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**Medical-Legal Relations - The Brighter Side**

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IN THE MAY, 1956 issue of the Villanova Law Review \(^1\) an article by Melvin M. Belli of California discussed at length questions of medical professional liability, the availability of medical testimony and relationship between the medical and legal professions. A comment on these same subjects, prepared by the editor, appeared in the November, 1956 issue.\(^2\) Some of the observations and accusations included in the first article are, in my opinion and fortunately in the opinion of the editor, deserving of further consideration.

The unrestrained and colorful comments of Mr. Belli are always provocative and certainly his article entitled "An Ancient Therapy Still Applied: The Silent Medical Treatment" is no exception. In his forty-page indictment of the medical profession he has touched on subjects which are deserving of a fairer and more accurate treatment than he has given them. He has repeated and embellished some half-truths, which are extremely detrimental to physicians, without any comment as to the really constructive efforts that have been and are being made to solve the basic problems involved and with a total disregard for the effect of his statements on the relationship between the medical and legal professions.

No effort will be made in this reply to discuss the obvious "space filler" observations of Mr. Belli on such subjects as abortion, sterilization, artificial insemination and hospital records. These items are of sufficient importance to warrant separate treatment. Many excellent articles have been written on the medicolegal aspects of these problems which should be read by anyone interested in an accurate and complete presentation.\(^3\)

\(\text{** The Villanova Law Review has opened its pages to this response to Mr. Belli's article on the "equal time principle." The editors take no position on the controversy and of course do not endorse the author's view of Mr. Belli's article.}

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\(\text{1. Belli, An Ancient Therapy Still Applied: The Silent Medical Treatment, 1 Villanova L. Rev. 250 (1956).}

\(\text{2. Comment, Malpractice-Medicolegal Relations—Expert Testimony, 2 Villanova L. Rev. 95 (1956).}


(487)
In any discussion of medicolegal affairs it is advisable to reflect initially, if only briefly, on the fact that within the last thirty years the practice of medicine has become an increasingly complex undertaking, and during that period there has been a corresponding increase in related legal problems. The legal aspects of the patient-physician relationship has been complicated by many changes, including the practice of dividing the responsibility for the diagnosis, care and treatment of patients with other physicians; the advent of group practice, of health insurance and of contract practice; the growing number of circumstances in which the physician examines but does not treat, as in the examination of insured persons, of employees, of school children, of claimants of pensions, of claimants of damages for personal injury and of persons accused of crimes; the increase in the number of physicians employed on a part or full time basis, and the increase in the number of patients cared for through charity or by public funds.

I. MEDICAL PROFESSIONAL LIABILITY.

Certainly one of the most important examples of legal complications in medical practice involves the subject of medical professional liability. Although not a new problem it has, through a combination of recent circumstances, demanded an inordinate amount of attention from individual physicians and medical organizations. Some of the causes for this increased emphasis are the tendency of the public to seek financial remuneration for real or imaginary damage; the increasing tendency of juries to award more frequent and higher judgments; and inflation, necessitating higher payments for claims, judgments, and defense. The unfavorable articles in lay magazines dealing with the increased costs and medical care in general have created antagonism against the physician, while the favorable articles on new drugs, methods of treatment, and modern miracle surgery have in some instances been sufficiently exaggerated to lead the public to believe that a less than perfect result must be evidence of negligence.

What exactly then does the law require of a physician? It requires that when he undertakes to treat a patient he must possess and exercise the degree of knowledge, skill and care commonly possessed and exercised by other reputable physicians in the locality. If he holds himself out as a specialist he must meet the standards of the specialist in his chosen field. He must keep abreast of progress in his profession and utilize standard and accepted methods and procedures in diagnosis and treatment. He must act with the utmost good faith toward his patient
at all times. Of course he may not touch—certainly not operate upon—the patient without valid authorization. Further, his legal duty is not affected by the fact that his professional services are rendered gratuitously.

