THE ETHICS OF MIDDLE-CLASS ACCESS TO LEGAL SERVICES AND WHAT WE CAN LEARN FROM THE MEDICAL PROFESSION'S SHIFT TO A CORPORATE PARADIGM

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"All professions are conspiracies against the laity."'

INTRODUCTION

Broadcast in August 1977, a thirty-second advertisement for Jacoby & Meyers featured a balding actor who portrayed a middle-aged, middle-class man concerned about the cost of hiring a lawyer. "If you've got a legal problem and you're rich, you can afford an attorney," the actor says. "If you're poor, you get legal aid. But if you're in the middle, you should know about . . . Jacoby & Meyers." The commercial sums up the common image of the middle-class consumers' place in the American legal services market: ineligible for public assistance and unable or unwilling to pay exorbitant lawyer's fees, they are left out in the cold to fend for themselves.

Recent empirical surveys by bar associations tend to confirm that middle-class Americans often lack access to affordable legal services. These studies suggest that, more often than not, "ordinary" people with a need for legal services go without. Consistent with these studies, legal industry statistics show a continuing and dramatic shift in the allocation of legal services from individuals to corporate business interests.

The American legal community has recently engaged in a heated debate over the continuing wisdom of ethical rules that prohibit lawyers from sharing fees with non-lawyers and participating in multidisciplinary practices ("MDPs") with other professionals or non-professionals. That debate has usually focused on the efforts of large accounting firms to expand their role in providing legal services and

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on the needs of large, often multinational, businesses for integrated professional services. Mostly lost, though sometimes surfacing in the MDP dialogue, are the unmet needs of middle-class legal consumers. Advocacy groups representing the interests of middle-class consumers have been consistent supporters of the MDP concept. They contend that relaxation of the ethical rules prohibiting lawyers from sharing fees with non-lawyers would allow for more efficient and affordable packaging of services typically needed by middle-class consumers in areas such as real estate transactions, matrimonial and child custody disputes, financial and estate planning, employment contracts and disputes, and small business contracts and disputes.

Opponents of deregulating the ownership structure of legal service providers argue, on the other hand, that complete lawyer ownership and control of legal service providers is necessary to preserve lawyers' independent professional judgment on behalf of clients. The ethical prohibition on lawyers partnering with non-lawyers or providing legal services through businesses owned, even in part, by non-lawyers is a prophylactic rule necessary, they maintain, to protect this independence and the "core values" of the legal profession, including confidentiality, loyalty to clients, and avoidance of conflicts of interest.

While MDP proponents argue that the "core values" of the legal profession can be protected without the current prohibitions, most would stop considerably short of a radical opening of the legal services marketplace. A proposal of the recent American Bar Association ("ABA") MDP Commission, for example, would not have allowed passive investment in legal service providers. Commentators have labeled this residual resistance to complete deregulation and the inevitable, resulting advent of corporate legal service providers as the "fear of Sears." 3

But why not Sears? If the traditional business structure of legal practice has not met the legal service needs of most Americans, why not give corporate America an opportunity to do so? Could and would banks and other financial service providers, for example, be able to package legal services with financial services in a way that made them more affordable and more readily available to middle-class Americans? Could access to capital investments allow for better integration of legal and non-legal services and better use of technology to streamline and, therefore, reduce the cost of those services? More fundamentally, could deregulation of the ownership structure of legal service providers help to create a competitive legal

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services market that would fill the current market void for affordable middle-class legal service?

Whether in the form of simple partnerships between lawyers and other professionals or the specter of corporate legal service providers, our current response as a profession has been to shut the door with an unequivocal "No" to any deregulation of the ownership structure of legal service providers. While some state bar associations continue to explore possible amendments to the rules prohibiting sharing of fees with non-lawyers, the ABA House of Delegates in July of 2000 flatly rejected the reform proposals of its MDP Commission. We will not, the MDP opponents say, let the marketplace experiment with our "core values" or put us in a position where our "independence of professional judgment" might be compromised. Or, as proponents might cynically recharacterize that response: we will not let competition from non-lawyer providers of legal services erode our monopoly profits.

As a point of comparison, the medical profession has faced, and continues to struggle with, similar tensions between affordability and professionalism and had at one time parallel prohibitions on corporate ownership of medical service providers. In response to a perceived crisis in the cost of medical care, and with the help of a Federal Trade Commission ("FTC") ruling that the ban on corporate ownership was a violation of antitrust laws, the medical profession has moved quickly from a traditional model of fee-for-service by independent doctors to the currently predominant model of managed care by corporate medical service providers that employ physicians. The current American Medical Association ("AMA") ethical code addresses extensively a physician's professional responsibilities in the face of profit pressures from managed care providers but has no prohibition of any kind on the ownership or business structure of those providers.

The fee-for-service model, like traditional law practice, provides maximum protection for independent professional judgment on behalf of clients. This model, particularly in the absence of a competitive market, is not, however, without its own inherent conflict between the interests of the consumer and the professional. The danger is not of under-service or compromised quality of service, but of over-service and escalating cost: the more medical or legal services provided, the greater the professional fees in the fee-for-service regime. Managed care, on the other hand, like MDP or non-lawyer ownership of legal service providers, presents the risk of professional care decisions motivated by profit guidelines dictated to professional employees by business managers. Well-publicized cases of failure to provide needed care against a doctor's advice with sometimes fatal results have put the spotlight on this risk and fueled public concern over patients' rights.
Corporate medical care providers are, however, apparently here to stay. Containment of medical costs is considered too essential to the affordability of medical insurance plans to abandon altogether the new model. We are willing to manage the tension between professional independence of judgment and the profit-motivated business of providing medical services because the alternative is out-of-control medical costs.

One might conclude that the abuses by corporate providers of medical care should be a warning and a lesson to those who would open the legal services marketplace. The crisis of affordability for legal services is not so great, one might argue, to justify opening this Pandora’s box. But, when as much as 80% of the legal needs of ordinary consumers are going unmet according to bar association surveys, why is the lack of affordable legal services any less critical than the rising cost of medical care? If the medical profession can tolerate and manage the tension between professional independence of judgment and commerce to control cost when the health and lives of patients may depend on that judgment, why is the legal profession unwilling to tolerate and manage that same tension when only money or legal rights are at stake? Is it truly better to have no legal service than the legal side of Sears? Can this ethical tension be managed, as it is now in the medical profession, through professional standards or liability rules or some combination of the two?

Part I of this article briefly reviews the history of the prohibition on non-lawyer ownership of legal service providers and the current MDP debate. Part II reviews the existing empirical research on provision of legal service to middle-class consumers and discusses how the continuing prohibition on non-lawyer ownership of legal service providers may be a significant barrier to expanding service to those consumers. Part III describes the strikingly similar history of the medical profession’s parallel prohibition on non-professional ownership and its ultimate demise in the face of out-of-control costs. Part IV describes how medical ethics rules and liability standards have attempted to address the problem of preserving professional independence of judgment in the face of profit pressures from corporate providers of medical services. Part V discusses how the medical model may provide directions for managing the ethical conflicts created by relaxing or abandoning the prohibition on non-lawyer ownership of legal service providers.
ETHICS OF MIDDLE-CLASS ACCESS

I. THE HISTORY OF THE PROHIBITION ON NON-LAWYER OWNERSHIP OF LEGAL SERVICE PROVIDERS: THE "MDP" DEBATE

A. Origins of the Prohibition

When the ABA drafted its first ethics code in 1908, it did not prohibit lawyers from partnering with non-lawyers, or from sharing fees with non-lawyers.\(^4\) Nineteenth-century state ethics codes, the forerunners to the 1908 Canons, were also silent on the subject.\(^5\)

In 1928, the ABA adopted Canons 33, 34, and 35,\(^6\) which codified then recent opinions of the ABA ethics committee.\(^7\) Couched in precatory language, Canon 33 prohibited partnerships between lawyers and non-lawyers;\(^8\) Canon 34 prohibited fee-splitting between lawyers and non-lawyers;\(^9\) and Canon 35 prohibited lawyers from being employed by a corporation or other organization to render legal services to others.\(^10\)

The official report of one committee member stated that while "there is

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4. ABA Opinions of the Committee on Prof'l Ethics 1 (1967) (indicating Canon 34, which prohibited lawyers from partnering with non-lawyers was not adopted until 1928, twenty years after the original canons were adopted).

5. See Bruce A. Green, The Disciplinary Restrictions on Multidisciplinary Practice: Their Derivation, Their Development, and Some Implications for the Core Values Debate, 84 Minn. L. Rev. 1115, 1116 (2000).


7. See Canons 33-35; ABA Comm. on Ethics and Prof'l Responsibility, Formal Op. 8 (1925). Formal Opinion 8 concerned the propriety of a lawyer's employment with an automobile association that provided legal services to its members. See id. Opinion 10 dealt with the ethical implications of a lawyer-trust officer employed by a bank, representing that bank in proceedings involving the bank as trustee for minor heirs. See ABA Comm. on Ethics and Prof'l Responsibility, Formal Op. 10 (1926).

8. See Canon 33 ("Partnerships between lawyers and members of other professions or non-professional persons should not be formed or permitted where any part of the partnership's employments consists of the practice of law.").

9. See Canon 34 ("No division of fees for legal services is proper, except with another lawyer, based upon a division of service or responsibility.").

10. Canon 35 states:

    The professional services of a lawyer should not be controlled or exploited by any lay agency, personal or corporate, which intervenes between client and lawyer. A lawyer's responsibilities and qualifications are individual. He should avoid all relations which direct the performance of his duties by or in the interest of such intermediary.

Canon 35.

11. One of the Formal Opinions relied on for the codification, however, provided an "independent judgment" rationale. See Formal Op. 10, supra note 7. Opinion 10 proscribed a salaried lawyer-trust officer from representing a client in a trust proceeding. See id. The Committee on Professional Ethics opined as follows:

    As an employee his only duty is to his employer. As a lawyer he owes a duty to the Court and to the public, as well as to his client. Can he consistently act in these dual capacities at one and the same time? Being dependent on his employer's pleasure for his livelihood, can he properly observe that independence of judgment and action that are indispensable to the advocate
nothing inherently 'unethical' in the formation of partnerships between lawyers engaged in certain kinds of work and... some other form of expert," he was supporting the provisions "[a]s a matter of professional policy." Adoption of the new canons apparently was not without controversy and dissent. The drafting committee noted that "there is substantial difference of view in the profession respecting its recommendations as to partnerships, division of fees, intermediaries, and the bonding of lawyers," and that these differences were "radical and irreconcilable."

According to a recent study by Professor Bruce Green, the primary motivation for the adoption of the prohibitions was economic protectionism. "[B]ar leaders... acknowledge[d] that their motivation was primarily to protect lawyers' livelihood." They responded, in particular, to competition from corporations that were providing legal services. As one commentator noted in 1931, "[t]itle, insurance, trust, indemnity, collection and other corporations are spreading their tentacles over large segments of the lawyer's domain. It has been estimated that corporations to-day perform 60 per cent of corporate law work."

Indeed, according to Professor Green, the ethical prohibitions adopted by the ABA in the new 1928 canons had their origins in a 1909 New York law making it a misdemeanor for a corporation to "render or furnish legal services or advice, or to furnish attorneys or counsel or to render legal services of any kind." At that time, corporations employed lawyers to represent third parties in litigation and were not subject to the ethical prohibitions on lawyer advertising. This led members of the New York bar to seek protection from the legislature from what they considered unfair competition.

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in court?... He must be free to exercise his independent judgment as an attorney for the benefit of the interests he represents, which he could not be expected to do while under the domination of a third party as its salaried servant.

13. Id. (quoting Minority Report of F. W. Grinnell, 52 Rep. of the A.B.A. 378 (1927)).
14. Green, supra note 5, at 1139 (quoting Proposed Supplements to Canons of Professional Ethics, 13 A.B.A. J. 268 (1927)).
15. Id. at 1156.
16. Id. at 1135.
17. I. Maurice Wormser, Frankenstein Incorporated 164 (1931).
18. N.Y. Penal Law § 280 (1909); see Green, supra note 5, at 1120.
19. See Green, supra note 5, at 1119-20.
20. See id. at 1120.
When the New York statute was challenged in the courts, the chairman of the Brooklyn Bar Association's Committee on Grievances argued in the petitioner's brief in the New York Court of Appeals that competition from a corporation "is disadvantageous and unfair to me as a practising member of the bar of this state and others similarly situated." Another prominent supporter of the bill argued in a brief on behalf of the Attorney General that the law was "of special importance to young men, ambitious to become lawyers through the methods prescribed by existing laws and to those who have obtained the necessary license and have taken up the practice as a profession." In upholding the statute in 1910, the New York Court of Appeals, however, emphasized not protection of lawyers but protection of clients' interests and lawyers' independence of professional judgment in serving those interests. The court reasoned:

The relation of attorney and client is that of master and servant in a limited and dignified sense, and it involves the highest trust and confidence. It cannot be delegated without consent and it cannot exist between an attorney employed by a corporation to practice law for it, and a client of the corporation, for he would be subject to the directions of the corporation and not to the directions of the client. There would be neither contract nor privity between him and the client, and he would not owe even the duty of counsel to the actual litigant. The corporation would control the litigation, the money earned would belong to the corporation and the attorney would be responsible to the corporation only. His master would not be the client but the corporation, conducted it may be wholly by laymen, organized simply to make money and not to aid in the administration of justice which is the highest function of an attorney and counselor at law.

When the ABA Special Committee on Supplementing the Canons of Professional Ethics issued a report in 1926, it borrowed liberally from a 1920 report issued by a committee of the Conference of Delegates of Bar Associations. The Delegates report, in turn, contained excerpts from the 1909 New York statute. The ABA Special Committee noted that, while information and recommendations were sought from each bar association, "[t]he

24. In re Co-Operative Law, 92 N.E. at 16 (upholding N.Y. Penal Law § 280 (1909)).
26. Id.
results... were disappointing, as little information was received from these sources, outside of New York City." 27 The New York statute, passed at the urging of the protectionist New York bar, was, in this way, "influential in the drafting of the business canons." 28

B. The 1969 Model Code of Professional Responsibility

In 1969, the ethical canons were replaced by the ABA Model Code of Professional Responsibility ("Model Code"). 29 The Model Code reinforced and strengthened the canons' prohibitions on non-lawyer ownership of legal service providers. The precatory language of the 1928 canons was replaced with mandatory language. 30 Disciplinary Rule ("DR") 3-103(A) prohibited lawyers from forming partnerships with non-lawyers; 31 DR 3-102(A) prohibited fee-splitting between lawyers and non-lawyers; 32 DR 5-107(C) prohibited lawyers from practicing in a corporation controlled by non-lawyers; 33 and DR 5-107(B) prohibited lawyers from allowing non-lawyer third parties to direct their professional judgment in representing clients. 34

While these provisions were adopted with little or no debate, the Model Code, unlike the 1928 canon, did provide some theoretical justification for the prohibitions. 35 Because non-lawyers were not governed "by the same rules that govern the conduct of a lawyer," the prohibitions were deemed necessary to "protect the public." 36 The fee-splitting prohibition was justified as necessary to prevent the unauthorized practice of law by laymen. 37 With respect to

27. Id. at 586 n.59 (quoting 52 Rep. of the A.B.A. 374 (1927)) (internal quotes omitted).
28. Id. at 586.
31. "A lawyer shall not form a partnership with a non-lawyer if any of the activities of the partnership consist of the practice of law." Model Code of Prof'l Responsibility DR 3-103(A) (emphasis added).
32. "A lawyer shall not share legal fees with a non-lawyer..." DR 3-102(A) (emphasis added).
33. DR 5-107(C) stated:
   A lawyer shall not practice with or in the form of a professional corporation or association authorized to practice law for a profit, if: (1) A non-lawyer owns any interest therein... (2) A non-lawyer is a corporate director or officer thereof; or (3) A non-lawyer has the right to direct or control the professional judgment of a lawyer.
   DR 5-107(C) (emphasis added).
34. "A lawyer shall not permit a person who recommends, employs, or pays him to render legal services for another to direct or regulate his professional judgment in rendering such legal services." DR 5-107(B) (emphasis added).
35. See Andrews, supra note 12, at 589.
36. Model Code of Prof'l Responsibility EC 3-3.
37. EC 3-8 ("Since a lawyer should not aid or encourage a layman to practice law, he should not practice law in association with a layman or otherwise share legal fees
employment of lawyers by non-lawyers, the Code drafters articulated the same rationale that had led the New York Court of Appeals to uphold the 1909 New York statute prohibiting corporations from providing legal services—protection of the lawyer's independent professional judgment on behalf of the client:

A person or organization that pays or furnishes lawyers to represent others possesses a potential power to exert strong pressures against the independent judgment of those lawyers. Some employers may be interested in furthering their own economic, political, or social goals without regard to the professional responsibility of the lawyer to his individual client... [A]n employer may seek, consciously or unconsciously, to further its own economic interests through the actions of the lawyers employed by it. Since a lawyer must always be free to exercise his professional judgment without regard to the interests or motives of a third person, the lawyer who is employed by one to represent another must constantly guard against erosion of his professional freedom. 38

C. The 1983 ABA Model Rules of Professional Conduct

Responding to widespread general criticism of the Model Code, the ABA in 1977 appointed a Special Commission on Evaluation of Professional Standards, which came to be known as "the Kutak Commission" after its original chairman, Robert Kutak. The Kutak Commission was charged with the task of evaluating and revising the Model Code. Its recommendations resulted in the ABA Model Rules of Professional Conduct ("Model Rules"), 39 which were adopted by the ABA in 1983.

