

Comparative Professional Ethics: Law & Medicine

Fall 2002 - Course Outline

August 22 - Introduction

Introduction to course requirements.

Introduction to the main themes we will address this semester.

Dimitri A. Christakis & Chris Feudtner, M.A., Ethics in a Short White Coat: The Ethical Dilemmas That Medical Students Confront, *Academic Medicine*, Vol. 68, no. 4, p. 24 (April 1993): Description of Ethics Classes in medical school

Zitrin & Langford, pp. 17 –22: Ethics versus morality; lawyers can “ethically” defend a client who they know is immoral; “Having a code of ethics means never having to say you’re sorry”

66 –71: Lawyers more likely to be depressed, have emotional problems, drinking problems, etc.; widespread job dissatisfaction among lawyers; biggest complaint is long workdays; hard to anticipate as a student what ethical dilemmas will be faced as a lawyer; big firm culture; inability to reflect on one’s actions to determine if one is being ethical; unless you are habitually ethical, big firm culture is unethical; influence of house norms; obsession with money; needing to play the game, bill the most hours, have the most clients;

August 29 - Introduction to Codes; Competence as an Ethical Obligation

Introduction to Codes: The ABA's Code of Professional Conduct and The AMA's Code of Medical Ethics

Professional Competence: How is professional competence defined and enforced in a self-regulating profession? We will discuss the role of licensing boards, clients and patients, colleagues and self-discipline in defining and maintaining professional competence.

Zitrin & Langford, pp. 4-8: Early legal ethical standards came from common law; had little disciplinary enforcement; early ABA was more an exercise in exclusiveness, aimed at keeping out diverse groups (Jews); sought to regulate advertising as an anti-competitive measure more than for ethical concerns; ABA Model Code of Professional Responsibility came out in 1969; most states adopted the code for their own rules of conduct; ABA Model Rules came out in 1982; allows abrogation of atty-client confidentiality where necessary for public protection

Zitrin p.37-53: Undertaking a case; **Is it unethical to take a case in an area of law that you are inexperienced?**

“Finding the Right Lawyer” How does one find a competent lawyer? Word of mouth, bar assn. referrals, advertisements all have limited value; **very difficult for a layperson to find the right lawyer for their specific needs?**

“Why bad things happen to good lawyers” Three risk factors w/ bad clients: **Expectations**: Need to discern what is motivating client (greed, vengeance, etc) or if the client wants an outcome the legal system does not provide or cannot be achieved under the circumstances

Communication: Some clients require special handling to assure accurate communication/avoid unmet expectations; avoid client if unwilling to understand their matters;

Control: insisting on knowing everything; lawyer switching; avoidable delays, doing/telling the lawyer how to do their job; resisting retainers/fees; impatience; lack of self-control

“Law School Should be 2 yrs instead of 3” **growing estrangement between academia & law practice**; dropping from 3 yrs to 2 could relieve young lawyers of pressure to recoup their investment by working such long hours; deteriorating working conditions are part of an economy wide increase in competitiveness in all industries; law is becoming more like a business, while law school is becoming more like a grad school in humanities/social science;

“Protesting the closing of a clinic” Nothing much here; clinical emphasis law school (CUNY) has very low bar passage rate

“Marcia Chambers, Sua Sponte” Mentoring on the decline for many reasons; lack of business growth causes partners to hoard work from associates; clients demand more, want partners to do the work, refuse to pay if associates do the work; pressure to bill more hours takes away from mentoring time; decreasing institutional loyalty causes partners to view associates as dispensable workers rather than future partners; women & minorities find it tougher to get mentoring

“Legal Malpractice” Problem with a system where more money goes to plaintiff/defense malpractice lawyers than to aggrieved clients

Model Rule 1.1: A lawyer shall provide competent representation to a client. Competent representation requires legal knowledge, skill, thoroughness, and preparation reasonably necessary for the representation

Chapter 1 of Atul Gawande, *Complications: A Surgeon's Notes on an Imperfect Science*, Metropolitan Books (2002): Feel good crap about surgery; it takes a long time to become a good surgeon, but this guy takes 25 pages to say it.

Opinion 9.011: Physicians should strive to further their education throughout their careers; fulfilling mandatory CME requirement doesn't fulfill ethical obligation to maintain expertise; education, not amenities should be the primary motivation of attending CME activity; duties of faculty at CME conferences; duties of sponsors as related to acceptance of gifts

9.031: Obligation to report impaired, incompetent, unethical colleagues; impairment reported in-house; incompetent reported first to clinical authority, then to state licensing board; unethical reported according to nature of violation (licensing board, clinical authority, law enforcement); confidentiality for those under investigation.

9.032: Physician's duty to report adverse drug reactions to the med. community; do not need to have certain or reasonable causation to report a potential adverse reaction

Original Hippocratic Oath: No abortion, surgery or euthanasia allowed

Original Oath prohibits sex when making housecalls

Modern Oath created in 1964, gives more latitude-allows abortion & surgery; gives fewer negative consequences for violating the oath

Code of Ethics is different than Oath; Code makes docs/lawyers subject to ethical codes being enforced; medical ethics developed to separate personal honor

How to define competence:

<u>Legal Profession</u>	<u>Medical Profession</u>
1. Skills to research	1. Ability to listen
2. Ability to know what is unknown	2. Licensure
3. Preparedness	3. Quality of Education/Reputation of Med School
4. Resourcefulness	4. Proper specialization/experience
5. Ability to do what is promised	5. Good physical health
6. Pass the Bar exam	6. Stability
7. Experience	7. Mainstream

What do legal and medical competence have in common?

1. Affiliations
2. Not getting sued a lot
3. Reputation
4. Skill & Preparation
5. License

Rule 1.1: says nothing about experience

Fundamental elements of physician/patient relationship: Nothing squarely addresses competence

Principles of Medical Ethics: Incompetence defined; physicians are obliged to provide competence; how is competence defined? Results

Legal Malpractice PFC Elements: Lawyer did not act like a reasonably competent lawyer under similar circumstances; tough to prove b/c of 6th Amendment assistance of counsel clause; must prove abnormal practice **and** but/for causation; much tougher to show how legal malpractice was prejudicial;

Medical Malpractice PFC Elements: Doctor did not use skill and learning ordinarily used by docs under similar circumstances

Professional discipline: protects faith in the profession and prevents future harm

Market reaction: if doctor/lawyer is incompetent, they will be forced out by a lack of business

Whistleblower rule: duty to report

Why is there such a difference btw legal and medical training? Law firms still have an “informal residency”; there is a difference in the types of skills used; reading, arguing & talking are different from complicated surgery

September 5 – Confidentiality

We will look at the attorney-client and patient-physician privileges. We will also begin a review of the confidentiality obligations of physicians and lawyers, focusing on the differences between duties of confidentiality and legal privileges.

Legal	Medical
Attorney-Client	Doctor-Patient
Purpose: Full disclosure, competent advice, avoid liability, encourage compliance with law, encourages seeking of advice	Purpose: Full disclosure, proper care, enhance trust in profession, privacy, control of information, avoid liability, encourages people to seek preventive care

Zitrin & Langford, pp.103 – 121

People v. Belge, 372 N.Y.S.2d 798 (1975): Indictment of lawyer for failing to disclose where client hid bodies of his murder victims was dismissed on the grounds of privileged communication/interests of justice; different result in Texas where motion to suppress map locating a dead body from evidence was denied.

In Re Ryder, atty physically hid evidence that would incriminate his client in a safe deposit box; by concealing a shotgun and stolen money, Ryder acted without the bounds of law; deceptive subterfuge; conduct is not justified simply b/c a lawyer thinks they are acting in the best interest of their client; “To allow an individual lawyer’s belief to determine standards of professional conduct will in time reduce the ethics of the profession to the practices of the most unscrupulous.” Intent to return stolen \$\$ after client was tried mitigates amount of discipline imposed (18 mos. suspension)

People v. Meredith: Δ’s attorney was privy to removal of stolen wallet from scene of crime; atty-client privilege extends to protect observations made as consequence of protected communications; defense decision to remove evidence is tactical choice; if Δ counsel leaves evidence where it was discovered, observations are insulated from revelation; but if counsel removes evidence to examine/test it the original location loses protection of privilege.