In a comprehensive report 4 prepared in 1941, Dr. Hubert W. Smith attempted to define the fundamental principles on which the legal status of the varied problems of medical professional liability must be determined. In his report he has outlined a rationale rather than a mere catalogue of legal decisions.

In a more recent study 5 of the original sources of the law of professional liability, Dr. Andrew A. Sandor of California has analyzed all of the appellate court cases in the United States in the field from 1794 through 1955 with the exception of those resulting from counter-claims. His study shows not only the increased incidence of professional liability cases but also the areas of medical practice most vulnerable.

As impressive as Dr. Sandor’s figures are with respect to reported cases, it must be remembered that they reflect only a small fraction of the claims and suits filed each year against physicians. In some localities the likelihood of being sued is now so great that the practicing physician must recognize that it constitutes a definite occupational hazard. The incidence of professional liability claims has increased substantially during the past twenty years and the situation continues to grow worse. If this situation were evidence that the medical profession is becoming increasingly inefficient, then the solution would of course be obvious. But the blunt truth is that the majority of all professional liability claims and suits filed are without merit; more than half of them involve physicians who are above the average of their respective groups in skill, experience and professional standing. So frequent are these claims that in some localities any patient with a less than perfect end result is a potential claimant. If physicians were always able to obtain perfect results there would, of course, be no problem. But deaths, untoward and unexpected results, continuing disabilities, and complications occur and will continue to occur. There is always a chance that without any negligence on the part of anybody some unfortunate result, sometimes fatal, will happen.

4. H.W. Smith, Legal Responsibility for Medical Malpractice: I. Legal Matrix of Medical Malpractice, 116 A.M.A.J. 942 (1941); II. Malpractice: Something of the Anatomy of the Law, Id. at 2149; III. Forgotten Ancestors of American Law of Medical Malpractice, Id. at 2490; IV. Malpractice Claims in the United States and Proposed Formula for Testing Their Legal Sufficiency, Id. at 2670; V. Further Information about Duty and Dereliction, Id. at 2755; VI. Further Information about Direct Causation and Damage, 117 id. at 23.

Therefore, irrational and unrestrained comments concerning medical professional liability, such as Mr. Belli is prone to make, are complicating an already serious situation which is dangerous for the medical professional and the public. The damage suit club which he is waiving so irresponsibly over the heads of doctors may result in a serious deterioration in the quality of medical care.

If the present trend continues and if a physician must become increasingly apprehensive of legal suits, his own aggressive instinct will inevitably in some measure overcome his humanitarian and professional motivations. Such a doctor will be inclined to give too much time to protecting himself and less to the care of his patient. He may hesitate to assume responsibility in a case where the prognosis is poor. He will have a tendency to omit the highly successful, but slightly dangerous, medical procedures. Whether medically indicated or not he will exhaust every possible established laboratory aid in every case; he will, on the slightest indication, bring consultants into the case; he will prefer to keep the patient a longer time in the hospital than is necessary. By these means, although the cost to the patient is increased, the hazard to the attending physician will be reduced.

The great number of these claims and suits will inevitably have another undesirable effect. They will cause a lowering of professional prestige and mutual mistrust between the patient and his physician. This is distinctly detrimental to the patient. When a patient feels a positive assurance that he is in safe hands, the solace he gets favorably affects his rate and chances of recovery. Emotional relief plays a substantial part in the healing of organic disease.

The honest, capable, conscientious physician must also have assurance that as long as he is doing a competent job he is not going to be harassed by unfounded litigation.

II.

RES IPSA LOQUITUR.

