

Standard-of-Care Testimony: Best Practices or Reasonable Care?

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The standard of care is a mixed question of law and fact in which the factfinder is asked to determine what society is entitled to expect of a physician acting under certain specific circumstances. States frame this determination through case law and statutes.¹ The precise definition of the standard of care varies from one state to another. The exact language is applied to case-specific facts, to determine whether the physician's treatment of the patient was negligent.

The standard of care in malpractice cases is determined by the factfinder based on expert testimony, practice guidelines, the psychiatric literature, hospital policies and procedures, state and federal regulations, and other relevant sources. Managed care protocols and utilization review procedures are not necessarily authoritative.

Practice guidelines should be applied with caution to the highly specific fact patterns of malpractice cases. Practice guidelines evolve and change, driven by new developments in clinical practice and science. Studies find that no more than 90 percent of practice guidelines remain current after 3.6 years.² After 5.8 years, half of the practice guidelines are outdated. Practice guidelines set forth practice parameters that may or may not apply to a fact-specific case in litigation. Therefore, the sponsoring professional organizations issue disclaimers that the practice guidelines may not represent the standard of care. Moreover, there is considerable lag time, sometimes years, before current research and practice guidelines find their way into clinical practice.

The standard of care is not the same as the quality of care. Quality of care encompasses the adequacy of the total care that patients receive from health care professionals and providers, including third-party payers. Quality of care also depends on the patient's health care decisions and the allocation and availability of psychiatric services. The quality of care provided by the clinician may be below, equal to, or even above the acceptable standard of care.³

Psychiatrists who exercise the "skill and care ordinarily employed" by the "average psychiatrist" in the same or similar circumstances will not be found liable for any resultant injury, unless the jury errs or a judicial standard of care is imposed.⁴ Mistakes do not constitute malpractice, if the standard of care is not breached. The "skill and care ordinarily employed" standard, however, is changing.⁵ Generally, tort law has permitted physicians to set their own standard of care—for example, the practice of the "average physician." Physicians have needed only to conform their provisions of care to the customs of their peers. Defendants in ordinary tort claims, however, are required to use reasonable care under the same or similar circumstances.

An increasing number of states have rejected the "medical custom" standard by adopting the "reasonable, prudent physician" standard.⁵ The latter standard exceeds the statistical measure of the "average psychiatrist." Under the "reasonable, prudent" standard, even if 99 of 100 psychiatrists do not adequately perform and document suicide risk assessments, such omissions would be considered negligent practices that could harm patients at risk for suicide. Courts have held that negligence cannot be excused just because other physicians practice similarly.⁶ More is required. Actual practice must meet a reasonable, prudent standard of care.

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Best Practices

The standard of care does not require clinicians to utilize best practices or even good practices. The practices of the “average” or “reasonable prudent” psychiatrist, however, must be adequate according to the patient’s clinical needs.⁷ Legal standards are set at an acceptable minimum, whereas clinical standards strive for optimum care.⁸ The goal of evidence-based medicine, for example, is optimum treatment of the patient. One of the major spurs in the development of evidence-based medicine is the recognition that wide variations in medical practice exist.⁹ Evidence-based medicine brings together clinical expertise and best current research evidence.

Currently, there are more than 450 schools of psychotherapy. The standard of care is broad and vague. One therapist’s method of therapy may be considered suspect or even negligent by another therapist who practices a different type of therapy. This is the reason talk therapy alone is rarely the basis for a successful malpractice claim. Currently, some psychotherapies are being subjected to outcome studies to prove their efficacy.

In the management of psychiatric patients, a wide variety of approaches is beneficially employed, including multiple medications given at high doses. Treatment is often empiric because the clinician does not know which treatment will be the most effective.⁹ In an effort to discover new treatments for the mentally ill, psychiatry has encouraged innovation. The standard of care provided by practitioners of rational, innovative treatments would likely fall under the “respected minority rule,” if a respected minority of psychiatrists would employ the same treatment under similar circumstances.¹⁰

It is impossible for psychiatrists to stay abreast of the hundreds of journals and the latest research developments. Textbooks are outdated before they are published. Yet current research has established that certain treatments are more effective than others, though not for every patient. Among evidence-based treatments for psychiatric disorders, the clinician has various reasonable choices. Surveys show, however, that up to 40 percent of clinical decisions made at major academic medical centers are not based on research evidence.¹¹ This finding does not imply, however, that the clinical decisions were wrong or that the patients were harmed.

