

The Legal Implications of Healthcare Communications: What Every Pain Physician Needs to Know

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Accurate and sensitive communication of health care information is essential to effective patient management in the pain clinic, operating room, other health care settings. However, information relating to the health care status of a patient is sensitive and may be embarrassing or damaging if it falls into the wrong hands. Ethical cannons of medicine and statutory provisions have emphasized the obligation of the physician to safeguard patient confidences. However, threats to the confidentiality of medical information abound and are even more significant in our age of instantaneous communication characterized by the growing use of email, facsimile, and the Internet. This article outlines legal issues relating to communication in three key areas of health care law: confidentiality/breach of privacy, informed consent, and defamation. The major principles of the law in these areas are discussed and case studies are used to illustrate key points and give simple preventive strategies to help steer the delicate balance between sharing important healthcare information and protecting sensitive patient information.

Dr E saw patient XY in the pain clinic of a large referral hospital. XY had previously been seen and treated for reflex sympathetic dystrophy as an outpatient by physicians in a small town several hundred miles away. Dr E wrote a note in the electronic medical record: "It is difficult to imagine how therapy prescribed previously could have any chance of helping XY. In fact, earlier mistakes may have compromised my ability to effectively treat her."

Dr E may have thought she was protecting herself from malpractice exposure by blaming previous physicians for XY's difficult-to-treat condition. Unfortunately, not only does a comment like this increase the likelihood of malpractice action, but it also exposes Dr E to the risk of a lawsuit for libel initiated by XY's previous physicians.

Information in medical records is now read by a multitude of parties. Anything entered into the record should be considered a communication to others. The comment in this medical record is derogatory toward previous physicians. It expresses more than a different judgement regarding a particular clinical decision and goes on to express an opinion about the competence of previous caretakers.

This particular case reflects an additional problem. The ability to transmit medical information widely and quickly has never been greater. The use of email, facsimile, and the Internet presents a tremendous opportunity to improve health care by putting complete, accurate, and timely patient data in the hands of practitioners when they need it. However, the rapid dissemination of information has its downside. Whereas old-fashioned paper charts are available to dozens of people who provide care or review medical records for other purposes, an electronic medical record may be accessible to hundreds if not thousands of others. The potential for damage resulting from inaccurate or ill-advised communications is therefore magnified severalfold. Given the circumstances, it has never been more important for health care providers to have a rudimentary understanding of the legal implications of health care communications.

Although we tend to take it for granted, communication in the medical setting is of critical importance. Information must be shared effectively, but sensitively among health care

professionals if coordinated patient care is to be achieved. Communication between doctor and patient is also the basis of the relationship of trust and honesty, which must be in place for a physician to provide effective medical care to the patient. It is clear that information must be transmitted from patient to doctor and from doctor to other appropriate members of the healthcare team to ensure high-quality care. It is also true that the information relating to the health care status of a patient is often sensitive in nature and may be embarrassing or damaging if it falls into the wrong hands. How can healthcare information be transmitted in a way that maximizes its medical usefulness but minimizes the personal consequences resulting to the patient? Our article outlines several significant medical legal issues relating to communication in the health care setting.

Legal Background Go to: Choose

This article will focus on 3 key areas of communication law: confidentiality/breach of privacy, informed consent, and defamation.

Case 1 Go to: Choose

JO is a patient seen in the pain clinic of a major medical center for chronic shoulder pain. In the course of taking the history, Dr X learned that JO had a history of intravenous drug abuse. Dr X obtained an ELISA screening blood test that revealed JO was HIV-positive. He then notified the local health department of the positive test. He was asked to email a copy of the electronic record of JO's clinic visit to the health department, which he did. JO learned of the notification and sued Dr X for invasion of privacy and breach of confidentiality.

Confidentiality/breach of privacy

The notion of personal privacy is rooted in one of the important tenants of modern western philosophy: personal autonomy. This emphasis on priority of the individual as distinct from the welfare of the social group originated in the Renaissance when personal rights and responsibilities assumed greater importance in society [1]. The right to privacy is defined as the right to be left alone to perform one's personal affairs without unreasonable interference from the government or others as long as one's conduct is not unlawful or indecent [2]. Confidentiality is a subset of privacy that deals with the communication of information. Indeed, personal autonomy encompasses the right to control dissemination of personal information.