In his article Mr. Belli has discoursed at length upon the legal theory of res ipsa loquitur as a method of circumventing the need for expert medical testimony. He has reviewed some of the California court decisions, he has applauded their "liberal tendencies" and he has recommended that the "ingenious and alert [legal] practitioner should attempt the extension of res ipsa where expert testimony is not available." He has failed, however, to comment on the legal basis for the

6. Belli, supra note 1, at 262-270.
7. Belli, supra note 1 at 268.
It appears that the principle of res ipsa was first recognized in England in 1863 in a case\(^8\) in which a barrel rolled out of a warehouse window and fell on a passing pedestrian. Justice Holmes, while on the bench of the Supreme Judicial Court of Massachusetts defined the doctrine as:

"'Res ipsa loquitur,' which is merely a short way of saying that, so far as the court can see, the jury, from their experience as men of the world, may be warranted in thinking that an accident of this particular kind commonly does not happen except in consequence of negligence, and that therefore there is a presumption of fact, in the absence of explanation or other evidence which the jury believe, that it happened in consequence of negligence in this case."\(^9\)

Without questioning the doctrine as it has been applied in the past and as it still applied in most jurisdictions, considerations must be given to the recent tendency in some courts toward extending a perversion of the doctrine into the professional liability field to the detriment of the defendant-doctor and the public.

One of the California cases referred to by Mr. Belli in his article is Ybarra v. Spangard.\(^10\) In this case, to use Mr. Belli's own words, the court went "a long, long way" in applying the doctrine of res ipsa.\(^11\) This case among others is commented on in a very excellent and exhaustive article.\(^12\) In his comment on the court's opinion in this case Mr. Morris, a Cleveland attorney, says:

"The language of this court's opinion leaves no doubt but that it is applying not res ipsa loquitur, but the 'rule of sympathy' version. The court sympathizes with the unconscious patient who does not know what happened to him and so throws the defendant-surgeon into the lion's den of lay jury speculation, under the guise of res ipsa loquitur. We sympathize with the unconscious patient too. We agree that he is entitled to a full disclosure of the facts—of every detail of what went on while he was unconscious. But what he is not entitled to is res ipsa loquitur. One has to but look at the requirements of res ipsa loquitur to see that it cannot apply. First, the accident must be of a kind that ordinarily does not occur in the absence of someone's negligence. While such com-

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\(^11\) Belli, supra note 1 at 264.
Applications do not occur frequently in operations, they can and do occur for no known reason and without negligence on anyone's part. It has always been a fundamental axiom of the law that the mere happening of an accident, no matter how disastrous the consequences, is no evidence that there has been negligence.

"Furthermore, even the meager requirement of the rule of sympathy—that the evidence is more accessible to the defendant-doctor than to the plaintiff-patient—has not been met! The patient, no matter how unconscious during the operation, has no trouble obtaining all of the facts if he hires a competent attorney. Today all jurisdictions have broad rules of discovery, which compel production of all testimony in advance of trial so that every fact is known."

At the conclusion of his article and as a comment on the California cases in this field, Mr. Morris states:

"Thus the fallacy inherent in the rule of sympathy is that whenever a bad result follows an operation (where of course normally no such bad result occurs) it is presumed by the courts that the reason for the bad result must be some negligence on the part of the operating surgeon and therefore a lay jury is entitled to weigh the defendant-doctor's explanation of his conduct against such presumption without proof by expert testimony from another doctor of just what the defendant-doctor did wrong. In this situation the lay jury is forced to speculate between the defendant-doctor's explanation and the natural sympathy for the injured patient—with disastrous results to the defendant-doctor."

Thus it is apparent that there are numerous vices inherent in a distortion of the doctrine. It is unfair to the jury in professional liability cases in that the members are not permitted the medical education and assistance they need and are in fact entitled to in order to form a judgment fairly. It is also grossly unfair to the doctor in that it subjects him to a rule of sympathy and jury speculation, frequently with disastrous consequences. Through its distortion inroads are being made upon the sound legal principles which afford proper protection to the medical profession.

Physicians are continually urged to familiarize themselves with their legal responsibilities and what constitutes malpractice in the eyes of the law. This would seem to be an equally good recommendation for attorneys. It is of little value for them to quote proper instructions to a jury and sanctimoniously reassure doctors as to the protection available in professional liability suits, and at the same time encourage
spurious suits by disgruntled patients. More regard for the existence or non-existence of legal liability on the part of the physician and less on tricks and devices for getting a case to the jury would seem to be in order. It would also help to convince doctors that in testifying in a professional liability case or any other suit they were furthering the ends of justice rather than the economic status of a few overactive claim-conscious attorneys and their stimulated clientele.

