ED Legal Letter™

The Essential Monthly Guide to Emergency Medicine Malpractice Prevention and Risk Management

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Standard of care: Does it exist in every malpractice case?

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Editor's note: *This month's issue of* ED Legal Letter *details the lack of standardization of medical practice. Trepidation about litigation among emergency practitioners is a significant concern. Every patient encounter presents the chance for an adverse outcome. The standard of care is defined by experts as a well-established, set path with only one logical approach and outcome; in reality, the standard of care may be a tortuous path with many choices that may lead to dissimilar conclusions. This issue outlines the problems with determining the standard of care and how courts will interpret the standard of care.*

Medical malpractice lawsuits raise fear in the hearts of physicians, significantly increase the cost of medical care, and even impact the ability of patients to receive medical care. Unfortunately, many patients, attorneys, juries, and even expert witnesses, focus on bad outcomes without considering the other aspects of a medical malpractice case. The emotional impact of a brain-damaged child and tearful parents upon sympathetic jurors provides defendant physicians and insurers a strong impetus to settle cases with meritorious defenses rather than risk a megaverdict, even though the physician may not have been responsible for the patient's condition. A physician's breach of the duty to render treatment in accordance with the standard of care arguably is the most litigated topic in medical malpractice lawsuits. Defining and applying this concept is deceptively difficult.

Defining the Standard of Care

Consider the following question: "Does the standard of care require that an emergency physician inform a consultant of a change in a patient's condition?"

A medical expert's response to a question such as this often is the crux of a medical negligence claim. If an expert can convince a jury that informing a consultant of a change in a patient's status is the standard of care, an emergency physician who failed to inform the consultant likely would have been negligent for not doing so.

While an expert witness may help a judge or jury understand the issues involved in determining the standard of care, ultimately it is the judge's or jury's job to determine whether the standard of care was breached. To this end, the fact finders must rely on definitions imposed by law.

Legal Definition of the Standard of Care

The definition of the standard of care varies by state. Many court opinions and statutes defining the standard of care parallel the definition provided in *Black's Legal Dictionary*: "the average degree of skill, care, and diligence exercised by members of the same profession, practicing in the same or similar locality in light of the present state of medical and surgical science."[1] A representative example of a state court's definition of the standard of care is contained in the case *Jones v. Chicago HMO Ltd. of Illinois*.[2] The definition of the standard of care adopted by the Illinois Supreme Court required a professional to use the "same degree of knowledge, skill, and ability as an ordinarily careful professional would exercise under similar circumstances." Despite this fairly consistent starting point, the ways in which the standard of care may be defined vary widely.

Since the definition of the standard of care depends upon state law, courts have been more than willing to expand upon and clarify the definition according to their interpretations of state law. For example, in *Parrella v. Bowling*,[3] the trial court instructed the jury that the standard of care did not require "absolute accuracy" in a physician's practice or judgment, did not hold the physician to the "standard of infallibility," and did not require that a physician possess "the utmost degree of skill and learning known only to a few in [the] profession." Rather, the court explained that the standard of care required that the physician only possess "that degree of knowledge and skill commonly possessed by members of [the physician's] profession in [the physician's] specialty . . . in such a situation as that shown by the evidence." After a verdict for the physician, the plaintiff appealed, arguing, among other things, that the jury instructions given by the trial court were misleading. The Rhode Island Supreme Court affirmed the trial court's interpretation of the standard of care as being consistent with Rhode Island law.

Similarly, in *Franklin v. Toal*,[4] the Oklahoma Supreme Court explained that the issue in malpractice lawsuits was not whether a physician made a mistake, but rather was whether the physician used ordinary care in the treatment of the patient. Unless a mistake in judgment is "so gross that it makes the professional conduct substandard," the court held that a medical practitioner could not be held responsible. In a slightly different interpretation, the Wyoming Supreme Court held that the standard of care was the skill, diligence, knowledge, means, and methods "reasonably" exercised or applied during medical treatment.[5] The court excluded definitions involving medical custom and ordinary practices as

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being too rigid, holding that "[n]egligence cannot be excused on the grounds that others practice the same kind of negligence."[6]

There are several important points to keep in mind when defining the standard of care. First, definitions of the standard of care include reference to what "reasonable," "common," or "ordinary" practitioners would do. It would be unfair to judge a physician's actions according to what actions the leading practitioners in medicine would have taken. Second, physicians may make mistakes without practicing below the standard of care. In medical malpractice, as in almost every other aspect of litigation, a bad outcome does not necessarily mean that the standard of care has been violated. The important question in determining the standard of care is whether the physician acted reasonably under the circumstances, not whether a mistake was made. Some mistakes can be reasonable. Finally, the standard of care is very situation-specific. Most legal definitions include some reference to what should have been done under "same or similar circumstances." Blanket assertions that the standard of care requires certain conduct in all circumstances are likely to be misleading or simply untrue.

Applying the Standard of Care

Once the standard of care has been defined, the definition then must be applied to the specific facts in each case. There are some legal theories that may affect how the standard of care is applied.

