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# Ethics of the Attorney in Medical Malpractice Litigation

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*In medical malpractice litigation, providing legal representation to older patients or their healthcare providers carries significant ethical implications. However, there has been little scholarly or practical discussion of legal ethics concerning circumstances in which the medical malpractice plaintiff is an older person. The author sets forth a tentative outline of key issues that should be included in an analysis of legal ethics in the medical malpractice context, particularly when an older patient is involved.*

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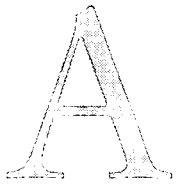

lthough periodic public-policy reform efforts attempt to change, either fundamentally or incrementally, the way in which specific patients' allegations of substandard, injurious medical treatment get resolved,[1] medical malpractice tort litigation is likely to remain an important component of the legal system in the United States for the foreseeable future.[2] The problems of medical malpractice and how the legal system deals with it are matters of substantial concern to older Americans and the physicians and other healthcare professionals who care for them.

Older persons are at disproportionately high risk for suffering harm as a result of medical errors, in terms of both incidence of errors and severity of injuries.[3] In fact, one major study of iatrogenic injuries found that patients sixty-five years of age and older accounted for twenty-seven percent of the hospitalized population, but forty-three percent of all error-related adverse events.[4] Although the number of older persons as medical malpractice plaintiffs has been disproportionately low in the past, that is beginning to change.

Providing legal representation to either patients (including older persons) who feel aggrieved by medical malpractice or healthcare professionals who are accused of professional negligence[5] carries significant ethical implications. Nevertheless, there is very little discussion in existing ethical codes or the published medical-legal literature—let alone in accessible gerontological sources—focusing precisely on the ethical considerations potentially pertaining to attorneys who represent plaintiffs or defendants in the context of medical malpractice litigation. There is an abundance of general materials regarding the ethics of litigation, including personal-injury cases; however, it is rare to find scholarly or practical

discussion of legal ethics concerning circumstances in which the medical malpractice plaintiff is an older person.

This article by no means purports to comprehensively fill this troubling void. Rather, I try here simply to identify and set forth a tentative outline of some of the major issues that ought to be included in an adequate analysis of legal ethics in the medical malpractice context, especially when an older patient is involved. The detailed work of that analysis must await the attention of subsequent commentators.

## Specific Issues for Counsel on Either Side

For medical malpractice cases that proceed through the adversarial tort system, it ordinarily is imperative for both plaintiff and defendant to purchase the services of expert witnesses. Ethical considerations may arise if an attorney for either side in the litigation attempts to compensate an expert on a contingency-fee basis—that is, agreeing to pay the expert an amount that varies depending on the outcome of the lawsuit. Because such arrangements may directly influence (and certainly present the appearance of directly influencing) the content and decisiveness of an expert's stated opinion, they are generally considered inappropriate.[6]

On a more basic level, to what extent do legal advocates in malpractice litigation have an ethical obligation to promote objectively preferable alternatives to the traditional ritual of "hired gun" adversary expert witnesses squaring off in a swearing contest? For example, legal advocates might have experts hired and paid by the court itself, and encourage courts to give more weight to clinical-practice guidelines or parameters[7] that have been developed through an extra-legal process of professional consensus.

A second set of ethical questions pertaining to counsel for either party in malpractice litigation revolves around implications of the availability of Alternative Dispute Resolution (ADR) mechanisms.[8] To what extent does an attorney have an ethical (and potential legal) duty to inform the client about the availability of ADR?[9] Especially when an older plaintiff for whom time is especially of the essence is involved, would the attorney's obligation go beyond just informing the client to affirmatively recommending that the ADR option(s) be pursued? If so, how vigorous must or should that recommendation be? May the defense attorney refuse to submit to ADR (which would presumably resolve the dispute more expeditiously), in order to use the usual slow pace of civil litigation in the courts to disadvantage an older plaintiff?

