MEDICOLEGAL CASE REVIEWS

The Standard of Care Is Not So Standard

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Standards are critical to our profession. They provide the benchmarks by which we critique the competence and conduct of ourselves and others as we strive to pursue excellence in all activities related to patient care. Our profession values objectivity and science-based medicine. In this brief review, Mr. Gittler identifies some discordances within our profession. "Guns for hire" and true, perhaps even objective, differences of opinion can lead to courtroom scenarios where it appears that we have failed to identify the performance standards that we assume are expected within our professional practices.

Can we do better? Perhaps additional, carefully designed and executed population-based studies on health care practices, widespread educational initiatives on evidence-based medicine, and consensus conferences on the best practices can assist us to define the practice "norms" that will establish and strengthen "standards" within the specialty of infectious diseases. This should enable both science and standards to become more important determinants of decisions and awards within our justice system.

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Malpractice lawsuits affect most physicians at some point in their career. Proving that malpractice has been committed is based on substantiation of a variety of elements, including that the patient was rendered care that was "below the standard" of care. While many physicians believe that the "standard" will be judged objectively on the basis of published scientific sources and accepted conventions, the standard is established rather by the testimony of expert witness(es). It is the expert testimony that sets the standard and is proof of the standard. The testimony is open for acceptance or rejection by the judge or jury for a variety of nonscientific reasons. We review what the defendant doctor might expect regarding proof required to establish breach of the standard of care and what the prudent expert should be obliged to demonstrate.

In the current, rapidly evolving medicolegal environment, risk management has become a byword for hospitals and insurers. To the practicing physician, a major risk to be managed is the threat of medical malpractice litigation. Despite the fact that >75% of the cases that actually reach court are found in favor of the physician/defendant [1], the ultimate verdict does not diminish the physician's anxiety or sleepless nights, effects on self-esteem, or the need to perpetually list on hospital or insurance applications any pending or prior malpractice actions initiated, even if they are subsequently resolved in the physician's favor.

This situation may also lead to practice patterns such as "defensive medicine" in the general medical community. The threat of awards for what are considered by some to be astronomical figures, and the undue consumption of time preparing for and attending a trial, often lead a physician/defendant to consider cutting the potential losses and consent to an out-of-court settlement, even when that physician believes no malpractice has occurred.

If ~1% of hospitalizations result in adverse events because of potential physician negligence [2] and that figure is extrapolated to the ~33.5 million hospitalizations that occur in the United States annually, then each year there are ~330,000 potential cases of malpractice [3] arising out of the hospital environment alone. There are also numerous outpatient encounters that can lead to malpractice claims. While 90% of patients who have an adverse outcome due to negligence do not file a malpractice suit [4], numerous suits are filed annually.

Establishing the Standard of Care

The essence of many malpractice suits is that the physician allegedly rendered medical attention that was below the "stan

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dard of care or practice'' and was therefore negligent. Assuming that it is also found that that negligence was a substantial factor in causing injury to the patient, then the doctor could be held liable for the consequent damages.

Most physicians expect that the standard of care applied in a case will be gathered from the scientific literature, from the textbooks and journals of the specialty that apply to a situation, and from the honest opinions of expert witnesses regarding the usual standard applied to similar cases treated by similarly trained colleagues. However, those expectations are not likely to be fulfilled, because of the sentiments and misconceptions of the public, the incentives for biased testimony, and the relative lack of sanctions for lack of integrity.

One of the primary problems is that the public (patients and juries) are often discouraged by modern health care and appear to expect more than medicine can reasonably offer. Often, patients seem to expect certainty of outcome in any individual case and are often disappointed by the inability of doctors to provide clear-cut answers and assurances [3, 5]. The divergence between such expectations and reality may result in consideration of a malpractice suit. Furthermore, one study of reasons for filing malpractice suits surprisingly found that 27% of patients who considered claims did so because of ''explicit recommendations by health care providers to seek legal counsel'' [3]. Casual remarks by colleagues and righteous indignation thus fuel the medicolegal malpractice fire. In addition, there has been increasing disconnection between scientific findings and research results on the one hand, and the law as it is applied to cases on the other hand, in large part because of the use of expert testimony [5].