III.

TEXTBOOKS IN LIEU OF MEDICAL TESTIMONY.

Within the last decade two states have adopted laws which would provide for the admissibility in evidence of textbooks in lieu of expert testimony. The Massachusetts law,\(^1\) adopted in 1949, provides:

"A statement of fact or opinion on a subject of science or art contained in a published treatise, periodical, book or pamphlet shall, in the discretion of the court, and if the court finds that it is relevant and that the writer of such statement is recognized in his profession or calling as an expert on the subject, be admissible in actions of contract or tort for malpractice, error or mistake against physicians, surgeons, dentists, optometrists, hospitals and sanitaria, as evidence; provided, however, that the party intending to offer as evidence any such statement shall, not less than three days before the trial of the action, give the adverse party notice of such intention stating the name of the writer of the statement and the title of the treatise, periodical, book or pamphlet in which it is contained."

In March of 1953, the state of Nevada adopted a law\(^14\) which is almost identical with the Massachusetts law. Both of these laws are an exception to the general rule that textbooks may not be admitted in evidence to establish the truth of statements found therein because of the fact that the author is not present and subject to cross examination.

IV.

AMERICAN MEDICAL ASSOCIATION STUDY OF PROFESSIONAL LIABILITY.

Despite the importance of the subject and the interest demonstrated in it by the public and the profession, a complete and comprehensive national study of professional liability has never been made. For this reason and in response to a number of resolutions presented to the

American Medical Association House of Delegates requesting advice and assistance, an exhaustive survey is now being conducted by the Association’s Law Department.

In planning the study it was decided that the following projects should be undertaken:

(a) An analysis of state insurance laws and regulations.
(b) A review of state statutes of limitation.
(c) An analysis of reported cases. A review has been completed of medical professional liability cases (605) reported from 1935 through 1955. This report shows the areas of medical practice in which professional liability cases occur most frequently, the circumstances usually surrounding such claims and their disposition.
(d) An analysis of professional liability claims involving physicians in government service.
(e) A survey and analysis of pertinent state legislation.
(f) A survey of state medical societies concerning the availability of professional liability insurance, the most prevalent problems in the field, and the status of claims prevention programs.
(g) A survey of the professional liability insurance programs of thirteen national medical societies.
(h) A survey of a random sampling of five per cent of the members of the American Medical Association. As a result of the information received, various analyses are being made showing the status of claimants as to age, sex, and occupation; negligent acts alleged; the relation of the physicians’ type of practice to the alleged negligent acts; the places where the incidents occur; and the disposition of all claims and suits.
(i) The preparation and publication of special articles dealing with such subjects as: The History of Professional Liability Claims in the United States; Medical-Legal Hazards of Anesthesia; Physicians Expressing Opinions as to Former Treatment; The Res Ipsa Loquitur Case; The Rule of Respondeat Superior; Hazardous Therapy; New Concepts in Professional Liability Suits; Professional Liability Claims Prevention; Professional Liability Insurance Limits; Professional Liability Claims in England; and The Law of Professional Liability.
Every effort has been made to conduct the survey in an objective and judicious manner and it is hoped that the results will contribute to existing knowledge in the field. The study will indicate the current status of the number and causes of professional liability claims and suits and the availability and cost of liability insurance. Armed with these facts, we should be in a position to plan a long range educational program for presentation to both the medical and legal professions.

The Law Department intends to continue its study of this subject after June, 1957, in other areas. An opinion survey among attorneys and members of the judiciary experienced in the handling of medical professional liability suits will be included. There will also be a study of insurance experience and rates and a survey of comparable fields of negligence actions.