During the lengthy pretrial stages of medical malpractice litigation, several opportunities ordinarily arise for settlement of the claim (and indeed most malpractice claims are settled prior to trial). Ethical questions arise if an attorney fails to pursue settlement when available terms would be beneficial to the client, but the attorney's personal financial interests would profit from prolonging the litigation.

Either attorney in medical malpractice litigation may have the chance, at deposition and/or trial, to cross-examine a present or former client from another case who is serving as an expert witness in the instant lawsuit. To what extent, if any, may the attorney utilize in cross-examination information obtained from the expert witness in a different context, which was predicated on a fiduciary or trust relationship? Such opportunities confront the cross-examining attorney with difficult ethical conundrums concerning tension between respect for confidentiality and loyalty within the attorney/client relationship, on one hand, and the attorney's responsibility to zealously advocate for each client, on the other.[10]

Finally, all members of the bar arguably have a general ethical obligation to work toward improving the fairness and efficiency of the overall system for resolving medical malpractice claims nationally and within particular jurisdictions. The current tort system often serves older patients especially ineffectively. The duty to promote systemic reform, however, may run contrary to both plaintiffs' and defense attorneys' personal stake in maintaining a long-standing system that has been very lucrative for them and for a small subset of their clients. Therefore, we must ask about the extent to which that real, tangible factor is a legitimate counterbalance to the attorney's more amorphous responsibility to serve the public good.

## Specific Issues for Plaintiff's Counsel

Successfully prosecuting a medical malpractice claim, particularly one involving geriatric issues, requires a specific blend of knowledge, experience, and skill. Thus, the threshold ethical issue is whether the attorney who is approached to evaluate a potential case and represent the injured patient possesses adequate

relevant competence to properly fulfill the necessary responsibilities. The ABA Model Rules of Professional Conduct provide in Rule 1.1, "A lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness, and preparation reasonably necessary for the representation." An attorney who takes on client representation without sufficient competence may be held legally liable for professional malpractice.[11]

If an attorney refers a person with a potential claim to a different attorney, may the referring attorney accept or even demand a referral fee? What are the ethical parameters when the original attorney takes on co-counsel? ABA Model Rules of Professional Conduct, Rule 1.5(e) provides:

> A division of a fee between lawyers who are not in the same firm may be made only if:
>
> (1) the division is in proportion to the services performed by each lawyer or, by written agreement with the client, each lawyer assumes joint responsibility for the representation;
>
> (2) the client is advised of and does not object to the participation of all the lawyers involved; and
>
> (3) the total fee is reasonable.

Advertisements for potential clients by law firms representing plaintiffs in medical malpractice actions are ubiquitous today. Attorney advertising, while protected by the First Amendment,[12] raises a host of ethical concerns regarding (among other things) taste, impact on public perceptions of attorneys and the legal system, and influence on the quality of care provided by anxious, intimidated healthcare professionals.[13]

One of the most controversial aspects of representing plaintiffs in medical malpractice litigation is the practice of compensating the attorney according to a contingency-fee agreement under which, typically, the attorney is paid a preset percentage of the plaintiff's eventual financial recovery if, but only if, there is a financial recovery. The ongoing debate over this practice is by now quite familiar: the dangers of incentivizing the plaintiff's attorney to elevate winning (and for the maximum amount) above all other values, versus the need for non-wealthy injured patients (and many older individuals fall within this category) to have an effective "key to the courthouse" to vindicate their rights.[14]

According to the ABA Model Rules of Professional Conduct, Rule 1.5 Fees:

> (c) A fee may be contingent on the outcome of the matter for which the service is rendered, except in [domestic relations matters or criminal defense]. A contingent fee agreement shall be in writing and shall state the method by which the fee is to be determined, including the percentage or percentages that shall accrue to the lawyer in the event of settlement, trial, or appeal, litigation and other expenses to be deducted from the recovery, and whether such expenses are to be deducted before or after the contingent fee is calculated. Upon conclusion of a contingent fee matter, the lawyer shall provide the client with a written statement stating the outcome of the matter and, if there is a recovery, showing the remittance to the client and the method of its determination.

