# Procuring a Cure Using the Law:

*A Legal Ethics Analysis of Utilising Lawyers in Healthcare Settings to Improve Patient Health and Access to Justice*

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## *Introduction*

Our health is not solely affected by our genes and choices. It is also affected by underlying social, cultural and economic determinants, collectively referred to as social determinants of health ("SDH").[1] SDHs manifest in a diverse array of domains including housing, healthcare, income, employment and education.[2] When problems occur in our social world related to these SDHs, they can contribute to us being unwell.[3] When such health difficulties occur, they are often at least underscored by legal problems.[4] Instead of seeking a lawyer to help solve these underlying SDHs, vulnerable New Zealanders are more likely to turn to their trusted healthcare providers.[5]

This reality has led to recognition of the role legal services could serve in improving health.[6] In New Zealand, the Ministry of Health and a number of healthcare organisations are increasingly recognising the role factors outside those which have traditionally been addressed by the health sector play in a patient's life.[7] However, the notion of integrating lawyers into the provision of healthcare services has not yet entered mainstream healthcare discussions in New Zealand.

One way of integrating medical and legal services is the concept of the health-justice partnership ("HJP").[8] The HJP models are a collaboration between healthcare and legal professionals to provide legal solutions for patients with health-harming legal problems.[9] By bringing lawyers into the space where those in need typically seek help, lawyers have a greater ability to reach those who would otherwise not seek their help.

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[1] Penelope Carroll and others "Widening the Gap: Perceptions of Poverty and Income Inequalities and Implications for Health and Social Outcomes" (2011) 37 Social Policy Journal of New Zealand 111 at 112; National Advisory Committee on Health and Disability *The Social, Cultural and Economic Determinants of Health in New Zealand: Action to Improve Health* (June 1998) at 8.

[2] Wendy Parmet, Lauren Smith and Meredith Benedict "Social Determinants, Health Disparities and the Role of Law" in Elizabeth Tobin Tyler and others (eds) *Poverty, Health and Law: Readings and Cases for Medical-Legal Partnership* (Carolina Academic Press, North Carolina, 2011) 3 at 21.

[3] Richard Wilkinson and Michael Marmot (eds) *Social Determinants of Health: The Solid Facts* (2nd ed, World Health Organisation Europe, Copenhagen, 2003) at 10 as cited in Linda Gyorki "Breaking down the silos: Overcoming the Practical and Ethical Barriers of Integrating Legal Assistance into a Healthcare Setting" (Fellowship Report, Winston Churchill Memorial Trust of Australia, 2013) at 21.

[4] Ellen Lawton and others "Medical-Legal Partnership: A New Standard of Care for Vulnerable Populations" in Elizabeth Tobin Tyler and Ellen Lawton (eds) *Poverty, Health and Law: Cases and Readings for Medical-Legal Partnership* (Carolina Academic Press, North Carolina, 2011) 71 at 74.

[5] Colmar Brunton (Report commissioned by the Ministry of Justice) *Legal Needs among Low Income New Zealanders* (Auckland, advance copy on file with the author) at 48 ("Legal Needs Survey").

[6] Paula Galowitz "The Opportunities and Challenges of an Interdisciplinary Clinic" (2012) 17(18) Intl J Clinical Legal Educ 165 at 168.

[7] See Carroll, above n 1, at 112.

[8] The term 'health-justice partnership' (HJP) is primarily used in Australia. In the United States, the equivalent is referred to as a 'medical-legal partnership'. I use the Australian term, as it is broader and better reflects the holistic purpose of such collaborations.

[9] Liz Curran "Health Justice Partnership Research ANU Research in Progress" (seminar presented to ANU Legal Conference, Canberra, October 2015) at 8.

The Minister of Health has recently expressed interest in increasing funding for this kind of preventative healthcare spending.[10] The Law Council of Australia has also recently released a comprehensive report on access to justice in Australia, with key recommendations including funding and supporting HJPs as multi-disciplinary models which help treat people's health issues with underlying legal contributors.[11] Justice Winkelmann has extrajudicially expressed that in order to increase access to justice in New Zealand, the legal profession needs to explore new ways of delivering legal services.[12] The HJP model is a feasible option for implementing this kind of "upstream" healthcare and preventative justice.[13] In this dissertation I will examine some of the ethical and practical issues that may arise for lawyers practising within an HJP model.

In Chapter I I will provide an overview of the HJP concept, the impact of HJPs as implemented overseas, and discuss how HJPs could benefit vulnerable New Zealanders.[14] The structure and efficacy of such partnerships as demonstrated in the United States and Australia are largely transferable to the New Zealand context, and therefore will be drawn on throughout this dissertation.[15] In this dissertation I will explore the benefits of healthcare professionals and lawyers working together on behalf of patients, rather than healthcare and legal professionals working isolated in respective professional silos.[16] I will outline three HJP models with differing levels of integration between the healthcare and legal professionals.

In Chapter II I will then examine the ethical barriers for lawyers practising in an HJP model under New Zealand's current legal ethical framework. To do this I have created several fact

[10] Lucy Bennett "Government announces review of New Zealand's health, disability system" *The New Zealand Herald* (online ed, Auckland, 29 May 2018) quoting Minister of Health David Clark: "[The new Labour government's fiscal plan will] focus on primary care and preventative health as well as the hospital system."
[11] Law Council of Australia "The Justice Project Final Report – Part 2: Legal Services" (23 August 2018) at 91.
[12] Justice Helen Winkelmann "Access to Justice – Who Needs Lawyers?" (2014) 13(2) Otago LR 229 at 242.
[13] "Upstream" healthcare involves treating the fundamental sources of illness, such as "pre-existing social, cultural, financial, environmental and historical factors": Victoria Smith "Upstream or downstream?" (2015) 203(10) Med J Aust 412 at 412. The term is based on the analogy of the source of a river being similar to the source of SDHs, both of which are located "upstream".
[14] "Vulnerable" New Zealanders in this context are those "without much money (students, beneficiaries, those unemployed or on low incomes), those who have trouble reading, are homeless, transient or in a crisis living situation, who come from a refugee background, or are adversely affected by disability, mobility issues, mental illness, or violence.": Community Law "Free Legal Help: Am I Eligible?" <http://communitylaw.org.nz/free-legal-help/eligibility/>. See also Elizabeth Tobin Tyler and Joel Teitelbaum *Essentials of Health Justice: A Primer* (Jones & Bartlett Learning, Massachusetts, 2018) at 34-35.
[15] The findings from Australian HJPs influenced by the American experience of combining health and legal services are transferrable to New Zealand because both countries operate under a common law system. This is based on evidence that the underlying trends which HJPs address transcend the particulars of different healthcare and legal systems: Peter Noble "Advocacy Health Alliances: Better Health Through Medical-Legal Partnership" (Fellowship Report, Clayton Utz Foundation, 2012) at 16.
[16] A discussion on the history and development of this multidisciplinary approach to healthcare is outside the scope of this dissertation. For background context on this, see generally Joel Teitelbaum and Ellen Lawton "The Roots and Branches of the Medical-Legal Partnership Approach to Health: From Collegiality to Civil Rights to Health Equity" (2017) 17(2) Yale Journal of Health Policy, Law and Ethics 343.

scenarios to demonstrate how an HJP could increase patient wellbeing. I then examine the ethical implications under our current Lawyers and Conveyancers Act (Lawyers: Conduct and Client Care) Rules 2008 ("the Rules"). The aim of this analysis is to determine which HJP model raises the least ethical barriers while still delivering practical benefits to the patient.

In Chapter III I will summarise the ethical implications of each HJP model explored in Chapter II, and examine the changes required to facilitate effective implementation of the HJP model that best balances benefits to patients and protection of the lawyer's role and independence. I will propose what such changes could look like, and ultimately conclude that changes to the Rules may be necessary to allow long-term effective and successful implementation of a beneficial HJP model in New Zealand.

This dissertation seeks to respond to the call for further exploration of the ethical and practical boundaries that are raised in these health law partnerships.[17] I aim to provide some preliminary insight as to how healthcare and legal professionals with different ethical obligations may collaborate in an HJP to successfully provide holistic care in the New Zealand context.[18]

The implementation of an HJP model in New Zealand would also require a number of other considerations to be taken into account, including financial, administrative and sociological considerations. My analysis in this dissertation is limited to the tenability of an HJP model for lawyers in light of professional ethical constraints. The following discussion therefore proceeds on the assumption that an HJP model is workable from the other perspectives as mentioned above.

[17] Marcia Boumil, Debbie Freitas and Cristina Freitas "Multidisciplinary Representation of Patients: The Potential for Ethical Issues and Professional Duty Conflicts in the Medical-Legal Partnership Model" (2010) 13 J Healthcare L & Poly 107 at 138.

[18] This dissertation is limited to discussion of access to civil justice. Access to criminal justice involves different considerations, and is thus beyond the scope of my research. See Winkelmann, above n 12, at 231.

## *Chapter I: An Overview of HJPs*

To understand how an HJP operates, it is useful to understand how it would work in practice. Imagine the following scenario:

> An infant girl, Sarah, is brought to the Dunedin hospital by her father Dan. Sarah is struggling to breathe and displays symptoms indicative of severe bronchiolitis. Sarah first fell ill with what appeared to Dan to be a common cold. However, Dan explains to the nurse Sarah has suffering from recurrent wheezing and coughing, and despite having been to their GP several times, her condition has not improved. Dan is very worried and at a loss as to what to do. The doctor diagnoses Sarah with bronchiolitis, and she remains in hospital for supportive care and monitoring for a week. She is discharged home but returns to the hospital twice more that winter with wheezing and bronchial issues.

