

**L**ast summer, a divided Arizona Supreme Court held in *Stanley v. McCarver*<sup>1</sup> that “the absence of a formal doctor–patient relationship does not necessarily preclude the imposition of a duty of care” on a physician,<sup>2</sup> abandoning the traditional rule requiring that such a relationship must exist before any duty may be recognized.<sup>3</sup> The decision has important implications for doctors who are called upon to examine individuals’ medical information in an array of nontreatment contexts.

An examination of the underlying facts, the background legal precepts and some of the decision’s more significant elements illustrates these implications.

### The Facts

At its core, the case was about an X-ray report that went to everyone—except the subject of the X-ray.

The one-page chest X-ray report was prepared by Mesa radiologist Robert R. McCarver. The X-ray was of Christine Stanley, who was applying for a job at a Mesa hospital, and it was taken in connection with Stanley’s pre-employment tuberculosis screening.

In the report, Dr. McCarver noted a “small nodule” on one of Ms. Stanley’s ribs, and he suggested “serial observation” of the nodule to “determine stability.”<sup>4</sup> He would later testify in his deposition, “Any small nodule may be cancer. Any small nodule may be one of 50 other things.”<sup>5</sup> McCarver also testified that when he submitted the report, he expected that its recommendations would be “followed up”—including by further examination of the nodule.<sup>6</sup>

They weren’t. McCarver submitted the report to the X-ray company that had contracted him to conduct the evaluation. The company forwarded the report to the hospital, which had a policy requiring it to notify job applicants of the results of examinations within 72 hours.<sup>7</sup> But nobody reported McCarver’s findings or suggestions to Stanley. About 10 months later, she was diagnosed with lung cancer.<sup>8</sup> (Ms. Stanley died in April 2004.<sup>9</sup>)

Stanley sued the hospital, the X-ray company and McCarver. She alleged that timely notice of McCarver’s findings and recommendations would have enabled her to discover and treat the cancer in time to stop its spread, and she charged all three defendants with negligence in failing to give her such notice.<sup>10</sup>

The Superior Court (per Judge Steinle) granted summary judgment in favor of Dr. McCarver, applying the traditional rule whereby doctors are not liable for their medical decisions in the absence of a doctor–patient relationship.<sup>11</sup> The Court of Appeals (per Judge Erlich, joined by Judge Weisberg and Superior Court Judge Wilkinson, sitting by designation) reversed. The

# The Medical Duty of Care

## Supreme Court Expands Relationship

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court noted that according to recent court decisions, as well as American Medical Association standards, physicians in Dr. McCarver’s position have an obligation to report the results of pre-employment examinations directly to the examinee.<sup>12</sup>

The Supreme Court granted review “to determine whether [Dr. McCarver] owed a duty to Ms. Stanley under the facts of this case.”<sup>13</sup>

### No Duty To Act, Except ...

If Dr. McCarver could be liable to Ms. Stanley, it would not be for what he did, but for what he didn’t do: He didn’t take affirmative action to ensure that Stanley was made aware of the findings and recommendations in his report. In taking review of this issue, the Supreme Court thus prepared to enter an area of tort law that has been in flux virtually from the beginning of the American legal system: the extent of an individual’s duty to take affirmative action to protect others from harm.

Under the American common law rule,<sup>14</sup> individuals cannot be held liable for failing to take affirmative action to prevent harm to others, no matter how minimal the effort required or how severe the consequences of inaction.<sup>15</sup> Under that rule, a person can walk blithely past a baby lying on a railroad track, with the sound of the approaching locomotive rumbling in his ears, and be absolutely immune from tort liability for the consequences of his inaction. Indeed, at common law even a physician “is under no duty to answer the call of one who is dying and might be saved.”<sup>16</sup> The Third Circuit’s Judge Becker has observed that the no-duty-to-act rule was a carryover from the early common law of England and is the product of a time and place powerfully affected by “a sense

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of rugged individualism combined with the harsh realities of industrialization.”<sup>17</sup>

In light of the rule’s often shocking amorality, it should be no surprise that it has been the subject of a fairly steady drumbeat of criticism.<sup>18</sup> But while it is easy to criticize the rule, it is much harder to fashion a suitable replacement for it.

