

The Urologist and the Law*

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The basic concepts of the law as they pertain to urology are no different from any other part of the law which pertains to the medical profession. I shall not spend a lot of time going over that, except to say that you owe the same duty that any other physician owes to a patient, and that is to exercise that degree of care which the average urologist would exercise under the same or similar circumstances. The courts generally say further, "in the same or similar communities," and then qualify it still further by saying, "regard being had for the state of medical science at the time." It narrows down to the fact that you do not have to be the best, but you cannot be the worst. If you conform to this standard, you have a reasonably good chance of staying out of trouble as far as the law is concerned.

Now let's go into two or three areas which have arisen recently and which should give all of the medical profession some concern. I am sure you have heard the term "informed consent." Basically, the term "consent" itself implies that if you do a procedure upon a patient without the patient's permission, you have committed a battery on that patient, and the patient is entitled to recover for any damages done. No expert testimony is required, and you can be liable for punitive damages which your malpractice insurance carrier will not pay. This is a very narrow field because very seldom do physicians today do procedures without some type of permission or consent.

But the area of "informed" consent is a much more complex proposition, and the problems are steadily increasing, both medically and legally. The underlying concept to this whole proposition is fundamental to American jurisprudence; that is, that every human being of adult years and of sound mind

has a right to determine what shall be done to his own body. There are numerous examples of this. One of the classic examples is that of the Jehovah's Witnesses who, because of their convictions, will not accept blood transfusions. The courts, all the way to the Supreme Court of the United States, have uniformly held that a person has such a right of refusal even if it means his death, and you have no right to intervene. When you get down to the basic premise that each individual should be allowed to determine what happens to him, no one can question the validity of the principle. It's good and it's sound. There are ramifications, though, when the patient has given consent but where a complication or risk develops. If the patient has not been told about the risk, he may bring a suit contending that he was not adequately informed and had he been, he would not have consented. This is not a battery, although in some places this has been attempted in order to get punitive damages. The courts uniformly recognize that this is no more than a breach of duty, the duty that you have to treat your patient properly. There is a duty to inform the patient of what you are going to attempt to do and the possible complications and risks, and a failure to do so amounts only to a breach of that duty. It is treated in the same category as any other negligence action.

From this, then, let us consider the two basic principles which must be kept in mind. First of all, the patient has a right of self-determination, and this imposes upon you the duty to make a disclosure to him. Second, the amount of the disclosure is to be measured in terms of "reasonable." Basically, that is what the courts have said, and that is what the duty is based upon. These principles are generally recognized, although I must say they are not recognized in all places, and have been treated rather casually in some places. The majority rule among the states today is that in determining how much is to be disclosed to a patient, the same rule is followed

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as determines the standard of care in treating the patient, namely, what the standard is within the medical community. This is generally followed and has been a reasonably good defense up until now. I might say, for those of you who are from Virginia, the question has not arisen here, and I do not anticipate any great problems.

There are two recent cases, however, which throw a shadow over the whole question of consent and disclosure. They do not set forth any specific rules to be followed, but they do establish that the duty goes much further than anyone had ever contemplated. The first was a case from the Court of Appeals of the District of Columbia handed down in May 1972. To summarize briefly, a nineteen-year-old male had only a back pain. He was seen by a series of physicians and finally by a neurosurgeon who recommended that he have a laminectomy. He was not told that about 1% of the laminectomies end up with some sort of paralysis. He agreed to the operation, and unfortunately, after a chain of varying events, he became paralyzed. The District Court which heard the case ruled, as a matter of law, in favor of the physicians, both on the question of malpractice and negligence in the way the operation was performed and also on the failure to inform the patient of all the risks involved. The Court of Appeals reversed the case on all issues and sent it back for trial on the merits. Some of the statements made by the court are general statements which apply across the board:

Due care demands that the physician warn the patient of any risks to his well-being by the contemplated therapy. The patient must have some understanding and familiarity with the therapeutic alternatives and their hazards. The physician must disclose the choices and the dangers inherently and potentially involved.