Evidence-based medicine is necessary but not sufficient for providing effective, quality health care.¹²

It is intended to support clinical decision-making in association with other relevant clinical information. Employing evidence-based treatments does not automatically establish that the standard of care has been met.

Best practice is a moving target, defined in part by the clinician’s training, knowledge, and experience, as well as the severity and complexity of the patient’s illness. Clinical practices may also be influenced by the decisions of third-party payers, litigation trends, risk management, commercial promotions of drugs, medical controversies in the media, administrative decrees, and other factors.¹³

Expert Opinion: Clinical Practice Versus Court Testimony

In the hierarchy of the types of clinical evidence, expert opinion is at the very bottom.⁹ No standards exist to assess the reliability of expert opinion alone, in clinical settings. When there is no evidence from well-conducted clinical trials, expert opinion can play a role in treatment and management decisions.¹¹

In contrast, expert psychiatric opinion is central to psychiatric malpractice litigation. Whereas evidence-based medicine aims at optimizing treatment, the law is evidence-based in the pursuit of justice. The rules of evidence are different from the rules of science. Judicial judgments are directed at upholding society’s rules and values and deterring antisocial behavior.

Evidence must be relevant and competent before it can be admissible. Expert witnesses are expected to provide reasoned, factual support for their opinions. When providing standard-of-care testimony, the expert must take into account the highly diverse, complex, clinical presentations of psychiatric patients; the variety of available treatments; the relative paucity of research evidence for treatment selection; and the current restrictions on treatment resources. There is no stock answer to the question: what is the standard of care? The courts apply reasonable standards to fact-specific cases. Expert witnesses should not impose unreasonable standards of care on psychiatrists.

Vignette: A respected academician and researcher is retained as an expert by the plaintiff in a malpractice case filed against a psychiatrist, alleging that she negligently prescribed and monitored a drug that caused the plaintiff a chronic, debilitating injury. The plaintiff’s expert performed the original research on the drug. The expert lectures widely about the efficacy and

safety of the drug. During the deposition, the expert testifies that the psychiatrist committed 21 deviations in the standard of care, though few or any are related to causation. The defense expert testifies that the plaintiff's expert's criticisms are based on "best practices," not on the practice of the "average" psychiatrist as required by state statute. The number and nature of the criticisms by the expert reveal bias, which is brought out by the defense attorney on cross-examination at trial.

Credible Expert Testimony

Voltaire, in a letter to Frederick the Great, advised: "Doubt is not a very pleasant condition, but certainty is absurd." The legal standard for expert opinions by a physician requires a level of confidence expressed as "reasonable medical certainty," the meaning of which is less than clear.¹⁴ Malpractice cases are civil suits that require plaintiffs to prove their allegations by a "preponderance of the evidence," defined as the weight of the evidence (51% vs. 49%).¹⁰ Thus, the expert witness has considerable leeway in providing standard-of-care testimony in malpractice cases. Credible expert witness testimony is fact based. Fictional testimony is idiosyncratic, bearing little or no relationship to the "ordinarily employed" practice of the "average or reasonable, prudent" psychiatrist.

It was Edward R. Murrow who said, "Everyone is a prisoner of his own experiences. No one can eliminate prejudices—just recognize them."¹⁵ This is the foundation for credible expert testimony. Acknowledging and correcting biases underpins the American Academy of Psychiatry and Law's ethics instruction to adhere to the principle of "honesty and striving for objectivity."¹⁶ Unnoticed and uncorrected biases (e.g., personal, social, political, financial) are a threat to providing expert testimony in accordance with the principles of ethics.

Psychiatric malpractice cases are marked by zealous advocacy. They are usually intensively litigated. Physicians' reputations are at stake. The possibility exists that the plaintiff may receive a large monetary award. In this highly adversarial litigation, biases may arise that threaten the credibility of expert testimony. Expert testimony about the standard of care can become polarized and skewed under the intense pressure of litigation. Core biases in standard-of-care testimony may be the result of a lack of expertise, the application of personal, subjective standards and hindsight bias. The taxonomy of expert witness biases, however, is extensive.¹⁷

A lack of clinical expertise by the expert witness, when providing the standard-of-care testimony, is

unfortunately common, especially among recently graduated psychiatrists, psychiatrists who are not actively practicing, and some academic psychiatrists. For example, expert witnesses who have not treated a psychiatric inpatient in years or been inside an inpatient unit since their residencies have opined on the standard of care in inpatient suicide cases.

