Minimizing Malpractice Risks by Role Clarification

The Confusing Transition from Tort to Contract

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The purposes and applications of informed consent are the subject of confusion and controversy according to a President's Commission report. The Commission suggests shared decision making as the new ideal for physician-patient relationships, but notes that such a changed ideal will not be initiated by court action. The four models of decision making are the traditional model, informed consent, collaboration, and patient choice. Misunderstandings about these and other terms arise when they are implied; therefore, they should be defined expressly. Mutual expectations should be ascertained and common misunderstandings that erode relationships and lead to litigation should be clarified. Without agreements, different models may be selected and expectations about responsibility may differ. Such agreements may be documented by notes in patients' charts, supported by intake procedures that teach patients about defining responsibility, and questionnaires that elicit values, needs, and preferences. The literature on the evolution of contract principles in health care is reviewed, with informed consent viewed as a judicial stepping stone from tort to contract. A framework for defining mutual expectations is presented. Physicians' patterns of allocating responsibility by express and implied agreements should be evaluated and changes made where needed.

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The President's Commission for the Study of Ethical Problems in Medicine (1) has reported that widespread confusion exists about informed consent. The study noted fundamental differences among courts' definitions of the standards of care, expressed doubt about relying on the judicial system for answers, and offered shared decision making as the new ideal for physician-patient relationships (2):

> The realities of court decisions on informed consent thus fall short of the law's professed commitment to the value of self-determination. Since "the courts imposed primarily a duty-to-warn on physicians," thereby avoiding a judicial recognition of the proposition that patients have a decisive role to play in the medical decisionmaking process, they have merely reinforced "physicians' traditional monologue of talking at and not with patients." As a result they have missed the opportunity to move toward what is needed: "a new and unaccustomed dialogue between physicians and their patients. . . .
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> The Commission, while recognizing the difficulty of the task, believes that "shared decisionmaking" is the appropriate ideal for patient-professional relationships that a sound doctrine of informed consent should support. The Commission doubts that this will occur, however, if primary reliance is placed on the courts. . . .
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> Some commentators have seen the basis for a new view of the role of medicine and the nature of the patient-provider relationship: The traditional paternal model of medicine was premised on trust in the physician's technical competence and moral sensitivity and was characterized by patient dependency and physician control. This model is being replaced gradually by one in which patients are increasingly involved in decisionmaking concerning their own medical care. . . .
>
> The role of the health care professional thus appears to be in a "phase of incomplete redefinition," as one Commission witness noted. . . .
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> The Commission encourages, to perhaps a greater degree than is explicitly recognized by current law, the ability of patients and health care professionals to vary the style and extent of discussion from that mandated by the general presumption.

This paper clarifies the difference between *informed consent*, which is a hybrid tort concept, and *shared decision making*, which is a characteristic of contractual relations. Physicians and patients should assume responsibility for their roles in a historic transition from viewing medical malpractice as a tort, to seeing the basis of professional responsibility in contract.

The doctrine of informed consent has worked poorly in the clinical setting. It makes health care professionals nervous and insecure and it alienates patients. Courts consider consent documents only one form of evidence and examine all other evidence as well. The President's Commission has reported that in one survey only 37% of physicians and 52% of patients thought the legal requirements for informed consent were explicit. When asked the purpose and effect of informed consent forms, 55% of physicians and 79% of patients said the forms protect physicians from lawsuits. Of both groups, only 65% thought the forms helped physician and patient communications (3).

Lidz and colleagues (4) have concluded:

> For those who have harbored great hopes for the doctrine of informed consent as a vehicle for social reform within the mental health care system, the findings of this study will come as a disappointment. We saw no evidence that informed consent law, as currently implemented, had substantial positive effects.

