Reconciling the Exercise of Judgment and the Objective Standards of Care in Medical Malpractice

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I. Introduction and Background

There are two core principles in the law of negligence. The first is that negligence law is a fault-based theory of liability (rather than strict liability), and therefore requires proof that the defendant's conduct was substandard. The second is that a person's conduct should be evaluated according to objective criteria, rather than by a subjective assessment. Objective means according to some external referent or test. By contrast, a subjective evaluation would have an internal perspective, evaluating a person's conduct in terms of his individual capabilities. The standard of care for professional health care providers has generally been governed by negligence law and, as such, malpractice liability largely depends on the existence of substandard conduct as determined by objective criteria. Notwithstanding the overtly objective orientation

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1. See, e.g., Vaughan v. Menlove, 3 Bing. N.C. 468, 132 Eng. Rep. 490 (1837); RESTATEMENT (SECOND) OF TORTS § 283 cmt. c (1965) ("objective and external" standard); W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 32, at 173-74 (5th ed. 1984) [hereinafter PROSSER & KEETON]. There are a number of explanations for this preference. First, an objective test is more workable as a rule of loss allocation than an unpredictable, emotionally-driven subjective test. Second, an objective test better promotes safety and loss reduction by its aspirational normative focus. Finally, an objective test is more conducive to the overriding compensatory (loss spreading, distributional) goals of tort law.
of negligence law generally, occasional subjective currents have been apparent. A..
Subjective ripples have also been manifest (and sometimes dissonant) in the law of
medical malpractice.

There has always been a certain precariousness in the core negligence fault-based
and objective principles in the malpractice setting. On the one hand, defendants have
feared that jurors would too often succumb to a hindsight tendentiousness that might
undermine the proof-of-fault requirement. Plaintiffs, on the other hand, worry that
subjective intimations in jury instructions might obscure the objectiveness of the
standard of care, and thereby insulate substandard care from liability. One question
that has proven particularly troublesome in malpractice cases is how to address the
matter of individual judgment — with its potentially subjective connotation — in the
formulation of the objective standard of care and jury instructions. This article will
address this tension as it is manifested in jury instructions on the standard of care in
malpractice cases.3

Although the objective nature of the standard of care for negligence cases in general
has been universally accepted, the implementation of this objective standard has
followed a number of paths. Some courts have chosen a paradigmatic approach
whereby the objective standard is conceived in terms of a putative reasonable
person — a modern "Everyman" — to whose standards of conduct the defendant's

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2. Perhaps the most prominent example is the extent to which the standard of care provides for an
individualized evaluation of the conduct of children. The usual formulation states the standard for
children in terms of "a reasonable person of like age, intelligence, and experience." Restatement (Second)
Torts § 283A (1965). A person endowed with superior knowledge and insights may also
be expected to act commensurate with those superior characteristics. See id. § 289(b) & cmt. m
(explaining that a person is required not only to satisfy the level of care expected of a reasonable person,
but also to exercise such superior attention, perception, memory, knowledge, intelligence, and judgment
that the person actually himself possesses); see infra Part III.B. The objective standard of care is also
modified to reflect the physical disabilities of the actor. See Restatement (Second) of Torts § 283C.

There generally has been more reluctance to modify the objective standard for defendants solely due
to their mental deficiencies and impairments. See Harry J.F. Korrell, The Liability of Mentally Disabled
Tort Defendants, 19 Law & Psych. Rev. 1 (1995). The Restatement has been somewhat ambivalent on
the subject. Compare Restatement (Second) of Torts § 283B (1965) (stating that insanity or mental
deficiency does not relieve defendant of duty to conform to objective standard) with id. § 895J & cmt.
c (1997) (stating that mental deficiency does not automatically confer immunity, but mental condition
may rob an individual of all capacity to understand risk "so that there is no negligence"). Courts have
been more willing to modify the objective standard for diminished mental capacity when addressing the
conduct of plaintiffs in the context of contributory or comparative negligence. See Alison P. Roney,
Note, Stacy v. Jodco Construction Inc.: North Carolina Adopts a Diminished Capacity Standard for

3. I had identified and briefly addressed the topics considered in Parts II, A and B, infra, in my
short treatise on Malpractice. See Joseph H. King, Jr., The Law of Medical Malpractice in a
Nutshell 65-75 (2d ed. 1986). The preceding text has now been succeeded by a later book in the
Nutshell series. See Marcia M. Broumil & Clifford E. Elias, The Law of Medical Liability in a

4. Everyman is the seminal drama of the pre-Shakespearean morality plays. See Everyman in Chief
Pre-Shakespearean Dramas 288 (Joseph Quincy Adams ed., 1924). The Doctor delivered the
Epilogue, stating in part:

This morall men may have in mynde.
conduct is compared and is expected to conform.\(^5\) Other courts have taken a more formulaic, conceptual approach, articulating the standard of care in terms of a cost-benefit analysis.\(^6\)

Various formulations for the standard of care in medical malpractice cases have also emerged. However, these formulations remain essentially objective.\(^7\) As a general principle, this objective standard in malpractice has usually been defined in terms of a professionally oriented standard that encompasses the teachings and practices of the medical profession.\(^8\) Yet the courts and legislatures have differed on the form that such a professionally oriented standard should take, and on the extent to which they should defer to the practices of the medical profession in defining the relevant standard. Under one common traditional construct, the standard of care for physicians was defined normatively in terms of "custom" or customary practices and medical lore.\(^9\) Under a customary practice orientation, the focus was upon what had

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Ye herers, take it of worth, olde and yonge!
And forsake Pryde, for he deceyueth you in the ende.
And remembre Beaute, Five Wyttes, Strength, and Dyscrecyon,
They all at the last do every man forsake, Save his Good Dedes there dothe he take —

... none excuse may be there for every man.

Id. at 303.

5. See PROSSER & KEETON, supra note 1, § 32, at 173-75.


9. See 1 LOUISELL & WILLIAMS, supra note 8, ¶ 8.04, at 8-34, 9.05 at 9-32 (1998); POSNER, ECONOMIC ANALYSIS, supra note 6, § 6.3, at 168 ("A doctor's duty of care toward his patient is to comply with the customary standards of the medical profession."); Mark A. Hall, The Defensive Effects of Medical Practice Policies in Malpractice Litigation, LAW & CONTEMP. PROBS., Spring 1991, at 119, 126; Donald E. Kaemar, Comment, The Impact of Computerized Medical Literature Databases on Medical Malpractice Litigation: Time for Another Helling v. Carey Wake-up Call?, 58 OHIO ST. L.J. 617, 641 (1997) ("Where customary practice is the rule, a physician is not responsible for noncustomary procedures and techniques until they are assimilated into the standards of practice."); Eric M. Levine, A New Predicament for Physicians: The Concept of Medical Futility, the Physician's Obligation to Render Inappropriate Treatment, and the Interplay of the Medical Standard of Care, 9 J.L. & HEALTH 69, 102 (1994-95); Alan H. McCoid, The Care Required of Medical Practitioners, 12 VAND. L. REV. 549, 605-09 (1959); Clarence Morris, Custom and Negligence, 42 COLUM. L. REV. 1147, 1163-67 (1942); Richard N. Pearson, The Role of Custom in Medical Malpractice Cases, 51 IND. L.J. 528, 528 (1976); Gary T. Schwartz, The Beginning and the Possible End of the Rise of Modern American Tort Law, 26 GA. L. REV. 601, 664 (1992); Theodore Silver, One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice, 1992 Wis. L. REV. 1193, 1211-25 (1992); Sam A. McConkey, IV, Comment, Simplifying the Law in Medical Malpractice: the Use of Practice Guidelines as the Standard of Care in Medical Malpractice, 97 W. VA. L. REV. 491, 499 (1995) ("[C]ustom plays a much
customarily been done. The standard of care for malpractice purposes has increasingly been addressed by statute. Although few statutes have expressly defined the standard in terms of custom or customary practice,¹⁰ numerous statutes contain language that seems (if taken literally) to focus on a standard based on what conduct or course has traditionally been followed, and thus are at least consistent with a customary practice perspective.¹¹ A number of statutes articulate the standard in a way that, at least


The article by Professor Silver contains a useful discussion of the origins of the professional custom rule. Basically, Silver attributes the custom rule to a blending of the duties of physicians both to possess professional skill and learning and to exercise them. In the process, according to Silver, the customary idea migrated beyond the duty to possess to also embrace the duty to exercise. He notes:

It is one thing to write... that a physician must possess customary skill and then, in using it, exercise ordinary care. It is another to state that the physician is merely obliged to possess and exercise customary skill... Thus, it seems, the professional custom rule was born, not by reason, but by linguistic and conceptual mutation — unintended, unplanned, and, at the very time of its birth, unseen.

Silver, supra, at 1223, 1225.

10. At least one state has done so, however. See VA. CODE ANN. § 8.01-581.20 (Michie 1992) (providing alternative formulations including one based on the "degree of skill and diligence practiced by a reasonably prudent practitioner" in Virginia, and when proven more appropriate, a standard based on the "customary practices" in the same or similar localities).

11. See ALA. CODE § 6-5-542(2) (1993) ("level of such reasonable care, skill and diligence as other similarly situated health care providers in the same general line of practice, ordinarily have and exercise"); ALASKA STAT. § 09.55.540(1) (Michie 1998) ("degree of knowledge or skill...ordinary exercised under the circumstances... by health care providers in the field or specialty"); Ark. Code Ann. § 16-114-206(a)(1) (Michie 1998) ("degree of skill and learning ordinarily possessed and used by members of the profession...in the same type of practice or specialty"); Del. Code Ann. tit. 18, § 6801(7) (1989) (defining standard of care as "that degree of skill and care ordinarily employed, under similar circumstances, by members of the profession"); Id. § 6854 (Supp. 1998) (providing that expert must be familiar with "the degree of skill ordinarily employed in the field of medicine on which he or she will testify"); La. Rev. Stat. Ann. § 9:2794(A)(1) (West 1997) ("degree of knowledge or skill possessed or the degree of care ordinarily exercised by physicians...or degree of care ordinarily practiced by physicians...within the involved medical specialty"); Neb. Rev. Stat. § 44-2810 (1993) (providing that standard of care for claims subject to Hospital-Medical Liability Act is "that which health care providers...would ordinarily exercise and devote to the benefit of their patients"); Nev. Rev. Stat. § 41A.009 (1997) (defining malpractice under Screening Panel statute as failure to "use the reasonable care, skill or knowledge ordinarily used under similar circumstances"); Or. Rev. Stat. § 677.095(1) (Supp. 1996) ("that degree of care, skill and diligence which is used by ordinarily careful physicians"); Vt. Stat. Ann. tit. 12, § 1908(1) (Supp. 1997) ("degree of knowledge or skill possessed or the degree of care ordinarily exercised by a reasonably skillful, careful, and prudent health care professional"). Some of the preceding statutes also contain language that apply various geographic limitations or qualifications on the standard of care. That language has been omitted from the parenthetical material following each statute. For a sample of various types of geographic frames of reference, see infra note 14. Furthermore, many statutes contain separate provisions dealing with claims based on a lack of informed consent.

It should be noted that some of the statutory language quoted above, such as the provisions from Alabama, Arkansas, Louisiana, and Vermont, for example, contains phrases that not only imply a customary practice focus, but might also suggest a broader standard encompassing reasonably expected or accepted practices. Those statutes refer not only to standards used or employed (perhaps suggesting
facially, seems more demanding and normative than the customary practice formulation. Instead of custom or habit, the standard of care is couched in terms suggesting a level of care expected of reasonable members of the defendant's profession and specialty. A number of cases, while retaining a professionally based perspective, have expressly rejected custom as a conclusive test for the standard of care. Frequently, the professionally based standards have been defined not only in terms of professional practices (whether tied to customary or reasonably expected practices) but also with a geographic frame of reference, although some states have, to varying degrees, adopted a national standard. Moreover, the applicable profes-

customary practice), but also to knowledge or skill that is possessed by physicians (perhaps inviting more of an expected practice analysis).

