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Contract Law as a Viable Alternative to Problems of Informed Consent

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CONTRACT LAW AS A VIABLE ALTERNATIVE TO PROBLEMS OF INFORMED CONSENT

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The problems of the physician in today's society have been compounded by the increasing number of malpractice issues. The latest and thorniest problem involves the concept of "informed consent," embodying the expression of Justice Cardozo that every individual has the innate right to determine what shall be done with himself.[1] Informed consent advances the conceptualization to include an *understanding* of what is proposed for one's medical or surgical management.[2] Intrinsic to this is the need to utilize clear terminology and to discuss potential complications as well as alternative modes of therapy and their specific attributes and disadvantages. The problem presented is that any question as to whether the patient truly understood his physician's explanation immediately becomes a jury issue, *i.e.*, a matter of fact. Compounding the complexity of the problem are recent decisions indicating the need for the doctor to provide whatever information the patient may require for his decisions rather than conform to a standard of practice in this regard.[3]

We have no clear-cut guidelines as to what to tell a patient, how much to tell the patient, or the basis on which the doctor must choose the information to be imparted. For example, should a one-in-a-million risk be disclosed?[4] And, indeed, we have no clear-cut guidelines as to what are the criteria of import.[5] Furthermore, neither legal nor medical precedent has

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[1] Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914). *See also* Norton, *Consent, A Problem in Medicine*, 69 MICH. MED. 111 (1970).

[2] 2 HOSPITAL LAW MANUAL *Consents* 2 (Attorney's Volume, G. Stroud ed. 1971) [hereinafter cited as HOSPITAL LAW MANUAL].

[3] *See, e.g.*, Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972); Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676 (1972); Miller v. Kennedy, 11 Wash. App. 272, 522 P.2d 852 (1974). *See also* HOSPITAL LAW MANUAL, *supra* note 2, at 2-9.

[4] In both Sterling Drug, Inc. v. Yarrow, 408 F.2d 978 (8th Cir. 1969), and Sterling Drug, Inc. v. Cornish, 370 F.2d 82 (8th Cir. 1966), a high level of duty was imposed on a drug company disseminating drugs with possible side effects.

[5] *See* Norton, *When Does an Experimental/Innovative Procedure Become an Accepted*

been established as a matter of law, and neither the "reasonable man" nor "standard of care" legal fictions—nor any other similar legal fiction—serves as a pilot through the channels of this dilemma. As one commentator has noted:

> This confusion emanates, in part, from the indiscriminate use of such words as . . . "informed consent." . . . [These words are] not terms of art that have a definite meaning established by decisions or statutes . . . [but] journalistic type words that mean what the user intends them to mean. Two people can use such words in their communications and be referring to entirely different ideas. A medical analogy would be the expression "heart trouble."[6]

Confusion has thus been created by ill-considered court opinions and dicta and efforts, in essence, at making law rather than interpreting law,[7] completely ignoring other possible bases for liability such as contract.

In contract law, liability is possible simply because an agreement to perform an act was made even though it later develops that the physician simply cannot perform and even though the patient's condition was made no worse.[8] Thus, obtaining no help from a strict application of tort law, this author looks to another source—that of contracts. Here we have extensive precedent, and indeed growing indications, of a middle route between tort and contract law, an example of which is found in the field of consumer protection as it relates to implied warranty.[9] This ultimate interrelationship has been manifest in the very confused historical origin between the two legal remedies of tort and contract to which few courts have fully addressed themselves.[10] Before applying such an interrelationship to informed consent, let us first review some basic principles of contract law.[11]

Procedure?, in PROCEEDINGS OF THE INTERNATIONAL SYMPOSIUM ON HUMAN EXPERIMENTATION (1974).

[6] M. Plant, *Informed Consent - A New Area of Malpractice Liability*, in INSTITUTE OF CONTINUING LEGAL EDUCATION, MEDICAL MALPRACTICE 29-30 (2d ed. 1964).

[7] *See* note 4 *supra*.

[8] Hawkins v. McGee, 84 N.H. 114, 146 A. 641 (1929) (doctor held liable in contract when he failed to fulfill his express guarantee to restore child to perfect health).

[9] Santo v. A. & M. Karagheusian, Inc., 44 N.J. 52, 64, 207 A.2d 305, 311 (1965) (implied warranty action commences in contract and terminates in tort). *See also* Kessler, *Products Liability*, 76 YALE L.J. 887, 891 (1967).

[10] *See* W. PROSSER, *The Borderline of Tort and Contract*, in SELECTED TOPICS ON THE LAW OF TORT 380 (1954); Poulton, *Tort or Contract*, 82 L.Q. REV. 346 (1966); Thornton, *The Elastic Concept of Tort and Contract as Applied by the Court of New York*, 14 BROOKLYN L. REV. 196 (1948).

