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Malpractice and the Presuppositions of Medical Practice*

*David T. Ozar***

INTRODUCTION

Why do people blame doctors for failures that are beyond anyone's control? In order to answer this question, it is first necessary to identify some of the key background assumptions—or “presuppositions”—of medical care as it is understood in this society by those who provide it and by those who seek it. This article will only offer an hypothesis about the culture of medical care in our society, because it would take a great deal of empirical work to demonstrate that this hypothesis tells the whole story. But the hypothesis offered here is a very plausible one and is supported by a lot of common sense observation and reflection on the part of many people. In addition, because of what it suggests about the current proliferation of medical malpractice cases and about how to rectify this situation, it is deserving of careful consideration by physicians and by all who are involved in the health care scene.

I. PRESUPPOSITIONS OF MEDICAL PRACTICE

As is the case with every profession, there are important presuppositions of the practice of medicine that are held both by the practitioners of the profession and by the lay community whom they serve. Many of these presuppositions are rarely examined, even though they impact greatly on medical decision making and define many of the most important features of the physician-patient relationship. In addition, through the interactions of patients and physicians and because of what the sociolo-

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gist Eliot Freidson¹ has called the *dominance* of the medical profession within health care in the United States, these presuppositions also impact significantly on the rest of our health care system.

For example, there was a time, not so long ago, when it was a central presupposition of medical practice that the physician was in charge and the patient was to do as he or she was told. For a long time, the notion of "doctor's orders" was not considered an hyperbole. Over the last two decades, however, this presupposition of the relationship between physician and patient has changed considerably. There has been much increased concern, for example, with "informed consent" and other aspects of the patient's role in medical decision making.

This concern with patient decision making was prompted in part by several important legal decisions, especially *Canterbury v. Spence*² in 1972, but it is also grounded more deeply in the medical profession's fundamental commitment to the patient's good and an increasing awareness on the part of physicians today that, in our pluralistic society, patients have many different conceptions of what is in their best interest.

But another set of presuppositions from that older relationship has not been much altered. These presuppositions concern the reasons *why* the patient was to obey the doctor's orders in the first place. First, the doctor possesses *knowledge* of the patient's condition and its causes, knowledge that the patient lacks; this is the physician's professional *expertise*. Second, through the application of this expertise, the doctor has the ability to control events: to bring an end to pain and disease, to repair injury, to restore health and function; this is the physician's *power*. While the medical profession is certainly more concerned today about the patient's own conceptions of their good than physicians were two decades ago, both physicians and patients still take it for granted that physicians possess *special expertise* and *special power* with regard to health and disease, pain and the ability to function, life and death.

Of course, some such presuppositions are surely justified, indeed even more so in recent years because medical science has

1. ELIOT FREIDSON, PROFESSIONAL DOMINANCE (1990); see also ELIOT FREIDSON, PROFESSION OF MEDICINE (1970) & ELIOT FREIDSON, PROFESSIONAL POWERS (1986).

2. *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), cert denied, 409 U.S. 1064 (1972); see also *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92 (N.Y. 1914); *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170 (Cal. Dist. Ct. App. 1957).

grown so much and, with it, the physician's ability to predict and control events. But important and challengeable elements of these presuppositions are closely connected to two realities: first, people's tendency to hold physicians responsible for bad outcomes that are beyond their control, and second, the impact of this pattern on medical malpractice litigation.

It is a part of our community's presuppositions about medical expertise and medical power that the physician's knowledge is, as it were, *total*, and the physician's power to control events is, as it were, *complete*. Of course, no physician would claim to personally have such a degree of knowledge or control. But most physicians would explain their modesty first in terms of the limits of any one practitioner to master so much knowledge and the many details of its application. Both physicians and patients would recognize that *medicine as a whole* is limited in both knowledge and power and that these limits affect every patient and every case. That this is true is well known, of course; but this truth does not enter very actively into either physicians' or their patients' presuppositions about medical practice.