Silverman article: complains of unfairness regarding prosecution’s ability to take possession of everything removed from scenes by a defense team w/o paying the bill and having the sympathy of judges on evidence motions

Model Rule 1.6: Confidentiality

- (a) a lawyer should not reveal info relating to representation of a client without consent, except for disclosures that are impliedly authorized to carry out representation and in paragraph (b)
- (b) A lawyer may reveal info if they believe it is necessary:
 - (1) to prevent client from committing a criminal act the lawyer believes is likely to result in imminent death/substantial bodily harm
 - (2) secure legal advice about compliance w/ rules
 - (3) to establish a claim of defense on behalf of the lawyer in a controversy btw lawyer & client, to establish defense to a criminal charge or civil claim against the lawyer based upon conduct in which the client was involved or to respond to allegations in any proceeding concerning lawyer’s representation of client.
 - (4) Comply with a court order

Bryson v. Tillinghast, 749 P.2d 110 (Ok. 1988): Π’s theories raised against doctor: (1) breach of doctor-patient privilege; (2) breach of implied protection from disclosure of criminal conduct in a contract for medical services; (3) licensing statute violation for breach of confidence; on count 1, court held there was a difference between “privilege” and “confidentiality”;

privilege: communication btw professional and client; precludes professional testifying against client or other release in judicial proceeding
confidentiality: information disclosed in confidence to professional; precludes disclosure to third parties without client’s consent

Opinion 5.05: Duty to maintain **confidentiality**; goes back to Hippocratic oath; info disclosed is confidential to the greatest possible degree, but the obligation to safeguard patient confidences is subject to certain exceptions which are ethically/legally justified b/c of overriding social considerations.

Confidential info that is disclosed is still confidential

Opinion 5.05: only disclose w/ express consent unless required to do so by law

Opinion 5.055: confidential care for minors; docs should involve minors in decision making process; docs should encourage but not force minors to involve their parents

Attorneys may disclose	Attorneys must disclose
1. To prevent bodily harm	1. Fruits of crime or instrumentality without divulging client confidence
2. To obtain legal advice	2. Must withdraw under certain circumstances
3. to establish a claim/defense	
4. to comply w/ law or court order	

Doctors may disclose when consequences for not doing so would result in:	Doctors must disclose when consequences for not doing so would result in:
1. Serious bodily harm	1. gunshot wound
	2. elder abuse
	3. HIV in certain circumstances

In general, attorneys have fewer obligations and greater discretion about disclosure

The different implications of disclosure are of the key differences between lawyers and doctors b/c information doctors disclose is **critical** to their patient; an attorney's job is to **protect against** outside demands for information;

It is more essential for a lawyer serving a client to maintain the privilege because a client has interests that are contrary to the outside world.

September 12 - Confidentiality and Duties to Third Parties

We will explore the limits of the professional's confidentiality obligation by analyzing the tension between the duty of confidentiality and duties to third parties, including a comparison of the duty to warn in the medical and legal professions.

Rule 3.3 Candor toward the tribunal

(a) A lawyer shall not knowingly:

- (1) make a false statement of material fact or law to a tribunal;**
 - (2) fail to disclose a material fact to a tribunal when disclosure is necessary to avoid assisting a criminal or fraudulent act by the client**
 - (3) fail to disclose to the tribunal legal authority in the controlling jurisdiction known to the lawyer to be adverse to the position of the client and not disclosed by opposing counsel; or**
 - (4) offer evidence that the lawyer knows to be false. If a lawyer has offered material evidence and comes to know of its falsity, the lawyer shall take reasonable remedial measures.**
- (b) The duties stated in paragraph (a) continue to the conclusion of the proceeding, and apply even if compliance requires disclosure of information otherwise protected by rule 1.6**
- (c) A lawyer may refuse to offer evidence that the lawyer reasonably believes is false**
- (d) In an ex parte proceeding, a lawyer shall inform the tribunal of all material facts known to the lawyer which will enable the tribunal to make an informed decision, whether or not the facts are adverse.**

Part (b) of Rule 3.3 implies that **Rule 1.6 is permissive** but Rule 3.3 is not.

Zitrin & Langford, pp. 121-130

Tarasoff: Patient had made direct threat on victim's life to therapist and later killed the woman; created exception to patient-psychotherapist privilege, upheld family's right to sue Univ of Calif.; created debate over whether there is a duty to warn;

McLaughlin: McLaughlin made remarks to his lawyer that could have been construed as a death threat to a judge who had issued a ruling against him; lawyer disclosed and McLaughlin sued for breach of atty-client privilege; McLaughlin had made (1) present threat to judge; (2) prior threat to another judge; (3) mentally imbalanced

Is there a duty to disclose? What if § had just "run his mouth" to get attention from a lawyer

-Confidential relationship can be formed when a lawyer listens to somebody without formally accepting them as a client; can also be formed when a client says something to a secretary before meeting a lawyer

Biddle v. Warren General Hospital, 715 N.E.2d 518 (Oh. 1999): patients brought claim alleging hospital disclosed patients' confidential information so a law firm could search for potential SSI eligibility for payment of patients' unpaid medical bills. Ohio supreme court held: (1) an independent tort exists for unauthorized, unprivileged disclosure to a 3rd party of nonpublic medical information that a physician or hospital has learned within a physician-patient relationship; (2) in absence of prior authorization, a physician or hospital is privileged to disclose otherwise confidential med info in those special situations where disclosure is made in accordance with a statutory mandate or common-law duty, or where disclosure is necessary to protect or further a countervailing interest which outweighs the patient's interest in confidentiality; (3) a third party can be held liable for inducing the unauthorized, unprivileged disclosure of nonpublic medical information that a physician or hospital has learned within a physician-patient relationship, if three elements are proven (i) Δ knew or reasonably should have known the existence of the physician-patient relationship; (ii) Δ intended to induce the physician to disclose info about patient or Δ reasonably should have known his actions would induce disclosure; (iii) Δ did not reasonably believe that physician could disclose that info to Δ w/o violating duty of confidentiality the physician owes the patient

Π claimed hospital (Δ) could not give medical records to attorney without express consent; Δ claimed attorney was hospital's agent, entitled to records to effectively represent hospital, essentially the same entities; attorney is bound by confidentiality to the hospital, hospital claims the circle is still closed; court did not buy hospital's argument b/c attorney has no duty to a patient in the way a doctor does; under circumstances of this case, there is no public or private interest to allow disclosure

Other issues arising: Patients' breach of duty to pay their medical bills? What if hospital had in house counsel? What about law firms' soliciting of clients?

Virgin v. Hopewell, 66 S.W.3d 21 (Mo. App. 2001): Patient told shrink she had a death wish when she drove; Π was injured by patient's reckless driving, sued hospital, claims there was duty to warn of the foreseeable risk of harm when patient drove; dismissed for failure to state a claim; affirmed on appeal; **duty to disclose depends on the level of certainty about what will happen next**; "establishing a duty [to disclose] in the instant case would erode, to say the least, the physician-patient privilege as well as subvert the purpose and policy behind it."

Lawyers/Docs should put pressure on clients/patients to "do the right thing" before making any disclosure

September 19 - Informed Consent and Issues of Client/Patient Autonomy

How do the two professions address the ethical issues that can arise in the decision making process? When, if ever, should the greater expertise and experience of the professional override the autonomy of the patient/client? Is it ever proper for the professional to withhold information from the patient or client?

Confidentiality addresses what must be kept inside the circle; consent addresses the obligations within the circle

Rule 1.0(e): Attorney-Client Informed Consent (new for 2002)

Informed consent denotes the agreement by a person to a proposed course of conduct after the lawyer has communicated adequate information and explanation about the material risks of and reasonably available alternatives to the proposed course of conduct.

Rule 1.2(c): Scope of representation

A lawyer may limit the scope of the representation if the limitation is reasonable under the circumstances and the client gives informed consent.

