

Boston University School of Law

Scholarly Commons at Boston University School of Law

Faculty Scholarship

1980

The Care of Private Patients in Teaching Hospitals: Legal Implications

George J. Annas

Follow this and additional works at: https://scholarship.law.bu.edu/faculty_scholarship



Part of the [Health Law and Policy Commons](#)



THE CARE OF PRIVATE PATIENTS IN TEACHING HOSPITALS: LEGAL IMPLICATIONS*

GEORGE J. ANNAS, J.D., M.P.H.

Associate Professor of Law and Medicine
Boston University School of Medicine
Boston, Massachusetts

IN Herman Melville's novel *Moby Dick* Ishmael searches for knowledge in diverse ways; he views the world not only through his senses but symbolically and metaphorically. At one point, he is tied to the pagan harpooner Queequeg by a "monkey-rope," and it is his duty to use this rope to pull Queequeg free from the sharks surrounding the dead whale that Queequeg is butchering when Queequeg slips from his perch atop the whale. Should he fail, Queequeg's weight will pull them both into the shark-filled waters. Ishmael ponders: "I seemed distinctly to perceive that my own individuality was now merged in a joint stock company of two: that my free will had received a mortal wound; and that another's mistake or misfortune might plunge innocent me into unmerited disaster and death. . . ."

Like Queequeg and Ishmael, patients are tied to their medical caretakers; mistakes affect them both. Unlike Queequeg and Ishmael, however, the burdens of any mistake are not borne equally: the patient suffers the most. Society has therefore begun to insist that medical caretakers, especially physicians, take all reasonable steps to inform their patients of their options, and to make sure that the decision on treatment is the patient's, not the physician's. This is based on our notion of free will and self-determination, although some may view it as a futile attempt to avoid fate.

I want to make two relatively simple points. The first is that all patients, private and nonprivate (the speakers this morning said that that distinction is fast fading, and we agree that it should), should be fully informed of the qualifications of those treating them, and have the right to refuse to be treated by anyone by whom they don't want to be treated. And second,

*Presented as part of a *Symposium on the Care of Private Patients in Teaching Hospitals: The Role of Residents* held by the Committee on Medical Education of the New York Academy of Medicine October 11, 1979.

that it is a mistake at this point to come up with a simple solution to this complex problem. It is premature to define rigid rules as to how patients should be informed, and what they should be informed about.

The first point is simplest for me, and I hope that it will be simplest for others: patients should have a right to be fully informed of the qualifications of those treating them. There is a long legal history behind this that leads lawyers at least to this conclusion, and I think that most physicians would agree. The conclusion is essentially based on the doctrine of informed consent. It is no secret to anyone that physicians have always had to get the consent of their patients before they treated them—before they touched them.

In days gone by we called an unconsented-to touching a battery, and physicians who touched their patients without their consent were sued for assault and battery—almost like a mugger on the street. But battery is the classic legal description for intentional touching of someone without consent. More recently the law has recognized that physicians are not like muggers, but are trying to do good for their patients, and so the concept of informed consent (a negligence doctrine) has developed. Yes, one must still get the patient's consent; but the key is that before one asks the patient to consent to a certain procedure, to anything that has serious risks, one is obliged (because of the fiduciary or trust relation between the physician and the patient) to inform the patient, to give the patient some information. The disclosures are similar to those in other areas: the bank has to state the annual interest rate, and the police when making an arrest must inform the one in custody of his rights. It is part of a consumer trend that one must disclose certain information to the patient before one asks for his consent.¹ That is what informed consent is about, giving the patient information before one asks for consent.² Why do it? Why do we think it important that patients have this information? I think we all know the answer.

It is the high premium our society has always placed on self-determination, on individual autonomy, and the right of each human being to control his own body. It is again the old concept of consent. Nobody can touch one's body without permission to do so, because whatever happens—good or bad—will happen to one's own body, not to someone else's body. And one should have the right to control that. Now, the informed consent doctrine is not terribly powerful in the sense that it does not state that one has a right to *understand* everything that is going to happen to one. What it states is that one has a right to be *informed* about it.

The current legal obligation of the physician is simply to present to the patient the information in an understandable manner. One can argue, however, that physicians have an ethical obligation to make sure that the patient understands what is going to happen to him.