This analysis of the culture of medical care focuses on nuances and, of course, it may be in error. But we must look carefully at the subtle shades of meaning that are taken for granted, that are the active presuppositions of physicians and lay patients alike, but that are left unstated. For in many cases the precise way in which they achieve their influence is *by being left unstated*. An open discussion of the notion that physicians' knowledge of the causes of pain, disease, life, health, and so on is *total* would surely require people to qualify their judgments about this notion and lessen their expectations. Similarly, if the proposal that physicians' control over these matters is *complete* were openly discussed, people would almost certainly withhold that conclusion and moderate their confidence in physicians' and medicine's ability to control events.

But neither the lay community nor the medical profession routinely speak or think in these ways. Both groups have preferred to entertain the other view, that of total knowledge and complete control, not by trying to defend it consciously—for that is something that could not be done—but rather by not thinking or speaking about it, thereby permitting it to effectively shape many of the attitudes and actions of both groups and to define many of their relationships.

There are reasons for this preference, of course, and they are worth noting. Patients do not want to die. They are fearful of pain and lost function. They *want* someone to have complete control over such events, someone who has total knowledge in order to effect such control. These are not foolish desires. Everyone has them, wishing for such a measure of control over their lives and for such knowledge as will provide it; this is true of many matters in life, not just with regard to health. So the motivations of the lay community that support an unexamined presupposition of physicians' total knowledge and complete power to control events are easy to understand.

But there are other motivations from the physicians' side that are also relevant. It is a powerful support to the ego of any person to be thought capable, especially in matters of the greatest import. Particularly for individuals who are, by temperament, *do-ers*, few presuppositions could be more supportive and satisfying than the presupposition of total knowledge and complete control. There was an era when physicians really had very little knowledge and even less control over events. In that era the stature of physicians within the community depended on other features of medical practice. But in our age, medicine has linked itself intimately with the sciences and technology, and it routinely rests its status on the presuppositions of knowledge and control that this association fosters.

Of course, the lay community of this age supports that linkage with enthusiasm. Though the limitations of science and technology are as evident around us as are their fruits, nevertheless those who are influenced by this culture routinely turn back again to science and technology to overcome these limits, the limits of science and technology itself. So powerful cultural support exists for the presupposition that medicine's knowledge is total and its control complete.

Naturally, physicians, as a group, are not any more egotistical or any more needy of commendation than other groups. Rather, the way in which the common human need for commendation is met among physicians has come to be linked—through a long cultural process—with an unstated presupposition of total knowledge and complete control over life, death, pain, and health. It is for such knowledge and control, and for bearing the responsibility for having such knowledge and maintaining such control, more than for any other reason, that physicians are appreciated and admired.

It is a clear implication of the foregoing that when a physician fails to understand some feature of a case or fails to control events in the desired or anticipated way, or more simply when things just do not turn out well, the physician is falling short of what society expects. The presupposition of total knowledge and complete control has no room in it for ignorance or bad outcome, and since this presupposition is the unstated but accepted framework of medical practice, medical practice that falls short of it is considered defective.

As has already been stated, every thoughtful person knows that medical knowledge and medicine's control of events are incomplete. But it is not this knowledge about medicine that sets the parameters of medical practice within our community. Physicians and the lay community alike have preferred to understand medical practice in another, not carefully examined way for many years. That understanding, which includes the presupposition of total knowledge and complete control, is currently more determinative of the physician-patient relationship, of the expectations and obligations of physicians, and of the social standards of both physicians' performance and their failures, than a truer picture of what is actually possible for medicine.

II. THE IMPACT OF THESE PRESUPPOSITIONS ON MEDICAL MALPRACTICE LITIGATION

Even granting all this, however, it is still not fully clear why the community turns to legal proceedings and seeks monetary compensation when a physician's actual limited knowledge and limited ability to control events are revealed in practice. It would seem to make more sense for the community to correct its presuppositions about medical practice rather than strike back at the practitioner who cannot live up to such clearly unrealistic standards. But the same presuppositions play a role in making litigation and monetary compensation seem the most appropriate reaction to a physician's failure.

