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Medicolegal Sidebar: The Law and Social Values: Conformity to Norms

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Introduction

The last two articles published in the Medicolegal Sidebar addressed the complex interplay between the law and social values [1, 2]. Sometimes, court decisions may appear to be arbitrary and unfair to the

medical profession, but a deeper examination of judicial rulings can show the practical tensions that courts sometimes face in adjudicating medical malpractice claims. We previously addressed the development of legal doctrines that are relevant to medical malpractice cases, such as “loss of chance” [1] and “res ipsa loquitor” [2]. In this article, we ask whether physician conformity to established and accepted treatment norms should always insulate the provider against medical malpractice claims.

The question is relevant because of the prevailing assumption among physicians that compliance with the medical standard of care requires

conformity to treatment norms that their peers would follow in comparable circumstances [14]. Indeed, a general assumption in medical malpractice litigation is that a physician or a surgeon who conforms to the prevailing norms of professional conduct, as described by an expert witness, should not be found liable for medical negligence [11]. However, as this article will illustrate, conformity to a medical norm as a measure of professional performance or medical negligence presents daunting challenges to American jurisprudence.

The Value of Conformity

There are historical examples that illuminate the complex role that conformity to norms has played in healthcare quality. For instance, Dr. William Stuart Halsted (1886–1922) is regarded as one of the most influential surgeons who redefined American surgery [6]. His biographer, Dr. Gerald Imber, described Halsted’s historically significant contributions to surgery as a “... compulsive attention to detail ... a thinking surgeon who sacrificed speed and style for scrupulous care and

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anatomical integrity” [9]. Compliance with Dr. Halsted’s principles for diligent surgery is well accepted to be the hallmark of classic, good surgical practice. Arguably, surgeons who conform to the high standards set forth by such a pioneering authority figure in surgery should be insulated from professional liability.

On the other hand, Dr. Halsted was the originator of the radical mastectomy as a treatment for breast cancer. The radical mastectomy remained the community norm for surgical treatment of breast cancer until the 1970s, even though there were major advances in the early diagnosis of breast cancer as well as the development of chemotherapy and radiation therapy as adjunct treatments [3]. However, the socio-cultural forces driving Halsted’s radical approach to breast cancer were so strong in the medical community that other surgeons developed a variation of Dr. Halsted’s radical mastectomy, which became known as the “super radical mastectomy,” to include wider dissection of lymph nodes [3]. As Dr. Imber reflected in his biography of Dr. Halsted, eventually “... a few well regarded surgeons dared to suggest that with the disease being discovered so much earlier, perhaps smaller, less mutilating surgery would suffice ...” [3]. In that era, a surgeon performing a less radical mastectomy would

therefore have been outside community norms of treatment, and possibly exposed to a malpractice claim, even though the less radical option would have been the correct one for the patient. Likewise, in the 1960s, a surgeon performing a less than complete meniscectomy in the knee joint would be outside the norms of accepted treatment, just as a surgeon performing a complete meniscectomy today (accepted and standard treatment in the 1960s) would be exposed to a medical negligence claim.

The Value of Nonconformity

Treatment standards, such as the radical mastectomy developed by Dr. Halsted, may become institutionalized in the medical community for reasons other than scientific evidence. If surgeons are going to be insulated from liability because they are conforming to such norms, does it not necessarily follow that nonconforming surgeons should be liable for professional conduct outside those norms? The flaw in this reasoning is reflected in the historical role that another pioneer surgeon, Dr. John Hunter, played in the evolution of surgery [12]. Hunter was a nonconformist who advocated the idea that for battlefield injuries, it was not always necessary to perform a deep dissection to extricate bullets

lodged in tissues. This proposition ran counter to the accepted notion that bullets were poisonous and must be removed, even if it meant potentially dangerous, major surgery on already-injured soldiers [4]. Hunter was widely criticized at the time for his contrarian stance, but his view would be vindicated later, when studies demonstrated that his approach greatly reduced battlefield mortality [12].

In describing conformity to norms in his book, *Hippocrates’ Shadow*, author David H. Newman MD, proposes the term “pseudoaxioms” [13]. He writes: “In medicine, as in most professions, some principles are axiomatic. Often, these principles are taught by well-intentioned elders who were handed the same axioms by their teachers – they’re simply passing them along. But in most cases, they never examined the evidence themselves ... When an axiom is handed down from generation to generation and it’s false, it is a ‘pseudoaxiom.’ Like pseudoscience, pseudoaxioms are false statements masquerading as truth, and in modern medicine they’re disturbingly common” [13].