The first of the series of articles and reports in the survey appeared in the February 2, 1957 issue of The Journal of the American Medical Association. One article has appeared and will continue to appear each week until the series is completed. The entire series will then be published in booklet form and distributed by the American Medical Association.

V.

MEDICAL EXPERT TESTIMONY.

It is wrong, in considering the availability of medical testimony, to confine one's thinking to professional liability cases alone. This is so because it leaves the false impression that the medical profession has boycotted the courtroom in such actions. The actual facts are that the vast majority of doctors have an aversion to appearing in court and testifying in any kind of lawsuit. Although a few have had unpleasant experiences as witnesses, most have been frightened by the exaggerated reports of their colleagues of “murderous cross-examination” by opposing counsel.

In fairness to the physician consideration must be given to the basic reasons behind this aversion. First, there is a fundamental difference in the method of approach of law and medicine to the discovery of truth. The lawyer attempts to maintain his position by argument and contention with opposing counsel. His life is one of advocacy of causes; his object is to magnify his own arguments and to belittle those of his opponent. The physician, on the other hand, does not live by contention. His training is in the free and open atmosphere of the laboratory, hospital, sickroom or private office. He demands full and
frank discussion and disclosure of all phases of a case. When all pertinent data are collected, he correlates them and forms a judgment. By training and practice, therefore, the whole tempo and attitude of the day-to-day experience of the physician and lawyer are totally different.

In addition to being unfamiliar with situations which to a lawyer are commonplace, physicians sometimes complain that they are made parties to the case in which they testify. This practice should, of course, be discontinued. Medical witnesses should testify concerning a certain set of facts and should never be made advocates in the proceedings.

Another reason for the doctor's hesitancy to act as a witness is his failure to understand the concept of examination and cross-examination. It appears to the average medical witness that while one attorney is trying to establish the truth, opposing counsel is trying equally hard to keep the truth from being brought before the jury and court.

The physician also dislikes the time that court cases take from his daily activities—and it is not because he fears he might lose a fee. Physicians today are very busy people with morning, afternoon and sometimes all-night hours. The effect of stories about doctors cooling their heels in court for hours on end while lawyers argue seemingly obscure legal technicalities is difficult to overcome.

However, in the interest of the profession and particularly of the public this hesitancy on the part of the physicians to testify must be overcome. The need for an all-out effort is obvious from the fact that from sixty-five to eighty per cent of all cases tried today require medical testimony; that seven out of ten personal injury cases are decided on medical rather than legal considerations. During the past decade medicine has been making tremendous strides—amazing progress with surgery and with drugs. Doctors are now able to do new, unusual and complicated procedures. Consequently when these procedures become germane to a litigated case an ethical and qualified physician should be available and willing to testify. Juries cannot and should not evaluate these matters without expert medical advice.

Further, the role of the medical expert witness should not be played by a few. It is appalling to note the unprofessional and unethical actions of the few doctors who have become "professional witnesses" for plaintiffs and defense counsel. This new "medical specialty" is an injustice to the medical profession and to the public, and should be eliminated. In this endeavor the active assistance of the legal profession is imperative, for, wherever a doctor testifies improperly there is at least one lawyer encouraging and misleading him.
VI.

RELATED ACTIVITIES OF ORGANIZED MEDICINE.

The American Medical Association, with a membership of some 157,000 physicians, is concerned with many problems of social, economic and political nature. Medical expert testimony is one such problem. It is one that has been of interest and concern to the medical profession for many years.

The proceedings of the House of Delegates of the American Medical Association, the policy-making body of the Association, contain many references to the subject. In 1914 a Committee on Expert Testimony reported after a three-year comprehensive survey of the entire field of medical expert testimony. The committee's recommendations were: to distinguish between matters of fact and matters of opinion, to place no restrictions on the testimony of fact, and to limit the testimony on opinion to those experts called by the court. The committee recommended that the compensation of such experts should be fixed by the court and charged as a part of the cost of the case or against the party requesting the testimony. The Association accepted the report with the comment that "the solution to this vexing problem cannot be forced; it must come gradually and with the cooperation of the American Bar Association and the various state bar associations."

