

DOCTORS vs. LAWYERS: THE PERILS OF PERFECTIONISM

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Sandy Johnson's keynote lecture is, in common with all of her work, subtly appreciative of the complexities of the interactions between the law's regulatory ambitions and the clinical practice in medicine—and especially the ways in which unexpected and unwanted results can follow from the application of seemingly unobjectionable and even noble ideals.¹ She urges us, in particular, to give respectful attention to the complaints of physicians in the trenches of medical practice, even when they seem self-protective, exaggerated, or even without any obvious merit on their face.

In my brief reflection on her lecture, I want to begin with a personal experience at the early moments of my involvement in issues of law and medicine when I had not yet learned the lesson that Sandy teaches us. In the early 1970s, I was just starting in the academy (with my newly minted law degree and a few years in government practice) and was invited to participate in a panel discussion before a group of doctors. New judicial decisions had recently emerged that appeared to intensify physicians' responsibility to obtain truly informed consent from patients, and many physicians saw these decisions as a harbinger of things to come—the early steps of the law's intrusion into their previously sacrosanct domain. My goal, as I saw it, in this panel discussion was to calm the physicians' concerns and, in particular, to lead them to see what I had distilled from my (very recently concluded) legal education—that is, to view legal interventions as a normal part of everyday life, not as a fearful and erratic behemoth, a raging bull in a very vulnerable china shop.

To accomplish this calming purpose, I offered the physicians a homely analogy. I asked for a show of hands about how many in the audience planned to drive home that evening in their own automobile. Most, of course, raised their hands. I then asked them to think about how certain they were, as they

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1. Sandra H. Johnson, Professor Emerita of Law & Health Care Ethics at Saint Louis University School of Law, Keynote Address at the Saint Louis University School of Law Richard J. Childress Memorial Lecture: Still Crazy After All These Years: Is Regulating Physician Practice an Exercise in Futility? (Oct. 17, 2008), in Sandra H. Johnson, *Regulating Physician Behavior: Taking Doctors' "Bad Law" Claims Seriously*, 53 ST. LOUIS U. L.J. 973 (2009).

were driving, that they couldn't be sued and perhaps even found liable for an unintended accident on the way home. I reminded them that the law did more than punish purposeful wrongdoing while driving, but also imposed liability for negligence, for momentary lapses of attention that led to someone's injury. I then triumphantly concluded, with what I saw as the inexorable logic of my analogy, that this prospect of liability for negligent use of their automobile didn't obstruct the physicians' willingness to drive home that night, and that, by parity of reasoning, they should be cautious but they shouldn't be discouraged or deterred from the ordinary practice of what they considered good medicine by the possibility that someone might sue them, and perhaps, even succeed in holding them liable for negligence.

No one in my audience was convinced. Physicians on the panel politely but firmly told me that my analogy was simply false—that their conduct in driving their automobiles was in an entirely different category from their conduct in practicing medicine, and that they were willing to run risks of legal liability in driving that were unthinkable and intolerable in the practice of medicine. After all, one of the physicians said to me, "People's lives are in our hands, their very survival depends on us as we practice medicine." But, I said, this is equally true when they are driving their cars—these two ton monsters could instantly inflict death on others in the blink of an eye. "It may look the same to you," this physician rejoined, "but that's only because you're not a doctor. The fact is that it's fundamentally different."

It took me some time and considerable reflection to understand that I was wrong and this physician was right—that is, for me to reach the conclusion that Sandy offers to us; to take seriously physicians' complaints about the law's intrusion into their enterprise even when (and perhaps especially when) these complaints don't fit lawyers' customary intellectual frameworks.² In this essay I want to elaborate on the difference that I've come to appreciate between physicians' driving their automobiles and practicing their profession of medicine. This difference illuminates a radical and important implication of Sandy's lecture.

