Medicolegal Implications of the Consensus Conference

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Abbreviations: ATT = antithrombotic therapy; CPG = clinical practice guideline; JAMA = Journal of the American Medical Association

(CHEST 2001; 119:337S–343S)

One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient (Francis Weld Peabody, 1881–1927).1

THE PROBLEM OF LIABILITY IN ANTITHROMBOTIC THERAPY

The major change in the medicolegal landscape regarding antithrombotic therapy (ATT) is that the problem has grown, not only in the United States but apparently in European countries as well. Many have put forward formidable arguments, at least in the United States, that the problem is growing as a direct consequence of pure greed rather than a continuing deterioration of the quality of medical care (vide infra), although in the midst of the current upheaval in virtually all aspects of medical care, the quality of medical care in some respects may have suffered as well. While Francis Weld Peabody’s observation quoted above still holds true as an ideal to be sought both for the benefit of the patient and for the reduction of legal liability, even broad application of such idealism is unlikely to have a significant impact on liability in the face of the enormous monetary rewards attainable with successful litigation.

As we have indicated before and do again in this section, very special and difficult liability problems exist in the ATT area. For example, the treatment of atrial fibrillation with anticoagulation to reduce the risk of devastating stroke as a result of cerebral embolization, a problem that represents for many physicians the most feared of bad outcomes, introduces the risk of potentially more devastating stroke due to intracerebral hemorrhage. While overwhelming scientific evidence may support such a therapeutic decision, a clever plaintiff’s attorney will transfer the responsibility from an intrinsically and unavoidably dangerous medicine to the physician, aided greatly by the presence of the patient in a wheelchair with a massive stroke. Clearly, we need better medicines with fewer side effects and dangers, and medicines that will not require continuous monitoring and regulation. Fortunately, some agents such as oral low-molecular-weight heparin may become available in the not-too-distant future. Until then, measures that enhance the physician-patient relationship and work toward the development of a kind of “co-management” agreement between physician and patient could contribute significantly to the quality of care for the individual patient. As in other areas of medical care, these efforts along with careful documentation of all relevant interactions related to patient care could go a long way toward reducing the risk of legal liability.

THE CONSENSUS CONFERENCE

The new format proposed by the Journal of the American Medical Association (JAMA) several years ago for consensus statements emphasized the need for a clear definition of the objective of the statement, the basis for the selection of participants, the manner in which the evidence was reviewed and evaluated, the manner in which consensus was developed, and the conclusions of the consensus conference.2 We will consider medicolegal aspects of a number of these areas of the consensus conference and statement according to the JAMA format. As a background for this, we will consider briefly the “standard of care,” malpractice implications of clinical judgment, and some aspects of the quality of medical care delivery in the context of the rapidly evolving health-care delivery system within which we function.

The Consensus Conference and the Standard of Care

The principal function of a consensus conference is to reflect a standard of practice in the area of interest. This in turn will be seen as representing an expression of what the legal profession calls the standard of care. Strictly speaking, it is not the standard of care as that designation applies in a malpractice trial, for example, because that designation refers specifically to the performance of a particular physician in a specific set of circumstances, and is developed for the jury through the interaction of expert witnesses and the lawyers for parties involved. Thus, a number of factors enter into the development of the standard of care in the manner in which that “standard” may most powerfully impact the practicing physician, i.e., the extent to which such a standard helps or harms that physician’s case. These include the scientific, medical, and other capabilities and personal qualities of the expert witnesses, including reputation. Very important as well is the makeup of the jury, the final arbiter in many cases of whether or not the physician charged with malpractice met or failed to meet the perceived standard of care in the context of the facts of the case presented. No doubt, the attitudes of the jury toward physicians and the medical-care system may bear importantly in their deliberations and decision. The appropriateness of this system as medical science becomes increasingly complex, of course, remains a subject of active debate.