There is no single doctrine of informed consent, and court decisions show a fluctuation of standards, confusing attorneys, jurists, and physicians. Standards of disclosure differ from what one patient considers ma-

terial, to what the reasonable man would want to know, to what the standard of practice among physicians might be. At least four other issues: standards of causation, exceptions, use of surrogates, and the effect of written consent, produce diversity, with some jurisdictions allowing agencies to define standards, and some attempting to spell them out by statute.

Evolution of Contract

Richard Epstein described the natural evolution of common law tort principals to doctrines contract in 1978. His article, "Medical Malpractice: The Case for Contract" (5), was addressed to the judicial community, and its suggestions went unappreciated by the medical profession. Epstein's noteworthy explanation of this historic trend led to an unanswered call for professional and public education programs on applying contract principles to health care relations (6). Since then, results of two government-funded studies showed the need for education in applying contracting skills to health care relations. The San Francisco Consortium Collaborative Health Program, funded by the National Institutes of Mental Health, was a study of misunderstandings between physicians, nurses, and patients, and was buried in a tide of federal budget cutting in 1982. The historic and controversial inquiry of the California Board of Medical Quality Assurance into the Medical Practices Act (the 2052 Project) concluded with comment from its chairman (7):

> . . . 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.

I began working in the medical field as a malpractice defense attorney in 1972. In addition to studying medical issues, I asked physicians about the causes of litigation. I recognized professional negligence in fewer than 20% of my cases, but found in all of them a breakdown in the physician-patient relationship that could be traced to an undiscovered misunderstanding about the allocation of responsibility between the parties. This misunderstanding caused unrealistic expectations that went unfulfilled and led to litigation. Attorneys then looked for negligence and when found, it was commonly in the midst of the pressures of a deteriorating relationship. Another call to establish professional education programs on contract was issued by a malpractice insurance carrier (8), and in 1983 I convened a discussion among medical educators in San Francisco (Spivey BE, Hamilton WK, Jonsen A, Needleman J, Pacific Presbyterian Medical Center. 11 August 1983). The group saw the need for professional education on contracting principles, but found no opportunities among current educational projects. The same year, articles were published on patients who refuse treatment (9) and physicians who usurp patients' prerogatives in decision making (10).

The present article was prepared for the University of California Medical Center Conference on Obstetrical Anesthesia in San Francisco in March 1987, and rewritten for general medical readership. I developed a two-part consulting format for evaluating a physician's patterns of allocating responsibility according to implied agreements, and clarifying misunderstandings by express agreements. It prepares the physician to restructure his relationships, document the process, and attend seminars about problems common within specialties. The Medical Decisionmaking Institute will sponsor public education on role clarification by agreement and administer professional education programs capable of certification to, and continued maintenance by, insurers who may condition coverage upon compliance with role clarification requirements.

Why Such Confusion About Informed Consent?

To understand the confusion about informed consent, one must first understand the concept of informed consent as a judicial stepping stone from tort to contract. Torts are civil wrongs between parties who have no contractual (express or implied) or consensual relation. Tort disputes are resolved according to common law principles known as standards of care. When a consensual relation exists, disputes are resolved according to the parties' expectations even when they have to be reconstructed by evaluating the implied agreement or by imposing a public contract, as in product liability. Courts apply tort principles when there is no apparent consensual or contractual relation between the litigants. Otherwise, contract principles govern, because it is thought that the parties' expectations, whether express or implied, form a more meaningful context for resolving disputes than the common law norms relied on in tort law. Epstein's article (5) explains how in many areas of common law, tort principles give way to quasi-contract and eventually to contract principles, as society identifies the risks of injury and begins to allocate responsibility to the appropriate party according to their ability to reduce these risks.

In articulating the informed consent rule, courts were suggesting consensual (contractual) solutions to problems of allocating responsibility for decisions. The scenarios from which these cases arose contained insubstantial evidence of the physician-patient agreement and were not argued on the basis of contract principles. I believe that courts' desires to shift attention from tort notions to contract principles were frustrated by tort lawyers who argued cases in a manner that has retarded this judicial evolution.