I have come to see two ways that driving an automobile and practicing medicine are fundamentally different. The first is in the relationship between driver and potential victim on the one hand, and between doctor and potentially harmed patient on the other. The patient comes to the doctor with a problem—often a very worrisome and maybe even directly life-threatening problem. In his discomfort, his pain, his anxiety, the patient turns to the doctor for relief, for cure, for some possibly magical intervention that can restore him to his ordinary life. The relationship between automobile driver and potential victim is quite different. The difference is not because many of the potential victims

2. Johnson, *supra* note 1, at 975–80.

are unknown to the driver beforehand, so that there is no personal relationship of trust and reliance between them. Some of the potential victims of my driving are passengers in my car; they are already well-known to me, and, if they are my children or grandchildren, they may be as dependent on me for protection and comfort as any patient is toward his physician.

But in these intense dependency relationships with automobile drivers, there is a crucial difference from the physician-patient relationship. Life may be at stake in what I'll call "automobile relationships," but we don't usually think that way about them when we climb into the car to go to the grocery store or to the toy store. Physician-patient relationships, by contrast, always carry some sense of heightened vulnerability on the patient's side—some worry that needs to be appeased, some pre-existing threat to well-being. In the automobile relationship, there may be good reason for anxiety as you step into the car; indeed, from a statistical perspective, you are much more likely to be injured in the course of driving to the grocery store than when seeing a doctor in her office or in the hospital. But in our day-to-day lives, using an automobile is so common that most of us put the risks and anxieties well out of mind. In the physician-patient relationship, risks and anxieties are much more toward the front of our awareness.

This psychological reality leads to a second fundamental difference between the automobile and the physician-patient relationships. It is not just that passengers feel different—less vulnerable, less anxious—from the way patients think about themselves; it is also that the automobile driver typically feels different about her relationship with the passenger than the physician feels about her relationship with the patient. The physician sees the worry, sees the anxiety from his patients in ways that the automobile driver does not, and the physician sees a special obligation to allay those concerns—to end the pain, to cure the disease, to restore care-free life. No automobile driver wants to injure others (unless he is a suicide bomber intent on inflicting injury), but the physician wants to do much more than avoid injury. The injunction to do no harm is only the first precept of medicine—but for most physicians, this is not the most important goal, even though the tradition ranks it first. The most important goal for physicians is to help, to alleviate suffering. Thus, when the legal system challenges the automobile driver's conduct, a finding of liability doesn't undermine the essence of the typical driver's self-definition. But the legal challenge to the physician's self-definition as a caretaker—or, indeed, any challenge by a patient or a third party in response to some unwanted event—is a much more profound and much more potentially shattering blow to the physician's very conception of herself.³

3. Cf. Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851, 1851 (1994) (discussing the effects of medical error on physician behavior, and finding that the medical culture of physician infallibility causes many physicians to view error "as a failure of character").

There is some considerable nobility in the physician's aspiration to cure and to comfort. This noble aspiration is also the mirror image of the typical patient's wish in his encounter with his physician. But there is also something grandiose and excessive in this expectation on both the physician's and the patient's side of the relationship. The fact is that this expectation, this aspiration, is doomed to fail at some time for all patients and for virtually all physicians. It necessarily fails for patients because death must come to each of them sometime. Many physicians are able to avoid contact with patients who die; but virtually all physicians, at some time in their practice, are involved with patients whom they cannot cure, even if the patients' diseases are not life-threatening. Everyone—whether patient or physician—knows the inevitability of failure in the medical enterprise. But this is an exceedingly uncomfortable reality. I'm willing to bet that there is no patient, just as there is no physician, who enters into the physician-patient relationship believing at the outset that it will inevitably fail in its shared goal of cure and comfort. Failure, that is, is a defeated expectation on both sides.⁴

And failure is precisely the circumstance where the law most forcefully steps into the relationship between doctor and patient. For the patient who passionately, even desperately, hoped for success—cure or comfort from his physician—a malpractice suit is a tempting route to vent angry disappointment. Relatively few patients take this route even when there are reasonable grounds to believe that their physicians committed some negligent act.⁵ But for those patients who do sue, this very act conveys not only anger and disappointment but also a sense of betrayal. Other tort suits for negligent injuries—including

4. In many circumstances, of course, the physician might conclude that cure or comfort is impossible and refuse to accept the patient as such, and thus refuse to enter into a physician-patient relationship. But I am restricting my attention to cases where both physician and patient are willing to engage one another in a therapeutic relationship and where the results are disappointing. This is when the law typically steps into the relationship. There are some outlier cases where the law is invoked because the physician refuses to provide care and to enter into the therapeutic relationship that the prospective patient requests; but those cases are unusual and are outside my concern here.

