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Elizabeth Tobin Tyler

Roger Williams University School of Law

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ALLIES NOT ADVERSARIES: TEACHING COLLABORATION TO THE NEXT GENERATION OF DOCTORS AND LAWYERS TO ADDRESS SOCIAL INEQUALITY

ELIZABETH TOBIN TYLER*

INTRODUCTION

“Medicolegal education in law and medical schools can give students a chance to discover ‘that the other group did not come congenitally equipped with either horns or pointed tails.’”¹

Stories of the antagonism between doctors and lawyers are deeply embedded in American culture. A 2005 New Yorker cartoon jokes, “Hippocrates off the record: First, treat no lawyers.”² The distrust and hostility are not new. A commentator noted in 1971:

The problem presented is an atmosphere of distrust, fear and antagonism—not all of which is unfounded. It is the result of lack of

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* Director of Public Service and Community Partnerships, and Lecturer in Public Interest Law, Roger Williams University School of Law (Bristol, RI). I would like to thank Dr. Patricia Flanagan, Dr. Jay Baruch, and Dr. Alicia Monroe from the Warren Alpert Medical School of Brown University for their willingness to venture with me into medical-legal teaching and for their invaluable assistance and support for this article. I also thank Dean David Logan, and my friend and colleague, Laurie Barron, for their constant support of this work. Special thanks to Ellen Lawton, Pamela Tames, Rebecca Kislak, Nancy Cook, and Maurine Tobin for their helpful comments and suggestions, and to Ken Rampino, Casey Williams, Joseph Loman, and Monika Bolino for their excellent research assistance.

1. Benjamin J. Naitove, Comment, *Medicolegal Education and the Crisis in Interprofessional Relations*, 8 AM. J.L. & MED. 293, 304 (1982) (quoting Frederic K. Spies et al., *Teaching Law Students in the Medical Schools*, 77 SURGERY 793, 795 (1975)).

2. Lee Lorenz, *Hippocrates Off the Record*, NEW YORKER, Mar. 7, 2005 (on file with author); accord John Gibeaut, *The Med-Mal Divide*, 91 A.B.A. J., Mar. 2006, at 39, 40 (“But for as much as they fear the justice system, many doctors just plain despise lawyers.”); Randy Retkin et al., *Lawyers and Doctors Working Together – A Formidable Team*, 20 HEALTH LAW., Oct. 2007, at 33 (explaining that doctors blame lawyers for the high price of medical malpractice insurance); Laura Parker, *Medical Malpractice Battles Get Personal*, U.S.A. TODAY, June 14, 2004, at 1A (“Some doctors are refusing medical treatment to lawyers, their families and their employees except in emergencies.”). See William M. Sage, *The Lawyerization of Medicine*, 26 J. HEALTH POL., POL’Y & L. 1179, 1181–84 (2001), for a historical summary of the divergence of the two professions.

communication; failure of understanding of basic professional objectives, methods, and philosophy of the co-professional; and above all, the mystique built up by ever-increasing malpractice insurance rates.³

Rather than focus on the divide between the professions over medical-malpractice lawsuits, some legal and medical practitioners and educators have begun to focus on what the professions have in common and what they have to offer one another. In fact, lawyers and doctors share many professional values. They both value professional autonomy and decision-making; both have a fundamental fiduciary duty to the individual client or patient;⁴ and “[b]oth professions have ethical aspirations and legal obligations to provide services to the community and individuals who cannot afford to pay them.”⁵

It is this third shared value—the aspiration and obligation of lawyers and doctors to provide services to the poor—that may offer the greatest potential for meaningful collaboration between the professions. In recent years both professions have begun to focus on the issue of social inequality and its effect on health and access to justice. The medical and legal professions are searching for ways to engage individual practitioners as well as their respective professional associations to better serve increasingly diverse and underserved populations. One of the most effective ways to address social disparity, and, in particular, its impact on children’s health, is for lawyers and doctors to join forces as advocates for poor families.⁶

Through a burgeoning medical-legal partnership movement, lawyers and doctors are finding that working together to serve poor clients and patients not only makes them more effective in addressing client/patient needs, but it also makes their professional lives more satisfying and fulfilling. In 1993, Dr. Barry Zuckerman, Chief of Pediatrics at Boston Medical Center, piloted a novel idea—developing a legal practice, the Family Advocacy Program, within the pediatric

3. Martin Lloyd Norton, *Development of an Interdisciplinary Program of Instruction in Medicine and Law*, 46 J. MED. EDUC. 405, 405 (1971).

4. *Tracy v. Merrell Dow Pharmaceuticals, Inc.*, 569 N.E.2d 875, 879 (Ohio 1991) (holding that physicians have a fiduciary duty to their patients); MODEL RULES OF PROF’L CONDUCT R. 1.6, 1.7 (2003) (establishing fiduciary duties for lawyers, such as the duty of confidentiality and prohibition on conflict of interest).

5. Peter D. Jacobson & M. Gregg Bloche, Commentary, *Improving Relations Between Attorneys and Physicians*, 294 JAMA 2083, 2084 (2005). Jacobson and Bloche conclude that “mutual distrust between attorneys and physicians impedes reasoned exploration of important health care delivery and policy issues. . . . A stable and rational health policy environment requires effective collaboration between the legal and medical professions.” *Id.* at 2085.

6. *See infra* Part I.

unit of the hospital to address social factors that impact poor children's health.⁷ Frustrated by social conditions that pediatricians alone could not address—unsafe housing conditions leading to lead paint poisoning, asthma and injury; lack of sustainable income affecting childhood nutrition; and poor access to educational and social services for children with special needs, just to name a few—Zuckerman hired a lawyer to collaborate with medical staff and to fight for poor families' legal rights.⁸

Nearly fifteen years later, his idea of the medical-legal partnership has taken off nationally. In 2006, Boston Medical Center received \$2.7 million in grants to replicate the program across the United States.⁹ As of this writing, there are sixty-six medical-legal partnerships in existence and an additional fourteen in development in the U.S.¹⁰ In August 2007, the Health Law Section of the American Bar Association recommended that the medical-legal partnership model be encouraged by the Association.¹¹

As medical-legal partnerships become more common as a way to address the social determinants of childhood health, one critical component in these programs will be to train law students and medical students to become effective practitioners who are sensitive to the connections between poverty, health, and law, and who can work collaboratively with interdisciplinary partners.¹² Recent reports from the Carnegie Foundation for the Advancement of Teaching, *Educating Lawyers: Preparation for the Profession of Law* and *American Medical Education 100 Years after the Flexner Report*, suggest that both legal and medical education focus too narrowly on knowledge-based learning and not enough on context-based problem-solving, professionalism, and ethics.¹³ Medical-legal education provides a unique

7. Carey Goldberg, *Boston Medical Center Turns to Lawyers for a Cure*, N.Y. TIMES, May 16, 2001, at A20; Sacha Pfeiffer, *BMC to go National with Legal Aid Program*, BOSTON GLOBE, Apr. 10, 2006, at A1.

8. See Barry Zuckerman et al., *Why Pediatricians Need Lawyers to Keep Children Healthy*, 114 PEDIATRICS 224, 224–25 (2004) (explaining the reasons that lawyers are needed in hospitals that primarily serve children from low-income families).

9. Pfeiffer, *supra* note 7.

10. Med.-Legal P'ship for Children, Medical-Legal Partnerships Nationwide (Sept. 2007), <http://www.mlpcforchildren.org/files/MLPC%20Site%20List%20September%202007.pdf>. While each program is based on the Boston model, the configuration of each program is different. For example, some are partnerships between legal services offices or law school clinical programs and hospitals or other medical settings serving low-income children and families. *Id.* See Jane R. Wettach, *The Law School Clinic as a Partner in a Medical-Legal Partnership*, 75 TENN. L. REV. 305 (2008), for a description of the benefits of law school clinical programs as partners in medical-legal partnerships. In addition, there are medical-legal partnerships which focus on issues other than child health, such as programs that serve patients with AIDS or cancer. Stewart B. Fleishman et al., *The Attorney as the Newest Member of the Cancer Treatment Team*, 24 J. CLINICAL ONCOLOGY 2123, 2123–24 (2006).

11. Paul R. DeMuro, *Report to the House of Delegates*, 2007 A.B.A. SEC. HEALTH L. REP. 120A.

12. See *infra* Part III.

13. WILLIAM M. SULLIVAN ET AL., CARNEGIE FOUND. FOR THE ADVANCEMENT OF TEACHING, *EDUCATING LAWYERS: PREPARATION FOR THE PROFESSION OF LAW* 191–92 (2007); Molly Cooke et al.,

opportunity to engage law and medical students in interdisciplinary problem-solving while also expanding their understanding of complex issues of social justice and inequality in our legal and health care systems.

From its inception, the Rhode Island Medical-Legal Partnership for Children (RIMLPC) has included a pedagogical component.¹⁴ Roger Williams University School of Law partners with the Warren Alpert Medical School of Brown University [hereinafter, "Brown Medical School"] to offer law and medical students a collaborative learning experience through a joint course, as well as legal externship and medical clerkship placements.¹⁵ Using the joint course as a model, this article explores a pedagogical approach to teaching law and medical students effective collaboration to achieve social justice and better health outcomes for poor children.

Drawing on the broader movements in legal and medical education which emphasize the teaching of ethics, social responsibility, and cultural competency in the lawyer-client and doctor-patient relationships, this article locates the RIMLPC academic approach within these broader goals. It then emphasizes the importance of interdisciplinary education for developing doctors and lawyers who can respond more holistically and effectively to increasingly diverse populations of clients and patients. It also explores the benefits and satisfaction interdisciplinary medical-legal education and practice bring to the students and practitioners themselves.

Part I describes in more detail the benefits of medical-legal partnerships for the families they serve as well as for lawyers and doctors who practice in them. Part II compares the recent calls from the legal and medical professions to more effectively serve disadvantaged populations. It also explores efforts by medical and law schools to incorporate the ethic of social responsibility into their curricula. Part III traces movements in both legal and medical education focused on the relationship between the practitioner and the client or patient. In both fields, educators are calling for more attention in the curriculum to teaching client/patient-centered counseling, ethical reflection, cultural competency, and interdisciplinary and holistic problem-solving to address complex client and patient problems. Part IV presents the RIMLPC model of interdisciplinary training for law and medical students which incorporates these pedagogical components. Part V discusses the interdisciplinary medical-legal seminar taught at Roger Williams University School of Law and Brown Medical School. The seminar was designed to introduce students to the connections between poverty, health and law, to explore ethical issues, and to practice interdisciplinary problem-solving. Finally, Part VI highlights

American Medical Education 100 Years After the Flexner Report, 355 NEW ENG. J. MED. 1339, 1341 (2006).

14. See R.I. Med.-Legal P'ship for Children, <http://www.rifap.org/index.cfm> (last visited May 5, 2008).

15. See *infra* Parts IV, V.

some of the barriers to interdisciplinary teaching in medical and law schools and presents ways to overcome them in order to reap the benefits to students, practitioners, and educators.

I. POVERTY, HEALTH AND LAW: THE BENEFITS OF MEDICAL-LEGAL PARTNERSHIP

The connection between poverty and health is typically understood in terms of access to proper health care. Poor people may have difficulty improving their health because they don't have health insurance or they can't access quality health services.¹⁶ But the connection between poor health and economic, social, and environmental factors is far more complex than access and is often overlooked by our health care and legal systems.¹⁷ Discussion of the social determinants of health is becoming more prevalent in academia and in legal and policy circles.¹⁸

As Dr. Barry Zuckerman describes it, “[c]hild health is inherently dependent on the social well-being of the family. Social and non-medical factors influence the development of childhood disease and the severity of the disease once it develops.”¹⁹ A child's chronic illness can affect a parent's ability to work, thus exacerbating economic instability. Poverty, and all that goes with it—substandard housing, nutritional deprivation, lack of access to adequate health and educational services—can make the individual pediatrician's job of treating a child's health problems seem insurmountable.

Access to lawyers, armed with knowledge about eligibility requirements for public benefits, educational rights of children with special needs, and tenants' rights to safe housing, can help dismantle some of those seemingly insurmountable

16. KARYN SCHWARTZ, HENRY J. KAISER FAMILY FOUND., HOW TRENDS IN THE HEALTH CARE SYSTEM AFFECT LOW-INCOME ADULTS: IDENTIFYING ACCESS PROBLEMS AND FINANCIAL BURDENS 1 (2007), available at <http://www.kff.org/uninsured/upload/7705.pdf>.

17. “Health is produced not merely by having access to medical prevention and treatment, but also—to a measurably greater extent—by the cumulative experience of social conditions over the course of one's life. . . . Much contemporary discussion about reducing health inequalities by increasing access to medical care misses this point.” Norman Daniels, *Justice, Health, and Healthcare*, 1 AM. J. BIOETHICS 2, 6 (2001); see also LU ANN ADAY, AT RISK IN AMERICA: THE HEALTH AND HEALTH CARE OF VULNERABLE POPULATIONS IN THE UNITED STATES 91–116 (2001).

18. See Mary Anne Bobinski, *Health Disparities and the Law: Wrongs in Search of a Right*, 29 AM. J.L. & MED. 363, 373–74 (2003) (“Socioeconomic status, as measured either by income or level of education, is strongly correlated with health status.”). Bobinski points out that efforts by the legal community to address disparities in health, such as public health regulation, are often met with frustration. See *id.* at 376. While attempting to hold health care systems more accountable to low-income populations or regulating industries such as tobacco may help prevent some health problems, these approaches do little to address the more complex problem of health disparity, which has its roots in broader social inequity. *Id.* at 379–80.

19. Zuckerman et al., *supra* note 8, at 224. See Steven Parker et al., *Double Jeopardy: The Impact of Poverty on Early Child Development*, 35 PEDIATRIC CLINICS N. AM. 1227 (1988), for an in-depth discussion of the impact of poverty on early childhood development.

barriers. Lawyers can also work with physicians to help them advocate more effectively for their patients by helping them to craft more persuasive letters to schools or government agencies about a child's needs. Working collaboratively with physicians can make a lawyer's job easier and more effective, as well. Having the expertise of a physician to testify or write an affidavit about the health effects of a landlord's failure to fix a leaky pipe or to abate lead paint hazards, for example, can provide stronger evidence in a difficult case.²⁰

The concept of medical-legal collaboration to address the connections between poverty and child health has not only opened up more effective ways to address social problems. It has also helped the professions envision a new role for doctors and lawyers, thus making their work more meaningful and more satisfying. By partnering lawyers and physicians to address the broader context affecting the health and stability of families and children, practitioners become holistic problem-solvers, not narrow specialists.²¹ In a sense, doctors become advocates for their patients and lawyers become healers for their clients. Lawyers, particularly legal services lawyers, often despair that they come to a problem long after any legal solution can make a meaningful difference in a client's life.²² By working collaboratively with medical professionals, lawyers can practice "preventive law."²³

As Zuckerman notes, one of the first points of contact for poor families when a child is born is their pediatrician: "The best way to help children is to help their parents, and the best way to reach parents is through their children."²⁴ If the pediatrician builds a relationship of trust with the parents, s/he often has a unique opportunity to address concerns before they cause health problems for the child.²⁵ Working with a physician to identify and address a legal problem early, a lawyer has the opportunity to provide support to a family before the problem reaches a

20. See David K. Shipler, *Total Poverty Awareness*, N.Y. TIMES, Feb. 21, 2004, at A15 and Sylvia Pagan Westphal, *Lawyers Help Patients Solve Problems*, WALL ST. J., Apr. 11, 2006, at D3, for further discussions of the benefits of medical-legal collaboration in addressing poverty and the Boston Medical Center model.