The concept of medical confidentiality is contained in both the Hippocratic oath and in the American Medical Association (AMA) Code of Ethics. As stated by the AMA code of ethics: "A physician shall respect the rights of patients, of colleagues and of other health professionals, and shall safeguard patient confidences within the constraints of the law" [3]. The confidentiality of the doctor-patient relationship establishes the trust that is essential to effective patient care. That trust is eroded when information obtained within the sanctity of the doctor patient relationship is disseminated inappropriately. The US Constitution does not contain any provision guaranteeing a right of personal privacy. Nevertheless, invasion of privacy is a well-recognized tort (a tort is legal cause of action, i.e., a wrong that the law provides a legal remedy to redress; a tort specifically is a wrongful act or failure to act which results in an injury to another person or another's property or reputation) that developed after the publication of an influential law review article that appeared in 1890 [4]. Although the law and the ethical canons of medicine recognize that privacy rights deserve certain protections, the confusing welter of state and federal laws and court decisions that have grown in this area makes it difficult to assess exactly what is protected and when. Although physicians are enjoined by ethical and legal constraints from disclosing confidential patient information, there are many exceptions that result in the transmission of large amounts of patient information leading at least 1 commentator to state,

"The only reasonable expectation of privacy is no expectation of privacy at all" [5]. This is especially true today in the era of instantaneous information transmission.

The sharing of information is crucial to effective patient care. With patients more mobile than ever, the ability to transmit patient records from one care provider to another has become more important. Electronic medical records provide significant advantages in this regard. With the stroke of a computer key, accurate, complete, and timely patient information can be transmitted across the country. The availability of this information has the potential to make patient care more effective and decrease costs resulting from duplication of services and tests. Analysis of electronic compilations of patient data can lead to improved practice standards and better use of health care resources. However, the availability of this information comes with a price: the sacrifice of some degree of patient privacy. It is easy for information about patients to be disseminated inappropriately in our information age [6]. Patient data displayed on a computer screen can be observed by all who pass by the terminal. Health insurers, public health authorities, health care researchers, peer review, and quality assurance groups all have some right to access individually identifiable patient data. Consent to the release of information for these purposes is often implied from the patient's signature on a consent to receive treatment form. Finally, there is always the potential for unauthorized release of patient data [7].

Congress has recently addressed the issue of medical records privacy in the electronic age in the Health Insurance Portability and Accountability Act of 1997 (HIPAA) [6]. This law established certain standards for electronic transmission of health data and placed an affirmative mandate on Congress to pass legislation protecting the privacy of individually identifiable health information by August 1999. As of this writing, Congress has been unable to pass a patient privacy bill and it seems likely that another provision of the law will be activated, one that requires the Secretary of Health and Human Services to promulgate regulations to provide privacy protection by February 2000 [8].


Aside from HIPAA, several other federal statutes provide some limited protection for medical information. For example, the Privacy Act of 1974 [9] confers limited safeguards on the disclosure of government held medical records and the Freedom of Information Act, which mandates wide disclosure of governmentally held information, provides an exception for the opening of personal medical information [10].

Federal case law is very conservative in its recognition of privacy rights. As mentioned previously, the Constitution does not grant an express right to privacy, but the US Supreme Court has stated on several occasions that there is a limited right to the privacy of personal information. However, this right has been strictly confined. In *United States v Westinghouse Electric* [12], the court established a balancing test that would apply to consideration of whether the release of a particular record was appropriate or inappropriate. This test considers a number of factors, including (1) the type of record requested; (2) the information contained therein; (3) the potential for harm to the involved individual in nonconsensual disclosure; (4) the injury resulting from disclosure to the relationship in which the record was generated; (5) the adequacy of safeguards against disclosure; and (6) the degree of need for access.

State law often provides more explicit protection of privacy rights. Twelve states have written privacy protections into their state constitutions and there are also a number of state laws in the area of privacy that especially recognize a provider-patient confidentiality privilege [6]. Three theories of recovery have met with some success in civil privacy actions in state courts. These include: (1) breach of a fiduciary duty of confidentiality [13] (the establishment of a doctor-patient relationship establishes a fiduciary duty on the part of physicians, hospitals and health systems); (2) invasion of a right to privacy [14] (although 48 states recognize this right broad disclosure of information has been required to establish a violation); and (3) breach of implied contract [15].

[The implied contract is that of patient confidentiality inherent in the physician-patient relationship].