Clinical Judgment and the Standard of Care

Another important factor to be considered with regard to the standard of care in a malpractice trial must be the role of the physician’s judgment in the context of the facts of the case. The importance of physician judgment should be emphasized in any statement that purports to contrib-
The Need To Demonstrate Enhancement of Quality of Care

The most important function of the consensus conference and any CPGs that may issue from it is not their use in litigation but in the improvement in the quality of care; the only real measure of success is the extent to which the quality of care is elevated. Thus, the organization, the scientific excellence of the participants and the discussions, the brilliance of the writing, etc, all these accomplishments fall short absent a positive impact on the quality of care. Thus, a brilliant statement from the consensus conference can hardly be considered a success in the absence of effective implementation. And even if implementation is effective, how do we know that the quality of care has indeed been elevated unless a credible evaluation has been carried out? Olson\(^3\) wrote in an editorial in JAMA that “Readers themselves must assess the quality and validity of consensus statements as they do all literature.” While this is undoubtedly true, such an evaluation of the quality of the written product cannot be the final measure of whether or not a consensus statement has achieved what must be perceived as its most important objective, i.e., the elevation of the quality of care.

Lack of Evidence of Quality of Care Enhancement by Consensus Conferences and CPGs

In the 1980s, CPGs were few and far between. Perhaps the most notable example of widely accepted and used CPGs were those that formulated relatively uniform approaches to cardiopulmonary resuscitation and emergency cardiac care.\(^4\) From the late 1980s to the present, there has been an explosion of CPGs as everyone, from organized medicine, peer review organizations, insurers, and state legislatures, to the US Congress, has become interested. By 1997, > 2,500 CPGs had become available. Earlier CPGs were developed primarily through the use of peer review and consensus conferences. More recently, the trend has been to base the CPGs on a comprehensive evaluation and weighing of scientific evidence by panels of experts. And the enthusiasm for CPGs has not been limited to the United States. Evaluations of the impact of CPGs on the quality of care and outcomes have been distinctly less frequent than the emergence of new CPGs themselves. Of 59 evaluations of CPGs in Britain, most found some effect on the process of care delivery but only 11 of 59 looked at the impact of CPGs on the outcomes of clinical care. A Canadian review of the impact of CPGs on patient outcomes provided little support that CPGs improved patient outcomes at the primary care level, but most studies looked at process rather than outcomes.\(^4\) It has been suggested that the failure to demonstrate positive outcome impact may relate to the lack of methodologically sound studies. The lack of evidence for the efficacy of consensus conferences and CPGs, despite what appears to be unbridled enthusiasm, may be due to the fact that they indeed may not positively affect clinical practice and outcomes. Alternatively, acceptance may be low, implementation inadequate or the evaluation process may so far be ineffective. However, the sheer weight of enthusiastic support is insufficient reason to disregard the fact that an innovation of such magnitude should not be permitted to go on unevaluated. For all the enthusiasm, there remains the possibility that CPGs could be having a negative impact on care, at some level, in some sector, on physician performance or on the physician-patient relationship that appears to be under continuing attack by the forces of market-driven medical practice.

Market-Driven Medicine: Impact on Quality of Care

The growth of CPGs has taken place during a period of vastly increased market-driven changes in medical-care delivery that have transformed the medical-care delivery system and continue to do so. One of the many consequences of the intensive market competition that has resulted is an instability in the managed-care system that tends to impact negatively on continuity of care. Some employees may offer a single health plan that may or may not be able to provide care up to the expectations implied by CPGs.

Thus, for whatever reasons, it is not yet clear whether CPGs have a positive impact on patient outcomes. However, it is quite clear that the number of CPGs that have been developed is greatly disproportionate to the paucity of evidence supporting their efficacy. And it may well be that a critical evaluation of the impact of CPGs, from the uniformity of implementation to the consistency and the quality of care delivery itself, may in the long run contribute more positively to health-care outcomes than the publication of more CPGs.