5. See PAUL C. WEILER, *MEDICAL MALPRACTICE ON TRIAL* 12–14 (1991) (“Two major studies of medical malpractice claims have documented rates of patient injury caused by negligent treatment that are far in excess of tort claims made by the patients, let alone claims eventually paid.” (citing CAL. MED. ASS’N & CAL. HOSP. ASS’N, *REPORT ON THE MEDICAL INSURANCE FEASIBILITY STUDY* (1977); HARVARD MED. PRACTICE STUDY GROUP, *PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK* (1990) [hereinafter *Harvard Study*])); David M. Studdert et al., *Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado*, 33 *IND. L. REV.* 1643, 1667 (2000) (confirming the results of the Harvard Study, which found that medical malpractice claims “lag well behind the incidence of negligent injury, and the two are seldom connected in the current system”).

automobile accidents in the misleading example that I first offered—are often motivated by pain and anger; but in those cases, the plaintiff typically does not feel the sense of betrayal that is the common underpinning of a medical malpractice suit.

And here we come to the nub of the problem. The physician who is the target of a malpractice suit does not simply know that the litigating patient feels a special edge of bitterness, of disappointment, and of betrayal. The typical physician, as I see it, also feels in some part of her own mind that her failure to cure and comfort the patient was indeed inconsistent with the very ethos of medicine, with the physician's role definition as healer.

The law excuses medical failures that were not caused by negligence.⁶ But it is a rare physician who excuses herself on this ground. Accidents may happen, and in many circumstances, they may be impossible to avoid. But the ethos of medicine does not admit that accidents may happen.⁷ The stakes are so high, the demand for perfection is so intense among physicians that, notwithstanding the law's forgiving exemptions, physicians in effect apply strict liability to themselves.⁸

This, I believe, is the fundamental reason that malpractice suits—the very fact of being sued, regardless of the ultimate outcome—are so devastating to so many physicians. The physicians are in the grip of their own internal demand for perfection; they are intolerant of anything less than a successful outcome for their patients. This is an unrealistic, impossible demand; but this is what a “good physician” demands of herself. A malpractice lawsuit in itself presses to the forefront of the physician's mind the fact that she has failed to live up to her own expectations, to her socially prescribed role of the magical healer.⁹ The fact that the malpractice suit is unlikely to succeed, the fact that the law does not demand perfection but forgives “reasonable” or “unavoidable” mistakes is no comfort to the typical, responsible physician.¹⁰

Let me give a specific case illustration of this phenomenon. One month before Sandy Johnson's lecture, as I was beginning to prepare my remarks for

6. See, e.g., *Brook v. St. John's Hickey Mem'l Hosp.*, 380 N.E. 2d 72, 76 (Ind. 1978) (clinical or therapeutic innovation); *Ouellette v. Subak*, 391 N.W.2d 810, 814–16 (Minn. 1986) (honest error in judgment); see also Johnson, *supra* note 1, at 1014–18.

7. See Leape, *supra* note 3, at 1851 (“[I]n the culture of medical practice . . . [t]here is a powerful emphasis on perfection both in diagnosis and treatment. In everyday hospital practice, the message is equally clear: mistakes are unacceptable.”).

8. Cf. *id.* at 1851–52 (“Physicians are expected to function without error, an expectation that physicians translate into the need to be infallible. . . . This kind of thinking lies behind a common reaction by physicians: ‘How can there be an error without negligence?’”).