The Kutak Commission, in its Revised Final Draft of the Model Rules presented to the ABA House of Delegates, recommended abandoning the Code's prohibitions on non-lawyer ownership of legal practices. Its proposed Model Rule 5.4 would have permitted non-lawyer participation in law firm ownership provided certain ethical obligations were met. 40 In its Report on the Final Draft, the

with a layman.

38. EC 5-23.
40. Proposed Final Rule 5.4 provided in full:
   Rule 5.4 Professional Independence of a Lawyer
   A lawyer may be employed by an organization in which a financial interest is held or managerial authority is exercised by a nonlawyer, or by a lawyer acting in a capacity other than that of representing clients, such as a business corporation, insurance company, legal services organization or government agency, but only if:
   (a) there is no interference with the lawyer's independence of professional judgment or with the client-lawyer relationship;
   (b) information relating to representation of a client is protected as required by Rule 1.6;
   (c) the organization does not engage in advertising or personal contact with
Commission wrote that there was a “demonstrable need for expansion of the means of making legal services more available” and that, in order to protect client interests the rules should focus not on “organizational forms,” but on “the actual potential for abuse.”

The ABA House of Delegates rejected Proposed Rule 5.4 after a floor debate in June of 1982. In its place, the delegates adopted a proposal by the General Practice Section to continue verbatim the Code's prohibitions on non-lawyer participation in ownership of legal practices. In a now-famous exchange on the floor, Professor Geoffrey Hazard, the reporter for and principal drafter of the Model Rules, was asked if Proposed Rule 5.4 would permit Sears, Roebuck to open a law office. When he responded in the affirmative, “the debate came quickly to a close and the General Practice Section’s version was adopted.”

While many other provisions in the Kutak Commission's Final Draft were modified by the House of Delegates, only Proposed Rule 5.4 was rejected in its entirety. The comments accompanying ABA Model Rule 5.4 include a one-sentence policy justification for keeping in place the prohibitions on non-lawyer participation in ownership of legal service providers: “those prohibitions ‘protect the lawyer’s professional independence of judgment.’”

prospective clients if a lawyer employed by the organization would be prohibited from doing so by Rule 7.2 or Rule 7.3; and
(d) the arrangement does not result in charging a fee that violates Rule 1.5.


42. Gilbert & Lempert, supra note 40, at 391.
43. Id. at 392. Rule 5.4, as adopted, provides in relevant part:
   Rule 5.4 Professional Independence of a Lawyer
   (a) A lawyer or law firm shall not share legal fees with a nonlawyer. . . .
   (b) A lawyer shall not form a partnership with a nonlawyer if any of the activities of the partnership consist of the practice of law.
   (c) A lawyer shall not permit a person who recommends, employs, or pays the lawyer to render legal services for another to direct or regulate the lawyer's professional judgment in rendering such legal services.
   (d) A lawyer shall not practice with or in the form of a professional corporation or association authorized to practice law for a profit . . . .

Legislative History, supra note 40, at 163.
45. Legislative History, supra note 40, at 164.
D. The ABA Commission on Multidisciplinary Practice

In August 1998, ABA president Phillip Anderson appointed the Commission on Multidisciplinary Practice ("MDP Commission") to consider again—in the context of recent developments in the delivery of legal services—the propriety of prohibitions on non-lawyer ownership of legal service providers.\(^{46}\) The focus of the MDP Commission, as evidenced by its title, was on partnerships between lawyers and other professionals to provide multiple professional services. To discharge their task properly, the Commission was asked to "set aside the financial interests of the profession and ensure that the public interest is served."\(^{47}\)

The Commission adopted "an extremely open and deliberative process," establishing a website where it posted its own memoranda, requests for comments, submissions from third parties, and submissions and presentations made at the various town-hall-type meetings the Commission held over the next year and a half.\(^{48}\) Between August 1998 and June 1999, the Commission heard sixty hours of testimony from fifty-six witnesses, as well as written and oral communications from numerous others.\(^{49}\) The Commission heard from a wide range of witnesses, including consumer advocates, representatives of accounting firms, law professors, chairs of ABA sections and standing committees, and U.S. and foreign lawyers.\(^{50}\)

In June 1999, the MDP Commission issued a Final Report, to be submitted to the House of Delegates in August of that year.\(^{51}\) Like the Kutak Commission before it, the MDP Commission recommended that the rules be amended to permit lawyers to partner with non-lawyers for the purpose of providing legal services and to share legal fees with non-lawyers, assuming certain ethical obligations were met.\(^{52}\) In crucial ways, however, the MDP proposal was significantly less radical than the Kutak Commission's proposal. Lawyers could only work in non-lawyer controlled MDPs if those MDPs submitted to an annual certification process.\(^{53}\) More importantly, unlike the Kutak Commission's proposal, the MDP Commission's proposal would not have allowed for passive

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47. Id.
50. Id.
51. See id.
52. See id.
53. Id.
investment in entities providing legal services, since “[o]wnership would be limited to members of the MDP performing professional services.”

Therefore, under the MDP Commission’s proposed rule change, a corporation, such as Sears, could not operate a legal services division, nor could investors buy into MDPs.

At the August 1999 ABA Meeting, the House of Delegates neither adopted nor rejected the Commission’s proposal to lift the restrictions on MDPs. Responding to an evident lack of support for adoption of its recommendations at that time, the MDP Commission moved to defer a vote on the recommendations in response to requests by state and local bar associations for more time to consider the issues. Ominously, the House adopted a resolution proposed by the Florida bar that no amendments to the Model Rules permitting lawyer participation in MDPs be made “unless and until additional study demonstrates that such changes will further the public interest without sacrificing or compromising lawyer independence and the legal profession’s tradition of loyalty to clients.”

In response to the Florida resolution, the MDP Commission continued its investigation of the issues. Its members met with state and local bar authorities to explain its position and receive additional public comment. In July 2000, the MDP Commission presented a revised report to the ABA House of Delegates. The proposal in the 2000 Report was even less radical than that in the 1999 Report. The 2000 proposal made it explicit that passive investment in MDPs was not authorized, and it would have permitted lawyers to share fees and partner with non-lawyer professionals only if “the lawyers [had] the control and authority necessary to assure lawyer independence in the rendering of legal services.” Precisely what quantum of “control and authority” was “necessary to assure lawyer independence” was left, perhaps deliberately, vague.

This time around, the House of Delegates flatly rejected the MDP Commission’s recommendation. After barely an hour of debate, it adopted instead a resolution based in large part on a report issued by the New York State Bar Association reaffirming the existing

54. Id.
55. See Dzienkowski & Peroni, supra note 48, at 146.
57. See Dzienkowski & Peroni, supra note 48, at 146.
59. Some members of the Commission would have compromised further and “added a specific requirement in the Recommendation that there be a lawyer majority ownership of an MDP... and that a primary purpose of the MDP be the delivery of legal services.” Id.
60. See Dzienkowski & Peroni, supra note 48, at 148; N.Y. State Bar Ass’n Special
prohibitions on non-lawyer ownership of legal practice.\textsuperscript{61} The drafters of the resolution wrote that “[t]he law governing lawyers was developed to protect the public interest,” and they urged state bar authorities to adopt the following principles:

[1]. Jurisdictions should retain and enforce laws that generally bar the practice of law by entities other than law firms.

[2]. The sharing of legal fees with non-lawyers and the ownership and control of the practice of law by non-lawyers are inconsistent with the core values of the legal profession.

[3]. The law governing lawyers, which prohibits lawyers from sharing legal fees with non-lawyers and from directly or indirectly transferring to non-lawyers ownership or control over entities practicing law, should not be revised.\textsuperscript{62}

The MDP Commission was discharged “with the Association’s gratitude for the Commission’s hard work and with commendation for its substantial contributions to the profession.”\textsuperscript{63}

E. Current State Bar Activity

The ABA is a voluntary organization without legal authority, and the rules of ethics that it promulgates have no coercive force unless and until adopted by the states. The organization’s influence on state bar associations has historically been considerable. After the ABA promulgated the ABA Canons (1908), and the ABA Model Code (1969), most states simply adopted the ABA’s rules without change.\textsuperscript{64} Today, however, “the ABA is not as influential as it once was,” and many states “have modified the Model Rules to reflect state practices and prior law.”\textsuperscript{65} Nonetheless, all fifty states and the District of Columbia have some form of the MDP prohibition, whether based on Model Rule 5.4 or its predecessors, and none allow non-lawyer ownership of legal service providers.\textsuperscript{66}

\textsuperscript{61} Dzienkowski & Peroni, supra note 48, at 147.


\textsuperscript{63} Id.

\textsuperscript{64} See Charles W. Wolfram, Modern Legal Ethics 55-58 (1986).

\textsuperscript{65} Dzienkowski & Peroni, supra note 48, at 149.

\textsuperscript{66} Two jurisdictions briefly flirted with rule changes that, like the Kutak Commission’s proposal, would have allowed for corporate ownership and passive investment in legal service firms. North Dakota, in January 1986, approved a proposed version of Model Rule 5.4 modeled on the Kutak Commission proposal, but the state Supreme Court, without comment, refused to adopt the change and restored
The MDP debate did not, however, end on the floor of the ABA House of Delegates. The vast majority of state bar associations have undertaken to conduct their own studies and make their own recommendations. As of August 1, 2001, forty-four states had commissioned a study of the MDP prohibition; of those, fourteen had recommended relaxing the prohibition, either in whole or in part, and fifteen had recommended keeping the prohibitions in place.67

II. THE PROVISION OF LEGAL SERVICES TO THE MIDDLE CLASS

A. The Problem of Defining the Middle Class

Any analysis of the effectiveness of the legal services industry in meeting the needs of middle-class consumers must confront an initial definitional problem: who are, or what is, the “middle class?” In the United States, the middle class is a notoriously amorphous socioeconomic category, and social scientists cannot agree on a single definition.68 Some studies stress income, others education, still others occupation, as the central factor in defining middle-class status.69 The elasticity of the category is demonstrated by the fact that most Americans define themselves as middle class.70 When Americans are asked to choose among lower, middle and upper class in most polls—even in surveys taken during the Depression—more than eight in ten Americans describe themselves as middle class.71 This includes two in ten of the people who make less than $15,000, and more than nine in ten of those who make over $75,000. It can truly be said of middle-class America that “even though no one can define it, everyone believes that they belong to it.”72

Even assuming that income is the correct yardstick to use, there is little agreement on what range of income is middle class. Some argue

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69. Id. at 968.
71. See id.
that the middle class must include the middle level of income and a
percentage of households above it, while others say you have to dip
below the middle point.\textsuperscript{73} When defining the middle class, politicians
tend to be inclusive, at least at the upper range. In his 1993 State of
the Union Address, President Bill Clinton proclaimed the wealthy to
be those with an income in excess of $100,000.\textsuperscript{74} New York Governor
George Pataki put the middle-class ceiling at $175,000, while
Congressman Fred Heineman, whose total income is $183,500,
proclaimed himself to be "lower middle class."\textsuperscript{75} These definitions
lend support to Barbara Ehrenreich's ironic claim that in America "in
order to be middle class . . . one also has to be rich."\textsuperscript{76}

For purposes of this Article, we also intend to be inclusive. We
consider the middle class to include those individuals and households
who are ineligible for publicly supported legal services\textsuperscript{77} but have not
yet accumulated capital sufficient to sustain a comfortable lifestyle
without maintaining their current income. We assume that most
Americans are within that group.\textsuperscript{78}

\section*{B. Empirical Evidence of the Gap Between Middle-Class Demand and
Available Service}

Reform-minded scholars have long assumed that there is an unmet
demand for legal services among middle-class Americans.\textsuperscript{79}

\begin{itemize}
3448490.
\item \textsuperscript{74} Jonathan Peterson, \textit{Who Is Considered Rich? It's the $100,000 Question}, L.A.
\item \textsuperscript{75} See Roberts, supra note 70.
\item \textsuperscript{76} Id.
\item \textsuperscript{77} The Legal Services Corporation ("LSC"), a private nonprofit corporation
established by Congress in 1974 to provide civil legal assistance, is required to
establish maximum income levels for those eligible for free legal assistance. See 42
U.S.C. § 2996f(a)(2)(A) (1994); 45 C.F.R. § 1611.3(a) (2000). Section 1611.3(b) of
the Corporation's Regulations establishes a maximum income level equivalent to 125%
of the Federal Poverty Guidelines, which in turn are established by the Department
of Health and Human Services. In 2001, to be eligible for LSC assistance, a family of
four must have an income no higher than $22,063. See Legal Services Corporation,
Federal Register Notices: 16 C.F.R. Part 1611 Eligibility: Income Level for
Individuals Eligible for Assistance, at http://www.lsc.gov/FOIA/fm/161101.htm (last
\item \textsuperscript{78} In 1999, 80\% of American households made less than $79,375, and the ninety-
fifth percentile began at $142,021. U.S. Census Bureau, Money Income in the United
\item \textsuperscript{79} See, e.g., Talbot D'Alemberte, \textit{Calling the Role of Lawyers: Providing Service
to All}, 21 Cap. U. L. Rev. 861, 863 (1992) ("What lawyers have failed to do is to
provide access to legal services for the poor and middle class."); Stephen Ellmann,
("The unavailability of lawyers to many who need them is a chronic problem . . . .");
Lawrence J. Fox, \textit{A Nation Under Lost Lawyers: The Legal Profession at the Close of
the Twentieth Century, Money Didn't Buy Happiness}, 100 Dick. L. Rev. 531, 541
(1996) ("[A]mong the middle class, it is almost impossible to find lawyers to perform
Comments such as Derek Bok’s that “[t]here is far too much law for those who can afford it and far too little for those who cannot,” or President Carter’s famous lament that “[90] per cent of our lawyers serve 10 per cent of our people,” have become truisms. Until recently, there has been little hard empirical data to support these contentions. In the past thirty years, however, data collection efforts on the part of the organized bar have attempted to measure and define the unmet demand for legal services among ordinary Americans.

These so-called “legal need” studies are by no means above criticism and are at best imprecise. The concept of legal need encompasses a variety of perceptions and beliefs as to the circumstances in which a lawyer’s services are necessary or appropriate. Tests applied in assessing whether need, regardless of definition, is being met also vary. With those limitations in mind, the legal needs studies provide valuable data for testing the hypothesis that there is in fact an unmet demand for legal services. Some of the numbers emerging from those studies are quite startling.

81. Jimmy Carter, Remarks at the 100th Anniversary Luncheon of the Los Angeles County Bar Association (May 4, 1978), in 64 A.B.A. J. 840, 842 (1978) (criticizing the legal profession for excessive litigation and self-interest, and inadequate service to the poor and middle class).
83. For a critique of the “legal needs” studies described in this section, see Deborah L. Rhode, The Rhetoric of Professional Reform, 45 Md. L. Rev. 274, 281 (1986). Rhode argues that:
   The “legal need” studies are problematic on several levels. From an empirical perspective, it is unclear precisely what is being measured. Any society generates a vast array of conflicts that could give rise to legal action. Whether they do is a function of the organization of the legal system and its broader cultural setting.
   Id.
84. See Marc Galanter, Delivering Legality: Some Proposals for the Direction of Research, 11 Law & Soc’y Rev. 225, 226 (1976) [hereinafter Galanter, Delivering Legality] (describing legal needs as a social construct, and not some “Archimedean starting point against which we can measure the adequacy of legal services”). For a critical view of the rhetoric and perceived wisdom surrounding the “litigation explosion,” see Marc Galanter, Reading the Landscape of Disputes: What We Know and Don’t Know (and Think We Know) About Our Allegedly Contentious and Litigious Society, 31 UCLA L. Rev. 4 (1983).
85. See Galanter, Delivering Legality, supra note 84.
The first major legal needs study, commissioned by the American Bar Foundation ("ABF"), was conducted in 1974 and updated in 1989. The study revealed that over two-thirds of the adult population will consult a lawyer at least once in their lifetime. Forty-nine percent of adults in the top quintile of the income scale had consulted a lawyer in the three years prior to 1989, but only 27% of adults in the lowest 10% had used legal services during the same period. Reasons offered by respondents for not seeking out a lawyer included (1) lack of information about the legal character of a problem; (2) not knowing how to find a lawyer; (3) not believing one can afford a lawyer's help; and (4) fear of lawyers and legal proceedings. Cost was the second most frequently cited reason for not seeking out a lawyer, and the authors concluded that "[c]ost remains a significant element in the decision to seek legal assistance."

More recently, in 1994 the ABA issued the Comprehensive Legal Needs Study, which was based on more than 3,000 interviews conducted with low- and moderate-income Americans during 1993 to determine their legal needs and their response to those needs. For purposes of the study, "moderate-income households" were defined to include households with a combined annual income above 125% of the poverty threshold but below $60,000. While the study's low point fits nicely with our middle-class floor—the point at which consumers are no longer eligible for state-funded legal services—its ceiling of $60,000 leaves out many households we would consider middle class. As a result, the study is only a partial picture of "middle-class" as we define it—more specifically, it is the lower half of the picture. With this caveat in mind, the results are nonetheless striking.