There is frustration and confusion in medical practice because this judicial evolution has been made slower by competitive, self-interested postures within the insurance industry and the legal system. Insurance companies and defense attorneys, both of whom educate physicians on the uses of consent forms and recording practices, preserve adversarial aspects within health care relations by attempting to improve physi-

cians' defensibility. There is no motivation in these fields to reduce the frequency of malpractice cases because their economic survival depends on continued litigation.

Epstein's work went unappreciated by the medical profession because it was addressed to the courts and did not suggest what physicians might do to hasten the evolutionary process described above. When physicians and patients clarify roles and responsibilities expressly, they change the context for judicial decision making by eliminating the need to rely on common law principles of tort law. Courts will recognize reasonable agreements as valid contracts and identify the inequities and abuses in them that should not be tolerated. Informed consent is a specific application of general consent (a defense to a battery), the tort from which medical negligence emerged. By applying the doctrine in practice as a tort defense, physicians heighten the adversarial nature of the physician-patient relationship and serve only their lawyers' mode of thinking and economic well-being.

The Effect of Confusion on Patient Relations

We are in the midst of an historic transition in the development of health care relations. Physicians have enjoyed autonomous decision making for centuries, and they are now being told they must share that responsibility, but they have not been told how. This difficulty is addressed in depth by Katz in *The Silent World of Doctor and Patient* (11):

> Since the promulgation of informed consent doctrine in 1957, physicians have of necessity become more aware of their new obligation to talk with patients about recommended treatments. Yet, by and large any disclosures have been limited to informing patients about the risks and benefits of proposed treatments, not about alternatives, and surely not about the certainties and uncertainties inherent in most treatment options. Most importantly, conversations with patients are not conducted in the spirit of inviting patients to share with their physicians the burdens of decision. Without such a commitment, dialogue is reduced to a monologue. Thus, what passes today for disclosure and consent in physician-patient interaction is largely an unwitting attempt by physicians to shape the disclosure process so that patients will comply with their recommendations.

Patients seeking meaningful decision-making roles, faced instead with doctors urging compliance, have turned from confidence and respect to suspicion and mistrust. Physicians have become defensive, insecure, and generally dissatisfied with medical practice. These symptoms need not continue.

The Opportunity and the Challenge

As a transitional doctrine, the case law of informed consent is as confusing to the legal community as it is to the medical profession. It is ever changing, reflecting rapidly changing elements of patient participation in decision making. Directing the medical profession in its responses to judicial demands for patient involvement, the insurance industry and the defense bar encouraged the use of documents designed to protect physicians in litigation.

Introducing consent forms just before treatment or surgery, and well after decisions have been made, undermines the role of the form in the shared decision-making process and perpetuates adversity in the physician-patient relationship. If physicians approach shared decision making in the same defensive manner, they will generate misunderstandings, unfulfilled expectations and disputes, and their agreements may be invalidated on the grounds of coercion. Some courts may not initially acknowledge private agreements in medical settings, but eventually most courts will affirm the validity of the agreements in general while refusing to ratify their abuses.

Courts will approach recognition of physician-patient agreements cautiously, acknowledging the obvious disparity of knowledge between the parties. Form agreements written by medical providers to apply to all patients may be considered contracts of adhesion and adjudicated voidable or unenforceable. Valid contracts must respect the interests of both parties. Educational material distributed before undertaking patient care can elicit patients' values and preferences through intake applications and questionnaires that prepare both parties to enter meaningful agreements. Avoid proposing contracts as take-it-or-leave-it documents that might settle a malpractice claim. Professional contracting is a process that calls on skills which are separate and distinct from those needed in scientific methodology for diagnosis and treatment. Preparation and individualization are the keys to avoiding problems of adhesion and unenforceability.