12. See ARIZ. REV. STAT. ANN. § 12-563 (West Supp. 1997) ("degree of care, skill and learning expected of a reasonable, prudent health care provider"); FLA. STAT. ANN. § 766.102 (1) (West 1997) ("that level of care, skill, and treatment which . . . is recognized as acceptable and appropriate by reasonably prudent similar health care providers"); Mich. COMP. LAWS ANN. § 600.2912a (West Supp. 1998) (holding general practitioners to "recognized standard of acceptable professional practice or care" and specialists to "recognized standard of practice or care within the specialty"); MONT. CODE ANN. § 27-6-103 (5) (1997) (Medical Legal Panel Act) (defining malpractice claims to include "departure from accepted standards of health care"); N.H. REV. STAT. ANN. § 507-E:2,1(a) (1997) ("standard of reasonable professional practice"); N.M. STAT. ANN. § 41-5-3(C) (Michie Supp. 1998) ("accepted standards of health care"); N.C. GEN. STAT. § 90-21.12 (1997) ("standards of practice among members of the same health care profession"); TENN. CODE ANN. § 29-26-115 (1980) ("acceptable professional practice"); WASH. REV. CODE ANN. §§ 7.70.040 (West 1992) ("that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he belongs"); id. § 4.24.290 (1998) ("exercise that degree of skill, care and learning possessed by other persons in the same profession"); see also Joseph H. King, Jr., In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula, 28 VAND. L. REV. 1213 (1975). Some of the preceding statutes also contain language that applies various geographic limitations or qualifications on the standard of care. That language has been omitted from the parenthetical material following each statute. See, e.g., infra note 14. Furthermore, many statutes contain separate provisions dealing with claims based on a lack of informed consent.

13. See Nowatske v. Osterloh, 543 N.W.2d 265, 271 (Wis. 1996). In Nowatske, the court impliedly approved a professionally based standard of care or at least acknowledged the professional focus of the standard of care for physicians, noting: "When a claim arises out of highly specialized conduct requiring professional training, . . . the alleged tortfeasor's conduct is compared with the conduct of others who are similarly situated and who have had similar professional training." Id. at 270. But, the court pointedly added:

[S]hould customary medical practice fail to keep pace with developments and advances in medical science, adherence to custom might constitute a failure to exercise ordinary care . . . . If what passes for customary or usual care lags behind developments in medical science, such care might be negligent, despite its customary nature. . . . [W]hile evidence of the usual and customary conduct of others under similar circumstances is ordinarily relevant and admissible as an indication of what is reasonably prudent, customary conduct is not dispositive and cannot overcome the requirement that physicians exercise ordinary care.

Id. at 271-72; see also Arnold J. Rosnoff, The Role of Clinical Practice Guidelines in Health Care Reform, 5 HEALTH MATRIX 369, 381 (1995).

14. Variations have included rules defining the standard of care with reference to the defendant's own "same" locality, to the "same or similar" locality, to the standards within the defendant's own state, and increasingly in recent years, to a national frame of reference. For examples of some of the various approaches respectively, see the following: Morris v. Thompson, 937 P.2d 1212 (Idaho 1997) (approving
sional standards are usually those that existed at the time the alleged negligent conduct occurred.\(^\text{15}\)

To the extent that a defendant-doctor's conduct is evaluated in professional terms and thus more narrowly than under the classic reasonable person paradigm, one might be tempted to view the malpractice standard of care as edging away from objective criteria toward accommodating more individualized factors. This professional perspective is, however, more accurately viewed as a subtle repudiation of the objective test, but rather as a retention of the objective criteria but with the relevant universe narrowed to some extent by the professional focus. The important thing to remember here is that notwithstanding these particularized rules for medical malpractice, the standard of care governing malpractice claims has in general remained essentially an objective one.

Overlaid against this general objective backdrop are a number of formulations that evolved as jury instructions to address the matter of the physician's exercise of judgment in delivering medical care. These "judgment" rules have affected malpractice claims in two ways. At the risk of oversimplification, these rules might be loosely described as operating as both the veritable sword and shield. First, various formulations of a so-called "error in judgment" rule (and its corollary principles) were designed to provide some cover for physicians whose decisions turned out, in retrospect, to have produced an unfavorable or unsuccessful result but that nevertheless were reasonable at the time and under the circumstances when they were made. A second concept requires that the physician not only satisfy the levels of care required of a reasonable member of his profession, but that, in addition, he also exercise his

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"best judgment" on behalf of the patient by drawing on any superior knowledge he may possess beyond that of his professional peers.

As will be explained, although the rationale for these rules is sensible, their formulation and application have been inconsistent, confusing, and, in some instances, misconceived. I propose that the courts reformulate both of the rules. With respect to the error in judgment rule, I recommend that the courts eschew the use of the loaded "error in judgment" language and other potentially subjective phrases commonly accompanying it in jury instructions. Ideally, the jury instructions should focus in a straightforward way on the underlying rationales for the error in judgment idea rather than employ shorthand catchall expressions in its place. Specifically and simply, the jury should be told that the fact that an unfortunate result occurred does not necessarily mean the health care provider's conduct was unreasonable. It should further be explained that a provider who chooses one therapeutic approach from among a number of reasonable acceptable alternative approaches should not be held liable merely because it appears, in retrospect, that some other reasonable approach might have changed the therapeutic outcome or prognosis.

With respect to the best judgment requirement, I suggest the following approach. Physicians should owe a duty, not only to satisfy objectively defined, reasonable, and professionally acceptable standards, but (to the extent noted below) also to give their patients the benefit of any superior knowledge or special insights they actually possess even if beyond that of their professional peers. To avoid confusion and undermining the objective standard of care, the latter duty should be articulated without using the "best judgment" language. Rather, it should be stated in straightforward terms of a duty to exercise one's superior knowledge or special insights. More specifically, I offer the following three guidelines.16

First, a physician should select or recommend (in accordance with informed consent requirements) the medical approach or technique he prefers based on his superior knowledge or special insights when choosing among reasonable professionally acceptable practices and alternatives. Second, a physician should select or recommend (in accordance with informed consent requirements) the medical approach or technique he prefers based on his superior knowledge or special insights when it reasonably appears to offer added safety without significant new risks or compromise of therapeutic effectiveness. And, third, when the course or technique favored by a physician was not one of the professionally accepted alternatives or practices, and posed significant risks or levels of therapeutic effectiveness different from those associated with acceptable practices, a more guarded application of the duty is appropriate. The patient should be informed of the full range of professionally acceptable alternatives or options, and only then should the physician communicate the approach he favors and the reasons for his preference, along with the other information and safeguards in the suggested guidelines. But, the duty posited should depend concomitantly on the courts' willingness to confer protection from liability on physicians acting in accordance with the guidelines I have proposed.

16. See infra Part II.B.2 for more detailed discussion of the approach that I recommend.
17. See infra notes 140, 145.
In summary, I believe that it is important that the jury not lose sight of the fact that a bedrock principle of malpractice law is that health care professionals are held to an objective standard of care. Perfection is neither realistic nor to be expected. At the same time, the objective nature of the standard of care also means that it is not enough for physicians to do their best if their conduct does not rise to the level of care required of similarly situated members of the profession. In order to reduce the risk of confusion or misunderstanding, I suggest that potentially confusing language revolving around the judgment terminology be eliminated from the jury instructions. At the same time, more specific instructions should be used to remind jurors that an unfortunate outcome does not automatically equate with substandard care, and that the practice of medicine does not consist of a monolithic single-lane pathway, but more often plural acceptable clinical choices. And, finally, when a physician in fact possesses relevant knowledge, understanding, or insights that are superior to that of his professional peers, he should be expected to afford his patients the benefit of that knowledge in accordance with the proposed guidelines.

II. The Confusing Exercise of Judgment Formulations

A. Exercise of Judgment as Shield

1. The Adverse Outcome Admonition

Over the years, it has become commonplace for courts in malpractice cases to elaborate on the standard of care by incorporating various formulations into the jury instructions that operated to afford greater protection to defendant-doctors. The first of these rules was based on the underlying premise that a doctor should not be liable merely because the patient suffered an adverse outcome. This "adverse outcome admonition" has been approved by many courts\(^8\) and some version of it is frequently included in the instructions to the jury.\(^9\) Its rationale is that liability for medical malpractice is not based on strict liability principles. Rather, as a form of negligence, it requires the existence of fault in the form of substandard conduct. Accordingly, at least in the absence of express guarantees of a specific outcome\(^10\) or as qualified by

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19. See, e.g., Hirahe, 959 P.2d at 835; Ouellette, 391 N.W.2d at 816; Morlino, 706 A.2d at 732; Nowatske, 543 N.W.2d at 274-75; 1 Louise & Williams, supra note 8, ¶ 8.04 at 8-53 to 8-54. But see Peters v. Vander Kool, 494 N.W.2d 708, 712 (Iowa 1993) (disapproving of including at least one version of the adverse outcome rule in the jury instructions, viewing such instructions as "comments on potential scenarios in which the standard of care may or may not have been adhered to"). Some states expressly require some type of adverse outcome jury instruction by statute. See Tenn. Code Ann. § 29-26-115(d) (1980).

the application of res ipsa loquitur, the mere fact that the results of treatment were unfavorable should not alone be equated with negligence or substandard medical care.

The adverse outcome rule should be implicit in most general statements of the standard of care in medical malpractice. The purpose of making it explicit in the instructions to the jury is to emphasize the fault-based nature of medical malpractice liability. It also underscores the appropriate perspective for juries in evaluating a defendant's performance in a malpractice claim. More specifically, it reminds the jury that the defendant's conduct must be evaluated in light of the facts known or reasonably available to the defendant at the time, rather than focusing on "hindsight." 22

2. Professionally Acceptable Alternatives Corollary

A second principle frequently invoked to elaborate on the standard of care in malpractice cases is that a physician should not be deemed negligent merely because the physician followed one reasonable, professionally acceptable course instead of another. 23 In other words, a physician should be entitled to choose among a number of professionally acceptable alternatives. This principle has been articulated in different ways. Sometimes it is said simply that a physician should not be held liable for following an "acceptable alternative," 24 or a course approved by a "respectable minority," 25 or "considerable number" 26 of members of his profession. Under this

21. See Harder v. F.C. Clinton, Inc., 948 P.2d 298, 304, 309 (Okla. 1997) (noting that "[n]egligence can never be presumed from showing no more than the happening of the harmful event," but nevertheless finding that the plaintiff had established sufficient facts to support her right to invoke the doctrine of res ipsa loquitur). See generally Furrow et al., supra note 20, § 6-3(a).

22. See Frakes, 1997 WL 536949, at *2 (upholding a verdict for the defendant while noting that "in hindsight" the decision by the defendant was incorrect); Rooney v. Medical Ctr. Hosp., Inc., 649 A.2d 756, 761 (Vt. 1994) (referring to this type of instruction as the "hindsight" instruction). For a discussion of the problem of a hindsight bias in medical malpractice claims, see Hal R. Arkes & Cindy A. Schipani, Medical Malpractice v. the Business Judgment Rule: Differences in Hindsight Bias, 73 OR. L. REV. 587 (1994). Arkes and Schipani define hindsight bias as "the tendency for people with knowledge of an outcome to exaggerate the extent to which they believe that outcome could have been predicted." Id. at 587. The tendency to apply a hindsight bias against medical decisions may be exacerbated by the wide availability of medical technical data bases. See generally Kacmar, supra note 9.

23. See, e.g., Lama v. Borrás, 16 F.3d 473, 478 (1st Cir. 1994) (applying Puerto Rico law and noting that a physician is not liable for an incorrect diagnosis or unsuccessful treatment if his conduct "fell within the range of acceptable alternatives"); Parris v. Sands, 25 Cal. Rptr. 2d 800 (Cal. Ct. App. 1993); Hirahara, 959 P.2d at 834 ("It is not negligent for a physician, based on the knowledge that he reasonably possesses at the time, to select a particular course of treatment among acceptable medical alternatives."); Peters, 494 N.W.2d at 713 (approving "alternative methods of treatment" rule, but only if an adequate factual basis is established by proof that there was more than one professionally acceptable method of treatment that was considered by the defendant in exercising his best judgment); Morlino, 706 A.2d at 732; Clark v. Doe, 695 N.E.2d 276, 280 (Ohio Ct. App. 1997); Graham v. Keuchel, 847 F.2d 342, 356 (Okla. 1993) (approving rule, but otherwise reserving judgment on "whether mistake in judgment instructions should be condemned"); Rooney, 649 A.2d at 760-61 (but must omit "error in judgment" language); Nowarske, 543 N.W.2d at 275; Furrow et al., supra note 20, at 250; 1 Louisell & Williams, supra note 8, ¶¶ 8.04[2], 9.05[3] (1998); Hall, supra note 9, at 128-29; Kacmar, supra note 9, at 644.

