

From the Editor

Ethics in Standards of Care: The Joy of Doctoring

The theme editor introduces a special issue examining ethical considerations in standards of care in medicine.

More than 2 years ago, my closest friend gave me a copy of *The Joy of Cooking* [1], commemorating our friendship and many wonderful home cooked meals together. Excitedly, I cracked it open and was awestruck by the incredible detail and sheer amount of information. My scientific side appreciated the chemical explanations of why food cooks. Who knew that "double-acting" baking powder is so called because of a simple 2-phase acid-base reaction, one of which is temperature sensitive? And pick your potato wisely—the amount of starch and moisture present reveals whether it is likely to be a "boiler" or a "baker." How could any future dinner party go wrong? Might professional chefs be nervous, their art reduced to a 1136-page book?

I quickly began attempts to follow the recipes *exactly*: 45 minutes in the oven? Set the stopwatch—accurate to a tenth of a second, of course. To my dismay, perfection was elusive. On some occasions, I simply did not have the required ingredients (Mace? I thought that was a self-defense spray). On others, I was unable to execute the actions required by the recipes (carving a turkey, for example, seems to require cooperation on the part of the turkey, not mentioned in the recipe). It became clear that professional chefs had little reason to be nervous.

This analogy perhaps parallels some of the frustration many health care professionals have with "cookbook care." Cookbook care is a phrase often used to describe the mechanistic application of clinical practice guidelines (CPGs) or one of its close relatives, evidence-based medicine (EBM). Though distinct concepts, both fall under the general rubric of "medical standards of care." The frustration takes at least 2 forms: first, frustration that EBM and CPGs take away the "art of medicine," reducing health care professionals to automated decision makers (like the professional chefs' worry, above); and second, frustration that, in some cases, the evidence and guidelines simply do not apply to his or her particular situation (my worry about the mace).

If the stakes in health care were only as high as that of a collapsed soufflé, this might not be a problem. But we all know that errors in health care are costly, both for the patients harmed and the system as a whole. Prior issues of this journal have discussed the related topics of medical error and patient safety (see *Virtual Mentor*, [March 2004](#) and [June 2004](#)). To call something a medical error, however, presupposes a standard against which to judge an act or decision; in turn, these standards require an evidentiary base. The December 2004 *Virtual Mentor*, therefore, examines some foundational questions surrounding the evidentiary base of medical standards of care and their application.

The increased availability of both EBM and CPGs tempts one to think in black-and-white terms: "All medical decisions are either consistent with the best evidence, or they are not; and when they are not, they are flawed." This statement implicitly supports "cookbook care" by suggesting that one course of action is the absolute best in every situation. In doing so, it wrongfully assumes that evidence is of uniform quality, availability, and, most of all, certainty. Medicine involves decision under uncertainty, however, and uncertainty comes in degrees.

Uncertainty is inseparable from the very processes of evidence gathering and standard setting, for they involve *development, dissemination, application, and enforcement*. All 4 processes involve uncertainty because all require, at some level, good judgment (scientific or otherwise). Although admittedly oversimplified—as stated, the 4 processes might seem to occur separately in time and ignore the obvious need for revision—this characterization of standard setting helps frame a range of potential questions: Who is an appropriate authority for developing standards? What

counts as a "good" evidentiary base? On what evidence is the standard based, and to what end is it directed (eg, a particular patient or society more generally)? How should such standards be disseminated, and what is the responsibility of individual health care professionals to seek their guidance? Should the enforcement of standards be accomplished via legal measures, by means internal to the profession, or both? How is the standard of care constrained or affected by social norms? This month's contributors address some of these questions, and more. They convincingly demonstrate that evidence-based medicine, clinical practice guidelines, and the concept of a standard of care are ethical issues, not merely scientific ones: normative judgments are employed throughout all stages of evidence gathering and in its eventual application.

We are interested in how our contributors answer these process-oriented questions because we are interested in the answer to a more general one: when does ignorance of the "best available evidence," or even its outright rejection, become morally blameworthy? As our authors point out, the relationship between so-called "cookbook care" and the "art of medicine" is neither a simple one nor one of mutual exclusion. The *Joy of Doctoring* can be found not somewhere in between, but rather through the synergistic use of appropriate guidelines, other decision making tools, and of course, patient values.

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Reference

1. Rombauer IS, Becker MR, Becker E. *Joy of Cooking*. New York: Scribner; 1997.
[Google Scholar](#)

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