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## Varying Standards of Care in Medicine

Charles J. Frankel\*

**T**HERE ARE MANY ROADS to Mecca. Some are more direct and less dangerous, others are fraught with hazards which must be overcome to enable the seasoned traveler to reach his destination. The unwary person may be fortunate and successful; yet he may easily lose his way. So it is in medicine and surgery. In the field of orthopedic surgery I have noted many different approaches to a particular problem. In many instances it is generally agreed that one method is as good as another, depending on individual familiarity with the technique. In other instances there is wide disagreement.

### The Procedural Dilemma in Treatment

Some people believe that oblique fractures of the tibia are best treated by immediate open reduction. Bohler states unequivocally that oblique fractures of the lower third of tibia should never be treated by open reduction. Fractures of the neck of the femur are sometimes treated by immediate use of a prosthesis, in other instances pin fixation is used. Treatment of fractures of the femur in young people are handled by closed methods of reduction which include traction. A recent paper by a well qualified orthopedic surgeon suggested that in all of his cases he was using intramedullary fixation. When the paper was presented at a scientific meeting, it was met with criticism by some and acceptance by others. On closer examination of the problem, one can find compelling arguments against such procedure and practically no reason, other than the economic, for its use.

Osteomyelitis may be treated in its early stages by antibiotics alone, but the surgeon must be alert to the need for surgical intervention. In many areas surgical intervention is mandatory and is followed by the use of antibiotics. Other questions come to mind. Should surgical implants and metallic internal fixation be left in place indefinitely, or removed after they have accomplished their purpose? Is homogenous bone to be used for bone grafting when autogenous bone is available? Should fractures of the elbow in children be treated by open reduction, or by closed methods which include traction and immobilization? Should necessary open reduction on fractures be done immediately, or should there be a waiting period of four to seven days? In the treatment of fresh fractures, should a circular cast be used, or should splints be applied? Is a skin-

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tight cast to be used in fresh fractures, or should the cast be padded? The treatment of compound injuries also provides many perplexing problems.

### **Aspects of a Malpractice Action**

An attorney recently asked me to evaluate the records on a malpractice action which he was contemplating. He felt that he had a hard and fast case, but his firm was friendly to physicians in the area and he wished to be doubly certain before prosecuting the claim. Since most of my consultant activities in malpractice actions are for the defense, I was slightly hesitant about becoming involved in the problem. I finally agreed to look into the records if the plaintiff would promise to seek a reasonable settlement, without formal litigation, in the event that I found affirmatively for him. I fully realized that I was brash in making the request. I also realized that counsellor could jolly well ignore his promise, which, in fact, was only a gentleman's agreement. At any rate, if it did nothing else, it tended to salve my conscience.

Hospital records indicated that the patient was a ten year old boy who had sustained a compound fracture of both bones of the forearm. He was immediately taken to the hospital. In the emergency room an intern noted that the wound was dirty and of the puncture variety, rather than an extensive wound. The forearm had an obvious deformity and the intern proceeded to wash away the dirt and called the private attending orthopedic surgeon. Several hours later the wound was washed again, the fracture set, and a cast was applied. An order was left for oral penicillin and the doctor went on his way. The hospital records indicated that the child was fretful and refused to take his penicillin. The parents were upset over what they felt was poor hospital care and when the surgeon came that evening (24 hours after the initial treatment) he noted for the first time that the child had not been given penicillin. He suggested that the child be kept in the hospital for further treatment. The parents, however, preferred to take the child home and did so in the morning. During the twenty-four hours after arrival at home the child complained of pain and swelling. He was taken to another hospital where the original doctor's partner partially split the cast and told the parents to return to his partner in several days. Eighteen hours later the child's pain and temperature had increased to a marked degree. He was then seen by a general surgeon who removed the cast, found evidence of gas gangrene, and amputated the arm just below the shoulder.

Question: Is such a catastrophic conclusion, for what should have been a smooth and uneventful convalescence, evidence per se of gross negligence? Unfortunately, many lawyers believe so, as do many members of a jury, particularly when they look upon the pitiful plaintiff day after day at the trial.

