Legal Aspects of Physician-Patient Communication

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Recent court decisions against physicians in malpractice suits are directing attention toward various components of the physician-patient communication process. An increasing number of states are taking the position that it is the physician's responsibility to provide information which is understood by the patient. In addition, those courts are placing the responsibility on the physician for the assessment of patient skills to assure comprehension and to provide the patient with sufficient information to enter into the decision-making process.

Analysis of legal aspects of physician-patient communication (patient education) has in the past been fairly restricted to the area of informed consent. Recent court decisions are directly influencing other components of that communication process. Those decisions often define the role of the physician in contrast with the traditional physician role as the omniscient authority figure in the patient-physician relationship. The courts are now saying that it is incumbent on the physician, or his extender, to provide the patient with sufficient information with which to make intelligent decisions about his condition and treatment.

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Medical Record Documentation

It has long been accepted that the medical record is extremely important. It contains the information the physician needs to monitor the patient's care; it is the means of conveying information to other providers concerning past management of the patient, and it may also be the only source of protection the physician has against charges of malpractice. The key to that protection lies in adequate documentation of all aspects of the physician-patient interaction. Inadequate documentation may be central to successful malpractice suits brought by the patient.

Until recently, the failure by physicians and hospitals to keep adequate records has been ruled in most jurisdictions not to constitute malpractice; rather, it amounts to rendering substandard care. In 1981, however, a $975,000 settlement against two physicians occurred for failure to keep rec-

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ords, even though had proper records been kept, the defendants may have had a good defense. The first physician was charged with failing to maintain adequate records, and the second physician was held guilty of malpractice in performing surgery without reviewing the patient's nonexistent history.[1]

Failure to obtain an adequate medical history has often resulted in successful malpractice litigation. The Texas case of *Cortez vs Miser* involved a 45-year-old meatpacker who sustained hepatitis after receiving halothane for anesthesia.[2] The patient developed jaundice and was treated for halothane-induced hepatitis. Five months later the patient's original problem necessitated additional surgery. The anesthesiologist in the second surgery was not notified of the patient's earlier treatment for hepatitis. Halothane was administered again and resulted in the patient's death. A court-approved settlement in the amount of $275,000 was awarded for the $7,300 per year worker.

The two above-cited cases do not constitute precedent, as they are not appellate court decisions. They nevertheless are informative and may well indicate a trend.

As demands increase upon physicians, more responsibilities are placed upon paramedical personnel and nurses. It, then, is also imperative that physician extenders are skilled in communicating with the patient and the attending physician. Their function as a conduit of information is required for their own legal protection as well as that of the physician.

Ramsey vs Physicians Memorial Hospital[3] and *Folley vs Bishop Clarkson Memorial Hospital*[4] are two cases involving a nurse's failure to adequately communicate with a physician. In the first case, two young brothers were brought to a clinic, where the nurse took the medical history. The mother told the nurse that she had recently found ticks on both boys. The nurse made no notation of that information on the chart. The physician made a diagnosis of measles, as did the family physician, who saw both boys two days later. One died before the correct diagnosis of Rocky Mountain Spotted Fever was made, and a substantial verdict was rendered even though the disease is rare, not contagious, symptoms are easily confused with measles, and multiple cases in a family are unusual.

In the second case a woman presented herself to the delivery room. The nurse taking her medical history failed to record the patient's comments of a recent sore throat. While hospitalized after the birth of her child, the patient not only complained of a sore throat, but also had an elevated temperature. The attending physician prescribed only aspirin for the fever. Thirty-one hours after giving birth, the patient died of a streptococcal infection. Both the physician and the hospital were found to be liable.

Duty Measured from Physician's or Patient's Viewpoint

The United States courts are clearly divided on the duties of a physician to inform the patient. Generally, this dichotomy is based upon whether the duties should be measured from the physician's or the patient's viewpoint. Courts in some states have held that a physician's duty to disclose to his patient the risk of a proposed procedure or treatment is limited to those risks physicians customarily disclose. In those courts patients are required to prove the custom in the community. Reasons given for measuring "duty from the physician's viewpoint" are that otherwise each physician would be required to spend much unnecessary time in going over with every patient every possible effect of any proposed treatment and that medical malpractice actions are inhibited.[5] Patients could feasibly have extreme difficulty with the burden of proof required in malpractice cases under this rule because of the possible unwillingness of physicians to testify against one another.

A growing number of jurisdictions adhere to the "duty measured from patient's viewpoint." Under this rule the physician's duty to inform the patient of the risks of a proposed treatment is measured by the patient's need for information to make an intelligent decision whether to accept or reject the proposed treatment. Courts accepting this rule and rejecting the community standard point out that even if there can be said to be a medical community disclosure standard for any prescribed treatment, it appears so nebulous that physicians become vested with virtually absolute discretion. Further, unlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision.

General conclusions, based on summation of numerous court cases, lead to these three chief tenets: (1) Every human being of adult years and sound mind has a right to determine what should be done with his own body. (2) True consent to what happens to one's self is the informed exercise of a choice, requiring an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. (3) The average patient has little or no understanding of the medical art, and ordinarily has only his physician to provide the enlightenment necessary to reach an intelligent decision.