Rule 1.2 was formerly the scope of representation; now it's the allocation of authority

Objectives: A lawyer cannot question why or if a client wants representation, i.e. a lawyer cannot tell a client "don't get a divorce"; a lawyer should educate and advise with the benefit of experience

Rule 1.6(a): Disclosure with informed consent

A lawyer should not reveal info relating to representation of a client without consent, except for disclosures that are impliedly authorized to carry out representation

Rule 1.7: Conflict of Interest

(a) Except as provided in paragraph (b), a lawyer shall not represent a client if the representation involves a concurrent conflict of interest. A concurrent conflict of interest exists if:

- (1) the representation of one client will be directly adverse to another client; or**
- (2) there is significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to another client, a former client or a third person or by a personal interest of the lawyer.**

(b) Notwithstanding the existence of a concurrent conflict of interest under paragraph (a), a lawyer may represent a client if:

- (1) the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client;**
- (2) the representation is not prohibited by law;**
- (3) the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and**
- (4) each affected client gives informed consent, confirmed in writing**

Rule 1.4 Communication

(a) A lawyer shall:

- (1) promptly inform the client of any decision or circumstance with respect to which the client's informed consent, as defined in Rule 1.0(e), is required by these Rules;**
- (2) reasonably consult with the client about the means by which the client's objectives are to be accomplished;**
- (3) keep the client reasonably informed about the status of the matter;**
- (4) promptly comply with reasonable requests for information; and**
- (5) consult with the client about any relevant limitation on the lawyer's conduct when the lawyer knows that the client expects assistance not permitted by the Rules of Professional Conduct or other law**

(b) A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.

Rule 1.14: Diminished Capacity

(a) When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment, or for some other reason, the lawyer shall as far as reasonably possible, maintain a normal client-lawyer relationship with the client.

(b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian

(c) Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.

Wilkinson v. Vase, 295 A.2d 676 (RI 1972): The patient was treated for cancer after doctors found a shadow in her chest cavity that appeared on an x-ray. They recommended that she undergo a "trial" course of deep radiation therapy. After she underwent therapy there was shrinkage in the tumor and the doctors diagnosed her with a malignant tumor in the right upper mediastinum. The patient continued radiation treatment. Several years later, the patient's skin on her chest and back broke down from radiation burns. As a result, she needed extensive plastic surgery. At one point, the patient was told that she never had cancer. The court held that there was evidence from which the jury could infer that the diagnosis was negligently made and erroneous in fact, and that, therefore, the trial court erred in granting the directed verdict. The court also found that there was evidence that the patient was improperly given a double exposure of radiation and that the issue of negligent treatment should have been submitted to the jury. Additionally, the court held that there was error in directing the verdict on the issue of informed consent and that the trial court erred in not allowing the patient's amendment to add *res ipsa* as a claim.

Majority Rule: Treats informed consent the same way as medical malpractice; requires Π to establish (1) w/ expert medical testimony what a reasonable practitioner would have disclosed; (2) physician has deviated from this standard

Minority (*Natanson*) rule adopted: in absence of an emergency, a physician has an obligation to make a reasonable explanation and disclosure to his patient of the risks and hazards involved in a proposed course of treatment to the end that whatever consent given by the patient to the prescribed treatment may be an informed and intelligent consent; that where a physician is silent and makes no disclosure whatever, he has failed in the duty owed to the patient and the patient is not required to produce expert testimony to show that the doctor's failure was contrary to accepted medical practice but rather that it devolves upon the doctor to establish that his failure to make any disclosure did in fact conform under the existing conditions to accepted medical standards; and that where actual disclosures have been made and are ascertainable, the patient then must produce expert medical testimony to establish that the disclosures made were not in accord with those which reasonable medical practitioners would have divulged under the same or like circumstances. ***Wilkinson* held the trial court erred in requiring plaintiff to produce expert testimony regarding propriety of Δ's silence about hazards of treatment.**

Opinion 8.08: Physician-Patient Informed Consent

Requires patient to have information; patient should make their own determination; physician obligated to present medical facts accurately to patient or individual responsible for patient's care; physician has ethical obligation to help patient make choices from alternatives consistent with good medical practice;

Exceptions to informed consent (1) Patient is unconscious and harm from failure to treat is eminent; (2) risk-disclosure poses such a serious psychological threat to patient as to be medically contraindicated

Opinion 8.12: Patient Information

Physician should deal honestly w/ patients at all times; patients have a right to know their past and present medical status; if physician's mistake causes significant medical complications, physician is ethically required to inform the patient of all facts necessary to understand what has occurred; physician is ethically obligated to inform patients of changes in their diagnosis.

Zitrin & Langford, pp. 307 - 323, skim 232 – 331

People v. Deere: Δ killed 3 people, pleaded guilty, refused to give himself any defense, insisting that he wanted to die; counsel death penalty appeal is automatic, even if Δ does not want to appeal; on appeal Δ claimed atty was deficient in failing to offer any evidence in mitigation; new Δ's attorney offered mitigating evidence, but death penalty was affirmed on appeal

The court affirmed the judgment of the trial court. Defendant was convicted of one count of first-degree murder and two counts of second-degree murder, accompanied by a finding of a multiple-murder special circumstance, [Cal. Penal Code § 190.2\(a\)\(3\)](#). The penalty was fixed at death. The penalty judgment was reversed. Following a remand for retrial of the penalty phase, the sentence was again fixed at death. On appeal, defendant argued that his attorney rendered ineffective assistance of counsel at the penalty phases in failing to raise the issues of defendant's mental competence to stand trial and waive a jury. The court found that the contentions lacked merit. Defendant cited no evidence to support the claim. Instead, he referred to the testimony of his

former girlfriend and her sister indicating that at the time of the murders defendant was despondent. The trial court inquired directly on several occasions whether defendant wished to waive his right to a jury trial. Defendant responded clearly and unequivocally that he did. The trial court also observed that defendant appeared to be rational and intelligent. There was no merit to defendant's claim that counsel was deficient.

Did original attorney do the right thing or should attorney have presented mitigating evidence? Why didn't Δ hang himself in the jail cell? Why not use a court appointed fact finder? Someone else was appointed to present mitigating evidence.

A counsel has no ethical obligation to accept the moral and legal choices of the client and has no ethical obligation in this instance to advocate [for death] on behalf of the client; but it is still up to the lawyer to decide how to argue.

Richard Barbieri: *A Fight to the Death*: Mason has a death sentence, lawyer trying to get Mason out of the sentence, filed habeas corpus to seek new trial; client was trying to fire the lawyer, no longer wishing to fight the execution; client found new lawyer to try to waive appellate rights; anti-death penalty lawyer tried to fight to the end insisting Mason was incompetent to decide for himself whether to live or die; pro-death lawyer attended the execution and waited for a signal from Mason to refile an appeal Mason had chosen to withdraw; prosecution said it would honor a decision to appeal, even in the gas chamber; Mason was executed; Was Mason a severely disabled person as evidenced by his "volunteering" to die?

September 26 - Conflicts of Interest

After an overview of legal conflicts of interest, we will ask whether similar concerns exist in the medical profession and, if so, how they are best addressed?

Zitrin & Langford, pp. 175-189, 260-269

-The vast majority of conflicts never ripen, but it is never known which conflicts will ripen and the only way to protect the interests of all clients is to take preventive measures at the inception of representation; best to but a disclaimer on attorney-client privilege being absolute before clients begin to confide in an attorney;

-Good stuff on conflict of interest concerning current/former clients bottom 184 & top 185

-Ethical problems in Music Industry w/ lawyers representing artists and recording labels at the same time w/o telling the artist; can be remedied with full disclosure and client's consent to go forward;

-Prospective Waivers: approval has been limited due to the need to describe conflicts with sufficient clarity; also the waiver would have to be re-evaluated if circumstances changed to see if further waiver was necessary

What is a former client? Is a "matter" necessarily litigation? Is adversity limited to direct representation or can an adverse relationship be more subtle or indirect? What is a substantial relationship between current and former representations? Is it based on facts or legal issues or confidential information that can be used against a former client? Were material confidences rebutted? Can it even be presumed that the attorney received confidences from the former client?

