Indiana Law Review

Volume 12 1979 Number 4

Medical Malpractice: Informed Consent to the Locality Rule

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I. INTRODUCTION

Medical malpractice litigation is not a modern phenomenon.[1] In the last decade, however, it has reached what some believe to be crisis proportions.[2] A report printed in 1974 showed that malpractice claims were increasing at the rate of eight to nine percent per year.[3] Because only a small proportion of medically related injuries results in malpractice claims,[4] there is a great probability that malpractice suits will increase as patients become more aware of legal remedies.

Two legal doctrines, res ipsa loquitur and informed consent, are regarded by the medical profession as the legal foundation for the expansion in malpractice liability.[5] During the period in which these doctrines have found increasing acceptance in the courts, an older legal doctrine, the locality rule, has come under increasing attack. The purpose of this Article is to demonstrate that informed consent and the locality rule are not incompatible. The two doctrines are

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[1]*See* Landon v. Humphrey, 9 Conn. 209 (1832); Grannis v. Branden, 5 Day 260 (Conn. 1812); Cross v. Guthery, 2 Root 90 (Conn. 1794); Seare v. Prentice, 103 Eng. Rep. 376 (K.B. 1807); Slater v. Baker, 95 Eng. Rep. 860 (K.B. 1767); Hill v. Cheyndut, London Guild Hall Plea and Memoranda Rolls (Roll A. Feb. 13, 1377).

[2]*See generally* STAFF OF HOUSE COMM. ON INTERSTATE & FOREIGN COMMERCE, 94th Cong., 1st Sess., AN OVERVIEW OF MEDICAL MALPRACTICE (Comm. Print 1975). [hereinafter cited as STAFF REPORT].

[3]*Id.* at 5 (citing AM. MED. NEWS, Nov. 4, 1974).

[4]A study of 23,750 discharges from two hospitals showed that 517 patients received injuries from improper medical treatment. Only 31 malpractice claims were filed during the year in which the study was made. Since there were only 12,600 malpractice claims throughout the nation in 1970 and 30 million hospital admissions, it appears that only a small fraction of medical injuries results in malpractice claims. STAFF REPORT, *supra* note 2, at 5.

[5]*Id.* at 24-25.

founded upon similar considerations, and informed consent may be used to give new vitality to the locality rule.

II. The Locality Rule

A. Development

Due to the reluctance of judges to impose a standard on a profession which deals with matters beyond the judges' knowledge, medical custom is the standard generally used to determine negligence in medical malpractice cases.[6] This is, in effect, a reasonable man standard, in which the reasonable man is endowed with the skill and knowledge of the ordinary physician.[7] Historically,

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[6]*See* Pearson, *The Role of Custom in Medical Malpractice Cases*, 51 Ind. L.J. 528, 528 (1976) (citing J. Waltz & F. Inbau, Medical Jurisprudence 42 (1971)). *See also* McCoid, *The Care Required of Medical Practitioners*, 12 Vand. L. Rev. 549, 558-59 (1959).

[7]Helling v. Carey, 83 Wash. 2d 514, 519 P.2d 981 (1974), cast some doubt on whether custom would continue to be an element in medical malpractice claims. In that case, the Washington Supreme Court refused to consider a well-established custom of ophthalmologists not to administer glaucoma tests routinely to patients under age 40. The court stated: "The issue is whether the defendants' compliance with the standard of the profession of ophthalmology . . . should insulate them from liability under the facts in this case . . . ." *Id.* at 517, 519 P.2d at 982. The court, impressed by the fact that the test was easy to conduct, harmless, and relatively inexpensive, held that custom was not determinative of liability. *Id.* at 518, 519 P.2d at 983.

Custom should prevail as the standard used to determine negligence in medical malpractice cases. Judges and juries are unable to determine the standard, and juries are too sympathetic. *See* Morris, *Custom and Negligence*, 42 Colum. L. Rev. 1147, 1164-65 (1942). Further, since the doctor might lose his good reputation, in addition to the amount of the judgment, and since "[t]he reasonably prudent man 'test' would enable the ambulance chaser to make a law suit out of any protracted illness," custom is the preferred rule. *Id.* at 1165. It has also been urged that the physician's judgment is an art which should freely serve the patient without any interference with his "developed instinct in diagnosis and treatment." McCoid, *supra* note 6, at 608. For a summary of those that favor, oppose, or simply recognize custom as the standard, *see* King, *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 Vand. L. Rev. 1213, 1245 n.128 (1975).

Helling, it has been predicted, will not be followed. *See* Pearson, *supra* note 6, at 534. This prediction is, thus far, an accurate one. The commentary on *Helling* has been extremely negative. *See, e.g.*, Curran, *Glaucoma and Streptococcal Pharyngitis: Diagnostic Practices and Malpractice Liability*, 291 New England J. Med. 508 (1974); 28 Vand. L. Rev. 441 (1975). There is, however, some support for *Helling*. *See, e.g.*, Dusinberre, *Diagnostic Screening and Malpractice*, 292 New England J. Med. 597 (1975); Note, *Comparative Approaches to Liability for Medical Maloccurrences*, 84 Yale L.J. 1141 (1975).

The courts have largely ignored the *Helling* decision. Only one case outside the state of Washington has cited *Helling*. In Barton v. Owen, 71 Cal. App. 3d 484, 139 Cal. Rptr. 494 (1977), the plaintiff alleged that the doctors' failure to timely perform a culture and sensitivity test, to take x-rays, to provide antibiotics, and to drain the infection constituted negligence. The court noted that situations can arise wherein common knowledge shows that a physician was negligent. *Id.* at 494, 139 Cal. Rptr. at 499.

the conflict in applying the standard has been in determining the test for the skill and care of the ordinary physician.

In the United States, the locality rule has traditionally resolved the conflict by formulating the test in terms of the skill and care of the average physician in the community or in communities similar to the one in which the physician practices. This rule was unknown to the common law of England.[8] Indeed, it was not introduced in the United States until the latter part of the nineteenth century.[9] Early cases in the United States did not consider locality in determining the standard of skill and care.[10] Prior to the development of the locality rule, the American standard was formulated as follows: "A physician or surgeon is only responsible for ordinary care and skill, and for the exercise of his best judgment in matters of doubt. He is not accountable for a want of the highest degree of skill."[11] The rule was much the same in England:

> If a Physician . . . undertakes the cure of any wound or disease, and by neglect or ignorance the party is not cured . . . such medical attendant is liable to damages in an action of trespass on the case: but the person must be a *common Surgeon*, or one who makes public profession of such business, . . . for otherwise it was the plaintiff's own folly to trust to an unskilful person, unless such person *expressly* undertook the cure, and then the action may be maintained against him also.

However, no cases were cited where the well-established custom of physicians was held to be negligent as a matter of common knowledge. Thus, to the extent that *Helling* held that a medical custom could be negligent as a matter of law, it can be distinguished from *Barton*.

Even the Washington appellate courts have noted that *Helling* was to be limited to the "unique" facts of that case. *See* Swanson v. Brigham, 18 Wash. App. 647, 651, 571 P.2d 217, 219 (1977); Meeks v. Marx, 15 Wash. App. 571, 577, 550 P.2d 1158, 1162 (1976). Further, a recent case stated that the *Helling* rule was abolished by statute. Gates v. Jensen, 579 P.2d 374, 376 (Wash. App. 1978).

Thus, the *Helling* rule does not appear to have any continuing vitality. This discussion will, consequently, assume that proof of custom is an essential element of a medical malpractice action.

[8]H. NATHAN, MEDICAL NEGLIGENCE 21 (1957).

[9]*See* Siirila v. Barrios, 398 Mich. 576, 248 N.W.2d 171 (1976); Shier v. Freedman, 58 Wis. 2d 269, 206 N.W.2d 166 (1973); McCoid, *supra* note 6, at 569; Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 51, 66 n.41 (1977); Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DE PAUL L. REV. 408, 410 (1968); Comment, *Standard of Care for Medical Practitioners—Abandonment of the Locality Rule*, 60 KY. L.J. 209, 210 (1971).

[10]Meisel, *supra* note 9, at 66 n.41 (citing McCandless v. McWha, 22 Pa. 261 (1853)).

[11]Simonds v. Henry, 39 Me. 155 (1855). *See* F. WHARTON & M. STILLE, TREATISE ON MEDICAL JURISPRUDENCE § 1273 (2d ed. 1860) (citing Leighton v. Sargent, 27 N.H. 460 (1853)).

> "And it seems that any deviation from the established mode of practice, shall be deemed sufficient to charge the Surgeon . . . ."[12]

Although these early cases did not expressly include the locality rule, they did not exclude it.[13] At most, they were silent on the issue of which geographic areas one should consider to determine the relevant standard. Implicit in the American rule and explicit in the English rule, however, was the concept that consent to the degree of skill affects the standard to be applied. In other words, a patient could expressly consent to a standard lower than the ordinary standard established by the profession.

Early American decisions illustrate the patient's right to choose the standard to be applied in the formation of his contract for treatment. If the standard established by the contract was not met, an action would sound in tort. In *McCandless v. McWha*,[14] the plaintiff alleged that the physician's improper treatment of a broken leg caused one leg to become shorter than the other. The Pennsylvania Supreme Court stated:

> We have stated the rule to be reasonable skill and diligence; by which we mean such as thoroughly educated surgeons ordinarily employ. If more than this is expected, it must be expressly stipulated for; but this much every patient has a right to demand in virtue of the *implied contract* which results from intrusting his case to a person holding himself out to the world as qualified to practice this important profession.[15]

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[12]J. PARIS & J. FONBLANQUE, 1 MEDICAL JURISPRUDENCE 80 (1823) (citations omitted).

[13]One author stated that if the locality rule had been suggested in England, it probably would have been rejected. H. NATHAN, *supra* note 8, at 21. In a compact country like England, however, it is easier to establish a national standard than in the United States. Fleming, *Developments in the English Law of Medical Liability*, 12 VAND. L. REV. 633, 641 (1959). "[I]t is nonetheless significant that the American practice has been equally rejected in the Dominions where social conditions bear a strong resemblance to those prevailing in the United States." *Id.* (footnotes omitted).

[14]22 Pa. 261 (1853).

