communications by foot, by horse, or by sail." The coming of steamships, railroads, telephones, automobiles and airlines would

custom whether the relevant locality is a small town, an entire state, a region of the nation or the entire union.

135. Comment, *Medical Malpractice-Expert Testimony*, 60 NW. U. L. REV. 834, 837-39 (1966); Waltz, *supra* note 109; William J. Stewart, Comment, *The Locality Rule in Medical Malpractice Suits*, 5 CAL. W. L. REV. 124 (1968); Douglas v. Bussabarger, 438 P.2d 829, 837 (Wash. 1968); Katherine R. Bowden, Comment, *Standard of Care For Medical Practitioners-Abandonment of the Locality Rule*, 60 KY. L.J. 209 (1971); Dale P. Shralow, Comment, *The Standard of Care for the Medical Specialist in Ohio*; Bruni v. Tatsumi, 38 OHIO ST. L.J. 203, 204 (1977); Lynda K. Zimmerman, Note, *Medical Malpractice: Locality Rule Abandoned in Massachusetts*, 23 SW. L.J. 585, 586-88 (1969); Hall v. Hilbun, 466 So. 2d 856, 866-73 (Miss. 1985); Brian Kibble-Smith & Arthur W. Haffner, *The Effect of the Information Age on Physicians' Professional Liability*, 36 DEPAUL L. REV. 69, 71-76 (1986).

136. See Stewart, *supra* note 135 at 126 ("In this age of modern communications and transportation, there is no reason why rural and small town doctors cannot remain as up-to-date as their big city brethren. Accordingly, there have been efforts to abolish or greatly weaken the [locality] rule"); Douglas v. Bussabarger, 438 P.2d 829, 837 ("Modern means of transportation permit country doctors to attend up-to-date medical seminars; the general circulation of medical journals makes new developments readily available to them, and they can easily and quickly communicate with the most modern and up-to-date medical centers in cities throughout the United States."). See also James O. Pearson, Annotation, *Modern Status of "Locality Rule" In Malpractice Action Against Physician Who Is Not A Specialist*, 99 A.L.R.3d 1133 (1980); Jay M. Zitter, Annotation, *Standard of Care Owed to Patient by Medical Specialist as Determined by Local, "Like Community," State, National, or Other Standards*, 18 A.L.R.4TH 603 (1982).

137. "Congress shall have power to . . . regulate commerce with foreign nations, and among the several states, and with the Indian tribes[.]" U.S. CONST. art. I, §8, cl. 3.

plainly reveal that the language was ill chosen. The United States Supreme Court would doubtless have decided long ago that the constitutional text stood for the principle of commerce in general. Even the strictest of "strict constructionists" would agree that the relevant principle applied to travel or communication undertaken through any and every mode. That decision would mean simply that the drafters had failed accurately to state the rule they wished to create. For a formulated rule that genuinely vindicates the social principle at which it is aimed is independent of time or technology.

It will not do, therefore, to think that the locality rule was at one time sensible, but, in view of altered technology, is now obsolete. If improved technology requires that a rule be abandoned, then that rule never existed, notwithstanding a century's worth of statements purporting to accredit it. Those courts purporting to abandon the locality rule today are in fact apologizing for its creation one hundred years ago. The rule is now discarded for the same reasons it never should have been announced. The *true* rule was, and still is, that a physician, like any other person, is bound to behave as would a reasonable person under analogous circumstances. Locality is a circumstance which at one time affected a reasonable person's actions and decisions in the practice of medicine (just as a horse was at one time the principle means of interstate transport).

Locality today is still a circumstance that surrounds a practicing physician as it does people engaged in any other activity. However, it is no longer the sort of circumstance that normally affects a reasonable physician's professional behavior. It is not, in other words, a *relevant* circumstance. And that is the change wrought by modern technology. It is wrong to write or to teach, simplistically, that the law has undergone change in regard to the standard by which it measures a physician's duty. The standard is no different from what it was a century ago. As one court wrote in relation to the diverse circumstances that might surround a railroad engineer, "[T]he standard is still the same. It is still nothing more than ordinary care under the circumstances. . . ."¹³⁸

One might ask why it is significant that the law announced a misconceived "rule" if it ultimately abandons that rule. The answer is that rules, once announced, develop lives of their own, and, even if their genesis is clearly erroneous, the law is slow to discard them. The locality rule still operates in several states, riding on the sheer momentum of "precedent."¹³⁹ Indeed, several states have afforded it the status of

138. *Cleveland, Columbus & Cincinnati R.R. Co. v. Terry*, 8 Ohio St. 570, 582 (1858). See also *supra* note 25 and accompanying text.

