How Bioethics Can Enrich Medical-Legal Collaborations

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Introduction

Medical-legal partnerships (MLPs) — collaborative endeavors between health care clinicians[1] and lawyers to more effectively address issues impacting health care — have proliferated over the past decade.[2] The goal of this interdisciplinary[3] approach is to improve the health outcomes and quality of life of patients and families, recognizing the many non-medical influences on health care and thus the value of an interdisciplinary team to enhance health. There are currently over 180 MLPs at over 200 hospitals and health centers in the United States, with increasing federal interest and potential legislative support of this model.[4]

This article examines the unique, interrelated, and often similar (although at times conflicting) ethical issues that confront the clinical and legal partners involved in MLPs. We contend that the ethical precepts of the clinical and legal professions should be seen as opportunities, not barriers,[5] to further the interdisciplinary nature of MLPs. In turn, our perspective emphasizes the shared ethical foundations. Among legal and clinical professionals, there is a "shared set of core social and ethical values, interests, and experiences," and a shared "respect for the individual and a commitment to reason, professional judgment, and experience as a basis for decision making."[6] An integral part of the ethical canons of each profession is the primacy of their duties (fiduciary obligations) to the people they serve. Each has a code of ethics that is self-imposed and in many ways remarkably similar.[7] Each professional can be seen as a healer and an advocate.[8]

Although the theories, schema, and specific guidance may vary, the commonalities in ethical approaches represent a potential bridge between legal and health care advocacy for patient/client well-being. Bioethics[9] has a role to play in building and analyzing this bridge: bioethics may serve as a discourse and method to enhance collaboration by highlighting common ethical foundations and refocusing legal and clinical partners on their similar goals of service for patients/clients. This article explores this bridging role of bioethics.

In Section I, the medical-legal partnership model is briefly explained. In Sections II and III, the principal

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tenets of legal ethics (II) and bioethics (III) are examined. Section IV applies the legal and bioethics principles and perspectives to specific case studies that illustrate legal and clinical ethical issues that may arise in MLPs. In Section V, we conclude with specific suggestions for next steps to improve these collaborations, focusing on changes in education in the professional schools and during the collaboration; awareness of the availability and importance of ethics consults; and modifications to legal ethics rules to facilitate interdisciplinary collaborations, such as those in MLPs.

I. Medical-Legal Partnership Overview

The MLP model has grown since the 1993 creation of a partnership to serve low-income pediatric patients and their families at the Boston City Hospital (now the Boston Medical Center).[10] In 2006, the National Center for Medical Legal Partnership was established to promote the development of medical-legal partnerships across the country.[11] Recognizing the success of the medical-legal partnership model, the American Bar Association (ABA) adopted a resolution in 2007 to encourage the development of medical-legal partnerships.[12] In 2008, the ABA launched the Medical-Legal Partnerships Pro Bono Support Project to further promote the creation of these programs.[13]

There are a variety of models used by individual MLP network members to facilitate collaborations between clinicians and lawyers.[14] The most common model is where a legal service entity partners with a hospital or health clinic to establish an onsite legal clinic at the health care facility to serve the patients of the health care entity. MLPs may also be based in law school clinics. In addition there are various pro bono models: for example, a law firm may "adopt" a medical clinic or a department within a health care setting.

While most MLPs started in pediatric departments, several have branched out successfully to other clinical departments, including: oncology, palliative care, HIV/AIDS, geriatrics, family medicine, internal medicine, and maternal health.[15] MLPs provide services in the areas of law that are most relevant to patients with health concerns, including: government benefits; housing; advance planning (wills, health care proxies, powers of attorney and permanency planning); immigration; insurance issues; family law; debtor/creditor matters; employment matters and special education.

An essential element of the MLP, regardless of the model, is collaboration between the legal and clinical partners to ensure ease of patient access to legal services or advocacy that may enhance care. The MLP builds upon the trust that the clinician has already established with the patient since it is often the clinician making the referral for legal assistance.

In addition to the direct legal services, another essential activity of the MLP is to facilitate training of legal and clinical professionals. Clinicians may learn about the legal (individual and systemic) issues affecting their patients. This training helps them make informed legal referrals and, where appropriate, assist with advocacy efforts. Such advocacy assistance could include filling out government and other forms with/for patients, writing letters to landlords, or educating lawmakers about the critical impact of policies on health. Lawyers may learn more about clinical issues affecting patient and family interests, and gain a better understanding of the language and culture of health care.

Working together enables clinicians and lawyers to address problems more effectively than either could do alone. Studies by various MLPs have shown that these models are cost effective and in fact can provide health care recovery dollars for the health care facility.[16] Studies have also shown that MLP training curricula positively affect physician behavior in addressing a patient's nonmedical needs.[17] MLPs also positively impact relationship-building among professionals through the collaborative experiences.[18] Finally, there have been evaluations on a MLP's positive impact on health outcomes and alleviating distress.[19]

As MLPs flourish, it would not be unexpected for more legal and clinical ethics issues to arise. In 2009, more than 13,000 people were served by MLPs across the nation.[20] The sheer number of cases might under-

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standably lead to a rise in ethical issues. In addition, as MLPs increasingly move from pediatric settings into other clinical disciplines (e.g., geriatrics, oncology, internal medicine, maternal health), MLPs will encounter new populations (the elderly, cancer patients, new mothers) who will generate a new set of ethical dilemmas. For example, MLPs centered in a geriatric practice will encounter issues regarding capacity. Maternal health patients may have concerns about the hospital's right to test their newborn for various diseases and drugs and turn to the MLP lawyer for advice. MLPs in oncology or hospice settings will most certainly encounter end-of-life ethical issues.

In addition, as MLPs become more integrated into the culture of the hospital and have greater involvement in the activities of hospitals and clinicians, this shift will generate a whole new set of ethical issues. For example, what happens when a clinician calls on the MLP lawyer (and not hospital counsel) for interpretation of the law: when does that information cross the line so that the MLP lawyer is perceived as the definitive legal source (and not hospital counsel)? Additionally, as more clinicians rely on the services of the MLP lawyer and seek more advice from the MLP lawyer, friendships and familiarity might lead to blurred roles and open the door to ethical dilemmas.

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II. Legal Ethics Primer

Legal ethics and professional responsibility are critically important concepts that dictate the essence of the legal profession and apply to all aspects of lawyer conduct. Typically, states regulate ethical conduct through an office or administrative agency charged with the responsibility of lawyer conduct and ethical oversight. Each jurisdiction chooses a baseline set of rules and principles that are codified in Rules or Codes of Professional Conduct which govern the ethical spectrum of the practice of law in that jurisdiction.

A. Principles of Legal Ethics[21]

The American Bar Association (ABA) has adopted a model set of ethical rules, namely the Model Rules of Professional Conduct (Model Rules), which are precatory in nature but serve as the basis for most state ethical rules and guidelines regulating lawyer conduct. Since the inception of the Model Rules in 1983, most states have adopted the exact format (or close parallel) of the ABA Model Rules.[22] The Model Rules are broken down into seven major categories, which form the framework for defining the essence of a lawyer's responsibility in any setting — namely, representation of a client with competence and diligence in a confidential fashion, free from any conflicts of interest. The basic principles of legal ethics that pertain to the representation of clients in a MLP revolve around the following core concepts: Lawyer-Client Relationship; Lawyer as Zealous Advocate; Conflict of Interest; Lawyer's Role as Counselor and Advisor; Independence of Professional Judgment; and Confidentiality (discussed in detail below).

Lawyers who work in an MLP are bound by the same principles of ethical conduct as lawyers working outside the MLP realm. A lawyer's conduct, whether the lawyer is an employee of a law firm, a legal service organization, health care institution, or a participant in a pro-bono program, is governed by rules of conduct that *take into consideration* employment venues, but *do not alter* essential standards or premises of ethical conduct based on the employment arrangement.

B. Principles Applied to Collaborative Setting

1. THE LAWYER-CLIENT RELATIONSHIP

The formulation of the lawyer-client relationship is the critical mechanism that triggers the application of the rules governing lawyer conduct in any setting. The MLP lawyer must remember that a lawyer-client relationship is not formed with the clinicians even though the lawyer's expertise may be utilized as an advisor[23] or "consultant" on matters such as eligibility for government benefits, remedies for substandard housing, or issues surrounding child protection or elder abuse. Thus, an MLP lawyer may work with and participate on an interdisciplinary team, provided that the lawyer makes it clear to the team that she is not the staff's legal advisor.[24] The lawyer's ethical obligations under state rules and codes do not attach until the lawyer meets with the client. It is when the lawyer interacts with a prospective client that the principles of loyalty, confidentiality, and conflict of interest arise.

