NORTH CAROLINA
BAR ASSOCIATION
SEEKING LIBERTY & JUSTICE

MEDICO-LEGAL GUIDELINES

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Preamble to Medico-Legal Guidelines

History Leading to the Proposed Revision of the N.C. Medico-Legal Code

Since the adoption of the original Medico-Legal Code by the North Carolina Bar Association and North Carolina Medical Society in 1956, the environment in which the physician and attorney interact has changed radically. With the introduction of standard rules of civil procedure and evidence, the broad bounds of contact between attorney, witnesses, and parties were defined. Adoption and subsequent revision of Rules of Professional Conduct further defined the attorney's ethical conduct and served as a guide in contact with physicians. Physicians, largely unfamiliar with these legal rules and guides, reacted only within the boundaries of professional respect, dignity, decorum, and the ethical principles of their health care profession. With the rise in importance and frequency of medical litigation, the professions have scrutinized attorney and physician conduct and have reached a consensus that there is a need to revise their inter-professional code. The Code was previously revised in 1972, 1986, and 1991 in attempts to update the original 1956 Code. The 1991 version was called "The Medico-Legal Guidelines of North Carolina" (the term "Guidelines" as used hereafter refers to all such versions as well as this document).

Recent Revisions

In 1997, the Joint Committee of the North Carolina Medical Society and North Carolina Bar Association decided the Guidelines should be updated given various changes in the law and because the Guidelines had not been effective in resolving certain recurring disputes between physicians and attorneys.[1] Significant revisions were made, and finally, in 2000, the Medical Society and the Bar Association adopted the 2000 Medico-Legal Guidelines.

In 2005, the Medico-Legal Liaison Committee updated the Guidelines to incorporate HIPAA privacy regulations and update other cited authorities. In 2008, Medico-Legal Guidelines were revised to include information concerning appropriate handling of mental health, substance abuse, and psychotherapy records. In 2014, the Medico-Legal Guidelines were revised again to reflect changes in applicable laws, the HITECH Act, the evolving use of electronic medical records, as well as the Medico-Legal Liaison Committee's recognition that the Medico-Legal Guidelines could be more user-friendly.

Physician Complaints

The Guidelines cannot recite all of the complaints that Physicians may have when dealing with attorneys, but common complaints include attorneys' use and sometimes misuse of subpoena power, including the failure to give physicians adequate notice of legal proceedings and the failure to pay fees of fact medical witnesses and retained medical witnesses.[2]

Physicians complain that they are uncertain of their legal duties in certain areas. Physicians are frequently confused about the duties attendant to their release of confidential medical information. They are not certain as to when they may, may not, and when they must release confidential medical records or speak with an attorney about a patient. They are often unsure about what services to bill for, whom to bill, and how to ensure payment resulting from services rendered in legal cases involving medical issues. They complain that they receive conflicting responses from attorneys regarding their duties and rights.[3]

Treating physicians, who may be potential defendants in professional liability litigation, complain that attorneys investigating those claims mislead them. The climate of inter-professional mistrust created in the professional liability context invades all areas of litigation.

Attorney Complaints

Likewise, the Guidelines cannot recite all of the complaints attorneys have about physicians. Common attorney complaints are that physicians fail to comply with subpoenas for their records or presence as a witness, that they fail to provide complete medical records, and that they bill excessively for medical records, consultation and testimony. Attorneys also complain that treating physicians refuse or are reluctant to consult with their patient's attorney or to provide live testimony on behalf of their patient. These areas of conflict cause problems for patients and attorneys, who of necessity rely on medical evidence in cases involving medical factual issues.

Scope

Throughout its history, the scope of various versions of the Guidelines has been limited to physician-attorney interactions. The Guidelines still purposefully do not apply to other health care professionals. However, there is no reason that the Guidelines cannot be considered by attorneys and other health care providers in their interactions with each

other. While the more recently adopted Guidelines, including the current version, have more specifically addressed certain areas such as workers' compensation, testimony regarding patient capacity/competency and cases involving drug and alcohol abuse medical records, the continual changes in various areas, including significant rule making changes in the area of workers' compensation make it difficult to incorporate all current rules and regulations into the Guidelines. Thus, the Guidelines are not intended to be, and should not be viewed as an exhaustive recitation of all applicable rules and regulations at any given time.

Professional Liability

Historically, the Guidelines have not addressed the interaction between attorneys and physicians who are defendants in professional liability actions. This relationship is governed by mandatory statutes, rules of ethics, and rules of procedure, and is not appropriately a subject of these Guidelines. However, these Guidelines do discuss situations where a physician may be a potential defendant in a professional liability case and also address situations where the physician is not a party-defendant but the legal action is based on claim of professional negligence asserted by a patient whom the physician treated or evaluated.[4] The Guidelines address some of the recurring concerns in this difficult area.

Treating Versus Non-Treating Witnesses

In earlier editions, the Guidelines did not always distinguish between physicians who were retained expert medical opinion witnesses and those medical witnesses who were fact witnesses by virtue of treating the attorney's client as a patient. The relationship between a physician who is a retained expert and an attorney is voluntary and reciprocal, and fee arrangements between them are business agreements restricted only by prevailing law and any ethical guidelines or requirements applicable to the attorney and/or physician. By contrast, interactions between treating physicians and patient's attorneys are not chosen, arising instead from their respective connections and duties to their mutual patient/client. The Guidelines, recognizing this distinction, preclude retained experts and attorneys from invoking the assistance of the Medico-Legal Liaison Committee in fee disputes arising between them. Nevertheless, some effort has been made in the more recent versions of the Guidelines to address matters related to "retained medical witnesses" and "fact medical witnesses" and to distinguish between the two types of witnesses where appropriate.

Throughout its history, the scope of various versions of the Guidelines has been limited to physician-attorney interactions. The Guidelines still purposefully do not apply to other health care professionals. However, there is no reason that the Guidelines cannot be considered by attorneys and other health care providers in their interactions with each other.

FOOTNOTES

1. Despite the presence of the Guidelines, recurring disputes persist between physicians and attorneys in the litigation context. Some of these disputes have been addressed to the Joint Committee of the North Carolina Medical Society and North Carolina Bar Association for dispute resolution. Other disputes have been explored by the North Carolina Bar Association Medico-Legal Liaison Committee, which conducted public hearings prior to preparing a new draft version of the North Carolina Medico-Legal Guidelines. The Committee invited speakers to the hearings who had experienced difficulty with the implementation of the Guidelines, and believed that the Guidelines needed change.
2. See Definitions of "Fact Medical Witnesses" and "Retained Medical Witnesses" in Section III, H. 1 and 2, as well as discussion of fees in Section V.
3. This occurs, in part, because the law is unclear in certain areas and uncertain in others, as reflected in these Guidelines. There also continue to be changes in the laws and rules that govern the interaction between physicians and attorneys, and thus at any given time it may be difficult to be aware of all of the changes in the law affecting those interactions.
4. In such latter situations, the physician may be required to provide testimony affecting defendant(s), including those for example who are co-workers, entities at which the physician or other health care provider works, colleagues, or persons or entities with whom a referral relationship exists.

I. Introduction

The North Carolina Medico-Legal Guidelines are the product of collaboration between the North Carolina Medical Society and North Carolina Bar Association. The Guidelines are the end-product of decades of cooperation between physicians and attorneys aimed at improving their inter-professional interactions in medical litigation. The Guidelines are not intended to and do not expand or limit any obligations of physicians or attorneys under existing federal or state laws or regulations.

The relationship between a physician and an attorney should be based upon mutual respect, courtesy, and understanding. Medical testimony is generally indispensable in legal cases to prove or disprove the nature or extent of injuries or other legally relevant medical conditions. Therefore, when accepting a patient, a physician also accepts the incidental obligation to cooperate in any legal proceedings in which the patient may become involved.[5] When attorneys make inappropriate or inconsiderate demands on physicians, they cause animosity between the professions. Without mutual cooperation by physicians and attorneys, their patients/clients become the unfortunate victim of professional ill will.

To promote inter-professional cooperation and courtesy, the particular responsibilities and expectations of physicians and attorneys should be more clearly defined. These Guidelines set out these responsibilities and expectations, citing legal and/or medical authority where applicable. These Guidelines are not exclusive, nor do they cover all situations or seek to define the outer limits of professional interrelationships. The Guidelines establish minimum aspirational standards for those relationships and encourage civility between the professions.