139. See *supra* note 135.

statutory codification.¹⁴⁰ One can readily document that it was error for American common law¹⁴¹ ever to have announced the locality rule and the professional custom standard, but in the absence of legislative intervention, one can give no assurance that the error will ever be undone.

V. THE MISSING OPINION

A. Patient v. A. Doctor (State Supreme Court, 1900)

Per Curiam,

Plaintiff brought an action alleging defendant physician's improper treatment of a fractured bone. At the close of trial, the court issued its charge to the jury and included this, instruction number four: "In treating his patients, a physician is obliged to have and to exercise the skill and care that would ordinarily be exercised by a physician in his community in the treatment of a similar case."

The jury returned a verdict for defendant and plaintiff appealed, citing as error the issuance of the fourth charge quoted above. The appeal affords us the opportunity to clarify certain matters related to medical malpractice and to lay solid premises on which our courts may treat this subject in the new century.

Through its evolving common law over these last hundred years our nation has committed itself to this belief: In diverse contexts, each citizen must show others such care and prudence as would be exercised by any ordinary and reasonable person operating under like circumstances. The

140. See, e.g., N.C. GEN. STAT. §90-21.12 (1975):

In any action for damages for personal injury or death arising out of the furnishing or the failure to furnish professional services in the performance of medical, dental, or other health care, the defendant shall not be liable for the payment of damages unless the trier of the facts is satisfied by the greater weight of the evidence that the care of such health care provider was not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged act giving rise to the cause of action.

See also ALA. CODE § 6-5-484 (1975); ARIZ. REV. STAT. ANN. § 12-563 (1982); ARK. CODE ANN. § 34-2614 (Michie 1985); IDAHO CODE § 6-1012 (1976); TENN. CODE ANN. § 29-26-115 (1980); WASH. REV. CODE § 7.70.040 (1975).

141. The English common law never developed anything akin to the locality rule and that is sometimes noted as a matter of "interest." See Katherine R. Bowden, Comment, *Standard of Care For Medical Practitioners-Abandonment of the Locality Rule*, 60 KY. L.J. 209, 210 (1971) (citing NATHAN, MEDICAL NEGLIGENCE 21 (1957)). The fact that England never developed a locality rule should be no surprise, because English courts did not fall prey to misconception and follow by articulating a "rule" that had no genuine niche to fill.

social progress thus achieved underlies the tort we now call negligence. History indicates that this cause of action is new only for its name and that it was for centuries clothed in a costume called trespass on the case. It further shows that the medieval doctrine concerning the "common callings," (meaning skilled professions), was probably its first expression.

It is true that early decisions often related the professional's duty to a contractual term "implied by law," but that was a fiction. Our forebears were steeped in formalism and could not see clear to impose a duty of due care on any person except through a legal device already in existence. Hence, the rule of common callings was related, ostensibly, to a contract implied by law. (If we, today, felt similarly bound by form we might have it that modern liability for negligence also arises from a "contract implied by law." We would then conceive that the terms call for reasonable behavior by all the contracting parties and that the parties are all persons everywhere.) Fortunately we are beyond the need of such fanciful constructions. The obligation of due care that each of us owes all others is a legal duty, plain and simple, and we do not attribute it to some imaginary contract.

It behooves the law to integrate modern insight and language with its historical foundations. Looking to the past and future, courts must cut away stray threads and loose ends so not to plague posterity with a legacy of disparate doctrines all of which, when scrutinized, stand for a single principle. With reference to medicine, we have lately heard the common law mumble of a "professional custom standard" and a "locality rule," whereby physicians are bound to give such performance as would be given by a competent colleague in their own community. We think these budding doctrines reflect serious misconception and we wish to arrest them before they flower. To fail in this obligation is to burden our heirs with the inconsistencies and injustices that invariably follow careless expression and laziness of thought.

Let us therefore, be clear: The practicing professional is first and foremost a person engaged in an activity. As such he is bound by that same duty of ordinary care as binds any person pursuing any activity. The professional is to make such judgments and show such behavior as would a reasonable person operating under like circumstances. His duty is no different from that of a cook, a candlemaker, a carpenter or a coachman. The physician is to ponder, reflect, consider, judge, and act--as would a reasonable person working under like circumstances.