2. LAWYER AS ZEALOUS ADVOCATE

A lawyer is ethically bound to assert her client's position as a diligent and competent advocate, even if she finds the client's goal and objectives repugnant.[25] This unique concept, whereby the lawyer stands as a zealous advocate for a client but remains detached from her client's ends, is often referred to as the principle of "neutral partisanship."[26] Thus, the MLP lawyer may

have to advocate for a position that is antithetical to the recommendation of the very same clinicians with whom the lawyer consults and works with on a daily basis. The MLP lawyer, however, must proceed as an advocate for the client, whose position (and thus the position advocated by the lawyer) may in fact conflict with the recommendations of the other (non-law) MLP partners. It is important that collaborative team members are made aware that the lawyer's ethical duty to advocate on behalf of the client is not an endorsement of the client's views or activities, but merely serves to fulfill her ethically mandated role as diligent or zealous advocate.[27]

3. CONFLICT OF INTEREST

Conflicts of interest in legal representation are generally governed by principles of loyalty, independence of professional judgment, and the duty of confidentiality to present or former clients. In the MLP setting, a lawyer must be attuned to the traditional rules governing conflicts of interest, making sure that present client matters do not conflict with the lawyer's other existing client matters, a lawyer's responsibilities to a third party, or the same or substantially related matters in which the lawyer represented previous clients.[28] In the MLP setting, conflicts of interests are likely to arise in a number of ways, including:

- As a potential conflict of interest between the potential/actual representation of the client vs. the interest of the collaborative partner (the hospital); and
- As a potential conflict of interest between the potential/actual representation of a client vs. the interest of a family member of a client.[29]

In the first scenario, since the MLP lawyer does not, nor presumably has ever, represented the hospital at any time, the potential conflict that arises many not implicate the applicable Rules of Professional Conduct, but the potential conflict is an actual one. The lawyer may be concerned that the continuation of the MLP might be jeopardized by her representation of an interest of a client that is in conflict with that of the hospital.[30]

In the second scenario, the lawyer must be attuned to a possible conflict of interest with the client's family, especially in areas where the clinicians may be working in a family-centered model to assure patient buy-in and family support. Here there may be conflicts between the clinician's efforts to provide holistic care (through family support) and the patient's individual wishes (independent of family desires). The lawyer and the clinician must be aware that ethical conflicts may arise, and that even those conflicts not involving rule interpretation might negatively affect the entire collaborative venture.

4. LAWYER'S ROLE AS COUNSELOR AND ADVISOR

A fundamental responsibility of ethical lawyering is based on the principle that a lawyer must provide independent advice and counsel to a client, utilizing not only legal rationale, but also taking into account social, economic, political, and moral factors as well.[31] Before the lawyer engages in advocacy, negotiation, or litigation on behalf of a client, she must first serve the role as an advisor, which provides the client with the backdrop on which to decide the course of action in the representation.

Often times, the lawyer's expertise can provide clients (i.e., patients) with greater access to clinical services — both through the direct advice provided to clients, and also as an information resource to clinicians who seek the lawyer's counsel on core issues surrounding poverty law, child welfare, and countless other patient centered legal matters. Keep in mind, however, that the lawyer's role as an "advisor" to a client is a legal duty, while her role as an information resource (a much less formal role) to members of the collaborative team is borne out of the unique relationship of the lawyer embedded in the clinical setting.

5. CONFIDENTIALITY

A crux of the lawyer-client relationship lies in the principle of client confidentiality. Confidentiality is a broad term that encompasses the benchmark concepts of the "ethical duty of confidentiality" defined in formal rules of professional conduct and the "attorney-client privilege." Thus, confidentiality not only refers to oral statements made by a client to her lawyer (implicating the attorney-client privilege), but just as important is "information relating to representation of a client" (implicating the lawyer's ethical duty of confidentiality).[32]

The common perception of lawyer-client confidentiality is that information provided to a lawyer by a client is protected by an inviolate obligation, which may not be breached unless certain conditions are met. The "attorney-client privilege" is the product of evidentiary law, and specifically protects communications (usually oral) proffered by clients to lawyers from being divulged by the lawyers in a testimonial (i.e., court) setting.[33] According to an ethical duty of confidentiality, however, any information relating to the representation of a client is confidential; thus, this duty to protect client secrets sweeps far broader than the attorney-client privilege. All jurisdictions have codified the duties surrounding confidentiality, and

the exceptions to this broad notion of client loyalty, in the applicable rules of professional conduct.

Obligations related to confidentiality lead to some critical questions, such as:

- May the collaborative lawyer routinely reveal the fact that she is representing a patient/family to the interdisciplinary medical team?
- How much, if any, information may the collaborative lawyer routinely reveal to a health care clinician or a treatment team about the representation in general and the client in particular?
- Are members of the interdisciplinary medical team part of the "firm" that represents a patient/family in a legal matter? May the legal collaborative "deputize" members of the medical team to the "firm?"
- Are mandated reporters of child abuse and neglect (e.g., hospital social workers and doctors) working with the collaborative project exempt from reporting abuse or neglect to the requisite child protection agency if the information is obtained as part of the confidential legal intake process?[34]
- If the collaborative lawyer learns about a forthcoming action adverse to the client as a result of participation in an interdisciplinary team meeting, does the lawyer have an ethical obligation to inform the client/patient about the impending action?

These scenarios occur on a daily basis in a MLP, so MLPs should think through these sorts of questions to ensure that the client's rights are not violated, and that the interdisciplinary collaborative team serves the best interest of the patient.

It has sometimes been suggested that lawyers in an MLP should have a client sign a release as part of the case-opening paperwork that would allow the lawyer to share information with the medical provider. However, such an approach may display a misunderstanding of the ethical rules that apply to lawyers. Model Rule 1.6 (which most states follow) provides, in relevant part, that a client give "informed consent" before a lawyer can reveal information relating to the representation of a client; informed consent is defined in Model Rule 1.0 (e) as "the agreement by a person to a proposed course of conduct after the lawyer has communicated adequate information and explanation about the material risks of and reasonably available alternatives to the proposed course of conduct." Thus, a conversation between the lawyer and client that includes the material risks and alternatives could only take place after there has been sufficient discussion of the issues and the ramifications, and not as part of the case-opening paperwork.

The MLP lawyer is not simply acting in a legal realm but also situated within a clinical one. Both clinical and legal professionals operate under a time-honored principle of confidentiality (i.e., physician-patient, psychiatrist-patient, and psychotherapist-patient), an obligation that is breached only under specifically defined circumstances.[35] Difficulties arise, however, when the lawyer joins the clinical team in a discussion regarding the team's patient — who also happens to be the lawyer's client.[36] The freedom and candor that surrounds the interdisciplinary discussion is anathema to the lawyer's ethical obligation of confidentiality (and may be to the clinician's as well). The lawyer is bound not to reveal information that may be critically important to the team's decision. Thus, the lawyer must be fully aware that she is operating in an environment that may preclude her from full participation in critical decision-making events.

While legal ethics cover the MLP lawyer in the clinical setting, it should not be forgotten that other ethical obligations govern the health care partners. Bioethical approaches play an important role in guiding the course of collaborative patient care, and often impact the outcome of the most challenging cases. Thus, all partners (especially legal ones) could benefit from a better understanding of bioethics.

III. Bioethics Primer

While law may ask what *must* we do, ethical inquiry asks what *ought* we do. In health care, the concept of ethical practice is not new; indeed, thousands of years ago, the Hippocratic Oath offered ideas of the right sort of doctoring, then primarily vis-à-vis protecting confidences and maintaining a "fatherly insistence on deciding unilaterally what is best for [patients]."[37] However, the 20th century brought with it advancements in health care technology altering our conceptions of what we can treat and how (e.g., transplant surgeries, test tube babies), our vision of what it means to be human (e.g., genomics), and our view of who should control who lives and dies (e.g., decision making at beginning and end of life). In addition, individuals increasingly began to call into question the authority vested in physicians to guide patient decision-making.[38] Coupled with the technological advancements were concerns over the complexity and costs of treatment in the face of limited resources. Bioethics emerged from a traditional understanding of "medical ethics" as its own field of applied study — crossing many professional boundaries — to help guide individuals, institutions, policymakers, and the public in an ever-changing and increasingly complex

environment.[39] Law did not recede in having influence in health care decision-making;[40] rather, bioethics became another mechanism to help resolve disputes.

A. What Is "Bioethics"?
First, it is important to explain what is meant by bioethics, and to consider how one distinguishes between bioethics[41] and medical ethics (which may in practice be used interchangeably). *Medical* ethics in its technical sense connects to the medical (i.e., physician) profession; medical ethics governs how a physician, as a professional, should practice — and has traditionally been seen as within the province of physicians only.[42] *Bioethics*, in recognition of our more complex health care environment, takes within its orbit medical ethics, but also includes ethical concerns of a range of professions and individuals, e.g., nurses, social workers, hospital administrators. In addition, it expands the scope of ethical inquiry to include not only clinical (i.e., "at the bedside" medical or nursing) issues but also many more "beyond the bedside" concerns, e.g., what happens at the institutional, research, public health, and policy levels.[43]

B. Bioethics Approaches (Methods)
It may also be helpful for all MLP partners to have some understanding of the methods of bioethics.[44] Although typically considered an applied field of study, bioethics grounds itself in theory. Two primary theories are discussed in the literature: one focused on an individual's duties (not dissimilar from a lawyer's fiduciary duties), and the other focused on the consequences of an individual's actions.[45] Their application is much like what their descriptive terms imply. A duty-bound professional would follow dictates of a relevant duty (e.g., obtain informed consent before any procedure); alternatively, a consequentialist would look not to a pre-existing duty but rather to the consequences of potential actions (e.g., obtaining informed consent or not), and would seek to maximize good over bad outcomes (e.g., enhanced patient outcomes and satisfaction).

