Shared Decision Making and Role Clarification Potentials in Integrated Medicine
by Jerry A. Green, J.D.

Summary

A sampling of surveys of physicians' roles regarding their scope of professional responsibility was studied and two patterns were identified. One pattern defined the professional responsibility physicians assumed in terms of scope of practice boundaries defined by licensure and accepted standards of practice, and offered holistic therapies as adjunctive or ancillary to treatment plans. This approach is compared with the integration of unconventional methodologies into conventional diagnostic or treatment plans with regard to professional responsibility risks and opportunities for patient and professional education.

Decisionmaking patterns are studied according to four models which distinguish shared decisionmaking from informed consent. Principles of collaborative planning for varying decisionmaking according to the kinds of decisions and the values and preferences of patients and physicians are @ defined and discussed. The values and risks of allocating responsibility by express agreement are compared with situations in which assumptions about decisionmaking responsibility may be implied from circumstances or accustomed practice.

I. Scope of Practice

Physicians informally surveyed in the course of practice management consulting, conducting risk management seminars, and evaluating medical malpractice and licensing issues, reveal two basic patterns of integrating holistic therapies into conventional medical responsibilities. Both apply to physicians utilizing holistic therapies by referral to other practitioners, and to physicians employing unconventional methodologies in their own practices.

Group A defines scope of practice boundaries.

Group A is identified and discussed herein as clarifying with patients that some holistic therapies should be seen as ancillary or adjunctive to medical treatment plans. In this group, the boundaries of medical treatment plans was understood as the diagnosis and treatment of pathological conditions. Some members of this group documented this distinction by intake applications containing questions designed to distinguish between a patient's concern about pathology and their interest in a more holistic objective, such as increased mind-body integration or balancing metabolic or energetic processes. Some documented the distinction by simple notations in charting. Some employed the distinction in the process of communications with patients without reference in formal charting.

Group B integrates holistic therapies into medical treatment plans.

Group B physicians are identified and discussed herein as making no distinction between the objectives of alternative therapies and the objectives of conventional medical treatment plans. It was not possible to determine whether physicians employed any such distinctions in their own minds when utilizing holistic methodologies in their practices or administered them as treatments for pathology.

Example: Physician liability for death of asthma patient treated homeopathically.

A Southern California internist was sued for the death of a 49 year old female asthmatic whom he was treating with homeopathy.! The defendant's attorney argued that conventional medical standards should not apply, because the doctor was practicing as a holistic health practitioner. He argued that, as

a homeopath, the standard of care should not be the same as that which is applied to conventional physicians. When asked, the defendant's attorney told me that his client did not have an express agreement with the patient regarding the scope of his professional responsibility and its relationship to traditional medical responsibility, although the patient was also seeing a pulmonologist, who had prescribed an inhaler. The physician's attorney stated that had such an agreement been in place, his argument would have been supported by evidence, giving him a better opportunity to affect the outcome of the case. Shortly before trial, the insurance company settled the case for the policy limits of $500,000, and the physician lost his coverage because of the liability.

II. Defining professional responsibility.

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 own standard of care represents or familiarizes them with "common practice," 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 ior 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 give expression to the intentions and expectations of the parties.

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 genera], agreements are tools for 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.

This article examines the hypothesis that the scope of professional responsibility in medicine may be recognized as the diagnosis and treatment of pathology, and that holistic modalities may be understood differently so that the application of customary standards of practice may be limited to customary medical functions. This is not to suggest that alternative therapies should always be defined

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 Pound. Res. J. 1976:87, Green, Jerry A., Minimizing malpractice risks by role clarification: the confusing transition from tort to contract. Annals of Internal Medicine, S/l/88, p.234

as outside the perimeters of medical practice boundaries. Some holistic therapies are more well suited to treating pathology than others.

Nevertheless, the distinction between treating biological diseases as manifested in physical or biochemical symptoms on the one hand, and on the other hand, affecting a patient's constitutional disposition (which is understood to involve a mental, emotional and energetic foundation) is a substantive one. It has a rich history as a philosophical cornerstone in medical science,4 and identification of the pathology model may be recognized in the language of our scope of practice statutes. Physicians can determine whether their clinical purpose is to treat pathology or affect the patient'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.

