Physician & Administrative Dialogue in Patient Care

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Abstract

What are the constructs of informative dialogue in patient care? What patient care requires what form of dialogue? When is each informative structure necessary? Is each specific situation unique? Could a formula be created to equate the subsections of verbal language for construction of a more complete & moral verbal narrative? This thesis includes when a physician must determine when and what to disclose to patients regarding their treatment and the correlating moral constructs of do no harm.

Keywords: patient disclosures, timeline of disclosures, acute care disclosures, chronic care disclosures, hospice care disclosures, legality of disclosures, patient dialogue, physician dialogue, health care administration
Physician & Administrative Dialogue in Patient Care

Physician and Administrative dialogue in patient care is critical to not only the potential success of a patient but also to assuage any potential legality issues derived from improper dialogue in patient care. This text goes about creating a solution for dialogues in patient care to create the proper implementation of language as part of medical disclosures.

**Understanding the Dialogue of Physician Related Disclosures**

When approaching a patient regarding the type of dialogue in which they should receive and how they should be informed Tom Beauchamp writes, “Many factors account for limited understanding in the informed consent process. Some patients are calm attentive and eager for dialogue, whereas others are nervous or distracted in ways that impair or block understanding” (Beauchamp, 141). More importantly Beauchamp writes about the “conditions that limit understanding” which are more concerning and more important than how the patient “feels about being informed.” In constructing dialogue, a physician or administrator must consider a multitude of other factors including timeline, legality, the number of solutions available for the patient’s recovery.

**Determining the Timeline of Disclosures**

The timeline of disclosures can be determined once a physician has a solid timeline for the patients care with the physician’s facility. This timeline can be broken down into three subsets – acute care, chronic care and hospice care.

**Acute Care Timeline of Disclosures**

Acute care can be defined as a form of active health care when a patient receives short-term treatment of a disease or illness. In terms of the disclosure of a physician regarding acute care, this subset in the timeline of disclosures does not necessarily make the physician in cases of
acute care liable on any specific level. When determining a timeline for acute care – a physician is more likely to not be the determining physician for the illness unless the timeline leaves the patient at risk of worsening his or her condition before leaving the physicians facility. In some cases of acute care, a physician is not inclined to answer any specific set of questions because he is most likely not the determining physician in terms of liability.

If the patient which a physician is treating at a hospital has already been informed of his or her condition – or if the patient at any such facility has been treated for a similar illness already and has a doctor which oversees the patient’s condition, the hospital physician is not inclined to have to disclose anything but the changes in the form of the patient’s condition. The dialogue in cases such as these may sound like:

“I (physician/hospital admin) have been informed that you are already under treatment for (your condition) at (hypothetical) medical facility. We have contacted your physician so that he may be active in all aspects of your treatment.”

This also includes that the physician who previously treated said patient is still current on the patients’ medical records, medications, and condition. Swaying the risk of legality from the current physician to the physician who initially treated said patient for conditions which the initial physician was aware of. This form of open dialogue makes the acute care physician fluent in all aspects of the patient’s treatment.

If the patient is coming to the hospital for a form of acute care in which the patient is unaware of his or her condition or if the patient does not have a physician which oversees his or
her condition – then it is the responsibility of the attending physician to disclose the regards of his patient’s condition to the responsible parties.

This condition is determinant on the number of days, number of solutions probable to his patient’s disease along with the determinant of the legality of his patient’s conditions in terms of disclosure and power of attorney. If the patient’s only potential option is an experimental treatment which can assuage the patient’s condition then there is no liability and the output of the dialogue can sound something like:

“There are no available solutions which our hospital can administer. You may find it beneficial to contact other treatment facilities regarding potential treatments which we, at this time, are not able to provide.”

This can be read with a sort of inclination of possibility. An explanation that if the patient could find some sort of experimental therapy or unsubstantiated treatment which comes with a larger allocation of potential risk – they may be able to find a facility willing to take that risk. These facilities would be larger in nature better equipped to handle different and more complex treatments although, if the hospital is a larger facility equipped for solutions which are less concrete – the nature of the language would trend towards explaining the situation, and stressing the risk. For a larger facility, the dialogue could come in some form like:
This form of dialogue is only a viable option for larger, more equipped facilities, in many cases the patients may be best advised for solely a course of medications which could be potentially better depending on the legal risk of the advised treatments. It is presumed that when a facility is better equipped to handle more experimental treatments that concurrently the hospitals (or physicians) insurance is good enough that it would negate the potential risk based on the viability of the patient’s treatment. Clearly some form of legal disclosure would also need to be addressed which would lessen the burden of risk on the hospital.

**Chronic Condition Timeline of Disclosures**

Then there is the timeline of a chronic patient and how to inform the patient, DPA or other responsible party about the nature of a patient’s condition. When informing of a chronic condition there are more variables in play than just an acute condition. The hospital is more inclined to use the concept of “do no harm” in determining the course of dialogue with the patient and related responsible parties. There can be no definitive date of any required disclosure especially when the hospital can transfer the patient to a long-term care facility. When informing a patient or his/or her kin of a chronic condition there are many more psychological factors in play.
Say that patient “A” has lost feeling in her feet, and she has a non-life-threatening disease which has a 10% chance of patient “A” being able to walk again. Instead of informing the patient that there is a “90 percent chance that you will never walk again” the physician can use language like:

“I have heard of many cases in which a patient with your condition has regained the ability to walk” or “Several studies show that with if you are strong enough and willing to work through therapy towards regaining the strength in your legs there is a strong possibility that you may regain the ability to walk.”

This lessens the legal burden on the responsible facility especially when they are equipped to be a part of any or all treatments.