What might have happened if rather than only receiving medical care, a lawyer had met with Dan as Sarah's caregiver? Imagine instead the following:

> When Dan mentions Sarah has been to the GP several times with no improvement, the nurse asks what Dan and Sarah's living situation is like. Dan explains the house he is renting in the North East Valley was previously a dingy student flat, but is the only housing he can currently afford as a solo parent. He says it is constantly damp and has small patches of mould growing, despite his best efforts to air out the house. The dampness is worsened by several leaks in the roof, for which he has asked the landlord to remedy several times to no avail. The nurse asks Dan if he might be interested in talking to a lawyer free of charge based in the hospital about his housing. Dan says he would be very interested.
>
> The lawyer is doing the rounds in the hospital, and comes to talk to Dan. After Dan explains the issues with his housing, with the lawyer's assistance Dan writes a letter to the landlord demanding they fix the leaky roof. Prompted by the possibility of legal action, the landlords promptly fixes the leaks in the roof. With the removal of the main source of dampness in the flat, Sarah's bronchiolitis and accompanying wheezing settles, and she returns to normal health after a couple of weeks.

Instances of children afflicted with bronchiolitis such as the scenario outlined above are disconcertingly common in New Zealand.[19] Damp housing is a common contributor to or cause

[19] See for example Torika Tokalau "Family told to stay in damp state house because new home is unsafe" (4 August 2018) Stuff Local News Western Leader <www.stuff.co.nz/auckland/local-news/western-leader/105954416/family-told-to-stay-in-damp-state-house-because-new-home-is-unsafe>; Ethan Donnell

of winter health problems in New Zealand,[20] with hospitals opening up several wards dedicated solely to caring for children with bronchiolitis.[21] The addition of the lawyer in the scenario above enabled the living conditions exacerbating Sarah's health conditions to be identified and addressed.[22] Instead of providing more medical care, the solution for Sarah in this scenario was to provide her with improved housing. This forms the conceptual basis of the HJP innovation: integrating legal assistance into healthcare to solve health problems capable of legal resolution.

### *A The Rationale for HJPs*

As outlined by Lawton and others, the rationale behind integrating legal assistance into healthcare is built on three key understandings:[23]

> (1) the social, economic and political context in which people live has a fundamental impact on their health; (2) these social determinants of health manifest in the form of legal needs; and (3) attorneys have special tools and skills to address these needs.

The role of the lawyer within the HJP model is to facilitate what Zuckerman and others refer to as "preventative law", by addressing their legal needs before they become urgent instead of following the traditional crisis-driven care model.[24] HJPs are becoming increasingly popular as a form of preventative healthcare in overseas jurisdictions. As of 2017, there were 48 HJPs operating in Australia,[25] and over 300 operating in the United States.[26] Both of these numbers have grown exponentially in the last five years.[27] It stands to reason that the benefits of HJPs could also be realised in New Zealand,[28] where access to civil justice is a challenge for many

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"Mould Sweet Mould: Inside New Zealand's Damp Housing Crisis" (22 August 2018) The Spinoff Society <https://thespinoff.co.nz/society/22-08-2018/mould-sweet-mould-inside-new-zealands-damp-housing-crisis/>.

[20] Donnell, above n 19.

[21] Elizabeth Craig, Pip Anderson and Catherine Jackson "The Health Status of Children and Young People in Otago" (report presented to Otago District Health Board, New Zealand Child and Youth Epidemiology Service, November 2008) at 137.

[22] Bryn Jones "Housing is a health issue too" (1 March 2018) The Spinoff Ātea <https://thespinoff.co.nz/atea/01-03-2018/housing-is-a-health-issue-too/>.

[23] Lawton and others, above n 4, at 74.

[24] Barry Zuckerman and others "Why Paediatricians Need Lawyers to Keep Children Healthy" (2004) 114(1) Pediatrics 224 at 226.

[25] Suzie Forell "Mapping a new path: The health justice landscape in Australia, 2017" (Report, Health Justice Australia, 30 August 2018) at 6.

[26] Marsha Regenstein, Jennifer Trott and Alanna Williamson "The state of the medical-legal partnership: findings from the 2016 National Centre for Medical-Legal Partnership Surveys" (Report, National Centre for Medical-Legal Partnership, August 2017) at 4.

[27] Forell, above n 25, at 6; Regenstein, Trott and Williamson, above n 26, at 8.

[28] The premise of HJPs relies on healthcare for vulnerable populations being accessible. This is called into question by research from Jackie Cumming "New Zealand's health service performs well, but inequities remain high" *The Conversation* (online ed, Australia, 20 September 2017). See also OECD "Unmet needs for health care due to cost" in *Health at a Glance 2017: OECD Indicators* (online ed, Paris, 2017) at 91, which shows New Zealand has a higher level of unmet care needs by cost for adults than the Organisation for Economic Cooperation and Development's (OECD) average.

people.[29] While in this dissertation I primarily focus on HJPs servicing vulnerable populations, the discernible benefits of HJPs extend to anyone who has a health problem with an underlying legal element.[30]

### *B The Need for HJPs in New Zealand*

Access to low cost legal services is a serious problem in New Zealand.[31] There are very limited services available and the main provider, the Community Law Centre, is constrained by its resources.[32] A recent study commissioned by the Ministry of Justice established that low-income New Zealanders have several unmet legal needs which directly harm their health and safety.[33] However, they are more likely to consult their trusted healthcare professional with these unmet legal needs than a lawyer.[34] Research shows people are more likely to seek assistance from healthcare providers for their issues which are capable of legal redress with healthcare providers.[35] Embedding lawyers in a healthcare setting improves the likelihood of those issues being resolved.

Responding to health problems with a multi-disciplinary approach, which recognises more than just biological determinants of health, is therefore a promising approach. At the time of writing, there was no formal collaboration partnership between healthcare and legal providers identified as currently operating in New Zealand on a substantially similar basis to the HJP paradigm.[36] In light of this need for low cost legal services in New Zealand, I will now turn to how HJPs may be able to fill this need.

### *C The Impact of HJPs*

While the goal of an HJP is to provide improved patient health, there is a lack of robust empirical evidence showing that HJPs improve patient health, or any improvements on a larger scale for the HJP professionals, the wider community, or the efficacy of the state in funding

[29] See Kayla Stewart and Bridgette Toy-Cronin "The New Zealand Legal Services Mapping Project: Finding Free and Low-Cost Legal Services" (Civil Justice Insights Series Report, University of Otago Legal Issues Centre, 21 May 2018) at 19.
[30] Margaret Castles "Possibilities for Multidisciplinary Collaboration in Clinical Practice: Practical Ethical Implications for Lawyers and Clients" (2008) 34(1) Mon LR 116 at 118.
[31] Steven Zindel "The parlous state of civil access to justice in New Zealand" *LawTalk 920* (New Zealand, 3 August 2018) 54 at 54; Winkelmann, above n 12, at 232; Legal Needs Survey, above n 5, at 45; Stewart and Toy-Cronin, above n 29, at 8.
[32] Stewart and Toy-Cronin, above n 29, at 16-17.
[33] Legal Needs Survey, above n 5, at 45.
[34] At 48.
[35] Gyorki, above n 3, at 23.
[36] There are some multidisciplinary teams operating in New Zealand for justice problems, for example the New Zealand Youth Court, which has team comprising of mental health nurses, alcohol and other drug clinicians, youth justice social workers, education officers, lay advocates and youth advocates working to help prevent reoffending.

preventative healthcare.[37] However, Teitelbaum and Lawton suggest the available data demonstrates that HJPs are an effective tool at improving patient health.[38]

HJPs are thought to provide patients with improved legal outcomes, by identifying legal issues and addressing them early.[39] This can have a secondary effect of improving a patient's health.[40] It is also thought that HJPs benefit patients by helping them to take their medications as prescribed;[41] arming them with the knowledge to better advocate for themselves in the future;[42] and reducing patient stress.[43] HJPs are also thought to provide institutional benefits, including an increase in professional satisfaction for the providers;[44] financial benefit to patient and healthcare organisations through an increase in care efficacy;[45] the development of trust between the HJP professionals;[46] the development of interdisciplinary professional skillsets;[47] and building up trust in the legal profession.[48] The building of trust in the legal profession has been observed by Professor Glock of the Yale Law School HJP:[49]

> We have patients who never trusted lawyers, who would never seek out legal help from which they could benefit, but who come to the medical setting and meet lawyers who become their advocates. That work helps build community, while improving healthcare.

