Mike Whitmer:

Hello and welcome. Thank you for joining us today. My name is Mike Whitmer. I'm Vice President of Corporate Relations at NCMIC, and I'm going to be moderating today's discussion. Before we get started, there's a few housekeeping items I'd like to review. Today's webinar was recorded previously to accommodate our guest schedules. As a result, we will not be taking questions live. But if you do have questions regarding today's webinars, please get in touch with us at NCMIC. We'll do our best to address your questions or provide right resources to help. You can go to contact us on ncmic.com or just give us a call.

Our next webinar is coming up on May 18th at 2:00 PM Central time, and I hope you'll be able to join us for that. So now for today's program. At NCMIC, our main job is to provide chiropractors with a defense in the event of a malpractice claim. These claims provide us with great risk management lessons, things the doctor did do, didn't do, could have done, should have done that impact the outcome of the case. Many times, an issue that comes up is informed consent. So today's cases and discussion is going to focus on that issue. So today we're focusing on some real life claims and lessons that we can learn from. And to help with that, we have two guests with us. First of all, we have Tom Jensen. Tom is an attorney in Minneapolis, Minnesota with the firm Lind, Jensen, Sullivan, and Peterson P.A. Tom has tried over 100 civil cases to juries in Minnesota, North Dakota, and Wisconsin as part of NCMIC's Network of Expert defense attorneys. Tom, thanks for joining us and being here.

Tom Jensen:

Thank you for having me.

Mike Whitmer:

We also have with us, Jamie Eibes. Jamie has been a senior claims representative at NCMIC for close to 20 years. He works directly with NCMIC policy holders, facing allegations of malpractice and the attorneys that we retain to defend them. So Jamie, thanks for being here as well.

Jamie Eibes:

Thanks for having me.

Mike Whitmer:

So for today's webinar, Tom's going to share with us some forms and some cases and some stories, and Jamie's going to share his thoughts on those scenarios as well. And then we're going to discuss the takeaways and the lessons that we can learn. So Tom and Jamie, thank you both for talking with us. And Tom, let's dig in. Thanks for being here, and let's start with some of your thoughts on informed consent, and then we'll get into some of the forms and cases.

Tom Jensen:

Sure. Thanks, Mike. And I think it's important to recognize that in informed consent, sometimes it's called negligent non-disclosure. It's a separate and independent form of claim that can be brought under the medical malpractice or chiropractic malpractice rubric. In other words, we're all familiar with the general malpractice claim. Did the doctor's conduct comply with good practice standards and the standard of care? And then secondly, did the doctor's conduct cause the patient's outcome? And we defend those claims, as you know, and they're readily familiar. The separate and independent claim is a claim for negligent non-disclosure, failure to obtain informed consent. Of course, the law requires, in every state, that significant or material risks be brought to the patient's attention so that they can consent to have the procedure done. All of you are familiar with this from your own practices or from being patients. And oftentimes, this is done by way of forms. Otherwise, oral disclosures of course, often happen and so forth.

I should note that when the law applies or looks at an informed consent claim, as I mentioned, there's basically two legal tests that I'm familiar with in the country. One is that the risk has to be significant, or in other parts of the country, that test is the material risk test. Is the risk a material risk? Here in Minnesota, the test is significant risk. And the thing is about it that we all would say... Let's take the case of stroke for example. No one thinks that is a significant risk, that is chiropractic care and stroke. No one thinks that. All the data shows that it's merely an association, and a very small one indeed. It has nothing to do with causation. Where I'm getting to with this point is that the question, "Was the risk significant?" in Minnesota, and probably in material risk states, "Is the risk material?" is viewed from the perspective of a reasonable patient.

What would a reasonable patient deem to be significant or material? It's not the subjective intent of the patient. Of course, the patient in the lawsuit will always say, "It was a significant risk or I would've viewed it that way." But because the question of informed consent requiring significant or material risk requires application of a reasonable patient, it gets a little murky and a little muddy, and it's not as clear as the power of those two terms, significant or material, might suggest. So enough of that law that I wanted to at least introduce some of the basic legal foundation for these claims as we [inaudible 00:06:05] them.