Most states also have statutes that protect the disclosure of HIV-related patient information [16] on the theory that such protections encourage HIV-positive patients to seek treatment. There are, however, many exceptions to these statutory and case law privacy protections. These run the gamut from the routine (i.e., mandatory disclosure of communicable diseases to public health authorities, submission of patient care information to health insurers in the context of billing and reimbursement, and disclosure of patient records in peer review activities) [6] to the extraordinary (i.e., duty of treating psychiatrist to notify potential victims of a patient's possible threat of violence) [17]. The issue here is to achieve a balance between 2 competing interests: (1) society's clear interest in learning about and treating or at least containing a serious communicable disease; and (2) JO's strong individual interest in keeping health care information that is sensitive and potentially damaging from being disseminated beyond his immediate care provider. Despite the laws in many states prohibiting disclosure of HIV status information, the balance in this case would probably be struck in favor of Dr X because most states have decided that providers must report certain positive diagnoses to public health authorities to better protect the health of society at large. Thus, most of the anti-HIV disclosure laws have statutory exceptions for health providers reporting cases to public health agencies.

Case 2	Go to:	Choose 
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Dr Y is a pain physician in an IPA run by a local health maintenance organization. He believes that patient CB would benefit from a dorsal column stimulator, but CB's health plan does not cover placement of such a device. Dr Y, in discussing this situation with CB, mentions that he believes that a dorsal column stimulator is a viable option to help with CB's pain, but that he, Dr Y, cannot place the stimulator because it is not covered under CB's health plan. Dr Y's contract with the health maintenance organization (HMO) prohibits him from disclosing treatment options to patients who are not covered by the patient's particular health plan. When the HMO finds that Dr Y suggested this treatment option to CB, the HMO drops Dr Y from its provider panel.

Informed consent

Personal autonomy dictates that a patient consent in advance to the type of evaluation and treatment proposed by his or her physician. As Justice Cardozo stated in 1914: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages. This is true except in cases of emergency, where the patient is unconscious and where it is necessary to operate before consent can be obtained" [18]. These words, although written long ago, ring true today. The courts have upheld in many cases that physicians are under an affirmative obligation, except in limited emergency circumstances, to obtain not just consent but informed consent before proceeding with treatment. Informed consent means giving the patient relatively complete information about the proposed treatment including risks, benefits, and alternatives [19]. The test used in determining what type of disclosure to make is the question "What would a reasonable person want to know to make an informed decision about whether to proceed?" [20]. In addition to the established precedents of case law regarding informed consent, nearly half of the states have informed consent statutes, which mandate that informed consent be obtained and in many cases contain express provisions about what type of information must be disclosed to patients [19].

Despite the important emphasis placed upon it by the legal system, evidence exists that informed consent may not really be very effective. A 1982 survey concluded that physicians do not do a good job of providing adequate information to patients, that patients often do not understand

what they are being told, and that the information physicians convey to patients in obtaining consent rarely affects a patient's decision whether to follow the physician's recommendation [21].

The physician's legal duty to obtain informed consent from a patient before rendering treatment conflicts with the contractual obligation imposed by a provision prohibiting discussion with a patient about services not covered by that patient's health plan. As in this case, so-called "gag" clauses place physicians in a difficult bind. What is a practitioner to do when faced with a contract clause that reads, "Do not discuss proposed treatments with health plan members prior to receiving authorization?" At one point in the mid-1990s many, if not most, physician contracts with HMOs contained gag clauses that limited a physician's ability to communicate with patients [22,23]. Thanks largely to vigorous legislative lobbying, there are now antigag laws in over half of the states [24].

The prohibition of gag clauses still has not completely resolved the physician's dilemma, however, because most physicians' contracts with managed care organizations (MCOs) contain "termination without cause" clauses that allow MCOs to drop providers from their panels for no reason and without a hearing. This is a not-so-subtle way of trying to influence physicians to steer patients away from expensive or experimental treatments, and it has many of the same negative impacts on doctor-patient communications that the more egregious gag clauses did. One commentator has suggested that MCOs will continue to sway physician decisions through these clauses until liability for negligent patient management decisions is leveled at individual MCOs [25]. Several states have passed laws of this type already but it is too early to tell what effect they will have on the doctor-patient relationship [26]. In any case, it seems that the best advice legally and ethically is to err on the side of a complete discussion of treatment options with patients. Dr Y, therefore, did the right thing in discussing a dorsal column stimulator with CB.

