Ethics of Evidence: Health Care Professionals in Public Benefits and Immigration Proceedings

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Ethics of Evidence: Health Care Professionals in Public Benefits and Immigration Proceedings

Jesselyn Friley*

ABSTRACT

This Article discusses the role of health care professionals in applications for public benefits and immigration relief. Medical-legal partnerships (MLPs) often represent patients who are applying for disability or veterans benefits, or who are seeking asylum based on past persecution. The strength of a patient’s medical evidence often determines whether their claim succeeds or fails. Many health care professionals provide corroborating evidence for their patients, but even when they do not, their opinions appear in the proceedings through medical records. Furthermore, health care professionals are not ordinary witnesses: Like lawyers, they are bound by their own ethical codes. This Article describes the role of medical evidence in public benefits and immigration proceedings; identifies the ethical rules that shape health care professionals’ participation in these proceedings; and provides brief suggestions for MLP lawyers seeking the best medical evidence for their clients.

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INTRODUCTION

Health care professionals play a crucial role in the vast administrative bureaucracy that gives people access to public benefits and immigration relief. For example, individuals applying for programs such as Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) must submit medical opinions as evidence of their disabilities. Veterans seeking compensation for injuries connected to their military service use their medical records to trace their current conditions to events that occurred in service. Asylum applicants can make a stronger case for past persecution if they have an affidavit from a psychiatrist or psychologist describing trauma symptoms or connecting physical and mental scars to past persecution. In the proceedings associated with each of these benefits, an administrative agency weighs medical opinions about the client’s medical condition against legal standards. Given the high volume of disability and immigration decisions each year, administrative proceedings like these are the main settings where health care professionals play a role in advocating for their patients.

Medical-legal partnerships (MLPs) play an important role in this ecosystem. Usually housed within health care facilities, MLPs connect lawyers with medical patients who have legal needs that impact their health. Although MLPs have different legal practices, lawyers at MLPs often help their clients apply for public benefits and immigration relief. Many health care professionals participate

1. Throughout this paper, I use “health care professionals” as a shorthand for all types of clinicians that interact with MLP clients, including psychiatrists and other mental health professionals, nurses, and specialists.


5. See, e.g., Garrison v. Colvin, 759 F.3d 995, 1008-09 (9th Cir. 2014); Gambill v. Shinseki, 576 F.3d 1307, 1310 (Fed. Cir. 2009); Morgan v. Mukasey, 529 F.3d 1202, 1206 (9th Cir. 2008).


7. See Bharath Krishnamurthy et al., What We Know and Need to Know About Medical-Legal Partnership, 67 S.C. L. REV. 377, 377 (2016).


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actively in their patients’ benefit applications, but even when they do not directly advocate for their patients, their words appear in administrative proceedings through medical records. These records are a significant source of corroborating evidence for applications for disability and veterans benefits. While not every asylum proceeding involves medical evidence, records are often used to corroborate stories of torture and trauma, and to bolster an applicant’s credibility. Thus, any medical professional who comes into contact with a patient can affect the outcome of their applications for public benefits or immigration relief simply by contributing to their medical records. These are an important nexus between the medical side and the legal side of an MLP.

In administrative proceedings and elsewhere, health care professionals are not ordinary witnesses. They are bounded by codes of professional ethics that emphasize independent judgment and honesty. Meanwhile, lawyers are also bounded by ethics rules that compel them to advocate for their clients as vigorously as they can. The interaction between these tenets of medical and legal ethics can be a source of conflict in MLPs. For instance, a lawyer may push a physician to tailor his treatment notes to match legal standards. In making such a request, the lawyer is fulfilling his obligation to secure the best outcome for his client. But, in going along with the request, the physician may have to compromise his ethical duty of professional independence. This type of overreach, while often motivated by the lawyer’s good-faith desire to achieve the best outcome for her client, can damage the physician’s trust in the lawyer and willingness to help. In some cases, a health care professional’s testimony can even damage a client’s prospects for making a successful claim for public benefits or immigration relief. A health care professional who expresses doubt about a patient’s candor, symptoms, or past

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10. See, e.g., 38 U.S.C. § 5103A (2012) (requiring the VA to make reasonable efforts to find records relevant to a veteran’s claim); Miller-Wilson, supra note 2 at 649.

