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THE STANDARD OF CARE IN MEDICAL MALPRACTICE CLAIMS, CLINICAL PRACTICE GUIDELINES, AND MANAGED CARE: TOWARDS A THERAPEUTIC HARMONY?

DANIEL W. SHUMAN*

I. THE DEVELOPMENT OF THE STANDARD OF CARE IN MEDICAL MALPRACTICE CLAIMS IN AN ERA OF FEE FOR SERVICE HEALTH CARE

The goal of the tort system is to reduce the level of injury and disability in society, which it seeks to achieve through tort judgments that deter unsafe conduct and compensate people injured by that unsafe conduct.¹ Negligence,² the basis for most medical malpractice tort claims, reflects this goal. To prevail in a medical malpractice action based in negligence, the claimant must convince the fact finder by a preponderance of the evidence that the health care provider, who owed a duty to the claimant, violated the applicable standard of care, thereby proximately causing injury to the claimant.³ Thus, in order for the tort system to operate as a vehicle to determine liability and to communicate what society regards as reasonable behavior for others in similar situations, it is necessary to articulate clearly a standard of care in malpractice litigation.

In the absence of legislation that defines what society expects of its members, what is commonly referred to as negligence per se⁴ (e.g., a traffic law that prohibits driving over 15 mph in a school zone communicates society's judgment that the standard of care is that it is unreasonable to drive over 15 mph in a school zone), courts have generally been unwilling to heed

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1. See Daniel W. Shuman, *The Psychology of Deterrence in Tort Law*, 42 U. KAN. L. REV. 115 (1993).

2. "[N]egligence is conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm." RESTATEMENT (SECOND) OF TORTS § 282 (1977).

3. See *id.* § 281.

4. See *id.* § 286.

Oliver Wendell Holmes' admonition to crystallize standards that express the collective wisdom of decision making in similar cases.⁵ Jurors, the decision maker in most medical malpractice cases,⁶ are not informed of or guided by the insights of decisions in similar cases. To the contrary, the inability or unwillingness to put aside knowledge of other decisions may result in a juror's disqualification. The judicial system's sole formal guidance to jurors for assessing the adequacy of care typically comes in the form of a standard medical malpractice jury instruction. A common set of instructions informs juries in malpractice cases that "the duty of the professional [is] to use such skill, prudence and diligence as other members of his profession commonly possess and exercise."⁷ This instruction hardly informs the jury more than to say that we should expect health care professionals to act the way that reasonable health care professionals usually act. Thus, the standards for judging appropriate medical practice tend to be case specific, informed by competing partisan experts employed by the parties.

This *uncrystallized* approach to setting the standard of care in medical malpractice cases has three failings. First, this approach may encourage health care professionals to employ costly, medically unnecessary, and often legally uncalled for procedures that expose patients to an additional set of risks (i.e., defensive medicine) because health care professionals lack clear guidance about the legal system's expectations of them. The use of case-specific standards leads health care professionals to shape their professional practice by relying on a hodgepodge of incomplete, inaccurate, or inconsistent information about settlements and jury verdicts, which are not formally collected, analyzed, and communicated to health care professionals.⁸ Second, this approach may encourage the institution of marginal claims by failing to provide lawyers with clear, consistent standards about what is expected of health care professionals. Ethically, if not financially, lawyers are compelled to be zealous advocates for their clients and thus inevitably interpret unclear, inconsistent standards of care in favor of the viability of their client's claims. Third, this approach may increase the risk of both false positive and false negative errors in assessing violations of the standard of care by failing to provide legal decision makers with clear guidance about the standard of care.⁹ In the absence of clear, consistent standards, judges

5. OLIVER W. HOLMES, JR., *THE COMMON LAW* 127-29 (1881). See Carol M. Rose, *Crystals and Mud in Property Law*, 40 STAN. L. REV. 577, 577-79 (1988).

6. See Neil Vidmar, *Empirical Evidence on the Deep Pockets Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases*, 43 DUKE L.J. 217 (1993).

7. *Bily v. Arthur Young & Co.*, 834 P.2d 745, 772 (Cal. 1992).