The "Locality Rule." The legal definition of the standard of care has long involved consideration of the community in which the alleged malpractice took place. Medical customs or practices in a "same or similar locality" were to be considered when determining a physician's liability, because courts apparently felt that physicians in small rural communities did not have the same opportunities as their urban counterparts to learn of the latest medical advances and use the latest medical innovations. Cases as far back as 1880 created this distinction,[7] and in several jurisdictions, defendants still enjoy protection from this doctrine through statutes and case law. Statutes in many states refer to the locality rule. A representative example is the Louisiana Revised Statute providing that:

> In a [medical] malpractice action . . . the plaintiff shall have the burden of proving . . . [t]he degree of knowledge or skill possessed or the degree of care ordinarily exercised by physicians . . . licensed to practice in the state of Louisiana and actively practicing in a similar community or locale and under similar circumstances . . . .[8]

Courts in several jurisdictions have dismissed actions against physicians when evidence presented did not define the standard of care for a given locale. For example, in *Williamson v. Elrod*,[9] an expert witness testified that a surgeon breached the standard of care by failing to arrive within one hour of a surgical consultation for evaluation of free air in the abdomen. The jury held the defendant surgeon negligent in the death of the patient and awarded $850,000 in damages. The Arkansas Supreme Court reversed the verdict and dismissed the case because the expert did not establish "what the degree of skill and learning ordinarily possessed by doctors in good standing in Little Rock or similar locales was." Without being able to define the standard of care, the Court held that any testimony the plaintiff's expert gave regarding the surgeon's failure to meet the standard was "of no merit."

Similarly, in *Frank v. East Shoshone Hospital*,[10] a plaintiff's expert admitted that he was not familiar "in any detail" with the emergency department (ED) procedures in effect at the time of the defendant emergency physician's alleged negligence. The Idaho Court of Appeals dismissed the case because the expert was not familiar with the local standard of care as required by Idaho statutes. The court noted that requiring a potential expert to question a local physician when reviewing the defendant's conduct did not "cast an onerous burden on plaintiffs in medical malpractice actions."

As medical knowledge becomes more widely accessible through national conferences and the Internet, and as national licensing and accreditation requirements standardize medical knowledge, the applicability of the locality rule has fallen out of favor. The Missouri Supreme Court eliminated the locality rule in 1972, noting that "[t]here is less and less justification for dual medical standards — one for modern medicine and another for not so modern, depending on locality," and holding that "[w]hen the reason for the rule vanishes, so should the rule."[11] In the 1998 case of *Sheeley v. Memorial Hospital*,[12] the Rhode Island Supreme Court recognized a "national approach to the delivery of medical services, especially in the urban centers of this country" when it joined the "growing number of jurisdictions that have repudiated the [locality rule] in favor of a national standard." The *Sheeley*

opinion listed court decisions from 20 other states that had already adopted the national standard at that time. Finally, in 2002, even the Idaho Supreme Court recognized an exception to Idaho's locality rule, stating that, despite statutory requirements, a local standard of care cannot be less than "minimum statewide standards" that are "required to have the fitness to be licensed."[13]

While the locality rule still is applicable in some jurisdictions, and may serve as a basis for dismissal of a lawsuit under certain circumstances, it appears that courts are embracing the concept of a national standard of care and making the locality rule merely a factor to be considered in whether a physician adhered to the standard of care.

The "Respectable Minority" Doctrine. Inherent in any adversarial legal proceeding is a disagreement between experts on the representative standard of care. Many times, the medical treatment a physician chooses may not comport with general medical consensus, but still may be practiced by a "respectable minority" of physicians in the same field. In some instances, a jury could determine that physicians practicing in the minority are adhering to the standard of care while physicians practicing in the majority are not (i.e., prescribing antibiotics to patients with upper respiratory infections). The respectable minority doctrine (also called the two schools of thought doctrine) often is used to show jurors that there can be more than one medically acceptable approach to diagnosing or treating medical problems. Increasing the number of medically acceptable approaches will expand the range of practices that fall within the standard of care. The minority must be "respectable," however; a physician cannot use this defense if only he and two other colleagues adhere to it.

The "two schools of thought" doctrine was explored in depth in the case of *Jones v. Chidester*.[14] The Pennsylvania Supreme Court reviewed holdings in more than 20 cases before reaching a decision that since the two schools of thought doctrine provides a complete defense to malpractice, it is insufficient to demonstrate that only a small minority of physicians agree with the defendant physician's questioned practice. The court interpreted the two schools of thought doctrine to mean that:

> "[w]here competent medical authority is divided, a physician will not be held responsible if in the exercise of his judgment he followed a course of treatment advocated by a considerable number of recognized and respected professionals in his given area of expertise."

Once an expert was able to provide a factual basis for the differing school of thought, the question then could be submitted to the jury to decide.

The Texas Supreme Court reviewed the respectable minority standard in the case of *Hood v. Phillips*, noting that there was no way to determine whether the respectable minority was practicing experimental, outmoded, rejected, or accepted forms of treatment.[15] Rather than reduce the issue of medical malpractice to "a poll of the medical profession," the court ruled that "[a] physician who undertakes a mode or form of treatment which a reasonable and prudent member of the medical profession would undertake under the same or similar circumstances shall not be subject to liability . . . ." The court held that the proper standard was to determine whether the defendant physician was negligent by utilizing "some form of treatment which a reasonable and prudent member of the medical profession would *not* undertake under the same or similar circumstances."