The rule of law and principles of due process require that the existence of a duty to act be defined clearly. A rule providing that individuals must act to prevent harm to others when their failure to do so would strike the majority of their state’s highest court as patently immoral simply won’t do.<sup>19</sup> Moreover, notwithstanding the criticisms leveled at the rule, few would suggest that Americans have overwhelmingly rejected the notion of “rugged individualism” or abandoned their traditional aversion to excessive interference with the market economy.<sup>20</sup>

For these reasons, some argue that any retreat from the common law rule ought to be the business of legislatures, rather than courts. Legislatures, after all, are better equipped to give citizens “fair warning” of the circumstances in which their inaction may lead to liability, and can be expected to reflect more accurately than courts their constituents’ degree of support for the individualist values that the rule reflects and promulgates.

In fact, legislatures have been responsible for much of the law’s retreat from the rule.<sup>21</sup> Arizona’s Legislature, for example, has

taken a bite out of the common law rule by specifying that an Arizona motorist who is involved in an accident must render “reasonable assistance” to persons injured in the accident.<sup>22</sup>

But American courts have never been content to cede the issue to legislatures entirely. Courts have instead held “that social policy justifies the imposition of a duty to act if one of a burgeoning group of special relationships exists between the parties.”<sup>23</sup> Among these “special relationships” on which a duty to act has been premised is the doctor–patient relationship.<sup>24</sup> In its traditional sense, such a relationship consists of a direct, consensual—normally contractual—relationship between a medical professional and a layperson, motivated by the layperson’s desire to receive medical treatment.<sup>25</sup>

In this case, all members of the Court seemed to agree that no “traditional” doctor–patient relationship existed between Ms. Stanley and Dr. McCarver. Stanley did not “associat[e]” with McCarver for the purpose of diagnosis or treatment. Indeed, she did not “associate” with him at all.<sup>26</sup>

How, then, could he have a duty to take affirmative action to protect her from harm?

### **The Majority: Duty-Bound**

To answer that question, the majority (per Justice Berch) first looked to recent court decisions reflecting the extent to which a doctor–patient relationship continues to be treated as a necessary precursor to the imposition of tort liability on physicians. The majority found that the doctor–patient relationship requirement had been “quietly eroding”<sup>27</sup> in many jurisdictions, with doctors increasingly being held liable for their negligent acts and for their failures to act even where no traditional doctor–patient relationship exists.<sup>28</sup> The majority also found in Arizona cases a “sliding-scale” approach to physicians’ duties, whereby the analysis is not confined to the yes or no question of whether a “formal” doctor–patient relationship exists, but instead considers “whether a *sufficient* relationship exists between the parties to make it reasonable, as a matter of public policy, to impose a duty.”<sup>29</sup>

The majority then turned to the particular nature of the “relationship” between Ms. Stanley and Dr. McCarver. Notwithstanding the lack of a treatment relationship, the majority reasoned, McCarver, in agreeing to review and report on Stanley’s X-ray, did “undert[ake] a professional obligation with respect to Ms. Stanley’s physical well being.”<sup>30</sup>

The majority also noted that the absence of a more formalized relationship did not alter the fact that “Dr. McCarver should have anticipated that Ms. Stanley would want to know of the potentially life-threatening condition and that not knowing about it could cause her to forgo timely treatment.”<sup>31</sup>

Finally, the majority noted that it could “envision no public benefit in encouraging a doctor who has specific individualized knowledge of an examinee’s serious abnormalities to not disclose such information.”<sup>32</sup> The majority affirmed the portion of the Court of Appeals decision imposing a duty on McCarver and

remanded the case for further proceedings.

## The Dissent: No Grounds for Duty

Chief Justice Jones dissented.

In his view, there was no “solid legal ground” underlying the majority’s imposition of a duty.<sup>33</sup> He stressed “the remoteness of any connection between Ms. Stanley’s general health and Dr. McCarver’s narrow undertaking as an independent contractor to read a tuberculosis screening X-ray for employment purposes.”<sup>34</sup> The cases cited by the majority were inapposite, the Chief Justice reasoned, because they did not find a duty with respect to relationships as “remote” and “attenuated” as the one between McCarver and Stanley.<sup>35</sup>

The majority’s reliance on Ms. Stanley’s expectations was likewise misplaced, he added, because legal duties must be based on a “legitimate legal source” rather than on “the personal expectations of an injured plaintiff.”<sup>36</sup>

Finally, the Chief Justice noted that it is the Legislature’s duty “to define the public policy of the state” and that the Legislature could have, but did not, impose a duty on doctors in Dr. McCarver’s position.<sup>37</sup> In the Chief Justice’s view, though there may be circumstances in which “a ‘moral’ obligation may manifest itself,” the existence of such an obligation does not necessarily signal the existence of “a ‘legal’ duty offering potential plaintiffs an opportunity to sue in tort.”<sup>38</sup>

## Nontreatment “Relationships”

The *Stanley* decision’s implications are as broad as the spectrum of situations in which doctors review nonpatients’ medical information. And that spectrum is broad indeed.