In 1929 the House of Delegates again adopted a resolution expressing its interest in the correction of the abuse of medical expert opinion evidence and offering cooperation to the American Bar Association and others in promoting the passage of legislation and in bringing about suitable changes in court procedure with reference to such evidence.

The American Medical Association has done more than just adopt resolutions on this matter. As an example, in October of 1955 the American Medical Association sponsored a series of three regional medicolegal symposia—in Chicago, Omaha and New York City.

A part of the program at each meeting was designed to acquaint physicians with their indispensability in litigation and to dispel their fears of testifying in court.

To this end a demonstration of a mock trial was presented to show the wrong way and the right way for a physician to act in his role as a medical witness. The demonstration was repeated before medical and legal groups in fifteen cities last year. In addition the members of the staff of the American Medical Association Law Department have presented talks on this subject at numerous medical or medicolegal meetings.
About a year ago the Wm. S. Merrell Company, drug manufacturers in Cincinnati, and the Dynamic Film Corporation of New York, saw the potential in the Medical-Legal field. They asked the American Medical Association to cooperate in the preparation of a series of six medicolegal films. After consultation with the American Bar Association it was agreed to begin the project, and our demonstration of the physician as a medical witness was selected as the first topic. The second film, which will be presented at the American Medical Association meeting in New York in June will deal with medical professional liability.

Again in March of this year the American Medical Association held another series of three regional medicolegal meetings—in Atlanta, Denver and Philadelphia. Over 1,000 attorneys and physicians attended these meetings to hear and participate in a day-and-a-half discussion of three subjects: The Use of Chemical Tests for Intoxication in Court, Trauma and Cancer, and Medical Expert Testimony.

VII.

COMMITTEES FOR THE REVIEW OF MEDICOLEGAL TESTIMONY.

Since its creation in August, 1954, the Law Department of the American Medical Association has received many inquiries from state and county medical societies desiring to initiate committees for the review of medicolegal testimony. Accordingly, each state society has recently been asked for information concerning the activity and experience that it or any of its county societies has had in organizing and maintaining such committees or in working on any other joint activities with the Bar Association.

The so-called Minnesota Plan was initiated in 1940, when a committee was appointed by the president of the Minnesota State Medical Association, with the approval of its council to review those court cases in which medical testimony appeared to the court, to the attorneys, or to physicians to have been so contradictory as to indicate that one or more of the medical witnesses had consciously deviated from the truth.

Thereafter, the Illinois State Medical Society, the Kansas Medical Society, the Chicago Medical Society and the Harris County Medical Society (Texas) established committees patterned after the Medical Testimony Committee in Minnesota. In addition to the above, the Louisiana, Indiana and the Wisconsin Medical Society have worked with their state bar associations in connection with the review of medicolegal testimony. The Medical Disciplinary Board Act of Wash-
In some states and cities, committees or panels have been created for the purpose of providing the courts with impartial medical expert witnesses. About fifteen years ago, the Los Angeles County Medical Association and the Los Angeles Bar Association jointly established a panel of physicians and surgeons to assist the courts in obtaining impartial medical testimony. Today, there are at least two physicians on the panel for selected specialties, or between twenty and twenty-four members. The panel physicians are selected by the joint committee of physicians and attorneys after each has indicated his willingness to examine the patient and testify. The court makes all the arrangements, including the establishment of time and place of examination and the compensation the physician is to receive. This cost is generally borne by the party who requests the appointment of the independent examiner. An impartial medical witness program is now in operation in New York County. A similar plan has been initiated by the Baltimore City Bar Association, the Maryland State Bar Association, and the Medical and Chirurgical Faculty of the State of Maryland.