Majority rule presumes that attorneys received confidences from their former clients, but this presumption is rebuttable

How should a lawyer's former involvement be imputed to a new firm? May not be a materially adverse if an attorney worked on the "periphery" of a case and did not actually "represent" a client (2d Circuit view); Can an allegedly "tainted" lawyer be successfully "screened"? Disqualification of lawyers: courts are increasingly unwilling to qualify to promote lawyer mobility & financial interests, discourage client hardship (attorney with DQ threat may pressure client to settle early); promote client choice.

Rule 1.7: Conflict of Interest

(a) Except as provided in paragraph (b), a lawyer shall not represent a client if the representation involves a concurrent conflict of interest. A concurrent conflict of interest exists if:

- (1) the representation of one client will be directly adverse to another client; or**
- (2) there is significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to another client, a former client or a third person or by a personal interest of the lawyer.**

(b) Notwithstanding the existence of a concurrent conflict of interest under paragraph (a), a lawyer may represent a client if:

- (1) the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client;**
- (2) the representation is not prohibited by law;**
- (3) the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and**
- (4) each affected client gives informed consent, confirmed in writing**

Rule 1.8 Fiduciary Duties

Too long to write down here

Rule 1.9 Conflict of Interest with Former Clients

(a) A lawyer who has formerly represented a client in a matter shall not thereafter represent another person in the same or a substantially related matter in which that person's interests are materially adverse to the interests of the former client unless the former client consents after consultation

(b) A lawyer shall not knowingly represent a person in the same or a substantially related matter in which a firm with which the lawyer formerly was associated had previously represented a client,

- (1) whose interests are materially adverse to that person; and**
 - (2) about whom the lawyer had acquired information protected by Rules 1.6 and 1.9(c) that is material to the matter;**
- unless the former client consents after consultation.**

(c) A lawyer who has formerly represented a client in a matter or whose present or former firm has formerly represented a client in a matter shall not thereafter:

- (1) Use information relating to the representation to the disadvantage of the former client except as Rule 1.6 or Rule 3.3 would permit or require with respect to a client, or when the information has become generally known; or**
- (2) Reveal information relating to the representation except as Rule 1.6 or Rule 3.3 would permit or require with respect to a client.**

Rule 1.10: Imputed Disqualification

- (a) While lawyers are associated with a firm, none of them shall knowingly represent a client when any one of them practicing alone would be prohibited from doing so by Rules 1.7, 1.8(c), 1.9 or 2.2**
- (b) When a lawyer has terminated an association with a firm, the firm is not prohibited from thereafter representing a person with interests materially adverse to those of a client represented by the formerly associated lawyer and not currently represented by the firm unless:**
 - (1) the matter is the same or substantially related to that in which the formerly associated lawyer represented the client; and**
 - (2) any lawyer remaining in the firm has information protected by Rules 1.6 and 1.9(c) that is material to the matter.**
- (c) A disqualification prescribed by this rule may be waived by the affected client under the conditions stated in Rule 1.7.**

What is the difference between materially and directly adverse? Which is a greater or lesser standard?

October 3 - Conflicts of Interest, cont.

Our second class on conflicts of interest will focus on financial issues. For example, what are the incentives inherent in different fee arrangements? When might conflicts arise between a physician's or lawyer's best professional judgment and economic constraints? How should the profession handle such conflicts?

There is an internal conflict between lawyer's self-interest and the interest of the client

Conflicts of interest: what if lawyers from same firm represent personal injury Π in PI case and PI Δ in divorce case? Both clients are owed fiduciary duties: (1) Confidentiality; (2) Loyalty

Remedies:

- (1) Informed Consent-get PI Δ /divorce client's consent up front;
- (2) Screening-keep divorce files from PI lawyer
- (3) Motion for disqualification: what needs to be shown?
- (4) Sue for breach of fiduciary duty; can this be done if there was no evidence that information was leaked within the firm?
- (5) Punitive damages for emotional distress, even if difficult to quantify

Zitrin & Langford, pp. 227-233, 237-250

-Possibility of lawyer's financial interests conflicting with client's interests, i.e. if fee/cost of representation is prohibitively high for client once representation has already begun? Is this issue different in a civil or criminal case? Under Rule 1.7(b)(1), is this "competent and diligent representation"?

-A lawyer should not take a case whose outcome could directly affect his personal finances, i.e. representing union employees in a CB negotiation with a company in which she holds stock

- Friendships w/o vested financial or legal interest probably don't rise to the level of a conflict of interest
- Lawyers are expressly prohibited by ABA from preparing wills for which they are beneficiaries; could be a problem if lawyer handles financial matters and provides companionship to elderly client who has no known relatives.
- What if a lawyer's business is struggling and settling would help the lawyer but not help the client? Or vice versa?
- Lawyer receiving a flat fee may have incentive to quickly dispose of the case
- Attorney billing hours might be tempted to drag the case on
- In criminal cases a lawyer can have a flat pre-trial fee and a secondary trial fee, thus eliminating the conflict that would tempt encouraging a questionable guilty plea; could have a very low initial fee to simply research probability of a valid defense;
- Courts will sometimes pay a lawyer to continue representing if client becomes indigent over the course of being represented
- Requirement of a written fee arrangement may eliminate some conflicts but not all of them;
- Evans v. Jeff D.*, 475 U.S. 717 (1986): a lawyer "should evaluate a settlement offer on the basis of his client's interests without considering his own interest in obtaining a fee."
- Debate over whether contingency fees should be allowed in criminal cases (the point I made in class about wealthy inmates having to pay their imprisonment costs who could pay on contingency if they are found not guilty and don't have to pay the costs)
- When can an attorney drop a client b/c they're a sleaze ball, while not telling the judge exactly why they're dropping the client (atty-client privilege) and also not having the client's consent to withdraw? It's tough to get a judge's consent to allow withdrawal; sometimes judges deny withdrawal if it's too close to the trial; a lawyer should not have to request an ex parte hearing to ask for withdrawal-it's a breach of atty-client privilege
- A client is entitled to the case file if they have paid the fees and their lawyer withdraws, but what if the client has not paid the fees? To what extent should a lawyer's work product be included in the definition of file? Many states have held that a client not paying fees is still entitled to the file, even if the fee agreement has a "retaining lien" provision; these liens are considered void/against public policy in Cali (go figure); Are lawyers obligated to turn over their own work as part of the file? More jurisdictions are including this work product as part of the file;
- What relationships are too close? Spouses on opposite sides of a case are disqualified, rule 1.8 allows for consent; other personal relationships often require disclosure/consent; what about changing nature of relationships (gay, lesbian, unmarried cohabitants, etc)
- Sex w/ clients; 25 states expressly prohibit sex w/ clients; this is a new development; sex w/ client may be a per se ethical violation but not necessarily legal malpractice; must prove that sexual conduct constituted a breach of fiduciary duty;
- Personal and political agendas can become a conflict under 1.7(b) if they "materially limit" the representation

Moore v. Regents of the University of California, 793 P.2d 479 (Cal. 1990) (redacted)

Π was leukemia patient; doctor used Π's cells w/o consent for research interest, obtained patent Court (majority) held that allowing Π's conversion claim would hinder research; Π would prefer conversion claim b/c property interest would allow collection of research \$\$

Π's burden of proof for a claim of breach of fiduciary based on lack of informed consent:

(1) Nondisclosure; (2) No reasonable person in Π's position would have consented
Research Interest/Economic Interest: these may override the doctor's duty of loyalty to their patient.

Opinion 8.03: **Under no circumstances may physicians place their own financial interests above the welfare of their patients.** The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. For a physician to unnecessarily hospitalize a patient, prescribe a drug, or conduct diagnostic tests for the physician's financial benefit is unethical. **If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit.** (II) Issued July 1986; Updated June 1994.

-What about an HIV positive doctor? What doctor's interests are protected by non-disclosure

October 10 - The Professional Relationship

This week's discussion of the formation and termination of professional relationships will also give us an opportunity to review some of the concepts introduced in previous classes. For example, when does the duty of confidentiality arise? What obligations persist after termination of the relationship?