Given HJPs are expected to deliver this wide range of benefits, it may be that New Zealand will follow Australia's lead in establishing HJPs. There is more work to be done to establish whether HJPs do in fact deliver these benefits. However, in this dissertation I am not primarily focussed on the evidential basis for HJPs. The question I seek to address is: what are the implications for lawyers' professional ethics when working in the multi-disciplinary HJP

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[37] Daniel Atkins and others "Medical-Legal Partnership and Healthy Start: Integrating Civil Legal Aid Services into Public Health Advocacy" (2014) 35 J Leg Med 195 at 208; Teitelbaum and Lawton, above n 16, at 366.
[38] See Teitelbaum and Lawton, above n 16, at 366.
[39] Law Council of Australia, above n 11, at 5; Lawton and others, above n 4, at 82.
[40] Teitelbaum and Lawton, above n 16, at 360.
[41] Joel Teitelbaum and others "Medical-Legal Partnership Fundamentals and Strategies" (seminar presented to the National Centre for Medical-Legal Partnership, 13 May 2016) at 6.
[42] Lawton and others, above n 4, at 83.
[43] Gyorki, above n 3, at 23; Regenstein, Trott and Williamson, above n 26, at 26.
[44] Robert Pettignano, Sylvia Caley and Susan McLaren "The Health Law Partnership: Adding a Lawyer to the Health Care Team Reduces System Costs and Improves Provider Satisfaction" (2012) 18(4) J Public Health Manag Prac E1 at E1.
[45] Regenstein, Trott and Williamson, above n 26, at 26; Lawton and others, above n 4, at 87.
[46] Law Council of Australia, above n 11, at 85-86; Amy Campbell and others "How Bioethics Can Enrich Medical-Legal Collaborations" (2010) 38(4) J Law Med Ethics 847 at 848; Mary Anne Noone and Kate Digney "It's Hard to Open Up to Strangers" (Research Report, Legal Services Board Victoria, 2010) at 110.
[47] Gyorki, above n 3, at 19; Mary Anne Noone and Kate Digney "It's Hard to Open Up to Strangers" (LaTrobe University Rights and Justice Program Research Report, Legal Services Board Victoria, 30 September 2010) at 110.
[48] See Saskia Righarts and Mark Henaghan "Public Perceptions of the New Zealand Court System" (2010) 12(2) Otago LR 329 at 343; Noone and Digney, above n 47, at 98-99.
[49] YLS Today "Finding a Cure Through Law" (June 15 2017) News <https://law.yale.edu/yls-today/news/finding-cure-through-law>.

setting? Before addressing this question, it is important to understand the difference HJP models, so I will now outline the characteristics of the three HJP models I will be considering.

### *D Potential HJP Models for Implementation in New Zealand*

I will explore the viability of introducing one of three possible HJP model structures into New Zealand: the HJP-Referral model; the HJP-Collaboration model; and the HJP-Integration model, all of which will be described below.[50] These three HJP models are variations on a partnership between a hospital and a community law centre ("CLC") to provide general civil legal services to vulnerable individuals. There is no 'one-size fits all' HJP model. The structures of individual models used are most effective when tailored to the need of the local community to be served.[51]

My analysis will explore the ethical barriers raised by various levels of integration of the CLC lawyer into the hospital on this basis. I have chosen CLC lawyers as the HJP legal partner based on the Australian pilot HJP finding that CLCs were the best suited due to their ability to operate with limited funds and flexible nature.[52] CLCs in New Zealand are set up specifically to increase accessibility to justice for vulnerable individuals,[53] and are therefore present as the best legal partner to pilot an HJP in New Zealand.[54]

#### *1 HJP-Referral*

This model is a loose referral network whereby healthcare professionals refer hospital patients who they identify as having potential legal issues for further help to a lawyer based off-site in a CLC for further help.[55] The CLC accepts referrals from a number of hospitals, who each refer individual cases for assistance.[56] The legal and healthcare professionals do not further directly collaborate in any way on patient cases.

Both the legal and healthcare professionals retain their full professional autonomy. The acceptance and priority of patient cases is determined entirely by the lawyer. The healthcare team does not have any input into the legal assistance past the initial referral to the lawyer. Referral networks do not involve structured interaction between the professionals or systematic

[50] The models discussed are drawn from the National Centre for Medical-Legal Partnership (the American equivalent of HJPs). The models differ according to level of lawyer integration in the healthcare setting. Jane Thorpe and others "Information Sharing in Medical-Legal Partnerships: Foundational Concepts and Resources" (Privacy Brief, National Centre for Medical-Legal Partnership, 2017) at 6.
[51] Gyorki, above n 3, at 44.
[52] At 69-70. The New Zealand Bar Association has also recently recommended it should be providing active support for CLC projects, such as HJPs. See New Zealand Bar Association "Access to Justice: Report of the New Zealand Bar Association Working Group into Access to Justice" (1 September 2018) at [2.41].
[53] See the definition of CLCs in s 85 of the Legal Services Act 2000 (repealed by the Legal Services Act 2011).
[54] Community Law "Free Legal Help: Am I Eligible?" <http://communitylaw.org.nz/free-legal-help/eligibility/>.
[55] Thorpe and others, above n 50, at 6.
[56] Teitelbaum and others, above n 41, at 9.

screening of patients for unmet legal needs.[57] This means there is no information sharing between the professionals, and no dedicated HJP staff. This loose referral network could provide some benefit to patients, although commentators question their efficacy.[58]

### *2 HJP-Collaboration*

In the HJP-Collaboration model, the lawyer is employed by the CLC but is based on-site across several hospitals part-time over the course of a week. The CLC is formally recognised as a partner institution to the hospital, but the CLC lawyer is not considered to be part of the healthcare team. The patients are screened by the healthcare team for unmet legal needs, and those patients are then asked if they would like to discuss possible legal assistance with an on-site lawyer.

With the patient's permission, the hospital healthcare professionals provide some initial information to the lawyer, and arrange for the lawyer to be able to come and see patients on the ward. The lawyer assesses whether the patient is eligible for legal assistance covered by the HJP, and if they are provides the client with a written retainer agreement to commence their lawyer-client relationship. The healthcare team may provide some input as to which clients should be accepted for further legal assistance, but client priorities are determined by the lawyer.

To the extent they have the patient-client's permission to do so, the lawyer and healthcare professionals sporadically discuss patient cases together, including sharing health and legal information pertaining to the patient's needs, on an as-needed basis. Healthcare services are viewed as the primary service the hospital offers, with the legal services providing a support mechanism to enable the best possible heath outcome for the hospital patients.[59] While the HJP partners remain as separate organisations, they deal with their shared patient-client needs at the same time.[60] This collaborative style is a 'warm-referral', rather than the cold-referral style of the HJP-Referral model.

### *3 HJP-Integration*

The HJP-Integration is a full partnership model, with the healthcare and legal professionals operating an HJP as one organisation under the umbrella of the hospital. In New Zealand this would mean that the lawyers, while trained by a CLC, would be employed by the local District

[57] Teitelbaum and others, above n 41, at 9.
[58] Elizabeth Tobin Tyler "Aligning Public Health, Healthcare, Law and Policy: Medical-Legal Partnership as a Multilevel Response to the Social Determinants of Health" (2012) VIII J Health & Biomed L 211 at 235 as cited in Peter Noble "Advocacy Health Alliances: Better Health Through Medical-Legal Partnership" (Fellowship Report, Clayton Utz Foundation, 2012) at 6.
[59] Castles, above n 30, at 129.
[60] At 129.

Health Board to provide legal services to patients. The embedded lawyers are formally recognised as part of the healthcare team. Hospital staff members run the administrative side of HJPs, carrying out tasks such as maintaining communication between the HJP professionals.[61]

The HJP healthcare professionals are trained by the legal professionals to recognise the "health-harming legal needs" of their patients, and work alongside the lawyers to provide tools to reduce and if possible remedy them completely.[62] Such lawyers spearhead and assist with the frontline screening of patients and offer immediate legal advice on-site for those who require it.[63] By being on-site, in the same manner as the HJP-Collaboration model, the lawyer and healthcare professionals develop and strengthen their inter-professional relationships, improving their ability to supply streamlined patient care and delivery of successful outcomes. Working as one seamless healthcare team improves the ease of referring patients to the legal staff consistently and efficiently.[64]

Acceptance by the HJP lawyer of a patient's case as a client would be a matter of discussion between all of the HJP healthcare team, including the lawyer. This discussion would occur once the HJP team had identified the patient has unmet legal need or needs. The priorities for accepting legal clients for the free legal assistance would align with the agreed institutional priorities of the HJP. There would also be an expectation of a feedback loop as to progress of a patient's legal and health status ongoing throughout the HJP process.[65]

### *E Summary*

The main distinction between the HJP models is the level of information sharing and information management style between the partners.[66] The process for gaining patient consent to disclose health information to the lawyer remains generally consistent across models. This process involves completing a written consent form with the healthcare staff's assistance. However, this can be adjusted to suit different patient needs: for example patients with lower literacy may require more comprehensive explanation to understand what they are consenting to, whereas more competent patients may only require a simple registration form.[67]

[61] Thorpe and others, above n 50, at 6.
[62] Regenstein, Trott and Williamson, above n 26, at 4.
[63] Zuckerman and others, above n 24, at 226; Thorpe and others, above n 50, at 6.
[64] Joanna Theiss and Marsha Regenstein "Facing the Need: Screening Practices for Social Determinants of Health" (2017) 45 J Law Med Ethics 431 at 431.
[65] Pamela Tames and others "The Lawyer Is In: Why Some Doctors are Prescribing Legal Remedies for Their Patients, and How the Legal Profession Can Support This Effort" (2003) 12 Boston University Pub Int LJ 505 at 510.
[66] Thorpe and others, above n 50, at 7.
[67] At 10.

There are various issues pertaining to HJPs that I have not covered in this dissertation, such as funding, employment specifics, and possibilities for HJP partnership outside of lawyers and doctors, to name a few.[68] Such considerations are outside the scope of this dissertation. I will therefore proceed on the assumption that there is a tenable solution for all of these issues, and will focus on finding a solution for implementation from a legal ethics perspective.