Finally, note that a physician still may be negligent under this doctrine if the second school of thought is not within the standard of care or if the physician does not use reasonable care when implementing the methods advocated by the second school of thought.[16]

Proving the Standard of Care Has Been Violated

Once the standard of care has been established, to prove medical malpractice a plaintiff also must show that the defendant physician breached the standard of care. There are several methods by which a plaintiff can prove that a physician violated the standard of care.

Res Ipsa Loquitur. The literal translation of *res ipsa loquitur* is "the thing speaks for itself." The legal theory behind this doctrine requires four elements: 1) an injury occurs; 2) the tangible thing causing the alleged injury is under the exclusive control of the defendant; 3) the occurrence causing the injury does not normally happen in the absence of negligence; and 4) the injury occurs without the fault of the plaintiff.[17] When these requirements have been met, courts generally have held that the common knowledge and practical experience possessed by an average layman allows jurors themselves to determine whether negligence occurred, without the need for expert testimony.[18] In medical malpractice cases, the doctrine of *res ipsa loquitur* has

been applied almost exclusively to cases in which sponges or surgical instruments have been left inside a patient's body after surgery.[19] This author is unable to find any instances of successful *res ipsa loquitur* claims against emergency physicians, although such actions are not inconceivable. Imagine a patient brought to the ED for severe dyspnea who had a perfect set of teeth before intubation, only to wake up after intubation with several chipped teeth. The patient was under the exclusive control of the physician after being sedated; chipped teeth during intubation do not usually happen in the absence of negligence; and since the patient was sedated, the injury could not have been the fault of the patient. Similar scenarios might involve patients who are sedated to reduce broken bones or dislocated joints and who accidentally fall off the cart onto the floor. An important point in the *re ipsa loquitur* argument is that while negligence may be inferred under certain circumstances, establishing causation still may require expert testimony. In other words, while the presence of a retained sponge might suggest negligence to a juror, establishing that the sponge was the cause of the patient's bowel obstruction still may be outside the common knowledge of an average layperson.

Published Materials

Certain types of published materials may be used to establish the standard of care in certain circumstances or to help an expert prove the standard of care in other circumstances. Statutes, practice guidelines, medical texts (also termed "learned treatises"), and *The Physicians' Desk Reference* have been cited as sources that may aid in establishing the standard of care. Some jurisdictions are more willing than others to accept published materials as stand-alone evidence of the standard of care. In either case, expert witnesses still generally are needed to show the relevance of the written materials and how the materials relate to the standard of care. Unfortunately, there is no consensus on whether published materials may be used to establish the standard of care.

Hospital policies frequently are used in an attempt to show that a physician was negligent. Plaintiff attorneys routinely request copies of any hospital policies relating to an alleged act of malpractice after a medical malpractice suit has been filed.

In *Moyer v. Reynolds*,[20] the Florida Court of Appeals held that hospital policies could be used to prove the standard of care. The plaintiffs in this case were the family of a 33-year-old woman who presented to an ED complaining of midsternal chest pain, shortness of breath, a near-syncopal episode, and numbness to the arms and legs. She had a history of tobacco use, high triglycerides, and high cholesterol. An electrocardiogram (ECG) was ordered and showed a computer reading of "high QRS voltage, ? Normal for age." After being examined and treated, she was discharged with a diagnosis of "hyperventilation." Several hours later, she was found unresponsive by family members and could not be revived. An autopsy revealed that the cause of death was a posterior myocardial infarct. A staff cardiologist who reviewed the ECG (presumably after the patient had died) testified, among other things, that it was a "standard medical practice" for the ED physicians at the hospital to contact the on-call cardiologist if the computer identified an abnormality such as "high QRS voltage, ? Normal for age." The trial court did not allow the cardiologist's testimony regarding the hospital policies to be brought out at trial, and there ultimately was a verdict in favor of the physician. On appeal, the reviewing court held that the hospital's policy and procedure do provide evidence of the standard of care, noting that there was a possibility that if the ED physician had complied with the policy in effect, the on-call cardiologist would have been consulted and the patient could have survived the heart attack. Since Florida courts allow a claimant in a medical malpractice action "to establish that the health care provider breached his or her own rule of practice or violated an industry standard as evidence of the standard of care," the trial court's failure to allow the cardiologist's testimony regarding the hospital policies required that the jury's verdict be reversed.

Similarly, in *Marks v. Mandel*,[21] a hospital, ED physician, and ED contract group were sued after an emergency physician allegedly failed to contact a trauma surgeon in a timely manner and failed to transfer a patient to a regional trauma center. Hospital policies were in place defining "emergency medical care" as being provided by "an Emergency Room contract physician with specialty consultation within thirty (30) minutes." Hospital policies also contained a section on transferring patients to regional trauma centers. The trial court excluded the information in the manuals from evidence. The Florida Appellate Court held that the hospital's ED policy

and procedure manual was admissible as evidence of the standard of care, stating that "internal manuals" should be admitted into evidence whenever they contain evidence of an industry custom or standard, or evidence that a defendant violated either its own policy or an industry standard. Since the hospital imposed a 30-minute time limit upon itself to have specialty consultation available, it could be held to that standard.

Finally, in *Byrd v. Medical Center of Central Georgia, Inc*.,[22] the Georgia Court of Appeals held that a physician not only could be considered negligent for failing to follow established department guidelines, but also could be considered negligent for not knowing that the guidelines existed.