Mike Whitmer:

Appreciate that, because it's something that we deal with. Here at NCMIC, we deal with this issue every day in claims that are coming in. And when our claims team starts to dig in and look at a claim, the informed consent process is definitely something that they're scrutinizing because it's going to make a difference in how the claim plays out. Jamie, any thoughts before we dig into some of the forms?

Jamie Eibes:

Yeah, absolutely. We do think it's an important process. Like Tom mentioned, most of the states do require informed consent to be written, and we always stress for the doctor to... After the initial forms are signed, the intake, to go over those risks, verbally with them as well. Because I think a lot of times, a lot of these patients are trying to get in and out as quickly as possible, and they're not reading the forms, they're signing them, just assuming they know what they say, and sometimes that can come back on them. So yeah, from our view, it's important to have these forms and verbally discussed with the patients.

Tom Jensen:

I wonder if I might also add in this segment of our discussion, Mike, this thought about the reasons why informed consent risk must be material or significant. Because the reality is that if patients are informed of extremely limited risks, many of them will say, "Well, I'm not going to have the care then. Okay, well, what is the option then?" Well, there are several. One would be physical therapy. We can all discuss the effectiveness for these types of conditions, maybe not. Certainly medications. There are risks to medications. What about opioids? There are big risks to opioids. The other alternative is to live a life of pain and not bring to the patient the merit and value of safe chiropractic care. So there's a balancing test here in the law and in reality, and that is that we should disclose material significant risks, but we should not necessarily engage the patients in discussions of things that are way out there because it might hinder the patient's approach to wellness that we're all focused on and trying to deliver. Thank you.

Mike Whitmer:

Thanks, Tom. Well, let's dig in. You had some forms to share and some stories that go along with those, so-

Tom Jensen:

Sure.

Mike Whitmer:

Why don't we dig in with that?

Tom Jensen:

Okay, sounds great. I'm going to just share the screen here, and we'll pull up this form. This is a form from a matter. You see at the top, informed consent to care. Let me blow it up a bit more. Informed consent to care. And it provides for patient signature, which is great. Hopefully you have that on your forms. And you see that I've highlighted here, a section that deals with risks of care. You see that. The risks of care include muscle spasms, temporary increase in soreness from moving the tissues, burns from EMS perhaps, those types of things, broken bones of the patient's osteoporotic, disc injuries, strokes, dislocations, strains, and sprains. Well, you see that word risks in the word strokes in this sentence. And I never, personally, to see the word strokes in the same sentence as risks because we put on very informative and correct evidence that chiropractic does not present a risk of stroke.

Now, to this doctor's credit, the sentence or the paragraph continues with reference to strokes, and it talks about... I think it talks about man association versus causation. But again, yeah, in fact, we can see the last sentence of this paragraph. The association with stroke is exceedingly rare and is estimated to be one in a million, or one in 2 million adjustments. Take away from this particular form. It suggests that chiropractic does present a risk of stroke, and the doctor in a trial would be confronted with that. And it also includes content that seems to soften that and talks about the association. But it can get a little messy when the doctors having to be questioned about the content of this paragraph. So that's one example of a form. Many are out there. And I'll yield then back to you, Mike.

Mike Whitmer:

Tom, so a question about that. So let's say that this is a doctor's form and we have a malpractice claim that we're defending, and this is part of that process. What's the conversation around this disclosure as

a risk? What does that look like when we're litigating this case? Does it make it worse? Does it help? How does this play out?

Tom Jensen:

Sure.

Mike Whitmer:

Even though we softened this at the end with talking about the association, but what challenges, what opportunities does this present during litigation?