While each of the HJP models outlined above may have different attractions and advantages, it is important that the chosen model is tailored to the needs and structure of New Zealand's healthcare system. Having outlined the expected benefits of an HJP model to New Zealand and explained the three models, I now turn to look at the ethical implications for lawyers working in an HJP. The ethical implications will be considered in relation to a lawyer working under each HJP model, and the variations in ethical barriers that arise between the models.

[68] Elizabeth Tobin Tyler, Melissa Rodgers and Dana Weintraub "Bridging the Health and Legal Professions through Education and Training" in Elizabeth Tobin Tyler and others (eds) *Poverty, Health and Law: Readings and Cases for Medical-Legal Partnership* (Carolina Academic Press, North Carolina, 2011) 97 at 117-121.

## *Chapter II: Ethical Analysis of HJP Models*

### *A Legal Ethical Framework in New Zealand*

Before discussing the ethical implications of the different HJP models, I will briefly outline the legal ethical framework mandating legal practice in New Zealand. The legal profession in New Zealand is principally self-regulated.[69] The New Zealand Law Society is the main governing body, with the Law Society's powers to govern the legal profession being conferred by statute and are subject to the state's authority.[70] The obligations lawyers owe to clients are set out in the Rules. These are the minimum standards New Zealand lawyers are required to observe in providing legal services. The Rules apply to all lawyers, irrespective of the professional setting in which they practice, including practice in a private law firm, sole practice, in-house counsel, or within the public sector.[71]

The core obligations of lawyers in New Zealand are premised on the following fundamental concepts as set in s 4 of the Lawyers and Conveyancers Act 2006 ("LCA"): upholding the rule of law and facilitating the administration of justice; independence in provision of client service; abiding by duties of care and fiduciary duties owed to clients; and protecting the interests of clients. Commentators in overseas jurisdictions where HJP models have already been trialled have identified some professional legal ethical obligations that may be compromised by working in an HJP setting. These include: confidentiality; avoidance of conflicts of interest; independence of professional judgement; mental capacity of clients; unauthorised practice of law; and others.

If a lawyer was to work in an HJP they would therefore be bound by, and would be required to observe, the Rules in the same way as those practising in any other setting. However, the professional ethical obligations of lawyers are not limited to the Rules, and are further guided by the common law and equity as to what constitutes acceptable professional legal conduct.[72] HJP lawyers would be required to balance providing a useful service in an unconventional setting, while still complying with legal ethical obligations. The differences in setting, where the lawyer is not acting as an independent practitioner, but rather as a part of a team or network of other professionals, could expose the lawyer to novel ethical challenges and render the lawyer liable to being in breach of the Rules.[73] Breaching the Rules could compromise not only a lawyer's position, but it would also have the potential to bring the profession into disrepute in the eyes of the public.[74]

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[69] Duncan Webb, Kathryn Dalziel and Kerry Cook *Ethics, Professional Responsibility and the Lawyer* (LexisNexis, Wellington, 2016) at 9.
[70] At 9.
[71] Lawyers and Conveyancers Act (Lawyers: Conduct and Client Care) Rules 2008, Preface.
[72] Webb, Dalziel and Cook, above n 69, at 72.
[73] See Castles, above n 30, at 120.
[74] See Webb, Dalziel and Cook, above n 69, at 98.

## *B Principles Applied to Case Scenarios*

Rather than thinking about these issues only in the abstract, it is instructive to examine the ethical issues in the context of an example. This provides a clearer explanation of how the Rules would work in practice in an HJP model. The example I have chosen is an elder abuse scenario. Reports of elder abuse in New Zealand have proliferated along with an increase in the ageing population.[75] Elder abuse is often difficult to detect, as 76 per cent of alleged elder abuse is carried out by family members.[76] It is estimated up to 10 per cent of New Zealanders aged 65 and over are elder abuse victims.[77] The Crimes Act 1961 provides direct statutory protection for vulnerable elderly people.[78] The threshold for criminal sanction is however very high, which renders intervention and protection of those experiencing abuse difficult.

An elderly person's admission to hospital can function as an important window of opportunity for an elderly patient to disclose abuse, and may be the only time they are separated from their abuser.[79] The provision of legal intervention in such cases of elder abuse may be helpful to assist in protecting elderly patients in harmful situations that do not meet the threshold of the Crimes Act provisions. I therefore use a fictional scenario of a patient suffering elder abuse to illustrate the benefits an HJP might provide while also exploring the legal ethical issues that may arise for the HJP lawyer.

*Case Scenario: Elder Abuse*

> Margaret, an 80 year old widow, is admitted to Auckland Hospital with a fractured hip after falling down the stairs at her home. Margaret is dishevelled, withdrawn and the nurses note that she seems to be slightly confused at times. Margaret has been brought into the hospital by her adult daughter Caroline, who is living with Margaret.
>
> An orthopaedic surgeon in the HJP team diagnoses a hip fracture and informs Margaret and Caroline that Margaret will require a surgical repair. The orthopaedic surgeon tells that Margaret that she needs to stay a week in hospital to allow for post-surgery recovery of her hip, following which she can be

[75] Mark Fisher and Janet Anderson-Bidois (eds) "This Is Not My Home: A collection of perspectives on the provision of aged residential care without consent" (Report, Human Rights Commission, 2018) at 12.
[76] Brenda Harwood "Level of elder abuse cases a great concern" *The New Zealand Herald* (online ed, Auckland, 17 June 2018). For an example of this, see Andrew Couper "Son 'relentless' in draining parents' life savings" *The New Zealand Herald* (online ed, Auckland, 6 Sep 2018).
[77] Harwood, above n 76.
[78] Crimes Act 1961, ss 195 and 195A.
[79] The Government-led Office of Seniors has recently taken to hiding crossword clues such as "Making an older person's decision for them" with the answer "abuse", in an effort to reach elder abuse victims being controlled by their abusers: Isaac Davison "Mother invests $100,000 in house only to be locked out and threatened" *The New Zealand Herald* (online ed, Auckland, 18 June 2018).

discharged. The surgeon indicates that Margaret's options are moving back to her home under Caroline's care, or moving into residential care. The surgeon notes that Margaret exhibits some confusion and requests a consultation from a geriatrician. The geriatrician diagnoses Margaret with early stage dementia.

While waiting on the ward for her surgery, Margaret talks to one of the hospital nurses and tells her that she does not want to continue living with Caroline. Margaret describes how Caroline controls the flow of Margaret's money, and spends most of it on herself. Margaret says that she is worried Caroline is going to continue draining her money and will not look after her properly. She is afraid it will get worse given she now cannot move around and the doctor has said she has dementia.

Margaret tells the nurse that she and Caroline went to visit a lawyer about a month ago, where she granted Caroline sole enduring powers of attorney (EPA). Margaret subsequently tells the nurse that Caroline was adamant that Margaret had "lost her marbles" and needed Caroline's help to manage her affairs. Subsequent to Margaret granting Caroline EPA, whenever Margaret has raised her opinion with Caroline or tried to discuss handling of money, Caroline gets verbally abusive towards Margaret and ignores her until she apologises for interfering with Caroline's care of her. Margaret's comments raise a red flag with the HJP nurse.

How the HJP nurse would next proceed would depend on the HJP model under which the hospital was operating. I therefore now turn to explain how the legal advice would be provided in each of the HJP models.

### *1 HJP-Referral*

The nurse would tell Margaret that she thinks Margaret would benefit from seeing a lawyer to talk about her situation. The nurse would give Margaret a business card of one of the HJP lawyers located at the local CLC. However, with her recovering broken hip and dependence on Caroline, it would be unlikely that Margaret could safely consult with the lawyer, or indeed be able to get to a lawyer without Caroline. Margaret tells the nurse that if Caroline did agree to let her see the lawyer to whom Margaret had been referred, she would insist on coming with her, thus negating the point of having legal help in the first place. This model is therefore unlikely to deliver legal services to Margaret.

### *2 HJP-Collaboration and HJP-Integration*

If the hospital was operating under either an HJP-Collaboration or an HJP-Integration model, the nurse would tell Margaret that the hospital has a lawyer on-site, who may be able to help Margaret with her home situation. The nurse would tell Margaret that she would like to raise this with the healthcare team and the lawyer, and would get Margaret's consent to do so.

The nurse would then indicate to the HJP team, including the lawyer, that Margaret may benefit from legal assistance. The lawyer would visit Margaret in her ward, introduce themselves and explain that they work in partnership with the hospital to provide holistic care for the hospital patients. If Margaret agreed, the lawyer would discuss Margaret's situation with her and evaluate her legal needs.

### *C Principles Applied to the HJP Setting*

The example of Margaret has shown how a patient's legal problems might become apparent in a healthcare setting, and how advice would then be given to that patient in the various HJP models. I now turn to the ethical issues that might arise for a lawyer practising in this setting. Continuing with the example of Margaret, I will compare how these issues may differ under each of the various HJP models.

#### *1 Confidentiality – information sharing*

Rule 8 obliges lawyers to protect and hold in strict confidence information concerning the client, the retainer and business affairs of the client acquired during the course of the lawyer's professional relationship with the client. This obligation extends indefinitely, including past the completion of the retainer pursuant to r 8.1. This obligation is reinforced by the principle stated in r 5.1, that the lawyer-client relationship is one of trust and confidence which must never be abused. However, r 8.4(a) authorises the lawyer to disclose confidential information to a third party duty with the express or implied authorisation of the client.