[11] The sections of this paper which deal with general contract principles were obtained from A. CORBIN, CONTRACTS (1952); L. SIMPSON, CONTRACTS (1965); S. WILLISTON, CONTRACTS (3d ed. 1957); W. PROSSER, LAW OF TORTS (4th ed. 1971) [hereinafter cited as W. PROSSER]. Because of the extensive reliance on these works, citations to specific sections and page numbers have been omitted.

CONTRACT PRINCIPLES

The term "contract" has been defined in many ways, and it is a common error to suppose that legal terms have one absolute and eternally correct definition. A study of the many usages of the term "contract" indicates three concepts, to wit: (1) the series of operative acts of the parties, or some part of these acts, expressing their assent; (2) a physical document executed by the parties; and, (3) the legal relations resulting from the operative acts of the parties. All of these concepts include the relation of right in one party and duty in the other. A contract has been defined, therefore, as a promise or set of promises for the breach of which the law gives a remedy or the performance of which the law recognizes as a duty. This duty does not inhere in the agreement itself but in the law applicable to the agreement—that is, by operation of law, one who makes a promise is bound to perform it. A contract is not law nor does it make law. It is the agreement plus the law that make the ordinary contract an enforceable obligation. Thus, duties are imposed rather than assumed. However, the conditions of legal liability can ordinarily be regulated by the terms of the contract. In fact, the parties often agree in advance as to what the damages or remedy might be in the event one party commits a breach. A good example would be liquidated damages clauses in construction contracts wherein the contractor agrees to pay a specific penalty for each day the project is late in completion.

Contracts can be express, as when the terms are stated by the parties, or they may be implied in fact, as when the terms of the contract are inferred from the facts of the case. Where, for example, a person performs services for another at the other's request and there is no express agreement as to compensation, a promise to pay the reasonable value of the services may be inferred. This promise to pay the reasonable value of the services is implied where one performs for another, with the other's knowledge, a specifically useful service for which a charge is usually made, and the latter either expresses no dissent or avails himself of the service.

To form a binding contract, an agreement must be made by competent parties who express definite assent in the forms required by law. The Statute of Frauds requires that contracts which cannot be performed within one year be in written form, or at least evidenced by a writing, whereas contracts which can be performed within a year may well be valid and enforceable even though strictly oral. The agreement must also be supported by sufficient consideration. It must not, at the time it is made, be obviously impossible to perform; and it must not contravene principles of law or public policy so as to be legally void at its inception as opposed to voidable by subsequent agreement of the parties. A contract is formed or made when the last act necessary to its formation has been accomplished, usually an acceptance by one party of an offer made by the other. Thus, the location of the formation of the contract is usually the place at which the offer is accepted.

Consent Contracts

Generally parties may agree in a consent contract to waive statutory rights, contract rights, or other rights unless a question of public policy is involved. It is not the rule that any agreement which assumes to place a person at the mercy of another's fault is void as against public policy. The law looks with disfavor, however, on provisions which relieve a person from liability for his own fault or wrong. It has been held that clauses limiting liability (exculpatory by their nature) are to be given rigid scrutiny by the courts and will not be enforced unless the limitation is fairly and honestly negotiated by the parties and entered into with full understanding of its implications; this is particularly true where the private contract is the only means one of the parties has of filling an important need.[12]

A release contract may be void as against public policy where one party seeks to be absolved from liability for future negligence. Further, a person cannot contract beforehand that he will not litigate a claim that may thereafter arise. Since it is the policy of the law to furnish everyone with legal remedies for any injuries received at the hands of another, an agreement which essentially imposes a penalty for seeking such a legal remedy is contrary to public policy and is subject to the penalty of forfeiture. Such an agreement must, of course, be distinguished from one which seeks to limit damages or recovery in advance. This type of contract is clearly legal as long as the damages stipulated in advance represent the parties' reasonable estimate of what the damages might be and do not therefore represent an arbitrary penalty.

Interrelationship between Contract and Tort

The prevailing rule on contractual remedies seems to be that a contract will *not* be construed to limit the remedial rights of the parties unless such an intention is clear. Nevertheless, when the contract prescribes a remedy for a breach, that remedy is generally exclusive if the contract clearly shows an intention to make it so. Where, however, there is no express or implied limitation in the contract making the stated remedy exclusive, the prevailing view seems to be that a party may at his election pursue either the prescribed remedy or any remedy the law gives as, for example, a tort action.

