



---

Winter 1-1-2004

## In Defense of the Professional Standard of Care: A Response to Carter Williams on "Evidence-Based Medicine"

Ann MacLean Massie

Washington and Lee University School of Law, [massiea@wlu.edu](mailto:massiea@wlu.edu)

Follow this and additional works at: <https://scholarlycommons.law.wlu.edu/wlulr>

 Part of the [Health Law and Policy Commons](#), and the [Medical Jurisprudence Commons](#)

---

### Recommended Citation

Ann MacLean Massie, *In Defense of the Professional Standard of Care: A Response to Carter Williams on "Evidence-Based Medicine"*, 61 Wash. & Lee L. Rev. 535 (2011).

Available at: <https://scholarlycommons.law.wlu.edu/wlulr/vol61/iss1/11>

This Note is brought to you for free and open access by the Washington and Lee Law Review at Washington and Lee University School of Law Scholarly Commons. It has been accepted for inclusion in Washington and Lee Law Review by an authorized editor of Washington and Lee University School of Law Scholarly Commons. For more information, please contact [christensena@wlu.edu](mailto:christensena@wlu.edu).

# In Defense of the Professional Standard of Care: A Response to Carter Williams on "Evidence-Based Medicine"

Ann MacLean Massie\*

## Table of Contents

I. Introduction .....	535
II. The Medical Standard of Care .....	540
III. The Appropriate Role of "Evidence-Based Medicine" .....	548

### I. Introduction

First, I would like to congratulate Carter Williams on receiving the Law Council Law Review Award for his excellent Note, *Evidence-Based Medicine in the Law Beyond Clinical Practice Guidelines: What Effect Will EBM Have on the Standard of Care?*<sup>1</sup> As the song says, "[i]f you become a teacher, by your pupils you'll be taught."<sup>2</sup> Little did I know that while Carter was sitting in my Health Care Quality Regulation Class, where we were focusing on medical malpractice—including, of course, the standard of care—he was writing his Note on "Evidence-Based Medicine," a phenomenon I had never heard of! I am very pleased to be part of this Colloquium and appreciate the opportunity to respond to Mr. Williams's thoughtful and provocative work.

---

\* Professor of Law, Washington and Lee University. B.A., Duke University, M.A., University of Michigan, J.D., University of Virginia. This Comment is an elaboration of remarks originally presented at the third annual Washington and Lee Law Review Student Notes Colloquium.

1. Carter L. Williams, *Evidence-Based Medicine in the Law Beyond Clinical Practice Guidelines: What Effect Will EBM Have on the Standard of Care?*, 61 WASH. & LEE L. REV. 479 (2004).

2. MARNI NIXON, *Getting to Know You*, on THE KING AND I (1956 Film Soundtrack) (Angel Records 2001) (original recording remastered).

Reading this piece set me to thinking about the interrelationships between law and medicine. The proverbial distrust between the members of these two professions is borne out by friends of mine who teach topics in Health Law and Bioethics in universities that have both law and medical schools. Some of my brave colleagues have taught classes with both law and medical students. They invariably report that the groups start off on opposite sides of the room, regarding their counterparts from the other profession with watchful and mistrustful eyes. In the most successful instances, the teacher is able to facilitate a situation where the students actually listen to each other and come to appreciate each others' professional positions; sometimes they actually mingle! But things do not always work out so happily, and some of my colleagues swear they would never try the mixture again. It strikes me that in the reluctant dance between law and medicine—more specifically, between lawyers, judges, legislators, and regulators, on the one hand, and health care providers, particularly doctors, on the other—the question, at any one point, is, "Who has the lead?"

Most of the time, it is clear that the law has the lead. The "health care industry," as it has come to be called, is one of the most highly regulated segments of American society. From Medicare<sup>3</sup> and Medicaid,<sup>4</sup> with their comprehensive regimes and multitudinous fraud and abuse regulations, to ERISA (Employee Retirement Income Security Act of 1974)<sup>5</sup> and EMTALA (Emergency Medical Treatment and Labor Act),<sup>6</sup> from HIPAA (Health Insurance Portability and Accountability Act of 1996)<sup>7</sup> to the Health Care Quality Improvement Act of 1986<sup>8</sup> and the Patient Self-Determination Act,<sup>9</sup> from the FRA (the Federal Rehabilitation Act)<sup>10</sup> to the ADA (Americans with Disabilities Act)<sup>11</sup> and other statutes too numerous to mention, each with its own volumes of regulations and all presided over by a host of alphabet-soup agencies, the influence of the federal government on even the minutiae of

---

3. Medicare Act of 1965, Pub. L. No. 89-97, 79 Stat. 290 (codified as amended in scattered sections of 26, 42 & 45 U.S.C.).

4. Medicaid Act, 42 U.S.C. §§ 1396–1396v (2000).

5. Employment Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001–1461 (2000).

6. Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd (2000).

7. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified as amended in scattered sections of 26, 29 & 42 U.S.C.).

8. Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101–11152 (2000).

9. Patient Self-Determination Act, 42 U.S.C. §§ 1395cc, 1395mm, 1396a (2000).

10. Federal Rehabilitation Act of 1973, 29 U.S.C. §§ 701–796 (2000).

11. Americans with Disabilities Act, 42 U.S.C. §§ 12101–12213 (2000).

health care practice is felt on a daily basis in every medical office and health care institution in the country. On the state level are licensing statutes,<sup>12</sup> official disciplinary boards,<sup>13</sup> numerous regulations that parallel or extend various federal provisions,<sup>14</sup> and the law of medical malpractice itself, usually found in a mixture of statutes and case rulings issued by the state's courts.

