

Emergency Medicine Grand Rounds

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Altered Standards of Care



STANDARD OF CARE is a slippery concept. It means very different things to different people.

From a philosophical standpoint (see *Plato's Cave* in Wikipedia), there is a standard of care that exists independently of all published materials, and it is the consensus of informed medical opinion of how to care for a given medical condition in the context at the time and place of the condition. This ideal form of the standard of care may occasionally be expressed clearly in the appellate decision of a malpractice case (case law = common law), and the sum of these judgments provides a broad view of what is considered malpractice and what is considered meeting the standard of care. But this is limited to the particular time and context of the case in question, and medicine changes over time, and contexts vary. Current editions of relevant textbooks are seen, to a degree, as expressing this ideal standard of care.

If we consult Black's Law Dictionary, we find the



definition at the center bottom of this page – a definition that is used after the fact to judge if malpractice occurred. While the idea that the standard of care varies in different areas, it is still widely-accepted that the standard of care varies depending on training and practice specialty, and as we will see below, the idea that standard of care changes when the context changes is gaining traction.

Most Google “medical standard of care” relate to the legal view. I found standardofcare.com particularly interesting: *The Standard of Care posts data relative to prognosis of varying medical and surgical illnesses. Interesting medical facts are also included. Data is added based on review of recently published information. References are available. The information is not all-inclusive or encyclopedic. We value your feedback, and welcome your inquiries into the many advertising opportunities we have to offer. As with any field of investigation, it is sage advice to “follow the money,” which in this case leads us overwhelmingly to malpractice law. But there are other “standards.”*

Types of Standard

In 1990, the IOM published a report that serves as the foundation of modern theories of the medical standard of care.¹

1. Field MJ, Lohr KN, eds. Institute of Medicine. Clinical Practice Guidelines: Directions for a New Program. Washington, DC: National Academy Press; 1990. Available at: <http://books>.

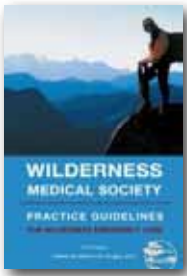
Objectives

1. Pretend you're a lawyer or a judge. Define “standard of care.”
2. Pretend that you're the President of the Medical Staff for a community hospital. Define “standard of care.”
3. Pretend that you're the Chief Medical Officer of a federal disaster team. Define “standard of care.”
4. Pretend you know something about this topic. Define “altered standard of care.”
5. Pretend you're a medical policy wonk. Give three different examples where altered standards of care would be reasonable.
6. Pretend you're a well-to-do trial lawyer. Explain why you refuse to consider altered standards of care, and sabotaged efforts to make malpractice exemptions for doctors serving for free during disasters.

Black's Law Dictionary

Standard of care. In law of negligence, that degree of care which a reasonably prudent person should exercise in same or similar circumstances. If a person's conduct falls below such standard, he may be liable in damages for injuries or damages resulting from his conduct. *See* Negligence; Reasonable man doctrine *or* standard.

In medical, legal, etc., malpractice cases a standard of care is applied to measure the competence of the professional. The traditional standard for doctors is that he exercise the “average degree of skill, care, and diligence exercised by members of the same profession, practicing in the same or a similar locality in light of the present state of medical and surgical science.” *Gillette v. Tucker*, 67 Ohio St. 106, 65 N.E. 865. With increased specialization, however, certain courts have disregarded geographical considerations holding that in the practice of a board-certified medical or surgical specialty, the standard should be that of a reasonable specialist practicing medicine or surgery in the same special field. *Bruni v. Tatsumi*, 46 Ohio St.2d 127, 129, 346 N.E.2d 673, 676, 75 O.O.2d 184. *See also* Malpractice.