It has been stated that a mere breach of contract cannot be converted into a tort. The dividing line between contract breaches and commission of torts, however, is often dim and uncertain. A tort may also include acts which involve a breach of contract. Thus, the same act may sustain an action based upon either tort or contract. Under this rule, it has been held

[12] For a discussion of the effects of a contract pursuant to which one party enjoys disproportionately greater bargaining power than the other see note 39 *infra*.

that accompanying every contract there is a common law duty to perform the thing agreed to be done with care, skill, reasonable expedience, and faithfulness; and the negligent failure to observe any of these conditions is a tort as well as a breach of contract. As noted above, under such circumstances, the general rule is that the plaintiff may elect which remedy to pursue. The dividing line seems to revolve around nonfeasance (doing nothing) and misfeasance (doing it improperly). The relationship between misfeasance and negligence issues seems obvious. In this context, we must mention the "common callings" concept of torts. This has been applied to public officers,[13] utilities,[14] and others[15] for nonperformance or even failure to agree to perform. Until recently, however, in the absence of specific legislation, a physician could not be held liable for turning people away for any reason or even for no reason at all.[16] The obvious objective of contract law must be noted to be to regularize the relationships between specific professions or industries and society, including the relationship between physician and patient.

CONTRACT RELATIONSHIPS

The contract between patient and doctor[17] is normally implied rather than express. The terms of this implied contract include: (1) that the physician will care for the patient's illness; (2) that the physician will exercise reasonable caution and skill appropriate to his special training; and, (3) that the patient will pay the physician the reasonable value of the service rendered. This implied contract between the doctor and the patient does not exist until both parties, albeit impliedly, agree. Where the patient is incompetent and thus cannot contract, however, another party such as a parent or guardian must agree on his behalf before a contract is formed.[18]

The contract of the parties is a tacit one based upon the conduct of the parties rather than explicit oral or written agreement. Depending upon the fact situation, this agreement can begin, for example, by (1) the patient merely entering a free clinic; (2) the nurse, as the doctor's agent, informing the doctor of the patient's illness and his commenting thereon

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[13] Hupe v. Sommer, 88 Kan. 561, 129 P. 136 (1913); Horner v. Terpin, 63 S.D. 309, 258 N.W. 140 (1934).

[14] Oklahoma Natural Gas Co. v. Graham, 188 Okla. 521, 111 P.2d 173 (1941).

[15] For example, the "common callings" concept has been applied to common carriers, innkeepers, and public warehousemen. *See* W. PROSSER, *supra* note 11, at 615.

[16] Hurley v. Eddingfield, 156 Ind. 416, 59 N.E. 1058 (1901). *See also* Randolph's Adm'r v. Snyder, 139 Ky. 159, 129 S.W. 562 (1910). The physician is bound, however, by civil rights legislation. *See* note 18 *infra.*

[17] *See generally* C.E. WASMUTH, LAW AND THE SURGICAL TEAM 209-51 (1969).

[18] In this connection, the question is apparently still open as to whether the doctor can refuse to enter into the contract solely because of the patient's race, religion, or national origin; however, the judicial trend in the area of civil rights indicates that the doctor can no longer so refuse. *See* W. PROSSER, *supra* note 11, at 615.

(which same comment then is communicated to the patient); (3) the doctor merely asking the patient a question about his illness or physically examining him; or, (4) the doctor discussing the patient's illness over the telephone with him. From the foregoing, it is clear that the circumstances surrounding the contract between the patient and the doctor do not have to be particularly intimate before a court will conclude that a contract was formed. Thus, the doctor must take precautions to insure that the contractual relationship is not entered into inadvertently.

As has been noted, one of the implied terms of the contract is that the doctor will exercise reasonable skill and caution. Another implied term is that the doctor will care for the patient. The physician runs the risk of breaching the contract (as well as being negligent in tort) if he attempts to limit abruptly the scope of, or terminate, the contract. To avoid this breach of contract and a potential negligence claim, any limitations on the normal terms of the implied contract must explicitly be made known to patients and agreed to by them. Further, if these limitations cause a situation where the doctor does not intend to render all of the necessary medical care, the doctor must provide an alternative source of care to which the patient is referred. The source to whom the patient is being referred must, of course, have agreed with the doctor to give the patient this care. Otherwise, it is not an alternative source at all.

Examples of limitations a doctor might wish to put on the contract with his patient include: (1) no house calls; (2) periods during which the doctor will not be available because he is, for example, taking a vacation or a day off or rotating hours with a partner; (3) service only during office hours; (4) no continuing relationship since this is but an initial consultation and not a referral; (5) examination of the patient conducted for purposes other than treatment, such as teaching, learning, or data collection for an insurance company.