24. Lama, 16 F.3d at 478 (applying Puerto Rico law).

25. Furrow et al., supra note 20, at 250; 1 Louisell & Williams, supra note 8, ¶ 8.04[2] at 8-
instruction, the jury must decide whether the course followed by the defendant was in fact embraced within an acceptable alternative.27 Thus, if there is a conflict in the expert testimony over whether or not a mode of treatment is professionally acceptable, that question should ordinarily be for the jury to resolve.28 It should be added that the defendant should also be expected to exercise reasonable care in connection with his decision. For example, a defendant who follows an approved course of action may still be liable if he did not lay a reasonable foundation by obtaining the needed information, such as by conducting a reasonable examination upon which to choose the course to be followed.29 Nor would he be exculpated for choosing an acceptable course if he executed that course negligently.30 The physician would also be required to obtain the patient's informed consent by disclosing appropriate information including information regarding risks and alternatives, to the extent required by the applicable standard of disclosure.31 And, finally, the protection afforded by the acceptable alternative rule would depend on how the court defines the range and boundaries of acceptable courses, and the degree of deference the court accords professional standards in general. A court less deferential to the conclusiveness of professional standards might, for example, decide to articulate the rule in terms of a physician who reasonably chooses among acceptable courses.

The acceptable alternative formulation should not be viewed as a repudiation of the objectiveness of the standard of care for physicians. Rather, it is more accurately perceived as enlarging the ambit or universe of the range of reasonableness for evaluating the professional conduct of doctors. This acceptable alternative tenet reflects important realities in the practice of medicine. The science of healing is dynamic, subject to continuing change and scientific advances. Going hand in hand with this dynamism is an inherent pluralism in medicine — a scientific world.

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26. See Jones v. Chidester, 610 A.2d 964, 969 (Pa. 1992) ("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 recognized and respected professionals in his given area of expertise."); FURROW ET AL., supra note 20, at 250; 1 LOISELL & WILLIAMS, supra note 8, ¶ 8.04[2] at 8-48.

27. See Nowatske, 543 N.W.2d at 276 (noting that "it is for the jury . . . to determine whether there is more than one method of treatment as well as whether the treatment methodchosen is among those methods recognized as acceptable").

28. See Jones, 531 A.2d at 969 (holding that once the experts testify as to the existence of a considerable number of professionals who support various alternatives, "[i]t then becomes a question for the jury . . . whether . . . there are two [or however many at issue] schools of thought such that the defendant should be insulated from liability").

29. See Ouellette v. Subak, 391 N.W.2d 810, 815-16 (Minn. 1986) ("[A] doctor must, however, use reasonable care to obtain the information needed to exercise his or her professional judgment, and an unsuccessful method of treatment chosen because of a failure to use such reasonable care would be negligent.").

30. See Clark v. Doe, No. C-950667, 1997 WL 195444, at *2 (Ohio Ct. App. Apr. 23, 1997); Nowatske, 543 N.W.2d at 275 (holding defendant "not negligent merely because he made a choice of a recognized alternative method of treatment if he used that required care, skill, and judgment in administering the method").

31. See infra notes 140, 144-46.
characterized by multiple therapeutic approaches to a medical problem all of which may command respect within at least some significant segment of the medical profession. The following rhetorical line from Alexander Pope has sometimes been invoked to illustrate the rationale underlying the rule: "[w]ho shall decide, when doctors disagree?"\textsuperscript{32} Despite all the impressive advances in modern medicine, there remains in it some aspect of uncertainty and mystery.

3. The "Error in Judgment" Language

Had the courts stopped with the two preceding formulations, a good deal of confusion, judicial energy, and legal resources might have been spared. But, many courts at one time or another could not resist hanging a few embellishments\textsuperscript{33} on the preceding jury instructions or attempting to formulate neat shorthand replacements for one or both of them. This tendency resulted in the inclusion of a variety of phrases in jury instructions that defy generalization except for a common element. Most of the additional language was anchored by the word "judgment." Perhaps the most common construct began with the statement (frequently qualified and explained\textsuperscript{34}) that a doctor could not be held liable for an "error in judgment."\textsuperscript{35} Other variations used "mistake in judgment."\textsuperscript{36} Frequently, phrases such as "mere," "honest,"\textsuperscript{37} "good faith,"\textsuperscript{38} or "bona fide"\textsuperscript{39} precede the error in judgment language.

The error in judgment rules and instructions were motivated by a desire to reinforce the preceding ideas — that liability should not automatically follow from the mere fact of an adverse outcome nor from the fact that a choice among professionally acceptable courses of action turned out, in retrospect, to have been more harmful or less

\textsuperscript{32} ALEXANDER POPE, Epistle to Several Persons, Epistle III, To Allen Lord Bathurst, in POETICAL WORKS I (Herbert Davis ed., 1996). This line is sometimes quoted to illustrate the rationale underlying the acceptable alternative rules. See PROSSER & KEATON, supra note 1, § 187 n.40. Although taken at face value, this idea does help explain the rationale for the rule, it is doubtful that Pope had physicians or medical doctors in mind here (or at least it is doubtful that his words were limited to medical doctors). Some critics believe he used the term "doctors" as a connotation for "[t]he learned." See Alexander Pope, An Epistle to Allen Lord Bathurst, THE OXFORD AUTHORS 639 ed. note (Pat Rogers ed., 1993).

\textsuperscript{33} One court described the so-called error in judgment rule as "nothing if not hoary." Rogers v. Meridian Park Hosp., 772 P.2d 929, 930 (Or. 1989) (en banc).

\textsuperscript{34} See infra note 56 and accompanying text.

\textsuperscript{35} See FURROW ET AL., supra note 20, at 237-38, 250; 1 LOUISELL & WILLIAMS, supra note 8, ¶¶ 8.04, at 8-54, 8.05 at 8-57, 9.05 at 9-34; Arkes & Schipani, supra note 22, at 602; Marshall B. Kapp, Medical Error Versus Malpractice, 1 DE PAUL J. HEALTH CARE L. 751, 755 (1997); Dorothy E. Bolinsky, New Jersey's Medical Malpractice Model Jury Instruction: @#! %&\textsuperscript{3} Comprehensible to the Jury?, 28 RUTGERS L. J. 261, 264-65 (1996). Thus, for example, Kapp writes that "[a] mere 'error in judgment' is not the basis for finding liability." Id.

\textsuperscript{36} 1 LOUISELL & WILLIAMS, supra note 8, ¶ 8.04 at 8-54.

\textsuperscript{37} Ouellette v. Subak, 391 N.W.2d 810, 815-16 (Minn. 1986) (rejecting a formulation containing "honest error" language, but approving instructions conveying the adverse outcome and acceptable alternative rules).

\textsuperscript{38} Ouellette, 391 N.W.2d at 815 (criticizing the "good faith" language, but approving instructions conveying the adverse outcome and acceptable alternative rules).

\textsuperscript{39} Shumaker v. Johnson, 571 So. 2d 991, 994 (Ala. 1990) (discussing and criticizing the "bona fide" language, although instruction that was rejected in the instant case used "honest" mistake or error in judgment language).
beneficial than an alternate course might have been. Given this rationale for the error in judgment jury instruction as well as the nature of the standard of care, the appropriate meaning of the language was that a defendant should not be liable for non-negligent errors in judgment. And, indeed, most of those courts that continue to expound the error in judgment language expressly qualify the rule in terms that one way or another suggest that the exculpatory scope of the rule is limited to non-negligent judgments.

Unfortunately, the error in judgment language has been a potential source of confusion and misconception to juries, and sometimes a tool for defense attorneys attempting to reinstate some intimations of subjectivity into an otherwise objective standard of care for malpractice claims. There are a number of explanations for these problems. First, some courts have not used sufficiently clear explanatory language to limit (at least unequivocally) the protection afforded by the rule to non-negligent errors in judgment. This creates a question as to whether the rule was meant to exculpate all errors in judgment or only non-negligent ones, and leaves open the possibility that a jury might misinterpret the rule as insulating all conduct, innocent and negligent alike, as long as it somehow seems to involve a thought process that could be deemed judgmental. Second, perhaps the error in judgment language, even when expressly limited to non-negligent judgments, remains incomprehensible to many lay jurors. Thus, it is also possible that a jury would misinterpret it despite inclusion of varying language that technically might be read by an attorney as a non-negligent qualification, but might easily be overlooked or misconstrued by a lay juror. Third, with or without some non-negligent judgment qualifying language, the common use of companion terms such as "error" or "mistake" in judgment was potentially misleading because it could be misconstrued to imply that the rule insulated even negligent judgments. Fourth, adjectives that often precede "judgment," such as "good faith," "innocent," or "bona fide," might well be interpreted selectively to suggest that the true test of

41. See infra note 56
42. See, e.g., Hall v. Hilbun, 466 So. 2d 856, 866 (Miss. 1985) ("A competent physician is not liable per se for a mere error in judgment."); overruled by Day v. Morrison, 657 So. 2d 808 (Miss. 1995); Matosie v. Gelb, 647 N.Y.S.2d 781, 782 (N.Y. App. Div. 1996) (stating that a doctor is not liable "for mere error in judgment if he or she has considered the patient's best interest after careful evaluation"); O'Sullivan v. Presbyterian Hosp., 634 N.Y.S.2d 101, 103 (N.Y. App. Div. 1996); Vera v. Beth Israel Hosp., 625 N.Y.S.2d 499 (N.Y. App. Div. 1995). Even in these cases, the context and language elsewhere in the opinions sometimes suggest that the error in judgment rule was intended to insulate only non-negligent errors in judgment. In O'Sullivan, for example, the court clearly implied that the error in judgment rule was referring to judgments in choosing among "medically accepted choices." O'Sullivan, 634 N.Y.S.2d at 104. In fact, the court in O'Sullivan later in its opinion may have expressly limited the rule to non-negligent errors in judgment, saying that "[l]iability may not be imposed for honest errors in medical judgment' but 'can and should ensue if that judgment was not based upon intelligent reasoning or upon adequate examination so that there has been a failure to exercise professional judgment." Id. at 104. And in Hall, in the same paragraph that contains the error in judgment language, the court also noted that "[a] physician does not guarantee recovery." Hall, 466 So. 2d at 866. Even the error in judgment sentence hints at a qualification by stating that one is not "per se" liable for an error in judgment. Id. at 871.
liability is not objective at all, but rather depends on whether the defendant has done his or her best — in other words expounding a subjective, "good faith" standard.