The method of attorney compensation in medical malpractice cases (i.e., the contingency-fee system) is a distinct ethical issue from that of the reasonableness of professional fees. Regarding the latter, ABA Model Rules of Professional Conduct, Rule 1.5 Fees states:

> (a) A lawyer's fee shall be reasonable. The factors to be considered in determining the reasonableness of a fee include the following:
>
> (1) the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal services properly;
>
> (2) the likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;
>
> (3) the fee customarily charged in the locality for similar legal services;
>
> (4) the amount involved and the results obtained;
>
> (5) the time limitations imposed by the client or by the circumstances;
>
> (6) the nature and length of the professional relationship with the client;
>
> (7) the experience, reputation, and ability of the lawyer or lawyers performing the services; and
>
> (8) whether the fee is fixed or contingent.

An attorney evaluating the validity of a potential client's case may be overly inclined to file a lawsuit on the client's behalf due to fear of being sued himself/herself (in the case of older clients, usually by

disgruntled family members) for legal malpractice for failure to pursue the claim. When the attorney takes such defensive action (despite his/her best judgment that the claim lacks merit) and fully expects that it will be withdrawn or dismissed eventually, the trouble, expense, and emotional turmoil caused to the defendant(s) and the demands placed by the claim on the administrators of the legal system raise significant ethical concerns. Related concerns also are implicated when a plaintiff's attorney demands punitive or exemplary damages in the complaint,[15] not because the attorney anticipates being able to establish an evidentiary basis for such damages but strictly as a tactical maneuver to gain the admission into the record of evidence relating to the defendants' financial well-being that might subconsciously sway the jury to award higher compensatory damages than it otherwise would have awarded. Similarly, we may question the ethical acceptability of the common tactic of naming in a malpractice complaint multiple defendants when the plaintiff's attorney, from the time of inception of the lawsuit, expects to later dismiss some of those defendants.

Prior to formally commencing litigation, an attorney representing the patient may seek to meet and discuss the medical care in question with the patient's treating physician. Ethical conflicts arise when such a meeting is sought, and certainly if it takes place, without the attorney explicitly informing the physician that he/she may be a possible defendant in a malpractice lawsuit to be brought by that attorney on the patient's behalf.[16]

Finally, to what extent, if any, should a plaintiff's medical malpractice attorney balance the traditional duty of fidelity and zealous advocacy owed to the individual client against the potential adverse ramifications of malpractice litigation for the larger society? For instance, should the attorney take into account the fact that collecting a large monetary judgment for a single client in a particular case might threaten the continued viability of certain healthcare facilities or services in the plaintiff's community? There is, for example, substantial evidence that aggressive litigation prosecuted over the past few years against nursing homes in Florida has had the proximate effect of making liability insurance for nursing homes so expensive in that state that a number of facilities are closing and that the availability of nursing home beds for individuals who need them has been severely compromised.[17] Conversely, is such an impact merely, as plaintiffs' attorneys contend, someone else's problem? Should plaintiffs' attorneys consider the ways in which large legal judgments are likely to encourage negative defensive medical practices by providers (e.g., excessive testing and interventions or avoidance of difficult patients), not only for the specific defendants in the litigated case but for other healthcare professionals who largely form their perceptions of legal risk through media coverage of malpractice litigation?[18] Is the harm to future patients stemming from such negative defensive provider practices irrelevant to the litigator whose actions at least partially inspire those practices?