Contracting, the process of making agreements, is not the same as obtaining an informed consent. Attempts at getting consent seek compliance. Contract involves choice. At first, keep new agreements aimed at issues that are most likely to benefit the clinical relationship. Do not think about contracting out of the tort system until making agreements that improve or clarify working relationships. Unless the agreement is beneficial, the patient will challenge any limitation on his or her cause of action. Expect courts to judge the reasonableness of contractual limitations on remedies according to the benefits gained by the patient.

By viewing the doctrine of informed consent as a judicial stepping stone to shared decision making, one can read the courts' decisions as suggestions that certain matters are best resolved at the clinical level, where the parties possess the knowledge, skills, and values that are most relevant. Physicians can thereby address the interest that the courts sought to protect, rather than trying to fulfill the literal mandates of an incomplete and misdirected judicial doctrine.

Katz (11) has identified the challenge facing medical education:

> Doctors cannot know how many patients are unable or unwilling to participate in decisionmaking until they radically change their perceptions of patients, assist patients in altering their perceptions of their doctors, and learn to speak with patients in new and unaccustomed ways. Put another way, to learn whether patients are able and willing to make decisions jointly requires first that doctors take responsibility for altering traditional patterns of interacting

with their patients; only then can patients be expected to assume the responsibility of informing their doctors that they wish to have a voice in decisionmaking. . . .

While the education of physicians for technical competence is at a remarkably high level, their education for shared decisionmaking competence is deficient. Medical educators need to appreciate more than they do that learning how to converse with patients is as difficult a task as learning about diseases, their patho-physiology, diagnosis, and treatment.

Contract Elements

Physicians should not think about patient agreements in legalistic terms. Agreements are contracts, but, more simply, they are verbal plans. They can, but need not, be agreed to in writing. They may be evidenced by written instruments in different ways. Their basic elements are purpose, the complementary responsibilities of both parties, and a term, or time frame. Purpose should be defined in language pertaining to the physician's scope of practice and should be described in terms of diagnosis or treatment of pathologic conditions, as these are the foundations of evaluating standards of care. Attempts to manipulate dynamics of health that are within individual control (behavioral changes) should be considered separately, and conditioned on the patients' responsibilities, on which they depend. Expectations of medical treatment should also be conditioned on the patients' roles, on which they depend (continuity of visits, use of medications). Agreements should relate to the physician's skills and abilities and the patient's individual values and needs. Medical responsibility can be limited to advice concerning diagnostic course, prognosis, treatment alternatives, or monitoring a known condition during a period of behavioral changes, and need not encompass treatment.

Physicians and patients make agreements, or believe they do, every day. So what is new or different about these suggestions? Every contract contains a unique blend of express and implied terms. The following suggestions may allow physicians to evaluate the issues most likely to be misunderstood when left to be implied by circumstances, and enable creation of a practice or procedure for clarifying them expressly. Every physician practices within a pattern of allocation responsibility (expressly and by implication) that reflects unique personal values and the ability to define responsibility expressly. Create simple agreements that make sense and permit them to change. Make them verbally and reflect on their wisdom in light of your needs before considering how to document them. Do not think of contract as a new solution to legal problems. The task is to learn how to structure relationships to reduce unfulfilled expectations that erode relationships and generate disputes.

Decision Making

Allocating responsibility for decision making (Table 1) most often generates misunderstandings that produce litigation. In the traditional model, alternative 1, the physician decides the diagnostic course and treatment, and trust and confidence replace the need for express consent. Often, physicians assume this model prevails and fail to discover the patient's assumption that one of the three other models applies.

Table 1. *Decision-Making Models*[a]

Model	Roles of Physician and Patient
1. Traditional	Physician decides. Patient trust and confidence replaces the need for consent.
2. Informed Consent	Physician decides with patient's informed consent.
3. Collaboration	Joint decisions.
4. Patient choice	Patient decides with physician's counsel.

[a] Make agreements with patients about which model governs which decisions and permit agreements to change according to need.

