## LAW & MEDICINE

# Which Standard of Care?

**Question:** As a general internist with a large practice, you own your own x-ray machine, and you regularly obtain and interpret your patients' x-rays instead of having a radiologist read them. Assume that the community standard is for radiologists rather than internists to read x-rays. What level of accuracy or standard of care will you be held to?

**A.** That of a general internist.
**B.** That of a reasonable doctor using his or her best judgment.
**C.** That of a radiologist.
**D.** A standard between that of a radiologist and a general internist.
**E.** That of an x-ray technician whose expertise in radiology is similar to yours.

BY S. Y. TAN, M.D., J.D.

**Answer: C.** A doctor is usually held to the objective standards of fellow doctors, given the circumstances of the case. Specialists will be held to a higher standard: that ordinarily expected of fellow doctors in that specialty. However, if you, a generalist, assume the duties normally performed by a specialist, the law will consider that you are representing yourself as capable of functioning at that level. In the above case, if internists do not regularly read their own x-rays and you, an internist, choose to do so, you will be held to the standard of a radiologist. Choice B is incorrect because "best judgment" is not a legal standard that governs malpractice matters.

The legal duty owed by doctors to their patients is that of reasonable care, defined as that level of care expected of the reasonably competent doctor—that is, a professional standard, not that of a reasonably prudent layperson, the latter being the standard used in negligence actions. Thus, Alabama has held that physicians must "exercise such reasonable care, diligence, and skill as reasonably competent physicians" would exercise in the same or similar circumstances (*Keebler v. Winfield Carraway Hospital,* 531 So.2d 841 [Ala. 1988]). An Illinois court used similar words: "[A] physician must possess and apply the knowledge, skill, and care of a reasonably well-qualified physician in the relevant medical community" (*Purtill v. Hess,* 489 N.E.2d 867 [Ill. 1986]). And in Hawaii, "the question of negligence must be decided by reference to relevant medical standards of care for which the plaintiff carries the burden of proving through expert medical testimony" (*Craft v. Peebles,* 893 P.2d 138 [Haw. 1995]).

While the professional standard applies to injuries arising out of medical care, the "reasonable person" standard continues to govern non–health care activities such as falls on slippery hospital floors. Unfortunately, the distinction may not always be clear. As one author put it, "Sometimes it is difficult to differentiate bad housekeeping and bad medical care, as where rats in a hospital repeatedly bit a comatose patient" (Dobbs, D.B. 2000. *The Law of Torts.* St. Paul, Minn.: West Group. Chapter 14, referring to *Lejeunee v. Rayne Branch Hospital*, 556 So.2d 559 [La. 1990]).

The doctor's specialty does matter in legal proceedings addressing the standard of care. The surgeon will be judged according to the community standard of the ordinarily skilled surgeon, and the internist according to that of other internists. But there is a separate duty to refer if the case is outside the doctor's field of expertise. If the standard is to refer to a specialist, the internist who undertakes to personally treat the patient within that specialty will be held to that higher standard. In *Simpson v. Davis,* for example, a general dentist performed root canal work and was therefore held to the standard of an endodontist (*Simpson v. Davis,* 549 P.2d 950 [Kan. 1976]).

The law expects doctors to provide reasonable care to their patients, even for conditions arguably outside their specialty. In a recent lawsuit, a gynecologist failed to consider appendicitis in a 32-year-old woman who presented with fever, chills, nausea, and lower abdominal pain. This delay in diagnosis led to rupture. The defendant-gynecologist argued that the diagnosis of a urinary tract infection or a pelvic condition was appropriate given the doctor's specialty. The gynecologist did not document the abdominal and pelvic examinations in detail, and did not obtain an ultrasound study. The trial court entered a verdict for the plaintiff; jury members later confided that the verdict would have been different had the doctor simply included appendicitis in the differential diagnosis ("Not My Specialty." *The Doctor's Advocate,* Third Quarter, 2006).