8. See Shuman, *supra* note 1, at 124.

9. The Harvard Medical Practice Study which reviewed records of 31,000 patients revealed both sets of errors. While approximately 400,000 patients are injured through medical negligence each year, fewer than 50,000 malpractice claims are brought. Thus, far too few claims are brought. It is estimated that two-thirds of these claims did not involve negligently caused injuries. Thus, most of the claims were brought in the wrong cases. See David M. Studdert & Troyen A. Brennan, *Deterrence in a Divided World: Emerging Problems for*

and juries alike are more likely to be influenced by a multitude of extra-legal factors that may skew their decisions.¹⁰

However serendipitous the decision to set the standard of care in this fashion may seem when viewed in isolation, in context there is a logic to it. Reflecting the felt necessities of the time,¹¹ this individualized post hoc approach to ascertain the standard of care for determining the tort liability of health care providers reflects the practice of fee for service medicine. Just as quality considerations dominated cost considerations in medical decision making in the practice of fee for service medicine, quality considerations have also dominated cost considerations in the tort liability standard for medical malpractice claims that evolved in that era. Although the standard of care asked the decision maker to assume a foresight perspective considering only the circumstances known at the time of the conduct examined, the decision maker enjoyed the *benefit* of hindsight.¹² From this hindsight perspective, asking jurors to assess the reasonableness of the physician's actions on a case-by-case basis skewed cost benefit considerations. It focused on the known harmful outcome to this plaintiff rather than the cost-benefit analysis to the plaintiff as a member of the class of persons at risk. With knowledge that the costs of medically necessary care were generally absorbed by health care insurers,¹³ the jury was free to determine, without the limitation of crystallized standards, what it thought was then medically

Malpractice Law in an Era of Managed Care, 15 BEHAV. SCI. & L. 21, 26-27 (1997).

10. See generally DANIEL KAHNEMAN ET AL., *JUDGMENT UNDER UNCERTAINTY: HEURISTICS AND BIASES* (1982).

11.

The general test in malpractice litigation against health care professionals is whether the defendant adhered to prevailing professional standards in providing care. This judicial reinforcement of professional norms endorses at least implicitly the values that underlie the fee-for-service model of health care. As a result, historically, ethical, legal, and financing principles were largely congruent.

John Petrilla, *Symposium: Ethics, Money, and The Problem of Coercion in Managed Behavioral Health Care*, 40 ST. LOUIS U. L.J. 359, 381 (1996).

12. See Norman G. Poythress Jr., *Negligent Release Litigation: A Proposal for Procedural Reform*, 17 J. PSYCHIATRY & L. 595 (1989); David B. Wexler & Robert F. Schopp, *How and When to Correct for Juror Hindsight Bias in Mental Health Law Malpractice Litigation: Some Preliminary Observations*, 7 BEHAV. SCI. & L. 485 (1989)

13.

Since the growth of employer-provided health insurance after World War II, health professionals generally have been free to order for their patients any accepted diagnostic procedure or treatment, knowing that third-party payers would cover the costs. Thus, clinicians had both the obligation to determine what care their patients reasonably required and the power to provide or otherwise obtain that care.

Paul S. Appelbaum, *Legal Liability and Managed Care*, 48 AM. PSYCHOLOGIST 251, 252 (1993).

necessary and, therefore what should have been done.¹⁴ Just as the treating physician was largely unencumbered by cost considerations in the delivery of care, the factfinder was also largely unencumbered by cost considerations in assessing the adequacy of care.

Whatever sense this approach may have made to setting the standard of care in an era of fee for service medicine, the potential conflict that may arise is obvious when this approach is applied in an era of managed care. Physicians whose practice is now dominated by cost considerations are judged by a standard that does not reflect these cost considerations. Indeed, the court in *Wickline v. State*,¹⁵ one of the few decisions that addresses a physician's duty to a patient in light of the limitations of a managed care plan, noted that managed care should "not be permitted to corrupt medical judgment,"¹⁶ implying that the physician's duty to the patient should not be altered by the nature of the managed care plan. Subsequently, in *Wilson v. Blue Cross of Southern California*,¹⁷ the California Court of Appeal again noted that the physician's duty of care should not be dictated by fiscal considerations. This case involved a malpractice claim following a patient's suicide because he had been discharged based on Blue Cross' refusal to authorize the full recommended four weeks of psychiatric hospitalization.¹⁸

There has been little change in what society expects of health care providers as manifested in malpractice law to reflect the structural changes in health care delivery.¹⁹ But, there may exist a potential vehicle to address many of these problems to the satisfaction of both the health care and the legal professions: clinical practice guidelines. Clinical practice guidelines offer the possibility of clear, consistent standards of cost effective care. Are these clinical practice guidelines a potential boon to the courts and the health care professions? If so, why have the health care professions been so concerned about their development, and why has the legal system not embraced their use in malpractice claims?

14.

