COMMENTARY

THE LAWYER IS IN: WHY SOME DOCTORS ARE PRESCRIBING LEGAL REMEDIES FOR THEIR PATIENTS, AND HOW THE LEGAL PROFESSION CAN SUPPORT THIS EFFORT

I. INTRODUCTION

This Commentary describes a thriving multidisciplinary law firm at work within a Boston, Massachusetts, hospital, and explores several logistical and ethical challenges that a true multidisciplinary practice must confront.

Boston Medical Center ("BMC") pediatricians are frequently confronted with the reality that their patient-families' basic needs for housing, nutrition, safety, and healthcare are routinely not met, resulting in poor child health and well-being. At BMC, New England's largest safety-net hospital, healthcare providers serve a racially and ethnically diverse, low-income population. Over fifty percent of the patient population has income below the poverty level. In BMC's Department of Pediatrics, that means that the majority of the children served live in poverty. Research clearly demonstrates that children living in poverty are more often exposed to health and developmental risks than their wealthier counterparts.[1]

Frustration at watching children experience avoidable hardships led the chairman of the Pediatrics Department to take the highly unusual step of incorporating lawyers into the clinical treatment team, founding the Family Advocacy Program ("FAP"). Since 1993, lawyers have helped pediatricians at BMC and affiliated community health centers prevent illness, injury, and malnutrition.[2] Although laws to prevent harm or poor health exist, bureaucratic obstacles and lack of compliance by government agencies, landlords, and others

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[1] *See* Steven Parker, M.D. et al., *Double Jeopardy: The Impact of Poverty on Early Child Development*, 35 THE PEDIATRIC CLINICS OF NORTH AMERICA 1227 (1988).

[2] *See* Barry Zuckerman & Ellen Lawton, *A Partnership for Kids' Health*, BOSTON GLOBE, July 25, 2001, at A11.

often deprive families of the benefits and services to which they are legally entitled.[3] However, many physicians who know that their patients' unmet needs are having a deleterious impact on their patients' health don't have the knowledge or experience to advocate effectively in the legal arena.[4] Lawyers do.[5]

For several reasons, the pediatric setting is a natural choice to implement advocacy interventions with poor families. First, pediatricians are trained to view children not as isolated patients, but as members of a family shaped by a myriad of social, economic, and environmental facts. Despite this awareness, pediatricians may not know how to respond when these factors adversely affect a child's health and well-being. Second, frequent contact with primary care physicians in early childhood (an average of fifteen visits in the first five years) results in long-term, trusting relationships between pediatricians and families. This gives the pediatrician the opportunity to observe patient and family well-being over time.[6] Pediatricians are well-positioned to perform preventive screening for psycho-social issues that may be remedied by legal advocacy. In the clinical setting, continuity of care allows physicians to gauge the effectiveness of interventions over time, to observe and participate in the growth and development of their patients, and to see how different events within a family can affect a child's health.[7] Expanding the definition of continuity of care to include legal assistance has the potential to improve substantially child health and family stability over time.[8]

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[3] *See id.*

[4] *See id.*

[5] *See id.*

[6] Trust promotes continuity of care, which is a hallmark of good primary (i.e., preventive) care. *See* BARBARA STARFIELD, PRIMARY CARE: CONCEPT, EVALUATION AND POLICY (1992). A trusting patient-doctor relationship both increases patients' willingness to disclose personal and non-medical information and promotes continuity and adherence. *See* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 308-09 (3d ed. 1989).

[7] *See* BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS 3 (Morris Green, M.D. & Judith S. Palfrey, M.D., eds., 2d ed. 2002), *available at* http://www.brightfutures.org/bf2/pdf/index.html (last visited Mar. 26, 2003).

[8] Establishing a stable and consistent relationship with a primary care physician can provide families with continuity of care, advice, and support, increasing the likelihood of identifying and intervening in medical conditions at early stages. The American Academy of Pediatrics recommends that all pediatric patients have an identifiable medical home where health services are accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent. *See* Charles Onufer, *What Families Need to Know About a Medical Home*, *available at* http://internet.dscc.uic.edu/dsccroot/parents/famlibrary.asp#medhome (last visited Aug. 27, 2002); *See* Letter to the editor from James R. Hughes, M.D. et al., *Fragmentation of Care and the Medical Home*, 60 PEDIATRICS 559, 559 (1977). Too often, Medicaid patients do not have an identifiable medical home and are subject to fragmented care through clinics or emergency departments. *See* Louis I. Hochheiser, M.D. et al., *Effect of*

Few professionals face the burden of the wide-ranging obligations that physicians, particularly pediatricians, must confront.[9] If pediatricians determine that cockroaches are triggering severe asthma in a child, they are expected to take steps with the family's landlord to ameliorate the situation. If a child suffers a laceration in a gang fight, pediatricians are expected to consult with the appropriate authorities regarding the child's safety.[10] If a child is suffering from growth failure, pediatricians are expected to ask questions about maternal depression, illness, drug use, and family financial status.[11]

In responding to these myriad patient needs, pediatricians confront many institutional barriers. That is, the process of interventional advocacy often requires the training and insight of legal practice. To advocate effectively, pediatricians must work within a reasonable time frame, assess needs effectively, assimilate data, review existing resources, and focus on the area of greatest need. These are the contributions of legal services to the provision of care.[12] The incorporation of lawyers creates a truly formidable team.

This Commentary recognizes that primary care physicians have an invaluable, substantial role as leaders, influencing the health and welfare of the communities they serve.[13] Because poor families find it increasingly difficult to meet their basic needs for housing, safety, nutrition, income, education, and healthcare, it is clear that an interdisciplinary approach is a logical and necessary response to the crisis. The integration of public interest attorneys into the healthcare setting can bridge gaps in information, resources, and legal assistance, and provide needed advocacy, guidance, and support. Indeed, public interest attorneys are just beginning to realize their potential as resources and facilitators in the clinical setting. The FAP model described below shows that the success of patient-family advocacy intervention lies in strong interdisciplinary partnerships between pediatric healthcare providers and attorneys.

This Commentary will proceed as follows. Part II defends the concept of multidisciplinary practice ("MDP"), responding to objections raised by some members of the legal profession. Part III addresses a series of ethical dilemmas that can arise when lawyers, doctors, social workers, and nurses work together on behalf of patients and clients.

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the Neighborhood Health Center on the Use of Pediatric Emergency Departments in Rochester, New York, 28 NEW ENG. J. MED. 148, 150-52 (1971).

[9] *See* Hochheiser et al., *supra* note 8, at 152.

[10] *See* Judith Palfrey, *Tensions in Delivering Care to Children*, *in* HEALTH CARE FOR CHILDREN: WHAT'S RIGHT, WHAT'S WRONG, WHAT'S NEXT (Ruth E.K. Stein ed., 1997).

[11] *See id.*

[12] *See id.*

[13] *See* Bernard Guyer, *Promoting Community Pediatrics: Recommendations from the Community Access to Child Health Evaluation*, 103 PEDIATRICS 1370 (1999).