Of course, I recognize the need for at least most of these laws and regulations. Medicare, once so opposed by the American Medical Association (AMA),<sup>15</sup> has turned out to redound to the benefit of both practitioners and health care institutions. Some of the laws that affect health care providers are directed against discrimination. Others benefit workers who obtain health benefits through their employment. A fair number have been enacted in direct response to reprehensible behavior on the part of some members of the health care profession, such as Medicare fraud by some doctors and clinics, or "patient dumping" by hospitals refusing emergency care for patients unable to pay. State licensing statutes and disciplinary boards aim to protect the health care consumer from unqualified or unethical practitioners—certainly an important social goal. The federal Health Care Quality Improvement Act of 1986<sup>16</sup> established a National Practitioner Data Bank to track disciplinary actions and malpractice payments so practitioners could not simply move from one state to another to escape the ramifications of prior bad records.

Into this mix, inject the tort system, which has been accused of much of the high cost of malpractice insurance and hence of medical care in general.<sup>17</sup> Talk to almost any doctor, and he or she will tell you of the perceived need to practice "defensive medicine"—that is, at times to "overtreat," or provide more tests or even medicines than are really necessary, just in case a dissatisfied

---

12. See, e.g., VA. CODE ANN. § 54.1-2930 (Michie 2003) (requiring that candidates to practice medicine be eighteen years of age, of good moral character, and have successfully completed specified educational requirements).

13. See, e.g., VA. CODE ANN. § 54.1-2400 (Michie 2003) (listing the general powers and duties of health regulatory boards).

14. See, e.g., Health Care Decisions Act, VA. CODE ANN. §§ 54.1-2981 to -2993 (Michie 2003) (setting forth Virginia law governing advance directives).

15. See, e.g., Mark. R. Yessian & Joyce M. Greenleaf, *The Ebb and Flow of Federal Initiatives to Regulate Healthcare Professionals*, in REGULATION OF THE HEALTHCARE PROFESSIONS 169, 170 (Timothy S. Jost ed., 1997) (noting strong professional opposition to Medicare and Medicaid at the time of their passage).

16. Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11152 (2000).

17. See, e.g., Michelle M. Mello et al., *The New Medical Malpractice Crisis*, 348 NEW ENG. J. MED. 2281, 2282-83 (2003) (labeling the current malpractice insurance crisis as "one of both availability and affordability" and noting that physicians, hospitals, and insurers lay much of the blame on the trial bar).

patient might choose to sue over an outcome that failed to meet the patient's expectations.<sup>18</sup>

Clearly, medical malpractice is not a myth. The Institute of Medicine Report, *To Err Is Human*, released in 1999, shocked Americans with its findings that over one million injuries and almost 100,000 deaths occur annually in this country as a result of mistakes in patient care.<sup>19</sup> The famous Harvard Medical Practice Study,<sup>20</sup> conducted in New York in 1984 by a screening group of medical administrators and nurses and then by board-certified physicians at the physician-review stage, identified 1,133 "adverse events" from a population of over 31,000 records.<sup>21</sup> Physicians identified 280 of these as resulting from negligent care.<sup>22</sup> Using these figures, the study estimated the incidence of adverse events to represent 3.7% of all hospitalizations in New York in 1984.<sup>23</sup> The study also estimated that negligence occurred in 27.6% of all adverse events, which amounted to 1.0% of all hospital discharges in the state of New York that year (98,609 cases altogether).<sup>24</sup> Interestingly, those conducting the study concluded that "eight times as many patients suffered an injury from negligence as filed a malpractice claim in New York State. About sixteen times as many patients suffered an injury from negligence as received compensation from the tort liability system."<sup>25</sup> Furthermore, these researchers found that "many cases in litigation were brought by patients in whose records we found no evidence of negligence or even of adverse events."<sup>26</sup>

If these statistics are both accurate and representative, the tort system is obviously not doing a very efficient job of compensating patients who suffer adverse events as a result of negligence while receiving hospital care. But we cannot force people to sue, and my real point here is, first, the subsidiary one

18. See BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 41 (4th ed. 2001) (noting that "from one quarter to one third of medical services may be of no value to patients").

19. See Lucian L. Leape et al., *What Practices Will Most Improve Safety? Evidence-Based Medicine Meets Patient Safety*, 288 JAMA 501, 501 (2002) (summarizing the findings of INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (1999)).

20. The Report of the Harvard Medical Practice Study to the State of New York, *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York*, in FURROW ET AL., *supra* note 18, at 32.

21. *Id.*

22. *Id.*

23. *Id.*

24. *Id.*

25. *Id.* at 34.

26. *Id.*

that not all "adverse events" are attributable to negligence—in the Harvard Practice Study, just over a quarter were deemed to result from negligent care—and second, more importantly, it was board-certified *physicians* who were entrusted by the study with the judgment of whether any given adverse event was indeed the result of negligence.<sup>27</sup> Self-serving, you may say. But I would ask, who else would actually be qualified to evaluate the work of other physicians? Besides, remember that these doctors identified numerous instances of behavior they deemed negligent where the patient did not even bring a malpractice action.