Moving from theory to practice, principles are often employed to frame bioethical issues in clinical settings. Typically four main principles are recognized today: (1) beneficence, (2) non-maleficence, (3) justice, and (4) autonomy.[46] Beneficence refers to acting for the benefit of someone's health; alternatively, non-maleficence put simply means "do no harm." Justice refers to seeking fairness in distributing benefits and burdens of treatment and in allocating limited health care resources. Autonomy, of paramount importance in law and ethics, relates to self-determination: the ability of a competent adult to decide what treatment he or she wants or does not want.[47]

Finally, casuistry has emerged as a key ethical approach for dealing with clinical cases in context.[48] A pragmatic approach to addressing ethical issues, casuistry involves the search for a case sufficiently similar to one's own to help figure out what to do and how in the current situation. This approach benefits from its similarity to medical (and legal) reasoning wherein clinicians turn to prior experience to guide decision-making? Collectively, in practice we see a blend of approaches applied in real-world cases, akin to tools that clinicians may use to analyze difficult cases. These tools may also help facilitate communication across professions and with patients and families.

C. Moving Theory to Practice: Ethics Consulting in Clinical Settings
So, how do ethical issues play out in the health care setting? First, the "who:" for larger health systems and academic medical centers, a select group of individuals will often take the lead role as ethics consultants for the institution (or health system), with regularly scheduled rotations as on-call consultants. Smaller and community hospitals may rely on nearby larger centers with more expertise or academic colleagues knowledgeable about bioethics to help with consulting. Increasingly, ethics consultants have additional training in bioethics to help conduct analyses and guide decision-making processes, particularly with complex, emotionally fraught, or novel issues.[49]

Larger health care institutions often also have an ethics committee.[50] In addition to an ethics consult (or case review) role, institutional ethics committees take a lead in the review and drafting of ethics-related policies, and may also be responsible for ethics education of staff and trainees for the institution or system.[51] A multidisciplinary body (ideally led by someone with ethics training), members typically include physicians, nurses, social workers, other clinicians, community representatives, and spiritual care staff. Some committees also choose to include hospital counsel and/or risk management staff, although including these individuals is not without controversy. Certainly, many ethical issues dovetail legal matters; however, the committee may take on a more or less "legalistic" (i.e., institutional, risk averse) tone with their inclusion. Caution is often urged, as is the enunciation of a clear description of each member's role on the ethics committee and the committee's purpose.[52]

Depending on the setting within which the MLP is situated — namely for those increasing number of MLPs based in hospitals or academic medical center settings serving patients with complex needs (as of 2008, MLPs housed in 73 hospital settings, a growing number)[53] — an ethics consultant or ethics committee

may thus be an additional resource to offer a different perspective on a vexing case facing an MLP. The consult may serve to reorient parties to common goals and to reaffirm, to the fullest extent possible, patient decision-making. Even when formal ethics consultations are not an option, an understanding of bioethics principles may serve as a useful discourse to navigate thorny issues crossing disciplinary boundaries in patient care.

It is worth noting that many lawyers enter the ethics field and act as ethics consultants, which may become their primary or sole role for the institution. These legally trained representatives should be clear about the difference between ethics consulting and legal counseling, be able to identify when they are acting in which role, and recognize the limits of such roles.

How might an ethics consult happen? Normally anyone involved in the case may call the designated ethics institutional number for ethics guidance, including faculty, staff, patients, and family members. After the call is made and a consult requested, the process typically includes a discussion with the requestor, the attending physician (if not the requestor), and the patient and relevant family members (if not the requestors).[54] The consultant also meets with others on the medical team to get a clear picture and ascertain key facts and points of conflict. The case may require legal research (but not necessarily a referral to hospital counsel) to assist in the ethical analysis, but purely legal or risk management perspectives are not the substance of the ethics consult. Potentially an MLP attorney may be consulted during this process, so long as care is taken not to negatively impact any lawyer-client relationship.[55] The MLP lawyer should view this as an opportunity to enhance collaboration by being part of forward progress on a case (or as a means to remove obstacles), and not as a challenge to his/her authority. It would be helpful for all MLP partners to see the bioethics consult (formal or informal) as a means to think more broadly, across traditional boundaries, about how best to serve the patient/client — similar to how the MLP itself represents a broadened perspective on the diversity of professionals and resources that can work together to enhance patient care.

Why might a consult be requested? Sometimes a member of the clinical team calls for a consult because of a disagreement within the team, a challenge with communication (not necessarily an ethical issue, but often referred for an ethics consult), and/or an issue with a patient or family decision. Alternatively, a patient or family member may seek a consult because a clinical order is seen as over- or under-treatment. Or there may be a concern about the patient's capacity to make a decision, or whether a surrogate decision-maker is acting in the patient's best interest. Thus, a frequent focus is on patient decision-making capacity. The ethics consultant does not perform the capacity assessment, but considers what sorts of assessments have been made and applied to the current decision, and helps sort out the role, if any, of the family and treatment team in decision-making.

Ethics consultants do not superimpose their judgment on the clinician-patient relationship or make a clinical treatment decision (or legal decision), but rather foster conflict resolution by identifying ethical issues and guiding decision-making through ethical reasoning. To do this, the ethics consultant or committee draws on ethics principles and other bioethics approaches, and also examines patient and family preferences and contextual issues (e.g., cultural and religious factors, financial and economic factors, legal and institutional policy issues, etc.).[56] The goal is to support favored options via reasoned judgment, with due consideration of each option's consequences.

It is worth noting that many lawyers enter the ethics field and act as ethics consultants, which may become their primary or sole role for the institution. These legally trained representatives should be clear about the difference between ethics consulting and legal counseling, be able to identify when they are acting in which role, and recognize the limits of such roles. MLP legal partners should also be clear about their role as distinguished from hospital counsel. When there is a bioethics consult on a case in which an MLP is also involved, it should be emphasized that while legal matters may be an issue, they are not *the* issue for the consult.

Now that some of the basics of bioethics analysis and ethics consultation have been explained, and to better understand how bioethical issues might arise

and/or how bioethical analysis might help bridge clinical and legal perspectives in the context of MLPs, it would be helpful to see how the perspectives apply in different sorts of cases. A range of case types exist, from bioethics mutually supporting (i.e., working in concert with) law to actualize patient goals, to bioethics guiding parties struggling with the application of the law, to bioethics illuminating and expanding law's focus. A sample case from each general type follows. These cases are illustrative of the sort that have vexed several of the authors and have been in the press.[57] They are intended to illustrate how bioethics might offer a different perspective for the MLP partners that is of particular importance when there may be a legal response available for a particular issue, but one that does not necessarily resolve the underlying conflict. As more MLP partners become aware of the benefits of a consult or the value in understanding basic bioethics theories, these offer the MLP team a new tool and allows them to think outside the box in enhancing patient/client care. It also dovetails with the holistic systems-based approach that MLPs endorse, building on a social work perspective (who are often critical members of the MLP team).

IV. Case Studies

A. Ruth and Bioethics Mutually Supporting the Law

Ruth, a 58-year-old single woman, was taken to the hospital Emergency Room with severe shoulder pain. An X-ray showed a significant amount of fluid in the lungs. Further tests showed that Ruth had ovarian cancer, which had already spread to the lungs. She began chemotherapy in advance of surgery. After admission to the hospital, it was discovered that she did not have any advance directives, and was referred to the onsite MLP lawyer.

Ruth wanted her good friend Jane to serve as her health care agent and power of attorney and asked Jane to be present when she met with the MLP lawyer. During the bedside legal consult the lawyer heard Ruth clearly state her wishes regarding end-of-life care. She expressed that she did not want to be maintained as a "vegetable" (in a neurovegetative state), and wanted "no tubes; I am going to die anyway." The lawyer helped her complete a New York State Health Care Proxy and Power of Attorney form.

The day following the lawyer's visit, Ruth developed severe respiratory distress and was unable to communicate with the health care team. As was the custom at the hospital, a covering doctor called Ruth's sister, listed as "next-of-kin" on the face sheet of the medical record, having been so identified in a previous admission. Her sister arrived in New York to learn of the gravity of Ruth's condition, which soon deteriorated; she developed a severe pneumonia, needing intubation and sedation. Jane, acting as Ruth's health care agent, wanted to follow Ruth's wishes, but Ruth's sister from California, with whom Ruth was not close, wanted her to be intubated as she was upset about her sister's newly diagnosed illness and did not want to "let her die."