87. See Cramton, supra note 86, at 541 n.23.
88. Id. at 542.
89. Id.
90. Id. at 542 n.28 (alteration in original).
93. Id. at 3.
94. The study designers chose to place the high point of "moderate" income at the top one-fifth of the population. See id.
The report found that 52% of all moderate-income households reported a legal need in 1992. The term “legal need” as used in the study meant “specific situations members of households were dealing with that raised legal issues—whether or not they were recognized as ‘legal’ or taken to some part of the civil justice system.” The most commonly reported needs among moderate-income households were (1) personal finance and consumer needs (17%); (2) housing and property (12%); (3) employment-related legal needs (12%); (4) community and regional controversies (12%); (5) estates (10%); and (6) personal and economic injuries (10%).

When asked what steps they took to deal with their legal need, only 39% of respondents in the moderate-income category turned to a lawyer for help. This means that almost two-thirds of moderate-income Americans with legal needs in 1992 received no professional assistance. The most common reasons offered for not seeking professional assistance were the respondents’ conclusions that it was not really a problem, they could handle it on their own, or a lawyer’s involvement would not help matters. Perhaps surprisingly, only 8% of respondents cited cost as a factor in not seeking a lawyer. Fifty-four percent of those who did turn to a lawyer for help declared themselves satisfied with the results, compared to a 39% satisfaction rate among those who took no action at all.

Several state bar studies have been conducted since the ABA’s 1994 Comprehensive Legal Needs Study. The most extensive and recent is the Oregon State Bar’s report, “The State of Access to Justice in Oregon,” which detailed the legal needs of 1,011 low- and moderate-income persons throughout Oregon in 1999 and 2000. Unlike the 1994 ABA study, the Oregon study did not separate out the results for low-income (those who qualify for free legal assistance) and

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95. Id. at 8.
97. Legal Needs Study Summary, supra note 92, at 10.
98. Id. at 20.
99. Id. at 26.
100. Id. But see Joyce Palomar, The War Between Attorneys and Lay Conveyancers—Empirical Evidence Says “Cease Fire!”, 31 Conn. L. Rev. 423, 438 (1999). Palomar found the following: [A] major reason for not having a lawyer in a home purchase transaction is the parties’ desire to avoid the expense. Of 132 homebuyers surveyed in 1990 in Columbus, Ohio, most stated that expense was their reason for not hiring a lawyer. Twenty-three percent of 107 homebuyers questioned in a 1993 New Jersey survey responded similarly.
101. Legal Needs Study Summary, supra note 92, at 32.
moderate-income persons. Nonetheless, the results are pertinent to our inquiry since, as the ABA study itself showed, there is little divergence between the legal needs of low- and moderate-income persons.

The greatest legal needs experienced by respondents in the Oregon study were in the area of housing (32%), public services (31%), family (27%), employment (27%), and consumer problems (25%). Most of these legal needs went unmet. Survey respondents reported that they obtained legal representation for fewer than 20% of their legal problems. When asked to explain why no legal assistance was sought in these cases, respondents replied as follows:

- Nothing can be done: 17%
- Not a legal problem: 12%
- Nowhere to get help: 12%
- Too much hassle: 12%
- Worried about cost: 11%
- Afraid or intimidated: 11%
- Turned to other help: 7%
- Help not needed: 7%
- Advised not worthwhile: 1%
- Did not want public dispute: 1%
- Other: 10%.

As with the ABA study, there was a high degree of satisfaction with the outcome among those who did seek a lawyer’s help (76% satisfaction rate), compared with those who did not seek a lawyer’s help (24% satisfaction rate). The authors of the study came to the conclusion that the “current legal services delivery system cannot

103. The Oregon study “examine[d] the civil legal needs of low (up to 125% of poverty) and moderate-income (between 125% and 200% of poverty) households.” Id. at 3.
104. Id. at 5. For example, the ABA’s 1994 study reported 47% of low-income households had a legal need, statistically indistinguishable from the reported 52% of legal needs for moderate-income households. See Legal Needs Study Summary, supra note 92, at 8. Moderate-income households did turn to a lawyer for help in greater numbers a reported 39% of the time, however, compared to 29% for low-income households. See id. at 20.
105. Dale, supra note 102, at 19.
106. Id. at 29.
107. Id. at 34.
108. Id. at 32.
meet the critical legal needs" for legal services among lower- and moderate-income Oregonians.109

The results of the Oregon study are echoed in other state studies. A 1996 study commissioned by the California Bar Association concluded that "the legal needs of approximately three-quarters of all poor people are not being met at all;"110 and, while the picture was not so gloomy for "middle-income" Californians, "they are still unable to afford representation in many instances," resulting in "harm and injustice to these families of moderate means."111 A Florida Bar Association study found similarly that 70% of legal needs faced by low- and moderate-income Floridians went unmet.112 The Colorado Bar Association reported that 75% of the legal needs of low-income persons were going unmet, and that "[p]ersons with moderate-incomes share the frustration of being unable to obtain critical professional advice and representation in the legal system."113

In the summer of 1995, the Commission on Providing Access to Legal Services for Middle Income Consumers of the New York State Bar conducted a telephone survey of six hundred New Yorkers with annual incomes between $25,000 and $95,000.114 At first blush, the results of the New York study paint a somewhat rosier picture of the legal profession’s ability to meet the needs of middle-class consumers. More than one-fourth of those consumers polled had used an attorney in the prior six months, and another one-fourth had used an attorney some time in the previous six months.115 More than one-half of those who had used an attorney had done so for a will, for an inheritance or probate matter, or to buy or sell real estate.116 Only 9% responded "Yes" to the question "Have you ever been unable to get an attorney for an important problem when you thought you needed one?"117 The Commission found this "unmet need . . . of a relatively modest proportion [to be] a surprising and satisfying result of the survey."118

109. Id. at 38.
111. Id.
115. See id.
116. See id.
117. Id. app. The most common reason given (24%) for the inability to get a lawyer was that one "could not afford the legal services." Id.
118. Id. (indicating statement in "The Survey" section).
The New York results may seem to be at odds with the ABA and Oregon studies, which found that a low percentage of moderate-income people with a legal need turn to a lawyer for help; but the three studies are probably reconcilable. Some of those counted by the ABA and the Oregon study as needing legal assistance did not recognize that they had a legal need and would also not, therefore, be among those who would identify themselves as unable to get an attorney. On the other hand, respondents likely answered “Yes” to the New York question “have you ever been unable to get an attorney?” only if they had actually tried unsuccessfully to get a lawyer. Others may have never looked despite a perceived legal need for a variety of reasons (as was true in the ABA and Oregon studies), including that they were convinced before looking that they could not afford a lawyer. Indeed, one-fourth of those surveyed in the New York study reported that they could not afford the services of an attorney, and another 20% said that it would depend on the circumstances.\(^\text{119}\) In addition, the Commission found a substantial gap between what New Yorkers thought they could afford and what lawyers actually charge.\(^\text{120}\)

While difficult to compare because of their different methods and focus, the bar association legal needs studies confirm as a whole what has long been assumed. A significant number of Americans with legal needs are not getting professional assistance.

C. Middle-Class Consumers Versus Corporations: How the Market for Legal Services Is Dominated by Commercial Interests

What accounts for this gap between legal need and accessible legal service for ordinary Americans? The first, and most obvious, reason is the cost of hiring a lawyer. Second, and related, ordinary Americans are unable to compete with business interests and high-wealth individuals who command an ever greater share of the legal services market and drive further upward the cost of legal services.

The high cost of legal services is hardly a secret. Average hourly rates for lawyers in the United States in 1998 were $180; large-firm partners averaged $250 an hour, with the top ten percent charging in excess of $385 per hour.\(^\text{121}\) At these rates, even a simple legal matter can cost tens of thousands of dollars.\(^\text{122}\) Newspapers are full of anecdotal evidence of the high cost of legal services. The prosecution of a discrimination lawsuit against a day-care center that netted the plaintiff $158,500 cost $224,000 in legal fees.\(^\text{123}\) A chemist’s claim of

\(^{119}\) Id.

\(^{120}\) Id.


\(^{122}\) See id.

\(^{123}\) See Bob Doucette, Day Care Loses Appeal in Discrimination Suit, Saturday
employment discrimination that netted him $230,453 cost $1.3 million in legal fees and expenses. The legal fees for a copyright dispute over a subscription worth $590 came to $1 million. Bill Clinton’s legal bills in connection with the Paula Jones and Monica Lewinsky scandals were approximately $10 million, while the Starr investigation cost taxpayers over $50 million. Total revenues earned by law firms in the United States exceeded $75 billion annually in 1987. The reality is that lawyers are now so extraordinarily expensive that low- and middle-income Americans, when faced with a legal need, often must forego the assistance of a lawyer.

Lawyers are not only costly in absolute terms. Ordinary consumers face an additional obstacle to securing a lawyer’s services: a bidding process against the businesses and high-wealth individuals that command more and more attention from the legal services industry—a bidding process they cannot possibly hope to win. In a landmark 1975 study of the Chicago bar, the authors found a high degree of differentiation in the legal profession between those who serve business clients and those who serve personal clients. While the bar is formally unified, the authors described a division of two separate hemispheres of lawyering, with large law firms populated by elite law school graduates serving business interests occupying one and small or solo practitioners serving personal and small-business interests occupying the other. In 1975, 53% of legal effort in Chicago was devoted to the corporate sphere and 40% to the personal sphere.
When the authors updated their study in 1995, the authors found that the share of legal effort going to corporate clients had increased to 64%, while the total amount of legal effort on behalf of individuals had fallen to 29%.

U.S. Census Bureau data suggests that the trend revealed by these Chicago studies is likely repeated across the country. The percentage of lawyers' income received from individual clients declined nationally from 52.2% of lawyer receipts in 1972 to 39.6% in 1992. In the same time period, receipts from business interests increased from 42% to 50.9% nationally. In Los Angeles, receipts from individuals fell from 46.2% in 1982 to just 31% in 1992, while receipts from businesses climbed from 49.5% to 56.6% in the same time period. This pattern is not confined to "large market" cities like Chicago and Los Angeles. In Sacramento, for example, receipts from individuals decreased from 50.4% to 46.3% of total lawyer receipts between 1982 and 1992, while receipts from businesses increased from 38.8% to 45.2% in the same period.

Structural changes in the legal services industry reflect this flow of legal services toward business interests and away from individuals. Large law firms serving businesses and high-wealth individuals are big and getting bigger. In the 1950s, thirty-eight law firms in the United States had more than fifty lawyers, and more than half of these were in New York City. In 1985, over five hundred firms had fifty or more lawyers. Firms with over a hundred lawyers grew from less than a dozen in 1960 to 251 in 1986. In 1968, the largest law firm in the United States had 169 lawyers. In 2001, only one of the law firms appearing on American Lawyer's top 100 list had less than two hundred lawyers, with Skadden, Arps boasting 1,441 lawyers overall. In contrast, the percentage of solo practitioners among lawyers in private practice declined from 64% in 1960 to 47% in 1999. Particularly telling is the rate-of-growth of expenditures on

134. See id.
135. See id.
136. See id.
138. See id. at 749.
139. See id.
140. See id.
141. See id.
legal services, which was 555% for business interests from 1967 to 1992, more than twice the rate-of-growth for individual client expenditures during that same period.\textsuperscript{144}

D. The Prohibition on Non-Lawyer Ownership of Legal Service Providers and the Middle Class

1. The Role Played by the Prohibition in Keeping the Cost of Legal Services Unaffordably High

Even recognizing that the market for legal services has become increasingly dominated by commercial interests, one might legitimately ask, "So what?" Is this anything more than the response of a properly functioning market to changes in the U.S. economy? After all, the U.S. economy has undergone surges of explosive economic growth in recent decades, and major changes in the institutional mechanisms that regulate corporate actors have further contributed to the demand for legal services in the commercial sector.\textsuperscript{145} Those changes include increasing and broad-based government regulation of business in the 1970s; the expansion of corporate tort liability for injuries to workers, consumers, and other third parties; the rise in the financial conception of the corporation leading to unprecedented numbers of corporate transactions in the 1980s and '90s; and the deregulation of corporate finance and corporate transactions.\textsuperscript{146} Should not the parallel growth of law firms to serve those economic interests be expected—in fact, welcomed? Is not the ever-increasing dominance of the business sector of the legal services industry simply a function of the competitive market for legal services, with services flowing to the market players who value them the most?

This assumes, however, a competitive market for legal services. In fact, the market for legal services is noncompetitive and strictly regulated on the supply-side by the service providers themselves. The

\textsuperscript{144} See Marc Galanter, "Old and in the Way": The Coming Demographic Transformation of the Legal Profession and Its Implications for the Provision of Legal Services, 1999 Wis. L. Rev. 1081, 1088.


\textsuperscript{146} See id.; see also Robert MacCrate, "The Lost Lawyer" Regained: The Abiding Values of the Legal Profession, 100 Dick. L. Rev. 587 (1996). MacCrate noted that:

New areas of law and regulation, largely designed by lawyers, created whole new fields for legal services, such as the environment, occupational health and safety, nuclear energy, discrimination and individual rights, health and mental health care, biotechnology, and the development and use of computers. At the same time, economic activity vastly expanded, new business enterprises multiplied, and the number of transactions in every segment of the economy proliferated.

MacCrate, supra, at 600-01.
regulation of the supply of legal services takes several forms.\textsuperscript{147} One is the direct regulation of access to the profession by way of admission requirements to law school, the bar examination, and the bar admission process.\textsuperscript{148} Another is the prohibition on the practice of law by non-lawyers, which ensures that the business of providing legal services is a monopoly enjoyed exclusively by lawyers.\textsuperscript{149} Another significant form of regulation is enforced through the profession’s “ethical” rules. Specifically, ABA Model Rule 5.4, and its predecessors and state equivalents, prohibit any non-lawyer participation in the ownership of legal service providers, including passive investment.\textsuperscript{150}

The result of these interlocking and complimentary regulations is a strictly regulated and noncompetitive market. “In a competitive market, greater production efficiencies translate into lower prices as competitors bid prices down towards the new, lower costs.”\textsuperscript{151} When the supply of legal services is deliberately kept low, legal resources are inevitably “pulled disproportionately into the commercial sphere, and individuals are largely priced out of the market.”\textsuperscript{152} As Gillian Hadfield has argued convincingly:

Lawyers in fact face a string of powerful market incentives to charge fees above those that would emerge in a competitive market. As is typical of noncompetitive markets, the legal market results in prices being determined by the value placed on them by consumers, not the cost of providing the service. The allocation of lawyers’ efforts are thereby skewed to those who place high monetary value on legal services and are able to pay these large sums: generally, commercial clients.\textsuperscript{153}

Hadfield further contends:

The cost of monopoly ... is ... the inertia and unresponsiveness of an insulated service provider. The legal system qua system is largely immune to pressures to reduce costs: those with disputes have no coercive alternative to the costly system if they are plaintiffs and no choice, period, if they are defendants. The autonomy of law is, in very important respects, that of an institution that can establish its

\textsuperscript{147} See Cramton, supra note 86, at 544.
\textsuperscript{148} See id.
\textsuperscript{150} See Annotated Model Rules of Prof'l Conduct R. 5.4 (1999); supra Part I.
\textsuperscript{152} Hadfield, supra note 121, at 956.
\textsuperscript{153} Id.
own values... without pressure to take into account an important value for participants in the system: the cost of participating.\textsuperscript{154}

The legal services regulatory scheme and its various prohibitions thus play a prominent role in ensuring that the price of participation in the legal services market remains too high for most Americans.

Though it is only one facet of the regulatory scheme, the ethical prohibition on non-lawyer ownership of legal service providers plays a notable role in restricting the supply of legal services to ordinary Americans. By denying to non-lawyers the opportunity to buy and resell the services of lawyers, granting to lawyers the exclusive right to earn a profit from investment in the legal services industry, and denying to non-lawyers the opportunity to compete for management positions in for-profit law firms, the ownership restriction serves to "keep the law business all in the family."\textsuperscript{155} It helps to keep the market for legal services noncompetitive and the price of legal services artificially high. By prohibiting alternative vehicles for the delivery of legal services, the ethics rules virtually ensure that low- and middle-income consumers will go underserved, since ordinary consumers cannot possibly hope to win a bidding war against commercial interests for the limited goods available in a noncompetitive market.\textsuperscript{156}

The anticompetitive effects of Model Rule 5.4 and its predecessors have not escaped the notice of the FTC, which has taken the position that the corporate ownership prohibition should be abolished.\textsuperscript{157} Jeffrey I. Zuckerman, then Director of the FTC Bureau of Competition, in urging the Supreme Court of Kentucky not to adopt Rule 5.4, emphasized those anticompetitive effects:

Proposed Rule 5.4 would limit the ability of lawyers to establish multidisciplinary practices with other professionals, such as psychologists or accountants, to deal efficiently with both the legal and nonlegal aspects of specific problems. [It]... also would appear to bar lawyers from including any lay persons, such as marketing directors, as partners in their law firms. Finally, such a restriction would appear to prohibit corporate practice, and thereby prevent the use of potentially efficient business formats. . . .

. . . .