11. See, e.g., Tadesse v. Gonzales, 492 F.3d 905, 911 (7th Cir. 2007); DEBORAH E. ANKER, LAW OF ASYLUM IN THE UNITED STATES § 3:10 (2016).


14. See, e.g., Miller-Wilson, supra note 2, at 649.


16. See, e.g., infra note 73 and accompanying text.
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injuries can derail the application entirely.17

This symposium Article explores a gap in the MLP literature on the role of health care professionals as witnesses in administrative adjudication and on the ethical considerations surrounding that role.18 The nature of an MLP requires that the same health professionals and lawyers collaborate repeatedly to bring the same types of claims on behalf of different clients. It is critical that health care professionals and lawyers work well together in this environment. Furthermore, unlike other contexts in which health care professionals appear as expert witnesses, an MLP lawyer usually does not have the luxury of sending the patient to another physician for a second opinion—the patient’s treating physicians are likely to be the only source of testimony.19

Part I provides background on MLPs and describes the following three forms of administrative proceedings—social security disability hearings, service-connected compensation for veterans, and asylum proceedings. Part II describes the role of health care professionals in these proceedings, using statutory, regulatory, academic, and case law sources to show how medical corroboration can make or break a claim. Part III provides an account of the reasons why health care professionals may hesitate to provide corroboration for their patients, including the medical profession’s tradition of independence and the differing roles of information in medicine and in law. Part IV offers suggestions for lawyers in MLPs seeking to improve their relationships with health care professionals and to secure the best possible outcomes for their clients.

I. MLPs AND ADMINISTRATIVE ADVOCACY

As a brief primer, the first MLP was established in 1993.20 MLPs connect

17. See Rand, supra note 16 at 30.
18. There is, however, already a literature on possible conflicts between legal and medical ethics in the realms of confidentiality, mandatory reporting, and privilege. See, e.g., Rand, supra note 16, at 35; Scott, supra note 5; Killelea, supra note 2.
health care professionals with lawyers who can help their patients with legal needs. Civil legal aid can alleviate many of the social, financial, and environmental causes of poor health and, in turn, health care providers can be a referral source for legal services organizations. MLPs help patients with legal needs involving their income (e.g., government benefits), housing and utilities, education, employment, legal status, and personal and family stability. A lawyer representing an MLP client may give advice, write a letter on the client’s behalf, file forms with a government agency, or provide full representation in front of a tribunal. Health care professionals at MLPs can be doctors, nurses, community health workers, or mental health practitioners, and they attend to medical needs from acute conditions to chronic mental and physical illnesses. The legal and medical sides of the MLP usually co-locate at health care facilities, but there are many variations on the model. By combining the efforts of lawyers and health care professionals, all MLPs aim to offer better services to clients with interrelated health and legal needs.

Some of the most important legal needs can only be solved through administrative proceedings. For instance, many MLPs have clients with disabilities or other barriers to earning income. Lawyers can help these clients apply for public benefits programs, such as SSDI and veterans benefits, which are managed by an extensive administrative bureaucracy. Similarly, MLPs may also have clients who are undocumented, but may be eligible for immigration relief, such as asylum or withholding of removal. Such relief can only come from asylum officers and immigration judges, who are also part of a vast system of administrative proceedings. An applicant whose claims for benefits or immigration relief is denied can appeal to the relevant administrative agency, and then to the federal courts.

An MLP client’s application for benefits will likely give him the opportunity to present evidence before a neutral decision-maker. For example, the Social Security Administration relies on administrative law judges (ALJs) who conduct SSDI and SSI hearings and make initial decisions on benefits applications.

21. See Krishnamurthy et al., supra note 7, at 377.
22. Id. at 377–378; James Teufel et al., Legal Aid Inequities Predict Health Disparities, 38 Hamline L. Rev. 329, 355 (2015) ("A growing body of evidence supports that legal representation results in improved health outcomes.").
24. Id. (listing civil legal aid interventions of the forms described above).
25. See Krishnamurthy et al., supra note 7, at 381.
28. See supra note 8 and accompanying text.
29. 5 U.S.C. § 3105 (2012); Kent Barnett, Against Administrative Judges, 49 U.C. Davis L.
Executive Office of Immigration Review (EOIR) employs immigration judges (IJ$s) to review applications for asylum and other forms of immigration relief.\textsuperscript{30} For initial benefits determinations, the Department of Veterans Affairs relies on ratings specialists at local offices and has veterans law judges (VLJs) decide any appeals of these decisions on an open record.\textsuperscript{31} Lawyers at MLPs help their clients through these proceedings, just as they would help them through a trial in a federal or state court.