The Intensive Care Unit staff was unsure if they could follow the agent's direction, and in frustration, the agent called the MLP lawyer, who reinforced her rights through the proxy form. The hospital administration was uncomfortable allowing the physician to follow the agent's direction when a family member opposed that direction. An ethics consult was called.[58]

1. THE LEGAL PERSPECTIVE

The principal role of the MLP lawyer in this case was to act as an advisor and retained lawyer who worked on Ruth's behalf to help her complete the Health Care Proxy and Power of Attorney form. The lawyer-client relationship arose when the lawyer advised and assisted Ruth during the bedside consultation. In Ruth's case, the lawyer has an ethical duty to avoid a conflict of interest while representing Ruth, even though the representation merely consisted of a bedside consultation and limited assistance in filling out paperwork. Any confidential information acquired from Ruth during the consultation must be preserved, unless the lawyer is implicitly authorized to reveal that information as part of her representation or permitted to reveal by the client; in this case, the client did not authorize any release of confidential information.[59] The questions then arise as to (a) whether the fact that the MLP is partially funded by the hospital creates an ethical conflict of interest; and (b) whether the lawyer's relationship with the hospital, and specifically the MLP's relationship as an inherent part of the health care team, creates an untenable practical conflict of interest.

First, while the lawyer's employment in the MLP is partially funded by the hospital, this does not create a *de facto* ethical conflict of interest that would prevent her from advocating on Ruth's behalf, even in matters affecting the hospital administration. It should be clear to all parties from the outset that the MLP lawyer is not retained to represent the hospital and thus she has not formed a lawyer-client relationship with the hospital in any manner. It is incumbent upon the hospital administration to recognize the boundaries encompassed by the MLP lawyer, and to respect the role the lawyer plays in representing her client in a diligent, competent and zealous fashion, even when it conflicts with the hospital administration.

In this case, members of the clinical team might be curious about the lawyer's conversations with Ruth, or

any information the lawyer learned during the brief interaction between the two while filling out the proxy forms. Here lies the crux of the lawyer's dilemma, as she is ethically bound to keep those interactions confidential — unless the client gives informed consent,[60] yet she also may feel obligated to participate in the clinical process, answer questions posed by her clinical partners, and avoid being evasive. An MLP lawyer's communication with other partners about these obligations of confidentiality before the fact, however, often alleviates this dilemma; clinicians must understand from the outset the lawyer's limited ability of information sharing.

2. THE BIOETHICS CONSULT

A central issue in this case for ethical analysis is who should decide what to do, and related to this, what is the capacity of the patient to make her own decisions. At this time, Ruth is sedated, so it is hard to gauge her current wishes. A likely initial ethics consultant question to the clinical team would be whether Ruth could be awakened sufficiently to have the "capacity" to discuss her wishes given the current state of affairs. If able to do so, proxy decision-making would not be necessary given the patient's capacity.

If unable to communicate with Ruth (as the facts seem to indicate here), having an agent designated and wishes stated so close in time to Ruth's current status would weigh on the side of no intubation, especially given the gravity of Ruth's diagnosis. During the consult, Jane should describe the discussion she had with Ruth when she was designated as Ruth's agent: that Ruth did not want to be in a vegetative state or on tubes. An ethics consult could help to clarify, however, what Ruth meant by "no tubes." Perhaps intubation might simply be a time-limited event to deal with the pneumonia. It would be important to clarify Ruth's wishes as to what she wanted, and whether Ruth's wish not to be intubated was a general request (as was not being in a "vegetative state"), or might be something she would allow in certain circumstances for a certain time period (e.g., to recover from pneumonia to have surgery).

ICU team discomfort might relate to not being a party to the discussion about Ruth's wishes. Ideally, the physician is involved in these important discussions.[61] It would be advisable for the physician to discuss Ruth's wishes with her and include information from the discussions in the patient's record. Formal documentation (e.g., proxy document) should also be in the record. The hope is that the agent and the clinical team are familiar with the patient's wishes to ensure that the agent does not simply act in the patient's best interests (a secondary surrogate decision-making goal), but in fact decides as the patient would have if able, i.e., substituted judgment (a primary goal for surrogate decision-making).

One might argue that it seems the distant sister is acting in Ruth's best interests by keeping her alive, given how new her diagnosis is and the option of surgery. Although a proxy form was signed and agent designated, given Ruth's sisters concerns, the ethics consultant may recommend that the team and Jane spend more time with Ruth's sister describing the full clinical picture, the gravity of Ruth's diagnosis, what Ruth had said she wanted, and the potential risks and benefits of aggressive care, such as intubation and mechanical ventilation. This could "buy" a little time to allow Ruth's sister to absorb the information and grieve.

The MLP lawyer can be party to certain ethics discussions, particularly since the MLP lawyer was there when the client signed the proxy form (mindful, of course, of limits on what the lawyer can share). In this case, the consult process was separate from any MLP involvement. While such may be typical of how MLP lawyers become involved in ethics consults, more education about the ethics consult process and bioethics approaches could help lawyers and other MLP partners to better understand how they fit within the context of the case and to be better prepared to address issues from a bioethics perspective. In the future, however, the MLP lawyer may also more proactively consider how an ethics consult or bioethics approach could clarify Ruth's wishes via a more "collaborative" process (i.e., through a shared "ethics" discourse) to build bridges between legal and clinical advocacy for Ruth.

In sum, a bioethics consult in this case would investigate many of the same issues a legal consult would: capacity, autonomy, decision-making authority, and when placed in context, how to deal with relationships affected by our decisions. Bioethics may help support legal goals of effectuating Ruth's wishes. This perspective also brings to light capacity concerns and benefits from seeking out interdisciplinary input into addressing those concerns to achieve Ruth's wishes: bioethics is a tool to engage deeper discussions across disciplinary boundaries.

B. Annie and Bioethics Informing the Law's Application

Annie is a 15-year-old girl who is regularly seen in the adolescent clinic in a large metropolitan hospital. Annie's mother has signed a general hospital "Consent to Treat" form that allows Annie to receive routine well and sick care without the need for an accompanying adult. At her last well-care visit upon turning 15, Annie asked her primary care physician (PCP) about

methods of contraception and admitted that she has recently begun a sexual relationship with a new boyfriend. She would not reveal the boyfriend's age during that encounter.

During her most recent visit, she presented with the following information: she is having unusual abdominal pains; is bleeding abnormally; has experienced periodic burning sensations while urinating; and that day experienced a small amount of discharge from her vagina. Her PCP ran a routine battery of tests and took a detailed history, during which Annie admitted that she is presently engaged in a sexual relationship with a 20-year-old man whom she calls her "boyfriend." Annie reported that because of her mother's displeasure with the relationship, she has recently moved in with her boyfriend and the boyfriend's sister, saying her mother would "kill her" if she returned home now.

The PCP asks Annie whether any of her sexual encounters were forced, and whether she is a consensual partner in the relationship with her boyfriend. Annie refuses to answer. The PCP notices heavy makeup around her eye; yet, when he attempts to examine Annie's face, she pulls away. The PCP suspects that Annie has been subjected to facial trauma and is attempting to hide a black and blue mark on her right cheek.

At this point, the PCP believes that Annie has contracted a sexually transmitted infection (STI), is possibly pregnant, and may be holding out other vital information regarding her relationship with her boyfriend. The PCP calls the MLP lawyer, saying he will go to hospital counsel to discuss reporting obligations (if any) related to parental neglect;[62] however, he would like advice about what to do with Annie generally in this situation since there are tricky confidentiality and other legal issues. Furthermore, he suspects that Annie is not capable of negotiating the maze of social services that may be available to her and requests that the MLP lawyer meet with her to discuss her legal options.

The MLP lawyer meets with Annie in the exam room and informs her that their conversation will remain confidential, subject to a few exceptions (e.g., if fear of substantial bodily harm). At first Annie is hesitant to say anything to the lawyer, but eventually she admits that she has been assaulted a "couple of times" by her boyfriend, and that he has forced her to engage in sexual intercourse on a few occasions against her will. Despite this, she indicates that she loves her boyfriend and wishes to return to his apartment and continue her relationship with him. She also asks the MLP lawyer to keep this information confidential; although she likes and respects the PCP, she thinks that he might take steps to separate her from her boyfriend.

1. THE LEGAL CONSULT (AND LEGAL ETHICS PERSPECTIVE)

The MLP lawyer in this case is faced with several significant legal ethical dilemmas. As is typical of many MLP lawyers, the lawyer in this scenario is playing a dual role — that of an informal consultant to the medical provider, and as a legal confidante and advisor to the patient. While many times these roles coincide and result in collaborative outcomes, in this case the lawyer is faced with a difficult ethical conflict.