Beginning with the heartland territory of the *Stanley* decision itself, the practice of using physicians for pre-employment medical screenings is widespread. In addition, physicians commonly review medical information in the absence of a traditional doctor–patient relationship in a number of other contexts:

- Similar screening procedures are used in connection with applications for Social Security disability insurance,<sup>39</sup> life insurance, admission to educational and other institutions, and other programs.
- Managed-care companies employ “utilization management” physicians to review individuals’ medical records to determine whether particular treatments should be authorized.
- Physicians commonly review nonpatients’ medical records in preparing to participate as experts in litigation.
- Mental health professionals examine nonpatients’ medical records when called on to evaluate a parent’s fitness to take custody of a child.

And the circle can be drawn still wider: It is quite common for doctors to consult informally with one another about the treatment of their patients, sharing patient information to the extent necessary to obtain useful advice from their colleagues.<sup>40</sup>

In all of these situations, medical practitioners could incur a professional obligation to an individual, despite the absence of a traditional doctor–patient relationship. Whether a duty exists will depend on the facts of each case. Generally, the more a medical professional learns about an individual’s medical condition, the more likely it is that a duty will be imposed, especially if the professional has unique knowledge or expertise relevant to the indi-



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vidual’s condition.<sup>41</sup>

On the other hand, it is unlikely that a duty will be imposed on a physician who, without reviewing an individual’s medical records, informally discusses a case with a treating physician who has similar training and expertise. But, unfortunately for doctors seeking a “safe harbor,” *Stanley* confirms that there are no “bright-line” rules for doctors to follow once the requirement of a “traditional” doctor–patient relationship has been set aside.

## So What’s a Doctor To Do?

### “A matter of contract”

Toward the end of its opinion, the majority responded to Dr. McCarver’s warning that an adverse holding would scare doctors away from participating in pre-employment screening examinations and “open the floodgates of litigation.”<sup>42</sup> Rejecting this argument, the Court offered a brief dictum that, read in isolation, seems to suggest a cure-all for the potential liabilities implicated by the holding: “Finally, we note that doctors may deal with this issue as a matter of contract. They may, for example, require X-ray subjects to consent to having the results reported only to the employers.”<sup>43</sup>

This suggestion should be swallowed with a few grains of salt. There a number of reasons to question the efficacy of the “consent” approach.

The main problem with the “consent” approach is that a doctor may act negligently in not reporting adverse medical information directly to the subject even if the subject has expressly “consented” to the nonreporting. The doctor can argue that the subject’s consent made it reasonable to rely on others to make the information available to the subject. But the argument will not be strong when the facts indicate that such reliance was misplaced. In such cases, the key issue will be whether, by his consent to the nonreporting of crucial information, the subject effectively has contracted away his right to recover for the doctor’s negligence. This is the issue that the Restatement until recently addressed under the rubric of “express assumption of risk” and now refers to as “contractual limitations on liability.”<sup>44</sup>

The contractual-limitation approach is generally accepted, but the degree of protection it would provide physicians in this context is uncertain. Arizona’s Constitution specifies that the defense of assumption of risk “shall, in all cases whatsoever, be a question of fact and shall, at all times, be left to the jury.”<sup>45</sup> On its face, this provision might appear to prevent a physician from using a plaintiff’s signature on a consent form to secure summary judgment on an “express assumption of risk” theory. But the Court of Appeals recently held that this constitutional provision did not apply to an express contractual release-and-waiver agreement.<sup>46</sup> Physicians should not take too much heart, however: The Arizona Supreme Court has granted review of that decision.<sup>47</sup>