Termination of the doctor-patient contract must be done within the legal framework for ending contracts if the doctor is to avoid a breach. The patient can, of course, unilaterally withdraw from the contract. If this occurs, to protect himself, the doctor is wise to inform the patient in writing that he understands that the patient has ended the agreement, advise the patient of any further medical care he should receive, and possibly offer the patient referral to another doctor and cooperation with this or any other doctor the patient selects. If the physician wishes to end the contract unilaterally, he must at least give the patient sufficient warning and inform the patient where he can obtain alternative sources of care. Failure to take these steps may well lead to a claim that the doctor abandoned the patient. The third method of terminating the contract is by mutual agreement between the doctor and the patient. This may occur when they both agree that no future treatment is necessary, or, when the patient is referred to another doctor or a specialist with the understanding that this second doctor will assume treatment of the patient from that point on.

Part of the original implied contract is the implied consent of the patient to be treated by the doctor. When, however, the methods of medical care to be used in diagnosis or therapy become potentially dangerous or, when, as in the case of sterilization, they have known serious or irreversible side effects, the patient's consent must be explicitly obtained in advance of the treatment. This should be done in a writing, an express contract, in order to have the necessary evidence that consent was obtained if a question later arises. Failure to obtain consent may be grounds for an action in battery. Further, if the patient is not properly forewarned of the possible results of the proposed treatment, his consent becomes, in the eyes of the law, no consent at all. This again opens the doctor to an action in battery. In cases where the medical requirements of the patient prevent advising him of such matters as risks and side effects, the requirement that the patient be informed gives way. To protect himself, however, the doctor is wise to discuss the issues with a responsible relative and obtain his or her consent. With the exception of those instances involving consent of parents or legal guardians, the contract aspects of this third party consent in a medical situation have not, to date, received judicial attention. With the advent of Good Samaritan statutes, however, the physician's stance is being reviewed. Vermont has already enacted a statute,[19] similar to many in Europe, requiring that aid be rendered to all who are seriously ill or injured; thus, the doctor's relationship with the patient becomes a contractual one based on the aims and objectives of society rather than on a privity of interests voluntarily and mutually acted upon.

The interaction of contract and tort is even more evident in the area of misfeasance and negligence. The American courts, by dicta, have extended tort liability to virtually every contractual situation where defective performance may injure the individual. Attorneys[20] and physicians[21] have been held liable in tort for negligence.

> If a defendant may be held liable for the neglect of a duty imposed on him, independently of any contract, by operation of law, a fortiori ought he to be liable where he has come under an obligation to use care as the result of an undertaking founded on a consideration. Where the duty has its roots in contract, the undertaking to observe due care may be implied from the relationship, and should it be the fact that a breach of the agreement also constitutes such a failure to exercise care as amounts to a tort, the plaintiff may elect, . . . to sue in case or in assumpsit.[22]

What I am leading up to is the essence of this presentation—a recommendation that our legislatures and judiciary begin seriously to analyze and

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[19] VT. STAT. ANN. tit. 12, § 519(a), (c) (1968).

[20] *See* Coggin, *Attorney Negligence . . . A Suit Within a Suit*, 60 W. VA. L. REV. 225 (1958).

[21] Huysman v. Kirsch, 6 Cal. 2d 302, 57 P.2d 908 (1936).

[22] Flint and Walling Mfg. Co. v. Beckett, 167 Ind. 491, 498, 79 N.E. 503, 505 (1906).

consider contract law as a more reasonable approach to those negligence issues specifically involving the problems of *informed* consent.[23]

There can be no question of privity since the patient and practitioner both have direct contact and explicit and/or implied contractual relationships.[24] The duty of a physician or surgeon to act with skill and due care has its foundations in public considerations which are inseparable from the nature and exercise of his calling. It is predicated by the law on the relationship which exists between physician and patient which is the result of a consensual transaction. Furthermore, this relationship is contractual, whether viewed as an express contract, one implied in fact, or one implied in law (a legal fiction purporting to effect a just result regardless of the intentions of the parties).[25]

