

Medical Custom and Medical Ethics: Rethinking the Standard of Care

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In the regime of Anglo-American tort law, every person has a responsibility to comport him- or herself with “due care” in going about day-to-day activities so as not to imperil the health, safety, or general welfare of others. The gold standard for determining what constitutes due care in any particular situation is what a reasonable person, similarly situated, would do. Determinations of due care are necessarily fact specific. Nevertheless, the general objective is to strike an appropriate balance between an unrealistically high standard of caution and one that fails to take into account the known or foreseeable risks of any human endeavor. The same standard applies to individuals regardless of their age (so long as they have reached majority), gender, race, and level of education or economic status. The standard also applies to fictional “persons” such as corporations. The usual or prevailing custom and practice in an industry or occupation may provide relevant evidence of what constitutes “due care” in the activities common to it, but that evidence can be effectively overcome or rebutted by competent, credible evidence that the custom and practice either diverges from what it has been asserted to be or that the custom and practice is itself unsafe or otherwise poses an unreasonable risk of harm to others. Until quite recently, a singular exception to this general principle of tort law was made for the medical profession. We will consider this exception in the next section.

With a gradualness and subtlety that has eluded many, even in the medical and legal professions, a trend away from this special treatment for medicine has emerged. Several notable cases involving the care of dying patients, some of which have been featured in prior articles in this journal, provide the impetus for reconsideration of the medical profession’s unique status in tort law and the tempering of it in many jurisdictions.¹ The inclination of an increasing number of jurisdictions to reevaluate the reasons for such singular deference to a particular profession is indicative of the changing nature of healthcare and the public perception of physicians. There are ethical as well as legal and public policy implications to the trend that we will also consider.

The Medico-Legal Tradition: Custom and Practice as the Standard of Care

Throughout most of the modern era, Anglo-American tort law has consistently recognized an exception to the authority of the jury to determine, under the facts and circumstances of each individual tort suit, what constitutes due care and whether or not the defendant’s conduct (act or omission) fell within it.²

That singular exception was for the medical profession. In the case of a physician charged with negligence (medical malpractice), the role of the jury was limited to determining what was the customary practice under the relevant circumstances and whether the defendant physician's conduct was consistent with it. This determination was made by consideration of expert testimony offered by both sides to the litigation, as well as by other evidence such as medical texts and journal articles. If the jury concluded from the evidence that the defendant's care of the patient was consistent with the customary practice, then they must find that there was no departure from the standard of care and hence no liability. It was not within the purview of the jury to determine that the defendant's care of the patient was consistent with the standard of care but nevertheless negligent because the customary practice fell below the minimal standard of acceptable care.

The Traditional Judicial Skepticism of Deference to Customary Practice

Two of the most distinguished judges in the history of American jurisprudence wrote often-quoted decisions in which they rejected any predilection to disempower the law from denouncing and penalizing practices that posed unacceptable risks to the general public or identifiable persons. Just after the turn of the 20th century, Supreme Court Justice Oliver Wendell Holmes wrote the following in a case involving a claim for personal injuries by a railroad employee arising in the course and scope of his duties: "What usually is done may be evidence of what ought to be done, but what ought to be done is set by the standards of reasonable prudence, whether it is complied with or not."³ The railroad had argued on appeal that evidence indicating that the railroad cars had been handled in the usual and customary way at the time of the plaintiff's injuries should have precluded the jury from finding that the defendant had been negligent. The emphasis in the above-quoted passage of Mr. Justice Holmes is on the word "may." What is usually done, particularly in industries or professions where the concept of custom and practice is much more relevant than in isolated instances of individual conduct, might well rise to the level of a rebuttable presumption of due care. However, as he indicates, the trier of fact (judge or jury) must be at liberty to conclude, based upon competent and credible evidence, that usual and customary manner of doing things may not rise to the requisite level of "ordinary prudence" that sound principles of tort law demand.