Why would a psychiatrist lacking expertise take such a case? The reasons are many, but avarice, egotism, and naiveté are likely significant biasing factors. For example, the expert may have little or no understanding of how the "average or reasonable, prudent practitioner" practices in current managed-care settings. The standard-of-care testimony provided by these experts is often exposed under skillful cross-examination to be fanciful, or worse, incredible. The American Psychiatric Association Resource Document on Peer Review of Expert Testimony asks on its Peer Review Evaluation Form, "Does the expert acknowledge the limitation of his/her expertise in this area of litigation and the extent to which he/she has consulted with others in formulating an opinion?"¹⁸

Vignette: A forensic psychiatrist is contacted by an attorney to review the records of a patient who committed suicide on an inpatient unit. The psychiatrist has courtesy staff privileges at a local community hospital. She attends the quarterly staff meetings of the department of psychiatry. On occasion, she has sent patients for hospital admission to psychiatrists who treat inpatients. The psychiatrist has time open in her schedule to conduct the review. Additional income also would be welcomed in alleviating her strained financial situation. Since the psychiatrist has not treated an inpatient for 10 years, the attorney's request for case review is declined. The attorney is referred to a psychiatrist who currently treats inpatients.

Narcissistic bias is obvious in experts who insist that their testimony on the standard of care is the only correct one, even when the standard of care relates to a controversial area of practice.¹⁹ Their position is, "It is so because I say it is so." The narcissistic expert does not admit to any limitation in knowledge. The expert's psychiatric practices are proffered as the standard of care "to a reasonable medical certainty," a talismanic utterance that attempts to cast a spell of certitude upon the expert's testimony. The practice of the "average or reasonable, prudent psychiatrist" is ignored or disparaged.

The hallmark of the narcissistic expert is the inability to acknowledge that there are often "two sides" to every case. Such a witness is unable to consider the strengths of the opposing expert's testimony regarding the standard of care but sees only the weak-

nesses. At deposition or trial, the narcissistic expert will not concede the possibility that credible expert opinions can differ, especially when the psychiatric literature and current research are inconclusive regarding the standard of care. “Know it all” experts perceive themselves to be the engine of the litigation vehicle that the attorney drives into court rather than, more often, the hood ornament. Humility is notably absent. If the expert is asked the question: “Doctor, do you have any biases in this case?” The answer is a dismissive, “No,” instead of an acknowledgment of possible biases and the remedies undertaken to correct them. Attorneys are quick to inform juries that “no bias is high bias.” This kind of testimony is vulnerable to *Daubert* scrutiny and vigorous cross-examination at trial.

Vignette: During deposition, a forensic psychiatric expert providing testimony on the standard of care is asked if he has biases. The expert acknowledges that, in forensic cases, he has a tendency to view litigants as patients. This bias exists because of having had a large clinical practice for many years. The psychiatrist states that an awareness of this bias allows him to correct for it.

Hindsight bias can afflict psychiatric experts when providing standard-of-care testimony. Since the litigation occurs after the fact, the outcome is known. A retrospective reconstruction of the standard of care that occurs years after a patient’s suicide requires understanding psychiatric practice at the time of the suicide and the concurrent circumstances.²⁰ Retrospective bias oversimplifies a complicated clinical situation, especially the uncertainties surrounding clinical judgment at the time of the alleged negligence. The challenge for experts is to place themselves in the “shoes” of a contemporaneous observer to assess the clinical decisions made at that time.

Vignette: A psychiatrist testifies in a suicide case that the defendant psychiatrist violated the standard of care in the assessment of the patient’s suicide risk. The suicide occurred six years before the trial. The psychiatrist is asked on cross-examination: “Doctor, would you agree that the psychiatrist who treats the patient is in a better position in determining what care was appropriate for the patient than you are, reviewing the case six years later?” The psychiatrist answers that while the primacy of the on-site physician should be considered, the treating psychiatrist deviated from the standard of care by relying solely on a “no harm contract,” rather than performing an adequate suicide risk assessment.

Conclusion

Psychiatric testimony regarding the standard of care in malpractice cases is not solely the province of the forensic psychiatrist. In fact, most standard-of-

care testimony is provided by general psychiatrists who are not forensic psychiatrists. Credible expert testimony requires that clinical standards of care determined by evidence-based medicine and best practices to optimize patients’ treatment be distinguished from the legally defined “average or reasonable, prudent practitioner” standard of care. Acknowledgment and correction of biases are critical. Humility is the guardian of credible testimony.

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