I believe it is an important point that *physicians* were the ones identifying their colleagues' malpractice because, in the dance between law and medicine, this is where the lead traditionally changes, and in my view, appropriately so. For all the myriads of laws, regulations, and judgments issuing from governmental entities at every level pertaining to the delivery of health care, the legal system—whether in the form of legislatures, administrators, judges, lawyers, or juries—has thus far not tried to tell health care providers *how* to practice their profession. Wisely, and necessarily, I think, the law has left issues of how to diagnose and treat the patients under their care to health care providers themselves. So long as other members of their own profession were unable to find fault—or, in a "battle of experts," to convince a jury to find fault—with the medical care rendered to a patient, the law would not interfere with a health care provider's professional judgment and practice.

Mr. Williams's extensively and admirably researched paper indicates to me that this picture may be changing. If I read him correctly (and I have to admit that I did not track down all of his sources myself, although I looked at a goodly number), an increasing number of legal scholars would like to modify the tort law standard of care where medical malpractice is concerned. They apparently advocate taking away from the medical experts the substantive measure of what constitutes negligence in medical care and subjecting that standard to a purely legal definition. Some commentators in the world of legal (as opposed to medical) scholarship suggest that the concept of evidence-based medicine might appropriately be used by a judge in instructions to a jury, to the effect that if a doctor's treatment of a patient did not comply with the latest empirical research, the jury would be entitled to find that doctor negligent, regardless of what the physician's peers might have averred on the stand with respect to the manner in which most competent doctors would have handled the situation. To the extent that these scholars wish to replace the so-called "medical standard of care" with a purely legalistic one, I respectfully disagree.

---

27. *Id.* at 32.

Such a move, it seems to me, would represent an arrogant usurping by the law of the prerogatives and professionalism of another great profession. I think that the analogies to legal malpractice, to the extent that they are used to bolster a legal requirement as applied to health care professionals, are misplaced.

On the other hand, Mr. Williams offers an analogy to the courts' use of the "business judgment rule" which strikes me as apt. By bifurcating the *substantive* evaluation of whether medical malpractice occurred from the assessment of the *process* which the doctor used in the given case, Williams's suggestion respects the professionalism of another area of expertise, in that it relies upon knowledgeable representatives from that other area to provide the court with the appropriate criteria for judging the quality of what was done. At the same time, it leaves room for the operation of the jury's proper function in determining the ultimate question of whether the physician acted properly—that is, the legal question of negligence.

## II. *The Medical Standard of Care*

What is the so-called "medical standard of care"? As the foremost treatise in health law states, "[t]he medical profession itself sets the standards of practice and the courts enforce these standards in tort suits."<sup>28</sup> In other words, the judge's instructions to the jury will be to the effect that the jury can find negligence only if it finds that the defendant deviated from the appropriate medical care in the situation, as established by expert testimony from health care professionals in the same specialty or kind of practice as the defendant.

In the history of medical malpractice law, the standard of care against which a health care professional's behavior was to be evaluated took the form of the "locality rule": the obligation that physicians "treat their patients with such care and skill as would be furnished by a reasonably competent practitioner operating in the same community."<sup>29</sup> The locality rule was intended to protect rural physicians from having to be as advanced in training and resources as their urban counterparts.<sup>30</sup> The rule was modified to the "similar locality rule"—an evolution usually attributed to the difficulty of persuading doctors in the same community to testify against each other

---

28. 1 BARRY FURROW ET AL., *HEALTH LAW* 270 (2d ed. 2000) [hereinafter *HEALTH LAW*].

29. Theodore Silver, *One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice*, 1992 WIS. L. REV. 1193, 1226 (1992) (emphasis omitted) (describing the history of medical malpractice from the fourteenth century and noting that the locality rule came into existence in this country in the nineteenth century).

30. *Id.*; see also FURROW ET AL., *supra* note 18, at 171 ("The locality rule has been viewed as a subsidy for rural areas . . .").

(resulting in a so-called "conspiracy of silence")<sup>31</sup> and to the possibility that a small community might have only one doctor, or that all the doctors in a community might have failed to advance in the same manner as their counterparts in other similar practices and locations; the premise was that such physicians should not be protected by their mutual ignorance.<sup>32</sup>

In the last thirty years or so, thanks predominately to advances in modern technology, a "national standard of care" has largely supplanted the locality rule. A frequently cited Mississippi case, *Hall v. Hilbun*,<sup>33</sup> takes note of the "'nationalization' of medical education and training" and the "ready access to professional and scientific journals and seminars for continuing medical education from across the country"<sup>34</sup> and defines the relevant standard of care as a national one.<sup>35</sup> Specifically, in the words of the court:

The duty of care . . . takes two forms: (a) a duty to render a quality of care consonant with the level of medical and practical knowledge the physician may reasonably be expected to exercise, and (b) a duty based upon the adept use of such medical facilities, services, equipment and options as are reasonably available.<sup>36</sup>

Note that the two prongs of the duty delineated here permit the trier of fact to evaluate the health care professional's behavior both in terms of national standards, insofar as knowledge and skill are concerned, and in terms of local conditions—such as the kinds of medical resources available to the practitioner, wherever the person may be located.

The medical duty of care, whether defined by nature of locality, by state,<sup>37</sup> or as national in character, is frequently referred to as a "custom-based standard of care." Because of this reference to custom, a number of commentators tend to regard the medical standard of care as not only special to the profession, but looser than the reasonably prudent person standard of care applied to everyone else by the trier of fact in determining negligence. These commentators point

---

31. FURROW ET AL., *supra* note 18, at 171.

32. Silver, *supra* note 29, at 1227. However, Silver disagrees and asserts that the law is no different today than it was a century ago. *Id.* at 1226–36; *see also* DAN B. DOBBS, *THE LAW OF TORTS* § 244 n.5 (2000) ("Negligence cannot be excused on the ground that others in the same locality practice the same kind of negligence.").