Zitrin & Langford, pp. 77 – 79

-Ethical traps of getting a client; if approached at a social gathering, should try not to give any advice to someone to give them the impression they're already your client

-Issue of when representation actually begins; most authorities agree that neither retainer nor formal agreement is necessary to establish attorney-client relationship; relationship can be inferred by conduct of lawyer including casually rendered advice; 3-part test in *Kurtenbach*: (1) Did client seek advice from lawyer; (2) Was it within lawyer's area of competence; (3) Did lawyer either directly or implicitly agree to give requested advice; reasonable expectations and reliance of putative client are important factors; many states look to the reasonable belief of the putative client.

Model Rule 1.16 –Declining or Terminating Representation (2001)

(a) Lawyer **must** decline to represent or withdraw if:

- (1) Representation will result in violation of rules of professional conduct/other law;
- (2) Lawyer is mentally/physically impaired
- (3) Lawyer is discharged

(b) Lawyer **may** withdraw if withdrawal will not be materially adverse or if:

- (1) client persists in a course of action involving lawyer's services that lawyer reasonably believes is criminal or fraudulent
- (2) client has used lawyer's services to perpetrate crime/fraud
- (3) client has objective that the lawyer considers repugnant/imprudent
- (4) client has not fulfilled obligation to lawyer re: services and has been given reasonable warning
- (5) unreasonable financial burden to continue representation
- (6) other good cause

(c) Lawyer should continue to represent when ordered by a tribunal notwithstanding good cause

(d) Upon termination, lawyer should reasonably protect client's interests; allow time for employment of other counsel; surrender papers to which client is entitled; refund payments that have not yet been earned; lawyer may retain papers to the extent permitted by law

Model Rule 1.18-Duty to Prospective Client (2002 only)

(a) Discussing potential relationship = prospective client

(b) Duty of confidentiality even when no relationship ensues

(c) Lawyer subject to (b) shall not represent a client with interests materially adverse to those of a prospective client in the same or substantially related matter; if a lawyer is disqualified in (c), no lawyer at that lawyer's firm may knowingly undertake/continue representation in such matter except as provided in (d)

(d) Lawyer receiving disqualifying info may still represent if:

(1) affected/prospective client have given informed consent in writing; and

(2) lawyer who received the info took reasonable measures to avoid exposure to more disqualifying info than was reasonably necessary to determine whether to represent; and

(i) disqualified lawyer is timely screened from any participation in the matter and apportioned out of any fee therefrom; and

(ii) written notice is promptly given to the prospective client

Togstad v. Vesely, Oppo, Miller & Keefe, 291 N.W.2d 686 (Minn. 1980)

Attorney advised client at intake meeting that she and her husband did not have a case for medical malpractice against hospital; Plaintiff's expert witness testified that when an attorney is consulted as to whether he will take a case, the lawyer's only responsibility in refusing it is to so inform the party. He testified, however, that when a lawyer is asked his legal opinion on the merits of a medical malpractice claim, community standards require that the attorney check hospital records and consult with an expert before rendering his opinion.

Respondent clients were successful in their action for legal malpractice against appellants, attorney and law firm, as a jury found that appellant attorney was negligent, and as a result, respondents suffered damages. Appellants sought review of the trial court's denial of their motions for judgment notwithstanding the verdict, or alternatively, for a new trial. The court affirmed the trial court's denial of appellants' motions, holding that there was sufficient evidence in the record that established that an attorney-client relationship existed, that appellant attorney acted negligently or in breach of contract, that such acts were the proximate cause of respondents' damages, and that but for appellant attorney's conduct respondents would have been successful in the prosecution of their medical malpractice claim. Appellants were not entitled to a reduction of that award for a hypothetical contingency fee.

To show legal malpractice: (1) attorney client relationship; (2) Δ negligent/breached contract; (3) proximate causation; (4) but for attorney's conduct, client would have been successful

Issue of whether the meeting was an initial consultation; possibility that the meeting was not considered legal advice by the lawyer but it was considered by the client

In the event of a mutual mistake, who should be responsible, attorney or client?

Attorney should warn client when/if legal advice is not being given; law firm websites do that;

- (1) Should have informed about statute of limitations
- (2) Should have met standard of examining medical records (Rule 1.1)
- (3) Should have consulted expert witness

Lownsbury v. VanBuren, 94 Ohio St. 3d 231 (2002): On appeal, the parents contended that they presented sufficient evidence to raise a genuine issue of material fact as to the existence of a consensual relationship between the doctor and the wife as she was delivering her daughter. Specifically, the parents argued that a physician-patient relationship could be established between a supervisory physician at a teaching hospital and a hospital patient without evidence that the physician was either in direct contact with the patient, consulted by the treating residents, or otherwise actively involved in the patient's care. The appellate court found that the determinative issue was not whether the doctor had any contact with the wife or the residents treating her, but whether and to what extent he assumed the obligation to supervise the residents at the city hospital. A review of the record showed that the consent form constituted substantial evidence that the doctor was required to take an active role in supervising the hospital's residents and caring for the hospital's patients. As such, a genuine issue of fact existed as to whether the doctor owed a duty to the wife.

Physician-patient relationship can be formed through a contract signed btw physician and hospital, even if doctor has never met a particular patient

Patient's expectations; residents at teaching hospital can invoke physician's liability

Opinion 10.05: 1) Physicians must keep their professional obligations to provide care to patients in accord with their prerogative to choose whether to enter into a patient-physician relationship.

(2) The following instances identify the limits on physicians' prerogative:

(a) Physicians should **respond to the best of their ability in cases of medical emergency** (Opinion 8.11, "Neglect of Patient").

(b) Physicians **cannot refuse to care for patients based on race, gender, sexual orientation, or any other criteria that would constitute invidious discrimination** (Opinion 9.12, "Patient-Physician Relationship: Respect for Law and Human Rights"), nor can they discriminate against patients with infectious diseases (Opinion 2.23, "HIV Testing").

(c) Physicians **may not refuse to care for patients when operating under a contractual arrangement that requires them to treat** (Opinion 9.12, "Patient-Physician Relationship: Respect for Law and Human Rights"). **Exceptions to this requirement may exist when patient care is ultimately compromised** by the contractual arrangement.

(3) In situations not covered above, it **may be ethically permissible** for physicians to decline a potential patient when:

(a) The treatment request is **beyond the physician's current competence** (Opinion 9.12, "Patient-Physician Relationship: Respect for Law and Human Rights").

(b) The **treatment request is known to be scientifically invalid, has no medical indication, and offers no possible benefit to the patient** (Opinion 8.20, "Invalid Medical Treatment").

(c) A specific treatment sought by an individual is **incompatible with the physician's personal, religious, or moral beliefs**.

(4) Physicians, as professionals and members of society, should work to assure access to adequate health care (Fundamental Element VI).* **Accordingly, physicians have an obligation to share in providing charity care** (Opinion 9.065, "Caring for the Poor") **but not to the degree that would seriously compromise the care provided to existing patients**. When deciding whether to take on a new patient, **physicians should consider the individual's need for medical service along with the needs of their current patients**. Treatments range along a continuum from necessary to sustain life, to necessary to sustain functioning health, to useful to sustain functioning health, to discretionary. **Clearly, greater individual need for a service corresponds with a stronger obligation to treat.** (I, VI, VIII, IX) Issued December 2000 based on the report "Potential Patients, Ethical Considerations," adopted June 2000. *Considerations in determining an adequate level of health care are outlined in Opinion 2.095: "The Provision of Adequate Health Care."

