Shared Decision Agreements Transform Professional Liability Standards

By Jerry A. Green, JD[1]

Shared decision making agreements shift the context for defining professional liability from tort to contract. They involve patients in decision choices and can absolve healthcare practitioners from liability for care that varies from accepted standards under principles of professional negligence according to tort law, which principles would apply in the absence of a contractual relationship.

I. Scope of Practice

Standards of care.

Standard of care is a cornerstone concept in each of the two principal professional liability risks. Civil liability exists when the physician's care is determined to have fallen below the standard. Professional regulation, which challenges one's license to practice medicine, asks the same question in order to evaluate conduct, but usually applies an aggravated concept of negligence (such as gross negligence.) While each liability risk involves other issues, they both depend upon the standard. The standard of care is generally understood as the care and treatment which may be expected of an ordinarily prudent physician under similar circumstances.[2] The standard of care as a concept eludes the level of reliability which it appears to imply. What makes sub-standard practice always debatable, is that the "standard" includes both the personal subjective judgments of the expert, and their unique view of "common practice." Rarely questioned is the assumption that their personal standard of care represents or familiarizes them with "common practice." All this is assumed upon their qualification as an expert.

In this potential mine-field of uncertainty, we explore the ability to limit the application of standards of care by role clarification agreements. For reasons discussed in greater detail elsewhere,[3] the capacity of parties to define their relationships by mutual agreement *changes the context* for applying common law notions of tort liability, of which the accepted practice standard is one. Private agreements change the context for evaluating professional responsibility from the common law tort principles defining negligence to principles of contract. Courts recognize contracts as prevailing over tort principles because they promote collaboration and because they

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[2] The standard of care is usually specialty specific, however if a general physician undertakes a specialized function, he will be held to the standard of care expected of the specialty. The same principle applies to one practicing a function of a specialty different than his own.

[3] Epstein, Richard, LLB, Medical malpractice: the case for contract. Am. Bar Found. Res. J. 1976:87,
Green, Jerry A., J.D., Minimizing malpractice risks by role clarification: the confusing transition from tort to contract, Annals of Internal Medicine, 8/1/88, p.234

give expression to the intentions and expectations of the parties. A 1977 criminal case recognized contract when the prosecutor and the court agreed that "a regular practice of contracting with clients in order to clarify the role of a non-medical health practitioner" justified dismissing charges of unlicensed medical practice.[4]

Before analyzing strategies for employing this opportunity, we should acknowledge that, while disputes may be argued on the basis of standards of care, claims are rarely brought by patients for this reason. Malpractice attorneys look for poor medical outcomes, sufficient damages, and unfulfilled expectations as sufficient reasons to justify undertaking a formal (litigation based) search for evidence of substandard practice. The following analysis of role clarifying risk management strategies is unnecessary in order to imagine the impact of role clarification agreements on expectations and outcomes alone. In general, agreements are tools for communication and identifying and revising unrealistic expectations. They are also mechanisms for improving outcomes by securing the cooperation upon which successful outcomes depend. In short, agreements tend to make relationships work.

Potential boundaries for defining or limiting the application of accepted standards of practice.

Let's examine the assumption that the scope of professional responsibility in medicine may be recognized as the diagnosis and treatment of pathological conditions.

The distinction between treating biological diseases as manifested in physical or biochemical symptoms on the one hand, and on the other hand, treating the dynamics of health that are within a patient's control or addressing "mind-body-spirit" dynamics is a substantive one. Physicians can determine whether their clinical purpose is to treat pathology or manage the unique manifestation of an individual's constitutional disposition. If their clinical objectives are understood and supported by their patients, role clarification enables their intention to remain at the core of our inquiries about professional responsibility. Defining scope of practice roles enables physicians to make choices known and supported by patients, and to tailor the nature and extent of their responsibility to their values, skills and intentions.

Scope of practice statutes.

Most scope of practice statutes are based upon the prohibition (without a medical license) against diagnosing and treating pathological conditions. As has been previously stated, one also usually finds that such statutes embody the medical model of pathology. Consider the California statute:

> CALIFORNIA BUSINESS AND PROFESSIONS CODE
> Sec. 2052. "Unlawful Practice of Medicine" Defined:
> Any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating

[4] *People of the State of California vs. Dana Ullman,* March 9, 1977. Municipal Court Oakland-Piedmont Judicial District, County of Alameda, No.98158.

> the sick or afflicted in this state, or who *diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition* of any person ... is guilty of a misdemeanor. (Italics are mine.)

