

## Multidisciplinary Representation of Patients: The Potential for Ethical Issues and Professional Duty Conflicts in the Medical-Legal Partnership Model

Marcia M. Boumil

Debbie F. Freitas

Cristina F. Freitas

Follow this and additional works at: <http://digitalcommons.law.umaryland.edu/jhclp>

 Part of the [Health Law Commons](#)

---

### Recommended Citation

Marcia M. Boumil, Debbie F. Freitas, & Cristina F. Freitas, *Multidisciplinary Representation of Patients: The Potential for Ethical Issues and Professional Duty Conflicts in the Medical-Legal Partnership Model*, 13 J. Health Care L. & Pol'y 107 (2010).

Available at: <http://digitalcommons.law.umaryland.edu/jhclp/vol13/iss1/7>

This Article is brought to you for free and open access by DigitalCommons@UM Carey Law. It has been accepted for inclusion in Journal of Health Care Law and Policy by an authorized administrator of DigitalCommons@UM Carey Law. For more information, please contact [smccarty@law.umaryland.edu](mailto:smccarty@law.umaryland.edu).

# MULTIDISCIPLINARY REPRESENTATION OF PATIENTS: THE POTENTIAL FOR ETHICAL ISSUES AND PROFESSIONAL DUTY CONFLICTS IN THE MEDICAL-LEGAL PARTNERSHIP MODEL

MARCIA M. BOUMIL\*

DEBBIE F. FREITAS\*\*

CRISTINA F. FREITAS\*\*\*

This Article explores some persistent questions that arise in interdisciplinary collaborations. In the past decade much writing has praised the benefits of the medical-legal partnership model—where physicians and lawyers work together to improve the health outcomes of low-income children. At the same time, however, many sympathetic skeptics have worried about the ethical implications of lawyers and physicians sharing privileged information. For example, physicians and lawyers often have conflicting obligations such as mandated reporting requirements that apply to physicians but typically not to lawyers. This Article examines some of the legal and ethical issues that confront the medical-legal partnership model. Part I explores the benefits of physicians and lawyers working together on behalf of patients to realize outcomes that neither can achieve on their own. Part II addresses some of the ethical dilemmas that can arise when lawyers and physicians share information. This Article also includes the original findings of a 2009 partnership-wide survey regarding common partnership practices that relate to the topics discussed. This Article concludes that as long as critical professional obligations are recognized and care is taken to preserve ethical boundaries, physicians, lawyers, and social workers can collaborate without posing undue risk to each other's ethical

---

Copyright © 2010 by Marcia M. Boumil, Debbie F. Freitas, and Cristina F. Freitas.

\* Associate Professor of Public Health and Community Medicine, Tufts University School of Medicine; M.S., Tufts University; J.D., University of Connecticut; LL.M., Columbia University.

\*\* J.D., 2010, Northeastern University School of Law; M.P.H., 2010, Tufts University School of Medicine.

\*\*\* J.D., 2010, Northeastern University School of Law; M.P.H., 2010, Tufts University School of Medicine.

commitments, compromising each other's professional duties, or diminishing the quality of patient care.

#### INTRODUCTION

The medical-legal partnership<sup>1</sup> (MLP) model refers to an arrangement wherein a health care organization affiliates with a legal and/or advocacy entity for the purpose of addressing a patient's health care needs that cannot be remedied by medicine alone.<sup>2</sup> For example, asthma patients who reside in mold-ridden apartments benefit only marginally from asthma medication prescribed by their physicians since the medication does little to ameliorate the underlying housing conditions that exacerbate the asthma.<sup>3</sup> MLPs take a more comprehensive approach to improving the health status of patients by addressing the broader issues that impact patient health.<sup>4</sup> By introducing on-site legal advocacy into traditional medical settings, such as hospital departments and medical clinics,<sup>5</sup> the MLP model seeks to address the underlying socioeconomic determinants that perpetuate poor health.<sup>6</sup> For over a decade, the MLP model has promoted the integration of advocacy services into the health care setting by adding lawyers and social workers, including students and volunteers, to the health care team.<sup>7</sup> As of 2010, seventy-seven partnerships utilized the MLP model.<sup>8</sup> While the MLP model

---

1. In this Article, the term *medical-legal partnership* (MLP) includes those hospital clinics and other medical providers who have teamed with lawyers or other advocates in order to address the socioeconomic roots of a patient's illness. While some MLPs may have a focus on a particular patient population (children, cancer patients, etc.), the benefits and risks of utilizing the MLP model to serve the population are likely shared, regardless of specialization.

2. See Randy Retkin et al., *Lawyers and Doctors Working Together—A Formidable Team*, HEALTH LAW., Oct. 2007, at 33, 34 (discussing the growing "importance of the psychosocial, legal, economic, ethical, and cultural aspects" that surround health care).

3. Alina Das, *The Asthma Crisis in Low-Income Communities of Color: Using the Law as a Tool for Promoting Health*, 31 N.Y.U. REV. L. & SOC. CHANGE 273, 288 (2007).

4. See, e.g., Retkin et al., *supra* note 2, at 33–34 ("While physicians are ideally placed . . . to observe the health effects of . . . their patients' care, it is a lawyer who can offer the perspective and resources needed to understand patients' medical-legal problems . . .").

5. Barry Zuckerman et al., *Why Pediatricians Need Lawyers to Keep Children Healthy*, 114 PEDIATRICS 224, 225 (2004).

6. Retkin et al., *supra* note 2, at 33.

7. See, e.g., Barry Zuckerman et al., *supra* note 5, at 225 (describing the model used at Boston Medical Center, which began over a decade ago and incorporates several lawyers, students, and volunteers). In a 2009 MLP survey conducted by the authors of this Article, in which forty-five partnership sites participated, over 95% of the sites utilized at least one lawyer, 93% utilized at least one medical doctor, 80% utilized at least one social worker, 53% utilized at least one law student, 44% utilized at least one paralegal, 31% utilized at least one medical student, 17% utilized at least one Master of Public Health student, and 8% utilized at least one undergraduate student. This survey was approved by the Tufts University Investigational Review Board and is available from the primary author upon request.

8. See Nat'l Ctr. for Med.-Legal P'ship, MLP Network, <http://www.medical-legalpartnership.org/mlp-network> (last visited Feb. 1, 2010). These partnerships have joined in a

initially focused exclusively on serving children, it has recently embraced a broader service population, including: the elderly, HIV patients, cancer patients, chronically ill adults, and other vulnerable populations.<sup>9</sup>

The common goal of these partnerships is to promote the health and well-being of patients through medical-legal collaboration.<sup>10</sup> Many of these patients lack

---

voluntary affiliation known as the *MLP Network*, in order to facilitate the dispersion of best practices, information exchange, and collaboration amongst MLP sites. *Id.* According to the MLP Network, these sites include: Albany Law School Health Law Clinic; Chicago Medical-Legal Partnership for Seniors; Child Advocacy Today; Child and Youth Law Program; Child Health Advocacy Program, Charlottesville; Child Health Advocacy Program, Richmond; Children's Health Advocacy Project; Children's Law Center/Health Access Project at Children's National Medical Center; Cincinnati Child Health-Law Partnership; Cleveland Community Advocacy Program; Colorado Medical-Legal Partnership; Delaware Medical-Legal Family Advocacy Program; East Bay Medical-Legal Partnership; Families' Legal and Medical Partnership; Family Advocacy Project; Family Advocates; Family Advocates of Central Massachusetts; Family Healthcare Advocacy Project; Family Healthcare Medical-Legal Partnership; Family Legal Health Program at the Hospital for Sick Children; Health Advocacy Program; Health Education Advocacy and Law Project, Lynchburg; Health Education Advocacy Law Project, Suffolk; Health Education and Legal Support; Health Law Partnership; Health Law Partnership for Families; Indiana Health Advocacy Coalition; Iowa Legal Aid Health and Law Project; Jacksonville Family Advocacy Program; KIDS LEGAL Medical Partnership; Legal Aid for Children; Legal Initiatives for Kids; Legal Services Program; LegalHealth; Leonard Street and Deinar Legal Clinic; Los Angeles Medical-Legal Collaborative for Education; Los Angeles Medical-Legal Partnership; Marin Medical-Legal Partnership; Medical-Legal Assistance for Families; Medical-Legal Partnership for Children in Durham; Medical-Legal Partnership for Children in Hawaii; Medical-Legal Partnership for Children, Chicago; Medical-Legal Partnership for Children, Kansas City; Medical-Legal Partnership for Children, Nashville; Medical-Legal Partnership for Children, Phoenix; Medical-Legal Partnership for Children, Tulsa; Medical-Legal Partnership of New Orleans; Medical-Legal Partnership Project; Medical-Legal Partnership, Boston; Medical-Legal Partnership, Holyoke; Medical-Legal Partnership, Philadelphia; Medical-Legal Partnership, West Palm Beach; Medical-Legal Partnership, West Virginia; MedicoLegal Partnership for Children—RioGrande Valley; MedLaw Project; Montana Family Advocacy Program; Nebraska Medical-Legal Partnership; New Hampshire Health Law Collaborative; New Jersey Legal Assistance to Medical Patients Project; New Mexico Medical-Legal Alliance for Children; Peninsula Family Advocacy Program; Program for the Health of the People; Project HEAL; Rhode Island Medical-Legal Partnership for Children; Rochester Health Education and Law Partnership; San Francisco Medical-Legal Partnership; Silicon Valley Medical-Legal Partnership; Southeast Kansas Medical-Legal Partnership; Southern Illinois Law and Health Project; Syracuse Medical-Legal Partnership; The Lancaster Medical-Legal Partnership for Families; The San Diego Benefits Advocacy Project; The University of Michigan Law School Pediatric Advocacy Initiative; Toledo Medical-Legal Partnership for Children; Tucson Family Advocacy Program; Volunteers of Legal Service Children's Project; Washington Medical-Legal Partnership for Children. *Id.*

9. See Barry Zuckerman et al., Comment, *Medical-Legal Partnerships: Transforming Health Care*, 372 LANCET 1615, 1616 (2008) ("In the USA, the future of [MLPs] will involve broad expansion to multiple high-risk populations (the model originated in paediatrics), such as those who are elderly, disabled, or affected by chronic disease."); Amy Killelea, Note, *Collaborative Lawyering Meets Collaborative Doctoring: How a Multidisciplinary Partnership for HIV/AIDS Services Can Improve Outcomes for the Marginalized Sick*, 16 GEO. J. ON POVERTY L. & POL'Y 413, 419, 431–36 (2009) (discussing MLP services for HIV patients).

10. The MLP model essentially operates according to three core principles: (1) direct access to legal services and on-going advocacy for patients in order to prevent poor health outcomes; (2) train health care professionals regarding socioeconomic determinants of poor health and how legal resources can alleviate the burden of those determinants; and (3) advocate systemically to affect local, state, and

the resources or wherewithal to advocate for themselves.<sup>11</sup> The MLP model provides pro bono legal and advocacy services for those unable to pay.<sup>12</sup> MLPs typically provide education, advocacy, and direct legal services to patients whose health conditions stem from, or are exacerbated by, housing, utilities, nutrition, special education, immigration, health insurance, disability, or safety concerns.<sup>13</sup> Clinicians who identify these issues, but have few resources to address them, can refer patients to the MLP where advocacy staff can attempt to address the underlying causes of patients' poor school performance, safety issues, or lack of adequate food, heat, electricity, or hot water.<sup>14</sup> When these issues are identified, the clinician offers the patient a referral to the MLP, indicating the nature of the medical condition and the socioeconomic situation that may be contributing to it. If the patient is agreeable, the advocacy staff meets with the patient, gathers a more comprehensive history, and proposes possible means of intervention. Potential strategies can range from phone calls to lawsuits filed on behalf of the patient.<sup>15</sup>

Communication between the clinical and advocacy staff is an essential component of the MLP because the multidisciplinary collaboration requires the exchange of information.<sup>16</sup> Medical conditions frequently have a social or environmental component;<sup>17</sup> an understanding of this interaction is at the heart of the multidisciplinary MLP model and is necessary to tailor appropriate

---

national policy in order to realize broad improvements in child health. Barry Zuckerman et al., *From Principles to Practice: Moving from Human Rights to Legal Rights to Ensure Child Health*, 92 ARCHIVES OF DISEASE IN CHILDHOOD 100, 101 (2007).