The Guidelines use a definition of "medical records" that was agreed upon by the North Carolina Medical Society and the North Carolina Bar Association. Other than in the Guidelines, this specific definition likely does not appear elsewhere unless it was borrowed from the Guidelines. As reflected in the definitions sections of the Guidelines, as well as in Appendix A-1 and A-2 to the Guidelines, there are numerous statutes and regulations, both Federal and State, which give a definition of the term "medical records" or of the type of information contained in a patient's medical records. The North Carolina Medical Board also has position statements related specifically to medical records.[6] The statutory definitions and Medical Board position statements are not completely consistent with one another and thus defining what constitutes a patient's "medical records" that a physician must produce in response to a release or subpoena seeking the production of all of the patient's medical records has been and continues to be a source of confusion between physicians and attorneys. This confusion has the potential to, and has in fact, caused problems for both physicians and attorneys when a complete set of medical records is not produced in response to a medical records release or a subpoena. Unfortunately, given all of the potential documents (in hard copy and in electronic form), as well as various machines that now store patient data, determining everything that may constitute the complete medical records of a patient is very difficult, even when the patient or attorney seeking medical records is very specific about what is sought. When a patient or attorney generically requests "medical records," this difficulty is increased. The Guidelines attempt to create a common framework for the production of medical information maintained by physicians with respect to their patients and to further discussion between physicians and attorneys regarding the information sought and to be produced pursuant to a medical records release or a subpoena. Generally, it is the goal of these Guidelines to encourage attorneys to be as specific as possible when requesting information in the custody or control of a physician that may constitute patient "medical records" and for physicians and their staff responding to medical records requests and subpoenas to consider all of the potential sources of patient information.

FOOTNOTES

5. See AMA Code of Medical Ethics, § 9.07 "Medical Testimony," (Noting that "physicians have an obligation to assist in the administration of justice.")
6. See N.C. Medical Board Position Statements: "Access to medical records," "Medical record documentation" and "Retention of medical records."

II. Specific Regulations

These Guidelines do not and are not intended to supplant any mandatory rules, laws or regulations. Mandatory rules (for example the Rules of Professional Conduct governing attorney behavior, the North Carolina Rules of Civil Procedure governing court procedure, the North Carolina Rules of Evidence governing the admissibility of evidence in court proceedings and the Rules of the North Carolina Industrial Commission governing workers' compensation cases), other rules, statutes, and regulations (including but not limited to HIPAA and the HITECH Act) take precedence over these Guidelines, and are always subject to change. Some relevant citation to applicable rules, laws, professional codes and position statements, and/or regulations are contained in the text of these Guidelines.

DEFINITIONS

The following definitions apply throughout these Guidelines:

A. "Physician" Defined: A physician is a person licensed to practice medicine by the North Carolina Medical Board as that term has historically been understood, i.e., medical and osteopathic physicians.[7]

B. "Attorney" Defined: An attorney is a person licensed to practice law in North Carolina by the North Carolina State Bar, or otherwise authorized to practice by North Carolina law. [8]

C. "Health Information" Defined: Health Information means any information, whether oral or recorded in any form or medium, that: (1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) Related to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. [9]

D. "Designated Record Set" Defined. Designated record set means (1) a group of records maintained by or for a covered entity that is: (i) The medical records and billing records about individuals maintained by or for a covered health care provider; (ii) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (iii) Used, in whole or in part, by or for the covered entity to make decisions about individuals. (2) For purposes of this definition, the term "record" means any item, collection or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.[10]

E. "Medical Records" Defined[11]: Medical records are a collection of Health Information and the Designated Record Set for a particular individual whether created by a physician or other health care provider[12], as well as received from a physician or other health care provider. If they contain information covered by the prohibitions against redisclosure found in 42 C.F.R. Part 2, in N.C.G.S. Sections 8-53.3, 53.4, 53.5, 53.7, or 53.8, in N.C.G.S. Chapter 122C, or in any other provision of federal or state law, the physician may produce the balance of the record, redacting the portion that may not be redisclosed, along with a statement that "the redacted records may not be released without either patient consent or a court order in accordance with applicable laws and regulations."[13] Medical records contain information that may be or are inherently sensitive and personal, and contain information that relates to an individual's physical or mental condition, medical history, medical diagnosis, or medical treatment, as well as demographic and other information that identifies or has the potential to identify the individual (e.g., patient name, address, social security number, unique identifier, etc.).[14]

F. "Medical Report" Defined: A medical report is a report generated by a physician at the request of an attorney in order to assist the attorney in preparing for litigation which involves a patient's medical condition, treatment, or prognosis. A medical report may be a narrative summary of the medical record, or it may be a response to requests for expert opinions regarding the patient's condition, treatment, or prognosis not contained in the medical record. The preparation of a medical report may, in some instances, require the physician to obtain a current evaluation of the patient.[15]

G. "Independent Medical Examination" Defined: An independent medical examination is a medical examination in which a person is required or agrees to submit to a medical examination by a physician selected or approved by a court, administrative agency or other adjudicatory body or by the mutual agreement of the parties.[16]

H. "Medical Witness" Defined: A medical witness is a physician or other healthcare provider who provides testimony concerning one or more medical issues involved in a lawsuit or claim. Three types of medical witnesses are recognized by the N.C. Medico-Legal Guidelines.[17] They are:

1. "Retained Medical Witness" Defined: A retained medical witness is a physician or other healthcare provider who has been retained by one of the parties to litigation to provide expert opinion testimony or evidence concerning one or more medical issues involved in the lawsuit or claim. [18]

2. "Fact Medical Witness" Defined: A fact medical witness is a physician or other healthcare provider who is called upon to testify or provide evidence because they have treated a patient who is a party or witness in a lawsuit or claim. [19]

3. "Independent Medical Witness" Defined: An independent medical witness is a physician or other healthcare provider who has been selected or approved by a court, administrative agency or other adjudicatory body or by the mutual agreement of the parties to perform an independent medical examination.