Case 3	Go to:	Choose 
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Dr Z, a pain physician, has just finished seeing AR, a patient who has come to the clinic complaining of chronic back pain. Dr Z's history and physical examination reveals exaggerated pain behavior and a variable examination suggestive of malingering. AR tells Dr Z that he is involved in litigation over his back pain and requests that Dr. Z "certify" him as disabled. AR overhears Dr Z dictating his visit note in the front office in the presence of his nurse and receptionist. "AR clearly has no physical basis for his complaint. He is highly emotional and prone to exaggeration. This illness is all in his head." Dr Z does write AR a prescription for an antidepressant medication. Based on Dr Z's note, AR's health plan refuses to cover the costs of AR's prescription. AR sues Dr Z for defamation.

Defamation

Defamation is a tort that establishes legal liability for an attack on a person's reputation. It is intended to protect one's reputation from the harm that can be caused by false statements made to third parties [27]. Written defamation is termed libel, whereas oral defamation is termed slander. Physicians are frequently placed in situations where they can potentially or actually have made damaging remarks about the reputation of others. In many respects, the law of defamation has become as difficult to sort out as that of privacy.

The tort of defamation has its origins in English common law, when reputation was viewed as a fundamental principle of the economic and social system [28]. Most of the development of defamation law in the United States has taken place at the state level but a number of Supreme Court decisions and federal statutes have also affected the current state of the law.

In defamation law, as in privacy, the courts are obliged to balance competing considerations. Free speech is an important principle of US society and a fundamental right guaranteed by the First Amendment of the Constitution. Courts are reluctant to abridge free speech rights unless a compelling reason exists. Conversely, a person's reputation is valued by society and valuable to an individual. Defamation seeks to protect these personal interests. In general, the following elements must be present to support a claim of defamation. First, a statement must be defamatory. A test of the defamatory nature of the statement is to ask the question "Would people think worse of the person in question as a result of reading/hearing this?" [29]. Second, the statement must be false. Third, the statement must be communicated to a third party. Fourth, in most cases the person making the defamatory statement must have known or should have known that the statement was false. Finally, at least in some cases, the person being defamed must be able to prove some damages directly attributable to the defamatory statement [30].

An example of how the intersection between federal and state law complicates the legal landscape is provided by the landmark 1964 Supreme Court case of *New York Times v Sullivan* [31]. In this case, the Supreme Court decided that the First Amendment limited the ability of states to formulate defamation law that protects individual economic and social interests but also limits free speech. Sullivan, a city commissioner from Montgomery, Alabama, brought a suit for libel against the New York Times in the Alabama state courts, alleging that an advertisement relating to civil rights demonstrations in Alabama, which the paper published, contained false and defamatory information. The commissioner won a \$500,000 jury verdict that was affirmed on appeal in Alabama. In reversing the state court's decision, the Supreme Court set aside the traditional common law approach to defamation and held that when public officials bring a defamation action, they must show that the defendant published the statement with "actual malice," i.e., with knowledge of its falsity or reckless disregard for the truth, to prevail. Thus, at least in cases involving public figure plaintiffs, the barrier to obtaining redress for defamation was considerably heightened.

In several cases plaintiffs have attempted to claim that physicians are public figures. For example, in *Sparagon v Native American Publishers, Inc* [32], the defendant newspaper printed an article that alleged that the plaintiff negligently performed a procedure on a patient that caused complications, resulting in the amputation of the patient's leg. The upshot was the plaintiff did not perform the procedure, but the newspaper claimed the plaintiff was a public figure imposing on himself a higher burden of proof. The court rejected this argument because the plaintiff was not a high-profile physician who occupied the public stage by becoming embroiled in medical or public health controversies. In contrast, the court in *Rodriguez-Erdman v Ravenswood Hospital Medical Center* reached the conclusion that the plaintiff physician was a public figure precisely because he had projected himself into the public limelight by holding press conferences and writing newspaper articles about a dispute he had with the defendant hospital.

Many medical defamation cases that have been litigated in the past deal with 1 of 2 broad areas. First, there are a series of cases in which physicians who were refused hospital credentials subsequently brought suit against hospital-credentialing committees or individual members of those committees for defamation of character. These cases have almost uniformly proved unsuccessful [33-35]. Another group of cases involves a situation where a physician reveals information about a patient to a third party to warn that third party of the dangers the patient's medical condition might pose to the public. Patients, claiming the information revealed was defamatory, have brought a number of lawsuits in this situation. These too have usually proved unsuccessful, except in cases where information disclosed was not truthful [36-38].