The Judicial View of Conformity

The competing values that arise from surgeon compliance with established norms came to light in the 1974 legal

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case of *Helling v Carey*, tried in the state of Washington [8]. *Helling* is a frequently cited [5], seminal case in medical malpractice jurisprudence because, for the first time, an American court set forth its view of what the medical standard of care should be in light of reason and logic, rejecting accepted treatment norms to the contrary. This doctrine was established in nonmedical civil litigation some four decades earlier in a legal case titled *The T. J. Hooper* [16] and its principles were extended to apply to medical litigation in *Helling*. In *Hooper*, Justice Learned Hand remarked that "... courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission" [16].

In the *Helling* case, plaintiff Ms. Helling had experienced intermittent pain in her eyes for a period of 9 years, during which time she was in the care of an ophthalmologist, Dr. Carey. Since the patient was younger than 40 years of age, Dr. Carey failed to perform a noninvasive test that was widely available to screen for glaucoma. In the state of Washington, ophthalmologists did not perform pressure tests on patients younger than 40 years of age, because the risk of glaucoma was only one in 25,000 in that age group. When Dr. Carey finally diagnosed glaucoma, Ms. Helling was

32 years of age, and had suffered permanent, partial vision impairment.

In the lawsuit that followed, Ms. Helling stressed that the accepted standard of care for ophthalmology was incorrect, and did not protect patients like her from glaucoma. Additionally, the defendant, "by reason of his special ability, knowledge and information," was negligent in failing to give the pressure test at an earlier point in time [8]. The defense pointed to the fact that Dr. Carey had fully complied with the prevailing standard of care when he did not perform testing for glaucoma [8].

The lower court, agreeing with the defense, rejected Ms. Helling's notion that the standard of care should have reasonably required the doctor to test her for glaucoma, notwithstanding the established community standard of care to the contrary. Indeed, expert testimony from both sides agreed that the ocular pressure tests were never performed routinely on patients younger than 40 years of age. The plaintiff appealed to the Washington Court of Appeals, who agreed with the lower court's reasoning. Finally, on appeal to the Washington Supreme Court, the judgment of the lower courts was reversed, and the court found in favor of Ms. Helling.

In a ruling that many believed set a disturbing precedent for medical malpractice jurisprudence,

the Washington Supreme Court said that "The incidence of glaucoma is one out of 25,000 persons under the age of 40 [which] may appear quite minimal. However, that one person, the plaintiff in this instance, is entitled to the same protection, as afforded persons over 40, essential for timely detection of the evidence of glaucoma where it can be arrested to avoid the grave and devastating result of the disease. The test is a simple pressure test, relatively inexpensive. There is no judgment factor involved, and there is no doubt that by giving the test the evidence of glaucoma can be detected. The giving of the test is harmless if the physical condition of the eye permits" [8].

Not surprisingly, the *Helling* ruling provoked a heated debate about the appropriateness of courts defining medical standards. One commentary stated, "*The Helling vs. Carey* medical malpractice case serves as frightful reminder of the potential consequences of allowing courts to craft their own standards of medical care" [10]. Nonetheless, the *Helling* case is historically important because it clarified the proper role of conformity to medical norms in assessing medical liability. What has evolved is the legal principle that conforming to norms may be one measure of medical prudence, but it is never the only measure of such.

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In the 1982 legal case of *Harris v. Groth*—which followed the *Helling* ruling, and was also tried in the State of Washington—the Court summarized the state of jurisprudence with regards to conformity as follows: “The standard of care against which a healthcare provider’s conduct is to be measured is that of a reasonably prudent practitioner, possessing the degree of skill, care, and learning possessed by other members of the same profession in the state of Washington. The degree of care actually practiced by members of the profession is only some evidence of what is reasonably prudent—it is not dispositive” [7].

Discussion

Conformity to norms has become an important issue in orthopaedic surgery both for practitioners and industry. Practice guidelines, national standards such as the Surgical Care Improvement Project standards, and evidence-based medicine all seek to introduce uniformity in the practice of medicine and surgery, with the goal of reducing errors and improving the quality of care. Yet, uncomfortable questions remain. Did, for example, the orthopaedic implant industry collectively establish an inappropriate norm when it introduced metal-on-metal hip

implants, devices that were advocated by developer surgeons and subsequently recalled after significant patient injury? Is knee arthroscopy for painful, early osteoarthritis pseudoaxiomatic, partial-pseudoaxiomatic, or a well-established orthopaedic intervention? Are the indications that have been established for total knee replacement sufficiently refined to prevent significant numbers of unnecessary surgical procedures, given that one large multicenter, longitudinal cohort study has shown that at least one-third of total knee replacements are done for inappropriate indications? [15] These have become provocative and complex questions for medical professionals.

Orthopaedic surgeons need to feel comfortable that they are not exposed to malpractice liability if they comply with established orthopaedic practice norms that are viewed as the prevailing standard of care. However, as this article has shown, surgeons need to look beyond perceived professional norms, and remain alert that their professional conduct will be viewed by courts in light of the reasonableness and prudence of their professional performance, regardless of the conduct, judgment, or even expert opinion of their peers.

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