Together, these rules suggest a certain image of medical decisionmaking, one in which physicians may only consider therapeutic benefits and harms; judgments of cost-effectiveness are out-of-bounds. There is no general 'Learned Hand test' in malpractice law that requires physicians to provide those tests and treatments (and only those tests and treatments) that are cost-benefit justified. Indeed, the law seems to view all economic calculations as a threat to the delicate fiduciary relationship between healer and patient.

Jonathan J. Frankel, Note, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1317 (1994).

15. *Wickline v. State*, 192 Cal. App. 3d 1630 (1986).

16. *Id.* at 1647.

17. *Wilson v. Blue Cross of S. Cal.*, 271 Cal. Rptr. 876 (Cal. Ct. App. 1990).

18. *See id.*

19. *See Studdert & Brennan, supra* note 9, at 26-27; *Petrilla, supra* note 11, at 380.

II. THE EVOLUTION OF CLINICAL PRACTICE GUIDELINES

“[C]linical practice guidelines (CPGs) are [ideally] sets of suggestions, commonly set forth as decision rules, that reflect informed opinion on how to treat a certain illness or condition. CPGs are generally derived from scientific studies comparing the effectiveness of various clinical approaches to treating a particular medical situation.”²⁰ The impetus for CPGs arose from observations of wide ranging variations in regional practices and the desire to determine and inform practitioners what works best and what does not.²¹ By ascertaining and encouraging the use of tests and procedures that work and discouraging those that do not, CPGs offered the opportunity to improve the quality of health care and, additionally, to contain its cost.²²

Although clinical practice guidelines were initially driven by concerns with the quality of care, currently their use by managed care plans is often driven by concerns with the cost of care. As cost-benefit considerations have come to dominate the provision of health care, managed care plans have increasingly utilized clinical practice guidelines to guide a provider’s decision making.²³ “[G]uidelines can provide a basis on which to pay for services as well as to assess and evaluate practitioner and health system performance.”²⁴ In many instances, managed practice plan providers agree to be bound by guidelines in ordering tests and procedures. This shift in orientation has fueled many physicians’ fears that CPGs are a threat to physician autonomy.²⁵

A significant consideration in this fear is who authors the guidelines. Presently, there are three sources of guidelines—governmental entities, professional specialty groups, and third party payers. The federal government, for example, is charged with developing “clinically relevant guidelines”²⁶ through the Office of the Forum for Quality and Effectiveness within the Agency for Health Care Policy and Research “to enhance the quality, appropriateness, and effectiveness of health care services.”²⁷ Professional specialty groups, such as the American Society for Anesthesiologists, have created guidelines to address risk management issues.²⁸ And, third party payers, such as managed care plans, have implemented guidelines for par-

20. Arnold J. Rosoff, *The Role of Clinical Practice Guidelines in Health Care Reform*, 5 HEALTH MATRIX 369, 370 (1995).

21. *See id.*

22. *See id.* at 371.

23. *See* John D. Ayres, *The Use and Abuse of Medical Practice Guidelines*, 15 J. LEGAL MED. 421 (1994).

24. Stephen M. Merz, *Clinical Practice Guidelines: Policy Issues and Legal Implications*, 19 J. ON QUALITY IMPROVEMENT 306, 307 (1993).

25. *See* Rosoff, *supra* note 20, at 374.

26. 42 U.S.C.A. § 299b-1(a) (West 1997).

27. *Id.*

28. *See* Merz, *supra* note 24, at 308.

icipating health care providers.²⁹

III. THE FUTURE OF PRACTICE GUIDELINES AND THE STANDARD OF CARE IN AN ERA OF MANAGED CARE

Courts have only just begun to use practice guidelines to address the standard of care in medical malpractice litigation. Without much fanfare, litigants have introduced and courts have approved the use of practice guidelines to provide evidence of the relevant standard of care.³⁰ For example, in *James v. Woolley*³¹ the court upheld a finding of negligence in choosing a vaginal delivery rather than recommending a cesarean section. The court relied, in part, on the physician's failure to comply with the American College of Obstetrics and Gynecologists' guideline recommending a cesarean delivery for babies estimated to weigh more than 4,000 grams.³² Similarly, in *Pollard v Goldsmith*,³³ the court found evidence of a violation of the standard of care in failing to follow the guidelines promulgated by the American College of Surgeons' Prophylaxis Against Tetanus and Wound Management. The guidelines required that patients with wounds indicating an overwhelming possibility of tetanus must be given human-immune globulin.³⁴

In these cases, the guidelines functioned much like expert testimony to inform the court about the nature of existing practice, seemingly one step removed from the partisanship that often characterizes the presentation of privately retained experts. Not surprisingly, practice guidelines are deemed appropriate for this purpose because existing or customary practice is a central consideration in setting the standard of care in a medical malpractice claim.³⁵ Guidelines used in this manner are not binding on the factfinder but merely shed light on existing practice. Thus, this judicial use of guidelines seems likely to continue to be accepted by the courts.