Although the PCP has referred Annie to the MLP lawyer, the lawyer is *not* retained by the PCP or the adolescent clinic but is merely serving in an advisory capacity, and neither the PCP nor the adolescent clinic are "clients" under any set of legal ethics rules or codes. The expectations of the PCP, however, are rooted in the notion that the lawyer and clinician are working toward the same goal — ensuring the health and well-being of the adolescent patient. If the lawyer's only contact was with the PCP as information resource, her advice would be rooted in her knowledge of the law surrounding an adolescent's right to make health care decisions independent of parental notification or consent. The relationship, however, would not be lawyer-client based.

Upon meeting with Annie, however, the MLP lawyer must work within the constraints of legal ethics rules to determine whether she must honor the confidentiality of the prospective client/patient (i.e., Annie) or whether there are extenuating circumstances that might compel her, as a matter of ethical duty, to reveal the issues of domestic violence and physical harm. In addition, the lawyer is bound by her ethical duty to counsel and advise the teenager in terms of the legal ramifications of her status as a minor and the potential implications of a child welfare referral by the PCP.

Most difficult here is the practical conflict of interest that arises when the lawyer discovers from the adolescent client the forced sexual activity and the physical assault — and how that information plays into her role as an "advisor" to the PCP. While the lawyer has no legal "ethical" duty to reveal the adolescent's confidences to the PCP, her failure to do so may practically impinge upon the critical collaborative relationship that exists between the two professional providers. Thus, the lawyer might be upholding the highest aspirations of her profession by keeping the patient's information confidential, but she may be undercutting the notions of trust and loyalty that play an important part of the lawyer's role in the medical-legal collaborative setting. With this tension in mind, the lawyer is not in a position to discuss potential referral to the child welfare agency with the PCP, and should direct the clinician to seek counsel from colleagues or hospital counsel.

2. THE BIOETHICS PERSPECTIVE (AND POTENTIAL BIOETHICS CONSULT)

In this case it is not clear that mandatory reporting would apply given a lack of involvement by the parents in the case; however, clinicians may be confused about legal obligations and concerned with how such affect ethical ones. It is here that bioethics has a role to play, where legal obligations may be seen as impinging on certain ethical obligations of the PCP. Confidentiality in health care is a paramount value in health care, especially with adolescents where confidentiality may enhance their help-seeking behavior; trust in their PCP; and their engagement in care, with the ultimate result being more effective treatment. The PCP must consider what is in the best interests of his patient. This includes avoiding harm to Annie, which breaking confidences may do; the latter may also negatively impact the ability to develop a strong physician-patient relationship.

Thus, the PCP may feel torn between potential legal reporting requirements and his desire to maintain a strong relationship with Annie to get her the care she needs. A bioethics consultant's role is not to endorse breaking the law, but she can urge sensitivity when working with clinicians who may struggle to balance legal and ethical obligations, and can also sensitize the lawyers to the ethical concerns these clinicians face. Lawyers and clinicians may also be better educated about how reporting plays out in real world situations.

It is also important to remember that Annie, as an adolescent, sits within a family, raising further ethical obligations. The PCP can try to partner with Annie and facilitate conversations between Annie and her mother so that Annie gets the support she needs. He may feel frustrated by legal requirements that would set bright-lines on disclosure when he wishes to maintain a bit more discretion in how this process unfolds. A formal ethics consult may help the PCP think through the best process and means of communication in sensitive situations such as this.

If a potential ethics consult precedes (or runs parallel to) MLP involvement with Annie's case, the MLP could see the consult as a means to clarify legal obligations, and the limits of the MLP lawyer role in contrast to hospital counsel, in a less adversarial (or "turf" challenging) way. If no consult has been called, however, the MLP lawyer could use a bioethics approach as a mediating function: it can be an invaluable means to open up the lines of communication so that all critical voices are heard and the focus reoriented to Annie's best interests, a unifying goal among all MLP partners.

In sum, in these sorts of cases, bioethics can help explain how law may seem clear but may (a) be questionable in application (e.g., if the PCP must report in this sort of situation where there is no clear parental involvement); and/or (b) create other ethical concerns if applied (e.g., Annie's confidentiality and trust in PCP). Bioethics facilitated and framed discussion may help to illuminate these issues and clarify roles, expectations, and obligations of all parties, with Annie's best interests as the unifying objective.

C. Mr. G. and Bioethics Illuminating the Law and Expanding Its Focus

Mr. G., a 75-year-old undocumented immigrant from Mexico, was admitted to the hospital for a neurological work-up. He had radiation necrosis from prior radiation on a brain tumor. The hospital determined that the tumor was inoperable, but because of Mr. G.'s altered mental status (including possible dementia), inability to communicate, and an inability to walk or eat without assistance, he could not be safely discharged to his home. Other than Mr. G.'s niece, with whom he lived, his family still lived in Mexico, including a younger sister (his niece's mother).

As an undocumented immigrant, Mr. G.'s only access to health benefits in the hospital was Emergency Medicaid, which covered his care when first admitted as an emergency patient, but which was not covering his on-going (non-acute) treatment. The social worker assigned to Mr. G.'s case was urged to find him a nursing home for discharge as his on-going needs did not require hospital care, and the growing costs of that care were falling on the hospital. However, each nursing home she approached declined transfer due to his lack of insurance and immigration status.

At this point, the hospital unit's social worker referred Mr. G.'s niece to the onsite MLP, a project funded in part by the hospital, to determine whether Mr. G. would be eligible for non-Emergency Medicaid. After interviewing Mr. G.'s niece, the MLP lawyer determined that there was no basis to adjust Mr. G.'s status in the U.S. and therefore no basis to make him eligible for non-Emergency Medicaid.

The hospital administration then considered if discharge and subsequent private repatriation might be the best solution, as they believed that the care would be adequate and he had a sister in Mexico to help manage that care. The Administrator asked the unit social worker to begin to work with the niece to safely transport Mr. G. back to Mexico. The niece, knowing how poor the family in Mexico was, did not think that repatriation was in the best interests of Mr. G. and expressed her concerns to the MLP lawyer.

1. THE LEGAL CONSULT (AND LEGAL ETHICS PERSPECTIVE)

When initially consulted, the MLP lawyer was working in concert with the goals of the hospital to investigate and potentially advocate on Mr. G's behalf regarding Medicaid eligibility. However, as time went on, it became apparent that the goals of the MLP as advocate for the client and the hospital's goal to obtain financial remuneration for Mr. G.'s care began to diverge. The hospital was concerned about the costs of having Mr. G. remain in the hospital and now sought repatriation, not insurance reimbursement. The MLP lawyer was concerned about the potential consequences of this discharge plan. There is a clear conflict now between the MLP's duty to its client, the niece, and the hospital administration.

2. THE BIOETHICS PERSPECTIVE (AND POTENTIAL BIOETHICS CONSULT)

The social work staff was quick to consult with the legal team regarding immigration issues; however, they should be encouraged to seek out an ethics consult for a different framing of this situation. An ethical analysis would focus on concerns over a potential unsafe discharge and abandoning a patient with medical issues. A central theme in ethics is to "do no harm": an immigration/deportation focus in this case may harm Mr. G. by taking him from a place where clinical relationships have formed. Also, his unstable medical condition could suffer from movement to a country with potentially inadequate resources for someone in his medical condition. Beyond individual harm, Mr. G. also resides in an immigrant community to which the hospital provides a variety of services, which it is able to do because over time it has built trust with this community. Acting hastily with Mr. G. could harm trust not only at the individual level, but also at the community level, raising a potential public health risk (i.e., risk at a larger immigrant population level).

The MLP lawyer in this case, unlike the preceding two, may not see the bioethical issue or need for an ethics consult, but rather may feel the sole conflict is that between her own legal obligations to the client and a sense of loyalty to the hospital and its interests. Critically, then, recognition of the availability of a bioethics consult or use of a bioethics approach may help the MLP lawyer and other partners see the case through a new lens: that of providing care to a vulnerable patient from an immigrant community where clinical input may be invaluable in making a strong case, and not simply a legal matter.

Thus, in this case a bioethics perspective might serve to educate the interdisciplinary team as to issues they might not otherwise recognize as critical in this sort of case, namely issues when addressing health care needs of an immigrant *and* an immigrant community. While focused on the legal status of Mr. G. and concerns of deportation, viewed through a bioethics prism, the partners might also recognize other harms to Mr. G.'s health (e.g., unsafe discharge) from a move. Furthermore, at issue is not simply deportation of Mr. G. but also how the treatment of one patient may affect relationships with a larger pool of patients from Mr. G.'s community (e.g., raise fears of deportation or repatriation if seek treatment).

As to education in professional schools, many issues arise from the nature of ethics and how it is traditionally taught. Legal ethics are codified while bioethics is less focused on the right "code" and more on the application of a range of methods and approaches to help resolve difficult cases in context.