Objective of the Consensus Statement: Immediate and Longer Term

The objective of the consensus statement must be defined clearly. An example of a clear definition of objective was provided by Drs. Dalen and Hirsh in the introduction to an earlier version of the ACCP Consensus Conference on Antithrombotic Therapy: “We hope that these recommendations will assist clinicians in providing safe and effective antithrombotic therapy to their patients.” While clearly expressing the immediate objective, i.e., to enhance the quality of care delivery in the area of ATT, Dalen and Hirsh\(^5\) went on to underscore the important catalytic role of such a conference for the achievement of longer-term objectives: “We are certain that these recommendations will lead to further dialogue and stimulate further studies in this important area of therapeutics.” While this function has important implications for the development of perfections in the scientific data over time that may be expected to improve ATT in...
the future, the legal implication is also clear: all the answers are not in. Thus, there is clearly room for the clinician to exercise his or her judgment, as alluded to above, with regard to a specific patient with a specific set of clinical characteristics. The guidelines, then, are intended to be just that: guidelines. If ideally developed and ideally packaged, these guidelines will be of the greatest use to the greatest number of practitioners in providing safe and effective ATT. As such, they will be helpful guides to the standard of care for the protection of the practitioner from charges of substandard performance, thus performing a legally beneficial role for the benefit of the practitioner while hopefully improving the quality of patient care. The better the guidelines are, the easier it should be for the physician to act properly in the best interests of his or her patient, although, to date, clear evidence to support that highly desirable outcome has not been forthcoming.

Credibility of the Consensus Conference

The credibility of the consensus conference recommendations clearly will depend on the degree to which legitimate differing views are presented and discussed openly. Not only is this important from the viewpoint of comprehensive discussion, it is important from a legal viewpoint, in that the law has recognized the opinions of “respected” minorities, which may differ from the majority opinion. Thus, “consensus” must not be forced: it is an anticipated and desirable outcome if it can be achieved. If legitimate respected minority opinions exist, these also should be disclosed as such.

Selection of Participants

Thus, selection of the participants so that a comprehensive range of scientific and medical opinions will be represented, presented, and discussed is of paramount importance to ensure a credible and comprehensive set of recommendations. Not only need there be balance on the issue of content, there must also be balance on the issue of personality. A daunting figure on one pole of an argument should not be permitted the opportunity to intimidate a less confident presenter at the other pole.

Selection, Evaluation, and Presentation of Evidence

An excellent section on this subject is included in this volume, and only a few brief comments will be made here. When prior consensus conferences have been held and published recommendations issued, each of the prior recommendations must be reviewed and critiqued carefully and comprehensively by experts who represent the extent and range of opinions on the subject. Criteria for evaluating new scientific and medical data have now been developed as the earlier chapter on this subject in this publication indicates. The new JAMA format, referred to above, along with the rationale for it provided by Olson, are particularly helpful guides in the development and implementation of the consensus process. Opinion, however expert, should clearly be subservient to credible data published in respected peer-reviewed journals and preferably validated by independent investigators. Absent of a credible scientific database, expert opinion honed by the process of informed discussion remains the only alternative approach to developing state-of-the-art guidelines.

Legal Implications of the Scientific Database

The importance of the scientific database to the consensus statement and any CPGs that may emerge from it springs from the connection of any guideline to its scientific basis: if the scientific basis is unequivocal, the guideline based on it is likely to be strong as well. It is now common practice to characterize the strength of the science, and such a grading was carried out at the Sixth ACCP Consensus Conference on Antithrombotic Therapy, as per the chapter on the selection and evaluation of the science, vide supra. Theoretically, then, the stronger the scientific basis the more difficult it would be to defend deviation from a guideline based on it. The grading of the science should reveal the limitations of the science base and, in so doing, provide justification for deviation from a recommended guideline in certain circumstances, and support such deviations as were made on the basis of physician judgment.