	Relationship w/ Prospective Clients	Formation of Relationship	Termination of Relationship
Medical	1. Free to choose who to serve except in emergencies 2. Cannot discriminate based on race, gender, infectious disease (or other invidious discrimination) 3. Contractual obligations must be honored 4. May decline if patient's disease is beyond doc's competence; or 4a. Incompatible w/ doc's beliefs; or 4b. not indicated; or 4c. no scientific support	1. Free to choose who to serve except in emergencies 2. Patient expectations	Give treatment that is medically indicated <u>or</u> reasonable assistance to obtain alternate care: 1. Mutual consent 2. Dismissal by patient 3. Withdrawal by physician after reasonable notice 4. Cessation of the need Physician still has fiduciary duty to treat patient even if patient misses an appointment
Legal	Cannot represent client if: 1. It would result in a violation of model rules. 2. lawyer's mental/physical condition such that they cannot be competent to represent 3. Discharge has occurred Rule 1.18: Duties to prospective clients Rule 6.5: Limited Legal Services Programs	Giving of advice can cause formation in eyes of prospective client (and all fiduciary duties)	Lawyer may withdraw if: 1. No material/adverse effect on client 2. Client persisting in crime or fraud 3. Client used lawyer's svcs in crime/fraud 4. Client insisted upon action repugnant to lawyer 5. Client doesn't pay 6. Representation will result in \$ burden to lawyer 7. Other good cause

October 24 - The Supervisor-Subordinate Relationship

Associates in a law firm and residents in a hospital are licensed professionals with independent ethical obligations to their clients or patients. At the same time, associates and residents are subject to the supervisory authority of law firm partners and teaching physicians. We will discuss the ethical concerns that can arise in the supervisor-subordinate relationship.

Zitrin & Langford, pp. 637-646, 654-663

- Associate following orders from partners against their own beliefs/well-founded opinions
- Kelly* case: discharge of associate for blowing whistle on fraudulent billing of a partner; expresses concerns to associate/partner; gets the cold shoulder/blackballed at firm; reports fraud to authorities; given choice to get the fuck out now or announce resignation and get a favorable reference; sues for breach of K on grounds that firm cannot discharge an associate for insisting a firm report to disciplinary authorities the professional misconduct of one of its lawyers; the firm loses when it rallies behind one of its popular partners before determining whether loyalty was warranted;
- Issue of partners coyly managing projects in a CYA manner to put the blame on associates; firm may be reluctant to support associates in these situations b/c of the firm's reputation being at stake
- Difficult to just say no when asked to write an opinion letter of questionable propriety
 - Duty to report unethical conduct; some courts hold there is an absolute duty; others allow a shield given the blackball treatment afforded whistleblowers
- The bigger the firm, the greater the harm that can be inflicted on clients, 3rd parties & the legal process; potential system of law firm discipline; could be a good way of developing favorable ethical track records over time; difficulty of firm-wide discipline; model rules are more tied to individual discipline-tough to break this pattern;
- Firms with strong mentoring programs are increasingly rare; firms don't give enough feedback (only 30 min/yr); more pressure to bill, less insight about quality of work;
- "Greedy Associates"-grievance forum; disillusionment with long hours, boredom with content of work, etc.

Model Rule 5.1: Responsibilities of a Partner or Supervisory Lawyer (2001)

- (a) A partner in a law firm shall make reasonable efforts to ensure that the firm has in effect measures giving reasonable assurance that all lawyers in the firm conform to the rules of professional conduct.**
- (b) A lawyer having direct supervisory authority over another lawyer shall make reasonable efforts to ensure that the other lawyer conforms to the rules of professional conduct.**
- (c) A lawyer shall be responsible for another lawyer's violation of the rules of professional conduct if:**
 - (1) the lawyer orders or, with knowledge of the specific conduct, ratifies the conduct involved; or**
 - (2) the lawyer is a partner in the law firm in which the other lawyer practices, or has direct supervisory authority over the lawyer, and knows of the conduct at a time when its consequences can be avoided or mitigated but fails to take reasonable remedial action.**

Model Rule 5.2: Responsibilities of a Subordinate Lawyer (same in '01/ '02)

(a) A lawyer is bound by the rules of professional conduct notwithstanding that the lawyer acted at the direction of another person.

(b) A subordinate lawyer does not violate the rules of professional conduct if that lawyer acts in accordance with a supervisory lawyer's reasonable resolution of an arguable question of professional duty.

Opinion 9.055: Clear policies for handling complaints from medical students, resident physicians, and other staff should be established. **These policies should include adequate provisions for protecting the confidentiality of complainants whenever possible.**

Confidentiality of complainants should be protected when doing so does not hinder the subject's ability to respond to the complaint. **Access to employment and evaluation files should be carefully monitored to remove the possibility of tampering. Resident physicians should be permitted access to their employment files and also the right to copy the contents thereof, within the provisions of applicable federal and state laws.**

Medical students, resident physicians, and other staff should refuse to participate in patient care ordered by their supervisors in those rare cases in which they believe the orders reflect serious errors in clinical or ethical judgment, or physician impairment, that could result in a threat of imminent harm to the patient or to others. In these rare cases, the complainant may withdraw from the care ordered by the supervisor, provided withdrawal does not itself threaten the patient's immediate welfare. **The complainant should communicate his or her concerns to the physician issuing the orders and, if necessary, to the appropriate persons for mediating such disputes.** Mechanisms for resolving these disputes, which require immediate resolution, should be in place. Third-party mediators of such disputes may include the chief of staff of the involved service, the chief resident, a designated member of the institutional grievance committee, or, in large institutions, an institutional ombudsperson largely outside of the established hospital staff hierarchy.

Retaliatory or punitive actions against those who raise complaints are unethical and are a legitimate cause for filing a grievance with the appropriate institutional committee. (II, III, VII) Issued June 1994 based on the report "Disputes Between Medical Supervisors and Trainees," adopted December 1993 (JAMA. 1994; 272: 1861-65).

Talk of the Nation, June 18, 2002 program, National Public Radio: Harmfulness of 120-hr workweeks/36-hr shifts for med residents; certain indignities of learning any craft; good to reduce weekly hours of med. residents; patient care different b/c of expectation to be available 24/7 to care for patients; high cost to cutting back residents' hours and replacing them with higher-paid assistants; military boot camp is a paying of dues-ranking officers like to impose the same hardships they felt on new recruits; first year of law school is paying dues; hours at a firm not like a resident but still pretty bad, also the high salary makes people less sympathetic about the stress; pranking the newbie more likely to occur at an employer where hours aren't billed; new pilots also pay their dues w/ low salaries

Clinical Ethics in Chicago, case commentary, AMA website: Does a med student viewing a film who makes an observation about patient in film have a duty to inform the physician/patient?

Student told by doc not to tell patient, but was uncomfortable not informing; little harm in telling patient he may have cancer compared w/ great harm in not telling patient; author believes there is a duty to warn; withholding info could delay potentially beneficial treatment until somebody else finds out; author suggests student contact attending in writing (non-confrontational); if this is not well-received then make an ethical consultation;

October 31 - No Class

November 7 - Lawyer Advertising & Solicitation

The marketing activities of physicians and lawyers have traditionally been subject to much greater restriction than those of other businesses. We will study the restrictions on the advertising and solicitation activities of professionals and consider the assumptions implicit in those restrictions.

Zitrin & Langford, pp. 743 - 761

Model Rules 7.1, 7.2, 7.3

November 14 - Physician Advertising

Snell v. Dept of Professional Regulation, 742 N.E.2d 1282 (Ill. App. 2001)

Bailey v. Morales, 190 F.3d 320 (5th Cir 1999)

Opinion 5.02: There are **no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices.** A physician may publicize him or herself as a physician through **any commercial publicity or other form of public communication** (including any newspaper, magazine, telephone directory, radio, television, direct mail, or other advertising) provided that **the communication shall not be misleading because of the omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive.**

Because the public can sometimes be deceived by the use of medical terms or illustrations that are difficult to understand, **physicians should design the form of communication to communicate the information contained therein to the public in a readily comprehensible manner. Aggressive, high-pressure advertising and publicity should be avoided if they create unjustified medical expectations or are accompanied by deceptive claims.** The key issue, however, is whether advertising or publicity, regardless of format or content, is **true and not materially misleading.**

The communication may include: (1) the **educational background** of the physician; (2) the basis on which **fees** are determined (including charges for specific services); (3) **available credit** or other methods of payment; and (4) any **other nondeceptive information.**

Nothing in this opinion is intended to discourage or to limit advertising and **representations which are not false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act.** At the same time, however, physicians are advised that certain types of

communications have a significant potential for deception and should therefore receive special attention. For example, **testimonials of patients** as to the physician's skill or the quality of the physician's professional services **tend to be deceptive when they do not reflect the results that patients with conditions comparable to the testiniant's condition generally receive.**

Objective **claims regarding experience, competence, and the quality of physicians** and the services they provide **may be made only if they are factually supportable. Similarly, generalized statements of satisfaction with a physician's services may be made if they are representative of the experiences of that physician's patients.**

Because physicians have an ethical obligation to share medical advances, **it is unlikely that a physician will have a truly exclusive or unique skill or remedy. Claims that imply such a skill or remedy therefore can be deceptive. Statements that a physician has an exclusive or unique skill or remedy in a particular geographic area, if true, however, are permissible.** Similarly, a **statement that a physician has cured or successfully treated a large number of cases** involving a particular serious ailment **is deceptive if it implies a certainty of result** and creates unjustified and misleading expectations in prospective patients.