Almost 30 years later, the esteemed Justice Learned Hand wrote more expansively on this issue:

In most cases reasonable prudence is in fact common prudence; but strictly speaking it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It never may set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not exclude their omission.⁴

The "calling" to which Justice Hand was referring in the case was the tugboat industry; the issue was whether it was negligent for the owners and operators of these craft to have delayed in installing and adequately maintain-

ing in operational condition radios by means of which they could receive up-to-date weather forecasts. The tugboat in question had a nonfunctioning radio that in fact had been supplied by members of the crew, not the owner. Most tugboats at the time had none, despite the undisputed fact that the technology was readily available, relatively inexpensive, and, if used consistently, had the potential to prevent precisely the type of accident that gave rise to the litigation.

There may be a certain superficial logic for the protection the law afforded medical practitioners from extraprofessional scrutiny of the prudence (or lack thereof) of their customary practices. That logic is also reflected in the traditional exclusion from vicarious liability for physician negligence that the law afforded healthcare institutions. Usually, an organization can be held vicariously liable for the negligence of an employee or an agent over whom it has the ability to exercise some authority or control. However, until the middle of the 20th century, and much later than that in some jurisdictions, the law presumed that physicians, even those directly employed by hospitals or other types of healthcare organizations, could not be controlled in this fashion because the practice of medicine required a license to practice that such organizations did not and could not possess.⁵ The persistence of this policy position is anomalous in that it has not been applied in other comparable situations. For example, the corporate entities that own and operate airlines do not possess a pilot's license, but they will certainly be held vicariously liable for the negligence of the pilots they employ who do possess such a license. Similarly, corporate entities who employ a host of other highly skilled and specially trained professionals, from attorneys to architects to engineers, are routinely held vicariously liable for individual instances of professional negligence. But moving beyond the issue of corporate liability, it is also the case that the law has not hesitated to subject the customary practices of those other professions to objective scrutiny, and to find, when the circumstances warranted, that they fell below a minimally acceptable level of prudence or safety.

Early Departures from the Special Treatment Afforded Medical Custom and Practice

Perhaps the most significant and yet the subtlest departure from the deference shown to medical custom and practice was the formulation by common law courts of the doctrine of informed consent. When the doctrine came to be articulated and applied in the 1950s and 1960s, it was not the routine practice of physicians to disclose to patients the precise nature of the procedures they recommended, their known risks as well as their anticipated benefits, and the alternatives along with their known risks and benefits, including doing nothing (sometimes referred to as "watchful waiting").⁶ Nevertheless, within 15 years (roughly 1957-1972) both state and federal courts throughout the United States had consistently determined that such timely and candid disclosures were essential to a patient's fundamental right to make medical decisions.⁷

A second major transformation of tort liability in healthcare law took place during precisely the same period of time. While the courts were recognizing a new doctrine and potential basis for institutional and professional liability, that is, informed consent, they were also abolishing a doctrine that had insulated hospitals and other healthcare institutions from liability for negligence in

patient care, that is, charitable immunity. The rationale and public policy behind the demise of charitable immunity was cogently and concisely stated by the Supreme Court of New York in language that was quickly adopted verbatim by other jurisdictions:

The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses, and interns, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of "hospital services" expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.⁸

If the New York Supreme Court's characterization of hospital operations as a business in which prospective customers (patients) are promised comprehensive "hospital services" directed toward "cure" of the patient's medical problems was true in 1957, it is all the more compellingly applicable not only to the hospitals of the 21st century, but also to the managed care organizations that have proliferated in the last 15 years.⁹ *Bing* marked not only the beginning of the end for hospital charitable immunity, but also the rise of vicarious liability of healthcare institutions for the negligence of their professional staffs.