A bevy of interpretive scale-tipping doctrines also tend to erode the effectiveness of the contractual-limitation approach. Contracts limiting liability for negligence are not enforced unless they are deemed to express themselves in “clear, definite, and unambiguous language.”<sup>48</sup> If they take the form of standardized forms prepared by the stronger party and presented for signature to the weaker (as the “consent” forms envisioned by the *Stanley* dictum presumably would be), they will be “construed strictly, favoring reasonable

interpretations against the defendant.<sup>49</sup>

Moreover, even when these contracts are sufficiently “clear” and “definite” and can survive strict interpretation in the plaintiff’s favor, they may be declared “unenforceable as a matter of public policy.”<sup>50</sup> Public policy may well lead to the rejection of one-sided standard-form “consent” agreements, signed under the economic pressure of a job application, that impair an individual’s ability to receive prompt notice of possibly life-threatening medical conditions.<sup>51</sup>

In the end, there may be nothing to lose in pursuing the contractual-limitation approach. But it should not be relied on as a panacea for potential *Stanley*-type liability.

### Communicate, Communicate, Communicate

A legally safer course is to do what the medical profession’s ethical guidelines recommend: communicate important information concerning an examinee’s health directly to the examinee.

In finding that Dr. McCarver had a duty to Ms. Stanley, the Court of Appeals relied in part on an opinion of the American Medical Association’s Council on Ethical and Judicial Affairs stating that a physician who performs an “isolated assessment” of an individual’s health for an employer or business “has a responsibility to inform the patient about important health information or abnormalities that he or she discovers during the course of the examination.”<sup>52</sup> The court also noted that the American College of Radiology had issued a similar guideline, exhorting radiologists to communicate directly to the treating physician or, if necessary, to the subject any conditions for which “immediate patient treatment is indicated.”<sup>53</sup>

This approach has much to recommend it.

First, because a physician may not have the subject’s consent to report incidental medical findings to an employer, communicating such information directly to the subject avoids the possibility of the doctor being held liable for the adverse consequences of reporting information outside of the scope of the examination to the employer. Second, direct reporting seems more consistent



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with the core principles of negligence law. The classic negligence analysis calls on individuals to discount the possible adverse consequence of a certain course of action by its probability, and then to weigh the discounted figure against the burden

required to avoid that outcome.<sup>54</sup> When the consequence is a fatal disease, even a small probability will yield a substantial discounted figure. (It pays, therefore, to pay close attention to the “worst-case” implications of medical information, particularly because judges and jurors may find it hard not to apply “20-20 hindsight” and view a worst-case outcome as likely simply because it happened.) And most important, in *Stanley*-type situations the burden of acting will be (or will appear to a jury to be) trivial.<sup>55</sup> The question on the jurors’ minds will be, “Why didn’t the doctor just call the subject, or send her a letter, and say ‘You’d better have this checked out’?”

Even the direct-communication approach, however, is not without complications. An individual may react poorly to receiving news of a potentially fatal medical condition from a physician he has never met. The intrusion of an uninvited medical consultation upon an existing physician–patient relationship may damage that relationship. And in some contexts, the communication of medical information directly to the examinee may actually create risks, as when the examinee suffers from a mental illness.

As a general matter, however, doctors retained to examine and comment on the medical data of nonpatients should consider insisting that they be provided with good contact information for the subjects, and then using the contact information to communicate their findings and recommendations to the subjects directly. If possible, they should include a brief plain-language explanation of the significance of their findings, because in these contexts there may not be a treating physician to interpret them.<sup>56</sup>

This may not be the “traditional” approach, but as the legal conception of the doctor–patient relationship unmoors itself from “traditional” understandings, the way in which nontreating doctors handle medical information will need to do likewise. **AZ**

### endnotes

1. 92 P.3d 849 (Ariz. 2004).
2. *Id.* at 856.
3. *See id.* at 851.
4. Appellant’s Opening Br. in No. 1 CA-CV 02-0328 (Ariz. Ct. App.) App. 1.
5. *Id.* App. 2 p. 38.
6. *Id.*
7. *Stanley*, 92 P.3d at 850-51.
8. *Id.* at 851.
9. Michael Kiefer, *Woman Loses Life, But Suit May Go On*, ARIZ. REP., July 22, 2004, at B1.
10. *Stanley*, 92 P.3d at 851. The hospital later declared bankruptcy and was dismissed from the case. *See id.*
11. *Stanley v. McCarver*, 63 P.3d 1076, 1077 (Ariz. Ct. App. 2003). The superior court dismissed the X-ray company, rea-