The essential elements of a claim may vary from state to state, but in general, in order to prevail, the plaintiff/patient must establish that the care that was given was beneath the level that would have been provided by the majority or a respectable minority of physicians practicing under similar circumstances. Generalists and specialists are held to different standards [6], unless a generalist attempts to treat a specialized problem that would ordinarily call for a referral [7, 8]. In that case, the generalist will be held to the standard of the specialist.

The plaintiff must also show that failure to meet the standard of care caused, or was a substantial factor in causing, the damage (the definition of legal causation may vary from state to state, but the concept is generally the same). This is the basic rule of ''no harm, no foul.'' The patient must be able to prove that actual damage did occur as a result of the negligence.

Adapting the Basic Rule

While physicians are generally required to exercise the degree of skill and competence ordinarily possessed by fellow practitioners (''peers'') under similar circumstances, there are numerous situations in which this basic rule can be applied, and the analysis of compliance with the standard of care must be adapted for each variation. For example, the nonspecialist may be held liable for medical malpractice for failing to call in a specialist [9]. The nonspecialist could be held liable if it were proven to a judge or jury that a majority of nonspecialists under the same circumstances would normally have called in a specialist. This rule applies to the ordering of diagnostic tests, the interpretation of test results, the institution of therapy, or the withholding of therapy. Again, one must still prove causation for this element to be of significance.

There are circumstances where the proof of negligence does not require expert testimony. In instances where the negligence would be obvious, even to the layperson, such as a surgeon who cuts off the wrong leg, or an injection with a dirty needle, then there need not be expert testimony to establish this element. The doctrine of *res ipsa loquitur* might apply. More specifically, that doctrine applies when a layperson can conclude without the assistance of medical testimony that (a) a result would not have occurred in the absence of negligence, (b) the instrumentality or agency of injury was within the exclusive control of the defendant doctor, and (c) the patient did not contribute to the injury by any voluntary act (e.g., falling out of a gurney).

In the context of a legal case, the standard of care, i.e., proof of what a reasonable doctor would or would not have done under given circumstances, is thus usually ''proven'' by ''expert testimony'' of another physician chosen by either the plaintiff's attorney or the defendant's attorney. Medical experts are usually well paid by the attorneys who engage them and may be selected by the attorneys on the basis of the positions they will likely take on any given issue. In the United States, the qualifications of experts are presented by the attorneys for whom they testify and the criteria for expertise are inexact, vague, and usually very liberal. Rather than excluding such testimony for lack of qualification, generally the judge simply instructs a jury that they may take information on qualifications into account in weighing the testimony—determining its value relative to other testimony.

There are notable exceptions. For example, in California there is a specific legal requirement that in order to qualify to testify as an expert in emergency room medicine one must have had substantial experience in an acute care hospital within the preceding 5 years [10]. However, such requirements are the exception rather than the rule. So, the expert may or may not have significant experience in the same specialty or have seen similar patients, may or may not have done any research in the area under examination, and may or may not be considered an expert by his/her peers. The expert's credentials may be cross-examined by the opposing attorney on the same basis, but a well-prepared witness (and usually there are preparatory sessions before a trial) can often overcome such obstacles, at least in the mind of the jury. The credentials of expert witnesses and their depositions are available before the trial according to the rules of discovery (the process of investigating the facts before the trial).

Many physicians assume that these experts will produce concrete (as concrete as medicine gets, that is) guidelines generated

from textbooks, published peer-reviewed articles, or local customs for evaluating the actions of the doctor accused of malpractice. Even in this context, however, it is well known that medicine is not an exact science, and there are a number of gray areas in terms of appropriate diagnosis and treatment. So, the law recognizes that there are often alternate methods of treatment, all of which may be acceptable.