When contradictory opinions are present in respected medical journals, the work of the consensus conference may become more important and more difficult. A careful discussion of all credible information may lead to an impasse. If so, this must be confronted and reported, and the best recommendations based on expert opinion may be the only available alternatives. The level of urgency of any call to expedient development of needed research data should depend on the gravity of the unanswerable therapeutic question.

The Consensus Process

It is well recognized that the process by which the consensus statement and any other product that may issue from it will rely heavily on the manner and quality of the process by which consensus itself is developed. An array of approaches to the development of consensus has been identified. These range, for example, from the National Institutes of Health process that “combines aspects of the judicial system [in which an impartial jury makes a decision based on the evidence presented], a scientific meeting [in which professional colleagues share their findings], and a town meeting [where any interested person can express an opinion]”. The central purpose in the consensus process, whatever format is chosen, is the following: (1) to ensure a comprehensive presentation of all relevant scientific information, including minority opinions by respected experts who are dedicated to the objectives of the conference; (2) to ensure a full and balanced discussion of this information among these experts, usually in small groups and in a manner in which the facts are emphasized and personal qualities of
persuasion are minimized; (3) presentation of what has been agreed on and what has not been agreed on to the general session; and (4) faithful incorporation of the developed consensus and exceptions to consensus in the article for publication.

Finally, the practice of bringing manuscripts to the conference so that publication deadlines can be met should be examined carefully, and clearly all such manuscripts should be subject to prior review and open discourse and debate at the time of the conference.

**Government and Professional Organization and Practice Guidelines**

Practice guidelines for the use of both diagnostic procedures and therapeutic interventions have been developed by the American College of Cardiology and the American Heart Association, often jointly. These apply to a number of specific disease states, e.g., myocardial infarction and heart failure, and to a number of procedures ranging from ECG to cardiac catheterization. The purpose of these guidelines is to make clear to the practicing physician/cardiologist what experts in cardiovascular medicine consider to be the minimum acceptable performance standards in each of these areas. Such impartial guidelines should provide a clearer indication to physicians of what is expected of them by their peers. This expectation, in turn, will tend to make the somewhat abstract standard of care quite a bit more concrete for physicians, patients, lawyers, and judges. In terms of balance, this should work in favor of the conscientious practitioner, both from a medical and from a legal point of view, although no clear evidence supporting this opinion has yet become available.

**Special Medicolegal Problems in ATT**

**Science vs Civil Litigation**

It seems unlikely, despite the best efforts of physicians and scientists such as those involved in this consensus conference, that improvement in the quality of care delivery will significantly reduce the burden: litigation in medical-care delivery. One of the principal reasons for this is thought by many to be the manner in which medical malpractice cases are litigated, and particularly the role of the expert witness. In the course of addressing this problem in an address at the Fordham University School of Law in the 1997, former US Attorney General Richard Thornburgh used the term “junk science” to apply to the “... testimony of expert witnesses hired not for their scientific expertise, but for their willingness, for a price, to say whatever is needed to make the client’s case.” It is more likely that physician actions to develop approaches that at once enhance quality care and reduce the risk of all the litigation will be necessary. One of the strategies likely to be effective in the ATT area is a well-implemented program for shared responsibility between physician and the patient, the strategy that clearly has the potential for reducing negative outcomes.

