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Customary and Evidence-Based Practice in Relation to Medical Malpractice

Customary medical practice refers to the standard of care generally accepted as satisfactory by a group of medical professionals in the same specialty. A departure from these accepted norms are frequently cited and applied when determining medical negligence. In other words, the allegation is that the doctor's performance was below the standard at which most doctors would perform in a similar situation. In Ireland, the standard tort test for negligence is that the medical practitioner acted in a way that no other reasonably competent, skilled practitioner would have acted under similar circumstances. In addition, there is a duty at common law to keep reasonably abreast with modern literature and practices. Continued medical education (CME) is now a requirement for all doctors in Ireland.

Tort law allows the medical profession to set its own standards in that doctors need to conform to the medical custom of their peers. Practices that are widely followed by a large group of practicing physicians could not be regarded as negligent. Some commentators suggest that this approach may over protect obsolete practices. It is well recognised that there can be long delays in the adoption of new best medical management.[1].

However, it is increasingly being accepted that customary practice is not necessarily a guarantee of proper care even it is being undertaken by a number of one's peers. In the US, the approach towards customary care is changing. It is being increasingly replaced by processes that examine the defendant doctor's clinical care according evidence-based practice rather than customary practice. This is part of the move towards a patient centred concept of reasonable medical care[2]. The term restatement is used to describe this change of emphasis in medical malpractice.

Aaron et al.[3] have recently written on this changing landscape in medicolegal practice. The issue of legal standards of care for medical liability are highlighted. Previously, medical negligence meant the failure to behave with ordinary care or reasonable care. The doctor should practice with the skill and knowledge possessed by other similar members of good standing in their profession. However, the new approaches no longer factor in deference to the practice habits of physicians only. Evidence-based practice is becoming more prominent in the courts.

Doctors, according to the authors, have been slow to adapt to changes in medical science. Instead they tend to rely on practices based on decades-old training. The new approach to tort will allow the plaintiff to point to the best scientific evidence and to argue that a reasonable doctor would have practised accordingly. Younger doctors are more likely to

embrace the evidence-based approach rather than the customary practice. Decision- making is changing from subjective judgements towards a more formal analysis of evidence. This means that in some malpractice cases the judgement will override customary practice if it is deemed to have been below contemporary standards. However the patterns of change are far from complete. One reservation is that the evidence-based approach to the management of a clinical problem or condition is frequently not widely implemented. This means that there is uncertainty how the measure will perform at the clinical coalface. The new innovation needs to be road-tested and modified accordingly when it applied to the wider population of patients. This is the challenge for translational medicine which refers to the 3 pillars of bench side, bedside, and community. It bridges the gap and helps to ensure that safe, effective and innovative treatments reach patients as quickly as possible. Clinicians may have difficulties in understanding the research findings and lack the skill set to introduce them into their clinical day-to-day practice. There is a gravitational pull towards the tried and trusted and 'what we know best'.

The other concern is that guidelines vary in quality depending to a large extent on whether the authors have the appropriate expertise and integrity. In particular whether it was designed with the patient's best interest in mind. Most guidelines become outdated after 3 years and some guideline developers lack the formal structures for updating them. Another potential dilemma is when different groups or colleges have produced differing guidelines on the same medical condition.

One of the most challenges facing a doctor is how to interact and communicate with a patient and their family when an unanticipated harm has take place. There is the ethical desire to speak with candor and to express regret for the adverse outcome. This is set against the backdrop that there may be subsequent litigation against both the doctor and the institution. In Ireland guidance is provided by the patient safety act[4] which came into effect on September 26, 2024. It defines open disclosure as an open, honest, and timely communication with the patient and their family following a patient safety incident. There is a legal requirement to disclose a list of specific major incidents called notifiable incidents which for most cases the patient has died, the exception being infants who suffered hypoxic-ischaemic encephalopathy. Information shared as well as an apology made as part of the open disclosure cannot be used for certain legal and regulatory purposes.

In the US, the University of Michigan no longer take a deny and defend approach to litigation claims. Being honest with patients, conducting root-cause analysis, and offering compensation for deficient care ultimately does not lead to increased costs.

The overall direction of travel is towards safe medical care and support for patients and care givers rather than relying on protracted legal technicalities.

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In summary, there is a change in medical litigation away from a reliance on medical custom only and a move towards a more evidence based approach. The equipoise, however, remains undetermined.

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