The similarity of "standard practice" contract concepts and "standard of care" negligence precepts is evident.[26] In many situations, it may be difficult to distinguish between contractual obligations and those imposed by customary law. This is particularly true in the area of commercial transactions where repetitive dealings tend to create standardized expectations. Thus, if problems arise which are left without verbal solution in the parties' contract, they will commonly be resolved by a determination of what "standard practice" is with respect to the issues in question.[27] As to similarities between "informed consent" in contract and tort, a comparison of relevant portions of the *Restatement of Contracts* and the *Restatement of Torts* proves to be significant. The *Restatement of Contracts* states that "(1) There is no privilege of non-disclosure, by a party who . . . knows that the other party is acting under a mistake as to undisclosed material facts, and the mistake if mutual would render voidable a transaction caused by relying thereon . . . (2) Where non-disclosure is not privileged it has the effect of a material misrepresentation."[28] The *Restatement of Torts* provides that "One party to a business transaction is under a duty to disclose to the other before the transaction is consummated . . . facts basic to the transaction, if he knows that the other is about to enter into the transaction under a mistake as to such facts and that the other, because of the relationship between them, the customs in the trade, or other objective circumstances, would reasonably expect a disclosure of such facts."[29]

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[23] *See* F. KESSLER & G. GILMORE, CONTRACTS, CASES AND MATERIALS 116-17 (2d ed. 1970). For a balance scale of the various factors involved in tort and contract theories of recovery see Appendix I *infra*.

[24] For a discussion of privity of contract see Bohlen, *Fifty Years of Torts*, 50 HARV. L. REV. 1225 (1937).

[25] 1 S. WILLISTON, CONTRACTS § 3A (3d ed. 1957).

[26] L.L. FULLER & M.A. EISENBERG, BASIC CONTRACT LAW 93 (3d ed. 1972).

[27] *Id.* On standard practice and usage of trade see RESTATEMENT (SECOND) OF CONTRACTS § 248 (1973).

[28] RESTATEMENT OF CONTRACTS § 472 (1932).

[29] RESTATEMENT (SECOND) OF TORTS § 551 (2)(e) (Tent. Draft No. 12, 1966).

Whenever considering contract issues, the terms "offer," "acceptance," and "consideration" become paramount. In the medicolegal sense, the offer is based on the reliance of the patient on the physician presenting himself as a professional practitioner of the healing arts. The consideration or exchange is the application of the healing art in exchange for a financial reward—*i.e.*, a fiduciary relationship.[30]

We often hear the comment in our law schools that "[l]aw is the expression of societal needs." Society has indeed begun to express itself. In Minneapolis, Minnesota, Dr. Donnell D. Etzweiler has expressed it this way:

> The written contract formalizes the concept that patients share in the responsibility for their own health. Consumer participation can be effective only if patients are properly prepared to assume these responsibilities and are accepted as members of the health care team. . . .
>
> . . . When you write it out, it means more. It's a motivational thing . . . .[31]

One enterprising firm has prepared informational briefs in the form of a pseudocontract.[32] These have been sold to medical practitioners for use in imparting information regarding intended medical and surgical management. The signature imposed is intended to serve as an acknowledgement of information so received; a blank for a witness' signature is provided; and, the form is intended to be dated. The format is contract. The principle is contract.

These two examples suggest the major problems of informed consent which must be addressed in regard to contract factors as well, to wit:

> 1. Would the data presented prove to be detrimental to the patient? Would a patient, fearful of possible though remote disastrous complications, delay surgery and other therapy to the point where that very delay presents additional risk to health and even life? What are the psychological effects? How will this affect the doctor-patient relationship of trust?
> 2. Would all patients from all backgrounds understand the content and implications of the oral explanation or explicit, written contract provisions? The problems of language, colloquial usage, ethnic variances, and many other factors are present here.
> 3. Would any consent, informed or not, be truly free of coercion? In this example, what does the patient with a medical need for an exploratory (diagnostic) abdominal laparotomy

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[30] *See* Miller, *The Contractual Liability of Physicians and Surgeons*, 1953 WASH. U.L.Q. 413 (1953).

[31] American Medical News, Oct. 14, 1974, at 12, col. 1.

[32] In-Forms, Inc., P.O. Box 4581, Albuquerque, N.M. Sample forms are reprinted in Appendix II *infra*.

(where the differential diagnosis might possibly include malignancy) have as an alternative choice? Can the patient, for example, tolerate surgery without anesthesia? Would this then be a "contract of adhesion"?

4. How much does the patient really want to know? Despite recent judicial opinions,[33] the pragmatic experience of every physician indicates that in life, limb, or organ risk situations, very many patients do *not* want to be extensively informed. They eagerly seek the father figure—not God figure—to assume the emotional and decisionmaking burden of the physician-patient trust relationship. Is this a canard?

Another concern is the effect of the contract concept on the courts. Certainly, we have adequate precedents both in medicine[34] and law for the development of boards of arbitration. This arbitration provision could readily be included in contracts. Inclusion would not be intended to avoid the legal processes. Rather, it could provide an organized and more easily accessible route for such processes. With this clause included, the number of court cases could be limited by the use of administrative arbiters. Thus, contract law, presenting an alternative, also provides a route to shorter delays in litigation through the use of such administrative hearing examiners. Precedent is found in the extant system of no-fault insurance hearings, workmen's compensation boards, uninsured motorist funds, and assurance land funds.