V. Implications/Next Steps

There are many ways that the collaborations between and amongst the professionals involved in MLPs could be further enhanced by changes and improvements. We will focus on three main recommendations in this article: (1) changes in education — in professional schools and during the collaboration (both as part of the formation stage of the MLP and after its creation); (2) awareness of the availability and importance of an ethics consult to expand the options of MLPs in dealing with points of conflict; and (3) modifications in the applicable legal ethics rules to facilitate interdisciplinary collaborations, such as those in MLPs.

A. Changes in Education

As to education in professional schools, many issues arise from the nature of ethics and how it is traditionally taught. Legal ethics are codified[63] while bioethics is less focused on the right "code" and more on the application of a range of methods and approaches to help resolve difficult cases in context.[64] In part the divergence in aims relates to the greater formalism in legal ethics; additionally, bioethics must confront and incorporate a ranges of professions in its application (i.e., not guide the behavior of a single professional).

We recommend that each profession's ethics training incorporate positive aspects of the other (as is true for many issues in these collaborations).[65]

In addition to the changes in traditional ethics training, professional training should also address specific ethical challenges raised by interdisciplinary collaboration.[66] Professor Tobin Tyler noted that educators have called for "more attention in [the] curriculum to teaching client/patient-centered counseling, ethical reflection, cultural competency, and interdisciplinary and holistic problem-solving to address complex client and patient problems."[67] Clinicians' professional training and that in law schools should incorporate electives on interdisciplinary advocacy and healing into the curriculum.[68]

In the formation stages of the MLP, discussions between the various professionals should include an understanding of the ethics rules of each of the professions and the potential impact of those rules on the MLP. Protocols to address some of these ethical issues should be created prior to the beginning of the MLP.[69] All members of the MLP should also receive training in bioethics and the value of a bioethics perspective (including potentially a consult) in the MLP (discussed below). Once the MLP has been created, continuing discussions of the ethical and professional role issues should be built into the MLP.[70]

Education offered by and through MLPs has typically been primarily about the legal partners training clinicians on legal and advocacy matters. Endorsed here is greater attention to what the legal partners have to learn about clinicians' various ethical obligations and professional standards. For example, it would help if lawyers better understood the ethical and professional tensions that arise in the face of mandatory reporting obligations (e.g., concerns with maintaining confidentiality and enhancing trust in clinician/patient relationship).

Further, additional training in bioethics for all partners could make real the idea of a cross-disciplinary "collaboration" by focusing attention on common ethical issues (e.g., capacity and informed consent, confidentiality) and fiduciary obligations to help actualize patient/client interests. While each profession's language may differ, expertise vary, and approaches diverge, bioethics can be a bridge across professions to help members of the MLP team see differences not as oppositional but as varied approaches to reach similar desired ends. No profession's expertise would be discounted, but rather brought to the table to reach mutual goals. The intent would be to use bioethics education to lessen points of conflicts, and to facilitate understanding of the various professional roles and values in the MLP.

B. Use of Bioethics Consult and Bioethics Review

For those times when conflict cannot be avoided, use of ethics consults could introduce a neutral party into the issues in which the MLP lawyer is involved. While we recognize that not all MLPs may have access to institutional ethics committee or ethics consultants, we also realize that a growing number of MLPs are within hospitals or academic medical centers, or otherwise have ties to such, and so access to committee review is increasingly an option, especially as laws give more validity to the ethics committee role.[71] The MLP partners should be educated about the value of the ethics consult and, when appropriate, how to request it. For example, the ethics consult could be useful to resolve family conflicts in end-of-life care, even when legal issues are involved. A bioethics consult could foster communication and reframe seeming conflicts as opportunities for sharing and mutual learning. Bioethics is not about consensus or majority rules; however, the consult process may facilitate conflict resolution through greater understanding of the many facets of a case through appropriate sharing by each team member regarding his/her knowledge of key facts and expertise in how to deal with issues. Consults may also point towards the need for additional education or policy activities (e.g., education of unit staff about working with immigrant populations; policy development to better clarify obligations when working with the potentially abused adolescent patient). Moreover, even if the MLP is in a setting where an ethics consult or committee review is not readily available, the bioethics training recommended for all MLP partners could be useful to navigate complex issues.

C. Modification of Legal Ethics Rules

As to changes in the applicable ethical rules, modifications could be made to allow for increased collaboration in multidisciplinary practice. When the ABA examined multidisciplinary practice in 1998 through a Commission of Multidisciplinary Practice, the focus was on multidisciplinary practice in the corporate business world (e.g., law and accounting) and not in the non-profit world. The Commission specifically looked at Model Rule 5.4: Professional Independence of a Lawyer, proposing five new models to allow attorneys to practice in multidisciplinary practice,[72] all of which the ABA House of Delegates rejected.

It is time to take a fresh look at these multidisciplinary practices in non-profit organizations, including MLPs: a specific model that should be explored is the expansion of the definition of the "legal team." A possible approach is to expand this definition to include non-lawyers that assist the lawyer in the representation of the client in non-profit multidisciplinary orga-

nizations providing direct legal services to low-income and "other vulnerable client populations."[73]

Importantly, while there have been many suggestions to substantially change the form of the legal relationship, changes to legal ethical rules are not simple and could have unintended consequences. Understanding the complicated nature of these suggestions, we recommend that the ABA (and perhaps state bar associations) create a commission to study and recommend changes that could be made to facilitate non-profit interdisciplinary collaborations.[74] The commission could also examine other suggestions to facilitate MLPs in non-profit organizations, such as modifying the rules to permit the offering of interdisciplinary services while maintaining client confidentiality.[75]

Conclusion

In this era of health care reform, with an expanding health care consumer base and cost-driven calls for innovation in practice models, it is likely that MLPs will grow in number and scope. Our recommendations seek to foster this growth by focusing on that which we believe can solidify more effective interdisciplinary partnership: an understanding of and participatory discourse in ethics. The commonalities in ethical approaches of the various professions in MLPs represent a bridge between clinical and legal advocacy for patient/client well-being. Understanding the similarities and differences, and the role of bioethics, would help the interdisciplinary partners in the MLPs to navigate the often complex and intricate ethical challenges that confront this unique treatment team. Building on our vision of bioethics as a bridging discourse, we see in bioethics a means to reinforce the *collaboration* that is the foundation of the MLP. We suggest that bioethics represents a potentially valuable resource for conflict resolution and cross-professional collaboration by providing a discourse that borrows from legal and medical ethical traditions. MLP lawyers, in particular, may value the bioethics perspective to better understand the health care landscape within which they practice.

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References

1. It is recognized that lawyers and health care professionals may each be considered "clinicians;" however, within this article, when "clinician" is used, it will refer strictly to the health care professional.
2. There is ample literature on the medical-legal partnership model and theory. See, e.g., E. Cohen, et al., "Medical-Legal Partnership: Collaborating with Lawyers to Identify and Address Health Disparities," *Journal of General Internal Medicine* 25, Supp. 2 (2010): 136-139; R. Retkin et al., "Medical-Legal Partnerships: A Key Strategy for Mitigating the Negative Health Impacts of the Recession," *Health Lawyer* 22, no. 1 (October 2009): 29-34; J. Wettach, "The Law School Clinic as a Partner in Medical-Legal Partnership," *Tennessee Law Review* 75 (2008): 305-313; P. Tames et al., "The Lawyer Is In: Why Some Doctors Are Prescribing Legal Remedies for Their Patients and How the Legal Profession Can Support This Effort," *Boston University Public Interest Law Journal* 12 (2003): 505-527.
3. Some use the terms interdisciplinary and multidisciplinary interchangeably, but they have different meanings. Multidisciplinary is more akin to a "separate but equal" partnership, while "interdisciplinary" implies a more integrated teaming among disciplines. See R. L. Jessup, "Interdisciplinary Versus Multidisciplinary Care Teams: Do We Understand the Difference," *Australian Health Review* 31, no. 3 (2007): 330-331.
4. See National Center for Medical Legal Partnerships, "About Us," *available at* <http://www.medical-legalpartnership.org/about-us> (last visited October 6, 2010) [hereinafter NCMLP]. As for federal support, the Medical-Legal Partnership for Health Act was introduced into the U.S. House of Representatives and Senate on July 29, 2010 (H.R.5961 and S.3668).
5. Much of the relevant literature examines how to deal with the ethical barriers in interdisciplinary work. A. Anderson et al., "Professional Ethics in Interdisciplinary Collaboratives: Zeal, Paternalism, and Mandated Reporting," *Clinical Law Review* 13 (2007): 659-718; see Tames et al., *supra* note 2, at 513, 525-526; J. M. Norwood and A. Paterson, "Problem-Solving in a Multidisciplinary Environment? Must Ethics Get in the Way of Holistic Service?" *Clinical Law Review* 9 (2002): 337-372.
6. P. D. Jacobson and M. G. Bloche, "Improving Relations between Attorneys and Physicians," *JAMA* 294, no. 16 (2005): 2083-2085.
7. There is remarkable similarity between the two professional codes. See *Model Rules of Professional Conduct*, at Preamble (2002); American Medical Association, *Principles of Medical Ethics* (Chicago: American Medical Association Press, 2008).
8. A lawyer as an advocate and a doctor as a healer are typical characterizations. However, as described by Professor Charity Scott, a doctor is also an advocate as an "economic advocate" (advocate with health insurance providers for the patient to obtain treatment that is medically necessary) and a "care advocate" (advocate for the patient in any conflict over the care with the patient or patient's family). C. Scott, "Doctors as Advocates, Lawyers as Healers," *Hamline Journal of Public Law and Policy* 29 (2008): 331-399. A lawyer can also be a healer, as part of the broader roles for a lawyer in the Model Rules (i.e., counselor; consider moral, economic, social and political factors in acting as advisor), and as a problem solver, helping to make things better for people involved in the legal system. *Id.*
9. Medical ethics and bioethics are sometimes used interchangeably. However, as discussed in this article, bioethics results from a recognition that ethics apply to more than the physician profession and the clinical realm; bioethics encompasses ethics in health care and biomedicine.
10. NCLMP, "About Us: History," *available at* <http://www.medical-legalpartnership.org/about-us/history> (last visited October 6, 2010).
11. *Id.* (formerly the "Medical Legal Partnership for Children").
12. D. I. Schulman et al., "Public Health Legal Services: A New Vision," *Georgetown Journal on Poverty Law & Policy* 25 (2008): 729-779, at 763 (citing American Bar Association, Health Law Section, Report to the House of Delegates, Recommendations (August 2007), *available at* <http://www.abanet.org/AIDS/docs/ABA_MLP_Resolution Aug2007adopted.doc> (last visited May 25, 2010).
13. H. Thomas Wells, American Bar Association President, to American Bar Association Members, October 21 2008, *available at* <http://www.abanet.org/legalservices/probono/ medlegal/docs/wells_letter.pdf> (last visited May 25, 2010).
14. While it is beyond the scope of this article to be an exhaustive treatise on MLP models, there are several articles that define