In recent years, many courts have addressed the error in judgment question. The clear trend has been to reject the notion that the error in judgment rule should operate to relieve a defendant for negligent judgments.43 The courts have been more divided, however, on whether to retain even appropriately qualified error in judgment language.44 Courts have expressed a variety of criticisms of various "error in judgment" formulations. The most common concern has been that error in judgment instructions have potential for confusing or misleading the jury.45 A number of courts also have criticized jury instructions couched in terms of a "mistake"46 in judgment or an "error"47 in judgment. Some courts have objected to inclusion of adjectives such as "bona fide,"48 "good faith,"49 "honest"50 or "best"51 judgment language, and similar phrases. A few courts have focused directly on the "judgment" language

43. See infra note 56 and accompanying text.
44. See infra notes 56-57 and accompanying text.
46. See Shumaker, 571 So. 2d at 993-94 (rejecting "honest mistake" and "honest error in judgment" language); Graham v. Kevelch, 847 P.2d 342, 355, 356 n.62 (Okla. 1993) (discussing issue of appropriateness of such instructions but not deciding the question).
48. See Shumaker, 571 So. 2d at 994 (rejecting completely the error in judgment language and also rejecting "bona fide" language although instant instruction used "honest" mistake or error in judgment language); Morlino v. Medical Ctr., 706 A.2d 721, 732 (N.J. 1998) (approving in dicta the language at issue in the instant case which did not include "bona fide"); Rogers, 772 P.2d at 932 (dicta) (summarizing cases and rejecting error in judgment instruction in instant case which did not use "bona fide" phrase).
49. See Shumaker, 571 So. 2d at 994 (completely rejecting the error in judgment language; also rejecting "good faith" language although instant instruction used "honest" error in judgment language); Ouellette v. Subak, 391 N.W.2d 810, 816 (Minn. 1986) (rejecting the error in judgment language, particularly subjective words like "honest" and "good faith"); the instruction in question used the "honest error" language); Morlino, 706 A.2d at 732 (dicta) (approving language used in the instant case which did not include "good faith" language); Rogers, 772 P.2d at 932 (dicta) (summarizing cases; court rejecting error in judgment instruction in instant case which did not use "good faith" phrase); DiFranco v. Klein, 657 A.2d 145, 148 (R.I. 1995) (rejecting use of "good faith" or "honest" error in judgment instruction).
50. See Shumaker, 571 So. 2d at 994 (completely rejecting the error in judgment language, and specifically rejecting "good faith" and "honest" error in judgment phrases although instruction in instant case did not use "good faith" judgment language); Ouellette, 391 N.W.2d at 816 (rejecting the error in judgment language, particularly subjective words like "honest" and "good faith"); the instruction in question used the "honest error" language); Morlino, 706 A.2d at 732 (dicta) (approving the language at issue in the instant case which did not include "honest" language); DiFranco, 657 A.2d at 148 (rejecting use of "good faith" or "honest" error in judgment instruction).
The most serious concern is that an error in judgment instruction, perhaps even if it contains elaborating language that renders it technically correct (by limiting the rule to non-negligent judgments), could nevertheless still mislead a jury into thinking that the rule was that defendants should never be liable as long as they were exercising their "judgment." To the extent that a jury might be led to believe that some sort of "good faith" standard applies, it would run counter to the core principle of negligence law in general and malpractice law in particular that liability should be governed by objective rather than subjective criteria. The potentially misleading or confusing effects of various error in judgment instructions have also sometimes been deemed inconsonant with statutory formulations of the standard of care for medical malpractice. Courts have also expressed concern that jury instructions containing some version of the error in judgment language might invite defense counsel's arguments that focus on or emphasize language that could direct jury attention away from objective criteria.

Courts have followed several routes in an effort to assure that negligent judgments are not improvidently insulated from liability by error in judgment jury instructions. Some courts have continued to employ some variation of the error in judgment language, but have taken pains to frame the error in judgment phraseology in a way so as to convey that only non-negligent judgments should be protected from liability. Other courts have decided that the safest course was simply to eliminate

52. See Rogers, 772 P.2d at 933; Rooney, 649 A.2d at 760. The Rogers court noted that the word "judgment" could refer to a choice between acceptable courses (thus implying that only non-negligent judgments were exculpable), or could mean that "substandard conduct is permissible if it is garbed as an 'exercise of judgment.'" Rogers, 772 P.2d at 933; see also Bolinsky, supra note 35, at 280-81.

53. See Shumaker, 571 So. 2d at 993; Ouellette, 391 N.W.2d at 815; DiFranco, 657 A.2d at 149.

54. See Shumaker, 571 So. 2d at 992; Leazer v. Kiefer, 821 P.2d 957, 960 (Idaho 1991); Rogers, 772 P.2d at 932; Rooney, 649 A.2d at 760.

55. See Rooney, 649 A.2d at 760. The Rooney court noted that the final argument of counsel for defendant-doctor "centered largely on the theme that she did her best 'under fire.'" Id. The court noted further that counsel, "acknowledging that not all patients survive, . . . expounded: 'But, that's life. You [the doctor] do your best, you try your hardest.'" Id.; see also Leazer, 821 P.2d at 961 (rejecting the "best judgment" language, and noting that "[d]efense counsel . . . saw the error and capitalized upon it in his closing argument"); Bolinsky, supra note 35, at 278.

the error in judgment terminology altogether. And, finally, a few have attempted to adopt a compromise of sorts, rejecting the more potentially subjective terminology, but allowing some use of the "judgment" language.

4. Suggested Formulation

The error in judgment controversy essentially boils down to two questions. The first relates to the form of the jury instructions, specifically whether to retain any of the "judgment" formulations. The second is more a matter of substance, and focuses on the appropriate message — whether an effort should be made to communicate the adverse outcome and acceptable alternative rules even if the error in judgment language is eliminated from the instructions.

Our goal in instructing the jury on the standard of care in malpractice cases should be to preserve the integrity of the objective standard of care, while at the same time attempting to make sure that physicians are not held to a higher standard than reasonableness contemplates. To promote this goal, I suggest the following approach. First, courts should avoid the error in judgment language along with such potentially subjective accompaniments as good faith, honest, bona fide, and best judgment. I would also include in the list of phrases to be avoided the word "judgment," even if it were not encumbered by the preceding types of potentially subjective adjectives. And second, the courts should continue to give the jury instructions on the adverse
outcome idea and on the physician's right to choose reasonably among professionally acceptable therapeutic alternatives. Thus, juries should be cautioned against any misguided temptation to equate an adverse outcome with negligence or "malpractice," and against application of standards that unreasonably impinge upon the professional discretion of physicians to decide reasonably among competing professionally acceptable therapeutic alternatives. The courts should, however, communicate these latter two messages in a straightforward manner, without the loaded error in judgment gloss.

With respect to the first question — the matter of the appropriate form of the instruction — it should be noted at the outset that the realities of jury confusion and lack of understanding are much broader problems. They are certainly not limited to medical malpractice standard of care instructions. One author's admonition regarding other rules in the malpractice context is also apt for the error in judgment incantation: "A rule, which ought never to have been stated, will encyst itself in the fabric of negligence law and undermine its structure."61 Any benefit from its use has been outweighed by the potential confusion and misconception about the objective standard of care that it may engender among lay jurors. Studies suggest that jury instructions in general are not producing the desired levels of juror comprehension.62 Peter Tiersma comments that "[i]ke priests debating fine points of a Latin mass to be delivered to French-speaking peasants, lawyers devote tremendous energy to refining arcane statements of the law that mean little to the jury."63 Lay jurors are not, as instructions sometimes seem to presume, blank slates,64 but rather developed human beings with preconceptions.65 Nor is it realistic to assume that lay jurors are educated or prepared mentally to digest and process complex legal principles served up to them in a brief formal incantation. The plight of jurors is even worse than one writer's analogy to a law school class in which the entire course consisted of a verbatim reading of the rules followed by an examination.66 As another writer states, '[i]t is all too easy for those of us who are lawyers or judges to forget what the world looked

61. Silver, supra note 9, at 1239 (criticizing, from a fictitious court opinion in a hypothetical case, the development of the professional custom and locality rules in medical malpractice cases). Silver notes that "[l]ooking to the past and future, courts must cut away stray threads and loose ends so not to plague posterity with a legacy of disparate doctrines all of which, when scrutinized, stand for a single principle." Id. at 1237 (criticizing, from Silver's court opinion in a hypothetical case, the evolution or emergence of the professional custom orientation of the standard of care in medical malpractice cases).

62. See Bradley Saxton, How Well Do Jurors Understand Jury Instructions? A Field Test Using Real Juries and Real Trials in Wyoming, 33 LAND & WATER L. REV. 59, 61 (1998); Peter M. Tiersma, Reforming the Language of Jury Instructions, 22 HOFSTRA L. REV. 37, 41-42 (1993) ("[T]he studies . . . have overwhelmingly concluded that the assumption that juries adequately understand their instructions is simply no longer tenable.").

63. Tiersma, supra note 62, at 41.

64. See Peter W. English & Bruce D. Sales, A Ceiling or Consistency Effect for the Comprehension of Jury Instructions, 3 PSYCHOL. PUB. POL. & L. 381, 383 (1997). English notes that "[u]nfortunately, the art of writing jury instructions has yet to abandon the view of the juror as a passive information recipient, without prior knowledge to affect newly incoming information." Id.

65. See id. at 386.

like before we entered law school." Barriers to effective understanding thus may go beyond semantics and linguistics, and involve difficulties not merely with language but with the underlying concepts. Not only do jurors experience difficulty in comprehending the meaning of courts' instructions, there is also a serious question as to how well jurors can bridge the gap between understanding and applying the legal concepts.

Notwithstanding the pessimism of some observers about the potential for or effectiveness of reforms in jury instructions, or the likelihood of their adoption, a number of thoughtful commentators believe rewriting instructions could produce worthwhile improvement in jury understanding and, by extension, the fact-finding process. For example, some have suggested that instructions should be written according to psycholinguistic principles.

Of course, the problem of instructing juries is much larger than the immediate concern here of whether to eschew the "judgment" word in instructions in malpractice cases. Indeed, contesting nuances in nomenclature by post-trial procedures and appeals is akin to stirring the ashes of an old temple after it has been repeatedly ravaged by fires. Our efforts should be directed toward constructing a foundation of simple, straightforward ground rules that can realistically point the jurors in the right direction. It may be that the jury system simply cannot do what the legal community continues to pretend that it does — thoughtfully and predictably distill and apply arcane legal rules to increasingly technical and complex factual situations. And, it may be that this society, so exhausted from decades of getting and spending, simply does not have enough intellectual and political energy left to confront this poorly concealed fiction.

For present purposes, though, the least we can do is not make it worse. One way to facilitate jury understanding is to delete the loaded and potentially misleading "buzz" words, while preserving enough in the way of plainly stated guidance to point jurors in the right direction.

68. See id. at 877 n.46 (quoting Daniel H. Marigolis et al., Jury Comprehension in Complex Cases, 1990 A.B.A. SEC. LITG. 234-35, 288-89 ("[J] is not the language per se that is problematic for them, but instead, that the legal concepts embodied in those words present comprehension difficulties.").
69. See id. at 879 ("Social scientists have found that jurors often still cannot correctly apply the law to a set of facts despite the fact that the jury instructions have been greatly simplified.").
70. For example, a debate has persisted in recent years over whether or not there is ceiling on the ability of jurors to reconcile their prior knowledge with the court's instructions. See English & Sales, supra note 64, at 383-95 (describing the work and findings of various researchers, but questioning conclusions about such a ceiling, and noting that significant improvements in juror comprehension have been realized by rewriting instructions).
71. See id. at 383; May, supra note 67, at 876; Tiersma, supra note 62, at 42.
73. See English & Sales, supra note 64, at 383; Tiersma, supra note 62, at 42 ("[J]urors have much less difficulty understanding jury instructions that have been rewritten in light of psycholinguistic principles."); Bolinsky, supra note 35, at 271-77.
Once it is decided to delete the error in judgment language, the question of the message remains, specifically whether to continue to instruct the jury on the underlying ideas from which the misbegotten error in judgment language sprang. Should the adverse result and acceptable alternative ideas still be communicated to the jury? A number of well-reasoned opinions by good judges have so held.74 And, the use of these two types of instructions continues to command widespread support.75

The analysis in Roney v. Medical Center Hospital, Inc.76 is instructive here. After noting that "the 'mere error in judgment' instruction begs for a meaning,"77 the court stated that the proper focus should be on the "message intended by the... instruction — that a doctor may choose among several proper alternatives, even though the one chosen leads to an unfortunate result."78 And since this message was not self-evident79 from the error in judgment instruction itself, Justice Morse basically advised courts to bypass the error in judgment language and directly address the underlying ideas: "The instruction would have been more understandable if it had spelled out that when a doctor chooses between appropriate alternative medical procedures or actions, harm that results from the doctor's choice of one alternative over the other is not necessarily malpractice."80 Other well-reasoned opinions have similarly urged the purging of subjective language, "while retaining a jury instruction on the limitations of professional liability."81

75. See supra notes 18, 19, 23 and accompanying text.
76. 649 A.2d 756 (Vt. 1994).
77. Id. at 760.
78. Id.
79. See id. In fact, the error in judgment instruction may even subvert the intended message by, for example, misleading the jury into believing that selection of an acceptable course of treatment absolves a physician of liability even if that treatment was administered negligently. See id. at 761.
80. See id. at 760.
81. See Ouellette v. Subak, 391 N.W.2d 810, 815 (Minn. 1986); see also Hirahara v. Tanaka, 959 P.2d 830, 834 (Haw. 1998) (rejecting the error in judgment and best judgment language, but recognizing the continuing validity of the principle that a physician is not negligent for selecting "a particular course of treatment among acceptable alternatives," and the appropriateness of jury instructions on at least the adverse outcome rule). Thus, the Ouellette court would continue to "caution the jury that liability should not be imposed merely because of a bad result or the 'wrong' choice of an accepted method of professional care." Ouellette, 391 N.W.2d at 815. The court recommended the following instruction:
A doctor is not negligent simply because his or her efforts prove unsuccessful. The fact a doctor may have chosen a method of treatment that later proves to be unsuccessful is not negligence if the treatment chosen was an accepted treatment on the basis of the information available to the doctor at the time a choice had to be made; a doctor must, however, use reasonable care to obtain the information needed to exercise his or her professional judgment, and an unsuccessful method of treatment chosen because of a failure to use such reasonable care would be negligent.
To a student of malpractice law, the adverse outcome and acceptable alternative ideas may seem implicit in the general objective standard of care. Why then, one might ask, do we need the two rules for elaboration? And indeed, one thoughtful commentator has argued against a tendency to emboss on the basic principles of negligence law when articulating the standard of care rules for medical malpractice. Professor Silver (addressing geographic limitations on the standard of care in the form of various so-called "locality rules") argues against what he characterizes as "specially articulated" rules. While Silver's position would promote formulations of conceptual brevity and simplicity, I nevertheless believe that the need for particularized elaboration on the standard of care for physicians justifies the risks to the intellectual purity of Silver's less encumbered approach.