When considering the specific content of the proposed contracts, it is important to keep in mind the admonition not to have predominant clauses possibly considered as "exculpatory clauses" or leading to "contracts of adhesion." Exculpatory clauses purporting to relieve from liability for negligence are generally enforced "unless (1) it would be against the settled public policy of the State to do so, or (2) there is something in the social relationship of the parties militating against upholding the agreement."[35] Thus, it is apparent that, in the area of medical malpractice, excessively restrictive clauses would be deemed to be void as against public policy and wholly unenforceable.[36] Similar treatment would be given to exculpatory clauses limiting liability. The *Uniform Commercial Code* states that "[l]imitation of consequential damages for injury to the person . . . is prima facie unconscionable,"[37] though other provisions may be applied.[38] The principle is one of the prevention of apprehension and unfair

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[33] *See* note 4 *supra*.

[34] N.J. SUP. CT. R. 4:25B, *discussed in Karcher, Malpractice Claims Against Doctors: New Jersey's Screening Process*, 53 A.B.A.J. 328 (1967).

[35] Jackson v. First Nat'l Bank, 415 Ill. 453, 460, 114 N.E.2d 721, 725 (1953).

[36] *See* ILL. REV. STAT. ch. 80, § 91 (1971). *See also* RESTATEMENT OF CONTRACTS § 575(b); Tunkl v. Regents of Univ. of Cal., 60 Cal. 2d 92, 383 P.2d 441, 32 Cal. Rptr. 33 (1963).

[37] UNIFORM COMMERCIAL CODE § 2-719(3).

[38] UNIFORM COMMERICAL CODE § 2-302 states:

surprise and of disturbance of allocation of risks because of superior bargaining power.[39]

Another consideration in recommending the contract approach has to do with the time to consider one's decisions. In nonemergency cases, there *is* time: time to consider and reconsider; time for acceptance; time to place the fear factor in proper perspective. Thus, this is a positive side of our suggestion. It also suggests a dual doctrine providing for instructions and explanation by the physician and consent (contract) by the patient. Indeed, this would provide for efficient and earlier use of consultants, patient advocates, and others involved in the decisionmaking process.

We must once again emphasize the fact that the creation of the physician-patient relationship is a matter of ordinary contract law in most circumstances. An "express" contract will be held to exist when a patient seeks out a physician and asks him to treat a specific ailment and the physician agrees to do so. An "implied" contract then extends from the actions of the parties and not from the verbal contract. We are merely taking the question of whether an implied contract did in fact exist out of the realm of conjecture.

CONCLUSION

We must come to the recognition that the tort remedy does *not* basically insure the best medical care. Tort law "protects" the individual client or patient only if we consider recompense or retribution as protection. There is no definitive evidence that the quality of medical care has improved under the current tort remedies of law. We also need to be fully aware of the societal effects of our current system. Much has been written about the practice of "defensive medicine." There can be no question about overtreatment, excessive use of diagnostic and documentational

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1. If the court as a matter of law finds the contract or any clause in the contract to have been unconscionable at the time it was made the court may refuse to enforce the contract or it may enforce the remainder of the contract, without the unconscionable clause, or it may so limit the application of any unconscionable clause as to avoid any unconscionable result.

2. When it is claimed or appears to the court that the contract or any clause thereof may be unconscionable the parties shall be afforded a reasonable opportunity to present evidence as to its commercial setting, purpose and effect to aid the court in making the determination.

[39] In Campbell Soup Co. v. Wentz, 172 F.2d 80 (3d Cir. 1948), the court refused to enforce a contract in which the plaintiff had, by virtue of its superior bargaining power, retained the right to withdraw from the contract at no cost to itself under certain circumstances. *See also* Bolgar, *Contract of Adhesion: A Comparison of Theory and Practice*, 20 AM. J. COMP. L. 53 (1972); Dauer, *Contracts of Adhesion in Light of Bargain Hypothesis: An Introduction*, 5 AKRON L. REV. 1 (1972); Reeves, *Exculpatory Clause: Does It Really "Save Harmless"?*, 37 J.B. ASS'N KAN. 11 (1968); Note, *A New Test of Exculpatory Clauses in Texas: A Much Needed Change*, 26 BAYLOR L. REV. 449 (1974); Note, *Contracts of Adhesion Under California Law*, 1 U. SAN FRAN. L. REV. 306 (1967).

tests, ever increasing costs of practice, and, therefore, the cost to the patient and public. The effect of this latter problem, never realistically faced by ardent supporters of our advocacy system, certainly contributes to the patient entering the health delivery system ever later.

