

Improving Relations Between Attorneys and Physicians

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DURING THE PAST 30 YEARS, THERE HAVE BEEN 3 SEPARATE medical liability crises. In the first 2 crises, which occurred in the 1970s and the 1980s, either physicians experienced increasingly unaffordable insurance premiums or many specialists were unable to purchase insurance at any price. The current crisis has elements of both, especially for high-risk specialties. Cumulatively, the recurrent crises have exposed the rawness of physician antipathy toward attorneys and the legal system. That antipathy appears to be deeper and more pervasive than ever before,¹ making it hard to imagine that relations between attorneys and physicians can get much worse.

For example, according to an Associated Press report, a South Carolina surgeon ceased treating a patient when he found out her husband was a trial lawyer. In New Hampshire, a neurosurgeon told the head of the state's trial lawyers that he would not treat him for nonemergencies. A plastic surgeon in Mississippi refused to treat the daughter of a state lawmaker because of the father's stand on malpractice suits.²

Several physicians had gone so far as to post names of plaintiffs, their attorneys, and expert witnesses on a Web site (since removed) designed to identify patients who initiated medical liability litigation.³ The American Medical Association debated a resolution that would ethically permit physicians to refuse treatment for attorneys involved in medical malpractice cases.⁴ Although the motion was soundly defeated, it reveals the extent of some physicians' pent-up frustrations and depth of anger toward attorneys and the liability system. A *New Yorker* cartoon titled "Hippocrates off the Record" captures the animosity, with the caption reading, "First, treat no lawyers."⁵

These developments raise the specter of a profound breach between attorneys and physicians. Therefore, it is important to consider ways to repair the relationship. Arguably, much of the antipathy stems from entrenched mistrust over medical liability rather than fundamental and irredeemable differences. The mutual distrust is not over differences in core values but over different approaches for resolving the inevitable conflicts that arise. As elemental as the liability debate may be, it is only one aspect of a widening set of interactions between law and medicine. To avoid

any further ruptures, a renewed physician-attorney dialogue that emphasizes shared values and concerns for patient safety is desirable.

Mutual Antagonism and Shared Values

Most commentary focuses on what divides the 2 professions. Observers note that the 2 professions have different world views⁶ and that the difference between medicine's concern for preserving health and the law's focus on individual autonomy and responsibility in clinical settings can generate deep misunderstandings in the adversarial context of litigation.⁷ But these assessments are incomplete. They overlook a shared set of core social and ethical values, interests, and experiences that help define physicians and attorneys as professionals.⁸ The 2 professions share respect for the individual and a commitment to reason, professional judgment, and experience as the basis for decision making.⁹

The tension between attorneys and physicians does not occur in a vacuum. It is the product of the historical relationship between the 2 professions, along with physicians' general dissatisfaction with a seemingly unfriendly legal system. Just as important, it occurs within the broader context of what constitutes a profession and how individual physicians and attorneys understand and abide by their professional responsibilities. The contentiousness has been exacerbated in recent years with the decline of physician authority over health care delivery and the rise of managed care.

Mutual Antagonism. As Fox¹⁰ observes, the antagonism many physicians feel toward lawyers is the result of fundamental disagreement about 5 issues: the nature of authority, how conflict should be resolved, the relative importance of procedure and substance, the nature and significance of risk, and the legitimacy of politics as a method of solving problems.

Such disagreements reflect different approaches to decision making (eg, adversarial vs scientific methods) and physicians' unwillingness to relinquish clinical authority to non-

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medical parties, especially judges and juries sitting in retrospective judgment of clinical decisions.

A further difference is that the essential goal for physicians is to preserve patients' health; attorneys often focus on preserving their clients' self-determination.^{7,11} Take, for example, a homeless mentally ill person who does not want to be institutionalized. His or her physician might judge that it is in the patient's best medical interests to be institutionalized, but the person's lawyer tends to see the primary obligation as protecting the patient's liberty. Thus, a common vocabulary or understanding of each profession's rationale for resolving problems is often lacking, as are shared approaches to knowledge. Terms and concepts seemingly obvious to one group can have different meanings for the other, exacerbating the antagonism.

An additional factor in the professions' mutual distrust is that physicians project on attorneys their disappointment with courts and regulators and these actors' effects on medical practice. Physicians resent the subordination of outcomes to processes inherent in litigation. In turn, attorneys resent physicians' resistance to the legal system's mechanisms for making decisions. For physicians, it can be easier to blame legal disappointments on the system's agents and messengers—the attorneys—than to criticize legal rules and procedures.

Shared Values. Viewing physicians and attorneys as adversaries risks overlooking their shared values as professionals. First, professional autonomy is highly valued, yet under attack, in both fields. Much of the physician antipathy toward managed care is driven by attempts to restrict physician autonomy. Attorneys face analogous challenges to their professional independence from the increasing concentration of legal work in large, bureaucratic law firms and other institutional settings.¹²

Second, attorneys and physicians owe primary duties to the individual client and patient, respectively, as part of their canons of ethics. Central to their shared professional role is the concept of fiduciary duty; that is, they stand in relationships of trust to their patients or clients. Taking responsibility for the quality of advice to and care or representation of the patient or client is common to how physicians and attorneys function. The perceived integrity of law and medicine as professions rests on public confidence that practitioners place the patient's or client's interests above other considerations, including financial remuneration. These duties are elemental to the professions and are assumed with the taking of oaths on graduation from medical school or induction to the bar.