Tom Jensen:

Right. Great question, and here's the answer. The word risk, I think means a real risk. In other words, there's a risk of stroke from chiropractic. And again, I emphasize that all the meta-analysis, peer reviewed literature, the scientific studies have plainly shown that there is no risk of stroke to chiropractic care. So when the doctor's being questioned about this form, you can just imagine that the patient's attorney would say, "Well, you concede, don't you doctor, that strokes are a risk of your care?" Well, yes, it is in that sentence. But as you continue to read through here, you can see that, well, really it's just an association. Well, you can get tripped up a little bit on this. And I think from a practical perspective, it's not helpful content to a doctor in using this type of form. Good forms reference, the association, and association, in my view, is not risk because I always believe that if something is a risk, it's a risk. We should always be thinking in terms of association, and the form should be very clear that it's just an association. And what's an association?

The rooster crows, the sun comes up, right? That's an association. Does the rooster cause the sun to rise? No, it does not. It's an association. It's not cause and effect. Hopefully, in all those words, Mike, I've answered your question.

Mike Whitmer:

Jamie, anything to add?

Jamie Eibes:

No, Tom, pretty much hit it right on the nail. Again, plaintiff attorneys are going to try to muddy the waters. If something's not listed in the informed consent, and let's say, strokes not listed in the informed consent and we're dealing with the stroke case, they're going to ask the doctor, "Are you aware of these potentials?" Some experts say that it can be caused from chiropractic. We say it doesn't. So we defend these cases very aggressively, but again, your informed consent's not going to be five pages long so we know you're not going to write a book on it, but hitting the main pieces and risks, like Tom mentioned, is only going to help the defense of the case and eliminate any of those arguments that plaintiff's counsel may try to throw in a mix to, again, muddy the waters.

Mike Whitmer:

Do either of you have an example of a case that you've worked with where in a stroke case, since we're talking about that topic right now, we'll move on to some others in a bit here, but of a stroke case where informed consent played an important role, either positively impacting or negatively impacting the outcome?

Jamie Eibes:

Yeah, absolutely. I had a case in Missouri where the informed consent is required. It's a statute, it's required, and we didn't have it. It was an extremely defensible case. But as we all know, when we get these jury instructions, the first question on there, Tom, correct me if I'm wrong, the first question, did the doctor breach a standard of care? And without that informed consent that's required, that poses as a little bit of a concern. So again, the case settled for a nuisance amount, but it was definitely a case that we could have tried and won just due to the medical circumstances behind it.

Mike Whitmer:

And a question for either one of you in general, how defensible are stroke cases? How are those defended? When a patient walks into a doctor's office, they're fine and they leave by ambulance? How do we defend that?

Tom Jensen:

Well, that's a whole nother webinar, but I can give you the elevator speech.

Mike Whitmer:

All right.

Tom Jensen:

And you all of this anyway, but what we do is we hire these expert doctors up at University of Calgary human performance laboratory have studied how far can a chiropractor stretch a vertebral artery. And it's impossible to stretch a vertebral artery far enough to dissect the artery. Just the biomechanics prevents that from occurring. And then we get into all the studies, association, causation, which show that's actually, there's slightly bigger association between visits to a medical doctor and ensuing stroke than visits to a chiropractor and ensuing stroke. And there's some old literature that's out there that comes up in the cases. But anyway, we put... And then the other thing that we do is that we hire neuroradiologists who, A, can age the blood in the dissection, in the rent using imaging. And if the age of the blood in the rent is older than the timing of the adjustment, well, it just rules it out. So there's lots of outstanding defenses based on sound, actual science that makes the claims very defensive.

Mike Whitmer:

Yeah. Jamie, anything to add?

Jamie Eibes:

Oh, I agree a hundred percent.

Mike Whitmer:

Okay. All right. Let's move on then. Anything else on the topic of stroke before we move on?

Tom Jensen:

Well, yeah if you wouldn't mind and maybe.

Mike Whitmer:

Yeah, go right, Tom.

Tom Jensen:

Yeah. Okay, if I could pull up maybe another form that could be helpful. Bear with me one minute.

Mike Whitmer:

Yep.

Tom Jensen:

So this one will be... I'm going to share this one, but I'm actually going to change it out. Can you see this one okay? It says informed consent for chiropractic care.

Mike Whitmer:

Yep. We can see that great.