I say this for several reasons. First, if we assiduously avoid the use of error in judgment language (and its common and more subjective accompaniments), as I have urged, the risks of juror confusion are reduced to acceptable levels. Second, I believe the two messages communicated by spelling out the adverse result and acceptable alternative rules are important tools for achieving a heedful application of the fault-based standard of care in malpractice cases. Otherwise, the potential dangers of the jury applying a hindsight bias are too great. These two messages might also help to assuage pervasive physician apprehension of being unfairly savaged by malpractice litigation, and the pernicious effects of such fear on the quality of medical care.

Third, the explicit instructions on the acceptable alternative rule reinforce the importance of respecting some diversity in professional approaches. This is essential to the progress of medical science. Fourth, such diversity-fostering jury instructions may serve to counter some of the potential dangers in the haphazard process by which mainstream medical standards sometimes evolve into overly narrow standard practices. And finally, the adverse outcome and acceptable alternative instructions

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Id. at 816. Note that under my recommended approach, the word "judgment" would not be used even when not accompanied by the "error in" or such potentially subjective adjectives as "good faith" or "honest." Therefore, in terms of the form of the instruction, I would play it safer than the language recommended in Ouellette to the extent that Ouellette refers to the "exercise of his or her . . . judgment."

82. See Silver, supra note 9, at 1238 (criticizing, from a fictitious court opinion in a hypothetical case, specially articulated locality rules in the standard of care in medical malpractice cases).

83. See generally Arkes & Schipani, supra note 22 (discussing the threat of hindsight bias in the medical malpractice setting).

84. See Kapp, supra note 35, at 752. Kapp notes that physician apprehension about potential involuntary involvement in litigation might inhibit attempts to discover and address the incidents and causes of medical errors.

85. One commentator describes the difficulties caused by ineffective information diffusion associated with the process by which standard modes of medical practice develop. See Kacmar, supra note 9, at 642. He observes:

Although some clinical policies are produced by medical societies, specialty associations, and government "think-tanks" . . . , the overwhelming majority . . . are produced not by a singular, recognizable group but by thousands of physicians acting individually. Over a period of years, hundreds of comments, articles, and reports converge to form a policy, which, if accepted by the majority of the medical community, becomes the "standard practice." Oversimplification, lack of proper methodology, and overemphasis
underscore the reality that an expectation of perfection or error-free medicine is unrealistic, and thereby facilitate more constructive self-scrutiny by individual physicians, greater collegial support, and more effective loss prevention strategies.66

It is not unusual in negligence law to elaborate through particularized constructs even though those same principles may be implicit in the general formulation of the standard of care. Thus, a number of other aspects of negligence law (not confined to the malpractice setting) have been addressed by particularized jury instructions despite the fact that those elaborating principles would be implicit in the basic standard of care formulation to a person with a background in tort law. For instance, the Restatement of Torts teaches that "the fact that the actor is confronted with a sudden emergency which requires rapid decision is a factor in determining the reasonable character of his choice of action."67 Under an emergency instruction, the standard of care remains the same with the emergency merely one of the circumstances to be taken into account by a reasonable person. Thus, the Restatement elaborates on the effect of emergency on evaluating a person's conduct even though the existence of an emergency is legally a "factor" that would be implicit in the general rule requiring conformity to the standard of conduct of a reasonable person "under like circumstances,"68 with the emergency being one of the circumstances.

The question of the use of elaborating particularized instructions for the emergency situation has engendered some disagreement among the courts, with some courts abolishing the use of such instructions, and others approving or at least allowing some form of elaborating instructions.69 Nevertheless, just as I believe the more sensible approach is to allow an elaborating jury instruction in true sudden-emergency

on empirical forms of knowledge can result in unjustified conclusions . . . and . . .

frequently, if a certain recommendation is repeated often enough, it can quickly become

standard practice. This cycle is then perpetuated as doctors tend to look to informal

information sources, such as other colleagues, for answers in lieu of looking outside their

own medical circles for new studies, data, or procedures that may call into question the

standard methodology.

Id. It has been observed that one danger in overreliance on consensus is that it "may do no more than identify the point at which . . . errors, oversimplifications, and biases converge; . . . not what is best." David M. Eddy, Clinical Policies and the Quality of Practice, 307 N. ENG. J. MED. 343, 343 (1982), quoted with approval in Kaemar, supra note 9.

66. See Lucian L. Leape, Error in Medicine, 272 J.A.M.A. 1851 (1994). Leape persuasively argues that a "concept of infallibility" (or a "perfectibility model") of physician performance impedes "insight and support" by inducing "fear of embarrassment by colleagues, fear of patient reaction, and fear of litigation." Id. at 1852. A more realistic and constructive attitude would focus on systemic ways for discouraging, preventing, and neutralizing errors. See id. at 1868.


68. Id. § 283. Similarly, the standard of care required of a person with a physical disability is that of a reasonable person "under like disability." Id. § 283(C). Here too, this idea is implied in the general rule, with one's physical infirmities as merely part of the "circumstances" under which the reasonable person must act. Id. § 283(C) cmt. a.

situations, so too for present purposes, I think such elaborating instructions should be approved in the malpractice context. Jury instructions that communicate and explain the adverse result and acceptable alternative rules are appropriate even if they are implicit in the general standard of care formulation for physicians. Such elaborating detail is important in facilitating the understanding by lay jurors, especially when they are confronted with the technical complexities of a malpractice case. While I appreciate the dangers that a particularized instruction may confuse some jurors or receive too much attention or weight, that risk is equally applicable to the entire trial process, of which the instructions comprise a relatively short component.

There is a temptation in framing jury instructions to strive for black-letter terseness and purity in order to avoid too much post-trial scrutiny. But, that cannot be the only answer. Such terseness is shortsighted, and ultimately will sow the seeds of the jury system's failure. Nor should jury instructions receive short shrift on the expectation that things can be rectified later and if necessary, the case be retried. That kind of thinking presents its own kind of moral hazard.90 Waiting to address the problem of ambiguous jury instructions until after the verdict has been rendered, often at the appellate stage, fosters chaos, confusion, and stark unpredictability. A carefully worded straightforward elaboration is preferable to either the risk-averse shell game of meaninglessly terse instructions or to the haphazard attitude toward the trial stage with the serious attention to detail reserved for appeals.

B. Exercise of Judgment as Sword

1. Exercise of "Best Judgment" or Superior Knowledge

Various formulations of the standard of care for physicians have commonly included a requirement that, in addition to satisfying the objective demands of acceptable professional practice (or some other variation of a professionally based standard of care), the physician must also exercise his "best judgment."91 This requirement has impacted malpractice cases in two ways. First, inclusion of the "best judgment" terminology in jury instructions has sometimes raised concerns similar to those addressed in the preceding section.92 Thus, plaintiffs have occasionally challenged93 the best judgment language as potentially confusing or misleading and

90. See Tom Baker, On the Genealogy of Moral Hazard, 75 Tex. L. Rev. 237 (1996). In the modern sense, moral hazard represents the "perverse consequences" that may follow from "well-intentioned efforts to share the burdens of life" or "cushion the consequences of bad behavior," because such may then encourage or promote the conditions or behavior that engendered the occasion for those efforts. Id. at 238-39 (quoting James K. Glassman, Drop Budget Fight, Shift to Welfare, St. Louis Post-Dispatch, Feb. 11, 1996, at B3).
91. See authorities cited infra notes 97-98.
92. See authorities cited supra note 51-52 and infra note 93.
93. Some courts have disapproved of the "best judgment" language when used in the shield sense to the potential benefit of defendants based on concerns that it might undermine the objectiveness of the standard of care to the plaintiff's detriment. See Hirahara v. Tanaka, 959 P.2d 830, 834-35 (Haw. 1998) (rejecting the error in judgment and best judgment language, but recognizing the continuing validity of the principle that a physician is not negligent for selecting "a particular course of treatment among acceptable alternatives," and the appropriateness of jury instructions on at least the adverse outcome rule);
as undermining the objectiveness of the standard of care. The second (and more
direct) effect of the best judgment rule has been to support an additional ground upon
which to base a claim that a defendant-physician negligently failed to satisfy the duty
of care owed to his patients. It is this second dimension of the best judgment idea that
is discussed in this subsection.

General negligence principles commonly require that a person not only exercise
reasonable care, but also apply any superior knowledge or skills that he may possess.
Thus, the Restatement states that one is not only required to act as a reasonable
person, but also to exercise "such superior attention, perception, memory, knowledge,
intelligence, and judgment as the actor himself has." The comments elaborate that
if the actor in fact possesses more than the minimum qualities of the reasonable
person, "he is required to exercise the superior qualities that he has in a manner
reasonable under the circumstances." In other words, "the standard becomes . . .
that of a reasonable man with such superior attributes."

The preceding idea can be extrapolated into malpractice cases in two ways. In one
general sense, the duty to draw on one's superior attributes provides a conceptual
premise for holding medical professionals to the standards of expertise reasonably to
be expected from members of their learned profession. And in a more specific way,
the best judgment rule has sometimes been invoked to extend a physician's obligations
even further, beyond the level of care and expertise demanded of a representative
member of defendant's learned profession and specialty by requiring that the defendant
also draw upon any personal attributes or knowledge that are superior to that of his
professional peers. I will address this latter use of the rule and the potential conflicts
that might be created by a thoughtless application of the rule. I will also suggest a
suitable formulation of the rule.

Although a number of courts and commentators include a duty to exercise
one's best judgment in their litany of the components of the standard of care, the rule

Leazer v. Kiefer, 821 P.2d 957, 960-61 (Idaho 1991); id. at 961-63 (Bristline, J., concurring); Rooney v.

94. RESTATEMENT (SECOND) OF TORTS § 289(b) (1965); see also id. §§ 299 cmt. f, 299A cmt. b
(stating that if a person rendering professional services "has in fact greater skill than that common to the
profession . . ., he is required to exercise that skill . . .").

95. Id. § 289(b) cmt. m.
96. Id.
statute); McAllister v. Ha, 496 S.E.2d 577, 581 (N.C. 1998) (stating in dicta that physician must satisfy
professional standards and use his best judgment in care of the patient, and also noting that these
requirements have been "refined" by statute); Brazie v. Williams, 634 N.Y.S.2d 274, 275 (N.Y. App. Div.
1995) (stating that medical malpractice can arise from "lack of knowledge, lack of ability, failure to
exercise reasonable care or failure to use one's best judgment"). At least one state includes a requirement
that, in addition to a requirement that the defendant have conformed to the objective professional
standards, that he also have "exercised his best judgment in the application of that skill." LA. REV. STAT.
ANN. 9:2794(1), (2) (West 1997).