[15]*Id.* at 268 (emphasis added). In Smothers v. Hanks, 34 Iowa 286, 290 (1872), the court noted: "The case of McCandless v. McWha . . . is so often cited . . . that we deem it proper to give it here a somewhat extended analysis." The Iowa Supreme Court found certain inconsistencies in the *McWha* opinion that relate to the standard of care, but the holding in the case that an implied contract is the basis of the standard of care was not questioned. The *Smothers* court noted that *McWha*, at times, appeared to require the skill and care of the ordinary physician, but, at other times, appeared to require the skill and care of thoroughly educated physicians. *Smothers* concluded that ordinary care was the correct standard. *Id.* at 292.

This court would require a person who holds himself out as a physician to possess the skill of an ordinary physician. The reason for this minimum standard was the implied contract resulting from the undertaking to cure. Thus, the foundation for the requirement of ordinary skill is found in the law of contract, not tort. Just as a person who contracts to deliver a cow cannot fulfill the contract by delivering a pig, so, the courts determined, a party who contracts to deliver the skills of a physician cannot fulfill the contract by delivering the skills of a layman. Absent any express stipulations, a certain level of competence became an implied term of the contract.

Although the locality rule was not discussed in early cases, the rule is consistent with the decisions which held that an implied contract controlled the standard of care. If the standard of care is based on consent to a specific level of competence in a geographic area, it is logical to hold that the parties intended the standard of care in their implied contract to be the one prevailing in the locality in which the contract was formed. As will be seen, later courts have so held, although they appear to have reached this result because of the unfairness to the physician in holding otherwise. By implication, these courts reasoned that it would be unfair to hold a physician to a higher standard than that to which the parties had impliedly consented.

In *Heath v. Glisan*,[16] the plaintiff's injured elbow was permanently dislocated because of the defendant's negligence. The court stated:

> "A physician or surgeon is only responsible for ordinary care and skill, and for the exercise of his best judgment . . . ."
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> . . . .
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> By ordinary skill, is meant such degree of skill as is commonly possessed by men engaged in the same profession.
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> . . . .
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> In determining whether the defendants possess ordinary professional skill, it is proper to consider the evidence in regard to their education, the time, and greater or less extent of their practice and experience in the profession, as well as other evidence touching the question.[17]

Presumably, it would have been permissible to show that the defendant's skill was affected by the locality in which he practiced. At the time of *Heath*, the courts were still developing the test for ordinary care. If the court found that the physician's skill was affected by the

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[16] 3 Or. 64 (1869).

[17] *Id.* at 65-67 (quoting F. WHARTON & M. STILLE, MEDICAL JURISPRUDENCE § 1273 (2d ed. 1860) (emphasis added)). *See also* Boydson v. Giltner, 3 Or. 118 (1869).

community in which he practiced, it would have been a simple step to then hold that the test of ordinary skill was determined by the standard in a particular community.[18]

The step was taken in *Smothers v. Hanks*,[19] one of the earliest cases to announce the locality rule as the test for ordinary skill and care: "It 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."[20] As support for this holding, the court cited, among other cases, *Howard v. Grover*,[21] and *Simonds v. Henry*.[22] In *Howard*, the court had merely said: "[T]he defendant is not liable for a want of the highest degree of skill, but for ordinary skill,"[23] and the *Simonds* court had stated: "[Physicians] are held responsible for injuries resulting from a want of ordinary care and skill."[24] Thus, the locality rule evolved from the general rule of ordinary skill and care. The patient consented to the ordinary skill and care that the physician had impliedly agreed to provide. Whether this standard was met would be determined by the standard in the community in which the physician practiced.[25]

Originally, courts applied the "same locality rule." *Tefft v. Wilcox*[26] appears to be the first express application of this rule in the United States. The court stated:

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[18]For other early cases, see Ritchey v. West, 23 Ill. 329 (1860); Long v. Morrison, 14 Ind. 495 (1860). The court in *Ritchey* stated: "[H]e must . . . be held to employ a reasonable amount of care and skill. . . . [H]e must possess and exercise that degree of skill which is ordinarily possessed by members of the profession. . . . This the law implies . . . ; but when the services are rendered as a gratuity, gross negligence will alone create liability." 23 Ill. at 330. *Cf.* McNevins v. Lowe, 40 Ill. 209 (1866) (holding that fees do not bear on the standard of skill and care required); Patten v. Wiggen, 51 Me. 594 (1862) (malpractice asserted as defense to physician's claim for fees).

Professor McCoid has pointed out:

> These decisions, of course, antedated any fully developed theory of negligence as a separate basis for action. Although more recent decisions have not entirely abandoned the view that the physician-patient relation is a contractual one to which certain implied undertakings attach, the emphasis today is far less on contract and far more upon the law of negligence as a basis of liability.

McCoid, *supra* note 6, at 551.

[19]34 Iowa 286 (1872).

[20]*Id.* at 289-90.

[21]28 Me. 97 (1848) (cited in 34 Iowa 286, 290).

[22]39 Me. 155 (1855) (cited in 34 Iowa 286, 290).

[23]28 Me. at 101.

[24]39 Me. at 157.

[25]*See* notes 14-16 *supra* and accompanying text.

[26]6 Kan. 46 (1870).

"There are many neighborhoods, in the west especially, where medical aid is of difficult attainment. Yet cases of disease and surgery are constantly occurring, and they must of necessity fall into the hands of those who have given to the subject but little if any thought. Thus, the inexperienced and the unlearned attend to the surgery in their way, or it is not attended to at all. . . . *In such cases no more can be expected* of the operator than the exercise of his best skill and judgment. In large towns and cities, are always found surgeons and physicians of the greatest degree of skill and knowledge. They are to be held to a corresponding high degree of responsibility. . . . In the smaller towns and country, those who practice medicine and surgery, though often possessing a thorough theoretical knowledge of the highest elements of the profession do not enjoy so great opportunities of daily observation and practical operations, where the elementary studies are brought into every day use, as those have who reside in the metropolitan towns, and though just as well informed in the elements and literature of their profession, they should not be expected to exercise that high degree of skill and practical knowledge possessed by those having greater facilities for performing and witnessing operations, and who are, or may be constantly observing the various accidents and forms of disease. It will not therefore, as a general thing, require so high a degree of knowledge to bring this class of physicians up to the rule of ordinary knowledge and skill as in places where greater facilities are afforded by which higher professional knowledge is attainable."[27]

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[27] *Id.* at 63-64 (quoting J. ELWELL, A MEDICO-LEGAL TREATISE ON MALPRACTICE AND MEDICAL EVIDENCE 22-23 (1866) (emphasis added)). The court did not accurately quote Elwell, although the quotation was substantially correct. The material referred to in Elwell reads:

> It may, at times, be difficult to determine just what the "ordinary degree of skill," as used by law writers, amounts to. It may vary in the same State or country. There are many neighborhoods, in the West especially, where medical aid is of difficult attainment; yet cases of disease and surgery are constantly occurring, and they must, of necessity, fall into the hands of those who have given to the subject but little, if any thought. Thus the inexperienced and the unlearned attend to the surgery in their way, or it is not attended to at all. In such a case, and under such circumstances, and for these reasons, the ordinary degree of skill required by law would be good common sense, or such knowledge as the operator had, joined with a good purpose to help the afflicted, even if such interference rendered the patient a cripple for life. This is the law in both England and this country. Even in England, it was said by Hullock, in the case of Van Butchell, that "many persons would be left to die if irregular surgeons were not allowed to practice."

Without question, this court would permit implied consent to a relatively low standard of care. The reason for the lower standard, whether for lack of talent, learning, or experience, seemed to be immaterial. The court noted that the basis for liability was in contract: "[The physician] is never considered as warranting a cure, unless under a special contract for that purpose; but his contract, as implied in law, is, that he possesses that reasonable degree of learning, skill and experience, which is ordinarily possessed by others of his profession . . . ."[28] Thus, the first case to expressly adopt the locality rule formulated the test for ordinary care by the law of contracts. The expectations of the patient which resulted in the legal standard of care to be applied were derived from the patient's implied consent to the standard of care in that locality.

Under the same locality rule, the standard of care in any community other than the one in which the physician practiced was immaterial.[29] If only one physician practiced in the community, he set the standard of care. If a patient was forced to agree to a lower standard because other physicians were not available, his agreement could not be truly voluntary; yet, judges implied consent out of a sense of fairness to both parties. Since the implied standard of care

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> In these cases, no more, of course, should be expected of the operator than the exercise of his best skill and judgment, however limited that might be.
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> In large cities and towns, are always found surgeons and physicians of the greatest degree of skill and knowledge. Their pretentions are properly large. They are to be held to a corresponding high degree of responsibility. They contract to do more than the ordinary physician, and they are paid a higher price for what they do; consequently the contract is more difficult to fulfill.
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> In the smaller towns and country, those who practice medicine and surgery, though often possessing a thorough theoretical knowledge of the highest elements of the profession, do not enjoy so great opportunities of daily observation, and practical operations; where the elementary studies are brought into every day use; as those have who reside in the metropolitan towns; and though just as well informed in the elements and literature of their profession, they should not be expected to exercise that high degree of skill and practical knowledge possessed by those having greater facilities for performing and witnessing operations, and who are, or may be, constantly observing the various accidents and forms of disease.
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> It will not, therefore, as a general thing, require so high a degree of knowledge to bring this class of physicians up to the rule of ordinary knowledge and skill, as in places where greater facilities are afforded, by which higher professional knowledge is attainable.

J. ELWELL, *supra*, at 22-23 (footnotes omitted).

[28]6 Kan. at 61-62 (citing Simonds v. Henry, 39 Me. 155 (1855); Howard v. Grover, 28 Me. 97 (1848); Leighton v. Sargent, 27 N.H. 460 (1853)).

[29]For other early cases with a "same locality rule," see Force v. Gregory, 63 Conn. 167, 27 A. 1116 (1893); Smothers v. Hanks, 34 Iowa 286 (1872); Hathorn v. Richmond, 48 Vt. 557 (1876); Gates v. Fleischer, 67 Wis. 504, 30 N.W. 674 (1886).

for rural doctors was lower than the standard for urban doctors, it was assumed that a rural doctor and patient had impliedly agreed to the patently lower standard. The standard of care is no longer patently lower in rural areas.[30] Absent informed consent to inferior medical care, courts can no longer reasonably imply consent to achieve a fair result.

