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INTRODUCTION

A large body of literature shows a clear link between an individual's health and social, environmental, and behavioral factors.[1] For example, housing code violations may cause or exacerbate respiratory conditions, and domestic violence may lead to repeated emergency room visits.[2] These so-called social determinants of health account for as much as sixty percent of the risk of premature death, with thirty percent of the remaining preventable deaths attributable to genetic predispositions and only ten percent attributable to access to medical care.[3] Despite the significant impact that social, environmental, and behavioral health factors have on health, the United States spends approximately twice as much on medical care as it spends on

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1. *See* David A. Asch & Kevin G. Volpp, *What Business Are We In? The Emergence of Health as the Business of Health Care*, 367 NEW ENG. J. MED. 888, 888 (2012) ("[A]n enormous body of literature supports the view that differences in health are determined as much by the social circumstances that underlie them as by the biologic processes that mediate them."); *see also* John V. Jacobi, *Multiple Medicaid Missions: Targeting, Universalism, or Both?*, 15 YALE J. HEALTH POL'Y, L. & ETHICS 89, 97 (2015) ("[Nonmedical factors] can be more powerfully determinative of the health of a population than the delivery of traditional health services.").

2. *See* Bharath Krishnamurthy et al., *What We Know and Need to Know about Medical-Legal Partnership*, 67 S. C. L. REV. 378, 383 (2016) (showing that several studies have found that MLP programs have reduced ER visits for asthma patients following housing interventions, improved pregnancy outcomes and lowered rates of abuse).

3. Sandra Braunstein & Risa Lavizzo-Mourey, *How the Health and Community Development Sectors Are Combining Forces to Improve Health and Well-Being*, 30 HEALTH AFF. 2042, 2043 (2011), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.0838 ("[S]ocial circumstance, environmental exposure, and behavior are estimated to account for sixty percent of the risk of premature death"); MAIA CRAWFORD ET AL., MILBANK MEM'L FUND, POPULATION HEALTH IN MEDICAID DELIVERY SYSTEM REFORMS 2 (2015), http://www.milbank.org/uploads/documents/papers/CHCS_PopulationHealth_IssueBrief.pdf. (illustrating the proportionate effects that various factors have on health status).

social services.[4] However, a paradigm shift is taking place in the health care delivery system. In response to payment reforms that reward improvements in patients' health and reduced health care spending, providers are increasingly turning their attention to the social determinants that adversely impact their patients' health.[5] In recent years, a leading strategy for doing so is the medical legal partnership ("MLP").

MLPs address the health-harming social and legal needs of patients and communities by integrating the expertise of health care, public health, and legal professionals.[6] At a minimum, health care providers participating in a MLP refer patients that require legal assistance to lawyers, while social workers within the MLP will often address those patients' related social needs.[7] The legal partner may also train the medical partner's support staff in identifying patients with health-harming legal needs and in using any available legal interventions.[8] For example, the lawyer may educate the medical partner's staff on identifying individuals who may be eligible for social security disability insurance ("SSDI") or on how to effectively navigate the SSDI application and appeals process.[9] Some MLPs also combine health and legal tools to advocate for broad policy changes that combat social or environmental factors adverse to health, such as poor housing conditions.[10]

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4. *See* Jennifer DeCubellis & Leon Evans, *Investing in the Social Safety Net: Health Care's Next Frontier*, HEALTH AFF. BLOG (July 7, 2014), http://healthaffairs.org/blog/2014/07/07/investing-in-the-social-safety-net-health-cares-next-frontier ("[F]or every dollar spent on health care, only 50 cents is invested in social services").

5. *See* Jessica Mantel, *Tackling the Social Determinants of Health: A Central Role for Providers*, 33 GA. ST. L. REV. 217, 222 (2017) ("In response to reforms adopted under the ACA, providers increasingly are turning their attention to the nonclinical factors that adversely affect their patients' health").

6. *See* Krishnamurthy et al., *supra* note 2, at 379 ("The MLP approach to health is designed as an integrated, upstream effort among health care, public health, and legal sectors that collectively work to improve social conditions for people and communities.").

7. *See id.* at 380 ("In the MLP approach, health care, public health, and civil legal aid services are integrated in a way that allows clinical staff at hospitals, clinics, and other sites to screen for health-harming legal needs, work in tandem with legal professional . . . and . . . refer patients to a civil legal aid team.").

8. *Id.* at 379.

9. *See id.* at 380 (presenting a table with potential MLP interventions, such as "[s]ecure housing subsidies, protect against utility shut-off" and "[a]ppeal denial of food stamps, health insurance").

10. *See id.* at 384–85 ("Medical-legal partnerships have shown significant community benefits by alleviating system-wide social conditions, such as housing reconstruction to meet city codes that affect community and population-wide health."); *see* also *Professor Emily Benfer Quoted on Lead Poisoning in HUD Housing*, LOYOLA U. CHI., BEAZLEY INST. FOR HEALTH L. & POL'Y, https://www.luc.edu/law/centers/healthlaw/stories/archive/professoremilybenferquotedonleadpoisoninginhudhousing.shtml (last visited May 22, 2018) (illustrating how an MLP can

Despite its promise for addressing the underlying social and legal causes of poor health, the MLP model faces significant privacy and data sharing challenges.[11] Medical professionals are subject to various federal privacy and health laws, and lawyers must adhere to professional conduct rules such as client confidentiality.[12] These laws and professional conduct rules can hinder the free exchange of patient-client information between an MLP's medical and legal partners.[13] This Article catalogs the relevant legal and ethical considerations related to MLP data sharing and identifies how these obligations might undermine the effectiveness of MLPs by hindering data sharing and integration among MLP professionals. In doing so, this Article encourages policymakers to consider whether it may be necessary to modify federal and state health privacy laws or lawyers' professional conduct rules to enhance MLPs' effectiveness in addressing patient-clients' health-harming legal and social needs.[14]

Part I of the Article opens with an overview of MLPs and explains the benefits of partnerships that follow an integrated, multidisciplinary approach over the referral model. Next, Part II describes the regulatory framework governing the sharing of patient information from the medical partner to the legal partner and identifies potential barriers to doing so. Then, Part III catalogues the relevant legal and ethical considerations applicable to sharing client information from the legal partner to the medical partner and highlights potential ways these obligations might compromise the needs of MLP clients. Finally, Part IV calls for additional empirical research about MLP data sharing practices.

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effectively address policy issues). For example, the Loyola University Chicago School of Law Health Justice Project, a MLP between Loyola University Chicago and Erie Family Health Center, brought together a coalition of health care providers, legal aid groups, scientists, and public health experts to advocate for regulatory change to address the issue of lead poisoning in HUD housing. Their work led to HUD submitting a proposed rule amendment in March 10, 2016 that adopted more rigorous measures for acceptable lead levels. *Id.* The rule has since been adopted.

11. *See* JANE HYATT THORPE ET AL., INFORMATION SHARING IN MEDICAL-LEGAL PARTNERSHIPS: FOUNDATIONAL CONCEPTS AND RESOURCES 2 (2017) ("MLPs are designed to enable healthcare practitioners and legal services providers to communicate directly in order to address legal issues that may impact a patient's health. However, these communications may implicate federal and state privacy and security laws, such as [HIPAA].").