FOOTNOTES

7. N.C. Gen. Stat. Ch. 90, Art. 1 governs the licensure of medical and osteopathic physicians in North Carolina. A physician should expect any non-physician practitioners working under their supervision to follow the Guidelines as well. Other health care providers not working under the supervision of a physician also are encouraged to follow the Guidelines but are not required to do so unless otherwise instructed by their regulatory Board.
8. An attorney should expect any non-attorney personnel working under their supervision to follow the Guidelines as well.
9. 45 C.F.R. § 160.103
10. 45 C.F.R. § 164.501
11. As indicated in the "Introduction," other definitions of "medical records" appear in North Carolina and Federal statutes and regulations. See Appendix A-2.
12. N.C. Medical Board "Access to medical records" (Position Statement adopted 11/93, amended 5/96, 5/97, 3/02, 8/03 and 9/10) ("Each licensee has a duty on the request of a patient or the patient's representative to release a copy of the record in a timely manner to the patient or the patient's representative, unless the licensee believes that such release would endanger the patient's life or cause harm to another person. This includes medical records received from other licensee offices or health care facilities.")
13. Production of a "privilege log" or similar document describing the information that is redacted would violate several of these provisions, as a description of the type of medical care sought would itself be confidential.
14. See AMA Code of Medical Ethics Sec. 5.07, "Confidentiality: Computers" and Sec. 5.075 Confidentiality: Disclosure of Records to Data Collection Companies" (regarding confidentiality and computerized data bases). N.C. Gen, Stat. § 132-1.10(d) prohibits anyone who is preparing or filing a document to be recorded or filed with the court to include social security numbers and other personal confidential information.
15. See N.C. Gen. Stat. 90-411 (regarding reasonable fees for the preparation of medical reports). See also N.C. Rule of Civil Procedure 35.
16. Independent medical examinations occur in a number of contexts. For civil actions in North Carolina's state courts, see N.C. Rule of Civil Procedure 35. In workers' compensation cases, independent medical examinations can occur upon agreement of the parties, order of the Industrial Commission, or pursuant to N.C. Gen. Stat. § 97-27. Reference should be made to any Rules adopted by the Industrial Commission for guidance regarding communications with independent medical witnesses in workers' compensation cases. http://www.ic.nc.gov/ncic/pages/comprule.htm With regard to social security disability claims, see 20 C.F.R. §§ 404.1517 and 416.917, which discuss when the Social Security Administration will purchase a consultative examination of a disability claimant. The reports generated from these examinations are kept in the claimant's file and are available for review by the claimant and/or the claimant's representative by going to the office that has the file. The reports are not automatically sent to the claimant or the claimant's representative. The claimant may direct the Social Security Administration to release the report to his or her own doctor. See also 20 C.F.R. §§ 404.1519 to 404.1519t, 416.919 to 404.1519t, 409.1512, and 416.927 (regarding Social Security Administration Medical Advisors).
17. The obligations of medical witnesses under the Guidelines may differ, depending upon which type of medical witness they are and/or testimony they are providing. See also Turner v. Duke University, 325 N.C. 152, 381 S.E.2d 706 (1989) for a discussion about the differences between the first two types of medical witnesses identified.
18. See AMA Code of Medical Ethics, Sec. 9.07, "Medical Testimony" ("When physicians choose to provide expert testimony, they should have recent and substantive experience or knowledge in the area in which they testify, and be committed to evaluating cases objectively and to providing an independent opinion. Their testimony should reflect current scientific thought and standards of care that have gained acceptance among peers in the relevant field. If a medical witness knowingly provides testimony based on a theory not widely accepted in the profession, the witness should characterize the theory as such. Also, testimony pertinent to a standard of care must consider standards that prevailed at the time the event under review occurred.") See also Rule 702(b) – (e), (h) of the North Carolina Rules of Evidence.
19. See AMA Code of Medical Ethics, Sec. 9.07, "Medical Testimony" ("Physicians who serve as fact witnesses must deliver honest testimony. This requires that they engage in continuous self-examination to ensure that their testimony represents the facts of the case. When treating physicians are called upon to testify in matters that could adversely impact their patients' medical interests, they should decline to testify unless the patient consents or unless ordered to do so by legally constituted authority. If, as a result of legal proceedings, the patient and the physician are placed in adversarial positions it may be appropriate for a treating physician to transfer the care of the patient to another physician.")

III. Specific Situations

A. MEDICAL RECORDS

1. Ownership of Medical Records

Usually, records made or collected by or at the direction of a physician in connection with the treatment and evaluation of a patient are maintained and retained by the physician, hospital or other individual or institutional care giver. The original record is deemed to be the property of the physician, hospital, or other individual or institutional care giver. The patient has a qualified right to say who may receive information contained in the record.[20]

a. The Patient's Right to Seek an Amendment to the Designated Record Set

Under HIPAA, a patient has a right to have a covered entity amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set. A covered entity may deny an individual's request for amendment, if it determines that the protected health information or record that is the subject of the request: (i) was not created by the covered entity, unless the individual provides a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment; (ii) is not part of the designated record set; (iii) would not be available for inspection under 45 C.F.R. § 164.524; or (iv) is accurate and complete.[21]

Under HIPAA, a patient has a right to have a covered entity amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.

2. Inspection and Copying of Medical Records

a. Required Authorization

An original of the medical records or any part thereof should not be removed from the possession of a physician, hospital, or other individual or institutional care giver except upon court order, but the original should be available for inspection or copying with proper authorization.[22] A patient may give verbal authorization for the production of medical records, but a physician has the right to require that any request for medical records be in writing,[23] and if the patient is directing that the medical records be provided to anyone other than the patient, the request must be in writing.[24] Proper written authorization can be provided by the patient, an individual empowered by law to act on the patient's behalf regarding disclosure of medical records, or by order of a court or administrative agency having jurisdiction and authority to mandate such disclosure. Specifically in workers' compensation cases, there is a statutory policy "to protect the employee's right to a confidential physician-patient relationship while allowing the parties to have reasonable access to all relevant medical information, including medical records, reports, and information necessary to the fair and swift administration and resolution of workers' compensation claims, while limiting unnecessary communications with and administrative requests to health care providers."[25]

b. What Should be Produced in Response to Appropriate Authorization.

Under HIPAA, an individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set, for as long as the protected health information is maintained in the designated record set, except for: (i) psychotherapy notes; (ii) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and (iii) protected health information maintained by a covered entity that is:(A) subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 263a, to the extent the provision of access to the individual would be prohibited by law; or (B) exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2).[26]. Although attorneys are encouraged to be as specific as possible, when a request for "medical records" is made, all documents meeting the definition of "medical records" set forth in the Guidelines should be produced unless a smaller subset of records is requested.

c. Permissible Charges for Copying Medical Records and Format in which Records are Provided.

In personal injury liability and social security disability cases, permissible charges for copies of medical records are governed by N.C. Gen. Stat. 90-411. Further, in personal injury liability cases, a physician may not charge for copies of medical records requested by a patient's attorney if they wish to preserve a lien for their medical services against the patient's recovery of monetary damages for personal injury from a third party.[27] In cases other than those involving personal injury liability or social security disability, "a reasonable cost-based fee" that includes only the cost of "copying, including the cost of supplies and labor of copying" as well as the cost of postage if the copy is sent by mail, can be charged.[28] Under HIPAA, a covered entity must produce the records in the form or format requested by the individual, if it is readily producible in such form or format.[29] If records are maintained electronically, and cannot be produced in the format requested by the patient, a copy must be provided in a "readable electronic form" rather than a hard copy.[30] HIPAA provides that if access can be provided in electronic format, and that format is requested by an individual, then the patient should be allowed to receive it by paying a reasonable fee associated with reproducing the records electronically, but under the HITECH Act, the cost of producing records maintained in an electronic health record cannot exceed the labor and supply costs of reproducing the same.[31] In workers' compensation cases, permissible charges for copies of medical records are governed by N.C. Gen. Stat. § 97-26.1[32]. In social security disability cases, see 20 C.F.R. §§ 404.1514 and 416.914, and N.C. Gen Stat. § 90-411.

In personal injury liability and social security disability cases, permissible charges for copies of medical records are governed by N.C. Gen. Stat. 90-411. Further, in personal injury liability cases, a physician may not charge for copies of medical records requested by a patient's attorney if they wish to preserve a lien for their medical services against the patient's recovery of monetary damages for personal injury from a third party.[27]

d. Withholding Records where Patient Account for Medical Services Not Paid

A physician may not refuse to provide copies of medical records (including the bill for services provided to the patient) on the ground that the patient has not paid the amount due on his account for medical and other services.[33]

3. Requesting Medical Records or a Medical Report From a Treating Physician

a. Notice

An attorney should give a patient's treating physician reasonable notice of the need for inspection and copying of medical records, or of the need for preparation of a medical report. The notice should clearly specify the information and documents requested. Notice may be provided by written correspondence, or by a subpoena, and should be accompanied by appropriate authorization to release the information requested.

b. Authorization

Proper authorization is necessary before a physician can release medical information. No attorney should request and no physician should furnish any medical information concerning the history, physical or mental examination, condition, diagnosis or prognosis of a patient except with the written consent of the patient, the patient's authorized representative, an appropriate judicial or administrative order, or in conformity with other applicable legal authority.[34] A physician may disclose to a family member or other person(s) identified by a patient prior to his or her death who was involved in the individual's care or payment for health care prior to the individual's death, protected health information of the individual that is relevant to such person's involvement, unless doing so is inconsistent with any prior expressed preference of the individual that is known to the physician.[35] The scope of the authorization determines the scope of the inspection, release, copying or report. If the requesting attorney wants information beyond what is authorized to be released, the attorney must obtain additional authorization. A subpoena signed by an attorney, without more, is insufficient to allow a physician to produce any patient medical information.

c. Promptness

The physician, with proper authorization from the patient or the patient's authorized representative, should promptly furnish the attorney with a complete medical record or medical report. **HIPAA requires that records be produced within 30 days of a request or within 60 days if the requested records are kept off-site.**[36] Delay in providing the medical record or medical information may prejudice the opportunity of the patient to settle their claim or lawsuit, may delay the trial of a case, or may cause additional expense or the loss of important testimony.[37]

4. Special Considerations for Substance Abuse Diagnosis and Treatment Records and for Psychotherapy Notes

Under federal and state law, information about an individual's substance abuse or mental health diagnosis or treatment can be a trap for the unwary litigator seeking this information as well as for the physician or health care facility holding the information. Protected information includes any information about an individual, whether or not the information is in writing or recorded in some other form, and includes the patient's identity, address, medical or treatment information, and all communications by the patient to program staff.[38] The facility is prohibited from even acknowledging whether the individual is or ever was a patient at the facility absent the patient's written consent or an appropriate court order.[39] Disclosure—and subsequent re-disclosure—of records generated at a federally-assisted drug or alcohol abuse facility is strictly prohibited by complex federal rules, with criminal penalties for violation.[40] See Appendices G-1 and G-2 for an authorization form that complies with all federal and state laws and rules regarding release of substance abuse and mental health records.

a. Substance Abuse Records: (Mental health information that is part of a substance abuse record is treated in the same manner as described herein.)