Those are rather broad, sweeping admonitions. The court said that the standard is "what is reasonable under the circumstances and that this is not to be determined solely by the physician." The court went on to say that this is a matter in which laymen have knowledge and are in a position to express an opinion or view. It is not in the same category as the type of treatment that should be rendered for a particular condition. All of the risks which potentially affect the decision to be made by the patient must be revealed. The court defines this by saying,

"A risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy." That is a way of saying that you must put yourself in the patient's position, so to speak, in prospect and not in retrospect. If a reasonable person, knowing what the risk is, might forego the procedure, you must tell him what the risk is. The court has gone further and said, "A very small chance of death or serious disability may well be significant; a potential disability which dramatically outweighs the potential benefit of the therapy or the detriments of the existing malady may summon discussion with the patient."

Whenever nondisclosure or particular risk information is open to debate by reasonable-minded men—laymen, not physicians—the issue is for the finder of the fact, the jury. What in effect the court has said is that the question of whether or not the patient should have been told about certain risks is going to be a jury issue in every case. No matter how many times the court may instruct the jury that they are not to view the case in retrospect, it is impossible for them not to do so. They cannot get out of their minds what has already happened.

The second case came up even more recently than the first—in October 1972 in California. In this particular instance, the surgery was for the treatment of a duodenal ulcer, a very small duodenal ulcer that had been very difficult to diagnose, even by x-ray. The surgeon explained that there were certain risks in the general anesthesia. He explained the nature of the operation, but none of the inherent risks, one of which is that in a certain percentage of the cases—I think about 5%—there may be some injury to the spleen or its adjoining structures. The patient did have injury to the spleen because one of the arteries broke loose, and he almost bled to death internally. Neither did the physician explain that the evolution of a new ulcer might occur; he got one of those. The patient had several other complications and he sued the doctors and the hospital. This court came to the same general principle as the court in the District of Columbia, holding that, as to the duty to disclose available choices of therapy and dangers inherently and potentially involved, the physician must comply. The right of self-decision by the patient is the measure of the defendant's duty to reveal.

Now, both of these cases recognize two general exceptions which you should keep in mind. One is in the case of an emergency or where the patient is incapable of making a decision because of mental incompetency or infancy. If the treatment is immediately necessary, you can proceed without any type of consent. If the patient is incapable of making any type of decision because of infancy, the parents can certainly be fully advised and the consent obtained from them, if there is no emergency situation. The second refers again to the majority rule and there the court says that where the welfare of the patient dictates that he should not be told, there is reason not to tell him, but the burden of proving this is on the physician, not on the patient. In other words, this is an excuse or a reason for nondisclosure. The burden is on the plaintiff to prove he was not told, and if he was not, it is up to you to justify not having told him. The court pointed out that the fact that the patient may decide not to have therapy is not reason for not telling him.

One court pointed out that nondisclosure is justified only where the reaction to the risk information, as reasonably seen by the physician, is menacing, almost life threatening to the patient. That is almost the only instance in which you would be justified in not telling the patient. In this regard, I should warn you that you must have expert testimony to back up your decision. In the case in the District of Columbia, the surgeon testified that it was not in the best interest of the patient to tell him that he might be paralyzed from this laminectomy. The court paid no attention to that statement whatsoever, saying that it was for the jury to decide, since the physician was the only one who said this, and he had not given any background or any medical reason why it would have been harmful to the patient. There was no reason to believe that he was emotionally unstable or anything of that kind. I realize full well the restraints this places upon the medical profession, but I do not think we can ignore the fact that to some extent a person does have a right to determine what is going to happen to him.

Both of these cases attempted to set forth certain types of things that a patient should or should not be told and little can be derived from reviewing these, because they do not make that much sense. One of the cases, for instance, referred to minor procedures and complicated procedures, and what you do in one case and what you do in the other. Of course, you can imagine what's going

to happen when someone says, "Well, it wasn't minor, after all; it was complicated."

There is another type of situation you encounter in "informed consent" cases. A patient was to have an arteriogram performed. There was no emergency; it was not necessary at the time that it be done; it was an optional procedure. The surgeon did not tell him that there was a risk of paralysis inherent, and he became paralyzed. The plaintiff recovered—that is, a verdict against the doctor.

