Medical-Legal Partnerships: A Working Model That Needs More Work

*Hena Mehta**

Introduction

Medical-legal partnerships (MLPs) are "collaborative endeavors between healthcare clinicians and lawyers to more effectively address issues impacting healthcare."[1] A large body of literature recognizes the various benefits MLPs provide to patient-clients[2] and the legal and medical professions.[3] Typically in a MLP, a healthcare provider and a legal team work together to address a patient-client's legal and medical problems.[4] Lawyers that take cases through an MLP are either assigned in-house or do the work pro bono.[5] Scholarship has identified the key functions and goals of MLPs.[6] Two primary forms of MLPs attempt

* J.D. 2025, George Mason University Antonin Scalia Law School.

[1] *See* Amy T. Campbell, et al., *How Bioethics Can Enrich Medical-Legal Collaboration*, 38 J.L. Med. & Ethics 847, 847 (2010).

[2] The term "patient-client" is used throughout the Comment to refer to individuals who are being treated medically and receiving legal representation by an MLP.

[3] *See,* e.g., Bharath Krishnamurthy, et al., *What We Know and Need to Know About Medical-Legal Partnership*, 67 S.C. L. Rev. 377, 379 (2016); Jeremy Conrad, *Medical-Legal Partnerships Leverage Pro Bono Help for Whole-Person Care*, Washington Lawyer, Nov. 2023 at 10; AMA Journal of Ethics, *Ethics Talk: Medical-Legal Partnerships and the Promise and Challenge of Physician Advocacy – An Interview with Megan Sandel*, at 01:34 (Mar. 2016), https://journalofethics.ama-assn.org/podcast/ethics-talk-medical-legal-partnerships-and-promise-and-challenge-physician-advocacy-interview-megan (explaining that "there are definitely times when the only way that a family or an individual will get access to the legal care that they need is through a medical-legal partnership.").

[4] *See* Conrad, *supra* note 3, at 10; Krishnamurthy, *supra* note 3, at 379 (The MLP approach involves a "health care team that integrates civil legal aid expertise to address health-harming legal needs for low-income population at risk for poor health and well-being.").

[5] *See* Conrad, *supra* note 3, at 11; Marcia Boumil, et al., *Multidisciplinary Representation of Patients: The Potential For Ethical Issues and Professional Duty Conflicts in the Medical-Legal Partnership Model*, 13 J. Health Care L. & Pol'y 107, 110 (2010).

[6] *See, e.g.*, Boumil, *supra* note 5, at 109; Jennifer Trott & Marsha Regenstein, *Screening for Health-Harming Legal Needs*, Nat'l Ctr. for Med. Legal P'ship, 1, 9 (2016), https://medical-legalpartnership.org/wp-content/uploads/2016/12/Screening-for-Health-Harming-Legal-Needs.pdf; Rebecca Hutson, et al., *Medical-Legal Partnerships*, 13 AMA J. Ethics 555, 556 (2011).

to reach this goal: Highly integrated MLPs and lowly integrated—or referral model—MLPs.[7] The highly integrated MLP model allows legal and medical staff to provide legal and medical services to a patient-client in the same location.[8] The referral model requires a medical professional to refer patient-clients to a legal services provider it has contracted with to administer a patient's legal services independent from the medical entity.[9] Although each model is designed differently, it harbors inherent ethical problems for attorneys.[10] One form of this ethical problem, a conflict of interest, may implicate hardship toward an attorney's fiduciary duties in an MLP setting.[11] This Comment unpacks a conflict of interest that may arise under a unique circumstance: When a medical professional participating in an MLP commits medical malpractice against a patient-client represented by an attorney in that same MLP.

Consider the following unique scenario. A patient arrives at a medical facility to seek care for a respiratory infection caused by uninhabitable living conditions at his apartment. This medical facility participates in a highly integrated MLP. The medical professional treating the patient recommends intrusive surgery and the patient consents. After surgery, the medical professional relays to the patient that he might have a legal claim against his landlord. The patient consents to pursuing a legal claim after speaking to a lawyer. Next, the medical professional contacts the contracted legal services provider to take on the patient's case. The attorney arrives on-site to meet with the patient in the presence of the patient's medical care team.[12] He recognizes a claim and begins the patient-client's legal representation.

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[7] *See* Jessica Mantel & Leah Fowler, *A Qualitative Study Of The Promises And Perils of Medical-Legal Partnerships*, 12 NE. U. L. REV 186, 194 (2020).

[8] *See* Janet Hyatt Thorpe et al., *Information Sharing in Medical-Legal Partnerships: Foundational Concepts and Resources*, NAT'L CTR. FOR MED. LEGAL P'SHIP, 1, 6 (2017), https://medical-legalpartnership.org/wp-content/uploads/2017/07/Information-Sharing-in-MLPs.pdf.

[9] *See* Mantel & Fowler, *supra* note 7, at 194.

[10] *See On Demand: MCLE: Who's the Client? Ethical Issues in Medical/Legal/Community Partnerships*, LA L. LIBR., (Oct. 25, 2021), https://www.lalawlibrary.org/hidden-classes/1767-live-zoom-mcle-who-s-the-client-ethical-issues-in-medical-legal-community-partnerships; Sermo Team, *Identifying and Navigating Ethical Issues in Healthcare*, SERMO (Apr. 19, 2024), https://www.sermo.com/resources/ethical-issues-in-healthcare/ (identifying patient confidentiality as "one of the biggest legal and ethical issues in healthcare").

[11] *See* Mantel & Fowler, *supra* note 7, at 246.

[12] Note that in a referral model MLP, the medical professional will give the referral to the patient, and it is the patient's responsibility to contact that attorney to discuss potential legal representation.

Subsequently, the patient-client falls ill, and the cause of his illness is attributed to a piece of surgical equipment left in him during the surgery. The attorney, who has a contractual relationship with the medical entity that was negligent, is faced with a conflict of interest. How can the attorney continue to represent this patient-client knowing that the medical entity that he has a contractual relationship with caused his harm?[13] The attorney, aware of the doctor's fault for contributing to the patient-client's worsened condition, must choose the appropriate ethical remedy: Either withdraw his representation or show that such a circumstance falls within a recognized exception so that he may continue his representation ethically.[14]

Scholarship has briefly addressed a variation of this type of hypothetical where a lawyer participating in an MLP is confronted by a prospective client who seeks to file a medical malpractice claim against the hospital.[15] In such a scenario, scholarship has concluded that Rule 1.7 of the American Bar Association's Model Rules of Professional Conduct (MRPC), which addresses conflicts of interest involving current clients,[16] may not apply.[17] According to MRPC 1.7's text, a concurrent conflict of interest exists when "there is a significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to . . . a third person or by a personal interest of the lawyer."[18] Existing analysis has correctly identified that MRPC 1.7 would not solve this issue because the hospital was never the lawyer's client and the client seeking to file a medical malpractice claim was only a prospective client, not an actual client.[19] The focus of this Comment, however, presents a slightly different scenario that involves ABA Model Rule 1.7. Here, the lawyer is already representing a client

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[13] Note that when a healthcare provider affiliated with an MLP commits medical malpractice upon a patient-client the legal team is representing, the contractual relationship formalizing the MLP creates the conflict of interest for the legal team, not the MLP's level of integration. As a result, both high and low integrated MLPs confront a conflict of interest in such circumstances.

[14] *See* MODEL RULES OF PRO. CONDUCT r. 1.16 (AM. BAR ASS'N 2024) (explaining the rules for mandatory or permissive withdrawal of representation by an attorney).

[15] *See* Campbell, *supra* note 1, at 850.

[16] *See Variations of the ABA Model Rules of Professional Conduct*, ABA CPR Pol'y Implementation Comm., 1, 1–11 (2021), https://www.americanbar.org/content/dam/aba/administrative/professional_responsibility/mrpc-1-7.pdf (showing that all fifty U.S. jurisdictions and the District of Columbia have adopted some form of ABA Model Rule 1.7).

[17] *See* Campbell, *supra* note 1, at 850.

[18] *See* MODEL RULES OF PRO. CONDUCT r. 1.7(a)(2) (AM. BAR ASS'N 2024).