the MLP's purpose and potential models. For example, see, B. Zuckerman et al., "Why Pediatricians Need Lawyers to Keep Children Healthy," *Pediatrics* 114, no. 1 (2004): 224-228; R. Retkin et al, "Lawyers and Doctors Working Together – A Formidable Team," *Health Lawyer* 20, no. 1 (2007): 33-36; see also references in *supra* note 2.

15. LegalHealth, "Our Trainings," *available at* <http://legalhealth.org/about/ourTrng.htm> (last visited October 6, 2010).
16. K. J. Rodabaugh et al., "A Medical-Legal Partnership as a Component of a Palliative Care Model," *Journal of Palliative Medicine* 13, no. 1 (2010): 15-18, at 16.
17. See Cohen et al, *supra* note 2, at 137-39.
18. *Id.*, at 137.
19. E. Lawton et al., "Disparities in Health, Disparities in Law: The Global Potential of Individual Advocacy," in P. Cholewka and M. M. Motlagh, eds., *Health Capital and Sustainable Socioeconomic Development* (Boca Raton: CRC Press, 2008): at 419-439; D. Weintraub et al, "Pilot Study of Medical-Legal Partnership to Address Social and Legal Needs of Patients," *Journal of Healthcare for the Poor and Underserved* 21, Supp. 2 (2010): 157-168.
20. NCMLP, "2009 Medical-Legal Partnership Site Survey Results," *available at* <http://www.medical-legalpartnership.org/mlp-network/network-site-survey> (last visited October 6, 2010).
21. This Section provides an overview of fundamentals of legal ethics, particularly areas relevant to MLPs. Readers wishing a more thorough examination could consult a number of treatises on legal ethics, e.g., D. L. Rhode and D. Luban, *Legal Ethics*, 5th ed. (New York: Foundation Press, 2009); L. G. Lerman and P. G. Schrag, *Ethical Problems in the Practice of Law*, 2nd ed. (New York: Aspen Publishers, 2008).
22. For a comprehensive guide to each state's application of ethical rules and codes, see American Bar Association, "Center for Professional Responsibility: Links to Other Legal Ethics and Professional Responsibility Pages," *available at* <http://www.abanet.org/cpr/ links.html> (last visited April 19, 2010).
23. The term "advisor" is used in a generic sense - to provide general legal information to the collaborative team. It is not meant to imply that the lawyer has assumed the role of an "advisor" pursuant to the Rules of Professional Conduct. See *Model Rules of Professional Conduct, supra* note 7, at R. 2.1 ("Advisor") (2002).
24. See Tames et al., *supra* note 2.
25. Interestingly, the Model Rules do not contain a requirement that a lawyer "zealously" advocates for a client. The preamble to the rules, however, provides that a lawyer "zealously asserts the client's position under the rules of the adversary system." See *Model Rules of Prof'l Conduct, supra* note 7, at Preamble § 2. It is generally accepted that lawyers may refuse to represent a prospective client, or withdraw from representing an existing client, if the client's position is morally repugnant to the lawyer's. See *Model Rules of Professional Conduct, supra* note 7, at R.1.16 ("Declining or Terminating Representation").
26. See D. L. Rhode, "Ethical Perspectives on Legal Practice," *Stanford Law Review* 37 (January 1985): 589-651, at 605; W. H. Simon, "The Ideology of Advocacy: Procedural Justice and Professional Ethics," *Wisconsin Law Review* 29, no. 1 (1978): 29-144, at 36-38. Note that this concept should be recognizable to clinicians, who also have an obligation to uphold a capable/competent patient's autonomous wishes, even if not the clinician's own.
27. See *Model Rules of Professional Conduct, supra* note 7, at R.1.2(b) (2002) ("[a] lawyer's representation of a client...does not constitute an endorsement of the client's political, economic, social, or moral views or activities").
28. Present and former client conflicts are governed by the principles of loyalty (to present clients) and confidentiality (to former clients). See *Model Rules of Professional Conduct, supra* note 7, at R. 1.7 and 1.9 (2002) (providing the guideposts for identifying conflicts of interest for present clients, and the duties to avoid conflicts of interest to former clients, respectively).
29. While this paper does not intend to focus on the nuances and complexities of the rules of professional lawyer conduct, it raises the issue of potential conflict of interest that should be addressed at the outset of every potential collaboration.
30. For example, the lawyer may encounter a client who seeks redress for a medical error committed by the hospital, but her pursuit of a remedy on behalf of the client would likely be her last act as a collaborative partner with the hospital. The very nature of MLPs precludes adverse action by the lawyer in the collaborative setting against the collaborative partner.
31. The lawyer's role as an Advisor is found in Model Rule 2.1. See *Model Rules of Professional Conduct, supra* note 7, at R. 2.1 (2002) ("in representing a client, a lawyer shall exercise independent professional judgment and render candid advice. In rendering advice, a lawyer may refer not only to law, but to other considerations such as moral, economic, social and political factors, that may be relevant to the client's situation").
32. See *Model Rules of Professional Conduct, supra* note 7, at R 1.6 (2002).
33. See *Restatement (Third) of Law Governing Lawyers* § 68 (2000) (stating that privilege is generally extended to include "(1) a communication, (2) made between privileged persons, (3) in confidence, (4) for the purpose of obtaining or providing legal assistance for the client").
34. See Anderson et al., *supra* note 5, at 659-718; P. Galowitz, "Collaboration Between Lawyers and Social Workers: Re-examining the Nature and Potential of Relationships," *Fordham Law Review* 67 (1999): 2123-2154; R. Retkin et al., "Attorneys and Social Workers Collaborating in HIV Care: Breaking New Ground," *Fordham Urban Law Journal* 24 (1997): 533-565.
35. All three relationships are governed by codes that allow for the breach of confidentiality. Typically, lawyers may breach confidentiality when faced with a situation where she knows that a client is about to commit an act that will result in substantial bodily harm or death. See *Model Rules of Professional Conduct, supra* note 7, at R 1.6 (2002). A psychiatrist may reveal confidential information in order to protect individuals or the community from "imminent danger." See American Psychiatric Association, *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*, 2009 rev. ed. (Arlington: American Psychiatric Association, 2009): at 5-6.
36. See Tames et al., *supra* notes 2 and 24, at 514-517.
37. L. Vaughn, *Bioethics: Principles, Issues, and Cases* (New York: Oxford University Press, 2010): at 51. For more on the "Hippocratic Tradition," see R. M. Veatch, *A Theory of Medical Ethics* (New York: Basic Books, Inc. Publishers, 1981): at 18-26.
38. D. J. Rothman, *Strangers at the Bedside* (NY: Basic Books, Inc., 1991): at 1.
39. See A. R. Jonsen, *The Birth of Bioethics* (New York: Oxford University Press, 1998) ("Even though medical ethics, bioethics' predecessor, was shaken by notable and notorious events, it was a slow accumulation of concerns about the ambiguity of scientific progress that turned the old medical ethics into the new paths of bioethics," at 3).
40. See C. Scott, "Why Law Pervades Medicine: An Essay on Ethics in Health Care," *Notre Dame Journal of Law, Ethics and Public Policy* 14, no. 1 (2000): 245-303; G. J. Annas, *Standard of Care: The Law of American Bioethics* (New York: Oxford University Press, 1993).
41. "Biomedical ethics" is also sometimes used.
42. See Rothman, *supra* note 38, at 102; for information on the difficulty of defining "medical ethics," see Jonsen, supra note 39, at ch.1; for a "contract" theory of medical ethics, see Veatch, *supra* note 37.
43. For an interesting discussion of "Bioethics as a Discipline," see Jonsen, *id.*, at ch. 10.
44. This discussion is not meant to be an exhaustive exploration of the field of bioethics, but rather to provide a brief overview of certain core concepts and methods of bioethics. There are any number of sources readers may turn to for a more in-depth exploration, some mentioned in references in this paper. Other leading treatises include (but are not limited to), R. B. Baker