Electronic environments have begun to invite claims for on line defamation. For example, in *Cubby v Compuserve* [39], an Internet service provider was sued for the republication of defamatory

statements made by a subscriber. In finding for the service provider, the court reasoned that the company had no opportunity to review the subscriber's posting and had no way of knowing that the material posted was defamatory. However, the court went on to say that if the provider knew or reasonably should have known the statements were defamatory, it would be obligated to stop the activity. More cases involving electronic defamation are sure to result from our growing reliance on this form of communication.

Finally, in another parallel with privacy law a number of exceptions have emerged that shield various types of individuals from claims of defamation. For example, statements made during government proceedings and those made by a public official acting within the scope of his or her official duties have been considered privileged [40]. Another qualified privilege attaches to physician peer-review activity. The public has a strong interest in having the medical profession police its ranks to ensure that only well-qualified individuals are given opportunities to practice. Thus, nearly all states give peer-review committee members qualified immunity from civil liability [41]. However, this privilege may be overcome by a showing of malice. Congress has also recognized the importance of physician peer review. The Health Care Quality Improvement Act (HCQIA) was passed in 1986 to provide "incentive and protection" for physicians engaged in peer-review activity [42]. The statute creates protection for acts taken "in reasonable belief that the action was warranted by the facts" after a "reasonable effort to obtain the facts." The fact that HCQIA does not provide blanket immunity is made clear by *Brown v Presbyterian Healthcare Services* [43], in which a physician was able to maintain a claim of defamation against the defendant hospital by showing that its peer review action "was not taken after a reasonable effort to obtain the facts of the matter."

In assessing Case 3 it is clear that Dr Z has communicated statements to third parties that have the potential to damage RA's reputation. Two elements of an action for defamation are thus present. RA can prove at least some economic damages because his health plan is refusing to pay for his medication based on Dr Z's note. The outcome of the case will depend on whether Dr Z's statements are false, and if they were false, whether he should have known they were false. Although he certainly is not practicing good medicine, Dr Z's statements would probably be defensible as falling within the scope of his professional judgement. It cannot be too strongly stated that the medical record is no place for editorializing, attributing blame to others, or making off-hand remarks.

Conclusions

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The cases discussed above illustrate some of the major legal issues in health care communications that can emerge in the day-to-day practice of medicine. It is important for physicians to exercise careful professional judgement in what they say about patients and colleagues and about how and where they say it. The growing use of electronic forms of communication, with their considerable power to disseminate information broadly, make this a more pressing concern today than it was even 5 years ago. The Internet, email, and the electronic medical record have opened entirely new horizons for health care communications law. That fact notwithstanding, the best way to avoid potential legal pitfalls is to practice good medicine. Good medicine demands not only excellent technical skills and clinical judgement, but also the establishment of an effective therapeutic relationship with patients. It also calls for maintaining good relationships with professional colleagues. These factors are especially significant today because medical consumers are more knowledgeable and demanding than ever before. In addition to these practical considerations, the ethics of medicine as a profession demand that physicians safeguard the rights of patients and colleagues. Thus, medical ethics and good practice both argue in favor of respecting the dignity of patients and fellow practitioners. Keeping in mind the importance of a professional approach to patient relations, avoiding potential liability for faulty communications is mostly a matter of common sense and good judgement. A

good rule of thumb to exercise is always to pause to think twice about the potential impact of what you are about to say or write. This simple precaution will put most physicians in good position to avoid the specter of potential legal problems. It will also help to ensure that interpersonal relationships are maintained on a plane that promotes optimal therapeutic effectiveness. Our patients and society expect no less than this commitment.