21. See *infra* Part III.C.

22. See Ellen M. Lawton, *The Family Advocacy Program: A Medical-Legal Collaborative to Promote Child Health and Development*, MGMT. INFO. EXCH. J., Summer 2003, at 12, 13 ("[L]egal advocates typically see a case after a crisis has already emerged—the family receives an eviction notice, or a child's illness results in job loss. There is no comparable provision for a 'legal check-up' or 'preventive legal care.'").

23. See Ellen M. Lawton, *Medical-Legal Partnerships: From Surgery to Prevention?*, MGMT. INFO. EXCH. J., Spring 2007, at 37, 37–38 (describing the medical-legal clinic setting "as the gateway to preventive law for the legal services population, [helping] families . . . get access to the legal help they need before the crisis of eviction or job loss that would typically lead them to legal services.").

24. Lawton, *supra* note 22, at 12 (quoting Dr. Barry Zuckerman, Chief of Pediatrics, Boston Medical Center).

25. See *id.* at 12–13 (explaining that many low-income families believe that their pediatrician is their most trustworthy source of information).

crisis point.²⁶ Catching problems early may make the lawyer's advocacy more meaningful and permanent. Similarly, pediatricians are more likely to ask about and respond to the systemic problems that affect child health if they have the support and expertise of a lawyer who can offer solutions or training in available remedies.

The medical-legal partnership empowers doctors and lawyers to serve their patients and clients in ways that they, in isolation, could never do. It gives doctors tools for addressing those questions they fear to ask.²⁷ It gives a lawyer the opportunity to focus time and resources on a client in a more holistic way, taking advantage of the resources and knowledge of the physician.²⁸ Finally, it opens a new door for both professions to revisit ethical questions—what is the social responsibility of physicians and lawyers for serving the poor? How can each profession be more effective in serving those who are often left out of the system? What are the boundaries of the professional role? How can the professions shift their focus toward prevention?²⁹

II. SOCIAL RESPONSIBILITY: THE ROLE OF THE LEGAL AND MEDICAL PROFESSIONS IN ADDRESSING INJUSTICE AND DISPARITY

In the last decade, there has been heightened awareness, in both law and medicine, of the need for professional responsibility for the poor and disenfranchised. In the legal profession, attention has focused on unmet legal need and a recognition that access to legal services is severely restricted by the inability to pay. In the medical profession, the focus has been on health disparities by race, ethnicity, and socioeconomic status. Each profession continues to struggle with how to address social disparity and with how to define the professional obligations of individual practitioners in meeting the needs of disadvantaged populations.³⁰

26. Lawton, *supra* note 23, at 37–38.

27. Lawton, *supra* note 22, at 14–15 (“Repeatedly, health care providers report an unwillingness to screen for an issue when there is no clear resource for referral if the screening is positive. . . . [H]aving access to a lawyer ensures the availability of information and assistance for particular problems that go beyond a pediatrician, nurse or social worker’s ability or time to solve.”).

28. *Id.* at 13 (“Because of their expertise in evaluating and screening, pediatric health care providers can act as legal sentinels—spotting red flags for legal issues BEFORE they turn into a crises . . .”).

29. Because the practice of pediatric medicine is frequently oriented around the preventive model, the medical-legal partnership fits well within medical practice focused on children. Zuckerman et al., *supra* note 8, at 227.

30. See DEBORAH L. RHODE, *PRO BONO IN PRINCIPLE AND IN PRACTICE: PUBLIC SERVICE AND THE PROFESSIONS* 73–81 (2005), for an excellent discussion comparing the historical developments in the legal and medical professions with regard to professional obligations to serve the indigent.

A. Law

A national study conducted by the American Bar Association in 1994 concluded that low-income people received legal assistance for “roughly one in five of all legal problems identified.”³¹ In 2005, the Legal Services Corporation (LSC) published a report, *Documenting the Justice Gap in America*, which found that for every client served by a legal services program funded by the LSC, at least one person who sought help could not be served because of a lack of resources.³² Recently, there have been calls in some corners of the legal profession for a “Civil Gideon.” *Gideon v. Wainwright* is the Supreme Court case recognizing the right of criminal defendants to have counsel appointed by the state when they are unable to pay for private counsel.³³ “Civil Gideon” would guarantee the right of counsel for the poor in certain civil proceedings.³⁴ Many still believe that guaranteed counsel for civil matters is a long way from being realized.³⁵

The American Bar Association has become increasingly outspoken about the need for lawyers in private practice to fill the gap in legal services for the poor. In 1983, the American Bar Association House of Delegates adopted Model Rule 6.1 of the ABA Model Rules of Professional Conduct, which stated that a lawyer “should render public interest legal service.”³⁶ In 1993, the rule was amended to specify that lawyers should serve low-income people without charge as well as perform other forms of volunteer legal service.³⁷ The current Rule 6.1 sets an aspirational goal for pro bono publico: “Every lawyer has a professional responsibility to provide legal services to those unable to pay. A lawyer should aspire to render at least (50) hours of pro bono publico legal services per year.”³⁸ Some states have adopted the rule in its entirety; others have modified versions.³⁹

31. LEGAL SERVS. CORP., DOCUMENTING THE JUSTICE GAP IN AMERICA 2 (2005), available at <http://www.lsc.gov/JusticeGap.pdf> (summarizing the findings of the Comprehensive Legal Needs Study funded by the ABA and released in 1994).

32. *Id.* at 3–4.

33. *Gideon v. Wainwright*, 372 U.S. 335, 343–45 (1963).

34. Russell Engler, *Toward a Context-Based Civil Right to Counsel Through “Access to Justice” Initiatives*, 40 CLEARINGHOUSE REV. 196, 196 (2006).

35. See Laura K. Abel, *A Right to Counsel in Civil Cases: Lessons from Gideon v. Wainwright*, 40 CLEARINGHOUSE REV. 271, 271 (2006) (discussing difficulties in implementing the right to counsel in criminal proceedings and cautioning that “[a]ny exploration of a civil right to counsel . . . must be based on an understanding of the criminal right-to-counsel experience”).

36. MODEL RULES OF PROF’L CONDUCT R. 6.1 (1983); accord AM. BAR ASS’N STANDING COMM. ON PRO BONO AND PUBLIC SERV., AM. BAR ASS’N, SUPPORTING JUSTICE: A REPORT ON THE PRO BONO WORK OF AMERICA’S LAWYERS 6 (2005).

37. MODEL RULES OF PROF’L CONDUCT R. 6.1 (1994).

38. MODEL RULES OF PROF’L CONDUCT R. 6.1 (2006).

39. AM. BAR ASS’N STANDING COMM. ON PRO BONO AND PUBLIC SERV., *supra* note 36, at 6. Seventeen states have adopted the rule verbatim or with minor modifications; twenty-six states have adopted a version of the 1983 rule. *Id.*; e.g., ALASKA STAT. RULES OF PROF’L CONDUCT 6.1 (1999 & Supp. 2007) (adopting Rule 6.1 word-for-word). Some states or bar associations have adopted policies

These rules have met with limited success. A 2005 survey by the ABA, *Supporting Justice: A Report on the Pro Bono Work of America's Lawyers*, found that only 66% of the attorneys surveyed said that they did some pro bono work and it was determined that, on average, each attorney provided thirty-nine hours of free pro bono service to poor individuals or organizations serving the poor as well as an additional thirty-eight hours of service for other non-profits, civil rights groups and activities aimed at improving the legal profession.⁴⁰

LSC has also called for increased private attorney involvement in addressing the unmet legal needs of the poor. In April 2007, LSC published an action plan for private attorney involvement for its grantee legal services agencies which includes strategies for partnering with the private bar, the judiciary, and law schools.⁴¹

Some legal commentators, frustrated by the lack of voluntary response from the private bar to the need for pro bono service, have argued that lawyers should be mandated to provide a specified amount of pro bono service each year.⁴² These arguments are usually framed around two concepts: that "access to legal services is a fundamental need" and that "lawyers have some responsibility to help make those services available."⁴³ The arguments range from the idea that lawyers have a government sponsored monopoly on the practice of law and therefore have an obligation to serve those without access to the system, to the idea that lawyers have a moral obligation to poor clients.⁴⁴

Opponents of mandatory pro bono argue that while it is the moral obligation of lawyers to serve the poor, mandating that they do so is unrealistic and an inefficient means of solving the problem.⁴⁵ Still others claim that mandatory pro bono violates the constitutional rights of attorneys.⁴⁶ Some reject the idea that pro bono service is part of the lawyer's professional obligation at all. They argue that

with aspirational pro bono rules or, in some cases, requirements for memberships. AM. BAR ASS'N STANDING COMM. ON PRO BONO AND PUBLIC SERV., *supra* note 36, at 6; *e.g.*, VA. CODE ANN., SUP. CT. R. 6.1 (2005).

40. AM. BAR ASS'N STANDING COMM. ON PRO BONO AND PUBLIC SERV., *supra* note 36, at 11, 13.

41. Legal Servs. Corp., LSC 2007 Action Plan for Private Attorney Involvement 2 (2007), http://www.lri.lsc.gov/LRI/LSC_2007_Action_Plan_for_PAI.pdf.

42. Barlow F. Christensen, *The Lawyer's Pro Bono Publico Responsibility*, 6 AM. BAR. FOUND. RES. J. 1, 16-19 (1981); *see also* Jennifer Murray, Comment, *Lawyers Do It for Free? An Examination of Mandatory Pro Bono*, 29 TEX. TECH L. REV. 1141, 1148 (1998) (outlining the arguments in favor of mandatory pro bono legal services).

43. Deborah L. Rhode, *Cultures of Commitment: Pro Bono for Lawyers and Law Students*, in ETHICS IN PRACTICE: LAWYERS' ROLES, RESPONSIBILITIES, AND REGULATION 264, 265 (Deborah L. Rhode ed., 2000).

44. Kellie Isbell & Sarah Sawle, Current Developments, *Pro Bono Publico: Voluntary Service and Mandatory Reporting*, 15 GEO. J. LEGAL ETHICS 845, 851 (2002).

45. Denise R. Johnson, *The Legal Needs of the Poor as a Starting Point for Systemic Reform*, 17 YALE L. & POL'Y REV. 479, 483 (1998); Murray, *supra* note 42, at 1162-63 (discussing the administrative difficulties and functional objections to mandatory pro bono service).

46. Murray, *supra* note 42, at 1156.

legal service to the poor is society's burden, not the professional responsibility of the individual lawyer to address.⁴⁷

B. Medicine

Like the legal profession, the medical profession has begun to focus on disparate treatment of people by the health care system based on race, ethnicity and socioeconomic status.⁴⁸ Just as the ABA and the LSC have documented disparities in legal service to the poor, studies of the health care system reveal substantial disparities based on socioeconomic status as well as race and ethnicity. *Healthy People 2010*, a 2000 report by the U.S. Department of Health and Human Services, notes the correlation between health and social determinants such as poverty and the lack of access to education and medical care:

In general, population groups that suffer the worst health status are also those that have the highest poverty rates and the least education. Disparities in income and education levels are associated with differences in the occurrence of illness and death, including heart disease, diabetes, obesity, elevated blood lead level, and low birth weight. Higher incomes permit increased access to medical care, enable people to afford better housing and live in safer neighborhoods, and increase the opportunity to engage in health-promoting behaviors.⁴⁹

In 2002, the Institute of Medicine (IOM) of the National Academies released a report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*,⁵⁰ documenting wide disparities in health care. The report finds that racial and ethnic disparities in health care are substantial, even after accounting for differences in access to health care caused by lack of insurance or ability to pay.⁵¹ In the U.S., "racial and ethnic minority patients are found to receive a lower quality and intensity of healthcare and diagnostic services across a wide range of procedures and disease areas."⁵² The report points squarely at practitioners as part

47. Charles Fried, *The Lawyer as Friend: The Moral Foundations of the Lawyer-Client Relation*, 85 YALE L.J. 1060, 1079–80 (1976); see also DAVID LUBAN, *LAWYERS AND JUSTICE: AN ETHICAL STUDY* 246 (1988).

48. INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 35 (Brian D. Smedley et al. eds., 2003).

49. U.S. DEP'T OF HEALTH & HUMAN SERVS., *HEALTHY PEOPLE 2010: UNDERSTANDING AND IMPROVING HEALTH* 12 (2d ed. Nov. 2000); accord Alexander R. Green et al., *Integrating Social Factors into Cross-Cultural Medical Education*, 77 ACAD. MED. 193, 193 (2002) ("Lower socioeconomic status is arguably one of the most powerful single contributors to premature morbidity and mortality in the United States and worldwide.").

50. INST. OF MED., *supra* note 48.

51. *Id.* at 79.

52. *Id.* at 77. The committee recognized, however, that the connection between race, ethnicity, and poverty cannot be ignored. *Id.* at 123 ("This persistent pattern of inequality suggests that interventions to eliminate disparities must be comprehensive and sustained, and that raising public and healthcare provider awareness of the problem is an important first step.").

of the problem, concluding that health provider “[b]ias, stereotyping, prejudice and clinical uncertainty . . . may contribute to racial and ethnic disparities in healthcare.”⁵³

The report highlights two places where diverse patients may encounter problems: (1) the healthcare system and regulatory climate (including such concerns as the lack of interpretation services for patients with limited English)⁵⁴ and (2) the clinical encounter (including issues of bias by the health care provider and patients’ reaction to physician behavior).⁵⁵ The IOM committee offers several recommendations for the medical profession to address the problem of health disparities, physician bias, and unequal treatment.⁵⁶ First, it calls for cross-cultural education of medical professionals.⁵⁷ Second, it calls for better data collection on patient and provider race to “disentangle factors that are associated with healthcare disparities.”⁵⁸ In addition, the committee concludes that strategies should include less fragmentation of health care for low-income patients, increased interventions to promote better clinical encounters between physician and patient, such as interpretation services, and recruitment of more minority health care providers.⁵⁹

Just as the legal profession has struggled with ways to inculcate a sense of personal and professional responsibility for the poor and other disadvantaged groups, the medical profession is searching for ways to address disparities in health care among the poor and racial and ethnic minorities. The American Medical Association (AMA), like the American Bar Association (ABA), emphasizes in its professional code the individual physician’s obligation to provide care for indigent patients. The language of the AMA Code of Ethics 9.065 is strikingly similar to ABA Rule 6.1: “Each physician has an obligation to share in providing care to the

53. *Id.* at 178.

54. *Id.* at 125–59.

55. *Id.* at 160–79.

56. *Id.* at 6–23. Legal analysts have also begun to focus on physician bias and its effect on patient care and decision-making. Mary Crossley, *Infected Judgment: Legal Responses to Physician Bias*, 48 VILL. L. REV. 195, 197 (2003).

