Beyond the Standard of Care

A New Model to Judge Medical Negligence

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Abstract

Background The term “standard of care” has been used in law and medicine to determine whether medical care is negligent. However, the precise meaning of this concept is often unclear for both medical and legal professionals.

Questions/purposes Our purposes are to (1) examine the limitations of using standard of care as a measure of negligence, (2) propose the use of the legal concepts of justification and excuse in developing a new model of

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examining medical conduct, and (3) outline the framework of this model.

Methods We applied the principles of tort liability set forth in the clinical and legal literature to describe the difficulty in applying standard of care in medical negligence cases. Using the concepts of justification and excuse, we propose a judicial model that may promote fair and just jury verdicts in medical negligence cases.

Results Contrary to conventional understanding, medical negligence is not simply nonconformity to norms. Two additional concepts of legal liability, ie, justification and excuse, must also be considered to properly judge medical conduct. Medical conduct is justified when the benefits outweigh the risks; the law sanctions the conduct and encourages future conduct under similar circumstances. Excuse, on the other hand, relieves a doctor of legal liability under specific circumstances even though his/her conduct was not justified.

Conclusions Standard of care is an inaccurate measure of medical negligence because it is premised on the faulty notion of conformity to norms. An alternative judicial model to determine medical negligence would (1) eliminate standard of care in medical malpractice law, (2) reframe the court instruction to jurors, and (3) establish an ongoing consensus committee on orthopaedic principles of negligence.

Introduction

Medical liability lawsuits are civil actions designed to determine whether a doctor was professionally negligent and whether the negligence caused harm to the patient. Litigation determines whether losses suffered by a patient from a poor outcome should be shifted to the doctor in the

form of a verdict that compensates the patient. The goal of a medical negligence trial is to reach a fair and just decision on whether a patient's losses from a medical injury should be redistributed to the doctor. To achieve fairness in medical negligence lawsuits, clear and well-defined criteria for determining medically negligent conduct are essential.

The criteria familiar to most orthopaedic surgeons for acceptable professional conduct relates to complying with a standard of care. Yet, as a measure for determining medical negligence, the standard of care may serve as nothing more than a medium for opposing expert witnesses to express their competing medical opinions. Conventionally, the concept of standard of care is often interpreted as a reference to customary norms. Standard of care is based on the following syllogism (defined as a form of deductive reasoning consisting of a major premise, a minor premise, and a conclusion):

Major premise: I will not be held liable for malpractice if my professional conduct is reasonable, diligent, and prudent.

Minor premise: The professional conduct of the majority of orthopaedic surgeons is the measure of reasonableness, diligence, and prudence.

Conclusion: If I conduct myself in the same manner as the majority of orthopaedic surgeons, my professional conduct will be deemed reasonable, diligent, and prudent, and I will not be held liable for malpractice.

The weakness of the syllogism resides in the minor premise. The majority of orthopaedic surgeons in a given locality may or may not treat patients in a reasonable, diligent, and prudent manner. Similarly, surgeons who sometimes deviate from customary norms may not necessarily be unreasonable or careless. In fact, medical progress has often come from the practices of nonconforming doctors whose innovations derived from alternative ideas about the norms of medical practice.

The purposes of this article are to (1) examine the inherent limitations of using standard of care as a measure of negligence, (2) introduce the legal concepts of justification and excuse in judging medical conduct, and (3) propose specific elements of a new model by which the law could more accurately judge medical conduct and achieve fair, just, and accommodating outcomes.

Search Strategy and Criteria

We identified articles and texts that discuss variations in medical practice as these relate to medical negligence in the LexisNexis legal database. LexisNexis is a database used by law professionals to identify legal cases, law review articles, texts, and related writings. Of the resources

identified, we filtered selected works by using the keywords "fairness" and "utility." A similar search was made using general Internet search engines to include nonlegal writings that have addressed medical negligence. From a review of these sources, the material in this article was developed.