I describe and discuss the customary scope of practice as a boundary without implying that it is necessarily the only concept which might be used in practice management. The scope of practice boundary, however, is familiar, and it carries certain common implications. The boundary reflects the relationship between methodologies in many situations involving the integration of medicine and holistic therapies. Physicians may see their scope of practice boundary as being so broad as to include all health care concerns, or as limited to physical or biochemical pathology, excluding dynamics of health that are within individual control. Each physician defines his own scope of professional responsibility either expressly or by implication with every patient. In the absence of an express agreement to the contrary, customary standards of practice will likely determine the boundaries of professional responsibility, and they will likely interpret them broadly, until lager numbers expressly clarify their roles. I think we can assume that this number is growing, and will continue to grow.5

The basic principles of applying role clarification to limit the application of accepted standards of practice may be applied to any conceptualization of medical practice boundaries. The medical model of pathology is exemplified here because it is consistent with licensing laws and standards of care, and because it excludes the goals of many holistic modalities which, in their classical expression, attempt to define an objective which is distinct from the treatment of pathology. This distinction may be seen in homeopathy, acupuncture and other oriental disciplines, somatic practices, mind-body therapies, body psychotherapy, and in the use of nutrition and herbal remedies.

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:

4 Divided Legacy, Harris Coulter, 3Vols., Wehawken Books, Wash.D.C.

ASSUMPTIONS ASSOCIATED WITH THE EMPIRICAL AND RATIONALIST SCHOOLS

Empirical School	Rationalist School
Observation and experience as knowledge source	Logical analysis as knowledge source
Studies growth or balance of vital energy	Studies disease entities
Workings of life-force unknowable	Presumes hypothesis of knowable cause
Peculiar symptoms determine uniqueness	Common symptoms identity cause of disease
Relies upon subjective data	Depends on objective data
Individual is fundamentally energetic/spiritual	Individual is material, chemical, mechanistic
Healing by similars may provoke crisis	Treatment seeks removal of symptoms
Health is internal/environmental balance	Health is absence of disease
Holistic methodology	Atomistic/reductionistic methodology
Client/patient seen as authority	Doctor/practitioner is authority

J.A. Green, The health care contract: a model for sharing responsibility. Somatics, 3,4. 1982
(Drawn from Coulter, supra.)

:> The popular trend toward assuming responsibility for nutrition, fitness and stress managment leads logically to increased responsibility for health care decisions.

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 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.)

I have not heard of, nor have I seen reported, any cases in which the first principle (that of prohibiting the practice of a mode or system of treating the sick or afflicted) has been used to prosecute the unlicensed practice of medicine. I have assumed that this is the case because that portion of the statute is less precise than the latter portion. 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 holistic 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.6

Comparing Risks

Perhaps the first question to address when deciding whether to identify a holistic modality as part of or ancillary to a medical treatment plan is whether the modality is consistent with the accepted standard of practice in a particular situation. The interest in identifying a non-pathological purpose is greater if forgoing accepted practice might be dangerous, or if the modality would be considered substandard.7 The next question is whether the modality may be seen in non-pathological terms. For

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

7 Standards of practice require conventions, from which we can infer patterns of behavior. As in the homeopathy example, there really is no accepted standard relative to the holistic therapy, because it isn't an aspect of conventional practice. We can argue that there may be an accepted practice for the modalities which have been subjected to random clinical trials, however most research trials have been testing efficacy for the treatment of specific pathologies. This raises a logical and philosophical conundrum when we acknowledge the vitalistic assumptions regarding attempting to cure the person, not the disease. In addition, a formidable challenge to the. tradition of random clinical trials had been raised by the relative efficacy of outcomes studies. (See Theodore Pincus, Analyzing long term outcome of clinical care without randomized controlled clinical trials: the

example, EDTA chelation for arteriosclerosis would appear less likely to be seen in non-pathological terms than addressing an asthma patient's constitutional disposition with homeopathy. Where might treatment of contusion with Arnica, or treating infection with Golden Seal be? Are there sufficient studies establishing the clinical efficacy of a certain holistic remedy as treatment for a particular pathology to support its recognition as acceptable practice? Does giving Arnica as a constitutional remedy appear different that prescribing it for bruising?