First of all, the power and importance within human life of social presuppositions like those under discussion here must not be underestimated. Human beings cannot live without habits as individuals or without social habits as communities. Human beings living together depend so greatly on such social habits and the presuppositions that support them that they are most unlikely to set aside an important social habit on the basis of a single defective situation. Therefore, the natural response of a

particular patient or patient's family to a physician who falls short of total knowledge and complete control is not to challenge the habitual presuppositions about the physician-patient relationship that all involved take for granted. The more natural response is to continue to hold the presuppositions and to blame those who do not live up to them. For the presuppositions we are speaking of are rarely challenged. Instead, in most medical situations, they are actively reinforced and maintained through the efforts of physicians and the lay community alike, as well as by the culture at large.

Of course, it is true that, when physicians speak to one another, the vast majority are quite candid about the limitations of their own abilities, and those of medicine as a whole, in the face of the incredibly complex challenges that nature places before them. Within the community of physicians, the presuppositions of total knowledge and complete control are much less operative. But the conversations in which these facts are acknowledged are not carried outside the staff rooms and medical conference rooms. The awareness that these presuppositions are mythical is not systematically communicated to the lay community. Consequently, there is no direct challenge to the operative presuppositions of the relationship between physician and patient.

This awareness *could* be broadcast more widely. Since physicians still dominate the health care system, this alternate way of viewing medicine and health care generally could, by the action of physicians, come to temper and even transform the physician-patient relationship. But in that case, there are prerogatives, the prerogatives of those who are assumed to possess total knowledge and complete control, that would have to be foregone. It is interesting to wonder, if the matter were put simply in these terms, whether the medical community would be willing to make this trade-off.

A second aspect of the lay community's recourse to legal procedures, the aspect that leads to the conviction that monetary compensation is appropriate, is more subtle. But it too involves the presuppositions under examination. Consider the long-accepted position of physicians near the very top of the economic ladder. (Admittedly, this position is currently under some challenge, both by reason of the cost of malpractice litigation itself and under the influence of other sets of events.) Most physicians would probably defend their incomes and consequent high

standards of living on the basis that their work is harder than most. It is taxing work, both physically and mentally. It involves long and odd hours, being on call even during leisure times. It requires a long, arduous, and expensive training program. It subjects physicians to great stress and to other losses and risks. And it imposes on them a responsibility that they justly experience as a burden (though a worthy one), namely the responsibility for decisions of life and death and other matters of the highest significance.

Some lay people who complain about physicians' salaries and wealth are no doubt simply jealous. But many others would point out instead that many occupations involve physically and mentally taxing work. Many people work very long hours in order to earn just a third or a fifth of the living that a physician in this society can ordinarily take for granted. Many other occupations require a long, arduous, and expensive training or apprenticeship. And some of these occupations cannot offer salaries to those who have completed their training that physicians can routinely claim even during their residencies, much less in independent practice.

Nevertheless, setting aside some gross aberrations and perhaps some overall shortening of the earning ladder, most members of the lay community would still very likely grant the justice of physicians' position near the top of the earning ladder. The reason for this is almost certainly people's persistent conviction that physicians bear a great deal of responsibility.

But the lay view of this responsibility does not focus so much on the specific responsibility that most physicians would emphasize, the responsibility for making decisions about life and death and other matters of the highest significance. This is not the most important aspect of medical practice when it comes to our society's view of the physician deserving his or her reward. Instead, the responsibility that is most widely held to justify the economic position of physicians in the community is specifically the responsibility for possessing *complete knowledge and total control* over life, death, pain, and health.

