On Becoming a Teacher of Family Medicine

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The emergence of family practice education in the past decade has created an unprecedented demand for faculty. Since no reservoir of trained teachers existed, it has become necessary for practicing family physicians to enter the academic world and assume the role of teacher. This paper examines the internal processes by which this transformation occurs. It begins with the fantasies common to physicians who are considering the decision to teach, and progresses through self-assessment of qualifications to a consideration of the content of family practice teaching. It concludes with guidelines for negotiation with an academic institution and the early stages of professionalization in the new role.

Now is an unusual time to be a family physician, and to participate in the opportunities that have opened up to us in the last decade with the development of the specialty of family practice. Being a family physician now imposes special responsibilities on us to become teachers, whether we become full-time faculty or whether we simply participate voluntarily in the academic programs of a department of family practice. In no other medical discipline is the interrelationship between the practicing physician and the medical school department so important. Many family physicians will have an opportunity to be involved as teachers, so we have some obligation to think about this.

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The View From Inside

I would like to approach this subject from a personal standpoint and talk about being a teacher of family medicine from the inside. Most of us who think about becoming a teacher have a number of fantasies that need to be sorted out. First of all, there is a certain seductiveness about becoming a teacher. We may have the fantasy of the long, white coat or the gold-headed cane. We have some identification with an important person in our own past who was a good teacher. A family physician probably does not exist who has not at some point been tempted to take the plunge into teaching.

For some of us there is a fantasy that has to do with a sense of oughtness, a sense of calling, a feeling that perhaps this is something we owe or we ought to do. A still, small voice or a nagging obsession may tell us that we owe it to teach because of what we have received from our own teachers. For some of us the idea of teaching may take on the character of a moral crusade – we may feel that we can succeed where others have failed, or we may feel a need to right some academic wrongs that we think have existed for a long time. There may be a hint or two of anger against some of our past education and experiences.

On the other hand, there is often an element of fear in this fantasy of becoming a teacher. We would like to do it but we are not so sure that we can really make it. There is a feeling that we might fail if we tried to become teachers. Maybe we would be exposed as impostors, we are afraid that the medical students and residents will expose our ignorance. We have a fear of being embarrassed, and we have doubts about our own competence. What this all adds up to is a feeling of ambivalence and uncertainty as we let ourselves experience fantasies about teaching.

When you begin to allow yourself to let these fantasies become a little more serious, you may share them with your spouse or a friend. You do it in an off-hand way with a little humor. You send out a trial balloon and say, "I'd like to get out of this rat race and get into the medical school." You're trying to see what the other person's reaction will be and, if it is not incredulous, and if you get a little encouragement, you let the fantasy grow. A little external support will help this fantasy to bloom.

Self-Assessment

If you decide to be serious about becoming a teacher, the next step would be to do a self-examination and try to determine whether or not you qualify. Part of the self-examination

should begin with a consideration of what evidence there is of intellectual activity in your life now. Most of us as family physicians have not done traditional academic tasks. We have not written papers, given lectures, or done research; but there is evidence of intellectual activity in our lives and we need to look for that. What do you read (not only in medicine but outside of medicine)? What are your hobbies? What about traveling? There should be some evidence of intellectual curiosity.

What leadership roles have you performed? This is evidence of intellectual activity. What about your ability to speak? What about your involvement in your hospital medical staff or medical society? What about your committee work and elected offices within organized medicine? What about your responsibility in other organizations such as civic clubs, church groups, and others? When I consider someone as a potential faculty prospect who does not have a traditional curriculum vitae, they are the things that I look for, and I think they are equivalent in many ways to traditional academic accomplishments. Another point to think about is how people behave toward you as a person. Can you persuade them? Can you negotiate? Do people confide in you? Do you form friendships easily? These are skills that will come in very handy if you decide to become a teacher.

The next step in self-examination is to review your style as a person and your personality characteristics. Do you have a sense of humor? Do you take yourself too seriously? A sense of humor will cover a multitude of sins. How do you handle your anger? This is one I had to talk about to myself a lot. What do you do when you get frustrated to the point of anger? How impulsive are you? How impatient are you? How compulsive are you? I have seen people worry for a couple of years trying to make a decision. They just cannot pull the trigger, and if you are that compulsive, the academic life is not for you. What is your suspiciousness index? It is certainly a good quality in a teacher to be skeptical, but it is not a good quality to be cynical, and if one has the kind of suspiciousness that sees "the enemy" everywhere and is cynical towards the world, I doubt that this would be a good qualification for a teacher.