Under an HJP-Referral model, there is no information sharing between the lawyer and the healthcare professionals past the initial referral. This would mean no issues of confidentiality would be raised for the HJP lawyer.

Under an HJP-Collaboration model, the lawyer and healthcare professionals may engage in some information sharing. This would be done as is necessary to clarify points as the professionals work separately to solve the patient's health and legal issues. To do this in accordance with his or her ethical obligations, the lawyer would need explicit or implied consent from Margaret to disclose to the healthcare team any information Margaret has discussed with her subsequent to the retainer arising pursuant to r 8.4(a). Under this model, the lawyer would be able to seek Margaret's consent to disclose as issues would arise that the

lawyer believed could benefit from the healthcare team's input. The lawyer would be able to limit which healthcare professionals were privy to any such discussions, and would have clear control over the amount of information divulged to the healthcare professional. As part of the HJP agreement, the healthcare professionals would agree to maintain the confidentiality of the information disclosed. The lawyer would therefore not be in breach of r 8.5, which requires that where disclosure of confidential information is permitted, it is limited to the appropriate person, and to the extent reasonably necessary for the permitted purpose.

The HJP-Integration model envisages the lawyer and healthcare professionals sharing case notes or files and engaging in ongoing frank discussions about patient cases.[80] Informed patient consent is thus essential for the HJP-Integration model to be able to function as intended. However, some commentators have questioned whether such client consent is meaningful for those who have no other options to gain legal assistance, as they will agree to nearly anything to get help they could not otherwise afford.[81]

It would be best practice for the nurse here to get Margaret's written consent to disclose her confidential information to the HJP lawyer under both the HJP-Collaboration and HJP-Integration models, together with her health information. Reducing such consent to writing creates clear expectations for both parties as to what will and will not be shared in the HJP team. Even with informed consent, it is possible that disclosure of such information to all the healthcare staff – who would not all be on a need-to-know basis – may be a breach of r 8.5.

Margaret's ability to require the lawyer to withhold discrete facets of information from the healthcare professionals would leave the lawyer in a difficult situation in shared case discussions.[82] Imagine for example that during Margaret's conversation with the lawyer, she said Caroline had threatened not to bring her children to visit Margaret if she goes into residential care. This is because moving into care would require selling Margaret's home to pay for the cost of care, leaving Caroline without the free accommodation to which she has become accustomed. Margaret asks the lawyer not to disclose this to anyone, especially not any of the healthcare staff. Margaret does not want Caroline to discover inadvertently through the healthcare staff that she is seeing a lawyer, and thus risk losing the relationship with her grandchildren. This would not be a problem under the HJP-Collaboration model, where there are not ongoing discussions between the lawyer and the healthcare professionals, but it would be problematic under the HJP-Integration model.

[80] Stacy Brustin "Legal Services Provisions through Multidisciplinary Practice – Encouraging Holistic Advocacy While Protecting Ethical Interests" (2002) 73 U Colo L Rev 787 at 827; Tames and others, above n 65, at 522.
[81] Castles, above n 30, at 135; Brustin, above n 80, at 827.
[82] Galowitz and others "Ethical Issues in Medical-Legal Partnership" in Elizabeth Tobin Tyler and others (eds) *Poverty, Health and Law: Cases and Readings for Medical-Legal Partnership* (Carolina Academic Press, North Carolina, 2011) 157 at 172.

Under each of the HJP-Collaboration and HJP-Integration models, the different information held by each class of professionals could cause tension for people working together. The healthcare professionals may get frustrated with the lawyer's adherence to Margaret's decision to return to her home when, on their understanding of Margaret's situation, it appears to be the worst outcome for her. This would be likely to impinge on the relationship between the legal and healthcare professionals. As a result, the HJP lawyer may be tempted to breach client confidentiality and tacitly inform the healthcare professionals as to the underlying reasons behind Margaret's seemingly ill-advised decision to return to her home under Caroline's care. The temptation for tacit disclosure would be higher for lawyers operating in an HJP-Integration model than in an HJP-Collaboration model, as the former involves constant interaction with the healthcare professionals. It would not arise at all in an HJP-Referral model, where there is no such inter-professional interaction.

The HJP lawyer in this situation could explain to Margaret that the healthcare professionals would be under a strict duty of confidentiality, and as such they would not be able to tell Caroline that Margaret was consulting, or what Margaret was discussing, with a lawyer.[83] However, if Margaret persisted in her request that the information about the threat of withholding the grandchildren not be disclosed, then the HJP lawyer would have to respect such a request.

Rule 8.2 allows mandatory disclosure of confidential client information under certain specified circumstances including the anticipated commission of serious crime; where disclosure is necessary to prevent serious risk to a person's health or safety; or where disclosure is required by law. It is unlikely any of the these exceptions to confidentiality under r 8.2 would cover disclosure to the healthcare staff of Caroline's threat to withhold Margaret's grandchildren from her.

Rule 8.4(c) allows discretionary disclosure of confidential information in order to protect the interests of a client in circumstances where due to incapacity, the client is unable effectively to protect his or her own interests. It is possible this may apply to Margaret's situation to allow disclosure to the healthcare staff, given there is some uncertainty over her mental capacity. However, the nature of the information means its disclosure to the healthcare staff would be unlikely to assist in protecting Margaret's interests.

The HJP lawyer would therefore be obliged to withhold this information from the healthcare professionals. The lack of ability to disclose could give rise to frustration on both sides. This may be assuaged by ensuring the HJP professionals have a clear understanding of the

[83] New Zealand Medical Association "Code of Ethics" (2014), Recommendation 12. This Code is not ethically but not legally binding. Practising medical practitioners agree as part of practising to be bound by the Code of Ethics. Therefore, their registration rides on compliance with the Code, as with lawyers and the Rules.

differences in their professional ethical requirements through comprehensive training prior to commencement of the HJP.

### *2 Independence of professional judgement*

A lawyer's ability to deliver independent advice may also be compromised in an HJP setting.[84] In Margaret's case, without the extra information to which the lawyer is privy, the HJP healthcare team would feel strongly that going into residential care would not be in Margaret's best interests. At their next shared case meeting, they express their concerns about discharging her back into Caroline's care.

Under r 5, a lawyer must be free from compromising influences or loyalties when providing services to his or her clients. The lawyer must exercise his or her judgement for the sole benefit of the client,[85] which must be objective and independent.[86] The lawyer must always promote the interests of the client to the exclusion of any third party interests.[87] The HJP lawyer's ethical mandate is therefore to advise Margaret of her options, and carry out her instructions to protect Margaret's liberty and to assist her in moving back home.[88]

The HJP lawyer's independence may be tested when the healthcare professionals express strong doubt in respect of whether Margaret's instructions are in her best interests. This strong influence may tempt the lawyer counsel Margaret strongly against returning home to a greater extent than usual, as the lawyer has been exposed to the healthcare professionals' discussions. Paula Galowitz, when discussing HJPs in a United States setting, suggests that such close collaboration between the HJP professionals on client cases runs the risk of causing their professional judgement to merge, and instead present HJP clients with a holistically decided solution.[89] The aim of HJPs is not to provide one simple stream of advice to patients, but to make it easier for them to make informed choices by presenting them with options from multiple professional perspectives which have had the benefit of a holistic overview of the patient's scenario through the HJP discussions.[90]

This means that while they can discuss aspects of client situations and seek alternate perspectives, HJP lawyers must be careful to exclude the healthcare staff from entering the final judgement process and provide the client independent and objective advice pursuant to r 5.3. While this tension can often exist for clients not seen within an HJP setting, the inherently

[84] Webb, Dalziel and Cook, above n 69, at 189.
[85] Lawyers and Conveyancers Act (Lawyers: Conduct and Client Care) Rules 2008, r 5.2.
[86] Rule 5.3.
[87] Rule 6.
[88] See the example of the mentally ill homeless person given in Peter Jacobson and Greg Bloche "Improving Relationships Between Physicians and Attorneys" (2005) 294(16) JAMA 2083 at 2084.
[89] Galowitz and others, above n 82, at 162; Brustin, above n 80, at 862-863.
[90] Brustin, above n 80, at 862.

collaborative nature of HJPs with other professionals may heighten this tension for HJP lawyers, particularly under the HJP-Integration model where there are ongoing multidisciplinary team meetings.[91]

A method for mitigating any potential compromise of professional independence in the HJP-Integration model could be specifying the nature and extent of the HJP services offered, including what type of cases the lawyer can undertake, and the criteria for patient eligibility to receive HJP legal assistance.[92] Such an agreement would be a helpful touchstone for all professionals to help keep in mind their differing ethical obligations. The same criteria would be helpful in the HJP-Collaboration context. However, the lawyer under that model would have complete control as to the kinds patients they would take on as clients, and the extent of legal services they would offer these patients.