References Go to:

- 1 Tarnas R. *The Passion of the Western Mind: Understanding the Ideas that Have Shaped our World View*. New York, NY: Ballantine Books; 1991.
- 2 Southwick AF. *The Law of Hospital and Healthcare Administration*. 2nd ed. Ann Arbor, Mich: Health Administration Press; 1988.
- 3 American Medical Association. *Code of Medical Ethics: Current Opinions with Annotations*. Chicago, Ill: American Medical Association; 1996.
- 4 Warren, Brandeis. The right of privacy. *Harv Law Rev* 1890;**4**:193 220.
- 5 Burris S. Health care privacy and confidentiality: the complete legal guide by JP Tomes. [Book review]. *J Legal Med* 1995;**16**:447 52.
- 6 Carter PI. Health information privacy: can Congress protect confidential medical information in the information age? *Wm Mitchell Law Rev* 1999;**24**:223 86.
- 7 Lohr KW & Donaldson MS, eds. *Health Data in the Information Age: Use, Disclosure and Privacy*. Washington, DC: Institute of Medicine; 1994.
- 8 Anonymous. Privacy picture still clouded as deadline nears. *Association of American Medical Colleges Reporter* 1999;**8**:1,5.
- 9 USC § 552(a) 1984.
5
- 10 USC § 552(b)(6) 1984.
5
- 11 *Whalen v Roe*, 429 US 589 (1975).
- 12 *United States v Westinghouse Electric*, 638 F. 2d 570 (3d Cir 1980)
- 13 *Watts v Cumberland County Hospital System, Inc*, 330 SE 2d. 242 (NC Ct App 1985).
- 14 *Lake v WalMart Stores, Inc*, 582 N.W. 2d 321 (Minn 1998).
- 15 *Hammonds v Aetna Cas & Sur Co*, 243 F. Supp 793 (ND Ohio 1965).

- 16 PA. Stat. § 7602 (Purdon's Supp. 1994).
- 35
- 17 *Tarasoff v Regents of U of California*, 551 P. 2d 334 (Calif 1976).
- 18 *Schloendorff v Society of New York Hospital*, 211 NY 125, 129, 105 NE 92, 93 (1914).
- 19 Foley HT & Dornette WHL. *Consent and Informed Consent in Legal Issues in Anesthesia Practice*. Philadelphia, Pa: FA Davis; 1991
- 20 *Crain v Allison*, 443 A 2d. 558, 562 (DC App 1982).
- 21 Government Printing Office. *Ethical Problems in Medicine and Biomedical and Behavioral Research: Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship. Views of Informed Consent and Decision Making: Parallel Surveys of Physicians and the Public. Vol 2*. Washington, DC: Government Printing Office; 1982.
- 22 Spielman BJ. After the gag episode: physician communication in managed care organizations. *Seton Hall Legis J* 1998; **22**:437 74.
- 23 Gordon GH, Baker L, Levinson W. Physician-patient communication in managed care. *West J Med* 1995; **163**:527 31.
- 24 Miller TE. Managed care regulations in the laboratory of the states. *JAMA* 1997; **278**:1102 9.
- 25 Liang BA. The practical utility of gag clause legislation. *J Gen Int Med* 1998; **13**:419 21.
- 26 Page L. Patient death prompts first use of Texas' new HMO law. *Am Med News* 1998; **41**:1.
- 27 Eldrege LH. *The Law of Defamation*. Indianapolis, Ind: Bobbs-Merrill Co; 1978.
- 28 *Rosenblatt v Baer*, 383 U.S. 75, 92 (1966) [Stewart J. concurring].
- 29 Parsons D. The dangers of libel and how to avoid them. *BMJ* 1993; **306**:253 255.
- 30 Mathews DR. American defamation law: From Sullivan, through Greenmoss, and beyond. *Ohio State Law J* 1987; **48**:513 32.
- 31 *New York Times v Sullivan*, 376 US 254 (1964).
- 32 *Sparagon v Native American Publishers, Inc.* 542 NW 2d 125 (SD 1996).

- 33 *Spencer v Community Hospital of Evanston*, 87 Ill. App 3d 214, 408 NE 2d 981 (1980).
- 34 *Bradwein v Gustman*, 367 So 2d 725 (Fla App 1979).
- 35 *Goodley v Sullivan*, 32 Cal App 3d 619, 108 Cal Rptr 451 (1973).
- 36 *Griffin v Cortland Memorial Hospital, Inc*, 85 A 2d 837, 446 NYS 2d 430 (1981).
- 37 *Simonsen v Sweson*, 104 Neb. 224, 177 NW 831 (1920).
- 38 *Barry v Moench*, 8 Utah 2d 191, 331 P 2d 814 (1958).
- 39 *Cubby v Compuserve*, 776 F Supp 135 (SDNY 1991)
- 40 Restatement (Second) of Torts § 611-612 (1976).
- 41 Oliverio, J. Hospital liability for defamation of character during the peer review process: sticks and stones may break my bones, but words may cost me my job. *West Virginia Law Rev* 1990;**92**: 739 60.
- 42 USCA § 11101-11152 (West 1995 Supp 1997).
- 43 *Brown v Presbyterian Healthcare Services*, 101 F 3d 1324 (10th Cir 1996).