Tom Jensen:

Okay. Well, here's an example of an older form that, although it's 2019, I see a sign there, that not a big fan of. So in this form, we see the material risks inherent in chiropractic adjustment. Do you see that? And in this paragraph, we see reference to stroke. Okay. It does include reference to the association, but you can see it. Well, doctor, you say in your old form that stroke is a material risk inherent in chiropractic adjustment. And then we get into the probability paragraph there, one in a million chance and so forth. Again, I just think that it gives credence to the idea that stroke is a risk of chiropractic care. If I may, Mike and Jamie, if I can add this, this was in a case. In fact, it was in a case that I had where a patient was quadriplegic, a piece of disc entered the spinal canal and basically squished the spinal cord.

So the question was, of course, standard of care was that, okay, causation? But you see, in this particular form, you see this reference? This is not it, but you see diaphramatic paralysis, and you see cervical myelopathy. Well, the chances that many patients are going to be familiar with what that means are very low. So I should point out that according to the informed consent guideline of the Association of Chiropractic Colleges, which is out there on the web and injury lawyers can access it, they do have a good note here that the elements of informed consent should be described in layman's terms. And here, when we see diaphragmatic paralysis, I realize that's not the quadriplegia involved here, or cervical myelopathy, those are not layman's terms. And so scrutinize your own forms and see if terms like that are out there. I have another form if you'd like. In fact, it's a non form case, Mike and Jamie, in which the doctor did not use a form, but gave informed consent. I'd be happy to talk about that if you'd like.

Mike Whitmer:

Before we do, Jamie, do you have anything to-

Jamie Eibes:

Yeah. I was just going to add... Tom mentioned layman terms, and this kind of goes back to what I said about going over the consent forms verbally with the patient. That's a good time to do that and explain it in layman terms to those patients so they fully understand. And then also document the file that informed consent was signed and verbally discussed as well. It goes a long ways.

Mike Whitmer:

And I'd like to chime in on the layman terms because I had an experience with my mother many years ago when she was treating for cancer. It was one of the early visits to the oncologist office, and receptionist gave us the form. I was there with her. That was not English. It was medicalese. She didn't understand it. I didn't understand it. I actually called a friend of mine who's an RN, and she couldn't believe that that was on their form. So my mother was going into this session with the doctor, not only not understanding what had been disclosed, but very frustrated because she was unable to and felt like she should. So she was frustrated, she was kind of angry about it, and it just kind of set the whole process... She's there for treatment to get better, and we've put this obstacle in that process when it shouldn't be an obstacle. It should be an education opportunity. It should be an opportunity for a dialogue between the provider and the patient. And that was not the experience at all.

And I often wondered if we had ended up in a lawsuit situation. To me, that informed consent process would not be defensible because the patient couldn't understand it. So I think that's a such a key point, that these disclosures be in layman, terms that the patient can understand, but then even more importantly, have the conversation so that the doctor is insured that the patient does understand.

Tom Jensen:

Yep.

Mike Whitmer:

Tom, you said that you had another form to share and pull up.

Tom Jensen:

Yeah. Thanks a lot. Yeah, thanks a lot, Mike. So let me pull this up. I'm going to go to... Let's see. Okay. Here, I call it Informed Consent Each Visit PDF. Okay. So can everyone see this? It says informed consent.

Mike Whitmer:

Yep, patient.

Tom Jensen:

Okay. So this is a current case working on, and this particular doctor does not use any intake forms, no informed consent form. And so the doctor does discuss informed consent principles with the patients, certainly at the initial visit. And as Mike and Jamie have been talking about, the more oral dialogue that the doctor can have with the patient about this the better, because it's more likely the patient will remember and not simply say at the trial that nothing was ever discussed, but also it's just good to get the information out. And so in this case, the doctor does not use a form which presents, I think, some heightened risk. And then let's look at what the eChart macros, I suspect, exist in that clinic's software. So I just sniped the sentences from... What do we have here? Five visits. So let's assume that the first visit, informed consent was discussed, patient had no questions, patient agreed to begin care. Okay, great. Terrific. And then the doctor can describe what was said. But then you notice in succeeding visits, we see the same sentence, except for the last one.