What is your pessimism index? There is something in medicine analogous to the Myth of the Golden Age. I discovered this as a medical student. I do not know how it is transmitted from one generation of students to another, but almost every generation thinks they are the last in the line who are going to have a chance to practice medicine as in "the good old days." I thought that for at least ten years until I found other people younger than I who thought they were the last. If I knew how this myth is transmitted so effectively I think I would have the secret of teaching. Among medical students today, some are pessimistic about their own futures. I have been amazed to see this in junior medical students who worry about the future of medical practice, about the government, and about hospital privileges. A strong sense of pessimism is not a good quality in a teacher. William Osler said that one of the most important things for a teacher is the capacity for enthusiasm. What is your capacity for surprise? Can you be amazed? This is an important characteristic for a teacher.

And I suppose the last thing is – what is your attitude towards change? Inflexibility and rigidity will only lead to abrasions, scars, and sometimes transfusions.

What to Teach

Next it might be important to consider what you have to teach. I have seen some teachers try to organize their whole style around the dropping of "pearls," and you really cannot do that constantly – unless you are away from home a lot. What you really have to teach as a family physician is your experience. That is the "stuff" you have been building all these years, and so you have to ask yourself what you know about your own experience. You know the old line about 20 years' experience compared to one year's experience repeated 20 times – they are not the same thing. It gets back to how you reflect on your experience and what data you have about your experience. We certainly teach from anecdotes; I do not disparage anecdotal teaching at all, but it is important that we move beyond anecdotes to be able to generalize to some extent. So you have to think about your experience. You know where you have been in your practice. Most of the teaching that family physicians do I consider to be relational rather than informational. That is not to deny the informational aspects but what we really have to teach as family physicians are ideas that have to do with relationships. In reflecting upon one's experience there are two equally important activities. One is to compress a long experience into a single view which gives perspective. The other is to expand a short experience to illuminate a problem. There are critical moments in clinical practice when an important exchange takes place or a new understanding dawns. Good teachers can capture these moments and hold them still long enough for their students to share them.

The last question about experience that I would ask you is, "What is it that turns you on in medical practice?" We all have areas of enthusiasm – some clinical conditions that seem more important. If you do not have any, how are you going to focus upon your experience?

The Risk

Suppose that you decide that you want to become a full-time teacher. You have been a preceptor, you have had a student in your office, and you have organized a seminar, but now you have opted for full-time teaching. You cannot avoid a risk factor. You cannot know whether you are going to like it until you take the plunge. Like any other major decision in life – marriage, a business deal, forming a practice group, etc – the most important things you want to know about in advance you cannot know. There comes a moment of commitment. This requires a certain amount of risk and courage, as Carl Sandburg wrote in his poem, *The Plunger,* "Plunger, take a deep breath and let yourself go." There is a time in deciding to become a teacher when you take in that last breath and let go.

I would also urge that you be honest with yourself about whether or not you are motivated to teach by any negative things in your life. I have learned in interviewing prospects to ask about trouble. Is a prospective teacher trying to get away from any-

thing? Is he or she trying to escape from a bad marriage, from physical disability, from drugs, from alcohol, from financial trouble? There has to be a proper level of honesty. These things would not necessarily mean that you would be disqualified, but they have to be taken into account.

Finding a Position

Once you have decided to risk it, the next step is to seek what you consider to be the right position for yourself. There is a courtship ritual and there are some interviews. If you do get involved in negotiating with a medical school there are three questions you should ask to find out what the system is like: (1) How do I hire a secretary? (2) Where do I park my car? and (3) How do I order paperclips?