\section*{II. Health Care Professionals’ Roles in Administrative Advocacy}

While lawyers usually handle written and oral advocacy, health care professionals contribute a significant portion of the evidence in the administrative proceedings described above. All of these proceedings give applicants the opportunity to present evidence, including medical records, declarations, and other documents, in support of their claims.\textsuperscript{32} Applications for asylum, disability benefits, and service connected compensation for veterans all either require or benefit from some form of positive testimony from a health care professional.\textsuperscript{33} For instance, asylum applicants can make a stronger case for past persecution if they submit medical evidence of physical or mental trauma.\textsuperscript{34} Veteran law judges decide applications for discharge upgrades and service connected compensation based on evidence from medical records of a veteran’s health before, during, and after service.\textsuperscript{35} Applicants for disability benefits have better odds if a health care professional provides compelling testimony that they can no longer engage in activities required by their work due to a severe medical condition.\textsuperscript{36} In these types of benefit applications, an administrative decision-maker weighs testimony about the client’s medical condition and history against legal standards. This section will briefly describe the role that health professional testimony plays in each of these types of proceedings, from the perspective of the legal standards and regulations that govern them.

\begin{thebibliography}{9}
\bitem{33} See infra notes 34–36.
\bitem{34} See Morgan v. Mukasey, 529 F.3d 1202, 1206, 1211 (9th Cir. 2008); Tadesse v. Gonzales, 492 F.3d 905, 911 (7th Cir. 2007); Ardalen, supra note 4 at 14–15.
\bitem{35} Manchanda et al., supra note 9, at 11.
\bitem{36} See Miller-Wilson, supra note 2, at 644, 649.
\end{thebibliography}
A. SSI and SSDI

The Social Security Administration (SSA) offers two disability benefit programs. The Supplemental Security Income (SSI) program supports people who are both indigent and disabled.37 Meanwhile, a person who is insured and disabled—but need not necessarily be indigent—is eligible for SSDI.38 The two programs use the same process to determine whether an individual is disabled.39 Health care professionals’ testimony and medical records are important parts of the process, because an individual must have a severe physical or mental impairment or combination of impairments to qualify for benefits.40 ALJs also have a duty to develop the record, assessing the value and credibility of each medical opinion presented by both sides.41

Disability proceedings are adversarial, and almost 80% of applicants are represented by an attorney.42 Both sides have the opportunity to present evidence and to contest the evidence put forth by the other side.43 Usually, the applicant will submit medical records and other evidence from a treating physician.44 The SSA will then send the applicant to at least one consultative medical examiner for an outside assessment of the applicant’s impairments.45 Medical records also play a role because an ALJ must discount any physician conclusions that are not supported by medical evidence.46 As one commentator has noted, these records are “often, at best, unhelpful with regard to the legal question of whether the client is disabled and at worst they unintentionally undermine the client’s application.”47

Concerns about the subjectivity of medical evidence abound throughout the system.48 Even the Supreme Court has acknowledged that a consulting physician may have an incentive to make a finding of not disabled, while a treating physician may favor a finding of disabled in a close case.49 Courts have attached different amounts of deference to the opinions of treating physicians versus those of

38. Id.
39. Id.
41. Krent & Morris, supra note 37, at 376.  
42. Id. at 375.  
43. Miller-Wilson, supra note 2, at 659.  
44. Id. at 661.  
45. Id.  
46. See, e.g., Mays v. Colvin, 739 F.3d 569, 575 (10th Cir. 2014).  
47. Miller-Wilson, supra note 2 at 649.  
48. Id. at 664, 667 ("Courts . . . realized that physicians’ sworn statements—viewed as sacrosanct because of their reliability—were in fact neither more or less reliable than any other type of opinion evidence.").  
consultative physicians, but, in any event, physicians’ words have stronger weight than applicants’ words. For instance, a claimant can testify as to the extent of her pain and other symptoms, but a physician’s description of symptoms—even if they are entirely subjective—is given more weight under the regulations.