It is my personal feeling, as a physician-attorney and a member of the American College of Legal Medicine, that I have a duty to remain completely objective, and to avoid, if possible, in my consultant activities, accepting a role as advocate for either party.

I began research on this problem and examined every facet of the record. I then checked to see what the experts had to say about the treatment, step-by-step. Academically, I learned a great deal which enhanced my professional expertise. However, for practical purposes, most of the information was going to be acted upon by a thoroughly confused jury.

Did the defendant surgeon follow acceptable standards?<sup>1</sup> Practically all of the standard textbooks recommend that compound injuries be cleansed or debrided. According to the records, this was done. But the record further indicated that the debridement consisted only of cutting away some of the skin edges. By definition, debridement means the removal of devitalized tissue. Place the first demerit on the debit side of the ledger. I looked further and noted that Campbell's Operative Orthopedic text classified compound fractures into types 1, 2, 3 and 4. Type 1 consisted of small puncture wounds which required only washing and possible excision of skin edges. Enter a merit point. Then a look into McLaughlin's excellent text on trauma disclosed with devastating clarity, that a puncture wound may cover a large area of devitalized, infected tissue in the recesses beneath the wound. All such wounds must be enlarged, thoroughly inspected in the crevices, and devitalized tissue removed completely. Enter another demerit.

I talked with six orthopedic surgeons who live and work in a fairly enlightened medical community. Four of the six usually follow the tenets laid down by Campbell. The two remaining surgeons teach and follow the tenets of McLaughlin. If we are to apply the *locale theory*, I suppose the majority would hold that the procedure, as followed by the defendant surgeon, met all of the standards of the community. If the survey was extended beyond the community, we would probably meet with the same conclusions.<sup>2</sup> According to the rules of law, after conflicting testimony

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<sup>1</sup> Derr v. Booney, 38 Wash. 2d 678, 231 P. 2d 637 (1951); Annot., 54 A.L.R. 2d 193 (1951) held that a patient may recover for injuries sustained only by showing the standard of surgical practice in the community and that the surgeon failed to follow the methods prescribed by the standard. The testimony of other physicians that they would have followed a different course of treatment or disagreement among physicians of equal skill and learning as to what the treatment should have been does not establish negligence. When such is the case, a court must hold for the physician as a matter of law, the reason being the jury may not be allowed to accept one theory to the exclusion of the other.

<sup>2</sup> Ales v. Ryan, 8 Cal. 2d 82, 64 P. 2d 409 (1937); held that conformity with the standards of care observed by other physicians practicing in the same or similar community is not a defense in a malpractice action when the standard relied upon is shown to constitute negligence in that it fails to guard against injury to a patient from a reasonably foreseeable contingency. Generally, negligence cannot be excused on the ground that others in the same locality practice the same kind of negligence.

has been presented, the jury weighs the evidence and would probably decide in favor of the defendant, assuming they were not emotionally predisposed toward the plaintiff.<sup>3</sup> If the defendant were held to be negligent, it would certainly be contrary to the weight of the evidence, at least, on the issue of having performed the surgery correctly or incorrectly. On the other hand, if the defendant prevails, plaintiff would be told that he has been the victim of an *act of God*, and that no human act could have intervened to have saved his limb.

### Revaluation of Standards by Expanded Liability

Are we to rationalize this problem by stating that men do have differences of opinion, or that there are many different ways to treat a condition; or further that the physician's judgment is not to be questioned or mistaken for negligence?<sup>4</sup> Every physician is aware of the fact that patients often get well despite substandard treatment. Often the accumulated experience of patients getting well on substandard treatment, unrecognized as substandard by the physician, may be the means whereby the physician develops his so-called judgment.<sup>5</sup>

I was struck repeatedly during the research on the above case, and many others like it, by similar issues that arise from the deficient standard of manufacture of automobiles. For many years the liability of the automobile manufacturer for a poorly engineered product was unthinkable. Certainly no one outside of the automobile industry had the expertise of the world's foremost automobile engineers. In our situation we have the renowned expertise of an author's widely accepted textbooks contrasted with the more humble opinion of some country practitioner. It is time that the experts be held accountable if it can be shown that what they have taught is physiologically and biologically unacceptable, and is indirectly responsible for the bad result that follows the faulty therapeutic approach.