II. MULTIDISCIPLINARY PRACTICE SHOULD BE EMBRACED, NOT FEARED

A. MDP Embraces Core Professional Values

Multidisciplinary practice is consistent with the legal profession's core value of public service. By creating new and innovative legal service delivery systems, legal and law-related services are made more available to people most in need of assistance. Commentators have noted that:

> [A] number of surveys have shown that not only poor people, but also many people of moderate means do not have access to or utilize lawyers when they have legal problems. If the establishment of multidisciplinary practices helps to serve these unmet legal needs, then the profession should support such efforts. To fight these creative delivery systems, far from representing responsible professional behavior, smacks of trade unionism, medieval guilds, and downright greed.[14]

A medical-legal collaborative, like FAP, is just one example of how multidisciplinary practice can and does work in the public interest. By providing legal assistance in concert with medical and social services, FAP helps low-income families meet their basic needs, thus increasing the likelihood of family stability and child health.

We begin with a defense of this multidisciplinary model because some prominent segments of the legal profession remain skeptical of the MDP movement. The best known source of such opposition is the American Bar Association ("ABA"). In 1998, the ABA established a commission to study MDP and its implications for the professionalism and economic interests of American lawyers.[15] In 1999, that commission issued a report concluding that MDP was not such a dangerous or worrisome concept.[16] At the ABA's annual meeting in 1999, the House of Delegates rejected the report and its conclusions. Despite the careful study and the reasoned analysis of the commission, the rank and file members of the ABA feared the prospect of greater multidisciplinary activity by lawyers and non-lawyers working together.[17]

We should note, though, that the objections from lawyers within the ABA stem from concerns that are not present in a public interest practice such as FAP.

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[14] *See* Gary A. Munneke *A Multidisciplinary Practice in Your Future?, in* MULTIDISCIPLINARY PRACTICE: STAYING COMPETITIVE AND ADAPTING TO CHANGE 1, 6 (Gary A. Munneke & Ann L. MacNaughton eds., 2001).

[15] *See* Mary C. Daly, *Choosing Wise Men Wisely: The Risks and Rewards of Purchasing Legal Services from Lawyers in a Multidisciplinary Partnership*, 13 GEO. J. LEGAL ETHICS 217, 273 (2000); Charles W. Wolfram, *Comparative Multidisciplinary Practice of Law: Paths Taken and Not Taken*, 52 CASE W. RES. L. REV. 961, 971 (2002).

[16] *See* COMMISSION ON MULTIDISCIPLINARY PRACTICE, AMERICAN BAR ASSOCIATION, REPORT TO THE HOUSE OF DELEGATES, RECOMMENDATIONS (1999), *available at* http://www.abanet.org/cpr/mdprecommendation.html.

[17] *See* Daly, *supra* note 15, at 221-24, 279-80; Wolfram, *supra* note 15, at 970-74.

These include worries about competition from large accounting firms and multinational financial services offices. There is much reason to believe that the same lawyers who rejected the ABA report would support innovative public interest endeavors like FAP.[18]

B. The FAP Model Breeds a Culture of Advocacy in Healthcare

As noted in the Part I, since 1993, FAP has incorporated at least one lawyer into the Pediatrics Department of BMC with the goal of providing legal assistance to families whose health outcomes are contingent on social changes that medical interventions alone may not address. The inclusion of a lawyer into a world of doctors, nurses, and social workers was simply an acknowledgment of the shared roles that professionals must play in a complex modern society. The creation of FAP adopted and transformed for the public interest sector a principle of legal practice regularly employed by private law firms in multinational corporate transactions: effective problem resolution often requires the collaboration of multiple service providers with complementary backgrounds and training.

Initially, FAP offered training and case consultation to healthcare providers and direct legal assistance to families in three legal practice areas: public benefits, housing, and health insurance access. As the program evolved, the lawyers and the healthcare providers learned each other's professional jargon, culture, and customs. FAP staff began attending residency education forums and department, division, and faculty meetings to ensure that providers knew about FAP services, and when and how to make referrals. These meetings provided opportunities for FAP staff to gather feedback on service delivery. In addition, they enabled staff to integrate advocacy services better in the healthcare setting and to deepen their understanding of the complex psychosocial needs of poor families and how these services relate to health outcomes.

FAP also realized that limiting service to three legal areas was impractical. Patient-families are often challenged by many issues that require a wide range of legal experience and support in a one-stop shopping model. In response, FAP expanded its staff and expertise to include three lawyers versed in multiple practice areas including family, education, and immigration law. FAP developed a network of advocacy resources to fill gaps in FAP experience and service and to refer matters to other organizations to leverage its service capacity. FAP began collaborating with pediatricians on systemic reform efforts related to recurrent problems faced by patient-families.

Essential elements of this successful multidisciplinary model include: weekly walk-in legal clinics at outpatient sites; FAP staff participation in departmental meetings; meaningful ongoing collaboration on individual family matters and systemic reform; the addition of a medical director to the FAP team; and the

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[18] *See* Stacy L. Brustin, *Legal Services Provision Through Multidisciplinary Practice—Encouraging Holistic Advocacy While Protecting Ethical Interests*, 73 U. COLO. L. REV 787, 792 (2002).

development of doctor-friendly advocacy materials and tools. Working as a team, lawyers and their healthcare partners have succeeded in breaking the silent barriers of skepticism and distrust initially encountered when the program was begun. Creating a culture of advocacy among pediatricians and patient-families has been the key ingredient FAP has contributed to improve the quality of care.

III. MULTIDISCIPLINARY PRACTICE CAN BE INNOVATIVE AND ETHICAL

A. Introduction to the Issues and a Sample Family Story

Even successful innovations in legal service delivery raise challenging questions about professional standards of ethics and responsibility. How do patient-advocacy lawyers educate healthcare providers about patient and family rights without intruding upon hospital general counsel's territory regarding staff responsibility and liability? How do lawyers empower healthcare providers to advocate for families without assisting non-lawyers in practicing law? How does a lawyer working in a medical setting satisfy her obligations of confidentiality to individual families when those obligations might run counter to a healthcare provider's mandatory reporting responsibilities? What precautions should a patient-advocacy lawyer take to protect against interference with her independent professional judgment? These are just a few of the many questions FAP staff members have contemplated as they attempt to provide good legal service in a healthcare setting. This Commentary does not purport to address all of the questions that might arise from multidisciplinary practice models, nor does it reflect the variations in states' rules of professional responsibility. Instead, it seeks to outline some of the challenging issues FAP has encountered and prescribe some practical remedies.

Participation in multidisciplinary clinical team meetings is the most recent addition to the FAP advocacy initiatives. Examination of these meetings illustrates the range of ethical issues FAP faces. The program involves a team of mental health clinicians—psychiatrists, psychologists, and social workers—who work with children suffering the effects of trauma. The clinicians invite a FAP lawyer to join them at the earliest possible stage of patient-family intervention—intake and case conference sessions. The team meets weekly to discuss new and ongoing patients—what they've learned about each patient's trauma history, what more they need to know about the patient and the patient's family in order to treat him, and how to develop and implement an appropriate treatment plan. The presence of a patient-advocacy lawyer allows clinicians to move beyond the traditional treatment modalities of in-office therapy and psychopharmacology and to assist families in changing or overcoming environmental stressors—such as substandard housing; inadequate income; custody, guardianship, and visitation concerns; special education access; and immigration status issues. Armed with essential information about the family's legal rights, clinicians are more likely to address these issues with a patient's family and feel secure in the knowledge that if a family needs help, a referral to FAP for legal assistance is easily accessible.