But that is not currently the law. That is the law only in the case of human experimentation.³ The law is based on giving patients certain information, and the specific information we are talking about is the information "I am a medical student," "I am an intern," "I am a resident." What does this mean in terms of training? What is legally required?

Now it is true to say, if one reviews the literature, that there is almost no instance where anyone has been sued—intern, resident, or medical student—for failure to disclose his training status. I think that such a suit is highly possible, but I cannot state that it will happen because I do not know that it has ever happened. It is likely to happen in the future, but I am not trying to scare anyone; it may never happen. I do not think that this should be done because of fear of being sued. I think that it should be done because it is right and because I believe that patients have a right to make decisions themselves.

The only case I have been able to find involving a medical student is an outrageous one, a 1932 case involving a pregnant woman who had come to the hospital to have a baby.⁴ She told the first medical student that she wanted a doctor. Instead, he called a dozen more medical students, each of whom performed pelvic and rectal examinations on her. She kept screaming that she did not want this done, but they laughed and told her to shut up. That was not a hard case for the court to decide. It was clearly outrageous. The court said in very explicit words, and this is still the law, that a physician or medical student has no more right needlessly and rudely to lay hands on a patient against her will than a layman. Back again to the old concept of consent. No one has the right—neither physician nor resident nor medical student—to lay hands on anyone without his consent.

That is the law. That was an outrageous case, the kind of thing that one hopes doesn't happen anymore. But there has been a movement in this country to try to enforce that obligation, the obligation to permit patients to refuse to be examined by medical students, in clearer language. It is not yet a major movement; there aren't many statutes and regulations affecting this, but there are some. I want to tell about some of them. One of the things I do in Massachusetts is act as vice chairman of the Board of

Medicine. I have held this post the past four years, and one of the things that the Medical Board heard was that medical students in Massachusetts (specifically in teaching hospitals, of course) were being introduced to patients, as they are in many places in this country, as “young doctors” or simply as “doctors.”

The board, composed of five physicians and two public members, took the position that this is wrong and, more than that, that the board should say something about it. And two years ago a regulation was passed in Massachusetts, and is now the law for that Commonwealth. It requires that all physicians who supervise medical students make sure that the medical student is identified visibly to the patient as a medical student.⁵ That means that he has a name tag that says “Medical Student” and, more important, that he informs each patient that the patient has a right to refuse examination or treatment by the medical student. Now the board has no power over medical students. The only enforcement would consist in taking action against the supervising physician, and that has never been done. The purpose was not to punish physicians, just to try to change their behavior by getting those who have not been introducing medical students as medical students to do so.

The second thing that happened, more recently, is that the legislature in Massachusetts passed a Patients’ Bill of Rights. One of the items in this bill of rights, not phrased very well, but one can see what the legislature had in mind, is that patients have a right “to refuse to be examined, observed or treated, by students, or any other facility staff without jeopardizing access to psychiatric, psychological or other medical care and attention..”⁶ A key phrase is that patients have a right to refuse to be examined, observed, or treated by students. I think that what the legislature wanted to say was “students and residents,” but they said students and any other facility staff, overstating the case somewhat for our own purpose. But the point is that this is a public issue. It is no longer an issue that is just discussed within the medical profession. It is an issue that society, through licensing agencies and legislatures, is starting to take very seriously, and the view I think will be unanimous that there is no good reason why patients should not have a right not only to know who is taking care of them and what their professional qualifications are, but also a right to refuse participation.

A final point I want to make about full disclosure is worthwhile as a start, and that is to give every patient a booklet about what it means to be

in a teaching hospital when he is admitted. An advertising campaign in the community to explain to everybody what a teaching hospital is makes sense because I would guess that almost no one in the general community has much of an idea of the difference between a medical student, intern, and resident. And almost nobody knows what happens in a teaching hospital.

I think that it is a good idea to tell patients this. But it is not true that if one explains this to them, and they enter the hospital, they are then stuck, and can no longer refuse to be treated by students or house officers. The analogy is with the blanket consent form that many patients are asked to sign when they enter the hospital: "I hereby consent to be treated by Dr. X and anyone he designates, for whatever disease he thinks I am suffering from, and in whatever manner he thinks I should be treated."