In another case, a patient of oriental descent developed hypopigmentation—I believe it was during pregnancy. She consulted a dermatologist, who recommended dermabrasion, but he did not tell her that it was only 50% effective and that the condition might even be worse after he finished. It was worse, and she sued him. There was no question in that case. The court said that he had failed to conform to the duty imposed upon him to advise the patient fully of the successful nature of the operation if performed, and also of its chances of failure.

The courts have said, in effect, that if there is a serious risk of death or danger of death, even if the percentage is very small—down to 1% in one of the cases—the physician must so advise the patient. Also, he should explain any alternative methods of treatment. Frequently, this is omitted. I have found this to be true in any number of cases in which I have been involved. The physician has not told the patient that there were other methods of treating the condition, and he has left the patient with the impression that the one recommended by him was the only one. What it boils down to is this: If the patient doesn't want to take the chance, on what basis can the medical profession justify forcing him to do so? If you can answer that question, then you have solved the problem, because then you can omit anything you want to.

Some simple "do's" and "don't's": You must or should disclose the general procedure and generally what you expect to do, and what the patient should expect from the procedure. Also, you should identify the surgeon who is going to perform the surgery, and whether or not others will assist, particularly residents. In several of the teaching institutions, I have found that they do not tell a patient ahead of time that the surgery may be performed by residents. The risk of serious harm or death, where applicable, should be disclosed. This would be true in any major case, or certainly where any general anesthetic will be used. The peculiar risks of the

procedure involved should be explained to the patient. There's a greater duty to disclose if the procedure is experimental, new or novel, ultrahazardous, if there is a possibility of altering the sexual capacity or fertility of the patient, if it is purely for cosmetic purposes or if it is an optional procedure.

The "don't's" that you might add to this include: Do not say that any procedure is simple, under any circumstances. Do not ever tell a patient that no complication can occur. Do not just answer the patient's questions and expect that to fulfill your obligation to fully inform the patient. Do not expect others to make a disclosure for you, such as the anesthesiologist who may come to see the patient, or any of the house staff. Do not minimize any part of the procedure or make a guarantee of any kind or any statement that resembles a guarantee or an assurance that you or the procedure will cure the patient.

There is one exception, of course, and that is if the patient specifically does not want to be informed, you do not have to do so. Some people may not want to be informed of what can happen to them. If they do not want to, you should not burden them with it, but you should certainly document the circumstances very amply and very completely in the chart.

I point out these two cases because they are a sharp departure from what has been the rule. How many states will proceed to follow this I have no idea. But a word of caution is always in order: If you adequately protect yourself in this regard, you are certainly on the safe side. As I understand it, it is always better to overtreat than to undertreat.

With respect to infants, I would mention that the consent should come from the parents; also, that now in most of the states 18, not 21, is the age of majority. Suppose an eighteen- or nineteen-year-old college student comes into your office needing treatment. He has no means of support, and you are concerned about who is going to pay your bill. You get in touch with the parents and ask them by long-distance telephone if they will take care of the bill. They tell you that they will. Suppose a long series of treatment is undertaken, and the bill mounts into the thousands of dollars. The parents do not want to pay the bill, and they do not have to. At least in Virginia, and in most other states, the promise to pay the debt of another has to be in writing to be enforceable. This is the so-called statute of frauds. All you have to do is get the parents to write you a letter and tell you that they are

responsible for the care and treatment of their child.

Another thing to keep in mind is the value of a good set of records. One of the primary problems that I have run into is the inadequacy of some of the records kept by some of your colleagues, but I am sure none of you would neglect these. It is customary not to write down negative findings, but it is very easy to write down "otherwise negative" after you have made an examination. At least give some notation there, since the chart has to be your only means of remembering several years later that you did make other examinations. If there is a particular area of the patient's body that was being treated or was injured at one time and has cleared up, a notation of this should be made in the chart to back up the fact that you did an examination.

I spent eight days recently in a case where one of the main contentions was that a neurological examination had not been performed upon a patient from the day he was admitted to the hospital to the day he was discharged. The physician said that he had, but there was nothing in the chart to prove it. We were able to get out of it all right, but it was a difficult proposition. It is easy to correct. Any time the patient refuses treatment, this fact should be put into the chart. If you have a discussion with the patient with regard to the type of treatment, the alternatives, the risks, and so forth, this should also be put in the chart.