Proposed Rule 5.4 might limit potentially procompetitive professional ventures, innovative business formats, and perhaps

\begin{\footnotesize}
\begin{enumerate}
\item Id. at 993.
\item See supra Part II.C.
\item See Andrews, supra note 12, at 620. Parallel ethical prohibitions in the AMA code of ethics were struck down by a 1979 FTC decision. See infra text accompanying notes 232-40.
\end{enumerate}
\end{\footnotesize}
some forms of prepaid legal services. [It] . . . might prevent lawyers from achieving savings in marketing that could be passed on to consumers. For example, the proposed rule would not permit a retailer such as Sears to employ attorneys to provide legal services to the public. If attorneys were permitted to enter into such an arrangement, it would be feasible for them to advertise on a national scale and share advertising time with other Sears service providers, such as its insurance, stock brokerage, and realty subsidiaries.\footnote{158. Letter from Jeffrey I. Zuckerman, to Robert F. Stephen, C.J. of the Supreme Court of Kentucky 5-6 (June 8, 1987), quoted in Andrews, supra note 12, at 620 (omissions in original).}

The U.S. Supreme Court has held, however, that lawyer rules of professional conduct are protected as "state action" when they are adopted by a state's highest court.\footnote{159. See Bates v. State Bar, 433 U.S. 350, 361 (1977).} This state action defense protects "anticompetitive activities carried out by private parties pursuant to a clearly articulated state policy that is supervised actively by the state generally."\footnote{160. See Andrews, supra note 12, at 620.}

Because the MDP prohibition ensures zero non-lawyer investment in the business of law, consumers of legal services are denied the benefits of investment that would almost certainly be forthcoming, given the size of the legal market were it not for the prohibition. Any industry that grows at almost twice the pace of the gross national product, as the legal services industry did between 1977 and 1988, is likely to attract investment.\footnote{161. Between 1977 and 1989 the Gross National Product grew by 260% whereas the legal services industry grew by some 480%. See Nelson, supra note 145, at 345 (citing Robert E. Litan & Steven Salop, More Value for the Legal Dollar: A New Look at Attorney-Client Fees and Relationships 2 (Aug. 1992) (unpublished paper presented at Annual Meeting of ABA)).} Despite the unmet needs for legal services,\footnote{162. See supra Part II.B.} individuals' expenditures on legal services increased 261% from 1967 to 1982.\footnote{163. See Sander & Williams, supra note 128, at 441.} Therefore, were it not for the prohibition on non-lawyer investment, we could expect to see specific investment in the legal service market for ordinary consumers despite the dominance of commercial interests in the market for legal services. As Stephen Gillers points out, "[t]he rule of thumb has been that a law firm associate's time should be billed at a rate that nets a profit of one-third after deduction of salary and overhead. That's a pretty good margin, one other investors might be willing to undersell."\footnote{164. Gillers, supra note 155, at 268.}

Enhanced production economies with resulting increase in quality of service may also result from the integration of legal services with other professional services in MDPs. MDPs, unlike independent law firms, have the ability to deliver an integrated team approach to serving client interests and problems requiring services in different
fields. The ability of MDPs to provide so-called “one-stop shopping” may lead not only to lower-cost provision of legal services but better service for consumers generally because of the broader expertise of the service providers and the close cooperation of a professional, interdisciplinary team. The MDP prohibition is a “virtual guarantee that the quality of expertise generally available to clients will be lower than optimum.” Given the likely cost-savings and convenience, middle-income individuals are likely to choose an integrated provider of professional services rather than a stand-alone professional enterprise.

2. The Information Barrier, Technology, and Non-Lawyer Investment in Legal Service Providers

In addition to affordability, the legal needs studies highlight another important barrier to middle-class access to legal services: lack of information. Unlike high-wealth individuals and corporations, middle-class consumers often simply do not recognize their legal needs or, if recognized, do not know how to go about meeting them. Those survey respondents who needed but did not seek legal services often cited lack of information or not knowing how to find a lawyer as factors in that decision. Twelve percent of such respondents in the Oregon study said there was nowhere to get help, and another 12% said it was too much trouble. Those respondents who did consult a lawyer rarely used the systems currently relied on by the legal profession for reaching this sector of society. In the ABA’s legal needs study, just 4% of moderate-income households that engaged a lawyer did so through a lawyer referral service. Eleven percent


168. See Trebilcock & Csorgo, supra note 151 (listing potential cost savings for consumers using MDPs are in searching, contracting, coordinating, monitoring, and information costs).

169. See supra text accompanying note 89.

170. Dale, supra note 102, at 34.

171. Inst. for Survey Research, Temple U., Legal Needs Among Moderate-Income
reported finding a lawyer through the telephone directory and 6% reported finding a lawyer through either a "legal hotline, electronic or print media, direct solicitation, prepaid legal plan, [or] service provider." 172 Traditional information and intake systems are apparently inadequate to meet the needs of middle-class consumers of legal services.

One obvious way to address this information gap is to harness the emerging Internet and computer software technologies to make legal services information more readily accessible to middle-class consumers. 173 These technologies are relatively inexpensive, extremely accessible, and have interactive capability as well as virtually unlimited capacity to convey information.

There is little question that individual and household Internet access in the United States is climbing rapidly, particularly among middle-income Americans. 174 Data on Internet use indicates that, after e-mail, searching for information is the most common use of the Internet among home users. 175 People are literally turning to the Internet to look for answers. They use the Internet to obtain medical diagnoses and prescription drugs, to trade stock, to secure a mortgage, and to transact business. 176 Very often, the answers lay people are looking for are answers to legal problems. As one commentator put it, "[i]n cyberspace, the much-decried unmet legal needs of middle-income people are available for the world to see, with just a few clicks of a mouse. The Internet abounds with tales of legal woe, presented through a number of different vehicles." 177 Perhaps predictably, the


172. Id. at 53.


174. In August 2000, more than half of all households (51%) in the United States had computers, a 58% increase in twenty months, and 41.5% of U.S. households had Internet access. U.S. Dep't of Commerce, Falling Through the Net: Toward Digital Inclusion, A Report on Americans' Access to Technology Tools 1 (2000), http://www.ntia.doc.gov/ntiahome/digitaldivide. The share of individuals using the Internet was at 44.4% in August 2000, an increase of 32.7% in twenty months. Id. at 33. Internet access in middle-income households rose more rapidly than in any other income bracket. Over 46% of households with income between $35,000 and $49,999 had Internet access in August 2000, up from 29.5% in 1998. Id. at 8. Households with incomes between $50,000 and $74,999 climbed from 43.9% to 60.9% in the same time period, while households with incomes over $75,000 went from 60.3% to 77.7% with Internet access. Id. Internet access in rural households is also climbing rapidly, with 38.9% having Internet access in August 2000, an increase of 75% in twenty months. Id. at 5.

175. Id. at 48.


legal self-help industry has quickly embraced emerging technologies, with websites such as FreeAdvice.com, Lectlaw.com, Nolo.com, and software packages like Turbotax and Willmaker enjoying increasing popularity.\footnote{178}

Why has the sector of the bar serving middle-class clients not recognized and tapped into the Internet’s potential for reaching those with legal needs? In fact, though traditionally slow to embrace new technologies, more and more law firms are now on-line with their own websites.\footnote{179} But once again, a distinction is apparent between the sector of the profession serving business clients, and the small law firms and solo practitioners typically serving small business and middle-income consumers. Surveys conducted by the ABA’s Legal Technology Resource Center show that small firms are not embracing the Internet as fast as large law firms. A 1999 survey found that 71\% of large law firms, but just 32\% of small firms, had their own websites.\footnote{180} For whatever reason—whether it be cost constraints, time constraints, operational inefficiencies associated with serving middle-income consumers of legal services, or simply a failure to recognize the Internet’s potential for reaching a mass market for legal services—the sector of the bar devoted to serving middle-income clients has not yet harnessed the Internet’s potential for meeting those clients’ needs.

One explanation is that many lawyers traditionally serving middle-class consumers perceive the Internet, with its proliferation of legal self-help resources, as well as self-help computer software, as the enemy.\footnote{181} Indeed, potential clients may seek answers to their legal questions or attempt to prepare their own legal documents with on-line assistance rather than suffering the inconvenience and expense of visiting a lawyer. To the degree that such consumers can adequately


\footnote{179. See William Hornsby, Improving the Delivery of Affordable Legal Services Through the Internet: A Blueprint for the Shift to a Digital Paradigm (2000), at http://www.lawschoolconsortium.net/hornsby@20article.htm (on file with the Fordham Law Review).}


meet their needs in this way, the Internet may already be helping to address the problem of providing more affordable legal services to the middle class. On the other hand, those consumers whose needs require the individual attention of a trained lawyer may be ill-served by a self-help legal website or legal assistance software.

Ideally, Internet and computer software technology would be utilized to provide more affordable legal information, advice, and services to middle-class consumers, but those consumers would get the assistance of a trained lawyer who is focused on their individual circumstances when necessary and appropriate. Information technology services and practicing lawyers would collaborate to produce an optimal and affordable blend of accessible services.

This consumer-friendly collaboration has not yet emerged and is less likely to do so under the current regime of exclusive lawyer ownership of legal service providers. Optimal use of Internet and computer software technology for the benefit of middle-class legal consumers will likely require significant capital investment and comprehensive planning. Because Model Rule 5.4 and its state counterparts prohibit non-lawyer investment in the legal services industry, any investment in technology services or integration of technology with existing legal services must come from within the profession, from law firm partners, or from their shareholder counterparts. The potential for costly technological investment, especially by lawyers that focus on middle-class clients (mostly small law firms and solo practitioners), is, therefore, limited.

Permitting access to non-lawyer capital, either through direct access to equity markets or capital contributions from non-lawyer partners, could result in the capital infusion necessary for investment in technology that would help to fill the gap for legal information and services sought by middle-class consumers. Efficient use of technology could help consumers with legal needs connect more easily with legal service providers, who would tap into the currently underserved middle-class market for legal services. Investments in

182. See generally Fischer, supra note 176. A recent celebrated example of the online “lay legal expert” is one Marcus Arnold, a fifteen-year old boy from Perris, California who became the number one ranked “law expert” on the AskMe.Com website in the summer of 2000. See Michael Lewis, Faking It, N.Y. Times, July 15, 2001, § 6, at 32, 35.


184. Adams & Matheson, supra note 3, at 30 (discussing the benefits of allowing law firms access to equity markets).

185. Integration of legal services with other professional services—truly multidisciplinary practice—would further increase the efficiencies resulting from this harnessing of modern information technology. Legal services could be bundled with related professional services and offered to consumers in an integrated package or menu. Consider H&R Block’s Internet venture, www.hrblock.com, which provides its
technology by corporate-backed legal service providers would also allow for faster, more efficient, and more affordable service to those consumers once the connection was made. Routine questions could be answered, and routine services provided, largely through software technology, and consumers with more individualized needs could be identified through the same technology. The technology is available, the need is established, and the middle classes are on-line. What is missing are properly capitalized service providers willing to make the necessary investment.

Pointing out this potential does not resolve the ethical issues at the center of the on-going MDP debate; rather, in the context of middle-class consumer needs, it places the issues in a more urgent light. Certainly this brave new world of integrated, technology-assisted legal service would pose legitimate ethical concerns. Would individualized client needs be adequately identified and addressed? Could confidentiality be properly established and protected despite the extended use of technology? Would providers with packaged services put undue pressure on clients to use services they do not need? And, of course, the fundamental concern traditionally used to justify the prohibition on non-lawyer ownership of legal service providers remains: would non-lawyer owners of such service providers put undue profit pressure on lawyers that would inhibit their exercise of independent judgment on behalf of clients? This concern would no doubt be exacerbated by the very efficiencies that recommend the proposed new regime, including, one could expect, packaging of legal services with other services on a prepaid, flat fee, or premium basis.

Those within the profession who have thus far successfully resisted any erosion of the prohibition on non-lawyer ownership of legal service providers do so, of course, in the name of consumer protection. The prohibition, they argue, is necessary to protect lawyers’ independent professional judgment and other core values of the legal profession from the inevitable and irresistible pressure to compromise those values that would result from non-lawyer ownership. As demonstrated by the parallel conflict faced by physicians under the regime of managed care discussed below, those concerns cannot be dismissed out-of-hand.

Given the current failure of the market to meet the needs of ordinary consumers of legal services and the apparent role of the customers with access to tax professionals, investment specialists, or mortgage brokers, all with one click of the mouse. See H&R Block, at http://www.hrblock.com (last visited Oct. 19, 2001). Given the increasing presence of the middle classes on-line, there is every reason to expect H&R Block’s customers would take advantage of its legal services division, if one were permitted.

186. See Testimony of David A. Swankin, Citizen Advocacy Center (Mar. 24, 1999), at http://www.abanet.org/cpr/swankin.html ("[T]hose who would retain the current restrictions do so in the name of consumer protection, when quite the opposite is the case.").
prohibition of the non-lawyer ownership of legal service providers in that failure, however, one must, at a minimum, seriously question the organized bar’s unwillingness to tolerate and regulate that conflict. What one judge said of the restrictions on the unauthorized practice of law applies with equal force to the MDP restriction:

There is a point at which an institution attempting to provide protection to a public that seems clearly, over a long period of time, not to want it, and perhaps not to need it—there is a point when that institution must wonder whether it is providing protection or imposing its will. It must wonder whether it is helping or hurting the public.  

Or, put slightly differently, what good are the profession’s core values to those who do not make it through the lawyer’s office door?

III. HOW DOCTORS BECAME CORPORATE EMPLOYEES: THE PARALLEL, BUT RECENTLY DIVerging, HISTORY OF THE PROHIBITION ON NON-PHYSICIAN OWNERSHIP OF MEDICAL SERVICE PROVIDERS

In its attempts to regulate the ownership of professional service providers, the medical profession has struggled with the same issues that face the legal profession, including especially the tension between affordability and protection of professional autonomy. The medical profession followed a parallel path of ethical and legal prohibitions until a crisis of rising costs forced open the medical services marketplace. For the better part of the twentieth century, the American Medical Association’s (“AMA”) code of ethics prohibited physicians from working for corporations that sold their services to the public. In striking parallel to the ABA’s rationale for adopting Rule 5.4 and its predecessors, the AMA justified its prohibition on the basis that allowing corporate control of physicians would jeopardize their exercise of independent professional judgment in treating patients. A statutory ban on corporate ownership, known as the “corporate practice of medicine” doctrine, presented a further obstacle to corporate ownership.

These ethical and legal prohibitions have crumbled, however, under mounting political, social, and economic pressure, and today corporate delivery of medical services is the norm. In an effort to control mounting health care costs the medical profession made, or was forced to make, the same “deal with the devil” of corporate ownership that lurks at the fringe of the MDP debate in the legal community. That deal was made not so much to increase access to medical care but to control the cost of that care and its impact on employer- and government-financed medical insurance plans.

The medical profession’s experience under new ownership provides us with a glimpse into one alternative future, an opportunity to observe how corporate ownership can impact the professional-client relationship. The entry of corporations has indeed slowed the growth of health care costs but not without a price. That price has been borne by physicians, who have experienced a decrease in autonomy under their new bosses, and by patients, who are resentful of corporate interference in the physician-patient relationship.

A. Early History: Ethical and Statutory Prohibitions on Corporate Delivery of Medical Services

At the turn of the nineteenth to the twentieth century, for-profit corporations were involved in the delivery of medical services in two forms. In the first form, known as “contract practice,” corporations employed physicians to serve the medical needs of their employees. Businesses concentrated in remote areas, such as the mining, lumber, and railroad industries, found that to attract physicians to the sparsely settled regions where their employees were concentrated, it was necessary to offer the inducement of a fixed salary. The second form, known as “corporate practice,” involved for-profit businesses selling physician services to the public. “Corporate practice” was particularly popular in Oregon and Washington, where lay-managed corporations contracted with mining and lumber companies to provide medical services to employees. These practices disturbed some members of the AMA, who had only recently established control over the medical services industry and saw for-profit corporations as a threat to that control.

189. Id. at 201-02.
191. Starr, supra note 188, at 204-06.
192. The lot of the physician in the early nineteenth century was not a good one. See Chase-Lubitz, supra note 190, at 449. Though a great deal of disparity existed among physicians of the day, many had only a mediocre standard of living, and the profession’s standing in society was low. Id. at 448. Additionally, physicians faced serious competition for patients from “irregulars,”—quacks and healing sectarians.” Id. The practice of medicine was considered by many to be an “inferior occupation.” Id. Dissatisfied with their situation, physicians held a national medical convention in 1846 and subsequently formed the AMA. Id. at 449. The AMA set out to improve the status of its members and to establish the “preeminence of the ‘regular’ medical profession.” Id. It did so by adopting and enforcing a code of ethics that distinguished its members from less reputable practitioners, supporting licensing legislation that limited competition and regulated the quality of its members, and pushing for educational reform. Id. at 455. By the turn of the twentieth century, the AMA had “brought public respect and greater financial reward to physicians and established the...
The AMA's original Code of Ethics, promulgated in 1847, made no mention of the "corporate practice" of medicine, or of lay control of physician services. From its inception, however, the AMA had made clear that it was hostile to the "contract" or "corporate" practice of medicine. In 1869, the AMA's House of Delegates adopted a resolution recommending "that all contract physicians, as well as those guilty of bidding for practice at less rates than those established by a majority of regular graduates of the same locality, be classed as irregular practitioners."\textsuperscript{195} The AMA recommended to state societies in 1872 "[t]hat members of the profession hired ... for definite, stipulated wages, by ... corporation[s], or any other money-making institution whatever ... are to be classed as irregular practitioners."\textsuperscript{195} Again in the 1890s, the AMA issued a statement to the effect that the contract and corporate practices had "gone too far" and that "too much of the spirit of trade has found its way into the profession, and [that] its further encroachment should be resisted—not encouraged."\textsuperscript{196} In 1927, an AMA Judicial Council report stated that "[t]here is no doubt that the [contract] practice is growing in frequency and becoming widespread. In fact, it is entering into so many phases of the practice of medicine as to be a distinct menace to the stability of our organization."\textsuperscript{197}

Not everyone was opposed to contract and corporate medical schemes. The high costs of health care and its unavailability to persons of moderate means led to the formation of the Committee on the Costs of Medical Care in 1926, which was comprised of leaders in medicine, public health, and the social sciences.\textsuperscript{198} After six years of study, the committee issued a report concluding that persons of low and moderate means were underserved by the medical profession.\textsuperscript{199} The committee made several recommendations to address this problem, including the expansion of contract practices through group prepaid medical practice.\textsuperscript{200} Nine physician members of the committee, including the Secretary and Chairman of the AMA and

\begin{footnotes}
\item[193] See id. at 458.
\item[194] In re Am. Med. Ass'n, 94 F.T.C. 701, 897 (1979) (internal quotes omitted).
\item[195] Id. at 897-98 (internal quotes omitted).
\item[196] Id. at 898 (internal quotes omitted).
\item[197] Id. (internal quotes omitted).
\item[199] Battaglia, \textit{supra} note 198, at 157-58 n.11 (noting the committee concluded that each income segment studied "failed to receive the amount of medical services necessary for good care"); McDowell, \textit{supra} note 198, at 693-94 n.9.
\item[200] Am. Med. Ass'n, 94 F.T.C. at 898.
\end{footnotes}
the Chairman of the AMA’s Judicial Council, issued a minority report opposing the committee’s recommendations. In 1933, the AMA House of Delegates endorsed the minority report as “expressive, in principle, of the collective opinion of the medical profession.” The following year, the House of Delegates added to its ethics code a provision which prohibited physicians from working for lay-owned medical service providers:

It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy.