The latter portion contains both the prohibition against diagnosis and treatment and the medical model of pathology. The italicized portion is subject to both a narrow and a broad interpretation. Because it is a criminal statute, it is constitutionally required to be interpreted narrowly. This principle would apply to our understanding of the rather open ended phrase *"or other physical or mental condition of any person,"* which might mean just about anything if it were broadly construed.

If the aforementioned conditions (ailment, blemish, deformity, disease, disfigurement, disorder, injury) exemplify a common principle, judicial customs of statutory interpretation would assist us by limiting the application of "other ... conditions" to only other similar conditions. Since it is reasonable to conclude that the enumerated conditions are all *pathological* conditions, it would follow that the final phrase might be read to mean "other physical or mental *(pathological)* condition(s). This interpretation may also be supported by our recognition that, historically speaking, medical education and training is based upon the concept of pathology.

In 1982-83, California Board of Medical Quality Assurance conducted hearings on such far reaching questions as how medical licensure served the public interest, whether its laws were unreasonable constraints on the grown of emerging perspectives and whether the law should be modified. It was called The 2052 Project because it considered the potential repeal of Cal. Bus. & Professions Code Sec. 2052, discussed above. The chairman concluded the inquiry stating that:

> ...the central issue concerning the scope of professional responsibility was the need for doctors (and indeed all health practitioners) to establish with patients a process for clarifying their individual and mutual responsibilities in clinical relationships. This can best be accomplished through public and professional education about the manner in which we allocate responsibility in all other relationships -- the making of individual agreements and contracts.[5]

Documentation

Health care agreements need not be in writing nor need they be signed documents. In fact, documents which purport to define questions of professional liability (such as waivers or disclaimers) are viewed with suspicion and may be invalidated as overbearing, unconscionable, or against public policy. They might even be argued to be evidence of wrongful knowledge, suggesting that the author or proponent expected that by their execution, questionable practices might be made acceptable. Actually, all documents purporting to be contracts are more accurately

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[5] Ben Winters, California Board of Medical Quality Assurance 2052 Committee Memorandum, 5/20/83.

just *evidence* of the meeting of the parties' minds on the essential elements of their agreement. Contract law examines all writings, material evidence, personal recollections, and the context, in order to determine the parties' intentions.

Writings that serve other legitimate clinical purposes, such as gathering information, are both more reliable, more professional, and because they are less legalistic, they are more acceptable in general. An intake application asking for the patient's concerns about pathology separately from their interests in constitutional matters or wellness concerns would serve a legitimate clinical purpose and document a scope of practice agreement. Agreements could be simply noted in the chart or confirmed in writing by correspondence without appearing legalistic or projecting the defensive attitude that alienates patients. Professional correspondence, especially when copied to the patient, is a useful and inoffensive way to confirm verbal dialogue about roles.

II. Allocating Responsibility for Decisions

Confusion generated by informed consent.

Decisionmaking patterns were surveyed and studied according to four models identified in a 1988 effort[6] to explore the variety of decisionmaking styles suggested by a 1982 President's Commission.[7] The Commission identified professional and social difficulties with the judicially imposed doctrine of informed consent, including widespread confusion about its requirements. A more recent study suggests that nine out of ten surveyed decisions fail to inform patients sufficiently to participate meaningfully, and less than one percent assessed patient understanding.[8]

The Kentucky case of Kovacs v. Freeman[9] exemplifies the extent of confusion which informed consent can generate. The Supreme Court, however, finally clarified why a signed consent was not a contract, and articulated the elements essential for judicial recognition of health care contracts that would support agreements which define how consent is understood and used. The opinion illustrates judicial reluctance to expanding the application of common law consent doctrines, and hints at meaningful guidelines for recognizing health care contracts. The Court addressed two questions:

Is a consent to surgery a contract? Should evidence of oral agreements contrary to the consent be precluded by the parole evidence rule (which is a contract principle)?

Freeman, the patient, signed a consent authorizing Dr. Lane to perform back surgery. Dr. Lane testified to Freeman's oral consent for Dr. Kovacs to operate with Lane assisting, and the patient's complaint for damages from a post-operative spinal

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6 Jerry A. Green, JD, note 2, supra.

7 President's Commission for The Study of Ethical Problems in Medicine and Biomedical Research. Making Health Care Decisions: The Ethical And Legal Implications Of Informed Consent In The Patient-Practitioner Relationship. USGPO ;1:105 (1982.)

8 Clarence H. Braddock, et al., Informed Decision Making in Outpatient Practice, JAMA, Vol.282, No.24, p.2313-2320, 12/22/99.