Third, physicians and attorneys have duties to society, as well as to the individual patient or client, creating the potential for role conflict. Neither profession operates apart from societal values and goals. Both professions have ethical aspirations and legal obligations to provide services to the community and to individuals who cannot afford to pay them.

Fourth, self-promulgated ethical codes and norms regulate the 2 professions. The codes enshrine the professions' similar moral aspirations and explain to the public what constitutes ethical medical or legal professional behavior. Each code binds the practitioner to a set of ethical strictures and embodies a sense of purpose, aspirations, and ideals.

Fifth, physicians and lawyers find themselves increasingly subservient to their respective institutional environments. Institutional constraints are a shared experience in shaping the options and perspectives of medical and legal practitioners. Professional sovereignty is being eroded by government regulation and by consumers with access to information previously available only to professionals. Both professions are struggling to preserve their domains, as well as lay belief in their unique expertise and judgment.

Moving Toward Accommodation

Does it matter if the differences between the 2 professions have been overstated and the similarities understated? Even if important shared values have been overlooked, those shared values are arguably of little practical significance. In contrast, the differences present the real impediments to cooperation. Just because the 2 professions share strong ethical codes and a concern for the individual they represent does not necessarily enable them to unite on questions of public policy or clinical duty. Nor do the shared values mitigate different perspectives on questions of medical liability. Shared values alone will not ameliorate the searing distrust arising from malpractice litigation or bring the 2 professions eagerly to the negotiating table. Even in a best-case scenario, there is unlikely to be congruence between the 2 professions about either patient care or health policy; differences along the dimensions noted above are likely to remain.

Nevertheless, focusing on shared values, interests, and experiences, as opposed to differences, provides both a rationale for reexamining the relationship and a fresh perspective for establishing a cooperative dialogue. The differences discussed above were more important in the fee-for-service era, and the similarities are more germane in the managed care environment. When health care operated under the fee-for-service system, physician interaction with attorneys was mostly confrontational over medical malpractice allegations. With the emergence of health care as a business and a regulated industry, physicians are increasingly reliant on attorneys to secure their business interests. In many of these situations, attorneys are allied with, rather than antagonistic toward, physicians.

For instance, in the increasingly prevalent arrangement of a joint venture between a nonprofit health system and a physicians' group, physicians and attorneys are not natural antagonists. Instead, in negotiating the arrangements, the emphasis is on reinforcing shared professional values for providing better health care in a competitive environment. The imperative of working closely together to achieve business

objectives tends to submerge differences and to underscore shared professional values.

Although each profession's self-interest might provide a more powerful motivation for cooperation than shared ethical values, such self-interest can yield socially beneficial cooperation. To help restore public trust in each profession, working together to improve quality and reduce medical error serves both professions' interests and the public's welfare.

From the patient's perspective, antagonism between the professions subordinates good medical care to other interests. If physicians are overly concerned about liability, they may take actions that jeopardize patient welfare, such as excessive testing or treatment.¹ Likewise, public policy may suffer if the professions are unable to develop a better system to detect lapses in quality. Most important, attorneys and physicians share a concern for patient safety that could form common ground for future collaboration.¹³ Indeed, it was not too long ago that attorneys and physicians cooperated effectively during the congressional debate over the enactment of a patients' bill of rights.¹⁴

Finally, medicine is increasingly importing concepts from law in adapting to cost constraints, especially the use of processes (such as structured dispute resolution) and clinical outcome measures. Examples include the use of clinical practice guidelines as "evidence" of best practices and the establishment of external grievance processes to resolve differences among patients, physicians, and health plans over clinical decision making.⁹ Physician demand for independent external review of coverage denials, modeled in part on legal due process standards, is likely to erode the medical profession's resistance to legal process, thinking, and values. Physicians may also welcome the due process model as protection against managed care's challenges to professional autonomy.

Next Steps

With numerous state and federal tort reform proposals either pending or already enacted, there is an opportunity to revisit issues of mutual concern in a much less contentious environment. How might the professions pursue accommodation?

To begin with, major stakeholders, including professional and trade associations representing physicians, attorneys, hospitals, health plans, and insurers, could come together to consider some of the central problems facing law and medicine. For example, a crucial issue in US health policy is how to set limits on resource use in a manner that accommodates both individual patients' autonomy and society-wide conceptions of fairness. A collaborative effort to identify underlying questions, pursue agreement on basic principles, and bridge disciplinary and professional differences would be a useful beginning. The Institute of Medicine is a potential forum for this because of its stature and independence.¹⁵

In the near term, a key point of intersection between attorneys and physicians will be implementation of the recently enacted Patient Safety and Quality Improvement Act of 2005.¹ Through the establishment of patient safety organizations, the act creates a system for confidential reporting of adverse medical events. Working together, the 2 professions can apply their respective institutional knowledge to determine what information needs to be collected and protected without compromising accountability.^{16,17} Ensuring that the act achieves its goal of balancing patient safety with accountability for medical error provides a unique opportunity to improve the quality of medical care while simultaneously establishing a template for productive cooperation.

In conclusion, mutual distrust between attorneys and physicians impedes reasoned exploration of important health care delivery and policy issues. Unrelenting antagonism is harmful to patients and undermines the formulation of effective health policy. If the 2 professions continue to fight old battles and accentuate differences, they are unlikely to help resolve pressing health policy concerns. Focusing on their shared values and identifying ways to build on what they have in common will have the opposite result. A stable and rational health policy environment requires effective collaboration between the legal and medical professions. Whether a revitalized dialogue can achieve substantive results remains to be seen. But there is no satisfactory alternative to collaboration.

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