While the format changed over the years, the substance of this ethical prohibition survived intact until the 1970s. The AMA’s position on lay involvement in the provision of medical services was straightforward: there must be “no capital formation in medical care (other than what doctors accumulated) ... and ... if medicine required any capital that doctors themselves could not provide, it would have to be contributed gratis by the community, instead of by investors looking for a profit.”

State statutes passed at the urging of the medical profession were an additional barrier to corporate ownership of medical practices. A small number of states passed legislation explicitly prohibiting corporations from providing medical services to the public. More typically, state courts read a prohibition on corporate practice into state medical practice acts providing for the licensing of physicians. Courts reasoned that because a corporation was nonpersonal in nature, it could not meet the qualifications of the licensure statute and, therefore, could not practice medicine. This questionable

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201. The minority report stated that “[a]ny method of furnishing medical care which degrades the medical profession through unfair competition or inadequate compensation ... must be condemned.” Id. (internal quotes omitted).
202. Id. at 899 (internal quotes omitted).
203. Id. (quoting AMA Principles of Medical Ethics 1934) (internal quotes omitted).
204. Starr, supra note 188, at 216.
207. See Parker v. Board of Dental Exam’rs, 14 P.2d 67 (Cal. 1932); People v. United Med. Serv., Inc., 200 N.E. 157 (Ill. 1936); State v. Winnebago Co-Op Burial Ass’n. 22 N.W.2d 800 (Iowa 1946); People v. Woodbury Dermatological Inst., 85 N.E.
statutory interpretation was bolstered by policy arguments parallel to those advanced in favor of the prohibition on non-lawyer ownership of legal service providers. It was unacceptable for non-professionals to control a professional’s judgment; the profession should not be made available for commercial exploitation; and a physician’s loyalty would be divided between patient and employer, to the detriment of the patient. In fact, courts holding that state licensing statutes prohibited the corporate practice of medicine sometimes cited In re Co-operative Law, the New York case that upheld that state’s ban on the corporate practice of law.

The historical parallels between the efforts of the legal and medical professions to ward off lay ownership of professional service providers are, thus, quite striking. Like the ABA, the AMA adopted ethical rules prohibiting its members from working for lay-owned professional service providers. Like the ABA House of Delegates, the AMA House of Delegates rejected the recommendation of an independent commission that it discard this prohibition so that professional services might reach underserved populations. Like the legal profession, the medical profession successfully urged passage or interpretation of statutes prohibiting corporations from “practicing” in its field. As in the case of the legal profession, these prohibitions were justified by supporters as necessary to protect professional independence of judgment.

B. From Physician Control to Corporate Control: The Demise of the Ethical and Statutory Prohibition on Corporate Ownership of Medical Services Providers

For the better part of the twentieth century, the medical profession succeeded in avoiding competition from lay-controlled medical service providers. Ethical prohibitions and state statutes combined to lock physicians into “simple partnership-style practice arrangements.”

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697 (N.Y. 1908).


211. 92 N.E. 15 (N.Y. 1910).


Reimbursement was on a fee-for-service basis. Like most lawyers today, physicians simply provided services and billed their clients directly for those services. Even when private insurance for hospitalization and physician services emerged in the 1930s and soon became a common workplace benefit, reimbursement still followed the fee-for-service model. Physicians simply billed insurance carriers rather than patients.

The fee-for-service system, which was “virtually set in stone” until the mid-1960s, benefited physicians tremendously in the short-term. Without competition from corporations, physicians enjoyed exclusive, increasingly lucrative ownership rights in business associations delivering medical services. Fee-for-service reimbursement, coupled with the emerging indemnification scheme, resulted in what one commentator has called an “extraordinarily generous, uncritical reimbursement system.” Physicians had exclusive control over the method and cost of treating patients and were generally assured of payment from insurers, who in turn passed along the increasing costs to employers. Because “physicians were economically empowered to define good care with very little outside influence . . . medical routines were largely a function of what physicians believed their patients needed.”

Not surprisingly, the cost of medical services rose steadily. Physicians’ exclusive ownership rights ensured little or no price competition among providers of medical services and prevented the creation of potentially more economical business structures. The reimbursement system fueled price inflation by minimizing cost considerations in physician decision-making and encouraging maximum use of new and costly medical technologies. Perhaps the straw that broke the back of the fee-for-service system was the federal government’s entry into the medical insurance field in 1965, when it created the Medicare program to provide public assistance to individuals over sixty-five years old and the Medicaid program to extend health coverage to the needy. The creation of Medicare and Medicaid added fifty million people to the health care market and

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215. Id.
216. Id. at 79.
217. Id. at 80.
218. Id. at 81.
220. Morreim, supra note 214, at 84 n.21.
222. Kilcullen, supra note 221, at 17.
forced the federal government to consider the rising costs of medical services, which had shattered its projections for Medicare and Medicaid spending.\footnote{223}{Between 1967 and 1970 Medicare hospital expenditures rose an average of 18.1\% annually, while the overall inflation rate was 5.2\%. See \textit{id.} at 18 n.92 (citing Karen Davis et al., Health Care Cost Containment 16 (1990)).}

With both the federal government and private employers feeling the pinch of the rising cost of health care insurance, the old system of fee-for-service reimbursement and physician control over the delivery of medical services began to crumble. In 1973, Congress passed the Health Maintenance Organization ("HMO") Act.\footnote{224}{Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e-1 (2001).} An HMO is the most common type of managed care organization ("MCO"), which is a corporation organized to provide and arrange for an array of basic and supplemental health care services.\footnote{225}{MCOs vary widely in their "approach, financing, physician involvement, and philosophy." Kate T. Christensen, \textit{Ethically Important Distinctions Among Managed Care Organizations}, 23 J.L. Med. & Ethics 223, 223 (1995). Perhaps the most important distinction is between for-profit organizations, which trade shares publicly, and nonprofit organizations, which are governed by the rules of charitable organizations. \textit{id.} For-profit HMOs organize relationships with their physicians in one of three basic ways: the staff model, the group model, and the independent practice association ("IPA") model. Diana Joseph Bearden & Bryan J. Maedgen, \textit{Emerging Theories of Liability in the Managed Health Care Industry}, 47 Baylor L. Rev. 285, 292 (1995). In a staff model HMO, the corporation employs physicians directly as salaried employees. \textit{id.;} James P. Freiburg, \textit{The ABCs of MCOs: An Overview of Managed Care Organizations}, 81 Ill. B.J. 584, 586 (1993). In a group model, the HMO enters into a contract with a group of physicians, who are independent contractors, to provide medical services to the HMO's members on a "capitated" basis—that is, the physician is paid a fixed amount on a monthly basis for all HMO enrollees assigned to that physician no matter how many enrollees actually receive treatment. Bearden & Maedgen, supra, at 292; see also 42 C.F.R. § 417.1 (2000). In the IPA model, individual practitioners who contract with HMOs are reimbursed on a discounted fee-for-service basis, rather than on a capitated basis, and no periodic limits are imposed on the total fees charged. Freiburg, supra, at 586; see also 42 C.F.R. § 417.1 (2000).}

The distinguishing characteristic of an MCO is that the MCO both insures for the cost \textit{and} provides for the delivery of health care services to its subscribers, by either employing physicians or negotiating contractual relationships with physicians.\footnote{226}{See Jacob S. Hacker & Theodore R. Marmor, \textit{How Not To Think About "Managed Care,"} 32 U. Mich. J.L. Reform 661, 669 (1999) ("Perhaps the most defensible interpretation of 'managed care' is that it represents a fusion of two functions that once were regarded as largely separate: the financing of medical care and the delivery of medical services."); Jonathan P. Weiner & Gregory de Lissovoy, \textit{Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans}, 18 J. Health Pol. Pol'y & L. 75, 78 (1993) ("What usually distinguishes the managed care plans from those that are more traditional is that there is a party that takes responsibility for integrating and coordinating the financing and delivery of services across what previously were fragmented provider and payer entities.").}

The MCO contracts with the patient, in exchange for periodic, prepaid premiums, and with physicians, to deliver the necessary medical services. Typically (and crucially),
MCOs reimburse the physician-providers of health care with negotiated, fixed periodic payments. In passing the HMO Act, Congress hoped to encourage the spread of corporate medical providers, and thereby deflate rising health care costs.

The HMO Act was instrumental in breaking down the barriers to corporate ownership of medical service providers. While the Act did not explicitly preempt state corporate practice prohibitions, it superseded state laws and practices requiring medical society approval before physicians could furnish services to HMOs and participate in the governance of an HMO, and those prohibiting HMOs from soliciting members through advertising. The remainder of the job was done by the states. Many states took their cue from the federal government and enacted legislation specifically exempting HMOs from the corporate practice prohibition. Many others simply ceased enforcing the doctrine, if they had not already done so. While statutory corporate practice prohibitions are not entirely moribund in

227. Chase-Lubitsz, supra note 190, at 482. Some commentators argue that the HMO Act in fact preempts state corporate practice prohibitions, since Congress could hardly have allowed the obvious barrier posed by these prohibitions to HMO development to stand. See Philip C. Kissam & Ronald M. Johnson, Health Maintenance Organizations and Federal Law: Toward a Theory of Limited Reformmongering, 29 Vand. L. Rev. 1163, 1218 (1976).

228. 42 U.S.C. § 300e-10 (2001). Section 300e-10(a) states:

   In the case of any entity —
   (1) which cannot do business as a health maintenance organization in a State in which it proposes to furnish basic and supplemental health services because that State by law, regulation, or otherwise—
   (A) requires as a condition to doing business in that State that a medical society approve the furnishing of services by the entity,
   (B) requires that physicians constitute all or a percentage of its governing body,
   (C) requires that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of services for the entity,
   (D) requires that the entity meet requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency, or
   (E) imposes requirements which would prohibit the entity from complying with the requirements of this subchapter, and
   (2) for which a grant, contract, loan, or loan guarantee was made under this subchapter or which is a qualified health maintenance organization for purposes of section 300e-9 of this title (relating to employees' health benefit plans),
   such requirements shall not apply to that entity so as to prevent it from operating as a health maintenance organization in accordance with section 300e of this title.

42 U.S.C. § 300e-10(a).

229. Mars, supra note 205, at 260 app.

230. Chase-Lubitsz, supra note 190, at 470; see Lisa Rediger Hayward, Revising Washington's Corporate Practice of Medicine Doctrine, 71 Wash. L. Rev. 403, 413 (1996).
some states, federal and state HMO legislation has effectively ensured that it no longer stands in the way of systematic health care reform.

If the statutory prohibitions on corporate ownership of medical service providers went with something of a whimper, the ethical prohibitions went with a bang. In 1979, the FTC held that those prohibitions, as then embodied in Section 6 of the AMA’s Principles of Medical Ethics, violated the antitrust laws. It ordered the AMA to modify its ethics code accordingly.

The AMA had argued that the ethical prohibitions were necessary to prevent non-physicians from having undue influence over medical procedures. The FTC dismissed this argument, stating that it was “difficult to see how such sweeping ethical proscriptions are needed to prevent . . . non-physicians from having undue influence over medical procedures.” It concluded in forceful terms that the profession’s ethical concerns could not justify insulating the medical service industry from the competitive marketplace:

The end result of [the AMA’s] energies has been the placement of a formidable impediment to competition in the delivery of health care services by physicians in this country. That barrier has served to . . . deter the offering of innovative forms of health care and to stifle the rise of almost every type of health care delivery that could potentially pose a threat to the income of fee-for-service physicians in private practice. The costs to the public in terms of less expensive, or even, perhaps, more improved forms of medical services are great.

231. One commentator counts five states that, at least in the mid-90s, were actively enforcing the doctrine. Hayward, supra note 230, at 413. Another commentator has called the surviving corporate practice prohibitions “legal landmines, remnants of an old and nearly forgotten war, half-buried on a field fast being built up with new forms of health care organizations.” Arnold S. Rosoff, The Corporate Practice of Medicine Doctrine: Has its Time Passed?, 12 Health L. Dig. 1, 3-4 (Supp. Dec. 1984). For a discussion of the sporadic recent applications of the doctrine, see Chase-Lubitiz, supra note 190, at 470-74.

232. Section 6 of the Principles of Medical Ethics stated that “[a] physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.” In re Am. Med. Ass’n, 94 F.T.C. 701, 896 (1979). The AMA Judicial Council made it clear that Section 6 prohibited both certain contract-type practices, and physicians working for for-profit medical service enterprises. Id. at 896-97. Section 6 listed the types of contract arrangements considered unethical by the Judicial Council. Id. Opinion 5 of Section 6 prohibited a physician from “dispos[ing] of his professional attainments or services to any hospital, corporation or lay body . . . . under terms or conditions which permit the sale of the services of that physician by such agency for a fee.” Id.

233. Id. at 996-1018.
234. Id. at 701.
235. Id. at 1017.
236. Id. at 1018.
237. Id. at 917.
The FTC further stated:

To say that physicians are above “trade,” and to assert that they are entitled to preserve their basic ethical values despite deleterious effects on competition, would be to completely remove physicians from a marketplace setting, rather than admit that the services they offer, the delivery of which are both highly necessary and equally highly respected, might better comport with the public’s needs were they subject to appropriate competitive factors . . . . \(^{238}\)

Because the AMA’s ethical restrictions “tip[ped] the balancing scales against the needs of the public and in favor of the maintenance of the financial security of physicians,” they were “unfair under Section 5 of the Federal Trade Commission Act.” \(^{239}\) Quoting the Supreme Court, the FTC concluded that the fact that “competition is not entirely conducive to ethical behavior . . . is not a reason . . . for doing away with competition.” \(^{240}\)

The FTC’s cease and desist order, which enjoined the AMA from restricting participation by non-physicians in the ownership of businesses offering medical services, was affirmed by the Second Circuit with minor language modifications and by an equally divided Supreme Court. \(^{241}\) In 1980, the AMA revised its ethical code and renamed it the Principles of Medical Ethics. \(^{242}\) Section 6 of the most

\(^{238}\) Id. at 954.

\(^{239}\) Id. at 956.

\(^{240}\) Id. (quoting National Society of Professional Engineers v. United States, 435 U.S. 679, 696 (1978)).

\(^{241}\) See Am. Med. Ass’n v. FTC, 638 F.2d 443, 453 (2d Cir. 1980); Am. Med. Ass’n v. FTC, 455 U.S. 676 (1982). The section of the FTC Order relevant to corporate ownership of medical services is quoted in full as follows:

It is further Ordered that respondent American Medical Association . . . do forthwith cease and desist from:

A. Restricting, regulating, impeding, advising on the ethical propriety of, or interfering with the consideration offered or provided to any physician in any contract with any entity that offers physicians’ services to the public, in return for the sale, purchase or distribution of his or her professional services, except for professional peer review of fee practices of physicians;

B. Restricting, interfering with, or impeding the growth, development or operations of any entity that offers physicians’ services to the public, by means of any statement or other representation concerning the ethical propriety of medical service arrangements that limit the patient’s choice of a physician;

C. Restricting, interfering with, or impeding the growth, development or operations of any entity that offers physicians’ services to the public, by means of any statement or other representation concerning the ethical propriety of participation by non-physicians in the ownership or management of said organization; and

D. Inducing, urging, encouraging, or assisting any physician, or any medical association, group of physicians, hospital, insurance carrier or any other non-governmental organization to take any of the actions prohibited by this Part.

\(^{242}\) Judicial Council, AMA, Principles of Medical Ethics (1958), available at
recent (2001) code states that a “physician shall . . . be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.”

With the ethical and legal barriers to corporate ownership of medical service providers out of the way, corporate providers quickly moved to the center of the medical service delivery system. Fewer than forty HMOs operated in the United States in 1972, with a little less than three million members. By 1985, the number of HMOs increased to 263, with over eighteen million members, and by 1998 there were fifty-six million Americans enrolled in HMOs. Approximately 45% of all U.S. physicians are now under contract with an MCO.