11. See, e.g., Monisha Cherayil et al., *Lawyers and Doctors Partner for Healthy Housing*, 39 CLEARINGHOUSE REV. J. POVERTY L. & POL'Y 65, 68 (2005) (noting that low-income individuals in need of healthy housing "often lack the knowledge and ability to defend their rights vis-à-vis their landlords and inspectional services").

12. Zuckerman et al., *supra* note 9, at 1616.

13. See Zuckerman et al., *supra* note 5, at 224–25 (discussing factors that contribute to poor health in children).

14. See, e.g., Chén Kenyon et al., Commentary, *Revisiting the Social History for Child Health*, 120 PEDIATRICS e734, e736 (2007) (explaining that where problems arise from poor housing conditions and other environmental factors, lawyers may be more helpful than doctors in attaining a legal remedy).

15. See, e.g., Cherayil et al., *supra* note 11, at 69 (describing legal assistance offered for individuals in need of healthy housing, beginning with contacting the landlord and culminating in civil and criminal action); Das, *supra* note 3, at 290–91 (discussing the use of legal remedies for asthma patients whose condition is triggered by poor housing conditions).

16. In the 2009 MLP survey, *supra* note 7, 80% of the sites reported having clinical staff share information verbally with advocacy staff either in person or via telephone, 55% allowed advocates access to a patient's medical record, 52% shared information via a written referral in an email, 50% shared information via a written referral that was faxed, 43% shared information by delivering the referral to the advocacy staff in person, and 41% shared information by documenting the referral in the medical record.

17. See Abraham E. Morse et al., *Environmental Correlates of Pediatric Social Illness: Preventative Implications of an Advocacy Approach*, 67 AM. J. PUB. HEALTH 612, 615 (1977) (discussing the relationship between environmental factors and the existence of acute medical conditions in children).

interventions and treatments. At the same time, this model risks creating conflicts among the professional duties and ethical obligations of the diverse MLP providers, potentially compromising the patients' rights that MLPs strive to uphold.<sup>18</sup> Despite the significant benefits of integrating the provision of legal services into the health care setting,<sup>19</sup> such risks should be fully explored to avoid unintended consequences to these partnerships and the patients they serve.

### I. PROFESSIONAL SYNERGY TO BENEFIT PATIENTS

Overall health is a function of many determinants, including economic, social, environmental, genetic, and racial factors.<sup>20</sup> These factors disproportionately affect low-income individuals,<sup>21</sup> whose increased exposure to environmental hazards, poor sanitation and safety, and inadequate nutrition exacerbate their medical conditions.<sup>22</sup> When these social determinants wreak their havoc on the health of vulnerable populations, hospital departments and medical clinics are typically the first witnesses.<sup>23</sup> For this reason, the health care setting often provides an ideal place in which to address these interactions.<sup>24</sup>

Patients trust medical providers with personal information and may speak to them about financial hardships, troubled relationships, and other socioeconomic stressors.<sup>25</sup> This trust facilitates the identification of health-related social problems.<sup>26</sup> It also leads patients to value their physicians' advice and to follow their recommendations.<sup>27</sup> Due to the shortage of primary care physicians in the

---

18. See *infra* Part II.C.

19. For additional discussion of the benefits of the MLP, see Elizabeth Tobin Tyler, *Allies Not Adversaries: Teaching Collaboration to the Next Generation of Doctors and Lawyers to Address Social Inequality*, 11 J. HEALTH CARE L. & POL'Y 249, 253–55 (2008).

20. See Mary E. Northridge, Editorial, *It Takes Lawyers to Deliver Health Care*, 95 AM. J. PUB. HEALTH 376, 376 (2005) (calling for a “deeper understanding of the social, historical, and environmental” factors that contribute to individual health).

21. Agency for Toxic Substances & Disease et al., *Environmental Health*, in U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTHY PEOPLE 2010: OBJECTIVES FOR IMPROVING HEALTH 8-9 to -10 (2d ed. 2000), available at <http://www.healthypeople.gov/document/pdf/Volume1/08Environmental.pdf> (“Studies have linked race and socioeconomic status to increased exposure to environmental hazards . . .”).

22. *Id.* at 8-4.

23. David I. Schulman et al., *Public Health Legal Services: A New Vision*, 15 GEO. J. ON POVERTY L. & POL'Y 729, 771 (2008).

24. *Id.*

25. See Arvin Garg et al., *Improving the Management of Family Psychosocial Problems at Low-Income Children's Well-Child Care Visits: The WE CARE Project*, 120 PEDIATRICS 547, 553 (2007) (demonstrating that parents were candid in their discussions with health care providers because of their motivation to get to the root of their family's health problems).

26. See *id.* at 553–54 (noting that such trust-based relationships have “significant[ly] impact[ed] . . . referral rates for family psychosocial problems”).

27. See David H. Thom et al., *Measuring Patients' Trust in Physicians when Assessing Quality of Care*, 23 HEALTH AFF. 124, 124, 126 (2004) (concluding that improved trust will likely improve health

U.S.,<sup>28</sup> primary care visits have become shorter and less frequent.<sup>29</sup> Therefore, each clinic visit, and the opportunity it provides to intervene in the overall health of the patient, becomes more important. The MLP model also becomes increasingly valuable as physicians identify social or environmental factors that contribute to their patients' morbidity, but have less time to address those contributory factors.

Despite being at an increased risk for illness,<sup>30</sup> research has consistently demonstrated that children from less affluent families utilize health care services less frequently than children from moderate and affluent families.<sup>31</sup> Indeed, low-income children receive fewer well-care visits, are less likely to receive timely vaccinations, and wait longer to seek medical care when sick.<sup>32</sup> Maximizing the utility of each health care visit is therefore essential. By pairing clinicians with on-site advocacy, the MLP model attempts to address, more holistically, poor health outcomes by simultaneously targeting many of the socioeconomic antecedents.<sup>33</sup>

The collaboration of lawyers and physicians allows patients to leave the medical clinic with a more comprehensive prescription for improved health.<sup>34</sup> Indeed, while a physician may prescribe medication to treat their patients' acute illness, an advocate may intervene with phone calls, letters, and court filings, that cite pertinent statutes and case law, in order to address the underlying problem.<sup>35</sup>

---

outcomes based on findings that "patients with higher trust in their physician were significantly more likely to report engaging in . . . recommended health behaviors").

28. Barbara Bein, *Fewer Medical Students Choose Family Medicine in 2009 Match*, AM. ACAD. OF FAM. PHYSICIANS NEWS, Mar. 19, 2009, <http://www.aafp.org/online/en/home/publications/news/news-now/resident-student-focus/20090319match.html>.

29. Thomas Bodenheimer, *Primary Care—Will It Survive?*, 355 NEW ENG. J. MED. 861, 861–62 (2006); Press Release, Am. Optometric Ass'n, *Recession Cutting into Doctor Visits, According to New Consumer Survey* (Sept. 29, 2009), available at <http://www.aoa.org/x13475.xml>.

30. Pamela Tames et al., *Commentary, The Lawyer Is In: Why Some Doctors Are Prescribing Legal Remedies for Their Patients, and How the Legal Profession Can Support this Effort*, 12 B.U. PUB. INT. L.J. 505, 505 (2003).

31. E.g., Anne Elixhauser et al., *Health Care for Children and Youth in the United States: 2001 Annual Report on Access, Utilization, Quality, and Expenditures*, 2 AMBULATORY PEDIATRICS 419, 422 (2002); Sylvia Guendelman et al., *Access to Health Care for Children and Adolescents in Working Poor Families: Recent Findings from California*, 43 MED. CARE 68, 68 (2005).

32. Elixhauser et al., *supra* note 31, at 422.

33. Jane R. Wettach, *The Law School Clinic as a Partner in a Medical-Legal Partnership*, 75 TENN. L. REV. 305, 307 (2008); see also J. Michael Norwood & Alan Paterson, *Problem-Solving in a Multidisciplinary Environment? Must Ethics Get in the Way of Holistic Services?*, 9 CLINICAL L. REV. 337, 341 n.9 (2002) (defining *holistic services* as "an approach taken by some lawyers . . . that includes awareness . . . that the client may have additional unmet non legal needs").

34. Tames et al., *supra* note 30, at 505–06.

35. See Cherayil et al., *supra* note 11, at 69 (discussing an array of legal options to obtain healthy housing, from contacting the landlord to filing a civil or criminal action); Retkin et al., *supra* note 2, at 34 (explaining that physicians and a lawyer/advocate have the ability to work together to effectively treat all aspects of a patients' life, exposing the patient to a broader treatment plan).

For instance, asthmatic patients not only obtain a prescription for an inhaler,<sup>36</sup> they also leave with strategies to compel recalcitrant landlords to remove mold and implement pest management strategies;<sup>37</sup> children diagnosed with ADHD obtain a prescription for a stimulant<sup>38</sup> and progress toward an individualized education plan,<sup>39</sup> and domestic violence victims receive medical treatment, a safety plan, and an application for a restraining order. These types of complex health needs defy a solely medical or legal solution, and patients benefit greatly from the joint medical-legal effort.<sup>40</sup>

Utilizing advocacy in clinical settings in order to achieve both immediate medical relief as well as long-term improvements in health-related social problems has been recognized as an effective strategy in improving patient health since the late 1970s.<sup>41</sup> Barry Zuckerman and the Family Advocacy Program at Boston Medical Center first pioneered the concept of using lawyers to provide clinical on-site advocacy in the early 1990s, allowing patients to realize the benefit of multidisciplinary interventions.<sup>42</sup> One current MLP collaboration between St. Luke's Roosevelt Hospital and the New York Legal Assistance Group reported that advocacy intervention succeeded in eleven of twenty-one cases involving substandard housing issues where independent doctor and social worker intervention had previously failed.<sup>43</sup> More importantly, in those patients who had received legal advocacy intervention, visits to the hospital emergency room for the same problem were reduced by ninety-four percent.<sup>44</sup> As Zuckerman recently noted, when legal issues arise, lawyers can help physicians keep their patients healthy because "[l]awyers . . . have the precise tools necessary for effective intervention—knowledge of how to navigate decision-making systems, expertise in the assertion of different types of legal authority, and training in the art of advocacy and persuasion."<sup>45</sup>

---

36. See, e.g., F.E. Hargreave et al., *Assessment and Treatment of Asthma*, 25 CAN. FAM. PHYSICIAN 1207, 1209 (1979) (discussing the treatment of asthma via inhalers).

37. Wettach, *supra* note 33, at 306.

38. Ctrs. for Disease Control & Prevention, Attention-Deficit/Hyperactivity Disorder: Treatment, <http://www.cdc.gov/ncbddd/adhd/treatment.html> (last visited Feb. 21, 2010) (describing stimulants as the "best-known and most widely used treatments" for ADHD).

39. Cf. Wettach, *supra* note 33, at 307–08 (explaining that the medical-legal partnership enables those with bipolar disorder and anxiety to establish an education plan designed specifically for the individual).

40. *Id.* at 307.

41. See, e.g., Morse et al., *supra* note 17, at 612–15 (discussing family advocacy in pediatric settings).

42. Tyler, *supra* note 19, at 250–51; Zuckerman et al., *supra* note 5, at 225.

43. Ed Susman, *Analysis: An Asthma Patient's Best Friend?*, REDORBIT.COM, Oct. 25, 2006, [http://www.redorbit.com/news/health/705869/analysis\\_an\\_asthma\\_patients\\_best\\_friend/index.html](http://www.redorbit.com/news/health/705869/analysis_an_asthma_patients_best_friend/index.html).