57. INST. OF MED., *supra* note 48, at 19–20.

58. *Id.* at 21.

59. *Id.* at 13–14, 17. The legal profession has also called for increasing the number of minority lawyers as a way to address racism in broader society. The mission statement of the ABA’s Commission on Racial and Ethnic Diversity in the Profession is to serve as a “catalyst for creating leadership and economic opportunities for racially and ethnically diverse lawyers within the ABA and the legal profession.” Am. Bar Ass’n, <http://www.abanet.org/minorities> (last visited May 5, 2008). Further the Commission “provide[s] a voice to surface and tackle issues of discrimination, racism and bigotry, and to inspire the ABA and the profession to value differences, to be sensitive to prejudice, and to reflect the society they serve.” *Id.* The IOM recommendations have been echoed by others who argue that anticipated demographic changes make critical the need for interventions such as minority recruitment to the medical profession, interpreter services and provider education on cross-cultural issues. *E.g.*, Joseph R. Betancourt et al., *Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care*, 118 PUB. HEALTH REPS. 293, 297–99 (2003).

indigent All physicians should work to ensure that the needs of the poor in their communities are met. Caring for the poor should be a regular part of a physician's practice schedule."⁶⁰ The Code stops short of the ABA's aspirational goal of 50 hours per attorney,⁶¹ but makes it clear that physicians have a responsibility to the poor in their communities.⁶²

But like the legal profession, incorporating pro bono into the private practitioner's schedule has been difficult. In fact, because of the health care system's reliance on insurance and managed care, physicians are even less likely than lawyers to offer individual pro bono services to the poor.⁶³ While the federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires that emergency medical departments provide a medical screening and treat emergencies regardless of ability to pay,⁶⁴ primary care for the poor generally depends on their eligibility for government funded programs.⁶⁵ Because the Medicaid and Medicare programs, focused on the very poor, disabled, and elderly are so intricately woven into the American health care system, some argue that they have contributed to the medical profession's movement away from the notion of a professional obligation of individual physicians to provide free indigent care.⁶⁶ "[W]hy emphasize the charitable obligations of physicians and potentially let government off the hook?"⁶⁷

Nonetheless, some see a renewed focus on public service and professional obligation rising in the medical profession.⁶⁸ To instill an ethic of social responsibility for the poor, the medical profession, like the legal profession, has begun to turn to the education of young doctors as a way to reinvigorate the notion of the individual physician's professional responsibility and to explore how best to incorporate pro bono into practice.

60. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS'N, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS 284-85 (2006).

61. *Id.* In 1992 the AMA rejected an ethics committee recommendation that physicians devote ten percent of their income or 50 hours per year to serving the poor. Rhode, *supra* note 43, at 76.

62. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, *supra* note 60, at 284-85. A 1994 advisory opinion expanded on the obligation by listing examples of how doctors can treat the indigent: treating a patient at no cost or reduced cost, and/or offering pro bono time at hospitals, clinics or shelters. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS'N, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS 138 (1994) (discussing the findings of a report written by the AMA entitled "*Caring for the Poor*"). The advisory opinion suggests that the amount of time offered by an individual doctor will vary according the circumstances of his/her practice. *Id.*

63. Rhode, *supra* note 43, at 78.

64. 42 U.S.C. §§ 1395dd(a)-(b)(1) (2000).

65. See Rhode, *supra* note 43, at 75 ("[T]ens of millions of individuals do not qualify for Medicare or Medicaid benefits, lack health insurance, and are unable to afford private care.").

66. See Rhode, *supra* note 43, at 75.

67. Sage, *supra* note 2, at 1188.

68. Retkin et al., *supra* note 2, at 33-34.

C. *Legal Education*

The debate over mandatory pro bono for practicing attorneys has taken a different route in the legal academy. For the past decade, the ABA and the American Association of Law Schools (AALS) have been promoting the importance of incorporating pro bono service into the law school experience. In 1996, the ABA amended its Accreditation Standards to provide that “[a] law school should encourage its students to participate in pro bono activities and provide opportunities for them to do so.”⁶⁹ The accreditation standard for curriculum was amended in 2006 to provide that “a law school shall offer substantial opportunities for . . . student participation in pro bono activities.”⁷⁰

Similarly, in 1999 the AALS Commission on Pro Bono and Public Service Opportunities issued a report which recommended “that law schools make available to all law students at least once during their law school careers a well-supervised law-related pro bono opportunity and either require the students’ participation or find ways to attract the great majority of students to volunteer.”⁷¹ Partly, in response to these pleas from the ABA and AALS, law school pro bono programs have flourished in the past ten years, with some schools adopting mandatory pro bono graduation requirements. In 2001, to track the development of pro bono programs in law schools, AALS published a handbook on law school pro bono programs.⁷²

The rationales for encouraging law schools to adopt mandatory pro bono requirements vary. Some argue that law schools should play an important role in addressing unmet legal need in the communities in which they exist.⁷³ Law students learn important legal and personal skills as well as the value and ethic of pro bono service.⁷⁴ Others suggest that to achieve this greater understanding by law students about the needs of the poor, pro bono programs “should not be marginal

69. Office of the Consultant on Legal Educ., *Standards for Approval of Law Schools and Interpretations*, 1996 A.B.A. SEC. LEGAL EDUC. & ADMISSIONS BAR 31.

70. Office of the Consultant on Legal Educ., *Standards and Rules of Procedure for Approval of Law Schools*, 2006 A.B.A. SEC. LEGAL EDUC. & ADMISSIONS BAR 18.

71. ASS’N OF AM. LAW SCHS., *LEARNING TO SERVE: THE FINDINGS AND PROPOSALS OF THE AALS COMMISSION ON PRO BONO AND PUBLIC SERVICE OPPORTUNITIES* 7 (1999).

72. ASS’N OF AM. LAW SCHS., *A HANDBOOK ON LAW SCHOOL PRO BONO PROGRAMS* 6–7 (2001), available at <http://www.aals.org/probono/probono.pdf>. Currently, there are thirty-five law schools that require some type of pro bono or community service work to graduate; eighteen of those require that the work be law-related and not receive academic credit. Standing Comm. Pro Bono & Pub. Serv. et al., Am. Bar Ass’n, *Chart of Law School Pro Bono Programs* (Aug. 15, 2007), http://www.abanet.org/legalservices/probono/lawschools/pb_programs_chart.html.

73. Caroline Durham, *Law Schools Making a Difference: An Examination of Public Service Requirements*, 13 *LAW & INEQ.* 39, 49 (1994).

74. Christina M. Rosas, Note, *Mandatory Pro Bono Publico for Law Students: The Right Place to Start*, 30 *HOFSTRA L. REV.* 1069, 1071 (2002) (“Mandatory pro bono requirements are a useful tool in law school curricula for instilling a greater understanding of the importance of pro bono work in the profession’s newest recruits.”).

components of a law school's mission; [instead,] [t]hey must be interwoven into the fabric of curriculum, programs, and scholarship of the faculty, and become more central to the future vision of legal educational institutions."⁷⁵ Arguments against mandatory law student pro bono programs have mirrored those against mandatory attorney pro bono: mandatory service is an infringement of students' constitutional rights,⁷⁶ or an ineffective approach to the problem of unmet legal needs.⁷⁷

But the debate about mandatory pro bono programs is not the only place that the role of law students in serving the poor arises. In 1992, the ABA published a report known as the *MacCrate Report*, which proposed a list of fundamental lawyering skills and values, including promoting justice and fulfilling the profession's responsibility for ensuring that legal services are provided to the poor.⁷⁸ To accomplish this, the ABA suggested that:

Law school deans, professors, administrators and staff should be concerned to convey to students that the professional value of the need to 'promote justice, fairness and morality' is an essential ingredient of the legal profession and the practicing bar should be concerned to impress on students that success in the practice of law is not measured by financial rewards alone, but by a lawyer's commitment to a just, fair and moral society.⁷⁹

Many law schools have addressed the need to teach law students the importance of serving the poor through curriculum focused on poverty law and

75. David Hall, *The Law School's Role in Cultivating a Commitment to Pro Bono*, 42 BOSTON BAR J. 4, 4 (1998). Hall goes on to argue that mandatory pro bono programs in law schools are "not the equivalence of academic penance." *Id.* at 20. Instead, Hall urges that pro bono "graduation requirements are premised on a sound educational principle. If students are exposed to helping those who can't afford an attorney, and exposed to the type of legal problems the poor face in this country, there is a greater probability that they will be inclined to do this type of work once they become lawyers." *Id.*

76. Rosas, *supra* note 74, at 1078–84.

77. Rhode, *supra* note 43, at 40–41.

78. Task Force Law Schs. & Profession, *Statement of Fundamental Lawyering Skills and Professional Values*, 1992 A.B.A. SEC. LEGAL EDUC. & ADMISSIONS BAR 93. Specifically, Value 2 reads:

As a member of a profession that bears 'special responsibilitie[s] for the quality of justice,' a lawyer should be committed to the values of:

Promoting Justice, Fairness, and Morality in One's Own Daily Practice

. . . .

Contributing to the Profession's Fulfillment of its Responsibility to Ensure that Adequate Legal Services Are Provided to Those Who Cannot Afford to Pay for Them;

Contributing to the Profession's Fulfillment of its Responsibility to Enhance the Capacity of Law and Legal Institutions to Do Justice.

Id. (alteration in original) (citation omitted).

79. AM. BAR ASS'N, LEGAL EDUCATION AND PROFESSIONAL DEVELOPMENT – AN EDUCATIONAL CONTINUUM 333 (1992).

issues of equal justice.⁸⁰ They have also expanded opportunities for students through clinical legal education, in which law students serve underrepresented clients and community organizations under the supervision of a faculty member.⁸¹ Law students also receive hands-on training in serving low-income and underserved populations through externship programs where they work under the supervision of an attorney in a non-profit legal services office or government agency.⁸²

D. Medical Education

Similar to the goals of the ABA's *MacCrate Report*, which identified core skills and values that law students should receive in law school, the Association of American Medical Colleges (AAMC) and the Accreditation Council for Graduate Medical Education (ACGME) have developed core competencies for medical students which include an emphasis on professional responsibility and engagement with issues of social inequity. For example, in 2000 the AAMC Core Curriculum for medical residents sets goals for teaching residents that they should "use their influence to improve the health of the communities where they live and practice" and they should "understand the roles that physicians can play in meeting the health care needs of the poor in addressing health inequities that exist between different populations in the society and in promoting the general health of the public."⁸³ To do this, "[r]esidents should be able to serve as the patient's advocate . . . to provide care to all, regardless of ability to pay; and to know about community health care needs and resources."⁸⁴

One approach to incorporating the social determinants of health into the curriculum and teaching medical students to understand health in its broader social context is to "revisit" the common understanding of a patient's "social history." In *Revisiting the Social History for Child Health*, the authors argue that medical students should be taught to ask a patient or caregiver a range of questions about

80. See Larry R. Spain, *The Unfinished Agenda for Law Schools in Nurturing the Commitment of Pro Bono Legal Services by Law Students*, 72 UMKC L. REV. 477, 480-91 (2003), for discussion of curricular reform to address social justice concerns.

81. E.g., Univ. of Md. Sch. of Law, Cardin Requirement, <https://www.law.umaryland.edu/publicservice/cardin.html> (last visited May 6, 2008).

82. See Russell Engler, *From the Margin to the Core: Integrating Public Service Legal Work into the Mainstream of Legal Education*, 40 NEW ENG. L. REV. 479 (2006), for an excellent discussion of the value of each of these approaches and the need for more coherence in law school programs aimed at equal justice.

83. ASS'N AM. MED. COLLS. ET AL., GRADUATE MEDICAL EDUCATION CORE CURRICULUM 11 (2000).

84. Jack Coulehan et al., *The Best Lack All Conviction: Biomedical Ethics, Professionalism, and Social Responsibility*, 12 CAMBRIDGE Q. HEALTHCARE ETHICS 21, 27 (2003) (citation omitted).

social domains.⁸⁵ They suggest using the mnemonic, “IHELLP” as a guide, which stands for “income, housing/utilities, education, legal status/immigration, literacy and personal safety”⁸⁶

Like the movement in legal education toward development of mandatory or, at least, voluntary pro bono programs, medical education has also begun to emphasize hands-on community service as critical to the development of good doctors. Although perhaps not as far along in formalizing public service in the curriculum as law schools, there is evidence that service learning is taking off in medical school programs. The AAMC has a proposed accreditation standard that demands that medical schools provide opportunities for service learning to their students.⁸⁷ Similar to ABA Accreditation Standard 302(b)(2),⁸⁸ the AAMC standard makes it clear to medical schools that they should promote and support public service opportunities.⁸⁹ Some in the medical field would like to see the standards have more teeth, similar to the mandatory language of the ABA’s 302(b)(2) that directs medical schools to incorporate public service and professional responsibility into the curriculum: “It is not unreasonable to expect the AAMC and ACGME, along with medical schools and other professional organizations, to flesh out their

85. Chen Kenyon et al., *Revisiting the Social History of Child Health*, 120 PEDIATRICS e734, e735–36 (2007), available at <http://pediatrics.aappublications.org/cgi/reprint/120/3/e734>.

86. *Id.* at e736.

87. ASS’N OF AM. MED. COLLS. ET AL., *supra* note 83, at 11–12. Specifically the *AAMC New Standard on Service Learning* states:

Medical schools should make available sufficient opportunities for medical students to participate in service-learning activities, and should encourage and support student participation.

“Service-learning” is defined as a structured learning experience that combines community service with preparation and reflection. Students engaged in service-learning provide community service in response to community-identified concerns and learn about the context in which service is provided, the connection between their service and their academic coursework, and their roles as citizens and professionals.

“Sufficient opportunities” means that students who wish to participate in a service learning activity should have the opportunity to do so. To encourage student participation, medical schools could do such things as developing opportunities in conjunction with relevant communities or partnerships, providing information about available opportunities, offering elective credit for participation, or holding presentations or public forums. Support for student participation could include offering or providing information about financial and social support for student service-learning (such as stipends, faculty preceptors, community partnerships).

LIAISON COMM. MED. EDUC., FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL: STANDARDS FOR ACCREDITATION OF MEDICAL EDUCATION PROGRAMS LEADING TO THE M.D. DEGREE 10–11 (2007), available at <http://www.lcme.org/functions2007jun.pdf>.

88. Office of the Consultant on Legal Educ., *Standards and Rules of Procedure for Approval of Law Schools*, 2007–2008 A.B.A. SEC. LEGAL EDUC. & ADMISSIONS BAR 19–20 (“A law school shall offer substantial opportunities for . . . student participation in pro bono activities . . .”).