33. *Hall v. Hilbun*, 466 So. 2d 856 (Miss. 1985).

34. *Id.* at 870.

35. *See id.* at 870–71 (discussing the "inevitable ascendancy of national standards").

36. *Id.* at 872.

37. *See, e.g.*, VA. CODE ANN. § 8.01-581.20 (Michie 2003) (defining standard of care to be "that degree of skill and diligence practiced by a reasonably prudent practitioner in the field of practice or specialty" in Virginia).



out that in other areas of human activity, custom may be considered, but it is generally not accorded the conclusive weight that it receives in medical malpractice cases.<sup>38</sup> Thus, the foremost health law treatise states:

Defendants trying to prove a standard of care normally present expert testimony describing the actual pattern of medical practice, without any reference to the effectiveness of that practice. Most jurisdictions give professional medical standards conclusive weight, so that the trier of fact is not allowed to reject the practice as improper. In tort litigation not involving professionals, courts are willing to reject customary practice if they find the practice dangerous or out-of-date.<sup>39</sup>

The rationale for the special medical standard of care is, of course, the notion that the practice of medicine involves the exercise of a degree of knowledge and expertise that the layperson is not capable of either understanding or evaluating.<sup>40</sup> Furthermore, the adage that "medicine is an art, as well as a science" expresses the idea that medical judgments vary, not only with respect to a set of symptoms, but also with respect to each individual patient, viewed in the context of that person's individual health history and, perhaps, behavioral patterns.<sup>41</sup>

38. Note, however, that the relevant Restatement section applies to all professions, not just medicine. It provides: "Unless he represents that he has greater or less skill or knowledge, one who undertakes to render services in the practice of a profession or trade is required to exercise the skill and knowledge normally possessed by members of that profession or trade in good standing in similar communities." RESTATEMENT (SECOND) OF TORTS § 299A (1965).

39. 1 HEALTH LAW, *supra* note 28, at 270; *see also* DOBBS, *supra* note 32, § 242, at 633 (distinguishing the "medical standard of care" from the "reasonable person standard"); Phillip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 165 (2000) ("Physicians, and sometimes other professionals, have been treated much more favorably [than ordinary tort defendants.]"); Arnold J. Rosoff, *Evidence-Based Medicine and the Law: The Courts Confront Clinical Practice Guidelines*, 26 J. HEALTH POL., POL'Y & L. 327, 332 (2001) (noting that "an expert [physician] is supposed to testify not as to what she or he thinks is the proper way to treat the case at hand but, rather, as to what others in the profession commonly would do in such a situation"); Silver, *supra* note 29, at 1212 ("[A] physician's duty is not measured by the ordinary rule of reasonableness, but rather by professional custom within the profession.").

40. *See* Silver, *supra* note 29, at 1214–15 (suggesting that the human body is "too temperamental to allow that a doctor be held to the simple standard of reasonableness" and that the practice of medicine, in general, is best assessed by those with relevant experience). Silver disagrees, however, and asserts that "the judgment required of the conscientious physician is not one whit more subtle than that demanded of a conscientious lawyer, teacher, writer, engineer, or probably, any other person pursuing a skilled calling." *Id.* at 1216 n.67. It is noteworthy that Professor Silver has earned both J.D. and M.D. degrees and thus has particular knowledge of this subject.

41. *See, e.g.*, Hall v. Hilbun, 466 So. 2d 856, 870 (Miss. 1985) ("Medicine is a science, though its practice be an art . . ."); *see also* David Azevedo, *Can You Spot a Litigious Patient?*, MED. ECON., June 13, 1994, at 70, 73 (quoting one practitioner on seeking to avert possible

The so-called "custom-based standard of care" has been subjected—by Mr. Williams and others—to the criticism that when physicians are allowed, in essence, to determine the substantive standards applicable to their behavior, they may be inclined to rest on their laurels. The implication is that they may not bother to keep up with the latest advances in medical knowledge, or they may continue to treat a particular disease or condition the same way just because they have always done it that way and see no need to change or even to question the efficacy of what they are doing.

Notice, however, that an important basis for the Mississippi Supreme Court's justification of a national standard of care for physicians was the easy availability for doctors everywhere of the latest medical literature and seminars for continuing medical education.<sup>42</sup> Since the *Hall v. Hilbun* decision in 1985, this ease of access has increased exponentially with the development of the Internet. Courts defining the medical standard of care with reference to accepted medical practice clearly expect that definition to include an obligation on every physician's part to stay abreast of the latest developments in the profession.

In fact, I suggest that the terminology custom-based standard of care is a misnomer. It conjures up a picture of precisely the criticism that has been leveled against it—physicians lazily continuing to rely on what they learned in medical school, without bothering to keep up with new discoveries and techniques. "Acceptable medical practice," which is the terminology most often used in jury instructions in cases I have read,<sup>43</sup> is both more open-ended

---

litigation, "I try to let patients know that medicine is an art as well as a science"); Morgan Feely, *Drug Treatment of Epilepsy*, 318 BRIT. MED. J. 106, 106 (1999) ("Even in this era of evidence based medicine, there is an art as well as a science in choosing the best drug treatment for patients with epilepsy. The choice of treatment needs to be matched to the patient . . ."); Jason Twinn, *How the Art Has Been Stolen From General Practice*, PULSE (London), Sept. 8, 2001, at 26 (lamenting that though medical school mentors had taught that "[m]edicine is an art as well as a science," the "art" has been "stolen" by the British Department of Health, which is "committed to science, efficiency and effectivity" and insists that medical decisions be made based upon "guidelines, protocols and internet printouts"); Antonio Vaz Carneiro, *Clinical Reasoning. What Is Its Nature? Can It be Taught?*, 22 REV. PORT. CARDIOL 433, 433 (Mar. 22, 2003) ("The old saying 'medicine is an art as well as a science' emphasizes the need to integrate the methodology of evidence-based medicine . . . with the methodology of the arts and humanities, seeking a medical praxis that satisfies patients as well as doctors.").