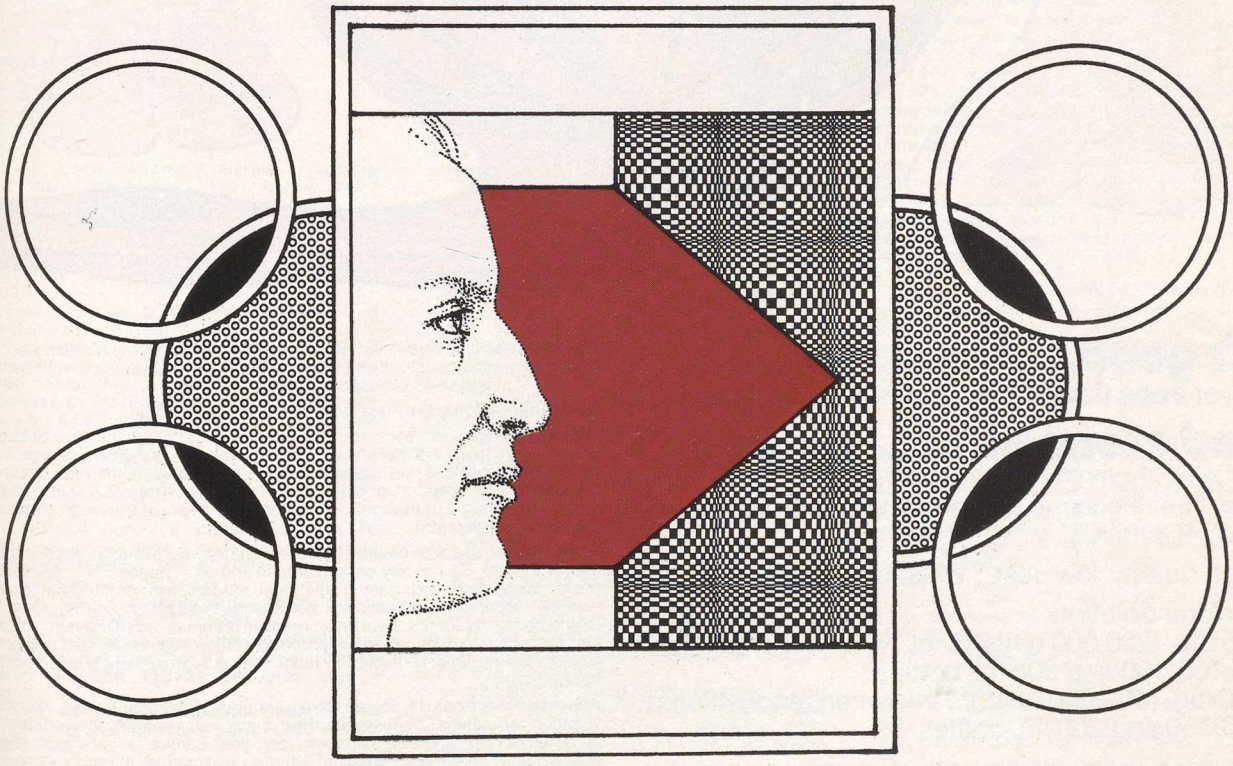
If you can get answers to those three questions, they will tell you about the personnel policies of the organization, where you stand on the totem pole, and what the purchasing procedure is. If you know those things and can live with them, you can get along in most any organization. I would urge you not to make a deal for your old desk or your old secretary. Either one of those is not a good thing to take with you into your new job.

You find out after all this careful consideration and after making the jump that you do not know quite what is going to happen. You are now in a new social system in which you do not know the rules. There is a different sense of time – a certain inertia. Most doctors work on a cycle of two weeks – "If you are not better in two weeks come back." But in the medical school it might be six months or more for the system to respond. There is a different set of rewards. You do not have patients coming by and telling you what a good doctor you are. Instead you have people criticizing you, either implicitly or explicitly. You are not sure what the rewards are.

You should use the first six months in your new job to professionalize yourself in the new role. This has to do with meeting and talking to as many people as you can, traveling as much as your department budget will allow, and developing one or more special interests to use as your "ticket" as you negotiate in the academic world. You need to develop proper relationships with residents and students. Teaching is not much different from taking care of patients; what you can do for people is a function of the relationship you have with them. This is as true of teaching as it is with anything else.

Summary

I hope that the transformation from practicing physician to teacher which has been described does not sound too formidable. It is indeed serious business and like all disciplined tasks it exacts a certain price, not only from oneself but also from one's family. Perhaps in a few years a new generation of teachers will emerge who have had the benefit of more or less formal preparation, but for now there seems to be no alternative to learning on the job. It is a credit to the family physicians in the Academy that hundreds have been willing to accept the risks and to commit themselves to change. Most of these physicians have experienced enough gratification to continue and I urge others to consider teaching. The immediate future of our discipline requires it.