A specific case example best illustrates this model. During the course of a team meeting, clinicians raised concerns about a caregiver's temporary custody status and inadequate income and their impact on the child's sense of security, stability, and overall well-being. The child, a twelve-year-old African-American female, showed symptoms of depression, mood disorder, and post-traumatic stress disorder compounded by significant developmental delays, including selective muteness. She had suffered severe neglect while in the custody of her biological mother, was exposed to domestic violence committed by her biological father, and, after careening through the foster care system for five years, was placed with her grandmother at age eleven. Her grandmother is an elderly but capable caregiver; however, there was some suspicion that the grandmother had allowed the girl unsupervised visits with her biological mother. Clinicians turned to the FAP lawyer for an explanation of the permanent guardianship process, for guidance on helping the grandmother obtain public benefits like food stamps, transitional assistance and supplemental security income, and for advice about possible child protection issues.

There are at least three separate circumstances in which a FAP lawyer's participation in the team meeting might raise ethical questions: (1) Where FAP has no former or ongoing relationship with the patient or family in question; (2) where the FAP lawyer attending the team meeting has a relationship with the family or patient; and (3) where another FAP lawyer, not present at the team meeting, had or has a relationship with the family or patient. For the purpose of these examples, we will refer to the participating FAP attorney as Karen, the grandmother as Sally Davidson, and the child as Keisha. Of course, all of these names and the story's facts have been invented for purposes of the following discussion.

B. Scenario #1: No Former or Current Relationship with Patient or Family

In this iteration, Karen joins with the team and listens as they discuss families without identifying names or information. So, for instance, a psychologist speaks about "Keisha" or "Ms. D," without further identifying the patient or her family. In this scenario, we assume that Karen does not recognize and has no prior professional contact with the family.

Professional responsibility questions arise out of the role that Karen ought to play in this meeting. One possibility is that Karen participates in a full, "neutral," best-interest fashion. She offers her informed judgment about how the law affects families like this one and what legal advocacy might assist the family. She could also suggest legal strategies that might aid the long-term success of the family members by depriving some family members of their rights in the short-term. For example, Karen can explain how a care and protection petition[19] filed

[19] Under Massachusetts law, a care and protection petition may be filed with the Department of Social Services by anyone who suspects that a child is being abused. This

against the father might keep the child safe while providing the father with counseling and support services, even though he might reject the intervention and even retain an attorney to oppose it. Because Karen does not represent anyone specifically, she can chime in with whatever seems best for the family as a whole.[20]

As Karen comments on issues regarding guardianship, nutrition and income supports, and care and protection proceedings, she should not be seeing the hospital staff as her clients and should refrain from offering the staff advice about their, or the hospital's, liability or obligations. Why? In part, because she has been brought into the team configuration as a patient's attorney, even though she is not officially representing the patient or her family. Also, the hospital has its own counsel and the concept of division of labor suggests that Karen should not be usurping that role.[21] The entire arrangement is conceptually cleaner if Karen

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type of petition is frequently referred to as a 51A. *See* MASS. GEN. LAWS ANN. ch. 119, § 51A (2003).

[20] Compare this "neutral" stance with a different one. For example, Karen might see herself as the family's surrogate defense lawyer, making arguments that she thinks a family would want made if they had hired her. This option seems unacceptable, but we note first its initial plausibility. FAP was created, in part, because families need legal aid lawyers for their holistic improvement. Since there are not enough legal aid lawyers around, the mind-set of a lawyer like Karen is to think strategically, and zealously, in her job at FAP. Indeed, because this family might be referred to Karen's legal assistance program at the end of the team discussion, or some time thereafter, Karen may take on the role of a defender so that she can continue that role when she gets the case for real.

Despite these initial arguments favoring a zealous role, there is little reason for Karen to assume that role at the outset. First, and perhaps most importantly, the *team* concept implies and seems to require a good-faith, open collaboration among the members. It is not adversarial, and it is intended to assist the family members in the most enlightened way possible. An outside lawyer with a specific legal and rights-based agenda would not be invited to be part of this team. Karen should not be such a lawyer if her role in the multidisciplinary team is to be respected and fulfilled. Second, if Karen acts zealously and advocates for one family member's rights at the expense of another's (for example, in the case of a care and protection petition), Karen could not later serve as the surrogate lawyer for the family member whose rights she had helped to deny.

It seems, then, that given the role of the team and the role of the FAP lawyer within the team, Karen ought to participate in team meetings as a neutral, educated collaborator, offering predictions, strategic judgments, and explanations of substantive legal rights, unfiltered by an allegiance to any one member of the family. It is true, however, that nothing in the ethics rules *prohibits* the second version just described, where Karen serves as a zealous defense lawyer in the discussions of the case. This latter approach, however, seems imprudent given the collaborative aims of FAP.

[21] Neither rationale is totally persuasive. If Karen is not representing a family, and she is a lawyer not adverse to the hospital or its members, there is no *rule or doctrine* that bars her from giving the staff advice for its own sake. And it may be difficult to discuss things with the team without the members' discerning *something* from Karen about their liability and obligations.

explicitly informs the team members that they need to look to corporate counsel for advice about their own positions.[22]

There are three ethics questions that arise in this team-participation arrangement. The first is whether it is proper for a lawyer to act as an advocate without a client. The second is what Karen's stance should be regarding the anonymous family once the family becomes a client of FAP, which will presumably happen from time to time. A third question then follows from the first two: when Sally becomes a FAP client, does Karen have an obligation to disclose her participation in the team meeting discussions or the content of those discussions?

1. Ethics Question #1: Acting as a Lawyer Without a Client

The first ethics question arises from Karen's acting as a lawyer without a client. Possible conflict of interest issues arise with respect to the team members' liabilities, which preclude a lawyer from serving in this kind of consulting role. Most of the lawyering rules were drafted with the image of a lawyer as a representative of some client, individual or collective, in mind.[23] As a result, the rules do not limit a lawyer who does not represent a client from discussing legal issues with others, unless those "others" see the lawyer as offering advice for their sake. That is the risk in this scenario.[24]

If Karen's role in the team meeting is to offer legal advice on which the members will rely as they perform their duties, then either the team members or the hospital, or both, become Karen's clients.[25] Serving as counsel to the team and/or the hospital is not FAP's mission, and such an attorney-client relationship might restrict Karen's work with patient-families later. Assuming that she does not want to create such a relationship, the question remains what purpose is served by Karen's presence in the team meeting. The answer is that she is serving as a predictor of how the law will affect the families in question—e.g., how SSI payments might work, how a guardianship proceeding is pursued, how a special education plan might be created, etc.—so that the medical and social work providers can perform their roles more effectively. She is not offering them advice, but rather educating them about their patients' legal environment and

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[22] In-house counsel represents the hospital and does not represent any of the individual team members as such. Indeed, in cases of liability or obligation disputes, the hospital might have a direct conflict of interest with the individual staff clinicians, who might be blamed for any negligence or malpractice.

[23] *See, e.g.*, MODEL RULES OF PROF'L CONDUCT R. 1.7, 1.8, 1.9 (2001) (all referring to representation of "a client"). We also note that in 2000, the ABA approved an amendment to the Model Rules deleting Rule 2.2, which had governed a lawyer's role as an intermediary since the inception of the Model Rules in 1983.