The same locality rule was formulated during a time when application of the standard of ordinary care was still in its incipient stage. This rigid standard was never applied or was soon abandoned in many jurisdictions. Instead, the "similar locality rule" was adopted.[31] The basic flaw in the same locality rule which led to adoption of the similar locality rule was analyzed by the Michigan Supreme Court in *Pelky v. Palmer*:[32]

> We may reasonably take judicial notice that a surgeon's skill depends somewhat upon his experience and opportunity for witnessing operations, and *it is to be expected* that the degrees of surgical skill met with in different localities will be affected by these things. While a man with no skill, or inconsiderable skill, should not shelter himself behind the claim that he was the only practitioner in his neighborhood, and therefore that he was possessed of the ordinary skill required, although shown to possess less than the ordinary skill to be met with in such localities, or, as the books sometimes say, in the general neighborhood, it is true that the character of the locality has an important bearing upon the degree requisite.[33]

Abandonment of the same locality rule is similar to voiding an unconscionable clause in a contract.[34] It would not be good public policy to permit any one professional to set unilaterally the standard to be applied to his practice. *Pelky* makes it clear that the purpose of the locality rule is not to insulate physicians from liability, but to set a

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[30]*See* text accompanying notes 56-57, & 132-35 *infra*.

[31]*See* Whitesell v. Hill, 101 Iowa 629, 70 N.W. 750 (1897); Burk v. Foster, 114 Ky. 20, 69 S.W. 1096 (1902); Pelky v. Palmer, 109 Mich. 561, 67 N.W. 561 (1896); McCracken v. Smathers, 122 N.C. 799, 29 S.E. 354 (1898); McBride v. Huckins, 76 N.H. 206, 81 A. 528 (1911); Mutschman v. Petry, 46 Ohio App. 525, 189 N.E. 658 (1933); Bigney v. Fisher, 26 R.I. 402, 59 A. 72 (1904); RESTATEMENT (SECOND) OF TORTS § 299A (1965).

[32]109 Mich. 561, 67 N.W. 561 (1896). *See also* W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 32, at 164 (4th ed. 1971); McCoid, *supra* note 6, at 570; Meisel, *supra* note 9, at 66 n.41; Waltz, *supra* note 9, at 411; Comment, *Standard of Care for Medical Practitioners—Abandonment of the Locality Rule*, *supra* note 9, at 210.

[33]109 Mich. at 563, 67 N.W. at 561 (emphasis added).

[34]The purpose of the doctrine of unconscionability is to prevent oppression and unfair surprise. *See* U.C.C. § 2-302 (1972); J. CALAMARI & P. PERILLO, THE LAW OF CONTRACTS § 9-40 (2d ed. 1977).

fair test for ordinary skill and care. A specific community is not so unique that similar communities cannot be found and utilized to determine the appropriate standard. Assuming, then, that similar communities can be found, the purpose of the locality rule can be fulfilled: a fair test will be applied to determine ordinary skill and care.[35]

Despite the reasons for the similar locality rule, it has come under increasing attack by the commentators, and some have predicted its eventual demise.[36] Many courts are questioning the locality rule as never before. Consequently, it is nearly impossible to be certain of the rule in some jurisdictions. Lower courts have sometimes moved away from the locality rule before the highest court of the state. The rules announced by a few courts are so vague or inconsistent that one cannot be sure of the test for ordinary skill and care. Finally, in some jurisdictions the courts have not considered the specific issue for quite some time. Nevertheless, several courts appear to hold that locality is only a factor in determining the standard of ordinary skill and care.[37] Most courts, however, appear to apply the similar locality rule,[38] while a few still seem to ap-

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[35]*See* notes 14-16 *supra* and accompanying text. A related problem is the competency of expert witnesses to testify. *See* Annot., 37 A.L.R.3d 420 (1971).

[36]*See* Pearson, *supra* note 6, at 539-40; Waltz, *supra* note 9, at 415. *See generally* Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729 (1970).

[37]*See* Priest v. Lindig, 583 P.2d 173 (Alaska 1978); Landeros v. Flood, 17 Cal. 3d 399, 551 P.2d 389, 131 Cal. Rptr. 69 (1976); Kenney v. Piedmont Hosp., 136 Ga. App. 660, 222 S.E.2d 162 (1975) (construing GA. CODE § 84-924 (1970)); Burrows v. Hawaiian Trust Co., 49 Haw. 351, 417 P.2d 816 (1966); Perin v. Hayne, 210 N.W.2d 609 (Iowa 1973) (citing McGulpin v. Bessmer, 241 Iowa 1119, 43 N.W.2d 121 (1950)); Seaton v. Rosenberg, 573 S.W.2d 333 (Ky. 1978) (citing Blair v. Eblen, 461 S.W.2d 370 (Ky. Ct. App. 1970)); Crosby v. Grandview Nursing Home, 290 A.2d 375 (Me. 1972); Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 349 A.2d 245 (1975); Brune v. Belinkoff, 354 Mass. 102, 235 N.E.2d 793 (1968); Germann v. Matriss, 55 N.J. 193, 260 A.2d 825 (1970); Faulkner v. Pezeshki, 44 Ohio App. 2d 186, 337 N.E.2d 158 (1975) (quoting Ault v. Hall, 119 Ohio St. 422, 164 N.E. 518 (1928)); Pederson v. Dumouchel, 72 Wash. 2d 73, 431 P.2d 973 (1967); Trogun v. Fruchtman, 58 Wis. 2d 569, 207 N.W.2d 297 (1973).

[38]*See* Harvey v. Kellin, 115 Ariz. 496, 566 P.2d 297 (1977); White v. Mitchell, 568 S.W.2d 216 (Ark. 1978); Murphy v. Dyer, 409 F.2d 747 (10th Cir. 1969) (applying Colorado law); Fitzmaurice v. Flynn, 167 Conn. 609, 356 A.2d 887 (1975); Harris v. Cafritz Mem. Hosp., 364 A.2d 135 (D.C. 1976) (citing Quick v. Thurston, 290 F.2d 360 (D.C. Cir. 1961)); Schwab v. Tolley, 345 So. 2d 747 (Fla. Dist. Ct. App. 1977); Kingston v. McGrath, 232 F.2d 495 (9th Cir. 1956) (applying Idaho law); Borowski v. Van Solbrig, 14 Ill. App. 3d 672, 303 N.E.2d 146 (1973), *aff'd*, 60 Ill. 2d 418, 328 N.E.2d 301 (1975); Joy v. Chau, 377 N.E.2d 670 (Ind. Ct. App. 1978) (citing Worster v. Caylor, 231 Ind. 625, 110 N.E.2d 337 (1953)); Webb v. Lungstrum, 223 Kan. 487, 575 P.2d 22 (1978); Siirila v. Barrios, 398 Mich. 576, 248 N.W.2d 171 (1976); Harris v. Bales, 459 S.W.2d 742 (Mo. Ct. App. 1970); Tallbull v. Whitney, 564 P.2d 162 (Mont. 1977); Kortus v. Jensen, 195 Neb. 261, 237 N.W.2d 845 (1976); Carrigan v. Roman Catholic Bishop, 104 N.H. 73, 178 A.2d 502 (1962); Wiggins v. Piver, 276 N.C. 134, 171 S.E.2d 393 (1970); Benzmiller

ply the same locality rule.[39]

The trend towards abandonment of the locality rule is regrettable. The reasons given for application of a different test for ordinary skill and care are not convincing. The locality rule has been criticized because:

> (1) It may effectively immunize from liability any doctor who happens to be the sole practitioner in his community. . . . (2) The practitioners in a community are able to establish the standard of care which could, perhaps, be an inferior one; (3) A "conspiracy of silence" in the plaintiff's locality could effectively preclude any possibility of obtaining expert medical testimony.[40]

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v. Swanson, 117 N.W.2d 281 (N.D. 1962); Runyon v. Reid, 510 P.2d 943 (Okla. 1973); Eckleberry v. Kaiser Foundation N. Hosps., 226 Or. 616, 359 P.2d 1090 (1961); United States *ex rel.* Fear v. Rundle, 506 F.2d 331 (3d Cir. 1974) (applying Pennsylvania law); Schenck v. Roger Williams Gen. Hosp., 382 A.2d 514 (R.I. 1977); Steeves v. United States, 294 F. Supp. 446 (D.S.C. 1968) (applying South Carolina law); Methodist Hosp. v. Ball, 50 Tenn. App. 460, 362 S.W.2d 475 (1961); Sebree v. United States, 567 F.2d 292 (5th Cir. 1978) (applying Texas law); Swan v. Lamb, 584 P.2d 814 (Utah 1978); Bly v. Rhoads, 216 Va. 645, 222 S.E.2d 783 (1976); Schroeder v. Adkins, 149 W. Va. 400, 141 S.E.2d 352 (1965); Govin v. Hunter, 374 P.2d 421 (Wyo. 1962) (citing Phifer v. Baker, 34 Wyo. 415, 244 P. 637 (1926)).

It is important to note that some define "locality" in a "medical sense" and others define it in a "geographical sense." P. Keeton, *Medical Negligence—The Standard of Care*, 10 TEX. TECH L. REV. 351, 361 (1979). The geographical sense would seem better, for any other definition would lead to unpredictable and unjustifiable results. The locality rule was first defined in a geographical sense, and the reasons for that definition remain.

It is also important to note that some opinions purporting to follow the locality rule have extended the area which they define as "same or similar." *See, e.g.*, Gist v. French, 136 Cal. App. 2d 247, 271, 288 P.2d 1003, 1018 (1955) ("'[C]ommunity' means . . . such an area as is governed by the same laws, and the people are unified by the same sovereignty and customs."); Fitzmaurice v. Flynn, 167 Conn. 609, 617, 356 A.2d 887, 892 (1975) (the state of Connecticut); Flock v. J.C. Palumbo Fruit Co., 63 Idaho 220, 238, 118 P.2d 707, 715 (1941) ("centers readily accessible"); Tvedt v. Haugen, 70 N.D. 338, 349, 294 N.W. 183, 188 (1940) (points easily accessible). These holdings are actually a back-door method of abandoning the locality rule, although they are still more fair to the physician than a national standard.