The *Physicians' Desk Reference* is another publication that may be used to establish the standard of care. Significant differences exist between jurisdictions as to how the *Physicians' Desk Reference* can be used to prove the standard of care. A minority of jurisdictions allow the *Physicians' Desk Reference* to be used as substantive proof of the standard of care for prescribing medications: if a physician deviates from the recommendations contained in the *Physicians' Desk Reference*, negligence is assumed. A representative case holding is contained in *Fournet v. Roule-Graham*,[23] in which a patient with a previous history of deep venous thrombosis suffered a massive blood clot after being prescribed estrogen-containing contraceptives. The defendant physician and her expert witnesses testified that 70% of obstetricians and gynecologists nationwide would find no risk between the use of Provera and the development of deep vein thrombosis — in essence, making an argument that her treatment conformed to what a reasonable obstetrician would do under the same or similar circumstances. The Court of Appeals held that the *Physicians' Desk Reference* was an authoritative medical source and that there was no evidence that the *Physicians' Desk Reference* should "be ignored for any reason." The court also stated that, despite expert testimony to the contrary, it was not persuaded that the "OB/GYN community is correct and the *Physicians' Desk Reference* is wrong."

Alternatively, most courts allow the *Physicians' Desk Reference* to be considered as one of the factors to determine whether a physician's actions fall within the standard of care. In these cases, expert testimony must be used to supplement information contained in the *Physicians' Desk Reference*.

Spensieri v. Lasky[24] involved a 29-year-old plaintiff who developed dysfunctional uterine bleeding, was evaluated by the defendant, and was prescribed oral contraceptives containing a high estrogen content. When the bleeding persisted, the defendant physician prescribed supplemental estrogen without examining the patient. Within a month of receiving the increased dose of estrogen, the patient suffered a severe stroke, rendering her a quadriplegic. The patient filed suit, alleging that the physician failed to adequately monitor her after prescribing the additional estrogen.

During the trial, the plaintiff's expert claimed that the *Physicians' Desk Reference* was a "standard of care" for physicians who prescribe oral contraceptives. The plaintiff argued that physicians must adhere to the recommendations contained in the *Physicians' Desk Reference* when prescribing and monitoring medications. The Court of Appeals rejected the notion that the *Physicians' Desk Reference* alone was sufficient to establish the standard of care. Allowing the *Physicians' Desk Reference* to be used as a sole criterion for standard of care, the court held, would allow the drug manufacturers, rather than medical professionals, to determine the proper standard of care. The use of the *Physicians' Desk Reference* in this case was to provide evidence establishing the existence of a "warning" to a physician regarding a drug. The court held that it was up to the jury to evaluate the warning's "accuracy, clarity, and relative consistency." Multiple other jurisdictions also have held that the *Physicians' Desk Reference* alone may not be used to establish the standard of care, but that it may be used as an adjunct to expert testimony.[25]

"Learned treatises," such as medical textbooks and journal articles, comprise another subset of written materials that may be used to help establish the standard of care. The use of learned treatises generally is limited to specific circumstances based on the legal theory of hearsay. Federal and state courts recognize that when an article is presented as evidence, there usually is no way to cross-examine the author to determine the basis for any written statements. Additionally, authors do not write book chapters or journal articles under oath. Since there is no way for a court to determine whether the statements in books or journals represent acceptable medical theories, use of learned treatises generally is limited to exploring the opinions given by expert witnesses.

State statutes regarding learned treatises often

parallel Federal Rule of Evidence 803(18), which states that for a learned treatise to be admissible as evidence, it must be established as a "reliable authority" and the expert witness either must have relied upon the learned treatise in formulating an opinion or must have been questioned on the material during cross-examination. Written material may be established as "authoritative" by either the testimony of the witness, by other testimony, or by judicial notice (meaning that a judge rules that a treatise is authoritative without any testimony). While a majority of courts follow the guidelines set forth in the Federal Rule of Evidence 803, at least one jurisdiction has not adopted this rule, reasoning that allowing written information to be read into evidence would give the party offering the written evidence a "free shot" at providing expert testimony without the opposing party having the ability to cross-examine the expert who wrote the material.[26]

Applicability to Emergency Medicine

The potential admissibility of hospital policies and protocols as evidence of the standard of care puts the emergency physician in a difficult situation. On one hand, an emergency physician who fails to become familiar with hospital policies and protocols for the ED risks being held negligent for not doing so. On the other hand, an emergency physician who is familiar with hospital policies and protocols but fails to follow them also risks being held negligent. Overly optimistic hospital policies or protocols requiring that patients receive specified treatment within specific time limits may impose unnecessary liability on both the physician and the hospital. Limiting or generalizing policies and protocols applicable to physicians may be one way to decrease hospital and physician liability.

The admissibility of published materials as evidence of the standard of care also has a significant impact upon the practice of emergency medicine. For example, emergency physicians routinely use medications for off-label indications. Even though there is no *Physicians' Desk Reference* indication for using the nausea medication Compazine (prochlorperazine) as treatment for pain, many physicians find that intravenous Compazine is quite effective in aborting migraine headaches. In some jurisdictions, the lack of a *Physicians' Desk Reference* indication using Compazine for headache could be used as conclusive evidence that a physician was negligent if he or she prescribed intravenous Compazine for migraine headaches and an adverse consequence occurred. If an expert were to testify to a causal relationship between a physician's "negligent" use of Compazine and some damages the patient suffered, the prescribing physician could be liable for malpractice.