WMS Practice Guidelines

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Here we find the following categories:

- **STANDARDS OF QUALITY:** statements of the minimum acceptable level of performance or results, what constitutes excellent performance or results, and the range in between.
- **MEDICAL (OR CLINICAL) PRACTICE GUIDELINES:** systematically developed statements to assist practitioners in their decision making in specific clinical settings.
- **MEDICAL REVIEW CRITERIA:** statements used to assess the appropriateness of specific decisions, services, and outcomes in the delivery of health care.
- **PERFORMANCE MEASURES:** specific measures of a quantitative nature that estimate or monitor compliance with medical quality standards, medical practice guidelines, and medical review criteria by health care professionals.

When we speak of “altered standards of care” we usually think of a truly catastrophic disaster:

- lack of equipment and supplies,
- lack of adequate trained personnel,
- an austere environment, and
- lack of access to specialized medical capabilities.

This implies that the usual **STANDARDS OF QUALITY** cannot be met, and standard **MEDICAL REVIEW CRITERIA** aren’t appropriate. Some or all of these factors may apply during:

- wilderness search and rescue,
- wilderness expeditions,
- tactical operations,
- military operations,
- missions to medically-underserved areas.

For the first two, we are fortunate that there is little financial incentive for lawyers to be involved, and a high level of interest among the wilderness medical community. The *WMS Practice Guidelines*,² first appearing as position statements in the 1980s, have been refined to provide a definitive set of **MEDICAL PRACTICE GUIDELINES** for wilderness search and rescue and expeditions. There is no widely-recognized set of practice guidelines for disasters, but there are persuasive arguments that a disaster is, in essence, a wilderness, and that the WMS guidelines should suffice.

There are currently efforts by the Department of Homeland Security to standardize disaster and wilderness medical care by all its medical assets (e.g., Coast Guard, Border

Patrol, Secret Service, Federal Emergency Management Agency), which probably presage a more general government effort to standardize. While this focuses more on wilderness than disaster settings, the expectation is that the standards will apply to both. This also focuses more on EMS than physician-level care.

Standards of care for wilderness and truly catastrophic disasters, at least in the ideal Platonic sense, are fairly well established. But for later phases of catastrophic disasters, or in disasters that are not quite as catastrophic (i.e., some hospitals are still functioning), what should be the standard of care?

As far as ED Information Systems (EDIS), there have been discussions (see www.ed-informatics.org) about scalability – when overwhelmed by patients, the EDIS can be put into one of several disaster modes. For example, when a certain point of saturation is reached, one presses a button on the EDIS, and no longer are nurses expected to routinely gather information about domestic violence, and immunizations. This allows the EDIS to continue to limp along rather than to be totally abandoned as has happened in catastrophic disasters in the past.

In August 2004, the Agency for Healthcare Research and Quality (AHRQ) convened a conference to discuss the need for altered standards of care for public health emergencies. Their report, *Altered Standards of Care in Mass Casualty Events, Bioterrorism and Other Public Health Emergencies*, came up with ten suggestions, six of which start with “develop,” two of which start with “identify,” one of which starts with “create” and one of which starts with “continue.” These boil down to a research agenda; little has been done to advance these.

Unlike more-unified nations such as Israel or Britain, the US is a federation of more than 50 states, territories and Indian nations, each of which establishes its own laws regarding the practice of medicine. There is a mechanism for getting uniform state laws – known as the National Conference of Commissioners on Uniform State Laws, which has representatives from every state, and whose recommendations are taken very seriously by state legislatures. The NCCUSL has had a number of successes over the years – the Uniform Commercial Code is a good example. After Hurricane Katrina, the Gulfcoast states desperately needed physicians, there were many physician volunteers from other states – but they were not licensed in the Gulfcoast states. The NCCUSL started working on the Uniform Emergency Volunteer Health Practitioners Act. Originally the Act provided for malpractice protection for unpaid volunteer physicians, but the Association of Trial Lawyers of America – recently renamed the “American Association for Justice” – got it removed, and it only later got put back, in watered-down form.



Bandaging after I&D in the “OR” along the Gulfcoast after Hurricane Katrina

¹ nap.edu/books/0309043468/html/index.html.
² Wilderness Medical Society., Forgy WW. Wilderness Medical Society practice guidelines for wilderness emergency care. 5th ed. Guilford, Conn.: Falcon Guide; 2006.