**Informed Consent as a Basis for Shared Responsibility in ATT**

This is particularly likely to be true once both patient and physician confront together the fact that bad outcomes occur when dangerous medical problems exist, especially when such problems require therapies that also are inherently dangerous. Unlike a number of other medical conditions, once the patient becomes a candidate for ATT, that patient is often at risk either with or without ATT for the rest of his or her life. Furthermore, with regard to the most feared and most devastating problems for which ATT is prescribed, i.e., crippling stroke and death, the therapy used to reduce the risk of the underlying disease contributes another basis for crippling stroke and death. This reality argues for a unique kind of interpersonal contract between physician and patient, a contract that implies not only full discussion and disclosure of risks and benefits, but a kind of “co-care” pact in which the patient accepts co-management responsibility and commits to maintain that role over time. This may be facilitated through the use of a kind of running “report card” by which patient and physician can keep track of patient-specific responsibilities in the co-care endeavor. Efforts to develop such a model have begun and will be tested in the clinical arena. The recording of events and behaviors that may negatively affect either the underlying disease process and/or the therapy will serve as a basis for grading the participation of both physician and patient over time; will serve as a basis for in-course corrections on an as-needed basis; should improve both the quality of care and the physician-patient relationship, and, hopefully, by multiple mechanisms reduce the propensity for litigation by improving the physician patient relationship, and by providing a careful chronicle of the care provided to the patient as well as the patient’s contribution to that care program.

**The Medicolegal Risk of ATT**

The legal nightmares of ATT are, of course, a plaintiff attorney’s dream. In few areas of medicine are the “complications” of the decision to use or the decision to withhold therapy as predictable and as devastating as a crippling stroke, the adverse effect we will concentrate on not because of its frequency but because of its potentially dramatic effects. It is perceived by many as being worse than loss of life. From the viewpoint of legal liability, the patient who has suffered a devastating stroke and has survived brings a much more powerful weapon to the court in a malpractice action, that weapon being the deformed partial person who was like any juror prior to the stroke. Jurors, like most of us, are terifified by the prospect of being the victim of a stroke. Empathy is immediate and powerful. How could this happen? “If it happened to her, it could happen to me.” Sensibilities may be rubbed raw, especially with the help of an experienced plaintiff’s attorney. It is the physician’s job to prevent such a catastrophe in this day and age, is it not? There is a spontaneous reflex toward compensation on the part of the jury that must be overcome by the defense, and this may not be possible. The orientation of the jury may be shaped more by emotion than by an inclination to plumb the
truth. There is a natural tendency to hold the physician responsible even before the facts are heard. This is a difficult climate, one in which even the blameless physician may be unable to elude a sense of hostility.

**Legal Liability Crisis Points**

There are a number of medical crisis points in the decision-making process in the antithrombotic area, and each of these may become a legal crisis point. As with medical decisions in general, the potential for legal liability in the area of ATT begins when the patient is first considered to be a candidate for ATT or should have been considered a candidate. However, this field is rather unique, in that many such patients are from that moment on at risk for what may be the most feared complication in medicine, *ie*, a devastating stroke and, worse yet, that such a patient is at risk both with ATT and without it.

As noted above, the physician may become liable either for the decision to use ATT, *eg*, should the patient suffer a hemorrhagic stroke, or for the decision to withhold or withdraw should the patient suffer an embolic stroke. Once therapy has been started, the physician may find himself or herself at risk for not reaching therapeutic range in time, for not maintaining the therapeutic range, for failing to detect bleeding at an earlier time. Since a disastrous outcome is to be expected in a predictable percentage of patients with or without treatment and with or without “ideal” treatment, it is clear that there is no “safe” area once the patient is in the “club” as a candidate for ATT. This reality brings with it important forebodings for the physician who is charged with malpractice. The fact that the physician made decisions that would have been viewed to be within the standard of practice does not necessarily mean he or she will be exonerated. While there may be many reasons for such an unreasonable result, one important one is that the jury may not be educated successfully to the fact that these patients are truly living at the edge of disaster, not because of their physician but because of the disease substrate, which poses a direct and serious threat, and by the treatment that also poses a direct and serious threat, not to mention the important additional factor which is time, since many patients will require ATT for the rest of their lives.