And this begs the question, is it likely that the doctor started every subsequent visit after the initial visit and went through the list of known risks, transient soreness, possible bone fractures, some bruising, maybe EMS burns? Is it likely the doctor went through that with the patient who'd already been in for care on succeeding visits? Well, hopefully. I assume that this did occur. But the problem in court cases is

maintaining or not losing, I should say, credibility with the jury. Will the jurors be swayed by a plaintiff's attorney's argument that these are just macro sentences, and it really never happened, and the doctor did not warn the patient at all? The doctor will say that he or she did warn the patient. But if the doctor loses that, from what could be macro repetition in e charting, wow, you might see that credibility in terms of standard of care issues or causation issues could be impacted by something like that. So hopefully that shows another dimension to informed consent claims administration when a form is not used.

Mike Whitmer:

Yeah. Yeah.

Jamie Eibes:

Yeah. We get a lot of calls from doctors inquiring about, "Hey, how often do I got to redo these forms and informed consents?" And obviously, you don't need to go over the informed consent process every time they come in. That was discussed the first time. But reminders are good, especially if you've got a patient who hasn't been seen in a year or two. They're coming in with maybe some different symptoms from what before, so you're basically starting from scratch with the intake form. Treatment may be different from the last session from a year ago or whatnot. But even at that point, it's a good reminder to maybe go over that informed consent at that point.

Tom Jensen:

Yeah, exactly. Excellent point.

Mike Whitmer:

And Jamie, I want to take that just a little bit, step further.

Jamie Eibes:

Yeah.

Mike Whitmer:

So let's say that I'm a patient, I am under regular chiropractic care. Let's say I go three times a month. My original complaint was low back pain. I've had good success with that, clearing up, but I still go, maintenance. I go a couple times a month. But then I show up, and I've got a severe headache and neck ache. All right?

Jamie Eibes:

Yep.

Mike Whitmer:

And so my doctor starts treating me a little bit differently because I've got a new complaint. New informed consent process, or is the one we went through earlier good enough?

Jamie Eibes:

Well, I guess it depends on the informed consent, how much language was in it. One of the symptoms and signs of a stroke is neck pain and head pain. That's preexisting the chiropractic treatment. So if you

don't have that in there, maybe that's a good time to maybe go over and do a new informed consent. Clearly, I'm not a chiropractor, but I'm guessing, just from my claims experience, that doctor's going to do a full new exam due to the new complaints to rule anything out. Sometimes imaging is important. They maybe want to get a film taken before they start treating. So yeah, when you got someone coming in with some new complaints, like I said earlier, you're kind of starting back over again. We need to attack this maybe a little bit differently now with the new complaints.

Mike Whitmer:

Yeah. Tom, any comment?

Tom Jensen:

I totally agree. I think it's right on. Yeah.

Mike Whitmer:

All right. It's a question that I get when I'm out talking with doctors. I get that. "How often do we have to do this? Yeah, when do we have to do this?" So I think that it is a common question out there. All right. Tom, do you have another form and scenario?

Tom Jensen:

Yeah, sure. Yeah, thanks. I'm going to pull up an example of a form. We tend to focus on stroke, but it doesn't reference stroke. So let's see what that looks like. I will grab this one, and I will go to, let's see, no stroke IC form. All right, so here's a form where the doctor indicates the risks that might occur from chiropractic care, muscle soreness and irritation, headache pain, muscle spasm and stiffness, maybe dizziness or nausea. What a great form. Now. Now, don't throw the tomatoes. Don't throw the tomatoes at me, but the reason that I like this form is because since chiropractic care cannot cause strokes, there's no risk of stroke from chiropractic care, therefore there's no reason to mention it. And so now, again, you say, "Well, Tom, there's go on the internet. There's reference to stroke and chiropractic." I understand. Let me show you an approach to dealing with that, that might be helpful.