Limitations in Using Standard of Care to Judge Medical Conduct

Acceptable Medical Conduct

In the medical malpractice case of *Helling v Carey* [5], the Washington Supreme Court had to determine whether following a customary norm was the exclusive measure of acceptable medical conduct. The plaintiff in *Helling v Carey* was a 32-year-old woman who was not screened for glaucoma and subsequently became blind. According to the accepted standard of care, routine screening for glaucoma was not performed on patients younger than 40 years since the risk in that age group was only one in 25,000. In *Helling v Carey*, the plaintiff's attorney contended the customary practice was, in fact, unacceptable, and the defendant ophthalmologist was therefore negligent. The court agreed, quoting Justice Oliver Wendell Holmes: "What is usually done may be evidence of what ought to be done, but what ought to be done is fixed by a standard of reasonable prudence, whether it is usually complied with or not." Therefore, in *Helling v Carey*, despite the fact that the minor premise or common practice was adhered to by the defendant, the court concluded the defendant was negligent.

As *Helling v Carey* illustrated, the practical application of the standard of care as a measure of negligence is difficult, especially with a constantly changing knowledge base and best-practice recommendations. For example, if a single report of a new implant shows better results, is an orthopaedic surgeon compelled under the standard of care to start using that implant? Past experience would suggest early reports of great success are often followed by later failures, and one could easily argue the prudent surgeon should wait for incontrovertible evidence before changing current practice. If so, would prudent waiting for more data constitute the standard of care in using a new implant?

In her book *Overtreated* [1], author Shannon Brownlee addressed the work of scholar John Wennberg who in the year 2000 showed Medicare recipients living in areas with low per capita Medicare spending were healthier than their counterparts living in areas with high per capita Medicare spending. In fact, mortality rates were higher for patients living in areas with high per capita Medicare spending. Wennberg also found large geographic variations in the

rates of elective surgeries and commented: “Orthopedic surgeons have a number of procedures they can become familiar with—knee replacements, hip repair, back surgery. They sub-specialize in certain procedures that they become comfortable with, and then hunt for opportunities to do those procedures... They look for patients who fit the paradigm, the kind of case they specialize in. They get known for a particular procedure: this orthopedist is a knee guy; this one does backs... Because they are orthopedists, they ignore other possible remedies” [1]. Brownlee added her thoughts: “... Such remedies include telling a patient with back pain to go home and take some pain medication and wait, or try moderate exercise and stretching, which may work as well or better than surgery for most patients. When your only tool is a hammer, everything looks like a nail” [1].

What the above commentary suggests is that there are inherent conflicts of interest in medicine that may lead to the development of customary norms that are not in the best interests of the patient. For example, direct-to-consumer marketing encourages patients to demand certain medications or procedures. Orthopaedic surgeons may contribute to this demand by promoting new technologies to gain a competitive advantage in the orthopaedic marketplace. These realities suggest a need to redefine negligence in a way that does not rely on customary norms since conflicts of interest or even caprice may affect how doctors customarily conduct their practices.

The Concepts of Justification and Excuse

One approach to examining medical negligence is to consider two legal principles that can modulate legal liability, ie, justification and excuse [4]. There are important distinctions between justification and excuse, but differentiating them can still be difficult. As one legal scholar wrote, “Justifying and excusing claims bear different relationships to the rule of liability. To justify conduct is to say that in the future, conduct under similar circumstances will not be regarded as wrongful or illegal. Excusing conduct, however, leaves intact the imperative not to engage in the excused act” [4].

A medical management decision is said to be justified when the benefits of that decision outweigh the risks. To say a medical decision is justified means the law sanctions the decision and encourages future decisions under similar circumstances. Excuse, on the other hand, is a mechanism to relieve a doctor of legal liability even though the medical conduct was not justified. Excusable conduct is an exception that should not lead to legal liability even though it is not conduct that would be encouraged in the practice of medicine.

Justification is related to the risk-creating conduct of a doctor. Excuse relates to the predicament of the doctor. In other words, justification refers to “actions” and excuse focuses on the “actor.” Justification is a utilitarian concept, based on the weighing of risks. If the benefits outweigh the risks, then the conduct is said to be justified and is not negligent, even if the patient is injured. For example, it may be justified to administer intravenous antibiotics to a patient with an infection (benefits outweigh risks) even though the patient could experience a serious adverse reaction to the antibiotic. Society would want to encourage doctors to use antibiotics similarly in the future, notwithstanding the fact that some patients will be injured from the antibiotics.

