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The Medicolegal Code of Cooperation

Robert E. Cahill Jr.

The Medicolegal Code of Cooperation

by Robert E. Cahill, Jr.

Since 1964, a group of concerned Maryland doctors and lawyers have been laboring to improve relations between the professions. In that year, the major medical and legal professional organizations agreed to form a Medicolegal Committee, and to adopt a Medicolegal Code of Cooperation.

Recently, a subcommittee was appointed to revise and redraft that Code. The Committee adopted the Revised Code in April of 1981, and the interested professional organizations registered formal approval in June.

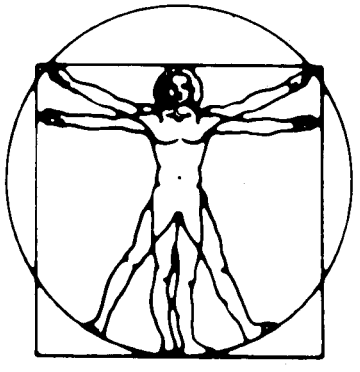
Historically, the sphere in which physicians and lawyers must interact has been fraught with an uneasy tension. The problem was exacerbated in the early 1970's by what has been called the "medical malpractice crisis." The onslaught of malpractice arbitration and litigation has seriously hindered "constructive medicolegal activities and endeavors to improve interprofessional relationships," Cyril H. Wecht, *The Interfaces of Law and Medicine,* 1Am. J.L. and Med. 89 (1975).

However, at least one source has recently perceived "a slight shift in attitude, as a dialogue has begun—at universities and through a few professional organizations—between the two professions," Gibson and Schwartz, *Physicians and Lawyers: Science and Conflict,* 6 Am. J.L. and Med. 173 (1980). In Maryland, the effort began in 1964, when the Maryland Bar Association, the Bar Association of Baltimore and the Medical and Chirurgical Faculty of the State of Maryland (Med-Chi) agreed to form a joint committee, responible for advancing communications as well as the common interests of the two professions. Historical references to Medicolegal Code and Medicolegal Committee from Glenn, *New Medicolegal Code of Cooperation Adopted,* Maryland Bar Journal 14 (October 1981).

Since then, the Medicolegal Committee, which is composed of doctors and lawyers appointed by the respective professional organizations, has considered disputes arising between the physicians and lawyers, and has generally attempted to promote harmony and understanding between the professions.

Also in 1964, the Committee adopted the Medicolegal Code of Cooperation, which subsequently gained the approval of the State Bar, the Baltimore City Bar, and Med-Chi. Originally, the Code purported to govern professional conduct in the malpractice arena, requiring lawyers to fully and fairly investigate and analyze facts to determine whether a cause of action existed before filing suit, and requiring doctors to testify on behalf of malpractice plaintiffs with legitimate grievances. Its language was broad and general, aimed at "promotion and perpetuation of harmony between the professions" and "achieving a fuller understanding of mutual problems." *Laws, Rules and Regulations of the Medical-Chirurgical Faculty of the State of Maryland* 48-51.

The New Medicolegal Code of Cooperation purports to govern coordination of the efforts of doctors and lawyers in order to best serve the needs of the patient-client. Language addressing the lofty goals of harmony and understanding between the professions has been largely removed, and all specific references to professional conduct in the medical malpractice area have been deleted. "The big change has been to leave all of the nebulous concepts out and put in hard-core rules, so that if somebody takes a look at the New Medicolegal Code of Cooperation, they can find what the rule is for a certain situation," states E. Dale Adkins, III, Esquire, principal drafter of the New Code.



The first substantive section of the Code addresses the subject of medical records and reports. Physicians are directed to submit, and in some cases to prepare, reports and records which "must" contain sufficient information to allow the client's medical condition to be evaluated. Additionally, physicians are directed to "promptly" furnish requested medical information upon receipt of a proper authorization. Finally, physicians are permitted to charge a "reasonable fee" for providing such information, including reproduction and preparation costs. Attorneys are made responsible for seeing that reasonable charges are promptly paid.