One of the reasons that this use of guidelines as evidence of existing practice is likely to be accepted by the courts is that the guidelines do little to change existing practice.³⁶ The standard of care remains case specific,

29. See Rosoff, *supra* note 20, at 374.

30. See Lori Rinella, Comment, *The Use of Medical Practice Guidelines in Medical Malpractice Litigation—Should Practice Guidelines Define the Standard of Care?*, 64 U. MO. KAN. CITY L. REV. 337 (1995).

31. *James v. Woolley*, 523 So. 2d 110 (Ala. 1988).

32. See *id.* at 112.

33. *Pollard v. Goldsmith*, 572 P.2d 1201 (Ariz. Ct. App. 1977).

34. See *id.* at 1203.

35. See Joseph H. King, Jr., *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 VAND. L. REV. 1213 (1975).

36. From an evidentiary standpoint, admissibility of these practice guidelines presents surmountable traditional evidentiary issues. For example, as an out of court statement raising hearsay concerns, guidelines may be analyzed within the learned treatise exception to the hearsay rule or as the basis for an expert's opinion exempt from hearsay scrutiny. See Sam A.

and, concomitantly, health care professionals and the courts remain at a loss for authoritative guidance as to appropriate health care. Compliance with or deviation from the guidelines has no direct legal effect because the fact-finder is free to reject these guidelines. Thus, when a health care provider resorts to a guideline in resolving patient care issues, it is unclear what legal effect that decision may have later if a jury should be asked to second guess that decision in a medical malpractice claim. Accordingly, this use of practice guidelines does little to respond to the failure to provide clear, consistent guidance to health care professionals, lawyers, and the courts.

To address this problem, several states, including Florida,³⁷ Kentucky,³⁸ Maine,³⁹ and Maryland,⁴⁰ have taken a first step by enacting statutory schemes to adopt and implement practice guidelines designed, among other things, to play a role in ascertaining the standard of care in medical malpractice litigation. While it is unrealistic to expect practice guidelines to address every clinical decision a physician must make,⁴¹ nonetheless they offer to address a multitude of decisions in a more informed and systematic fashion. The Maine statutory scheme seems to have been the model for this approach. In 1992, Maine embarked on a Medical Liability Demonstration Project that created four medical specialty advisory committees charged with developing "practice parameters and risk management protocols . . . [that] define appropriate clinical indications and methods of treatment."⁴² The goal of the project was to reduce the practice of defensive medicine. Physicians who participate in the project must agree to limit their practice of defensive medicine, and, in exchange, compliance with these standards is admissible as an affirmative defense in an action for professional negligence. This legislation is an innovative first step in setting standards of practice to guide the judiciary and the health care professions.

There are, however, two interesting and interrelated features of the guidelines that deserve additional attention. First, the legislation permits the guidelines to be used defensively by physicians to prove compliance with the standard of care, but not offensively by claimants to prove deviation from the standard of care. Second, there are no case reports of the use of these guidelines. Permitting defensive use of the guidelines may well reduce incentives to engage in medically unnecessary practices and procedures, although proof of the reduction of unnecessary practices is still un-

McConkey, Note, *Simplifying the Law in Medical Malpractice: The Use of Practice Guidelines as the Standard of Care in Medical Malpractice Litigation*, 97 W. VA. L. REV. 491, 510-17 (1995).

37. See FLA. STAT. ch. 408.02 (1996).

38. See KY. REV. STAT. ANN. § 342.035 (Michie 1996).

39. See ME. REV. STAT. ANN. tit. 24, §§ 2971-2979 (West Supp. 1995).

40. See MD. CODE ANN., HEALTH-GEN. I § 19-1602 (1996).

41. See Edward B. Hirshfeld, *Should Practice Parameters Be the Standard of Care in Malpractice Litigation?*, 266 JAMA 2886 (1991).