9. See generally *id.* (suggesting that physicians view error, as is implicated in a malpractice suit, as a “failure of character”).

10. See WEILER, *supra* note 5, at 25 (finding that injured patients are successful in less than half of their tort claims).

the occasion and wondering about how I could convey this mismatch between the law's conception of forgiveness in malpractice litigation and the typical physician's disbelief in this forgiveness, I read an account of a physician-patient interaction in the *New York Times Magazine* which captured exactly what I had in mind. The article is by Dr. Lisa Sanders, who regularly writes for the *Times Magazine*, and is entitled, *Diagnosis: The Strep Throat That Wasn't*.¹¹

The article begins with a seventeen-year-old boy in the pediatric intensive care unit of a children's hospital in St. Louis.¹² "[T]he boy had been well until six days earlier, when he awoke with a fever and sore throat"; the next day he saw his family doctor, who diagnosed strep throat and prescribed a five-day course of azithromycin.¹³ The doctor did not do a strep test "because the diagnosis seemed obvious."¹⁴ Notwithstanding the antibiotic, the boy's symptoms—fever, swelling in his neck, considerable pain—intensified and his parents took him to the hospital.¹⁵

During the next three days, the boy's condition continued to deteriorate, and the hospital physicians desperately tried one test after another to diagnose his illness but could identify nothing.¹⁶ Finally, one physician noticed a bacteria in the blood cultures that revealed the existence of a rare condition known as Lemierre's disease.¹⁷ This disease was responsive to penicillin but not to other antibiotics, including azithromycin; because penicillin had been the treatment of choice for nearly all sore throats during the 1960s and 1970s, this already rare disease had been virtually wiped out.¹⁸ But because of "more cautious use of antibiotics" in medical culture today and the development of new drugs that replaced penicillin for routine treatment of sore throats, Lemierre's disease had begun to reappear, though still only rarely.¹⁹ The family doctor, of course, missed this diagnosis. But it took the intensive care team at the St. Louis hospital three days to come upon it; and according to Dr. Sanders's account, even these physicians almost overlooked the unusual bacteria in the patient's blood culture.²⁰

Sadly, however, the definitive diagnosis came too late. The patient died three weeks later in the ICU; during the nine days from onset of the illness to

11. Lisa Sanders, *Diagnosis: The Strep Throat That Wasn't*, N.Y. TIMES MAG., Sept. 14, 2008, at 13.

12. *Id.*

13. *Id.*

14. *Id.*

15. *Id.*

16. Sanders, *supra* note 11, at 14.

17. *Id.*

18. *Id.*

19. *Id.*

20. *Id.* at 13–14.

the correct diagnosis, the young man's lung capacity had been virtually destroyed.²¹ By that time, no conceivable treatment could reverse the fatal course of this rare disease.

It is clear from Dr. Sanders's account that none of the physicians involved—from the family physician to the treatment team in the hospital—had been negligent in any way. The patient had a rare disease that had virtually disappeared over thirty years ago, and it took a team of specialists some three days of urgent searching after the patient's hospitalization to identify it. But listen to the interviews Dr. Sanders conducted with the young man's mother and family physician:

When the boy's mother told the doctor back home that her son had died, he cried like a baby, she told me. "I have never lost a patient—like this—completely unexpectedly," the doctor said recently, his voice wavering as he recalled that day. "Never lost one because I missed the diagnosis." He had never even heard of Lemierre's disease before this boy died from it, but he is determined never to miss the diagnosis again. He has changed his practice: now everyone with suspected strep will have a throat culture to check for both strep and Lemierre's. "Maybe that's overkill, and I'll probably end up treating too many of my patients with antibiotics," he added thoughtfully. "But I don't ever want to lose a patient like this again."²²

This is, of course, a tragic story. The family physician's compassion for the young man's death and his mother's loss is palpable. And it would have been heartless, cruel beyond words, if the family physician had justified his own behavior when he spoke to the mother. But I suspect from the tone of Dr. Sanders's account that this physician did not entirely believe that his conduct was justified. I sense some element of self-blame in his "crying like a baby" and in the radical way he resolved to alter his practice to ensure that he, at least, would never miss this rare disease again. By his own account, he overreacted—as he put it himself, he engaged in "overkill" to make sure that he would never "lose a patient like this again."