[39]*See* Parrish v. Spink, 284 Ala. 263, 224 So. 2d 621 (1969); Loftus v. Hayden, 379 A.2d 1136 (Del. Super. Ct. 1977); Ardoin v. Hartford Accident & Indem. Co., 360 So. 2d 1331 (La. 1978) (construing LA. REV. STAT. ANN. § 9:2794 (West Supp. 1979)); Hill v. Stewart, 209 So. 2d 809 (Miss. 1968); Lockart v. Maclean, 77 Nev. 210, 361 P.2d 670 (1961); Gandara v. Wilson, 85 N.M. 161, 509 P.2d 1356 (1973); Spadaccini v. Dolan, 63 App. Div. 2d 110, 407 N.Y.S.2d 840 (1978); Hansen v. Isaak, 70 S.D. 529, 19 N.W.2d 521 (1945); Pepin v. Averill, 113 Vt. 212, 32 A.2d 665 (1943).

[40]Ardoin v. Hartford Accident & Indem. Co., 360 So. 2d 1331, 1337 (La. 1978) (citations omitted). *See also* Comment, *Standard of Care for Medical Practitioners—Abandonment of the Locality Rule*, *supra* note 9, at 210.

The first criticism is clearly not true if the similar locality rule is applied. The third criticism is also unjustified. It is difficult to believe that physicians in all similar communities would conspire in refusing to testify. Of the three, the second criticism is the most legitimate, although it too is insufficient. Conceivably, similar communities could all rely on the locality rule and establish a lower standard of care, but a conspiracy of this type is extremely improbable. The more reasonable assumption is that physicians in similar communities will independently establish the best standard they are capable of producing.

Another criticism of the locality rule is that the purpose for the rule is no longer present. It will be recalled that the purpose of the locality rule was to provide a fair test for the ordinary standard of care. A test based on a similar locality was fair because the ability of a physician appeared to vary with the type of community, resulting in implied consent to the standard of care available.[41] The position that the purpose of the rule is no longer present is well stated in *Ardoin v. Hartford Accident & Indemnity Co.*:[42]

> Indeed, whatever may have justified a locality rule for physicians fifty or a hundred years ago cannot be reconciled with the actualities of medical practice today. The quality of medical training has improved dramatically. With modern transportation and communication systems, new techniques and discoveries are available to all doctors within a short period of time through seminars, medical journals, closed circuit television presentations, special radio networks for doctors, tape recorded digests of medical literature, and current correspondence courses.[43]

Statements similar to that in *Ardoin* are increasinlgy frequent.[44] While the observation in *Ardoin*—that medical training and the ability to remain current in the field have improved—is accurate, it

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[41]*See* notes 19-25 *supra* and accompanying text.

[42]360 So. 2d 1331 (La. 1978).

[43]*Id.* at 1337 (citing Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 349 A.2d 245 (1975); Bruni v. Tatsumi, 46 Ohio St. 2d 127, 346 N.E.2d 673 (1976); Waltz, *supra* note 9; 25 ARK. L. REV. 169 (1971); Comment, *The Locality Rule in Medical Malpractice Suits*, 5 CALIF. W.L. REV. 124 (1968); 38 OHIO ST. L.J. 203 (1977); Comment, *Standard of Care for Medical Specialists*, 16 ST. LOUIS UNIV. L.J. 497 (1972); Comment, *Standard of Care for Medical Practitioners—The Locality Rule*, 14 S. S.D.L. REV. 349 (1969); Comment, *Recent Developments—Medical Specialists and the Locality Rule*, 14 STAN. L. REV. 884 (1962); Note, *An Evaluation of Changes in the Medical Standard of Care*, *supra* note 36).

[44]One commentator stated: "There is no longer any reason why a small-town physician cannot practice at the level of competence of his urban counterpart." A. HOLDER, MEDICAL MALPRACTICE LAW 59 (2d ed. 1978).

is an incomplete analysis of whether a need for the locality rule exists in society today. It will be recalled that the court in *Tefft* noted that the standard of care could vary because of the differences in communities alone. The argument in *Ardoin* only approaches the question of whether rural physicians still suffer from the inability to remain current in their field. Obviously, the quality of medical training and the ability to remain current in the field have improved; however, the locality rule is concerned with whether skill and care differ between one type of community and the next and is not concerned with whether the overall quality of medical care has improved. *Ardoin* justifiably points out that rural physicians now have greater opportunities to remain current in their field, thereby reducing the disparity in experience and training between rural and urban physicians. Even so, *Ardoin* and other cases have failed to recognize that the quality of physicians in rural and urban areas may be affected by circumstances beyond the physicians' control.

A recent article by Dr. William Kane in *The Journal of the American Medical Association*[45] surveys the problems and disadvantages which rural physicians must face. Contrary to what recent opinions appear to assume in dealing with the locality rule, Dr. Kane states: "The quality of medical services provided in rural areas is difficult to assess. We know little about the quality of care provided by physicians regardless of where they practice."[46] Perhaps, then, the courts should slow the current race to abandon the locality rule, a race precipitated by the assumption that no justifiable reason exists for a lower standard of care in rural communities. Although little is known about the quality of medical services in any area, it is clear that "[r]ural people have far fewer health care workers available to them than do people in urban areas."[47] In fact,

> [t]he most crucial and basic problem of rural health care is the distribution and availability of physicians, dentists, and other health workers in rural areas. The availability of such professionals directly affects the type of rural health facilities, the quality of care provided, the availability of preventive health services, and the nature of practice in rural areas. The problems in this area are certainly not new.[48]

Dr. Kane advances several reasons for the relatively lower number of physicians in rural areas: Loss of an informal atmosphere for

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[45]Kane, *Rural Health Care*, 240 J.A.M.A. 2647 (1978).
[46]*Id.* at 2648.
[47]*Id.* at 2647.
[48]*Id.* at 2649.

discussion with fellow physicians; limited availability of group practice; and lower economic reasons to support his "expectations for income, family and leisure time, professional contact with peers, and continuing education."[49] A lack of adequate health insurance, public or private, may account for part of the difference in financial resources between rural and urban areas.[50] The future promises no respite for rural areas:

> [T]he statistics point to a need for concern, especially when the number of incoming physicians may not be keeping pace with the physicians leaving rural areas and where the physicians in rural areas are an older age group, further removed from formal training than their more urban counterparts.[51]

Any attempt to impose a higher standard upon physicians who are responding to conditions beyond their control may exacerbate an already serious problem. An increase in the overall liability of rural physicians might further lower the standard of care—presumably the opposite effect intended by abandoning the locality rule.

Even assuming that the statement in *Ardoin* is true, what is to be gained by relaxing the rule? One author opined: "The doctors will continue to set by customary practice the standard by which they are to be judged, but any increase in geographical boundaries will improve the overall level of practice."[52] This argument appears to assume that, in fact, the standard of care varies from one area to the next. If so, then the reason for the locality rule is still present. If the goal is improvement of the overall level of practice in the United States,[53] it hardly makes sense to accomplish this goal by increasing the liability of physicians in areas where they are performing as best they can, given the circumstances.

On the other hand, what is to be lost if the similar locality rule is abandoned? If, in fact, the standard of care varies from similar types of communities to different types of communities, physicians will be judged unfairly. A physician from a metropolitan area would set the standard of care that is required in many smaller communities, even though these communities are presumably receiving the best care that the physicians are capable of providing. If there is no difference in the standard of care between large and small com-

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[49]*Id.*

[50]*Id.* at 2648.

[51]*Id.*

[52]Note, *An Evaluation of Changes in the Medical Standard of Care*, *supra* note 36, at 741.

[53]Waltz, *supra* note 9, at 420, stated: "The fall of the locality rule will exert pressure for uniformly adequate health services, a goal to which both law and medicine are surely united."

munities, and if a similar locality rule is applied, the resulting standard by which the physician is judged would be the same under a similar locality rule as under a national standard.

In summary, there is probably much to be lost and little to be gained by adopting a national or state standard. Those who favor abandonment of the similar locality rule have lost sight of the reason for the rule and how it developed. Reasonable skill and care were implied from the undertaking to treat the patient. For various reasons,[54] ordinary skill and care were determinative of reasonable skill and care. This degree of skill and care was the standard to which the patient presumably consented, and which could be altered by consent. The test for ordinary skill and care developed to be that which was available in similar communities, for the standard varied because of differing circumstances between large and small communities. To abandon the locality rule when the need for it remains, when the benefits of abandonment are few and the risks great, would be a serious error.

Although the locality rule is justified today, implied consent to the locality rule is no longer justified. Judges reasonably implied consent to the locality rule in years past, but conditions at the time warranted the implication:

> As recently as the turn of the century, a patient had less than an even chance of benefiting from an encounter with a physician. Physicians were just beginning to emerge from the era when they were essentially tradesmen, often with little more to offer their patients than comfort and company during illness and death. The principal causes of mortality were the infectious diseases against which the medical community stood impotent. There were few medical schools, few diagnostic tests, no specific treatment of disease, and no specialization of physicians.[55]

Today, conditions have changed dramatically, resulting in increased expectations by the patient:

> During the past century, however, medical progress has brought about a radical change in the doctor's ability to diagnose and treat disease. Infectious disease has all but been conquered—such chronic diseases as heart disease have become the major killers. Hospitals have replaced "pest houses," and medical education has become increasingly demanding and exact. As technology has increased the doc-

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[54]*See* note 7 *supra* and accompanying text.

[55]G. Annas & J. Healey, Jr., *The Patient Rights Advocate: Redefining the Doctor-Patient Relationship in the Hospital Context*, 27 VAND. L. REV. 243, 251 (1974) (citations omitted).

> tor's ability to deal effectively with more health-threatening situations, it has also widened the gulf between doctor and patient. More problems can be diagnosed and treated, the doctor's time is more in demand, and he has less time to spend with his patient to develop a working relationship of trust and mutual respect. As medical advances become more subtle and complex, explaining diagnoses, procedures, treatments, and alternatives to the patient becomes more difficult. Concurrently, widespread publicity—especially through television and newspaper coverage of medical breakthroughs and portrayal of medical crisis resolutions in fiction—generates greater public expectations. Though some way must be found to restore the expectations of the medical consumer to reality, there is a sense in which such expectations represent the inadequacies of the present doctor-patient and hospital-patient relationships. The doctor's position has been strengthened and the patient's weakened by technological advances; it is no longer beneficial to the patient to maintain the doctor-patient relationship of 140 or even 40 years ago. Too much has changed.[56]

In addition to changes in technology and the ability to diagnose ailments, concomitant changes occurred in the system of educating physicians:

> The "locality rule" (never recognized in England) had its origin in the very old and far away days when there were many little institutions which called themselves medical schools. Students were admitted who could show a high school diploma or furnish a certificate from a school principal that the bearer had completed the "equivalent" of a high school course of study. At the end of the course, he was given an M.D. degree. Passing the licensing board was in the nature of a formality. In many rural communities, ever thereafter the doctor was on his own. Frequent refresher courses, now generally attended, were unknown. . . .
>
> Now medical schools admit only college graduates. They are equipped to the highest point of efficiency and turn out doctors who must continue their studies by internships and by actual experience under expert supervision. They continue to study, continue to attend refresher courses, and have access to journals which afford them opportunity to keep them current in the latest treatments and procedures.[57]

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[56] *Id.* at 251-52 (citations omitted).