Continued from page 317

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94. Tozek F. & Krasik J. Medical-legal Aspects of Adverse Drug Reactions, 1970 (Legal Medicine Annual 247, 256 (C. Wecht ed., Appleton-Century-Crofts, New York, 1970)
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101. Leibowitz v Ortho Pharmaceutical Corp. 224 Pa. Super. 418, 307 A. 2d 449 (1973)
102. See note 62 supra
103. See notes 73-75 supra and accompanying text
104. See notes 83-91 supra and accompanying text
105. See notes 93-95 supra and accompanying text
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108. See notes 101-102 supra and accompanying text
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114. Id
115. Charlton v Montefiore Hospital, 45 Misc. 2d 153, 256 N.Y.S. 2d 219 (1965); Robbins v Nathan 189 App. Div. 827 179 N.Y.S. 281 (1919); see generally, note 113 supra
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118. W. Prosser, Torts 218 (3rd ed. 1964); 58 Am. Jr. 2d Negligence, §480 at 55 (1971)
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120. See note 113 supra at 280
121. Three situations justify less than complete disclosure: (1) emergencies, where communication may not be possible or the time involved to make the disclosure would materially increase the risks to the patient; (2) where the emotional or psychological state of the patient is such that a lengthy disclosure of possible adverse effects may precipitate a psychophysiological response; and (3) a remote risk, Note, 41 U. Cin. L. Rev. 224, 227 (1972)
122. These examples of "special duties" were abstracted from Rheingold & Davey. Standard of care in medical malpractice cases. 1974 Legal Medicine Annual. 279, 289-92 (C. Wecht ed., Appleton-Century-Crofts, New York, 1974)
123. See notes 36-69 supra and accompanying text
124. Note that expert testimony may be required to show that one drug is less dangerous than another but equally effective. Nonetheless, this testimony may be obtained from a source outside of the immediate medical profession, such as a toxicologist or pharmaceutical company
125. 186 Kan. 393, 350 P. 2d 1093 (1960)
126. 5 Cal. 3d 321, 486 P. 2d 684 (1971), noted in 41 U. Cin. L. Rev. 224 (1972)
127. 5 Cal. 3d at 323, 486 P. 2d at 685
128. Garlock v Cole, 199 Cal. App. 2d 11, 18 Cal. Rptr. 393 (3d Dist. 1962); Saffold v Scarborough, 91 Ga. App. 628, 86 S.E. 2d 649 (1955); Williams v Menehan, 191 Kan. 6, 379 P. 2d 292 (1963)

Book Excerpts

The following article has been selected by the Publisher from its new book, *Legal Medicine 1976,* edited by Cyril H. Wecht, in the hope that it will have immediate usefulness to our readers who otherwise might not have had access to it.

Physician's Liability to Non-Patient Third Parties

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Introduction

A current national concern is the malpractice crisis. A review of recent cases identifies several causes for increased malpractice liability being imposed on physicians. In general, the courts have been requiring a higher standard of care from physicians. The courts have increasingly imposed liability on physicians for failure to adequately warn third parties of potential hazards due to dangerous medical and psychiatric aspects of the patient's problem.

Furthermore, the courts have with regularity been allowing damages to relatives for pain, suffering, and mental anguish caused by the physician in the negligent treatment of the patient. This is particularly true if the courts determine that the negligent cause was "outrageous."

Wives as well as husbands may collect for loss of consortium when it was the result of negligent management of the spouse. Under the common law, damages for loss of consortium was available to the husband only. As an extension of this legal doctrine, other siblings have been held to be damaged by the birth of a child born as a result of physician negligence.

Duty to Warn

A review of materials presented at meetings, conferences, seminars, and in the literature reveals that there is a complete preoccupation with the physician's liability to the patient with little thought given to his potential liability to third parties. In the past, physicians have been held legally liable by the courts when they failed to relay necessary information and a third person had been harmed.[1] This legal doctrine imposing a duty on the physician to adequately and appropriately warn is applicable to the practice of medicine whenever it is part of the physician's professional responsibility to give information involving a person's safety. This includes patients and third persons, who may even be strangers, but in dangerous proximity to them.