C. Impact of Lay Corporate Ownership on Provision of Medical Services

While there is substantial evidence that the shift to managed care has successfully slowed the growth of costs in the medical services industry, the new corporate owners have exerted pressure on the traditional physician-patient relationship. In attempting to drive costs down and increase profits, corporate medical service providers “creat[e] conflicting loyalties for the physician . . . [and] undermine the physician’s fundamental obligation to serve as patient advocate.” The AMA has described the resulting conflict of interests this way:


245. Id.

246. Id.


248. Between 1993 and 1997, health care costs stabilized at 13.5% of the gross domestic product (“GDP”), a substantial enough achievement given that health care expenditures rose from 8.9% of GDP in 1980 to 12.1% of GDP in 1990. Erica Worth Harris, The Regulation of Managed Care: Conquering Individualism and Cynicism in America, 6 Va. J. Soc. Pol’y & L. 315, 321 (1999). Health care inflation, which was 18.6% in 1988, dropped to approximately 2% in 1993. Id. This cost control has apparently not, however, translated into increased access to medical care. In 1987, 12.9% of the population was uninsured for medical care; that figure had increased to 16.3% in 1998. See Walter L. Stiehm, Poverty Law: Access to Healthcare and Barriers to the Poor, 4 Quinnipiac Health L.J. 279, 285 n.24 (2001).

Managed care involves at least two conflicting loyalties for the physician, conflicts that are not unique to managed care. First, physicians are expected to balance the interests of their patients with the interests of other patients. When deciding whether to order a test or procedure for a patient, the physician must consider whether the slot should be saved for another patient or not used at all to conserve the plan's resources. Second, managed care can place the needs of patients in conflict with the financial interests of their physicians. Managed care plans use bonuses and fee withholds to make physicians cost conscious. As a result, when physicians are deciding whether to order a test, they will recognize that it may have an adverse impact on their income.\textsuperscript{250}

Other restrictions imposed by managed care organizations have included limiting a patient’s choice of physician,\textsuperscript{251} prospectively reviewing physician decisions to ensure the decision was “medically necessary,”\textsuperscript{252} rigidly adhering to treatment directives, thereby limiting physicians in their range of clinical options,\textsuperscript{253} and contractually limiting information physicians can provide to their patients.\textsuperscript{254}

\textsuperscript{250} \textit{Id.}

\textsuperscript{251} First, managed care subscribers are limited in their choice of physician to those physicians who have contracted with, or are employed by, the MCO. \textit{See id.} at 330. Second, patient choice is limited because MCOs “deny[] access to . . . medical specialists until the subscriber has obtained the approval of a primary care physician.” \textit{Id.} Third, MCOs impede continuing physician-patient relations when an employer changes plans, or the employee herself changes jobs. Harris, \textit{supra} note 248, at 343. The restrictions on patient choice “prevent[] a trust relationship from being established between doctor and patient.” \textit{Id.} at 343-44.

\textsuperscript{252} So-called prospective utilization review involves the use of an independent review to determine if the treating physician’s decision is necessary and cost-effective. Deven C. McGraw, \textit{Financial Incentives to Limit Services: Should Physicians be Required to Disclose These to Patients?}, 83 Geo. L.J. 1821, 1826 (1995). The use of a third party to oversee physician decisions is a “direct and visible interference in [physician] clinical decision-making.” \textit{Id.} at 1830. As another commentator has said, “[i]n managed care’s arsenal of cost-control weaponry, probably none is more potent . . . than superseding the physician’s autonomy by a managerial-review process in which armies of claims clerks, administrators, . . . and technocrats of every description insinuate themselves into a complex system that authorizes, delivers, and pays for medical services.” Gerald W. Grumet, \textit{Health Care Rationing Through Inconvenience: The Third Party's Secret Weapon}, 321 New Eng. J. Med. 607, 608 (1989).

\textsuperscript{253} Treatment directives, also known as clinical practice guidelines, are “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.” Arnold J. Rosoff, \textit{The Role of Clinical Practice Guidelines in Health Care Reform}, 5 Health Matrix 369, 370 (1995) (quoting Inst. of Med., Clinical Practice Guidelines: Directions for a New Program 8 (Marilyn J. Field & Kathleen N. Lohr eds., 1990)). Developed in response to observed substantial variations in practice approaches, MCOs have latched on to treatment directives as yet another cost-control mechanism, and “rigid protocols or standards of care” are now issued with increasing frequency. Mark A. Hall, \textit{Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment}, 137 U. Pa. L. Rev. 431, 450-51 (1988); see John D. Ayres, \textit{The Use and Abuse of Medical Practice Guidelines}, 15 J. Legal Med. 421, 437 (1994). MCOs may make adherence to practice guidelines a contractual condition of employment for
The most fundamental source of conflicts of interest for the physician is the use of financial incentives in physician compensation schemes to reduce costs. Whereas the traditional fee-for-service system encouraged physicians to over-utilize medical services, thereby increasing health care costs, the modern compensation system provides incentives to physicians in various ways to under-utilize medical services, thereby decreasing health care costs, with a resulting increase in the HMOs' bottom line. The use of financial incentives is fast becoming the norm. By the mid-90s, more than 60% of HMOs utilized compensation schemes that placed physicians at some personal financial risk when making clinical decisions. HMOs utilize financial incentives in a "seemingly infinite variety of ways," all with the purpose of influencing physicians in their clinical decision making. Three commonly used financial incentives are capitation schemes, bonuses, and withholding schemes.

physicians or deny reimbursement for treatment decisions going beyond the guidelines. See Ayres, supra, at 437; Hall, supra, at 450 n.66.

254. A major controversy erupted in the mid-1990s over the use by MCOs of so-called "gag clauses," provisions in MCO-physician contracts which limit the physician's discretion in providing certain information to patients. See Joan H. Krause, The Brief Life of the Gag Clause: Why Antigag Clause Legislation Isn't Enough, 67 Tenn. L. Rev. 1 (1999). MCO use of gag clauses led to a swift political response, and by 1999 almost every state had passed legislation banning the use of gag clauses in MCO contracts. Id. at 2. Subter restrictions on physician-patient communication still exist, however. MCOs may employ de facto unwritten restrictions on the discussion of certain treatment options. See id. at 13. MCOs may also utilize the "termination without cause" clauses that are common in MCO-physician contracts to prohibit physician disclosure. Id. at 13-14. Indeed, the General Accounting Office ("GAO") has stated that "it is the contractual relationship itself—its short duration and provision for termination without cause—that may make physicians feel constrained from speaking entirely openly with their patients." Id. (quoting U.S. General Accounting Office, GAO/HEHS-97-175, Managed Care: Explicit Gag Clauses Not Found in HMO Contracts, But Physician Concerns Remain (1997)). Finally, in giving physicians financial incentives to under-treat patients, or otherwise avoid costly treatment, MCOs can expect physicians to "internalize the incentive structure and impose their own restrictions on interactions with patients." Id.


256. Id. at 402.

257. In a capitation system, the HMO remunerates a participating primary care physician at a flat rate for each enrolled patient for a specific period of time. Allison Faber Walsh. Note, The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations, 31 J. Marshall L. Rev. 207, 218 (1997). Physicians are paid a pre-determined rate based on the number of subscribers to the plan and receive the same amount of money per payment period regardless of the services provided to patients, or the costs of those services. Id. If a subscriber has no need for medical services in the payment period, the physician nonetheless receives his fixed payment. Id. Likewise, if a patient requires medical service in excess of the amount contracted for, no additional payment is given, and the physician must "take the loss" on the difference. Id.

Bonuses reward cost-effective physicians in a variety of ways, taking into account factors such as physician cost-effectiveness, physician time, patient
While there is to date little evidence that financial incentives employed by managed care organizations have had a negative impact on the quality of care received by patients, the common public perception is to the contrary. Media horror stories of shoddy treatment at the hands of HMO bureaucrats are legion, and fuel this perception. Not surprisingly, consumers who read sensational news accounts come to believe that managed care endangers the quality of the care they receive. This perception, regardless of its accuracy, undermines the traditional physician-patient relationship, based as it is on trust. Patients now "know" that treatment determinations are no longer a matter just between themselves and their physician, but are also a matter of some importance for the managed care corporation. Whether it be treatment directives, utilization review, gag clauses, or the myriad of financial incentives their treating physicians face, patients are all too aware of a corporate presence in their doctor's office.


Under a withholding scheme, the HMO withholds a percentage of the capitated payment or fee and places it into a risk pool which "acts as a buffer, insuring that the total amount set aside for patient care under the plan is not exceeded." Latham, supra note 255, at 404. If any funds remain at the end of the payment period, they are distributed to the participating physicians. Id. The existence of a pool of withheld funds provides physicians with an incentive to keep costs low, so that they can take advantage of the distribution. See id. 258. In 1992, the Health Care Financing Administration ("HCFA") reported that no researcher has found "a link between the quality of care provided under the Medicare and Medicaid programs and the structure of physician incentive plans," nor is any link established between increased morbidity and mortality rates among managed care patients compared with fee-for-service patients. Latham, supra note 255, at 407 n.84 (quoting HCFA Proposed Regulations, 57 Fed. Reg. 59,024, 59,026 (1992)). A 1987 study of more than 1500 individuals who were randomly assigned to either an HMO or to a traditional fee-for-service insurance plan concluded that while the HMO costs were lower than the fee-for-service plan, there were "no significant differences in health between individuals in the two plans three years after the study began." David Orentlicher, Health Care Reform and the Patient-Physician Relationship, 5 Health Matrix 141, 162 (1995).


IV. ATTEMPTS TO PROTECT INDEPENDENT PROFESSIONAL JUDGMENT IN THE FACE OF PROFIT PRESSURES FROM CORPORATE MEDICAL SERVICE PROVIDERS

In response to the new pressures placed on physicians' previously insulated independence of judgment, the medical profession has adopted standards addressing the physician's ethical duties in the era of managed care and corporate medical providers. While those standards have no force of law, they are a condition of AMA membership, and a physician can be expelled for noncompliance. More significantly, courts have held physicians to the same standards in the corporate era as they were held to in the professional era, making it clear that a physician's primary duty is still to patients and not to their corporate employers. "The MCO made me do it" is not a permissible defense to substandard professional care. And perhaps most importantly, though complicated and encumbered by the Employee Retirement Income Security Act of 1974 ("ERISA") preemption and the corporate medical prohibition itself, courts have held MCOs vicariously liable for physician malpractice, thus providing MCOs with an incentive not to interfere in the professional judgment of their employee physicians to the detriment of patients.

A. The New Ethical Rules

The ethical response in the medical profession to the threats to physician autonomy posed by the new regime of managed care and corporate ownership has been somewhat equivocal. To a degree, the medical profession's response has been to acknowledge that cost-containment and corporate control are simply a fact of professional life and to embrace their virtues. In acknowledgment of the FTC ruling, the AMA's revised Principles of Medical Ethics and Current Opinions both reiterate that member physicians are free to enter into any type of employment relationships they wish. The AMA's Code

262. See discussion infra Part IV.B.1.
263. See discussion infra Part IV.B.2.
264. See Agrawal, supra note 221, at 408 ("Professional standards have evolved to acknowledge the legitimacy of cost considerations in clinical decisions.").
265. See Revised Principles, supra note 243; Council on Ethical and Judicial Affairs, AMA, Current Opinions, E-8.05 ("The contractual relationships that physicians assume when they... agree to provide services to the patients of an insurance plan are varied. Income arrangements may include hourly wages[,]... annual salaries[,]... and share[s] of group income.... Arrangements also usually include a range of fringe benefits...."). The Current Opinions herein cited are available at the American Medical Association's website at either http://www.americanmedicalassociation.org/apps/pf_online/pf_online?i_n=browse&doc=bySubject/E-8.00.HTM (last visited Oct. 18, 2001) or http://www.americanmedicalassociation.org/apps/pf_online/pf_online?i_n =browse&doc=bySubject/E-2.00.HTM (last visited Oct. 18, 2001).
of Ethics ("the AMA Code") actually extols the benefits of capitation, the most vilified tool of the new corporate owners. Another provision warns physicians to be "conscious of costs." In fact, the AMA Code specifically addresses the ethical obligations of physicians in management positions and physicians who now work as medical directors for managed care organizations.

The only provision in the AMA Code that directly addresses the problem of lay interference states that "physicians should not be subjected to lay interference in professional medical matters and their primary responsibility should be to the patients they serve." In various other provisions, the AMA reaffirms the primacy for physicians of their patients' interests. In June 2001, the AMA revised its Principles of Medical Ethics for just the fourth time in history, adding a new principle that states, "[a] physician shall, while caring for a patient, regard responsibility to the patient as paramount." Specifically addressing the threat posed by MCOs, Opinion 8.13 states that "[t]he duty of patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the system of health care delivery in which physicians practice. Physicians must continue to place the interests of their patients first." Physicians in management positions are likewise told to "put the needs of patients first;" though physicians should be "conscious of costs," nonetheless, "concern for the quality of care the patient receives should be the physician's first consideration."


267. See E-8.051 ("The application of capitation to physicians' practices can result in the provision of cost-effective, quality medical care.").

268. Id. E-2.09.

269. Id. E-8.02, E-8.021. A medical director is a physician "employed by third-party payers in the health care delivery system . . . or by entities that perform medical appropriateness determinations on behalf of payers." Id. E-8.021. Physicians functioning as medical directors are warned that whenever they make decisions affecting individual or group patient care, "they are functioning within the professional sphere of physicians and must uphold ethical obligations, including those articulated by the AMA's Code of Medical Ethics." Id.

270. Id. E-8.05.


273. Id. E-8.02.

274. Id. E-2.09.
Elsewhere, however, the AMA Principles assert that "physicians have an obligation to consider the needs of broader patient populations within the context of the patient-physician relationship." The AMA Code does not specifically address how physicians are to reconcile the new ethic of "socially conscious" decision-making with the old ethic of fidelity to patients first.

In the new era of limited medical resources, physicians may be asked to make allocation decisions. The AMA's position on this issue is clear: don't allocate, advocate. Since the physician's first duty is to the patient, the "treating physician must remain a patient advocate and therefore should not make allocation decisions." Allocation decisions should be made "at a policy making level so that individual physicians are not asked to engage in bedside rationing." The AMA also calls for "[a]dequate appellate mechanisms for both patients and physicians... to address disputes regarding medically necessary care." With regard to financial incentives and resulting conflicts of interest, the AMA approach is to avoid an outright ban on such incentives and, instead, "manage and minimize" the threat those incentives pose. Because "[u]nder no circumstances may physicians place their own financial interests above the welfare of their patients," the AMA has made "financial incentives... permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care." Physicians are cautioned to "evaluate the financial incentives... before contracting with [the HMO]... to ensure that the quality of patient care is not compromised." If the compensation scheme calls for capitation, physicians are told to "seek agreements... that provide sufficient financial resources for all necessary care" and not to "assume inordinate levels of financial risk." The AMA lays out a number of factors for physicians to consider when entering into a contractual arrangement, such as "[t]he size of the plan and the time period over which the rate is figured," and cautions physicians to "[c]alculat[e]...
incentive payments according to the performance of a sizable group of physicians rather than on an individual basis.\footnote{285} The AMA puts the onus firmly on physicians to consider their contractual relations and their compensation arrangement with managed care plans so as to avoid financial incentives that may jeopardize patient care.

The disclosure rules the AMA has adopted in the face of managed care cut in two separate directions. First, with respect to disclosure of treatment options not covered by the plan, physicians have a simple, straightforward, affirmative duty to disclose such options: "The physician’s obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient’s managed care plan."\footnote{286} Second, with respect to the physician’s financial incentives, the AMA’s ethics code places the onus on the managed care organization, not the physician, to disclose such incentives to the patient.\footnote{287} Physicians have no affirmative duty under the ethics rules to inform patients of the potential conflict associated with their compensation. Rather, they "must be prepared to discuss with patients any financial arrangements that could impact patient care."\footnote{288} The AMA places the onus for incentive disclosure on the managed care organizations, entities over which it has no authority, on the rationale that it is better that "patients are aware of such incentives prior to enrollment."\footnote{289}

The AMA’s response to managed care’s threat to professional independence of judgment is thus something of a compromise. Commentators have criticized that response because it appears to leave unresolved the physician’s ethical role in the corporate era.\footnote{290} But perhaps the biggest problem with looking to the AMA to ensure professional independence of judgment is jurisdictional: the AMA

\footnotesize{\begin{itemize}
\item Id. E-8.13(3)(b).
\item Id. E-8.13(2)(f); see also id. E-8.132 ("If the . . . HMO does not permit referral . . . when the physician believes that the patient’s condition requires such services, the physician should so inform the patient so that the patient may decide whether to accept the outside referral at his or her own expense . . . ").
\item See id. E-8.13(3)(a). "Any incentives to limit care must be disclosed fully to patients by plan administrators upon enrollment and at least annually thereafter." Id. (emphasis added). "Patients must be informed of financial incentives that could impact the level or type of care they receive. This responsibility should be assumed by the health plan to ensure that patients are aware of such incentives prior to enrollment." Id. E-8.054(4) (emphasis added).
\item Id. E-8.054(4).
\item Id. (emphasis added); see also AMA Council on Judicial and Ethical Affairs, Financial Incentives and the Practice of Medicine 4 (Dec. 1997), http://www.ama-assn.org/ama1/up.PDF (on file with the Fordham Law Review) ("A compelling argument can be made for disclosure prior to enrollment in a health plan, as the structure of financial inducements could influence the patient’s decision to purchase a specific form of coverage.").
\end{itemize}}
can regulate physicians but not their corporate employers, the interfered-with party, but not the interferer.