and L. B. McCullough, eds., *The Cambridge World History of Medical Ethics* (New York: Cambridge University Press, 2008); B. Steinbock, ed., *The Oxford Handbook of Bioethics* (New York: Oxford University Press, 2007); B. Steinbock, J. D. Arras, and A. J. London, eds., *Ethical Issues in Modern Medicine*, 6th ed. (New York: McGraw-Hill, 2003); E. H. Loewy, *Textbook of Healthcare Ethics* (New York: Plenum Press, 1996).

45. T. Shannon, ed., *Bioethics*, 4th ed. (Mahwah, NJ: Paulist Press, 1993): at 3-5; see Vaughn, *supra* note 37, at 31-36. For a more in-depth discussion, see also references, *id.*
46. See T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 6th ed. (New York: Oxford University Press, 2008); see also Shannon, *id.*, at 5-10.
47. "Autonomy" seems an obvious value, but can be tricky as applied. How much capacity does a patient need to autonomously make a decision? What if one's wishes are not clearly known and the family cannot agree on a decision? Or what if the patient is an adolescent, on the cusp of legal adulthood? These are the sorts of cases that vex the treatment team and may result in an ethics consult (and certainly have been known to cause many a legal issue as well).
48. See A. R. Jonsen and S. Toulmin, *The Abuse of Casuistry: A History of Moral Reasoning* (Berkeley: University of California Press, 1988).
49. It is also worth noting that medical schools include some sort of ethics training, as do schools of nursing and health professions, with the aim that all entering health care professionals be capable of ethical analysis.
50. Smaller health care institutions, while perhaps lacking this formal ethics committee structure, will have a process to evaluate ethics cases.
51. For a discussion of the role of ethics committees, see C. J. Dougherty, "Institutional Ethics Committees," in S. G. Post, ed., *Encyclopedia of Bioethics*, 3rd ed. (Woodbridge: MacMillan Reference, 2003): at 444-447. See also B. Hosford, *Bioethics Committees: The Health Care Provider's Guide* (Rockford, MD: Aspen, 1986) (discussing factors influencing growth in number of ethics committees, how they are formed, key functions, legal issues, and special types).
52. See K. A. DeVille, "Lawyers and Bioethics: Balancing Being Lawyers and Conferring with Medical Ethics Advisors," *Defense Counsel Journal* 68, no. 4 (2001): 466-473. See also Hosford, *id.*, at 129-136.
53. NCMLP, *Medical-Legal Partnership Network Annual Partnership Site Survey - March 2009, available at* <http://www.medical-legalpartnership.org/mlp-network/network-site-survey> (last visited October 7, 2010).
54. For an informative summary of the clinical ethics consultation process, see G. A. Kanoti and S. Younger, "Clinical Ethics Consultation," in Post, ed., *supra* note 51, at 439-44.
55. Section IV of this article includes case examples with an ethics consult.
56. Prominent models for clinical bioethical analysis may be found in A. R. Jonsen, M. Siegler, and W. J. Winslade, *Clinical Ethics: Approach to Ethical Decisions in Clinical Medicine*, 4th ed. (New York: McGraw-Hill, Inc., 1998); J. C. Fletcher, P. A. Lombardo, M. F. Marshall, and F. J. Miller, eds., *Introduction to Clinical Ethics*, 2nd ed. (Hagerstown: University Publishing Group, 1997); M. P. Aulisio, R. M. Arnold, and S. J. Younger, *Ethics Consultation: From Theory to Practice* (Baltimore: Johns Hopkins University Press, 2003). See also L. C. Kaldijan, R. F. Weir, and T. P. Duffy, "A Clinician's Approach to Clinical Ethical Reasoning," *Journal of General Internal Medicine* 20, no. 3 (2005): 306-311; B. Lo, *Resolving Ethical Dilemmas: A Guide for Clinicians*, 3rd ed. (Philadelphia: Lippincott, Williams & Wilkins, 2005): at 7, Table 1-1.
57. See, e.g., D. Sontag, "Immigrants Facing Deportation by U.S. Hospitals," *New York Times*, August 3, 2008.
58. Intended here is a "bioethics" (i.e., a health care related ethics) consult; however, within hospitals and health systems, which would be less aware of "legal ethics" related consults, typically one would refer to this as an "ethics consult" (vs. bioethics consult).
59. The assumption is made that the lawyer and Ruth entered into a retainer agreement defining the scope of the representation, even in this limited capacity.
60. Discussed *infra* Sec. II.5.
61. A process and form has been developed to facilitate this communication and translate it into a formal medical order, in New York known as the "MOLST" (medical order for life-sustaining treatment). N.Y. Pub. Health Law § 2977(13) (McKinney Supp. 2009). This additional sort of "paperwork" has its own critics, but physicians should be aware of policy support of formal documentation of patient wishes.
62. At this point, the PCP may have an obligation to report child neglect pursuant to his state's mandatory child abuse and neglect reporting statute. Generally, mandatory reporters (those defined by statute) are required to report abuse, neglect, injuries detected that are inconsistent or at variance with explanations provided, and children who are placed in imminent risk of harm. Many state reporting schemes require that a parent, guardian, or someone responsible for the care and protection of the child cause the abuse, neglect or imminent risk of harm. As a result, the mere fact that a minor is engaged in potentially illegal conduct (e.g., statutory rape) may not implicate child welfare reporting laws in many states because the conduct complained of does not emanate from parental malfeasance or parental nonfeasance.
63. The codification is the beginning of the process for resolving many ethical legal issues, not the source of resolution.
64. See Annas, *supra* note 40, at 6 ("[t]he law is mandatory, setting standards that can only be breached at the risk of civil or criminal liability. Ethics is aspirational, setting forth universal goals that we should try to meet, but for which we suffer no temporal penalty when falling short.").
65. See E. A. Egan, K. Parsi, and C. Ramirez, "Comparing Ethics Education in Medicine and Law: Combining the Best of Both Worlds," *Annals of Health Law* 13, no. 1 (2004): 303-325.
66. See, for example, Anderson et al., *supra* note 5; Norwood and Paterson, *supra* note 5; E. T. Tyler, "Allies Not Adversaries: Teaching Collaboration to the Next Generation of Doctors and Lawyers to Address Social Inequality," *Journal of Health Care Law and Policy* 11 (2008): 249-294.
67. See Tyler, *id.*, at 252.
68. There are valid differences of opinion amongst those involved in MLPs about whether the "training" in interdisciplinary collaborations should be during the professional school training or when the professionals are in practice. The authors believe that it is important to have it during the professional school training so that it affects and influences the training and socialization of the professionals.
69. Some of the issues that should be addressed in these protocols include the interaction with the referring source (i.e., what information provided by the healthcare professional as part of the referral and what information is reported back by the lawyer to the healthcare professional) and the respective roles in interdisciplinary case consultations.
70. See Norwood and Paterson, *supra* note 5.
71. See, e.g., Chapter 8, Laws of 2010, adding N.Y. Public Health Law Article 29-CC ("The Family Health Care Decisions Act"), at sec. 2994-m.
72. S. P. Simmons, *Report to the House of Delegates*, 1998 A.B.A. Comm'n on Multidisciplinary Practice.
73. S. L. Brustin, "Legal Services Provision through Multidisciplinary Practice — Encouraging Holistic Advocacy While Protecting Ethical Interests," *University of Colorado Law Review* 73 (2002): 787-865.
74. We do recognize the "not another commission" argument against this recommendation, but stress that this proposed commission would be formed with the specific goal to address the sorts of non-profit multidisciplinary practices that MLPs represent, and that are of growing use.
75. See H. A. Wydra, "Keeping Secrets within the Team: Maintaining Client Confidentiality While Offering Interdisciplinary Services to the Elderly Client," *Fordham Law Review* 62 (1994): 1517-1545, at 1537-1541.