89. LIAISON COMM. MED. EDUC., *supra* note 87, at 10–11.

current recommendations with an escalating series of carrot-and-stick (especially stick) requirements over the next few years.”⁹⁰

Regardless of whether there is a carrot or stick by accrediting bodies, some medical schools have developed opportunities for students to engage in public service. According to Deborah Rhode, “[o]nly five of the nation’s [twenty] top-ranked medical schools advertise these opportunities. However, foundations and medical societies, including the AMA and American Medical Student Association, are actively promoting such programs.”⁹¹ The goals of service learning in medical schools are similar to those of law schools: to give students a hands-on experience which will make them more likely to offer pro bono assistance in their careers and enhance their skills in serving patients in diverse communities.⁹² Additionally, like law schools, medical schools have developed course offerings and clerkship opportunities that focus on the social context of medicine and the doctor’s role in serving diverse communities.⁹³

III. MEDICAL & LEGAL EDUCATION: NEW APPROACHES TO DOCTORING AND LAWYERING

One thing is clear from the reforms being made in both legal and medical education: both professions are reassessing the way that they train law and medical students in light of the changing client and patient populations. As discussed above, both fields are emphasizing training in ethics by instilling a sense of social responsibility through curricula and public service programs. But educators in law and medicine are also calling for more curricula exploring the ethical dimensions of the doctor/patient and lawyer/client relationship. Amid fears that professional specialization in both law and medicine has left students ill-prepared for effectively serving their clients and patients, especially those with complex needs such as the poor, some are advocating reforms in the way that society prepares the next generation of lawyers and doctors.

A. *Client- and Patient-Centered Counseling: Narrative Listening*

Among both legal and medical academics and practitioners, there has been a growing chorus of critics of the trend in both professions toward specialization⁹⁴ at

90. Coulehan et al., *supra* note 84, at 29.

91. Rhode, *supra* note 30, at 80–81.

92. *Id.* at 81.

93. *E.g.*, Ass’n of Am. Med. Colls., Curriculum Directory, <http://www.services.aamc.org/currdir/> (last visited May 6, 2008); Stanford Sch. of Med., Public Service and Community Partnerships, <http://med.stanford.edu/community/service> (last visited May 6, 2008); Univ. of Md. Sch. of Med., Community Outreach, <http://medschool.umaryland.edu/community.asp> (last visited May 6, 2008).

94. Memorandum from Carl A. Sirio, Chair of Council on Med. Educ., on Impact of Increasing Specialization and Declining Generalism in the Medical Profession to the Reference Comm. C (2006) (on file with the Journal of Health Care Law & Policy) (examining the advantages and disadvantages of

the expense of the professional to client or patient relationship. Legal and medical educators argue that students need to be trained not just in the technicalities of their professions—medical diagnoses and legal principles—but also in how to effectively communicate and serve their patients as human beings.

1. Law

Initially introduced in 1977 by David Binder and Susan Price in a legal interviewing and counseling textbook, the theory of client-centered counseling “quickly emerged as the leading model of client counseling in American law schools.”⁹⁵ The client-centered approach to legal counseling “seeks to minimize lawyer influence on client decision-making However some proponents of client-centered representation seek to increase client participation in the legal representation, and thus value the lawyer-client collaboration over lawyer neutrality.”⁹⁶

Some theorists have emphasized narrative theory—the importance of client voice, and how the lawyer may translate the client’s story into legal language.⁹⁷ Thus, some emphasize that students should be taught listening skills in order not to simply identify the legal issues, but to better understand the client’s “experiences, interests and perspectives.”⁹⁸ This kind of understanding by the lawyer will more likely lead to a broader understanding of the client’s needs beyond the law and thus a more effective solution to her problems. Some proponents who encourage this approach to the lawyer-client relationship also emphasize ethics: understanding the client means treating her with dignity and respect and also empowering her to make decisions on her own behalf.⁹⁹ In other words, the client is more than her legal case; she is a complex human being.

increasing specialization in the medical profession); Michael S. Sparer, *Laboratories and the Health Care Marketplace: The Limits of State Workforce Policy*, 22 J. HEALTH POL. POL’Y & L. 789, 794 (1997) (arguing that medical schools have been instrumental in encouraging specialization by recruiting students with an interest in specialized research, hiring faculty who are specialists, and offering a curriculum focused on specialties, because specialization brings in more research dollars).

95. Katherine R. Kruse, *Fortress in the Sand: The Plural Values of Client-Centered Representation*, 12 CLINICAL L. REV. 369, 370 (2006) (describing the success of the “groundbreaking interviewing and counseling text-book” created by David Binder and Susan Price).

96. *Id.* at 371.

97. *Id.*; accord Clark D. Cunningham, *A Tale of Two Clients: Thinking about Law as Language*, 87 MICH. L. REV. 2459, 2482–83, 2491–94 (1989); Christopher P. Gilkerson, *Poverty Law Narratives: The Critical Practice and Theory of Receiving and Translating Client Stories*, 43 HASTINGS L.J. 861, 865–68 (1992).

98. V. Pualani Enos & Lois H. Kanter, *Who’s Listening? Introducing Students to Client-Centered, Client-Empowering, and Multidisciplinary Problem-Solving in a Clinical Setting*, 9 CLINICAL L. REV. 83, 91 (2002) (“Acute and astute listening are central to learning the clients’ experiences, needs and priorities. They are also central to ascertaining and understanding the clients’ abilities, resources and limitations.”).

99. Kruse, *supra* note 95, at 371–72.

One of the critical components of client-centered lawyering is reflection by the lawyer or law student—reflection about the role of the lawyer in the lawyer-client relationship, about the lawyer's own values, and about the lawyer's personal history, race, and socioeconomic status, and its effect on lawyer neutrality.¹⁰⁰ Thus, much has been written about teaching law students the importance of being conscious of “how one's attitudes, values, interests and culture affect one's interactions with others.”¹⁰¹

Law students are encouraged to use narrative listening skills and personal reflection to examine their professional role as lawyers and their relationship with their clients.¹⁰² Practitioners and educators who emphasize this kind of training for law students criticize traditional legal education as instilling in law students a hierarchical notion of the lawyer/client relationship.¹⁰³ Client-centered advocacy and reflective practice shifts the power dynamic between lawyer and client to one that emphasizes equality between the lawyer and client.¹⁰⁴

2. *Medicine*

Like the lawyer-client relationship, the physician-patient relationship is critical to effective medical care. As one recent book argues, accurate diagnoses and effective medical care rely as much on effective communication between doctor and patient as on scientific training: “How a doctor thinks can first be discerned by how he speaks and how he listens.”¹⁰⁵ Some medical educators have followed a similar path to legal educators in emphasizing patient-centered care alongside technical expertise.

Grounded in the development of primary care in the 1960s and 1970s,¹⁰⁶ and the introduction of bioethics into medical education in the 1970s,¹⁰⁷ medical schools have incorporated ethics training for medical students which includes physician-patient communication, reflection on the professional role of physicians, and narrative medicine which focuses on the values of empathy and trust. Like

100. See Susan Bryant, *The Five Habits: Building Cross-Cultural Competence in Lawyers*, 8 CLINICAL L. REV. 33, 51–55 (2001) (explaining that reflecting on the similarities and differences between a lawyer and his or her client, as well as acknowledging social constructions, such as racism, enable the lawyer to better understand the position of the client).

101. Kruse, *supra* note 95, at 389.

102. Enos & Kanter, *supra* note 98, at 91.

103. *Id.* at 85–86.

104. *Id.* at 94–95.

105. William Grimes, *Diagnosis as Art, Not Rocket Science*, N.Y. TIMES, Mar. 23, 2007, at E1 (quoting professor of medicine at Harvard Medical School Jerome Groopman). See JEROME GROOPMAN, *HOW DOCTORS THINK* (2007), for more information about Dr. Groopman's book..

106. Rita Charon, *Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust*, 286 JAMA 1897, 1898 (2001).

107. Jack Coulehan & Peter C. Williams, *Conflicting Professional Values in Medical Education*, 12 CAMBRIDGE Q. HEALTHCARE ETHICS 7, 13 (2003).

client-centered counseling and narrative theory in law, a patient-centered, narrative approach conceives medicine and the physician's role in a broader context:

As the physician listens to the patient, he or she follows the narrative thread of the story, imagines the situation of the teller (biological, familial, cultural, and existential situation), recognizes the multiple and often contradictory meanings of the words used and the events described, and in some way enters into and is moved by the narrative world of the patient.¹⁰⁸

Like legal educators, medical educators emphasize the importance of reflection by physicians and medical students. As one commentator writes, “[s]he needs to be aware of her own professional norms and values; to be able to express them to her colleagues, her patients and their families; and to work with these other actors to provide ethically responsible care.”¹⁰⁹ As in law, those who emphasize this type of reflection argue that medical students need to understand their professional role and interactions with patients in a less hierarchical way than is traditionally taught in medical schools. They should question their notions of the “the identity of the professional and the power that is attached to this identity.”¹¹⁰

Like the legal profession, medical educators, who are emphasizing ethics education through the teaching of narrative medicine, reflective practice, and patient-centered counseling, are, in part, responding to what they view as the overly narrow approach of traditional medical education which focuses on detachment and objectivity rather than empathy and compassion.¹¹¹ To better serve patients, particularly in a managed care world, physicians must treat their patients as whole human beings and not medical diagnoses. As one commentator puts it, “[t]o adapt to the new environment, a good professional must not only exhibit the technical proficiency that allows her to do things right—she must also do the right thing.”¹¹²

108. Charon, *supra* note 106, at 1898–99.

109. Marian Verkerk et al., *Enhancing Reflection: An Interpersonal Exercise in Ethics Education*, 36 HASTINGS CTR. REP. 31, 31 (2004). This commentator proposes a model of ethics education that involves a three-step process. Step one “helps professionals to attain a heightened moral sensitivity to the vulnerabilities, values and responsibilities they encounter in their work” *Id.* at 32. Step two “helps them to understand that they are part of a practice that involves multiple perspectives and positions.” *Id.* Step three “helps them appreciate that they are participants in a socially shared practice that is partly constituted and re-created by their own collective actions.” *Id.*

110. *Id.* at 35.

111. See Coulehan & Williams, *supra* note 107, at 18. The authors argue that medical education does send the message that good doctors are empathic and compassionate, but it also strongly encourages detachment: “American medical education favors an *explicit* commitment to traditional values of doctoring—empathy, compassion, and altruism among them—coupled with an extraordinarily powerful *tacit* commitment to behaviors grounded in an ethic of detachment, self-interest, and objectivity.” *Id.* (emphasis in original).

112. Verkerk et al., *supra* note 109, at 31. Interestingly, critics of the current state of medical care argue that the infusion of medicine with law and the legal process have undermined context-based

B. *Cultural Competence*

To effectively serve their patients and clients in increasingly diverse justice and health care systems, new lawyers and doctors must also be sensitive to and reflective about cultural difference. While narrative approaches to counseling help practitioners and students expand their understanding of client/patient concerns, without conscious reflection on how cultural differences shape the lawyer/client and doctor/patient relationship, practitioners may be ineffective advocates for those they serve.

1. *Law*

In the late 1990s, some educators began to criticize the adoption in clinical legal education of the client-centered counseling model while ignoring, or at least not adequately addressing, racial and socioeconomic differences between lawyer and client. As Michelle Jacobs states:

Adherence to the client-centered counseling models in their present race-neutral constitution have not and can not [sic] cure the problem of client-manipulation. Nor, can they provide a solid blueprint for client empowerment, because the clients and their world views are not truly valued within the models.¹¹³

Cross-cultural lawyering theorists argue that lawyers and law students must understand how cultural differences may affect their assumptions about their clients and question the idea of lawyer “neutrality” in order to serve their clients effectively.¹¹⁴ Students are encouraged to reflect on their own cultural beliefs and attitudes and how these may be shaped by systems of power and privilege.¹¹⁵ Understanding this aspect of the lawyer-client relationship helps to break down the power dynamics, which may inhibit effective problem-solving.¹¹⁶

Learning cross-cultural lawyering skills is critical for all lawyers, regardless of the type of practice. Making students aware of the significance of cultural difference and unearthing what may be “invisible” to them in their relationships

medical ethics: “Medical ethics itself has become more like legal ethics: categorical rather than contextual.” Sage, *supra* note 2, at 1192.

113. Michelle S. Jacobs, *People from the Footnotes: The Missing Element in Client-Centered Counseling*, 27 GOLDEN GATE U. L. REV. 345, 401 (1997).

114. See Kimberly E. O’Leary, *Using “Difference Analysis” to Teach Problem-Solving*, 4 CLINICAL L. REV. 65, 77–78 (1997) (“[D]ecision-makers have an affirmative duty to try to understand the experiences, concerns and possibilities every actor affected by the problem . . .”). Clinical professors Susan Bryant and Jean Koh Peters offer methods for clinical teachers to teach “five habits” for building cross-cultural skills. See Bryant, *supra* note 100, at 35, 64–78.

115. See Kruse, *supra* note 95, at 389.

116. See Jacobs, *supra* note 113, at 377–78 (“What we, as clinicians, have failed to examine is how the unconscious racism, or, in other words, the lawyer’s or law student’s preconceived cultural notions will impact both the lawyer’s expectations of the client as well as the lawyer’s interpretation and understanding of the client’s actions and ultimate objectives.”).

with clients is an important part of skill-building: “By teaching the students about the influence of culture on their practice of law, we give them a framework for analyzing the changes that have resulted in their thinking and values as a result of their legal education.”¹¹⁷

2. *Medicine*

Like critics of client-centered counseling in legal education, some have criticized the bioethics approach to the patient narrative as too devoid of context, particularly with regard to poverty and the physician’s role in serving the indigent: “neither the substance nor the methodology of bioethics has focused on the ethics of physician charity care for the poor. The stories of the poor, the private physicians and their caregivers, remain untold as a matter worthy of serious ethical inquiry.”¹¹⁸

Even before the Institute of Medicine (IOM) published its report documenting racial and ethnic disparities and calling for cultural competence training for physicians, some medical educators were incorporating the issue of racial and ethnic differences into the curriculum.¹¹⁹ Recently, medical educators have stressed teaching students to reflect on their own cultural values over an approach focused on teaching students about *patients’* cultural differences:

Previous efforts in cultural competence have aimed to teach about the attitudes, values, beliefs, and behavior of certain groups [A] more effective approach is to learn a practical framework to guide inquiry with individual patients about how social, cultural, or economic factors influence their health values, beliefs and behaviors. . . . this approach focuses on the issues that arise most commonly due to cultural differences, and how they may affect a physician’s interaction with any patient.¹²⁰

Interestingly, some educators have criticized cross-cultural curricula for focusing solely on race and ethnic differences and not enough on social factors, such as socioeconomic status, but other factors such as “illiteracy, immigration experiences, religion, social stressors, and social support networks.”¹²¹ Failing to understand culture in this broader context may put medical students and residents at

117. Bryant, *supra* note 100, at 40.

118. Sidney Dean Watson, *In Search of the Story: Physicians and Charity Care*, 15 ST. LOUIS U. PUB. L. REV. 353, 360 (1996).

119. See e.g., Robert C. Like et al., *STFM Core Curriculum Guidelines: Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care*, 28 FAM. MED. 291, 291 (1996) (recommending core curriculum guidelines for cultural competence in medicine).

120. Joseph R. Betancourt, *Cultural Competence and Medical Education: Many Names, Many Perspectives, One Goal*, 81 ACAD. MED. 499, 499–500 (2006).

121. Alexander R. Green et al., *Integrating Social Factors in Cross-cultural Medical Education*, 77 ACAD. MED. 193, 193–94 (2002).