44. *Id.*

45. Zuckerman et al., *supra* note 10, at 101.



The synergy between lawyers and doctors also helps lawyers advocate more effectively for their clients.<sup>46</sup> Since advocating for patients' legal needs often requires documentation from medical providers,<sup>47</sup> the MLP model streamlines administrative processes and helps patients to obtain more quickly the public benefits and legal entitlements for which they are eligible.<sup>48</sup>

Despite the synergy that is created and the benefits that result from medical-legal collaboration, the model is vulnerable to the differing, and sometimes divergent, professional duties and ethical obligations of the physicians and advocacy staff.<sup>49</sup> In some circumstances, this model may unwittingly jeopardize the rights of the patient.<sup>50</sup>

## II. LEGAL AND ETHICAL CHALLENGES IN THE MLP MODEL

"Even successful innovations in legal service delivery raise challenging questions about professional standards of ethics and responsibility."<sup>51</sup> While multidisciplinary models, such as the MLP, have many benefits, such partnerships also give rise to several important questions. Does the MLP comply with the Health Insurance Portability and Accountability Act (HIPAA)?<sup>52</sup> When confidential medical information is shared with advocacy staff, does it lose its confidentiality?<sup>53</sup> When privileged legal information is shared with clinical staff, does it lose its privileged nature?<sup>54</sup> What is the legal status of non-lawyer MLP volunteers?<sup>55</sup> What is the role of informed consent in making MLP referrals?<sup>56</sup> What are the obligations of the MLP, or medical staff, if a matter giving rise to a mandated report is revealed in the course of advocacy?<sup>57</sup> Are there inconsistent professional obligations within the MLP model?<sup>58</sup> While no court has ruled on these potential ethical and duty conflicts, consider whether a multidisciplinary partnership exposes itself to

46. Ellen M. Lawton, *The Family Advocacy Program: A Medical-Legal Collaborative to Promote Child Health and Development*, 17 MGMT. INFO. EXCHANGE J. 12, 16 (2003).

47. For example, the Woman, Infants, and Children program (WIC), which provides nutritional supplements, education, counseling, and referrals to low income pregnant, postpartum, and breastfeeding women, their infants, and children up to age five, 7 C.F.R. §§ 246.10-.11 (2009), requires a health care provider to determine the applicant's nutrition risk. *Id.* § 246.10(d)(5). Additionally, both state and federal disability benefits and programs require documentation of the patient's impairments from medical providers. *Id.* § 246.10(d)(1)-(3).

48. Wettach, *supra* note 33, at 307.

49. *See infra* Part II.C.

50. *See infra* Part II.B.

51. Tames et al., *supra* note 30, at 510.

52. *See infra* Part II.D.

53. *See infra* Part II.B.

54. *See infra* notes 90-94 and accompanying text.

55. *See infra* notes 96-99 and accompanying text.

56. *See infra* notes 171-88 and accompanying text.

57. *See infra* notes 123-26 and accompanying text.

58. *See infra* Part II.C.

liability, or its clients to harm, in the case studies discussed below. A more detailed discussion of some of the professional and ethical conflicts that may arise when lawyers and doctors partner together to advocate for patients follows these scenarios.

#### A. *The Client in an MLP Model*

In today's society, when a family member gets sick, often the entire family presents to the health care facility.<sup>59</sup> For purposes of the MLP, any one of these family members may request advocacy services: a parent that initiates MLP contact on behalf of a child (such as in pediatric-oriented programs);<sup>60</sup> an adult child on behalf of a parent (such as in the newer elder- and oncology-oriented programs);<sup>61</sup> or a sibling on behalf of another needy sibling.<sup>62</sup> Since the very nature of an MLP is to utilize a holistic approach to health care,<sup>63</sup> members of the MLP frequently witness first hand the inherent ambiguity in identifying the client when families are involved in seeking advocacy.<sup>64</sup> Indeed, it is not unusual for family members to initiate contact, attend meetings, and even play a significant role in directing the course of representation.<sup>65</sup>

The fact that any family member may request services on behalf of a patient requires MLPs to be vigilant in identifying the client.<sup>66</sup> Identifying the client is essential to securing the fundamental attributes of the attorney-client relationship,

---

59. See Richard J. Botelho et al., *Family Involvement in Routine Health Care: A Survey of Patients' Behaviors and Preferences*, 42 J. FAM. PRACTICE 572, 574–75 (1996) (reporting that “most patients prefer that a family member or friend accompany them into the examination room” for a “family conference”).

60. See, e.g., Texas RioGrande Legal Aid, TRLA Times, <http://trlatimes.wordpress.com/2009/09/21/under-one-roof-trlas-mlaf-program/> (last visited Feb. 21, 2010) (presenting the story of a deaf child whose mother initiated medical-legal services on her child's behalf).

61. Cf. Teresa Stanton Collett, *The Ethics of Intergenerational Representation*, 62 FORDHAM L. REV. 1453, 1461 (1994) (“It is common in . . . elder law for the lawyer to be contacted by an adult child who requests . . . [representation] for the parent.”).

62. Cathy Allen et al., Sibling Leadership Network, *Expanding the Circle of Support Through Policy and Advocacy: Brothers, Sisters and Caregiving for Individuals with Developmental Disabilities*, in TAMAR HELLER ET AL., *THE SIBLING LEADERSHIP NETWORK: RECOMMENDATIONS FOR RESEARCH, ADVOCACY, AND SUPPORTS RELATING TO SIBLINGS OF PEOPLE WITH DEVELOPMENTAL DISABILITIES* 12, 13 (2008), available at [http://www.aucd.org/docs/resources/SLN\\_White\\_Paper\\_Final.pdf](http://www.aucd.org/docs/resources/SLN_White_Paper_Final.pdf) (discussing the unique role that siblings play in advocating for individuals with developmental disabilities).

63. See Tyler, *supra* note 19, at 274–77 (discussing holistic problem solving of the MLP).

64. Cf. Collett, *supra* note 61, at 1461 (“Client identification is far more complex when the initial contact is made by someone other than the person seeking representation, or when several individuals . . . [present] initially.”).

65. *Id.*

66. *Id.*

including loyalty, confidentiality, and competency.<sup>67</sup> These fundamental duties are owed solely to the client,<sup>68</sup> and the presence of third parties (such as family members or MLP team members) may compromise the evidentiary and testimonial privileges and legal immunities typically associated with lawyer-client communication.<sup>69</sup> Consider this situation:

Ms. Lopez visits Dr. Julio, her hospital-based, family practice physician, complaining of head and stomach pain. The physician has had a long relationship with the family and also treats her two children. Upon physical examination, he discovers bruises highly indicative of domestic violence on Ms. Lopez's body. She denies physical abuse and declines the assistance of the clinic's social worker who offers to refer her to a shelter. After being advised by the social worker that domestic violence puts children at risk and could result in her losing custody of her two children, ages five and eleven, Ms. Lopez reluctantly agrees to speak with a member of the MLP staff. A note of the MLP referral is made in the medical record, and Ms. Lopez meets with the MLP attorney, Maria Brown, that same day. After the intake, Attorney Brown assigns the case to a second year law student. Ms. Lopez agrees to have updates on her case shared with Dr. Julio, and the second year law student dutifully complies, sending periodic updates to Dr. Julio.

Over the next two weeks, Ms. Lopez eventually discloses that there is, in fact, domestic violence in her home and that both she and her eleven-year old son (a child of her prior marriage) have been victimized. Ms. Lopez, who has been subjected to violence in the past, is both emotionally and financially dependent on her husband, and terrified to leave her current home. Despite urging, Ms. Lopez feels powerless to implement any sort of meaningful safety plan to protect her children. Attorney Brown, the law student, and Dr. Julio discuss the matter including the immediate risk of danger to the older child. With few other options available to them, Attorney Brown, the law student, and Dr. Julio meet with Ms. Lopez to discuss the violence and urge her to adopt a plan to ensure her safety and that of the children. The law student takes detailed notes during the meeting. Before Ms. Lopez leaves, she agrees to seek shelter outside the home in the event of any further violent episodes.

Two weeks later, the older child's father (who has joint legal custody of the child) files an action in probate court seeking physical custody of the eleven-year old due to alleged domestic violence in the home. Ms. Lopez denies any such violence and her medical records support her denial of violence. The MLP's records are subpoenaed next. Despite her

---

67. Ingrid A. Minott, *The Attorney-Client Relationship: Exploring the Unintended Consequences of Inadvertent Formation*, 86 U. DET. MERCY L. REV. 269, 271 (2009).

68. *Id.*

69. See *infra* Part II.B.

claim of privilege, the child's father moves to compel release of the records, alleging that the presence of Dr. Julio during one or more interviews with Ms. Lopez and the sharing of information and/or records destroys any attorney-client privilege.

Has the attorney-client privilege been waived because of Dr. Julio's presence or the sharing of case updates? Are the privileges and testimonial immunities typically afforded to a lawyer transferable to the law student advocate? Does the work product doctrine further protect the MLP records?

### *B. MLP and Its Effect on Evidentiary Privileges and Legal Immunity*

The multidisciplinary quality of MLP work—the very attribute that makes the MLP model so dynamic and innovative—also creates important questions about how information can be shared among MLP legal and advocacy staff, the families served by the hospital, and the medical and social work staff without legal consequences (should litigation ensue). The intersection of the MLP model with three legal doctrines—confidentiality, attorney-client privilege, and the work product doctrine—may inadvertently result in undermining patient confidence and in compelling disclosure of client information.<sup>70</sup> Confidentiality protects all information discovered in the course of representation,<sup>71</sup> beginning at the moment a potential client seeks a lawyer's advice and enduring beyond the termination of the attorney-client relationship, unless a court orders the attorney to disclose private communications.<sup>72</sup> The attorney-client privilege (governed by the rules of evidence)<sup>73</sup> and the work product doctrine (governed by the rules of civil procedure)<sup>74</sup> begin once a litigation is contemplated.<sup>75</sup> The work product doctrine protects documents prepared in anticipation of litigation,<sup>76</sup> while the attorney-client privilege protects attorney-client communications.<sup>77</sup>

Generally, communication between a lawyer and a client is confidential and privileged as long as legal advice is sought from the attorney, in an effort to comply

---

70. MODEL RULES OF PROF'L CONDUCT R. 1.6 cmt. 3 (2008).

71. The information need not be learned from the client. In fact, all information learned in the course of representation, regardless of its source, is confidential. *Id.*

72. *Id.* R. 1.6(b)(6) & cmt. 1.

73. *See, e.g.*, FED. R. EVID. 501 (stating the general rule of confidentiality).

74. *See, e.g.*, FED. R. CIV. P. 26(b)(3) (stating the prohibition on discovery of attorney work product).

75. *See, e.g.*, *United States v. Martin*, 278 F.3d 988, 999 (9th Cir. 2002) (reciting the elements of the attorney-client privilege, which, not specifying a temporal component, merely requires that the communication be for the purpose of obtaining legal advice); *Jicarilla Apache Nation v. United States*, 88 Fed. Cl. 1 (2009) (“[F]or the [work product doctrine] . . . to apply, litigation need not already have commenced or be imminent; rather, there must merely be a real possibility of litigation at the time the documents . . . are prepared.”).

76. FED. R. CIV. P. 26(b)(3)(A).

77. FED. R. EVID. 502(g)(1).

with the law, and no other party was present.<sup>78</sup> The basic principle is relatively straight-forward: whatever a lawyer learns about the representation, from a client or otherwise, the lawyer may not share with any other person or entity without the client's express or implied permission, unless a special exception applies.<sup>79</sup> The few exceptions are generally limited to: prevention of imminent death or substantial bodily harm,<sup>80</sup> prevention of substantial injury to the financial or property interests of another,<sup>81</sup> defense against a claim made against the lawyer,<sup>82</sup> remediation or preemption of perjury or fraud on the court,<sup>83</sup> compliance with a court order,<sup>84</sup> or intervention when a client has a diminished capacity and, as a result, is not able to protect his own interests.<sup>85</sup> Nevertheless, the law allows some third parties to be present, primarily as agents of the lawyer or the client, in the scope of legal representation.<sup>86</sup> Disclosure of confidential information to, or in the presence of, third parties not in the scope of legal representation, however, will generally destroy the attorney-client privilege.<sup>87</sup>

---

78. The most commonly accepted privilege application limitation was set forth in *United States v. United Shoe Mach. Corp.*, 89 F. Supp. 357, 358–59 (D. Mass. 1950), and states:

The privilege applies only if (1) the asserted holder of the privilege is or sought to become a client; (2) the person to whom the communication was made (a) is a member of the bar of a court, or his subordinate and (b) in connection with this communication is acting as a lawyer; (3) the communication relates to a fact of which the attorney was informed (a) by his client (b) without the presence of strangers (c) for the purpose of securing primarily either (i) an opinion on law or (ii) legal services or (iii) assistance in some legal proceeding, and not (d) for the purpose of committing a crime or tort; and (4) the privilege has been (a) claimed and (b) not waived by the client.

*Id.*

79. See, e.g., MASS. RULES OF PROF'L CONDUCT R. 1.6(a)–(b) (2009) (stating the general rule and exceptions); MODEL RULES OF PROF'L CONDUCT R. 1.6 (2008) (same).