### *3 Avoidance of conflicts of duties*

A problem that would be unique to the HJP-Integration model would be conflicts of duties arising as between HJP clients. Imagine for example that during the HJP team meeting about Margaret, one of the doctors asks the lawyer whether the healthcare team has any legal authority to detain Margaret in hospital. Lawyers in an HJP-Integration model wanting to be seen as a helpful part of the team might find it difficult to refuse this 'cocktail' or 'over a cup of tea' advice.[93] This could include the healthcare professionals consulting the lawyer for legal information or advice on difficult situations for their clients, and on their professional and ethical obligations in relation to these.[94]

A lawyer working in an HJP-Collaboration model would easily be able to decline to answer the doctor's question, and explain that such a question would be more appropriate for the doctor to ask the legal counsel for the hospital. For an HJP-Integration lawyer, there is arguably the risk of such an integrated relationship imputing the lawyer as in-house counsel for the hospital, which would import an entirely different set of ethical issues under the Rules.[95] However, the main ethical concern for an HJP-Integration model lawyer giving such advice would be

[91] Compare Lawrence Fox "MDPs Done Gone: The Silver Lining in the Very Black Enron Cloud" (2002) 44 Ariz L Rev 547 at 553 as cited in Castles, above n 30, at 120. Fox discusses the finding that corporate multi-disciplinary partnerships have given rise to difficulties for lawyers in resisting influence from other parties in the multi-disciplinary partnerships that would sway them away from their professional obligations.
[92] Brustin, above n 80, at 861.
[93] Pamela Bresnahan "Beware the Cocktail Party Client" (1999) 85(9) ABAJ 80 at 80; Campbell and others, above n 46, at 849.
[94] Liz Curran "Lawyer Secondary Consultations: Improving Access to Justice: Reaching Clients Otherwise Excluded Through Professional Support in a Multi-Disciplinary Practice" (2017) 8(1) Journal of Social Inclusion 46 at 48.
[95] Galowitz and others, above n 82, at 181; Lawyers and Conveyancers Act (Lawyers: Conduct and Client Care) Rules 2008, Chapter 15.

whether it would give rise to a lawyer-client relationship with the healthcare staff,[96] and thus create a conflict of duties for the HJP lawyer between the patient-client and healthcare staff-client.[97]

Whether a lawyer-client relationship arises between two parties depends on whether a contract of retainer has arisen under the Rules.[98] "Retainer" is defined exhaustively in r 1.2 as an agreement where a lawyer provides a client legal services "whether that agreement is express or implied, whether recorded in writing or not, and whether payment is to be made by the client or not." Under an HJP-Integration model, best practice would be to enter into an express agreement for the lawyer to provide legal services to the public as the hospital patients, with an ancillary agreement, express or implied, that as part of this undertaking the lawyer would be able to give advice to the healthcare professionals relating to the patients.[99]

Rule 6.1 forbids a lawyer from acting for more than one client on a matter in any circumstances where there is more than a negligible risk that the lawyer may be unable to discharge the obligations owed to all clients. Thus, to act for both the hospital staff and the hospital patient, the HJP-Integration lawyer would have to be confident there would be a negligible risk of him or her being unable to discharge the obligations owed to both clients.

The main obligation owed to the clients under this line of reasoning that may be implicated would be the fiduciary duty of loyalty. This duty is implied in r 5, which states lawyers must be free from outside influences compromising their service to their clients. The interests of both clients will usually be aligned, being to improve the patient's wellbeing. This would generally mean that there would be a negligible risk of the lawyer being unable to discharge their obligations to both parties. In such cases, the HJP lawyer will be able to act for both the patient and healthcare workers, as long as the lawyer has the informed consent of both. The risk for the HJP lawyer under the Rules in acting for both parties is that while their interests may align at the beginning, they may later diverge.[100] This is exemplified by Margaret's scenario, where the HJP lawyer would arguably be unable to discharge their duty of loyalty to both clients, as helping the doctor to detain Margaret would be against Margaret's interests.[101]

The problem in practice of allowing concurrent representation of clients each with potentially conflicting interests would be a potential chilling effect created with respect to practice as an HJP-Integration lawyer. The class of acts which would render the HJP lawyer in breach of the

[96] Compare the ABA Commission on Ethics and Professional Responsibility "Opinion 98-411: Ethical Issues in Lawyer-to-Lawyer Consultation" (1998) at 1, which states that such a relationship does not arise upon consultations between lawyers.
[97] Tames and others, above n 65, at 513.
[98] Webb, Dalziel and Cook, above n 69, at 156.
[99] Contrast Campbell and others, above n 46, at 849.
[100] See Webb, Dalziel and Cook, above n 69, at 211.
[101] At 211.

Rules would be broad to such an extent that it would create uncertainty as to whether the lawyer is acting within the bounds of his or her ethical obligations. This aversion would arguably create an unacceptable tension for the HJP-Integration lawyer, rendering them unable to simultaneously hold lawyer-client relationships with the hospital patients and healthcare workers under the Rules. This would limit their ability to collaborate and share information as per the overarching purpose of the HJP. An HJP-Integration lawyer in this situation would have to practice with an increased risk aversion to breaching the Rules than would occur in a non-HJP setting, which would undermine the point of the partnership in the first place.

However, it may be that in this context a lawyer-client relationship is not formed between the lawyer and the healthcare workers. Campbell and others argue that if the lawyer tells the healthcare workers they are not their lawyer, the lawyer is ethically able to work in the healthcare team without a conflict of duties arising under the American Bar Association Model Rules of Conduct.[102] This approach has some support in New Zealand.[103] Under this analysis, HJP-Integration lawyers could avoid the ethical difficulties of concurrent representation by making it clear to the healthcare professionals that a lawyer-client relationship does not exist between them.

However, even if a retainer did not arise between the lawyer and healthcare staff, the lawyer would still face problems of maintaining professional independence in respect of their relationship with the healthcare professionals as discussed in section 2 above. To act for the patient ethically under this interpretation, the lawyer would not be able to give the healthcare professionals legal advice, but the provision of legal information.[104] However, it is difficult to conceive how the lawyer and healthcare team could coordinate if the lawyer was not able to engage in discussions of the manner outlined above with the healthcare staff. The HJP-Integration model as it stands therefore is likely to be too risky for any lawyer to comfortably engage in and practice effectively to improve outcomes for the HJP patients.

### *4 Mental capacity of clients*

Returning to Margaret, by the time her broken hip has healed from surgery her dementia has not progressed. Margaret's early stage dementia renders the legal status of her mental capacity uncertain.[105] There is the potential for the different legal standards of capacity in existence to affect the HJP concept, on issues such as Margaret's capacity to retain and instruct the HJP

[102] Campbell and others, above n 46, at 849.
[103] Webb, Dalziel and Cook, above n 69, at 157.
[104] Tames and others, above n 65, at 513-514.
[105] Webb, Dalziel and Cook, above n 69, at 163; Alison Douglass "Mental Capacity: Updating New Zealand's Law and Practice" (Report for the New Zealand Law Foundation, Dunedin, July 2016) at 12.

lawyer.[106] This will be an issue for a lawyer regardless of whether they are practising under an HJP-Referral, HJP-Collaboration or HJP-Integration model.

Issues around a client's mental capacity will not be unique to HJP lawyers. Working in healthcare settings such as hospitals means that HJP lawyers will likely have a higher exposure to such clients. Clients experiencing issues around mental capacity are vulnerable people who are most likely to be in need of HJP support. HJP lawyers would therefore need to be alive to their duties to clients on these issues, especially where the Rules are largely silent.[107]

### *D Further Ethical Quandaries Applied to the HJP Setting*

The example of Margaret's case has demonstrated some of the ethical issues that might arise for a lawyer practising within an HJP model. Of course, patients will present with a great variety of legal problems in a diverse range of social and medical settings. Each will generate its own set of issues. It is not possible to canvass all of these, but it is helpful to briefly survey some of the other issues that might arise in different fact scenarios.

#### *1 Providing regulated services to the public*

Under s 9(1) of the LCA, a lawyer is guilty of misconduct if they provide regulated services to the public if not employed by specified employers including a lawyer, a legal partnership, an incorporated law firm, a CLC, or the Ministry of Justice. "Regulated services" are "legal services" under the LCA, which includes providing legal representation or giving legal advice in relation to a person's rights or obligations.[108] Under an HJP-Referral model, the lawyer would be employed by themselves as a lawyer, or a law firm – whether a partnership or incorporated – and thus able to offer regulated services to the hospital patients once referred, as members of the public.

The Lawyers and Conveyancers Act 2006 ("LCA") enables lawyers who are either direct employees of a CLC (s 9(1)(d)) or working under the auspices of a CLC (s 10(5)) to provide regulated services to the public. As the HJP-Collaboration model would involve the CLC and partner hospital remaining as separate organisations with the lawyer employed by the CLC, the HJP-Collaboration lawyers would fall under these sections. This means a lawyer in an HJP-Collaboration model would not be guilty of misconduct for providing legal help to hospital patients, as regulated services to members of the public.

[106] Webb, Dalziel and Cook, above n 69, at 164.
[107] At 164.
[108] Lawyers and Conveyancers Act 2006, s 6.

However, difficulties arise for the HJP-Integration lawyer under s 9(1), as they would be employees of the hospital through working for the local District Health Board. The purpose of their employment by the District Health Board is to provide legal advice to the hospital patients. Section 9(1) is subject to s 10, which creates exceptions to misconduct. Section 10(5) allows a lawyer who is not an employee of a CLC to provide legal services to the public under the auspices of a CLC.

The exception under s 10(5) of the LCA would not apply to the HJP-Integration lawyer in this scenario. As an employee of the District Health Board and part of the healthcare team, the HJP lawyer would not be considered as practising under the 'auspices' of a CLC. 'Auspices' is not defined in the LCA, but its ordinary meaning as defined in the Oxford Dictionary is "with the help, support or protection of".[109] The HJP lawyer would be guilty of misconduct for providing legal help to the hospital patients. Therefore, an HJP-Integration model would be clearly untenable for a lawyer to participate in without an amendment to the Rules or under the current Rules.