42. See *Hall*, 466 So. 2d at 870 (noting that physicians "have ready access to professional and scientific journals and seminars for continuing medical education from across the country").

43. See, e.g., *id.* at 871 (suggesting that instructions which contain the word "average" mislead jurors by causing them to overestimate the number of physicians who regularly engage in malpractice); see also 1 STEVEN E. PEGALIS & HARVEY F. WACHSMAN, *AMERICAN LAW OF MEDICAL MALPRACTICE* § 3.2 (2d ed. 1992 & Supp. 2002) (collecting cases concerning the standard of care in medical malpractice actions).

and more descriptive. The notion of acceptable medical practice also leaves room for variation, when there is more than one responsible way for a physician to treat a particular patient in a particular situation.<sup>44</sup> This leeway is known as the "respected minority rule" or the "two schools of thought" principle.<sup>45</sup> Additionally, the "best judgment rule" provides that when a physician is possessed of superior knowledge of some kind (perhaps as a result of experience or of participation in a medical research protocol), the physician is obligated to use that superior knowledge in treating the particular patient.<sup>46</sup>

Courts handling medical malpractice cases contemplate that accepted medical practice will include the possibility of variations when called for and the possibility of superior knowledge and skill when those are available to the physician in the given case. They also define the term "accepted medical practice" to include an obligation on any physician's part to keep up with developments in the field and to incorporate those into the physician's practice as occasion warrants.<sup>47</sup>

To those who want to change the standard of care in medical malpractice cases to a more legalistically-defined one, I would ask, where does the normative basis for this new definition come from? How can a trier of fact rely on anything *but* what the medical profession tells us is appropriate care in any given situation? Furthermore, the notion that a normative standard of

44. See *Hall*, 466 So. 2d at 871 ("Mention should be made . . . of the role of good medical judgment which, because medicine is not an exact science, must be brought to bear in diagnostic and treatment decisions daily."); see also 1 HEALTH LAW, *supra* note 28, at 271 ("Substantial regional variations exist in the use of many procedures, with no apparent differences in outcome . . .").

45. 1 HEALTH LAW, *supra* note 28, at 293 ("[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 for harm caused thereby to the patient." (quoting *Henderson v. Heyer-Schulte Corp.*, 600 S.W.2d 844, 847 (Tex. Civ. App. 1980))); see also John E. Wennberg & Philip G. Peters, Jr., *Unwarranted Variations in the Quality of Health Care: Can the Law Help Medicine Provide a Remedy/Remedies?*, 37 WAKE FOREST L. REV. 925, 936 (2002) (noting that evidence that low use of certain medical procedures yields better outcomes than high use can be used to protect "low-use physicians" under the "respectable minority" or "two schools of thought" doctrines").

46. See, e.g., *Burton v. Brooklyn Doctors Hosp.*, 452 N.Y.S.2d 875, 879–80 (App. Div. 1982) (noting that a physician must use all of the intelligence, skill, and information he or she possesses).

47. See, e.g., *id.* at 880 (finding that a doctor was liable for failing to apply his knowledge of his own hospital's developing practices); *Nowatske v. Osterloh*, 543 N.W.2d 265, 273 (Wis. 1996) (stating that "a reasonably competent practitioner is one who keeps up with advances in medical technology"); Angela Roddey Holder, *Failure to "Keep Up" as Negligence*, 224 JAMA 1461, 1461–62 (1973) (noting that while courts do not tend to find negligence on the sole basis of a failure to stay abreast of current advances in medicine, opinions assume that such a duty is part of the medical standard of care).

"currently accepted medical practice" is likely to yield deficiently outdated criteria is just not true. First, not only does the law of negligence assume that keeping up with the field is a part of the physician's duty, but the medical profession itself has embraced such a duty as an ethical obligation.<sup>48</sup> Well known commentator Lars Noah has observed that the AMA-defined ethical canon imposes the same duty on physicians as does the tort law.<sup>49</sup>

On the matter of staying abreast, it is also relevant that board certification, at least for family practitioners and increasingly for other specialties as well, may require periodic re-examination<sup>50</sup>—a process that we in the legal profession would never agree to! While there is no requirement that a physician be board-certified (and at least one court has ruled specifically that a doctor in a medical malpractice action could not be held to board certificate criteria as setting the standard of care),<sup>51</sup> a sufficiently high percentage of physicians are board-certified and their behaviors are likely to set the tone for the profession's definition of accepted medical practice. This means that any physician who has not kept up with advances in the relevant field of practice is likely to fall short of the professional definition of accepted practice.

To those who object that the current standard is below the reasonable person standard of ordinary care, I argue that, properly understood, the medical standard of care is actually only a variation specific to the circumstances where the actor has medical education and training and practices in the health care professions. I admit that courts have not always treated the medical standard in this way, but I believe that most of them do. The fact that some courts still may not does not mean that there is anything wrong with the standard itself.