And I'll use the one from our college up here. We're lucky in Minnesota. We have a chiropractic college here. I'm sure all of it. Hopefully, many of you attended it, Northwestern, which of course, is an outstanding chiropractic college, and they have a great student clinic there. And they have this informed consent form, which I think is out there on the internet. And what they include is they include the things that are risks, dizziness, nausea, flushing, fractures, osteoporosis, disc herniation, or prolapse. Let's skip stroke. We'll go down to other wrist burns from physiotherapy, devices, bruising. These are all known risks of care and not really significant. Disc herniation, perhaps. That would be another conversation. But what Northwestern does is it includes dialogue about stroke. And it's an excellent paragraph because it lays out, and I'll blow it up maybe a little bit bigger here, it lays out that a risk of stroke has been associated with chiropractic care.

And then it explains the defense references, the most recent research and notes there's no evidence of excess risk of stroke associated with chiropractic care. And it's just the result of a person having, as Jamie described, neck pain and head pain. People think it's musculoskeletal. They go to the chiropractor. Everybody thinks it's that, adjustments occur, but it's really a stroke in progress. So I do like this form. And the one tweak I would have on it is that I don't like this. Following are the known risks in bold, and then it includes temporary soreness and increased symptoms of pain. Again, you've heard my sensitivity about the word risk. But overall it is an excellent form, and I could be wrong, Jamie or Mike, is NCMIC's form similar in terms of the content?

Jamie Eibes:

Yeah, it is. We do have a sample that we provide to doctors that want to maybe update their form or just an entirely different form. Obviously, you can go on the internet and Google inform consent forms and there's thousands of them that pop up, but NCMIC does has have a sample that we do share with the insureds if they want one. So I'm happy to share that document.

Mike Whitmer:

Yeah. I would say that the form that we have out there, it is clearly labeled that this is a sample. And one of the things that I think is a red, bold print at the top of that form, to share it with your legal counsel, with your counsel to make sure that it complies with the laws in your state and that it meets the needs of your practice. With informed consent, I think that there's a desire for a one size fits all, and that's just not the case. And I think that the form needs to be right for your practice and your patients. And our form out there is offered as a starting point to share with your counsel, make sure that's compliant with your state laws and meets the needs, and then employ really with any form. We encourage doctors to have that reviewed by their legal counsel to make sure that's in compliance.

But I have heard stories of doctors using that form just downloaded straight off the internet and it's got a sample watermark through it, and it's got the disclaimer language at the top. And it's like think about your patient and how they're consuming that and how that's going to look during your defense during a malpractice claim where the sample form that was provided, the doctor didn't even bother to put it into their own format and take the watermark and the disclaimer off? So whatever form you're using, make sure you understand what it is, have it reviewed by legal counsel, and make sure that you're comfortable with it. Don't just slap something out there and use it because you found a form on the internet.

Jamie Eibes:

Yep, I agree.

Mike Whitmer:

Any comments?

Jamie Eibes:

No, I completely agree. And there's different forms out there. And one form that we've been getting a lot of phone calls on... And these types of cases have increased over the last couple years, and I think part of it was the whole me too movement. We get a lot of inappropriate touching cases. And most of the time, it's treatment misunderstood. So if you're going to be treating patients in sensitive areas, again, the verbal thing is huge. This is another good example of explaining and talking to your patient, "Hey, I'm going to be in and around these areas. Are you comfortable with this? Due to the pain that you're prescribing, this is the area that I need to be in." So I know even doctors have gone to the extreme and have a separate informed consent form due to that nature as well.

Tom Jensen:

That's good to hear. I just tried one of those in February in St. Paul. I was a... Let's see, it was an anterior rib adjustment where the doctor accessed the air around the armpit, [inaudible 00:39:49] on the shoulder, sort of a sliding adjustment, and there were allegations of boundary disputes. He did not have

a specific form, like you mentioned, but that is good. He had good descriptions of what he did and what he explained to the patient, and fortunately the jury agreed with it.