That is a common type of consent form and the courts have looked at it and said essentially what you can guess that they would say; that is not informed consent.⁷ It is not specific enough, doesn't tell what the risks are, what the advantages are, what the alternatives are. It just says that one can be a patient. Even if one has the booklets, even if one signs a form that says, "Yes, I agree that I am going to be in a teaching hospital," even if one tells them all about residents and students and they agree to it, patients still have the right to refuse to be seen by any particular intern, any particular resident, any particular student, or to have any particular procedures that they do not want done by residents to be done by someone better qualified.

That strikes me as being the law now, whether it is practiced or violated. And no matter what type of educational campaign is developed, it is important to maintain (and the law insists on maintaining) the patient's right to refuse particular procedures by interns and residents, just as patients have the right to refuse to undergo particular procedures by anybody.

That is the first point: patients should be fully informed of the qualifications of their physicians and should have the right to refuse. If an analogy is required (because there is almost no law on it) think about human experimentation. This sounds like a crazy analogy but the history of human experimentation in this country is analogous to the history of what the future holds on this matter. It began during the early 1900's with experiments on charity patients just because they were charity patients—outrageous experiments both here and in Europe. This led, after World

War II and the Nuremberg trials, to a rearticulation of the rights to refuse, to be informed, to be knowledgeable about human experimentation before taking part in it. Finally, we have recently proposed federal regulations that are very explicit about what experimental subjects must be told and what kind of consent must be obtained.³

I think that we are heading in that direction, not that it need get that complicated. We can profitably think about the progression that way, and because we can anticipate more regulation, I emphasise my second point: that we must be very cautious about premature regulation, very careful about setting rules at the present time about what should be done in this context because we have very little experience in this area.

Many of us have read Charles Bosk's book on surgical residency, *Forgive and Remember*.⁸ One point he makes in a footnote is that he would have liked to have studied the information residents gave to patients, how they got informed consent. He said that while that was his interest, it was not an important part of the training program in any of the teaching hospitals he studied. Informed consent was delegated exclusively to the residents, and they were essentially told to get the consent form signed. This was viewed as a housekeeping chore, not something integral to the physician-patient relation or to the practice of medicine. It seems to me that the first thing that must change is that getting consent, giving patients information, getting patients involved in decisions about their bodies has to be part of the medical curricula, at least in postgraduate medical education. This must be perceived as important by the attending and private physicians, or it will never be seen as important by the residents.

Second, it seems to me that we will have to face some really tough issues. I have no answers for these but we should be thinking about them, and maybe because we are thinking about it we don't want to discuss them. Do we have to tell patients, "This is the first time I am doing this procedure"? And if one is a third year medical student, "This is my first lumbar puncture," or arterial stick, bone-marrow aspiration, or whatever? But why stop at students and residents? One can go all the way to board-certified surgeons, and many very qualified surgeons have never done particular types of surgery. Let us say that they want to perform an operation they have never done before. Do they have to tell the patient: "I have 25 years of experience, but I have never done this particular procedure. I think that I can do it. I want to do it." This is a most interesting

question. Is this kind of information what the patient should not only be told, but should have the right to be told? I pose that merely as a question for now.

Professional Standards Review Organizations (PSROs) are obviously going through a similar thing, flippantly called one's "batting average." There is some suggestion that there are good hospitals and bad hospitals, and that one might be able to tell which is which by reviewing outcome measures, by asking, for example, "How many procedures have you done, doctor, and what is the survival rate?"—or using whatever other measures of success one might think applicable to a particular procedure.⁹

I think that is inevitable. One may not like that one way or another, but I think that it is coming. I do not think that there is any way, once this information is available to someone, whether a PSRO or any other organization, that that information can be kept secret for very long. It may be kept secret for a decade, but in the general trend of things there is no doubt that that kind of information is going to be disclosable, and I think that it should be.¹⁰

As far as teaching hospitals go, the first thing that will happen is that this type of information will be available on a hospital basis. I think that will be good. I think that teaching hospitals probably will have better statistics than most community hospitals and that if they do not they should be able to explain why, based on the mix of patients they get, the more complicated cases they get, and the people who come to them in later stages of their diseases. That is the kind of information patients need if they are to make informed decisions. The main argument against most of the things I have said is that it is "impossible to inform patients." One cannot. They never understand the surgery. They will never be medical students. They will never understand what a resident is. They will never really get it. And therefore they will make all kinds of decisions that really are not in their own best interests. Patients are really better off if we don't tell them these things, if we make the decisions for them.