42. ME. REV. STAT. ANN. tit. 24, § 2973 (West 1996).

clear in the Maine experiment. However, the failure to permit offensive use of the guidelines undercuts the incentive for physicians to utilize these empirically based decision rules. Where a physician fails to comply with a relevant guideline and the patient thereby suffers injury, unless the physician relied on an alternative guideline or can point to more recent research that would justify a deviation from the guideline, not holding a physician accountable for failure to follow the guideline encourages exactly the sort of flawed decision making that the guidelines are intended to avoid.⁴³ Moreover, the absence of mutuality in these guidelines (i.e., permitting only defensive use) raises serious constitutional questions that may chill their use by defense attorneys who do not wish to jeopardize a verdict with a constitutionally suspect procedure.⁴⁴ If defense attorneys are reluctant to jeopardize verdicts by using these guidelines defensively, the assurance the guidelines provide physicians relying on them may be undermined. Yet, it is important not to let this criticism overshadow the importance of the Maine project.

A significant failure of the current method of case specific analysis of the standard of care is the absence of crystallized standards to inform health care professionals what the legal system expects of them, thereby providing an incentive to practice defensive medicine. The use of practice guidelines as a way to establish the standard of care has the potential benefit of informing health care professionals of the standards by which they will be judged. However, some health care professionals fear that practice guidelines and the risk of malpractice exposure for failing to follow them, would unnecessarily limit their discretion and stultify the practice of medicine. This fear appears to explain Maine's limitation on the offensive use of guidelines to obtain physician support for the experiment. Moreover, there will inevitably be a lag between the adoption of guidelines and their incorporation into the prevailing practice in the relevant professional community, particularly when the guidelines are based on research that rejects the efficacy of current treatment approaches.⁴⁵

There has been a lively debate within the health care community about the utility of practice guidelines intended to improve "decision-making by detailing appropriate indications for specific medical interventions."⁴⁶ And, while many health care professional groups have addressed practice guidelines, the pace of their adoption and implementation reflects a profound ambivalence about their development and implementation within the health care community. Yet, practice standards offer health care professionals the opportunity to play a greater role in setting the standards of care that govern health care malpractice litigation.

43. See Robyn M. Dawes et al., *Clinical Versus Actuarial Judgment*, 243 SCIENCE 1668 (1989).

44. See Jennifer Begel, *Maine Physician Practice Guidelines: Implications for Medical Malpractice Litigation*, 47 ME. L. REV. 69, 88-89 (1995).

45. See Rosoff, *supra* note 20, at 380.

46. R. Dale Walker et al., *Medical Practice Guidelines*, 161 W. J. MED. 39, 39 (1994).

Consider, as an example, residency training standards for psychiatry. The practice in supervision of psychiatry residents ranges from intensive supervision of each patient a resident treats to no supervision at all for a portion of a resident's caseload. Often it is left to the discretion of the resident to choose patients to present to a supervisor. This practice paradoxically assumes that residents have the clinical sophistication to know with which patients they need help. Under this system of training, residents can impress their supervisor by choosing to present only those cases where they are particularly knowledgeable. Alternatively, residents can present patients they know their supervisor enjoys working with to gain favor with the supervisor. It is unusual for a program to assign and carefully track each of the patients that a resident is treating, especially outpatients.

Some supervisors meet with the patients that the resident they are supervising is treating, carefully review and sign notes in the patient's chart, and regularly review audio and videotapes of the patient's treatment. Other supervisors hear only a cursory presentation of a patient and never ask for follow up or look at the patient's chart. Further, some patients being treated by residents are not aware that they are being treated by a resident, or that there is a supervisor who is also involved in their treatment.

These differences in supervision are a function of a number of factors, including health care economics, time demands, and personal style. Undoubtedly these factors contribute to natural experimentation that yields some innovative approaches to supervision. But, what about when a bad outcome occurs (misdiagnosis or inadequate treatment, patient suicide, patient harm to a third party, or therapist/resident-patient sexual involvement) and suit is brought alleging that the risk of harm would have been timely identified with appropriate supervision? Although supervisors are not strictly or vicariously liable for the negligent acts of their residents (as an employer is liable without regard to the employer's fault for an employee's negligent acts committed within the scope of the employment relationship), supervisors are liable for the negligent acts of the resident that result from inappropriate (negligent) supervision.⁴⁷ How is the judge or jury to determine whether the supervision in a given case was appropriate?

Health care professionals have understandably decried asking lay judges and juries to arbitrate conflicting technical testimony from partisan experts that may cloak bad science, personal values masquerading as science, or worse, opinions influenced by financial remuneration.⁴⁸ Have the health care professions provided the courts with a viable alternative to ascertain what is adequate supervision? Does a clearly articulated professional consensus exist to assist courts to resolve the question of what supervision is appropriate for a psychiatric resident?

47. See Marshall B. Kapp, *Supervising Professional Trainees: Legal Implications for Mental Health Institutions and Practitioners*, 35 HOSP. & COMM. PSYCHIATRY 143 (1984).