80. E.g., MASS. RULES OF PROF'L CONDUCT R. 1.6(b)(1). The Model Rules of Professional Conduct are identical except for the provisions concerning the protection of financial or property interests. Compare *id.* (including an exception “to prevent the commission of a criminal . . . act that the lawyer reasonably believes is likely to result in death or substantial bodily harm”), with MODEL RULES OF PROF'L CONDUCT R. 1.6(b)(1) (including an exception “to prevent reasonably certain death or substantial bodily harm”).

81. MODEL RULES OF PROF'L CONDUCT R. 1.6(b)(2).

82. *Id.* R. 1.6(b)(5).

83. *Id.* R. 3.3(b).

84. *Id.* R. 1.6(b)(6).

85. *Id.* R. 1.14(b)–(c).

86. *Blumenthal v. Drudge*, 186 F.R.D. 236, 243 (D.D.C. 1999) (“It is true that in some cases the attorney-client privilege may be extended to non-lawyers who are ‘employed to assist the lawyer in the rendition of professional legal services.’ This extension of the privilege to non-lawyers . . . should only occur when ‘the communication [was] made in confidence for the purposes of obtaining legal advice from the lawyer.’” (citing *Linde Thomson Langworthy Kohn & Van Dyke, P.C. v. Resolution Trust Corp.*, 5 F.3d 1508, 1514 (D.C. Cir. 1993)) (alterations in original)).

87. E.g., *In re Teleglobe Commc'ns. Corp.*, 493 F.3d 345, 361 (3d Cir. 2007) (“[I]f persons other than the client, its attorney, or their agents are present, the communication is not made in confidence, and the privilege does not attach.”). Some jurisdictions have held that the presence of relatives who are

Whether the presence of third parties, such as spouses, parents, or siblings, in an otherwise privileged communication vitiates the attorney-client privilege varies by state and by circumstance.<sup>88</sup> Importantly, where the “client” is a minor, communications made to, or in the presence of, a guardian, in addition to the lawyer, generally will not destroy the privilege.<sup>89</sup> Communications made to, or in the presence of doctors may or may not be protected by the attorney-client privilege, but again, this differs by state and circumstance.<sup>90</sup> In some cases, the court has extended the attorney-client privilege to statements a client made to a physician and to conclusions the doctor reduced to writing from an examination where the client has consulted the doctor to assist her lawyer in preparing her case.<sup>91</sup> However, this extension is far from universal, particularly where no agency

---

not necessary for the protection of a client’s interests or for the transmission of information vitiates attorney-client privilege. *E.g.*, *Hearn v. Rhay*, 68 F.R.D. 574, 579 (E.D. Wash. 1975); *State v. Shire*, 850 S.W.2d 923, 931 (Mo. Ct. App. 1993). Other jurisdictions, however, provide that where relatives such as parents are present during attorney-client communications, hired and paid for counsel on their child’s behalf, did not intend to break the confidentiality of the communications, and were taking a parental interest and an advisory role on behalf of their child, no waiver of the attorney-client privilege occurs. *E.g.*, *State v. Sucharew*, 66 P.3d 59, 65 (Ariz. Ct. App. 2003); *Rosati v. Kuzman*, 660 A.2d 263, 266 (R.I. 1995).

88. For example, when a spouse or other relative was acting as the client’s agent at the time the communication was made to the attorney, the privilege was upheld. *See, e.g.*, *City of Indianapolis v. Scott*, 72 Ind. 196, 204 (1880) (holding that a husband’s communication to the attorney, even in the absence of the plaintiff, was privileged since he was acting as her agent); *O’Brien v. New England Mut. Life Ins. Co.*, 197 P. 1100, 1102 (Kan. 1921) (holding a client’s statement made to her attorney in the presence of her husband privileged). However, courts have been careful to note that merely being the client’s spouse was insufficient to support the privilege. *See, e.g.*, *LeLong v. Siebrecht*, 196 A.D. 74, 76 (N.Y. App. Div. 1921) (“The mere fact that he was her husband is not sufficient, nor is the fact that he acted as her agent in making the sale of the property.”). In other cases, where the client’s spouse and children were present during the client’s conference with the attorney, the court has rejected any privilege existing because “[a]nything that was said, and everything that was done, was said and done in the presence of all, and the very nature of what was said and done in the presence of all parties is inconsistent with the idea that the transaction was of a confidential nature and therefore privileged.” *See, e.g.*, *Hutton v. Hutton*, 337 P.2d 635, 639 (Kan. 1959) (holding that a communication made by a client to his attorney in the presence of his wife and three children regarding making a grant of property to his children was not confidential or privileged). However, where the attorney was secondarily representing a client’s sibling, the privilege was upheld despite the sibling’s presence during a meeting with the client. *See, e.g.*, *Taylor v. Taylor*, 177 S.E. 582, 584 (Ga. 1934) (holding that despite the client’s sister’s presence when the client executed a bill of sale to his sister, the communication with the attorney was still privileged).

89. *See, e.g.*, *De Los Santos v. Superior Court of Los Angeles County*, 613 P.2d 233, 236 (Cal. 1980) (holding that statements made by a minor to his mother-guardian made in the course of preparing answers to interrogatories and while responding to requests for information from the lawyer were within the attorney-client privilege).

90. *See* Michael G. Walsh, Annotation, *Applicability of Attorney-Client Privilege to Communications Made in Presence of or Solely to or by Third Person*, 14 A.L.R.4th 594, 632–35 (discussing communication by client to physician that were held privileged in some cases and not privileged in others).

91. *Jones v. Superior Court*, 372 P.2d 919, 921–22 (Cal. 1962) (holding that where the client was sent to the physician by his attorney to assist in his defense, the attorney-client privilege was extended);

relationship was established in advance,<sup>92</sup> or where the client sought treatment from the physician before engaging the lawyer's services,<sup>93</sup> as is generally the case in the MLP model. Further, there is some indication that even if a lawyer and a physician collaborate closely in anticipation of litigation, but no litigation ensues for several years, the privilege will not be extended to the physician visits because future litigation was only one motive for the communication, rather than being the exclusive motive.<sup>94</sup> For example, in *Zimmerman v. Nassau Hosp.*, the New York Appellate Division held that where "bringing the infant plaintiff to [the doctor] was not for consultation with respect to litigation, but rather was for a thorough examination, diagnosis and treatment . . . [a]lthough the prospect of litigation may have been cogent at the time, such multimotivated reports do not warrant immunity if litigation is but one of the motives."<sup>95</sup>

Another potential issue concerns the scope of the attorney-client privilege when the matter is handled by a law student working under the supervision of a bar-admitted attorney.<sup>96</sup> Several states have declined to extend the attorney-client privilege unless the student is working as the attorney's agent.<sup>97</sup> However, the presence of a state student-practice rule that allows law students to appear in court

---

*Webb v. Francis J. Lewald Coal Co.*, 4 P.2d 532, 533-34 (Cal. 1931), *overruled on other grounds*, *City & County of San Francisco v. Superior Court*, 231 P.2d 26, 28-30 (Cal. 1951) (stating that the attorney-client privilege covered statements made by the client to the physician to aid her attorney in the preparation of her case).

92. *Commonwealth v. Senior*, 744 N.E.2d 614, 617-18 (Mass. 2001) (holding that despite a defense attorney's request for a blood test, since the hospital employees were not legally agents of the defense team, the communication was not privileged).

93. *In re Estate of Wood*, 818 A.2d 568, 571-72 (Pa. 2003) (holding that comments made and reports given by a patient's physician to his attorney were not encompassed by attorney-client privilege).

94. *Zimmerman v. Nassau Hospital*, 76 A.D.2d 921, 922 (N.Y. App. Div. 1980) (holding that a medical examination requested by an attorney and conducted in the presence of the attorney, but not resulting in litigation until twelve years later was not privileged).

95. *Id.*

96. *See, e.g., Dabney v. Investment Corp. of Am.*, 82 F.R.D. 464, 465 (E.D. Penn. 1979) (recognizing the attorney-client privilege for "members of the bar . . . or their subordinates," listing such subordinates as including "any law student, paralegal, investigator or other person acting as the agent of a duly qualified attorney under circumstances that would otherwise be sufficient to invoke privilege").

97. *See, e.g., Barnes v. Harris*, 61 Mass. (7 Cush.) 576, 578 (1851) (holding that the communication of a law student who worked in an attorney's office was not privileged because "he was [n]either the attorney's agent [n]or clerk for any purpose"); *State v. Lender*, 124 N.W.2d 355, 359 (Minn. 1963) (holding that a communication with a recent law school graduate who had not yet been admitted to the practice of law was not privileged); *Dierstein v. Schubkagel*, 18 A. 1059, 1060 (Pa. 1890) (holding that "[a] law student is . . . on no higher plane than a blacksmith retained in a like service," and as such, any communication with a law student is not privileged); *Wartell v. Novograd*, 137 A. 776, 778 (R.I. 1927) (holding that the attorney-client privilege does not extend if the law student was not acting as an agent or clerk for the attorney in the transaction); *Holman v. Kimball*, 22 Vt. 555, 556 (1850) ("The privilege of refusing to disclose confidential communications in court . . . extends only to the relation of client and counsel, or attorney; and to extend it beyond that limit would be embarrassing to courts and liable to the grossest abuses.").

for limited purposes,<sup>98</sup> often allows the attorney-client privilege to extend to such students for those limited purposes.<sup>99</sup>

The scope of the work product doctrine is also implicated by the flow of information from attorneys to third parties such as doctors, social workers, and other advocacy staff. In general, the work product doctrine protects an attorney's written material, mental impressions, opinions, and theories in anticipation of, and

---

98. The Massachusetts Supreme Judicial Court, for example, has established a rule that reads: A senior law student in an accredited law school, or a law school authorized by statute of the Commonwealth to grant the degree of bachelor of laws or juris doctor, who has successfully completed or is enrolled in a course for credit in evidence or trial practice, with the written approval by the dean of such school of his character, legal ability, and training, may appear without compensation (a) on behalf of the Commonwealth (including a subdivision of the Commonwealth or an agency of the Commonwealth or of a subdivision) in proceedings in any division of the District Court, Juvenile Court or Housing Court Departments or in the Boston Municipal Court Department, provided that the conduct of the case is under the general supervision of a member of the bar of the Commonwealth who is a regular or special assistant district attorney, a regular or special assistant attorney general, or a corporation counsel, city solicitor, town counsel, assistant municipal counsel or assistant solicitor; (b) on behalf of indigent defendants in criminal proceedings in any division of the District Court, Juvenile Court or Housing Court Departments or in the Boston Municipal Court Department, provided that the conduct of the case is under the general supervision of a member of the bar of the Commonwealth assigned to the case by the Committee for Public Counsel Services or employed by a non-profit program of legal aid, legal assistance or defense or a law school clinical instruction program; and (c) on behalf of indigent parties in civil proceedings in any division of the District Court, Juvenile Court, Probate and Family Court, or Housing Court Departments or in the Boston Municipal Court Department, provided that the conduct of the case is under the general supervision of a member of the bar of the Commonwealth assigned by the Committee for Public Counsel Services or employed by a non-profit program of legal aid, legal assistance or defense or a law school clinical instruction program.

MASS. SUP. JUD. CT. R. 3:03(1). The Illinois Supreme Court has a similar rule:

A student in a law school approved by the American Bar Association may be certified by the dean of the school to be eligible to perform the services described in paragraph (c) of this rule, if he/she satisfies the following requirements: (1) He/She must have received credit for work representing at least three-fifths of the total hourly credits required for graduation from the law school. (2) He/She must be a student in good academic standing, and be eligible under the school's criteria to undertake the activities authorized herein.

A graduate of a law school approved by the American Bar Association who (i) has not yet had an opportunity to take the examinations provided for in Rule 704, (ii) has taken the examinations provided for in Rule 704, but not yet received notification of the results of either examination, or (iii) has taken and passed both examinations provided for in Rule 704, but has not yet been sworn as a member of the Illinois bar may, if the dean of that law school has no objection, be authorized by the Administrative Director of the Illinois Courts to perform the services described in paragraph (c) of this rule.

For purposes of this rule, a law school graduate is defined as any individual not yet licensed to practice law in any jurisdiction.