- soning that any duty to report the findings to Ms. Stanley would have belonged to the hospital. *Id.* The Court of Appeals affirmed the dismissal, holding that the X-ray company could not be liable for Dr. McCarver’s acts and omissions because he was an independent contractor. *Id.* at 1082.
12. *See id.* at 1078-82.
13. *Stanley*, 92 P.3d at 851.
14. The common law, “so far as it is consistent with and adapted to the natural and physical conditions of this state and the necessities of the people thereof, and not repugnant to or inconsistent with the constitution of the United States or the constitution or laws of this state, or estab-

- lished customs of the people of this state,” is binding on Arizona courts. A.R.S. § 1-201 (West 2004).
15. *See* DAN B. DOBBS, *THE LAW OF TORTS* § 314 (2000); W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* § 56 (5th ed. 1984); *Miller v. Arnal Corp.*, 632 P.2d 987, 990-91 (Ariz. Ct. App. 1981) (O’Connor, J.).
16. KEETON ET AL., *supra* note 15, § 56, at 375 & n.23.
17. *Lundy v. Adamar of New Jersey, Inc.*, 34 F.3d 1173, 1199 (3d Cir. 1994) (Becker, J., concurring in part and dissenting in part).
18. *See, e.g.*, KEETON ET AL., *supra* note 15, § 56, at 376 & n.30;

- Lundy*, 34 F.3d at 1200 (Becker, J., concurring in part and dissenting in part).
19. KEETON ET AL., *supra* note 15, § 56, at 376 (noting “the difficulties of setting any standards of unselfish service to fellow men”); *Calder v. Bull*, 3 U.S. 386, 388 (1798) (Opinion of Chase, J.) (“This fundamental principle flows from the very nature of our free Republican governments, that no man should be compelled to do what the laws do not require; nor to refrain from acts which the laws permit.”).
20. Alexis de Tocqueville posited in the mid-19th century that democratic, egalitarian societies are naturally disposed toward

individualism:

As social equality spreads there are more and more people who, though neither rich nor powerful enough to have much hold over others, have gained or kept enough wealth and enough understanding to look after their own needs. Such folk owe no man anything and hardly expect anything from anybody. They form the habit of thinking of themselves in isolation and imagine that their whole destiny is in their own hands.

ALEXIS DE TOCQUEVILLE, *DEMOCRACY IN AMERICA* 508 (1969). He also noted the danger that this tendency could cause each individual to be “shut up in the solitude of his own heart.” *Id.*

21. See KEETON ET AL., *supra* note 15, at 375 n.21; DOBBS, *supra* note 15, § 314, at 853 n.1.
22. A.R.S. § 28-663(A)(3) (West 2004). Another statute limits the liability of persons who gratuitously render “emergency care.” See *id.* § 32-1471.
23. *Lundy*, 34 F.3d at 1200 (Becker, J., concurring in part and dissenting in part).
24. See *Tarasoff v. Regents of the University of California*, 131 Cal. Rptr. 14, 22-23 (Cal. 1976).
25. See BLACK’S LAW DICTIONARY (“relationship”) (8th ed. 2004) (“the association between a medical provider and one who is being diagnosed or treated”); *Findlay v. Board of Supervisors of Mohave County*, 230 P.2d 526, 531 (Ariz. 1951) (“a consensual [relationship] wherein the patient knowingly seeks the assistance of the physician and the physician knowingly accepts him as a patient”) (*quoting* 41 AM. JUR., *Physicians and Surgeons* § 71); see generally James L. Rigelhaupt, Jr., Annotation, *What Constitutes Physician–Patient Relationship for Malpractice Purposes*, 17 A.L.R. 4th 132 (1982 & Supp. 2002).
26. *Stanley*, 92 P.3d at 858 (“There was no indication in the record that Ms. Stanley could identify the doctor who would perform the evaluation. Ms. Stanley had no contact with the doctor.”) (Jones, C.J., dissenting).

27. *Id.* at 851.