New York continued to be in the vanguard of an incipient trend among courts to contest the general proposition that the medical profession should be allowed to establish its own standards in all cases in which the quality of medical care is called into question. In a 1968 case brought against a hospital, a pediatrician, and an ophthalmologist by the parents of twin daughters who were born prematurely, underwent the administration of oxygen for four weeks, and as a result developed retrolental fibroplasias (RLF), the Court of Appeals (the highest court in the New York judicial system) ruled that "Evidence that a [physician] defendant followed customary practice is not the sole test of professional malpractice." The court went on to explain: "there is no policy reason why a physician, who knows or believes there are unnecessary dangers in the community practice, should not be required to take whatever precautionary measures he deems appropriate."¹⁰

At the time of the case, the oxygen therapy often administered to premature infants to sustain life and prevent brain damage was known to carry a significant risk of causing RLF, which can result in severe damage to the eyes, including blindness. Although the pediatrician in question ordered 6 liters of oxygen per minute for the first 12 hours, to be reduced to 4 liters per hour thereafter, the nurses continued to administer oxygen at the higher rate for an entire month and the pediatrician failed to note the discrepancy. The Court of Appeals concluded that the trial court had erred in its refusal to instruct the jury that the pediatrician might be found negligent for his failure to ascertain that his orders were not being followed. The only issue that had been submitted to the jury was whether the defendant physicians had conformed to practices generally considered to be acceptable in their specialties.

The Rise of Corporate Negligence in Healthcare

In another of the groundbreaking cases in healthcare law that characterized the mid-20th century, the Supreme Court of Illinois moved beyond mere vicarious hospital liability, a principle that was fraught with complexity and ambiguity as to whether a hospital could be held responsible for the negligent acts or omissions of physicians who were not employees of the hospital but were members of its medical staff, and formulated a new doctrine of corporate negligence.¹¹ This doctrine held hospitals directly responsible for the monitoring and supervision of the delivery of healthcare within the institution. In laying out this new doctrine, the Illinois court drew directly upon the previously quoted language from the *Bing* case to support the proposition that the hospital *qua* institution, not merely physicians and nurses, undertakes the treatment of patients. The court also addressed the arguments of the defendant hospital that the standard of care by which its conduct should be measured was “the care customarily offered by hospitals generally in its community.” To this argument the court responded: “Custom is relevant in determining the standard of care because it illustrates what is feasible ... and it warns of the possibility of far-reaching consequences if a higher standard is required. But custom should never be conclusive.” The court went on to observe that the relevant state regulations and standards, as well as hospital bylaws and policies introduced into evidence by the plaintiff, performed a similar role to evidence of custom in that they “aided the jury in deciding what was feasible and what the defendant knew or should have known.”¹²

For reasons that are not altogether clear, despite such outright judicial rejections of the proposition that conformity with medical custom creates an irrebuttable presumption that the applicable standard of care has been met,¹³ one somewhat later case became the most famous (or infamous, depending upon one’s perspective) example of a judicial refusal to conclusively presume that what most physicians actually do with regard to a particular medical condition is what most physicians ought to do. In *Helling v. Carey*, the Washington Supreme Court confronted a case in which all of the evidence offered by both plaintiff and defendant confirmed that the defendant physician’s care of the plaintiff was consistent with a well-recognized and widely prevailing custom and practice among ophthalmologists.¹⁴ The patient was, at all times relevant to the case, a woman well under the age of 40, which was the threshold for routine testing for glaucoma. After many years under the care of the defendant ophthalmologists for chronic eye problems, she was tested for glaucoma at the age of 32 and found to have the disease. The malpractice claim followed, in which she alleged that she had sustained severe and permanent damage as a result of their failure to timely diagnose her condition. The testimony of both plaintiff’s and defendants’ experts was to the effect that because glaucoma so rarely occurs in patients under the age of 40, the standard of care in ophthalmology does not require the routine administration of the test. The experts did acknowledge, however, that if the patient’s complaints and symptoms were such that glaucoma should be within the differential diagnosis, then the standard of care would call for performance of the test. The jury concluded that the defendants had not been negligent in their failure to suspect glaucoma and test for it earlier, and the Washington Court of Appeals affirmed the defense verdict.