In medicine, there is frequently a minority view as to how things ought to be done, so the standard of care need not necessarily be unanimous. So long as the minority view is held by a respectable group of doctors, the law will accept it as a legitimate alternative. However, this does not mean that any "on-the-fringe" publication on an issue will suffice. A minority view is reflective of a different approach to the same problem, but the care rendered must still comply with the standard of care espoused. In a Texas case, the court was not concerned with whether the practice was that of a respectable minority or a considerable number of physicians, but whether it met the standard. The case involved an augmentation mammoplasty procedure that resulted in silicone leakage. A number of qualified physicians had used that procedure, and this satisfied the court that the standard had been met (*Henderson v. Heyer-Schulte Corp. of Santa Barbara,* 600 S.W.2d 844 [Tex Civ. App. 1980]).

Finally, courts have in the past considered the locale where the tortious act took place, invoking the so-called "locality rule." This was based on the belief that different standards of care were applicable in different areas of the country, for example, urban vs. rural. However, this rule has been largely abandoned in favor of a uniform standard, because current medical training and board certifications all adhere to a national standard. But geographic considerations are not entirely irrelevant. Where the local medical facilities lack state-of-the-art equipment or specialists, courts will give due consideration to such conditions. Still, there is always the duty to reasonably transfer to an available specialist or facility, and failure to do so may form the basis of liability. ■

DR. TAN *is professor of medicine and former adjunct professor of law at the University of Hawaii, Honolulu. This article is meant to be educational and does not constitute medical, ethical, or legal advice. It is adapted from the author's book, "Medical Malpractice: Understanding the Law, Managing the Risk" (2006). For additional information, readers may contact the author at siang@hawaii.edu.*

# Economy Takes Toll on Addiction Treatment Programs

BY RENÉE MATTHEWS

BETHESDA, MD. — The current economic downturn has had a substantial impact on the prevalence and treatment of addiction in the United States, according to preliminary findings of data gathered from treatment program administrators.

Stress as a result of job loss or being in a family affected by job loss has led to an increased demand for addiction treatment services, which are themselves under siege due to lower funding, fewere counselors, and the ripple effects of hiring freezes, Paul Roman, Ph.D., said at the annual meeting of the Association of Medical Education and Research in Substance Abuse, sponsored by Brown Medical School.

Dr. Roman and Amanda J. Abraham, Ph.D., both of the University of Georgia, Athens, collected data during face-to-face and follow-up telephone interviews with treatment program administrators in the Clinical Trial Program (198), privately run programs (345), and atthe National Institute of Alcohol Abuse and Alcoholism (350).

The administrators reported a mean reduction of 13% in overall budget, 22% in grant funding, 17% in Medicaid income, and 12% in insurance payments. The dip in grant allocations alone correlated with an increase in uncollectible revenues, a decrease in staff and treatment slots, and the implementation of hiring freezes, he said.

Staff losses and hiring freezes cut across the management, counselor, and support staff categories: 14% of interviewees reported cuts at management level, 21% reported counselor losses, and 25% support staff losses. One-third of those interviewed said there had been hiring freezes across all three staff categories. Commensurate with these staff cuts, particularly at the counselor level, was a reduction in the number of treatment slots, which was reported by 12% of the interviewees. At the same time, there was a mean overall increase of 18% in patients.

"The American substance abuse treatment system is under considerable economic stress," Dr. Roman said. Smaller, nonprofit, nonhospital-associated programs have been hardest hit, as have programs with a higher percentage of Medicaid patients, a lower percentage of counselors with master's degrees, and more injection drug users and unemployed patients.

Regionally, almost half of the programs in the Pacific coast region were stressed, compared with 23% in the South Atlantic, 15% in the East North Central, and 8% in the Mid-Atlantic regions.

Dr. Roman said programs might capitalize on four "great opportunities" to bolster their bottom lines and treatment services: the growth of substance abuse problems in the elderly, the fact that Baby Boomers are aging into the high prevalence years of substance abuse, the implementation of parity for substance and alcohol use disorder treatment, and health care reform.

He emphasized, however, that leadership will be critical if providers are to join together to take advantage of these factors. "The most successful treatment programs … engage in concrete, measurable, identifiable, systemic strategic planning," he said. Programs should therefore consider how they could attract clients to and keep them in treatment, work to shed the chronic disease stigma associated with substance abuse, and tap new sources of referral, such as the workplace. ■

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