The statistical presentations by expert witnesses are often doomed to failure because they require a sophisticated understanding of the unique nature of ATT, an area in which dangerous measures must be mobilized because the patient’s predisposition to form blood clots within his or her circulatory system is a very dangerous condition. A second reason why the physician may fail to prevail despite having provided an acceptable level of care is that even an excellent defense may be insufficient to overcome the emotional impact of the once-healthy plaintiff now before the jury in a wheelchair, drooling, with a flaccid arm on his or her lap. The physician may be painted as a monster by the dramatic power of the outcome even in the absence of clear evidence of deviation from the standard of practice in this area. The wily plaintiff’s attorney may be successful in pointing out that the physician’s first obligation is to do no harm, and that when there is a risk of great harm, the diligence that the physician must exercise must be proportionate to the severity of that risk. The inference is that the outcome was preventable and the physician failed to prevent that outcome.

We are aware, of course, that some such outcomes, *ie*, stroke, are not preventable since stroke will occur in a small but predictable percentage of patients in whom ATT is indicated even when the therapeutic decisions are flawless. We are also aware that the frequency of stroke will increase as the therapy falls farther and farther below the ideal, whether or not such less-than-ideal therapeutic control is the fault of the physician or due to a number of other uncontrollable factors that are known to influence ATT.

**Can Consensus Statements Help Reduce Legal Liability?**

Perhaps. If we could live in an ideal world, we would do well from a medicolegal viewpoint to minimize or better yet eliminate variations in the indications for and methods of initiating, maintaining, monitoring, and suspending ATT. This, of course, is one of the main objectives of a consensus conference. It is also an objective that is virtually never achieved, primarily because there is insufficient scientific evidence to force complete unanimity on all important questions. Compromise alone may not be sufficient, however reasonable and well intended. It is often more desirable in the face of differing views to have each view analyzed as to justification. In the absence of credible justification, a view should be rejected. If credible justification exists for differing views, consideration must be given to setting forth these alternative approaches as acceptable options until persuasive data emerge to justify a reappraisal. Practice patterns that have been proved to be effective in a given set of circumstances should not be rejected without solid justification. Alternatively, practice patterns that have been proved to be less effective and that subject the patient to avoidable excess risk must be rejected if the improvements are feasible. The primary purpose of a consensus conference, of course, is to provide optimal guidance to the practitioner in the setting of his or her practice. If the practice guidelines generated by the consensus conference are successful in this regard, they will provide protection to the practitioner against unjustified malpractice actions.

**Informed Consent: a Potential Mitigator of Liability Risk?**

The purpose of informed consent is to preserve the autonomy of the patient. This is accomplished by educating the patient to the risks and benefits of the range of procedures and therapies that could be appropriate in view of the patient’s problems. The process by which informed consent is achieved should be based on an interaction between patient and physician in the course of which the patient is given sufficient information to make a choice. The physician is obliged to become persuaded that the patient has sufficient information and understanding to make an “informed” choice. In the course of this process, the patient forms certain opinions about the physician;
among the more important of these opinions are those that go to the issue of trust and the presence or absence of a sincere interest in the patient. Many a malpractice case has its seeds in the impression made by the physician on the patient during this encounter, an encounter that is more than likely fairly routine for the physician but is far from routine for the patient. Should the physician fail this test, and an adverse outcome follows, most experts would agree that the likelihood of litigation is much higher for any given set of facts. “Emotional malpractice” is real, is common, and is a powerful stimulus to litigation.

Informed Consent and the Physician-Patient Relationship: Alternatively, the process of achieving informed consent (or informed refusal that may be equally important) can be an important opportunity to enhance the physician-patient relationship, which seems to have taken a bad beating over the last decade. An attitude of interest and caring on the part of the physician can make a giant contribution to patient understanding; should an outcome be less than expected. Further, a meaningful discussion will permit the physician to understand and deal with specific apprehensions, and a brief notation of the patient’s concerns and the doctor’s responses to them can be important evidence in any subsequent malpractice action should the adequacy of informed consent come into question. This is particularly true in the face of the “antithrombotic dilemma,” ie, the fact that the patient requiring ATT is in a unique situation, in that he or she is at significant risk both from the therapy itself and from the disease.