28. *Id.* at 851-52; see generally J. P. Ludington, Annotation, *Physician’s Duties and Liabilities to Person Examined Pursuant to Physician’s Contract With such Person’s Prospective or Actual Employer or Insurer*, 10 A.L.R. 3d 1071 (1966 & Supp. 2002).
29. *Stanley*, 92 P.3d at 852.
30. *Id.* at 853.
31. *Id.*
32. *Id.* Having found that Dr. McCarver did have a duty to Ms. Stanley, the majority defined the contours of the duty with respect to the negligence standard generally applicable to individuals with special skills or training, stating that McCarver “assumed a duty to conform to the legal standard of care for one with his skill, training, and knowledge.” *Id.* at 854. The majority rejected the definition of McCarver’s duty articulated by the Court of Appeals, criticizing the lower court for relying too heavily on the guidelines promulgated by the American Medical Association and American College of Radiology. *Id.* at 854-55.
33. *Id.* at 857 (Jones, C.J., dissenting).
34. *Id.* at 856 (Jones, C.J., dissenting).
35. *Id.* (Jones, C.J., dissenting).
36. *Id.* (Jones, C.J., dissenting).
37. *Id.* at 857-58 (Jones, C.J., dissenting).
38. *Id.* at 857 (Jones, C.J., dissenting). Similar sentiments were expressed in an oft-cited decision of the Kansas Supreme Court: With the humane side of the question courts are not concerned. It is the omission or negligent discharge of legal duties only which come within the sphere of judicial cognizance. For withholding relief from the suffering, for failure to respond to the calls of worthy charity, or for faltering in the bestowment of brotherly love on the unfortunate, penalties are found not in the laws of men, but in that higher law, the violation of which is condemned by the voice of conscience, whose sentence of

punishment for the recreant act is swift and sure.

*Union Pac. Ry. Co. v. Cappier*, 72 P. 281, 282 (Kan. 1903).

39. See, e.g., *Peace v. Weisman*, 368 S.E.2d 319 (Ga. Ct. App. 1988).
40. The Arizona Court of Appeals already has stretched the circle of potential liability into at least part of the physician-to-physician consultation context. See *Diggs v. Arizona Cardiologists, Ltd.*, 8 P.3d 386 (Ariz. Ct. App. 2000) (nontreating cardiologist could be liable to fellow doctor’s patient after he assisted the treating physician in construing the results of the patient’s electrocardiogram). But the *Diggs* court emphasized the fact that the doctor seeking advice, unlike the doctor giving it, was not fully qualified to make the necessary determination on his own, meaning that the advising doctor was in a “unique position” to prevent harm to the patient. *Id.* at 390. The court acknowledged, “Generally, where a physician has been informally consulted, the courts deny recovery for negligence, theorizing that a duty cannot exist absent a contractual relationship.” *Id.* at 389.
41. See *id.*
42. *Stanley*, 92 P.3d at 855.
43. *Id.*
44. RESTATEMENT (THIRD) OF TORTS § 2 cmt. a (2000).
45. ARIZ. CONST. art. 18, § 5.
46. *Phelps v. Firebird Raceway, Inc.*, 83 P.3d 1090 (Ariz. Ct. App. 2004).
47. The briefing in the Arizona Supreme Court is available at the “azapp” Web log, www.azapp.com, in the posting for Aug. 19, 2004.
48. RESTATEMENT (THIRD) OF TORTS § 2 cmt. d (2000).
49. *Id.*
50. *Id.* cmt. e.
51. The Legislature could choose to protect physicians by limiting the application of such scale-tipping doctrines. Cf., e.g., A.R.S. § 12-553 (West 2004) (immunizing stable owners from liability if rider signed a release).
52. *Stanley*, 63 P.3d 1076, 1081 (Ariz. Ct. App. 2003) (*quoting* American Medical Association

- Council on Ethical and Judicial Affairs Opinion E-10.03, *Patient–Physician Relationship in the Context of Work-Related and Independent Medical Examinations* (June 1999)).
53. *Id.* (*quoting* American College of Radiology Standard for Communication: Diagnostic Radiology, Section V (2002)).
54. See *State v. Bolt*, 689 P.2d 519, 529 (Ariz. 1984); RESTATEMENT (THIRD) OF TORTS § 3 & cmt. d (tentative draft no. 1, 2001).
55. See *Union Carbide & Carbon Corp. v. Stapleton*, 237 F.2d 229, 232 (6th Cir. 1956) (“To have notified [the examinee] of these findings would have been a simple matter.”); *Dornak v. Lafayette Gen. Hosp.*, 399 So.2d 168, 170 (La. 1981) (“To notify plaintiff of the findings would have been a simple matter.”).
56. See *Meinze v. Holmes*, 532 N.E.2d 170, 174 (Ohio Ct. App. 1987) (holding that the “duty to communicate” was discharged by the sending of medical reports to the plaintiff’s attorney at the plaintiff’s request and noting that the “operative information” in the reports was “stated in plain, understandable terms”).