[19] *See* Campbell, *supra* note 1, at 850.

in his claim against his landlord and the conflict of interest involving the hospital occurred after this established representation. Such a scenario may introduce thoughts about the viability of client representation in both highly integrated and referral model MLPs.

This Comment argues that there is one MLP model better equipped to waive such a conflict and produce fewer inefficiencies: The referral model. This is because the limited nature of communication between medical and legal partners in this model bypasses serious inefficiencies that would result in attorneys withdrawing from client representation. This Comment also proposes the following framework to improve the current state of ethical issues clouding the MLP domain: (1) modern society should abandon highly integrated MLPs because only the referral model allows attorneys to keep representing their clients despite an ongoing conflict of interest, and (2) agreements in referral model MLPs between the medical and legal partners should remove provisions that prevent participating attorneys from suing the medical entity for their alleged malpractice against their patient-client because such provisions are contrary to the purpose of MLPs.

This Comment unpacks these thoughts and provides recommendations for further efficiency and sustainability of MLPs as a viable option for a patient-client to receive medical and legal aid. This is in part because the communication between medical and legal partners in a referral model MLP is severely limited once the medical partner provides a referral to the patient-client for legal services.[20] As a result, it is entirely possible that such MLPs bypass serious inefficiencies that can likely result in attorneys withdrawing from client representation.

Referral model MLPs appropriately address conflicts of interest that arise when the medical entity commits medical malpractice upon a patient-client who is receiving legal representation. It does not completely address, however, the patient-client's redress from the medical malpractice, which leads to another issue. Sample agreements generally prohibit attorneys from suing the medical entity during and after the MLP relationship expires.[21] Adverse provisions in the agreement between medical and legal entities threaten the ability to

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[20] *See* Jessica Mantel & Renee Knake, *Legal and Ethical Impediments to Data Sharing and Integration Among Medical Legal Partnership Participants*, 27 ANN. HEALTH L. 183, 188 (2018).

[21] *See* Sample Health Center Memorandum of Understanding (MOU) from Florida, NAT'L CTR. FOR MED. LEGAL P'SHIP, Aug. 2020, at 4, https://medical-legalpartnership.org/mlp-resources/florida-health-center-mou/ [hereinafter Sample MOU on NCMLP].

hold negligent healthcare providers accountable in an MLP. This results in the harmed patient-client retaining a different attorney to file a subsequent medical malpractice claim. This demand, however, is both highly inefficient and unwarranted in referral model MLPs because the patient-client already has an attorney through the MLP who can readily assist and is familiar with the medical entity. Then, society reverts to a practice that the adoption of MLPs was intended to assist.

Part I of this Comment will examine the two structural components of MLPs, the integration level and the agreement governing the venture. First, this Section will look at two types of MLP integration: (1) the referral model, also called low integration, and (2) high—or full—integration. Then, it analyzes a sample contract from the National Center of Medical Legal Partnership (NCMLP). Part II analyzes why highly integrated MLPs do not work. Specifically, it examines this integration model's flaws through the lens of confidentiality and conflicts of interest. Part III identifies why referral model MLPs are a better option than highly integrated MLPs for addressing confidentiality and conflict of interest concerns. Part IV provides recommendations for jurisdictions across the nation to uniformly adopt referral model MLPs and to remove provisions prohibiting attorneys from holding medical entities accountable for their alleged medical malpractice against patient-clients in agreements.

BACKGROUND

I. TYPES OF MLP INTEGRATION MODELS

"MLPs are not 'one-size-fits-all' ventures;"[22] however, there are two consistent parts that make up an MLP's foundation. First, each MLP is designed with an integration level that sets the baseline for information-sharing within the venture.[23] MLPs can be organized in two forms: (1) low integration and (2) high integration.[24] The level of integration provides insight into the type of information-sharing model that an MLP will have.[25] The integration level also impacts whether

[22] *See* Thorpe, *supra* note 8, at 2.

[23] *See id.* at 2, 5; Mantel & Knake, *supra* note 20, at 187–89.

[24] *See* Thorpe, *supra* note 8, at 2, 5.

[25] *See id.* at 5.

medical and legal services will be administered jointly or separately.[26] Although not dispositive, the integration level is significant in clarifying the boundaries of information sharing between the legal and medical partners of the MLP.[27] Second, the agreement formed between the medical and legal partners legally defines the responsibilities of both parties.[28]

A. *Lowly Integrated MLPs*

The referral model is regarded as the least collaborative form of integration.[29] In this model, medical and legal partners do not work together under the same roof—each entity operates separately and distinctly from the other.[30] The "partnership" is reinforced by a referral, occurring when a medical professional identifies a potential legal issue during a patient-client's treatment and provides them with the MLP attorney's basic contact information.[31] Under this integration model, the medical and legal partners of the MLP have limited contact with one another after the medical partner initiates the referral process.[32] The nature of the referral model does not authorize legal service providers to receive specialized knowledge on the patient-client's medical treatment or interact with their medical care team.[33]

1. How Referral Model MLPs Work

The first step in a referral model MLP is for a medical professional associated with the MLP to provide the patient with a referral to obtain legal services.[34] The very act of referring a patient for legal services is within the discretion of the medical professional.[35] As a result, not

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[26] *See id.*

[27] *See* Mantel & Knake, *supra* note 20, at 188.

[28] *See* Thorpe, *supra* note 8, at 5.

[29] *See id.* at 7.

[30] *See* Mantel & Fowler, *supra* note 7, at 194.

[31] *See* Mantel & Knake, *supra* note 20, at 188.

[32] *See* Mantel & Fowler, *supra* note 7, at 190.

[33] *See id.* at 194.

[34] *See id.* at 189.

[35] *See id.*

all screened patients may be recognized to have health-related legal claims.[36]

Once a patient-client is given the contact information to reach the legal services provider, it is the patient's responsibility to contact that provider to seek official representation for their respective claim or claims.[37] This means that it is on the patient to provide their Protected Health Information (PHI) for their legal claim.[38] Alternatively, the patient-client can consent for the medical entity to release their medical records directly to the legal services provider.[39]

Referral model MLPs force legal service providers to be reactive to all potential claims rather than proactive in acquiring them because the patient-client is "responsible for contacting the attorney for potential representation in this model, not the other way around."[40] In this model, the legal services provider does not initiate communication with the medical partner, as the "medical partner of the MLP is responsible for providing the referral to the MLP for the patient-client."[41] Their contribution does not involve participating in the patient-client's health care service.[42] The nexus between the medical and legal entities depends on the patient-client.[43]

2. Critiques of the Lowly Integrated Referral Model

Scholarship has identified the benefits of the referral model.[44] As a general note, referral model MLPs limit negative tension between medical and legal professionals because each entity is weary of the other.[45] First, such MLPs bypass some legal, ethical, and practical barriers that arise from sharing patient-client PHI with one another.[46]

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[36] *See* Mantel & Knake, *supra* note 20, at 188–89.

[37] *See id.*

[38] *See* Thorpe, *supra* note 8, at 4 (defining PHI as "a broad ranges of individually identifiable information relevant to a patient's health, healthcare, or payment for healthcare, including name, phone number, and address"); Mantel & Knake, *supra* note 20, at 189.

[39] *See* Thorpe, *supra* note 8, at 7–8.

[40] *See id.* at 7.

[41] *See* Mantel & Fowler, *supra* note 7, at 189.

[42] *See* Thorpe, *supra* note 8, at 7.

[43] *See id.* at 6–7.

[44] *See* Mantel & Fowler, *supra* note 7, at 197–99.

[45] *See id.* at 194 (explaining that medical and legal partners of an MLP "operate in largely separate silos" in a referral model).

[46] *See* Mantel & Knake, *supra* note 20, at 192.