[24] *See id.* (discussing the basic prohibition on conflicts of interest).

[25] *See, e.g.*, RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 14 (2000) (defining when an attorney-client relationship is established).

context. The dividing line between legal advice and this kind of education may be less clear than some other dividing lines, but it does exist.[26]

To the extent that Karen offers her wisdom about those matters that occur completely outside the hospital (as in the examples listed), there is little or no risk that the team members will misinterpret her predictions and explanations as advice about their actions. By contrast, when Karen's advice and predictions relate to actions in which the team members might play a part, such as the filing of a care and protection petition, the worry about advice-giving is greater. In those circumstances, Karen must take pains to be clear about her role and her inability to advise the hospital staff members. That said, can Karen still offer her predictions and explanations about how the courts or agencies work, if accompanied by all the proper warnings?

The answer to that question would appear to be yes, but it is a worrisome answer nonetheless. Let us imagine the most difficult set of circumstances. While discussing the family at a team meeting, the staff describes incidences of possible neglect or abuse by Keisha's father and asks Karen whether, given the particular facts, the father's acts rise to the legal level of neglect or abuse. Karen may provide a general explanation of the mandatory reporting laws and the investigative process conducted by the state Department of Social Services ("DSS"), but she should not offer her opinion as to whether the facts mandate reporting in this particular case; that would constitute advice to hospital staff on their rights and responsibilities as employees, an issue that falls outside Karen's responsibilities as a patient advocate. Instead, she should advise the clinicians to consult with the hospital's care and protection team and/or hospital general counsel, whose job is to advise on hospital and staff legal responsibility. As long as Karen educates the team members that she is not serving as their lawyer but instead serves as an independent lawyer who, when she is in a more conventional role, represents families and patients, she has not established an attorney-client relationship with the team members and has not violated any rule of professional conduct.[27]

2. Ethics Question #2: Acting as a Lawyer for a Family Discussed by the Team

This ethics question addresses Karen's responsibilities when the family about

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[26] *Cf.* Op. ABA Comm. on Ethics and Prof'l Responsibility, 98-411 (1998) (confirming the propriety of a lawyer's acting as a consultant without establishing an attorney-client relationship).

[27] *See id.* So long as the team members understand that Karen is not offering them advice about their own responsibilities or liabilities, and so long as Karen has no interests inconsistent with those of the team or the hospital, nothing in the "law of lawyering" precludes her from playing the role just described. We should note here that Model Rule 1.1 might apply to the team meeting setting just described, and a failure on Karen's part to work competently with the team could presumably trigger discipline under that rule. *See* MODEL RULES, *supra* note 23, R. 1.1.

whom she has heard information in the team meeting later comes to FAP for direct representation and advocacy. How, if at all, does Karen's participation in the team meeting affect her attorney-client relationship with the family?[28]

It helps here to distinguish two scenarios. In the first, easier case, Karen has offered advice to the team about the family which is in no way different from what that family's lawyer would have offered. Her suggestions about guardianship, food and income supports, etc., are entirely congruent with the family's interests. Obviously, when the family seeks direct assistance from FAP with an SSI claim or a food stamps appeal, Karen may represent them without any restrictions at all. Further, there is no reason for Karen to inform the family that she had heard about them during the team meeting, although nothing (save for some agreed-upon internal team commitments) precludes her from opting to disclose that fact if she wishes.

The second variation is more troublesome. Suppose that Karen hears during a team meeting about considerable distress in Keisha's family and offers her judgment about how a CHINS,[29] a 51A,[30] or some similar intervention might play out. As noted above, this role is proper on Karen's part and presumably helpful to the team.[31] Three weeks later, if Sally Davidson comes to FAP seeking legal advice on the CHINS or the 51A, and Karen recognizes Sally as the grandmother of Keisha, it seems that FAP must turn down that request, for Karen is likely tainted by her discussions with the team. Accepting representation in the 51A proceeding arguably does not qualify as a formal, direct conflict under the rules. Model Rule 1.7 (the concurrent conflict of interest provision) does not easily apply to disqualify Karen. Rule 1.7 prohibits proceeding if:

> (1) representation of one client will be directly adverse to another client; or
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> (2) there is a significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to another person, a former client or a third person or by a personal interest of the lawyer.[32]

Model Rule 1.7(a)(1) plainly does not apply since Karen has no other client whose interests conflict with Sally's.[33] Model Rule 1.7(a)(2) comes closer to

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[28] We assume here that Karen can recognize the family from the description offered at the team meeting, despite its previous anonymity.

[29] In Massachusetts, a CHINS petition (Child in Need of Services) can be filed by a school supervisor or guardian when a child consistently fails to attend school. It allows the court to place the child in DSS custody. *See* MASS GEN. LAWS ANN. ch. 119, § 21 (2003).

[30] *See supra* note 19.

[31] *See* note 24 and accompanying text. Again, we assume that Karen has made all appropriate warnings and disclosures to the team members that she is not serving as their, or the hospital's, lawyer.

[32] MODEL RULES, *supra* note 23, R. 1.7(a)(1)-(2).

[33] *See id.* at R. 1.7(a)(1).

covering this setting, but not entirely comfortably.[34] It is not clear that Karen's work with the team would create a "significant risk" of "material limit[ation]" in her advocacy on Sally's behalf.[35] Whatever limitation does exist arises either from her responsibility to "a third person" (that is, her allegiance to the team) or "a personal interest of" hers (that is, her need to avoid cognitive dissonance by defending Sally's actions after fellow team members "condemned" them).[36] Those responsibilities, though, seem less pointed than what is contemplated by Model Rule 1.7.

Although Model Rule 1.7 does not unambiguously bar Karen's decision to represent Sally after "educating" the team about the care and protection standards, prudence suggests that Karen, and FAP, should decline representation, if only because of the "appearance of impropriety" that accepting the case would cause.[37] Also, if Karen owes a duty of confidentiality to her team members and their discussions, that commitment creates more of a hindrance to her ability to represent Sally. Karen is now hobbled in her work for Sally in a way that a truly independent lawyer might not be (in that she cannot explore certain leads if doing so exploits the secret information she obtained in the team meeting).[38] Also, and this may be the crucial argument, Karen would be limited in her ability to challenge the credibility or the good faith of the complaining parties if they

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[34] *See id.* at R. 1.7(a)(2).

[35] *Id.*

[36] *See id.* It is easy to see how Karen could effectively represent Sally even after having participated in the team discussion. There is no doubt that Sally's version of her allegedly irresponsible behavior will be more favorable than that proffered at the team meeting, and Karen would then seek to develop evidence mitigating Sally's responsibility. In fact, the situation Karen finds herself in resembles more closely what the ethics texts refer to as a "positional conflict of interest," where a lawyer has argued in one case for one interpretation of a law, and then, with a different client with different advocacy needs, argues for the opposite legal ruling in a later case. *See, e.g.*, RESTATEMENT, *supra* note 25, § 159; RONALD D. ROTUNDA, PROFESSIONAL RESPONSIBILITY: A STUDENT'S GUIDE 270 (2002). The authorities tend to allow a lawyer to engage in positional conflicts, even without advance consent from the affected clients. *See id.*

[37] Some years ago, a familiar standard for establishing a possible conflict of interest was whether the lawyer's activity created "an appearance of impropriety." *See, e.g.*, MODEL CODE OF PROF'L RESPONSIBILITY DR 9-101 (1981) ("Avoiding Even the Appearance of Impropriety"). The 1983 Model Rules rejected that standard, following court opinions that held that the standard was "too slender a reed" on which to disqualify or discipline lawyers. Bd. of Educ. v. Nyquist, 590 F.2d 1241, 1247 (2d Cir. 1979); *see* AMERICAN BAR ASS'N, ANNOTATED MODEL RULES OF PROFESSIONAL CONDUCT 152 (3d ed. 1996). Despite the standard's loss of official status, many courts continue to rely on it in circumstances where a situation seems plainly wrong. *See, e.g.*, Burkes v. Hales, 478 N.W.2d 37, 43 (Wis. App. 1991); ANNOTATED MODEL RULES, *supra* at 152.