*2 Unauthorised practice of law*

A different concern may be the inadvertent provision by the HJP healthcare professionals of unauthorised services. Rule 2.11(a) provides that if a lawyer learns a person is providing unauthorised services in reserved areas of work, that person is committing an offence and the lawyer must report them to the Law Society.[110] If this occurs, the lawyer is then obliged to refuse to deal with that person further unless that would be contrary to the client's interests. This second requirement under r 2.11 would create a huge practical difficulty for the HJP to continue functioning as a collaborative setting.

For example, an HJP doctor armed with some legal knowledge from the HJP lawyer may be tempted to give advice which constitutes legal advice to the patient. Given the unconventional overlap between lawyers and healthcare workers in the HJP setting, patients may put the healthcare professionals on the spot with "just a quick question", which the healthcare professionals may feel they can answer even if it is a legal question. This is unlikely to arise in an HJP-Referral model, as the legal advice is completely separate, and so the healthcare workers would not have had sufficient exposure to the giving of legal advice to feel confident to do this. However, healthcare workers in the other HJP models would be more likely to be exposed to this situation. This would be especially so under the HJP-Integration model, given its high level of interaction between the lawyers and healthcare professionals.

[109] Oxford Dictionaries "Definition: Auspices" <https://en.oxforddictionaries.com/definition/auspice>.
[110] Lawyers and Conveyancers Act 2006, s 6. "Reserved areas of work" includes giving legal advice in relation to any current or prospective legal proceedings.

Related to this issue is the importance to establish clearly within an HJP the boundaries between professionals.[111] As outlined above, it would be understandable for a patient to be confused as to the scope of each professionals' role in such a partnership, and as such ask the healthcare professionals legal questions and vice versa. This could have further implications such as patients mistakenly conflating patient-doctor confidentiality with lawyer-client confidentiality, and therefore disclosing highly sensitive information to doctors where they will not have the same level of protection.

A way to avoid this could be to give the healthcare professionals comprehensive training on the appropriate boundaries between legal information and advice. This would be similar to the boundaries established for law students volunteering in CLCs, who are on the frontline interviewing clients at first instance but are strictly only able to provide legal information and not legal advice.[112] Such training would help healthcare professionals to identify when a patient question would be outside their expertise, and allow them to decline to answer the patient's question with confidence.

*3 Choosing between potential clients*

Another challenge may be choosing between worthwhile candidates for HJP assistance, who have diametrically opposing interests. Suppose an impoverished young couple were both hospitalised at the same time, alleging domestic violence against each other. The lawyer would be faced with a dilemma as to who to assist under the HJP, as it is clear that to take on both clients would be a clear conflict of duties under r 6.1. Regardless of the HJP model under which the lawyer would be operating, their best course of action in such a situation would be to refer the couple to separate lawyers. However, this course of action could be more complicated under an HJP-Integration model than it would be under an HJP-Collaboration model, if the healthcare staff held strong opinions about which person needed assistance, but the lawyer disagreed with them.

Another variation on this issue would be an HJP lawyer unable to represent a newly presenting patient with their legal problems, if they have previously advised a patient whose interests are in conflict with the new patient's. This would be more of a risk for the HJP-Integration lawyer embedded in a hospital, thus servicing a limited geographic radius of vulnerable people.

*4 Reporting of child abuse*

[111] Galowitz and others, above n 82, at 177.
[112] Otago Community Law Centre "Shift Worker Guide" (2016) at 8: "Explain that you are not a qualified lawyer and therefore, even if you may have the answers, you will need to double check with the lawyer. This is a safeguard for you and the organisation as we are covered by our professional indemnity insurance and therefore ALL advice must be given by a qualified lawyer."

One can imagine the difficulties arising where a patient has disclosed an instance of child abuse to the HJP lawyer but not the healthcare professionals. In New Zealand, there is no mandatory reporting law for healthcare professionals, but failure for a healthcare professional to report suspected grave abuse may leave them liable under s 195A of the Crimes Act 1961. This criminalises omissions by healthcare professionals to act in cases where the victim is in their care, the healthcare professional knows they are at grave risk of harm, and they fail to take reasonable steps to protect the victim from such risk. The effect of the Crimes Act provision is that where a healthcare worker has a suspicion of a lower than grave level of child abuse, they will be more likely to report it rather than not to avoid the possibility of criminal liability.

The Crimes Act provision applying to healthcare professionals does not apply to lawyers.[113] This creates a difficulty where the lawyer who knows of child abuse is unable to disclose this to the healthcare professionals, which could be especially challenging in the immersion of the HJP-Integration model. The exemption of lawyers from this section presumes the behaviour would fall short of qualification for disclosure of under r 8.2(b), where the lawyer believes disclosure confidential information is necessary to prevent serious risk to the health or safety of any person.

*5 Difference in length of relationship with patient*

A difficulty for HJP-Collaboration and HJP-Integration lawyers would be the difference in length of relationships with the patient between them and the healthcare staff. A lot of medical problems would not require ongoing relationships between the patients and the hospital, as the patients would be discharged back to the care of their general practitioner. However, these patients may have ongoing legal issues which will take time to resolve. This may cause the lawyer's case load to build up out of proportion to the number of patients being seen by the hospital, so that the lawyer would not be able to keep up with the demand for legal assistance.

The alternative would be to discharge the patients from the hospital based lawyer to the lawyer bases in the CLC, at the same time that they are discharged from hospital. However, CLCs do not have the resources to provide ongoing legal advice and representation for most people. Discharging the patients from the HJP legal services in this way would possibly leave them half-way through solving their legal needs, but unable to afford continued legal representation to see them completed. This would negate any help the HJP could provide patients in the first place. Parameters would therefore have to be set around limiting the number of patients accepted by the HJP lawyers to account for the difference in relationship length between the HJP professionals.

*E Summary*

[113] Oranga Tamariki Act 1989, s 15.

Having considered the ethical implications of the Referral, Collaboration and Integration HJP models, in Chapter III I will consider which model appears to offer the best balance of benefits for patients and ethical compliance for the HJP lawyer.

## *Chapter III: Recommendations for HJP Implementation in New Zealand*

### *A Choice of HJP Model for Implementation*

As illustrated by Margaret and the other scenarios above, HJPs may assist in providing solutions for patients and improving access to justice in ways that medical care or legal advice alone would not be able to achieve. However, these scenarios have also illustrated a number of ethical issues which may arise for lawyers practising in such a collaborative setting. In this chapter I focus on the HJP model that I consider most promising in terms of striking a balance between delivering benefits to the public and minimising ethical problems for lawyers – the HJP-Collaboration model. While amending the Rules or the LCA will not be required to establish the HJP-Collaboration model initially, I argue that full implementation of the HJP concept is dependent on amendment to the Rules. I will canvass possible ways to move forward in doing so.

#### *1 HJP-Referral*

The analysis in the previous chapter highlights both the potential benefits of an HJP system for the patient, and the correlated ethical problems that might arise in respect of the HJP lawyer's ethical duties. The HJP-Referral model is ethically the simplest. However, the trade-off for this simplicity, as we saw in the example of Margaret, is that this model would not be effective in terms of achieving the HJP's overarching, and arguably most fundamental, aim of providing convenient and holistic legal help to vulnerable people. The HJP-Referral model may assist a few patients in low-risk situations, but these benefits are not sufficiently significant enough to make it the preferred model.

#### *2 HJP-Integration*

The LCA does not currently allow for organisational structures related to the provision of legal advice which do not fall within its prescribed boundaries.[114] The HJP-Integration model, while likely to deliver the highest level of service to the patients, would render participating lawyers guilty of misconduct for providing regulated services to the hospital patients as members of the public. Therefore, it is not a viable HJP model to introduce into New Zealand under the current provisions of the LCA.

In addition to this legislative hurdle, the HJP-Integration model raises a number of other ethical barriers under the Rules. Working under an HJP-Integration model creates confidentiality and independence concerns, potential conflicts of duties, and raises the risk of the healthcare workers carrying out unauthorised practice of law. These ethical barriers mean that for the HJP-

[114] Charlotte Walker "One-stop Shops" *LawTalk* 855 (online ed, New Zealand, 21 November 2014).

Integration model to be workably implemented, the Rules would also be required to be amended. Practically speaking, the HJP-Integration model's ethical barriers far outweigh the marginal increase in benefit the hospital patients would receive from the integrated professional collaborations.

### *3 HJP-Collaboration*

The HJP-Collaboration Model may serve as a happy medium between respecting professional ethical boundaries and providing a worthwhile and effective multidisciplinary service for the benefit of the patients. The main advantage of the HJP-Collaboration model is that by not being fully integrated, there is a more clearly defined separation of roles for the HJP lawyer. Implementation of the HJP-Collaboration model does not appear to require amendment to the Rules or the LCA.

Whilst a lawyer under the HJP-Collaboration model is not likely to breach the Rules as they relate to confidentiality, avoidance of conflict of duties, and unauthorised practice of law, the model is potentially problematic with respect to the lawyer's independence obligations. In practical terms, this manifests as 'role strain'. Role strain is the situation where by virtue of a lawyer operating in various capacities, he or she may be internally conflicted which may adversely impact on the lawyer's wellbeing and impair their judgement. In the context of the HJP, this may compromise the lawyer's ability to deliver independent advice to the hospital patients. I will briefly turn to the justification for the HJP-Collaboration model despite its creation of role strain for lawyers involved, and then discuss the practical implementation of the model moving forward.