While written standards can be compelling evidence that a physician adhered to the standard of care, they are only one of the ways by which a breach of the standard of care may be established.

Physician Admissions

Perhaps the most damaging evidence of a breach of the standard of care are admissions defendant physicians make about the care they have provided. If a physician admits that he or she has breached the standard of care, the plaintiff may not need to prove the "breach of duty" aspect of a negligence claim.

As an example of how answers to seemingly innocent questions may be against a physician's best interests, reconsider the question posed earlier: "Does the standard of care require that an emergency physician inform a consultant of a change in a patient's condition?" A physician who blindly agrees with this inquiry has now established a blanket standard that a consultant must be notified for any change in a patient's condition. While the physician may have intended that an affirmative answer only include significant changes in a patient condition, such as new ischemic changes on an ECG or respiratory arrest, the question did not specify what changes should be relayed to a consultant. A patient's blood pressure may increase by 20 mmHg or the patient may vomit while in the ED. Using the physician's admissions, if the consultant was not notified about these minor changes in the patient's condition, the physician has effectively admitted that he was not practicing in accordance with the standard of care. Always keep in mind that the standard of care is *situation-specific*. By providing a specific yes/no answer to a general question, the unwary physician may have unintentionally made it much easier for the plaintiff to prove a breach in the standard of care. There are many cases in which physicians have damaged their defense by the admissions they made.

An example of a cross-examination in which a physician admitted that he breached the standard of care occurs in *Franco v. Latina*.[27] In this case, a surgeon performing a laparoscopic cholecystectomy misidentified the common bile duct as the cystic duct, causing bile duct injury that resulted in "severe

personal injuries and extreme pain and suffering" to the plaintiff. A jury trial resulted in a verdict for the defendant physician, but on appeal the Rhode Island Superior Court reversed the jury's decision, stating that "[r]easonable minds could not have come to the conclusion reached by the jury" when considering the evidence provided. The Superior Court noted that the evidence clearly showed that "defendant's own testimony . . . best supports the theory that defendant failed to meet the standard of care," citing the following exchange between the defendant and the plaintiff's attorney:

"Q: Now, isn't it true, [that experts recommend] the conclusive unmistakable identification of the structures that are supposed to be cut safely in a procedure like this?
A: Correct.
Q: And isn't it true that [there are multiple published articles demonstrating] recommended methods by which the doctor could and hopefully would conclusively identify the vital structures, cystic duct, cystic artery in this procedure?
A: Yes.
Q: There were differing methods, were there not, recommended as far as the techniques were concerned, to enable the surgeon to conclusively, unmistakably identify the proper structures?
A: Correct.
Q: So the standard of care . . . that you were obligated to follow, you and other surgeons doing this procedure, was to do whatever was necessary to conclusively, unmistakably isolate and identify the cystic duct, correct?
A: Correct.
Q: You didn't do that in this case, did you?
A: I was — I misidentified the cystic duct or I misidentified the common duct as the cystic duct."

The court held that the defendant's own testimony indicated that conclusive identification of the structures during the laparoscopic surgery was required to meet the standard of care and that the defendant, by his own admission, did not meet those requirements.

Notice how the questions posed by the attorney created a pattern in which the physician agreed with everything the attorney said — up until the attorney asked the physician to admit that he had breached the standard of care. While the physician did not directly answer the attorney's last question, his agreement with the attorney's prior questions had already established that the physician breached the standard of care.

An emergency physician's admissions served as one basis for an $18.5 million judgment for failure to diagnose subacute bacterial endocarditis in *Tierney v. Community Memorial General Hospital*.[28] The large plaintiff verdict was appealed, in part because there was no plaintiff expert testimony establishing that failure to hear the patient's alleged heart murmur was a deviation from the standard of care. However, the emergency physician made several admissions against his own interests — several of which probably were not necessary. The physician admitted that the patient had a fever of unknown origin and that a physician should consider endocarditis when a patient has a fever of unknown origin. Given the facts of the case, the patient did not have a fever of unknown origin by the traditional definition, and therefore, the issue of whether endocarditis should have been considered should have been rendered moot. Neither of these admissions needed to be made. The physician also admitted that the patient *probably* had a heart murmur, that he failed to hear the *probable* heart murmur, and that he *might* have diagnosed endocarditis had he heard the *probable* murmur. Rather than engaging in all of this speculation, the physician could have adhered to factual statements: he listened to the patient's heart, he did not hear a heart murmur when he listened to the heart, and patients with endocarditis may not have heart murmurs or may only develop heart murmurs late in the course of the disease. Without the physician's admissions, the plaintiff's verdict may have been overturned. But, using the physician's admissions, the Court of Appeals filled in the gaps in expert testimony by holding that the standard of care must have required the emergency physician to hear the plaintiff's murmur once the physician deemed it important enough to listen to the patient's heart — especially given the potentially serious consequences that could arise from bacterial endocarditis. The judgment for more than $18 million was affirmed.

An emergency physician's admissions also were sufficient to establish negligence in *Smith v. State*.[29] Rather than attempting to explain how his conduct was appropriate under the specific circumstances of his case, it was the emergency physician's testimony that a four hour delay in obtaining an ECG on a patient with dyspnea did not meet his usual standards, that had he received the ECG results sooner he would have

initiated an alternative treatment (including contacting a medical consultant), that charting in the case was inadequate, and that "in retrospect he would have told the nurses to add more documentation." The Court of Appeals used all this evidence to confirm a trial court's finding of negligence against both the emergency physician and the hospital.