Consistent with federal regulatory standards which apply to commercial advertising, a physician who is considering the placement of an advertisement or publicity release, whether in print, radio, or television, should determine in advance that the communication or message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser, and those which a reasonable, prudent advertiser should have discovered. Inclusion of the physician's name in advertising may help to assure that these guidelines are being met. (II) Issued prior to April 1977; Updated June 1996.

November 21 - Access to Legal and Medical Services

Who should pay for litigation? Who should pay for medical care? We will discuss fee-shifting statutes, employer-employee cost sharing and the role of the insurance industry. We will ask whether the professional has, or should have, an ethical obligation to provide pro bono services.

Zervos v. Verizon New York, 2001 WL 253377 (S.D.N.Y. March 14, 2001): Can't show that high-dose chemotherapy is better or that it provides a tangible benefit superior to treatment offered by insurance carrier; held that outside review procedure for determining coverage is not arbitrary & capricious, since carrier made a reasonable determination to no longer provide coverage; further review was also done by 2 outside reviewers who had no financial stake.

Smith v. Newport News, 148 F.Supp.2d 637 (E.D. Va. 2001): Plaintiff insured filed an action under the Employee Retirement Income Security Act (ERISA), [29 U.S.C.S. §§ 1132, 1133](#), alleging defendant health plan did not provide her adequate notice of the basis for its denial of her claim and a reasonable opportunity for review of the denial. She also sought a declaratory judgment that High Dose Chemotherapy (HDCT) treatment was covered. She filed a motion for preliminary injunction for an expedited trial.

Insured had Stage II breast cancer. Her doctor stated absent aggressive therapy, it would likely metastasize, at which point it would be virtually incurable, and that HDCT should begin immediately for an effective window of opportunity. The court found plan substantially complied with ERISA's requirements of notice of the basis for denial and the opportunity to appeal. She was sufficiently made aware of the issues to make a full presentation during administrative appeal. The plan delegated authority to interpret the terms of the plan as to questions of eligibility; plan administrator's interpretation would likely be evaluated under an abuse of discretion standard. But, there was a question whether it abused its discretion in interpreting the plan to deny coverage. Substantial evidence showed HDCT was a widely accepted treatment for patients in her condition, was not experimental, or investigative. The plan did not reserve coverage for only the most effective treatment available. Administrator did not interpret "essential" under the plan. It was not a frivolous or elective procedure, it was a chance to overcome an otherwise terminal disease and was safe. Plan agreed to no bond. Plaintiff's motion for a preliminary injunction was granted. No bond was ordered.

ERISA has arbitrary/capricious standard; public/personal interest in finding the best cancer treatment; to establish definition of medical necessity at a general level interrupts doc/patient relationship.

How should doctors use discretion in articulating a diagnosis to ensure a patient gets treatment? If a physician orders a treatment that is unusual they may be less pushy with insurance companies to protect their reputation.

Opinions 9.065: Each physician has an **obligation to share in providing care to the indigent**. The measure of what constitutes an **appropriate contribution may vary with circumstances** such as community characteristics, geographic location, the nature of the physician's practice and specialty, and other conditions. **All physicians should work to ensure that the needs of the poor in their communities are met**. Caring for the poor **should be a regular part of the physician's practice schedule**.

In the **poorest communities**, it may not be possible to meet the needs of the indigent for physicians' services by relying solely on local physicians. **The local physicians should be able to turn for assistance to their colleagues in prosperous communities, particularly those in close proximity**.

Physicians are meeting their obligation, and are encouraged to continue to do so, in a number of ways such as **seeing indigent patients in their offices at no cost or at reduced cost, serving at freestanding or hospital clinics that treat the poor, and participating in government programs that provide health care to the poor**. Physicians can also volunteer their services at **weekend clinics for the poor and at shelters for battered women or the homeless**.

In addition to meeting their obligation to care for the indigent, physicians can devote their energy, knowledge, and prestige to designing and lobbying at all levels for better programs to provide care for the poor. (I, VII) Issued June 1994 based on the report "Caring for the Poor," adopted December 1992 (JAMA. 1993; 269: 2533-2537).

Opinion 2.03: A physician has a **duty to do all that he or she can for the benefit of the individual patient**. Policies for allocating limited resources have the potential to limit the ability of physicians to fulfill this obligation to patients. Physicians have a **responsibility to participate and to contribute their professional expertise in order to safeguard the interests of patients in decisions made at the societal level regarding the allocation or rationing of health resources**. Decisions regarding the allocation of limited medical resources among patients **should consider only ethically appropriate criteria relating to medical need**. These criteria include **likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment**. In general, **only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes**. In making quality of life judgments, **patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients**. **Non-medical criteria**, such as ability to pay, age, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources **should not be considered**.

Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. **When very substantial differences do not exist** among potential recipients of treatment on the basis of the appropriate criteria defined above, **a “first-come-first-served” approach or some other equal opportunity mechanism should be employed to make final allocation decisions**. Though there are several ethically acceptable strategies for implementing these criteria, **no single strategy is ethically mandated**. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula. Decision-making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally.

The treating physician must remain a patient advocate and therefore should not make allocation decisions. Patients denied access to resources have the right to be informed of the reasoning behind the decision. The **allocation procedures** of institutions controlling scarce resources should be disclosed to the public as well as **subject to regular peer review** from the medical profession. (I,VII) Issued March 1981; Updated June 1994 based on the report "Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients," adopted June 1993 (Archive of Internal Medicine 1995; 155: 29-40).

Opinion 6.05: A physician **should not charge or collect an illegal or excessive fee**. For **example**, an illegal fee occurs when a physician **accepts an assignment as full payment for services rendered to a Medicare patient and then bills the patient for an additional amount**. A fee is **excessive when after a review of the facts a person knowledgeable as to current charges made by physicians would be left with a definite and firm conviction that the fee is in excess of a reasonable fee**. Factors to be considered as guides in determining the reasonableness of a fee include the following:

(1) the **difficulty and/or uniqueness** of the services performed and the time, skill, and experience required;

- (2) the **fee customarily charged in the locality** for similar physician services;
- (3) the **amount of the charges involved**;
- (4) the **quality** of performance;
- (5) the **experience, reputation, and ability** of the physician in performing the kind of services involved. (II) Issued prior to April 1977; Updated June 1994

City of Burlington v. Dague, 505 U.S. 557 (1992): The court considered whether a court, in determining an award of attorney's fees under the Solid Waste Disposal Act, [42 U.S.C.S. § 6972\(e\)](#), or the Federal Water Pollution Control Act, [33 U.S.C.S. § 1365\(d\)](#), could enhance the fee award above the "lodestar" amount in order to reflect the fact that a party's attorneys were retained on a contingent fee basis. The court noted that an enhancement for contingency would likely duplicate in substantial part factors already subsumed in the lodestar. The court found a number of reasons for concluding that no contingency enhancement was compatible with the fee-shifting statutes at issue. To award a contingency enhancement under a fee-shifting statute would, in effect, pay for the attorney's time in cases where his client did not prevail. The court noted that it had generally turned away from the contingent fee model in favor of the lodestar model. The court concluded that contingency enhancement would make the setting of fees more complex and arbitrary, hence more unpredictable and more litigable, and reversed the judgment affirming enhancement of the lodestar amount in awarding fees to respondent's attorneys. Judgment enhancing lodestar amount of attorney fees was reversed insofar as it affirmed a 25 percent enhancement of the lodestar amount for respondent's attorneys. Contingency enhancement was not consistent with the general rejection of the contingent fee model for fee awards, nor was it necessary to the determination of a reasonable fee. Enhancement for contingency was not permitted under the fee-shifting statutes at issue.