Another illustrative case of justified medical conduct is that of a hypothetical 80-year-old woman with multiple medical problems who presents with a displaced hip fracture. While undergoing a hip hemiarthroplasty, the patient suffers a massive myocardial infarction and cannot be resuscitated. Was the orthopaedic surgeon’s decision to perform surgery justified, such that the patient’s estate should be denied compensation despite the fatal complication? Would the decision to operate be one that society wants to encourage in similar, future situations? If so, then the actions of the surgeon are justified; while the outcome was poor, expedient hip hemiarthroplasty in the elderly patient with a displaced fracture is more likely than not to be beneficial.

In contrast, excuse is not related to utilitarian reasoning; instead, excuse examines the unique predicament of the decision maker whose conduct is in question. For example, after a serious accident, a patient is treated by a trauma team. Timely intervention saves the patient’s life despite overwhelming odds. But the treating doctors fail to diagnose an undisplaced femoral neck fracture that subsequently becomes displaced, leading to avascular necrosis, pain, and an eventual hip arthroplasty. Timely diagnosis would have preserved the patient’s own hip. This scenario cannot be defended on the theory of justified conduct since imaging studies would have identified the femoral neck fracture. Instead, the trauma team should be excused from liability because of the peculiar circumstances attendant to the case. It is unreasonable to expect a medical team faced with the predicament of saving a life over a limb not to prioritize life over all other considerations.

Cordas v Peerless Transportation Company is a legal case illustrating the application of excuse to tort law (the civil law that governs medical negligence) [2]. When armed robbers pointed a gun at a taxi driver’s head, the driver jumped out of the cab, and the running cab struck pedestrians. The court considered the act of jumping out of the taxi unjustified; society does not want to encourage

such conduct. “In the view of the crowd of pedestrians nearby, the driver clearly took a risk that generated a net danger to human life. It was thus an unreasonable, excessive and unjustified risk” [4]. The negligence question in this case was not whether the benefits of leaving his cab outweighed the risks (which they surely did not) but rather, “What can we fairly expect a person to do when he has a gun pointed at him?” [4]. By excusing the taxi driver’s unjustified conduct, we are posing questions of fairness and justice based on the limitations of what we can fairly expect of individuals, given the circumstances and predicaments in which they find themselves. Applying the principles of *Cordas v Peerless Transportation Company* to medical negligence cases, there are times when, even though an orthopaedic surgeon’s conduct may not be justified, it may still be excused.

When to Excuse Medical Conduct

In diagnostic malpractice cases, the failure to make the proper diagnosis through a more detailed history, comprehensive physical examination, or additional diagnostic testing is almost always unjustified. The reason is, had the poor outcome from a missed diagnosis been considered by the doctor, the benefit to the patient resulting from a more complete diagnostic workup would most certainly outweigh the risk or loss to that patient. But we cannot fairly expect doctors to consider every diagnosis, no matter how remote or seemingly inconsistent with the patient’s signs or symptoms. To be legally actionable, the misdiagnosis must be negligent. Deciding when otherwise negligent conduct is excusable requires more abstract reasoning because, in contrast to justification, excuse is not based on a simple utilitarian calculation.

One of the more controversial issues in malpractice law is whether a surgical mistake can be excused. This is particularly compelling in cases involving new medical technologies. A typical example relates to minimally invasive gall bladder removal. In its introductory phases, there were frequent injuries to the common bile duct during the learning curve. If the general surgeon during the learning curve divided a patient’s common duct, should the surgeon’s conduct be excused?

Surely, the mistakes made during the introduction of new technologies rarely involve justification since the complications result from a lack of familiarity rather than the benefits outweighing the risks. It may be impossible to determine whether new technologies are justified until enough data are collected to determine whether the benefits outweigh the risks.

Several recent examples of this dilemma exist in orthopaedic surgery. There has been increasing interest in