This is because the interactions between legal and medical staff are extremely limited and almost nonexistent[47] once the patient-client acts upon the referral he was given. Second, because the medical and legal partners cannot access a joint database system to record notes on a patient-client's file, the risk that information improperly becomes accessible to the wrong party is entirely avoided.[48]

With the benefits of the referral model come some identified difficulties.[49] This model promotes the medical and legal partners of this venture to function in "largely separate silos."[50] As a result, communication between legal and healthcare providers is severely limited.[51] Under this model, not all patients are screened for a possible legal claim.[52] Healthcare providers must agree to refer a patient's case to the legal services provider.[53] Moreover, some patient-clients with a possible legal claim lack transportation, financial, or emotional resources to connect with a legal services provider,[54] so some patient-clients "slip through the cracks" and ultimately may not receive the legal services they need.[55] Additionally, the referral MLP's structure may produce solutions for a patient-client that are purely legal, which may not be reflective of the solution that is required.[56] Such solutions have "reduced impact" because of the "limited coordination and communication" between the medical and legal partners of the MLP,[57] patient-client solutions are often "interrelated legal, medical, social and financial needs" and the legal partner of the MLP may not adequately address such issues when representing the client.[58] Thus, the referral model provides conflicting solutions to patient-clients with health-harming legal needs.[59]

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47 *See id.* at 188.

48 *See id.* at 195–96 (explaining that documenting MLP patient-clients using electronic health records can lead to other information being exposed to third parties).

49 *See id.* at 189–91.

50 *See* Mantel & Fowler, *supra* note 7, at 194.

51 *See* Mantel & Knake, *supra* note 20, at 188.

52 *See* Thorpe, *supra* note 8, at 7.

53 *See id.* at 6.

54 *See* Mantel & Knake, *supra* note 20, at 189.

55 *See id.*

56 *See id.* at 189–90.

57 *See id.* at 189.

58 *See id.* at 189–190.

59 *See id.* at 190.

B. *Highly Integrated MLPs*

In highly integrated model MLPs, medical and legal partners work collaboratively at a single location to serve patient-clients, mixing legal care with the patient-client's overall care.[60]

1. The Benefit of Increased Collaboration Between Professions

Once legal services are coordinated for a patient-client with health-harming legal needs, the patient-client's legal and medical care is given jointly.[61] Legal service providers can attend patient-client care meetings—or even attend care visits at patient-client residences—with medical professionals and legal service providers are privy to the information discussed in those meetings.[62] These meetings include the patient-client's social needs rather than being limited to the patient-client's strict medical or legal needs.[63] The legal and medical partners of the MLP engage in substantial information sharing in this model, which could mean both partners have joint access to patient-client databases.[64] In essence, the medical and legal professionals responsible for a patient-client's case are apprised of all information pertinent to the patient-client's care. This apparent benefit alleviates the "slipping through the cracks" problem.[65] Increased collaboration between medical and legal professionals assists the attorneys to represent the patient-client as well.[66] For example, medical staff can gather the necessary documentation for the patient-client's case and seamlessly locate patient-client files.[67] The inherent collaboration also alleviates the burden on the patient-client to provide their relevant health information to their attorney because all members of a patient-client's care team are present for important discussions.[68] The regular communication between patient-clients and attorneys encourages

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[60] *See* Mantel & Knake, *supra* note 20, at 190.

[61] *See* Mantel & Fowler, *supra* note 7, at 194.

[62] *See id.*

[63] *See id.*

[64] *See* Mantel & Knake, *supra* note 20, at 190–91; Thorpe, *supra* note 8, at 6.

[65] *See* Thorpe, *supra* note 8, at 7; Mantel & Knake, *supra* note 20, at 190.

[66] *See* Mantel & Fowler, *supra* note 7, at 195.

[67] *See id.*

[68] *See id.* at 196; Mantel & Knake, *supra* note 20, at 190–91.

effective legal representation because the attorneys can easily access a patient-client's information from their medical care team without solely relying on the patient-client's memory.[69] In addition to their databases, the presence of databases that attorneys and medical professionals have access to eliminates the cost of obtaining records directly from a medical provider.[70] Also, these databases allow medical and legal MLP partners to access the most up-to-date patient-client information.[71] This collaboration increases a medical professional's and an attorney's knowledge about the medical field.[72] It also produces meaningful solutions for patient-client needs.[73]

2. The Information-Sharing Problems of the Highly Integrated MLP Model

Despite all the praise, highly integrated MLPs have some insurmountable information-sharing problems.[74] On a basic level, for a patient's medical and legal care team to have access to their records, the patient-client must consent to the distribution of that information.[75] The first step towards patient-client consent is informing each patient-client of their privacy rights and that their PHI will be disclosed.[76] Sometimes, tracking down signatures and consent for every PHI release can be burdensome and costly.[77] Even once consent is properly documented, joint Electronic Health Records (EHRs) run the risk that patient information can be improperly shared with third parties.[78] As a result, medical and legal professionals participating in an MLP may only share "the bare minimum" with each other to protect a patient-client's confidentiality.[79] This practice is especially common among medical professionals to prevent the mishandling of their patient's

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[69] *See* Mantel & Knake, *supra* note 20, at 191.

[70] *See* Mantel & Fowler, *supra* note 7, at 207; Thorpe, *supra* note 8, at 7.

[71] *See* Thorpe, *supra* note 8, at 7.

[72] *See* Mantel & Knake, *supra* note 20, at 189.

[73] *See id.* at 191; Elizabeth Tobin Tyler, *Allies Not Adversaries: Teaching Collaboration to the Next Generation of Doctors and Lawyers to Address Social Inequality*, 11 J. HEALTH CARE L. & POL'Y 249, 254 (2008).

[74] *See* Mantel & Fowler, *supra* note 7, at 197–98; Mantel & Knake, *supra* note 20, at 195–96.

[75] *See* Mantel & Knake, *supra* note 20, at 196.

[76] *See id.* at 195.

[77] *See id.*

[78] *See id.* at 196.

[79] *See id.*

medical information by others, including attorneys.[80] These concerns undermine the concepts of "open communication" and "integration of medical, social, and legal services" that are central to highly integrated MLPs.[81] Such issues implicate ethical problems with EHRs in general.[82] When patient-clients consent to release their medical records, confidentiality concerns are not a barrier to the operations of highly integrated MLPs.[83] When there is a lack of consent in highly integrated MLPs, the question of who knows what becomes incredibly important.

Attorneys have to think carefully about their interactions in a highly integrated MLP because sharing case updates with medical staff may compromise attorney-client privilege.[84] In the legal profession, attorney-client privilege protects certain communications made by a client and his lawyer with the expectation of privacy and to receive legal advice.[85] Attorney-client privilege is protection recognized in the interest of public policy—to encourage individuals to feel safe when disclosing their private, sensitive information to other parties.[86] In highly integrated MLPs, however, attorneys may be forced, more often than usual, to grapple with the question of what sensitive information to disclose.[87] The question of who is privy to a patient-client's medical and legal history is at the heart of confidentiality concerns. Disclosing patient-client information, nonetheless, in any setting still poses a risk to patient-clients.[88] Just as medical professionals may withhold information out of fear of being sued,[89] attorneys may choose not to share information

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[80] *See id.*

[81] *See* Mantel & Knake, *supra* note 20, at 196–97.

[82] *See* Susan McBride, et al., *Identifying and Addressing Ethical Issues with Use of Electronic Health Records*, 21 ONLINE J. OF ISSUES IN NURSING 1, 3, 13 (2018), https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-23-2018/No1-Jan-2018/Identifying-and-Addressing-Ethical-Issues-EHR.html.

[83] *See* Mantel & Knake, *supra* note 20, at 198–99; Mantel & Fowler, *supra* note 7, at 213.

[84] *See* Mantel & Fowler, *supra* note 7, at 217; MODEL RULES OF PRO. CONDUCT r. 1.6 (AM. BAR ASS'N 2024) (discussing an attorney's fiduciary duty to client confidentiality).

[85] *See* Mantel & Fowler, *supra* note 7, at 205.

[86] *See id.* at 205–06; MODEL RULES OF PRO. CONDUCT r. 1.6(c) (AM. BAR ASS'N 2024) (requiring the attorney to make "reasonable efforts" to protect the disclosure of client communications).

[87] *See* Mantel & Fowler, *supra* note 7, at 216–18.

[88] *See id.* at 219.