[38] *See* Op. ABA Comm. on Ethics and Prof'l Responsibility, *supra* note 26, at 2-3 (warning that a lawyer who consults with another lawyer and who agrees to maintain confidentiality regarding that consultation may not be able to represent a later client if the confidentiality agreement restricts that later representation).

included her team colleagues.[39] For these reasons and others described in the prior section, FAP does not engage in the kind of work that would trigger these worries, namely, representation of clients in abuse and neglect settings or in CHINS proceedings.

Nonetheless, this discussion suggests one additional ethical question for FAP—how the legal assistance program ought to handle information learned in a team meeting if the family later approaches FAP for unrelated representation.

3. Ethics Question #3: Obligations to the New Client

The third ethics question arising from the team meeting context may be captured by extending the case example. Assume that Karen had participated in the discussion of Keisha's family and had offered an explanation of the team's options as they related to protecting Keisha from possible abuse or neglect. A few weeks later, Sally Davidson contacts FAP asking for help with an SSI claim filed on behalf of her granddaughter, and Karen soon recognizes the family. Does Karen have any obligation to disclose to Sally her participation in the team meeting discussions about the abuse and neglect worries or the content of those discussions?

The answer is probably no, but it is an uncomfortable no. So long as FAP and Karen are representing Sally on her granddaughter's SSI claim, and so long as the substance of that claim has no relationship to the matters discussed at the team meeting, Karen has no obligation as an agent or as a lawyer to discuss with Sally her involvement with the team.[40] However, nothing other than her own comfort or her sense of duty to the team precludes Karen from disclosing her involvement in the team's work if she desires or finds it prudent.

If we were to amend this hypothetical scenario so that the worries about abuse *did connect* in some fashion to the SSI claim on behalf of Sally's granddaughter,[41]

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[39] On the other hand, after a case has been referred to DSS and a separate investigation has occurred, the original reporter may not play a role any longer, as the agency relies on its own investigation to confirm charges.

[40] *See* MODEL RULES, *supra* note 23, R. 1.4. Any obligation as a lawyer would arise from Model Rule 1.4, which obligates Karen to inform Sally of information pertinent to the goals and strategies of the representation. The essence of the obligation is captured in the following language from the Rule's comment: "The client should have sufficient information to participate intelligently in decisions concerning the objectives of the representation and the means by which they are to be pursued to the extent the client is willing and able to do so." *Id.* at R. 1.4, cmt. 5. Because the abuse and neglect worries are separate from the SSI claim for which FAP has been retained (a separation we are assuming for now), Karen has no obligation, as the lawyer for the SSI claim, to talk to Sally about the abuse and neglect worries. Nor does she have any greater duties as an agent. *See* RESTATEMENT, *supra* note 25, § 20, cmt. d ("[S]ometimes a lawyer may have a duty not to disclose information [to a client], because it has been obtained from another client.").

[41] For instance, if the disability claim rested on mental impairment, depression, anxiety,

our conclusions would have to change. Specifically, where the information about the abuse and neglect has some material effect or influence on the SSI case, Karen cannot proceed without telling Sally that she possesses some information from the team's discussion. This is because Sally should know, as she is asked about the now-relevant family dynamics, that Karen has access to information that bears on what she is about to describe. Sally may choose to end the relationship once she learns that Karen was present at the abuse and neglect discussion (although the severe scarcity of subsidized lawyers available to Sally makes this choice perhaps entirely illusory), but Karen has no obligation to withdraw from the SSI case, *unless* Karen's responsibilities to the team preclude her from sharing information with Sally or her granddaughter.

These three ethics questions seem to cover the obvious concerns that might arise from Karen's participation in team proceedings in cases where she does not know the identity of the team's focus at the time of the team meeting. Different concerns arise when Karen recognizes her client as the team discussion begins. These concerns are explored below.

C. Scenario #2: Participating on the Team When the Topic is a Current Client

In this scenario, Karen attends a team meeting and discovers that the subject of the team's discussion, although couched in anonymous terms, is a current client of hers. This change in status obviously alters some of Karen's responsibilities. Were there an ongoing attorney-client relationship with, for example, Sally Davidson, Karen would be more constrained in her freedom to discuss the team's plans in the team meeting. She would also be limited, perhaps in the same fashion as described above, from disclosing the team's information to her client. It may help if we examine two situations separately:

1. Where a Client is Represented on the Same Subject Matter

Suppose first that the team raises the problems of an anonymous family and Karen recognizes the family as that of her client, Sally Davidson. Let us assume further that the team is concerned about housing issues, specifically whether Sally Davidson and Keisha are more susceptible to asthma because of the poor conditions of the family's apartment. As it turns out, Karen represents Sally in an eviction proceeding within which the habitability of the apartment is a central issue.

In this setting, Karen may reveal to the team her representation and the work that she is doing on this front *only* if she has express or implied consent from Sally to do so. That consent might come from an explicit waiver that Karen requests from her clients when beginning the representation of patient-families. Such a request would seek Sally's consent to permit Karen to discuss the fact of

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or the like, there might be a connection between these ailments and the stresses connected to Keisha's alleged abuse or neglect.

representation with the team or other hospital staff and perhaps to share the substance of the representation as well. Absent such an explicit waiver, it may be apparent from Karen's work with Sally that Karen has permission to discuss her housing issues with Sally's healthcare providers. If not, then Karen must ask Sally directly for such permission. Without it, Karen may not reveal her work with the family and must not participate in the team meeting in any way that might jeopardize the rights or interests of the Davidson family.[42]

2. Where a Client is Represented on a Different Matter

Assume now that Karen, attending a team meeting, recognizes the anonymous family as the Davidson family, whom she represents in an ongoing eviction proceeding. The topic of the team meeting, however, is not housing but the team's worry about Sally's possible abuse and neglect of her grandchild Keisha. Karen seems to have three choices: (1) participate just as she would if the family were not known to her; (2) participate in the discussion as Sally's advocate, with or without disclosing her relationship with Sally; or (3) decline to participate. None of these choices is comfortable or without problems, but are any of them either *prohibited* or, alternatively, *required* by the rules of ethics?

Only the first of the three options is prohibited. None seems required, at least by the rules of ethics, but Karen's obligations to the team may make one or more options unpalatable.