In its reversal of the lower court decision, the Washington Supreme Court did more than merely reject any conclusive presumption that compliance with custom and practice meets the standard of care. It went much further, holding that because the test was simple, harmless, inexpensive, and essential to a definitive diagnosis of a serious medical condition, the failure to perform it routinely to all patients was negligent as a matter of law. Commentary on the *Helling* decision has tended to be highly critical, essentially dismissing it as a rogue case.¹⁵ The criticism extends beyond the reasoning of the Washington Supreme Court, suggesting a failure of trial counsel on both sides of the case to introduce available and relevant evidence in support of their clients. For example, the defendants could have demonstrated that the pressure test for glaucoma in use at the time had a reputation for a high false positive rate, as a result of which young patients would be subjected to anxiety and further testing that might be neither simple nor inexpensive. If they had presented such evidence, perhaps the Washington Supreme Court would not have blithely asserted that the test was, among other things, "simple, harmless, and inexpensive." The plaintiff's counsel, on the other hand, could have introduced evidence showing that as high as 30% of Washington ophthalmologists routinely administered the pressure test to patients under 40.¹⁶ Had they done so, the decision might not have been as easily challenged as an egregious example of judges presuming to tell physicians how to practice medicine.

The Demise of the Hegemony of Medical Custom

Although no other court has presumed to find a particular custom and practice among physicians to be negligent as a matter of law, a surprising number have adopted the approach that expert medical testimony may provide the basis for a jury finding that adherence to the prevailing custom and practice, under the circumstances of the case, constituted negligence. One recent analysis concludes that 17 states have appellate decisions explicitly rejecting the view that mere conformity to the usual custom and practice constitutes conclusive evidence of practice within the standard of care, and that a distinct trend of courts in this direction is now discernable.¹⁷ Several cases are notable for their strongly worded assertions that the medical profession is quite capable of adopting and perpetuating practices that do not pass the test of reasonable prudence under present circumstances. For example, in 1992 the Colorado Supreme Court wrote:

The standards of medical practice cannot be determined simply by counting how many physicians follow a particular practice. Negligence cannot be excused on the grounds that others practiced the same kind of negligence . . . ascertaining the objectively reasonable standard of care is more than just a factual finding of what all, most, or even a "respectable minority" of physicians do. . . . The customary or prevailing practice may not be adequate or objectively reasonable in light of all of the facts and circumstances. . . . In such cases, healthcare professionals may be held to an objective standard of reasonable care which differs from the community standard.¹⁸

In 1996, the Supreme Court of Wisconsin expressed similar sentiments in equally strong language:

Should customary medical practice fail to keep pace with developments and advances in medical science, adherence to custom might constitute a failure to exercise ordinary care. . . .

The standard of care applicable to physicians in this state cannot be conclusively established either by a reflection of what the majority of practitioners do [*sic*] or by a sum of the customs those practitioners follow. It must instead be established by a determination of what it is reasonable to expect of a professional given the state of medical knowledge at the time of the treatment in issue. We recognize that in most situations there will be no difference between customary and reasonable practices. In most situations physicians, like other professionals, will revise their customary practices so that the care they offer reflects a due regard for advances in the profession. An emphasis on reasonable rather than customary practices, however, insures that custom will not shelter physicians who fail to adopt advances in their respective fields and who consequently fail to conform to the standard of care which both the profession and its patients have a right to expect.¹⁹

The only issue before the Wisconsin Supreme Court in this case was whether one of the jury instructions was consistent with the law of the state that in order to meet the standard of care a physician's conduct must do more than just conform with custom and practice, it must meet an independent standard of reasonable prudence under the circumstances. This, as previously noted, is the standard applied by courts generally in tort actions. The court held that the instruction as given to the jury in this case adequately conveyed the state of the law in the jurisdiction.

Understanding the Impetus for and the Implications of the Trend

Some of the courts that have recently rejected the prior position that the custom and practice of physicians conclusively determines the standard of care have sought to analogize it to the wholesale rejection of the locality rule in favor of a national standard of care. Throughout the 19th and much of the 20th centuries, physician defendants in malpractice cases were judged by local standards. For an expert witness to be deemed qualified by the court to testify as to the applicable standard of care, she had to demonstrate familiarity with the way in which patients such as the plaintiff were typically cared for by other physicians in the same or a similar community at the time in question. During the 1960s and 1970s, an increasing number of courts began to reject the locality rule on the ground that it was no longer consistent with the nature of medical education or practice. These courts noted that undergraduate and graduate medical education has been "nationalized."²⁰ All medical students must pass national boards. Medical schools and residency training programs must meet national accreditation standards. Practicing physicians are expected to participate in continuing medical education in order to stay up to date in their knowledge and skills. "Best practices" are based, more and more, on nationally recognized and widely distributed medical texts and journals, as well as clinical practice guidelines formulated by panels of experts drawn from throughout the nation and sometimes internationally.²¹ The nationalization phenomenon has increased exponentially with the advent of the Internet, national

medical databases readily available to all physicians wherever they may be located, the rise of regional and national managed care organizations, and the great mobility of healthcare professionals.