The courts have imposed a duty on physicians to inform patients and third parties of the potential danger of a contagious disease.[2] In four reported cases, physicians were held liable in negligence to third parties for failing to identify tuberculosis,[3,4] smallpox,[5] and scarlet fever[6] patients and also to warn as to the hazards of their contagiousness and communicability. The compensated third parties either suffered severe medical consequences or died from these diseases after continuing close contact with the patients.

The courts have, by indirection, recognized a physician's duty to warn a third party regarding the communicability of a patient's contagious disease. The Nebraska Supreme Court held[7] that the physician's conduct was a justifiable effort to protect others in resolving a suit by a patient against the physician for invasion of privacy. The defendant physician had taken it upon himself to advise the patient's landlady of a small hotel that the patient may have a contagious disease (syphilis) and that she should be careful to disinfect the patient's bedclothing and to wash her hands in alcohol afterwards. Acting upon this dire warning, the landlady removed all of the patient's belongings to a hallway and fumigated his room. It is obvious that the law cannot reasonably require a physician to keep silent while one of his patients acts irresponsibly or unwittingly exposes others to a risk of infection or some other harm or injury.

In another case[8] a physician was sued by an injured passenger for failing to advise a bus-driver-patient of the sedative effects of an antihistamine. Another physician was sued[9] by a pedestrian because he failed both to completely ascertain the nature of a patient's seizures and advise the patient of the hazards of driving. The patient had lost consciousness and control of the car while having a seizure and struck the pedestrian causing injuries.

Another aspect in which a physician was held liable to a third party is demonstrated in the following case.[10] An automobile driver who accidentally injured an individual was allowed to seek indemnity from the physician who negligently treated that individual as a patient and aggravated the patient's injuries. The patient had brought an action for damages against the driver, and the driver instituted a third-party lawsuit against the patient's physician. In the suit the driver alleged negligence on the part of the physician resulting in aggravation of the injured individual's condition. The court held that since the driver was responsible for all damages flowing from the accident, including the physician's negligent treatment, he could seek indemnification from the physician as to the injuries allegedly caused by the physician. In regard to the physician's negligence the driver was declared not actively negligent and could seek indemnification from the physician to the extent of the latter's negligence.

A review of this medical-legal problem was undertaken because recently the family of a murder victim was awarded damages for malpractice liability against a psychiatrist and his employing institution* to the murder victim. The suitor-patient had stated this intention two months earlier during a therapy session. The court concluded[11] that a physician or psychotherapist treating a mentally ill patient, just as a physician treating a physical illness, bears a duty to use reasonable care to give threatened persons such warnings are essential to avert foreseeable danger arising from

*Damages were awarded because of their failure to properly inform law enforcement officials of the stated intentions of one of their patients.

Continued on page 331

Continued from page 330

his patient's condition or treatment. If the potential victim cannot be reached, persons who might reasonably be expected to convey the message, such as relatives or the authorities, should be notified.

Although they created less of a sensation among physicians, this decision is in accord with several verdicts in recent years holding a health care provider liable to a third party for failing to adequately warn of the dangerous propensities of a patient.[12] In the most recent case,[13] the federal government was held liable for the wrongful death of a wife of a psychiatric patient who had been allowed to leave the Veterans Hospital on a work-release basis. The protestations and fears of the wife prior to the patient leaving the hospital were ignored. The employer was erroneously informed of the patient's diagnosis and was not advised of his dangerous propensities. No precautionary measures were arranged. Letters to the institution from the patient while on leave indicating continuing delusional ideas were ignored.

In two New York cases,[14,15] the courts held that an injured third party could bring a cause of action against a physician if he had been injured by a patient with dangerous propensities due to mental problems when the physician failed to adequately warn the third party. The court noted, however, that the plaintiff would have to establish that the physician knew or should have known of the dangerous propensities. In any event, this would be a question of fact for the jury. These court opinions do establish the duty of a physician to warn persons other than the patient of the possibility that the patient may pose a danger to such third parties.