ILL. SUP. CT. R. 711(a).

99. *E.g., In re Hatcher*, 150 F.3d 631, 636 (7th Cir. 1998), *motion for new trial denied by U.S. v. Gholson*, 1998 U.S. Dist. Lexis 20036 (N.D. Ill. 1998) (holding that a law student acting in a narrow and specific purpose as a lawyer is permissible to evoke the attorney-client privilege).



during the course of, litigation from discovery without a showing of substantial need or undue hardship.<sup>100</sup> The extent to which disclosure of that information, or any part of it, to a third party will remove that protection also varies by state and by circumstance.<sup>101</sup> Thus, a document prepared by a physician for an attorney in the course or anticipation of litigation is likely protected from disclosure, except under extraordinary circumstances. However, a document prepared by a physician of his own accord, such as a detailed MLP referral or case notes accompanying a referral made prior to more certain litigation, even if requested by an attorney, may not be covered by the work product doctrine.<sup>102</sup>

As a result of these potential limitations on the privacy of the patient's case, MLPs should include language in the client release or authorization form to share private health information that explains these potential limitations should the situation escalate to litigation in the future and their private information be sought.<sup>103</sup> Further, after obtaining an explanation of the potential limitations to the confidentiality and privileged nature of their case, clients should receive a choice as to whether case status information or updates should be provided and to whom.<sup>104</sup> Confidentiality, the attorney-client privilege, and the work product doctrine form an important legal shield to the compelled disclosure of a patient or client's private information. Consequently, MLPs should work to carefully limit the nature and scope of any disclosures (in particular case status updates) to referring clinicians and other providers.

### *C. Compromised Autonomy and Inconsistent Obligations of Professional Intervention*

While lawyers, physicians, social workers, and other professionals all serve patients in a professional capacity, the skills, values, and problem-solving approaches that result from their professional training vary greatly and lead to

---

100. See *Hickman v. Taylor*, 329 U.S. 495, 509–13 (1947) (holding that without a showing of substantial need or undue hardship, an attorney's work product was privileged from discovery); FED. R. CIV. P. 26(b)(3) (requiring a showing of "substantial need for the [attorney work product] to prepare for [the] case" and that the party "cannot, without undue hardship, obtain their substantial equivalent by other means").

101. For example, a letter from a physician to a client's attorney expressing the physician's opinion as to the cause of the client's illness in response to medical questions posed by the attorney in anticipation of litigation was found by one federal court to be "unquestionably work-product protected under Rule 26(b)(3)." *Sprague v. Dir., Office of Workers' Comp. Programs*, 688 F.2d 862, 869–70 (1st Cir. 1982). However, notes prepared regarding a patient's condition or treatment, even on the advice of an attorney, merely because litigation is possible "is not enough to cloak those reports with the protection given an attorney's work product." *Cryer v. Corbett*, 814 So. 2d 239, 247 (Ala. 2001) (quoting *Sims v. Knollwood Park Hosp.*, 511 So. 2d 154, 157 (Ala. 1987)).

102. *Cryer*, 814 So. 2d at 247.

103. See *infra* notes 178, 180, 192–95 and accompanying text.

104. See *infra* notes 201–03 and accompanying text.

inconsistent obligations.<sup>105</sup> Indeed, many of these skills, values, and problem-solving approaches are unique to each profession.<sup>106</sup> For instance, physicians, in general, are trained to employ reductionism, ruling out the ordinary before proceeding to the unusual, in order to solve a problem.<sup>107</sup> This problem-solving approach results in a physician culture that solves a patient's medical concerns independent of other concerns, leaving the overall well-being of the patient to other professions.<sup>108</sup> In contrast, social workers generally view a patient's concerns on a broader scale—connected to issues involving the larger family and community.<sup>109</sup> Finally, lawyers are generally trained in dispute resolution and the protection of individual legal rights.<sup>110</sup> This problem-solving approach reflects a legal culture that seeks to maximize only the client's advantage in a conflict situation.<sup>111</sup> With these diverse cultures and problem-solving approaches, collaboration between these professionals results in a formidable team<sup>112</sup> that provides holistic interventions.<sup>113</sup> Nevertheless, the potential for these interdisciplinary partnerships to result in compromised professional independence and obligations should also be considered.<sup>114</sup>

Independence of professional judgment is the hallmark of a profession, regardless of whether that profession is medicine,<sup>115</sup> social work,<sup>116</sup> or law.<sup>117</sup> When professionals who are educated and trained differently, practice different trades, and follow different ethical codes combine efforts to provide one holistic remedy, each may be required to compromise some of the professional autonomy that each practitioner typically exercises. These clashes of professional independence may

---

105. Norwood & Paterson, *supra* note 33, at 362–63.

106. *Id.*

107. *Id.* at 363.

108. *Id.*

109. *Id.*

110. *Id.*

111. *Id.*

112. Retkin et al., *supra* note 2, at 34.

113. *See id.* at 35 (stating that collaborations are able to address problems that neither profession could alone).

114. *See infra* notes 118–20 and accompanying text.

115. Donald Irvine, *The Performance of Doctors. I: Professionalism and Self Regulation in a Changing World*, 314 BRIT. MED. J. 1540, 1540–41 (1997) (discussing the importance of independence in the medical profession).

116. *See* NAT'L ASS'N OF SOC. WORKERS, NASW STANDARDS FOR CLINICAL SOCIAL WORK IN SOCIAL WORK PRACTICE 12 (2005), available at <http://www.socialworkers.org/practice/standards/NASWClinicalSWStandards.pdf> (requiring social workers to consult the code of ethics when confronted with a professional conflict of interest); Susan Poser, *Main Street Multidisciplinary Practice Firms: Laboratories for the Future*, 37 U. MICH. J.L. REFORM 95, 120–21 (2003) (noting the importance of the code of ethics for social workers who are faced with conflict).

117. *See generally* Stacy L. Brustin, *Legal Services Provision Through Multidisciplinary Practice—Encouraging Holistic Advocacy While Protecting Ethical Interests*, 73 U. COLO. L. REV. 787, 860–63 (2002) (discussing the independence of professional judgment in the legal profession).

arise in determining which cases are appropriate for MLP intervention, what level of intervention is necessary, and what intervention is most suitable for a particular case. This situation begs the question of whose voice reigns supreme in resolving these matters.

The American Bar Association Model Rules of Professional Conduct provide that lawyers are prohibited from practicing law where “a nonlawyer has the right to direct or control the professional judgment of a lawyer.”<sup>118</sup> The American Medical Association Code of Medical Ethics similarly provides that physicians should refuse administrative conditions that “are known to compromise professional judgment . . . .”<sup>119</sup> The National Association of Social Workers Code of Ethics also instructs that social workers “should not allow an employing organization’s policies, procedures, regulations, or administrative orders to interfere with their ethical practice of social work” and that they should take steps to ensure that practices are consistent with the Code.<sup>120</sup> Thus, three professions, three ethical codes, and three potential solutions, ranging from reductionism to contextualization to individual rights, are utilized to solve one particular problem.

While in many cases the various MLP team members may agree on a particular course of action, there are also some areas where individual professional obligations to the patient result in discordant approaches, and perhaps, unintended consequences. These clashes in professional obligations are most evident in reporting suspected child or elder abuse.<sup>121</sup> For example, consider this scenario:<sup>122</sup>

Ms. Smith brings her two sons, ages five and seven, into the pediatric clinic for a sick visit because their chronic asthma has worsened lately. Their pediatrician examines them and collects a patient history. The pediatrician believes that the recent exacerbation of the children’s

---

118. MODEL RULES OF PROF’L CONDUCT R. 5.4(d)(3) (2008).

119. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS’N, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION § 8.0501, at 220 (2008–2009 ed. 2008), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion80501.shtml>.

120. NAT’L ASS’N OF SOC. WORKERS, CODE OF ETHICS § 3.09(d) (1999).

121. See *infra* notes 124–25. The past decade has also witnessed the enactment of several laws requiring the reporting of domestic violence in states such as California, Colorado, Rhode Island, and Kentucky. Michael A. Rodriguez et al., *Mandatory Reporting of Domestic Violence Injuries to the Police: What Do Emergency Department Patients Think?*, 286 JAMA 580, 580 (2001). While these statutes are far from universal and require reporting to various authorities ranging from the police to a prosecutor to a social service agency, the same conflict of professional duties between mandated reporters and lawyers may arise. See Dina Schlossberg, *An Examination of Transactional Law Clinics and Interdisciplinary Education*, 11 WASH. U. J.L. & POL’Y 195, 224–25 (2003) (discussing the conflicting ethical obligations involved).

122. Although this case is also, to the best of the authors’ knowledge, fictitious, several news outlets have recently reported similar real-life stories involving minor children left alone at home who played with matches and sustained injuries, did substantial property damage, or both. E.g., Laura Headlee, *Kids Playing with Matches Spark House Fire*, WBIR.COM, June 18, 2008, <http://www.wbir.com/news/local/story.aspx?storyid=59647>.

asthma is likely due to the accumulation of rat and cockroach excrement in their apartment. The pediatrician increases the boys' asthma medications and refers the family to the MLP. The referral is noted in the children's medical record.

The MLP attorney receives the referral, interviews the family, and talks with the referring pediatrician. She then telephones the family's landlord to remind him of his obligations under the city's housing and sanitary codes and to suggest arranging for extermination services. The landlord reports that he knows the family well and has already fumigated Ms. Smith's apartment three times this past year. Further, he says that an annual inspection of the apartment complex revealed that Ms. Smith's apartment is the only one in the complex with pest problems. He believes the problem persists because Ms. Smith leaves her two young boys alone in the apartment after school, from 3:00 p.m. to 6:00 p.m., until she gets home from work. While the boys are alone, they spill food and they do not clean it up, which attracts the pests.

The landlord continues to say that he has thought about reporting that the children are being left home alone to the Department of Children and Families (DCF), but ultimately says, "It's not my problem. The family pays the rent and in this economic climate, I'm not in the business of chasing away paying tenants. I have no obligation to report anything."

The attorney looks in the MLP file and notes that Ms. Smith has signed a consent form allowing her to discuss information learned through advocacy with the boys' pediatrician. The attorney is also aware that if she discusses this information with the pediatrician, the physician will be obligated to report to DCF that the children are being left alone in the apartment. Uncomfortable with this course of action, the MLP attorney decides to first pursue her concerns with Ms. Smith, including determining whether Ms. Smith still consents to her speaking with the pediatrician. At this point, Ms. Smith revokes that authorization. The MLP attorney offers to help find childcare services for the boys, but Ms. Smith declines and dismisses that concern. Ms. Smith only wants the MLP to advocate for exterminating the apartment.

Two months later, while home alone, the boys are experimenting with a book of matches they found on the street. They successfully ignite two of the matches and then panic and drop the matches on the floor after burning their fingers. A fire ensues and causes injuries to one of the children, and fire damage to the apartment and to two adjacent apartments in the complex. The fire marshal investigates and immediately notifies DCF when he discovers that the children were home alone. A civil lawsuit follows to recover for the fire damage, and DCF initiates care and protection proceedings for the children in juvenile court.

In the course of these legal proceedings, the pediatrician's records are subpoenaed. The boys' medical records include the referral to MLP, and

the MLP records are subsequently subpoenaed. The MLP will claim that the records are privileged but it is unclear if this argument will be successful. The MLP records, if discoverable, would indicate that (1) the MLP attorney knew that the boys were home alone, and (2) the MLP initially had prior written authorization to discuss the interview findings with the pediatrician, but allowed the authorization to be revoked, thereby remaining silent.

Does the MLP attorney have a duty to keep the information she learned confidential from the boys' pediatrician? What if Ms. Smith had not revoked the authorization?