[57] Wiggins v. Piver, 276 N.C. 134, 139, 171 S.E.2d 393, 396 (1970).

In light of the consumer's increased expectations of medical treatment in all geographic areas and the radical change in the overall education of physicians, implied consent to the locality rule can no longer be justified. The locality rule should only be applied when the patient has given informed consent to the standard of care required by the locality rule.

B. Development in Indiana

No courts have been more consistent in applying the similar locality rule than those of Indiana. Development of the rule was similar to that in other states. From the early 1800's to about 1860, there were very few reported malpractice cases. The early rule first appeared in *Long v. Morrison.*[58] In that case the Indiana Supreme Court held that the physician "was liable for damages arising as well from the want, as from want of application, of skill."[59] The only Indiana case cited as support for this rule was *Connor v. Winton.*[60] In *Connor*, suit was brought against a veterinarian for negligent treatment of a horse. This case should stand for the proposition that the foundation for medical malpractice is the implied contract which results from the undertaking. The court stated: "When an act is done *gratis*, it is called in the books a mandate . . . . The degree of diligence required of the mandatory is equally well settled. He is bound only to slight diligence, and responsible only for gross neglect."[61] However, "[t]he general rule in relation to bailment is, that where the contract is of mutual benefit, as where the work is done for hire, there, ordinary diligence only is required."[62]

The court in *Long* interpreted *Connor* to mean that physicians and veterinarians would be held to a standard of skill and care which was implied from the undertaking. The standard of care would depend, under the holding of *Connor*, upon whether the treatment was done for payment or for free.[63] Even so, it was also said in *Connor* that "[w]hat would be simply negligent as to one thing, would be gross negligence as to another,"[64] thus requiring greater care in treating a valuable horse than a less valuable one. The court in *Long* apparently felt that a person was, of course, a very valuable "thing." Therefore, the court made no distinction between an under-

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[58]14 Ind. 595 (1860).

[59]*Id.* at 600.

[60]8 Ind. 315 (1856).

[61]*Id.* at 318.

[62]*Id.*

[63]It was decided very early in this state, unlike the common law of England, that a physician in Indiana could bring suit for fees owed to him. Judah v. M'Namce, 3 Blackf. 269 (Ind. 1833).

[64]8 Ind. at 319.

taking for hire and an undertaking for free, even though it did not expressly consider the question. This question was raised peripherally in *Peck v. Martin*,[65] a medical malpractice action in which lack of consideration was raised as a defense. The court stated: "The *duty* arising from such character and undertaking, to exercise a reasonable degree of care and skill is as apparent as if it were stated in terms."[66] One could read the case narrowly, for it was only decided that a duty arose regardless of payment. No express distinction was made, however, between the standard applied with payment and the standard without payment.

Indiana first adopted the similar locality rule as the test for the standard of skill and care in *Gramm v. Boener*:[67]

> It seems to us, that physicians or surgeons, practising in small towns, or rural or sparsely populated districts, are bound to possess and exercise at least the average degree of skill possessed and exercised by the profession in such localities generally. It will not do, as we think, to say, that if a surgeon or physician has exercised such a degree of skill as is ordinarily exercised in the particular locality in which he practises, it will be sufficient.
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> There might be but few practising in the given locality, all of whom might be quacks, ignorant pretenders to knowledge not possessed by them, and it would not do to say, that, because one possessed and exercised as much skill as the others, he could not be chargeable with the want of reasonable skill.[68]

Thus, the Indiana Supreme Court refused to adopt the *Tefft v. Wilcox*[69] standard that the proper test is determined by the same locality rule. The Indiana courts have repeatedly affirmed the ap-

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[65]17 Ind. 115 (1861).

[66]*Id.* at 117.

[67]56 Ind. 497 (1877).

[68]*Id.* at 501. As support, the court quoted from T. SHEARMAN & A. REDFIELD, LAW OF NEGLIGENCE § 436 (1869):

> The standard of skill may vary according to circumstances, and may be different even in the same state or country. In country towns, and in unsettled portions of the country remote from cities, physicians, though well informed in theory, are but seldom called upon to perform difficult operations in surgery, and do not enjoy the greater opportunities of daily observation and practice which large cities afford. It would be unreasonable to exact from one in such circumstances that high degree of skill which an extensive and constant practice in hospitals or large cities would *imply* a physician to be possessed of.

56 Ind. at 500-01 (emphasis added).

[69]6 Kan. 46 (1870). *See also* notes 26-34 *supra* and accompanying text.

plication of the similar locality rule in medical malpractice cases[70] and have even used the rule to set the standard of care for specialists.[71] In *Worster v. Caylor*,[72] the Indiana Supreme Court restated that the basis for the implied standard of care, as determined by the locality rule, is in contract:

> In the absence of a special contract, the physician or surgeon who assumes to treat and care for a patient impliedly contracts that he has the reasonable and ordinary qualifications of his profession and that he will exercise reasonable skill, diligence and care in treating the patient. . . .
>
> The degree of skill and care required of the physician or surgeon who is employed because he is a specialist, is that degree of skill and knowledge which is ordinarily possessed by physicians and surgeons who devote special attention to the ailment, its diagnosis and treatment, agreeable with the state of scientific knowledge at the time of the operation or treatment, in similar localities generally.[73]

Thus, the development of the locality rule in Indiana has, generally, paralleled the development of the rule in other states. The Indiana courts, like the courts in most other states, have continued to perceive the logic and fairness inherent in the locality rule. The similar locality rule however, may, have been altered or abolished in Indiana by statute.[74] The statute, which makes an opinion by a medical review panel a prerequisite to appeal, provides in

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[70]*See* Worster v. Caylor, 231 Ind. 625, 110 N.E.2d 337 (1953); Kelsey v. Hay, 84 Ind. 189 (1882); Joy v. Chau, 377 N.E.2d 670 (Ind. Ct. App. 1978) (although noting that the locality rule has been under increasing attack, the court concluded that any changes in the rule must come from the Indiana Supreme Court); Bassett v. Glock, 368 N.E.2d 18 (Ind. Ct. App. 1977); Adkins v. Ropp, 105 Ind. App. 331, 14 N.E.2d 727 (1938); Adolay v. Miller, 60 Ind. App. 656, 111 N.E. 313 (1916); Longfellow v. Vernon, 57 Ind. App. 611, 105 N.E. 178 (1914); Thomas v. Dabblemont, 31 Ind. App. 146, 67 N.E. 463 (1903); Baker v. Hancock, 29 Ind. App. 456, 63 N.E. 323 (1902); Smith v. Stump, 12 Ind. App. 359, 40 N.E. 279 (1895); Becknell v. Hosier, 10 Ind. App. 5, 37 N.E. 580 (1894).

In some opinions the standard which the Indiana courts applied was very general, leaving doubt whether the courts applied the similar locality rule. *See* Edwards v. Uland, 193 Ind. 376, 140 N.E. 546 (1923); Robinson v. Ferguson, 107 Ind. App. 107, 22 N.E.2d 901 (1939); McCoy v. Buck, 87 Ind. App. 433, 157 N.E. 466 (1927). These cases can, however, be read consistently with other cases which expressly apply the similar locality rule.

[71]*See* Joy v. Chau, 377 N.E.2d 670 (Ind. Ct. App. 1978). Many states no longer apply the locality rule to specialists. See cases cited in Ardoin v. Hartford Accident & Indem. Co., 360 So. 2d 1331, 1337 (La. 1978).

[72]231 Ind. 625, 110 N.E.2d 337 (1953).

[73]*Id.* at 629-30, 110 N.E.2d at 339 (citations omitted).

[74]*See* IND. CODE §§ 16-9.5-9-1 to 10 (1976 & Supp. 1978). For a discussion of the statute, see *The 1975 Medical Malpractice Act*, 51 IND. L.J. 91 (1975).

pertinent part: "All health care providers in this state, whether in the teaching profession or otherwise, who hold a license to practice in their profession, shall be available for selection as members of the medical review panel."[75] The statute also provides in pertinent part: "Any report of the expert opinion reached by the medical review panel *shall be admissible* as evidence in any action subsequently brought by the claimant in a court of law, but such expert opinion shall not be conclusive . . . ."[76]

Since members of the panel, by statute, may be from any area, and since there is no requirement that they know the standard of care and skill in the area in which the defendant physician practices, the statute does not appear to include the similar locality rule. The statute places the courts in an awkward position. One can only wonder what value the panel's report would be to the court if the similar locality rule is retained. It seems that, if the locality rule is followed, the report might be admissible, but irrelevant because it would not be material.

What, then, is the legislature attempting to accomplish? Does it intend to abrogate the similar locality rule by statute? If so, such a result would be regrettable. The Indiana courts, to date, have not considered the question.

A more reasonable interpretation of the statute would be that members of the panel must be selected consistently with the locality rule. In *Seymour National Bank v. State*,[77] the court stated: "[S]tatutes in derogation of the common law will be strictly construed; therefore, in case of doubt, we will favor a construction which is in harmony with the common law."[78] Because the statute does not expressly require members of the panel to be from both urban and rural areas, and because the statute does not mention the locality rule, the panel's report should be inadmissible if the members of the panel are not chosen in conformity with the locality rule. The party offering the panel's report as evidence in the case should have the burden of showing that the report was based on the standard of care in similar localities.

Changes in medical services in Indiana have also paralleled the changes in other states. Consequently, informed consent to the locality rule should be required before a patient can be said to have agreed to the standard of care in a similar locality.

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[75]IND. CODE § 16-9.5-9-3(b)(1) (Supp. 1978). The constitutionality of the requirement of submitting claims to the review panel has been upheld. *See* Hines v. Elkhart Gen. Hosp., 465 F. Supp. 421, 433 (N.D. Ind. 1979).

[76]IND. CODE § 16-9.5-9-9 (1976) (emphasis added).

[77]384 N.E.2d 1177 (Ind. Ct. App. 1979).