“particular risk of developing negative stereotypes for various cultural groups as poor and undereducated.”¹²²

Teaching students to understand the broader context in which they and their clients and patients live helps them to navigate the complexities of their practices and it is also likely to make them more effective practitioners. Nevertheless, understanding this context may not be enough to help new physicians and lawyers solve the increasingly complex problems faced by their patients and clients.

C. *Interdisciplinary Practice and Collaboration*

As legal and medical practice has become more specialized, the problems faced by practitioners, especially those who work with diverse populations, have become more complex and multidimensional. Some medical and legal educators have begun to emphasize interdisciplinary training as critical to preparing professionals for the increasingly complex legal and health care systems in which they will practice:

[T]he traditional model of professional education puts so much stress on the professional as an autonomous expert whom the client can trust because of his high degree of skill and high commitment to a professional ethic that we may well have trained out of most of our professionals the attitudes and skills that are needed to work in collaboration with others.

....

The implications are clear—society is generating problems that require interdisciplinary team efforts for their solution and, at the same time, sets of professionals who are less and less able to take part in interdisciplinary problem-solving efforts. This is true in medicine, in law, in psychiatry, in engineering, and in the academic profession itself .

....¹²³

Advocates of teaching interdisciplinary collaboration criticize traditional medical and legal education as too narrowly focused on technical skill.¹²⁴ Instead, they challenge students to consider medical and legal problems in their social contexts as well as to broaden their concepts of their professional roles and limits.¹²⁵

122. *Id.* at 194.

123. EDGAR SCHEIN & DIANE W. KOMMERS, *PROFESSIONAL EDUCATION* 36, 39 (1972).

124. *See* Naitove, *supra* note 1, at 293–94 (stating that the focus on technical skill has resulted in a “crisis in interpersonal relations” between medical and legal professionals).

125. *See* Green, *supra* note 121, at 193–94 (explaining that social factors should be included in cross-cultural medical education); Janet Weinstein, *Coming of Age: Recognizing the Importance of Interdisciplinary Education in Law Practice*, 74 WASH. L. REV. 319, 319–24 (1999) (explaining that clients are not one dimensional and therefore lawyers need to collaborate with other professions to better serve their clients).

1. Law

Interdisciplinary education has become popular not just in law schools, but in a wide variety of disciplines.¹²⁶ Among the many benefits of interdisciplinary education cited by its proponents are developing respect and appreciation among the disciplines; teaching team work and collaboration; developing a knowledge-base about other disciplines; teaching communication among disciplines; and teaching other disciplines' rules, beliefs and ethical principles.¹²⁷ Specifically, for lawyers and law students, interdisciplinary education has been proposed as a way to move away from the narrow approach to seeing problems primarily as legal claims. As Janet Weinstein argues, “[o]ne of the fundamental shortcomings of traditional lawyering, at least as taught in law school, is an inability to define problems in their broad and multidisciplinary respects.”¹²⁸

The next generation of lawyers will enter a more interdisciplinary practice environment. “One-stop-shops” of services including legal services, social services and case management have become popular in legal practices that focus on social justice.¹²⁹ Many in clinical legal education have designed clinical training models which incorporate interdisciplinary collaboration to better serve clients, but which also teach law students the value of collaboration with other professions.¹³⁰

Law Professor Kim Diana Connelly touts interdisciplinary education as necessary for lawyers to find solutions to complex problems:

Legal problems are like elephants: examining them from only one perspective gives a distorted image of the whole. In order to understand legal problems, lawyers often need to examine them from the perspective of multiple disciplines. Likewise, successful legal problem-solving sometimes means that lawyers need to be able to collaborate with other professionals in order to address a client's problems.¹³¹

126. Anita Weinberg & Carol Harding, *Interdisciplinary Teaching and Collaboration in Higher Education: A Concept Whose Time Has Come*, 14 WASH. U. J.L. & POL'Y 15, 15–16, 16 n.4 (2004).

127. *Id.* at 22.

128. Weinstein, *supra* note 125, at 324.

129. Stacy L. Brustin, *Legal Services Provision Through Multidisciplinary Practice—Encouraging Holistic Advocacy While Protecting Ethical Interest*, 73 U. COLO. L. REV. 787, 791–92 (2002) (discussing generally the benefits of multidisciplinary legal practice for addressing the complex needs of poor and marginalized clients); *see also* Enos & Kanter, *supra* note 98, at 91–92 (describing the benefits of a multidisciplinary approach to serving victims of domestic violence); Robin G. Steinberg, *Beyond Lawyering: How Holistic Representation Makes for Good Policy, Better Lawyers, and More Satisfied Clients*, 30 N.Y.U. REV. L. & SOC. CHANGE 625, 627 (2006) (discussing holistic representation for criminal defendants).

130. *E.g.*, Rose Voyvodic & Mary Medcalf, *Advancing Social Justice Through an Interdisciplinary Approach to Clinical Legal Education: The Case of Legal Assistance of Windsor*, 14 WASH. U. J.L. & POL'Y 101, 101–03 (2004).

131. Kim Diana Connelly, *Elucidating the Elephant: Interdisciplinary Law School Classes*, 11 WASH. U. J.L. & POL'Y 11, 13–14 (2003).

Connelly criticizes the narrow focus of legal education, concluding that “traditional legal education does little to provide law students with the skills relevant to working with non-legal ideas and the professionals who are trained in those ideas. The typical law school graduate is ill-prepared, in other words, to assess the elephant.”¹³²

2. *Medicine*

Medical educators, too, worry that the narrowness of professional training for doctors makes them unable to “assess the elephant.” Like their peers in law schools, medical educators argue that interdisciplinary education provides medical students with important skills in collaboration and communication and broadens their understanding of the complexities of their patients’ health care needs. “Patient needs are interdisciplinary, and improving health care is an interdisciplinary effort. Working as part of an interdisciplinary team to provide and improve health care is a skill; like other skills it is best learned *during* training, not after.”¹³³

Narrow training in a particular specialty may leave doctors incapable of communicating effectively with professionals from other disciplines: “the whole cognitive and perceptual approach embraced by the discipline. . . . become[s] [so] entrenched through repeated use, [that] communication with other disciplines can become increasingly challenging.”¹³⁴ When treating patients with complex health problems, particularly those with “socioeconomic pressures,” physicians need to collaborate and communicate with other professionals to effectively address their patients’ complex needs.¹³⁵

It should be noted, however, that the literature espousing the importance of “interdisciplinary education” in medicine has not focused on collaboration with other non-medical disciplines such as law or social work, but instead has tended to point to the importance of teaching medical students and residents to collaborate with other health care professionals—nurses, therapists, or other medical specialists.¹³⁶ Still, as interdisciplinary collaborations, such as medical-legal partnerships, become more prevalent in health care settings, one would expect medical educators to broaden the curriculum to include training in collaboration with a range of professionals.

132. *Id.* at 14.

133. Linda A. Headrick et al., *Continuous Quality Improvement and the Education of the Generalist Physician*, 70 ACAD. MED. (SUPP. 1) S104, S108 (1995) (emphasis in original).

134. Pippa Hall & Lynda Weaver, *Interdisciplinary Education and Teamwork: A Long and Winding Road*, 35 MED. EDUC. 867, 867 (2001).

135. *Id.*

136. E.g., Nilesh Chatterjee, *Infusing the Interdisciplinary into Medical/Health Sciences Education: Vitamins or Vaccines?*, 7 MED. EDUC. ONLINE, at 1, 1–6 (2002), www.med-ed-online.org/pdf/f0000033.pdf.

D. Holistic Problem-Solving

Just as some educators worry that legal and medical practitioners are not adequately trained to communicate and collaborate with other professionals, some are concerned that both traditional legal and medical education teach one-dimensional problem-solving. These educators emphasize the importance of teaching creative problem-solving with an eye toward addressing systemic issues that, if addressed, may prevent future problems for the client or patient.

1. Law

Training law students to become creative problem-solvers requires them to reach beyond their traditional notion of a legal problem and what is relevant to that problem. To fully serve a client and address his/her problems, the lawyer must not assume “that the problem is only, or even primarily, a legal problem.”¹³⁷ A recent report to the Carnegie Foundation for the Advancement of Teaching, *Educating Lawyers: Preparation for the Profession of Law*, criticizes traditional legal education for creating

abstraction of the legally relevant aspects of situations and persons from their everyday contexts. . . . By contrast, the task of connecting these conclusions with the rich complexity of actual situations that involve full-dimensional people, let alone the job of thinking through the social consequences or ethical aspects of the conclusions, remains outside the case-dialogue method.¹³⁸

The failure to recognize complexity may be most problematic for lawyers serving low-income clients. When working with low-income clients and striving for social justice, the lawyer needs to see the client’s problems in the broader context of the client’s life.¹³⁹

In addition, some argue that teaching problem-solving makes law students happier because it “helps bridge the gap for frustrated students between classes in law and the legal profession.”¹⁴⁰ Creative problem-solving teaches students

137. Weinstein, *supra* note 125, at 325–26.

138. CARNEGIE FOUND. FOR THE ADVANCEMENT OF TEACHING, SUMMARY, EDUCATING LAWYERS: PREPARATION FOR THE PROFESSION OF LAW, *available at* http://www.carnegiefoundation.org/dynamic/publications/elibrary_pdf_632.pdf (summarizing the key observations set forth in the Carnegie Foundation report); *see also* SULLIVAN ET AL., *supra* note 13, at 3, 5–6.

139. *See* Jane Aiken & Stephen Wizner, *Law as Social Work*, 11 WASH. U. J.L. & POL’Y 63, 64 (2003) (arguing that lawyers who practice social justice advocacy, in fact, have much in common with social workers).

140. Linda Morton, *Teaching Creative Problem Solving: A Paradigmatic Approach*, 34 CAL. W. L. REV. 375, 379 (1998) [hereinafter Morton, *Creative Problem Solving*]. Morton teaches an interdisciplinary course using public health problems to train law students in problem solving. *See* Linda Morton, *A New Approach to Health Care ADR: Training Law Students to be Problem Solvers in the*

important skills, but it also “offers a broader perspective on our roles as attorneys. It demands a focus on a lawyer’s duty beyond the normative legal rules pertaining to client advocacy, including a duty to promote societal justice, awareness of values, problem prevention, and self-reflection.”¹⁴¹ One of the goals of the creative problem-solving approach is to teach law students to think about prevention of future problems, not just solving current ones.¹⁴²

The “comprehensive law movement,” a term coined by Professor Susan Daicoff, brings together several models of legal practice, including therapeutic jurisprudence, preventive law, holistic justice, creative problem-solving and collaborative law.¹⁴³ As described by Professor Bruce Winick, “[t]he . . . marriage of [therapeutic jurisprudence] with the [p]reventive [l]aw model calls for ‘lawyers who practice their profession with an ethic of care, enhanced interpersonal skills, a sensitivity to their clients’ emotional wellbeing as well as their legal rights and interests, and a preventive law orientation that seeks to avoid legal problems.’”¹⁴⁴ These lawyers attempt to reach beyond the immediate goals of legal advocacy to understand the “impact on the psychological well-being or emotional life of persons affected by the law” and the role of lawyers and other players in this impact.¹⁴⁵ Thus, lawyers serve as “healers” to their clients, not just hired guns in the adversarial system. In the educational context, law students are taught to understand the lawyer-client relationship in the broader context of human relationships.¹⁴⁶

2. *Medicine*

Like those in the legal profession who criticize legal education as encouraging narrow thinking and failing to train students to tackle the complex problems of their clients, those arguing for reform in medical education stress the importance of teaching problem-solving to prepare students for the complex world of practice. Similar to the Carnegie Report on legal education, a recent report for the Foundation on Medical Education, *American Medical Education 100 Years after*

Health Care Context, 21 GA. ST. U. L. REV. 965, 971–72, 975–77 (2005) [hereinafter Morton, *A New Approach*].

141. Morton, *Creative Problem Solving*, *supra* note 140, at 380.

142. Janet Weinstein & Linda Morton, *Interdisciplinary Problem Solving Courses as a Context for Nurturing Intrinsic Values*, 13 CLINICAL L. REV. 839, 850 (2007).

143. MARJORIE A. SILVER, *THE AFFECTIVE ASSISTANCE OF COUNSEL: PRACTICING LAW AS A HEALING PROFESSION*, at xxvii (2007).

144. *Id.* at xxiv–xxv.

145. David B. Wexler, *Therapeutic Jurisprudence: An Overview*, 17 T.M. COOLEY L. REV. 125, 126 (2000).

146. See Susan L. Brooks, *Using Therapeutic Jurisprudence to Build Effective Relationships with Students, Clients and Communities*, 13 CLINICAL L. REV. 213, 214–15 (2006) (arguing that clinical legal education has much to learn from social work principles, which emphasize the importance of interaction between the social worker and client).

the Flexner Report, identifies the need to teach future doctors real world problem-solving: “It can be hard to teach messy real-world issues, but practitioners need to understand how these issues affect their patients and how to interact with, and ultimately improve, an exceedingly complex and fragmented system to provide good patient care.”¹⁴⁷

The report authors also assert that “[t]heoretical, scientific knowledge formulated in context free and value-neutral terms is seen as the primary basis for medical knowledge and reasoning.”¹⁴⁸ They argue that “[t]he moral dimension of medical education requires that students and residents acquire a crucial set of professional values and qualities, at the heart of which is the willingness to put the needs of the patient first.”¹⁴⁹ As with therapeutic jurisprudence, some emphasize the value of the doctor-patient relationship itself as integral to healing. In order to treat the whole patient, doctors (and medical students) must be cognizant of the experiences they bring, as both members of society and as professionals, to the clinical setting.¹⁵⁰ Doing so will bring greater satisfaction both for the patient and for the doctor.¹⁵¹

Concerns that traditional legal and medical education have emphasized technical skill and practice management over problem-solving and the professional relationship have led to calls for major reforms in the way we educate doctors and lawyers. But even before major curricular reforms take place, if in fact they do, some law and medical schools have begun to expand training in ethics, client and patient-centered counseling, cultural competency, interdisciplinary collaboration, and holistic problem-solving.¹⁵² As educators incorporate these concepts into the curriculum, medical-legal partnership in the academy can offer a rich opportunity to bring future doctors and lawyers together to explore issues of social justice and professional ethics, as well as to practice interdisciplinary collaboration and problem-solving. But it also offers a unique forum for dialogue between the professions—about the future of the legal and medical professions, about opportunities for reinvigorating our core values through service to our clients and

147. Cooke et al., *supra* note 13, at 1341–42.

148. *Id.* at 1341.

149. *Id.* The parallels to criticism of traditional legal education in *Educating Lawyers* cannot be missed: “The dramatic results of the first year of law school’s emphasis on well-honed skills of legal analysis should be matched with similarly strong skill in serving clients and a solid ethical grounding.” CARNEGIE FOUND. FOR THE ADVANCEMENT OF TEACHING, *supra* note 138, at 4. The summary of the report continues: “In their all-consuming first year of law school, students are told to set aside their desire for justice. They are warned not to let their moral concerns or compassion for the people in the cases they discuss cloud their legal analyses.” *Id.* at 6.