Now, shall we consider, specifically, the circumstances in which a practicing physician normally finds himself. The physician attends to his patient's health and, as a reasonable person, should know that special training is available to assist him in that pursuit. Indeed, as a reasonable person he would surely undertake that training before even beginning to practice, just as a reasonable coachman opens his eyes before beginning to drive. Moreover, during the course of his practice a reasonable physician would regularly pursue some additional training, formal or informal, in order to maintain currency in his field, just as a reasonable

coachman would keep his eyes open throughout his journey.

How much training does a reasonable person pursue before beginning to practice medicine and how much training does he pursue thereafter? The answer is that he does what is reasonable under the circumstances. Before beginning to practice, he follows a course of study offered by an established institution, since these are available. If he is reasonably diligent, then to a fair and average extent he masters what is taught. Thereafter, he continues to learn to a degree, as always, that is reasonable under the circumstances in which he practices.

Locality

In that last respect, one such circumstance pertains to the place in which the doctor practices, since access to continued learning differs from one locality to the next. Some of the learning that is reasonably within reach in the center of New York Island may not be so readily available in a rural Kentucky community. But let us here be very clear and careful. The standard that governs the rural physician is precisely the same as that which binds his urban colleague: Both are bound to behave reasonably under the prevailing circumstances. Yet a diligent and dutiful rural physician would not normally know what is known by a dutiful and diligent physician in an urban community; his circumstance is different—different because he does not happen to have the same resources of education at his disposal. By analogy, the competent coachman driving at night will not see all that is seen by a competent coachman driving in daylight. Both must behave reasonably and keep their eyes open, but what they see and what they know will differ, because they labor under different conditions.

The night coachman and the rural physician are alike in that their circumstances limit their access to information. Yet in respect of coachmen the common law does not articulate a “night-driver rule.” The law does not explicitly provide that “a coachman is bound to give such performance as would be given by a competent coachman traveling at the same hour.” It does not, in other words, take one of the many circumstances that might affect the reasonableness of a driver’s conduct and from it fashion a special “rule.” Nor should the law take so inappropriate an action in the case of the physician. There is no need of or sense to a specially articulated “locality rule.” Locality is no more and no less than a circumstance that naturally affects the reasonableness of a physician’s knowledge and skill.

If, as some envision, we should someday have cross country telephone connections, high-speed horseless carriages, and ships that sail by air, locality will not to so significant an extent be a circumstance that affects the reasonable physician’s access to training. For if such inventions should ever come to pass (not, of course, in this twentieth century, but in the twenty-second or twenty-third), the country doctor from the Arizona territory might speak by wire with other physicians

from around the union or travel to confer with New York-based colleagues in two days time.

Yet if the law should now be so misguided as to name a thing called a locality rule, that rule will surely develop an identity and momentum unto itself; if and when locality is no longer a circumstance relevant to medical negligence, the courts will nonetheless honor and apply "the rule," failing to see that it never ought to have been promulgated. Its enforcement will lead to irrational and inconsistent results. There will be calls to abolish it. Scholars will question and debate its purpose. Over decades or centuries, some jurisdictions may renounce it and others may not. A rule, which ought never to have been stated, will encyst itself in the fabric of negligence law and undermine its structure.

Let us be clear then that the physician of any and every sort of community is, like anyone else, obliged to act reasonably in all facets of his work including the acquisition and maintenance of skills. Locality may today be one of many circumstances that affect his reasonableness in this regard. Some day it may not, and for the law now to suffer the creation of anything denominated a "locality rule" would be shortsighted and irresponsible.

Custom

Once possessed of the skill and knowledge with which a reasonable person in our society would equip himself before treating a patient, the physician must then apply the same in a reasonable fashion. With reference to a particular patient he must do with his expertise that which a reasonable person would do.

That is not to say that the physician should "exercise the care that other physicians normally exercise," as some courts have lately averred or that in any given case he should literally behave as other physicians would. The physician must do, simply, that which any reasonable person would do under the circumstances, and those circumstances include the fact that he is possessed of the skill and knowledge already described. Persons of reasonable judgment cut wood, light fires, and hitch horses in different ways depending on what and how much they have been taught about these enterprises. The novice will perform in one way and the expert in another. Knowledge is a circumstance, and the physician, like any other person, is bound to behave as would a reasonable person possessed of his special knowledge.

Now do we acknowledge the obvious truth that a lay jury are not possessed of the physician's specialized knowledge. It might then be asked how they are to assess the reasonableness of a physician's behavior. The answer is not complicated. It is and has always been the place of witnesses to provide juries with information. Since the jury must decide whether a physician's behavior has been reasonable it must gather from qualified witnesses the learning it needs to make that judgment.