9 Ky., 957 S.W.2d 251 (1997)

infection (a risk of the procedure) lost in the trial court. The Court of Appeal reversed, holding that the written consent was a contract, that Kentucky's parole evidence rule precluded evidence of oral agreements contrary to the written consent, and ordered a directed verdict against Dr. Kovacs for performing an unauthorized surgery. Dr. Kovacs appealed to the Kentucky Supreme Court.

The Supreme Court reversed, holding that a consent to surgery was not a contract, therefore evidence of verbal agreements were admissible, and not precluded by the parole evidence rule. It reiterated established law that, in the absence of statutory requirements, consent to treatment need not be written, and may be oral or implied from conduct. It stated that the consent form lacked the required specificity of terms necessary for contractual recognition, and contained none of the earmarks of an enforceable contract. It enumerated the necessary contractual elements as including the specific obligations of performance by each party, and the term or time frame within which performance was expected. It added that the terms of a contract must be sufficiently complete and definite to enable a court to determine the measure of damages in the event of breach.

The Kentucky Supreme Court opinion suggests two important notions. The first is that courts are aware of the difficulties consent doctrines have caused, and are reluctant to further extend their application. For this reason, I believe the judicial trend to narrowly interpret consent doctrines will continue. The second idea is that solutions to clarifying misunderstandings that may stem from unrealistic expectations lie in contract, not in the norms of tort law. The Kentucky Court is suggesting that agreements containing the elements of contract, including complementary responsibilities and term, will be seen as valid contracts. As such, they have the capacity to modify how common law norms (such as informed consent requirements) may apply.

The President's Commission concluded that "shared decisionmaking is the appropriate ideal that a sound doctrine of informed consent should support."[10] After doubting that this will occur "if primary reliance is placed on the courts," it encouraged patients and health care professionals to "vary the style and extent of discussion from that mandated by the general presumption (informed consent.)"[11] Fifteen years before the Kovacs case, a President's Commission was calling for contractual clarification of how consent is understood and used.

Three common styles or models of making decisions, familiar to us in in other relationships, are compared here: collaboration, patient choice and the traditional professional assumption of responsibility. We can summarize these four decisionmaking models in the following manner:

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[10] Commission, supra, note 7, at p.38

[11] Id at p. 30

1. Traditional	Physician decides. Patient's trust and confidence replaces the need for consent.
2. Informed consent	Physician decides with the patient's consent based on disclosure of risks & alternatives.
3. Collaboration	Physician and patient discuss and decide jointly.
4. Patient choice	Patient decides with physician's counsel.

Physicians assuming traditional responsibility (Model 1) or informed consent (Model 2) will initiate conversation aimed at obtaining compliance and may generate adversity with patients who wish to collaborate or decide. Knowing which patients would rather trust the physician's judgment than make decisions themselves will ideally lead to more relevant and productive decisions with all patients. Knowing which patients prefer to collaborate or make their own decisions could avoid unnecessary adversity occasioned by divergent expectation about decisionmaking styles, and will enable parties to build true partnerships which may grow and change, and enjoy greater clinical success.

Physician preferences and patient education and referral.

Since 1980, I have served as consultant to other attorneys on medical issues in malpractice and personal injury cases. Through this role, I retained their expert witnesses, and during the '80s and '90s I gave two dozen presentations to physicians and insurance companies on this subject at grand rounds, symposia, and risk management conferences[12], at which I collected many personal anecdotes as the basis for the following reflections.

Physicians differ in their values and preferences for decisionmaking styles, and so do their patients. Some physicians inquire expressly about the values and preferences of patients for assuming responsibility in making decisions. Just how a physician uses these proposed models of making decisions is a function of his or her personality and style of communication.

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[12] "Mr. Green's professional presentation at Grand Rounds in Obstetrics and Gynecology at UCSF was extremely enlightening and very effective in defining the various roles played by each person." Edward C. Hill, M.D., Professor Emeritus "Mr. Green presented a fascinating program at the California Society for Healthcare Risk Management's Annual Education Program. All attendees showed great interest, and the Board of Directors of CHSRM were uniform in their praise of the refreshing presentation." Mark Cohen, ARM, RPLU, Director & Risk Management Consultant "I am fortunate to have found Mr. Green, who is a fruitful source of ideas on successfully structuring health care practice. In an educational format, he is unusually talented in explaining these ideas. He listens to client concerns, analyzes them cogently, and suggests approaches succinctly and effectively." K. Lee Peifer, Heath Care Attorney, Albuquerque, NM

Three patterns of decisionmaking preferences among physicians are predictable. Some feel that the largest percentage of decisions should be made by professionals; some thought by patients, and some identified collaboration. Not surprisingly, none identified informed consent for the most preferred category. Most reserved this preference to surgical procedures and high-risk medications. Of greater interest however, was that this inquiry revealed most physicians were unsatisfied with how their decisionmaking values comported with those of their patients. This was commonly identified as the most frustrating or troublesome aspect of their patient relations. For this reason, shared decision agreements should be preceded by a survey of patients values and options.