## Specific Issues for Defense Counsel

Perhaps the most pressing ethical challenge facing defense counsel in medical malpractice litigation revolves around identifying the locus of the attorney's duty of loyalty (i.e., identifying who the *client* is)[19] when there is a real or apparent conflict between the interests of the insurer and the defendant medical-care provider. The conflict may be exacerbated by the provider's apprehension of being reported by the insurer to the National Practitioner Data Bank as mandated by the federal Health Care Quality Improvement Act.[20] For example, may the defense attorney, on the basis of the insurer's financial interests, ethically settle a claim over a defendant provider's objection if the insurance contract so permits?[21]

Second, multiple defendants (e.g., attending physician, facility/agency Medical Director, Director of Nursing, facility/agency) are routinely named in medical malpractice complaints. Consequently, questions may arise regarding the propriety of the same attorney representing more than one provider in a lawsuit when the defendants share a common liability insurer—and hence unitary legal representation may be cost-effective—but who otherwise may not have identical interests in the litigation (e.g., when the different defendants are accusing one another of negligent patient care). ABA Model Rules of Professional Conduct, Rule 1.7 Conflict of Interest instructs:

> (a) A lawyer shall not represent a client if the representation of that client will be directly adverse to another client, unless:
>
> (1) the lawyer reasonably believes the representa-

> tion will not adversely affect the relationship with the other client; and
>
> (2) each client consents after consultation.
>
> (b) A lawyer shall not represent a client if the representation of that client may be materially limited by the lawyer's responsibilities to another client or to a third person, or by the lawyer's own interests, unless:
>
> (1) the lawyer reasonably believes the representation will not be adversely affected; and
>
> (2) the client consents after consultation. When representation of multiple clients in a single matter is undertaken, the consultation shall include explanation of the implications of the common representation and the advantages and risks involved.

A defense attorney is placed in an ethical bind when he/she discovers, through revelation directly from the client or other, independent sources of information, that the provider being defended has falsified medical records that ordinarily would be placed into evidence by either the plaintiff or defendant. Existing formal statements of ethical principles, here as elsewhere, are exceedingly vague. ABA Model Rules of Professional Conduct, Rule 3.3 announces:

> (a) A lawyer shall not knowingly:
>
> (1) make a false statement of material fact or law to a tribunal...
>
> (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.

The Rule is silent on the specifics of "reasonable remedial measures."

Another ethical bind for the defense attorney arises when an insurer who retained the attorney to defend one of its insured physicians (Physician #1) threatens to cancel the liability insurance policy of other physicians whom it insures (Physicians #2 and #3) if Physicians #2 and #3 testify as expert witnesses in a case against Physician #1. Such coercive, truth-suppressive conduct by the insurer is ethically dubious and defense counsel should actively resist participating in it.[22]

## Conclusion

Older patients who suffer serious iatrogenic injuries through the fault of healthcare providers, as well as those patients' families, need effective and efficient processes for vindicating their legal rights and attending to their needs. For the foreseeable future, attorneys will be central actors in all facets of whatever process(es) we perpetuate or develop to accomplish this objective.

Useful guidance for identifying and responding to the ethical challenges confronting legal counsel in this specific sphere is surprisingly sparse. This article, by outlining some of the more salient issues, aims to contribute to a needed discussion of those ethical challenges.

## Endnotes

1. *See, e.g.*, David M. Studdert & Troyen A. Brennan, *No Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 J.A.M.A. 217 (2001).

2. James C. Mohr, *American Medical Malpractice Litigation in Historical Perspective*, 283 J.A.M.A. 1731, 1736 (2000).

3. *See* Marshall B. Kapp, *Medical Mistakes and Older Patients: Admitting Errors and Improving Care*, 49 J. Am. Geriatric Soc'y, p. 1361 (2001).

4. Lucien L. Leape, Troyen A. Brennan, N. Laird et al., *The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II*, 324 N. Eng. J. Med. 377 (1991).

5. *See generally* Marcia M. Boumil & Clifford E. Elias, *The Law of Medical Liability In a Nutshell* (1995).

6. Florida Bar Committee on Professional Ethics, Formal Op. 98-1 (Mar. 27, 1998); California State Bar Standing Committee on Professional Responsibility and Conduct, Formal Op. 1984-79 (1984).