[89] *See id.* at 204 (recognizing an ancillary concept to client confidentiality in the law being doctor-patient confidentiality, also discussed in the Health Insurance Portability and Accountability Act ("HIPAA")).

with their medical partners fearing the negative consequences of jeopardizing attorney-client privilege.[90] Communications by a client to his lawyer are protected if the communication was made with the expectation of privacy.[91] This protection is forgone, however, if the client or his lawyer relays that information to a third party.[92] Courts have not uniformly decided whether shared communications between MLP attorneys and other care team members are protected by attorney-client privilege, which can lead attorneys to entirely withdraw from sharing case updates with medical staff.[93]

The very fact that attorneys have access to PHI in the highly integrated MLP setting raises direct confidentiality and HIPAA issues.[94] If the risk of disclosing information is outweighed by its benefits, attorneys may advise patient-clients to waive attorney-client privilege.[95] Such practice could diminish the concept of consent, however, because the patient's original wishes for certain information to remain confidential might be outweighed by greater legal concerns. If the patient-client consents to waiving privilege per the advice of his attorney, the information disclosed in patient-client care meetings, where attorney and medical professionals are privy to all information, is no longer protected.[96] Not only does the highly integrated MLP model present burdensome ethical considerations for attorneys, but it also comes with privacy costs that patient-clients must be prepared to confront.[97]

Another more serious issue is that if an attorney becomes aware of a condition the patient-client has that can negatively impact them in a subsequent legal proceeding, the MLP attorney may want to share that information with the medical professional so that the patient-client receives the proper treatment and diagnosis.[98] The attorney must tread carefully with this news, however, because if he discloses patient-client information with the medical partner without the patient-client's

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[90] *See* Mantel & Knake, *supra* note 20, at 200.

[91] *See id.* at 198.

[92] *See id.*; *see also* Mantel & Fowler, *supra* note 7, at 206.

[93] *See* Mantel & Fowler, *supra* note 7, at 214–16.

[94] *See id.* at 204–05, 209.

[95] *See* Mantel & Knake, *supra* note 20, at 199.

[96] *See* Mantel & Fowler, *supra* note 7, at 218–19.

[97] *See id.* (stating that "[d]isclosing even minimal client information to the medical partner is not without some risk, as the shared information no longer enjoys attorney-client privilege.").

[98] *See* Mantel & Knake, *supra* note 20, at 199.

consent, the attorney can be seriously disciplined.[99] Given this fear, attorneys may refuse to "give up too much information back to providers."[100] Attorneys must also balance advising clients to waive attorney-client privilege with upholding their legal obligation to client confidentiality in a highly integrated MLP.[101] The decision to waive privilege has been characterized as being a risk for a client.[102] This "core protection[] associated with legal advice"[103] is a protection that is more likely to be jeopardized in a highly integrated MLP than in a traditional setting where a potential client seeks legal advice.

In the context of mandatory reporting of abuse, there are additional information-sharing problems.[104] In most states, attorneys are exempt from mandatory reporting requirements because of their direct conflict with a lawyer's obligation to owe their client a duty of confidentiality.[105] Combining medical professionals who are mandated reporters with attorneys who are exempt from this mandate creates the potential for inconsistent professional obligations.[106] Mandated reporters are relaying information to third parties that would otherwise be confidential under attorney-client privilege. The sharing of this information could be harmful to a patient-client's legal representation.[107] An added layer of complication within the context of mandated reporting is the sharing of patient-client information via verbal or written case updates and file sharing between medical and legal staff.[108] Although the literature quells this concern by proposing that mandated reporters have limited exposure to confidential patient-client information,[109] this recommendation is difficult to implement in practice where legal and medical professionals often discuss patient-client plans daily.

An added layer of complexity arises with the skepticism that medical professionals may have toward attorneys, and vice versa.

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99 *See id.* at 198.

100 *See* Mantel & Fowler, *supra* note 7, at 217.

101 *See id.* at 216.

102 *See* Mantel & Knake, *supra* note 20, at 199.

103 *See id.* at 197.

104 *See id.* at 199–200.

105 *See id.*

106 *See* Boumil, *supra* note 5, at 126.

107 *See id.* at 126–27; *see also* Mantel & Fowler, *supra* note 7, at 199 (suggesting that "inconsistent [professional] obligations" can impact patient-clients).

108 *See* Boumil, *supra* note 5, at 126–27.

109 *See id.* at 127–28.

Some medical professionals are reluctant to opt into highly integrated MLPs and welcome attorneys into the mix because of fears that their patient-clients may sue them for malpractice.[110] This can create a tense working relationship between the medical and legal partners of an MLP.[111] Medical professionals may also be incentivized to speak less during meetings when attorneys are present to limit the words being used against them.[112]

Participation in a highly integrated MLP can also be distracting for the participating attorney.[113] In the interest of increased collaboration between medical and legal professionals, opportunities such as attending patient-client care meetings may detract from the attorney's primary responsibility to administer legal services.[114]

These aforementioned practices threaten the "exchange of information" that is "essential" to "multidisciplinary collaboration."[115] As a result, the quality of care given to a patient-client may suffer.[116] The less pleasant the relationship is between all parties, the more comfortable medical entities may be in choosing referral model MLPs over highly integrated ones.[117]

II. THE STANDARD MLP CONTRACT

The Memorandum of Understanding (MOU) is the agreement that memorializes the terms and conditions for the medical and legal partners.[118] The MOU outlines the responsibilities of each partner, including financial arrangements, information-sharing policies, and how patient-clients will be connected to legal services.[119]

The National Center for Medical Legal Partnership's website contains sample MOUs, most recently from August 13, 2020.[120] This

110 *See* Juliann Schaefer, *Beware of HIPAA Zealots*, 27 FOR THE RECORD 22, 22 (2015); Mantel & Fowler, *supra* note 7, at 198.

111 *See id.*

112 *See* Mantel & Knake, *supra* note 20, at 196–97.

113 *See, e.g.*, Mantel & Fowler, *supra* note 7, at 216–18; Boumil, *supra* note 5, at 117–23.

114 *See* Mantel & Fowler, *supra* note 7, at 198.

115 *See* Boumil, *supra* note 5, at 110.

116 *See id.* at 138 (concluding that when professional ethical obligations are maintained, physicians, lawyers, and social workers can collaborate without compromising patient care).

117 *See* Mantel & Fowler, *supra* note 7, at 198.

118 *See* Thorpe, *supra* note 8, at 5.

119 *See* Sample MOU on NCMLP, *supra* note 21, at 1–4.

120 *See id.* at 1.

agreement includes many important baseline provisions. First, MLP attorneys and staff provide legal services to patient-clients at no cost.[121] Justification for this has been attributed to the idea that low-income individuals may face more barriers in accessing legal services.[122] Second, MLP attorneys are prohibited from taking legal action against medical professionals participating in the MLP.[123] Attorneys also cannot represent any client in any future matter involving the medical entity or its staff as an adverse party.[124] Third, client representation is not allowed in certain cases, including, but not limited to, criminal, personal injury, or medical malpractice; cases involving representation of a party that would conflict with another current or former client under ethical codes; or cases adversarial to the medical partner or its staff.[125] Attorneys are allowed to take cases such as income support, health insurance, and nutritional supplements (Medicaid, Medicare, and so on); advance directives (preparation of Powers of Attorney, Healthcare Surrogate, Living Will); and elder advocacy (assisting seniors 60+ who have been subjected to abuse, exploitation, or neglect).[126] Fourth, legal service providers and accompanying staff who are employees of the legal service providers, completely separate from the medical entity.[127] Fifth, absent written consent, medical or legal MLP partners may not retrieve the records of the other's domain.[128] Finally, MLP legal staff must provide educational materials to the medical staff of the MLP to increase their knowledge about the various factors affecting patient health.[129]

The sample agreement lists states that the "MLP attorney is responsible for conducting an evaluation once the medical partner

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121 *See id.* at 4.