the concept of treating open tibial shaft fractures using débridement, irrigation, and internal fixation with primary closure of the traumatic wounds [6]. An older generation of surgeons may argue traumatic wounds should never be closed primarily. Modern clinical practice may suggest orthopaedic surgeons can safely close wounds associated with open fractures when they believe it is appropriate [7]. Are these surgeons acting responsibly? Are their actions justified? What if a larger series in the future shows a higher nonunion rate related to infection; would their actions then be excusable in hindsight? The introduction and marketing appeal of metal-on-metal total hip bearings offers another instance of new technology in orthopaedic surgery [8]. The laboratory science and early clinical reports suggested improved longevity and wear patterns, and many surgeons adopted metal-on-metal bearings in young patients with THAs. This technology has now fallen out of favor due to adverse reactions and recalled products [3]. Should the surgeons who used this new technology, which was FDA approved, be held responsible in any way for the complications? Did the available literature justify the use of these new designs? Is it the surgeon’s responsibility to ensure the literature is not biased or otherwise unreliable? Should the early adopters of new technology be held to a higher standard of reasonable prudence, even if other surgeons in their community are not? The answers are not easy, and the concept of standard of care does not provide much guidance in these instances.

Excuse can arise in academic centers due to the relationship between the residents and the attending doctors. Can we fairly expect a resident to act independently by refusing to follow the attending doctor’s recommendation? Assume a hypothetical case in which an obese 13-year-old boy underwent a proximal tibial osteotomy for Blount’s disease. Because rigid fixation could not be obtained, a supplementary circular cast was used. During the first postoperative night, the patient began to complain of severe pain in his leg. The resident administered pain medication and split the cast into two planes. Four hours later, the patient was still complaining of severe pain. Distal pulses became difficult to palpate. The resident wanted to remove the cast altogether, but the attending instructed the resident to leave the cast alone and to administer a larger dose of pain medication. The patient continued to complain of severe pain, and later that day, compartment syndrome was diagnosed, with an eventual poor outcome. Should the resident’s conduct be excused since he was following the attending doctor’s orders? Was the resident legally responsible for acting on his concern about the patient’s condition, notwithstanding the instructions from the attending doctor? In this case, the concept of standard of care provides little guidance to judging conduct. Instead, we can view each actor’s conduct as excusable or not under the attendant circumstances.

A New Model for Defining Medical Negligence

In light of the practical difficulties in judging medical conduct, as illustrated in the above examples, we propose a model for determining medical negligence based on justification and excuse, described above. Such a model would include the following elements: (1) eliminating standard of care as the benchmark for measuring medical negligence, (2) reframing court instruction to jurors, and (3) establishing an ongoing consensus committee on orthopaedic principles of negligence.

Eliminate Standard of Care in Determining Medical Negligence

The concept of standard of care should be eliminated from the malpractice vocabulary for both procedural and substantive reasons. The procedural reasons pertain to common misconceptions about how jurors reach a verdict in medical negligence cases. One misconception is that jurors return a verdict of innocent or guilty in malpractice cases. Since malpractice is a part of civil law, rather than criminal law, jurors do not determine guilt versus innocence in a civil trial. In civil cases, it is a role of the jury to determine the facts or to decide which set of facts to believe. A jury verdict is an answer, or a series of answers, to questions. It is not uncommon in complex cases to ask the jury multiple questions.

In a medical negligence case, the jury is usually asked to answer the two-pronged question, "Do you find the defendant was negligent and the defendant's negligence proximately caused the plaintiff's injury?" If the jury returns a "yes" answer to this question, a further question may be "Did the plaintiff in any way contribute to his/her own injury?" This question relates to a legal concept called contributory negligence that may serve to mitigate the damages awarded. Importantly, the jury is never asked the question, "Did the defendant violate the prevailing standard of care, thereby proximately causing the plaintiff's injuries?"

The court does instruct the jury that a violation of the standard of care is a form of negligence, but that instruction does not alter the verdict form, which seeks the jury's answer to the question, "Was the defendant negligent?" Standard of care, which creates confusing issues on conformity to norms, should be eliminated as both a question to be asked of opposing experts and as a component of the court's instructions.

Expert witness would not be asked, "Did the defendant violate the standard of care?" Rather, they would be asked, "Do you have an opinion as to whether or not the defendant doctor was negligent?" The second question is more straightforward than the first, which introduces potentially

misleading issues of geography, experience, resources, and other variables. By asking an expert whether the defendant was negligent, the query is broad enough to account for whether the defendant was a first-year resident, lived in a rural community, or injured a patient when the injury was inherently unavoidable. Further, the negligence question avoids the implied sanction of conformity and the implied suggestion that nonconformity is a form of poor patient care.