B. Legal Liability as a Means of Ensuring Professional Independence of Judgment

While primarily concerned with properly compensating victims of inadequate care, liability rules also play a vital role in enforcing professional standards in the corporate era. Medical malpractice law requires physicians to "use the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing." When a physician fails to meet that standard, she is liable for any resulting harm. Some have argued that, because physicians no longer exercise unilateral resource control in the health care industry, the standard of care should be adjusted accordingly. The prevailing view, however, reflected in the developing case law, is that both physicians and corporate medical providers that employ them should be held legally responsible for failing to meet the required professional standards. Rather than attempt to create new standards for the new system, the traditional principles of medical malpractice already in place, if applied to physicians and institutions alike, should ensure adequate professional standards. Imposing vicarious liability on corporations for interfering with a physician's independent professional judgment to the detriment of a patient will provide them with an incentive to avoid such interference.

1. Physician Liability

In the corporate era, at least some courts have held that "the MCO made me do it" is not a defense to physician negligence. Physicians

291. See Timothy Stoltzfus Jost, The Necessary and Proper Role of Regulation to Assure the Quality of Health Care, 25 Hous. L. Rev. 525 (1988). Jost described: Professionals and institutions who deliver care that deviates from the standard of adequate care established by the profession and that results in injury to patients face retrospective review that may result in the forced payment of money damages. By forcing providers themselves to pay costs caused by their mistakes, the malpractice system in theory requires them to take all precautions that cost less than the cost that lack of precaution would impose on others. Id. at 572.
293. See id.
294. See Bernard Friedland, Managed Care and the Expanding Scope of Primary Care Physicians' Duties: A Proposal to Redefine Explicitly the Standard of Care, 26 J.L. Med. & Ethics 100 (1998); E. Haavi Morreim, Medicine Meets Resource Limits: Restructuring the Legal Standard of Care, 59 U. Pitt. L. Rev. 1, 21-22 (1997).
295. Gerald B. Hickson, Commentary: Don't Let Primary Care Physicians Off the Hook So Easily, 26 J.L. Med. & Ethics 113, 114 (1998) (arguing that "all parties engaged in health services delivery ... [should] share risk for any adverse outcome").
296. Id. at 113.
employed by MCOs are held to the same standard of care and the same tort liability as traditional physicians, "regardless of the HMO policy."\(^{297}\)

*Wickline v. State*\(^{298}\) is illustrative. In *Wickline* the physician requested approval from the MCO for an extended eight-day postsurgery hospital stay for his patient. Instead, the MCO approved only a four-day extension. The physician did not protest the denial and wrote the discharge order for his patient on the day specified by the MCO. As a result of the early release, the patient's condition deteriorated, and eventually her leg had to be amputated. The plaintiff sued the MCO, alleging that the MCO's decision denying a longer hospital stay caused her injuries. The court held that the MCO was not liable. In dicta, it pointed the finger squarely at the treating physician:

> [T]he physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour.\(^{299}\)

The court went on to scold the physician for his failure to contest the MCO's determination:

> There is little doubt that [the physician] was intimidated by the [MCO] but he was not paralyzed by [the MCO's] response nor rendered powerless to act appropriately if other action was required under the circumstances. If, in his medical judgment, it was in his patient's best interest that she remain in the . . . hospital . . . beyond the extended time period originally authorized by [the MCO], [the physician] should have made some effort to keep [the patient] there. He himself acknowledged that responsibility to his patient.\(^{300}\)

Thus, similar to ethical standards later adopted by the AMA,\(^{301}\) the *Wickline* court would place a burden on the MCO physician to advocate for the patient in the face of limitations on care imposed by the MCO.

Relying on the doctrine of informed consent,\(^{302}\) plaintiffs have attempted with little success to impose on physicians an affirmative


\(^{298}\) 192 Cal. App. 3d 1630 (1986).

\(^{299}\) Id. at 1645.

\(^{300}\) Id. at 1645-46.

\(^{301}\) See discussion supra Part IV.A.

\(^{302}\) The doctrine of informed consent is premised on the idea that every person has the right to determine what shall be done to her own body; it requires physicians to inform patients of the risks involved in a proposed treatment. See Prosser, *supra* note 292, at 190.
duty to disclose their financial incentives to undertreat patients. In Moore v. Regents of the University of California, the California Supreme Court held:

[A] physician must disclose personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment; and (2) a physician's failure to disclose such interests may give rise to a cause of action for performing medical procedures without informed consent or breach of fiduciary duty.303

Courts have been reluctant, however, to apply this doctrine to require disclosure of financial incentives in managed care contracts with physicians. In Ching v. Gaines, for example, the plaintiff claimed that the defendant-physician had breached his fiduciary duty by failing to disclose information concerning financial incentives in the physician's compensation arrangements that provided him with a disincentive to treat the patient.304 Despite Moore, the court held that the physician had no duty to disclose those financial incentives.305

Some plaintiffs have attempted to introduce evidence that a physician's care decision was motivated by his own financial interest as proof of malice justifying an award of punitive damages.306 In Bush v. Dake, a Michigan court held that the question of whether a financial incentive provided by an MCO caused a physician to provide inadequate care, thereby committing malpractice, was a fact question for the jury.307 Most courts have, however, rejected this theory of relevance,308 particularly where the physician denies that financial incentives affected the decision in question.309

Since the HMO Act of 1973 specifically provides for incentive schemes,310 some courts are reluctant to consider the impact of

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305. See id. at 237.
306. See Bearden & Maedgen, supra note 225, at 346.
308. See, e.g., Sweede v. CIGNA Healthplan, 1989 WL 12608 (Del. Super. Feb. 2, 1989) (granting physician's motion for summary judgment on issue of punitive damages); Madsen v. Park Nicollet Med. Ctr., 419 N.W.2d 511, 515 (Minn. Ct. App. 1988) (finding trial court did not abuse discretion in excluding evidence of financial incentive because evidence "was only marginally relevant, and potentially very prejudicial").
310. 42 U.S.C. § 300e(c)(2)(D) (1994) (allowing qualifying HMOs to "make arrangements with physicians... to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians"); see also Pulvers v. Kaiser Found. Health Plan, 160 Cal. Rptr. 392, 394 (Cal. Ct. App. 1980)
financial incentives on physician decision-making where Congress has specifically allowed for them. Evidence of financial incentives may also be excluded on the basis that it is more prejudicial than probative. In a recent malpractice case in Minnesota, an appellate court upheld the trial court’s decision to exclude evidence of financial incentives because “the voluminous evidence on managed care and the respective financial risks . . . [was] the type of evidence that would confuse, mislead, and prejudice a jury.”  

2. Corporate Liability

Whether an MCO can be held liable for the malpractice of its physicians has been a major battleground in the new era of corporate medical care. A large body of academic commentary has endorsed vicarious liability for MCOs. Some commentators have argued that only the threat of liability will provide MCOs with sufficient incentive to foster professionalism among their physician ranks and not jeopardize patient welfare by overriding the professional judgments of member physicians. It is contended that enterprise liability would give MCOs an incentive to rationalize cost-containment measures, and that MCOs not subject to liability would have no incentive whatever “to consider the likelihood that MCO policies might contribute to negligent physician decision-making and patient injury.”

As a policy justification for imposing tort liability on corporate providers, commentators have also pointed out that corporate providers are better positioned than physicians to address systemic problems such as the information defects that give rise to many

("[T]he use of . . . ‘incentive’ plans is not only recommended by professional organizations . . . but . . . they are specifically required by section 300e of the Health Maintenance Organization Act of 1973.").

313. Havighurst, supra note 312, at 20.
314. Brewbaker, supra note 312, at 135; see also Petrovich v. Share Health Plan, Inc., 719 N.E.2d 756, 764 (Ill. 1999) ("HMO accountability is essential to counterbalance the HMO goal of cost-containment. To the extent that HMOs are profit-making entities, accountability is also needed to counterbalance the inherent drive to achieve a large and ever-increasing profit margin.").
315. Brewbaker, supra note 312, at 135.
malpractice claims. Liability may also encourage MCOs to hire physicians with the best credentials rather than those that come at the lowest cost. Accountability and fairness also argue for liability by the corporate provider. Since corporate providers have typically assumed a certain amount of control over medical management decisions, they should be asked to bear the cost of decisions that result in deviations from the established standard of medical care.

Patients seeking to hold MCOs liable for harm resulting from negligent care, however, face several substantial obstacles. The largest stumbling block is federal preemption of state law claims due to ERISA, a comprehensive statute designed to regulate the creation and administration of employee benefit and pension plans. ERISA's definition of an employee welfare benefit plan includes plans established by an employer to provide medical care or benefits to its employees. ERISA preempts state law causes of action that "relate to" any employee benefit plan covered by the statute. MCOs have effectively utilized ERISA preemption as an affirmative defense to many state law liability claims. The Supreme Court recently narrowed ERISA preemption for MCOs, however, when it held in Pegram v. Herdrich that only "pure eligibility" decisions, as opposed to treatment decisions, or "mixed" eligibility decisions, are preempted by ERISA. This holding appears to pave the way for most state law claims alleging that MCOs improperly denied care.

316. See id.; Sage, Emerging Managed Health, supra note 312, at 167.
318. See Donald M. Berwick et al., Curing Health Care: New Strategies for Quality Improvement 12 (1990) ("The doctor no longer really controls health care, ... (control is shifting, structure is shifting, the pattern of care is shifting, ... ).
319. We are speaking here only of common law liability, and not liability under state or federal statutes, which further complicates the liability picture. Texas's law became "the first in the nation [to] allow[] individuals to sue health maintenance organizations" and others may soon follow. See Christine Lockhart, The Safest Care is to Deny Care: Implications of Corporate Health Insurance, Inc. v. Texas Department of Insurance on HMO Liability in Texas, 41 S. Tex. L. Rev. 621 (2000); see also Me. Rev. Stat. Ann. title 24-A, § 4313 (West 2000) (creating private right of action against health plans). MCOs may well soon be liable for delivering substandard care under federal law. See Greg Miller, House OKs Patients' Rights Bill, L.A. Times, Aug. 3, 2001, at A1. The so-called patients' bill of rights movement is not necessarily an unwelcome development in MCO boardrooms, however, as the bill that passed the house places strict caps on damages, as do some state statutes. See, e.g., title 24-A, § 4313 (limiting noneconomic damages to $400,000 and disallowing punitive damages).
321. § 1002(1)(A).
322. "Except as provided in subsection (b) of this section, the provisions of this subchapter ... shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan ... ." § 1144(a).
325. See Thomas R. McLean & Edward P. Richards, Managed Care Liability for
ERISA is not, however, the only obstacle to imposing liability on MCOs. Mandatory arbitration clauses, prevalent in MCO contracts, have effectively channeled many health care disputes into private arbitration fora and out of the court system, impeding the doctrinal development of MCO liability in the courts.\footnote{326} In addition, a handful of states have statutorily immunized MCOs from malpractice liability.\footnote{327} A final obstacle, ironically enough, is the corporate practice of medicine doctrine in those few states that have not yet abolished the doctrine. A small number of courts have granted summary judgment to MCOs in malpractice cases on the illogical basis that a corporation could not possibly be liable for the malpractice of a profession that it is statutorily barred from practicing.\footnote{328}

Despite these obstacles, corporate providers have been exposed to common law liability in a host of guises.\footnote{329} Most commonly, courts have found MCOs liable for physician negligence that results in harm to patients on a theory of vicarious liability.\footnote{330} Precisely what

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326. Corporations generally prefer arbitration over the court system, since arbitration involves “reduced litigation costs and a perceived immunity from sympathy-induced punitive damages awards.” Chittenden, \textit{supra} note 307, at 494. Federal regulations, and most state MCO statutes require MCOs to maintain administrative dispute resolution procedures. \textit{See} 42 C.F.R. § 417.124(g) (2000). Even though arbitration is a creature of contract, and no party is required to submit to arbitration, the Supreme Court has held that questions regarding a party’s intent to arbitrate a dispute are to be resolved in favor of arbitration. \textit{See} AT&T Technologies, Inc. v. Communications Workers, 475 U.S. 643, 648 (1986); Moses H. Cone Mem’l Hosp. v. Mercury Constr. Corp., 460 U.S. 1 (1983). State efforts to protect consumers from odious arbitration clauses have been struck down under the Supremacy Clause as violative of the Federal Arbitration Act. \textit{See} Doctor’s Assoc., Inc. v. Casarotto, 517 U.S. 681 (1996).

327. \textit{See}, e.g., Ala. Code § 27-21A-23(d) (1975) (“No person participating in the arrangements of a health maintenance organization other than the actual provider of health care... shall be liable for negligence, misfeasance, nonfeasance or malpractice in connection with the furnishing of such services and supplies.”); N.J. Stat. § 26:2J-25 (1996) (exempting anyone “participating in the arrangements of a health maintenance organization” other than the actual providers from liability for “negligence, misfeasance, nonfeasance or malpractice”).


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“version” of vicarious liability is employed has depended in part on
the form of the defendant MCO.331

The doctrine of respondeat superior provides that an employer may
be held liable for the negligence of an employee if the employee acted
in the course and scope of his employment.332 To successfully prevail,
a plaintiff must show the employer effectively controlled the
employee in the performance of the employee’s job.333 Staff model
HMOs, which employ physicians directly, provide the best targets for
plaintiffs relying on respondeat superior.334 In Sloan v. Metropolitan
Health Council, for example, plaintiffs brought an action against a
staff model HMO for the negligence of its physician-employee.335 The
HMO provided its physicians an annual salary and fringe benefits
pursuant to written employment contracts, and the physicians in its
employ were not permitted to maintain an independent practice
without the HMO’s permission.336 The trial court granted summary
judgment to the defendant HMO, holding that a HMO could not be
liable for the malpractice of a physician in its employment.337 The
appellate court disagreed, finding that because the HMO’s medical
director “policed medical services and established policy” and because
the medical director’s judgment was final, the requisite degree of
control existed; a claim of vicarious liability could, therefore, be
maintained against the HMO.338

Similarly, in Gugino v. Harvard Community Health Plan, the
Massachusetts Supreme Court held that a health plan may be
vicariously liable for a physician-employee’s malpractice.339 The plan
could be held liable so long as there was a “factual basis for inferring
that the [p]lan had power of control or direction over the conduct” of

331. See supra note 225 (discussing various forms of HMOs).
332. See Prosser, supra note 292, at 499–500.
333. Id. at 501 (listing the many factors to be taken into account in determining the
existence and degree of control).
334. See Chittenden, supra note 307, at 455 (“The staff model HMO, which
employs its physicians on a salaried basis and often provides its own medical facilities,
fulfills most of the ‘master-servant’ relationship requirements.”).
336. Id. at 1105.
337. Id. at 1106.
338. Id. at 1109. The defendant HMO argued that it could not possibly have
controlled the physician, because the physician was exercising his independent
professional judgment. The court found:

[N]o logical basis for denying liability . . . on the ground that the professional
must exercise a professional judgment that the principal may not properly
control . . . [T]he touchstone of the principal's liability for the tortious acts
of his agent is merely whether they are done within the course and scope of
the employment.

Id.
the physician. The court’s job was made easier in *Gugino* because the defendants conceded the physician was their employee.

In one unusual case, *Schleier v. Kaiser Foundation Health Plan*, the U.S. Court of Appeals for the District of Columbia held that a staff model HMO could be vicariously liable for the actions of a negligent physician based on the theory of respondeat superior, even though the physician was an independent contractor. The court found that the requisite control existed because the contracting physician was engaged by an HMO-employed physician who had “some ability to control [the consultant’s] behavior in that he answered to [plaintiff’s] primary care-taker, a[n] [HMO] doctor.”

More commonly, however, when the negligent physician is an independent contractor, as in a group model HMO or an IPA, the plaintiff must rely on a theory of ostensible agency. Ostensible agency arises when a principal represents or creates the appearance that a person is the principal’s agent, and a third party reasonably relies on that representation. To make out a valid ostensible agency claim against an MCO, a plaintiff must show two elements: (1) the patient “look[ed] to the institution rather than the individual physician for care” and (2) “the hospital [held] out the physician as its employee.”

In *Boyd v. Albert Einstein Medical Center*, for example, the plaintiff sued a group model HMO for the negligence of a contracting physician on a theory of vicarious liability by way of ostensible agency. The trial court granted summary judgment to the

340. *Id.*
341. *Id.*
343. *Id.* at 177.
345. *See* Restatement (Second) of Torts § 429 (1965). Section 429 states:
One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.

*Id.* Section 267 of the Second Restatement of Agency states:
One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.

Restatement (Second) of Agency § 267 (1958).
defendant, and the appellate court reversed. The appeals court found several issues of triable fact bearing on the issue of whether the negligent physician was the ostensible agent of the HMO, including the allegations that the HMO's promotional materials promised to “protect and promote the[] health” of their subscribers; the plaintiff paid the HMO directly for the physician’s services; the plaintiff was limited in choice of physician to a list pre-approved by the HMO; the plaintiff could not see a specialist without HMO approval; and, even when the plaintiff was allowed to see a specialist, the HMO, not the plaintiff, chose the specialist. The court concluded that, because the plaintiff “was required to follow the mandates of [the] HMO . . . there [was] an inference that [the plaintiff] looked to the institution for care and not solely to the physicians.”