Statements physicians make against their own interests do not necessarily have to be made during formal court proceedings, either.

While it may be beneficial for physicians to admit their mistakes at times, physicians may inadvertently make unwarranted admissions of liability, thereby compromising a malpractice defense. Although a physician may feel emotionally responsible for a "bad outcome," the law does not hold physicians responsible for bad outcomes. The standard of care requires only that a physician act *reasonably* under the given circumstances, not that a physician guarantees a good result. There may be an entirely reasonable excuse justifying a physician's actions in one instance when the same physician would have acted differently under slightly different circumstances. Unwarranted admissions about justifiable care unnecessarily might compromise an otherwise defensible case.

Expert Testimony

While it is the jury's function to determine whether the standard of care has been breached, in a vast majority of cases the jurors must rely upon the testimony of a medical expert to explain the standard of care under given circumstances. Unfortunately, use of such a subjective standard frequently has been criticized. A well-respected federal court judge, the Honorable Thomas Penfield Jackson, noted that the "current practice of relying upon adverse expert opinion testimony alone to establish the standard [of care] is primitive, crassly subjective, and prone to exploitation, if not actual corruption."[30]

To establish the standard of care, the expert should determine what "reasonable," "common," or "ordinary" practitioners would do in circumstances similar to the case being reviewed. Such analysis often does not take place. There is an overwhelming tendency for experts to determine what they would have done in a given situation and then to assume that other physicians should have acted in the same way.[31] Using oneself as a frame of reference to determine the standard of care is a natural tendency. After all, it is difficult to imagine that any physician would consider that he or she practices below the standard of care. Despite this natural tendency, a subjective physician standard is insufficient to establish either a standard of care or a breach in the standard of care. In *Donais v. U.S.*,[32] the plaintiff's expert opined that an undesirable result after ophthalmologic surgery constituted a breach in the standard of care, but neither plaintiff's nor the defendant's experts were able to define the baseline standard of care that established malpractice. The U.S. Court of Appeals, citing Illinois case law, stated that when testifying experts simply provide conflicting opinions about what they consider to be a "correct technique," there is insufficient evidence of a standard of care to submit the case to the jury. This court specifically noted that a plaintiff cannot establish the standard of care or a breach thereof "merely by presenting the testimony of another physician who states that he would have acted differently from the defendant."

Subjective determinations of the standard should be considered unfair to the physician being reviewed and have been determined as legally insufficient to establish the standard of care. Attempts at using an objective standard may prove equally frustrating.

Does a Standard of Care Always Exist?

An expert should provide an objective opinion on how a "reasonable," "common," or "ordinary" physician would have acted under the same or similar circumstances. Regrettably, there is no readily available objective method for determining such a "reasonable physician standard." Despite this lack of objective data, experts seldom are asked to justify the basis for their opinions about how a reasonable physician would have acted under certain circumstances. It seems counterintuitive that some of the most revered expert witnesses are leading authors of textbooks or professors emeritus practicing at prestigious university-based institutions, having little or no recent clinical experience and little or no basis for determining how a reasonable or ordinary physician would act. Even more distressing are retired physicians subject to no practical peer review who act as expert witnesses and who testify to outdated standards or to standards read in books rather than standards they and the physicians around them currently practice.

Even when physicians critique the care of a colleague, they seldom agree on the "standard of care"; finding consensus of opinion is elusive. On many

occasions, especially when multiple treatment options are available, ethical experts may have to admit that no true standard of care exists.

Consider, for example, a scenario presented in the Standard of Care Project, an ongoing reader feedback feature of the magazine *Emergency Physician's Monthly*.[33] In this hypothetical case, a 38-year-old female sought care for "suicidal thoughts." Although she had no specific plan, she did have a history of one suicidal gesture several years prior to her presentation. She was actively using cocaine and was unable to find a place to go for the night. The emergency physician was able to find the patient placement in a shelter, but the patient refused to go, insisting that she needed "psychiatric care." The patient was discharged with outpatient follow-up appointments, but refused to leave and had to be escorted from the ED by security guards while screaming, "I'll show you" to the ED staff.

Of the physicians responding, 23% believed that the standard of care was not met, stating that the patient was at an "increase[ed] risk for suicide" and chastising the physician for "assum[ing] that the patient was 'using the system.'" Fifty-nine percent of physicians believed the standard of care was met, citing the patient's "low risk" for suicide and believing that the patient was "manipulative" and had a "hidden agenda." The remaining 18% of physicians were undecided.

How should a jury decide this case? Consider that 59% of experts believed the standard of care was met (citing the patient's *"low"* suicide risk), while 23% of experts believed the standard of care was not met (citing the patient's *"high"* suicide risk). It is this divergence in opinion that often confuses a jury — one expert vigorously arguing one extreme while a second expert makes an equally compelling argument for the opposite extreme. Since the jury is not capable of deciding these complicated medical issues, jurors may be left to decide the outcome of the case based not upon the factual issues, but rather upon which expert was more convincing.