What information does the jury need in this regard? First let us

describe that which it does not need. It does not need to know what physicians generally do in cases like the one at issue, anymore than it would need to be told whether most coachmen drive with their eyes open or closed. If a coachman should drive with his eyes closed, his liability for injuries thus caused follows not from breach of custom but from the jury's own determination that such a course of conduct is not reasonable. To evaluate a physician's conduct, jurors require information that will allow them to comprehend the decision that the defendant faced in the situation that gave rise to the alleged misfeasance. That leads us to consider the kind of information reasonable persons take into account in structuring their decisions and their behavior.

In all activities from the simplest to the most complex, the essence of reasonableness is the assessment of advantage and disadvantage. Reasonable judgment and conduct lie in the way one evaluates the likelihood of harm on one side and the potential for good on the other. A poor swimmer is surely unreasonable if in order to cool himself, he decides to dive into water that is deeper than his own height. To a reasonable person such action creates a potential for harm that far outweighs the promised benefit of physical comfort. Yet, if that same inexperienced swimmer should dive into the same water in order to attempt the rescue of a drowning child, he is not unreasonable. The good to be gained in that situation is of greater measure than the potential for harm although that potential is surely substantial. With reference to the swimmer we have just discussed, a juror may need no witness to describe the potential for harm and for good associated with the two hypothetical situations. Such understanding accompanies common experience. But in terms of activities that physicians undertake common experience does not usually serve so well. A lay person normally lacks knowledge on which to assess the possibility of damage or benefit that attends the placement of a splint in a particular location, the failure to visit a particular patient within a given time period, or the decision to perform surgery when a patient complains of abdominal ache. Hence, in a medical malpractice suit the jury requires reliable testimony regarding the likelihood of damage and benefit that attend the acts or omissions complained of as they in turn would normally be perceived by a physician of reasonable knowledge and understanding.

So it is not for the medical expert to testify that the defendant should have taken one or another action, nor is his function simply to tell the jury that the majority of physicians would have pursued a particular course of conduct. Rather the expert is to advise the jury as to the relative burdens and benefits that the reasonably well-educated physician would have perceived in connection with the action or inaction at issue. With such advice, the jury is then enabled to determine whether the defendant's judgments and behavior were reasonable. Such is the knowledge that renders the witness competent to give evidence and such is the only relevant information he has to offer. Indeed, we rule that a plaintiff in order to establish a *prima facie* case of malpractice must

present such evidence as would allow the jury correctly to imagine the defendant's position at the time of the alleged wrong and to apprehend from his perspective the risks and rewards that appertained to his conduct or decision. In many instances that will mean that an expert must be introduced as already discussed. Yet an expert would not be required if by chance the relevant risks and benefits were within the contemplation of the lay juror who has had ordinary experience of life.

Having established that medical custom is not the measure of medical malpractice, we have still to consider this question: shall evidence of professional custom be admitted, even, to the jury's hearing? We are inclined to think it should but the purpose of its admissibility must be clear. We suppose it is proper for the law to assume that in any endeavor, professional or personal, most persons behave reasonably on most occasions. With that in mind and only with that in mind, we believe that evidence of what most persons do in a particular situation is evidence of reasonableness. Medical practice is no different in this respect from any other engagement, and we therefore rule that in a medical malpractice action as in any other suit for negligence, either party may offer evidence of customary practice and such may be considered by the jury in its determination regarding the reasonableness of the defendant's actions.

VI. CONCLUSION

The imaginary opinion just presented embodies thought that might have corrected the unfortunate directions that later nineteenth century common law followed with respect to medical malpractice. Such an opinion might have restored to effectiveness the relatively crude but sound lines of logic that expressed themselves in the earlier part of the century when, in the long process of discovering the law of negligence, many courts began in their way to perceive that medical malpractice suits were negligence actions and nothing more.

To be sure, however, the opinion in "*Patient v. Doctor*" never was issued because it never was conceived. Instead the common law proceeded through the nineteenth century and into the twentieth along a bumpy and blunderous course, carrying with it the scars of failed understanding. These included the professional custom standard and the locality rule which even to this day, it seems, is inadequately understood even by courts that have criticized and abandoned it.

The jurisprudential phenomena that fostered the professional custom and locality rules gave rise to other doctrines which I will discuss in the two articles to follow.¹⁴² Definitive correction of the historical error that now burdens medical malpractice law lies in the power of the legislature. The last article in this series will propose a statute directed to that end.

142. See *supra* note 4.