If the matter is looked at in this way, it is quite natural not only to blame the physician for lack of knowledge or failure to control events, but also to seek compensation from the physician accordingly. For if it is specifically by reason of the physician's special burden of responsibility for having total knowledge and complete control—if not in the physician's own

person, then in the whole medical profession that each physician has at his or her disposal whenever needed—that the physician is so amply rewarded in our economic system, then the physician who does not bear this burden properly should pay the price, and a steep one because of the sizeable rewards that bearing this responsibility justifies.

III. CHANGING THE PRESUPPOSITIONS

These brief comments cannot fully substantiate the claims made here about the presuppositions of medical practice or their impact on medical malpractice litigation. But they can stimulate reflection in a certain direction that also has implications for changing current patterns of malpractice litigation.

The first conclusion to draw is that the accepted presuppositions about medicine need to be changed so that they conform more truly to the reality of limited medical knowledge and medicine's limited ability to control events. But it is obviously not going to be enough to simply say that these views are not true. Alternative, correct presuppositions must take the current presuppositions' place. In this connection, there are five themes that ought to be incorporated into our society's presuppositions of medical practice. Each of these themes has many implications and their incorporation into our society's presuppositions about medical care, especially if all five were incorporated, would profoundly change medicine and health care generally in this society.

First of all, it should be stressed in our accepted conception of medical practice that human interventions are only part of the story. It is the human body that heals and recovers its normal functions, in major part through its own resources. Human interventions can be portrayed as enhancing the *body's* power to heal and care for itself, rather than as being *the* healing power in the process. Following this alternative view, when a person's body lacks the wherewithal to heal or recover, it is not first and foremost because of a failure of its human assistants. In other words, medical care should be viewed as a cooperative venture with nature, rather than principally an act of human domination of nature.

Secondly, the role of the *patient* in health care must be greatly emphasized, as it is every bit as important as the role of the health professional. This includes not only patient cooperation with regimens of therapy, but, even more, the patient's attitude

towards his or her condition, the patient's will to heal, to recover, to return to his or her former life, to adapt to new circumstances, and so on. Medical practice must be viewed much more as a cooperative venture with the patient since the patient's body will ordinarily respond to the professional's intervention only when the patient's psyche or spirit supports its healing or adapting capabilities. If a patient cannot or will not bring his or her resources to bear on health, recovery, or adaptation, as the circumstances may require, resulting in a less than desirable outcome, then it is much easier to understand that there may have been no failure on the part of the patient's care-givers, who are seen as co-workers, not as the sole do-ers in the process.

Thirdly, health care should not be viewed chiefly as the work of physicians who are only incidentally aided by and made more efficient through the efforts of other health care workers. That view, though it is the common view of most physicians and most patients, passes over the obvious fact that medicine does not possess all the forms of expertise that are needed for contemporary health care to be successful and on which medical practice itself obviously depends. The social dominance of the medical profession over the other health professions has served to support the presupposition that physicians are responsible for all the knowledge and control involved in giving care. But in fact many other forms of expertise and control that are distinct from the knowledge and control of the physician are necessary.

In sum, the many forms of expertise and control that are needed in health care should be blended into a single, cooperative program of care that will meet each patient's needs. Our presuppositions of medical practice should therefore view health care as it is, a *cooperative* venture of many professions with many distinct and interdependent forms of expertise, rather than as the work of one dominant superprofession capable of mastering all the knowledge and effecting all the control by itself. This change would lead to a much more correct picture of the actual expertise and power of the medical profession.

Fourth, three sets of circumstances need to be clearly distinguished: 1) the situation in which a medical intervention leads to a bad outcome of some sort—either the intervention does not achieve its goals or some other harm or risk of harm is created in the process—but in which *no one's bad work* is involved; 2) the situation in which a medical intervention leads to a bad outcome, and while it results from a physician's bad work (that is,

work falling below the profession's minimal relevant standards regarding diagnosis, treatment, or communication with the patient), the bad work is an example of the minor, occasional sub-standard work that all fallible humans inevitably perform; and 3) the situation in which a medical intervention leads to a bad outcome resulting from some physician's bad work that is, as the American Dental Association nicely puts it in its *Principles of Ethics and Code of Professional Conduct*, "gross or continual," actually doing great harm or happening repeatedly so as to suggest a significant risk that the physician will produce similar bad work in the future.³