If a drug manufacturer labels his product incorrectly, or gives incorrect directions for its use, he is often liable for the damage that is sustained. Publishing textbooks and teaching carry tremendous responsibilities. Too often publishing is done for purposes other than education.

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<sup>3</sup> *McDermott v. Manhattan Eye, Ear and Throat Hospital*, 15 N.Y. 2d 20, 203 N.E. 2d 469, 474 (1964). "It is not always a simple matter to have one expert, a doctor in this case, condemn in open court the practice of another, particularly if the latter is a leader in his field. In consequence the plaintiff's only recourse in many cases may be to question the defendant doctor as an expert in the hope he will thereby be able to establish his malpractice claim."

See also, King, *The Adverse Witness Statute and Expert Opinion*, 4 Wayne L. Rev. 228 (1958).

<sup>4</sup> *Duckworth v. Bennett*, 320 Pa. 47, 181 A. 558, 559 (1935). "Where competent medical authority is divided a physician will not be held responsible if, in the exercise of his judgment, he followed a course of treatment advocated by a considerable number of his professional brethren in good standing in his community."

<sup>5</sup> Long, *The Physician and the Law* (3rd ed. 1968).

Perhaps liability will remedy frivolous research and writing. More important, it may force changes in the medical curriculum to insure that standards of care in medicine and surgery are constantly re-evaluated before they are passed on to the medical student and to the resident as dogma.

It can be argued that medicine is not an exact science and that there must be differences of opinion. However, where the differences of opinion are widely disparate, a more critical look should be taken. A re-evaluation should be made, not on the basis of end result studies alone, but on a restatement of physiological, bacteriological and biological principles. For example, if an author who was of the opinion that puncture compound wounds should be merely washed, was cross-examined and asked how he could be sure that there was not any devitalized tissue beneath the puncture wound, of necessity, he would have to state that he could not be sure, but that in his experience, he had never had any difficulty. On the other hand, what if you were to examine the expert who has clearly demonstrated in his textbook that puncture wounds, on occasion, do harbor deadly bacteria which are nourished by unexplored, unseen, devitalized tissue beneath the puncture wound? You would have to conclude that one of the experts based his opinions on good fortune and the other based his opinions in accord with good surgical and physiological principles.

It is to be expected that in a large textbook there are bound to be a number of mistakes. Likewise, the surgeon who has a large practice may make mistakes. The surgeon anticipates such a situation by carrying insurance. Is the teacher responsible for the sins of his pupil? Or, like the automobile manufacturer, does his responsibility end with the graduation of the student? Where an individual can show that he has followed the precepts of his teachers, and in so doing has been led astray, is it reasonable to charge him with entire responsibility because he should have taken time to recheck each precept before he put them into use? It is obviously impossible for a young practitioner to forego practice until he acquires, by observation, enough experience to authoritatively question statements made by his peers.

### Conclusions

Today, with rapid communication and advanced educational methods, *the locale rule*, pertaining to standards of care, should be revised. This has occurred in several jurisdictions. Responsible educators must develop a standard of care which is universal and, which meets all of the necessary biological requisites. The same standard should apply in Podunk as in Boston. An acceptable standard can be developed in Podunk as well as in Boston. The same evaluation process should be applied to any new development regardless of where it originates. Too often prin-

principles are accepted from name institutions that would be summarily rejected if offered by less well known groups. Medical schools, teachers and textbook writers have a definite responsibility; first, to help educate and train practicing physicians, and secondarily, to broaden their interests to include research and teaching. Our younger generation has begun to question their elders. Perhaps it is time for all of us to ask more questions.

In most medical schools the study of trauma is an elective. Can you imagine a West Point graduate being sent into combat ignorant of the fundamental use of weapons, yet cognizant of military tactics? The usual answer from many Deans is that "We cannot train tradesmen; we must have scientists." A little more pragmatism, not less idealism, is required. If medical schools, like General Motors, were challenged, perhaps constructive changes could be brought about.

The first duty of Physicians is to provide the best care for their patients. Lawyers should be interested in providing the Courts with improved standards of care so that justice can be dispensed on an enlightened, and impartial basis.