B. Veterans Benefits

The Department of Veterans Affairs (VA) administers a number of benefits programs, the largest of which compensates veterans for injuries incurred or aggravated by their military service. Unlike SSA benefits, service-connected compensation is awarded according to a non-adversarial process. The VA rates the severity of service-connected disabilities on a scale from 0 to 100 percent. Veterans with more than one disability receive a single combined rating, and a rating of 10 percent or higher entitles a veteran to compensation. Ratings specialists are not doctors and are not permitted to make their own medical judgments. By statute, the VA has a duty to assist veterans in making their claims for compensation. Usually, this means that the VA will make reasonable efforts to obtain and analyze the veteran’s medical records, but occasionally, the VA must also provide a non-partisan medical opinion at no cost to the veteran. This opinion need not involve a personal examination, but it must (1) involve a thorough and contemporaneous examination of records, (2) take into account prior medical treatment, and (3) fully inform the reviewer about the disability.

Similar to ALJs working for the SSA, VA reviewers must weigh medical records and opinions that are inconsistent or inconclusive. Aside from these rare VA-ordered examinations, a veteran’s medical records form the backbone of her application for service-connected compensation. These records may include

50. Miller-Wilson, supra note 2 at 662–63.
51. 20 C.F.C. § 404.1527(c)(2); Garrison v. Colvin, 759 F.3d 995, 1012, 1014 (9th Cir. 2014) (describing the standards for discrediting treating physician testimony, and the comparatively less strict standards for rejecting a patient’s symptom testimony).
52. Board of Veterans Appeals, supra note 31.
53. See Krisch, supra note 32, at 57 (2012).
55. Id.
56. Krisch, supra note 53, at 64 (citing Gambill v. Shinseki, 576 F.3d 1307, 1310 (Fed. Cir. 2009) (Moore, J. concurring)).
57. 38 U.S.C. § 1110(a), (b) (2012).
58. See, e.g., Cook v. Principi, 318 F.3d 1334, 1336 (Fed. Cir. 2002).
59. Krisch, supra note 32, at 63.
60. See 38 C.F.R. § 4.2 (2017) (“Different examiners, at different times, will not describe the same disability in the same language. . . . It is the responsibility of the rating specialist to . . . reconcile[] the various reports into a consistent picture . . . .”)
additional commentary from a variety of medical professionals who have treated the veteran over many years. Older medical evidence is relevant to the question of whether a veteran’s service caused or aggravated his disability, and the backwards-looking nature of the inquiry can lead to further inconsistencies. An additional challenge for veterans is that the VA prefers to see medical conclusions stated in probabilistic terms—for example, whether a certain disability is “mostly likely” or “at least as likely as not” caused by an event that occurred during a veteran’s service. Health care professionals may be reluctant to make such conclusions, let alone state them in these terms, for reasons that I will discuss below, especially if they are unaware that doing so would help their patient satisfy the relevant legal standards. Failure to do so can lead to a decision denying service connection.

C. Asylum

Asylum is a form of immigration relief that grants legal status to individuals who have experienced past persecution, or who have a well-founded fear of future persecution, in their home countries. Under the REAL ID Act of 2005, applicants must be credible. Immigration judges review asylum applications and conduct hearings with the applicant and with any witnesses she might want to call.

Although not every asylum claim requires medical evidence, health care professionals can be highly effective witnesses for two main reasons. First, a physician or a psychologist may be able to corroborate a torture victim’s story by diagnosing and treating scars and wounds caused by weapons, physical abuse, or other trauma. Even when past persecution does not leave a physical mark on an applicant’s body, he may submit medical records indicating a diagnosis of posttraumatic stress disorder (PTSD) or other mental condition. A health care professional’s second role in an asylum proceeding is to defend against an adverse credibility finding. Medical experts can explain the causal relationship between an