In addition to the work of the medical societies, the American Bar Association, the state bar associations, the National Conference of Commissioners on Uniform State Laws, and many individuals within the legal profession have devoted their talents liberally in an effort to eliminate some of the problems associated with the use of expert witnesses. And as I understand it, the consensus is that impartiality can best be achieved by somehow making the expert a neutral witness, not obligated in any way to either party. Two means for accomplishing this have been suggested: one by legislation and the other by voluntary agreement.

The report and recommendations of the National Conference of Commissioners on Uniform State Laws, in 1936 and 1937, adequately describe both legislative and voluntary efforts to that date. The recent report \(^\text{15}\) of the Special Committee of the Association of the Bar of the City of New York on its Medical Expert Testimony Project includes a review of voluntary programs and objectively and adequately describes the very excellent medical testimony project of the New York Bar.

Both reports bespeak the efforts of the bar to improve the quality of medical expert testimony. Yet despite the continued and conscientious efforts.
tious efforts of both professions it cannot be said that a solution has been discovered. None of the suggestions yet offered has had wholehearted acceptance by the judiciary, the bar or the public.

Although the basic reluctance of physicians to testify in litigation generally is undoubtedly greater in medical professional liability cases, the reasons should not be hard to understand. Further, to assume that the medical profession is unique among professional groups in this regard is false. In one of the very cases cited by Mr. Belli in his article, the judge stated “Physicians, like lawyers, are loathe [sic] to testify that a fellow craftsman has been negligent, especially when he is highly reputable in professional character.”

The professions of law and medicine are both far from exact sciences. There is fortunately room for, and in practice there exists, in both professions, many different, equally valid opinions on a given set of facts. Both groups deal with complicated problems, the solutions to which can vary, in an individual case, on the basis of the most minute difference in circumstances.

In an address 17 presented in Dallas last August, Dr. Dwight H. Murray, President of the American Medical Association, said in this regard:

“In medicine there has been, and I hope always will be, room for disagreement. Many procedures have their own adherents and when suggested therapy differs there will always be strong supporters for each approach. As an example, some doctors in setting a fracture prefer a slight offset of the bones on the theory that a stronger callus is formed. Others demand positive and complete alignment. Either can point out examples of his theory ... walking, riding, swimming or golfing. Either honestly could express disagreement in private or on the witness stand, with the treatment given by the other.”

These factors, when combined with the natural friendship and pride existing between members of the same profession, are bound to result in a reluctance on the part of a physician or an attorney to condemn publicly a fellow practitioner. If the opposite were true the resulting professional climate would most certainly stifle legal and medical progress and establish a relationship between members of the professions and between the professional man and his patient or client which would seriously impede the administration of justice and impair the public health.

In areas where it is obvious that physicians or attorneys are neglectful of their obligations or are dishonest, then the two professions should work together to disfranchise those who make a mockery of justice. Licenses should be withdrawn by the state from the physician who sells his testimony to the highest bidder or shades it to the extent that he is paid. And by the same token it follows that lawyers who engage in and encourage such physicians should be denied the right to practice their profession.

VIII.
INTERPROFESSIONAL COOPERATION.

Although members of both professions and medical and legal associations at the national, state and local levels have had these matters of interprofessional concern under consideration for some time, it was only comparatively recently that concrete steps have been taken to solve them. Since 1954 the American Medical Association has greatly accelerated its efforts in the field of medicolegal relations to meet what it considers to be a growing desire on the part of the legal and medical professions to join in a sincere cooperative effort.