The devastation that this physician felt and his active resolve to make sure that no patient of his would ever suffer this harm again are in the noblest tradition of medical practice. This kind of demanding perfectionism, this refusal to pass any blame away from himself and onto others, is exactly what society wants, exactly what we prospective patients want, because we know that someday we might long in desperation for a physician's healing touch.

There is, however, a problem that arises from this perfectionism. The problem comes because perfectionism breeds two different (though directly related) responses among physicians—and both of these responses compound

21. Sanders, *supra* note 11, at 13–14.

22. *Id.*

the difficulties in the relationship between legal regulation and medical practice.

The first response to perfectionism is the heroic self-image of the individual physician acting alone.²³ This self-image is reflected in the special status of the attending physician who expects and typically obtains deference from other health care providers. This special status is at odds with the contemporary promotion of a “team” conception in the delivery of health care. The idea of teamwork among health care professionals, though much recommended, has had great difficulty in securing traction in actual practice because of the heroic insistence that the attending physician must possess complete and unquestioned control of medical treatment.

The “team” idea has also been put forward as the preferred way to depict the relationship between physician and patient.²⁴ This collaborative ideal appears clearly preferable in principle both to the old conception of physician authoritarianism and to the unrealistic prescription of patient control.²⁵ But this “teamwork” ideal also has had great difficulty in practical implementation, in spite of its regular incantation as an ideal.²⁶

The unrealistic, but powerful demand for medical perfectionism is, as I see it, the fundamental underlying reason that the heroic ideal of the individual physician maintains its grip, notwithstanding the strong reasons supporting the conception of physicians sharing authority with both the health care “team” and the patient “consumer.” As my late colleague Jay Katz explained in his classic account of *The Silent World of Doctor and Patient*, the principal barrier within the medical profession against accepting the obligation to fully inform patients is physicians’ unwillingness to admit their uncertainties about treatment efficacy to their patients.²⁷ Physicians’ reluctance is implicitly reinforced by patients’ unwillingness to acknowledge that their physicians are indeed uncertain about treatment efficacy.²⁸ Both physicians and patients cling to the impossible goal of perfection; and if physicians acknowledge their need or even their willingness to collaborate with anyone (whether other physicians, other health care personnel, or the patient), this increases the likelihood that

23. Cf. Leape, *supra* note 3, at 1851–52 (“[A] fundamental goal of medical education [is] developing the physician’s sense of responsibility for the patient. If you are responsible for everything that happens to the patient, it follows that you are responsible for any errors that occur. While the logic may be sound, the conclusion is absurd, because physicians do not have the power to control all aspects of patient care.”).

24. See Ezekiel J. Emanuel & Linda L. Emanuel, *Four Models of the Physician-Patient Relationship*, 267 JAMA 16, 2225 (1992).

25. *Id.* at 2225–26.

26. *Id.* at 2226.

27. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 165–206 (1984).

28. *Id.* at 101.

uncertainties about treatment outcomes will become visible.²⁹ The belief in the possibility of medical perfectionism can only be sustained through a concerted effort at denial—as Jay Katz put it, through silence.³⁰ The regime of physician authoritarianism—the unquestioned dominance in treatment decisionmaking by the individual attending physician—maintains its psychological grip in order to protect the myth of perfectionism. Any challenge to the treatment decisions made by the individual physician—whether that challenge comes from other health care professionals, from patients, or from lawyers, judges and juries in malpractice cases—is intolerable because this challenge in itself exposes the fragility of the perfectionist ideal in medical practice.