## *B Justification for the HJP-Collaboration Model: Role Obligation Morality*

It is important to consider the implications of an HJP model not only from an ethical perspective, but also from a human perspective. A lawyer practising in any domain is naturally afflicted by influences much more fundamental than confidentiality or independence requirements, but rather human nature per se. A lawyer, as a human agent, cannot perfectly operate in accordance with ethical rules or their underlying principles without being to some extent susceptible to a balancing exercises which is inherent in the notion of making a judgment call, an exercise which is patently fundamental to legal practice.

Tim Dare argues that it is simply unacceptable to require lawyers to balance competing moral obligations within their legal role while acting for a client.[115] Occupying different roles subjects one to different obligations and permissions.[116] It is much simpler for lawyers to stay true to

[115] Tim Dare *The Counsel of Rogues: A Defence of the Standard Conception of the Lawyer's Role* (Ashgate Publishing, Farnham (UK), 2009) at 34.
[116] At 34.

their professional ethical obligations when they have one line of responsibility. A lawyer's ethics run with, and cannot be considered in a discrete vacuum from, their role.

Applying Dare's analysis to the HJP-Collaboration model, where the lawyer may feel like they also owe moral duties to the healthcare professionals, the lawyer's sense of responsibility to their patient-client is susceptible to becoming confused. The lawyer's role obligations to the patient as their client require them to act in a manner inconsistent with the normative moral obligations owed to the doctor.[117] By increasing the lawyer's professional exposure to the healthcare team, the lawyer's allegiances may subtly shift to accommodate more for the healthcare team's perspective than is acceptable under the Rules. Thus consistent with Dare's thesis, it would be untenable to expect an HJP-Collaboration lawyer to be able fully to discharge their duties in providing legal services to clients, absent considerations of duty or obligation owed to the healthcare staff.

Although this is arguably not a basis upon which a lawyer should be engaging, a pragmatic view needs to be taken. As with any area of legal practice, it is necessary to make minor concessions to strict observance to fundamental ethical principles in order to facilitate what is the ultimate purpose of legal practice – the provision of justice. As I have discussed, the HJP structure is to a large extent purposed to facilitate access to justice. The potential of a lawyer conflating moral consideration pales in comparison.

### *C Long-Term Implementation: Modification of the LCA and the Rules*

Having justified choosing the HJP-Collaboration model, I will now consider the changes needed to the Rules and the LCA to allow for its successful long-term implementation. The HJP-Collaboration model as I have described it in preceding chapters is tenable for lawyers under the LCA and the existing Rules as both currently stand. However, s 9 of the LCA may cause problems if lawyers not affiliated with CLCs wish to practice as HJP legal partners in the future. The effect of s 9 is that non-CLC lawyers cannot currently provide pro bono assistance outside of their employment. If the HJP model was to be further developed so that lawyers practising within an HJP would not be limited to those employed by CLCs as legal partners, then it would be necessary to amend s 9 of the LCA.

However a Members' bill, which at the time of writing is a proposed bill, may solve this issue. The Lawyers and Conveyancers (Employed Lawyers Providing Free Legal Services) Amendment Bill would amend s 9 by making it subject to a new s 10A. The enactment of the provisions contemplated by this bill would allow a lawyer who is an employee of a law firm or in-house counsel to do free legal work "other than for the lawyer's employer, on conditions set by the New Zealand Law Society". This Bill would improve access to justice by allowing

[117] At 31.

lawyers to deliver pro bono assistance in an HJP without being guilty of misconduct, such as those working for a District Health Board under an HJP-Integration model. Tapping into this huge legal services market would be crucial for expanding HJPs to be sustainable beyond the initial proposed CLC lawyer pilot.

It is pertinent to note that on the basis of the current drafting of s 10A, the provision of free legal work would be subject to conditions set by the New Zealand Law Society. Due to the infancy of this proposed amendment, it is not possible to comment on whether other conditions may be imposed that would further mitigate or otherwise obstruct the implementation of the HJP-Collaboration model as described above. At this stage, the proposed s 10A at least removes a large legislative barrier impeding the long-term tenability of the HJP concept.

In addition to the amendment of s 9 of the LCA, amending the Rules may also be required to make the HJP-Collaboration model viable long-term in New Zealand. The changes required would not be a necessary element from an ethical standpoint. However, they would clarify the ethical constraints in grey areas, and enable the HJP lawyer to do their work in confidence without fear of accidental breach of the Rules through a misunderstanding. Therefore, the long-term success of the HJP-Collaboration model may benefit from adjustment to the Rules.

This would be most practically effected by qualifying the applicability of the Rules to lawyers practising within an HJP setting.[118] This could be effected by providing for certain 'safe harbours', whereby to the extent the HJP lawyer is operating within the bounds of the HJP framework, he or she would be deemed not to be in breach of the Rules. For instance, a safe harbour could be as follows:

> An HJP lawyer will be deemed not to breach of the confidentiality obligation contained in r 8 where he or her discloses information particular to a client-patient's case where such lawyer, in his or her capacity as an HJP lawyer within the HJP-Collaboration model (the terms of which would be defined by the Rules) discloses information to medical staff which (a) serves the patient's best interests; and (b) assists in providing, and only to the minimum extent that provides, the patient with health outcomes that would not be achieved but for the provision of such information.

This would serve the dual function of removing the potential chilling effect under r 8.5, and therefore provide a more workable, pragmatic basis upon which the HJP lawyer could operate.

As a qualification to the above proposal, it is worth noting that where HJPs have created ethical difficulties overseas, recommendations in the literature have stopped short of proposing

[118] See Louise Trubek and Jennifer Farnham "Social Justice Collaboratives: Multidisciplinary Practices for People" (2000) 7(1) Clinical L Rev 227 at 269-270.

alternate drafts for existing ethical rules.[119] It is notable that in other jurisdictions, commentators have exposited that changing ethical rules should be a last line of defence,[120] as modifying the Rules may have a number of unforeseen and unintended consequences. Norwood and Paterson have expressed doubt over the practicality of drawing up a special subset of ethical rules for a specific type of multi-disciplinary partnership such as an HJP.[121] Concerns arise over who would take responsibility for drafting such rules, who would be able to enforce them, and whether the carving out of exceptions in this manner would be seen as reducing the ethical credibility of the HJP services.[122]

However, New Zealand's Rules were drafted from the point of being a minimum standard of conduct expected, instead of an aspirational standard for conduct, as is the case in some Australian states.[123] Instead of providing guidance for best practice, the Rules take the approach of guiding the "bad lawyer" to avoid breach of their minimal obligations.[124] This creates uncertainty as to what is best practice for lawyers in unconventional settings such as HJPs, as the Rules were drafted with those practising in conventional legal settings in mind. Carving out best practice exceptions for HJP lawyers may therefore be a more appropriate manner for guiding HJP lawyers, and in fact allow the practice of HJP lawyers to be more ethically credible than it would otherwise.

### *D Summary*

The HJP-Collaboration model presents as the best option to implement as a pilot into New Zealand. It offers a balance of improved service and access to justice for patients, while allowing the HJP lawyer to remain almost entirely within their ethical bounds. However, it appears that long-term success of such a model will require adjustment to the LCA and the Rules. I suggest that allowing pro bono practice for employed lawyers under the LCA, and creating 'safe harbour' provisions under the Rules, may give the HJP practising lawyers breathing room needed to immerse themselves in the HJP without fear of breaching their duties.

[119] Brustin, above n 80, at 830.
[120] Castles, above n 30, at 142.
[121] Michael Norwood and Alan Paterson "Problem-Solving in a Multi-Disciplinary Environment – Must Ethics Get in the Way of Holistic Services" (2002) 9 Clinical L Rev 337 at 352-353.
[122] At 341.
[123] Webb, Dalziel and Cook, above n 69, at 98; Duncan Webb "Why Should Poor People Get Free Lawyers" (1998) 28(1) VUWLR 65 at 69-70.
[124] See Trubek and Farnham, above n 118, at 268.

## *Conclusion*

New Zealand has an access to justice gap for vulnerable New Zealanders with unmet legal needs. We know that these vulnerable people are more likely to seek help from healthcare professionals instead of lawyers, when the underlying causes of the health issues are often legal. As a result, these unmet legal needs can manifest themselves in a knot of health and legal issues. Providing a 'cure' for a patient's health by untangling these issues requires a holistic understanding of a person's life circumstances.[125] By providing legal assistance where people are most likely to seek out help, HJPs could be a viable tool to close the gap in this area and help provide legal solutions for vulnerable patients' unmet legal needs.

The innovation of the HJP-Collaboration model promises to deliver improved patient health and access to justice while remaining ethically viable for the lawyers involved. Implementation of this HJP model appears to be relatively straightforward under the LCA, and would not leave the lawyer in breach of their ethical obligations under the Rules. Therefore, HJP lawyers will be able to work collaboratively with healthcare professionals to provide comprehensive services for hospital patients to help them with their unmet legal needs.

While initial implementation of the HJP-Collaboration model into New Zealand will not require any changes to the Rules, it will be necessary to provide the HJP practitioners with some very specific training on how to respond to these problems. As the HJP-Collaboration model gains traction in New Zealand and the experiences of the ethical barriers that arise in practice for the pilot HJP are documented, this will better inform the changes that will need to be made to the Rules and the LCA in future. As New Zealand searches for ways to improve access to justice for vulnerable members of our society, HJPs are a promising innovation that may help further this goal.

[125] Tobin Tyler and Teitelbaum, above n 14, at 121.

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