122 *See* Megan Sandel, et al., *Medical-Legal Partnerships: Transforming Primary Care By Addressing The Legal Needs Of Vulnerable Populations*, PROJECT HOPE 1697, 1698 (2010), https://www.fcm.arizona.edu/sites/default/files/MLP%20Transforming%20Primary%20Care%202010%20Health%20Affairs.pdf.

123 *See* Sample MOU on NCMLP, *supra* note 21, at 3.

124 *See id.*

125 *See id.* at 4.

126 *See id.*; *see also* 45 C.F.R. § 1609.1 (providing statutory restrictions for legal partners of MLPs funded by Legal Service Corporations including which types of cases they may accept).

127 *See* Sample MOU on NCMLP, *supra* note 21, at 3.

128 *See id.* at 2.

129 *See id.* at 1; *see also* Krishnamurthy, *supra* note 3, at 381 ("MLP legal and health professionals develop and deploy trainings to ensure that the people who work in the clinical setting can recognize healthharming civil legal needs . . . .").

identifies a patient with health-harming legal needs."[130] As part of the MOU's record-keeping requirement, attorneys must provide brief summaries of all consultations or representation of a referred patient-client.[131] This sample agreement may not be adopted by all entities forming an MLP, but there are certain provisions and changes that attorneys may benefit from.

ANALYSIS

I. HIGHLY INTEGRATED MLPS HARBOR INSURMOUNTABLE ETHICAL ISSUES

Attorneys participating in a highly integrated MLP may face challenging ethical dilemmas that may become either nonwaivable or incredibly burdensome to the continued provision of legal representation to an eligible patient-client. More specifically, an attorney's participation in a highly integrated MLP may make it harder for him to successfully waive a conflict of interest that may occur during their client representation, complicating his obligation under MRPC 1.7.

Conflicts of interest, governed by ABA Model Rule 1.7, involve the duty of loyalty attorneys have to current and former clients.[132] Conflicts of interest do not solely occur when an attorney has an obligation to former or other clients, but occur from an attorney's "personal interest" or responsibility to a "third person."[133] They can also arise during the course of a lawyer's representation of a client,[134] in which case the attorney may waive the conflict when certain conditions are met.[135] Ultimately, an attorney who is confronted with a conflict of interest during his representation of a client must either (1) withdraw representation or (2) waive the conflict of interest if the circumstances support that avenue.[136]

A conflict of interest can occur when a lawyer's representation of a current client interferes with his obligations to a third party, and

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130 *See* Sample MOU on NCMLP, *supra* note 21, at 1.

131 *See id.*

132 *See* Campbell, *supra* note 1, at 850.

133 *See* MODEL RULES OF PRO. CONDUCT r. 1.7(a)(2) (AM. BAR ASS'N 2024).

134 *See* MODEL RULES OF PRO. CONDUCT r. 1.7 cmt. (AM. BAR ASS'N 2002).

135 *See* MODEL RULES OF PRO. CONDUCT r. 1.7(b)(4) (AM. BAR ASS'N 2024).

136 *See* MODEL RULES OF PRO. CONDUCT r. 1.7 cmt. (AM. BAR ASS'N 2002).

vice versa.[137] To illustrate how an attorney's participation in a highly integrated MLP can create a non-waivable conflict of interest, recall the hypothetical posed at the beginning of this Comment.[138] For the time being, put aside the fact that the sample MOU described previously contained a provision prohibiting the attorney from taking legal action against any of the medical entity's healthcare providers during their contractual relationship and even after it expires.[139] Let us assume that the attorney in a highly integrated MLP seeks to have that conflict of interest waived and, if successful, will be able to continue representing his patient-client.

Let's start with the basics: The harmed patient is the attorney's client[140] and the medical entity is not. The medical entity, however, is in a binding, contractual relationship with the attorney. A medical entity owes a patient-client the duties of loyalty, confidentiality, and competency, even when the patient-client is victimized by the medical entity.[141]

This type of conflict of interest requires an analysis under ABA Model Rule 1.7 because the harmed patient-client's representation "is at significant risk of being materially limited" because of the attorney's present contractual relationship with a "third person" (the medical entity for the purposes of this Comment).[142] This type of conflict is forbidden unless certain circumstances exist where such a conflict can be waived.[143] For the conflict of interest to be waived, four elements must be satisfied:

> (1) the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client; (2) the representation is not prohibited by law; (3) the representation does not involve the assertion of a claim by one client against

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137 *See* Campbell, *supra* note 1, at 850.

138 Recall that a patient-client developed an illness from his landlord violating housing laws and the patient is seeking medical and legal services from a highly integrated MLP. The patient required surgical treatment, which was completed by MLP medical staff, but a piece of surgical equipment was left inside him, and he now wants to file a medical malpractice claim against the surgeon.

139 *See* Sample MOU on NCMLP, *supra* note 21, at 3.

140 *See* Campbell, *supra* note 1, at 850.

141 *See* Boumil, *supra* note 5, at 116.

142 *See* MODEL RULES OF PRO. CONDUCT r. 1.7(a)(2) (AM. BAR ASS'N 2024).

143 *See* MODEL RULES OF PRO. CONDUCT r. 1.7(a) (AM. BAR ASS'N 2024) (stating "a lawyer shall not represent a client if the representation involves a concurrent conflict of interest.").

> another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and (4) each affected client gives informed consent, confirmed in writing.[144]

Attorneys participating in highly integrated MLPs will be unsuccessful in waiving the conflict of interest because it will likely fail under the first and fourth elements.[145]

To waive a conflict of interest, the first element requires the attorney to reasonably believe that he can represent the client, both diligently and competently, despite the conflict of interest.[146] The ABA Model Rules define both diligence[147] and competence.[148] Diligence requires attorneys to "act with commitment and dedication to the interests of the client with zeal in advocacy upon the client's behalf."[149] This element requires honesty from the lawyer. It is in the client's interest to receive favorable legal care that adequately addresses their health-harming legal needs.[150] An attorney's interest of participating in a binding contractual relationship with the medical entity that caused their patient-client harm may go against that patient-client's interests,[151] specifically given the attorney's contractual relationship with a medical entity to provide pro bono service to patient-clients. The attorney's personal interest in maintaining clientele from participating in an MLP conflicts with his duty of diligence to his client, and a contractual relationship with the patient-client's tortfeasor certainly does not alleviate this problem.

Moreover, the praised "substantial sharing of information between medical and legal partners"[152] and "collaborative exchange of information"[153] in highly integrated MLPs end up hindering a patient-client's interests because the attorney frequently communicates

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144 *See* MODEL RULES OF PRO. CONDUCT r. 1.7(b)(1)–(4) (AM. BAR ASS'N 2024).

145 Note that even if the attorney fails on a single element, the conflict is not waived. This Comment limits discussion to the two elements that will likely fail.

146 *See* MODEL RULES OF PRO. CONDUCT r. 1.7(b)(1) (AM. BAR ASS'N 2024).

147 *See* MODEL RULES OF PRO. CONDUCT r. 1.3 (AM. BAR ASS'N 2024).

148 *See* MODEL RULES OF PRO. CONDUCT r. 1.1 (AM. BAR ASS'N 2024).

149 *See* MODEL RULES OF PRO. CONDUCT r. 1.3 cmt. (AM. BAR ASS'N 2002).

150 *See* Mantel & Knake, *supra* note 20, at 184.

151 *See* MODEL RULES OF PRO. CONDUCT r. 1.7 cmt. (AM. BAR ASS'N 2002) (stating "[t]he lawyer's own interest should not be permitted to have an adverse effect on representation of a client.").

152 *See* Mantel & Knake, *supra* note 20, at 189.