If the considered practice risks offending the accepted standard of treatment, and its purpose can be seen in non-pathological terms, an agreement distinguishing it as ancillary or adjunctive to a treatment plan would support the argument that the accepted standard of practice should not be applied to the resolution of a resulting professional responsibility dispute.8 This was the argument asserted in the asthma case discussed initially. It was unsuccessful because there was no evidence of a supporting agreement. The physician in that case exemplifies Group B. We don't know whether his use of homeopathy was constitutional or not. If he had used a classical approach and addressed the patients constitutional disposition, he might have elected a practice management strategy of Group A, defining his function as separate from the patient's pulmonologistwho was monitoring vital capacity and potentially advising the patient when to seek emergent care. This would reduce the chances of misunderstandings resulting in poor clinical outcomes and aggrieved patients.

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

Writings which serve other legitimate clinical purposes, such as gathering information, are both more reliable, more professional, and appear less legalistic. An intake application asking for the patient's concerns about pathology separately from their interests in constitutional matters orwellness concerns would serve a legitimate clinical purpose besides documenting a role clarification agreement. Literature distributed prior to receiving the intake application might discuss the differences between treating pathology and mediating vitality. A subsequent discussion and agreement that any concern about pathology is insufficient to warrant medical treatment for a specified time during which a vitalistic interest is explored might be reasonable. The application would illustrate how information has been gathered in preparation for the discussion about the differences between pathology and holistic objectives. It would prepare both parties to discuss and agree upon clinical objectives which might address either or both purposes. Such agreements could be noted in the chart or confirmed in writing by correspondence without appearing legalistic or projecting a defensive attitude which may alienate patients.

When less documentation appears necessary, verbal dialogue about the issues may simply be confirmed by chart notation or correspondence. One should probably expect that where no role clarification about the scope of practice is documented, holistic therapies, if questioned, will be assumed to be part of the medical treatment plan and evaluated by accepted standards of care as treatments of pathology. If the holistic therapy is administered by an unlicensed practitioner, the physician may be seen as assisting unlicensed medical practice, which would also give rise to civil malpractice liability without the need to prove substandard practice separately (negligence per se.)

consecutive patient questionnaire database. Advances m Mind-Body Medicine, Spring 1997 and the dialogue which followed. Harris Dienstfrey, Advances, 15:2, p. 82, 1999.)

8 A standard of practice reflecting holistic objectives by physicians under similar circumstances would greatly reduce the risk of liability in civil malpractice actions and in professional regulatory matters.

If, on the other hand, the holistic therapy can be considered ancillary to the medical treatment plan, role clarification agreements can protect both the physician against the charge of negligence and the holistic practitioner against the charge of unlicensed medical practice. Referrals to holistic practitioners should not be made on prescription slips. This document suggests that it is part of the medical treatment plan. I also caution against the use of informed consent documentation regarding holistic modalities which are to be understood as ancillary or adjunctive to (and not a part of) medical treatment. Like prescriptions, informed consent is a medical principle which is intended to apply to medical treatments. Extending the concept of informed consent beyond accepted practices for the treatment of pathology will meet with judicial reluctance9 and it will obscure the distinctions which have been discussed. If documentation of risks and alternatives is desired without relying upon medical model concept, the idea of informed choice is more befitting the contract model. For the reasons previously stated, patient choice pursuant to a health care contract would be recognized by a court as superior to the tort notion of informed consent.10

III. Allocating Responsibility for Decisions

Confusion generated by informed consent.

Decisionmaking patterns were surveyed and studied according to four models identified in a 1988 effort!l to explore the variety of decisionmaking styles suggested by a 1982 President's Commission.12 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.13

The Kentucky case of Kovacs v. Freeman14 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 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

9 Moore v. Baker, 1991 U.S. Dist. Lexis 14712 (S.D. Ga., Sept. 5, 1991), aff'd, 989 F.2d 1129 (llth Cir. 1993). Advice of chelation as a treatment alternative to carotid endarterectomy not required by informed consent law.

10 See the. following discussion of Kovaks v. Freeman.

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

12 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.)

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

HKy.,957S.W.2d251 (1997)

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.

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.

The President's Commission concluded that "shared decisionmaking is the appropriate ideal that a sound doctrine of informed consent should support."15 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.)"16 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:

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.