The Medicolegal Dilemma of ATT: If we address the ways in which the product of a consensus conference may best produce the desired enhancement of the quality of medical practice and reduce the threat of legal liability, each alternative approach at every step in the continuum of ATT needs to be considered in these terms. It may be possible to utilize informed consent as both an educational tool with the patient and a defensive measure with regard to legal liability risk. The process of informed consent can be, and perhaps should be, used to convey the fact that the patient being considered for ATT will from that moment never be in an entirely safe condition with regard to such serious complications as stroke. While this is conveyed to some extent by the listing of the potential complications of receiving and not receiving ATT on the informed consent form, the manner in which this information is imparted often fails to characterize the fact that the patient will be, often for the remainder of his or her life, at risk for serious complications, with or without ATT. The purpose of this emphasis is not to protect the physician at the expense of badly frightening the patient, but to provide to the patient what is in fact required by the legal requirements of informed consent, that is, an understanding of all material information about the therapy that the individual may choose to accept and the alternatives to that therapy. Such a process should permit the patient to appreciate that he or she from that moment on is at risk, however small, of a potentially disastrous occurrence as a result of either his or her disease or of the therapy used to protect the patient from that disease.

Informed Consent in the “Treatment” of the ATT

Dilemma: One approach to the dilemma of ATT might be to attack the dilemma head on, and elicit the patient’s full commitment of cooperation to deal with the potential problems, thus making patient and physician a team working to reduce patient risk. This may be possible by confronting the patient with the dilemma at the outset, making certain that the patient understands the problem, and immediately thereafter addressing the strategy that the physician has developed for them to best reduce risk by working together. The discussion thereafter may then focus on the importance of adherence, the critical importance of maintaining ranges of therapeutic effects when necessary, dietary advice, and early response by the patient to particular new symptoms and/or signs, etc. And perhaps as importantly, the elements of this discussion should be documented carefully in the patient’s medical record and should clearly document those patient responses that indicate understanding of both the risks, the fact that those risks exist both with and without the therapy and thus create the dilemma, and the fact that the patient understands the importance and relevance of those factors that may impact negatively on the patient.

Such an approach to informed consent is appropriate because anything short of it fails to adequately set forth the patient’s reality, with and without therapy. Furthermore, it forms a solid basis for the patient’s cooperative participation in his or her care. And finally, it may be the single most important aspect of the physician-patient relationship to be introduced to the jury should a malpractice action be brought.

Strength in Unanimity: When justified by scientific fact, however, unanimity is most desirable both from a medical practice basis and as a means of minimizing the risk of legal liability. There are a number of areas in ATT that may be amenable to the potential benefits of unanimity, but one should suffice as an example. Anticoagulant clinics are not employed universally for the follow-up of patients receiving ATT, and there are good reasons put forward by both those who use and favor the use of such clinics and by those who use and favor the use of alternative approaches. If there are credible data to support one approach over the other in terms of better control and fewer side effects, there is little doubt that practitioners who use the “less effective” system are at higher risk of legal liability. In the absence of credible evidence to support equivalency of a method in question, a defendant may be seen by a jury as not having exercised a level of diligence demanded by the risk (especially of stroke) to the patient, and should stroke supervene, it will be very difficult to mount a defense sufficient to overcome this charge. While there may be good, important, and practical reasons for the less desirable approach, including the fact that it may not be less desirable but simply has not been adequately evaluated, in the face of the stroke victim staring into the jury, these practical reasons are likely to fall on deaf ears.
REFERENCES

1 Peabody FW. The care of the patient. JAMA 1927; 88:877–882
2 Instructions for preparing structured abstracts. JAMA 1995; 273:28–30
3 Olson CM. Consensus statements: applying structure. JAMA 1995; 273:72–73
4 Guidelines for cardiopulmonary resuscitation and emergency cardiac care. JAMA 1992; 268:1172–1176
6 Hillman BJ. The consensus of committees [editorial]. Invest Radiol 1992; 27:1