Any individual who has a good faith belief that abuse or neglect of a child or elder is occurring may report that abuse or neglect.<sup>123</sup> Certain professionals, however, such as social workers and physicians, have been designated by state statutes as mandated reporters.<sup>124</sup> Importantly, attorneys are not typically considered mandated reporters of child and elder abuse or neglect.<sup>125</sup> Attorneys are granted legal privileges and immunities in order to maintain their clients' confidences.<sup>126</sup> Since the details that would lead an attorney to suspect child or elder abuse would likely be revealed during the course of client representation, that information would be confidential and protected by the attorney-client privilege.<sup>127</sup>

By partnering mandated reporters, such as physicians and social workers, with legally-privileged practitioners, such as lawyers, the MLP model creates the potential for inconsistent professional obligations when child or elder abuse concerns arise. For example, the provision of verbal or written case updates from the legal staff to the clinical staff, or cross-disciplinary file-sharing, poses

---

123. *E.g.*, 42 U.S.C. § 5106a(b)(2)(A)(vii) (2006) (requiring that, in order to receive federal funding for child abuse prevention programs, states must establish "provisions for immunity . . . for individuals making good faith reports of suspected or known instances of child abuse or neglect"); Lisa Hansen, Comment, *Attorneys' Duty to Report Child Abuse*, 19 J. AM. ACAD. MATRIMONIAL LAW. 59, 67 (2004) ("Any citizen may report suspected child abuse provided that person has a good faith belief that abuse is occurring.").

124. Hansen, *supra* note 123, at 67. For example, under Massachusetts law, a report may be filed with the Department of Children and Families by anyone who suspects that a child is being abused. This type of report is frequently referred to as a *51A*. See MASS. GEN. LAWS ANN. ch. 119, § 51A (West 2009).

125. Hansen, *supra* note 123, at 67–68. Some states, such as Mississippi, Nevada, Ohio, and Oregon, do include attorneys as mandated reporters of abuse. MISS. CODE ANN. § 43-21-353 (2009); NEV. REV. STAT. ANN. § 432B.220 (LexisNexis 2009); OHIO REV. CODE ANN. § 2151.421 (LexisNexis 2009); OR. REV. STAT. §§ 419B.005, .010 (2007). Even in states where lawyers are not mandated reporters, state rules of professional conduct may allow lawyers to report child or elder abuse, neglect, or criminal actions that are revealed during the course of client representation if the abusive or criminal activity poses a potential danger to clients or other members of the public. See MODEL RULES OF PROF'L CONDUCT R. 1.6(b)(1) (2008) (allowing an attorney to "reveal information relating to the representation of a client . . . to prevent reasonably certain death or substantial bodily harm").

126. See *supra* Part II.B.

127. Hansen, *supra* note 123, at 67–68.

confidentiality concerns<sup>128</sup> with mandated reporting consequences.<sup>129</sup> Since the legal standard of certainty in many state mandated reporter statutes requires only “reasonable cause to believe,”<sup>130</sup> “reason to believe,”<sup>131</sup> or even reliance on the “statements of a person worthy of belief,”<sup>132</sup> a mandated reporter inadvertently learning case-related information from legally-privileged practitioners may be required to make a report. Indeed, there is some indication that when a mandated reporter learns of circumstances that may constitute child or elder abuse from a third party, that mandated reporter *must* make a report of the alleged abuse.<sup>133</sup>

However, the inconsistencies in professional obligations within an advocacy team are not novel. State ethics boards have been grappling with how to diminish patient confusion while encouraging patient trust and confidence in the context of multidisciplinary models.<sup>134</sup> While no immediate solution exists, several recommendations for best practices have emerged. For instance, the D.C. Bar Legal Ethics Committee has noted that “[t]he inconsistent duties of the social worker and the lawyer—the social worker to report under the child abuse and neglect law, the lawyer to assure that confidences and secrets of a client are preserved—require that the lawyer take steps to assure that the client understands the inconsistency” where the lawyer and social worker can be found within common walls.<sup>135</sup> Erecting metaphorical confidentiality screens or confidentiality walls in the form of staff training, specific consent forms, and “shadow files” to keep protected information segregated from other general case information have also been suggested.<sup>136</sup>

---

128. MODEL RULES OF PROF'L CONDUCT R. 1.6 cmt. 4 (“Paragraph (a) prohibits a lawyer from revealing information relating to the representation of a client. This prohibition also applies to disclosures by a lawyer that do not in themselves reveal protected information but could reasonably lead to the discovery of such information by a third person.”).

129. Alexis Anderson et al., *Professional Ethics in Interdisciplinary Collaboratives: Zeal, Paternalism and Mandated Reporting*, 13 CLINICAL L. REV. 659, 692–94 (2007). In the 2009 MLP survey, *supra* note 7, only 10.5% of partnerships utilized a structure where no advocacy information was shared with a medical provider, clinician, or social worker.

130. *E.g.*, MASS. GEN. LAWS ANN. ch.119, § 51A (West 2009); NEV. REV. STAT. ANN. § 432B.121(1) (LexisNexis 2008).

131. *E.g.*, MINN. STAT. ANN. § 626.556(3)(a) (West 2008); OKLA. STAT. ANN. tit. 10A, § 1-2-101(B)(1) (West 2009).

132. *E.g.*, R.I. GEN. LAWS § 40-11-2(11) (2009).

133. *See, e.g.*, *People v. Davis*, 126 Cal. App. 4th 1416, 1421, 1426 (2005) (concluding that, where a nursing home administrator learned of alleged abuse from the nursing staff, the Director knew or should have known that she was required to report that abuse).

134. Brustin, *supra* note 117, at 843.

135. *Id.* (quoting D.C. Bar Ass'n Legal Ethics Comm., Op. No. 282, *Duties of Lawyer Employing a Social Worker Who Is Obligated to Report Child Abuse*, reported in 126 DAILY WASH. L. REP. 1445 (July 31, 1998)).

136. Shadow files, which physically segregate protected information from other case information, have been suggested by several scholars and practitioners to protect confidentiality. *See* Schlossberg, *supra* note 121, at 225–26 & nn.106–07 (describing the use of shadow files as part of a “confidentiality screen . . . that prevent[s] certain persons from gaining access to protected client information”);

MLPs should become familiar with state reporting obligations, identify mandated and non-mandated reporters participating in the MLP teams, and examine the current extent of information provided to their patients regarding the team's composition.<sup>137</sup> If the team includes one or more mandated reporters, MLPs should take care to ensure that patients understand the inconsistency of professional obligations of each member. MLPs may also need to consider whether to limit the mandated reporters' exposure to confidential or privileged information. Finally, when resolving the ultimate question of what intervention, if any, to provide, practitioners should consider not only their ethical mandates and particularized training, but also their interface with legal requirements and its impact on patients.

#### *D. MLP and Compliance with HIPAA*

Confidentiality of patient information is reflected in common law<sup>138</sup> precepts, and is even incorporated into the Hippocratic Oath.<sup>139</sup> In 1996, Congress codified these duties formally in HIPAA,<sup>140</sup> which was enacted to enhance the privacy and security of patient information and "to improve . . . the efficiency and effectiveness of the health care system . . ."<sup>141</sup> In part, HIPAA set standards and requirements for the electronic transmission<sup>142</sup> of protected health information.<sup>143</sup> Specifically,

---

Jacqueline St. Joan, *Building Bridges, Building Walls: Collaboration Between Lawyers and Social Workers in a Domestic Violence Clinic and Issues of Client Confidentiality*, 7 CLINICAL L. REV. 403, 440 (2001) (listing the use of shadow files as a means of maintaining confidentiality). Some practitioners have established a system where the very existence and location of the shadow files containing the protected information are kept secret from social workers who could inadvertently access the information and would have a duty to make a mandated report. St. Joan, *supra*, at 442 & n.117.

137. See *supra* notes 118–36 and accompanying text.

138. See, e.g., *Springer v. Byram*, 36 N.E. 361 (Ind. 1894) ("Communications made by a patient to his physician, for the purpose of professional aid and advice, are . . . intended to be private and confidential, and can never be divulged without the consent of the patient . . ."); *Simonsen v. Swenson*, 177 N.W. 831, 832 (Neb. 1920) (recognizing a physician's duty to maintain patient information confidential); *Smith v. Driscoll*, 162 P. 572, 573 (Wash. 1917) (same).

139. "Whatever, in connexion [sic] with my professional practice, or not in connexion [sic] with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret." THE GENUINE WORKS OF HIPPOCRATES 780 (Francis Adams trans., Classics of Medicine Library 1985) (1849).

140. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936. HIPAA is composed of two titles codified in various sections of the U.S. Code. Title I governs health insurance plan access and portability, and amends the Employee Retirement Income Security Act, *id.* § 101, the Public Health Service Act, *id.* § 102, and the Internal Revenue Code, *id.* § 103. Title II governs health care fraud and abuse offenses and penalties, *id.* §§ 201–250, while also creating rules regarding the dissemination of private health information and administrative simplification via standardization, *id.* § 262. Title II also amended the Social Security Act. *Id.* § 231.

141. *Id.* § 261, 110 Stat. at 2021.

142. Electronic transmission includes the transmission of information through the internet, extranet, leased lines, dial-up lines, private networks, and the physical movement of electronic storage media. 45 C.F.R. § 160.103 (2009). Notably, paper, fax, and telephone voice communications are not considered electronic transmissions, *id.*, but are nevertheless HIPAA-protected if an otherwise covered entity uses

the Privacy Rule,<sup>144</sup> which took effect in 2002,<sup>145</sup> regulates the use and disclosure<sup>146</sup> of protected health information by or to covered entities,<sup>147</sup> business associates,<sup>148</sup> and hybrid entities.<sup>149</sup> Consider this scenario:<sup>150</sup>

---

or discloses the protected health information contained therein. See Jennifer Fisher Wilson, *Health Insurance Portability and Accountability Act Privacy Rule Causes Ongoing Concerns Among Clinicians and Researchers*, 145 ANNALS INTERNAL MED. 313, 314 (2006) (summarizing the HIPAA privacy protections as “limiting how . . . covered entities can use patients’ personal medical information . . . that is on paper, in computers, or communicated orally”).

143. Protected health information encompasses individually identifiable health information that:

(1) [i]s created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) [r]elates 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; and (i) [t]hat identifies the individual; or (ii) [w]ith respect to which there is a reasonable basis to believe the information can be used to identify the individual.

45 C.F.R. § 160.103. Common examples of protected health information include names, geographic subdivisions smaller than a state, all dates (except year) pertaining to an individual’s health care, phone and fax numbers, social security numbers, medical record numbers, account numbers, license numbers, or vehicle identification numbers, photographs, finger or voice prints, URLs, and IP addresses. *Id.* § 164.514(b)(2)(i). Importantly, regardless of how the protected health information is transmitted, it is protected by HIPAA. *Id.* § 160.103. This means that verbal communications and print communications that contain protected health information are also regulated under HIPAA. Wilson, *supra* note 142, at 314.

144. Per their statutory duty, the Department of Health and Human Services has promulgated five rules and standards under Title II of HIPAA: the Privacy Rule, the Transactions and Code Sets Standards, the Security Rule, the Unique Identifiers Standard, and the Enforcement Rule. U.S. DEP’T HEALTH & HUMAN SERVS., HIPAA ADMINISTRATIVE SIMPLIFICATION STATUTE AND RULES, <http://www.hhs.gov/ocr/privacy/hipaa/administrative/index.html> (last visited Feb. 21, 2010). The Security Rule and the Privacy Rule work in conjunction in that all forms of protected health information (paper and electronic) are governed by the Privacy Rule, 45 C.F.R. §§ 164.302–316, while the Security Rule focuses exclusively on the security of electronic protected health information. See *id.* §§ 164.500–552.

145. Standards for Privacy of Individually Identifiable Health Information, 67 Fed. Reg. 53,182, 53,182 (Aug. 14, 2002) (codified at 45 C.F.R. pts. 160, 164).

146. *Disclosure* is defined as “the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.” 45 C.F.R. § 160.103. *Use* is defined as “the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.” *Id.*; see also *id.* § 164.502 (describing the circumstances under which a covered entity may or may not use or disclose protected health information).

147. A *covered entity* is a health plan, a health care clearinghouse, or a health care provider “who transmits any health information in electronic form in connection with a transaction covered by” HIPAA (essentially those electronic transmissions containing protected health information). *Id.* § 160.103.