61. See, e.g., Wagner v. Principi, 370 F.3d 1089, 1096 (Fed. Cir. 2004).
63. Id. at 71.
64. See, e.g., Fagan v. Shinseki, 573 F.3d 1282, 1290 (Fed. Cir. 2009) (“[B]ecause the report did not state that the veteran’s disability was likely service connected, [it] was insufficient to establish service connection.”).
68. ANKER, supra note 11, at § 3.10; Caitriona Palmer & Kerri Sherlock, DOCTORS AND LAWYERS: FIGHTING FOR IMMIGRANT RIGHTS, HuM. RTS. 23 (1998).
69. Palmer & Sherlock, supra note 68, at 23.
70. See, e.g., Morgan v. Mukasey, 529 F.3d 1202, 1206 (9th Cir. 2008); Tadesse v. Gonzales, 492 F.3d 905, 911 (7th Cir. 2007); Mukamunson v. Ashcroft, 390 F.3d 110, 122–23 (1st Cir. 2004).
applicant’s past persecution and her current inability to remember events or to explain them in a coherent, consistent narrative.\textsuperscript{71} In a treatment setting, medical professionals can also help asylum seekers recount episodes of past persecution in a “coherent and linear manner, understandable to U.S. adjudicators.”\textsuperscript{72} A number of cases have acknowledged the importance of physician or mental health expert testimony in asylum cases.\textsuperscript{73}

To summarize, testimony from health care professionals is a crucial part of the administrative proceedings that determine who get disability benefits and service-connected compensation, and can play a vital role in some asylum cases as well. Health care professionals participate directly in Social Security proceedings by providing treating physician testimony, and they may submit affidavits on behalf of veterans seeking service-connected compensation. They may also serve as experts in asylum proceedings, testifying as to an applicant’s injuries from past persecution and explaining the effects of past trauma on memory and other aspects of an applicant’s presentation. In all three types of proceedings, however, health care professionals help build the medical records that the applicant will use as a primary source of evidence to support their application. Whether they want to or not, health care professionals exert significant control over their patients’ fates in administrative proceedings.

\section*{III. Health Care Professionals as Witnesses and Advocates}

If a physician were like any other witness, a lawyer would try to help him craft his testimony in ways that would be most helpful to the client. The lawyer would instruct the physician to describe the patient’s symptoms in ways that align closely or exactly with the legal standards most relevant to the application. For physicians treating veterans, this preparation would mean identifying a causal relationship between an event in service and a current diagnosis and using probabilistic terms to discuss that relationship. For asylum applicants, it would mean stating that the applicant’s account of persecution is credible and that it fits with the applicant’s physical and mental manifestations of trauma. For disability applicants, it would mean tailoring a description of symptoms to legal standards and emphasizing the relationship between an impairment and the tasks required by the applicant’s job. In any of these proceedings, a health care professional can provide insight into any inconsistencies between the different medical opinions that appear in an applicant’s medical records. A medical professional who treats a patient over a long period can use medical records to build up a case for a particular public benefit over time. A lawyer who regularly works on these types of claims—and especially

\begin{itemize}
  \item \textsuperscript{71} Anker, supra note 11, at § 3.10; Ardalen, supra note 4, at 6.
  \item \textsuperscript{72} Ardalen, supra note 4, at 13; Rand, supra note 16, at 20–21.
  \item \textsuperscript{73} See, e.g., Zeru v. Gonzales, 503 F.3d 59, 73-74 (1st Cir 2007); Lopez-Umanzor v. Gonzales, 403 F.3d 1049, 1050 (9th Cir. 2005).
\end{itemize}
an MLP lawyer who works with a relatively constant set of medical professionals—can improve his client’s position by asking a clinician to formulate his medical records, affidavits, and letters to the court in these ways.

But, a lawyer cannot treat a physician like any other witness. Like many other professionals, including lawyers, health care professionals are bounded by ethical codes.\textsuperscript{74} Although these codes allow health care professionals to take on advocacy roles, professional values and cultures can conflict with a lawyer’s means of advocating on behalf of a client.\textsuperscript{75} For instance, many physicians recognize the importance of public benefits programs in improving their patients’ health.\textsuperscript{76} But, they may be reluctant to help their patients obtain those benefits if doing so requires them to compromise their professional independence.\textsuperscript{77} Zealous advocacy is no longer an ethical requirement of the legal profession,\textsuperscript{78} but a lawyer’s efforts to “maximize the client’s advantage and minimize any disadvantage” can easily make a physician feel uneasy about her own ethical obligations.\textsuperscript{79}

The rest of this section provides a brief background on the American Medical Association’s Code of Medical Ethics, which is representative of the various codes governing health care professionals and describes how its principles can lead to two forms of conflicts between lawyers and physicians working with MLP clients. One of these conflicts stems from values that both professions share: professional independence. Another conflict reflects differing conceptions in the two professions: the role of information in medicine is very different from the role of information in a procedure-bound, adversarial legal profession.