Reframe the Court's Instruction to the Jury

It is a unique function of the American judicial system that judges are neutral and cannot express an opinion about the evidence. Instead, the judge decides what law applies to the case and instructs the jury about what law it needs to follow. The sole function of the jury is to make factual determinations and apply those factual determinations to the law as instructed. Most jury instructions today that relate to determining the standard of care in medical negligence cases derive from the 1898 legal case of *Pike v Honsinger* [10]. Applying the principles discussed in this article, it is time to reformulate jury instructions to avoid reliance on the faulty notion of conformity to norms. Instead, modified jury instructions could include the following content:

Ladies and gentlemen, you have heard all the evidence and the arguments in this case. The plaintiff claims the defendant was negligent and, as a result of that negligence, the plaintiff is entitled to monetary damages. This is a civil case and not a criminal case. Nothing about this trial requires you to reach a determination about whether the defendant is a good or bad doctor, intended to harm his/her patient, or was motivated by malice.

This trial is not about improving our healthcare system by finding for one party or another. Rather, it is litigation between private parties where your verdict is based solely on factual findings, which you will apply to the law as instructed, to reach a fair and just verdict.

Since the plaintiff is seeking damages from the defendant, if your verdict is for the plaintiff, it will have the impact of redistributing losses that the plaintiff claims to have suffered to the defendant. If your verdict is for the defendant, then the plaintiff will have to bear the burden of his/her losses. This is referred to as distributive justice. It is important for you to understand the plaintiff is not entitled to recover damages simply because he or she is unhappy with the treatment provided by his/her physician or surgeon and its outcome.

Under the law of this state, the redistribution of plaintiff's losses can only occur if the defendant physician/surgeon was negligent. In determining negligence, you should consider the risk-creating conduct of the defendant or the predicament of the defendant. By risk-creating conduct, the court is referring to whether or not the defendant's actions or inactions were justified. By justification, the court means was there reason for the defendant to believe his/her medical management was more likely to benefit the patient than harm the patient? The burden of proving the defendant's actions/inactions were not justified is on the patient.

Since medicine is complex, there are times when it is not easy for doctors to know with any certainty whether their decisions are more likely to benefit or harm the patient. If you find that to be the circumstances in this case, then the defendant has an obligation to inform the patient of all material uncertainties and alternative treatments. By material, the court means those uncertainties that impact a patient's medical treatment decision making. The burden of proving the defendant doctor failed to properly inform the patient is on the plaintiff.

In determining negligence, you are not limited to calculating whether the benefits outweighed the risks to the plaintiff in this case. You should also consider the predicament of the defendant doctor. This is known in law as excuse. An example of excuse would be an airplane crash where emergency room doctors are so overwhelmed with severely injured patients that they cannot provide the level or quality of care of normal circumstances. If the defendant doctor claims his/her conduct is to be excused, the burden of proof is on the plaintiff to establish the predicament of the defendant should not excuse him/her from liability.

The actual court instructions would be more expanded to include definitions of negligence and would address other areas such as judging the credibility of witnesses and understanding burden of proof. Nonetheless, reframing the instructions to include language such as that suggested above could orient the jury toward the principles of justification and excuse as methods for determining the presence or absence of medical negligence.

Establish an Ongoing Consensus Committee on Orthopaedic Principles of Negligence

One of the criticisms of standard of care set forth in this article is that it is a vague and amorphous concept, providing no meaningful guidelines to jurors and contributing

to jury confusion and even anarchy if the jurors have deep-seated biases against one party or the other. It would be productive in achieving just malpractice verdicts if there were a consensus committee in the orthopaedic community that established principles of quality and safety to assist the jury in reaching factual conclusions about the presence or absence of negligence. Since every medical case is different, these consensus standards would only serve as guidelines, but these guidelines would have the potential to focus the jury's attention on the factual decision that it needs to make. This would eliminate the frequent complaint from both plaintiffs and defendants that experts are only advocates and that many verdicts are the by-product of emotion rather than reason. There are several examples of these consensus standards that can be developed.

In diagnostic orthopaedic malpractice cases, one consensus principle might be: "In performing a differential diagnosis, when there is evidence of a potential time-sensitive poor outcome, the orthopaedic surgeon must rule out the most serious condition first." If there were agreement by the consensus committee that this was a principle of quality that helped define negligence, it would allow the jury to focus on the central factual issue of the presence or absence of a "potentially time-sensitive poor outcome."