98. See FURROW ET AL., supra note 20, at 239 ("On rare occasions, the courts have allowed the case
to proceed in spite of agreement that the defendant satisfied the customary practice of her specialty,
where evidence is presented that the defendant was aware of dangers in the standard practice."); Arkes
& Schipani, supra note 22, at 601; Kacmar, supra note 9, at 638.
has seldom been the center of focus or figured centrally in the outcome of a malpractice claim. Perhaps the most notable reported instances in which the rule has actually played a central role are two New York cases involving severe eye impairments suffered in the summer of 1953 by infant-patients caused by retrolental fibroplasia (RLF).\textsuperscript{99}

In \textit{Toth v. Community Hospital at Glen Cove},\textsuperscript{100} prematurely born twin infants were blinded or partially blinded by RLF caused by excess oxygen administered to them following their birth. Their pediatrician had ordered the administration of oxygen because he believed it was needed to preserve their lives and prevent brain damage.\textsuperscript{101} His written orders were to the effect that after the first twelve hours, the oxygen level was to be reduced from six to four liters per minute. Among the allegations of negligence directed at various defendants, plaintiffs contended that the oxygen was not reduced in accordance with the pediatrician's instructions, and that the defendant-pediatrician was negligent in failing to discover promptly that the oxygen had not been reduced by the nurses as directed.\textsuperscript{102}

At trial in \textit{Toth}, the only question the jury was asked to decide was whether the doctors had conformed to the acceptable professional practice in their specialties.\textsuperscript{103} A verdict was rendered for the defendant-physicians, and was affirmed by the appellate division.\textsuperscript{104} Although the evidence was conflicting, apparently there was at least sufficient evidence to support a jury finding that the defendant-pediatrician acted in accordance with acceptable medical practice by ordering the administration of oxygen. The defendant-pediatrician argued essentially that, even if the infants had received exclusively the higher six-liter dosage throughout, by finding that he had complied with acceptable medical practice, the jury was implicitly also finding that the administration of six liters without reduction was consistent with acceptable medical

\textsuperscript{99} Retrolental fibroplasia is a bilateral retinopathy occurring in premature infants treated with excessively high concentrations of oxygen, characterized by vascular dilation, proliferation, and tortuosity, edema, and retinal detachment, with ultimate conversion of the retina into a fibrous mass . . .; usually, growth of the eye is arrested and may result in microophthalmia, and blindness may occur. 

\textsuperscript{100} 239 N.E.2d 368 (N.Y. 1968).
\textsuperscript{101} See id. at 370.
\textsuperscript{102} See id.
\textsuperscript{103} See id. at 371.
\textsuperscript{104} See id. (discussing procedural history).
practice.\textsuperscript{105} Therefore, so the argument goes, any failure to discover that his order of a lower dosage had not been executed should be irrelevant since even the higher dosage was "acceptable."\textsuperscript{106}

On further appeal, the court of appeals reversed and ordered a new trial against the pediatrician and hospital, holding that a physician "should use his best judgment and whatever superior knowledge, skill and intelligence he has."\textsuperscript{107} Thus, even if the higher dosage actually received by the patients was acceptable, that fact did not relieve this defendant of liability under the circumstances for his alleged failure reasonably to assure that the safer course that he had ordered was implemented. The court added pointedly:

If a physician fails to employ his expertise or best judgment, and that omission causes injury, he should not automatically be freed from liability.

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\textsuperscript{105} See id. at 372.

\textsuperscript{106} See id.


In Koehler, the plaintiff alleged that the defendant was negligent in performing an abortion and as a result failed to terminate her pregnancy. One of the plaintiff's contentions was that the defendant should have used a sharp curette along with a suction curette in performing the procedure. Plaintiff relied on testimony by the defendant that he always used both. The expert testimony, however, indicated that the use of the sharp curette was "purely a matter of choice, being purely an alternative," and that the method actually employed conformed to "proper and accepted practice." Id. at 464. The Appellate Division reversed a trial court verdict for the plaintiff, finding that there was not sufficient evidence on causation, and alternatively that the fact that the method actually employed conformed to "proper and accepted practice" precluded a finding of negligence. Id. Although the court of appeals affirmed, it did so exclusively on causation grounds. See Koehler, 399 N.E.2d at 1141. Moreover, there is dicta in the court of appeals opinion suggesting at least tacit support for the best judgment rule. The court of appeals noted that "[i]t may well be that defendant . . . routinely followed procedures more demanding than those dictated by customary medical practice, and that a failure to adhere to these added precautionary measures in the circumstances of this case would amount to negligence." Id.

The Poulin case also involved RLF-induced blindness suffered by an infant allegedly treated with excessive oxygen. The infant was in respiratory distress and required the administration of oxygen. Poulin, 542 P.2d at 256. The dispute centered in part over the proper method for adjusting oxygen levels for cyanotic premature babies. Expert testimony supported both the method plaintiff claimed should have been used, and the method defendant-pediatrician used. The plaintiff also attempted to rely on a superior-knowledge argument in two ways. First, the plaintiff asserted broadly that since the defendant was trained in a "large, prestigious medical school in Chicago," licensed in five states, and board certified, that he should therefore be required to exercise superior knowledge. Id. at 268-69. Plaintiff requested an instruction that a physician possessing superior knowledge greater than others practicing in the same or similar communities was "required to use whatever superior knowledge, skill and intelligence he has." Id. at 269 n.42. The Alaska Supreme Court, relying on the state statute, rejected this contention or that the statute set a "minimum standard." Id. at 270. Rather, it held that specialists were held to a higher standard only to the extent of a specialist practicing in "similar communities" (under a since-amended version of the statute). Id. at 269. Second, the plaintiff sought to use defendant's knowledge more narrowly in conjunction with a duty to supervise. The plaintiff was held entitled to an instruction that if the physician believed oxygen levels greater than necessary were harmful, he was obligated reasonably to supervise the nurses to assure that oxygen did not exceed necessary levels.
because in fact he adhered to acceptable practice. There is no policy reason why a physician, who knows or believes there are unnecessary dangers in the community practice, should not be required to take whatever precautionary measures he deems appropriate. . . . We see no justification for the position that, as a matter of law, because other reputable physicians did not think the precautions necessary and did not view the treatment actually given as improper, there may be no tort liability.\textsuperscript{108}

The failure to afford the jury the option of considering this additional ground of possible negligence warranted a new trial.

Twelve years later another New York case was decided involving blindness due to RLF caused by excessive oxygen given to a premature infant. In \textit{Burton v. Brooklyn Doctors Hospital},\textsuperscript{109} the five to six week prematurely born plaintiff was transferred the day after his birth to a hospital designated as the premature nursery care center. There, the plaintiff came under the care of Dr. Lawrence Ross, a pediatric resident. Dr. Ross, concluding that the plaintiff was a vigorous infant in good condition, and aware that oxygen had been implicated as a cause of RLF, ordered that the oxygen be "reduced . . . as tolerated."\textsuperscript{110}

Two weeks prior to the arrival of the plaintiff at the defendant-transferee hospital, the hospital had announced the conclusions of its own study that "prolonged oxygen therapy may be related to the production of RLF."\textsuperscript{111} Nevertheless, because the results of its investigation were deemed insufficient, the hospital decided to participate in a national human research study attempting to determine the role of oxygen in RLF and the effect of its withdrawal or curtailment.\textsuperscript{112} The study's protocol provided that only one out of every three participating premature infants be placed in an "increased" oxygen environment whereas two out of three were to be placed in "reduced" oxygen.\textsuperscript{113} Apparently, this method of distribution was designed to subject the least number of infants to the risk of blindness that statistical methods would permit.\textsuperscript{114} What's more, only sixty-eight of 760 babies in the study throughout the United States were placed in the increased oxygen environment.\textsuperscript{115} Two days after the plaintiff's arrival at the defendant-hospital, Dr. Mary Engle, a member of the hospital staff, on

\textsuperscript{108} \textit{Tooth}, 239 N.E.2d at 373.

\textsuperscript{109} \textit{452 N.Y.S.2d} 875 (N.Y. App. Div. 1982). The alleged malpractice in \textit{Burton} occurred the same year as that in \textit{Tooth}.

\textsuperscript{110} \textit{Id.} at 878.

\textsuperscript{111} \textit{Id.} at 877.

\textsuperscript{112} \textit{See id.}

\textsuperscript{113} \textit{See id.} at 878. The opinion is not entirely clear whether the infants on "reduced oxygen" were also administered additional oxygen but at lower levels, or were given no additional oxygen. The more likely meaning of the court's language is that those on "reduced oxygen" also received additional oxygen but at a reduced level. \textit{See id.} at 876 (implying that oxygen was administered to the reduced-oxygen group with "curtailment of the supply . . . to clinical need"); \textit{Id.} at 880 (stating that the babies in the larger group "were given curtailed oxygen, while only one out of three was placed in increased oxygen").

\textsuperscript{114} \textit{See id.} at 878.

\textsuperscript{115} \textit{See id.}
the instructions of the Chairmen of the Department of Pediatrics,'" entered the following order for the plaintiff: "Oxygen study: In prolonged oxygen at concentration greater than 50%."117 Dr. Engle had thereby countermanded the order of Dr. Ross without ever examining the plaintiff or speaking to his parents. Moreover, her order was written despite the fact that she had no responsibility for the care of premature infants and was a coauthor of the hospital's own study that had concluded that increased oxygen might be unnecessary for premature infants.118

As a result of Dr. Engle's order, concentrations of oxygen administered to the plaintiff were (over a span of twenty-eight days) increased up to a high of nine liters and to an environment as high as 82%.119 Except for faint light perception, the plaintiff was rendered totally blind.

At trial, a verdict was rendered against Dr. Engle for, inter alia, malpractice in the treatment of the plaintiff and lack of informed consent. Unlike the initial trial in *Toth*, here the jury was presented with the question whether Dr. Engle was negligent in permitting increased oxygen for a prolonged periods, "even though it was common practice at the time, when they [Dr. Engle and the hospital] were aware of the possibility that RLF might result."120 On appeal, the court affirmed the liability121 verdict against Dr. Engle, holding that the evidence supported a finding by the jury that Dr. Engle failed in her duty to the plaintiff with regard to both the treatment and informed consent.122

In response to Dr. Engle's reliance on the assertion that "prolonged oxygen was routine practice"123 at the time, the appellate court explained:

> Although the conventional wisdom at the time believed that increased oxygen was essential to the survival of premature babies, the hospital and Dr. Engle cannot avail themselves of the shield of acceptable medical practice when a number of studies, including their own, had already indicated that increased oxygen was both unnecessary and dangerous, particularly for an otherwise healthy baby, and especially when the attending physician, who had primary responsibility for the patient's health, had recommended a decrease. "[A] physicians should use his best judgment and whatever superior knowledge, skill and intelligence he has."124

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116. At the time, Dr. Engle was serving as the Chairman's assistant for purposes of coordinating the hospital's participation in the Cooperative Study. *See id.*
117. *Id.*
118. *See id.*
119. *See id.*
120. *Id.* at 879.
121. *Id.* at 879.
122. The court affirmed the finding of liability, but ordered a new trial on the issue of damages. *See id.* at 882.
123. *See id.* at 879.
In concluding its analysis of the best judgment requirement, the Burton court supported its holding that the case was submitted to the jury on a proper charge, quoting the following language from Toth: "If a physician fails to employ his expertise or best judgment, and that omission causes injury, he should not automatically be freed from liability because he in fact adhered to acceptable practice." I believe that the above rule as finally articulated in Burton (and taken from Toth) was formulated in terms that were broader than are either necessary or appropriate.

There are two problems with the preceding broad, unqualified formulation of the best judgment rule. First, it contains the "best judgment" language. As explained in the preceding section, that language poses a risk of confusing or misleading a jury in ways that may subvert the premise that, at a minimum, health care providers must adhere to an objectively defined standard of conduct. The best judgment rule, as already explained, should supplement the objective standard of care, representing an additional requirement rather than a substitute for it. The best judgment language may, however, mislead the jury into incorrectly believing that subjective notions inherent in the exercise of one's best judgment supplant the objective standard of care. Therefore, I suggest that the duty to exercise one's best judgment be formulated for the jury without the "best judgment" language.