It is my recommendation that, if you are going to perform planned surgery on a patient, you should take his consent in your office before the patient goes into the hospital. Then he cannot complain that he was under sedation, or that he was upset, or any number of other things that might influence his making a wise and full decision.

A chart should contain, at each instance, the complaints of the patient, the history, the type of examination made, the treatment, the medication, if any, and any instructions which you gave the patient. Also, if the patient fails to keep an appointment, you should have your office staff thoroughly instructed to document this on the chart and then in the appointment book, and do not throw the appointment books away. There have been several instances where this information was deemed crucial, and we were able to go back into the records and prove that a patient had failed to keep an appointment, after the patient had testified that he was never told to come back.

I need not emphasize that any treatment which

may in any way affect the sexual ability of the patient is particularly sensitive, apparently for everyone and should be well documented. This should be thoroughly explained to the patient; even the remote possibilities should be thoroughly explained. If there is any question about it, it would not hurt to obtain written consent. There have been several cases recently where physicians who have performed vasectomies have been sued because the operations were not effective. There have been cases where people have been allowed a recovery of damages for the cost of rearing a perfectly normal child who was unwanted, after the husband or the wife had supposedly been sterilized. This is becoming a very sensitive situation, and it is a place where many of your colleagues have gotten into trouble. In one case which I read, no tests were run after the vasectomy was performed to determine whether there were any sperm. Others have given assurances to the patients that if they let the physicians perform the operation they would not have any more children. That is what I mean by not giving any guarantees. Do not say anything that can be construed as a guarantee. Be sure that the consent form you use spells this out clearly and simply, that there is no assurance that the operation will be effective, and that there is no guarantee of any kind.

With respect to the treatment of infants, I should say that the courts will intervene on behalf of an infant in a case where treatment is necessary or where the lack of treatment will be detrimental to the infant. Cases in point are where courts have ordered transfusions for Jehovah's Witnesses. In one case, the court ordered a T/A because the child needed it and the parents objected.

There are two cases in particular which I have seen recently where the court approved kidney transplants. One was where the donor was about 27 years old and mentally incompetent. He had the only really good matching kidney, and the court gave its approval for the use of the kidney from the incompetent to help his brother. They had psychiatrists who came in and testified that this would be of benefit to the incompetent because he was emotionally and psychologically dependent upon the well-being of his brother. Another case was that of twins about nine years old. The court said there again, based upon medical testimony, that it would be detrimental to the surviving infant if he knew that he could possibly have saved the life of his twin but was not given the opportunity to do so.

There is one last area of which we should be aware. That is alienation of affection by doctors on patients or spouses of patients. The significant thing is not only the conduct of the physician but the liability of his partners in his conduct. In one case, involving the pediatrician of a group practice the husband went to the senior partner, who was the managing partner, and complained about the pediatrician's conduct toward his wife. The managing partner did not do anything about it. He did not even discuss it with his partner, and after it was over, the court said it was up to the jury to decide whether this amounted to consent to the conduct of his partner. If it did, then the partnership, as well as the man who was involved personally, could be held liable, and this was true even though it did not involve partnership time.

There was a recent case where a patient and her husband recovered from a physician—I understand it was a psychiatrist—\$30,000 in compensatory damages and \$120,000 in punitive damages for alienation of affection. I do not know how long this had been going on, but it went on long enough for the jury to decide to punish someone. You should be aware of the fact that malpractice insurance does not cover punitive damages. Even if there is coverage for compensatory damages—and it is questionable whether there is, in that kind of case—there certainly would not be for the punitive damages. You would have to pay that out of your own pocket.

In this regard, never examine any female patient without your nurse being present. It has almost reached the point where you should not even talk to her without your nurse being present.

Some of the matters I have referred to may seem unusual or unlikely and thus may not be long remembered. Let me reiterate, however, the importance of two items in particular. If nothing else remains long in your minds, do not forget that complete and adequate records are essential, both in the hospital and in the office. Nothing else will take their place when they are needed. Finally, keep in mind always the significance of informed consent. It is a rapidly changing principle and one which touches literally every field of medicine. It may be difficult to accept in all its aspects. You may not, probably do not, agree with much of it, but it is here to stay. It is an established legal concept, and it is far better to recognize it as such and learn to live with it rather than be caught by it. Good luck!