153 *See id.* at 197.

with the entity that caused the patient-client harm. The attorney can become closely affiliated with his medical colleagues, and separating such a relationship may be difficult because a patient-client's medical and legal care is administered jointly in highly integrated MLPs.[154] The quality of a specific patient-client's representation may suffer when the attorney's affiliation with the medical professionals that caused his patient-client harm is substantive. Given these strong considerations, the first element under Rule 1.7(b)(1) is not satisfied under such circumstances.[155]

To further support the argument that an attorney's diligence toward his patient-client is clouded by personal interest, the MLP attorney may maintain a working relationship with the medical entity to keep receiving clients to represent pro bono.[156] It is possible that MLP attorneys have a greater incentive to maintain a good working relationship in hopes of contract renewal and continuation of patient-clients to represent. For example, the attorney may have an underlying incentive for pro bono work for CLE credit—depending on the jurisdiction they are barred in—or a minimum number of annual hours. As a result, it would be in the attorney's personal interest to maintain a pleasant relationship with his medical counterparts so that the multidisciplinary relationship reflects well on his continued employment of pro bono clients. If a harmed patient-client were to recognize these factors, it may be difficult for them to consent to the attorney's continued representation of their case. This may hold true especially when the attorney frequently communicates with the medical professional that harmed the patient-client and continues to work with them to provide legal and medical services to other patient-clients. A harmed patient-client may view this practice as deceptive and morally be unwilling to allow the attorney to represent them.

The fourth element requires a patient-client to give "informed consent, confirmed in writing" to waive the conflict of interest.[157] Informed consent is obtained once the "lawyer has communicated adequate information and explanation about the material risks of

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154 *See* Mantel & Fowler, *supra* note 7, at 196.

155 MODEL RULES OF PRO. CONDUCT r. 1.7(b)(1) (AM. BAR ASS'N 2024).

156 *See* MODEL RULES OF PRO. CONDUCT r. 1.7 cmt. (AM. BAR ASS'N 2002) (stating "when a lawyer has discussions concerning possible employment with an opponent of the lawyer's client . . . . such discussions could materially limit the lawyer's representation of the client.").

157 MODEL RULES OF PRO. CONDUCT r. 1.7(b)(4) (AM. BAR ASS'N 2024).

reasonably available alternatives to the proposed course of conduct."[158] The attorney must obtain informed consent from the client in writing.[159] It is very likely that the harmed patient-client would not consent for the attorney, who has a deep-rooted relationship with the medical entity, to continue representing them on their initial case. The patient-client may realize that the attorney, who is required to have his best interests regarding the legal case in mind, also has a contractual obligation to their tortfeasor. Alternatively, the patient-client may not be comfortable with the idea that the attorney will still be in frequent communication with medical professionals of the entity that harmed him. This may lead the patient-client to question whether he wants an attorney with that relationship to represent him. The patient-client may fire the attorney, thus concluding their attorney-client relationship,[160] or refuse to give consent for the attorney to continue their representation given the new, complicating circumstances. Considering the above factors, the patient-client will likely not give informed consent to waive the conflict of interest and allow the attorney to continue representing him.

Given the above discussion, the inability of the attorney to waive the conflict of interest forces one result: The MLP attorney must withdraw his representation of that patient-client because the continued representation is a non-waivable conflict that, if continued, would violate Rule 1.7.[161] Highly integrated MLPs, therefore, cannot support the waiver of a conflict of interest when the medical partner of the venture commits medical malpractice upon a patient-client that an attorney participating in the partnership is already representing. Either the MLP attorney is forced to withdraw representation from that patient-client because of his ethical obligations or the patient-client will decide to terminate the attorney because of the strong moral considerations of the situation. This leads to the conclusion that highly integrated MLPs may encounter frequent turnover rates when confronted with a conflict of interest as described in this Comment.

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158 MODEL RULES OF PRO. CONDUCT r. 1.0(e) (AM. BAR ASS'N 2024).

159 MODEL RULES OF PRO. CONDUCT r. 1.0(b) (AM. BAR ASS'N 2024).

160 *See* MODEL RULES OF PRO. CONDUCT r. 1.16 cmt. (AM. BAR ASS'N 2002) (stating "[a] client has a right to discharge a lawyer at any time, with or without cause, subject to liability for payment for the lawyer's services.").

161 MODEL RULES OF PRO. CONDUCT r. 1.16(a)(1) (AM. BAR ASS'N 2024) (stating that "[a] lawyer . . . shall not represent a client . . . if (1) the representation will result in violation of the Rules of Professional Conduct.").

II. REFERRAL MODEL MLPS ARE THE BETTER ETHICAL ALTERNATIVE

By encouraging medical and legal collaboration through limited interactions, referral model MLPs better address the challenging ethical issues faced by attorneys participating in highly integrated MLPs.[162] By reducing the opportunities attorneys and medical professionals have to share patient-client information, referral model MLPs could achieve the same result—assisting the patient-client with their medical and legal needs—with significantly less hassle. In light of these developments, this Comment advocates for the uniform adoption of referral model MLPs because that model resolves challenging ethical issues attorneys may face and protects the patient-client's interest in receiving competent, diligent, and zealous representation.

A. *Confidentiality Issues Resolved with Referral Model MLPs*

Referral model MLPs appropriately address confidentiality concerns that may plague an attorney's ability to comply with the MRPC. Referral models operate in a completely different manner that avoids sharing patient-client information by giving the patient-client control of which medical records the attorney can possess or access.[163] The patient-client can either personally provide the attorney with the requested medical information or request that the medical facility send the attorney those records.[164] Regardless of the patient-client's preferred method of sharing, the attorney is not communicating with the medical professionals without the patient's consent.[165] This model is structured so that the patient-client adopts an information-sharing structure that the patient-client is comfortable with.

Moreover, referral model MLPs better maintain the legal protections of attorney-client privilege. Rather than compromising attorney-client privilege like in highly integrated MLPs, all conversations that take place between an attorney and patient-client in a referral model MLP are not ordinarily in the presence of medical staff.[166] Once the patient-client

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[162] *See* Mantel & Knake, *supra* note 20, at 188.

[163] *See* Mantel & Knake, *supra* note 20, at 188; Thorpe, *supra* note 8, at 7.

[164] *See* Mantel & Knake, *supra* note 20, at 188.

[165] *See id.*

[166] *See id.*

acts upon the referral by meeting with an attorney, the subsequent conversation is no longer subject to joint information channels as in highly integrated MLP models.[167] No medical professionals participate in that conversation and thus do not compromise the protection of those conversations unless the patient-client consents to third parties being involved.[168] As a result, the referral model MLP would simulate the "traditional" lawyer retention process that clients go through when considering whether to file a civil suit, with the bonus of increasing the legal profession's collaboration with medical partners to better serve the patient-clients. This model also minimizes the burden imposed on attorneys in highly integrated MLPs where attorneys make premature decisions on these topics without certainty of the outcome.[169] Rather than encouraging practices that can lead to ethical dilemmas that attorneys must resolve, the referral MLP model allows the patient-client to control how their information is shared.[170] The client is the center of attention for obtaining information, which can assist attorneys greatly in the search for factual information without involving medical professionals directly at the outset.[171] Considering all these factors, the universal adoption of referral model MLPs appropriately handles the confidentiality issues that can arise in highly integrated MLPs.

B. *Conflict of Interest Issues Resolved with Referral-Based MLPs*

Referral model MLPs are better equipped to waive a conflict of interest, like the one presented in this Comment, than a highly integrated MLP. As discussed, a factor hindering the waiver of a conflict like the one discussed in this Comment is that a great degree of collaboration between the medical and legal partners adds more attachment to the attorney's personal interest in the agreement. In a referral model MLP, however, the relationship between the attorney and medical partner is

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167 *See* Mantel & Fowler, *supra* note 7, at 207; Thorpe, *supra* note 8, at 7.

168 Whether or not the communications will be privileged also depends on if they fall into a recognized state-based exception where the client loses the protection.

169 *See generally* Mantel & Fowler, *supra* note 7, at 216; Mantel & Knake, *supra* note 20, at 199.

170 *See* Mantel & Knake, *supra* note 20, at 188; Thorpe, *supra* note 8, at 7.

171 *See* Fatima M. Bolyea & Emily S. Fields, *The Collaborative Advantage: Including Clients In The Litigation Process*, 103 MICH. BAR J. 26, 28 (2024) (stating "[c]lients often have access to documents, records and other evidence directly relevant to the case . . . . the client is a repository of valuable information.").

quite limited.[172] As a result, the MLP attorney may not have a strong relationship with the medical partner that caused his patient-client harm. This may convince a patient-client to give written consent to waive the inherent conflict of interest. The design and composition of referral model MLPs make it more likely that an attorney, confronted with a conflict of interest where the medical entity he has a contract with committed malpractice upon his current patient-client, can successfully waive that conflict and continue to represent the harmed patient-client. Let us look at the Rule 1.7(b) analysis in greater depth.