12. *See id.* at 4 (explaining that sharing patient information within MLPs may trigger privacy and safety statutory requirements for both medical and legal professionals).

13. *See id.* at 1 ("MLPs are designed to encourage and enable this communication, but the information privacy legal framework may still present obstacles, both real and perceived, to effective information sharing.").

14. *See generally* Paul R. Tremblay, *Toward a Community-Based Ethic for Legal Services Practice*, 37 UCLA L. REV. 1101, 1101 (1990) (raising a similar question regarding community norms and adjustment of expectations for legal practice when serving low-income clients).

I. MEDICAL LEGAL PARTNERSHIPS

Low-income individuals frequently cope with legal and social issues that adversely impact their health.[15] Exposure to hazardous chemicals, lead paint, mold, dust, or pest infestation in the workplace or home can cause or aggravate respiratory conditions such as asthma.[16] Stress from coping with unemployment, economic hardship, racism, or other challenges can lead to psychological conditions while simultaneously damaging immune defenses, vital organs, and physiological systems.[17] Financial insecurity may lead individuals to delay or forego needed health care.[18] In addition, financial insecurity may force individuals to consume less nutritious food, thereby increasing their risk for medical complications, obesity or malnutrition.[19]

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15. *See* Paula Braveman et al., *The Social Determinants of Health: Coming of Age*, 32 ANN. REV. PUB. HEALTH 381, 385–86 (2011) (discussing the impact of the physical aspects of neighborhoods, housing, and the workplace on health); *see also Facts About Mold and Dampness*, CDC, https://www.cdc.gov/mold/dampness_facts.htm (last updated Sep. 5, 2015) (claiming that damp and moldy environments may cause respiratory infections and trigger asthma symptoms).

16. Braveman et al., *supra* note 15, at 385–86; *Facts About Mold and Dampness*, *supra* note 15.

17. *See* Braveman et al., *supra* note 15, at 388 (noting that stress may trigger the release of substances that damage the immune defenses, vital organs, and physiological systems); *see also* Patti Neighmond, *People with Low Incomes Say They Pay a Price in Poor Health*, NPR (Mar. 2, 2015, 4:05 AM), http://www.npr.org/sections/health-shots/2015/03/02/389347123/people-with-low-incomes-say-they-pay-a-price-in-poor-health (reporting that surveys and studies suggest that lower-paying jobs and unemployment harm health, which increases the risk of conditions such as stroke, heart disease, diabetes, and emotional or psychiatric conditions).

18. *See* Jeffrey T. Kullgren et al., *Nonfinancial Barriers and Access to Care for U.S. Adults*, 47 HEALTH SERVS. RES. 462, 467 (2007) ("[Presenting a survey that found] barriers in the affordability dimension were the most common reasons for unmet need or delayed care (18.5 percent)."). While the insurance reforms and subsidies put in place by the ACA lower these barriers, they do not completely eliminate them. *See* Benjamin D. Sommers, *Health Care Reform's Unfinished Work—Remaining Barriers to Coverage and Access*, 373 NEW ENG. J. MED. 2395, 2395–96 (2015) (explaining that, for people with higher incomes who do not qualify for subsidies under ACA, cost remains a significant barrier to obtaining health insurance, and even among insured individuals high cost-sharing can limit access to timely and affordable care); *see also* FROST & SULLIVAN, WHITE PAPER ON PATIENT NONADHERENCE: TOOLS FOR COMBATING PERSISTENCE AND COMPLIANCE ISSUES, 4 (2005), www.frost.com/prod/servlet/cpo/115071625.pdf (displaying a survey of 10,000 patients found that seventeen percent identified cost issues as a reason for their not taking medications as directed by their physicians).

19. *See* Binh T. Nguyen, Kerem Shuval, Farryl Bertmann & Amy L. Yaroch, *The Supplemental Nutrition Assistance Program, Food Insecurity, Dietary Quality, and Obesity Among US Adults*, 107 AM. J. PUB. HEALTH 1453, 1455 (2015); Michele Ver Ploeg, *Access to Affordable, Nutritious Food is Limited in "Food Deserts"*, U.S. DEP'T AGRIC. (Mar. 1, 2010), http://www.ers.usda.gov/amber-waves/2010-march/access-to-affordable,-nutritious-food-is-limited-in-%E2%80%9Cfood-deserts%E2%80%9D.aspx#.VrZbCtIrJhE (explaining that "food deserts" are neighborhoods where residents live far from supermarkets or other food retailers that provide affordable and nutritious food, thus they rely instead on smaller

Lawyers are uniquely situated to help individuals address these and other underlying causes of poor health by supporting patient-clients' access to available government services and legal protections.[20] For instance, lawyers can provide legal aid to individuals who have been denied health insurance coverage or public benefits such as Medicaid and SSDI.[21] Lawyers can also help individuals enforce their legal rights under anti-discrimination, housing, employment, and education laws and in obtaining protective orders against abusive partners.[22] Moreover, lawyers can assist with immigration and creditor/debtor issues, as well as family law and estate planning matters such as divorce, guardianship, and powers of attorney.[23]

Further, physicians, nurses, hospitals, and other providers are ideally positioned to identify patients with health-harming legal and social issues, and can adeptly facilitate the receipt of legal and social support services.[24] Providers witness the impact of social determinants on individuals' health firsthand.[25] Patients' trust in medical professionals also promotes individuals sharing sensitive information with their providers, such as personal information on issues such as domestic violence, financial hardship, immigration concerns, and other legal and social challenges.[26] Therefore, providers have the ability to screen for health-harming legal and social needs and refer those patients needing assistance to lawyers and social workers.[27] The MLP model supports this integration of medical, legal, and social

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stores that often do not carry healthy foods and/or charge higher prices).

20. Caitlyn Weiss & Jonathan Pyle, *Addressing the Social Determinants of Health by Placing Legal Advocates in Community Health Centers*, SOC. INNOVATIONS J. (Oct. 19, 2016), http://www.socialinnovationsjournal.org/social-issues/95-health/2184-addressing-the-social-determinants-of-health-by-placing-legal-advocates-in-community-health-centers.

21. *Civil Legal Aid 101*, U.S. DEPT. OF JUST., https://www.justice.gov/atj/civil-legal-aid-101 (last updated Oct. 21, 2014).

22. *See id.* (specifying housing, elder abuse, child abuse, employment, school accommodations, and domestic violence as a legal area where assistance is provided by lawyers).

23. *See id.* (listing family law and consumer protection as areas where legal assistance is available).

24. *See* Marcia M. Boumil et al., *Multidisciplinary Representation of Patients: The Potential for Ethical Issues and Professional Duty Conflicts in the Medical-Legal Partnership Model*, 13 J. OF HEALTH CARE L. & POL'Y 107, 111 (2010) ("Patients trust medical providers with personal information and may speak to them about financial hardships, troubled relationships, and other socioeconomic stressors. This trust facilitates the identification of health-related social problems.").

25. *Id.*

26. *See id.* ("Patients trust medical providers with personal information and may speak to them about financial hardships, troubled relationships, and other socioeconomic stressors.").