A divergence of expert opinion was also noted in a study by Hartz, et al.[34] In this study, surveys were sent out to more than 500 Iowa physicians describing seven malpractice cases and asking the physicians to comment on the care provided. Between 51% and 63% of physicians responded to the surveys. Of those responding, at least two-thirds disagreed with the testimony of at least one expert in each case. This inconsistency in opinions between physicians may reflect the lack of a standard of care in many cases.

Not all cases have such a divergence in expert opinion. Consider this second case from the Standard of Care Project.[35] An 18-year-old female sought evaluation for a one-day history of vaginal bleeding and mild cramping suprapubic pain. There was a small amount of unclotted blood on the pelvic examination. No masses or tenderness were noted on the bimanual examination, but the ovaries were unable to be definitively identified by palpation. A quantitative pregnancy test was consistent with an estimated gestational age of seven weeks. The emergency physician did not obtain an ultrasound in the ED, but instead discharged the patient with instructions to see the obstetrician. The patient died from a ruptured ectopic pregnancy while waiting for the follow-up appointment with the obstetrician.

Of the physicians responding to the scenario, 98% believed that the standard of care had been breached, with many making comments that the case was a "slam-dunk" and "no-brainer." Several physicians cited references to textbooks backing up their assertions. Two physicians who believed that the standard of care might have been met relied either upon the "local standard" or upon the patient being provided with explicit follow-up instructions as defenses to the poor outcome.

Does such an overwhelming physician consensus that this patient should have had a pelvic ultrasound establish a pelvic ultrasound as the "standard of care" in a pregnant female with abdominal pain? A plaintiff's attorney would argue this point, but the physician shouldn't necessarily agree. Recall that the standard of care is *situation-specific*. An ultrasound might not be indicated if the female patient was 20 weeks pregnant and had a catheterized urine specimen showing hemorrhagic cystitis. Similarly, an ultrasound probably would not be indicated to rule out ectopic pregnancy if the female patient had a quantitative HCG of only 50 I.U. since an intrauterine pregnancy would not be visible on a pelvic ultrasound at such an early gestational age. Even in the hypothetical patient presented, an ultrasound report from earlier in the week demonstrating an intrauterine pregnancy would probably have eliminated the need for a repeat ultrasound to exclude an ectopic pregnancy on her presentation to the ED. Rather than being applicable to all pregnant female patients, the second Standard of Care Project case illustrates only that in some cases, the standard of care requires an emergency physician to obtain an urgent abdominal

ultrasound on a seven-week pregnant female who presents with vaginal spotting and cramping suprapubic pain.

Complicating the issue further, even when there appears to be a consensus of expert opinion regarding a physician's actions, a standard of care may still not be established. A recent study by McGlynn, et al.[36] showed that significant percentages of patients did not receive recommended care from their physicians. Using established clinical guidelines as evidence of recommended care, the study found that in some cases nearly 90% of patients were managed inappropriately by their treating physicians. Most patients received little more than 50% of the treatment recommended by established guidelines. If this study is any indication, up to 90% of physicians might consider inappropriate care as the "standard" to which other physicians should be held. Physicians who practice according to established guidelines could ironically be accused of "negligence" by a consensus of uninformed physicians who have failed to educate themselves about updates in medical practice.

The varied fact patterns in each case and the wide divergence in physician opinion regarding patient management should create some doubt whether the standard of care can be stated definitively in all cases. These same variables should create an even higher degree of skepticism as to whether the standard of care consistently can be proven in a court of law.

Conclusion

The ability to define the standard of care and to prove that the standard of care has been breached is the cornerstone of most medical malpractice actions. Although legal definitions of the standard of care abound, applying these definitions to specific cases can prove a daunting task undermined by subjectivism. In some circumstances, a standard of care may not exist. A physician who follows applicable guidelines stands a much better chance of defending malpractice actions alleging that the physician failed to adhere to the standard of care.