Of the various problems addressed in the Code, the one dealt with in this section seems least serious. "I think most physicians today are readily prepared to give up their medical records on a patient," says Adkins, "if they are presented with an appropriate release." The statutory mandates governing authorizations and disclosure of medical records are relatively clear and unambiguous, see, MD. ANN. CODE art. 43 §54 L, M; (1980 rep. vol.) art. 48A §354-0 (1980 rep. vol.).

But Adkins feels that the fees which some physicians charge lawyers for copies of medical records continue to be a source of friction between practitioners. It is this type of dispute that is regularly considered by the Medicolegal Committee. Dr. Emidio A. Bianco, a three year member of the Committee, and its current Co-Chairman, is both a doctor and a lawyer. He states that "this is the kind of thing we get into. But I don't think it is a common problem, because inevitably it is the same group of doctors and lawyers. We talk about what a reasonable fee is, but instead of saying 'ten cents a page is a reasonable xeroxing charge,' we ought to say 'What you

ought to consider is reproduction costs plus handling charge.' "

The next substantive group of provisions in the Code governs medical testimony. The rules in this section compel lawyers to give doctors fair notice of trial and deposition dates, and to schedule these dates so as to cause physicians as little inconvenience as possible. Additionally, lawyers are told that they "may" choose to meet with physicians prior to trial or deposition in order to "review the issues and questions which may be expected to arise.

"In my experience practicing," says Adkins, "I think a lot of lawyers abuse their powers under the rules, in the tort area especially, by subpoenaing doctors, with no notice to them whatsoever, for the first day of the trial, even though it may be a three or four day trial. I don't know how many of these types of complaints ever come to the Medicolegal Committee. I suspect not many, but it happens all the time. Perhaps one of the reasons doctors don't complain to the Committee is because we don't have enough dissemination of the Code."

Dr. Bianco perceives a different problem in the area of physician deposition and trial testimony. That problem, according to Bianco, is the Code's *suggestion* that doctors and lawyers meet prior to the date of testimony being taken, in order to review questions that are likely to arise. Says Bianco, "I think it is essential that the lawyer and physician meet to try to give the best possible testimony when the facts need to be reviewed. It is not a question of telling the doctor what to say, but one of finding out what he can say. Too often the two meet for the first time on the witness stand or in the courtroom. What we have to do now is to sit down and write regulations that would require doctors and lawyers to communicate before trial."

The final substantive section of the Code covers physician compensation. In this section both lawyers and doctors are warned that physician compensation for time devoted to preparation for trial or deposition should never be contingent upon the result of the case. The client-patient is said to be "initially responsible" for compensating the physician. But physicians are authorized to request compensation in advance, or in the alternative, to ask lawyers to agree to be personally responsible for payment. In this connection, the Code is clear that it is the *duty* of the attorney to see that the physician is promptly paid. Physicians may also ask lawyers to secure the patient's agreement that "outstanding medical bills" be paid from any settlement, judgement or insurance proceeds.

Dr. Bianco points to one further problem in the area of physician testimony which he says is a cause for concern. That problem is the product of the By-law of the Maryland Med-Chi Faculty which governs physicians testifying as expert witnesses. Section 9 of Article XIV, Disciplinary Procedures, reads as follows:

> "Any member of the Faculty who purports to testify as an expert witness in any matter of litigation before the courts or judicial bodies of Maryland or any other state, territory or the District of Columbia, shall be regarded as having violated the 'Principles of Medical Ethics' and be subject to disciplinary action as provided in this Article, if such a member does not possess basic educational and professional knowledge as a general foundation for his testimony, and in addition have current professional experience and practical familiarity with the problems that are being considered, and is not actively engaged in the practice in the medical field under consideration." Bylaws, Medical and Chirurgical Faculty of the State of Maryland, Article XIV 9 (amended September 26, 1981).