27. *Id.* at 112 (demonstrating the importance of each clinical visit in screening social determinants of health).

services, and is the most efficacious method of achieving these goals.[28]

Nevertheless, MLP models vary greatly, particularly regarding the degree of collaboration among the MLP partners and their information-sharing practices.[29] At one end of the spectrum, there are MLPs with limited interactions between the medical and legal partners.[30] Under this referral model, the medical partner only refers patients with health-harming legal needs to the legal partner, sometimes simply providing the patient with the legal partner's contact information; thus, the responsibility is allocated to the patient to affirmatively seek assistance.[31] In this scenario, any health information given to the lawyer is either provided directly by the patient-client or transferred from the medical provider to the lawyer upon the patient-client's specific request.[32] Alternatively, the medical provider may directly communicate with the legal partner and schedule the meeting between the patient and MLP lawyer, but the information provided to the legal partner is limited to the patient's name, contact information, and a general description of potential legal needs (e.g., "domestic violence issue").[33] For MLPs following the referral model, communication between the legal partner and the medical provider is either nonexistent or limited to sharing the outcome of the legal services (e.g., "restraining order obtained").[34]

At the other end of the spectrum are MLPs that integrate the full range of services they offer individuals.[35] Under this model, the MLP lawyer works collaboratively with the medical provider's staff as part of an interdisciplinary team of professionals.[36] Patient-clients receive a package

28. *See* Krishnamurthy et al., *supra* note 2, at 380 ("In the MLP approach, health care, public health, and civil legal aid services are integrated in a way that allows clinical staff at hospitals, clinics, and other sites to screen for health-harming legal needs, work in tandem with legal professionals . . . .").

29. *See* THORPE ET AL., *supra* note 11, at 2 ("There is wide variation across MLP designs and accordingly, wide variation in their information-sharing needs, practices and preferences.").

30. *See id.* at 5–6 (offering examples of different MLP formation and integration models).

31. *See id.* at 6 ("Any PHI transferred from medical partner to legal partner is requested by and transferred by patient.").

32. *Id.*

33. *See id.* at 8 (explaining that some PHI transfer may be broad in scope or merely limited to name and contact information); *see also* TISHRA BEESON ET AL., CTR. FOR MED.–LEGAL P'SHIP, MAKING THE CASE FOR MEDICAL–LEGAL PARTNERSHIPS: A REVIEW OF EVIDENCE 2 (2013) (listing domestic violence as a legal issue of concern in MLP models).

34. *See* THORPE ET AL., *supra* note 11, at 8 (describing the varying scope of patient authorization in different MLP models); *see also* BEESON ET AL., *supra* note 33, at 2.

35. *See* THORPE ET AL., *supra* note 11, at 7 (presenting the varying degrees of integration in a table).

36. *See id.* (describing a fully integrated MLP as one where a legal institution is "formally recognized" as part of health care team and service system); *see also* Pamela Tames et al., *The Lawyer Is In: Why Some Doctors Are Prescribing Legal Remedies for*

of legal and non-legal support from the MLP team, with services often provided at the same location (typically within the medical setting).[37] The MLP team also may meet regularly to discuss patient-clients' ongoing clinical, social, and legal needs.[38] In contrast to the referral model, the integrated, multidisciplinary model involves substantial sharing of information between the medical and legal partners.[39]

While the referral model allows MLPs to provide much needed legal services to patient-clients, it poses several problems. First, many patient-clients fall through the cracks under the referral model and go without needed legal assistance.[40] Individuals who must affirmatively reach out to the legal services provider and directly provide any necessary health information spend much time and energy doing so.[41] Those who lack transportation or the financial and emotional resources, however, may be unable to navigate this process.[42] Consequently, these individuals may not receive help for their health-harming legal needs.[43]

Second, even when the individual does obtain legal assistance, limited coordination and communication between the legal and medical partners can result in narrow solutions with reduced impact.[44] Patient-clients' problems are rarely "purely legal in nature"; rather, they often involve complex and interrelated legal, medical, social, and financial needs.[45] Yet, when the lawyer retained to assist the patient-client does so in isolation, he or she may overlook important aspects of an individual's problems or neglect needs with

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Their Patients, and How the Legal Profession can Support This Effort, 12 B.U. PUB. INT. L.J. 505, 510 (2003) (illustrating a medical-legal model comprised of multidisciplinary teams); *see also* J. Michael Norwood & Alan Paterson, *Problem Solving in a Multidisciplinary Environment: Must Ethics get in the Way of Holistic Services?*, 9 CLINICAL L. REV. 337, 347 (2003) ("[A holistic approach to problem-solving for clients]] requires the use of a multidisciplinary team with expertise drawn from a range of professions and specialties").

37. *See* THORPE ET AL., *supra* note 11, at 5 ("[The integrated MLP model may involve] location of legal services on site at a health care organization"); *see also* Stacy L. Brustin, *Legal Services Provisions through Multidisciplinary Practice - Encouraging Holistic Advocacy While Protecting Ethical Interests*, 73 U. COLO. L. REV. 787, 792 (2002) ("[Multidisciplinary practice models can offer] a package of services in one accessible location").

38. *See* Tames et al., *supra* note 36, at 510 (describing an MLP program where the MLP team of professionals meets weekly to discuss new and ongoing patients).

39. *See* THORPE ET AL., *supra* note 11, at 5 ("[The MLP] may be very integrated, with substantial sharing of information between healthcare practitioners and legal services providers . . . .").

40. *See* Brustin, *supra* note 37, at 846 ("The attorney is making the referral to assist the client, but the referral has no connection to the consumer action.").

41. *Id.* at 789.

42. *Id.*

43. *Id.*

44. *Id.*

45. Norwood & Paterson, *supra* note 36, at 347.

no apparent legal solution.[46] For instance, a lawyer retained to prevent a patient-client's eviction may overlook or leave unaddressed the underlying conditions that led to the eviction action, such as unemployment or financial insecurity.[47] A lack of communication between the medical and legal side may further exacerbate this issue. In practice, when medical and legal partners provide services in separate silos, each may fail to consider alternative solutions to the patient-client's problems that fall outside their respective disciplines. By way of illustration, a lawyer representing patient-clients living in substandard housing may focus on initiating legal action against the derelict landlord, even though relocation—a non-legal solution—may present a more optimal solution for some individuals. Relatedly, when a MLP's medical and legal partners operate separately, their advice to the patient-client may conflict and thereby confuse the patient-client. For example, the lawyer's advice to initiate legal action (e.g., sue the landlord) may contradict guidance offered by the medical partner's social worker or other staff (e.g., move to new housing).[48] The referral MLP model consequently may yield incomplete, conflicting solutions to a patient-client's health-harming legal, psychosocial, and financial needs.

In contrast to the referral MLP model, the integrated, multidisciplinary MLP model better serves the complex needs of vulnerable individuals and their families, thus offering greater potential to improve patients' health. As noted above, the integrated, multidisciplinary approach customarily offers the full range of clinical and non-clinical MLP services at a single location.[49] Providing services at a single location forecloses the need for the individual to travel to the legal services provider or navigate an unfamiliar setting, increasing the likelihood that individuals will actually receive needed legal support.[50] Moreover, the integrated, multidisciplinary model supports

46. Jeffrey David Colvin, Brooke Nelson & Katie Cronin, *Integrating Social Workers into Medical-Legal Partnerships: Comprehensive Problem Solving for Patients,* 57 SOC. WORK 333, 335 (2012).