Under the first element,[173] the attorney is likely to reasonably believe that he can provide competent and diligent representation to his harmed patient-client because his limited interaction with the harm-causing medical professional means he may not know the medical professional very well. The medical professional only retains the attorney's basic contact information to provide to a patient-client in need of legal assistance.[174] The two professions operate in "separate silos" where communications are remote.[175] This lack of a developed relationship may allow the attorney to continue representing the patient-client because the attorney will not communicate with the medical professionals in-person and work with them as often as they would have under a highly integrated model. Such a relationship makes it more likely that the attorney can uphold the principles of diligence and "act with commitment and dedication to the interests of the client" because their judgment is not clouded by their professional relationship with the medical professionals that harmed the patient-client.[176] Although the attorney may still retain a personal interest in receiving pro bono clients per his contract, that interest is not clouded by the individualized connections the attorney would have formed by participating in a patient-client's care with medical professionals. Rather, the attorney better defend the patient-client's interest by not having a close relationship with the medical partner that caused the patient-client's harm.

Moreover, elements two and three of ABA Model Rule 1.7 can be quickly satisfied.[177] The second element is satisfied assuming that

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172 *See* Mantel & Knake, *supra* note 20, at 188.

173 *See* MODEL RULES OF PRO. CONDUCT r. 1.7(b)(1) (AM. BAR ASS'N 2024).

174 *See* Mantel & Knake, *supra* note 20, at 188.

175 *See* Mantel & Fowler, *supra* note 7, at 194.

176 *See* MODEL RULES OF PRO. CONDUCT r. 1.3 cmt. (AM. BAR ASS'N 2002).

177 *See* MODEL RULES OF PRO. CONDUCT r. 1.7(b)(2) (AM. BAR ASS'N 2024).

the MOU in the referral model MLP does not contain provisions that prohibit the attorney from suing and that no other state or federal laws bar the continued client representation in such circumstances.[178] Similarly, the third element[179] is likely to be satisfied because, under the hypothetical posed in this Comment, the patient-client's initial claim through the MLP is not against a different client of the attorney's in a different proceeding.

It is also more likely that the harmed patient-client will consent to waive the conflict of interest when the attorney does not have a significant relationship with the medical entity that caused them harm, satisfying the fourth element.[180] Although the patient-client might see the benefit that the attorney is receiving through the contractual relationship he has with the medical entity, this fact may be a small consideration in the patient-client's overall decision-making process. This is because the patient-client may recognize that the lack of communication between the attorney and the medical partner is enough to keep the attorney's judgment from being compromised in regards to their case. Moreover, the patient-client may be more inclined to consent to waive the conflict of interest because that will allow him to retain the attorney with whom he has already built a relationship. Patient-clients who trust their attorneys with their sensitive PHI may feel more comfortable keeping that attorney when given the opportunity.[181] Referral model MLPs promote limited interaction between the two partners, which patient-clients may view as a minimal moral hiccup compared to the ethical issue that arises from malpractice in an MLP.

III. UNIFORM ADOPTION OF REFERRAL MODEL MLPS AND MOU REFORM

The purpose of an MLP is to encourage the collaboration of the two professions in providing clients with the resources needed to address their social needs.[182] To properly navigate the ethical issues

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[178] Please see Section III(B) for a discussion for recommendations on efficient contract drafting in MLPs.

[179] *See* MODEL RULES OF PRO. CONDUCT r. 1.7(b)(3) (AM. BAR ASS'N 2024).

[180] *See* MODEL RULES OF PRO. CONDUCT r. 1.7(b)(4) (AM. BAR ASS'N 2024).

[181] *See* Bolyea & Fields, *supra* note 171, at 28 (stating "[c]lients who have positive experiences with their attorneys are more likely to return for additional legal services and recommend the attorney to others.").

[182] *See, e.g.*, Tyler, *supra* note 73, at 254.

that attorneys face in MLPs, however, there should be a uniform integration level across all jurisdictions for all participating attorneys and medical professionals. This Comment argues there are two primary reasons for the universal adoption of referral model MLPs over highly integrated models. First, as described previously, highly integrated MLPs present too many ethical considerations for attorneys and make it less likely for attorneys to successfully waive a conflict of interest, like the one described in the Introduction. The end result is for the attorney to withdraw representation for the impacted patient-client.[183] Second, the inability of attorneys in an MLP to pursue legal action against the medical entity during their agreement and beyond, as enumerated in the sample MOU,[184] is highly inefficient. Attorneys who are contractually affiliated with a medical entity cannot conduct formal discovery or investigative proceedings against those medical professionals who engage in medical malpractice and are thus unable to hold those medical professionals accountable.[185] By including such provisions in legally binding agreements, society accepts that attorneys, professionally trained litigators, cannot use the legal system this nation has in place for addressing such wrongdoing or seeking justice for harmed patient-clients.

To improve each of these systemic issues, this comment proposes two recommendations: (1) instead of using the two primary forms of MLP, the highly integrated and referral models, society should adopt only the referral model as the uniform MLP structure and (2) MOUs between medical and legal partners in referral model MLPs should eliminate provisions that prohibit an MLP attorney from suing the medical entity or its affiliated professionals.

A. *Society Should Uniformly Adopt the Referral-Based MLP Model*

As described above, the referral model MLP alleviates most ethical concerns of information-sharing because the patient-client is in control of supplying the information pertinent to their representation.[186] By

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[183] *See* MODEL RULES OF PRO. CONDUCT r. 1.7(a) (AM. BAR ASS'N 2024) (stating that "[e]xcept as provided in paragraph (b), a lawyer shall not represent a client if the representation involves a concurrent conflict of interest.").

[184] *See* Sample MOU on NCMLP, *supra* note 21, at 3.

[185] *See generally id.*

[186] *See* Mantel & Knake, *supra* note 20, at 189, 197–99.

encouraging collaboration between medical and legal professions in a "safer" way, the referral model MLP achieves the same result of serving patient-clients with legal and medical services without the burdensome ethical considerations attorneys have to confront. Limited interactions between medical and legal partners may make medical partners not as concerned with malpractice suits because medical requests would be pursuant to an Authorization.[187] Attorneys would no longer be required to split their time to attend a patient-client's medically related treatment. Moreover, referral model MLPs do not threaten the viability of attorney-client privilege and the work product doctrine because medical and legal professionals are no longer working in the same location and are not in frequent contact with one another.[188] Additionally, patient-client consent is easily achieved in the referral model MLP because the patient-client controls the information shared.[189] As previously described, the referral model may allow attorneys to waive the conflict of interest more easily under 1.7(b) when the medical entity commits medical malpractice against their client. This may result in a reduction in attorneys withdrawing from client representation when that type of conflict of interest occurs under those circumstances. Until future solutions are developed that support high levels of integration between medical and legal partners without burdening attorneys with ethical issues and making it harder to waive a conflict of interest under the circumstances described in the hypothetical, MLPs across the nation should adopt the referral model.

The problems identified with the referral model[190] are not detrimental to the model's uniform adoption. Patient-clients will indeed "slip through the cracks" under this model.[191] More patient-clients will "slip through the cracks," however, if highly integrated MLPs are adopted because the attorney confronted with the hypothetical in this

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187 *See* Mantel & Knake, *supra* note 20, at 196 (stating "[m]edical providers also may worry that the legal partner will initiate a medical malpractice claim against the provider"); *id.* at 194 (stating "[t]herefore, medical providers participating in MLPs typically obtain prior written authorization from patients before disclosing PHI to the legal partner.").

188 *See* Mantel & Fowler, *supra* note 7, at 214 (stating that "uncertainty surrounds the question of when the attorney-client privilege applies to the back and forth communications between the MLP attorney and other care team members, as well as communications between other care team members and the patient-client.").

189 *See* Mantel & Knake, *supra* note 20, at 188, 197–99.