The last decision in California has created concerns among physicians anew. They contend that it compromises the physician-patient relationship which imposes a professional, ethical, moral, and legal duty on the physician to protect his patient's privacy and confidentiality.[16,17] Further, it raised the specter of liability based on retrospective judgment, which is immensely different from a prospective judgment. There is also the question of where does the duty to warn begin or end, and what if a patient threatens a whole community or people of a certain race, ethnic or religious groups, or members of one of the sexes. Physicians are troubled by a court's language which demands that they make a subjective evaluation when a patient indicates he might do injury.

An answer to this dilemma is found in our judicial system which recognizes a physician's professional discretion not to reveal information, if, in his judgment, it is undesirable or unnecessary.[18] Further, the physician can protect himself by making an appropriate entry in the patient's record. Even if the failure to disclose is later proven to have been a mistake, this will be considered an error in judgment, and not negligence, for which the physician is not legally liable. There are many times when the interests of the individual come into conflict with the rights of the public and the physician must decide between the rights of the individual and compromise for the benefit of the public.[19]

Liability to Third Parties

The criminal liability of the health care provider for failing to report certain diseases or activities required by law such as contagious diseases, injuries due to criminal activities or accidents, the battered child syndrome and similar situations is well established.

In a recent case[20] a natural father brought suit against four physicians for failure to report a suspected child abuse. Under the State of California statute, it is a violation of the penal code not to report suspected child abuse. The child had been brought to the physicians on three occasions with severe injuries inflicted by the mother's boyfriend, ultimately resulting in permanent brain damage. The suit claimed $5 million in damages due to their negligence. (The suit was settled out of court with a $600,000 trust fund established for the benefit of the child.)

The potential liability of a tort feasor to a third party is well established under the common law. One circumstance involves the right of a father and a husband to recover damages for injuries to a child or a wife, respectively. In both instances, the third-party father or husband has standing to sue the wrongdoer on the theory that the injured child or wife is his property and he is entitled to recover the loss of services to which he is entitled.

A sign of the time is exemplified in a recent court decision.[21] The wife had filed an action against the physician and hospital for loss of consortium, alleging professional negligence in the course of the treatment of her husband resulting in several complications, including sexual dysfunction. The court, in upholding the right of the wife, noted that in tracing the common law origin of the action for loss of consortium, the wife, under the common law, was equated to a chattel of the husband. She had similar status to a servant and the husband technically owned her. Today the wife is an equal to her husband. Since the wife is her husband's equal, there is no valid justification for treating them differently in matters relating to the marital relationship. If the husband has the right to recover for the loss of consortium, so does the wife. This represents the modern version of a well established potential liability of physicians to non-patient third parties.

A source of suits by husbands against physicians for loss of consortium has been the delivery of a baby by a wife after the failure of a sterilization operation, contraceptive prescriptions, or failure to timely diagnose the pregnancy. In one case, the other siblings were allowed to recover for loss of love and affection, attention, and economic and financial advantage advantage due to the birth of the unexpected child. The court's rationale[22] was that the siblings in being had to share these assets. Since they were not unlimited in amount, each sibling would get less than if the unexpected baby had not been born. The siblings

Continued on page 353

Continued from page 294

stresses are causally related to strokes (CVA) in black persons. Thesis three concludes that, "Neither multiple life changes nor variations in psychosocial assets were related in this study to complications of pregnancy." Thesis four measures family competence by a simple criterion: the number of absences from school. This is fascinating but incomplete.

This small book may be a good antidote for the young physician just completing a superscientific internship and may be of interest to others in family practice within the limits suggested above.

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Medical Genetics: Principles and Practice. *James J. Nora and F. Clarke Fraser. Lea and Febiger, Philadelphia, 1974, 399 pp., $20.00.*

This is an excellent text which provides within a single volume basic genetic information and its applications to the clinical problems that fall broadly within the sphere of medical practice. It contains relevant information for family physicians, pediatricians, and obstetricians. While the family doctor usually knows the family, its attitudes and socioeconomic background, he may have neither the genetic knowledge nor the time to fulfill the functions of a genetic counselor. However, it is important that he have sufficient background of knowledge to assist the family in obtaining necessary advice and guidance.