A subpoena alone, even one signed by a judge, is never sufficient to compel disclosure of certain types of these records; the party seeking disclosure must provide either highly specific written consent from the patient that meets the requirements of the rules, or a court order framed in precise accord with the rules along with a subpoena.[41] There are separate federal rules governing procedures and criteria for issuance of court orders authorizing disclosure of substance abuse records for noncriminal and criminal purposes,[42] although exemptions do exist for reporting incidents of suspected child abuse and neglect to appropriate State or local authorities.[43] A court order allowing disclosure of substance abuse records must:

1. Limit disclosure to those parts of the patient record essential to fulfill the objective of the order.
2. Limit disclosure to those persons whose need for the information is the basis for the order.
3. Include necessary measures to limit disclosure for the protection of the patient, physician-patient relationship and treatment services, i.e. sealing the case record.

Disclosure of substance abuse records may only occur if other ways of obtaining the information are not available or would not be effective and the public interest and need for disclosure outweigh the potential injury to the patient, physician-patient relationship and treatment services.[44] Attorneys seeking court orders for the production of substance abuse documents should make sure that the order they obtain contains the appropriate language to allow a physician to disclose such records and be in compliance with 42 CFR Part 2.

b. Mental Health Records:

The Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985 has specific rules regarding the disclosure of information by physicians at facilities whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers.[45] [46]

c. Psychotherapy Notes:

HIPAA provides extra protections for psychotherapy notes.[47] A specific authorization separate from any other authorizations must be obtained for any use or disclosure of psychotherapy notes. For more information see 45 C.F.R. § 164.508(a)(2).[48]

d. Communicable Diseases

Physicians are required to keep strictly confidential all information and records, whether publicly or privately maintained, that identify a person who has AIDS virus infection or who has or may have certain other communicable diseases.[49] In certain circumstances enumerated in N.C. Gen. Stat. § 130A-143, such information may be disclosed.

B. Guidance to Physicians about Capacity or Competency

Physicians may be asked on behalf of a patient to testify as to the capacity of the patient to take certain actions, serve in certain roles or their competency generally. While the guidelines cannot serve as an exhaustive list of all of the questions a physician may be asked about their patients, the following opinions are those that an attorney may routinely ask a physician to give about their patient, along with the standards upon which the physician will be asked to opine:

1. Opinions of Incompetency for Incompetency Procedures.

"Incompetent adult" means an adult or emancipated minor who lacks sufficient capacity to manage the adult's own affairs or to make or communicate important decisions concerning the adult's person, family, or property whether the lack of capacity is due to mental illness, mental retardation, epilepsy, cerebral palsy, autism, inebriety, senility, disease, injury, or similar cause or condition.[50]

2. Opinions of Capacity/Incapacity to Serve as Fiduciary.

Individuals may be appointed to serve as a fiduciary in many roles, including any one or more of the following: Personal Representative (Executor or Administrator of a decedent's estate). Trustee of an inter vivos or testamentary trust, Agent (Attorney-in-Fact) under a General Power of Attorney, or Health Care Agent under a Health Care Power of Attorney. The North Carolina Uniform Fiduciaries Act does not provide any method or standard for determining incapacity of a fiduciary. Some documents, particularly trusts, may provide for a mechanism or procedure for determining the incapacity of a fiduciary. If an individual fits the definition of "incompetent adult" as described above, the individual is not fit to serve as a fiduciary. Given the high level of responsibility and good faith, and the potential consequences to the person or property of others, the level of capacity for a fiduciary should be higher than for an individual simply acting for himself.

3. Opinions on Testamentary Capacity or Lack Thereof.

A testator has testamentary capacity if he comprehends the natural objects of his bounty; understands the kind, nature and extent of his property; knows the manner in which he desires his act to take effect; and realizes the effect his act will have upon his estate.[51] The capacity required to create, amend, revoke, or add property to a revocable trust is the same as the capacity required to make a will.[52]

"Incompetent adult" means an adult or emancipated minor who lacks sufficient capacity to manage the adult's own affairs or to make or communicate important decisions concerning the adult's person, family, or property...

4. Opinions on Contractual Capacity or Lack Thereof.

A higher level of mental capacity is necessary to enter into a contract than is required for testamentary capacity. In North Carolina, courts have said the measure of capacity is the ability to understand the nature of the contract, its scope and effect, or its nature and consequences. It is not that the person should be able to act wisely or discreetly, nor to drive a good bargain, but that he should be in such possession of his faculties as to enable him to know at least what he is doing and to contract understandingly.[53]

C. Consultation and Testimony

1. Consultations

It is professional courtesy for physicians and attorneys to cooperate with one another and to abide by applicable statutes and rules so that the medical questions involved in controversies are fairly and adequately explored and presented. Where appropriate, a frank discussion between the patient's physician and the patient's attorney is helpful to give each a complete understanding of the medical and legal issues involved. When such a discussion occurs, their mutual patient/client benefits: time is saved, confusion is minimized (making settlement more likely), and inter-professional understanding is enhanced. To that end, the patient's physician(s) and attorney(s) should attempt, when appropriate, to discuss the medical questions prior to mediation, deposition, or trial. The patient's physician and the attorney should agree up front regarding the charges, if any, by the physician for consulting with the attorney at the various stages of litigation so as to avoid any later dispute.

A physician has an obligation to consult with a patient's attorney if the patient has given them written consent to do so. If a patient who has a legal claim requests a physician's assistance, the physician should furnish medical evidence, with the patient's consent, in order to secure the patient's legal rights.[55]

However, patients' physicians may not communicate with an attorney or any other person about a patient's treatment, evaluation, or condition without the written authorization of the patient or the patient's authorized representative, or a court order, or other lawful authority. In workers' compensation cases, there may be circumstances under which the employer or its representative may communicate with physicians.[54] When in doubt, a physician should contact the N.C. Industrial Commission to ascertain the current status of the law on this issue.

A physician has an obligation to consult with a patient's attorney if the patient has given them written consent to do so. If a patient who has a legal claim requests a physician's assistance, the physician should furnish medical evidence, with the patient's consent, in order to secure the patient's legal rights.[55] However, this obligation to consult may be limited if the patient has, or may have, a potential malpractice claim against the physician.[56] If a physician is unclear whether the obligation to consult with a patient's attorney may be limited, the physician is encouraged to ask the advice of their professional liability insurer, consult with legal counsel for the North Carolina Medical Society, and/or consult with their own attorney.

