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MEDICINE AND THE LAW

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THE law, unlike medicine is not a science, but a philosophy of dynamic accommodation among individuals in relationship to each other and in reciprocal responsibility to and from society. This philosophy in a social-political entity is expressed in rules and regulations governing human conduct and is called the law, which is paramount.

The Law confers benefits as well as imposing duties and in our modern society, with its humanitarian principles, expresses increasing concern for the welfare of members of the society.

Important to us here is the legislation of the past quarter-century in which we have experienced change from private and local social welfare to national systems embracing larger categories of recipients with ever-increasing monetary and service benefits. In fact more social legislation has been enacted during this period than in all the history of man.

Concurrent with this change and, in fact, significantly contributing to the need for the accelerated changes has been the developments in medicine eradicating endemic and epidemic disease and prolonging life, including the lives of the catastrophically injured.

With these expanded laws are the ever-increasing administrative agencies, judicial and quasi-judicial courts necessary to interpret and apply the laws to the supplicant requesting, not necessarily requiring, the benefit.

Imposed on the public law benefits are additional benefits in the private sector; the quality and quantum of these benefits in combination depend upon need in the various categories; the qualifying criteria upon which they are granted is the greater the need, the larger the quantum of benefit.

Consequently, the granting of the benefits, whether before a court in a liability suit, or a quasi-judicial judge in a Workmen's Compensation claim, is dependent on the credibility and quality of evidence of disability in support of the claimed right.

The law as interpreted and applied by the courts is now subject to considerable manipulation of emotion, bias and prejudice, and direction of social conscience of the judge or jury trying the issues of fact which will determine the quantum of the benefit to be awarded.

One can then expect that the party, whether it be the plaintiff or defendant, will attempt to contrive and stage the organisation and presentation of evidentiary testimony, where there is controversy, to manipulate the esoterica of the judge or jury to accomplish his goal.

The principle objective of the plaintiff, because he has been offered no other alternative satisfactory to him, is to be rewarded the maximum monetary quantum available, and this is the only criteria.

We now come to comment upon the role which the patient, his doctor and lawyer, and each involved discipline will play, preparatory to the time of decision disposing of the case, either by trial or settlement; or where there are legislative or contractual benefits continuing for periods up through the lifetime of the patient.

The physician in treating catastrophic injury or illness, first concerned with the life saving process, must recognise that beyond that is the greater obligation and responsibility to make the life saved a responsible and contributing member of the society in which the patient will live; or at least assure that the patient should not cost the society and its productivity more than it can afford.

While, with the age of specialisation and scientific sophistication in health care, some success has been realised in life saving aspects, failure in projecting and maintaining the art of medicine by the physician, *i.e.*, knowledge, understanding and concern with the factors and conditions outside of medicine which affects the patient, has become a *force majeure* in the failure to optimally restore the patient.

Significant emphasis must allude to the arrogance in attitude which permeates the field of medicine, and in most instances prevents or inhibits communication with the patient and those responsible to him about his condition, plans for his future or what he can reasonably expect from medical and associated discipline treatment.

Of even greater importance, is that the patient is rarely consulted about goals, objectives and lifetime expectations. Communication in depth to elicit the concerns of the patient about his future is most often delegated to para-medical and social services. It is seldom understood that the real concern of the patient, after the acute and sub-acute stage is not that he will die but that he will live; with the attendant responsibility of social and economic survival in a society which is materialistically orientated and now has a surfeit of people for whom it has no place.

The patient, knowing that he is going to live, searches for an island of economic security which he hopes to find in the various benefit systems provided by law and sets about to exploit them for his desired goals.

Each individual patient will, of course, have different objectives and goals. Those entering the pre-morbid state with a background of work success, job satisfaction, socio-cultural attainment and acceptable life style will, in most instances, require minimum benefits from the law and most likely manipulate for health and functional restoration to permit as promptly as possible a return to the security which arises from his personal assets and confidence. As the pre-morbid personal assets and confidence diminish the need of other resources for security increase and finally we find that small group totally dependant for survival upon the external benefits provided by law.

The lawyer together with the social agencies are the allies who will help each of the foregoing persons to attain the desired benefit level and in preparation will call on the physician for recommendations.

The treating physician, in making his recommendation and evaluation, should not concern himself with the liability aspects of the case, but only with the causal connection with the trauma and the extent of disability, with emphasis on the extent and magnitude of loss of function, care and attendance required to maintain the patient during life; and, if qualified to do so, speculate on life expectancy. However, whether asked to do so or not, he must comment on the important aspect

of what physical function remains and what the patient can or could do with those functions if appropriately motivated.

Unfortunately, communication is generally so absent between the lawyer and the doctor that no real community of interest exists to suggest methods and approaches to mitigate the consequence of the injury.

Usually, the lawyer for the defence is traditional and prosaic in his approach to mitigating damages, while the plaintiff's lawyer is imaginative in attempting to enhance disability.

In this process the patient, with prompting from his lawyer, feels his security threatened to the point of the need to defend the disability by magnifying its extent.

It is small wonder then that the physician is frustrated in his failure to restore the patient to the optimum level expected.