From a public policy standpoint, there was also a natural and understandable reluctance on the part of judges and juries to accept the proposition, inherent in the locality rule, that patients in rural areas could not reasonably expect to receive the same quality of care from their local healthcare institutions and professionals as residents of metropolitan areas. In the process of moving away from the locality rule, courts did recognize exceptions to the national standard, primarily taking into account disparities in resources between large and small and urban and rural healthcare institutions. But for many aspects of the practice of the health professions, a uniform standard of care was expected.

Consistent with the demise of the locality rule is the rejection of the idea that it would be acceptable for small and insular groups of professionals to maintain practices—out of conscious choice, cultivated ignorance, or sheer intellectual lassitude—that had been abandoned by their peers elsewhere after having been shown to be flawed or ineffective because the science and technology had simply moved far beyond the quality of care they afforded. The refusal of courts to hold the locality rule sacrosanct did not so much reflect some new distrust of or disdain for the medical profession as it did a reaffirmation of the general proposition that common law courts have a legitimate role in framing public policy. Perhaps without exception, such major changes in legal doctrine are a response to a felt need to bring policy and practice in line with some new reality. In the case of informed consent, for example, the new reality was that patients had a vital role to play in decisions about medical treatment that might profoundly affect their well-being, if not their lives.

However, by reflecting on the profound resistance of the medical profession to the doctrine of informed consent, we can begin to appreciate the sense of righteous indignation that would be likely to accompany the widespread acceptance of the proposition that judges and juries might be granted license to second-guess the prudence of any particular medical custom. Physicians roundly criticized the doctrine of informed consent for being based on a self-evident fallacy, that is, that the average layperson could understand enough about any particular medical procedure to give a consent that was truly informed. The specter of the *Helling* case looms large with regard to this point as well. The *Helling* court ruled as a matter of law, without any link to expert testimony or other medical evidence in the record, that the entire subspecialty of ophthalmology failed to exercise reasonable prudence in its approach to the risk of glaucoma. However, as previously noted, in that regard *Helling* remains an anomaly. When courts increasingly recognize the possibility, however remote, that the entire medical profession, or a numerically significant portion of it, might persist in a practice that is inconsistent with reasonable prudence, they presuppose that such a determination will be premised on competent and credible medical evidence.

There is little question, however, that the mere acknowledgment of the possibility that a court might be justified in arriving at such a conclusion effectively displaces the medical profession from the unique place in the pantheon of professionals that it formerly occupied. We can speculate as to the underlying factors that might motivate the courts, and society as a whole, to think in a new and much less flattering way about those who practice medi-

chine. Such speculation is highly likely to take us, before very many twists and turns, to the dramatic proliferation of managed care and the way in which these organizations have been able to dictate policies, procedures, and practices to physicians in dramatic and unprecedented ways. After all, although hospitals have long been replete with such policies and protocols, those were the product of the organized medical staff.

There is a widespread public perception, vociferously denied by managed care organizations and the national associations that represent that industry, that physicians are frequently and systematically constrained by managed care organizations in their efforts to provide quality care to their patients. Having been disempowered in this way, at least in the eyes of the general public, the fear is that custom and practice are no longer products of collective professional judgment, but rather the financially driven concerns of managed care entities. Driven by such concerns, one can imagine broad public support for the willingness of courts to intercede and set standards of reasonable prudence in the care of patients, below which it will never be acceptable to fall, no matter how many physicians managed care can bludgeon or intimidate into such practice patterns through industry-generated guidelines, financial incentives and disincentives, or the ultimate threat of removing them from the list of approved providers.