On its face, this regulation would seem to require that medical professionals who purport to render expert testimony at trial must be qualified as specialists, and as current practitioners. However, the only Maryland cases which address this question directly, *Harold v. Radman*, 31 Md. App. 184, 355 A.2 477 (1976), aff'd. *Radman v. Harold* 279 Md. 167, 364 A.2 472 (1977), hold that as a matter of law, such qualifications are not necessary. It should be noted that these cases included expert testimony of witnesses in a medical malpractice action. The standard in Maryland would appear to be that the witness must have only "sufficient familiarity with the particular medical technique involved in the suit." Since the current Medicolegal Code provisions governing medical testimony place a greater emphasis on the relationship between the patient's treating physician(s) and the patient's lawyer(s), this problem would be more likely to arise within Med-Chi itself, possibly after a physician has been forced to decided whether to testify in a trial on the basis of what appear to be two inconsistent standards.

"The problem is that doctors want to be compensated," says Adkins, "and some of them ask for too much money. A lot of lawyers work on low budgets. So now the doctors feel that if they have to deal with a lawyer, they should get the money up front. Their experience has been that they either don't get paid until the case is settled, or they never get paid."

Says Dr. Bianco, "One of the problems that the Committee is faced with is the somewhat exorbitant fees that physicians will charge to testify, which don't seem to me to be based on potential income for time lost in the office. Again, we are faced with the question of a reasonable fee, and it is going to vary from doctor to doctor, because they have varying potential incomes."

It is clear that compensation disputes between doctors and lawyers will persist without regard to what preventative action is taken by cooperative adjudicative committees, or even the statutorily enabled disciplinary bodies. But as Adkins says, "[F]rom the doctor's point of view regarding payment of fees, the final resolution is court."

Section Five of the Medicolegal Code, establishes the maintenance of the Medicolegal Committee. Among the enumerated tasks of the Commit-

tee appear the following two areas:

"...5. Consideration of disputes arising from interprofessional relationships including violations of the above Code.

6. Referral of legal or ethical violations, including violations of this Code, to the Commission on Medical Discipline or the Attorney Grievance Commission in appropriate situations. . ."

MD. ANN. CODE art. 14 §401 (1981 rep. vol.) "Commission on Medical Discipline"; *Md. Rules,* Subtitle DV, Discipline and Inactive Status of Attorneys."

One of the major criticisms directed at the Code is the lack of means for enforcement of its provisions. "We don't have any authority," says Dr. Bianco. "All we can do is refer people to the Disciplinary Commission or the Grievance Committee, which seems like a slightly radical step to take. Before that, there ought to be some kind of pressure that can be applied to get people to do what is reasonable."

"But you must keep in mind,' says Adkins, "that this is a document put forth by two voluntary, private professional organizations. Nobody has to be a member of the Med-Chi, and nobody has to be a member of the Bar Association. I don't know what else we can do, in terms of putting teeth in the Code, besides referring physicians or lawyers to the appropriate disciplinary body."

If professional mistrust and discourtesy are as rampant as some practitioners indicate, perhaps there will never be an end to the strained alliance between doctor and lawyer. Nonetheless, the interests of the patient-client will always require the efforts of both. It is more likely than not that this effort will continue to be hampered by the one impediment noted by Dr. Bianco, when he observed that "from a very mundane, visceral point of view, physicians continue to dislike lawyers intensely." The Medicolegal Code of Cooperations, and the Committee created to enforce its principles, provide some evidence that in the future, the barriers may begin to descend.

Medicolegal Code of Cooperation

Preamble

When a person requires a combination of medical and legal assistance, his or her physician and lawyer best serve that person by cooperating with each other. The members of the Maryland State Bar Association, the Medical and Chirurgical Faculty of the State of Maryland, the Bar Association of Baltimore City, and those bar associations and component medical societies listed below adopt this declaration of principles as ethical standards of conduct for attorneys and physicians in such situations.

Section One

The Perspective of the Attending Physician and the Attorney

Attending physicians and attorneys approach medicolegal problems from different points of view. The attending physician is primarily concerned with the patient's medical treatment. The patient's attorney is concerned with the most effective presentation of the patient's medical condition and problems, and the adverse attorney is required to thoroughly investigate the patient's contentions.

If a physician chooses not to continue treatment of a patient involved in a medicolegal situation, he should immediately notify the patient and allow the patient reasonable opportunity to obtain another physician.