Model Rule 6.1: Pro Bono Service (2001)

A lawyer should aspire to render at least 50 hrs/yr of pro bono service and

(a) provide the service to:

- (1) persons of limited means**
- (2) charitable organizations designed primarily to address the needs of persons of limited means**

(b) provide additional services by:

- (1) delivering legal services at little or no fee to organizations where the payment of standard legal fees would significantly deplete resources/be inappropriate.**
- (2) Deliver legal services at substantially reduced fee to persons of limited means**
- (3) Participate in activities to improve law/legal profession**

Lawyer should voluntarily contribute \$ to orgs. that provide legal svcs to persons of limited means

Model Rule 1.5

November 26 -- The Doctor as Witness & the Ethical Code Governing the Working Relationship between Physicians and Lawyers

We will discuss the ethical obligations of the physician when he or she becomes a participant in the adversarial legal system. What are the physician's ethical obligations when he or she is serving as a fact witness in litigation? Are they any different if the physician is participating as an expert witness?

Brandt v. Medical Defense Associates, 856 S.W.2d 667 (Mo 1993): Appellant physician challenged a judgment of the lower court that dismissed his civil conspiracy and breach of fiduciary duty claims against respondent, insurer and physicians. Appellant's claims were based upon the disclosure of information during appellant's prior medical malpractice case. The court held that appellant waived the medical privilege when the medical issues were joined in the underlying medical malpractice case. The court affirmed the judgment of the lower court because it found that the ex parte contacts between respondent physicians and attorneys associated with the medical malpractice case did not result in a breach of fiduciary duty as the testimonial privilege and fiduciary duty of confidentiality had been waived. The court determined that appellant had made no claim that respondent physicians had exceeded the scope of the waivers and that the lower court had properly dismissed appellant's petition.

It's causes of action: (1) breach of fiduciary duty; (2) invasion of privacy; (3) civil conspiracy
Once a patient files a lawsuit and puts a medical condition at issue, the confidentiality privilege is waived; court held **a patient cannot use confidentiality as a shield**; doctors are difficult witnesses, have competing concerns of truth/loyalty; When should a doctor act as an advocate? Docs not normally advocates, but can be in limited settings; Is truth a higher goal than patient receiving their desired treatment?

Spaulding v. Zimmerman, 116 N.W.2d 704 (Minn. 1962): Plaintiff father on behalf of his minor son filed an action against defendant drivers for injuries sustained in a car accident. After the parties settled, the minor filed a motion to vacate the settlement. The District Court of Douglas County (Minnesota) vacated and set aside its prior order approving the settlement and releases executed by the minor and his parents under Minn. R. Civ. P. 60.02. The drivers appealed. The minor's injuries were diagnosed as a severe crushing chest injury, a cerebral concussion, and bilateral fractures of the clavicles. The defense's expert, who also examined the minor, reported that the minor had an aorta aneurysm, which may have been caused by the accident. At settlement negotiations, the minor's parents were not aware of the report received by the defense. The parties settled and the trial court approved the settlement. The drivers argued that the trial court was without jurisdiction to vacate the settlement because no mutual mistake of fact was involved, because there was no duty to disclose, because insurance limitations formed the basis for the settlement, and because the motion to vacate the order for settlement and to set aside the releases was barred by rule 60.02. The court found that the fact that the settlement did not contemplate the aorta aneurysm gave the trial court reason to exercise its discretion in vacating the settlement under rule 60.02. The court further found that there was no evidence that the defense had disclosed either to plaintiff's counsel or the trial court that insurance limitations were involved in the settlement.

Affirmed.

Opinions 10.03: When a physician is **responsible for performing an isolated assessment** of an individual's health or disability for an employer, business, or insurer, **a limited patient-physician relationship should be considered to exist**. Both "Industry Employed Physicians"

(IEPs), who are employed by businesses or insurance companies for the purpose of conducting medical examinations, and "Independent Medical Examiners" (IMEs), who are independent contractors providing medical examinations within the realm of their specialty, may perform such medical examinations.

Despite their ties to a third party, the responsibilities of IEPs and IMEs are in some basic respects very similar to those of other physicians. IEPs and IMEs have the same obligations as physicians in other contexts to:

(1) Evaluate objectively the patient's health or disability. In order to maintain objectivity, IEPs and IMEs should not be influenced by the preferences of the patient-employee, employer, or insurance company when making a diagnosis during a work-related or independent medical examination.

(2) Maintain patient confidentiality as outlined by Opinion 5.09, Industry Employed Physicians and Independent Medical Examiners.

(3) Disclose fully potential or perceived conflicts of interest. The physician should inform the patient about the terms of the agreement between himself or herself and the third party as well as the fact that he or she is acting as an agent of that entity. This should be done at the outset of the examination, before health information is gathered from the patient-employee. Before the physician proceeds with the exam, he or she **should ensure** to the extent possible that the **patient understands the physician's unaltered ethical obligations, as well as the differences that exist between the physician's role in this context and the physician's traditional fiduciary role.**

IEPs and IMEs are responsible for administering an objective medical evaluation but not for monitoring patients' health over time, treating patients, or fulfilling many other duties traditionally held by physicians. Consequently, **a limited patient-physician relationship should be considered to exist** during isolated assessments of an individual's health or disability for an employer, business, or insurer.

The **physician has a responsibility to inform the patient about important health information or abnormalities that he or she discovers during the course of the examination.**

In addition, the physician should ensure to the extent possible that the patient understands the problem or diagnosis. Furthermore, when appropriate, the physician should suggest that the patient seek care from a qualified physician and, if requested, provide reasonable assistance in securing follow-up care. (I) Issued December 1999 based on the report "Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations," adopted June 1999.

Opinion 9.07: As a citizen and as a professional with special training and experience, the **physician has an ethical obligation to assist in the administration of justice.** If a patient who has a legal claim requests a physician's assistance, the **physician should furnish medical evidence, with the patient's consent, in order to secure the patient's legal rights.**

Medical experts should have recent and substantive experience in the area in which they testify and should limit testimony to their sphere of medical expertise. Medical witnesses should be adequately prepared and should testify honestly and truthfully to the best of their medical knowledge.

The medical witness must not become an advocate or a partisan in the legal proceeding. The medical witness should be adequately prepared and should testify honestly and truthfully. The attorney for the party who calls the physician as a witness should be informed of all favorable and unfavorable information developed by the physician's evaluation of the case. It is unethical for a physician to accept compensation that is contingent upon the outcome of litigation. (II, IV, V, VII) Issued June 1986; Updated June 1996 based on the report "Ethical Guidelines for Medical Experts," adopted December 1995.

Opinion 2.065: Physicians can ethically participate in court-initiated medical treatments only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. In accordance with ethical practice, physicians should treat patients based on sound medical diagnoses, not court-defined behaviors. This is particularly important where the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment. In these cases, diagnosis can be made initially by the physician who will do the treatment, but must then be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations. A recognized, authoritative medical body, such as a national specialty society, should pre-establish scientifically valid treatments for medically determined diagnoses. Such pre-established acceptable treatments should then be applied on a case-by-case basis. The physician who will perform the treatment must be able to conclude, in good conscience and to the best of his or her professional judgment, that the informed consent was given voluntarily to the extent possible, recognizing the element of coercion that is inevitably present. In cases involving in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that the informed consent was given in accordance with these guidelines. (I, III) Issued December 1998 based on the report "Court-Initiated Medical Treatment in Criminal Cases," adopted June 1998.

Interprofessional Code for Physicians and Attorneys