All that may very well be true, but it flies in the face of an essentially democratic tradition that says that patients have a right to make decisions about their own bodies, even foolish decisions. It means nothing to tell a patient that he has a right to consent if one does not also give the patient the right to say no, even when we think that he is dead wrong, even when the whole medical profession thinks that he is wrong.

Patients have the right to control their lives and to make decisions about

their own bodies. And that gives them the right to make foolish decisions as well because otherwise the right means nothing.

Let me conclude by again saying that I think that patients should be fully informed, and have the right to refuse to be treated by any particular individual on the medical staff. A long legal tradition is founded on self-determination and autonomy. The human-experimentation analogy is a good one to project where we are going during the next five or 10 years. It is too soon, in my view, for legislation and regulations. That would probably create more problems that it would solve. A final example may illustrate this.

Massachusetts has just passed a law saying that any woman suffering from breast cancer has a right "to complete information on all alternative treatments which are medically viable."⁶ That is the law in Massachusetts. It is required. Now physicians and surgeons are asking what it means. One of the members of our board, who will go nameless, said at the last meeting, "Well, as far as I'm concerned there aren't any alternatives. A radical mastectomy is the only thing you should do."

That is precisely why the statute was passed, because surgeons like him don't tell patients about their alternatives. But still, even though I agree with the spirit of that statute, I do not think that it should have been embodied in law. One can envision a law on every specific medical procedure, setting forth what patients must be told, and one can envision cookbook-like mimeographed forms being handed out: "You are having a radical mastectomy; here are 10 pages of all of the possible things that could happen and all of the alternatives." That strikes me as counter-productive. It would be destructive to patients and destructive to physician-patient relations.

We do not want that. Physicians have an opportunity now to avoid a legislative solution by trying to work out solutions to this problem among themselves. I would suggest that in doing so physicians look to lawyers as sources of help, people who have had some experience working with legislation and regulations, people who have been down this road before in the matter of human experimentation. Lawyers, at least most of them, are not trying to make physicians' lives more difficult, but really are trying to do what they have been trained to do—to act as problem solvers. I have worked now for about six years in a medical school setting, and I still get the impression that many physicians are Ahabs piling all the evils of the world upon the white whale, and that the white whale to them is the legal

profession. I hope that the physicians here will take away the idea that if lawyers do not have the solutions today, the law offers possible solutions for tomorrow. Like patients and physicians, lawyers and physicians are also tied together by a monkey rope, and it is to our mutual advantage and the advantage of society for us to work together.

REFERENCES

1. Annas, G. J. and Healey, J. M.: The patient rights advocate—Redefining the doctor-patient relationship in the hospital context. *Vanderbilt Law Rev.* 27:243-69, 1974.
2. Annas, G. J.: Informed consent. *Annual Rev. Med.* 29:9-14, 1978.
3. Annas, G. J., Glantz, L. H., and Katz, B. F.: *Informed Consent to Human Experimentation—The Subject's Dilemma*. Cambridge, Mass., Ballinger, 1977.
4. *Inderbitzen v. Lane Hospital*, 12 P.2d744 (Ct. App. 1st. Dist. Div. 1, Cal. 1932).
5. Massachusetts Board of Registration in Medicine, Rules and Regulations, VI.3 (1977).
6. Mass. G.L.c.111, S70E.
7. Annas, G. J.: *The Rights of Hospital Patients*. New York, Avon, 1975, p. 69.
8. Bosk, C. L.: *Forgive and Remember: Managing Medical Failure*. Chicago, University of Chicago Press, 1979.
9. Annas, G. J.: Public Access to Health Care Information—PSRO Data and its Availability to Patients and Consumers. In: *Quality Assurance in Health Care*, Egdahl, R. H. and Gertman, P. M., editors. Germantown, Md., Aspen Systems, 1976.
10. Luft, H. S., Bunker, M. D., and Enthoven, A. C.: Should operations be regionalized? *N. Engl. J. Med.* 301:1364-69, 1979.