Jury Nullification of Medical Custom and Practice

Precedent in case law is established at the level of the appellate court. The locality rule was abolished and informed consent became a duty of physicians because a majority of appellate courts throughout the United States declared that to be the law going forward. Nevertheless, juries too have demonstrated a propensity to find physicians liable for substandard care even in the face of expert testimony that the defendant's treatment of the patient was consistent with the custom and practice of physicians generally and, it should be added, in the absence of any influence of managed care. Two cases dealing with pain management, and previously discussed in this journal, are paradigmatic.²²

The custom and practice of physicians in providing pain management, even in the care of terminally ill and dying patients, has been shown by numerous studies to be extremely conservative.²³ Physicians were, for the most part, loathe to prescribe opioid analgesics, and when they did the data demonstrated that they prescribed them in dosages that were too small, too infrequent, and with regard to dying patients, too late in the progression of the disease to insure a dying process that was free of pain and other distressing symptoms that require strong and consistently administered analgesics for relief. As a result, appropriately aggressive pain management, intended to ensure that a patient experienced no unnecessary pain, was the exception rather than the rule.²⁴ Beginning in the early 1990s, there were nationally promulgated clinical practice guidelines, but these tended to guide the practice of only a distinct and insular minority of physicians. The same phenomenon of routine undertreatment was, unsurprisingly, true also for nurses, hospitals, and skilled nursing facilities.²⁵ That being the case, any healthcare institution or professional who was actually sued for failure to provide effective pain relief should, in theory, be able to avoid liability by simply presenting competent, credible expert testimony that the prevailing custom and practice did not insure that patients

would have their pain promptly and effectively relieved, and that any clinical practice guidelines that purported to provide such care had not been accepted by the majority of institutions or professionals who actually provided patient care.

If the standard of care in any malpractice case were indisputably the relevant custom and practice, that is, of most physicians, nurses, hospitals, skilled nursing facilities, then the defendants in these cases would have an ironclad defense. Yet in both cases the jury found the defendant healthcare professional and/or institution liable and assessed damages in excess of \$1 million.²⁶ The failure of the defendants in either case to pursue an appeal of the verdict indicates that they considered the prospects of a favorable disposition of the case by an appellate court to be poor, which presumably would not have been the case if we were confronting instances of “runaway juries.”

A third case, filed in northern California, was the second in that jurisdiction alleging that undertreatment of the pain of an elderly (85-year-old) man with terminal mesothelioma by physicians and nurses at a hospital and subsequently a skilled nursing facility constituted elder abuse.²⁷ Although the clinical facts of the case and their legal implications were in dispute, the medical records indicated that despite significant patient distress, the only pain medication he received throughout a 6-day hospitalization was 1–2 vicodin pills every 4 hours prn (“as needed”), which was ordered at the time of his admission to the hospital. When he was transferred from the hospital to a skilled nursing facility (SNF), pain was not mentioned in the discharge summary and no orders for pain medication (even the vicodin) were written, despite the fact that pain levels in the 6–7 range (on a 10-point scale in which 10 is “the worst pain imaginable”) were noted in his chart throughout the hospitalization. The patient did not receive any pain medication in the SNF until 3 days following admission. The physician responsible for the care of this patient in the SNF, a patient whose condition was clearly deteriorating in the terminal phase of his illness, saw him only once in the 20 days between his admission and his death. Gradually increasing doses of pain medications were provided only after the patient’s daughter persistently complained to the nursing staff and then the attending physician about her father’s continued distress.

The position taken by the defendants in this case, as with the cases that came before, was essentially that the care and treatment of the patient had been consistent with the usual and customary practice of physicians caring for patients in hospitals and SNFs, and hence was not even medical negligence, let alone elder abuse, which requires proof of recklessness, malice, oppression, or fraud by clear and convincing evidence.²⁸ Expert witnesses with solid credentials were prepared to testify that each of the individual and institutional defendants had met their legal responsibilities. The case was settled recently as to all defendants just prior to the scheduled trial date. The amount of the settlement as to each of the individuals and institutional defendants is confidential.