A physician assuming alternative 1 or alternative 2 will generate conversations aimed at getting compliance. There will be no shared decision making or patient choice in these instances. Relations are usually eroded by divergent assumptions about this issue. This issue is probably the reason for the phenomenon of treatment refusal (9).

Shared decision making in alternatives 3 and 4 offers a more meaningful level of patient participation than consent. Shared responsibility alleviates the need for consent, unless the agreement contemplates consent, as in alternative 2, which is why contract principles supercede tort concepts in the judicial process. Knowing which patients would rather trust the physician's judgment than make decisions themselves will lead to more relevant and productive conversations with all patients. Those who wish to share responsibility for decisions must first be divided into consenters, collaborators, and deciders before it will be accurately understood how to converse with them.

Many patients will choose the traditional model when examining all four. Discussing options will enable physicians to learn their patients' predispositions and values, which is essential for making judgments on their behalf. Presenting the options invites agreements on terms that are essential to successful relationships. It will also identify patients whose values and needs you are unable to satisfy before becoming invested in a deteriorating relationship.

Clarifying the Decision-Making Model

Underlying almost all medical malpractice cases whether involving professional negligence or not, are hidden misunderstandings about the decision-making model. Physicians and patients view this issue differently because they rarely discuss it, or because the differences between the options are not clearly understood. Clarifying the model will permit shared decision making and avoid misunderstandings. Malpractice litigation will be reduced significantly because destroyed relationships, which are responsible for the many cases not involving recognizable professional negligence, will be avoided. The pressures of de-

teriorating relationships which increase the risks of human error will be eliminated. Express agreements about the decision-making model will also permit the change of model, which is often desired at different periods in the relationship. Such changes are required when the patient's dependence on the physician changes. Without express agreements about decision making, these changes often occur but go unnoticed. When patients are incapacitated due to unconsciousness or emergency, each decision-making model may apply to designated agents, family members, or patient advocates.

Choosing the Model

A middle-aged patient is hospitalized for his first gall bladder attack; immediate removal of gall bladder is advised. Options of non-removal are rejected by the physician because of the patient's health, age, convenience, and availability of good medical care. These options are not discussed with the patient in the traditional model. The potential clarification of the issue by prior agreement should now be considered.

Discuss whether the decision can be made by the patient (with or without physician concurrence) or jointly. Decide first how the decision should be made. The physician in the first instance may learn the patient is unable or unwilling to share decision making and could then proceed. The patient might be willing to share in the decision process or decide alone. Patient decisions or collaborative decisions require a different exchange of information than those where consent or compliance is sought—not necessarily more information. Relevant exchanges will alter the course of deteriorating relations.

If the patient wishes to collaborate or decide alone, age, convenience, availability of care, and the behavioral changes (nutrition, stress, exercise) that might influence the risk for future episodes if surgery is foregone, should be discussed. The patient's responsibility for shared or independent decision making should be recognized.

If the consent model is used, the physician advises the patient of risks and alternatives according to customary practice as required by current state law. If the parties decide to collaborate, mutual agreement is necessary to proceed. If patient choice is desired, the physician may continue to treat a patient whose judgment leads to a course of action different from what the physician would elect. In this model, physicians should communicate reasonable boundaries and limit their professional relationship accordingly. Physicians and patients decide for themselves if the model is acceptable. Physicians may work differently with different patients, or limit their practices to certain patients. They will, however, learn to gear anticipated outcomes and mutual expectations according to varying levels of responsibilities assumed by both parties.

Agreements with patients are usually objected to, as they require too much time. An implied agreement, however, is always attempted. Generally, express agreements will be made in 5 to 10 minutes. Patients cannot share decision making if physicians attempt to solicit consent or compliance and dictate the dialogue. In these situations, any consent obtained is probably vulnerable to a charge of coercion.