An attorney investigating a potential professional liability claim should avoid misleading the physician regarding the physician's potential malpractice liability. Where the patient's attorney is investigating a specific physician's potential professional liability or reasonably foresees that the physician's actions may be the basis of a claim, the attorney has an obligation to so advise that physician.[57]

2. Physician Deposition Testimony

Deposition testimony of a physician is sometimes necessary and is preferably arranged at a scheduled time at a convenient place that can reasonably accommodate a deposition. If the physician can provide reasonable accommodations at his/her office, the attorney should agree to do the deposition there.[58] Depositions are necessary for one or more reasons. A deposition is a discovery tool which allows one side of a lawsuit to discover the information known to witnesses for the other side. Typically, the attorney opposing the patient's claim is prohibited from communicating with the patient's physician prior to trial except at a deposition.[59] The opposing attorney is frequently in need of the physician's deposition testimony in order to defend against the patient's claim. The deposition is usually that attorney's only opportunity to discern the physician's opinion regarding the patient's medical condition. A deposition may also be necessary to perpetuate testimony[60] or for later use instead of the physician's appearance at trial in order to accommodate the physician's schedule, even though a physician's appearance in court is usually the most effective way to present testimony. A deposition may be a preferable alternative to trial testimony, however, when the attorney believes the physician's testimony is of secondary importance. Physicians should agree to videotaped depositions when requested as this is usually being done to accommodate the physician's schedule. North Carolina Rules of Evidence and of Civil Procedure sometimes prohibit an attorney from using a deposition in state civil court. In those instances, the physician must appear in court to testify.[61]

FOOTNOTES

20. In workers' compensation cases, see N.C. Gen. Stat. § 97-25.6 and rights of employer to receive information even absent consent of employee. See also AMA Code of Medical Ethics, Sec. 10.1 "Fundamental Elements of the Patient-Physician Relationship" ("The patient has the right to receive information from physicians. . . . Patients are also entitled to obtain copies or summaries of their medical records [and] to have their questions answered. . . ."); See also footnote 12. Complex rules govern the disclosure of medical information about an individual's substance abuse, diagnosis or treatment, and the disclosure of such information is not exhaustively addressed in these Guidelines. See Part IV(A)(4), infra, and N.C. Gen. Stat. § 122C-3(9). HIPAA citation regarding personal representatives can be found at 45 C.F.R. 164.502(g).
21. 45 C.F.R. 164.526(a)
22. HIPAA mandates that a valid authorization must contain, at a minimum: (1) a description of the information to be used or disclosed; (2) the name(s) of those authorized to make the requested use or disclosure; (3) the name of the person(s) to whom the covered entity may make the requested use or disclosure; (4) the purpose of the use or disclosure; (5) an expiration date or event (e.g., end of research study); and (6) the signature of the individual and date (if the authorization is signed by a personal representative of the individual, a description of such representative's authority). 45 C.F.R. § 164.508(c)(1)(i-vi). Also, § 164.508(c)(2) requires that the authorization contain statements adequate to place the individual on notice that the individual has the right to revoke the authorization, the ability or inability to condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization, and the potential for information to be disclosed pursuant to the authorization to be subject to redisclosure.
23. 45 C.F.R. § 164.524(b)(l)
24. 45 C.F.R. § 164.524(b)(3)(ii)
25. N.C. Gen. Stat. § 97-25.6(a). N.C. Gen. Stat. § 97-25.6(c)(1) provides that "an employer is entitled, without the express authorization of the employee, to obtain the employee's medical records containing relevant medical information from the employee's health care providers.". N.C. Gen. Stat. § 97-25.6(b) defines "relevant medical information" is defined as any medical record, report, or information that is any of the following: (1) Restricted to the particular evaluation, diagnosis, or treatment of the injury or disease for which compensation, including medical compensation, is sought; (2) Reasonably related to the injury or disease for which the employee claims compensation; and/or (3) Related to an assessment of the employee's ability to return to work as a result of the particular injury or disease. Reference should be made to the Rules of the Industrial Commission or contact made with the Industrial Commission regarding the right of the employer or others acting on its behalf to obtain medical records without the express authorization of the employee. HIPAA permits such disclosure under an exemption that reads: "A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation...." 45 C.F.R. § 164.512(l). See also AMA Code of Medical Ethics, Sec. 5.09 "Confidentiality: Industry-Employed Physicians and Independent Medical Examiners," ("When a physician renders treatment to an employee with a work-related illness or injury, the release of medical information to the employer as to the treatment provided may be subject to the provisions of worker's compensation laws. The physician must comply with the requirements of such laws, if applicable. However, the physician may not otherwise discuss the employee's health condition with the employer without the employee's consent or, in the event of the employee's incapacity, the appropriate proxy's consent.")
26. 45 C.F.R. § 164.524(l)
27. See N.C. Gen. Stat. §§ 44-49 and 44-50. See also N.C. Rule of Professional Conduct 1.15-1 and N.C. RPC 69, ("Payment of Client Funds to Medical Provider") and N.C. RPC 125 ("Disbursement of Settlement Proceeds") (requiring attorney to obey client's instruction not to pay medical providers from the proceeds of settlement in the absence of a valid physician's lien).
28. 45 C.F.R. § 164.524(c)(4)
29. 45 C.F.R. § 164.524(c)(2)
30. 78 Fed. Reg. at 5,702
31. 45 C.F.R. § 164.524(c)(2); HITECH Act; North Carolina currently has no statute setting forth the costs of producing records electronically, and thus the HIPAA standard in 45 C.F.R. § 164.524(c)(4) should apply.
32. North Carolina Industrial Commission Minutes, January 12, 1995. See Appendix E for additional information.
33. See N.C. Medical Board, "Access to medical records" (Position Statement, adopted 11/93, amended 5/96, 9/97, 3/02, 8/03 and 9/10) ("Medical records should not be withheld because an account is overdue or a bill is owed.") An attorney may not pay client bills for treatment, although they may advance medical litigation expenses on behalf of a client. See N.C. Rule of Professional Conduct 1.8(e), RPC 80, "Lending Money to a Client," and CPR 157 (attorney may advance cost of medical examination if same is litigation expense).
34. See N.C. Gen. Stat. §§ 8-53 and 8-44.1; N.C. Rule of Civil Procedure 45(c); the Rules of the Industrial Commission. See RPC 162, "Communications with Opposing Party's Physicians" (prohibiting attorney from communicating with opposing party's non-party treating physicians unless the opposing party consents, in non-workers' compensation setting); RPC 180 "Communications with Opposing Party's Physicians" (extending that prohibition to passive listening); RPC 224 (extending prohibition to employer's attorney in workers' compensation setting). See also RPC 184 "Communications with Physicians Performing Autopsy" (allowing opposing counsel to communicate with pathologist performing autopsy without decedent's personal representative's consent). Compare AMA Code of Medical Ethics §§ 5.05 "Confidentiality," ("The physician should not reveal confidential information without the express consent of the patient, subject to certain exceptions which are ethically justified because of overriding considerations."); See also Sec. 5.055 "Confidential Care for Minors," and Sec. 5.06 "Confidentiality: Attorney-Physician Relation"
35. 45 C.F.R. § 164.510(b)(5)
36. 45 C.F.R. § 164.524(b)(2)(i) and (ii)
37. N.C. Medical Board "Medical record documentation" (Position Statement, adopted 5/94, amended 5/96, 5/09 and 5/13) (medical record "provides a legal document to verify the delivery of care").
38. 42 C.F.R. § 2.11

39. 42 C.F.R. § 2.13
40. See 42 U.S.C. 290dd-3; 42 C.F.R. § 2.1 et seq. Examples of federal assistance triggering coverage of the rules include tax exemption and participation in Medicare or Medicaid. 42 C.F.R. § 2.12(B). Also, see N.C. Gen. Stat. §§ 122C-51 et seq.
41. See 42 C.F.R. §§ 2.31, 2.33 (written consent); 42 C.F.R. § 2.61 et seq. (court orders).
42. See 42 C.F.R. §§ 2.64, 2.65
43. See 42 U.S.C. §§ 290dd-2 and N.C. Gen. Stat. § 122C-52 through 55.
44. 42 CFR § 2.64
45. See N.C. Gen. Stat. §§ 122C-52 through 56.
46. See Appendices G-1, G-2 and I for sample releases and a court order satisfying requirements for disclosure of substance abuse and mental health records.
47. See Appendix A-1 for the definition of psychotherapy notes.
48. See Appendices G-3 and G-4 for a sample authorization form satisfying HIPAA requirements for release of psychotherapy notes.
49. N.C. Gen. Stat. § 130A-143.
50. N.C. Gen. Stat. § 35A-1101(7)
51. In re Estate of Whitaker, 144 N.C. App. 245, 547 S.E.2d 853 (2001)
52. N.C. Gen. Stat. § 36C-6-601
53. Matthews v. James, 88 N.C. App. 32, 362 S.E.2d 594 (1987)
54. See N.C. Gen. Stat. § 97-25.6 and footnote 25.
55. See AMA Code of Medical Ethics § 9.07, "Medical Testimony," ("As citizens and as professionals with specialized knowledge and experience, physicians have an obligation to assist in the administration of justice. When a legal claim pertains to a patient the physician has treated, the physician must hold the patient's medical interests paramount, including the confidentiality of the patient's health information, unless the physician is authorized or legally compelled to disclose the information. Physicians who serve as fact witnesses must deliver honest testimony. This requires that they engage in continuous self-examination to ensure that their testimony represents the facts of the case. When treating physicians are called upon to testify in matters that could adversely impact their patients' medical interests, they should decline to testify unless the patient consents or unless ordered to do so by legally constituted authority. If, as a result of legal proceedings, the patient and the physician are placed in adversarial positions it may be appropriate for a treating physician to transfer the care of the patient to another physician.")
56. Compare § 9.07, "Medical Testimony and § 8.12, "Patient Information" (requiring physicians to be honest and open in their dealings with patients even in situations where "a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient.").
57. See Rule 4.3 of the North Carolina Revised Rules of Professional Conduct.
58. In criminal cases in North Carolina state courts, medical witnesses usually testify at the trial because medical testimony is rarely taken by deposition.
59. Crist v. Moffatt, 326 N.C. 326, 389 S.E.2d 41 (1990); RPC 162.
60. This occurs when the witness may be legally unavailable at the time of a subsequent trial.
61. For example, absent the consent of the opposing party, witness depositions may not be used in lieu of live testimony unless an exception applies. N.C. R. Civ. P. 32(a)(4). See also N.C. Gen. Stat. § 8-83(11).