[78]*Id.* at 1186.

III. Consent—Informed and Otherwise

A. The Requirement of Consent

An individual's control over his bodily integrity would appear to be a basic right in a free society. In the context of medical treatment which is not mandated by some public necessity,[79] English courts have long recognized that a physician's authority to treat his patient must be founded upon consent.[80] As early as 1767, the court in *Slater v. Baker*[81] noted: "[I]t is reasonable that a patient should be told what is about to be done to him, that he may take courage and put himself in such a situation as to undergo the operation."[82] More than one hundred years after *Slater*,[83] American courts also held that consent was a necessary ingredient of the physician-patient relationship, but did not base their decision on English precedent.[84] In *Rolater v. Strain*,[85] the Oklahoma Supreme Court quoted with approval a statement of the basic principle underlying the need for consent before a physician may treat a patient:

> "Under a free government at least, the free citizen's first and greatest right which underlies all others—the right to the inviolability of his person, in other words, his right to himself—is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon, however

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[79]*See generally* Dunham v. Wright, 423 F.2d 940 (3d Cir. 1970) (emergency treatment); *In re* President and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir. 1964) (blood transfusion); Koury v. Follo, 272 N.C. 366, 158 S.E.2d 548 (1968) (emergency treatment); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976) (state's interest in preserving life); Gravis v. Physicians & Surgeons Hosp., 415 S.W.2d 674 (Tex. Civ. App. 1967) (emergency treatment). *See also* Riga, *Compulsory Medical Treatment of Adults*, 22 Cath. Law. 105 (1976).

[80]*See* Slater v. Baker, 95 Eng. Rep. 860 (K.B. 1767).

[81]95 Eng. Rep. 860 (K.B. 1767).

[82]*Id.* at 862. The court also found that obtaining consent was the "usage and law of surgeons." *Id.*

[83]*Slater* is, in some respects, a very modern case. The defendants, Baker and Stapleton, were employed by Slater to cure his broken leg. Therefore, it was clear that he consented to treatment. Baker, however, used an unusual, if not unknown, method in treating the leg. In the words of the court, "[i]t seems as if Mr. Baker wanted to try an experiment with this new instrument." *Id.* Liability on the part of the defendants was predicated on a lack of consent by Slater to the unusual operation. The defendants also raised the objection that the action was improperly brought as a special action upon the case, when it was properly one of trespass. Although legally correct, the defense was rejected. Compensation of victims of medical malpractice without strict adherence to procedural requirements is not a modern development.

[84]*See* Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906); Theodore v. Ellis, 141 La. 709, 75 So. 655 (1917); State v. Housekeeper, 70 Md. 162, 16 A. 382 (1889); Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905); Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914); Hunter v. Burroughs, 123 Va. 113, 96 S.E. 360 (1918).

[85]39 Okla. 572, 137 P. 96 (1913).

> skillful or eminent, who has been asked to examine, diagnose, advise and prescribe (which are at least necessary first steps in treatment and care), to violate without permission the bodily integrity of his patient by a major or capital operation, placing him under an anaesthetic for that purpose, and operating on him without his consent or knowledge."[86]

Soon after World War I, cases alleging unauthorized treatment began to occur more frequently.[87] Even where no adverse effect could be proved, recovery was permitted if the physician went beyond the consent obtained.[88] At first, American courts were willing to find valid consent even though little information concerning the treatment was provided to the patient.[89] Liability was found only when no consent had been obtained or when defendant's actions had clearly gone beyond the consent given.[90] Liability on this basis has been permitted where the patient consented to an exploratory operation and a mastectomy was performed;[91] where the patient consented to an operation with no greater risk than an electromyogram and a far more dangerous procedure was carried out;[92] and where the patient consented to an appendectomy and her fallopian tubes were removed.[93] Courts also found consent lacking when fraudulent or misleading information was provided to the patient in order to obtain his consent.[94]

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[86]*Id.* at 575, 137 P. at 97 (quoting 37 CHICAGO LEGAL NEWS 213 (1905) (discussing Pratt v. Davis, 118 Ill. App. 166 (1905)). In 1914 Justice Cardozo wrote: "Every human being of adult years and sound mind has the right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages." Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914).

[87]*See* Note, *Consent as a Prerequisite to a Surgical Operation*, 14 U. CIN. L. REV. 161 (1940).

[88]*See* Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905) (patient consented to operation on right ear; physician operated on left ear); Corn v. French, 71 Nev. 280, 289 P.2d 173 (1955) (patient consented to exploratory surgery and doctor performed a mastectomy); Rolater v. Strain, 39 Okla. 572, 137 P. 96 (1913) (patient consented to operation on express agreement no bone was to be removed; physician removed sesamoid bone).

[89]*See generally* Meisel, *supra* note 9, at 77-81.

[90]*See, e.g.*, Meek v. City of Loveland, 85 Colo. 346, 276 P. 30 (1929); Zoterell v. Rapp, 187 Mich. 319, 153 N.W. 692 (1915); Corn v. French, 71 Nev. 280, 289 P.2d 173 (1955).

[91]Corn v. French, 71 Nev. 280, 289 P.2d 173 (1955).

[92]Berkey v. Anderson, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969).

[93]Tabor v. Scobee, 254 S.W.2d 474 (Ky. 1952).

[94]"They could not, of course, compel her to submit to an operation, but if she voluntarily submitted to its performance, her consent will be presumed, *unless she was the victim of a false and fraudulent misrepresentation* . . . ." State v. Housekeeper, 70 Md. 162, 170, 16 A. 382, 384 (1889) (emphasis added). *See* Wall v. Brim, 138 F.2d 478, 479 n.7 (5th Cir. 1943); Waynick v. Reardon, 236 N.C. 116, 72 S.E.2d 4 (1952). *But see* Hunt v. Bradshaw, 242 N.C. 517, 88 S.E.2d 762 (1955).

During the 1950's, courts began to require not only that physicians obtain consent, but also that the consent be an informed one. That is to say, a physician's duty to obtain consent without affirmatively misleading a patient was metamorphosed into an affirmative duty to give information which would allow the patient to decide whether or not the cure was worth the risk.[95]

B. Informed Consent

As is the rule with other legal doctrines, the term informed consent is deceptively simple and has a meaning which changes from jurisdiction to jurisdiction.[96] Courts have disagreed over the treatment of two basic issues: (1) What cause of action is created if informed consent has not been obtained, and (2) what standard is used to determine whether the patient has been adequately informed?

Courts are divided on the question of whether a patient's cause of action for lack of informed consent is based on negligence or battery. In early cases, courts failed to distinguish between consent that was lacking or obtained by misrepresentation, and less than fully informed consent.[97] In each case, the courts found the proper claim

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[95]Slater v. Baker, 95 Eng. Rep. 860 (K.B. 1767), contained the seeds which could have grown into a requirement of informed consent. However, one of the first American decisions to speak of an affirmative duty on the part of a physician to inform his client of the risk involved in treatment was not rendered until 1955. In Hunt v. Bradshaw, 242 N.C. 517, 523, 88 S.E.2d 762, 766 (1955), the court stated: "Failure to explain the risks involved, therefore, may be considered a mistake on the part of the surgeon, but under the facts cannot be deemed such want of ordinary care as to import liability." That dictum was relied upon by the California appellate court in Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957), in creating an affirmative duty of disclosure to permit informed consent by the patient.

[96]There is a large body of legal literature on the law of consent. *See, e.g.*, Meisel, *supra* note 9; Riskin, *Informed Consent: Looking for the Action*, 1975 U. ILL. L.F. 580; Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628 (1970); Note, *Who's Afraid of Informed Consent? An Affirmative Approach to the Medical Malpractice Crisis*, 44 BROOKLYN L. REV. 241 (1978); Note, *Informed Consent Liability*, 26 DRAKE L. REV. 696 (1977); Note, *The Evolution of the Doctrine of Informed Consent*, 12 GA. L. REV. 581 (1978).

[97]Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906) (battery for removal of uterus without knowledge or consent of patient); Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905) (battery for operation on left ear when consent obtained only for operation on right ear); Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914) (battery where patient consented to examination but not to operation to remove tumor); Rolater v. Strain, 39 Okla. 572, 137 P. 96 (1913) (battery for removing bone during operation when consent given only if no bone to be removed); Slater v. Baker, 95 Eng. Rep. 860 (K.B. 1767) (patient not informed of unusual method used to treat broken leg; trespass the proper cause of action).

to be one of battery.[98] In *Natanson v. Kline*,[99] the supreme court of Kansas became the first court to hold that a physician's liability for failing to inform a patient of the risks and alternatives to proposed medical treatment should be based on negligence, not on battery.[100] Unauthorized treatment was distinguished from conventional assault and battery on the theory that the physician acts in good faith with the intent of helping his patient, unlike the battery tortfeasor who usually acts out of malice with no intent of aiding his victim,[101] a distinction which had been rejected by the supreme court of Minnesota in 1905.[102] Although some jurisdictions after *Natanson* have continued to apply the law of battery to situations where informed consent is lacking,[103] the trend has been to apply the law of negligence.[104]

Significant consequences arise from favoring negligence over battery as the underlying cause of action. A physician may be held liable without proof of actual damages under a battery theory.[105] In addition, battery and negligence cases may be subject to different

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[98]Gray v. Grunnagle, 423 Pa. 144, 223 A.2d 663 (1966) (failure to warn a patient of an inherent risk of permanent paralysis held to be a battery); Belcher v. Carter, 13 Ohio App. 2d 113, 234 N.E.2d 311 (1967) (battery for failure to warn of radiation burns); Nolan v. Kechijian, 75 R.I. 165, 64 A.2d 866 (1949) (trespass to the body and negligence for operation to strengthen ligaments of spleen and spleen removed); Wall v. Brim, 138 F.2d 478 (5th Cir. 1943) (operation for removal of a cyst located on the neck without full disclosure of the risks held a "technical battery").

[99]186 Kan. 393, 350 P.2d 1093, *clarified on rehearing*, 187 Kan. 186, 354 P.2d 670 (1960) (radiation treatment produced a severe burn; on first hearing court held cause of action proper in either battery or negligence; on rehearing, negligence and not battery held to be proper cause of action).

[100]*Id.* at 401-02, 350 P.2d at 1100.