In discussions with members of both the medical and legal professions, this author has found an unbelievable rigidity. Mental slavery to precedent alone ignores the very flexibility inherent in the legal process. Certainly we are aware of decision reversal, dictum, and, above all, the herald signal that minority opinions have often given to enlightened legal and social expression. Progress in law and justice can never be achieved without that intellectual experimentation which challenges precedent, customary practice, and the concepts of status quo. The concepts and problems presented herein may very well fall within this category of intellectual experimentation. That decision lies within the prerogatives of the innovative attorney and judiciary concerned with the *effects* of the legal process on society as a whole rather than on an individual client.

APPENDIX I

SCHEMATIC COMPARISON OF CONTRACT AND TORTS
(INFORMED CONSENT STRESSED)

CONCEPT	*CONTRACT*	*TORT: INFORMED CONSENT*
1. Rationale	Embodies protection of the individual in the context of societal interests.	Informed consent can be considered a form of warranty—a promise.
2. Precedent	Extensive legal precedent for guidance.	Confused definition of informed consent, no specific precedent, vague.
3. Legal Burden	Equally shared by plaintiff and defendant.	Primarily borne by physician in reality despite legal fiction of plaintiff having to prove "fault."
4. Agreement	Clearly mutual.	Patient only—physician must prove patient agreed. Consent problem in proof.
5. Vehicle	Written explicit.	Primarily verbal; occasionally explicit and written (value questioned at present); implied most often.
6. Extent	Specifically delineated.	Impossible to cover potentialities completely or adequately. Many unknown factors.
7. Duties	Primarily fixed by the parties themselves.	Primarily fixed by law or its interpretation.
8. Scope of Damage Test of Forseeability		Proximate cause rule. Thereafter, can expand without limit to include psychological and other questionably provable harm.
9. Basis	Voluntary agreement of mutuality (most of the time).	Negligence issue—difficult to prove either voluntary or agreement aspect.
10. Consumer Protection	A blend of contract and tort.	Implied warranty in both.
11. Privity	Explicit.	Implicit.
12. Liability	Strict liability for failure to perform.	Need proof of negligence or other wrongful conduct. For example, failure to perform leading to injury (proximate cause) would have to be proved. Also need sequence of 4 elements of tort (duty, failure of duty, proximate cause, injury).

13.	Statute of Limitations	Usually longer.	Shorter. A fiction under the "discovery rule," however, may in fact lead to a period of time which would be longer than one found in contract.
14.	Advantages	1. Limited to those for which defendant has tacitly or impliedly assumed and/or foreseen. 2. Based on law and equity, not emotion and dramatics.	1. Primarily benefits the plaintiff. 2. Punitive damages allowed. 3. Recovery allowed for "mental suffering" emotion rules—not fact or law. 4. Recovery for wrongful death on basis of failure to inform. Also other tort bases. 5. May obtain even where contract fails for lack of proof, uncertainty, etc.
15.	Disadvantages	May and usually will require third party to interpret and prepare. Money to pay for such services may not be available to all.	Rarely includes third party. No specific fees. Available to all. Almost impossible for patient to resist denying he did hear and understand physician's explanation, and, just as unrealistic to expect M.D. to prove he did give an acceptable explanation. Major problem of proof.

BENEFITS TO SOCIETY OF CONTRACT VERSUS TORT AND BENEFITS TO PATIENT-DOCTOR RELATIONSHIP

Philosophic approach: A clearer delineation of the responsibility of *each* party. Societal interests should and indeed must—if we are not to have an unbearable burden on the professions—require the patient to accept knowingly some of the risks of health care. The practicalities of the present trend have been to place the burden on the professional. Anesthesia problems and cardiac arrest are illustrative.

APPENDIX II—1

PROCEDURE: GENERAL ANESTHESIA

Your doctor plans to give you "general anesthesia" for the operation you are considering. General anesthesia involves making the patient completely unconscious or "completely out" during the operation. The anesthetic drugs are usually given to the patient by injecting them into the patient's bloodstream and by having the patient inhale them. Complications from general anesthesia are infrequent, but they do occur; and complications are more frequent in patients who are in poor general health than in patients who are in good general health.