Within the context of complications of surgery, another principal of quality might be: "Orthopaedic surgeons cannot guarantee the outcome of their surgery because certain unfortunate results are unavoidable. These unfortunate results are known as complications. Unfortunate results can also be the result of negligence. In determining whether an unfortunate result is unavoidable or negligent, it is useful to know whether the orthopaedic surgeon was aware of the potential complication before commencing surgery and took action to reduce the likelihood of its occurrence." Such a principle would focus the jury's attention on the relevant factual issues such as whether the surgeon was aware of potential complications and took any actions to reduce the potential harm to the patients from those complications.

These consensus principles could be used in two different contexts and serve at least two useful purposes. First, they could be used by experts in their testimony as uncontroverted principles to be applied to their opinion and the basis for their opinion. Second, the establishment of a consensus quality/negligence committee would serve to refine principles of quality in the face of a dynamic environment in which orthopaedic surgeons practice medicine.

These consensus principles also have utility for orthopaedic surgeons and jurors. Orthopaedic surgeons who make themselves aware of these principles are more likely to have better patient outcomes and fewer malpractice lawsuits. Jurors who are made aware of these consensus principles are more likely to return verdicts that are fair and

just because they would be grounded in definitions of negligence that are far more concrete than standard of care.

Validation of the Model

Peters [9] reported studies comparing panels of unbiased doctors' opinions on whether a medical malpractice lawsuit was frivolous or meritorious. The studies cited demonstrated a substantial difference between the medical panel conclusions and the jury verdicts, suggesting the current framework for determining negligence does not achieve just and fair results. To validate the proposed model, similar panels could be established and their findings compared and contrasted to a statistically large enough sample of mock trials. This could determine whether the proposed revisions to defining negligence would lead to more fair and just verdicts.

Discussion

Standard of care has been used in law and medicine to determine whether medical care is negligent. However, the precise meaning of this concept is often unclear for both medical and legal professionals. Our purposes were to (1) describe the inherent problems of using standard of care as a measure of negligence, (2) examine the role of justification and excuse in judging medical conduct, and (3) outline the framework of a new judicial model for determining medical malpractice with the goal of more fair, just, and accommodating outcomes.

The primary limitation of the present work is the difficulty in validating whether the proposed model will produce just legal decisions. Since no legislature or court has yet adopted the proposed model, its impact can only be measured through focus groups which, at best, simulate the presentation of cases in a courtroom environment. The rationale for this article is to establish alternative criteria for determining the legal standards by which judges and juries determine whether a doctor is negligent. This new model, if effective, will result in a less ambiguous measure of medical negligence with productive consequences for both physicians and patients.

The impetus for the proposed model is that the present method of determining medical negligence is flawed. The present system asks jurors with potentially no background in medicine to decide what must be acceptable medical conduct. Traditionally, jurors have had to make this decision by determining whether the doctor complied with or violated the standard of care. The criteria embodied in determining the standard of care are often confusing since the word standard implies a norm that is usually defined by

professional customs. In other civil liability cases, conformity to a norm can be easily determined by the jury. For example, jurors have an easier time deciding whether an automobile driver violated the norm of failing to halt at a stop sign. But in medical negligence cases, no clear norms exist that allow a jury to easily determine negligence. Not only is there an array of opinion in the medical community over what is acceptable, but the concept of standard of care may mislead jurors into thinking, if most doctors perform medicine in an acceptable manner, the outcomes will be good. This may prejudice patients whose care is unacceptable, notwithstanding the fact that the standard of care was followed. It may also prejudice nonconforming doctors who are practicing in an acceptable, even laudable, way by implying care that falls in the minority view is unacceptable. It would be much easier for a jury to determine whether medical care was acceptable under circumstances where the doctor had a substantial basis for believing the management plan was more likely to introduce a benefit to the patient rather than harm. It would also allow jurors to look beyond a mere risk-benefit calculation and ask what can be fairly expected from a doctor in a certain set of circumstances.

In essence, when the only criterion to determine medical negligence is a standard of care, it is a practical equivalent for a jury presented with no rational criteria at all. The foundation of malpractice law must be an understandable and practically applicable negligent or nonnegligent model. This article sets forth a meaningful framework for that basis.

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