Agreements among Doctors

Clarifying roles by agreement can also help anesthesiologists and surgeons avoid conflicts with each other about judgments on the methods of administering anesthesia. Anesthesiologists working with surgeons who want to decide the method of administering anesthesia can seek mutual agreement on the decision-making model that will govern their work. The basic options are 1) the surgeon decides with advice from the anesthesiologist; 2) collaboration and joint decisions; and 3) the anesthesiologist decides with advice from the surgeon.

Agreements may apply different procedures to each decision, such as the surgeon selecting the analgesic agent and the anesthesiologist governing its use. Such agreements may be seen in the form of correspondence, procedure manuals, memoranda, or notations in the record.

Contracts between surgeons and anesthesiologists could also improve communication with patients about options and risks in anesthesia. Surgeons could agree to communicate with patients according to discussions with the anesthesiologists, to distribute handouts as provided, or to obtain completion of a questionnaire or interview concerning values, choices, and desired role in making decisions. By soliciting such an agreement from surgeons, anesthesiologists can determine what level of participation can be expected and plan for direct communication with the patient when necessary. Surgeons and anesthesiologists could clarify responsibility for taking presurgical histories of food intake and drug sensitivities. Similarly, agreements among consulting or referring physicians may clarify boundaries of shared responsibility on a wide range of subjects that frequently generate misunderstandings.

Documenting Agreements

Several types of records of patient agreements are acceptable. A signed document titled "contract" is only considered evidence of a contract. A court will view the contract as the "meeting of the minds," and any evidence may be relevant to establish the terms included. A contract record is any summary of the consensual terms in the relationship. It documents the verbal agreement that is the context for understanding the treatment plan. Other evidence of patient agreements include recollection, behavior, correspondence, recordings, and notes.

Consider the differences between the notes of a patient agreement on the one hand and waivers or disclaimers on the other. Waivers and disclaimers are statements that claim to define behavior so as to reduce or eliminate liability, and are viewed suspiciously by the courts. Unreasonable waivers and disclaimers may be disregarded as against public policy.

Dispute Resolution Agreements

Formal dispute resolution procedures such as arbitration agreements have spearheaded our recognition of the contractual nature of physician-patient relationships. These procedures change the forum for resolving disputes and do not identify the terms that are necessary for successful relationships. When presented at the beginning of a relationship, arbitration contracts actually increase malpractice risks by focusing attention on the early anticipation of failure before a constructive working relationship is established. These agreements and other contractual proposals, such as limitations on actions and awards, will make more sense to patients and to courts when offered with agreements about terms that are essential to successful relations.

Professional Control over Standards of Practice

By making express agreements that clarify the decision-making model and other terms that are essential to successful relations, physicians will change the context of judicial decision making from tort to contract. Cases that go to court will reveal contractual elements addressing the interests courts seek to protect—patient involvement in the decision-making process—and will not have to be decided according to judicially defined concepts of informed consent. Physicians will be able to identify the unrealistic expectations that generate litigation and develop practices built on self-defined terms, producing effective clinical relations instead of many that would have deteriorated and gone to court. Most importantly, however, future case law generated by disputes in relationships structured by contract will respect the professional function of role clarification at the clinical level. In this manner, physician and patient contracts can reclaim professional control over judicially determined standards of practice.

Conclusion

Over the past 10 years risk management functions developed by insurance companies have increased significantly. The practice of reviewing files and office procedures to improve the defensibility of physicians is appropriate for insurers, although it leads to defensive medical practice and increasing adversity between the parties; however, I would suggest that the risk minimization be the responsibility of the profession. By risk minimization, I mean reducing the frequency of litigation by controlling the unfulfilled expectations that lead to litigation. Physicians, not lawyers, courts, or legislators, create the risk of liability in their relationships with patients. Only physicians can reduce that risk by managing their relations. Agreements are the tools with which all relationships are made manageable. Clarifying roles and responsibilities at the clinical level will strengthen the ailing relationship between physician and patient and give a new and positive direction to the course of health care.

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Kentucky Supreme Court Ruling on Tort/Contract Boundaries

by Jerry A. Green, J.D.