In representation of a patient, an attorney may wish to obtain a second medical opinion regarding his client's condition. The attorney should not refer his client for examination or treatment to a second physician unless the attending physician is advised or the attending physician has voluntarily terminated his care and treatment of the patient. If an attorney refers a client for a second opinion, both the attending physician and the physician to whom the client has been referred should be notified.

Section Two

Medical Records and Reports

Most medicolegal situations are resolved by an evaluation of medical records and reports. Documents submitted by an attorney in support of a client's claim must contain sufficient information to allow that client's medical condition to be evaluated. Sufficient information may be contained in a physician's medical records or a hospital record. In some cases, however, a special report by the physician may be requested.

Authorizations

An attorney should furnish the physician a proper Authorization for release of medical information regarding the patient unless not required to do so by law (see Annotated Code of Maryland, Article 43, Section 54L). When a treating or consulting physician receives a request for medical information accompanied by a proper Authorization, he should promptly furnish that information or the documents requested. If an attorney requests records or reports, he should specify whether a copy of the medical records maintained by the physician in treating the client will suffice or whether a special report is necessary. In the latter case, the attorney's request should specify the information needed in the report.

Fees

A physician may charge a reasonable fee for furnishing medical records or reports. If only existing medical records are requested, the charge should be for the reproduction and staff time incurred in that reproduction. If a special report must be prepared, the charge may include compensation for the physician's time expended as well as staff preparation time and reproduction. It is incumbent upon an attorney to see that the physician is promptly paid any reasonable bill submitted for furnishing medical records or reports.

Section Three

Medical Testimony

Often in a medicolegal situation, the physician's testimony is necessary either at a deposition or trial. In either context, it is particularly important that the attorney recognize the demands that patient care places upon a physician's time. Thus, notice and scheduling of the physician's appearance must be given the utmost consideration by the attorney. Physicians should understand, particularly in the context of a trial, that the date testimony is required is not always flexible, and, accordingly, should arrange their schedule in an attempt to be present. Either depositions or videotape depositions offer an alternative to live court testimony. Attorneys should consider this alternative for the convenience of physicians whose schedules cannot accommodate appearances in court.

Prior to presenting testimony from a physician or producing a physician for testimony at a deposition, an attorney may choose to meet with that physician and review the issues and questions which may be expected to arise. If the attorney makes such a request, the physician should cooperate by making himself available at a reasonable time to meet with the attorney prior to giving the testimony.

An attorney should consult with the physician or his staff prior to arranging depositions, and, if possible, prior to scheduling a trial date so that a date convenient to the physician may be selected. (Such a consultation may not be required where the physician is adversary to the attorney's client.) If it is not possible to consult with the physician or his office staff prior to scheduling a trial date, the physician should be immediately notified of the date upon which the trial has been scheduled.

A physician should cooperate with the attorney representing his patient regarding the scheduling of depositions or trial appearances. Should any changes occur in the physician's schedule which make it difficult for him to appear on a previously scheduled date, he should immediately notify the attorney of those changes. Similarly, the attorney should always keep the physician advised of changes in the time of or necessity for his appearance. A physician should be immediately notified if a trial is postponed or cancelled and his testimony is not necessary.

An attorney should not issue a Subpoena for a physician without advising him such Subpoena is to be issued and the date upon which the physician is requested to appear. (This requirement may not apply in situations where the physician is an adversary to the attorney's client.) During trials an attorney should attempt to work out an "on-call" arrangement with the physician so as to cause him as little inconvenience as possible in connection with his court appearance.

Section Four

Physician Compensation

A physician is entitled to be compensated for time devoted to preparation for testimony and deposition. (This requirement may not apply in situations where the physician is an adversary to the attorney's client.) Compensation should be related only to time involved and never to the outcome of the controversy. If a situation occurs where a physician has cancelled appointments in anticipation of medical testimony and does not receive enough notice of a postponement or cancellation of the testimony to reschedule those appointments or otherwise use the time, he is entitled to reasonable compensation regardless.