---

48. See AM. MED. ASS'N, *Principles of Medical Ethics: Principle V*, in COUNCIL ON ETHICAL & JUDICIAL AFFS. CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS (1999) ("A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.").

49. See Lars Noah, *Medicine's Epistemology: Mapping the Haphazard Diffusion of Knowledge in the Biomedical Community*, 44 ARIZ. L. REV. 373, 403 n.135 (2002) (describing the physician's duty to stay abreast of developments in his field).

50. Conversation with Wesley Ross, M.D., Board-Certified Family Practitioner, (Aug. 8, 2003) (stating that certification in family practice requires re-examination every six years, and other specialties increasingly are also demanding a periodic re-certification process).

51. See *Campbell v. Vinjamuri*, 19 F.3d 1274, 1276–77 (8th Cir. 1994) (evidence of an anesthesiologist's failures to pass a board certifying examination was not relevant to whether he was negligent in his duties of properly positioning a patient or properly supervising a nurse anesthetist). The court stated further that "it would be improper for the jury . . . to conclude that because a physician was unable to pass his board exams, he was negligent on a specific occasion." *Id.* at 1277.

The medical standard of care and the general negligence standard of ordinary care are undeniably different.<sup>52</sup> However, as Professor Dobbs has noted:

In spite of these profound differences [of phraseology and of the requirement that experts must testify as to the standard of care in a medical malpractice case], courts seem increasingly to blend the language of reasonable person with the language of professional standards in an uncertain mixture with uncertain effects.<sup>53</sup>

Over the last several decades, I suggest that the "mixture" of the language of the reasonable person standard with the language of professional standards has become more prevalent, with effects that—far from being "uncertain"—help the jury recognize that the health care professional's behavior must do more than conform to custom; the behavior must also be reasonable under the circumstances. It is misleading to refer to the "customary standard" as though custom alone answers the negligence question. The legal system should require not only that a physician possess a professionally-defined degree of knowledge, training, and skill, but also that he or she remain aware of developments in the pertinent field of medicine and apply them accordingly, with the due care any reasonable person is expected to exercise under the circumstances at hand. What due care would consist of in any given set of medical circumstances can be answered only by a medical professional acquainted with the field in which the defendant practices. It cannot be answered by a judge as a matter of law; nor can a jury make such an evaluation without guidance from medical experts.

A leading case illustrative of the combination of the professional standard with the obligation to use ordinary care (as tort law defines that phrase) is *Nowatske v. Osterloh*,<sup>54</sup> which Mr. Williams discusses in his Note. In *Nowatske*, the Supreme Court of Wisconsin specifically refuted the plaintiff's argument that holding defendant physician to a professional standard of care was insufficient because it did not require the physician to be aware of current medical science. The court stated that "[t]he plaintiff is correct in suggesting that physicians, like all others in this state, are bound by a duty to exercise due care."<sup>55</sup> The court went on to quote with approval the amicus brief of the State Medical Society of Wisconsin: "the basic standard—ordinary care—does not change when the defendant is a physician. The only thing that changes is the

---

52. DOBBS, *supra* note 32, § 242, at 633 (noting that health care defendants need show only an adherence to custom, "regardless of how risky the custom or how unnecessary").

53. *Id.*

54. *Nowatske v. Osterloh*, 543 N.W.2d 265 (Wis. 1996).

55. *Id.* at 270.

makeup of the group to which the defendant's conduct is compared."<sup>56</sup> In its elaboration on this point, the court cites earlier Wisconsin cases holding that "the physician 'was bound to bring to [the plaintiff's] [sic] aid and relief such skill as is ordinarily possessed and used by physicians . . . having regard to the advanced state of the profession at the time of treatment.'"<sup>57</sup> To my mind, this statement is a clear enunciation that a physician can be held liable for negligence *either* if the physician is lacking in the training and skill that he or she ought to have in the relevant area of practice, including a knowledge of current medical science, *or* if the physician has failed to exercise ordinary care in the application of that skill and training in the plaintiff's case. I do not find this statement by the Wisconsin Supreme Court to be in any way ambiguous or uncertain.

"Okay," the critic might say, "so the courts have it right in Wisconsin. What about every other state?" I argue that in fact, most of them "have it right" as well. To buttress my argument, I call on an article published in this Law Review in 2000 by Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*.<sup>58</sup> Peters starts from the common assumption that the custom-based standard of care requires only that a physician handle a medical matter in the way it has always been done.<sup>59</sup> Then he notes that, in fact, this assumption is less true than it once was:

By the beginning of 1999, a dozen states had expressly refused to be bound by medical customs. Nine additional states, while not explicitly rejecting deference to custom, had chosen to phrase the duty owed by physicians in terms of reasonability, rather than compliance with medical customs. In addition, the steady pattern of defections from the custom-based standard of care over the past several decades suggests that more states will follow.<sup>60</sup>

Peters goes on to note that "[s]eventeen states have appellate cases that explicitly reject deference to custom in medical malpractice cases. [And] [i]n at least twelve of those states, the cases rejecting custom-based standards appear to be authoritative today."<sup>61</sup> If we count all seventeen of those states, we are up to thirty-eight states altogether. Peters also tells us that states which still use the

---

56. *Id.* (citing Brief for the State Medical Society of Wisconsin as Amicus Curiae at 2, *Nowatske* (No. 93-1555)).

57. *Id.* (alteration in original) (citations omitted).

58. Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163 (2000).

59. *See id.* at 166 ("Absent proof of departure from custom, the plaintiff could not prevail.").

60. *Id.* at 170.

61. *Id.* at 172.

language of custom in their standards "do not appear to police adherence very closely," and in those jurisdictions, cases have gone to the jury on the grounds that the care provided was "not 'acceptable' or 'appropriate'" or "fail[ed] to meet the 'standard of care.'"<sup>62</sup> All of this suggests that the professional standard of care is not looser than the ordinary standard of tort law, and further, that medical malpractice defendants are not permitted to rest on their laurels and simply demonstrate that they acted in a manner compliant with what has always been done, regardless of advances in medical science since the days of their training.

Historian Theodore Silver, who has earned both the J.D. and M.D. degrees, must be relieved at these developments. His article in the 1992 *Wisconsin Law Review*, *One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice*,<sup>63</sup> argues that the ordinary rule of reasonableness was never intended to be excised from the professional standard of care. Tracing tort law back to the nineteenth century, Silver notes that "[l]ike the medieval common law that preceded it, early nineteenth century law held the physician to the standard that was destined to become the foundation of negligence. The courts of that day did not consider that it should be otherwise, nor was there any reason they should have."<sup>64</sup> Yet by the end of the nineteenth century, courts had lost sight of this fact, and the professional standard of care came to be separately defined by reference to custom.<sup>65</sup> This development led to the mischief of which critics of that standard complain. If Peters is correct about the "quiet demise" of a purely custom-based standard in state courts, then the "harmful error" cited by Silver has been largely overcome.

### III. *The Appropriate Role of Evidence-Based Medicine*

How does the recent phenomenon of evidence-based medicine enter into this picture? What relevance does it have for the standard of care in a medical malpractice lawsuit? I maintain that it is becoming very relevant. Physicians increasingly embrace the concept, develop the research studies upon which it depends, teach its principles in medical schools, and incorporate the dynamic of evidence-based practice into their daily patient care. As this occurs—which it

---

62. *Id.* at 170.

63. Theodore Silver, *One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice*, 1992 WIS. L. REV. 1193 (1992).

64. *Id.* at 1211.

65. *See id.* at 1211–12 (tracing the history of malpractice law).

seems to be doing, rather rapidly<sup>66</sup>—the professional standard of care used by courts in malpractice cases will naturally include the question, "Did the defendant physician in the case at hand research the latest available information to determine what the best evidence in the field would indicate to be the most appropriate way to handle the presenting medical situation?" In other words, the medical standard of care itself will absorb the basic concepts of evidence-based medicine as a key element for submission to the jury on the question of negligence (even if the phrase itself is not used).

To my mind, the single most relevant characteristic of evidence-based medicine—for our purposes here—is that it is a phenomenon occurring among *physicians themselves* as they seek to improve the quality of the health care they provide. No statute has told doctors that they must study and utilize those practices encompassed in the term "evidence-based medicine." No regulatory agency has formulated rules for physician behavior based on the concept—although the Institute of Medicine, established in 1970 by the National Academy of Sciences pursuant to its congressional charter, does recommend the establishment of infrastructure to support the ease of use of the latest available evidence by practitioners in their respective clinical practices.<sup>67</sup> The federal Agency for Healthcare Research and Quality has established a coordinated program of twelve "Evidence-Based Practice Centers" to "conduct systematic, comprehensive analyses and syntheses of the scientific literature on clinical conditions/problems that are common."<sup>68</sup> The centers "include universities . . . research organizations . . . and health care organizations and associations . . ."<sup>69</sup> These developments, along with similar efforts in Canada and England, which in turn have been joined by health care professionals on the international scene,<sup>70</sup> have spawned "a number of evidence-based

---

66. See, e.g., *USERS' GUIDES TO THE MEDICAL LITERATURE: A MANUAL FOR EVIDENCE-BASED CLINICAL PRACTICE* xiii–xv (Gordon Guyatt & Drummond Rennie eds., 2002) (noting the origins of the movement during the late 1970s at McMaster University in Canada as "critical appraisal," and later, "bringing critical appraisal to the bedside," the first appearance of the term "evidence-based medicine" in the autumn of 1990; and the burgeoning of the movement through a series of *JAMA Users' Guides to the Medical Literature* between 1993 and 2000); *INST. OF MED., CROSSING THE QUALITY CHASM* 145–63 (2001) [hereinafter IOM] (discussing the Institute's recommendation that the Department of Health and Human Services implement and maintain a comprehensive EBM program); *DAVID L. SACKETT ET AL., EVIDENCE-BASED MEDICINE: HOW TO PRACTICE AND TEACH EBM* 2 (2000) (noting "the rapid spread of EBM").

67. IOM, *supra* note 66, at 145–48.

68. *Id.* at 150.

69. *Id.*

70. *Id.* at 149 (discussing the Cochrane Collaboration, started in 1992 in Oxford, England, which "currently [2001] comprises about 50 Collaborative Review Groups, which produce systematic reviews of various prevention and health care issues").



journals . . . as well as numerous 'best-evidence' departments in other journals."<sup>71</sup>

We consumers of health care should, I think, take heart that the medical profession is so busily engaged both in using rigorous scientific methodology to establish the best treatments for optimum health care and also in making the results readily accessible to practitioners everywhere. But not surprisingly, the EBM movement has its critics among the profession as well—those who would utter a cautionary word, particularly with respect to the notion of using EBM as a normative legal standard for evaluating patient care.