150. Cathy Risdon & Lori Edey, *Human Doctoring: Bringing Authenticity to Our Care*, 74 ACAD. MED. 896, 897 (1999).

151. *Id.* at 898–99.

152. *See infra* notes 155–57 and accompanying text.

patients, and about how to address the apparent dissatisfaction among many medical and legal practitioners and students.¹⁵³

Furthermore, as law schools and medical schools increasingly participate in medical-legal partnerships in their communities¹⁵⁴ that offer direct service to clients, thoughtful training for law and medical students is critical to providing them with the skills and reflective insights necessary for interdisciplinary practice. Since its founding in 2002, the Rhode Island Medical-Legal Partnership for Children has included a joint medical-legal class which develops new lawyers and doctors committed to interdisciplinary practice focused on holistic and client- and patient-centered care.

IV. THE RHODE ISLAND MEDICAL-LEGAL PARTNERSHIP FOR CHILDREN: A MODEL FOR TRAINING THE NEXT GENERATION OF LAWYERS AND DOCTORS

The Rhode Island Medical-Legal Partnership for Children (RIMLPC), modeled on the original Family Advocacy Program at Boston Medical Center, was started in 2002 as a partnership of Brown Medical School, Hasbro Children's Hospital in Providence, Rhode Island Kids Count, Rhode Island Legal Services, and Roger Williams University School of Law.¹⁵⁵ RIMLPC, though based on the Boston Medical Center model, is unique in that it partners Rhode Island Legal Services with Hasbro Hospital to provide legal services to patients and their families and has a formal academic component through collaboration between Brown Medical School and Roger Williams University School of Law.¹⁵⁶

153. See DAVID HALL, *THE SPIRITUAL REVITALIZATION OF THE LEGAL PROFESSION* 1–3 (2005) and ANTHONY T. KRONMAN, *THE LOST LAWYER: FAILING IDEALS OF THE LEGAL PROFESSION* 2–3 (1993), for discussion of the dissatisfaction in the legal profession and a reassessment of values. See Lawrence S. Krieger, *What We're not Telling Law Students—and Lawyers—That They Really Need to Know: Some Thoughts-In-Action Toward Revitalizing the Profession from Its Roots*, 13 J.L. & HEALTH 1, 3–4 (1998), for discussion about the dissatisfaction of law students. See Abigail Zuger, *Dissatisfaction with Medical Practice*, 350 NEW ENG. J. MED. 69, 69 (2004), for discussion of dissatisfaction in the medical profession.

154. Currently, ten medical-legal partnerships have formal partnerships with law schools, but many others have law student involvement in their programs. Med.-Legal P'ship for Children, *supra* note 10.

155. Roger Williams Univ. Sch. of Law, Feinstein Institute: Community Partnerships, <http://law.rwu.edu/sites/fils/partnerships/> [hereinafter Roger Williams Univ. Sch. of Law, Community Partnerships] (last visited May 6, 2008) (explaining that RIMLPC was started in 2002); Med.-Legal P'ship for Children, *supra* note 10 (listing the members of RIMLPC). As the Director of Public Service and Community Partnerships at Roger Williams University School of Law, the author of this article directs the Public Service Program and teaches a law course entitled "Poverty, Health and Law: The Medical/Legal Collaborative" and other public interest law courses. Roger Williams Univ. Sch. of Law, Feinstein Institute: Staff, <http://law.rwu.edu/sites/fils/staff/> [hereinafter Roger Williams Univ. Sch. of Law, Staff] (last visited May 6, 2008).

156. MEDICAL-LEGAL COLLABORATION, BEST PRACTICES & STRATEGIES FOR CAPACITY-BUILDING 9 (2005). RIMLPC (originally the Rhode Island Family Advocacy Program) was started by a pioneering medical student, Jyothi Nagraj, who had discovered the Family Advocacy Program at Boston Medical School and decided that the model should be adopted at Hasbro Children's Hospital in Providence. R.I.

RIMLPC has four components: (1) free legal services for low-income families referred by their pediatric health care providers; (2) training for doctors, nurses, social workers and other health care providers on how to identify common legal issues encountered in medical settings; (3) training for the next generation of doctors and lawyers through an interdisciplinary course for law and medical students and supervised internship experiences; and (4) advocacy on systemic and policy issues affecting families identified through case work at RIMLPC.¹⁵⁷

A. *Free Legal Services for Low-Income Families through the Health Care Setting*

Hasbro Children's Hospital, located in Providence, Rhode Island, is the primary care site for roughly 11,500 low-income patients per year.¹⁵⁸ It is also home to the Teen Tot clinic, directed by Dr. Patricia Flanagan, which provides primary care for teen mothers and their babies.¹⁵⁹ Families who access primary care for their children at Hasbro Children's Hospital may be referred to an on-site attorney who provides legal advice and/or representation on issues that affect child health, such as substandard housing, access to public benefits and health care, family safety, or educational rights of special needs children.¹⁶⁰ The attorney, who is employed by Rhode Island Legal Services, meets with clients who are referred from pediatricians, residents, hospital social workers, and the Help Desk, a desk staffed by Brown undergraduates through a program called "Project HEALTH" which offers referrals to services, such as job training, public housing, and

LEGAL SERVS., EXECUTIVE SUMMARY: STRATEGY GRANT APPLICATION 1, 4 (2003) available at http://www.nlada.org/Training/Train_Civil/Equal_Justice/2004_Materials/064_2004_Burch_Handout1; Roger Williams Univ. Sch. of Law, Community Partnerships, *supra* note 155 (explaining that the RIMLPC was previously called the Rhode Island Family Advocacy Program). Nagraj worked in collaboration with Dr. Patricia Flanagan at Hasbro Children's Hospital to develop a partnership with Rhode Island Legal Services and to pilot the program during the summer of 2002. R.I. LEGAL SERVS., *supra*, at 4. RIMLPC now has an attorney director employed by Rhode Island Legal Services who directs all of the activities of the program and supervises law and medical students. Roger Williams Univ. Sch. of Law, Community Partnerships, *supra* note 155. An advisory board with members from each of the partnering organizations advises the director on programming. MEDICAL-LEGAL COLLABORATION, *supra*, at 22; *see also* R.I. Med.-Legal P'ship for Children, Our Advisory Board, <http://www.rifap.org/advisors.cfm> (last visited May 6, 2008).

157. *See generally*, R.I. MED.-LEGAL P'SHIP FOR CHILDREN, ANNUAL REPORT (2007) (on file with author).

158. Hasbro Children's Hospital, Number of Patients Per Clinic in Fiscal Year 2007 (on file with author).

159. The Teen Tot Clinic is a special program within the Adolescent Health Care Center at Hasbro Children's Hospital. Lifespan, Hasbro Children's Hospital, <http://www.lifespan.org/hch/services/adolescent/> (last visited May 13, 2008).

160. R.I. LEGAL SERVS., *supra* note 156, at 5; Project HEALTH, Family Help Desk, <http://www.projecthealth.org/OurLocations/providence/fhd.php> [hereinafter Family Help Desk] (last visited May 6, 2008).

clothing.¹⁶¹ When the client grants permission, the RIMLPC attorney collaborates with the health care provider to develop solutions to the legal issues affecting the child's health.¹⁶² The approach to the client is both holistic and collaborative. The attorney does not interview the client solely about the issue for which s/he was referred, but completes a comprehensive assessment of the family's needs.¹⁶³ Like the notion of the medical "home" in which preventive and comprehensive services are offered in a trusting and accessible environment,¹⁶⁴ RIMLPC provides a legal "home" for the family. Collaboration between professionals ensures that the family has a medical-legal team working to alleviate the strains that affect child and family health.

B. Training for Medical Providers

The RIMLPC attorney, as well as other attorneys from Rhode Island Legal Services, trains pediatric staff about available services and benefits for poor families and gives them an overview of legal issues that their patients' families may encounter.¹⁶⁵ Workshops have included such topics as rules regarding eligibility for public benefits and health insurance; educational rights of special needs children; rights of immigrants; and landlord/tenant rights and responsibilities.¹⁶⁶ Medical staff are not expected to give patients legal advice, but understanding government programs allows them to feel more comfortable asking families about issues that may affect a child's health and to be knowledgeable about resources. Having this training, pediatricians are more likely to identify when legal assistance may be warranted. Physicians are given an "advocacy code card,"¹⁶⁷ developed by

161. R.I. LEGAL SERVS., *supra* note 156, at 5. Project HEALTH (Helping Empower, Advocate and Lead through Health) was also started by Dr. Barry Zuckerman at Boston Medical Center. Project HEALTH, Our Founders, <http://www.projecthealth.org/AboutUs/history.php> (last visited May 5, 2008). Project HEALTH "works to break the link between poverty and poor health by mobilizing college students to provide sustained public health interventions in partnership with urban medical centers, universities and community organizations." Project HEALTH, Our Mission, <http://www.projecthealth.org/AboutUs/about.php> (last visited May 5, 2008). Project HEALTH's locations include Boston, New York, Providence, Baltimore, Chicago, and Washington D.C. Project HEALTH, Our Locations, <http://www.projecthealth.org/OurLocations/locations.php> (last visited May 5, 2008).

162. R.I. LEGAL SERVS., *supra* note 156, at 5.

163. R.I. Med.-Legal P'ship for Children Intake Questionnaire (on file with author).

164. Med. Home Initiatives for Children with Special Needs Project Advisory Comm., Am. Acad. Pediatrics, Policy Statement, Policy Statement, *The Medical Home*, 110 PEDIATRICS 184, 184 (2002).

165. R.I. LEGAL SERVS., *supra* note 156, at 6-7.

166. *See id.*

167. The "code card" with information about government programs and community resources was the brainchild of partnering doctors and lawyers at Boston Medical Center who realized that it offered a quick reference in a format that doctors would be comfortable with. R.I. Med.-Legal P'ship for Children, Advocacy Resources in RI (on file with author).

RIMLPC similar to those they carry with medical information, with resources they can share with patients.

C. *Supervised Experience and Training for Students*

Through the law school's public interest law externship program, two law students work at RIMLPC each semester under the supervision of the director/attorney for academic credit.¹⁶⁸ Students participate in every aspect of the program, including client interviewing at the hospital, managing cases, and development of trainings for medical providers. Additional students participate in RIMLPC through the law school's mandatory public service program.¹⁶⁹ These students assist with intake and interviewing of clients as well as research projects and development of materials for legal education trainings for medical providers.

Medical students participate in RIMLPC through the medical school's community health clerkship program.¹⁷⁰ Students identify a specific project and work collaboratively with the law students, attorney, and/or their supervising physician on the project. When possible, medical students and law students work together on the project, offering them the chance to explore a topic from an interdisciplinary perspective.¹⁷¹ The joint medical-legal seminar offered by the law school and medical school will be discussed in detail in Part V.

D. *Systemic and Policy Advocacy*

One of the goals of medical-legal partnerships is to use the information learned from individual cases to advocate for systemic change.¹⁷² Some doctors who serve low-income patients express frustration about their inability to affect systems which stand in the way of their patients' health and well-being.¹⁷³ For

168. Roger Williams Univ. Sch. of Law, Community Partnerships, *supra* note 155.

169. See Roger Williams Univ. Sch. of Law, Public Service, <http://law.rwu.edu/sites/files/publicservice/default.aspx> (last visited May 6, 2008) (noting that all Roger Williams law students must complete public service to graduate).

170. Brown Alpert Med. Sch., Community Health Clerkship: Community Health Clerkship Field Experiences, <http://bms.brown.edu/pubhealth/mph/chc/page.php> (follow "Field Experience" hyperlink; then follow "Field Experience Options" hyperlink) (last visited May 6, 2008).

171. For example, during the fall of 2006, a medical student worked with two law students to study teen mothers' access to educational services during and after pregnancy. The medical student interviewed patients in the Teens Tot Clinic at Hasbro Children's Hospital, which offers medical care to both teen mothers and their babies. She also met with representatives from schools and community-based service organizations. The law students investigated teen mothers' legal rights to educational services.

172. Lawton, *supra* note 23.

173. See Richie Poulton & Avshalom Caspi, Commentary: *How Does Socioeconomic Disadvantage During Childhood Damage Health in Adulthood? Testing Psychosocial Pathways*, 34 INT'L J. EPIDEMIOLOGY 344, 344-45 (2005) (explaining that low-income individuals are more susceptible to health problems in adulthood because they face more psychological stress and lack of access to social capital).

example, a physician may see through repeated encounters with patients that a particular school district violates families' right to special education services. As RIMLPC continues to develop, it is hoped that systemic advocacy will become a larger component of the program. To date, it has worked on systemic issues such as school districts' failure to provide out of school services for teen parents as required by law, policies regarding utility shutoffs for poor families, and tenants' rights legislation.

V. INTERDISCIPLINARY MEDICAL-LEGAL SEMINAR

Interdisciplinary medical-legal teaching is not new. In 1982, Naitove touted the benefits of "medicolegal" education as a way to improve relations between the professions.¹⁷⁴ Law and medical schools have partnered over the years for interdisciplinary classes. These have primarily focused on professionalism and ethics,¹⁷⁵ have engaged students in discussions focused on medical malpractice,¹⁷⁶ and have used issues of health care policy for interdisciplinary problem-solving.¹⁷⁷ While the Roger Williams University School of Law/Brown Medical School seminar incorporates issues of professionalism and broader exploration of health policy, its focus, when developed in 2002,¹⁷⁸ was unique.¹⁷⁹ The seminar was designed to bring medical and law students together to discuss ethical issues and practice interdisciplinary problem-solving while exploring substantive issues affecting poor and disenfranchised clients and patients. Topics include poverty and

174. Naitove, *supra* note 1, at 294.

175. See, e.g., David B. Wilkins, *Redefining the "Professional" in Professional Ethics: An Interdisciplinary Approach to Teaching Professionalism*, 58 L. & CONTEMP. PROBS. 241-42 (1995) (describing an interdisciplinary medical-legal course taught at Harvard that focused on helping law and medical students explore issues of professionalism and ethical reasoning in law and medicine). Professor Paula Galowitz of NYU School of Law and Dr. Mark Schwartz of NYU Medical School bring law students and medical students together to explore and compare professional roles for a course that focuses on "the nature of the professional roles and relationships with patients/clients, exploring similarities and differences." NYU Law, Course Management System, <http://its.law.nyu.edu/StudentCourseInfo.cfm> (search "Doctor-Patient" in "Course Title" box) (last visited May 6, 2008).

176. Naitove, *supra* note 1, at 294-95.

177. Morton, *A New Approach*, *supra* note 140, at 966.

178. Roger Williams Univ. Sch. of Law, News & Events, In the Spotlight: A 'Value Added' Education, (Mar. 1, 2005), http://law.rwu.edu/news/spotlight/details.aspx?spotlight_id=21.