Mike Whitmer:

I would just add one thing to that. When we're on the topic of boundaries, and Jamie's absolutely right, this is something that we see all too frequently. And there's actually a case that I use in the classroom when I'm working with students that the female doctor was treating a male patient for effects of Parkinson's, and the patient responded well to treatment and then they started to... Because doctors of chiropractic do see their patients frequently and spend more time with them, these relationships do develop, very strong relationships between the doctor and the patient, which can go too far. And in this particular case, it did go too far. The doctors started seeing the patient after hours and on weekends, when there are other staff around. And then they started to a sexual relationship. And it was in the doctor's notes. The doctor made an attempt to informed consent away this very inappropriate boundaries violating relationship that she was embarking on with the patient. And this was in the record as their discussion.

"You are doing this consenting, you are doing this on your own free will. There is no coercion. You agree not to sue me for sexual misconduct in the future or for anything." What do you think of that type of informed consent and disclosure?

Jamie Eibes:

Not good.

Mike Whitmer:

Yeah.

Jamie Eibes:

Putting that in the files, not a good thing.

Tom Jensen:

Wouldn't want to take that one to the licensing [inaudible 00:42:01].

Mike Whitmer:

Yeah, exactly. And that's the thing. And when we're talking about boundaries, when I'm talking with doctors, that is a comment that I get frequently. Why is it inappropriate to have a sexual relationship with a patient when it's amongst consenting adults? And the answer is because there's an inherent imbalance of power in the doctor-patient relationship that makes those relationships unethical and inappropriate. Every state agrees on that. Everywhere, the doctor-patient relationship, the fiduciary nature of that relationship prohibits these relationships, and no amount of informed consent is going to make it okay. That's the point I wanted to make. So while we're on that topic of informed consent, there are some things informed consent does not allow you to do. So with that, Tom, do you have anything else to pull up or-

Tom Jensen:

Well, just I'll mention a couple things-

Mike Whitmer:

Sure.

Tom Jensen:

... Mike and Jamie, from... Again, the Association of Chiropractic Colleges, their informed consent guideline, they emphasize the doctor should have a record in her or his clinical file documenting it. We all agree with that, confirming that consent was given. I think signatures are helpful on these forms, of course. We talked about the need to use a lay terminology. The association says, "For the consent to be legally effective, the patient must receive sufficient information concerning the proposed procedure, potential benefits and risks, common alternatives, including refusing care in the associated risks. Without the disclosure," they say, "the decision cannot be made." They also support the idea that the doctor also engaged in a thorough verbal discussion as we've been describing in addition to the form and not just the form to the exclusion of other information.

Mike Whitmer:

All right. Jamie, anything to add? Yeah.

Jamie Eibes:

No. Like you mentioned at the beginning of the webinar, if doctors have questions, concerns, obviously let us know-

Mike Whitmer:

Yep.

Jamie Eibes:

... and we can hopefully walk them through it.

Mike Whitmer:

All right. One thing that I do want to mention on our resources section of ncmic.com, we have a lot of content related to informed consent. We do have that sample form out there. But along with that, we have a lot of content around informed consent to help doctors do it in the right way, hopefully put them in a very defensible position, should they end up in a malpractice lawsuit situation. So point you out there for that. Any parting comments before we wrap up here?

Jamie Eibes:

Not for me.

Mike Whitmer:

All right.

Tom Jensen:

I don't think so.

Mike Whitmer:

Okay. Jamie, Tom, thank you very much for taking time with us today. This has been great information. I'm glad that we've have the opportunity to have this conversation.

So as we wrap up, I just have a few reminders for our listeners, the resources section on ncmic.com that I just mentioned, we have lots of information out there on informed consent ,and this webinar will be posted the out there following the broadcast. We are continually adding to our content with information to help you navigate daily practice and deal with challenges that you face. We have information out there on a wide variety of topics, so I hope that you do check that out. You can also keep up to date on new resources from NCMIC by following us on Facebook, Twitter, and Instagram.

One last reminder, our next webinar is scheduled for Thursday, May 18th at 2:00 PM Central time, and I hope that you'll be able to join us for that. Once again, thank you for listening, and talk soon.