The person who administers the anesthetic may have to place a tube from the mouth or nose of the patient and into his windpipe in order to assist breathing. This is usually done when the patient is unconscious, and has been known to cause temporary and permanent damage to the lips, teeth, nose, throat, voice box, and windpipe. Because the patient loses protective reflexes while under general anesthesia, damage to the eyes and networks or nerves in the body is possible. This damage could cause pain in the eyes; decreased vision; and numbness, weakness, pain, and paralysis in the arms, legs, trunk and neck. Rarely, the drugs which are used in general anesthesia can have toxic or damaging effects on the liver, kidneys, heart and lungs. Because general anesthesia temporarily impairs the patient's breathing mechanisms, pneumonia, lung collapse, water on the lungs, and even brain damage are also potential complications. It is also possible that airway obstruction or a state of "suffocation" will occur during general anesthesia. This could result in the need for an emergency tracheostomy, which is an operation in which the neck and windpipe are opened so that breathing can be maintained. Another rare complication of general anesthesia is injury to the blood vessels that supply blood to the hands or feet. This injury could cause permanent deformity of the hands or feet, or even "kill" fingers and toes. General anesthesia temporarily impairs the function of the urinary system. Occasionally patients have difficulty urinating after this type of anesthesia. This could result in the need for a temporary tube being placed in the urinary bladder to allow urine to drain.

Some of the complications of general anesthesia may require surgery; some may cause permanent deformity and inconvenience and prolonged illness; and rarely, some are fatal. There are also other potential complications from general anesthesia. However, it is not possible to advise you of every imaginable complication. The purpose of this form is not to frighten you or upset you. The bad complications referred to are extremely unlikely. The purpose of this form is merely to insure that your decision to have general anesthesia is not made in ignorance of the risks of this procedure.

Additional risks:
(To be filled in by doctor, as necessary)

_____

_____

I CERTIFY: I have read or had read to me the contents of this form; I understand the risks involved in this procedure; all blanks or statements requiring insertion or completion were filled in, or crossed out before I signed.

Date:_____ Signed: _____

(By patient or person legally authorized to consent for patient)

Witness:_____

(THIS IS *NOT* A CONSENT FORM. A CONSENT FORM MUST ALSO BE SIGNED BY THE PATIENT.)

APPENDIX II—2

PROCEDURE: SPINAL ANESTHESIA

Your doctor plans to give you "spinal anesthesia" for the operation you are considering. Spinal anesthesia involves injecting a drug directly into the spinal canal to cause a loss of feeling and temporary paralysis in approximately the lower one-half of the body. This drug is injected through a needle which is inserted into the back and into the spinal canal. A "local" anesthetic or medicine to "deaden" the skin is usually administered first so that the entire procedure will involve only very little pain. Complications from spinal anesthesia are infrequent, but they do occur; and complications are more frequent in patients who are in poor general health than in patients who are in good general health.

Headache may occur following spinal anesthesia. Generally, this lasts only a few days at most; however, it has been known to last weeks or months. Occasionally, this headache is complicated by buzzing in the ears and difficulty in hearing. Since spinal anesthesia involves temporary paralysis of nerves, various nervous system complications very rarely occur. These complications could cause weakness or paralysis of eye muscles; inability to urinate; inability to control bowel movements; loss of sexual function; meningitis, or inflammation and disease of the lining of the brain and spinal cord; disease of the spinal cord, itself; partial or total paralysis or inability to move a part of the body; and even death. Damage to the supporting structures of the back also rarely occurs. This could cause temporary or permanent backache; and numbness, weakness, and pain in the thighs, legs, and feet. Another rare complication of spinal anesthesia is the development of infection. This can result in draining wounds, painful and unsightly scars, prolonged illness, and the need for surgery.

Because spinal anesthesia temporarily alters the distribution of blood in the body, abnormalities of the heart, blood vessels, and kidneys are possible. Rarely, this can cause chronic kidney disease, heart irregularities and heart stoppage, brain damage, and even death.

Some of the complications of spinal anesthesia may require later surgery; some may cause permanent deformity, disability, inconvenience, and prolonged illness; and rarely, some are fatal. There are also other potential complications from spinal anesthesia. However, it is not possible to advise you of every imaginable complication. The purpose of this form is not to frighten you or upset you. The bad complications referred to are extremely unlikely. The purpose of this form is merely to insure that your decision to have spinal anesthesia is not made in ignorance of the risks of this procedure.

Additional risks:
(To be filled in by doctor, as necessary)

_____

_____

_____

I CERTIFY: I have read or had read to me the contents of this form; I understand the risks involved in this procedure; all blanks or statements requiring insertion or completion were filled in, or crossed out before I signed.

Date:_____ Signed: _____

(By patient or person legally authorized to consent for patient)

Witness:_____

(THIS IS *NOT* A CONSENT FORM. A CONSENT FORM MUST ALSO BE SIGNED BY THE PATIENT.)