Confronted with these failures, what can be suggested under the law and the litigation system it fosters which would not only ameliorate these shortcomings of the practice of law and medicine, but significantly improve the likelihood of attaining for the patient a result satisfactory to him and the concerned participants?

We must be creative and innovative to attain the moral and ethical goals which the law, in abstract, contemplates in its enactment abandonment of the traditional medical and legal role playing is a prerequisite.

The unfortunate fragmentation of the patient into his temporal, physical and spiritual aspects can no longer be tolerated in treatment by the physician and service by the lawyer.

Neither profession can be of meaningful aid or service if the social goals and survival obligation of the patient are unrecognised or ignored.

The physician must not arrogate for medicine the continuing premier status with respect to all the patient needs, but should content himself with exchanging dominant roles with the lawyer and other disciplines as the need of the patient demands.

He must be willing to draw into the continuing process by means of his awareness and knowledgeable communications, the lawyers and others representing the various interests, who may, and most often do, have the means of asserting and aiding him in his treating and restorative obligation to the patient.

The lawyers in electing a new role, that of being an advocate not an adversary, must recognise that they can no longer approach the representation of their client without broad communication with each other and with the treating physician and paramedical personnel directed towards providing a milieu in which the patient has reason to attain the optimum restorative level.

Ideally, the catastrophically injured patient must be brought into the curative and restorative process, but not into the adversary process regardless of the extent of the liability question or monetary awards, if any, to be forthcoming.

The lawyers should treat these questions in communication among themselves and the defence lawyer should make available, where none exists, the essential economics necessary during the acute and restorative period in order to ameliorate the concern of the patient for immediate or near future economic survival.

The defence counsel is certainly justified in offering this assistance and even more justified in giving guidance to the patient and his counsel in respect of the availability of the best facility and physician to treat the injury.

It may shock most physicians to find that a few lawyers are more aware and

knowledgeable about quality of treatment available than is the physician, particularly where catastrophic injury is involved.

The lawyers now must begin the process of assessing the extent of disability so that the process can continue to bring about a most speedy disposition of the case consistent with the plateau reached by the patient.

It is important then that the economic baseline for special damages *i.e.*, the economic loss arising from medical expense, wage loss, attendant care, etc., be determined. The aid of a mutually agreed physician of outstanding ability in the field will assist immeasurably in assessing the true extent of functional disability and future needs of the patient. The doctor has become an advisor and not an advocate for a particular contention of either party.

The next step in the process is the resolution of the question of the defendant's liability. Counsel will, hopefully, have become aware and cognisant of the facts supporting his case on the issue of liability.

There is no reason now that they cannot make a determination on the probability of liability being assessed against the defendant by judge or jury, taking into consideration that in most cases of catastrophe, the nature of the injury has strongly influenced findings in favour of the plaintiff, although the award of damages has usually been compromised by the trier of the fact when relating its decision to the difficulty on clarity of the liability issue.

Counsel, who have become informed and aware of the hazards and rewards possible, are better able to bring reasonable assessments to resolve the issues and will usually determine and agree on a global figure representing both special and general damages (the latter representing loss of amenities of life, paying and suffering, etc.) influenced by how each views his probability of success at trial.

Foremost, however, is that in any disposition by agreement there must be sufficient funds remaining to the plaintiff to take care of his real economic need and provide the security for him and his family, which will not be dissipated through improvidence of misadventure. The obligation to see that this is accomplished, in my opinion, must be that of the lawyers representing both parties to the agreement.

Utilising the foregoing manipulation within the frame-work of the law we have, in our practice representing defendants, been most successful in avoiding the hazard of trial for the patient as well as our client by obtaining a most satisfactory result for the patient in providing an improved life-style for him and his family, initiating stimuli for positive rather than negative motivation in creating substitutes acceptable to the patient to compensate for loss. This all by constant intervention and communication with the patient, his family, counsel, physicians and others involved in his case.

SUMMARY

1. Public and private benefits offering security for life if the need is of sufficient magnitude inhibits optimum restoration of the patient.
2. The physician frequently does not recognise nor is concerned with the pre-morbid attitude, goals or life-style of the patient and does not effectively deal with the future temporal needs of the patient, thereby contributing to less than satisfactory levels of restoration.
3. The law and its objectives as practised by the lawyers often develop into an

intense adversary posture, threatening the security of the patient and jeopardising a satisfactory level of restoration.

4. Administration of the law by judicial and quasi-judicial judges and juries is manipulated to give the highest award possible, therefore the plaintiff will not be restored to the satisfactory level of which he is capable.

5. There is hostility and little communication between physician and lawyer again contributing to the patient's failure in restoration.

6. The adversary system is accused of creating conditions contributing to unsatisfactory restoration but can be utilised as a motivational force with innovative and creative thinking on the part of the professions to meet the real needs and goals for security of the patient and motivate his restoration.

7. Communication and role-playing exchange between the professions and the patient as his condition will require, promote a successful and acceptable restoration.

8. The counsel involved develop the process for prompt financial disposition without involving the patient in the adversary process or in trial.