Endnotes

1. Black HC, ed. *Black's Legal Dictionary*, West Publishing Co., St. Paul, MN (1991).
2. 730 N.E.2d 1119 (Ill. 2000).
3. 796 A.2d 1091 (R.I. 2002).
4. 19 P.3d 834 (Okla. 2000).
5. *Vassos v. Roussalis,* 658 P.2d 1284 (Wyo. 1983).
6. *Id*.
7. *Small v. Howard*, 128 Mass. 131 (1880).
8. La. R.S. 9:2794. Text from this statute appears on-line at www.legis.state.la.us/tsrs/tsrs.asp?lawbody=RS&title=9&section=2794. See also, e.g., North Carolina General Assembly Statutes 90-21.12, Idaho Statute 6-1013.
9. 72 S.W.3d 489 (Ark. 2002).
10. 757 P.2d 1199 (Idaho 1988).
11. *Gridley v. Johnson,* 476 S.W.2d 475 (Mo. 1972).
12. *Sheeley v. Memorial Hospital*, 710 A.2d 161 (R.I. 1998).
13. *Grover v. Smith*, 46 P.3d 1105 (Idaho 2002) (in reference to a dentist who, without performing a physical examination, referred a patient with severe headaches to an oral surgeon to have teeth pulled instead of referring the patient to a medical doctor for treatment of what turned out to be intracerebral bleeding).
14. 610 A2d 964 (1992).
15. *Hood v. Phillips*, 554 SW.2d 160 (Tex. 1977)
16. See, e.g., West Virginia's Proposed Jury Instruction #108 for Medical Malpractice Actions contained at (www.state.wv.us/wvsca/jury/medprof.htm#102). See also *Nowatske v. Osterloh*, 543 N.W.2d 265 (Wis. 1996) (interpreting Wisconsin statutes and holding that a physician still can be held negligent if the physician fails to "exercise reasonable care in using that recognized alternative method").
17. *Black's Legal Dictionary* at 905. See also, *Coleman v. Rice et al*., 706 So. 2d 696 (Miss. 1997).
18. See generally, *Coleman v. Rice et al*., 706 So. 2d 696 (Miss., 1997); *Gannon v. Elliot*, 19 Cal App 4th 1 (Cal., 1993); *Pekar v. St. Luke's Episcopal Hospital*, 570 S.W.2d 147 (Texas, 1978).
19. See, e.g., *Coleman v. Rice et al*., 706 So. 2d 696 (Miss., 1997); *Tice v. Hall*, 313 S.E.2d 565 (1984).
20. 780 So. 2d 205 (Fla. 2001).
21. 477 So. 2d 1036 (Fla. 1985).
22. 574 S.E.2d 326 (Ga. 2002).
23. 783 So.2d 439 (La. 2001). See also, *Mulder v. Parke Davis & Co.*, 181 N.W.2d 882 (Minn. 1970); *Ohligschlager v. Proctor Community Hosp.*, 303 N.E.2d 392 (Ill. 1973).
24. 723 N.E.2d 544 (N.Y. 1999).
25. See e.g., *Morlino v. Medical Center of Ocean County*, 706 A.2d 721 (N.J. 1998); *Bissett v. Renna*, 710 A.2d 404 (N.H. 1998); *Craft v. Peebles,* 893 P2d 138 (Hawaii 1995).
26. *Courtney v. Taylor*, 708 N.E.2d 1053 (Ohio 1998).
27. 2002 R.I. Super. LEXIS 9.
28. 645 N.E.2d 284 (Ill. 1994).
29. 517 So. 2d 1072 (La. 1987).
30. Observations on the Search for Objective Proof of the Standard of Care in Medical Malpractice Cases, *Wake Forest Law Review,* Fall 2002; p. 953.
31. Ely, John, et al., *Determining The Standard Of Care In Medical Malpractice: The Physician's Perspective*, Wake Forest

CE/CME Objectives

[For information on subscribing to the CE/CME program, contact customer service at (800) 688-2421 or e-mail customerservice@ahcpub.com.]

The participants will be able to:

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- identify a "standard of care" for treating particular conditions covered in the newsletter;
- identify cases in which informed consent is required;
- identify cases which include reporting requirements;
- discuss ways in which to minimize risk in the ED setting.

Law Review, Fall 2002; p. 861 (cite at 865).

32. 232 F.3d 595 (7th Cir. 2000).
33. Standard of Care Project, *Emergency Physician's Monthly,* Vol. 8, No. 7, July 2001. Text also appears on EP Monthly's web site at www.epmonthly.com/EPStanCarPro.asp?showarchive=1&artname=162.
34. Hartz A, et al. Physician surveys to assess customary care in medical malpractice cases. *J Gen Intern Med* 2002; 17:546, 547-549.
35. Standard of Care Project, *Emergency Physician's Monthly;* Vol. 8, No. 3, March 2001. Text also appears on publication's web site at www.epmonthly.com/EPStanCarPro.asp?showarchive=1&artname=94.
36. McGlynn EA, et al. The quality of health care delivered to adults in the United States. *N Engl J Med* 2003; 348(26): 2635-2645.

CE/CME Questions

21. Which of the following is *least* likely to be used as proof of the standard of care?

A. Learned treatises
B. Expert testimony
C. Plaintiff's testimony
D. Defendant physician's testimony
E. Clinical guidelines

22. Which claim would most likely fulfill the requirements for *res ipsa loquitur*?

A. A patient with a penicillin allergy who suffers an anaphylactic reaction after a physician prescribed amoxicillin/clavulanate
B. A patient who suffers a myocardial infarction after being discharged from the emergency department with a diagnosis of indigestion
C. A febrile child who develops meningitis after his parents fail to follow up with a primary care physician as instructed
D. A patient who is alleges that a physician sexually assaulted her during a pelvic exam
E. A patient who wakes with a corneal abrasion after sedation for a shoulder reduction

23. Which statement is *false*?

A. A consensus of expert physician opinions will establish the standard of care.
B. There may be more than one standard of care for a specific incident.
C. The standard of care should not be determined solely by what a reviewing physician would have done differently from the physician being reviewed.
D. The standard of care is situation-specific.
E. A standard of care for a specific incident may not exist.

24. Why can't a learned treatise be used to prove the standard of care under most circumstances?

A. The information contained in the treatise may be outdated.
B. There may be flaws in the manner by which the treatise came to a conclusion.
C. The author of the treatise probably did not write the treatise under oath.
D. There is no way to cross-examine the author about the treatise if the treatise is read into evidence.
E. All of the above

Answers: 21. C; 22. E; 23. A; 24. E.

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Physicians and nurses participate in this continuing medical education/continuing education program by reading the article, using the provided references for further research, and studying the questions at the end of the article. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. There is no need to complete and return a Scantron form. To clarify confusion surrounding any questions answered incorrectly, please consult the source material.

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