There is a sad paradox here. In actual practice, the most reliable way to approach the ideal of the perfect treatment decision is through intense collaboration among health care professionals and with patients. A “perfect treatment decision” must be based on two elements: the most up-to-date scientific knowledge, which in its burgeoning complexity cannot possibly be mastered by individual physicians acting on their own; and the patient’s values in choosing among various treatment options with different mixes of benefits and risks, which cannot possibly be known by individual physicians unless they openly and honestly collaborate with their patients. But these means toward practicably obtainable perfection in medical decisionmaking are regularly ignored in order to preserve the myth that “perfect perfection”—like “perfect love”—admits no doubts and, among other things, means never having to say “I’m sorry.”

The heroic image of the individual, authoritarian physician is not, however, the only way that the myth of medical perfectionism distorts medical practice. There is another response to this myth which has become increasingly prevalent in the practice of medicine: flight from accepting responsibility for patient care by physicians who sense the impossibility of this perfectionist goal. This response has become especially common in the contemporary era of medical specialization. The specialist looks at the patient only through the narrowed lens of his special expertise and sees only specific organs or bodily functions, but not the “whole patient.” From the perspective of specialized medicine, the “whole patient” is somebody else’s responsibility—except that in our world of specialization, the “whole patient” frequently turns out to be no one’s responsibility.

This retreat may seem to contradict the heroic self-image of the physician as *conquistador*, as the custodian of life and death. But the systemically pervasive denial of responsibility for the whole patient is, psychologically speaking, the mirror image of the heroic physician. Both responses—excessively assumed and excessively denied responsibility—arise from the

29. *Id.* at 195.

30. *Id.*

extravagant, unattainable demands of medical perfectionism. The heroic physician insists on more responsibility than he could ever conceivably achieve—that is, on exclusive responsibility that he shares with no one, thus, pushing himself out onto a tight rope with no net, a too-taut rope that must inevitably snap at some time. The narrow-visioned specialist also sees the excessive demands of perfectionism, but he recoils from it and pulls away from realistic possibilities of serving his patient's holistic welfare if only he would accept a fuller measure of responsibility.

Wholehearted collaboration—actively shared responsibility for treatment decisions among health care providers and patients—is the sensible middle ground between these broadly portrayed extremes of unquestioned physician authority or complete denial of responsibility. But the underlying, though unacknowledged, ethos of medical perfectionism pushes this reasonable middle ground out of sight and thus makes it difficult—if not impossible—to strike this middle ground in practice.

We can see this unfortunate dynamic at work in the specific context of medical pain management—an area that Sandy Johnson discussed in her lecture and in which her contributions to improved medical practice are substantial. The physician who is hostile to any external regulation of his pain prescribing practices—even resisting any inquiry into his conduct, as Sandy notes—has many realistic concerns.³¹ But beneath the fear of legal sanctions or even of legal expenses, the engine driving this hostility among physicians is the regulator's refusal to give automatic and complete deference to the physicians' "medical judgment."³² When this deference is refused, the fragility of the myth of physician perfectionism is exposed; in the unforgiving light of this exposure, the reflexive response of many physicians is to flee from accepting any treatment responsibility. This physician, as Sandy observes, retreats behind a narrowly conservative pain control practice that is well within the restrictive constraints of "safe harbors," or he withdraws from the enterprise altogether and limits his prescriptions to clearly ineffective dosages of Tylenol.³³ In this flip-flop between physicians' insistence on total, unreviewable responsibility and abdication of any responsibility for pain management, the sensible middle ground of collaborative pain control treatment tends to get lost.

There are, to be sure, recent trends in medical practice that are pressing for this middle ground. During the last decade, pain and palliative care consultative services have been established through which specialists are on

31. See Johnson, *supra* note 1, at 1018–22.

32. See *id.* at 1001–03.

33. *Id.* at 1018–22.

call to assist front-line physicians in responding to difficult cases.³⁴ The availability of these services is still uneven: some seventy percent of large, usually university-affiliated, tertiary care hospitals have established such consultative services, while fewer than half of smaller community-based hospitals have done so.³⁵ Moreover, even in hospital settings where such services exist, the pain specialists have had to exercise considerable diplomatic efforts: first, to get consultative referrals from physicians who are reluctant to share any responsibility; and second, to ensure that the referring physicians remain involved with the pain patient by working with the consultative service rather than simply “dumping” pain management responsibility on it.³⁶ As I see it, the difficulty experienced by specialist pain consultants in navigating between these extremes is fueled by the ethos of medical perfectionism pressing individual physicians to choose between either complete responsibility or zero responsibility for their patients’ pain management.