48. See Banks Anderson, Jr., *The Expert Witness*, 97 OPHTHALMOLOGY 1390 (1990).

The Accreditation Council for Graduate Medical Education ("ACGME"), a private consortium of five prestigious health care organizations, has promulgated Special Requirements for Residency Training in Psychiatry.⁴⁹ Although these privately promulgated standards are not binding on courts, they may provide courts with a professional consensus to guide them. Thus, this avoids the need for courts to explore uncharted territory, and rely solely on partisan guides chosen by the litigants.

The ACGME's requirements specify that there must be two hours of individual supervision weekly and that residents must have "sufficient and high quality supervision."⁵⁰ Beyond that, however, the requirements fail to explicate what constitutes sufficient and high quality supervision. Indeed, this standard seems a bad joke on the tort system's clear but prospectively useless guidance to act like a reasonable person under the circumstances. The ACGME requirements are devoid of guidance on questions that courts are called on to resolve in claims of inadequate supervision: should the supervisor be informed of all patients the resident is treating; should the supervisor review the resident's care of each patient and, if so, how often; and, should the supervisor observe, in whole or in part, individual therapy sessions in person or require them to be taped and reviewed, in whole or in part? None of these types of specific questions are addressed in the requirements. As a consequence, when harm occurs, the adequacy of supervision will be judged, and at least for that case, the standard of practice will be set exclusively by the judge's or jury's lay assessment of the litigants' competing experts.

Are there compelling reasons to leave these questions for courts and health care professionals to resolve on a case by case basis? Is it not possible to specify standards of practice that will address these issues? Would not standards of practice likely have a beneficial impact on the quality of care? Is there an absence of research driven professional consensus or an absence of homogeneity such that standards of practice would artificially resolve genuine professional disagreements or fail to incorporate the flexibility to account for relevant patient differences? In some instances, individual variability may call for guidelines that tolerate deviation or the absence of research driven professional consensus may call for options that indicate a number of possibilities, none of which are shown to be superior. Where that variability is not present and the research reveals no genuine disagreement, however, there is no reason to permit deviation.⁵¹

There is professional consensus, for example, that sexual contact between therapists and patients is improper, and that sexual contact between

49. ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., SPECIAL REQUIREMENTS FOR RESIDENCY TRAINING IN PSYCHIATRY (1990).

50. *Id.*

51. See David M. Eddy, *Clinical Decision Making: From Theory to Practice: Designing a Practice Policy: Standards, Guidelines and Options*, 263 JAMA 3077 (1990).

psychiatric residents and patients occurs.⁵² Standards of practice that require that the supervisor be informed of all patients the resident is treating, and require review of the resident's care of those patients, are capable of specification and would likely have a beneficial impact on the quality of care by alerting the supervisor to potential boundary problems and inappropriate care. While appropriate review of the resident's care cannot be guaranteed to identify all such problems, the absence of review can be guaranteed to identify none.

When specific standards can be articulated and would likely benefit the quality of care by concisely informing health care practitioners of the most recent and best research driven answers to questions they now encounter,⁵³ why would the health care professions hesitate to promulgate them? Often, one of the loudest expressions of concern is that standards of practice would become judicially enforced norms resulting in an avalanche of malpractice litigation.⁵⁴ The fear that standards of practice would indiscriminately increase the risk of malpractice litigation is not well taken. Specific standards clarify for health care professionals and lawyers conduct that is subject to tort sanctions. Specific standards articulate appropriate practice rather than leaving health care professionals to rely on the current ambiguous standards that encourage the practice of defensive medicine and encourage plaintiffs' lawyers to pursue marginal cases. Thus, rather than increasing the risk of malpractice litigation across the board, specific standards permit health care professionals to act unilaterally to decrease the risk of suit by conforming their practice to these standards.⁵⁵

Of course, when a specific standard is violated, standards of practice increase the probability that the health care professional will be found liable. But, informing health care professionals and the courts of the standards and enforcing them is exactly the point of professionally imposed standards. Health care professionals should be held accountable when they deviate from relevant empirically grounded professional standards without good cause, and thereby cause harm to patients. If standards of practice fail to inform professionals and do not provide judicially enforceable norms, they are unresponsive to the needs of health care professionals and courts. It leaves health care professionals uninformed of expectations of them, and leaves courts to resolve these issues by their own artifices. Rather than having judges and juries lacking technical sophistication choose what standard to apply on a case by case basis, based upon a presentation by partisan experts, is it not better to have the professions articulate their own stan-

52. See Nanette Gartrell et al., *Psychiatric Residents' Sexual Contact with Educators and Patients: Results of a National Survey*, 145 AM. J. PSYCHIATRY 690 (1988).