The immediate corollary of rejecting the myth of total knowledge and complete control is the claim that situations of the first sort (bad outcomes but no one has done any bad work) can occur. If physicians do not actually have total knowledge or complete control of events, then sometimes they will do their very best and things still will not come out as desired. Unfortunately, the claim that there can be bad outcomes without anyone being guilty of bad work is profoundly counter-cultural, precisely because the myths of total knowledge and complete control so thoroughly dominate this society's presuppositions about medical care.

Major reeducation to change these presuppositions requires straightforward assertions in every treatment situation that physicians' knowledge and control are limited and that things may happen that are not desired but that cannot be predicted or controlled. The only alternative is to accept the corollary of the myths of total knowledge and complete control. That corollary is the view that every bad outcome is the consequence of someone's bad work. Rejection of these myths requires rejection of the equation of bad outcome and bad work.

The distinction between situations of the second and third kinds is probably more difficult to understand, and may in fact challenge important and longstanding assumptions within the law of negligence. It recognizes that some number of minor, occasional mistakes is the lot of every human being and that human beings are not to be treated in the same way for these mistakes as for mistakes that are "gross or continual," involving

3. AMERICAN DENTAL ASSOCIATION, *PRINCIPLES OF ETHICS AND CODE OF PROFESSIONAL CONDUCT* (1993). A more detailed discussion of these categories in dentistry will be found in DAVID OZAR & DAVID SOKOL, *DENTAL ETHICS AT CHAIRSIDE: PROFESSIONAL PRINCIPLES AND PRACTICAL APPLICATIONS*, ch. 9 (1994).

or portending great or continued harm to patients. These two kinds of mistakes are ethically very different, and this ethical difference needs to be reflected in our society's presuppositions about medical care.

In other words, if human beings are acknowledged to be fallible and their fallibility is viewed as acceptable because it is unavoidable, then distinctions must be made among human beings' mistakes. Those who cannot avoid a certain number of minor, occasional mistakes—which is everyone—should not be treated as if they were failing in their professional roles when they make them. It is only gross or continual substandard treatment that should count as a failure in one's professional role.

To be sure, even a minor, occasional failure to correctly diagnose, treat, or communicate with a patient is a failure to keep one's contractual commitment with that patient. The physician must take what subsequent steps are necessary to fulfill the original contract, or rectify the harm caused by the failure if that is possible. Determining what is professionally and ethically required in such a situation is not simple and needs careful study. But these failures must not be equated with those that involve a failure in professional role.⁴

Clearer distinctions between these three different circumstances and then education of our society to habitually make these distinctions would significantly change society's views about medical practice and society's patterns of response to bad outcomes resulting from bad work when they occur. In other words, these distinctions would be incorporated into our society's presuppositions about medical care.

Fifth, in light of the points already made, medicine should carefully examine another of its presuppositions that is closely linked with the presuppositions of complete knowledge and total control, a presupposition that supports and reinforces the others. This is the presupposition that in every instance there is one best therapy. Physicians know from experience, of course, that many situations arise in which the one best action cannot be identified, but rather several courses of action, each with distinct benefits and drawbacks, are all meritorious. But in medicine such a situation is ordinarily viewed as defective, as the exception, as a situation that a more complete practice of medicine

4. There may be something to be learned about such responses to one's own bad work from the law of "no fault"; a discussion of no-fault theory is beyond the scope of this paper.

would somehow eliminate. The possibility of multiple meritorious and professionally adequate interventions does not have a prominent place in our presuppositions about medical practice. It is at best an occasional exception to the rule of one best therapy.