148. A *business associate* is an outside entity that is not an employee of a covered entity, but nevertheless performs functions covered by HIPAA on behalf of covered entities (again, essentially sending or receiving electronic transmission of protected health information). *Id.* Entities that provide legal, actuarial, accounting, consulting, data aggregation, management, administration, accreditation, and financial services are considered business associates. *Id.* On February 17, 2009, President Obama signed the American Recovery and Reinvestment Act of 2009, Pub L. No. 111-5, 123 Stat. 115, which included several provisions amending HIPAA. Michael Maffeo, *The Relationship of Privacy Provisions in the Stimulus Bill to Health Information Technology*, J. HEALTH CARE COMPLIANCE, May-June 2009,



Alex Jones suffers from HIV that is substantially under control due to vigilant medical management by Dr. Johnson, his infectious disease physician, as well as expensive antiretroviral medications. Both have been largely covered by his employer-sponsored health insurance. Last month, Mr. Jones was laid off. He believes that his termination was due, at least in part, to his expensive medical treatment, but a number of his coworkers were also laid off. He has been offered continued insurance coverage under COBRA, but his limited unemployment benefits are not adequate to pay for his rent, living expenses, health insurance, and medications. Mr. Jones came to see Dr. Johnson to see if there was something he could do. An MLP volunteer was shadowing Dr. Johnson that day and sat in with Dr. Johnson as he saw patients. Mr. Jones was referred via email to the clinic's MLP for consultation. The referral contained Mr. Jones' name, phone number, and a brief summary of his case.

During the course of his interviews with the MLP advocate, Mr. Jones disclosed that he regularly engages in unprotected intercourse with multiple sexual partners without revealing his HIV status. He is reportedly unaware that such behavior is illegal in his state,<sup>151</sup> and he rationalizes that he was infected in the same way, without legal consequence to the partner who infected him.

In Mr. Jones' state, a lawyer is permitted to report a client to law enforcement authorities when it is disclosed that the client intends to commit a future crime of violence.<sup>152</sup> Physicians are also urged to do so

---

at 55, 55. Importantly, the Act requires business associates to comply with several of the HIPAA rules and standards that previously only applied to covered entities and subjects business associates to the same civil and criminal penalties as covered entities for violation of those rules and standards. American Recovery and Reinvestment Act, § 13404, 123 Stat. at 264 (to be codified at 42 U.S.C. § 17934).

149. A *hybrid entity* is a covered entity that performs both covered and non-covered functions. 45 C.F.R. § 164.103. HIPAA applies only to the covered component of the entity. Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,462, 82,502 (Dec. 28, 2000) (to be codified at 45 C.F.R. pts. 160, 164).

150. In a 2003 national study of 1421 known HIV-infected individuals receiving medical care for the disease, 42% of homosexual or bisexual men and 19% of heterosexual men reported engaging in sexual intercourse without disclosure of their seropositive status, especially in non-exclusive partnerships, leading the authors to conclude, "[r]isky sex without disclosure . . . is not uncommon among people with HIV." Daniel H. Ciccarone et al., *Sex Without Disclosure of Positive HIV Serostatus in a US Probability Sample of Persons Receiving Medical Care for HIV Infection*, 93 AM. J. PUB. HEALTH 949, 949-52 (2003).

151. See, e.g., 720 ILL. COMP. STAT. ANN. 5/12-16.2(a)(1) (West 2009) ("A person commits criminal transmission of HIV when he or she, knowing that he or she is infected with HIV . . . engages in intimate contact with another . . ."). At least thirty states have similar laws criminalizing knowingly exposing another to HIV (or other STD). ACLU, STATE CRIMINAL STATUTES ON HIV TRANSMISSION—2008 (2008), available at [http://www.aclu.org/files/images/asset\\_upload\\_file292\\_35655.pdf](http://www.aclu.org/files/images/asset_upload_file292_35655.pdf). Several other states provide for sentence enhancement in the penalty phase of sexual offenses if knowing exposure to HIV (or other STD) is a factor in the crime. E.g., ALASKA STAT. § 12.55.155(c)(33) (2009).

152. The Model Rules of Professional Conduct state:

if there is both imminent danger of serious bodily harm and one or more identifiable victims. The likelihood of Alex transmitting the HIV virus to a partner is approximately 5% during each act of unprotected sexual intercourse. Alex has not authorized the MLP to discuss this matter with his physician and does not intend to do so himself.

Approximately one year later, Dr. Johnson and the clinic's MLP receive a subpoena pursuant to a lawsuit filed against Alex Jones by a woman who alleges that she was a sexual partner of Alex's, that he failed to disclose his HIV status, and that she has become infected. The subpoena calls for records from Dr. Johnson and the MLP, presumably to determine whether the clinic knew that Alex was engaged in behavior that would endanger the health of others. The woman further alleges that the private health information contained within the MLP records is discoverable via subpoena because the clinic's MLP falls within HIPAA.

Is the MLP covered under HIPAA? If so, is shadowing a clinician HIPAA-compliant? Is the MLP referral process HIPAA-compliant? Assuming the lawyer-client privilege does not attach to the information in the MLP record, can the plaintiff seek the MLP records under HIPAA?

MLPs, in their various forms, likely contain components that fall into each of the three categories above under the auspices of HIPAA. For example, in so far as medical clinics or physicians transmit protected health information electronically, they are "covered entities" under the HIPAA Privacy and Security Rules.<sup>153</sup> Similarly, services relating to a covered function rendered to a covered entity, such as legal services to a medical clinic, are contemplated by the Privacy Rule to be business associates.<sup>154</sup> Finally, covered entities such as clinics or hospitals that contain departments that are not within the scope of HIPAA are hybrid entities.<sup>155</sup>

---

A lawyer may reveal information relating to the representation of a client to the extent the lawyer reasonably believes necessary: (1) to prevent reasonably certain death or substantial bodily harm; (2) to prevent the client from committing a crime or fraud that is reasonably certain to result in substantial injury to the financial interests or property of another and in furtherance of which the client has used or is using the lawyer's services; (3) to prevent, mitigate or rectify substantial injury to the financial interests or property of another that is reasonably certain to result or has resulted from the client's commission of a crime or fraud in furtherance of which the client has used the lawyer's services; (4) to secure legal advice about the lawyer's compliance with these Rules; (5) to establish a claim or defense on behalf of the lawyer in a controversy between the lawyer and the client, to establish a defense to a criminal charge or civil claim against the lawyer based upon conduct in which the client was involved, or to respond to allegations in any proceeding concerning the lawyer's representation of the client; or (6) to comply with other law or a court order.

MODEL RULES OF PROF'L CONDUCT R. 1.6(b) (2008).

153. 45 C.F.R. §§ 160.103, .302.

154. *Id.* §§ 160.103, .500.

155. *Id.* § 164.103; *see also* U.S. DEP'T HEALTH & HUMAN SERVS., NIH PUB. NO. 03-5388, PROTECTING PERSONAL HEALTH INFORMATION IN RESEARCH: UNDERSTANDING THE HIPAA PRIVACY

The limitations placed on the use and disclosure of protected health information by or to covered entities, business associates, and hybrid entities under HIPAA are therefore important for MLPs to consider in their intra-team communications.<sup>156</sup>

MLPs utilize many methods of sharing patient information, particularly in making referrals.<sup>157</sup> At a minimum, these referrals typically include patient contact information and a reason for referral.<sup>158</sup> Even this limited information, however, contains protected health information regulated under the HIPAA Privacy Rule, regardless if it is delivered on paper, via telephone, spoken in person, faxed, or emailed.<sup>159</sup> In fact, despite misconceptions regarding the exclusion of oral communications,<sup>160</sup> the same HIPAA protections must be afforded to all types of communication that contain protected health information, regardless of the medium used to transmit the protected health information.<sup>161</sup> Electronic communication is further protected specifically by the Security Rule, which requires or addresses<sup>162</sup> additional barriers to inadvertent disclosure such as personal or entity authentication,<sup>163</sup> automatic computer log-off,<sup>164</sup> email encryption,<sup>165</sup> and internally protected networks.<sup>166</sup>

---

RULE 6 (2004), [http://privacyruleandresearch.nih.gov/pdf/HIPAA\\_Booklet\\_4-14-2003.pdf](http://privacyruleandresearch.nih.gov/pdf/HIPAA_Booklet_4-14-2003.pdf) (explaining that a covered entity may be designated a hybrid entity if the entity “performs both covered and noncovered functions as parts of its business operations”).

156. See *supra* notes 100–02 and accompanying text.

157. In the 2009 MLP survey, *supra* note 7, 79.5% of sites share patient referral information verbally via telephone or in person, 54.4% of sites allow advocates access to patients’ medical records, 52% share referral information via email, 50% share referral information via fax, and 43.2% deliver referral information in person. All of these methods of transmission are regulated by the HIPAA Privacy Rule and/or the Security Rule insofar as the information transmitted contains protected health information. See §§ 160.103, 164.306 (defining broadly the types of transmission that are regulated).

158. The 2009 MLP survey, *supra* note 7, found that 100% of the forty-five MLPs surveyed included the reason for referral in the referral, 93% included patient contact information, 46.5% included a summary of the patient’s health condition, and 27.9% shared the patient’s entire medical record.

159. See § 160.103 (defining protected health information).

160. See Niklas Moeller, *Noise Considerations: Distractions, Errors and Privacy*, 136 CAN. PHARMACEUTICAL J. 35, 35 (2003) (“Often over-looked is the fact that the [HIPAA Privacy Rule] include[s] the oral communication . . . of any individual health information.”).

161. § 160.103.

162. The Security Rule delineates two categories of implementation specifications: those that are required, and those that are addressable. *Id.* § 164.306(d)(1). Required implementation specifications are mandatory, while those listed as addressable are left to each institution to access the reasonableness and appropriateness of each implementation specification dependant on its environment. *Id.* § 164.306(d)(2)–(3).

163. *Id.* § 164.312(d).

164. *Id.* § 164.312(a)(2)(iii).

165. *Id.* § 164.312(e)(2)(ii).

166. *Id.* § 164.312(e)(1). For more guidance regarding administrative safeguards, see *id.* § 164.308; for physical safeguards, see *id.* § 164.310; and for technical safeguards, see *id.* § 164.312.

The presence of MLP interns in the clinical setting shadowing clinicians also raises important questions under HIPAA.<sup>167</sup> Clinical shadowing, or the observation of clinicians by interns during their patient interactions, is an essential component of professional education and is equally valuable in the MLP setting.<sup>168</sup> Indeed, clinical shadowing provides hands-on experience, mentorship, a more sophisticated understanding of the complex dynamics involved in providing services, and ultimately, informs and improves future service provision.<sup>169</sup> Despite the social and therapeutic value of clinical shadowing, however, the potential for intern disclosure of protected health information raises HIPAA concerns.<sup>170</sup>

Importantly, HIPAA permits disclosure of protected health information without the patient's authorization for treatment, payment, or health care operations.<sup>171</sup> Training initiatives like shadowing arguably fit comfortably into *health care operations*, which HIPAA defines to include health care "training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities."<sup>172</sup> Indeed, there is even an argument that the services provided by the entire MLP team—medical, legal, or otherwise—likewise fit into the treatment exemption under HIPAA.<sup>173</sup> Nevertheless, many programs at least

---

167. See John C. Moskop et al., *From Hippocrates to HIPAA: Privacy and Confidentiality in Emergency Medicine—Part II: Challenges in the Emergency Department*, 45 ANNALS EMERGENCY MED. 60, 61 (2005) (highlighting that the presence of students of medicine and other health professions in the emergency department may affect individual patient privacy).

168. See, e.g., John J. Costonis, *The MacCrate Report: Of Loaves, Fishes, and the Future of American Legal Education*, 43 J. LEGAL EDUC. 157, 158 (1993) (discussing the importance of clinical internships in the medical profession); Moskop et al., *supra* note 167, at 61 ("Observation of and participation in clinical care are essential aspects of medical education . . .").

169. Costonis, *supra* note 168, at 159.

170. Moskop et al., *supra* note 167, at 61.

171. 45 C.F.R. § 164.506.