47. *See id.* at 335–36 (discussing the benefits of integration among MLP lawyers and social workers jointly addressing the needs of a patient facing possible eviction). *Cf.* Brustin, *supra* note 37, at 793 ("[A] lawyer who obtains a restraining order for a client experiencing domestic violence has addressed one narrow aspect of the problem. The client will most likely need counseling, financial assistance, and possible medical treatment – all services a lawyer cannot provide.").

48. *See* Brustin, *supra* note 37, at 862 ("Professionals will analyze a situation and offer advice framed by values, ethics, standards, and priorities emphasized within their particular profession. . . . As a result, a client who sees a social worker may receive advice that would contradict the legal advice her attorney would offer.").

49. *See* THORPE ET AL., *supra* note 11, at 5–9 (describing on-site legal services); *see* Brustin, *supra* note 37, at 792 ("By housing a variety of services under one roof, professionals of different disciplines can bring their skills and expertise to bear upon the complex problems that clients face and develop more comprehensive, effective solutions.").

50. *See* THORPE ET AL., *supra* note 11, at 5; *see also* Brustin, *supra* note 37, at 792; *see*

regular communication and sharing of information between the medical and legal partners, alleviating the need for the patient-client to provide his or her lawyer with all relevant information.[51] This promotes more effective legal representation as the lawyer already receives all of the relevant information necessary.[52]

Further, the integrated, multidisciplinary MLP model's holistic approach also allows the MLP to offer patient-clients comprehensive, coordinated assistance. When medical and legal professionals collaborate, they contribute different skill sets and perspectives. This in turn promotes complementary, multifaceted solutions to patient-clients' clinical and non-clinical needs.[53] To give an example, rather than simply helping a patient-client dealing with domestic violence obtain a restraining order, as occurs under the referral MLP model, an integrated, multidisciplinary MLP can also provide behavioral health counseling, assist with developing a safety plan, locate alternative housing, and secure financial support.[54] Likewise, the model's team approach allows the MLP to consider whether a legal versus non-legal solution better meets a patient-client's needs.[55] For instance, when advising individuals living in substandard housing, the MLP professionals can jointly consider with the patient-client whether initiating legal action against the derelict landlord or moving to new housing is the preferred solution. For these reasons, many in the MLP world favor the integrated, multidisciplinary model over the referral model.[56]

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also Colvin, Nelson & Cronin, *supra* note 46, at 335 ("Collaborations between physicians, nurses, social workers, and attorneys meet the needs of families who require one stop shopping for effective assistance: Medical, legal and social supports need to be situated in the same location to ensure access by families.").

51. *Cf.* Norwood & Paterson, *supra* note 36, at 365 ("One of the significant advantages of working [multi-disciplinary partnership] problem-solving is the ease of information sharing among the professionals.").

52. *Id.*

53. *See* Brustin, *supra* note 37, at 793 ("[P]rofessionals from different disciplines can use their skills to develop more comprehensive solutions for clients . . . [The services of non-lawyers] complement the types of remedies a lawyer might secure for a client.").

54. *See id.* at 792 ("[A] multidisciplinary model can respond to the myriad needs of those who are poor or marginalized . . . ."); *cf.* Colvin, Nelson & Cronin, *supra* note 46, at 335 (explaining that an MLP that integrates social workers into its partnership allows the MLP to better connect patients and their families to community resources beyond those addressed by legal representation, and expands the pool of information, resources, and solutions accessible to lawyers and patients).

55. *See* Colvin, Nelson & Cronin, *supra* note 46, at 335 ("[By integrating the services of attorneys and social workers], [e]ven for issues with a legal remedy, social workers can provide other, non-legal solutions so that patients and families can choose the best course").

56. *See* THORPE ET AL., *supra* note 11, at 10 ("[I]t may be that a more integrated model . . . would improve case management and allow the legal partner to address legal issues that affect patient health more consistently and comprehensively than a referral model would allow."); Colvin, Nelson & Cronin, *supra* note 46, at 335 ("The complexity of the

Open communication among the various professionals within an MLP is essential to the success of the interdisciplinary team model.[57] Unfortunately, legal, ethical, and practical barriers often prevent MLP professionals from sharing patient-client information with one another.[58] We explore these barriers in Parts II and III below.

II. DATA SHARING FROM THE MEDICAL PROVIDER TO THE LEGAL SERVICES PROVIDER

Effective diagnosis and treatment of a patient's ailments necessitates that patients share sensitive and confidential information with their medical providers.[59] To ensure patients' willingness to do so, the medical profession has long been committed to protecting the privacy and confidentiality of patients' information.[60] In addition to fostering a patient-to-physician

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modern social problems of homelessness, poverty, intimate partner violence, child abuse, and chronic disease require a multidisciplinary approach to fully meet the needs of families and to reduce the burden on health."); Norwood & Paterson, *supra* note 36, at 347 ("[T]here is an increasing recognition that clients' problems are rarely purely legal in nature and that a more 'holistic' approach to problem-solving for clients may pay dividends rather than isolating the 'legal' problem from the rest. Such an approach requires the use of a multidisciplinary team with expertise drawn from a range of professions and specialties.").

57. Boumil et al., *supra* note 24, at 110 ("Communication between the clinical and advocacy staff is an essential component of the MLP because multidisciplinary collaboration requires the exchange of information."); *see also* THORPE ET AL., *supra* note 11, at 3 ("The American healthcare system is experiencing significant change, recognizing that an array of medical, social, geographic, and other demographic factors that impact patient and population health. Critical to the success of this transformation is the ability of stakeholders to exchange patient health information beyond a medical office visit, including sharing information with non-medical support service providers (e.g., social and legal services). Data sharing models that support access to patient information across and beyond traditional settings of care delivery, including non-medical support personnel and services, are necessary to improve and maintain healthcare quality and safety and reduce cost growth.").

58. *See infra* Parts II and III. *See also* THORPE ET AL., *supra* note 11, at 1 ("MLPs are designed to encourage and enable this communication, but the information privacy legal framework may still present obstacles, both real and perceived, to effective information sharing."); Boumil et al., *supra* note 24, at 111 ("[The integrated, multidisciplinary MLP] model risks creating conflicts among the professional duties and ethical obligations of the diverse MLP providers, potentially compromising the patients' rights that MLPs strive to uphold.").

59. *Cf.* Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 466, 498–500 (2002) (describing the need for patients to share relevant, personal information in order to obtain the best treatment from medical professionals); David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX 141, 147–48 (1995) ("In order for patients to rely so heavily on their physicians when they are most vulnerable, patients must be able to trust deeply in their physicians' dedication to their interests. Such deep trust would not be possible without assurances from the physicians that patients will not have their interests sacrificed in favor of the interests of their physicians or of other patients.").