179. In the last two years, as the medical-legal partnership model has spread across the United States and has become part of law school and medical school clinical and public service programs, courses more similar to the Brown-RWU model have begun to develop. For example, in 2006, Dr. Dana L. Weintraub and attorney Melissa A. Rogers began teaching a course entitled "Medical-Legal Issues in Child Health" to students at Stanford Medical School and Stanford Law School. Stanford Law Sch., Medical-Legal Issues in Children's Health, <http://www.law.stanford.edu/program/courses/> (follow "2nd/3rd Year Program" hyperlink; then follow "Medical-Legal Issues in Child Health" hyperlink below "Interdisciplinary Legal Studies") (last visited May 6, 2008).

childhood asthma, substandard housing and lead poisoning, educational rights of special needs children, and family violence and mandatory reporting.¹⁸⁰

A. Course Structure

Second and third year students at Roger Williams University School of Law may elect to take a seminar entitled, "Poverty, Health and Law: The Medical-Legal Collaborative."¹⁸¹ The seminar meets weekly for two hours, with four of those sessions held jointly with Brown Medical School students at either the law school or the medical school.¹⁸² The law school course focuses on the connections between health and law; the lawyer's role in social justice; the lawyer-client relationship and cultural competence; the benefits of interdisciplinary education and holistic advocacy; professional ethical issues for lawyers, particularly in the context of interdisciplinary practice; and the substantive law topics that are addressed in the joint classes. Students write reflective essays, complete short case analyses, and work collaboratively with partners to complete a course project which involves creation of a legal education workshop and materials for health care providers on issues pertinent to poor families. These projects are provided to RIMLPC for use in its work with health care providers and clients at Hasbro Children's Hospital.

Second and third year medical students from Brown Medical School may opt to take an elective seminar entitled "Medicine, Law and Ethics."¹⁸³ This seminar is limited to the joint sessions with Roger Williams University law students, but students must prepare for these sessions with common readings also assigned to the law students.¹⁸⁴ The goals of the medical school seminar are to expand students' understanding of the social context of medicine, including a deeper understanding of the connections between poverty and health; the professional role of the physician in addressing this social context; the doctor-patient relationship; and the benefits of interdisciplinary collaboration. Medical students complete a reflection paper at the conclusion of each class.

The joint classes are structured around substantive legal and medical issues as a context for exploring the broader themes of the medical school and law school seminars. Through case simulations and role plays, students are presented with a

180. Elizabeth Tobin Tyler, Syllabus, Poverty, Health and Law: The Medical/Legal Collaborative (Fall 2007), <http://www.rifap.org/documents/MLSyllabus2007final.pdf>. The curriculum for the joint medical-legal classes was developed by the author in collaboration with Drs. Alicia Monroe and Jay Baruch of Brown Medical School in 2003.

181. *Id.* The course was originally titled, "Pursuing Social Justice through Interdisciplinary Practice: The Medical-Legal Collaborative." Roger Williams Univ. Sch. of Law, *supra* note 179.

182. Tyler, *supra* note 180.

183. *See* Brown Alpert Med. Sch., Concentration in Advocacy and Activism, <http://bms.brown.edu/students/curriculum/concentrations/advocacy> (last visited May 6, 2008).

184. *Id.*; Tyler, *supra* note 180.

complex narrative involving a child health problem that cannot be effectively solved by medical treatment alone and in which medical-legal collaboration offers a potentially better result. To illustrate how these concepts are explored in the joint seminars, I will focus on one joint class, which explores substandard housing and childhood lead poisoning as an example of the seminar's approach.

B. Lead Poisoning Simulation

Lead poisoning is an effective issue for exploring the intersection of poverty, health, and law.¹⁸⁵ Poisoning of young children from ingestion of lead paint chips or dust poses serious risks to their long-term health and well-being.¹⁸⁶ In Rhode Island, it remains one of the most pressing child health problems facing low-income families.¹⁸⁷ While major strides have been made in Rhode Island in the past ten years to reduce the number of children poisoned by lead, six percent of children entering kindergarten in 2007 tested positive for lead levels considered unsafe by the Centers for Disease Control (CDC).¹⁸⁸ Children in Rhode Island's urban core were twice as likely to be poisoned by lead.¹⁸⁹ While Rhode Island passed comprehensive legislation aimed at targeting unsafe rental housing in 2002,¹⁹⁰ the lack of resources committed to enforcement of lead safety regulations means that too many rental properties still pose a serious risk to children.¹⁹¹ Once more, due to

185. In addition to lead poisoning, substandard housing has multiple implications for child health from asthma and upper respiratory infections caused by mold, water leakage, poor ventilation or poor heating, to injury caused by unsafe conditions such as faulty electrical wiring or broken railings. It offers perhaps the best opportunity for medical-legal partnership because it invokes both legal and medical interventions. See generally Megan Sandel & Jean Zotter, *How Substandard Housing Affects Children's Health*, 10 CONTEMP. PEDIATRICS 134 (2000) (identifying the risks posed by substandard housing and providing case examples of successful medical/legal interventions). Other issues, like immigration status, which connect poverty and child health are also important in medical-legal collaboration and teaching. See, e.g., Samantha J. Morton & Megan Sandel, *Immigration 101 for the Pediatric Practice*, CONTEMP. PEDIATRICS, Apr. 1, 2005, at 34, 34; Lauren A. Smith et al., *Implications of Welfare Reform for Child Health: Emerging Challenges for Clinical Practice and Policy*, 106 PEDIATRICS 1117, 1117 (2000).

186. CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. DEP'T OF HEALTH & HUMAN SERVS., PREVENTING LEAD POISONING IN YOUNG CHILDREN 4 (2005), available at <http://www.cdc.gov/nceh/lead/publications/prevleadpoisoning.pdf>.

187. R.I. DEP'T OF HEALTH, CHILDHOOD LEAD POISONING IN RHODE ISLAND 1, 23 (2007) available at http://www.health.ri.gov/lead/databook/2007_Databook.pdf.

188. R.I. KIDS COUNT, RHODE ISLAND KIDS COUNT FACTBOOK 70 (2008), available at <http://www.rikidscount.org/matriarch/documents/089651%20for%20pdf.pdf> [hereinafter FACTBOOK]; R.I. KIDS COUNT, ISSUES FACING RHODE ISLAND'S NEEDIEST FAMILIES 19 (2004), available at <http://www.rikidscount.org/matriarch/documents/CAP%20Report%2001.20.04.pdf>.

189. FACTBOOK, *supra* note 188, at 70.

190. Lead Hazard Mitigation Act, 2002 R.I. Pub. Laws 875 (codified at R.I. GEN. LAWS §§ 42.128.1-1-42.128.1-13 (2006)).

191. See R.I. DEP'T OF HEALTH, HEALTHY HOUSING: WHY RHODE ISLAND SHOULD INVEST IN THE VISION (2007), available at <http://www.health.ri.gov/lead/HealthyHousingVisionRI2007.pdf> (discussing

Rhode Island's affordable housing crisis, low-income tenants are often faced with the untenable dilemma of staying in lead-infested apartments or becoming homeless.¹⁹²

Prior to the joint class, law and medical students read interdisciplinary materials on the health effects of childhood lead poisoning, the sociology of lead poisoning (disparate effects on children of color and poor children) and legal materials on tenants' rights to clean and lead-safe housing under the Rhode Island housing code and lead paint law. Community experts are invited to the joint session. These guests have included a nurse from a hospital-based lead clinic that offers comprehensive services to lead poisoned children; an advocate from the Childhood Lead Action Project, who is also the mother of a lead poisoned child; a pediatrician who treats lead poisoned children; and a housing attorney who works with low-income tenants.

Students then observe a role play involving a low-income single mother, "Ms. Johnson," whose child has been lead poisoned in her rental apartment. Ms. Johnson has been unresponsive to requests from her pediatrician to bring the child in for a visit after the pediatrician has received the high lead screening. Finally, late in the day, Ms. Johnson arrives. She is upset that her landlord has been informed by the Department of Health that her child has been lead poisoned because now he is threatening to evict her; she blames the pediatrician, Dr. "P". Dr. P is frustrated by what appears to be Ms. Johnson's lack of cooperation and unwillingness to put her child's health before all other considerations. Finally, after a tense conversation, the pediatrician convinces Ms. Johnson to speak to the attorney on staff at the hospital to see what her legal rights may be regarding eviction and finding a lead-safe apartment.

C. *Social Responsibility and Professional Boundaries*

One of the key components of the joint seminars is to engage law and medical students in thinking about the extent of their obligation to serve poor clients/patients who have complex social problems. What obligation do physicians have to the poor? How does this obligation compare with that of lawyers?¹⁹³ Students are asked to consider their professional training: How are messages about social responsibility conveyed or not conveyed in their legal or medical education?

the importance of enforcement in reaching the state's goal of eliminating childhood lead poisoning by 2010).

192. ELIZABETH TOBIN TYLER, *SAFE AND SECURE: ENFORCING THE RIGHT OF LOW-INCOME TENANTS AND THEIR CHILDREN TO LEAD-SAFE HOUSING* 9–10 (2002) (on file with the author).

193. Discussion often centers around whether lawyers have the same obligations to care for those who cannot afford to pay as do physicians. For example, students are asked to compare the physician's obligation to treat any patient in an emergency situation without regard to ability to pay with a lawyer's role in offering legal assistance to a poor client who may be evicted from her housing or lose an important public benefit causing her to lose her housing or not be able to feed her children.

These kinds of questions inevitably lead to the question of professional boundaries. If physicians are trained to address health problems, can they be expected to ask patients about their broader concerns—Why is Ms. Johnson so afraid of eviction? Does she really have no place to go? Students struggle with these questions. Often, medical students challenge the expectation that physicians should serve as “social workers.” If a physician begins to explore issues like housing with every patient, can she adequately address what she is there for—to provide medical care?

Similarly, law students are often reluctant to see their role as “solving all of the client’s problems,” rather than identifying and winning their client’s legal case. If Ms. Johnson’s legal problem is eviction, does the attorney have a role or obligation in assisting Ms. Johnson beyond trying to defend her in an eviction action, if that is what the client’s wishes are? Because these discussions occur in an interdisciplinary setting, students have the opportunity to reflect on their expectations about their own chosen profession, but also compare those expectations with students from another profession. The medical and legal professions are generally narrowly defined for students. Understanding Ms. Johnson’s concerns—larger than the medical problem of childhood lead poisoning or the legal problem of eviction—helps students reassess that narrow vision of their professional roles.

D. Ethical Reflection on the Physician/Patient and Lawyer/Client Relationship

The question of professional obligations and boundaries is explored further in the joint sessions by helping students to consider how they hear and listen to patient or client stories and to consider the problem from multiple viewpoints. Before attempting to “solve” Ms. Johnson’s problems, students are asked to first come up with a list of questions to help fill in Ms. Johnson’s “narrative.” In doing so, students step out of their narrow training in “discovery” of the facts relevant to a legal issue or “diagnosis” of a medical problem and into a broader understanding of the client’s/patient’s social context and struggles.

Students are then asked to consider what they have just observed in the role play from the perspectives of both Ms. Johnson and Dr. P. This discussion forces students to reflect on their own biases and assumptions about poor patients and clients. Some students immediately see Ms. Johnson as not sufficiently caring about her child’s health and deserving of blame. Should child protection services be called to remove the children if Ms. Johnson will not act? Why isn’t she more responsive to Dr. P’s attempts to help her? Others question Ms. Johnson’s choices: Is it possible that she can’t just move to a safe apartment? Why is she in this position to begin with? Why is she poor? Why is she a single mother? What support systems or resources currently exist for Ms. Johnson? How can the attorney and/or the physician help Ms. Johnson to identify resources?

Students also must imagine themselves in their professional roles, responding to Ms. Johnson's problem. How might the physician solicit information from Ms. Johnson to show her that she is on her side? Why might Ms. Johnson seem uncooperative? How might Ms. Johnson perceive Dr. P? Is there a perceived power differential between Ms. Johnson and Dr. P? How is Ms. Johnson likely to respond to the lawyer? How can the physician and the lawyer better understand the issues Ms. Johnson faces before trying to tackle her problem?

Before jumping into the medical or legal problem, students are asked to strip away their own assumptions about their role as problem-solver and first try to understand the problem from the client's perspective. One student reflects on this process:

By taking away professional labels, one is able to focus solely on the client herself, her problems, and her concerns. Once this is achieved, then the labels of the professionals can come back into play. It is only then that the lawyer should really start acting like a lawyer, giving legal advice, considering options to pursue, etc. This stage can be even more effective with the help of doctors, social workers, and other professionals, giving their opinions and advice about the problem *from the client's perspective*.¹⁹⁴

E. A Creative and Holistic Approach to Problem-Solving

After the role play, students are divided into small groups containing both medical and law students. They are asked to think creatively and holistically about Ms. Johnson's problem. The intentional irony created by the lead poisoning scenario we present is that if the lawyer does his job, he will prevent Ms. Johnson from being evicted from an apartment that may continue to poison her child. If Dr. P is to do her job, she will encourage Ms. Johnson to leave the unsafe apartment only to potentially put the child at risk of homelessness. In helping law and medical students to expand their thinking about creative problem-solving, we help them to reassess the problem beyond the narrow medical or legal context with which they are most familiar.

If Dr. P urges Ms. Johnson to leave her apartment in order to reduce her child's lead level without regard to the consequences of this advice, she has not holistically addressed the child's health. If her obligation is to protect her patient's health, she must understand that the child lives in unsafe housing because of poverty and her mother's limited choices. If the attorney sees Ms. Johnson's problem simply as an eviction case and that "winning" that case is his only obligation, then he might inadvertently cause future harm to the child.

194. Reflection Memorandum from a Roger Williams University Law Student to author (2004) (on file with author).

Working together, the law and medical students begin to ask important questions that redefine the problem and possible solutions: To whom can Ms. Johnson turn for help? How might Dr. P help her identify this help? What are Ms. Johnson's legal rights and in what context might these rights both protect her right to housing and protect her child's health? How might the attorney and Dr. P work together to achieve the goal of finding alternative housing or ensuring that Ms. Johnson's current housing is made lead-safe?

Reassessing their narrow professional roles, students begin to think more broadly about problem-solving. A law student reflects:

The first instinct of a law student is to find where the blame belongs, and then attack. During the acting I was thinking it is the doctor's fault . . . the mother's fault . . . no the doctor's fault that the problem was not being communicated. I also placed blame on the landlord. After thinking it through and discussing it in my group[,], I began to see that it is not [about] where the blame needs to be put, but [rather about] finding a solution. In some cases the solution will benefit all the parties involved, including the landlord. In order to advocate for the mother (or child) all the parties['] interests need to be examined and all sources of support need to be found. This entails finding community and medical support as well as taking legal action.¹⁹⁵

F. Effective Collaboration

Many students appreciate the benefits of a more in-depth venture into a patient's or client's social context, but are skeptical that in their narrow professional roles they could realistically engage in this type of practice because of time constraints and systemic barriers. Once more, they have been trained as lawyers and doctors. They are unsure that they have sufficient training or knowledge to deal with this type of complexity. The object of inviting interdisciplinary guests to the joint classes is not just to provide important substantive knowledge about a particular problem like childhood lead poisoning, but also for students to view a problem from more than one perspective and to see that problem-solving can take place in a broader context than within their narrow profession.