*Treatment* means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

*Id.* § 164.501. *Payment* refers to the activities of health plans or health care providers to obtain premiums or provide reimbursements, including determination of eligibility and coverage, risk adjustment amounts, billings, claims management, collection activities, review of health care services, utilization review activities, and disclosure to consumer reporting agencies. *Id.* *Health care operations* include conducting quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, underwriting, conducting or arranging for medical review, legal services, and auditing functions, business planning and development, and business management and general administrative activities. *Id.*

172. *Id.*

173. See McDERMOTT WILL & EMERY, INTRODUCTORY FREQUENTLY ASKED QUESTIONS REGARDING HIPAA, PRIVILEGE AND CONFIDENTIALITY IN THE MEDICAL-LEGAL PARTNERSHIP MODEL

introduce the student shadowing the clinician, describe their role, and obtain each patient's verbal consent.<sup>174</sup>

As a general rule, obtaining the patient's written authorization to disclose his or her protected health information to shadowing students and MLP legal partners<sup>175</sup> is the wisest course in areas where a court has not ruled specifically on this matter,<sup>176</sup> particularly since coordination between medical and legal providers can produce one comprehensive authorization form with separate sections that explain each distinct purpose of the disclosure.<sup>177</sup> Under HIPAA, a valid authorization form has several core requirements, including: (1) a specific and meaningful description of the information to be used or disclosed; (2) the specific identification or name of the person or class of people authorized to make the requested use of disclosure; (3) the specific identification or name of the person or class of persons to whom the covered entity may make the requested use or disclosure; (4) a description of the purpose of the requested use or disclosure; (5) an expiration date or event; and (6) the signature and date of the patient or the

---

(2008), available at <http://www.medical-legalpartnership.org/sites/default/files/page/Introductory%20FAQs%20White%20Paper%20--%20MWE%20and%20MLPC%20--%202008.pdf>.

Although an argument can be made that the purpose of MLP . . . involvement with patients is to address health-related legal issues in a manner that benefits treatment, and therefore MLP staff are part of the health care team, it is unclear whether such an argument would be accepted by courts as an appropriate rationale for disclosure of [protected health information] absent prior informed consent by the patient.

*Id.*; see also § 164.506 (describing use and disclosure of protected health information for treatment purposes).

174. *E.g.*, Office of Compliance Servs., Ind. Univ. Sch. of Med., Policy for Student Shadowing at IUSM, <http://comply.medicine.iu.edu/docs/StudShado.doc> (last visited Feb. 21, 2010); see also Moskop et al., *supra* note 167, at 61 ("Patients should be informed of the identity and role of all of their caregivers, including students.").

175. While another approach to providing advocacy services to patients might involve giving patients the contact information to the legal partner (rather than providing the legal partner with the patient contact information), if protected health information was to be used or disclosed by the legal partner, written authorization from the patient would still be necessary if the legal partner comes under the definition of a hybrid entity or business associate under HIPAA. See *supra* notes 147–49, 154–56 and accompanying text. Further, this alternative method of providing advocacy services may lose more patients than the standard MLP referral system due to lack of patient follow-up.

176. Aside from limited exceptions, HIPAA requires covered entities to obtain a valid written and signed authorization from a patient to use or disclose protected health information. § 164.508(a)(1). In some cases (such as a listing in a facility directory, disclosure to individuals involved in the patient's care, family members and close friends, and disclosure of the patient's location to a family member, personal representative, or person responsible for the patient), verbal consent is sufficient. *Id.* § 164.510. There are also several uses and disclosures of protected health information that can be made without the patient's consent such as disclosures to public health agencies, health oversight agencies, judicial and administrative proceedings regarding victims of abuse, neglect, or domestic violence, decedents, cadaveric organs, and other disclosures required by law. See *id.* § 164.512.

177. See Brustin, *supra* note 117, at 840–41 (stating that some organizations use a general retainer for all services provided).

patient's representative.<sup>178</sup> Disclosure of protected health information should also consist of providing "the minimum necessary [information] to accomplish the intended purpose of the use, disclosure, or request" in order to comply with HIPAA.<sup>179</sup>

Despite the limitations on disclosure of protected health information to those within the MLP team, HIPAA does not present an obstacle to the disclosure of protected health information to courts or administrative proceedings in response to a court order, subpoena, or a discovery request.<sup>180</sup> A covered entity may disclose protected health information in the course of any judicial or administrative proceeding in response to a court or administrative order, or in response to a subpoena or discovery request (without a court order) if the party seeking the information has sought a qualified protective order<sup>181</sup> for the information or has made reasonable efforts to give the subject individual notice.<sup>182</sup> While there has not yet been a reported case that addresses the vulnerability of MLP records to medical records, subpoenas, or discovery requests,<sup>183</sup> there is a risk that MLP records could be subpoenaed or sought through discovery as part of a patient's medical record.<sup>184</sup>

---

178. § 164.508(c)(1). The authorization must also include several required statements such as notice that the authorization may be revoked; the ability or inability to condition treatment, payment, enrollment, or eligibility upon the authorization; and the potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and therefore no longer protected. *Id.* § 164.508(c)(2).

179. *Id.* § 164.502(b)(1).

180. *Id.* § 164.512(e)(1).

181. A *qualified protective order* means:

[A]n order of the court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that (A) [p]rohibits the parties from disclosing the protected health information for any purpose other than the litigation or proceeding for which such information was requested; and (B) [r]equires the return to the covered entity or destruction of the protected health information (including copies made) at the end of the litigation or proceeding.

*Id.* § 164.512(e)(1)(v).

182. *Id.* § 164.512(e)(1)(ii). Further, a covered entity may make such a disclosure without the satisfactory assurances of the party seeking the information if the covered entity itself makes reasonable efforts to provide notice to the subject individual or to seek a qualified protective order. *Id.* § 164.512(e)(1)(vi).

183. One court has held on a narrow, related matter, however, that a physician could be required to testify based on the medical record "as [to] the dates on which he saw . . . patients, the fees charged and whether he referred the patient[s] to a certain attorney." *See In re Judicial Inquiry*, 8 A.D.2d 842, 843 (N.Y. App. Div. 1959).

184. There is no definition of what constitutes a medical record—a legal quandary shared by other areas of law including employment and reproductive rights. Barry Kozak, *At the Crossroads—The Intersection of Pregnancy Tests, a Deceased Baby and Medical Privacy Rights*, CHI. BAR ASS'N REC., Sept. 2002, at 39, 44 (exploring the dilemma regarding whether pregnancy tests completed by Planned Parenthood are part of a medical record subject to HIPAA); Caroline Palmer & Lynn Mickelson, *Falling Through the Cracks: The Unique Circumstances of HIV Disease Under Recent Americans with Disabilities Act Caselaw and Emerging Privacy Policies*, 21 LAW & INEQ. 219, 260 (2003) ("Current law does not define what constitutes a medical record outside of the context of the medical provider

This risk is particularly true if the MLP is found to be within the meaning of *health care provider*,<sup>185</sup> described within the *treatment*<sup>186</sup> exemption under HIPAA,<sup>187</sup> or shares mutual records between the legal and medical providers within the MLP.<sup>188</sup>

HIPAA is a complex law with many regulations, but its purpose, to protect the privacy of patient information, is one that is not novel.<sup>189</sup> MLPs should determine what category of entity that applies to each provider, and should contract around that understanding.<sup>190</sup> As suggested above, MLPs should consider keeping their medical and legal records separate.<sup>191</sup> MLPs should also consider creating a protected health information authorization form that specifically includes the members of the MLP team, for patients to sign prior to treatment by their health care provider.<sup>192</sup> Such a form should include separate sections for the patient to read and sign relating to each purpose for which the disclosure is authorized, such as student training and legal referral.<sup>193</sup> HIPAA training should also be provided to each member of the MLP team, including student interns and others who shadow team members.<sup>194</sup> Finally, communication between the MLP team should be tailored to include only the minimum information necessary to effectuate the

---

system. This lack of definition creates problems when medical information is brought into the workplace . . . .”).

185. *Health care provider* is defined as:

[A] provider of services (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

45 C.F.R. § 160.103.

186. *Id.* § 164.501.

187. *Id.* § 164.506.

188. See Brustin, *supra* note 117, at 847 (“[I]f nonlawyers have access to . . . [legal] files, or other communications, then attorney client privilege may be jeopardized.”).

189. See, e.g., Sophie Cockcroft et al., *How Does National Culture Affect Citizens’ Rights of Access to Personal Health Information and Informed Consent?*, 15 HEALTH INFORMATICS J. 229, 230 (2009) (stating that the Universal Declaration of Human Rights, the International Covenant on Civil Political Rights, and the European Convention of Human Rights all make reference to the importance of protecting individual privacy).

190. See generally Norwood & Paterson, *supra* note 33, at 365 (explaining the importance of recognizing boundaries related to confidentiality and how the limits they create must be accommodated for by the other team members).

191. See *supra* note 136 and accompanying text.

192. See Brustin, *supra* note 117, at 840–41 (arguing that there should be informed consent for cross-disciplinary information sharing describing the medical and legal services provided).

193. See *supra* notes 172–74 and accompanying text.

194. Bernard Lo et al., *HIPAA and Patient Care: The Role for Professional Judgment*, 14 JAMA 1766, 1767 (2005) (“Clinicians and institutions must develop privacy policies and procedures and train all staff about the privacy regulations.”).

purpose of the disclosure, and, if necessary, information firewalls should be erected so that only those authorized to access the information can do so.<sup>195</sup>

### III. RECOMMENDATIONS AND CONCLUSION

This Article describes the multidisciplinary benefits and challenges that confront MLPs. Although the collaboration of physicians and lawyers has realized holistic, beneficial, and long-term health outcomes for patients,<sup>196</sup> the MLP model raises novel legal and ethical concerns,<sup>197</sup> ranging from the difficulty in identifying the MLP client<sup>198</sup> to seemingly inconsistent obligations of service providers.<sup>199</sup> Ultimately, MLPs confront cutting edge legal and ethical issues on a daily basis.

This Article suggests recommendations for best practices based upon a review of the literature and analysis of the law. It is essential that MLP staff communicate with the patients at every stage of intervention. Indeed, MLPs must engage in explicit discussion with the patient even prior to the initial referral to advocacy staff.<sup>200</sup> In initiating a referral to an MLP, clinicians should utilize informed consent and should incorporate an informed consent section into the referral form in order to better inform the patients of the team's composition as well as limit the scope of those who receive information.

Communication is also necessary at later stages of the MLP-patient relationship. For instance, patients should be advised of the limits of confidentiality and each professional's duties, including mandated reporting requirements.<sup>201</sup> As a casual visitor to the medical clinic, the patient might not understand that not all information disclosed within the clinic's walls is confidential, nor is the clinic's staff composed solely of physicians. In addition to emphasizing the importance of limiting information to certain individuals in order to safeguard attorney-client privilege, a separation of files between those MLP professionals with and without an evidentiary or testimonial privilege should be considered.<sup>202</sup> It may also be advisable to carefully assess the individuals present in the attorney-client meetings in order to preserve attorney-client privilege, especially if the jurisdiction that the

---

195. *See id.* ("Clinicians and institutions must make reasonable efforts to use and disclose only the minimum identifiable information that is needed to accomplish the intended purpose."); *supra* note 179 and accompanying text.

196. *See supra* Part I.

197. *See supra* Part II.

198. *See supra* Part II.A.

199. *See supra* Part II.C.

200. *See* Brustin, *supra* note 117, at 842-43 ("The safest approach for protecting confidentiality is to explain [the roles and responsibilities of each team member] to a client at the outset of the representation.").

201. *See supra* notes 118-36 and accompanying text.

202. *See supra* notes 135-36 and accompanying text.



MLP is located in does not recognize other members of the MLP team as agents of the attorney.<sup>203</sup>

Additionally, MLPs should identify the mode of communication in their clinic that best preserves patient privacy and utilize that method to communicate only the minimally necessary protected health information to provide an effective MLP intervention.<sup>204</sup> While MLP intern shadowing initiatives are valuable and need not necessarily be excluded from an MLP,<sup>205</sup> HIPAA requires that MLPs provide training for all members of the health care team, including MLP interns and others who engage in shadowing.<sup>206</sup>

Finally, this Article is intended to serve as a call for future research, recommendations, and continued study of the legal and ethical challenges that MLPs encounter while providing this integral and comprehensive care to patients. Although complex and relatively unchartered, continued research in this area may help improve the organization of MLPs, as well as patient interactions and services, while avoiding legal conundrums. As long as critical professional obligations are recognized and care is taken to preserve the ethical boundaries of all professionals on the MLP team, physicians, lawyers, and social workers can collaborate without posing undue risk to each other's ethical commitments or compromising each other's professional duties or patient care.

---

203. *See supra* notes 70–80, 86–88 and accompanying text.

204. *See supra* notes 179, 195 and accompanying text.

205. *See* 45 C.F.R. § 164.501 (2009) (including training students in the definition of *health care operations*); *supra* note 171.

206. *Id.* § 164.530(b)(1) (“A covered entity must train all members of its workforce on the policies and procedures with respect to protect health information . . .”).