60. *See* Mary Anderlik Majumder & Christi J. Guerrini, *Federal Privacy Protections: Ethical Foundations, Sources of Confusion in Clinical Medicine, and Controversies in*

dialogue, the protection of patients' privacy also respects patients' autonomy by preserving their right "to decide with whom to share [their] personal information," while correspondingly insulating patients from the social, economic, and legal harm that can befall individuals following the disclosure of their personal information.[61] This commitment to patient privacy is embodied in the medical profession's rules of professional conduct.[62] Federal and state laws reinforce this commitment by similarly regulating the use and disclosure of patient information, the most important law being the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").[63] As explained below, however, HIPAA and general privacy concerns may hinder the sharing of information from the MLP medical partner to the legal partner.

Health providers must comply with the federal privacy regulations issued under HIPAA, generally known as the HIPAA Privacy Rule.[64] Under the HIPAA Privacy Rule, providers may only use or disclose a patients' individually identifiable health information, or protected health information ("PHI"), without patient authorization for certain purposes including treatment, payment, health care operations, and certain law-enforcement or public health activities.[65] In addition, when a provider discloses PHI for a permitted purpose, he or she generally may not disclose any PHI beyond the minimum amount of information necessary to accomplish the intended purpose.[66] When a provider seeks to use or disclose PHI for purposes not otherwise permitted under the HIPAA Privacy Rule, the patient (or their authorized representative) must give written authorization.[67] Accordingly, a

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Biomedical Research, 18 AM. MED. ASSOC. J. OF ETHICS 288, 288 (2016) ("The importance of privacy and confidentiality to the practice of medicine has been recognized from ancient times to the present").

61. *Id.* at 289.

62. *Code of Medical Ethics Opinion 3.2.1*, AM. MED. ASS'N, https://www.ama-assn.org/delivering-care/confidentiality (last visited May 22, 2018).

63. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-91, 110 Stat. 1936.

64. 45 C.F.R. §§ 106.103, 164 (2018).

65. 45 C.F.R. § 160.103 (2018) (stating that HIPAA protects protected health information (PHI), or all "individually identifiable health information" held or transmitted by a provider, health plan, health care clearinghouse, or their business associates. "Individually identifiable health information is information, including demographic data," that "relates to the [individual's] past, present or future physical or mental health or condition[,] the provision of health care to [the] individual[,] or the past, present or future payment for the provision of health care to [the] individual," if such information "identifies the individual[] or if there is a reasonable basis to believe [it] can be used to identify the individual."); 45 C.F.R. § 164.502(a) (2018).

66. 45 C.F.R. § 164.502(b) (2018). However, this limitation does not apply to disclosures from a provider to a second provider for treatment purposes or for disclosures required by state or federal law.

67. 45 C.F.R. § 164.508 (2018).

medical provider participating in a MLP may share patient information with their legal partner if the MLP's activities fall under one of the rule's permitted disclosures or if the patient themselves authorizes the disclosure.[68]

Some legal analysts argue that an MLP's activities should be considered "treatment" or "healthcare operations" under an expansive reading of the HIPAA Privacy Rule's definition of those terms.[69] However, these interpretations of the HIPAA Privacy Rule remain untested.[70] Therefore, medical providers participating in MLPs typically obtain prior written authorization from patients before disclosing PHI to the legal partner.[71] Upon receiving a patient's written authorization, the medical provider may share with the MLP lawyer any PHI relevant to the lawyer's legal services without violating HIPAA.[72] HIPAA, therefore, "should not be thought of as a barrier to establishment of MLPs or to effective communication between medical and legal partners."[73] Nor should HIPAA impede an MLP's adoption of the integrated, multidisciplinary model.[74] Other federal and state privacy laws that allow similar disclosure of patient information, with consent, are also not obstacles to MLP partners sharing patient information or adopting the integrated, multidisciplinary model.[75]

Nevertheless, our conversations with MLP professionals indicate that privacy concerns can impede the sharing of patient information from the medical partner to the legal partner. First, compliance officers, general counsel, staff members, and others within the medical partner organization may invoke HIPAA and other privacy laws to withhold information from the MLP legal partner based on a misunderstanding of the law.[76] Since its passage, individual and institutional level health care providers have reported widespread confusion about HIPAA, noting that it is "a frustrating barrier to coordinated delivery of care and appropriate sharing of [patient] information."[77] Commentators also report that

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68. Persons or entities (other than employees) performing functions or activities on behalf of the provider, or business associates, also must comply with HIPAA. 45 C.F.R. §164.502(a) (2018).

69. *See* THORPE ET AL., *supra* note 11, at 11–12 (discussing "treatment" and "healthcare operations" disclosures by MLPs).

70. *Id.* at 12.

71. *Id.* at 4.

72. *Id.*

73. *Id.* at 9.

74. *See id.* (noting that MLPs that use consent-based models that obtain written patient authorization have had "great success" integrating medical and legal services).

75. *See generally id.*

76. Majumdur & Guerrini, *supra* note 60, at 290.

77. *See id.* ("HIPAA is often invoked as a frustrating barrier to coordinated deliver of care and appropriate sharing of information (i.e., to promote patient well-being) . . . [, but] it is not the provisions of HIPAA but misunderstandings of privacy laws by health care providers (both institutions and individual clinicians) that impede the legitimate flow of useful information."); Vindell Washington, *"You Never Want to Go Back": The Promise of Health*

providers and their staff often fear that disclosure of patient information could lead to lawsuits, large regulatory fines, termination, or even prison sentences.[78] In addition, HIPAA, as an expression of privacy norms, may promote what one commentator calls a culture of privacy paranoia.[79] The combination of HIPAA confusion, fears about HIPAA sanctions, and a heightened privacy culture causes providers to resist sharing PHI even if legally permissible,[80] including in the MLP setting.

Second, operational challenges may hinder the sharing of patient information among MLP partners.[81] Procuring patient authorization to share PHI from the medical partner to the legal partner requires informing patients about their privacy rights and what information will be disclosed, obtaining patient signatures, and tracking consents.[82] Some providers may conclude that doing so is too costly or operationally burdensome.[83] Operational concerns also hinder MLP's use of electronic health records ("EHRs") to

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IT, HEALTH IT BUZZ (Oct. 17, 2016, 9:28 AM), https://www.healthit.gov/buzz-blog/from-the-onc-desk/promise-health/ (statement by former National Coordinator for Health Information Technology, U.S. Department of Health and Human Services, noting that he regularly heard confusion about HIPAA, and that "[p]eople insist that HIPAA makes it difficult, if not impossible, to move electronic health data when and where it is needed for patient care and health" and that "this misconception is widespread"); Robert Belfort et al., *Integrating Physical and Behavioral Health: Strategies for Overcoming Legal Barriers to Health Information Exchange*, ROBERT WOOD JOHNSON FOUND. (Jan. 2014), https://www.manatt.com/uploadedFiles/Content/4_News_and_Events/Newsletters/IntegratingPhysicalandBehavioralHealth.pdf ("Provider misconceptions about the restrictions imposed under state and federal laws may stifle data exchange that is legally permissible.").

78. *See* Juliann Schaeffer, *Beware of HIPAA Zealots: Fear of Federal Punishment and Lack of Training Can Lead Health Care Professionals to Overstep the Law's Boundaries*, 27 FOR THE RECORD 22, 22 (2015) (noting that staff members often fear that they will be sued, fined huge amounts, lose their jobs, or go to prison if they disclose PHI).