This text provides the necessary background knowledge of heredity and its relationship to disease, syndromes and disorders to enable the physician to perform this function adequately. It is well illustrated with photographs and diagrams of chromosomes as they occur normally and in the inherited diseases. The characteristic features of the inherited diseases are also illustrated. Diagnostic criteria are discussed at a level to warn physicians of diagnostic pitfalls. Methods of treatment are dealt with only in sufficient detail to give the physician an idea of what may be involved for the family.

The organization of the book is excellent. Much of the data is presented in tabular form for clarity and for ease of reference. This interesting and useful text should be of assistance to practicing family physicians as well as to those involved in undergraduate education and residency training programs.

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Approaches to the Care of Adolescents. *Edited by Audrey J. Kalafatich. Appleton-Century-Crofts, New York, 1975, 241 pp., $9.50.*

"Adolesence is indeed a stage separate and unique along life's continuum." With this statement, author Audrey Kalafatich introduces the reader to an excellent overview of how approaches to medical care for patients in this age group must also be unique.

This book was developed following a continuing education workshop for nurses held at The Ohio State University in 1971 and is primarily written for the undergraduate nursing student. The twelve people who each contributed a chapter or part of a chapter include seven nurses, three physicians, and two social workers. The reader is frequently reminded of the nursing orientation by references to the nurse-patient relationship and many paragraphs beginning with phrases such as, "the nurse needs," "as nurses" and "the nurse should." But the emphasis is on the unique qualities of health problems in adolescents and the multidiscipline approaches to dealing with these problems. Therefore, it holds the interest of the reader, whether or not he/she is a member of the nursing profession.

The book has increased relevance

Continued on page 336

Continued from page 332

because it discusses common problems, those encountered frequently in any medical practice that includes adolescents. Whole chapters are devoted to such topics as, "The Teenage Unwed Mother," "Obesity in Teenage Girls," "Venereal Disease in the Adolescent," and "Approaches to Hospitalized Teenagers." Case histories are used liberally and in a way that increases the reader's interest and helps relate issues discussed to the real world of health-care delivery.

The book is easy to read and can be finished in a few hours. It is not a reference text giving complete coverage of specific disease processes. Instead, it presupposes some prior medical knowledge and relates this knowledge to a particular group of patients – adolescents.

On the other hand, I do not recommend this book for the seasoned practitioner, nurse, or social worker. The kind of information given should prove very useful to the novice but is mostly "old hat" to one who has spent several years involved in direct patient care to adolescents. An exception to this is the solo practitioner who has had little experience with the team approach to medical care delivery and may find this aspect of the presentation useful.

To summarize, for residents in family practice and pediatrics, for students of medicine, nursing, social work, and related fields, and for some solo practitioners this very interesting and readable book has much to offer.

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Clinical Rheumatology: A Problem-Oriented Approach to Diagnosis and Management. *Roland W. Moskowitz. Lea and Febiger, Philadelphia, 1975, 331 pp., $14.00.*

This book is best described as a survey of the current "state of the art" of rheumatology in 1975. The organization is somewhat different than the usual textbook. It is organized into three parts. The first part deals with clinical examination, laboratory studies, and diagnostic techniques in rheumatology. The second part is organized by clinical problems, eg, acute monoarthritis, syndromes of muscular pain or weakness, and intermittent arthritis syndromes, rather than by disease entity. Detailed case reports are included to illustrate specific rheumatic diseases. The third part is devoted to a summary of problems in diagnosis and treatment of rheumatologic diseases and includes a useful chapter on local injection therapy.

The book contains the kind of information that an attending rheumatologist would transmit on rounds to residents and medical students. The author indicates that he is presenting his own particular approach to rheumatologic problems, which is documented by significant references at the end of each chapter. Because of the nature of the organization of the subject headings, repetition of information is frequent. In addition, there are omissions of significant information. Errors in the headings of differential diagnosis are also disturbing. The factual nature of the book lends itself to easy and rapid reading. In a sub-specialty of medicine of recent origin, we can expect an increase in books on the subject. This is not a significant textbook, but does contain information that is usable in the day-to-day management of rheumatologic problems in family practice.

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The Relation Between Physical and Mental Illness. *Michael Robin Eastwood. University of Toronto Press, Toronto and Buffalo, 1975, 119 pp., $10.00.*

In usual British fashion, Dr. Eastwood tells in a very organized and concise way (approximately one page) just what he is going to do in the book and then he proceeds to do it. Basi-

Continued on page 356