\textit{A. Medical Ethics and Professional Culture}

Like the legal profession, the medical profession adheres to a code of ethics.\textsuperscript{80} While legal ethics are the province of state law and bar associations, the American Medical Association (AMA) centrally governs medical ethics.\textsuperscript{81} The AMA’s Code of Medical Ethics consists of a set of nine principles and a series of ethical opinions and reports put forth by the Council on Ethical and Judicial Affairs.\textsuperscript{82} The principles have been revised several times since they were first adopted in 1847,\textsuperscript{83}

\begin{itemize}
  \item \textsuperscript{74} Boumil et al., supra note 26, at 119; AM. MED. ASS’N, supra note 12.
  \item \textsuperscript{75} See Charity Scott, Doctors as Advocates, Lawyers as Healers, 29 HAMLIN E. PUB. L. & POL’Y 331, 335, 340 (2008).
  \item \textsuperscript{76} See, e.g., Manchanda, supra note 3, at 11.
  \item \textsuperscript{77} See, e.g., Miller-Wilson, supra note 3, at 649.
  \item \textsuperscript{78} See Scott, supra note 75, at 354–55.
  \item \textsuperscript{79} Norwood & Paterson, supra note 27, at 363.
  \item \textsuperscript{80} See Frank A. Riddick, The Code of Medical Ethics of the American Medical Association, 5 OSCHNER J. 6, 6 (2003).
  \item \textsuperscript{81} Id. at 7.
  \item \textsuperscript{82} Id. at 6.
  \item \textsuperscript{83} AM. MED. ASS’N, supra note 12.
\end{itemize}
and in their current form, they emphasize that a physician should uphold standards of competence, respect patients’ privacy rights, and support access to medical care for all people, among other things.84 Like the law, medicine also has an uncodified "professional culture" that influences the values and analytical approaches that physicians act on every day.85

Of the many ethical rules and cultural norms that govern the medical profession, two aspects in particular affect a physician’s participation in administrative proceedings. First, the medical profession has a strong culture of independence—indeed, earlier versions of the Principles of Medical Ethics explicitly stated: “A physician should not dispose of his services under terms of conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill ...”86 Second, medicine is rooted in science, and medical professionals seek “the whole truth” about every aspect of a patient’s condition and to avoid distorting their opinions.87 I will refer to this second principle as an information value.

The medical profession’s interrelated norms about independence and information conflict with the legal profession’s own norms in different ways. The medical profession’s independence value has a parallel in the legal profession, which has a rule that emphasizes lawyers’ professional independence.88 When two members of different professions work with the same client and each comes from a profession that values independent judgment, there may be a clash of roles or cultures.89 Conversely, the medical and legal professions conceptualize truth in different ways.90 Lawyers have a duty of candor to the court—they may not hide bad facts or bad law91—but they are specifically trained to minimize any weak


86. Riddick, supra note 80, at App’x A (providing the full text of the 1957 AMA Principles of Medical Ethics).


89. See Bounmil et al., supra note 74, at 124.

90. See, e.g., Norwood & Paterson, supra note 27, at 363–64 (emphasizing that understanding, trust, and clear delineation of roles can help overcome cultural conflict).

spots in their arguments. A doctor diagnosing a patient or assessing the prognosis for a given procedure is unlikely to act in this manner.

To summarize, lawyers and physicians are bound by ethical codes that can come into conflict when they work together on behalf of a client. Both professions emphasize independent professional judgment, which inherently leads to clashes. Each profession has a different relationship to information and truth, which can lead to different approaches to describing patients’ conditions. These conflicts can impair medical-legal collaborations on behalf of people applying for disability benefits, service-connected compensation, and asylum. The stakes are especially high in MLPs because of the potential for repeated interactions between physicians and lawyers involving the same types of claims but different patients.

IV. SUGGESTIONS FOR LAWYERS SEEKING PHYSICIAN TESTIMONY

Although some level of conflict is inevitable in a multidisciplinary environment, lawyers can take steps to minimize its effects on clients in administrative proceedings. The two sources of conflict I have identified, independence and information, require different mitigation approaches on the lawyer’s part. This section offers insights about how lawyers can use these approaches to improve relationships with health care professionals at MLPs and to obtain better testimony for their clients.