In dentistry, by way of contrast, it is taken for granted that many clinical situations will arise in which there are equal options, each with its distinctive benefits and drawbacks, but all of them clinically acceptable and on balance meritorious, though often for different reasons.⁵ Some situations do arise in dentistry, of course, in which only one course of action fulfills the minimum standard of care. But such a situation, in which there is one and only one acceptable therapy, is the *exception* from the point of view of the presuppositions about dental care. In fact, since in such a situation patients cannot be given options, it is easily viewed as a defective exception. For in the ordinary dental situation, the patient's informed consent is not merely the patient's freely agreeing to what the care-giver judges to be best, but rather a choice by the patient among a set of therapeutic options that are all clinically acceptable, though differing in other respects.

If medicine were to change its understanding of the kinds of options it can present to the patient, taking a cue from dentistry in this respect and adapting it to the medical setting, this would remove some of the burden of responsibility from medicine's shoulders to invariably recommend *the* course of action that maximizes the patient's good. It would also support the notion already mentioned of viewing the physician and the patient as co-workers in the care-giving process. It would shift the conception of the patient's role from passive listener and then consentor, to active chooser on the basis of the patient's own values, goals, purposes, etc.

To be sure, in many medical situations today, the physician presents the patient with a set of limited options, each with risks, drawbacks, costs, etc., and then works with the patient to come to a mutually acceptable course of treatment. Many physicians, especially among the younger generations, have come to view this kind of relationship with the patient, involving *shared* judg-

5. See D. Sadowsky, *Moral Dilemmas of the Multiple Prescription in Dentistry*, 46 J. AM. C. DENTISTS 245-48 (1979). Paradoxically, Sadowsky bemoans this difference between medicine and dentistry and wishes dentistry could be more like medicine, rather than the other way around.

ments and choices about treatment, as the ideal physician-patient relationship. But such an ideal remains at odds with other deeply learned views of the physician's role. For the physician is *still* supposed to know completely and be able to control utterly at the same time that he or she tries to judge collaboratively and choose together with the patient. The fact that many physicians have learned to live with such schizophrenia does not make the system of presuppositions that requires it rational. Ambiguity, multiple competing values, imperfect technologies and understandings, and fallible humans are all part of actual medical practice and should be part of our society's presuppositions about medical practice as well.

CONCLUSION

Each of these five proposals has only been sketched briefly here. It would take a more careful examination of each, and of its implications beyond the present context, before the suitability of each proposal as a presupposition of medical practice could be fully affirmed. But it is important to note that these five themes, taken together and used to replace the presuppositions of total knowledge and complete control, would significantly undermine the patterns of reasoning that support current convictions that legal proceedings against physicians and efforts to wrest monetary compensation from them are just and appropriate responses to all bad medical outcomes.

While changing such solidly embedded presuppositions is surely a monumental task, physicians and lay persons alike *can* think, *can* question unstated assumptions, and *can* adopt new points of view. But to get the process started, they must start thinking and must be provided with reasonable alternatives—ways of thinking about medical practice and the physician-patient interaction that make sense and conform to actual experience. In the current situation, the crucial initiative in this process must come from the physicians, for the existing presuppositions make physicians the experts and give them the last word about the nature of medical practice. It is for this reason above all that they have held a position of dominance in the health care system. Therefore, physicians must set the needed reflective process in motion. Physicians must bring the unstated assumptions out into the light. They must invite the rest of the community to think about them. They must entertain and propose alternatives, presuppositions more responsive to actual

medical care, until they and the larger community working together develop an adequate conceptual basis for medical practice.

But it seems clear that there is another expert group of individuals who can help this re-education process greatly, and those individuals are the lawyers. Although principally trained to guide their clients through the law as it is, lawyers are also professionally committed to working for law as it ought to be, for assuring the soundness and justice of the whole legal system. The thesis of this article is that among the presuppositions of medical care in this society are elements that are not factually sound and that therefore challenge a proper understanding of justice regarding medical care. The legal community, then, like the medical community, has an important obligation to assist the community at large in rethinking these presuppositions.