LAW & MEDICINE

Which Standard of Care?

Question: As a family physician 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 generalists to read x-rays. What level of accuracy or standard of care will you be held to?

A. That of a generalist.

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 generalist.

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 generalists do not regularly read their own x-rays and you, a family physician, 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 generalists according to that of other generalists. 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 family physician 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. ■

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National Committee Considers Effect of IT on Patient Safety

BY MARY ELLEN SCHNEIDER

As physicians and hospitals begin to implement electronic health record systems in the hopes of earning financial incentives from the federal government, experts are considering how to ensure patient safety when working with health information technology.

The Health IT Policy Committee, which makes recommendations to the federal National Coordinator for Health Information Technology, met this Spring to discuss some of the areas where potential patient safety hazards exist. Topping the list were technology issues, such as software bugs, interoperability problems, and implementation and training deficiencies. Another major area of concern is the interaction of people and technology.

According to Paul Egerman, who co-chairs the Certification/Adoption Workgroup of the Health IT Policy Committee, straightforward problems with technology are actually the minority when it comes to safety issues. While these problems can be difficult to uncover, once they are discovered they can usually be easily and rapidly fixed.

The majority of safety issues surrounding health IT involve multiple factors. That complicates things, Mr. Egerman said, because that means that even if the technology worked perfectly, there could still be problems. "There are tons of issues that are completely independent of technology," said Mr. Egerman, who is CEO of eScription, a computer-aided medical transcription company.

Also of concern is that many of the health IT-related safety issues are local. Marc Probst, who co-chairs the Certification/Adoption Workgroup, said that each health care organization is unique, and relies on very different operating systems, security and privacy protocols, and even different types of monitoring. That puts the onus on individual organizations to stay on top of safety issues raised by their health IT systems, he said.

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"Every organization is going to be unique, so there is a local responsibility to HIT safety that our vendors simply aren't going to be able to keep up with," Mr. Probst, who is the chief information officer at Intermountain Healthcare in Salt Lake City, Utah, said.

The Certification/Adoption workgroup previewed some of its ideas for gathering more data on the HIT-related safety issues and the need for more training. The workgroup released a set of preliminary recommendations that call for patients to play a greater role in identifying errors. In the physician office, for example, patients should ideally be able to observe as physicians enter information into an electronic record so they can call attention to mistakes. On the inpatient side, patients and family members should be encouraged to look at medication lists.

To gain more data on the scope of safety issues, the workgroup also called for establishing a national database and reporting system that would allow patients and health care providers to make confidential reports about incidents and potential hazards. This could be used for evaluation and analysis, but also for dissemination of potential problems, Mr. Egerman said. ■