Recall that informational conflicts arise when lawyers attempt to omit, repackage, or de-emphasize information in a piece of evidence or in prepping a witness for oral testimony. As the AMA Code of Medical Ethics establishes, a physician has a more obvious duty to provide “the whole truth” than a lawyer does. This obligation can work to the client’s advantage in administrative proceedings. The right approach is not for the lawyer to persuade the physician to gloss over inconsistencies in medical records: instead, lawyers should encourage health care professionals to express their uncertainty explicitly.

In all three of the administrative proceedings discussed here, a health care professional’s opinion that expresses uncertainty can be structured so that it helps, rather than harms, a client’s chances. In social security disability proceedings, ALJs must acknowledge and assign credibility ratings to all physician opinions. An opinion that expresses some level of uncertainty may garner an advantageous credibility determination, especially if its conclusions are supported by the record.


93. See Dike, supra note 87, at 841.


95. See Dike, supra note 87, at 841.
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In service-connection proceedings, conclusions stated in probabilistic terms are welcome. In asylum cases, any corroboration from a health care professional—even a letter that says: "These scars are consistent with torture, but I cannot be certain that it actually occurred"—is likely to weigh in the applicant’s favor. In all of these proceedings, the health care professional’s expressions of uncertainty are not likely to be news to the judge or decision-maker, who is probably very familiar with the difficulties of assessing causation using only current disabilities, mental illnesses, or physical scars.

As discussed above, conflicts stemming from cultures of professional independence are inevitable when health care professionals and lawyers collaborate. Independence will always stand in the way when a member of one profession seeks to influence the way that a member of another profession does her job. A lawyer who is diligently representing his client will try to exert this type of influence every time he encounters a professional who could help a client’s legal case, but is not inclined to do so on her own. Health care professionals, from the perspective of their ethical code and professional norms, are right to resist this pressure. What, then, should a lawyer do to help secure the most helpful testimony he can?

Lawyers at MLPs are well-positioned to solve this problem. They can engage in advanced coordination and collaboration with physicians in a way that is disconnected from any particular client’s situation. This assertion is particularly salient where the medical side and legal sides of the MLP are closely knit—i.e., where the MLP’s legal clients are likely to be treated by one of a defined set of MLP-affiliated health care professionals. In such situations, an MLP lawyer knows that he is likely to seek corroborating testimony from these professionals at some point. This set of health care professionals is also likely to contribute to the medical records of his clients. As part of building up a collaborative medical-legal practice, medical professionals and lawyers should proactively discuss the aspects of their professional cultures that influence the ways that they advocate for patients. Lawyers can outline best practices for building medical records, testifying in hearings, and writing letters and affidavits on behalf of patients. This way, health care professionals will have the information they need to advocate strongly for patients, and their professional independence will not be compromised by a lawyer’s request to intervene on behalf of a specific patient.

No amount of advance coordination will eliminate the need for such requests entirely. Once a lawyer and her client decide to pursue a certain type of claim, the lawyer may need to ask for additional evidence, or a repackaging of existing evidence, from clinicians. Lawyers who face resistance to such requests may use forms that include legal standards—for example, "In your opinion, is it more likely than not that Client’s disability was aggravated by her military service?"—to pin

96. See, e.g., Morgan v. Mukasey, 529 F.3d 1202, 1206 (9th Cir. 2008).
down the health care professional's perspective on the client without putting words into his mouth. MLPs should also consider setting aside physician time and resources for clients who, for whatever reason, could benefit from a second opinion.97

CONCLUSION

This paper has described MLPs and the forms of administrative advocacy they take on for their clients. Emphasizing the importance of health care professionals' testimony in those proceedings, I have identified sources of lawyer-physician conflict as they relate to that testimony. Finally, I have offered insights about the ways that lawyers should approach their relationships with health care professionals at MLPs in order to reach the best outcomes for their clients without intruding on professional boundaries. Health care professionals' duties are first and foremost to their patients, just as lawyers' duties are to their clients. This uniting principle makes MLPs possible, and it can also give clients a better chance of obtaining the public benefits and immigration relief that they seek.

97. See Mehlman, supra note 19 and accompanying footnote text.