Front-line physicians’ reluctance to enlist consultative services and, in response to fears of legal liability, eagerness to retreat from providing pain treatment have the ironic consequence of physicians’ turning away from their best possible legal defense. If a physician encounters a patient with intractable pain, for whom the narrow pathway of the “safe harbor” for prescribing drug dosages is insufficient, the physician can venture beyond this guaranteed safety net, and yet protect himself against subsequent legal liability, by sharing his treatment decisions with the pain specialists available through consultative services. The risk of liability, either from professional disciplinary boards or from criminal law proceedings, typically arises when a physician acts entirely on his own. Support from pain specialists is typically invoked retrospectively by the challenged physician in legal proceedings. If this physician eschews the heroic self-image of the individual practitioner and enlists the collaboration of pain specialists in prospectively making treatment decisions, the likelihood of subsequent legal challenge would diminish virtually to the vanishing point. The very fact that the individual physician shared his decisionmaking process with the specialists would itself refute the suspicion that some disreputable concealment occurred in the isolated setting of the physician’s individual relationship with the patient. Put another way, in a collaborative case that is subsequently subject to legal challenge, the defendant’s dock would be very

34. Benjamin Goldsmith et al., *Variability in Access to Hospital Palliative Care in the United States*, 11 J. PALLIATIVE MED. 1094, 1099 (2008).

35. *Id.* at 1097–98. *See also New Study in Journal of Palliative Medicine Finds Palliative Care Access Varies Widely in the US*, MED. NEWS TODAY, Oct. 3, 2008, <http://www.medicalnewstoday.com/articles/124164.php> (article adapted from the *Journal of Palliative Medicine*’s press release).

36. *See* Paul K.J. Han & Robert M. Arnold, *Palliative Care Services, Patient Abandonment, and the Scope of Physicians’ Responsibilities in End-of-Life Care*, 8 J. PALLIATIVE MED. 1238, 1243–44 (2005).

crowded indeed, with so many well-credentialed “co-conspirators,” that no sensible external regulator would ever conclude that any legal sanction would or should be imposed.

But not all regulators are sensible. In this prescription for collaborative decisionmaking in pain management, there is no absolute guarantee against some rogue regulator behaving unreasonably. This possibility would not satisfy a physician obsessively insistent that his treatment decisions would never be second-guessed by anyone. My recommendation, for what I have called the “sensible middle ground” of collaborative decisionmaking in pain management or in medical treatment generally, may simply indicate that I have not yet learned the lesson that was first pressed upon me by physicians in the 1970s—the lesson that what appear to me as reasonable, manageable risks of legal liability are experienced by physicians as intolerable risks.

But if I am correct—that, to some degree at least, this intolerance for risk among physicians is impelled by their unrealistic demands on themselves for medical perfectionism—then in order to serve the best interests of physicians and their patients, the challenge for lawyers and physicians alike is to sort out the wholesome from the harmful impacts of the perfectionist demand. This is not easy to accomplish. It will be impossible to accomplish, however, if my view of the significance of medical perfectionism is perceived as a criticism of physicians. I do not mean to criticize, but rather to describe an underlying attitude which has important benefits, as well as some significant unwanted side effects, for both patients and their physicians. From this perspective, it makes no sense—it would, indeed, bring about considerable harm—to insist that the impulse toward perfectionism should disappear from individual medical practice or from the ethos of the medical profession. From this perspective, medical perfectionism resembles just about everything in the practice of medicine—a powerful force for good with some unfortunate potential for harm. In this, as in everything in medicine, the best first step for diminishing the harmful potential is to openly and explicitly acknowledge its possibility.