[101]The court stated: "What appears to distinguish the case of the unauthorized surgery or treatment from traditional assault and battery cases is the fact that in almost all of the cases the physician is acting in relatively good faith for the benefit of the patient." *Id.*

[102]In Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905), the defendant contended that assault and battery would not lie because of the "entire absence of any evidence tending to show an evil intent." *Id.* at 270, 104 N.W. at 15. The defendant's position was that, absent evidence he was motivated by wrongful intent or guilty of negligence, there was no assault and battery. The court disagreed with his theory of medical liability: "If the operation was performed without plaintiff's consent, and the circumstances were not such as to justify its performance without, it was wrongful; and, if it was wrongful, it was unlawful." *Id.* at 271, 104 N.W. at 16.

[103]*See, e.g.*, Belcher v. Carter, 13 Ohio App. 2d 113, 234 N.E.2d 311 (1967); Gray v. Grunnagle, 423 Pa. 144, 223 A.2d 663 (1966).

[104]*See* Di Filippo v. Preston, 53 Del. 539, 173 A.2d 333 (1961); Aiken v. Clary, 396 S.W.2d 668 (Mo. 1965); Kaplan v. Haines, 93 N.J. Super. 242, 232 A.2d 840, *aff'd*, 51 N.J. 404, 241 A.2d 235 (1968); Trogun v. Fruchtman, 58 Wis. 2d 569, 207 N.W.2d 297 (1973). *See also* Comment, *New Trends in Informed Consent?*, 54 NEB. L. REV. 66 (1975).

[105]W. PROSSER, *supra* note 32, § 9.

statutes of limitations.[106] Under the Federal Tort Claims Act,[107] a suit for medical malpractice may be rejected if based on battery.[108] One issue raised by bringing a cause of action in negligence for lack of informed consent is the standard of disclosure. While expert opinion may not be necessary to prove a battery, medical negligence actions have generally required expert testimony to set the standard of care.[109]

When the duty to inform was first developing, a physician or surgeon was called upon to inform his patient in only the most general terms concerning the planned course of treatment.[110] Courts did not require an extensive description of the risks and found liability only where no actual consent had been given,[111] or where the risk had been a certainty.[112] With the development of informed consent, courts had to find an appropriate standard for determining the scope of disclosure necessary for effective consent. After *Natanson*, which rejected battery as the underlying tort in cases alleging lack of informed consent, a majority of jurisdictions adopted the general medical negligence standard of medical custom for determining the extent of required disclosure.[113] Medical custom, for purposes

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[106]*See, e.g.*, Hershey v. Peake, 115 Kan. 562, 223 P. 1113 (1924).

[107]28 U.S.C. §§ 2671-2680 (1970).

[108]Under the Act the United States may be sued for the negligence of its employees, but not for their assault and battery. *Id.* § 2680(h). *Compare* Moos v. United States, 118 F. Supp. 275 (D. Minn. 1954) *with* Lane v. United States, 225 F. Supp. 850 (E.D. Va. 1964).

[109]*See, e.g.*, Karp v. Cooley, 493 F.2d 408, 420 (5th Cir.), *cert. denied*, 419 U.S. 845 (1974):

> The Texas standard against which a physician's disclosure or lack of disclosure is tested is a medical one which must be proved by expert medical evidence of what a reasonable practitioner of the same school of practice and the same or similar locality would have advised a patient under similar circumstances.

[110]*See* O'Brien v. Cunard S.S. Co., 154 Mass. 272, 28 N.E. 266 (1891) (consent implied from voluntarily submitting to a vaccination); McGuire v. Rix, 118 Neb. 434, 225 N.W. 120 (1929); Hunt v. Bradshaw, 242 N.C. 517, 88 S.E.2d 762 (1955) (failure to explain a risk of loss of use of arm). *See also* Meisel, *supra* note 9, at 79:

> What long passed for a valid consent to treatment was a simple interchange between patient and physician. In substance the physician said to the patient, "You need thus-and-so to get better," and the patient responded with some phrase or action indicating whether or not he intended to go along with the doctor's recommendations.

[111]Berkey v. Anderson, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969); Zoterell v. Repp, 187 Mich. 319, 153 N.W. 692 (1915); Corn v. French, 71 Nev. 280, 289 P.2d 173 (1955).

[112]Bang v. Charles T. Miller Hosp., 251 Minn. 412, 88 N.W.2d 186 (1958) (plaintiff consented to a prostate operation, but was not informed it would necessarily involve the cutting of his spermatic cords).

[113]*See, e.g.*, Karp v. Cooley, 493 F.2d 408 (5th Cir. 1974); Carmichael v. Reitz, 17 Cal. App. 3d 958, 95 Cal. Rptr. 381 (1971); Dunlap v. Marine, 242 Cal. App. 2d 162, 51

of consent, requires a physician to inform his patient of those risks which a reasonable medical practitioner would have disclosed.[114] In jurisdictions adhering to the locality rule, disclosure under the medical custom standard depends upon what a physician in the same or similar locality would disclose.[115] A plaintiff has the burden of establishing the medical custom by use of expert testimony, which is not always readily available.

An exercise of medical judgment usually plays no part in a physician's determination of risks that should be disclosed to a patient. Limiting an individual's information, while calling upon him to make the ultimate decision concerning medical treatment, characterized as consent, serves no valid medical or legal policy. The illogic of requiring informed consent, but permitting the consent to be limited in reality by medical custom was first rejected by the New Mexico Supreme Court in *Woods v. Brumlop.*[116] However, the pivotal decision on this issue was *Canterbury v. Spence.*[117] Canterbury, a youth of nineteen years, suffered from back pain. He consulted Dr. Spence and submitted to an operation that was described by the doctor as, not more serious "than any other operation."[118] Canterbury recuperated normally until he suffered a fall from his hospital bed which resulted in an immediate setback. At the time of the trial, he suffered from urinary incontinence, paralysis of the bowels, and required crutches to walk. His suit for legal recovery—as medical recovery appeared to be impossible—was predicated on two theories, one of which alleged the lack of informed consent.

The court emphasized the basis of the requirement of informed consent:

> The root premise is the concept, fundamental in American jurisprudence, that "[e]very human being of adult years and sound mind has a right to determine what shall be

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Cal. Rptr. 158 (1966); Di Filippo v. Preston, 53 Del. 539, 173 A.2d 333 (1961); Govin v. Hunter, 374 P.2d 421 (Wyo. 1962). *See also* Comment, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396, 1397 n.5 (1967).

[114]"Whether or not a surgeon is under a duty to warn a patient of the possibility of a specific adverse result of a proposed treatment depends upon the circumstances of the particular case and upon the general practice followed by the medical profession in the locality . . . ." Govin v. Hunter, 374 P.2d 421, 424 (Wyo. 1962).

[115]Karp v. Cooley, 493 F.2d 408 (5th Cir. 1974); Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960); Aiken v. Clary, 396 S.W.2d 668 (Mo. 1965); Kaplan v. Haines, 96 N.J. Super. 242, 232 A.2d 840 (1967), *aff'd*, 51 N.J. 404, 241 A.2d 235 (1968); Wilson v. Scott, 412 S.W.2d 299 (Tex. 1967); ZeBarth v. Swedish Hosp. Medical Center, 81 Wash. 2d 12, 499 P.2d 1 (1972); Govin v. Hunter, 374 P.2d 421 (Wyo. 1962).

[116]71 N.M. 221, 377 P.2d 520 (1962).

[117]464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

[118]*Id.* at 777.

> done with his own body. . . ." True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each.[119]

Explicit in this part of the opinion is the need for a patient to be informed not only of the risks involved in the treatment proposed by a physician, but also of alternatives to the treatment.

While recognizing that the majority of jurisdictions considering the issue had made the duty depend on whether it was the custom of physicians practicing in the community to make the disclosure to a patient, the court rejected this standard.[120] In place of the medical custom standard, the court used the patient's right of self-decision to shape the boundaries of the duty to reveal:

> That right can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked.[121]

The scope of disclosure in *Canterbury* becomes a function of a patient's right of self-decision. As a patient is unlearned in medical sciences, he has an abject dependence upon his physician for information on which to base his decision. The physician's disclosure of risks of treatment and possible alternatives must be measured against the patient's need for information. All risks that reasonably might affect the decision must be disclosed. A risk under this standard becomes material when "'a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.'"[122] Medical

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[119]*Id.* at 780 (quoting Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914)).

[120]The court stated:

> The majority of courts dealing with the problem have made the duty depend on whether it was the custom of physicians practicing in the community to make the particular disclosure to the patient. . . . We do not agree that the patient's cause of action is dependent upon the existence and nonperformance of a relevant professional tradition.

Id. at 783 (footnotes omitted).

[121]*Id.* at 786-87.

[122]*Id.* at 787 (quoting Waltz & Scheoneman, *supra* at 640).

testimony would only be necessary for the determination and explanation of the risks associated with a procedure.[123]

A failure to inform, when treated as negligence, does not create liability unless it has some causal relationship with injury to the patient. Where the patient would not have consented to the medical procedure had full disclosure taken place, and injury develops from the undisclosed risk, lack of informed consent may be said to be the cause of the injury. On the issue of whether consent would have been given had full disclosure taken place, courts have tended to apply an objective standard.[124] As expressed in *Canterbury*,"what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance."[125]

A privilege to withhold information necessary to form informed consent is recognized in situations where a patient is so ill or emotionally distraught that full disclosure would complicate treatment or pose psychological risks.[126] In determining whether full disclosure may bring on an adverse physical or mental condition in a patient, a health care provider must exercise medical judgment. The critical issue is whether the physician used sound medical judgment in determining that communication of risk information would present a threat to the patient's well-being. An example would be the determination by a physician that full disclosure of risks to a patient suffering from a serious heart condition would raise an unacceptable risk of a heart attack. Although it is entirely proper to consider the custom of the profession in determining whether a physician's judgment as to the danger was negligent, "[t]he privilege does not accept the paternalistic notion that the physician may remain silent simply

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[123]Miller v. Kennedy, 11 Wash. App. 272, 284, 522 P.2d 852, 861 (1974), *aff'd*, 85 Wash. 2d 151, 530 P.2d 334 (1975). The court explained:

> Those elements which are the province of the medical profession must be established by the testimony of medical experts in the field of inquiry. Thus, the existence of the risks and alternatives which were present in the particular physical condition would be beyond the knowledge of the layman and would have to be established by medical testimony.