In a strict and narrow sense, the undertreated pain cases that actually went to trial do not constitute, as does *Helling* and some of the informed consent cases noted previously, judicial or even jury standard setting. In each of these recent cases medical experts called by the plaintiffs testified (at trial or deposition) that the pain management provided to the patients was inadequate and (in two of the cases) departed significantly from that recommended by nation-

ally recognized clinical practice guidelines. By implication, such testimony challenged the position of the defendants that even if compliance with the usual custom and practice resulted in inadequate pain relief for a patient, that state of affairs could not give rise to liability because proof of compliance with medical custom establishes an irrebuttable presumption that the standard of care has been met. The counterargument that prevailed in these cases was that if respected clinical practice guidelines persuasively demonstrate that a patient's pain was unnecessary, then conformity with the medical custom and practice that countenanced such pain will not insulate healthcare institutions and professionals from liability. The latter argument appears to resonate with jurors, who have demonstrated a marked propensity to impose significant financial penalties on physicians who undertreat pain.

The Silence of the Lambs Revisited

Expert testimony that challenges the prevailing custom and practice of physicians, even when the testimony is bolstered by national clinical practice guidelines, has a tendency to raise the hackles of the medical establishment, as well as, of course, the professional liability insurance industry. Guidelines, by their very nature, are distinguished from rules or regulations that must be followed. In a strict and technical sense they are merely advisory. When applicable to a particular patient care situation, physicians are merely "invited" to consider them. From this perspective, guidelines do not become the standard of care unless and until they are consistently followed by a majority of physicians, thereby becoming the usual custom and practice. Expert witnesses who draw upon clinical practice guidelines that have yet to achieve widespread adherence as the basis for testimony that supports the contentions of plaintiffs in professional liability or elder abuse cases are, in the most contentious of settings, a courtroom, challenging the appropriateness of the customary practice of their colleagues.

Quite recently, a phenomenon has emerged that will make the potential adverse consequences of providing the kind of expert testimony discussed earlier much more significant, and hence increasingly difficult to secure. This phenomenon is the review of expert testimony by medical organizations to which the expert belongs. The Florida Medical Association, for example, reviewed such testimony, upon request by a member, 12 times between mid-2002 and late 2003. Other state medical associations are considering similar approaches. Eleven of the cases reviewed involved expert testimony on behalf of plaintiffs. Unfavorable peer reviews of such testimony could lead to dismissal from the association or even the filing of charges of unprofessional conduct by the state licensing authority. Similarly, the American Association of Neurological Surgeons has undertaken reviews of testimony in approximately 40 cases since 1983, all but one of which involved experts called by plaintiffs.²⁹ If the utilization of such a peer review process for expert testimony, complete with the imposition of real sanctions against those who are deemed to have had the temerity to challenge prevailing views, becomes widespread and is applied, not just against the few physicians who spend all of their time testifying as professional experts, but also against physicians who genuinely believe that some aspect of customary practice harms patients, then it could potentially impede the role of courts in scrutinizing the standard of care.

Conclusion

Replacement of the usual custom and practice standard of care with the reasonable physician standard of care constitutes a recognition by the courts that there have been, and in all likelihood will continue to be, instances in which a majority of physicians unreasonably delay the adoption of new and more effective approaches to some aspect of patient care. Such delays may reasonably be called into question, particularly when one of the consequences of the delay is that patients (and the families who care for and about them) appear to be subjected to unnecessary pain and suffering. The relief of pain and suffering is an exquisitely appropriate aspect of patient care to which the courts might apply this heightened level of review and scrutiny of customary medical practice. The duty to relieve suffering is, after all, an ancient and cardinal principle of medical ethics. When credible evidence has been presented that not just a particular physician, or an isolated, retrograde group of them, but a majority of the profession has failed to adopt practices that would materially reduce patient suffering, courts may properly conclude, in the tradition of great justices like Holmes and Hand, that a reasonable physician would not practice in this way and those who do should be called to account for the adverse consequences such practice has on the well-being of patients.