Physicians surveyed were asked to assess the relative frequency in which they believed the four decisionmaking models should be employed. They also estimated the relative preferences for decisionmaking styles among their patients. This permitted a subjective comparison of physicians and their own patient population regarding values and preferences for allocating responsibility for making medical decisions. They were asked to indicate which kinds of medical decisions were most appropriate

15 Commission, supra, note 7, at p.38
16 Id at p. 30

for each decisionmaking style. They were also asked to identify the most frustrating or troublesome aspect of their patient relations, and the most common misunderstandings which threatened clinical efficacy or led to disputes and grievances in their specialty. Most misunderstandings were about treatment expectations and risks of treatment.

Physicians differ in their values and preferences for decisionmaking styles, and so do their patients. There are currently only a few physicians who 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. Some physicians indicated that they intuited or guessed about their patient's preferences, based upon the kinds of questions patients asked. Sometime after being surveyed, physicians reported increased satisfaction about being able to be more "pro-active" in asking relevant questions themselves, and in identifying patient preferences. They understood different levels of participation, and had learned to elicit patient values, or to articulate their own preferences.

Three patterns of decisionmaking preferences among physicians are predictable and were identifiable. Some felt 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 that 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.

While physicians saw the potential for identifying the values and preferences of particular patients, most physicians either wanted the bulk of their patients to be more compliant with their judgment, or they wanted them 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 which possessed a variety of values and preferences. It was thought that patient decisionmaking values reflected geographic and demographic dimension of practices, although age and plan affiliation was also apparent.

Role clarification agreements identify potential misunderstandings and unrealistic expectations. They establish general parameters which 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 which 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 which clarifies any assumption which may not be shared, one introduces contract as a working tool that can be used again as needed. After outlining education possibilities in general, we shall consider some specific education and referral suggestions for different physician preferences.

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 acquisition 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 in this process may be achieved by expressing one's own values and preferences, and then further clarifying the landscape by 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 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 use.

Remember that decisionmaking values vary among professionals and know your boundaries. Identify your options. Allow for growth and change, perhaps by agreeing to play a decisive role initially, the condition that the patient contemplate the spectrum of options for future decisions. A decision to defer to defer a decision may lead to a better style of decisionmaking. Refer a patient to a colleague who prefers a different role and see if it is reciprocated to your mutual satisfaction. Such referrals build confidence for respecting your own practice management boundaries.

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, or those you feel bound by standards of care to make, and distinguish them from those which might be made jointly by collaboration. This may help patients see an alternative to the struggle for control.

With time and experience, you will both see the spectrum of decisionmaking responsibility and be able to consider more options. 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. However, the ideas of collaborative planning need not result in greater shared decision making. They are tools for discovering misunderstandings and unrealistic expectations. They 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.17 Consent is when the patient shows up for treatment, not when he/she signs the paper.

Shared decisionmaking 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.18 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 generates misunderstandings and adversity. 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.

IV. 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 are often 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.

The remedy for these misunderstandings is shared decisionmaking and role clarification. The scope of professional responsibility can be defined according to customary scope of practice boundaries, reserving the application of traditional standards of care to conventional treatments. Agreements which identify holistic methodologies as ancillary or adjunctive to medical treatment of pathology may be verbal and noted in the record. Intake applications which inquire about patients' concerns about pathology as distinct from interests in holistic objectives can also educate by addressing the relationship between treating pathology and holistic health supporting approaches. Such documentation offers more reliable communication, and is more professional than formal contracts because information gathering instruments serve legitimate clinical purposes.

17 One physician reports 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.
18 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.

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. With collaborative planning, doctors need not share decisions in all situations. They can identify and refer patients with contrary decisionmaking interests, or elect decisionmaking strategies which accommodate the values and preferences of individuals, while allocating responsibility according to their own interests and desires. As our health care system transforms itself, those practices which are built upon the foundations of collaborative planning will have more lasting value.

Jerry A. Green, J.D., has been a special consultant to attorneys on medical issues in malpractice for over twenty years. He conducts professional education programs on risk management, informed consent and role clarification. As a practice management consultant and President of Medical Decisionmaking Institute, he authored Collaborative Planning for Physicians, and Medicine and Holistic Practice, programs with which he consults on practice management and conducts professional seminars for physicians and various health practitioners. His work is available online at MedAgree.eom.