First, the adage that "medicine is an art as well as a science" points out the uncertainty inherent in virtually every medical situation—the necessity for the practitioner to exercise professional judgment in the light of all the circumstances unique to *this particular patient*.<sup>72</sup> Indeed, David Sackett and his colleagues, chief architects of the EBM movement,<sup>73</sup> include in the concept not only "best research evidence," but also the individual practitioner's "clinical expertise" and the individual "patient values" of each person undergoing treatment.<sup>74</sup> So long as the latter two remain primary components of optimum medical care, it will be not only inappropriate but actually impossible, I suggest, for the legal system to insist upon a standard of care that is other than the professional standard.

Secondly, EBM can be extremely helpful to clinicians as far as it goes, but the current circumstance is that it does not go very far. Because it is a fairly young movement, the number of medical questions for which there are current data developed according to principles of scientific methodology are quite limited.<sup>75</sup> Furthermore, those that exist often simply represent advances in technology, because that is where so much research is taking place.<sup>76</sup>

71. *Id.* at 150.

72. See, e.g., Edward B. Hirshfeld, *Should Practice Parameters Be the Standard of Care in Malpractice Litigation?*, 266 JAMA 2886, 2888 (1991) ("Working with uncertainty is where medicine becomes an art as well as a science, and it is not feasible to expect practice parameters to capture and express the art of medicine.").

73. See *USERS' GUIDES TO THE MEDICAL LITERATURE*, *supra* note 66, at xiii (identifying Sackett as a chief originator of EBM); IOM, *supra* note 66, at 147 (citing Sackett's definition of EBM).

74. SACKETT ET AL., *supra* note 66, at 1.

75. See, e.g., Lucian L. Leape et al., *What Practices Will Most Improve Safety?*, 288 JAMA 501, 502 (2002) (noting that a recent comprehensive Evidence Report omitted "many simple and well-accepted changes, such as the 15 best medication practices endorsed and recommended by the Massachusetts Hospital Association and the American Hospital Association" because they had not been subjected to the rigors of scientific methodology.).

76. *Id.* at 503 (noting that the evidence report was "heavily weighted toward . . . technical advances in care for the simple reason that these are the advances that have been studied" and

Third, my reading about EBM persuades me that its application is necessarily contextual in each instance. For that reason, the standard supplied by EBM itself may afford only an incomplete answer to the negligence question. In other words, not only must the physician decision-maker consider the uniqueness of the patient in the situation at hand, but each physician is necessarily part of a system with its own characteristics, which will be key in defining the range of choices the physician has. In *Hall v. Hilburn*, the case from which I earlier cited the definition of the physician's duty of care,<sup>77</sup> the court noted the necessity of taking into account the "medical facilities, services, equipment and options that are reasonably available."<sup>78</sup> One group of physicians, commenting on the utility of EBM, has noted that patient safety "is primarily a systems problem."<sup>79</sup> Improvement in patient care may therefore require numerous small adjustments in the way an entire system operates—for example, the series of steps that go into providing safe anesthesia care during surgery.<sup>80</sup> Yet "[t]he efficacy of systems changes is not as easily tested at the individual patient level as are specific practices."<sup>81</sup> Thus, in any given case, standards provided by EBM for individual physician choices may be incomplete without taking into account the entire milieu within which that physician was working at the relevant time. This information will be important to a jury in reaching its verdict on the issue of negligence. In such circumstances, the substantive standard provided by EBM may be useful, but it may not appropriately be called definitive.

At this point, we can see the value of Mr. Williams's suggestion that courts make use of EBM in much the same way that they use the business judgment rule in corporate law. As he notes, that doctrine is based on the notion that "courts do not possess the expertise to make complex business decisions."<sup>82</sup> Similarly, courts lack the expertise to make equally complex medical decisions. As in the situation where the business judgment rule applies, courts *can* evaluate the *process* by which a physician reached a medical decision. Did the doctor take into account not only knowledge gained from

---

that "[t]hat is where the evidence is.").

77. *Supra* notes 41–44 and accompanying text.

78. *Hall v. Hilburn*, 466 So. 2d 856, 871 (Miss. 1985) (stating that a physician has a duty to have a practical working knowledge of his local facilities, equipment, resources (including personnel and their competence), and options (such as specialized services or nearby facilities) reasonably available to him or her).

79. *Leape et al.*, *supra* note 75, at 504.

80. *Id.* at 505–06.

81. *Id.* at 504.

82. *Williams*, *supra* note 1, at 518.

personal clinical experience and from dealing with this particular patient, but also the most recent thinking on the best way to deal with the medical condition at hand, consulting whatever sources might readily yield that information—whether clinical practice guidelines, scientifically conducted trials easily accessible on the Internet, or recent articles in the medical literature?

At this point, the professional standard of care kicks in. In other words, the testimony of medical experts would help the jury to evaluate what steps the defendant physician should have taken in reaching a medical decision, and also what appropriate choice or range of choices for actual treatment should have resulted from taking those steps. This suggestion, like Mr. Williams's, envisions a bifurcated kind of question for the jury to consider: (1) Did the physician engage in an appropriate process to reach an acceptable medical decision?; and (2) Did the physician in fact render acceptable medical care? Courts will continue to need physician experts to guide the thinking of juries with respect to both these questions. The burgeoning movement of EBM is a positive development that, as it becomes increasingly widespread, will help to provide the answers.

---

---

JOHN RANDOLPH  
TUCKER LECTURE

---

---