Notes

1. Rich BA. Moral conundrums in the courtroom: Reflections on a decade in the culture of pain. *Cambridge Quarterly of Healthcare Ethics* 2000;11:180-90.
2. The technical legal term is "trier of fact," which is the judge in a bench trial and otherwise a jury. Because most medical malpractice cases are tried to a jury, I will use the term jury in place of the more cumbersome trier of fact. Any limitations on the role of the trier of fact apply with equal force to both judge and jury.
3. *Texas and Pacific Railroad v. Behymer*, 189 U.S. 468, 470 (1903).
4. *The T.J. Hooper*, 60 F. 2d 737, 740 (2d Cir. 1932).
5. This line of reasoning led to a once pervasive public policy known as the "corporate practice of medicine doctrine" that actually prohibited corporations and other business entities from engaging in the practice of medicine. One particularly scathing critique of the doctrine condemned it as "clouded with confused reasoning and founded on an astonishing series of logical fallacies." Hall MA. Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment. *University of Pennsylvania Law Review* 1988;137:518.
6. For what remains one of the most extensive and insightful explorations of the doctrine of informed consent by a physician, see Katz J. *The Silent World of Doctor and Patient*. New York: Free Press; 1984.
7. The dates selected are marked by two of the most often-cited appellate decisions at both (state and federal) levels: *Salgo v. Leland Stanford, Jr. University Board of Trustees, et al.*, 317 P.2d 170 (1957) and *Canterbury v. Spence*, 464 F. 2d 776 (D.C. Cir. 1972).
8. *Bing v. Thunig*, 143 N.E. 2d 3 (1957). The curious reference to hospitals as mere "procurers" of physician and nurses to take care of patients appears to be a reference to the much earlier, and often-quoted decision by the famous jurist Benjamin Cardozo. In that case, Cardozo had found a surgeon liable for performing a particular surgical procedure on a patient over her previously expressed refusal. In doing so, however, Cardozo declined to hold liable the hospital where the procedure was performed in reliance on the doctrine of charitable immunity and the rationale that in the second decade of the 20th century hospitals did not provide patient care, but merely "procured" physicians and nurses to perform such care for their patients. *Schloendorff v. Society of New York Hospital*, 105 N.E. 92 (1914).
9. Despite the obvious parallels between healthcare institutions and managed care organizations, at least with regard to the extent to which their policies and procedures impact the quality and

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- quantity of medical care provided to patients, until recently managed care organizations have been insulated from liability in situations in which healthcare institutions would not because of their ability to invoke the federal Employee Retirement Income Security Act of 1974 (ERISA). Because managed care is commonly a feature of employee benefit plans, and ERISA exempts such plans from most state regulation, managed care organizations have claimed that by virtue of ERISA they are exempted from state malpractice law. Over the last 10 years, managed care's ability to use ERISA as a shield has been seriously eroded by the courts. See Jordan KA. Tort liability for managed care: The weakening of ERISA's protective shield. *Journal of Law, Medicine & Ethics* 1997;25:160-79.
10. *Toth v. Community Hospital at Glen Cove*, 239 N.E. 2d 368, 373 (1968).
 11. *Darling v. Charleston Community Memorial Hospital*, 211 N.E. 2d 253 (1965). The case involved a high school football player who was brought to the hospital after breaking his leg. Because of a series of negligent acts and omissions by the attending physician and the nursing staff, the patient ultimately had to undergo a below-the-knee amputation.
 12. See note 11, *Darling* 1965:257.
 13. Other early cases taking a similar position—that medical custom is relevant but not conclusive evidence of the standard of care—include *Favalora v. Aetna Casualty & Surety Company*, 144 So. 2d 544 (La. Ct. App. 1962) and *Lundahl v. Rockford Mem'l Hosp. Ass'n*, 235 N.E. 2d 671 (Ill. App. Ct. 1968). 2d 544 (La. App. 1962); *Toth v. Community Hospital at Glen Cove*, 239 N.E. 2d 363 (1968).
 14. *Helling v. Carey*, 519 P. 2d 981 (1974).
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 27. *Tomlinson v. Bayberry Care Center, et al.*, No. C 02-00120, Superior Court, Contra Costa Co, CA (2002).
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