After my address to the California Society for Healthcare Risk Management, entitled "The Impact of Collaborative Planning on Informed Consent," CSHRM Past President Mark Cohen sought my comment on the reported case of Kovacs v. Freeman[1]. My presentation had chronicled the difficulties associated with informed consent, the 1982 President's Commission's suggestion that shared decisionmaking replace informed consent as the normative ideal, and explained how the growing popularity of collaboration in health care decisionmaking can establish a contractual foundation capable of superseding common law tort notions. The court in Kovacs clarified why a signed consent was not a contract, and articulated the elements essential for judicial recognition of health care contracts that would enable agreements defining how consent is understood and used. The opinion illustrates judicial reluctance to expanding the applications common law consent doctrines, and hints at meaningful contractual guidelines for providers and risk managers.

Facts: Freeman 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 due to a post-operative spinal 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 the 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.

Issues: 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)?

Analysis: 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.

Risk Management Implications: There is considerable confusion about informed consent among providers, risk managers, and among attorneys, courts and academics as well. This is because the doctrine has been imposed on the medical profession by the courts, who have articulated the ideal, but have not clarified the nature and extent of the required disclosures. By imposing a "duty to disclose" on providers, but leaving the criteria for adequate disclosure up to standards of practice, they have created a predictable dilemma for those looking to courts for judicial clarification of necessary details. In 1982, a President's Commission suggested that "shared decision making" is the appropriate ideal that a sound doctrine of informed consent should support, and concluded that we need "a new and unaccustomed dialogue between physicians and their patients" which it doubted

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[1] Ky., 957 S.W.2d 251 (1997)

would occur "if primary reliance is placed on the courts."[2] It has been previously suggested that informed consent may be seen as "a judicial stepping stone from tort to contract."[3]

I read the Kentucky Supreme Court opinion as suggesting two important notions. The first is that courts are aware of the difficulties which 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.

Risk managers today have the opportunity to avoid urging the imposition of informed consent requirements, and invite physicians to consider how role clarification and shared decisionmaking might be accomplished by collaborative planning. The growing interest in collaboration, with patients, and among practitioners, represents a trend away from normative practice requirements (accepted standards of care) and toward mutually defined contractual responsibilities. The Court is suggesting a foundation in private lawmaking that has greater potential for satisfying the diverse interest and needs of providers and patients than may be found in the adversarial norms of common law.

Increasing popularity of collaboration will inevitably give rise to the need for greater role clarification skills. This is essential in order to identify the unique skills and preferences of individuals, and in order to rationalize and maximize their collaborative potential. Two cornerstones of the healthcare contract are the scope of professional responsibility being assumed, and the allocation of desicionmaking responsibility. Decisionmaking agreements identify the patient as the decider, designate professional responsibility, or clarify a joint decisionmaking process. These three models will likely be preferred by most individuals over the ambiguities of informed consent requirements. Prior education can clarify general preferences and identify areas where different styles may apply.

The scope of professional responsibility may be clarified to encompass diagnosis and treatment of pathology (which is the basis for defining acceptable standards of practice as well as scope of practice re licensure) and reserve to patients those dynamics of health that are within patient control (such as lifestyle changes, stress management, nutrition and fitness.) Scope of practice boundaries are especially important in order to clarify when the integration of holistic therapeutics are considered as ancillary or adjunctive to (and not a part of) prescribed treatment plans. When professional responsibilities are thus defined in the practice of "alternative or complementary" medicine, a logical boundary for the application of traditional standards of practice may be argued.[4]

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[2] 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.)

[3] Jerry A. Green, Minimizing malpractice risks by role clarification: The confusing transition from tort to contract. Ann. In. Med., 109:234, 235 (1988)

[4] See Jerry A. Green, Collaborative physician-patient planning and professional liability: opening the legal door to unconventional medicine. Advances in Mind-Body Medicine, V.15 N.2, p.83-111, Spring 1999