53. See Robert H. Brook, *Practice Guidelines and Practicing Medicine: Are They Compatible?*, 262 JAMA 3027 (1989).

54. See John R. Ball, *Better Cookbooks Needed to Guide Physicians*, HOSPITALS, Nov. 5, 1988, at 96.

55. See Brook, *supra* note 53.

dards? Is that not what the courts and the health care professions claim to want? Perhaps not.

For health care professionals, specific standards of practice mean an end to business as usual. Without regard to their impact on quality of care or professional liability, standards of practice limit professional autonomy and redefine professional turf boundaries. They also risk exposing the limits of a profession's scientific knowledge by demanding research to support existing practices. Although health care professionals are interested in setting standards of practice to stave off judicial intrusion, when intrusion appears less imminent, interest in setting or complying with specific, professionally set standards of practice wanes.⁵⁶

For the courts, professionally determined standards of practice may also produce mixed results. In one regard, professionally determined standards respond to a multitude of judicial concerns. Not only on standard of care issues in malpractice claims, but in a broad range of civil and criminal cases, courts are regularly faced with questions of the limits of professional practice for which their training as lawyers provides no special insights: Can findings from animal studies be used to link drugs to birth defects in humans?;⁵⁷ Does clinical experience provide a basis for valid predictions of violent behavior?;⁵⁸ Are health care professionals able to make valid determinations whether a child has been sexually abused based on the child's post-event behavior?⁵⁹ Professional standards assist courts in ascertaining whether health care professionals have reached a consensus and, if so, who has that consensual knowledge. While courts have notoriously disregarded health care professionals' consensus in the past,⁶⁰ the courts have increasingly sought professional guidance that rises above the din of the adversary system.⁶¹

Health care professionals understandably ask why professional consensus should be not only a floor but a ceiling as well. If professionals are liable when they fail to meet these professional standards, should they not be absolved of liability when they meet these standards? Although professional consensus defines what courts regard as necessary and generally defines what courts regard as sufficient, it is not invariably what courts regard as the measure of sufficiency. An absence of mutuality appears to exist in judicial acceptance of professional standards as the measure of what is necessary, but occasional hesitation to accept professional standards as the measure of what is sufficient.

The explanation for this apparent absence of mutuality is found in the

56. See Jennifer B. Marks, *Primary Care Screening Practices: Falling Short of Recommendations*, 13 CLINICAL DIABETES 54 (1995).

57. See, e.g., *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993).

58. See, e.g., *Barefoot v. Estelle*, 463 U.S. 880 (1983).

59. See, e.g., *United States v. St. Pierre*, 812 F.2d 417 (8th Cir. 1987).

60. See, e.g., *Barefoot*, 463 U.S. at 880.

61. See, e.g., *Daubert*, 509 U.S. at 579.

role courts understand they are to perform in society. In the context of tort litigation, courts regard themselves as ultimately responsible for articulating what society expects of each of us. "Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission."⁶² The proverbial reasonable person of negligence law is a vehicle to articulate what society expects of each of us as we engage in conduct that poses risk to others. While professional custom defines the behavior of the reasonable professional in the vast majority of cases, courts fear that absolute deference to professionally imposed standards risks abrogating that responsibility. Thus, the willingness of courts to defer to professionally imposed standards as a measure of sufficiency is, in part, a function of the extent to which courts view these standards. Courts view them as an altruistic application of a specialized body of knowledge concerned with enhancing the quality of patient care rather than guild concerns.

Fairness matters in terms of the credibility of the judicial system and willingness to accept its decisions. Thus, mutuality is desirable through consistent treatment of violations and compliance with the professional standards. One way to assuage the courts' concerns with the goals of these practice standards and to convince them (or legislative bodies considering comprehensive malpractice reform) to recognize these standards as a ceiling as well as a floor is to address which groups should promulgate these standards. The concern that individual specialty groups or managed care organizations may be more concerned with advancing their own interests raises the appropriateness of a National Medical Standards Board.⁶³ While such an entity exacerbates concerns with loss of autonomy, it increases the likelihood that courts will perceive these practice standards as credible and uniform, and represent considered professional judgment about enhancing the quality of patient care.

IV. CONCLUSION

Clinical practice guidelines, like tort litigation, are intended to condemn substandard care.⁶⁴ What role might clinical practice guidelines play in resolving the problem of inadequate guidance to the medical and legal communities about the standard of care and physicians caught in an evolutionary glitch? Do they offer the possibility of therapeutically harmonizing the economic realities of medical practice and the standards by which it will be judged in malpractice litigation?