For those who are unfamiliar with the law and its intricacies, accessing legal reference resources is as complicated as accessing medical reference data is for nonphysicians. Legal references fall into a number of general categories including statutes, case law reports, law reviews, regulations issued by federal, state, and local administrative agencies, and textbooks and legal commentaries.

An example of a statutory citation is 42 USCA 1341, which would refer to volume 42 of the United States Code Annotated, section 1341. Statutes are passed by legislative bodies at federal, state, and local levels. Statutes comprise codes of laws that are in many cases aggregated into multivolume compendiums that are annotated to describe legal challenges that have been brought to the various provisions of each law and the resulting rulings of the courts involved. These documents are often extremely difficult to decipher because the numbering system used by the publisher that compiles the annotated code, the system used by federal and state governments, and the working number of the legislation as it is passed in a particular session of a legislature are all different. Extensive tables must be consulted to cross-reference the same piece of legislation.

In addition to the statutory language itself, a legislative history, including committee reports, hearing testimony, and other documents that were generated during consideration of the

legislation, is often available that is sometimes useful. Some of these documents are contained within the federal Congressional Record and others are published separately as reports or as bound hearing testimony. Given the fact that the body of statutes grows each year, periodic updates are also necessary to incorporate amendments to existing legislation as well as to report newly passed legislation.

An example of a case citation is *United States v. Sullivan* 376 U.S. 254 (1964), the opinion of which appears in volume 376 of the US Reports (which compiles Supreme Court opinions) at page 254, which was issued in 1964. Case reports are often organized by court of origin or by region of the country. Most cases reported are decisions of appellate courts at the federal or state level. These include the US Supreme Court, the Federal Circuit Courts of Appeals, and the appellate courts of the various states. Some district court rulings are also published at the federal level. Case reports are generally compiled temporally with each year's session of a particular court's work being compiled in a new volume of judicial opinions. In addition to court opinions, there are also rulings from various administrative law councils such as the Tax Court, the Interstate Commerce Commission, the Securities and Exchange Commission, and other agencies that are compiled into volumes and made available to interested segments of the legal and lay community. There are also reporter services that monitor developments in various segments of the law and produce binders of case decisions in these areas reached by various tribunals.

An example of a citation from a law review would be "Spielman BJ. After the gag episode: physician communication in managed care organizations. *Seton Hall Legis. J.* 1998; 22:437-74." Law review articles are generally published by law schools and are commentaries on particular issues of the law. Some law reviews are specialized in the sense that they deal with a particular area of the law and others are more generally oriented. Law reviews are a source of advancing and testing legal theories and as such serve a valuable function in the legal community.

Numerous federal, state, and local administrative agencies such as the Internal Revenue Service, Health Care Financing Administration of the Department of Health and Human Services, the Federal Aviation Administration, and many others are empowered to issue regulations that have the force of law. Much of this activity at the federal level is recorded in the Federal Register and the Code of Federal Regulations. These are extremely cumbersome documents consisting of thousands of pages annually that are difficult to access and use. The Federal Register also contains documents such as advisory opinions and other nonbinding interpretations of the law that are issued by federal agencies.

Legal textbooks and commentaries are similar to textbooks and monographs in the medical profession and generally deal with a specific topic or subject of the law in great depth. These are usually well-referenced with statutory and case law citations. There are also "keyword" series that are a survey of the entire body of the law referenced by specific legal topic or keyword. Luckily, there are some shortcuts that can be used in consulting the legal literature. These include the availability of a number of online databases similar to Medline that index case law, law review articles, and in some cases, statutes. Examples of these include West Law, Lexus Nexus, the Index to Legal Periodicals, and the United States Code Service. In addition, many federal and state agencies publish electronic versions of their regulations, advisory opinions, and statutes online on their web sites.

The best advice for a novice interested in exploring the legal literature, short of attending law school, is to go your local law library and ask the reference librarian for assistance in getting started.

Footnotes

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