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[42] We should clarify why Karen cannot, as a matter of course, reveal to the team at least the fact of representation, particularly in the example described, where Karen's "appearance" as counsel in the eviction action is a matter of public record in the Housing Court. The ABA's Model Rules prohibit a lawyer from revealing "information related to the representation of a client" without consent of the client, unless subject to an emergency exception. MODEL RULES, *supra* note 23, R. 1.6(a)-(b). Unlike the evidentiary attorney-client privilege, which does not encompass certain information (like the fact of representation or the identity of a client) and is waived by revelations in a public record the ethical rule is absolute unless an exception applies. *See, e.g.*, RESTATEMENT, *supra* note 25, §§ 68-86.

Massachusetts, however, has softened the absolute nature of the Model Rule 1.6 ethical obligation. The Massachusetts version of the ethics rule prohibits revelation of "*confidential* information relating to representation of a client." MASS. RULES OF PROF'L CONDUCT R. 1.6(a) (1998) (emphasis added). The Comment to Rule 1.6 makes clear that the modifier "confidential" does not limit the scope of the rule very much; the rule "applies . . . to virtually all information relating to the representation, whatever its source." *Id.*, at cmt. 5. As an example of information learned during the representation that might not qualify as "confidential," the Comment suggests "[t]he lawyer's discovery that there was dense fog at the airport at a particular time." *Id.* at cmt. 5A. So the most prudent understanding of Karen's obligation regarding disclosure of her representation of Sally Davidson, even as attorney of record in a public court proceeding, is that the information is protected unless Karen has permission from Sally to disclose it (which, of course, may be implied).

It would be unacceptable for Karen to participate actively in the discussion of the case in a way that might undercut Sally's interests. As Sally's lawyer, even if not on this matter, Karen ought to refrain from acting against her interests on an unrelated matter.[43] Admittedly, nothing in the Model Rules, or the Massachusetts rules, expressly make this point, but it is clearly implied by the duty not to oppose a current client, even on an unrelated matter, imposed under Rule 1.7.[44] Both the rules and the Restatement[45] refer to a lawyer's obligation *when representing a client* not to oppose the interests of another current client, even on unrelated matters. Neither covers the situation imagined here, where Karen, not representing another client but serving as a member of the team, might offer her legal judgments in a way that could harm the interests of Sally. Prudence, though, suggests that Karen not do so.

Next we consider Karen's second choice, to participate actively in the discussion but only as a lawyer looking out for Sally's interests. IfKaren did this without disclosing to the team that she represented Sally on an unrelated matter, she would appear to have breached an important duty to her team. If she participated actively and zealously after having told team colleagues that she happened to be "Ms. D's" lawyer, she would have breached no duty to her colleagues, but her input to the team would be diminished considerably, since her wisdom and insights would be seen through the lens of her commitment to Sally.[46] Thus, although not unethical, the second option is highly impractical and counterproductive in the context of FAP.

That leaves the final choice, which is for Karen to abstain from any participation in discussions on any topic relating to the client she represents. This is the safest route, but it has one small (but easily remedied) hitch. If Karen opts to abstain when the team's discussion concerns one of her clients, she will have

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[43] The rules do permit a lawyer to oppose a *former* client's interests as long as the matters are not substantially related. *See* MODEL RULES, *supra* note 23, R. 1.9(a).

[44] *See* MODEL RULES, *supra* note 23; MASS. RULES, *supra* note 42.

[45] *See* RESTATEMENT, *supra* note 25, § 128, cmt. b.

[46] We assume here that nothing prohibits Karen from advocating on behalf of a client on a matter for which she has never been retained by that client. The reasoning behind this assumption is as follows: Karen cannot make any discrete decisions on behalf of a person who has not retained her, nor commit that person to any specific stance. *See* RESTATEMENT, *supra* note 25, § 22 (indicating that client controls all substantive decisions); *cf.* MODEL RULES, *supra* note 23, R. 1.14, cmts. 9, 10 (offering a limited, emergency permission for a lawyer to act on behalf of a non-client who is unable to protect his or her rights and faces irreparable harm). At the same time, a lawyer may argue for legislative, administrative, or political positions or outcomes which will affect individuals who are not her clients. *See, e.g.*, MODEL RULES, *supra* note 23, R. 6.1 cmt. 8 (stating that lawyers ought to engage in political lobbying to improve the law). Since a lawyer may advocate for the rights of groups of people in general (while not binding those people in any way), it follows that a lawyer may advocate generally on behalf of a person whom she knows (and to whom she owes an allegiance), so long as she does not presume to commit that person to any position without having been retained by the person.

communicated to her colleagues that she represents Sally Davidson. We have already concluded that she may not do this without permission. This concern is fairly negligible for two reasons. First, if her colleagues infer from Karen's abstention that she probably represents some member of the family, it is hard to claim that Karen has impermissibly disclosed confidential client information, particularly since the fact of representation is unlikely, in any real sense, to be a deep secret which Sally would want kept under wraps. Second, as noted above, Karen may easily obtain from Sally permission to reveal at least the fact of representation, which eliminates this concern entirely.

3. The Lawyer's Obligation to Share Team Discussions with the Client

The discussion thus far has left one important question unanswered. Regardless of her chosen or required role in the team proceedings when her client's issues arise, does Karen have any obligation, or permission, to share with her client whatever information she has learned by sitting in on the meeting?

Of course, if the team has no objection to sharing information, then Karen may disclose whatever she would otherwise choose to share with a client. Conversely, if (as seems likely) the team prefers confidentiality about its discussions, Karen is bound by that contractual (and moral) commitment. But if the team insists on confidentiality and Karen learns something important about her client's *ongoing* case, should she cease representation of the client?

Let us make this concrete with an example. Suppose that the team raises a serious concern about the hazardous and overcrowded condition of Family D's apartment. It turns out that Karen represents Sally Davidson in a housing matter, the focus of which is whether Sally will accept a public housing unit in an area far from her current home. Sally thus far has resisted accepting the new apartment, against Karen's considered judgment.[47] In the team meeting, Karen hears that a hospital social worker may refer the matter to DSS if "Ms. D" does not act more responsibly about her children's housing safety concerns. If Karen does not disclose what she has learned about DSS to Sally, does her possession of that information affect her work with Sally so materially that she must cease her representation of Sally?

An answer that called for Karen to withdraw from representing Sally because of this tension would seem gravely unacceptable, even if some professional responsibility doctrine might point in that direction. In a world of private practice, with a wide range of attorney choices, Sally would be better off with a different lawyer. An unfettered and truly independent lawyer could talk to Sally about his fear that DSS might intervene if Sally did not accept the transfer to a safer apartment. Karen, however, must avoid relying on the protected, team-

[47] Of course, Karen's disagreement with Sally's chosen stance does not diminish her obligation to pursue Sally's preferred strategy, absent some incapacity on Sally's part or some serious moral difficulty created by Sally's instructions. *See* DAVID BINDER et al., LAWYERS AS COUNSELORS: A CLIENT-CENTERED APPROACH 16-19 (1990).

generated insights.[48] Some might say that this hindrance precludes Karen from continuing to work with Sally.

In the world of subsidized legal services, however, that answer is simply not realistic. Sally cannot obtain another attorney, as there is little market for free poverty lawyers.[49] The reasoning that might disqualify Karen in a private world simply cannot apply here. While no authority expressly makes this kind of distinction between private counsel and legal services lawyers, it is safe to say that Karen would not breach any duties to Sally by staying on as her lawyer. There is little doubt that Sally is better off with Karen as her (perhaps slightly hobbled) lawyer than she is with no lawyer at all.