IV. Trial Situations

A. Subpoenas

1. Witness Subpoenas

a. North Carolina State Courts

Under North Carolina law, physicians, acting as medical witnesses[62] are required to be subpoenaed before the Court may award them an expert witness fee after they have testified at a deposition or trial.[63] Physicians should not attempt to avoid service of subpoenas.

In issuing trial subpoenas to physicians, attorneys must consider and be mindful of the physician's patient scheduling needs. For that reason, the attorney should notify the physician of the intent to subpoena the physician to trial. **The trial subpoena itself should be issued as soon as practical, but in no event should a subpoena be issued later than seven days before trial.** Only a rare emergency calls for later issuance of the subpoena.[64] Where appropriate, the subpoena for attendance at the trial as a witness should reflect the actual time for the physician to appear and/or "will call when needed" or "on standby," if the actual time is uncertain. If the actual time is uncertain, the attorney or someone in the attorney's office should keep the physician informed on a daily basis as to the status of the trial. An attorney has little or no control over scheduling a case.[65] Accordingly, physicians should not necessarily alter the office schedule but should bear in mind the possibility of being called to court. At the same time, the attorney or someone in the attorney's office should keep the physician informed on a daily basis as to the status of the calendar. When a case is postponed or not reached during a court session, the attorney should immediately notify the physician. Physicians have continuing and often unpredictable responsibilities to their patients and, insofar as they are able, attorneys should make arrangements with a minimum of inconvenience or delay.

Court calendaring systems vary between judicial districts[66] in North Carolina. Under court calendaring rules in some judicial districts, a case will automatically reappear on a trial calendar if it has previously been postponed or not reached. The new trial session, and the case's position on the trial calendar, if known, should be relayed to the physician by letter as soon as possible. If for some reason the new trial week is inconvenient for the physician, they should notify the attorney immediately and in no event later than one week after notice of the new trial date.[67]

Under North Carolina law, physicians, acting as medical witnesses[62] are required to be subpoenaed before the Court may award them an expert witness fee after they have testified at a deposition or trial.[63] Physicians should not attempt to avoid service of subpoenas.

b. Workers' Compensation Cases

The Workers Compensation Rules of the North Carolina Industrial Commission and Chapter 97 of the North Carolina General Statutes should be consulted regarding the testimony of physicians. **A party to a workers' compensation case must obtain permission from the Industrial Commission before taking and offering the deposition of a medical witness.[68]** In those rare instances when physicians are subpoenaed to testify at a hearing, they will be on telephone standby until notified.

2. Subpoenas for Medical Records

Often parties to a lawsuit will subpoena medical records to a trial without requesting the presence of the physician who made them. As in the case of trial subpoenas to physicians (see Section V.A.1. above), subpoenas for medical records should be issued as soon as possible, but in no event should a subpoena be issued later than seven days before trial. Only a rare emergency calls for later issuance of the subpoena.[69] A physician's options in responding to a subpoena for medical records depend in part on who is subpoenaing the records, and on what authorization that person has to view the records. Subpoenas for medical records containing substance abuse and psychiatric information require special attention. See IV A. 4. above.

a. Records Subpoenaed With Authorization and/or Pursuant to Court Order or Other Authority

If the party subpoenaing the medical record has the written consent of the patient or the patient's personal representative to inspect the records, or if the subpoena is accompanied by a judicial or administrative order, or is issued in conformity with other applicable legal authority the subpoena may be complied within one of several ways. The custodian of the records may bring them to court and testify to their authenticity and completeness, or the records may be mailed to the presiding judge or their designee accompanied by an affidavit authenticating them signed by the medical record custodian.[70] Only those medical records expressly authorized by the order should be released in accordance with the order.[71]

b. Records Subpoenaed Without Authorization and Without Court Order or Other Authority

Medical records are often subpoenaed to North Carolina state courts by parties without authorization to inspect the records and without a court order requiring their disclosure.[72] This happens often in personal injury cases, where defense attorneys routinely subpoena plaintiffs' medical records for a variety of legitimate reasons.[73] A party may properly subpoena medical records they lack authorization to inspect by stating in writing on the subpoena that the records are being subpoenaed by one without legal authority to inspect them, and who will not inspect them absent the written consent of the patient or the patient's personal representative or judicial or administrative order, or in conformity with other applicable legal authority.[74]

A party may properly subpoena medical records they lack authorization to inspect by stating in writing on the subpoena that the records are being subpoenaed by one without legal authority to inspect them, and who will not inspect them absent the written consent of the patient or the patient's personal representative or judicial or administrative order, or in conformity with other applicable legal authority.[74]

Prior to the release of medical records subpoenaed without authorization and without court order or other authority, it is imperative to make sure that the release of such information is permitted under HIPAA. HIPAA will not allow health care providers to release health information pursuant to a subpoena that is not accompanied by an order of court or administrative tribunal, unless the health care provider receives "satisfactory assurance" from the requesting party that reasonable efforts have been made to (1) provide notice to the person whose records are being requested or (2) secure a qualified protective order for the records. Each of these alternatives must meet the requirements enumerated in the HIPAA rules. In the absence of such "satisfactory assurances" from outside sources, the health care provider must make a reasonable effort to provide the notice or seek a qualified protective order sufficient to meet the requirements of the rule.

Also, before releasing medical records subpoenaed without authorization and without court order or other authority, a physician should receive one of the following:

1. The patient's written authorization to release the information requested;
2. A court order to release the requested information;
3. A qualified protective order meeting the requirements of Section 164.512 (e);
4. Evidence demonstrating that reasonable efforts have been made to provide written notice to the individual whose records are being requested, in accordance with the requirements of Section 164.512 (e)(1)(iii); or
5. Evidence demonstrating that reasonable efforts have been made to secure a qualified protective order for the requested records, in accordance with the requirements of Section 164.512 (e)(1)(iv)[75].

Absent one of the above, a written objection to the subpoena may be made on the grounds that compliance would be in violation of HIPAA, specifically Section 164.512(e). The objection must be (1) in writing, (2) delivered to the party or attorney designated in the subpoena and (3) made within 10 days after service of the subpoena or before the time specified for compliance if the time is less than 10 days after service.[76]

In the event of an objection or a question about compliance, records-subpoenaed without authority may be placed in a sealed envelope addressed to the Judge presiding at the session of court to which the records have been subpoenaed, and marked: "To remain sealed until otherwise ordered by the presiding Judge."[77]

B. Notice for Trial

1. Initial Trial Settings

It is imperative both from the standpoint of the efficient administration of justice and the physician's scheduling needs that medical witnesses receive as much notice as possible in the setting of a particular case for trial. Under present calendaring procedures in North Carolina state court civil actions, only the week for trial can be designated specifically. There can be no assurances as to when or if the case will be reached that particular week.