The second problem with the formulation in Toth and Burton is that it could, if imposed too absolutely, create a serious dilemma for physicians. There is no problem if the course indicated by one's best judgment coincides with a professionally acceptable practice. But what if the course indicated by the physician's best judgment points in a direction outside the ambit of what is regarded as professionally acceptable? It is one thing to require a physician to exercise his best judgment even when it leads outside the mainstream practice or conventional teaching when there are no downside risks to taking an outlier course. It is quite another matter if a rule were to require that a physician follow his best judgment when it not only points outside acceptable practice but when the course indicated by that judgment itself raises significant risks different from those present in the accepted or standard professional practices.

This potential dilemma can be illustrated by the following hypothetical situation. Assume that accepted medical practice provides that when bacterial infection "ABC" is the suspected cause of acute endocarditis, initial treatment should usually consist of antibiotic "Alpha" alone or in combination with other antibiotics, until it is determined whether the causative organism is susceptible to it. If, however, there are solid objective grounds for believing that a strain of bacteria resistant to antibiotic Alpha is the cause of the infection, then antibiotic "Beta" is to be used until the susceptibility of the actual bacterial strain has been clarified by laboratory results. Also assume that antibiotic Beta is a more effective agent for present purposes than antibiotic Alpha,

125. Id. at 880 (quoting Toth, 239 N.E.2d at 373).
126. Although this illustration was based in part on an actual disease, the medical background was tailored to suit the legal context and may therefore not faithfully or comprehensively reflect current medical practice. See generally Adolph W. Karchmer & Morton N. Swartz, Infective Endocarditis, 2 Sci. Am. Med. 7-XVIII-15 (1998) (explaining the medical background on the illustration).
but that it poses special risks of certain side effects such as kidney damage and deafness in some patients. Now consider the following two scenarios:

Situation #1: The patient is suffering from acute bacterial endocarditis. Defendant-internist, based on his prior pre-medical experience as a drug counselor, believes that his patient is an intravenous (IV) drug user. Based on the patient's signs and symptoms, the doctor has no specific reason to suspect an Alpha-resistant strain. He does have a suspicion, based on his recent experience with other IV drug users with similar infections, that the causative organism might be resistant to antibiotic Alpha. Nevertheless, the doctor starts the patient on antibiotic Alpha while he awaits laboratory tests to determine susceptibility to various antibiotics. Unfortunately, the suspicion was correct and the bacteria proves resistant to antibiotic Alpha. Before the disease can be brought under control by antibiotic Beta, the patient suffers significantly worse valvular heart damage from the endocarditis than would probably have otherwise occurred had he been treated immediately with antibiotic Beta.

Situation #2: Assume the same facts as in Situation #1, except that based on this same suspicion, the doctor starts the patient on the more potent but more dangerous antibiotic Beta. Drug susceptibility laboratory results subsequently indicate that the infection was in fact susceptible to antibiotic Alpha. But, in the meantime, the patient suffered serious side effects from use of antibiotic Beta.

Under a broad literal application of the preceding language from Toth and Burton, would the doctor be liable in Situation #1 for not at least recommending the course indicated by his best judgment? And, in Situation #2, might our doctor be potentially liable (depending on how broadly the courts define the range of acceptable medical practice) for departing from the accepted professional practice based on his clinical suspicion?

Notwithstanding the use of a broad unqualified statement of the best judgment rule, other language in both Toth and Burton suggests that the courts may have had a more limited rule in mind. A careful reading of the courts' language suggests that the courts may have believed the cases involved situations that did not require them (on those occasions) to approve as unqualified and sweeping a rule as their language literally suggested. A narrower formulation would have been an option if either the course the defendant recommended instead of the standard practice should have reasonably appeared to the defendant to have offered added safety without significant new risks (in other words no significant downside), or, the course the defendant recommended that was indicated by his best judgment was within the ambit of acceptable professional standards as defined by the jurisdiction in question.

In Toth, the court repeatedly elaborated on its view of the best judgment rule in a way that suggests that it was focusing on situations in which the course indicated by a defendant's best judgment did not itself pose substantial additional risks under the circumstances. Thus, the court gives an illustration of a physician contemplating a highly dangerous treatment, when "exercising his best judgment, . . . decides that certain steps can safely be taken to minimize the risks." The court adds, "[i]t is not

127. See supra note 125 and accompanying text.
128. Toth, 239 N.E.2d at 373 (emphasis added); see also Koehler v. Schwartz, 399 N.E.2d 1140,
unreasonable to impose upon a physician, who believes that added precautions are necessary, the obligation that he act diligently in taking the necessary safety measures." Later, the court states that there was sufficient evidence to find that the course that the doctor, in the exercise of his judgment, entered in his written orders, "were made with a view toward minimizing" the risks of harm from excessive oxygen. The problem is that, in fact, the situation in Toth as it then appeared in the context of medical science at the time, did not merely involve "added precautions." There was concern at least at that time that oxygen was useful in reducing the risks of death or brain damage caused by the premature state of the infant. Indeed, the court in Burton poignantly described the dilemma as perceived by at least a considerable segment of physicians at the time as trying "to steer their tiny patients between the Scylla of blindness [from the administration of too much oxygen] and the Charybdis of brain damage [from inadequate oxygen]."

The opinions in both Toth and Burton also contain language suggesting that the situations there may not have posed such a stark legal dilemma for the physician because the course allegedly represented by the exercise of defendants' best judgment may arguably have been one of a number of acceptable courses. Thus, in Toth, while the court acknowledged its concern that "on occasion" the best judgment of a physician may not be "accepted by other physicians in general." But, in the instant case, the court seemed to assume it had a situation where the procedures actually used "had some reputable support in the profession." Thus, the court apparently viewed the potential conflict to which it alluded as hypothetical and "not present here." And in Burton, the court expressed skepticism that "increased oxygen was the only accepted practice" at the relevant time. The court noted that under the design of the national study, two out of three premature babies were to be given oxygen at a

1141 (N.Y. 1979) (noting in dicta that "[i]t may well be that . . . a failure to adhere to these added precautionary measures [that the defendant routinely followed] in the circumstances" would amount to negligence) (citing Toth) (emphasis added).

129. Toth, 239 N.E.2d at 373 (emphasis added). A Restatement illustration addressing the best judgment rule in the medical treatment context also seems to contemplate a situation in which the course that the physician was required to recommend was designed to enhance overall safety and, presumably, posed no significant additional risks. See RESTATEMENT (SECOND) OF TORTS § 289 illus. 14 (1965). It states:

A, a surgeon, is about to perform an operation. Because of long experience with such operations, A has the superior judgment which should enable him to recognize that it would be very dangerous to use a certain anesthetic upon the particular patient. Nevertheless A uses the anesthetic in the operation, and as a result the patient is injured. A is negligent, although an ordinarily competent and experienced surgeon would not have recognized the risk.

Id.

130. Toth, 239 N.E.2d at 374 (emphasis added).


132. Toth, 239 N.E.2d at 373 n.2.

133. Id.

134. Id.

level curtailed to clinical need while only one out of three was to be placed in increased oxygen. The court then noted pointedly that it found "it difficult to believe that any reputable institution would permit two out of three of its patients to receive unusual treatment [i.e., reduced oxygen rather than the increased oxygen], which might result in death or brain damage, unless it was fairly convinced that the conventional wisdom [i.e., increased oxygen] no longer applied."

From the preceding analysis, it appears that the Toth and Burton courts may have at least believed that they had various bases for applying a less sweeping version of the best judgment requirement, and may therefore have contemplated a narrower construct than a literal reading of some of their language may suggest. Moreover, there is a question whether the courts in either Toth and Burton needed to invoke the best judgment rule at all to support imposition of liability. One could argue that liability might have been imposed based on duties other than the "best judgment" requirement. In Toth, the defendant-physician had already exercised his best judgment. He was allegedly negligent for not discovering the alleged failure of others to carry out his orders. Therefore, his was not a failure to exercise judgment, but to discover a failure to timely execute it. And, in Burton, Dr. Engle never examined the plaintiff. As a result, she never established a foundation upon to which to render a thoughtful clinical judgment. The best judgment rule need not have been reached. Even if the best judgment rule had not been invoked, Dr. Engle should not have been permitted to claim reliance on accepted practice because this patient and his particular clinical circumstances had not been individually evaluated by her. A patient should have the right not to have medical decisions made without any clinical evaluation. Moreover, in Burton, the court had the additional informed consent basis for liability.

2. Suggested Approach

I suggest the following approach. Physicians should owe a duty not only to satisfy objectively defined, reasonable, and professionally acceptable standards, but also (to the extent noted below) to give their patients the benefit of any superior knowledge

136. See id. at 876, 890; see also supra note 113.
137. Burton, 452 N.Y.S.2d at 880.
138. This analysis is similar to the Restatement's position in the spring gun context. See Restatement (Second) of Torts § 85 cmt. d (1965). Comment d explains that the use of a device likely to cause death or serious harm is not protected from liability merely by the fact that the intruder's conduct is such as would justify the actor, were he present, in believing that his intrusion is so dangerous... as to confer upon the actor the privilege of killing or maiming him to prevent it.
Id. Under this language, one who sets a spring gun and leaves it will not be afforded dispensation by arguing that had he been present, force would have been justified by the appearance of necessity. A spring gun user who was not present when the device discharged should not be exculpated if there was no actual necessity for the use of such force. Even if an intruder's conduct would have created an impression that would have justified the mistaken belief by the defendant that he was privileged, "[a]n intruder whose intrusion is not of this character is entitled to the chance of safety arising from the presence of a human being capable of judgment." Id. (emphasis added).
139. See Burton, 452 N.Y.S.2d at 881.
or special insights they actually possess even if beyond that of their professional peers. To avoid confusion and undermining the objective standard of care, the latter duty should be articulated without using the "best judgment" language. Rather, it should be stated (as qualified by the guidelines below) in straightforward terms of a duty to exercise one's superior knowledge or special insights. More specifically, I offer the following three guidelines.

First, a physician should select or recommend (in accordance with informed consent requirements) the medical approach or technique he prefers based on his superior knowledge or special insights when choosing among reasonable professionally acceptable practices and alternatives. There would ordinarily be no problem here in accommodations for satisfying an objective standard of care and the duty to draw upon one's superior knowledge or special insights since the medical approach or technique preferred by the physician would also fall within the ambit of professionally acceptable practices.

Second, a more challenging situation may arise when a course or technique favored by the physician diverges from or falls outside the ambit of what are regarded at the time as acceptable medical practices. I offer the following guidelines in reconciling the potentially divergent tugs of the duty to follow acceptable professional practice with the duty to draw upon any superior knowledge or special insights one may possess. A physician should select or recommend (in accordance with informed consent requirements and in compliance with applicable statutes and regulations) the medical approach or technique he prefers based on his superior knowledge or special insights when it reasonably appears to offer added safety without significant new risks or compromise of therapeutic effectiveness. Under such circumstances, any apparent conflict is academic since the patient benefits from added safety with no downside.

Third, when the course or technique favored by a physician is not one of the professionally accepted alternatives or practices and entails risks or ranges of therapeutic efficacy significantly different from those associated with acceptable practices, a more guarded application of the duty to afford patients the benefit of one's superior knowledge or special insights is needed. This may present a dangerous situation for both the patient and his physician. Patients have a tendency to defer to their physicians, accepted practice or not. An improvident therapeutic preference expressed by the physician that lies outside the ambit of more time-honored modes of therapy may needlessly endanger a patient. The doctor runs the risk of being found negligent for violating accepted medical practices, especially if narrowly defined.

140. Whether a particular choice among options would be the physician's to select or the patient's to select in response to the physician's recommendation would depend on whether the informed consent rules in the jurisdiction required that a separate informed consent be obtained for the specific medical procedure or technique. Stated somewhat differently, it would depend on whether the procedure or technique would be deemed covered by a broader consent for a medical procedure for which the particular procedure or technique was deemed merely a constituent part not requiring a separate informed consent. For background on the informed consent requirements, see generally note 144.