**Hospice Care Timeline of Disclosures**

Once a patient has reached the point of hospice care – it is not determinant of what to inform the patient and responsible parties, but more-so when. In most cases surrogates need help in determining the best decision based upon the number of solutions available. This type of third party hospice disclosure is quite simple. The physician is to inform the responsible party of any and all timelines, remedies, and solutions to their responsible party’s disclosure. While a need to give a full disclosure of the nature of the responsible party’s patient, while many parties may
want the physician to make the decision for them. It is best to allow the surrogate to make that decision themselves. This would be the physician implementing dialogue such as:

“I can’t make the solution for you, but I can tell you that (solution A) has been proven of some success, and while (solution B) has been limited in the scope of treating the disease on hand.”

This form of dialogue helps to allow the surrogate decision to make the ability to make an informed decision without creating risks and legal issues for the medical facility. “Surrogate decision makers sometimes refuse treatments that would serve the interests of those that they should protect, and physicians sometimes too readily acquiesce their preferences” (Beauchamp, 192). This form of disclosure can be used in terms of how to disclose a patient’s condition without said patient losing complete hope of recovering from his or her disease. In cases like this a physician can say something like:

“We can give you a treatment of medication for your condition and check back in a couple weeks to see if there is any progress.”

This can be more substantiated in not letting the patient be completely aware that said patient is in hospice care, in fact disclosing the typical “we will make you comfortable” would be counter-productive to language which informs the family of a patient as to the true nature of the disease while allowing the patient being treated the hope the patient may need. Responsibilities to the medical facility may be such as after life decisions and the hospital staff must be informed of any sort of advance directive or DPA.
Understanding the Legality of Disclosures

While legality may not be the first thing a typical person thinks of when thinking of the dialogue involved in patient care, it’s importance is critical to the administration of a hospital. Called “advance directives” these plans break down into two subsets defined as “(1) living wills (which are defined as) substantive or instructional directives regarding medical procedures in specific circumstances. Along with (2) a DPA or durable power of attorney which is a legal document in which one person assigns another person authority to (make decisions for them if they are not able to)” (Beauchamp, 189).

The problem arises that in many cases these advance directives have less than perfect legality in terms of their concreteness to the true nature of the wants of a patient. In many cases a family member will say to the likes that there was a verbal agreement between the family member and patient but if that verbal dialogue cannot be substantiated through a written agreement then the patient’s true wishes may not be able to be substantiated as well. A physician is legally required to be completely truthful when a DPA is implemented and there is no question regarding the legality of this information.

This form of dialogue can include any proven remedies to the patients’ health but should never include any non-proven methods of treatment. When the physician or administrator is informing the patient or DPA of any nature of solutions, it is best to leave out any sorts of hypothetical treatments in the dialogue and construct the dialogue in a truthful manner but to consider the mental well-being of both the patient and any third parties as part of treatment. If the best course of action would be to allow the patient to determine what his or her directives would be while in treatment at the attending facility while the hospital makes said patient as lucid as possible with a justifiable legal aid to create a more concrete advance directive.
There also arise many factors in terms of the patients understanding of their treatment along with the legality to the likes of a third-party disclosure. Beauchamp writes that “Patients or subjects also need to share an understanding with professionals about (the nature of their condition)” (Beauchamp, 132).

If there is a substantiated DPA or other related directive then it is the legal responsibility of the entire hospital staff to align the treatment of the patient with his or her advance directive. If there is a formidable DPA or any of the like then the hospital’s responsibility is to disclose whatever is needed for there to be no issues legally for the hospital either during or after treatment.

**On Informative Dialogue**

We conclude this thesis to give a brief explanation on the psychology of disclosures. There have been many informative models created for physician related dialogue in patient care but most importantly is an understanding of the psychological affect and the true wants of the patient. Most ethical models “presuppose that persons possess known and fixed values, but this is inaccurate. People are often uncertain about what they actually want” (Edge, 10). So, when a person creates an advance directive or, more importantly when there is only some sort of verbal directive, it is important to know that patient’s true wishes change when they are in an, acute say hospice situation. What people want is the “capacity to reflect on their wishes and to revise their own – advance directive models” (Gedge, 9). The concept continues in that they want to be able to “modify their identity” or “change their preferences” because at a time when a great decision is to be made they want the entire spectrum of their options laid out by the physician of any facility in which their decision needs to be made.
This goes in concurrence with the concept on advance directives and their true legality. In this thesis, bringing up the legal structure of nullifying anyiformidable or unproven advance directives is critical. The concept of making a say, critical patient as lucid as possible and in turn allowing the patient to make his or her decision in as informed position as possible is paramount. If the facility can prove that the patient made any or all decision in as sound mind as possible—this concept concurrently eliminates any risk.

While many models exist, the responsibility of the facility is to be as informative as possible while not harming the mental health of the patient. There are times when third-party disclosure is necessary, there are times when DPA’s and advance directives need to be changed, times when the patient needs to have their informative process delayed or sped up. In any situation, the best model to use is one in which there is no definitive informative dialogue. The physician must understand the legality, the timeline, the potential solutions, and if the patient should even be treated or re-directed to another institution.

The morality of disclosures is unique to the patient – completely. The physician must understand the patient and then treat them in accordance with the psychological factors and ethical frameworks which come into play for each patient. Each patient is different, each surrogate decision maker is different – assessing how well, and what any surrogate knows may only be that of the individual and not the patient.

Conforming to the legality of each specific instance is key, and another factor to stress. Understanding that the dialogue changes as the patient changes, and as the patient changes they may or may not be better equipped to make any sort of decisions – but it is the job of the attending physician to weigh these factors and create a morally thoughtful dialogue which does not harm the patient mentally or physically.
References