2. Medical Witness Availability

Once an attorney has first received notification that a trial is to be scheduled, they should contact their medical witnesses regarding availability for trial. At that time, each medical witness should inform the attorney of those weeks when they will not be available to testify. Once the case has received a definite trial setting, the attorney should immediately confirm the medical witness' availability for that particular week by letter.

3. Final Trial Calendar

When a case appears on the final trial calendar for a particular week, the attorney should notify the medical witness regarding the calendaring of the case, its status on the calendar, and an estimate as to the day when the case will be reached. This should be confirmed in writing to the medical witness. If the medical witness has not already been subpoenaed, that should be done at this time.

4. Court Appearance

The business of the courts cannot be governed by the convenience of witnesses, whoever they may be. However, court appearances interrupt medical witness' professional schedule and attorneys should make every reasonable effort to minimize that interruption. The attorney should not require medical witnesses to come in court and sit for long periods of time waiting to be put on the witness stand. The attorney should give the medical witness as much advance notice as is reasonably possible, so that their patient schedule may be rearranged with a minimum of disruption. The medical witness should be alerted by telephone a reasonable time before he or she is actually needed in court.

Medical witnesses are obligated to be in court at the time requested, and should notify the attorney of their arrival. Timing is important not only for the orderly presentation of the case, but also for the convenience of everyone involved in the proceedings. Physicians have ongoing and often unpredictable responsibilities to patients. In such instances, the attorney should request that the medical witnesses be allowed to testify out of order or at another time. When a medical emergency arises, attorneys should be notified immediately in order to make alternative arrangements and, if appropriate, to seek the court's release of the medical witness or postponement of the medical witness' appearance until the emergency has passed.

C. Fact Medical Witnesses and Retained Medical Witnesses

1. Generally

a. Expert Status

As a fact medical witness, the physician's role is to provide information, not to advocate a position. The attorneys serve as the advocates. The fact medical witnesses, the court, and the attorneys should show mutual respect and consideration to each other. A retained medical witness will be expected to advocate on behalf of the party who retained them.

In general, in a court of law, there are two types of witnesses—fact and expert. Expert witnesses, because they possess knowledge not generally known to the jury, are allowed to express opinions. In order to be an expert, it is necessary to know more than the jury knows and to have an opinion about the subject under inquiry. In cases of alleged medical negligence, more stringent requirements apply. The presiding judge at trial may make an initial inquiry into the qualifications of an expert witness to testify and either permit or limit the testimony.

Because medical witnesses virtually always testify as experts, even when they may also be fact witnesses, the Guidelines treat all medical witnesses as expert witnesses, and differentiate between the types of expert medical witnesses.[78] In order to be accepted as an expert in a trial in North Carolina state courts, the presiding judge must find that the witness has expertise.[79]

Treating physicians, as fact medical witnesses, typically testify as hybrid fact-expert witnesses, because of their training and knowledge and by virtue of their treatment of a patient whose medical condition is at issue. They may testify about medical observations,[80] or to observations of facts unrelated to their medical expertise. They may also testify about their expert opinions within the scope of their medical expertise. These witnesses are referred to as fact medical witnesses in the Guidelines.

It is not necessary that a medical witness have treated or examined a patient in order to testify as an expert. Expert medical testimony may be based upon a review of the medical chart or a hypothetical set of facts. Witnesses who testify in this fashion typically have been retained by one of the parties for the purpose of providing expert opinion testimony, and do not have a physician-patient relationship with the party whose medical condition is at issue. These witnesses are referred to as retained medical witnesses in the Guidelines.

b. Preparation

Proper preparation for conferences, depositions, and trial testimony includes a review of the relevant medical records. The physician's office staff should cooperate in scheduling preparatory conferences and depositions at a mutually convenient time, when they are least likely to be interrupted by patient problems, other appointments or operating times. Attorneys should go to the physician's offices for such conferences unless the physician desires to meet elsewhere.

c. Independent Medical Examinations

Attorneys should provide independent medical witnesses with the ground rules of the independent medical examination submitted to them in writing, including who is to get a report, where copies should be sent, who is to pay for the examination, and the purpose and extent of the examination. Where the examination has been ordered selected or approved by a court, administrative agency or other adjudicatory body, attorneys should also provide the independent medical witness with a copy of the order approving or selecting them.

2. Fees

a. General Considerations

Medical witness charges for assisting attorneys in legal matters should be reasonable, reflecting the physician's experience, the level of specialization, the environment in which the physician practices, and the demand for his or her services. While an agreement on the fees charged by a retained medical witness will usually be negotiated at the beginning of the relationship, an attempt should also be made to discuss and agree upon the fees to be charged by the fact medical witness prior to the fact medical witness undertaking any specific task. It is generally accepted practice in North Carolina state court civil cases that fact medical witnesses are entitled to reasonable compensation for time spent in conferences, preparation of medical reports, depositions, time spent out of the office for court or other appearances, and for travel costs. The fact medical witness may require payment for depositions, conferences, and consultations at the time of the service.

It is generally accepted practice in North Carolina state court civil cases that fact medical witnesses are entitled to reasonable compensation for time spent in conferences, preparation of medical reports, depositions, time spent out of the office for court or other appearances, and for travel costs.

The recommended fee for a fact medical witness' court appearance should be measured from the time the fact medical witness leaves their office to go to court until they return to their office from court, and should also include compensation for time spent preparing to testify, even though a successful patient at trial is only allowed to recover from the opposing party the time actually spent at the trial testifying.[81] Under certain circumstances, the presiding judge will set a fee for the medical witness.[82]

An attorney is ethically prohibited from having an economic interest in a client's claim. Therefore, while an attorney may advance fees which are incurred in pursuing claims,[83] all such fees are ultimately the responsibility of the patient/client.[84]

An attorney should not place an undue burden on fact medical witnesses for services rendered at an attorney's request on behalf of a patient/client. **No attorney should request a fact medical witness to consult with them or prepare a medical report for them where the client is unable to pay for the same, unless they are willing to advance the cost of such litigation expenses or they have informed the fact medical witness that the client is unable to pay for their services.** If the client is unwilling to ultimately pay for the same, the attorney should not request such services.

For some patients and clients, prepayment is not feasible and alternative methods of payment must be considered. The fact medical witness, attorney, and the patient may agree to any lawful method of payment.

b. Fees in Workers' Compensation Cases

In workers' compensation cases, all expert witness fees, which include fees for fact medical witnesses and retained medical witnesses, may be subject to approval by the NC Industrial Commission. Regardless of the fees that such witnesses may charge, those fees may be limited by maximum amounts set by the Industrial Commission. Failure to promptly pay an expert witness following entry of an order to do so will result in the assessment of a 10% penalty. Medical witnesses and attorneys should seek an understanding as to the terms of payment for an expert witness fee, to the extent possible, prior to obtaining expert witness testimony in workers' compensation cases. [85]

c. Prohibition Against Contingent Fees

Attorneys are prohibited from offering and physicians are prohibited from accepting fees wholly or partially contingent upon the outcome of the matter in which medical testimony is offered.[86] A fee shall not be deemed contingent for the reason that the patient's financial condition may render collection difficult in the event that the patient does not prevail in a legal action.

d. Fees for Retained Medical Witnesses

All services and fees of retained medical witnesses are subject to negotiation between the physician and the contracting party. Also, unless agreed to between the parties, any such service rendered does not create a physician/patient relationship.

Retained medical witnesses are permitted to charge a reasonable fee if their court appearance is canceled without sufficient time for the physician to reschedule patients, surgery, and consultations. However, retained medical witnesses should make a reasonable effort to profitably reschedule their time in order to minimize expense or loss.

e. Fees for Independent Medical Witnesses

Independent medical witness fees may either be established by the court, administrative agency or other adjudicatory body selecting or approving them, or by the party seeking their appointment, or by the parties by agreement. Independent medical witnesses should determine how they will be paid, and by whom, prior to conducting the independent medical examination.

f. Pro Bono/Criminal Cases

When an attorney stipulates in writing that they are handling a client's case without charge or expectation of payment from any recovery, then a treating physician should consider providing medical reports and testimony free of charge. Should an attorney be awarded payment unexpectedly, the treating physician should be notified promptly by the attorney so that a charge may be made by the physician if appropriate.