79. *See* Jessica Jardine Wilkes, *The Creation of HIPAA Culture: Prioritizing Privacy Paranoia over Patient Care*, 2014 BYU L. REV. 1213, 1223–34 (2014) (arguing that HIPAA's privacy norms combined with its significant sanctions altered social values and customs, leading to "privacy paranoia" and a culture among providers that views "the act of sharing PHI [as] morally problematic").

80. *See* Schaeffer, *supra* note 78, at 22 ("In part thanks to fears of regulatory fines coupled with insufficient or irregular training, it seems not everyone in health care is up to speed on what HIPAA's privacy aspects really say and mean. Such insufficient know-how or misinterpretation of HIPAA can create communication hurdles for patients and may even impede good clinical care."); Jardine Wilkes, *supra* note 79, at 1214–15 (noting that confusion about HIPAA combined with fear of HIPAA's severe monetary penalties have led many covered entities to resist and fear sharing PHI and to adopt conservative privacy and security practices).

81. Belfort et al., *supra* note 77, 5–6.

82. *Id.* at 5 (obtaining patient consent to provider-to-provider sharing of PHI requires establishing "new, costly workflows for educating patients about their rights, obtaining signatures on consent forms, and tracking consents both internally and across the multi-provider collaboration").

83. *See id.* (stating that some providers may conclude that obtaining patient consent is "operationally infeasible or unduly burdensome" given the time and resources involved in establishing the procedures necessary to do so).

capture and share relevant information among MLP partners.[84] Coordinating services across MLP professionals is facilitated by documenting in the EHR the social determinants adversely impacting a patient's health, referrals to the MLP legal partner, the legal assistance provided, and other miscellaneous MLP activities.[85] However, the current state of EHR technology does not readily allow providers to segregate this information from other information in a patient's EHR.[86] Consequently, providers often cannot limit other staffs' access to the MLP-related information or exclude the information when patients' records are shared with other third parties.[87] Perhaps for this reason, many MLPs do not document the use of MLP services in patients' EHRs.[88] Among MLPs that do document information in patients' EHRs, many report that they "deliberately opt to include 'the bare minimum' information about legal services in the EHR to protect patient confidentiality."[89]

Finally, medical providers may be reluctant to share PHI with a MLP legal partner due to concerns about how the legal partner may use (or misuse) the information.[90] Specifically, providers may fear that they will incur tort liability or negative publicity if their legal partner's lax privacy and security practices result in a data breach.[91] Medical providers also may worry that the legal partner will initiate a medical malpractice claim against the provider, should the disclosed PHI reveal potentially substandard clinical care.[92]

These legal, operational, and ethical concerns regarding patients' privacy hinders open communication among MLP professionals and the integration

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84. *See generally* THORPE ET AL., *supra* note 11, at 7 (discussing information management and the transfer of EHR between medical and legal systems).

85. *See generally* Marsha Regenstein, et al., THE STATE OF THE MEDICAL-LEGAL PARTNERSHIP FIELD: FINDINGS FROM THE 2016 NATIONAL CENTER FOR MEDICAL-LEGAL PARTNERSHIP SURVEYS 23 (National Center for Medical Legal Partnership 2017) (discussing MLPs' documentation efforts).

86. *See* Belfort et al., *supra* note 77, at 9–10 (discussing data segmentation capabilities in patients' medical records).

87. *See id.* (explaining data segmentation, or "sequestering from capture, access, or view certain data elements that are perceived by a legal entity, institution, organization, or individual as being undesirable to share," presents significant technical challenges, "To be segmented, electronic health information must be structured and coded so that computers can distinguish between different types of health information and consistently treat them separately. Today, mush electronic health information is unstructured, having been entered into electronic systems using free-text fields that computers cannot easily segment.").

88. Regenstein et al., *supra* note 85, at 23 (reporting that among MLPs participating in the 2017 National Center for Medical-Legal Partnership Survey, only 58 percent formally document the use of MLP services in patients' medical records even though 96 percent of medical partners reported having an electronic health record system).

89. *See id.* (reporting that MLP professionals in interviews state that their MLPs have limited information in EHRs due to privacy concerns).

90. Belfort et al., *supra* note 77, at 5.

91. *Id.*

92. *Id.*

of their medical, social, and legal services. This, in turn, undermines the MLP's efforts to address patient-clients' health-harming legal needs. So, although patient privacy considerations are rooted in respect for individual autonomy, guarding patient privacy in the MLP context ultimately may undermine self-determination by frustrating MLP's endeavors to improve patient-clients' health.

III. DATA SHARING FROM THE LEGAL SERVICES PROVIDER TO THE MEDICAL PROVIDER

The collaborative exchange of information is intrinsic to the MLP's ability to serve vulnerable populations.[93] However, a long-enduring concern in public interest legal practice is that this information exchange may also threaten the core protections associated with legal advice: client confidentiality, attorney-client privilege, and the work product doctrine.[94] Other unique obligations between lawyers and clients—ensuring professional independence, the preservation of the duties of competence and communication, record preservation/retention, and supervision of non-lawyers/avoidance of the unauthorized practice of law—also potentially compromise data sharing and integration among MLP participants. These considerations are addressed below.

A. Confidentiality, Privilege, and Work Product Protections

The respect for clients' privacy interests underlies several professional conduct and evidentiary rules. The American Bar Association ("ABA") Model Rule of Professional Conduct 1.6, a version of which has been adopted in all United States jurisdictions, allows the lawyer to disclose client information only with clients' informed consent or under very narrow exceptions, such as prevention of imminent death or substantial bodily harm or to comply with a court order.[95] This obligation applies to any and all information revealed during and relating to legal representation; for these purposes, representation begins when the client first seeks legal advice and

93. *See generally* Regenstein et al., *supra* note 85, at 11.

94. *See generally* Gary Bellow & Jeanne Kettleson, From Ethics to Politics: Confronting Scarcity and Fairness in Public Interest Practice, 58 B.U. L. REV. 337, 355–56 (1978); Michelle S. Jacobs, *Legal Professionalism: Do Ethical Rules Require Zealous Representation for Poor People?* 8 SAINT THOMAS L. REV. 97 (1995).

95. *See* MODEL R. OF PROF'L CONDUCT 1.6 (A.B.A. 2017) ("A lawyer shall not reveal information relating to the representation of a client unless the client gives informed consent, the disclosure is impliedly authorized in order to carry out the representation or the disclosure is permitted by [a list of narrow exceptions which are permissive, not mandatory].").

continues even beyond the end of the attorney-client relationship.[96]

On the one hand, the attorney-client privilege is an evidentiary privilege derived from common law, and the work product doctrine stems from the rules governing civil procedure.[97] Both protect certain communications between the lawyer and the client from being introduced into evidence during trial.[98] Attorney-client privilege extends to any communication between a client and the lawyer (or the lawyer's assistant) made for the purpose of giving or receiving legal advice in a setting with the expectation of confidentiality.[99] On the other hand, the work product doctrine covers documents associated with the litigation such as a lawyer's mental impressions.[100] With few exceptions, this information cannot be used as evidence in any litigation unless the client waives privilege.[101] Essential to receiving this protection, however, is the expectation of confidentiality. In most instances, if the client or the client's lawyer discloses the information to a third party, privilege will no longer protect the revealed information.