141. See supra note 140.

142. See infra note 148.

143. See, e.g., Edenfield v. Vahid, 621 So. 2d 1192 (La. Ct. App.), writ denied, 629 So. 2d 1171
I suggest (with some trepidation) the following approach for this third type of situation. The patient should be informed of the full range of professionally acceptable alternatives, and only then should the physician communicate the approach he favors and the reasons for his preference. Full information should be disclosed to the patient in accordance with the applicable informed consent doctrine, and in any event should include information about the range of therapeutic alternatives irrespective of whether or not such information is ordinarily required under the informed consent rules of the jurisdiction in question. Thus, the physician should not only disclose information regarding professionally acceptable alternatives, but should, in accordance with the suggested guidelines, also communicate other possible courses based on the

(La. 1993) (imposing liability based on evidence that the defendant-surgeon's use of a non-absorbable suture in repairing an anal sphincter fell below the applicable standard of care, and despite defendant's testimony that his decision to use the non-absorbable sutures was based on the patient's size); Charell v. Gonzalez, 660 N.Y.S.2d 665, 668 (Sup. Ct. 1997), modified on other grounds, 673 N.E.2d 685 (A.D. 1998) (modifying damages). In Charell, the court recognized that engaging in "non-conventional" practices "may well necessitate a finding that the doctor who practices such medicine deviates from 'accepted' medical standards." Id. at 668. The court added that perhaps this problem could be solved "by having the patient execute a comprehensive consent containing appropriate information on the risks involved." Id. (dicta). See generally FURROW ET AL., supra note 20, § 6-5(b) (1995) (discussing malpractice cases involving "clinical innovation," which the authors characterize as "problematic").

144. The doctrine of informed consent protects the patient's right of self-determination by requiring that information regarding the treatment be communicated to the patient prior to receiving treatment. In this way, the patient's consent to treatment can be "informed." The complex subject of informed consent is beyond the scope of the present article. For an overview of the informed consent doctrine, see generally FURROW ET AL., supra note 20, §§ 6-9 to 6-11.

145. Thus, irrespective of whether a medical technique might ordinarily and otherwise be deemed subsumed and covered by the patient's informed consent to a larger procedure, when the physician offers the patient the option of choosing a technique not embraced by currently accepted practices, fully informed consent should also be obtained for that therapeutic component. See supra note 140.

146. Although the primary focus of the doctrine of informed consent has traditionally been on disclosure of the risks of the contemplated procedure, other information is also commonly required, including information about therapeutic alternatives to the treatment contemplated. See FURROW ET AL., supra note 20, § 6-11(c). Although the cases are somewhat divided, there is considerable support for a requirement that the disclosures required under the informed consent doctrine include information regarding acceptable alternative modes of diagnosis or treatment. See John H. Derrick, Annotation, Medical Malpractice: Liability for Failure of Physician to Inform Patient of Alternative Modes of Diagnosis or Treatment, 38 A.L.R.4th 900, 903-04 (1985 & Supp. 1997). Compare Flanagan v. Wesselhoeft, 712 A.2d 365, 371 (R.I. 1998) ("informed consent is not possible when a physician has failed to address both the material risks associated with and the viable alternatives to a recommended surgical procedure") with Farris v. Sands, 25 Cal. Rptr. 2d 800, 803 (Cal. Ct. App. 1993) (acknowledging other California cases that declared a duty to disclose "available choices," but refusing to recognize a general duty of disclosure under informed consent doctrine regarding treatment the physician does not recommend that is based on a contrary recognized school of thought within the medical community, except in unusual cases "involving surgery, cancer diagnosis or . . . treatment or other serious life-threatening procedures"; and emphasizing the duty to advise a patient to pursue a necessary course of treatment). Some states even mandate such disclosures by statute. See Wis. Stat. Ann. § 448.30 (West 1998) (providing duty, subject to limitations, to inform patient "about the availability of all alternative, viable medical modes of treatment and about the benefits and risks of these treatments"); Martin v. Richards, 531 N.W.2d 70, 75-76 (Wis. 1995) (construing statute as, inter alia, creating duty to inform patient of alternative modes of treatment and diagnosis).
physician's superior knowledge or special insights. The fact that a course or technique favored by the physician lies outside of what, at the time, was recognized as acceptable practice should be explained to the patient,\textsuperscript{147} there should be full compliance with the disclosure and informed consent requirements of applicable statutes and regulations,\textsuperscript{148} and the patient should be encouraged to obtain a second opinion before agreeing to the course preferred by the physician. It should then be the patient's decision whether or not to submit to the outlier course or technique favored by his attending physician.\textsuperscript{149} Furthermore, the physician must act reasonably in arriving at his preference. Therefore, the course preferred, albeit outside the ambit of acceptable professional practice, should still otherwise be a reasonable one under the circumstances.\textsuperscript{150} Such a course preferred and communicated by the physician should also not violate applicable statutes and governmental regulations.

The attending physician should owe a duty to his patient in accordance with the preceding guidelines to afford him the benefit of his superior knowledge or special insights, and should be subject to liability for harm caused\textsuperscript{151} by his failure to do so.\textsuperscript{152} At the same time, a physician who does reasonably communicate his superior

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\textsuperscript{147} Cf. Estrada v. Jaques, 321 S.E.2d 240, 255 (N.C. Ct. App. 1984) (stating that the "underlying tort principles of rationality that require informing before operating clearly demand more information when the proposed procedure is new and untested"). The fact that an approach favored by the physician did not fall within recognized practices could conceivably, depending on its nature and role in the overall treatment path, affect its coverage under a health insurance policy, plan, or program. When relevant and appropriate, this consideration perhaps should also be disclosed to the patient before he opts for an outlier approach preferred by the physician.

\textsuperscript{148} See, e.g., Daum v. Spinecare Med. Group, Inc., 61 Cal. Rptr. 2d 260, 271 (Cal. Ct. App. 1997) (recognizing potential liability for alleged failure to comply with statutes and regulations, to the extent applicable under the circumstances, relating to required disclosures to patients participating in clinical trials).


\textsuperscript{150} While under my proposal, the physician should not automatically be liable for communicating his preference for a course or technique not falling within acceptable practices at the time, he would be subject to liability if the jury found that his preference was otherwise unreasonable. The reasonableness of his preference should depend on objective scientific evidence. In order for the physician's preferred approach to be deemed reasonable, I believe that the acceptable practices must have reasonably appeared to pose a serious danger of injury to the patient or of therapeutic ineffectiveness, as compared to more favorable levels of risk and prospects of therapeutic success under his preferred approach. Furthermore, the course preferred by the attending physician must not have violated applicable statutes or governmental regulations.

\textsuperscript{151} To the extent that the duty to exercise one's superior knowledge or special insights involved a failure to communicate the course or technique preferred by the physician, the plaintiff should have to prove not only that the defendant breached that duty, but also that such failure caused the harm. For the purposes of this causation requirement, I suggest that the courts use the same causation rules here as they would apply in informed consent cases in the jurisdiction in question. See FURROW ET AL., supra note 20, § 6-14.

\textsuperscript{152} Moreover, application of the rule would depend on proof that a defendant in fact possessed
knowledge or special insights in conformity with the preceding guidelines should not be held liable for so doing. Thus, to the extent that the preceding suggested guidelines would induce a physician to communicate his insights in a way that might lead a patient on a path outside accepted medical practice, the physician should also be protected from liability. But, unless the courts or legislatures are willing to confer such protection from liability, the physician should not be required, at his peril, to communicate therapeutic courses or techniques to his patient that are outside the ambit of acceptable professional practice. In any event, if the courts define the range of acceptable professional practice with sufficient breadth and flexibility, as I believe they should, the occasions in which a physician's superior knowledge or special insights would lead outside a broadly conceived range of acceptable professional practice should rarely arise.\(^{153}\)

III. Conclusion

A central principle in both negligence law generally and in the rules regarding the malpractice liability of physicians specifically is that a person's conduct should be evaluated according to objective criteria, rather than by a subjective assessment. Notwithstanding this objective focus, occasional subjective currents have moved beneath the surface not only in negligence cases generally, but also in the area of medical malpractice. One question that has proven particularly troublesome in malpractice cases is the how to address the matter of individual judgment, with its potentially subjective connotation, in the formulation of the objective standard of care and jury instructions.

The standard of care governing malpractice claims against physicians has largely remained an objective one. Overlaid against this general, objective backdrop are a number of constructs that have evolved, usually as jury instructions, to address the matter of the physician's exercise of judgment in delivering medical care. These "judgment" rules have affected malpractice claims in two ways. First, various formulations of a so-called "error in judgment" rule and its underlying corollary principles were designed to provide some cover for physicians whose decisions turned out in retrospect to have been unfavorable but nevertheless were reasonable at the time and under the circumstances. A second and less commonly invoked construct requires that the physician not only satisfy the levels of care required of a reasonable member

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superior knowledge or insights. Thus, for example, the rule was not applied against the defendant-ophthalmologist in Toth because there was no evidence that he actually thought that the treatment the children were scheduled to receive was particularly dangerous. See Toth v. Community Hosp. at Glen Cove, 239 N.E.2d 368, 375 (N.Y. 1968). Liability would require, inter alia, either that the physician did not draw upon that knowledge or, if he did, that he failed to accord his patient the benefit of that knowledge under the preceding guidelines despite having decided that a different course was preferable, and that such failure caused the harm in question.

153. See Hood v. Phillips, 554 S.W.2d 160, 165 (Tex. 1977) (adopting a formulation of the standard of care based on what a "reasonable . . . member of the medical profession would undertake under . . . similar circumstances," and recognizing that physicians should be allowed sufficient latitude for reasonable innovation when appropriate in order that "medical science can provide greater benefits for humankind").
of his profession, but in addition also exercise his "best judgment" on behalf of the patient.

Although the rationales for the two preceding sets of rules are sensible, the application of the rules has been inconsistent, confusing, and overly broad. I have proposed that the courts reformulate the rules. With respect to the error in judgment rule, I recommend that the courts eschew the use of the loaded "judgment" word and various other potentially misleading phrases commonly accompanying it in jury instructions. Ideally, the jury instructions should focus in a straightforward way on the underlying rationales for the error in judgment idea rather than employ shorthand, catchall expressions in its place. Specifically, the jury should be told that the fact that an unfortunate result occurred does not necessarily mean the health care provider's conduct was unreasonable or constituted "malpractice." It should further be explained that a provider who chooses one approach among reasonable, professionally acceptable alternative therapeutic approaches should not be held liable merely because it appears, in retrospect, that some other reasonable approach might have changed the therapeutic outcome or prognosis.

With respect to the best judgment requirement, I suggest the following approach. Physicians should owe a duty, not only to satisfy objectively defined, reasonable, and professionally acceptable standards, but in addition (to the extent noted below) to give their patients the benefit of any superior knowledge or special insights they actually possess, even if beyond that of their professional peers. To avoid confusion and undermining the objective standard of care, the latter duty should be articulated without using the "best judgment" language. Rather, it should be stated in straightforward terms of a duty to exercise one's superior knowledge or special insights. More specifically, I offer the following three guidelines.

First, a physician should select or recommend (in accordance with informed consent requirements) the medical approach or technique he prefers based on his superior knowledge or special insight when choosing among reasonable, professionally acceptable practices and alternatives. Second, a physician should select or recommend (in accordance with informed consent requirements) the medical approach or technique he prefers based on his superior knowledge or special insight when it reasonably appears to offer added safety without significant new risks or compromise of therapeutic effectiveness. And, third, when the course or technique favored by a physician is not one of the professionally accepted alternatives or practices, and poses a significant risk or level of therapeutic effectiveness different from those associated with acceptable practices, a more guarded application of the duty is appropriate. The patient should be informed of the full range of professionally acceptable alternatives or options, and only then should the physician communicate the approach he favors and the reasons for his preference along with the other information and safeguards in the suggested guidelines. But, the duty posited should depend concomitantly on the courts' willingness to confer protection from liability on physicians acting in accordance with the guidelines I have proposed.

It is important that the jury not lose sight of the fact that a bedrock principle of malpractice law is that health care professionals are held to an objective standard of care. Perfection is neither realistic nor should it be expected. However, the objective
nature of the standard of care also means that it is not enough for physicians to do their best if their conduct does not rise to the level of care required of similarly situated members of the profession. Specific instructions should be used to remind jurors that an unfortunate outcome does not automatically equate with substandard care, and that the practice of medicine does not consist of a monolithic single-lane pathway, but of plural acceptable clinical choices. Finally, when a physician possesses knowledge or understanding that is superior to that of his professional peers, he should be expected to draw upon that knowledge for the benefit of his patients in accordance with the preceding guidelines.