If the patient is a victim in a criminal prosecution case, then the treating physician should provide a medical report to the investigating law enforcement agency free of charge.

FOOTNOTES

62. See Section III(E) above defining the types of medical witnesses recognized under the Guidelines. Where the Guidelines refer to a physician as a 'medical witness' the statement refers to all types of medical witnesses defined therein.
63. N.C. Gen. Stat. § 7A-305(d)(11) allows a Court the discretion in a civil case to award "reasonable and necessary fees of expert witnesses solely for actual time spent providing testimony at trial, deposition, or other proceedings." N.C. Gen. Stat. § 7A-314(d) addresses the compensation of an expert witness in both criminal and civil cases, noting that the expert witness "shall receive such compensation and allowances as the court, or the Judicial Standards Commission, in its discretion, may authorize." Each allows the Court in its discretion to authorize payment of expert witness fees and allowances, but only when the witness has testified (either at trial or deposition) after having been served with a subpoena. State v. Johnson, 282 N.C. 1, 191 S.E.2d 641 (1972); Town of Chapel Hill v. Fox, 120 N.C. App. 630, 463 S.E.2d 421 (1995). Neither section compels parties to seek a judicial determination of expert witness fees or who is to pay them. N.C. Gen. Stat. § 7A-454 addresses under what circumstances a court may order payment of expert witnesses who testify on behalf of indigent criminal defendants. N.C. Rule of Evidence 706 governs who shall pay, and what amount, shall be paid to expert witnesses appointed by the Court in civil and criminal actions. N.C. Gen. Stat. § 15-7 governs the payment of physicians appointed to conduct post-mortem examinations of homicide victims. In cases before the Industrial Commission, expert witness fees are set by the Commissioner or Deputy Commissioner hearing the case. See N.C. Gen. Stat. §§ 97-90(c) and 97-26.1.
64. A specific example of a "rare emergency" arises pursuant to the statutory provisions of N.C. Gen. Stat. § 50B-2, which permits a party alleging acts of domestic violence to seek a hearing on an ex parte or expedited basis.
65. Each time a case is scheduled for trial, an attorney must prepare the case fully and subpoena all the witnesses. Many times cases are scheduled for trial several times before they are actually called for trial by the Court.
66. Judicial Districts in North Carolina include one or more counties, depending upon whether the district is primarily urban or rural.
67. This is because attorneys do not have power to postpone scheduled trials and must apply to a Judge for a continuance. The later the application for a continuance, the less likely it is that the Court will grant the requested postponement.

68. See N.C. Gen. Stat. § 97-80 (d) and (e).
69. As noted in Section V.A.1.a., a "rare emergency" may arise pursuant to the statutory provisions of N.C. Gen. Stat. § 50B-2, which permits a party alleging acts of domestic violence to seek a hearing on an ex parte or expedited basis.
70. See N.C. Rule of Civil Procedure 45(c). Although Rule 45(c) specifically authorizes the "custodian of hospital medical records" to respond to a subpoena for "hospital medical records as defined in N.C. Gen. Stat. § 8-44.1" by certified mailing of the records, it has become common practice in North Carolina state courts for all types of medical records to be sent by certified mail unless an issue arises as to the authorization of the subpoenaing party to inspect the records. N.C. Gen. Stat. § 8-44.1 broadly defines "hospital medical records." A physician should not assume it is sufficient to send an affidavit in lieu of the personal appearance of the records custodian and should confirm with the patient's attorney that an affidavit will be acceptable.
71. 45 C.F.R. § 164.512(e).
72. N.C. Gen. Stat. § 8-53 authorizes a resident or presiding judge, in the trial division where the case is pending, or the Industrial Commission pursuant to law, to order the disclosure of the records without authorization at or before trial where to do so is necessary to a proper administration of justice. A person responding to such a subpoena where no authorization appears should only send the subpoena to the court where the action is pending.
73. Defense counsel may subpoena to a court proceeding the records of current and/or prior treating physicians they have no authority to inspect. In this situation, the attorneys involved expect that, if the patient's attorney objects to disclosure of the records to the defense counsel, the presiding judge at the trial of the action will examine the records in camera (privately) to determine whether the records should be ordered released for the inspection of the subpoenaing party. See N.C. Rule of Professional Conduct 1.2(c) and RPC 236 "Misuse of Subpoena Process" (prohibiting abuse of the subpoena process by subpoenaing medical records to an attorney's office where no legal proceeding is occurring).
74. See Appendix C, Sample Subpoena for Medical Records without Authorization and without Court Order or Other Authority to Inspect.
75. 45 C.F.R. § 164.512(e).
76. N.C. Rule of Civil Procedure, Rule 45(c).
77. See Appendix C, Sample Letter to Accompany Records sent to Court in Response to Sample Subpoena for Medical Records without Authorization and without Court Order or Other Authority to Inspect.
78. See II (E) above for definition of the three types of expert medical witnesses.
79. If a medical witness is not tendered to and accepted by the presiding judge as an expert, they may not express expert medical opinions and the judge will not have authority to award them an expert witness fee.
80. Medical observations will often be based on medical expertise and therefore be based on expert opinion. For example, when testifying to their medical diagnosis of a patient, the fact medical witness is expressing an expert medical opinion.
81. N.C. Gen. Stat. § 7A-305(d)(11).
82. This only occurs on motion of the party prevailing in a matter, if they have called the medical witness, the medical witness has testified pursuant to subpoena, and has been received by the court as an expert witness. In this instance, the prevailing party seeks to have the fee set and taxed against the losing party as a court cost. See N.C. Gen. Stat. § 7A-314. This fee may not necessarily represent the entire fee owed a retained or fact medical witness by virtue of their contractual relationship with the attorney and/or their patient or client. Nothing compels a party to move for expert witness fees to be taxed as costs. See also N.C. Gen. Stat. §§ 6-20 and 7A-305.
83. Such fees are called 'litigation expenses' and are to be distinguished from charges for treatment, which may not be ethically advanced by attorneys. See footnote 33.
84. Where the attorney incurring the fee does not represent the patient, the fee is nonetheless a litigation expense to be borne by his or her client. This typically happens when the defense attorney takes the deposition of a fact medical witness, and is responsible for their fees for testifying.
85. See N. C. Gen. Stat. §§ 97-25.6(i) and 97-26.1(iii) and NC Industrial Commission Rule 610(3).
86. See AMA Code of Medical Ethics §§ 9.07 "Medical Testimony" ("Physician testimony must not be influenced by financial compensation; for example, it is unethical for a physician to accept compensation that is contingent upon the outcome of litigation.") and 8.10 "Lien Laws" (allowing liens only where "the fee is fixed in amount and not contingent on the amount of settlement of the patient's claim against a third party). See also Rule 702(f) of the North Carolina Rules of Evidence. Cf. N.C. Gen. Stat. §§ 44-49 through 44-51 (N.C. lien laws allocating fees based on pro rata share of percentage of recovery).

V. Medico-Legal Liaison Committee

The N.C. Bar Association Medico-Legal Liaison Committee is composed of attorneys whose professional practice includes working with individuals and businesses who regularly represent or serve as legal counsel for patients, hospitals and related entities, insurance carriers, physicians, and other licensed and non-licensed health care providers, or otherwise have reason to interact with health care providers as a part of their practice. Its purpose is to create a better understanding, a closer relationship, and unity between the medical and legal professions, so that each may better serve the other and the public. In order to fulfill that purpose, the Medico-Legal Liaison Committee shall meet at least annually to:

- Promulgate revisions to these Guidelines as necessary to keep them legally current and effective;
- Report as necessary to the N.C. Medical Society and N.C. Bar Association about the work of the Committee and make any appropriate recommendations; and
- **Accept and mediate reported complaints of attorneys and physicians who experience problems related to a failure to comply with these Guidelines[87] and, where appropriate, forward such reports to the proper disciplinary authorities.**

FOOTNOTES

87. However, the Medico-Legal Liaison Committee will not mediate fee disputes between retained expert witnesses and attorneys, or between independent medical witnesses and attorneys.

NORTH CAROLINA
BAR ASSOCIATION
SEEKING LIBERTY & JUSTICE

MEDICO-LEGAL GUIDELINES

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