Sharing of client information from an MLP's legal partner to the medical partner implicates these rules. Confidentiality obligations under ABA Model Rule 1.6 are not destroyed when the MLP lawyer shares client information with other MLP professionals (although the lawyer might be subject to disciplinary action for disclosing the information absent client consent or satisfying one of the applicable exceptions).[102] Privilege and work product protections, by contrast, may be destroyed when the MLP lawyer shares client information with the medical partner and its staff.[103] This may have profound consequences for any future litigation, as shared information that might otherwise have been protected could be used as evidence against the client.

As with HIPAA, client confidentiality, privilege, and work product rules are not a barrier to data sharing and integration among MLP professionals, so long as the client consents to the disclosure of their information from the

96. *See generally* MODEL R. OF PROF'L CONDUCT 1.6 cmts. (A.B.A. 2017).

97. *See* Sue Michmerhuizen, *Confidentiality, Privilege: A Basic Value in Two Different Applications.*, A.B.A. CENTER FOR PROFESSIONAL RESPONSIBILITY (May 2007), https://www.americanbar.org/content/dam/aba/administrative/professional_responsibility/confidentiality_or_attorney.authcheckdam.pdf.

98. *See* UNIF. RULES OF EVIDENCE ACT § 502(b) (protecting the disclosure of information exchanged between clients and attorneys "for the purpose of facilitating the rendition of . . . legal services.").

99. *See* UNIF. RULES OF EVIDENCE ACT § 502(a).

100. FED. R. CIV. P. 26(b)(3).

101. *See* FED. R. EVID. 502(a).

102. MODEL R. OF PROF'L CONDUCT 1.6 cmt. (A.B.A. 2017).

103. Thomas E. Spahn, *Attorney-Client Privilege: Ensuring Confidentiality*, Practical Law Practice Note 5-502-9406.

legal partner to the medical partner.[104] However, a meaningful concern remains as to whether a client's consent for the convenience of MLP purposes might jeopardize the client in a subsequent legal proceeding. By way of illustration, assume that during the course of representation, a lawyer acquires information that suggests that his client has a serious mental health issue, such as depression or bipolar disorder. The lawyer may conclude that it would be in his client's interest to alert the medical partner of their suspicions so that the individual can receive proper diagnosis and treatment. However, should the individual later be party to a divorce proceeding or custody dispute, the information would no longer be protected by attorney-client privilege and could be used against the individual. Accordingly, as this example illustrates, the waiver of attorney-client privilege in the MLP context is not without risk to the client.

Thus, an MLP lawyer must weigh the potential benefits to the client of the disclosure of information to the medical partner against the potential risks of this information being used in future litigation.[105] Some MLP lawyers may conclude that the risks of disclosure are low and the benefits great, especially when disclosure may improve the medical care and social services the individual receives from the medical partner.[106] The MLP lawyer, therefore, may advise their client to waive privilege by consenting to the lawyer sharing information with the medical partner.[107] Nevertheless, other MLP lawyers may fear the potential adverse consequences of waiving privilege, and out of an abundance of caution, may choose not to share information with the medical partner. In the latter scenario, the desire to preserve privilege and work product protections is a barrier to the MLP adopting the integrated, multidisciplinary MLP model and freely sharing patient-client information across the legal and medical partners.

Moreover, in most states, inconsistent obligations exist between lawyers and health care providers/social workers for mandatory reporting of abuse. In most states, health care providers and social workers must report to law enforcement suspected abuse or domestic violence for certain individuals under their care, such as children or the elderly.[108] With the exception of a few states, lawyers are exempt from these obligations because a mandatory reporting requirement would directly conflict with the lawyer's professional

104. MODEL R. OF PROF'L CONDUCT 1.6(a) (A.B.A. 2017).

105. *See, e.g.*, Boumil et al., *supra* note 24, at 124–27 (balancing risks of use against client with medical benefit of disclosing information to the medical provider).

106. *Cf. id.* (providing examples of discordant approaches by legal professionals, medical professionals, and social workers in the MLP context).

107. *See* MODEL R. OF PROF'L CONDUCT 1.6(a) (A.B.A. 2017).

108. *See, e.g.*, Boumil et al., *supra* note 24, at 124–27 (describing mandatory reporting laws for different professions in the United States).

conduct duty of confidentiality.[109] Accordingly, these conflicting professional obligations may present yet another barrier between information sharing among MLP partners. Consider the following scenario: a client reveals to the lawyer that he has physically abused a family member and the lawyer suspects that this may be due to a behavioral health issue. The client might benefit from the provision of behavioral health treatment by the medical partner; however, not wanting to trigger the medical partner's mandatory reporting requirements, the lawyer chooses not to disclose the problem to the other MLP professionals because he feels that it is in the client's best interest to not destroy privilege.[110]

B. Other Professional Obligations and the Unauthorized Practice of Law

Other professional conduct rules for lawyers may also impact information sharing from the MLP legal partner to the medical partner. For instance, ABA Model Rule 5.4 prohibits lawyers from practicing law if "a nonlawyer has the right to direct or control the professional judgment of a lawyer."[111] In other words, lawyers owe clients a duty of loyalty. The relationship cannot be interfered with or influenced by third parties, such as a social worker or physician in the MLP setting, even if such third parties are well intentioned and knowledgeable about the client's health needs.[112]

Concerns about conflicts of interest also may hinder data sharing and integration across the MLP partners. As other scholars have identified, the

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109. *See* Alexis Anderson et al., *Professional Ethics in Interdisciplinary Collorboratives: Zeal, Paternalism and Mandated Reporting*, 13 CLINICAL L. REV. 659, 694–96 (2007) (discussing a lawyer's duty to report in certain situations, varying state-by-state); *see generally* MODEL R. OF PROF'L CONDUCT 1.6(a) (A.B.A. 2014).

110. *See* Anderson et al., *supra* note 109, at 714; Heather A. Wydra, *Keeping Secrets within the Team: Maintaining Client Confidentiality with Offering Interdisciplinary Services to the Elderly Client*, 62 FORDHAM L. REV. 1517, 1519–20 (1994); Boumil et al., *supra* note 24, at 126–28. The District of Columbia exempts social workers/mental health clinicians from statutory mandatory reporting requirements when employed by a lawyer for litigation purposes in order to avoid this sort of information sharing dilemma, but that only applies during litigation (which might not be occurring when the client is receiving treatment with the MLP). *See Ethics Opinion 282*, D.C. B. ASS'N (June 1998), https://www.dcbar.org/bar-resources/legal-ethics/opinions/opinion282.cfm ("The inconsistent duties of the social worker and the lawyer—the social worker to report under the child abuse and neglect law, the lawyer to assure that confidences and secrets of a client are preserved—require that the lawyer take steps to assure that the client understands the inconsistency."). In any event, this is not the norm for most jurisdictions.

111. A.B.A. Model Rule 5.4(d)(1) provides, in relevant part, that a lawyer is prohibited from practicing "with or in the form of a professional corporation or association authorized to practice law for a profit" if: 1) the nonlawyer owns any interest in the entity; 2) the nonlawyer is a corporate director of the entity; or 3) the nonlawyer "has the right to direct or control the professional judgment of a lawyer." MODEL R. OF PROF'L CONDUCT 5.4(d)(1) (A.B.A. 2017).