Patient Comprehension

The extent to which physicians have a legal duty to furnish adequate understandable instructions to patients is undefined. To date, the reported appellate decisions are few. It appears that in the future this area might well be one of the most highly litigated. A 1972 decision is informative.[6] In that case a woman covered under the Maine Worker's Compensation Law received an injury to her foot. The injuries were nominal, yet a cast was placed on her foot for a period of two weeks. When the defendant physician removed the cast, he told the patient to "get some decent supportive shoes." He did not specify where to go or what kind of shoes to get. No mention was made of getting shoes with fitted arch supports. Normally, with that type of injury, the employee would resume working after a short period. In this case, the patient returned seven months after the cast was removed complaining of severe pain in the foot. Thinking she was following her physician's instructions, the patient had purchased imitation space shoes with improperly fitted arch supports. Although this was a Worker's Compensation case, not malpractice, the court held that the physician was negligent in failing to communicate to the patient the need for support shoes and how they should be fitted. The court further ruled that the employee was entitled to Worker's Compensation benefits for the additional months she had been unable to work. It would appear that if the plaintiff had sued the physician for malpractice, she would have been successful. The court clearly indicated the physician has an absolute and positive duty to furnish the patient with understandable instructions.

It further appears that the physician's duty can extend beyond discharge of the patient. In *Martisek vs Answorth*,[7] a patient fell and was severely injured. The physician treated the patient for injuries to other parts of his body, and although an x-ray examination reflected some damage to an intervertebral disc, the physician failed to warn the patient of the damage to his back. The patient returned to work and three years later re-injured his back in the same place while lifting a 70-pound object. The court held that the physician's failure to warn the patient of the damage to his back and the probable weakening in the future of the muscles and ligaments surrounding the back injury constituted negligence. Finally, the court held that the physician was negligent in failing to warn the patient that he should limit his activities to avoid injury in the future.

Physicians also are legally bound to furnish complete information when a patient refuses treatment or a procedure. A 1980 California case[8] clearly indicates the duty of the physician to warn the patient of the consequences of declining certain treatment or procedures. The family physician, over a period of years, had suggested a Pap smear when he saw his middle-aged patient. On each occasion the patient refused the procedure. The physician did not document having informed her of the ease in which uterine cancer could be diagnosed by the procedure or of the otherwise possible undetected growth of the disease. She subsequently died, and her heirs sued the physician successfully. The court held that even when a patient declines a surgical procedure, tests, or clinical procedures, the physician has a duty to inform the patient of the consequences of refusal.

There are two landmark decisions that should be reviewed by anyone concerned with legal aspects of patient comprehension and informed consent. In *Salgo vs Leland Stanford, Jr, University Board of Trustees*,[9] it was held that the patient had a right to be informed. In the case of *Canterbury vs Spence*,[10] the courts decided that the patient must have an understanding not only of the suggested procedure but also the side effects, alternative procedures, and so on. It would appear the pendulum is swinging toward assurance that the patient completely and fully understands all material con-

siderations. If, as indicated by the courts approaching this dilemma from the patient's viewpoint, the physician has an obligation to make sure the patient understands, then the physician will have to analyze the patient's ability to understand.

Literacy Analysis Studies

In a study conducted by Northcutt,[11] it was shown that 20 percent of American adults are functionally illiterate or incompetent, and an additional 34 percent were barely functionally literate. Simple social tasks, such as addressing an envelope, reading newspaper want ads, and understanding medication directions were used to measure competency. Findings such as these could have serious legal implications for both verbal and written communication between the physician and patient.

Grunder[12] evaluated five representative surgical consent forms and found them to be approximately equivalent to material intended for upper division undergraduates or graduate students. This empirical study proved that four of the five forms were written at the level of a scientific journal, and the fifth was written at the level of a specialized academic magazine.

It would appear that some patients could misunderstand the information provided in those consent forms. Cassileth[13] actually proved that by a study of 200 cancer patients who were questioned within one day of signing the consent form for chemotherapy, radiation therapy, or surgery. The patients completed a questionnaire containing the content and implications of the forms they signed as well as their opinion of the purpose for the form. Only 60 percent understood the purpose and nature of the treatment procedures, and only 55 percent correctly listed even one major risk or complication. Seventy-five of the patients indicated the purpose of the form was to protect the physician's rights.

It has been suggested that written consent forms be worded at no higher than the seventh or eighth grade level.[12] However, other findings suggest that even that level may be too high for printed patient education material. Mohammed[14] found that the majority of patients in a study conducted on diabetes could not understand fourth, sixth, or eighth grade printed material.

Conclusion

Findings such as those cited above could have serious legal implications for both verbal and printed communication between the physician and patient. Court decisions concerned with physician-patient communication are directing attention toward assuring patient comprehension of information. There is a close relationship between reading and listening comprehension skills.[15-17] Assessment of either the patient's reading or listening skills will help the physician to provide verbal and printed information that is understood by the patient. The end result will be both a better informed patient and a physician who is better protected against malpractice suits in the area of patient-physician communication.

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