For example, the California jury instructions [11] state "Where there is more than one recognized method of diagnosis or treatment, and not one of them is used exclusively and uniformly by all practitioners of good standing, a physician is not negligent if, in exercising his or her best judgment, he or she selects one of the approved methods, which later turns out to be a wrong selection, or one not favored by certain other practitioners." Note, however, that there may be an obligation to inform the patient that other members of the medical profession might render a different diagnosis based on a contrary recognized school of thought [12].

However, experts need not rely on such evidence to support their testimony, "even when there are relevant studies in peer-review journals" [5] previously published. The testimony supplied by experts is the "proof," and their opinions are the evidence. Ignoring such authority is made all the easier given "widespread distrust and misunderstanding of science in American society and the view by jurors that medical research is irrelevant," as related in a recent article about breast implants [5]. Selection of jurors and their prior experiences and biases may have far more to do with the verdict than the scientific evidence presented. The courts also have compounded this problem "by ignoring the rules of science and handing down verdicts which fly in the face of evidence" [5].

The court may also impose its own view of the standard of care on physicians [13]. In a highly publicized decision in 1974, the court held that while it was not customary for ophthalmologists to perform screening tonometry on patients <30 years old because of the low incidence of disease in that population, the test should have been done for a 29-year-old patient who developed glaucoma because it was simple and easily performed and the disease has disastrous consequences if not recognized. In this case the court disregarded the usual physician's practice and imposed its own values.

Since the standard of care is generally established by expert witness testimony as subjectively interpreted by the judge or jury, verisimilitude can be a matter of the effectiveness of an attorney's presentation, the expert witness's demeanor or style or image, or how well the expert withstands cross-examination (which, in turn, usually depends on his legal experience at least as much as his medical experience). Ultimately, it is then what the jury believes regardless of any generally accepted medical doctrine that usually determines the standard of care in any case. Even the United States Supreme Court's finding [14, 15] that required federal judges to review expert testimony and set limits on admission based on reliability and relevance is often only loosely applied. State courts are sometimes under the same injunction.

The Statistics and Demographics of Malpractice

Under the current system, some interesting data have been accumulated about malpractice cases. A review [16] of 8,231 closed cases of medical malpractice that occurred in New Jersey between 1977 and 1992 found that in the 62% of cases that were considered defensible, the plaintiff received payment 21% of the time. However, of the 21% of cases considered indefensible and the 13% of cases with "unclear" defensibility, payment to the plaintiff occurred in 91% and 59% of cases, respectively. It was also noted that severity of injury was related to payments in cases with early settlements but was not related to "the likelihood of payment" in cases that required a jury verdict [16].

Another study [17] noted that male physicians were more likely to be sued than female physicians and that the rate of claims varied with the physician's age and peaked at ~age 40. There was no association of claims filed and physician's country or site of training, or with the type of medical degree (e.g., D.O. vs. M.D.) of the practitioner; board-certified physicians had a slightly increased risk of being sued. Internists had a history of 0.13 claims per physician per year compared to that for "all physicians," which was 0.19 claims per physician per year. No data were given for the medical subspecialties such as infectious diseases.

Summary

All of these findings raise serious questions as to what are and should be the duties and obligations of an expert witness and, as a corollary, what can be done, if anything, to assist in establishing fairness and scientific reason in a malpractice case. In order to ensure that an expert witness would impartially review the case records, give advice to the attorney based on reasonable care guidelines, and not be influenced by the attorney's strategy and position, there are several possible avenues: (1) Reduce the monetary incentive to shade one's opinions, perhaps by putting a limit on compensation for such services and requiring doctors to devote a minimal number of hours per year to consultations and testimony; (2) Enact more legislative requisites to determine qualifications for testifying; (3) Require preliminary hearings in each case, wherein the judge would determine whether the witness is truly an expert, with adequate, current experience and training; (4) Allow more liberal use of treatises, practice guidelines, and journals; (5) Exert more peer pressure on those who become "professional" witnesses; and (6) Have professional societies qualify and provide listings of acknowledged experts in a given discipline.

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