The client-patient is initially responsible for compensating the physician for time devoted to the legal proceeding. It is appropriate, however, for a physician to either request compensation in advance of expending time or to arrange that the attorney, in addition to the client-patient, be personally responsible for the bill. If the latter arrangement is agreed upon, it should be reduced to writing.

The patient is responsible for bills for medical treatment and it is inappropriate for the attorney to agree to be personally responsible for those bills. However, the physician may request the attorney to secure the patient's agreement that outstanding medical bills be satisfied from any settlement, judgment or insurance proceeds. If such an agreement is obtained, the attorney is personally responsible to see that it is carried out and is liable to the physician for failure to do so.

It is the duty of an attorney to see that a physician is promptly compensated for his time devoted to the proceeding. It is preferable for both the attorney and the physician to reach an agreement in advance concerning the amount of fees and expenses for time devoted to preparation or testimony. Neither the attorney nor the physician should enter into any agreement in which the physician's compensation is contingent upon the outcome of a case.

Section Five

Medicolegal Committee

The Medical and Chirurgical Faculty of the State of Maryland and the Maryland State and City of Baltimore Bar Assocations maintain a standing joint committee on interprofessional relationships. The committee is known as the Medicolegal Committee. Its purpose is to promote a close and more harmonious relationship between the two professions. The committee membership is composed of twelve attorneys and twelve physicians.

The Committee will consider all matters concerning interprofessional relationships between the two professions, including, but not limited to, the following:

1. Promotion and perpetuation of harmony between the professions.
2. Achieving a fuller understanding of mutual problems.
3. Promotion of educational programs of interest to both professions.
4. Publish guidelines regarding fees for record reproduction, preparation of medical reports, and time spent in preparation for and the giving of depositions and trial testimony.
5. Consideration of disputes arising from interprofessional relationships including violations of the above Code.
6. Referral of legal or ethical violations, including violations of this code, to the Commission on Medical Discipline or the Attorney Grievance Commission in appropriate situations.

In dealing with problems which arise between individuals, physicians, and attorneys, the Committee will recommend a course of action based upon the principles in the Medicolegal Code. Matters already in litigation between an attorney and a physician will not be considered by the Committee.

Section Six

General Provisions

Nothing contained in this statement of principles is intended to be inconsistent with provisions of law or rules of ethical conduct for attorneys or physicians, or to permit attorneys to gain undue advantage in furtherance of a medical/legal claim against a physician.

Approvals:

1. Bar Association of Baltimore City, Executive Committee, May 11, 1981.
2. Maryland State Bar Association, Board of Governors, June 11, 1981.
3. Medical and Chirurgical Faculty of the State of Maryland, Council Meeting, June 25, 1981.

In Purse—Suit of Liability

by Stephanie Melnicove

Diethylstelbestrol (DES) is a synthetic hormone that was initially manufactured to help menopausal women. After continued research, DES was found to be an aid for problem pregnancies and especially effective in the prevention of miscarriages.

Prior to 1952, the Food and Drug Administration (FDA) approved the use of DES on an experimental basis for problem pregnancies. The FDA required that a notice of potential danger be given with each DES product. By 1954, more than 267 companies marketed DES "On an unlimited basis rather than as an experimental drug, and they failed to warn of its potential danger." *Sindell v. Abbott Laboratories,* 163 Cal.Rptr. 132, 134 607 P.2d 924, 926 (1980).

In 1971, the connection was made between DES ingestion during pregnancy and gynecological cancer, in the female offspring. Subsequently, the FDA banned the use of DES for problem pregnancies.

What remains of the unbridled disregard for the FDA requirements is diagnoses of young women with various forms of gynecological cancer, whose mothers have no recollection of the precise manufacturer responsible for the DES taken. In most of the suits against the DES manufacturers, the crucial problem is that of identifying the manufacturer of the ingested pill.

The Defendants in the DES suits have all been DES manufacturers. Some have been able to exclude themselves by proving they did not market their product in the vicinity or at the time the drug was taken.

Because courts are primarily concerned with having the proper parties before the bench, many cases have