Guests are invited to participate in the group discussions as resources, but not as problem-solvers. Students brainstorm possible solutions. What legal options does Ms. Johnson have? If she defends her eviction – what is the likelihood that her apartment will be made lead-safe? How might the attorney and the physician work together to pressure the landlord to comply with housing code and lead safety regulations? How can the expertise of the physician be used to help the landlord

195. Reflection Memorandum from a Roger Williams University Law Student to author (n.d.) (on file with author).

understand the effects of violating safety regulations? How can the lawyer and physician work together to identify resources for Ms. Johnson – public benefits, subsidized housing, social service programs, nutritional programs – that might alleviate the effects of poverty on her and her children?

In thinking about how to collaborate to help Ms. Johnson, students have to reassess their idealized notions about the lawyer or doctor who saves the day. One student puts it this way:

The joint session's biggest effect was that it made me view a lawyer as a spoke in the wheel, as compared to the jack-of-all-trades. It was also good to reinforce the idea that as a lawyer you should not assume that your concerns are the same as your client's or other communities involving your client. Dealing with the medical students allowed me to see that law is an extremely important tool, but by no means a cure-all.¹⁹⁶

G. Professional Ethics

While exploring the potential benefits of interdisciplinary collaboration and holistic problem-solving, students also need to understand barriers to this type of practice created by professional ethical codes. As interdisciplinary practice has become more common for lawyers in recent years, much has been written about potential problems arising because of professional rules of conduct for lawyers governing confidentiality, conflict of interest, competence, and independence of judgment.¹⁹⁷ Although both the medical and legal professions have rules governing patient or client confidentiality, lawyers are held to a higher standard than physicians with regard to what client confidences may be shared with others. Physicians are mandated reporters of child abuse¹⁹⁸ while lawyers may not share client confidences about child abuse unless the client reveals potential imminent harm.¹⁹⁹

196. Reflection Memorandum from a Roger Williams University Law Student to author (2004) (on file with author).

197. See generally Alexis Anderson et al., *Professional Ethics in Interdisciplinary Collaboratives: Zeal, Paternalism and Mandated Reporting*, 13 CLINICAL L. REV. 659, 661–62 (2007) (illuminating the conflicting rules of professional conduct for both doctors and lawyers and proposing solutions to resolve the tension); Brustin, *supra* note 129 (analyzing whether professional rules of conduct that pose obstacles to a multidisciplinary legal practice apply to non-profit organizations); 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 (2002) (explaining the advantages of a multidisciplinary legal practice and ways to preserve the core ethical values in such a setting).

198. CHILD WELFARE INFO. GATEWAY, U.S. DEP'T OF HEALTH & HUMAN SERVS., MANDATORY REPORTERS OF CHILD ABUSE AND NEGLECT: SUMMARY OF STATE LAWS 2–4 (2008), available at http://www.childwelfare.gov/systemwide/laws_policies/statutes/mandaall.pdf.

199. ABA Model Rule of Professional Conduct 1.6: Confidentiality of Information states:

The sharing of information between a physician and a lawyer in a medical-legal partnership may most effectively facilitate problem-solving. But lawyers and physicians must be careful to maintain their ethical obligations to their clients and patients. Learning about and discussing the differences in professional ethical rules for doctors and lawyers facilitates understanding of both the potential constraints caused by them, but also the principles that underlie them. Furthermore, exploring these principles through a case simulation helps students to understand how abstract principles might play out in real practice.

Law students read an article written by lawyers and a doctor from the Medical-Legal Partnership for Children in Boston, which explores complex ethical dilemmas that may arise for lawyers in a medical-legal partnership.²⁰⁰ The article explores ways for lawyers in a medical-legal partnership to uphold ethical obligations to their clients while at the same time offering options for maintaining the benefits of interdisciplinary collaboration and problem-solving.²⁰¹ In the joint class, we ask students to explore these ethical boundaries while they collaborate to identify solutions to problems. In the lead poisoning simulation, the law students struggle with the possibility that Ms. Johnson will choose to take the path of least resistance and try to stay in the unsafe apartment to avoid homelessness. What if she fears pursuing enforcement of lead safety regulations for fear of retaliation by her landlord and asks her attorney to stop all action? What if she asks her lawyer not to tell her pediatrician that this is her choice? What obligation does the lawyer have to the client to act on her wishes? What obligation does the attorney have to her colleague, the pediatrician? Does the attorney have any obligation to the child?

(a) 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 paragraph (b);

(b) A lawyer may reveal information relating to the representation of a client to the extent the lawyer reasonably believes necessary:

(1) to prevent reasonably certain death or substantial bodily harm;

....

(4) to secure legal advice about the lawyer's compliance with these Rules;

(5) to establish a claim or defense on behalf of the lawyer in a controversy between the lawyer and the client, to establish a defense to a criminal charge or civil claim against the lawyer based upon conduct in which the client was involved, or to respond to allegations in any proceeding concerning the lawyer's representation of the client; or

(6) to comply with other law or a court order.

MODEL RULES OF PROF'L CONDUCT R. 1.6 (2006); accord CHILD WELFARE INFO. GATEWAY, *supra* note 198, at 4 (explaining that when a state has a mandatory child abuse reporting law the physician-patient privilege is most commonly denied while the attorney-client privilege is most commonly affirmed).

200. Pamela Tames et al., Commentary, *The Lawyer Is In: Why Some Doctors Are Prescribing Legal Remedies for Their Patients, and How the Legal Profession Can Support this Effort*, 12 B.U. PUB. INT. L.J. 505, 510-27 (2003).

201. *Id.*

While many clients are willing for their lawyer and their pediatrician to communicate and collaborate, and therefore give permission for sharing of information, it is important for law students to understand their ethical obligations to their clients. It is also important for medical students to understand the ethical obligations of lawyers. This may prevent them from misinterpreting a lawyer's unwillingness to share information as uncollegial. As students struggle with their ethical obligations, they must evaluate their relationship with their client, their potential for creative problem-solving, and their own ethical values.

A student reflection illustrates this point:

We had discussed many times the importance of understanding your client's objectives and involving the client in your legal analysis but I found in discussing the hypothetical that I made the mistake of assuming the goals Ms. Johnson wanted. I needed to be reminded that my ethical concerns needed to remain with the mother since she was my client and I was advocating on her behalf. Thus, my responsibilities to her are to discover what her hopes and goals are for the situation and to best legally assist her in achieving those goals. Personally, if I was told my child was lead poisoned I would want to move out as soon as possible but that may conflict with what Ms. Johnson in this case would have wanted. I have learned that many times there is conflict between personal beliefs and professional responsibilities but that the client always needs to come first. I think one probably needs to constantly remind themselves of this when practicing.²⁰²

VI. OVERCOMING THE BARRIERS TO MEDICAL-LEGAL INTERDISCIPLINARY TEACHING AND LEARNING

A. *Curricular Differences in Medical and Legal Education*

In developing the joint course, we were confronted with the reality that, despite many similarities in legal and medical education (as highlighted earlier in this article), there are many differences. While the law school curriculum is generally structured around a first year of required course work with some flexibility in choosing electives beginning the second year, the medical school curriculum has a less flexible structure for course electives after the first year. During the first two years, an elective was offered at Brown University Medical School entitled, "Crossing Borders: Practicing Socially Responsible Medicine in Complex Communities," and the joint sessions with the law school were a

202. Reflection Memorandum from a Roger Williams University Law Student to author (Oct. 12, 2004) (on file with author).

component of the course.²⁰³ While the first year elective at the Medical School offered a structured curriculum to build the joint sessions around, we found that because of the first year medical students' lack of exposure to medical school and to issues of poverty and health, there was a mismatch between their experience and knowledge and that of the second and third year law students.

In years three and four, medical students were offered the opportunity to participate in the joint sessions as a stand-alone seminar.²⁰⁴ This has allowed upper level medical students with more clinical experience to participate. But because they do not take a full elective course, they do not have the same investment that they otherwise would. The law students, on the other hand, receive full elective credit for the course and tend to be better prepared and invested in the course. We continue to try to find a way to integrate the joint seminars more fully into the medical school curriculum. Brown Medical School recently overhauled its curriculum, developing a new first year "doctoring" course which introduces students to clinical settings in the first year.²⁰⁵ The goal of this change is to better prepare Brown's medical students for patient care "to fulfill our nation's ever-evolving health care needs."²⁰⁶

Despite the hurdles, one of the benefits of engaging in interdisciplinary teaching is that it sheds light on the curricular similarities and differences across medical and legal education. As each profession struggles with how best to incorporate client/patient-based learning, cross disciplinary dialogue strengthens and informs the process.

B. Approaches to Teaching and Learning

Traditional legal education uses the case-based Socratic method to teach law students to "think like lawyers"—to parse out and analyze legal issues from a set of facts.²⁰⁷ Traditional medical education, on the other hand, has used primarily lecture to teach medical students the science they will need to diagnose illness.²⁰⁸

203. Elizabeth Tobin Tyler, Syllabus, Pursuing Social Justice Through Interdisciplinary Practice: The Medical/Legal Collaborative (Fall 2003), http://www.nlada.org/Training/Train_Civil/Equal_Justice/2004_Materials/064_2004_Tyler_Handout2.

204. Brown Alpert Med. Sch., Clinical Electives Alphabetical Listing, http://med.brown.edu/students/curriculum/cl_list (last visited May 6, 2008) (follow "Law, Medicine and Ethics Elective" hyperlink).

205. Brown Alpert Med. Sch., MD Curriculum 1st Year, <http://med.brown.edu/students/curriculum/year1curriculum.php?year=1> (last visited May 6, 2008).

206. Brown Medical School, Doctoring: The Prescription for Curricular Innovation 1 (n.d.) (quoting Eli Y. Adashi, Dean of Medicine and Biological Sciences for Brown Medical School) (on file with author). The Doctoring course was introduced in the fall of 2005. *Id.* at 1. The brochure explains that "[t]o keep pace with shifting patient demographics and desires, evolving health delivery practices, new information and new technologies, medical education, too, must change." *Id.*

207. Stephanie B. Goldberg, *Beyond the Socratic Method*, 36 STUDENT LAW., Oct. 2007, at 19, 19.

208. Archie S. Golden, *Lecture Skills in Medical Education*, 56 IND. J. PEDIATRICS 29, 29 (1989).

Law students, therefore, tend to assess their success based on their ability to formulate arguments and to “out-argue” their classmates.²⁰⁹ Medical students, tend to assess their success based on their ability to retain, digest and apply scientific information.²¹⁰ As one commentator notes, we teach law and medical students different approaches to seeking truth: “[T]he two professions look for truth in unrelated ways. While medicine seeks objective, absolute truths, the law, employing the adversary system, seeks relative truths.”²¹¹ Or, put another way: “In essence, lawyers are trained to look at a black and white situation and see the gray, while doctors are trained to find the black and white from a gray situation.”²¹² Bridging these differences in teaching and learning methods and expectations in an interdisciplinary setting is not easy.

The joint classes attempt to balance methods which offer some comfort to each group, while at the same time forcing students to move beyond their expectations for their own learning. Some lecture is offered for the purpose of background information about the particular medical issue and legal principles raised in the case. In their small groups, students are encouraged to exchange information from their fields that they think is relevant and useful for problem-solving. This allows students to draw on their own educational experiences and expectations. At the same time, the interdisciplinary problem-solving approach of the course encourages students to move away from the traditional methods they have learned in their disciplines and to rely on one another to formulate solutions. They are forced to ask questions that they would not ask in their regular classrooms.

Interdisciplinary teaching can also be challenging for faculty. Preparation of the joint sessions is labor intensive and requires the time and communication necessary to ensure that the legal and medical faculty are on the same page with regard to goals for the class. Just like students, faculty maintain assumptions about the other profession that may or may not be accurate. Interdisciplinary collaboration in designing this course has increased my understanding as a lawyer of the physician’s job as both “art and science,” and I have developed a much stronger appreciation for the complexities of the physician’s role. My medical

209. Kim Diana Connelly describes the different expectations of law students regarding learning from other graduate students in terms of the competitive nature of law school classrooms: “Law students . . . have no sense of shared purpose. Instead they are implicitly encouraged to have one aim—to outperform their colleagues. It is this morally vacuous struggle for supremacy that gives legal education its narrow and nasty character.” Connelly, *supra* note 131, at 35 (quoting William Prewitt Kralovec, *Contemporary Legal Education: A Critique and Proposal for Reform*, 23 WILLAMETTE L. REV. 577, 583 (1996)).

210. At the same time, legal education has looked to medical education as a model for developing clinical experiences for law students. Naitove, *supra* note 1, at 311.

211. Joan M. Gibson & Robert L. Schwartz, *Physicians and Lawyers: Science, Art, and Conflict*, 6 AM. J.L. & MED. 173, 176 (1980).

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

colleagues, similarly, have developed an awareness of the variety of roles lawyers play as well as the limitations lawyers face. Our dialogue has helped to remove the mystique of the other profession. We have learned to ask questions and to admit our own ignorance. Our collaboration and communication becomes an important model for our students. They see us ask each other questions and turn to each other for help: we, like our students, are not always the experts.

C. Structural and Logistical Barriers

At times, the greatest challenges to interdisciplinary education seem to be logistical. Brown Medical School is thirty miles away from Roger Williams University School of Law. Students are required to travel to attend the joint sessions. The joint sessions are held in the evening to avoid conflict with other classes. Unfortunately, this means that students often must travel through rush-hour traffic to another university. This can add stress for students who already have busy schedules and heavy academic demands.

We have found, however, that students are willing to take the extra steps necessary to attend the joint sessions. To overcome some of the logistical barriers, we have looked for ways to make the joint sessions as comfortable and accessible as possible. For example, prior to beginning each class, we provide dinner and a chance for the medical and law students to talk informally with one another. Students often enjoy the opportunity to share their educational experiences with students from another discipline and the chance to step outside of the routine of law or medical classes that dominate their lives.

CONCLUSION

The medical and legal professions are at a critical juncture. As both professions have drifted toward emphasis on technical specialization and have become mired in bureaucratic systems, they both are seeking to define the core values—the “heart”—of the profession.²¹³ At the centerpiece of this search for values is legal and medical education. How do we prepare the next generation of lawyers and doctors for the realities of practice—the increasingly diverse and complex populations they will serve? What professional responsibilities do lawyers and doctors have to address and prevent the inequities that plague our society?

There is also a renewed emphasis on training our future practitioners to be reflective about their ethical responsibilities to their clients and patients.²¹⁴ Fears that we have lost touch with the human beings we serve have led to calls for legal and medical education focused on holistic approaches to the “whole” client or patient.

213. *See supra* Part III.

214. *Id.*

The medical-legal partnership not only offers a model of holistic and interdisciplinary practice, but also provides a context for training law and medical students to reflect on their professional roles, to think critically about inequity and poverty, and to acquire tools for collaborative problem-solving.²¹⁵ Bringing law and medical students together to explore these issues will not only make them more sensitive practitioners, but encourage them to ask important questions of the systems in which they will work. Interdisciplinary legal and medical education, focused on exploring common goals, also offers students a model of cooperation rather than hostility and distrust at a time when many doctors and lawyers view each other as adversaries rather than allies. By learning to collaborate, the next generation of lawyers and doctors will find a more effective way to care for their clients and patients as well as a more professionally fulfilling way to practice.

215. *See supra* Parts IV, V.