IX.
MEDICOLEGAL CONFERENCES.

As indicated earlier, the Association through its Committee on Medicolegal Problems and its Law Department has planned, encouraged, and participated in medicolegal conferences at the regional, state and county levels. In developing the theme of these conferences, it was recognized that lawsuits are adversary proceedings and that conflict is a major element in the medicolegal field. Discussions and papers presented from the viewpoint of each profession proved that doctors and lawyers are both attempting to obtain the best results from individual and professional efforts. In presenting the view of medicine or law, every effort was made to clarify misunderstandings, not for the sake of understanding alone, but as a means to an end—the welfare of the individuals served, whether identified as patients, clients, or the public. At the regional meetings sponsored by the American Medical Association in 1955 and 1957 three broad areas of medicolegal relations were considered: medicine's contribution to the administration of justice; mutual medicolegal problems as viewed by each profession; and the role of a medical expert witness under proper and improper courtroom conditions.
In the area of the administration of justice there were provocative discussions on traumatic neurosis, trauma and disease, medical expert testimony, and medical science in the administration of criminal justice. In the area of medicolegal problems there were discussions of the several aspects of professional liability, a consideration of the professional man as a taxpayer, and an exploration of the best methods to insure unbiased medical expert testimony.

X.

MEDICOLEGAL LIAISON AND INTERPROFESSIONAL CODES.

The Cincinnati Bar Association and the Cincinnati Academy of Medicine were among the first groups to adopt formally an interprofessional code called "Standards of Practice Governing Lawyers and Doctors in Cincinnati." This agreement, which contains a preamble and twelve brief paragraphs, covers with clarity and efficiency three of the most important problems affecting the two professions, namely, the obtaining of medical testimony, medical records, and provision of adequate compensation to the physician for his services in connection with litigation.

Many other cities and states have followed their lead and have either adopted or are actively studying such a document. The codes, in general, contain provisions relating to written reports to be furnished by the doctor; conferences between physician and attorney prior to trial; arrangements made in advance for the physician to testify; the conduct of a physician while on the witness stand; and the compensation a physician should obtain for testifying. It is generally acknowledged that these codes will not, in and of themselves, eliminate interprofessional friction, but a continuing effort must be made if these problems are to be resolved.

In addition to such codes of understanding, the District of Columbia and twenty-five state medical societies have either established liaison with their bar associations or expect to do so in the near future.

Within the past month the American Bar Association and the American Medical Association appointed a national medical-legal liaison committee. This is a step that is long overdue and should provide another effective link between two great professions.

XI.

CONCLUSION.

It should be obvious to any conscientious and unbiased observer that an honest effort has been made during the past few years to improve the application of medical science in the administration of justice.
It is nevertheless still true that physicians in the practice of their profession have made and will continue to make their share of human errors, that physicians need to be educated to their responsibility to testify in court in various types of cases, that it is necessary to make a closer review of medical testimony of the type which is, unfortunately, solicited and presented, on occasion, for plaintiffs and defendants, and that a better rapport between the legal and medical professions is an absolute necessity. It is equally obvious that the mere existence of these facts and the need for improvement falls far short of the "medical conspiracy" which has been so glibly and irresponsibly alleged.

After reading such material as the book *Ready for the Plaintiff*, the published seminar presented by Mr. Belli at the Convention of the National Association of Claimants Compensation Attorneys in Los Angeles in 1956, and the article in the May, 1956 issue of the *Villanova Law Review*, it appears that some attorneys are dedicated to a continuation of the very conditions they decry.

I do not believe that they actually want unbiased medical testimony—what they really want is medical testimony favorable to their case.

They do not want ethical, objective and impartial medical testimony available in all litigation—they prefer a further distortion of the doctrine of res ipsa loquitur, and an extension of the legally objectionable type of legislation that has been enacted in Massachusetts and Nevada. True, these mechanisms produce "second-rate" medical evidence, but that appears preferable, to some, to the presentation of proper medical facts which may jeopardize the precious "adequate award."

Certainly Mr. Belli and those for whom he speaks cannot seriously contend that they are interested in better relationships between the medical and legal professions. Invitations to doctors to "rejoin the human race" and blanket denouncements of the entire medical community are hardly likely to encourage physicians to participate in interprofessional cooperative endeavors.

The American Medical Association, the American Bar Association, and many of the state and local medical and legal societies are just now becoming sufficiently acquainted with the mutual problems of medicine and the law to initiate concrete efforts at better understanding. The success of these efforts requires the assistance of all ethical and honest physicians and attorneys in the best interests of the public as well as the professions.