One possible way to preempt this problem is for FAP to advise its clients, at the beginning of the relationship, that FAP attorneys meet regularly with hospital staff and social workers, and that whatever the lawyers learn in those meetings cannot necessarily be shared with the clients. Each client could then be asked to sign a waiver as to any resulting limitations that might arise, so long as the lawyer reasonably believed that the ongoing representation would not be impaired.[50] Experience indicates that poor clients would accept this waiver, and it would ordinarily be in their best interest to do so.[51]

4. Prohibition Against a Lawyer's Sharing Client Information with Hospital Staff

The multidisciplinary quality of FAP's work—the very attribute that makes the FAP model so dynamic and innovative—creates intriguing questions about how

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[48] If possessing some confidential information leads a lawyer to limit what she would otherwise pursue on behalf of a client's case, the resulting impairment of representation might constitute a disqualifying conflict of interest, especially if the lawyer cannot disclose that impairment to the current client and obtain consent to the impaired representation. *See* RESTATEMENT, *supra* note 25, § 132, cmt. g(ii), illus. 7 (limitation on sharing information previously learned "may preclude effective representation of [a client] in the pending case"). *See also* Kevin McMunigal, *Rethinking Attorney Conflict of Interest Doctrine*, 5 GEO. J. LEGAL ETHICS 823, 825 (1992) ("*A resulting impairment* approach conveys the message that the boundary between permissible and impermissible conduct is the point at which the attorney's functioning is either actually impaired or certain to be impaired." (emphasis in original)).

[49] *See* Paul R. Tremblay, *Acting "A Very Moral Type of God:" Triage Among Poor Clients*, 67 FORDHAM L. REV. 2475, 2479-82 (1999) (discussing the scarcity of subsidized lawyers for the poor).

[50] *See* Boston Bar Association Ethics Committee 2001-B, *available at* http//www.bostonbar.org/ethics/opitalics01_B.htm (proposing a similar solution involving unexpected conflicts arising out of volunteer lawyer-for-the-day programs in probate and housing courts) (last visited Apr. 11, 2003).

[51] The Massachusetts Office of Bar Counsel frowns on advance waivers. *See id.* Notwithstanding that expressed policy, it is unlikely that any thoughtful reviewer of the practice suggested here would find it troublesome. *See id.*, n. 2.

information is shared among FAP, the families served by the hospital, and the medical staff and social workers. Although the basic principle is easy to state, its application may be fuzzy at times. The principle is obvious: whatever the FAP office learns from its clients, it may not share with any other person or entity without permission, express or implied, of the client, unless some emergency exception applies. The exceptions are limited to prevention of imminent death or substantial bodily harm,[52] prevention of substantial injury to the financial or property interests of another,[53] to defend the lawyer against a claim made against her,[54] to remedy or preempt perjury or fraud on the court,[55] to comply with a court order,[56] or to intervene when a client has diminished capacity and as a result is not able to protect his interests.[57]

Let us imagine how these principles might play out in the multidisciplinary FAP arrangement.

a. Disclosing non-representation to hospital staff

Healthcare providers make daily referrals to FAP for legal assistance. Families are referred to FAP through team meeting discussions, legal clinic appointments, and telephone calls. FAP interviews the family and evaluates whether the matter has merit and whether FAP has sufficient resources to provide the needed assistance. In certain instances, FAP will not accept the referral for reasons of triage (that is, taking only the most critical cases when resources are scarce[58]), availability of legal staff, non-compliance of family members, or insufficient legal merit. As one might expect, healthcare providers want to know whether families are helped by the specialists to whom they are referred. How ought FAP respond to such expectations?

This is a trickier question than some of those posed above, for when FAP refuses a case the non-client may be reluctant to provide a waiver or implicit permission to discuss the matter with the hospital. The prudent way to proceed is as follows:

• If the patient-family has disclosed to the healthcare provider the fact that FAP turned down a case, the provider may then inquire (or, perhaps, lobby on the patient's behalf) about the rejection. In response, FAP may discuss the fact that the case was not taken, but absent some indication of the non-client's assent, FAP should not reveal the reasoning for FAP's actions. FAP may have a standard

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[52] *See* MASS. RULES, *supra* note 42, R. 1.6(b). The Model Rules are identical except for the provisions concerning the protection of financial or property interests. *See* MODEL RULES, *supra* note 23, R. 1.6(b).

[53] *See* MASS. RULES, *supra* note 42, R. 1.6(b).

[54] *See id.*

[55] *See id.* R. 3.3(b); MODEL RULES, *supra* note 23, R. 3.3.

[56] *See id.* R. 1.6(b)(4).

[57] *See id.* R. 1.14(b); MODEL RULES, *supra* note 23, R. 1.14(c).

[58] *See* Tremblay, *supra* note 49, at 2484-98.

response that asks the hospital not to infer anything negative from its rejection of a case since triage and scarce resources make client choice a difficult process.

• If the hospital inquires on its own whether a case was accepted, FAP cannot answer that question, and should say so, referring the hospital to the patient. It may be that, given hospital and FAP procedures,[59] such an answer is an implicit admission that FAP has rejected the case; if so, there is little else FAP can do under the circumstances. The only practical remedy for this discomforting circumstance would be to encourage (or perhaps require) any patient referred to FAP to consent to FAP's disclosure of the simple fact of FAP's decision (but not of the reasons for that decision). This procedure could easily be accompanied by a standard protocol that lets team members and hospital staff know in advance that a decision by FAP not to accept a case does not imply any determination that the patient's legal claims lack merit.

b. Protecting client information from being shared with the hospital

Sometimes a client will reveal information to a FAP lawyer that she does not reveal to the hospital provider. If the two professionals are working separately, this is an awkward but not insurmountable problem since the conventional rules will prohibit the lawyer from telling the hospital professional what she knows, although the lawyer may not participate in a fraudulent or illegal activity.[60] However, in the paradigmatic FAP endeavor, a client will have signed a release allowing the lawyer and the hospital staff to work together in a holistic way to remedy her health and legal problems. Presumably, this release would allow sharing of information among the professionals. If such regular sharing is not an explicit element of the release, then the lawyer must use her judgment to discern whether the client understands that the lawyer and the psychiatric nurse and the social worker will be chatting together about the client's affairs. If so, then the discussion will ensue; if not, it should not. In this latter circumstance, the lawyer might wish to discuss carefully with the client the benefits (and risks) of such information sharing in the collaborative context of FAP.

Any permission from the client to share information is revocable, however, according to the usual rules. Therefore, even if a signed release is in place, a client may ask her lawyer to keep a secret in confidence, and that request should ordinarily be honored.[61] But note the complication here. Suppose that, in the

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[59] By this we refer to the possibility of FAP's asking all of its ongoing clients to consent to a communication to the hospital that FAP is working with the patient or the family—indeed, that is the central benefit of the interdisciplinary project.

[60] *See* MASS RULES, *supra* note 42, R. 1.2(d); MODEL RULES, *supra* note 23, R. 1.2(d).