There is supreme irony in the relationship between the health care pro-

62. *The T.J. Hooper*, 60 F.2d 737, 740 (2d Cir. 1932).

63. See Lucian L. Leape, *Translating Medical Science Into Medical Practice: Do We Need a National Medical Standards Board?*, 273 JAMA 1534 (1995).

64. See Troyen A. Brennan, *Practice Guidelines and Malpractice Litigation: Collision or Cohesion?*, 16 J. HEALTH POL. POL'Y & L. 67 (1991).

fessions and courts in setting professional standards of practice in malpractice actions. The courts claim that they are not interested in setting health care professional standards of practice and look to health care professions to set those standards.⁶⁵ And, the health care professions claim that they are interested in setting their own standards of practice without judicial interference.⁶⁶ These goals are congruent, and a visitor from another planet hearing them and nothing more might conclude that we live an enlightened, harmonious existence in which each profession understands its appropriate role to contribute to a just, therapeutic society.⁶⁷

Evidence of this enlightenment is, however, nowhere to be found in late twentieth century America. Standards for judging appropriate practice tend to be case specific because the task of developing and applying the standard of care in professional malpractice cases has fallen to the courts, but courts have generally been unwilling to crystallize standards that express the collective wisdom of judge and jury decision making in similar cases. And, courts, which claim not to be interested in setting standards of practice, regularly do so in particular cases choosing between contrasting normative standards advanced by opposing experts, and infrequently do so in using standards that reject apparent health care professional consensus.⁶⁸ Their willingness to set standards of practice may stem from their concerns with the necessity of standards for dispute resolution or the advancement of high quality care. Furthermore, the health care professions, which claim to be interested in setting their own standards, often resist setting specific standards of practice that can be applied by the courts. Their hesitation to set standards of practice may stem from concerns with economics, autonomy, malpractice, and exposure of the limits of a profession's scientific knowledge. The stated goals of courts and health care professions in setting professional standards of practice that are in theory congruent are in practice incongruent.

The consequence of this incongruence is significant. It endangers the

65. See *Strachan v. John F. Kennedy Mem'l Hosp.*, 538 A.2d 346, 349 (N.J. 1988) ("If 'procedures' are to be viewed as . . . indispensable . . . in the nature of a standard that governs the medical community . . . [t]hat is the business of the medical community itself, not of this Court.").

66. See Howard Greenbaum, *Current Standards of Practice in Medicine: The Medical, Judicial, and Legislative Roles*, 7 W. ST. U. L. REV. 3 (1979).

67. See generally DAVID B. WEXLER & BRUCE J. WINICK, *LAW IN A THERAPEUTIC KEY* (1996); BRUCE J. WINICK, *THERAPEUTIC JURISPRUDENCE APPLIED: ESSAYS ON MENTAL HEALTH LAW* (1997); DAVID B. WEXLER & BRUCE J. WINICK, *ESSAYS IN THERAPEUTIC JURISPRUDENCE* (1991); DAVID B. WEXLER, *THERAPEUTIC JURISPRUDENCE: LAW AS A THERAPEUTIC AGENT* (1990).

68. See *Helling v. Carey*, 519 P.2d 981, 983 (Wash. 1974) (rejecting the undisputed expert testimony about professional norms for administering glaucoma tests to people under forty). But see Jerry Wiley, *The Impact of Judicial Decisions on Professional Conduct: An Empirical Study*, 55 S. CAL. L. REV. 345 (1982) (a subsequent study revealed that the court's decision accurately, although accidentally, reflected the accepted professional practice which had been incorrectly described by the experts).

ability of the courts to ascertain and apply the standard of care correctly and consistently, and concomitantly undermines the public and the health care professions' confidence in the judicial system. Moreover, it endangers the ability of the courts to provide health care professionals with clear guidance on legal norms, thereby enhancing the risk of costly and risky, but medically unnecessary care. This incongruence is exacerbated by the existence of managed health care, whose economically driven effects on health care practice are a separate and often conflicting tension in practice standards.⁶⁹ Reflecting the realities of a rapidly disappearing era of health care, juries in malpractice cases are not instructed to consider economic matters in ascertaining the health care professional's duty to the patient. Thus, without practice standards to guide judicial assessments of professional practice, health care professionals are caught between the case specific method of setting of the standard of care that is insensitive to economic considerations and managed care plans that are driven by economic considerations.

69. See Appelbaum, *supra* note 13.