While physicians saw the potential for identifying the particular values and preferences of individual patients, most physicians wanted the bulk of their patients either to be more compliant with their judgment, or to assume more responsibility than they were accustomed to taking. Most of those surveyed had a clearer impression of the values of their patients as a whole than of segments of their patient population that possessed a variety of values and preferences. Patient decisionmaking values reflected geographic and demographic dimension of practices. Age and plan affiliations were also factors.

Role clarification agreements identify potential misunderstandings and unrealistic expectations. They establish general parameters that give more structure to relationships, but even more importantly, they introduce a new tool for revising plans in the future. Contracts are often thought of as static or rigid obligations that limit one's behavior and, I suspect, are commonly avoided for this reason. If instead, we think and speak of *collaborative planning,* we will emphasize the dynamic nature of role clarification agreements that may be modified as personal desires and circumstances require. By making a verbal agreement that clarifies assumptions that may not be shared, one introduces contract as a working tool that can be used again as needed.

Physicians can inquire of patients' general decisionmaking preferences in the early stages of their relationship, when tensions arise, or can elect to address all of their patients on the subject with general educational material. Relocation of offices, changes in associates, or acquision of new practices are ideal opportunities to introduce general education on the subject to all patients. Physicians' interested in developing the subject more slowly might design material intended for new patients only. These materials could then be used with patients who present challenging relationship difficulties, or when potentially discomforting tensions arise in otherwise satisfactory relationships. Some may wish initially to explore the concepts in conversations with patients so that the subsequent design of education material reflects one's individual values and interests as they are identified by experience.

Physicians wanting patients to assume more responsibility.

Physicians can indicate their own decision-making preferences in general terms, or indicate which kinds of decisions they prefer to address in a particular manner. Patients can be encouraged to consider different levels of responsibility for different kinds of decisions, and to understand that their preferences may change over time as

circumstances change and as options become more familiar. Some of those surveyed who recognized that their ideals favored collaboration and patient choice complained of frustrations with patients who wanted to be told what to do. A healthy reluctance to accept professional responsibility for decisions was often compromised by fears of losing patients, which can lead to physicians taking more responsibility than their science justifies. This may in turn cultivate a lack of patient responsibility. When there is a poor outcome, this dynamic is fodder for disputes and litigation.

A healthy alternative to attempting to persuade patients to take responsibility is simply to identify different decisionmaking styles that may be appropriate for a variety of situations or personal values, and allow the patient to reflect on where they may be along the continuum. Greater precision may be achieved by expressing one's own values and preferences, and then suggesting the *kinds* of decisions which you believe might warrant patient choice or collaboration as compared with those calling for more professional judgment. Whether to have surgery is more appropriate, in most cases, for patient choice or collaboration. Physicians will likely differ on whether to share decisions about surgical technique or operative route. Whether to medicate or modify behavior is a different kind of decision than which medication to choose or what dosage to prescribe.

Physicians seeking more patient compliance.

A comparable number of physicians expressed concerns about lack of patient compliance and frustration with patients who wanted more information than was thought necessary to cooperate in medical treatment plans. These physicians identified themselves as being more traditional in their decisionmaking values and preferences, and believed their understanding of medicine warranted greater trust and confidence from their patients than they were accustomed to receiving. They frequently approached the obligations of informed consent resentfully, and felt the doctrine as an imposition on physicians by lawyers and courts.

Defiant or uncooperative patients take more time and are higher liability risks. They struggle for their "right to decide" and may leave your practice as an expression of their non-compliance. Even when a patient has disappeared, the failure to follow diagnostic studies by contacting patients whose test results warrant further exploration may be alleged as negligence. Staying in touch with assertive patients in the decision making process is a key to understanding and preventing non-compliance.

These situations call for understanding the middle ground between traditional professional responsibility, patient choice, and informed consent, which collaboration represents. Struggles over "who decides" can be reduced by proposing that some decisions must be made by patients, some are best made by professionals, and others may be made jointly. Realizing that physicians and patients will differ *among themselves* in how they might allocate responsibility can open an inquiry into your respective values and preferences. Identify those decisions you won't delegate, and distinguish them from those which might be made jointly by collaboration.