[61] Where a lawyer represents multiple clients and does not offer secrecy to any one of the several clients relative to the others, if one client asks to share something with the lawyer alone, that client's request will ordinarily be denied. *See* MODEL RULES, *supra* note 23, R. 1.7, cmt. 31; *see also*, A. v. B. v. Hill Wallack, 726 A.2d 924, 925 (N.J. 1999); RESTATEMENT, *supra* note 25, § 60, cmt. l. In the FAP-hospital arrangement, the

midst of a steady, ongoing collaboration between legal and medical staff, a client asks to share a confidential fact with her lawyer, a fact which is important to the medical as well as the legal team. If the usual rules apply, then the lawyer will honor the client's request and not share information with the hospital. But doing so has important and disruptive consequences since the hospital presumably will rely on the expectation that information will be shared readily, and, obviously, the lawyer will not have permission to alert her hospital colleagues that she is no longer sharing all of the information as she was before. Thus, the usual rules will be insufficient in this unusual circumstance.

How should the FAP lawyer proceed? This is the sort of thing that the lawyer ought to negotiate with her clients in advance of the collaboration; if she has not done so, she may find herself in an irremediable position, unable to guarantee confidentiality. If a client were to blurt out a secret and *then* ask that the revelation not be shared, a lawyer who had not negotiated an arrangement might find herself in an uncomfortable predicament, similar to the lawyer in "the case of the unwanted will" (referring to a famous story reported by Professor Tom Shaffer of Notre Dame Law School[62]). Here's why: if Sally Davidson were to ask Karen if she could share something private with her at a time when Karen was working productively with the medical and social work team on the Davidson matters, Karen would have to offer the following caveat to Sally:

> As your lawyer, I have a professional duty to keep what you tell me secret, unless you direct me otherwise. You have previously signed a paper allowing me to talk about your case with the hospital team, but that paper can be withdrawn at any time, as you

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lawyer has no such stark obligation to the other party, and so the result is different.

[62] *See* Thomas L. Shaffer, *The Ethics of Radical Individualism*, 65 TEXAS L. REV. 963, 968-72 (1987). In this story, a lawyer drafts reciprocal wills for a husband and wife together as joint clients, each leaving all assets to the other. After the wife has signed her will, the husband tells the lawyer in confidence that he wants his will rewritten to leave a bulk of his estate not to his wife, but to his paramour. Because the lawyer has not adequately counseled the clients about the obligation to share all information with both spouses, the lawyer is in a tragic, existential dilemma. If he tells the wife of her husband's plans (as he must), he has committed a serious breach of his implied duty to the husband of confidentiality. If he respects the husband's confidence (even if he does not redraft the will), he has breached the duty owed to the wife to inform her of important developments related to the representation. Shaffer, who (as his article's title implies) is a deep critic of secular individualism and autonomy, argues that the lawyer represents "the family" as an indivisible moral unit, and the lawyer must confront explicitly the chasm that has developed in his clients' relationship. Few legal ethics scholars share Shaffer's perspective, tending instead to analyze the problem through the lens of competing rights and professional compromises. *See, e.g.*, DEBORAH L. RHODE & DAVID LUBAN, LEGAL ETHICS 481 (3d ed. 2000); Stephen Ellmann, *Client-Centeredness Multiplied: Individual Autonomy and Collective Mobilization in Public Interest Lawyers' Representation of Groups*, 78 VA. L. REV. 1103, 1125 (1992); Russell G. Pearce, *Family Values and Legal Ethics: Competing Approaches to Conflicts in Representing Spouses*, 62 FORDHAM L. REV. 1253, 1283-85 (1994).

know. So the answer to your question is "yes," but I need to warn you that once I know something that I cannot share with the team, I may not be able to continue to work with the team. Indeed, I will have to tell them that I will no longer be part of your team, and they will suspect that something is amiss. So it's not as simple as we might first think.

Why don't we talk about some things before you confide in me? Let's talk in very general terms about the risks that you see in the team's knowing about your affairs, as well as how things would look if I were to stop being part of the team. Maybe then you can decide whether to confide in me, or to tell me knowing that I might feel the need to share things with the medical and social work team.

If this conversation seems like the appropriate caution to a FAP client, then it makes sense for the FAP lawyer to have a similar conversation with each client at the beginning of any representation that will include hospital collaboration (which, given FAP's multidisciplinary mission, presumably covers most FAP clients). The early warning helps the client understand the professional roles, and, for what it's worth, "covers" FAP should a client blurt out something later, expecting it to be confidential.[63]

D. Scenario #3: Current Representation by a Different FAP Lawyer

Now let us assume the following: Karen attends a team meeting at which patients and families are discussed anonymously. At this particular meeting, the team discusses "Family D." Karen later learns that her colleague, a lawyer named Ben, represents Sally Davidson. The central question in this scenario is whether the fact that the FAP representation is by a lawyer other than Karen alters any of the suggestions offered in the first two scenarios.

In general, the answer to that question is "no." Because a lawyer working in a law firm is treated as representing all of the clients of the law firm,[64] we cannot ascribe different responsibilities to Karen when the family is Ben's client and not Karen's. There is, though, one intriguing twist to this scenario, and it concerns Karen's sharing information with Ben that Ben must then keep secret from his client.

Ordinarily, information known by one member of a law firm is deemed to be known by all members of the law firm.[65] This principle applies with special force to small, close-knit legal organizations, where fire walls and cones of silence are impractical.[66] Thus, in the context of professional responsibility, what Karen knows, Ben is deemed to know as well.

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[63] By "cover," I refer to the need to protect FAP from a claim of breach of duty, thus avoiding the situation that the lawyer in the unwanted will story found himself in when he failed to give early warnings to his joint clients. *See supra* note 62.

[64] *See* ROTUNDA, *supra* note 36, at 331, § 11-2.2.

[65] *See* ANNOTATED MODEL RULES, *supra* note 37, at 165; RESTATEMENT, *supra* note 25, § 123.

[66] *See* ANNOTATED MODEL RULES, *supra* note 37, at 174-75.

That said, there is still no reason at all for Karen to share with Ben information learned in the team meeting, which Ben could not share with his client. As such, the answers here seem rather straightforward and logical. If the information learned by Karen is such that the team permits sharing with the client, then, of course, Karen will share it with Ben. If, on the other hand, the information is protected by the team's ongoing confidentiality commitment, as discussed in the last section, then nothing obligates Karen to share the information with Ben, especially if doing so would then create some impairment in Ben's work for Sally, as explained above.

IV. CONCLUSION

The purpose of this Commentary is to describe an ongoing multidisciplinary practice and demystify some of the ethics and confidentiality challenges that frequently discourage potential partnerships across disciplines. At BMC, the presence and participation of lawyers in the clinical setting has radically affected healthcare providers' ability to treat their patients while facilitating preventive legal interventions that benefit patient-families directly and improve family health and well-being.

The key components of this successful collaboration are healthcare providers with the flexibility to expand their practice beyond traditional limitations and attorneys who can adapt to a different mode of legal practice, focused on *prevention*. It is also critical to enlist the support of the hospital or clinic general counsel, since she will play a role in resolving some of the dilemmas that arise for the FAP attorney. Finally, every multidisciplinary effort should seek out legal assistance and support from experts in academia and the local bar association, or board of bar overseers. In this way, each collaboration will obtain expert opinions tailored to its circumstances, including state and local rules and the specific practice or discipline. With this knowledge, we encourage both medical and legal providers to work together to improve children's and families' health and well-being.

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