[124]Prior to *Canterbury*, courts had given little consideration to causation in informed consent cases. *See* Plante, *An Analysis of "Informed Consent"*, 36 FORDHAM L. REV. 639, 667 (1968). *Canterbury*, counter to the assumption of most commentators prior to the decision, applied an objective test. *See* 464 F.2d at 791.

[125]464 F.2d at 791.

[126]*See, e.g.*, Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957); Williams v. Menehan, 191 Kan. 6, 379 P.2d 292 (1963); Twombly v. Leach, 65 Mass. (11 Cush.) 397 (1853). In Ferrara v. Galluchio, 5 N.Y.2d 16, 152 N.E.2d 249 (1958), the plaintiff was permitted to recover for mental anguish from the cancerophobia she developed upon learning from a nondefendant physician that radiation therapy a defendant physician had administered might cause cancer. *See also* Comment, *Informed Consent: The Illusion of Patient Choice*, 23 EMORY L.J. 503 (1974).

because divulgence might prompt the patient to forego therapy the physician feels the patient really needs."[127]

So far as *Canterbury* rejects custom as the controlling standard for informed consent, it has reinforced a tradition in American law which permits an individual to control his bodily integrity.[128] It rejects the notion that all a patient has a right to do is choose his physician, who then makes all other decisions. If informed consent was to remain a viable part of our medical jurisprudence, a rejection of custom was necessary to prevent physicians, instead of patients, from deciding whether risks outweigh potential benefits. However, so far as *Canterbury* fails to discuss the locality rule as it relates to informed consent, it may give the patient more medical expertise than he has either bargained or paid for.

IV. Informed Consent v. The Locality Rule

At the time of the *Canterbury* decision, the District of Columbia courts did not apply the locality rule in medical negligence cases.[129] The court did not, therefore, find it necessary to consider the locality rule as a factor separate from custom in determining the scope of disclosure. Jurisdictions that apply the locality rule, but admit the logic of rejecting medical custom as the controlling standard for disclosure, must consider the issue not dealt with by the District of Columbia court. As we have seen, the locality rule recognized a self-evident truth at the time of its creation: A physician in a small town, who did not necessarily possess a medical degree,[130] did not have the experience, skill, knowledge, or facilities of a physician in a larger and more affluent community. To the extent that a person

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[127]Canterbury v. Spence, 464 F.2d at 789. *But see* Roberts v. Wood, 206 F. Supp. 579 (D. Ala. 1962).

[128]*See, e.g.*, Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906); Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905).

[129]*See* Washington Hosp. Center v. Butler, 384 F.2d 331 (D.C. Cir. 1967); Garfield Memorial Hosp. v. Marshall, 204 F.2d 721 (D.C. Cir. 1953); Byrom v. Eastern Dispensary & Cas. Hosp., 136 F.2d 278 (D.C. Cir. 1943).

[130]At first, physicians in the United States

> learned their trade through observation and practice rather than any formal course of education. In the middle of the nineteenth century any man with an elementary education could become a doctor by taking a course for a winter or two and passing an examination, and even as late as 1900 there were many medical students who could not have gained entrance to a good liberal arts college.

D. Mechanic, Medical Sociology 316-17 (2d ed. 1978) (footnotes omitted). Medical schools in the United States were first subjected to accreditation in 1906 under the AMA Council on Medical Education. Early medical school curriculum consisted of a course of lectures over a period of six months. Formal education was supplemented by apprenticeships with physicians who had even less formal education. Note, *An Evaluation of changes in the Medical Standard of Care, supra* note 36, at 732-33 nn.16 & 17.

chose to use an obviously less qualified medical care provider, he was held to have consented to a lower standard of care.

One aspect of a physician's knowledge is how well he understands the risks involved and the alternatives available. To the degree an ordinary physician in a similar community would not be aware of the risks or of alternative procedures, the locality rule dictates no liability for failure of a particular physician to explain those factors in obtaining consent. This result is not due to medical custom, but because the patient has not bargained for the degree of expertise necessary for the physician to know of the factors. If the particular physician does, in fact, know of the risks or alternatives, he should be required to inform the patient if it would be a material factor in the decision.[131] An alternative method of treatment, even if not available in the patient's community, should be part of the duty to disclose because a reasonable person might well choose to pay the added expense of obtaining treatment away from the locality, if the alternative is local treatment with a higher degree of risk or greater likelihood of failure. Courts must carefully scrutinize this aspect of informed consent in locality rule jurisdictions due to a possible conflict of interest on the part of a physician seeking to retain a patient who would be better served outside the locality, where risks are less and the probability of success greater. Although it may be difficult for some physicians to admit that their skill, knowledge, and experience is less than that of their fellow practitioners in larger communities, the courts must require such disclosure if the difference in fact exists.

The locality rule is an important factor in determining the scope of disclosure required by the doctrine of informed consent. Physicians should not be required to have more knowledge of alternatives and risks than the locality rule would require for other aspects of their relationship with a client. However, this may cause an unfair result when viewed from the eyes of a typical patient. Although the locality rule was based upon factors obvious to a reasonable man when it was created, the difference between a physician in a small town and one in a large community is no longer as evident.

In the eyes of the typical patient-consumer, going to a physician is much like buying an automobile or large appliance. He has little knowledge or understanding of what he is purchasing, but he has expectations of what he will receive.[132] In dealing with consumer pro-

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[131]If a physician has actual knowledge or constructive knowedge (based upon the knowledge a doctor in the same or similar locality should possess) of the risk or alternative treatment, then his duty to disclose would be based upon the patient's need to know. *See* Canterbury v. Spence, 464 F.2d at 786-87.

[132]One commentator stated:

> When the patient visits a physician he comes with an image of the physician's role and the way it should be performed. This image reflects the

ducts, the law has tended to look to the reasonable expectations of the consumer, whether created by specific or implied warranties, and hold the product to that degree of performance.[133] A reasonable patient, or consumer of medical services, in our modern age sees physicians who have all graduated from the same or similar approved schools, undergone the same or similar intern programs, and passed (at least in his state) the same licensing examinations and procedures.[134]

It is no longer reasonable to assume that an individual consents to a lower standard of care by merely consulting a physician in his locality.[135] A more logical rule would be that, absent some evidence showing a patient knew the standard of care was lower than in other areas, an individual has a reasonable expectation that the basic standard of medical competence is the same as in other areas—a reasonable expectation that deserves legal recognition and protection.

Under the doctrine of informed consent, a physician is usually held to have a duty to disclose the risks of a proposed course of treatment, and possible alternatives to the treatment.[136] In jurisdictions presently following the locality rule, one of the risks of any course of treatment is a lower standard of care in the locality, and one of the alternatives is to receive a higher standard of care outside the locality. To the extent that a physician believes or should be aware that a local standard of care is lower than in other communities, he must be required, as part of informed consent, to disclose the possibility of a higher standard of care elsewhere. In the formation of the initial physician-patient relationship, where the physician's function is one of diagnosis, the duty would be to inform a patient that a more accurate diagnosis might be obtained in a larger community where physicians would have more experience in

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societal definition of the physician's role and subcultural expectations as well as the conceptions formed by the patient from prior experience or from hearing about experiences of other people.

D. MECHANIC, *supra* note 130, at 407.

[133]Dunham v. Vaughn & Bushnell Mfg. Co., 42 Ill. 2d 339, 247 N.E.2d 401 (1969). *See also* RESTATEMENT (SECOND) OF TORTS § 402A, Comment g (1965); Keeton, *Products Liability: Liability Without Fault and the Requirement of a Defect*, 41 TEX. L. REV. 855 (1963); Rheingold, *What Are the Consumer's "Reasonable Expectations?"*, 22 BUS. LAW. 589 (1967).

[134]*See generally Medical Education in the United States 1976-1977*, 238 J.A.M.A. 2761 (1977).

[135]*See* text accompanying notes 55-57 *supra*.

[136]Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Campbell v. Oliva, 424 F.2d 1244 (6th Cir. 1970); Dunham v. Wright, 423 F.2d 940 (3d Cir. 1970); Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); Bang v. Charles T. Miller Hosp., 251 Minn. 427, 88 N.W.2d 186 (1958). *See* Mills, *Whither Informed Consent?*, 229 J.A.M.A. 305 (1974).

diagnosis and more advanced facilities. Once a course of treatment is decided upon, the physician would have a further duty to inform his patient of alternative forms of treatment not available in the locality and of the possibility that physicians or surgeons in larger communities would have better facilities and more experience in carrying out the treatment and, therefore, have a higher standard of care. A patient who consents to local medical treatment, after having been so informed, may properly be held to have consented to the local standard of care.

V. Conclusion

It should be evident from the foregoing that the locality rule and the doctrine of informed consent are related concepts. During the nineteenth century, when courts in the United States first began to consider claims for legal redress in medical malpractice, the standard of medical care was, in fact as well as law, a local standard. Local medical practitioners in small communities had neither the education nor the experience of their fellow practitioners in larger communities. The courts, in determining the appropriate standard of treatment in the physician-patient contract, took judicial notice of these differences.

During the latter half of the twentieth century, the locality rule has come under increasing attack. Commentators, viewing the modern system for national accreditation of medical schools and statewide licensing procedures, have become less sympathetic to the view that a patient consents to a lower standard of care by consulting a local physician in a small community. Some have gone so far as to predict the demise of the rule.

While the locality rule has come under increasing attack, another doctrine, informed consent, has been waxing strong in the opinions of courts and commentators. As related, the doctrine of informed consent requires that a patient be given the information necessary for him to determine if he desires to undergo the treatment recommended by his physician. Two different standards have been applied by courts in determining the scope of this disclosure: the medical custom standard which views the issue as one to be determined by considering what a reasonable medical practitioner under similar circumstances would have disclosed, and the standard of what a reasonable patient would want to know before deciding on a course of treatment used in *Canterbury*.

Both the doctrine of informed consent and the locality rule have at their root the concept that the physician-patient relationship is one that must be based on consent. Under the locality rule, this consent is presumed to include consent to the standard of care found in

the locality. At the time of its creation, the obvious differences between a physician in a small town and a practitioner in a major community made the presumption of the locality rule reasonable. As the obvious differences have declined, although real differences continue to exist, it becomes more difficult to assume that a patient is aware of the lower standard of care available in his community. It is at this point the locality rule and informed consent coalesce. By disclosing to the patient the true nature of the standard of care in the community, and relating alternative treatments available in other communities, a physician permits his patient to make a choice. If the patient consents to treatment by local practitioners, after receiving this information, he has given informed consent to the locality rule.