112. *See* Boumil et al., *supra* note 24, at 123–24.

MLP structure presents "a potential conflict of interest between the potential/actual representation of the client versus the interest of the collaborative partner (the hospital); and . . . a potential conflict of interest between the potential/actual representation of a client vs. the interest of a family member of a client."[113] Accordingly, this conflict may cause the lawyer in an MLP to resist sharing client information.

The lawyer's duties of competence and communication can also be implicated in the MLP relationship context. ABA Model Rule 1.4 obligates lawyers to communicate regularly with the client, including the responsibility to "consult with the client about the means by which the client's objectives are to be accomplished; keep the client reasonably informed about the status of a matter;" and "promptly comply with reasonable requests for information."[114] Competent representation now requires lawyers to "keep abreast of changes in the law and its practice, including the benefits and risks associated with relevant technology" which encompasses technology related to data analytics and related issues such as preservation, control, and distribution of electronic or digital information.[115] Moreover, lawyers must maintain and preserve client records, and must deliver them promptly upon request.[116] When the representation ends, the lawyer must promptly return all papers and property, which includes personal data, to which the client is entitled.[117]

In addition, "supervising" lawyers must ensure that any non-lawyer assistants comply with the lawyer's own professional conduct guidelines, including the obligation to protect client confidentiality.[118] Consequently,

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113. Amy T. Campbell, et al., *How Bioethics Can Enrich Medical-Legal Collaborations*, 38 J.L. MED. & ETHICS 847, 850 (2010).

114. MODEL R. OF PROF'L CONDUCT 1.4 (A.B.A. 2017). *See also Ethics Opinion 282*, D.C. B. ASS'N (June 1998), https://www.dcbar.org/bar-resources/legal-ethics/opinions/opinion282.cfm (citing DC Rule of Professional Conduct 1.4(b) which provides that "A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation."); RULES OF PROF'L CONDUCT 1.4(b) (D.C. B. ASS'N 2014).

115. MODEL R. OF PROF'L CONDUCT 1.1 cmt. 8 (A.B.A. 2014); *see also Standing Committee Professional Responsibility and Conduct Formal Opinion Interim No. 11-0004*, ST. B. CAL., http://www.calbar.ca.gov/portals/0/documents/publiccomment/2014/2014_11-0004ESI03-21-14.pdf (last visited May 22, 2018) (observing that minimum competence in litigation demands "a basic understanding of, and facility with, issues relating to e-discovery," and that "obligations under the ethical duty of competence evolve as new technologies develop").

116. MODEL R. OF PROF'L CONDUCT 1.15(a) (A.B.A. 2014).

117. MODEL R. OF PROF'L CONDUCT 1.16(d) (A.B.A. 2014).

118. A.B.A. Model Rule 5.3(b) provides, in relevant part, "with respect to a nonlawyer employed or retained by or associated with a lawyer[,] . . . a lawyer having direct supervisory authority over the nonlawyer shall make reasonable efforts to ensure that the person's conduct is compatible with the professional obligations of the lawyer." MODEL R. OF PROF'L CONDUCT 5.3(b) (A.B.A. 2014).

when lawyers practice in the MLP context, they must ensure that the non-lawyer MLP professionals adhere to the above standards if the non-lawyers engage in activities that support MLP lawyer's representation of the patient-client.[119] Relatedly, lawyers also must take care to ensure that they are not enabling the unauthorized practice of law by the other professionals in the MLP.[120] While neither of these requirements affirmatively prohibit information sharing among the MLP lawyer and non-lawyer professionals, it is plausible that the burden of ensuring that non-lawyers do not undermine the lawyer's professional obligations might make some MLP lawyers resist the more fully integrated model and the sharing of client information with the other MLP professionals.

IV. AN AGENDA FOR FUTURE RESEARCH

As described in Parts II and III, several legal and ethical considerations potentially stand in the way of effective data sharing and integration among MLP professionals. And yet, some pioneering MLPs have largely integrated the MLP-related activities of their medical and legal partners. This leads us to speculate that the reluctance among some MLP professionals to freely share patient-client information is often based not on actual legal or ethical barriers to doing so, but rather on the other considerations we have identified—confusion about relevant health privacy laws, fears of the unknown, a workplace culture that elevates privacy, and confidentiality concerns over other interests, and operational challenges.

While a few MLP lawyers and academics authored articles describing some of the legal and ethical barriers to open communication among MLP professionals,[121] there are no fieldwork-based studies that comprehensively describe and analyze the real-world impact of current legal and ethical rules on MLPs' operations. Nor are there any studies that evaluate the extent to which other factors such as workplace culture or operational challenges hinder data sharing among MLP professionals. Thus, to better understand the impact of legal, ethical, and other considerations on MLP data sharing and integration, we spoke with several MLP experts and professionals.

Through our conversations with MLP experts and professionals, we found that in addition to legal and ethical obligations, institutional norms or policies might inhibit data sharing. For example, privacy officers in some health care institutions prohibit the MLP lawyer from participating in interdisciplinary

119. MODEL R. OF PROF'L CONDUCT 5.3 cmt. 3 (A.B.A. 2014).

120. *See* MODEL R. OF PROF'L CONDUCT 5.3(b) (A.B.A. 2014); *see also* MODEL R. OF PROF'L CONDUCT 5.5(a) (A.B.A. 2014).

121. *See generally* Tames et al., *supra* note 36; Krishnamurthy et al., *supra* note 2; Boumil et al., *supra* note 24; Joel Teitelbaum, *Obligation and Opportunity: Medical-Legal Partnership in the Age of Health Reform*, 35 J. LEGAL MED. 7 (2014).

team meetings focused on a patient's health-related needs. These norms may or may not be grounded in actual legal or ethical requirements. We believe, based upon these preliminary informational interviews with MLP experts and participants, that legal or ethical barriers are periodically cited as grounds for resisting data sharing and more fully integrated MLP models when, in fact, the law and ethics rules do not bar sharing or integration.

Further study is needed to better understand what is happening in the MLP field. Drawing from our preliminary research, we propose a larger empirical study to more broadly investigate these concerns, as well as the strategies MLPs employ to address these challenges. Specifically, our future research aims to fill the gap in existing research by exploring the extent to which legal, ethical, and other considerations (1) impact a MLP's adoption of an interdisciplinary team model, and/or (2) hinder the MLP's efforts to provide comprehensive, coordinated, holistic services. We believe this research would help MLPs identify "best practices" that would support their adoption of the integrated, multidisciplinary MLP model, and would provide the impetus for policy changes that would promote greater data sharing among MLP professionals.

CONCLUSION

MLPs are an innovation with tremendous promise for helping individuals coping with health-harming legal and social challenges. However, MLPs will not achieve their full potential if the participating professionals cannot freely share patient-client information. As identified in this Article, the special legal and ethical obligations of MLP professionals constrain the sharing of patient-client information. This is compounded by fear of the unknown, workplace culture, and operational challenges that additionally hinder MLP professionals' collaborative efforts. Thus, it is vital to conduct further research to develop best practices for data sharing among MLP professionals at both the individual patient-client level and population level in order to improve patients' health.