While collaborative planning teaches new forms of sharing decisions, recognize your own boundaries, and give yourself the gift of knowing when a referral to a more collaborative colleague may be saving yourself trouble in the future. Patients who lose the "battle for control" with their physician or managed care provider will likely look back to the experience in order to find someone to blame for a bad clinical outcome. A working referral relationship with a colleague in your specialty who may be more interested in collaborating with patients, may also be a resource for learning to function more collaboratively yourself. Collaborative planning need not result in greater shared decision making. These are tools for discovering misunderstandings and unrealistic expectations, and may be used as well for appropriate patient selection.

Clarifying how consent is understood and used.

Does shared decisionmaking replace the need for obtaining informed consent? Although many people think that the patient's signature on a well drafted consent satisfies legal requirements, remember that there is widespread recognition that the legal doctrine isn't working well, and that physicians, risk managers, lawyers and courts differ on what it requires.[13] Consent is when the patient shows up for treatment, not when he/she signs the paper. The doctrine is about what risks and alternatives have been "informed."

Shared decision making clarifies how consent is understood and used. It established the context for understanding appropriate dialogue about risks and alternatives. I suspect that courts will not permit shared decisionmaking to undermine the basic fairness which they believe the current judicial doctrine attempts to require. A more useful question might be whether shared decisionmaking, even when it results in a patient deferring to professional judgment, involves greater representation of a patient's interest and a more meaningful participation in decisions than informed consent.[14] If the answer is "yes," collaborative planning will bring more cooperation, increased clinical efficacy, reduced risks of unfulfilled expectations, and fewer disputes: in other words, cases that courts will never see.

Since informed consent is thought of as a defensive risk management strategy, physicians often end up seeking compliance, and are therefore likely to cultivate adversity. Seeking informed consent may generate misunderstandings and adversity, especially when consent forms are presented upon admission to hospital for procedures. When we think contractually, instead of thinking defensively, we can identify the basic terms that are necessary for the relationship to work. Defensive thinking misses this step. Agreements tend to identify the basic terms which are necessary to make a relationship work. The substantive interests which informed consent seeks to protect will be guarded as well by collaborative planning.

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[13] One physician told me that he conducts an informal survey of colleagues following their informed consent discussions, asking simply, whether they gave or got informed consent. The tally of responses appears to remain a consistent 50/50.

[14] Quite different from express choices are the situations in which deferring to professional may be implied from the necessities of emergency, unconsciousness, or infirmity. Once we learn collaborative planning in the easy cases, we will feel more comfortable applying the principles to surrogate decision makers or the challenges of social contract. For example, preferences and values regarding decisions during incapacity may be learned beforehand, communicated to surrogates, or incorporated into medical plans.

Conclusion

Every doctor practices with a combination of implied and express agreements which allocate responsibility in their clinical relationships. One's pattern of agreements reflects one's skills and preferences for sharing responsibility with patients. When roles are implied by conduct rather than defined by agreement, they may be misunderstood by both parties. Although many malpractice cases involve negligence, I believe that more originate in common misunderstandings about the scope of professional responsibility assumed and the allocation of responsibility for making decisions.

Employed together, shared decisionmaking and role clarification can transform adversity in clinical relationships and clarify the context within which informed consent is understood and used. It is the proper basis upon which sound applications of the consent doctrine should be based.[15] As our health care system transforms itself,[16] those practices which are built upon the foundations of collaborative planning will have more lasting value.

Bibliography

By Jerry A Green:
Contracts With Your Doctor? New Realities 1978 V.2, N.1
The Health Care Contract: A Model for Sharing Responsibility, Somatics 3:4 (1982)
Minimizing Malpractice Risks by Role Clarification: The Confusing Transition from Tort to Contract, Annals of Int Med 109/3: 234-241, 8/1/88
Dentistry and the Scope of Practice Boundaries: Holistic Practice Distinguished, Int J Biosocial & Med Res 13(1) Spring 91

By Others:
Epstein, R. Medical malpractice: the case for contract, *AmBar Found. Res.J* 1976, 1, 87
Epstein, R. Contracting out of the medical malpractice crisis. *Persp. in Biol. and Med.* Winter 1977, 228
Katz, Jay *The Silent World of Doctor and Patient* (1984)
President's Commission for The Study of Ethical Problems in Medicine and Biomedical Research. Making Health Care Decisions: The Ethical And Legal Implications Of Informed Consent In The Patient-Practitioner Relationship. USGPO ;1:105 (1982.)

[15] See Jay Katz, ibid.

[16] Richard Epstein's seminal articles on this subject make clear that the evolution of contract principles in areas previously governed by tort law (such as products liability, quasi-contract, etc.) takes decades when left to judicial means. This may be accelerated by informed leadership in the field.