7. *See* The National Guideline Clearinghouse (NGC) maintained by the federal Agency for Healthcare Research and Quality (AHRQ), www.guideline.gov (last visited Nov. 12, 2001).

8. John J. Fraser, Jr. and the Committee on Medical Liability, *Technical Report: Alternative Dispute Resolution in Medical Malpractice*, 107 Pediatrics 3, p. 602 (2001).

9. *See generally* Monica L. Warmbrod, *Could an Attorney Face Disciplinary Actions or Even Legal Malpractice Liability for Failure to Inform Clients*

*of Alternative Dispute Resolution?* 27 CUMBERLAND L. REV. 791 (1996-1997).

10. ABA Committee on Ethics and Professional Responsibility, Formal Op. 92-367, *Lawyer Examining a Client as an Adverse Witness, or Conducting Third Party Discovery of the Client* (Oct. 16, 1992); Pennsylvania Bar Association Committee on Legal Ethics and Professional Responsibility, Informal Op. 95-109 (1995).

11. *In re Moore*, 494 S.E.2d 804 (S.C. 1997) (lawyer erroneously believed statute of limitations in medical malpractice case would not run until after the lawyer obtained an opinion by the client's treating physician that malpractice occurred).

12. *Bates* v. *State Bar of Arizona*, 433 U.S. 350 (1977).

13. Christopher M. Mensoian, *Bates, the Model Rules, and Attorney Advertising*, 32 MCGEORGE L. REV. 77 (2000).

14. Peter Karsten, *Enabling the Poor to Have Their Day in Court: The Sanctioning of Contingency Fee Contracts, A History to 1940*, 47 DEPAUL L. REV. 231 (1998); Samuel R. Gross, *We Could Pass a Law...What Might Happen If Contingent Legal Fees Were Banned*, 47 DEPAUL L. REV. 321 (1998); Ted Schneyer, *Legal-Process Constraints on the Regulation of Lawyers' Contingent Fee Contracts*, 47 DEPAUL L. REV. 371 (1998); Michael Horowitz, *Making Ethics Real, Making Ethics Work: A Proposal for Contingency Fee Reform*, 44 EMORY L.J. 173 (1995).

15. For an explanation of punitive damages in the medical malpractice context, *see* Edward P. Richards III & Katharine C. Rathbun, LAW AND THE PHYSICIAN: A PRACTICAL GUIDE 41-42 (1993).

16. Pennsylvania Bar Association Committee on Legal Ethics and Professional Responsibility, Informal Op. 93-156 (1993).

17. LuMarie Polikva-West, Howard Tuch, & Karen Goldsmith, *A Perfect Storm of Unlimited Risks for Florida Nursing Home Providers*, 7 ETHICS, LAW & AGING REV., p. 81 (Marshall B. Kapp ed., 2001).

18. *See* Richard E. Anderson, *Billions for Defense: The Pervasive Nature of Defensive Medicine*, 159 ARCH. INTERN. MED. 2399 (1999); Marshall B. Kapp, OUR HANDS ARE TIED: LEGAL TENSIONS AND MEDICAL ETHICS (1998).

19. *Cf.* Marshall B. Kapp, *Who's the Client? Complex Conundrum in a Context of Conflicting Interests*, 5 J. ETHICS L. & AGING 95 (1999).

20. 42 U.S.C. §§1101-1152; 45 C.F.R. §60.1.

21. *See* Keith A. Brown, *Conflicts of Interest Between Insurer and Insured: When Is Independent Counsel Necessary?* 22 J.LEG. PROF. 211 (1998); Robert H. Jerry II, *Consent, Contract, and the Responsibilities of Insurance Defense Counsel*, 4 CONN. INS. L.J. 153 (1997-1998).

22. *L'Orange v. Medical Protective Company*, 394 F.2d 57 (6th Cir. 1968).