190 *See id.* at 189.

191 *See id.*

Comment would be forced to withdraw patient-client representation when all elements of Rule 1.7(b) are not satisfied. Therefore, a modified referral model adequately adjusted to address this issue would be more appropriate. For example, the modified referral model could switch to tele-meetings or phone calls between patient-clients and attorneys, as these solutions have gained traction since the COVID-19 pandemic. A patient-client who needs legal assistance can call the referred attorney for help. The attorney can then minimize hardship for the patient-client and accommodate any potential transportation issues that arise throughout their legal experience. That way, there is a trend in reducing the number of patient-clients that "fall through the cracks" solely because of lack of transportation or financial resources, as previously raised.[192]

Moreover, the claim that referral model MLPs provide "incomplete, conflicting solutions to a patient-client's health-harm legal, psychosocial, and financial needs"[193] is slightly exaggerated. Although a patient-client's needs might indeed encompass areas outside of basic medical and legal services,[194] the lack of communication between medical legal partners in a referral model MLP, as compared to the greater intercommunication in a highly integrated MLP, does not diminish the quality of service the patient-client receives for a specific need of theirs.[195] A lawyer is not responsible for resolving a patient-client's psychosocial and financial needs if that is outside the scope of that patient-client's legal representation.[196] An attorney's diligence extends to the patient-client's cause and does not require that attorney to "press for every advantage that might be realized for a client."[197] Nevertheless, referral model MLPs are one way to connect patient-clients with necessary legal representation and help address one of the many needs each patient-client seeks assistance with.[198] The argument

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192 *See id.*

193 *See id.* at 190.

194 *See id.*

195 Mantel & Fowler, *supra* note 7, at 199 (stating that "supporting greater integration between the medical and legal partners[] made [attorneys] too available to patient-clients and providers, which prevented them from completing legal work related to client representation.").

196 *See* MODEL RULES OF PRO. CONDUCT r. 1.2 cmt. (AM. BAR ASS'N 2002) (stating "[t]he scope of services to be provided by a lawyer may be limited by agreement with the client or by the terms under which the lawyer's services are made available to the client.").

197 *See* MODEL RULES OF PRO. CONDUCT r. 1.3 cmt. (AM. BAR ASS'N 2002).

198 *See generally* Mantel & Knake, *supra* note 20, at 187–88.

that the increased collaboration in highly integrated MLPs offers a more comprehensive solution for patient-clients is outweighed by the greater concern of managing detrimental ethical concerns.

B. *Recommendations for Effective MLP Contracting*

In addition to uniformly adopting referral model MLPs, the MOU for referral model MLPs should not advocate for or include provisions prohibiting attorneys from suing the medical entity either during the partnership or after it expires. This type of provision is highly inefficient; it forces a patient-client—already represented by an attorney—to seek additional legal representation elsewhere.[199] MLPs were, in part, created to make it more accessible for patient-clients to reach the legal care they need.[200] A patient-client's journey to becoming whole from medical malpractice may start with finding a new lawyer—a lawyer that may not have the same rapport with the patient-client as the one already representing that patient-client through an MLP.

It is important to acknowledge that the sample MOU expressly prohibited certain cases for the participating attorney to take.[201] MLPs nationwide can use the sample as a guide to determine what types of cases are feasible for an MLP context. Determining what is feasible for an MLP context may involve funding limitations[202] and the types of cases the legal partners of the MLP are comfortable with.[203] For example, criminal cases may be more complex for a pro bono attorney in this setting than housing or family law cases. A particular type of case that should be considered in the mix as universally feasible in referral models, however, is a medical malpractice case. Not allowing such cases to be taken on by an MLP attorney bars a competent attorney, who is already a patient-client's advocate on one claim, from holding medical professionals accountable that wronged his patient-client. Moreover, it can add more emotional, financial, and social hardship for the harmed patient-client to retain a separate attorney just for their medical malpractice claim. The nationwide adoption of referral model MLPs

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199 *See generally* Sample MOU on NCMLP, *supra* note 21, at 3–4.

200 Hena Mehta, *Medical-Legal Partnerships*, PRO BONO INSTIT. (Mar. 20, 2024), https://www.probonoinst.org/2024/03/20/medical-legal-partnerships/.

201 *See* Sample MOU on NCMLP, *supra* note 21, at 4.

202 *See* 45 C.F.R. § 1609.1 (providing statutory restrictions for legal partners of MLPs that are funded by Legal Service Corporations including which types of cases they may accept).

203 *See* Mantel & Fowler, *supra* note 7, at 192.

supports the claim that the attorney can stay neutral throughout the process, quelling concerns that the attorney may be a biased advocate in the proceeding.

The recommendations associated with MOU drafting do not stop here. MLPs must remain appraised of new technology and other developments that could impact their contractual relationship. Future research should effectively address the feasibility of new technologies and assess the pros and cons of applying those technologies to highly integrated models. Then, society can revisit increasing the presence of highly integrated models. For now, such models are grossly unprepared to handle a conflict of interest that disproportionately burdens participating attorneys.

CONCLUSION

As MLPs continue to gain popularity, ethical issues may also rise in prominence.[204] Of the multidisciplinary relationships recognized, literature has found the medical and legal professions to be the most important.[205] If these relationships are not maintained properly, "service to clients will suffer and ethical rules may be violated."[206] The ethical issues confronted in highly integrated model MLPs eventually lead to attorney withdrawal of representation and support an infeasible practice as compared to referral model MLPs.

By presenting more ethical issues for participating attorneys to confront compared to the referral model MLP, highly integrated MLPs heavily burden attorneys with upholding their ethical obligations.[207] From forcing attorneys to make tough judgment calls on various ethical issues to leaving attorneys without enough time to manage legal commitments to their patient-clients,[208] highly integrated MLPs are highly undeveloped to handle society's ethical problems. Specifically,

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[204] *See* Campbell, *supra* note 1, at 848–49.

[205] *See* J. Michael Norwood & Alan Paterson, *Problem-Solving in a Multidisciplinary Environment? Must Ethics Get in the Way of Holistic Services?* 9 CLINICAL L. REV. 337, 341 (2002).

[206] *See id.*

[207] Mantel & Fowler, *supra* note 7, at 217.

[208] *See* Mantel & Knake, *supra* note 20, at 199 (stating "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."); Mantel & Fowler, *supra* note 7, at 198–99 (stating "[a]ttorneys stretched thin with individual client matters simply may not have the time to participate in rounds, care team meetings, joint home visits, or other collaborative activities.").

these issues arise when the medical partner commits malpractice upon a patient-client who is receiving ongoing legal care. Promoting the result that the participating attorney will likely have to withdraw representation because of a conflict of interest that cannot be waived is not optimal. As discussed, referral model MLPs appropriately reduce ethical dilemmas for attorneys and still provide patient-clients with the care they need. Although communications between medical and legal partners are limited in a referral model MLP, this notion is not a discouraging factor; instead, it still encourages the union of two professions to work towards the common goal of serving the well-being of their patient-clients.

To better serve patient-clients, the MOU used by a referral model MLP must not include any provisions that bar the participating attorney from suing the medical entity. Such provisions promote a culture where medical entities may not be held accountable because the patient-client has to expend resources to find another attorney to represent him. To prevent patient-clients from "fall[ing] through the cracks"[209] in the course of retaining representation for such medical malpractice claims, these provisions should be eliminated from all MLP MOUs. These social and contractual recommendations will not correct all the flaws with MLPs, but they will help minimize the ethical issues and burdens that patient-clients might face when receiving care.

MLPs are great assets to our nation, but improving their operation and the assistance they provide to society requires frequent reflection, assessment, and evaluation. Society as it currently stands should adopt the referral model of MLPs and remove any MOU provisions that prohibit the MLP attorney from pursuing a claim against medical professionals within the MLP who become tortfeasors because such provisions hinder patient-clients from seeking justice. After all, if our justice system negatively impacts the patient-clients it was meant to serve, the benefits patient-clients are perceived to receive are distorted from the truth.

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[209] *See* Mantel & Knake, *supra* note 20, at 189.