Similarly, in Petrovich v. Share Health Plan, the Illinois Supreme Court allowed a suit to proceed against an IPA model HMO on a vicarious liability by way of ostensible agency theory because the HMO “promulgated such a system of control over its physicians that [the HMO] effectively negated the exercise of their independent medical judgment, to plaintiff’s detriment.”

In addition to vicarious liability for the negligent actions of their physicians, MCOs are also liable for any breach of duty owed directly to the patient. Courts have allowed plaintiffs to proceed directly against MCOs on a host of theories, including negligent selection and retention of sub-par physicians, negligent denial of care, bad faith

348. Id. at 1229.
349. Id. at 1235.
352. See Harrell v. Total Health Care, Inc., 781 S.W.2d 58, 60 (Mo. 1989) (finding HMO owed duty to subscribers to investigate competence of physicians and to exclude those who present foreseeable risk of harm).
353. The leading case in this area is Wickline v. State, 239 Cal. Rptr. 810 (Ct. App. 1986). See supra text accompanying notes 298-300. Though the court did not find the insurance company liable for a denial of treatment decision, in dicta the court wrote:

The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, including, when appropriate, health care payors. Third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient’s behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.

Wickline, 239 Cal. Rptr. at 819.
denial of care,\textsuperscript{354} bad faith breach of contract or breach of the
covenant of good faith and fair dealing,\textsuperscript{355} misrepresentation and false
advertising,\textsuperscript{356} and tortious interference in the physician-patient
relationship.\textsuperscript{357} Some large jury verdicts have been returned against
MCOs for denial of care decisions. In Fox v. Health Net, for example,
a California jury awarded $89 million, including $77 million in
punitive damages, to a breast cancer patient who died after the HMO
refused to pay for a bone marrow transplant.\textsuperscript{358}

Thus, despite the legal obstacles plaintiffs face when they seek to
hold an MCO liable for inadequate care or denial of care, courts have
been increasingly receptive to such lawsuits. Exposure to liability is,
therefore, probably the major deterrent to inappropriate
encroachment by corporate medical providers on a physician’s
exercise of independent professional judgment on behalf of a patient.

V. LESSONS FROM THE EXPERIENCE OF THE MEDICAL PROFESSION
UNDER CORPORATE MANAGEMENT

If one takes seriously the anecdotal and survey evidence of the legal
profession’s failure to meet the needs of middle- and lower-income
clients,\textsuperscript{359} it has serious implications for the on-going MDP debate. It
not only adds to the arguments for allowing partnerships between
lawyers and other non-lawyer professionals, it raises the corporate
specter that lurks at the edge of the MDP debate—and the “fear of
Sears” that it inspires.

The “ethical” rule that prohibits non-lawyer ownership of legal
services providers, embodied in Model Rule 5.4 and its predecessors,

\footnotesize{\textsuperscript{354} Johnson v. Humana Health Plans, Inc. (Cir. Ct., Jefferson Co., Ky. Oct. 20,
1998), reported in Nat’l L.J., Nov. 30, 1998, at B6 (awarding $13 million to patient for
bad faith refusal to pay for recommended hysterectomy).

\textsuperscript{355} See Williams v. HealthAmerica, 535 N.E.2d 717, 721 (Ohio Ct. App. 1987)
(bad faith failure to inform plaintiff of grievance procedures); Morris v. Health Net,
988 P.2d 940, 941 (Utah 1999) (bad faith failure to reimburse plaintiff for emergency
treatment); McEvoy v. Group Health Cooperative, 570 N.W.2d 397, 407 (Wis. 1997)
(bad faith denial of out-of-network services for anorexia).

suit to proceed alleging HMO promotional materials misrepresented quality of care,
screening of physicians, and freedom of access to specialty care).

adequate plaintiff’s characterization of the physician-patient relationship as
“hopelessly compromised by various undisclosed financial incentives ... provide[d]
to ... physicians in an effort to reduce expenditures on specialty care services.”); see
also Roger N. Braden & Jennifer L. Lawrence, Medical Malpractice: Understanding
1993) where an arbitration panel awarded over $1 million for an HMO’s intentional
interference with patient-physician relationship).

\textsuperscript{358} See Walsh, supra note 257, at 231-32 (discussing Fox v. Health Net, Civ. No.
219692 (Cal. Super. Ct., Riverside Co., Dec. 28, 1993)).

\textsuperscript{359} See supra Part II.B.
is, in fact, the anchor of the profession’s anticompetitive regulatory structure. Like the medical profession prior to the FTC decision that declared its parallel prohibition illegal, the legal profession is currently insulated from market forces that might otherwise provide competitive pressure for more affordable legal services. In the case of the medical profession, where service is provided primarily through insured plans, the prohibition on corporate ownership resulted in out-of-control costs borne largely by employers and the government, which finance those plans. In the case of the legal profession, it has meant that needed legal services are simply unavailable in many circumstances to middle- and lower-income consumers.

Current advances in Internet and computer software technology would seem to provide unprecedented opportunities for efficient and affordable delivery of needed services and effective collaboration among professionals serving clients’ related needs. Without lifting the current prohibitions on capital investment from outside the profession and resulting structural innovations, those opportunities will likely remain unfulfilled—at least as they might benefit middle- and lower-income consumers.

As was true for the medical profession, the ethical prohibition on non-lawyer ownership of legal services providers is defended as necessary to protect the “core values” of the profession and preserve the exercise of independent professional judgment on behalf of clients. If the effect of that ethical rule is, however, that a broad class of Americans is unable to get needed legal services, one must ask on whose behalf is that independent professional judgment being exercised? The answer increasingly seems to be large commercial interests that are generally well-informed and well-situated to command the independence and loyalty of the lawyers they employ in any event.

The strikingly parallel history of the prohibition on non-professional ownership in the medical profession is helpful in framing the issues still faced by the legal profession. It poses starkly, first of all, the restraint of trade issue. The FTC held in 1979 that medical ethical rules parallel to those in Model Rule 5.4 and its predecessors were anticompetitive, illegal restraints on trade. The FTC reasoned forcefully that the medical profession’s prohibitions on non-physician ownership of medical service providers had “deter[red] the offering of innovative forms of health care delivery” in order to protect the income of fee-for-service physicians and that “[t]he costs to the public in terms of less expensive or even, perhaps, more improved forms of medical care [had been] great.”

360. *See supra* notes 232-40 and accompanying text.
despite deleterious effects on competition" or to remove themselves wholly from the marketplace.\footnote{362} One is hard-pressed to explain why these conclusions do not apply with equal force to the legal profession and its prohibition on non-lawyer ownership of legal service providers.

To the degree that the "state action" doctrine, enunciated by lawyers sitting as judges, exempts lawyers' ethical rules—though not doctors' ethical rules—from antitrust scrutiny,\footnote{363} it would seem to say more about power than policy. Why should the fact that lawyers' rules have been ratified by other lawyers, sitting as state supreme court justices, distinguish them in any meaningful, policy way from doctors' rules that were not? As their parallel histories demonstrate, the rules were enacted for the same protectionist purposes in response to the same threat of corporate competition.

That the legal prohibition on non-professional ownership has not suffered the same demise as the parallel medical prohibition is probably attributable in large part to the difference in public perception of medical and legal services. Most people do not regard legal services at the same level of necessity as medical care. After all, what is typically at stake is not life or health but merely property or legal rights. For perhaps that reason, the government, except for the criminally accused and, to a limited degree, for those with no resources, has not engaged in large-scale subsidizing of legal services, certainly not for the middle-class. As a result, the prohibition on non-lawyer investment in the legal services industry has resulted not in a cost crisis that threatens government budgets but in unaffordable or inaccessible services for the middle class.

This gap in services would seem to argue—no less than the cost crisis in the medical profession—for a serious reexamination of the prohibition and its justifications. If we are willing to live with and regulate potential encroachments on professional independence of judgment in order to control rising costs when health and life itself are at stake, why are we unwilling to do so to make legal services more available when only property and legal rights are at stake?

The experience of the medical profession suggests that legitimate concerns over loss of professional autonomy to the detriment of clients can be adequately addressed through a combination of ethical rules and liability deterrents. While the cost-cutting methods introduced by corporate medical care managers have resulted in tragic denials of care in some instances, there is no evidence that the health care industry is facing a general quality of care crisis, and the complementary vice of over-treatment and unnecessary procedures has undoubtedly been reduced. Though imperfect and evolving,
attempts in the medical sphere to regulate the loss of professional autonomy in the corporate era can provide some lessons for how the same concerns might be addressed in the legal context. Moreover, because failures to properly exercise professional judgment on behalf of a civil client will usually result in loss of property rather than loss of life, those failures should be more tolerable and more remediable in the legal than in the medical context.

Model Rule 5.4 and its predecessors are prophylactic. By regulating the ownership structure of legal service providers, they address only indirectly the justification for their existence: protection of lawyers’ independence of professional judgment. Like the new, corporate era medical ethics rules, the legal rules of professional conduct could begin by affirming that value directly rather than indirectly and making its prohibition a basis for discipline. Lawyers, like physician, could be implored to maintain as paramount the interests of their clients and to exercise their independent judgment despite any attempts by lay service providers to put limitations on the exercise of that judgment. Current Model Rule 5.4(c), directed at the circumstance where a third party pays the client’s legal bills, already articulates this basic principle: “A lawyer shall not permit a person who recommends, employs, or pays the lawyer to render legal services for another to direct or regulate the lawyer’s professional judgment in rendering such legal services.” 364 Model Rule 1.8(f)(2) provides similarly that “[a] lawyer shall not accept compensation [from a third person for a representation of the client] unless there is no interference with the lawyer’s independence of professional judgment or with the client-lawyer relationship.” 365 This principle could be articulated specifically as it applies to lawyers employed by non-lawyer legal service providers.

The legal rules, like the medical rules, could also give lawyers affirmative duties of information and advocacy in the face of limitations on service. Lawyers could be given explicit ethical duties to explain to clients any limitations on service imposed by the service provider and to advocate on behalf of the client for the higher level of service. Indeed, lawyers already are obligated under Model Rule

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364. Annotated Model Rules of Prof’l Conduct R. 5.4(c) (1999); cf. Tully v. Edgar, 676 N.E.2d 1361, 1365 (Ill. App. 1997) (ruling that because of the “general duty applied to all attorneys to work for the best interests of their client, without regard to who may ultimately be paying their fees,” special attorneys general “must exercise independent judgment in protecting the interests of their state employee clients, without interference from, or with regard to the views of, the [a]ttorney [g]eneral”).

365. R. 1.8(f)(2); see also Model Code of Prof’l Responsibility DR 5-107(B) (as amended and in effect as of 1983), reprinted in ABA, Compendium of Professional Responsibility Rules and Standards (2001) (“A lawyer shall not permit a person who recommends, employs or pays him to render legal services for another to direct or regulate his professional judgment in rendering such legal services.”).
1.2(c) to obtain informed client consent for any limitations on the means or objectives of their representation.366

Beyond what has been required in the medical context, lawyers could also be required to fully disclose any financial incentives that they might have for reduction of service to the client and any contractual duties to the legal services provider that might impinge on their complete loyalty to the client’s needs. Current Model Rule 1.7(b) already provides:

A lawyer shall not represent a client if the representation of that client may be materially limited by the lawyer’s responsibilities to another client or to a third person, or by the lawyer’s own interests, unless:

(1) the lawyer reasonably believes the representation will not be adversely affected; and

(2) the client consents after consultation.367

Whenever a lawyer has an interest in the outcome of a matter that is likely to conflict with his client’s interests—whether it be a business, financial, property, or personal interest—“the lawyer should not undertake employment without the client’s consent, after a full disclosure of the relevant circumstances and legal risks.”368 This well-established principle could properly be interpreted to require disclosure of any financial incentive for reduced service resulting from the lawyer’s financial relationship with a legal service provider and the informed consent of the client to representation despite that incentive.

Perhaps most importantly, lawyers working for a corporate legal services provider could and should be subject to the same ethical rules that govern the conduct of all lawyers. There is no reason why the profession could not demand compliance with those rules and thereby protect its “core values” in the corporate provider context.

366. Rule 1.2(c) provides that “[a] lawyer may limit the objectives of the representation if the client consents after consultation.” R. 1.2(c). Paragraph 4 in the official comments to Rule 1.2 explains that “[t]he objectives or scope of services provided by a lawyer may be limited by agreement with the client or by the terms under which the lawyer’s services are made available to the client. . . . The terms upon which representation is undertaken may exclude specific objectives or means.” R. 1.2 cmt. 4.

367. R. 1.7(b) (emphasis added).

This would include compliance with the duty of confidentiality as embodied in Model Rule 1.6, which prohibits a lawyer from "reveal[ing] information relating to representation of a client unless the client consents after consultation, except for disclosures that are impliedly authorized in order to carry out the representation." 369 Except as necessary to the representation of the client, lawyers representing clients through corporate providers would not be at liberty to share confidential client information with other corporate employees, any more than lawyers are currently free to share confidences with other law firm employees. 370 They would not be allowed, without client consent, to share client information with other corporate employees for the purpose of marketing other corporate services to the clients.

The conflict of interest rules, embodied in Model Rules 1.7, 1.8, and 1.9, could and should apply without compromise in the corporate provider context. The rule of imputed disqualification, embodied in Model Rule 1.10, which disqualifies all members of a firm from representing a client if any member has a disqualifying conflict 371 should take account in the corporate or MDP context of the client representations, responsibilities, and interests of non-lawyer corporate employees. A lawyer working for the corporation would thus be prohibited from representing a client not only when another lawyer in the corporation would be prevented from representing that client but whenever a non-lawyer professional or other service provider in the corporation would be prohibited if the principles of Model Rules 1.7, 1.8, and 1.9 applied to them. Therefore, for example, under Rule 1.7, a lawyer would not be able to represent a client in a matter adverse to a financial planning client of the corporation without the informed consent of both clients.

This rule of imputation could be a major impediment to the ability of large corporations to take on legal representations, given the likelihood of resulting conflicts and the difficulties of maintaining an adequate conflict checking system. Large law firms, some of which have more than a thousand lawyers in multiple offices, are already facing this challenge. Corporate legal service providers could and should have the option, however, of creating a truly separate legal services division, or subsidiary corporation, to avoid imputation of conflicts throughout the corporation. Regulation by the profession of lawyers working for corporate legal service providers should

369. R. 1.6(a).
370. Under Model Rule 5.3, lawyers are responsible for reasonable efforts to ensure that non-lawyer assistants maintain client confidences to which they are privy and otherwise conduct themselves in a manner "compatible with the professional obligations of the lawyer." R. 5.3(b).
371. Model Rule 1.10(a) provides that "[w]hile lawyers are associated in a firm, none of them shall knowingly represent a client when any of them practicing alone would be prohibited from doing so by Rules 1.7, 1.8(e), 1.9 or 2.2." R. 1.10(a).
accommodate corporate structures that truly preserve the professional values of loyalty and confidentiality that the conflict rules are designed to protect, but only those that truly do.

Lawyers, like physicians, should and would also continue to be subject to liability according to the existing standard of care. If limitations or incentives from the corporate service provider resulted in a breach of duty and harm to the client, the lawyer could be held accountable in an action for malpractice or breach of fiduciary duty. While not intended to establish liability standards, the profession’s ethical rules are highly probative of the lawyer’s standard of care and often provide the foundation for such an action.372 A cause of action could arise against the lawyer if the client was harmed due to a breach of the ethical rules requiring exercise of independent professional judgment, failure to inform the client fully of all considerations affecting his legal rights, or failure to disclose financial incentives or limitations imposed by the corporate legal service provider.

In addition, MDPs or corporate service providers, like MCOs, could and should be directly liable for any malpractice committed by lawyers in their employ under the doctrine of respondeat superior.373 If lawyers work for corporate service providers as independent contractors, the doctrine of ostensible agency, as in the case of MCOs,374 should apply whenever the client reasonably believes that the lawyer is an agent of the corporation. If existing agency doctrine is not sufficient, legal service providers could be made responsible by statute, as a condition of licensing, for the malpractice of any lawyer over whom they exerted significant control or from whose services they profited directly.

A regime of this kind does not require excessive imagination. It would be similar in many ways to what we now have in one area where middle-class consumers typically do have access to legal representation—under liability insurance policies in which the insurer agrees to defend the insured against claims by third parties. As would be the case in the proposed regime of corporate legal service providers, counsel hired by insurance companies to defend policyholders must exercise their independent professional judgment on behalf of the client despite the sometimes conflicting interests of the company that employs them.375 While the lawyer’s ethical duties

372. The “Scope” preamble to the Model Rules states that “[t]hey are not designed to be a basis for civil liability.” Annotated Model Rules of Prof’l Conduct pmbl., at xvii (1999). They are, however, routinely relied on to establish a standard of care in cases asserting claims against lawyers for breach of their professional duties. See Geoffrey C. Hazard, Jr. & W. William Hodes, The Law of Lawyering § 1.1:201, at 10–13 (Supp. 1997); see, e.g., Fishman v. Brooks, 487 N.E.2d 1377 (Mass. 1986).

373. See supra text accompanying notes 332-43.

374. See supra text accompanying notes 344-51.

375. The process has been described as follows:

Under the terms of a typical liability policy, the insurer agrees in return for
are owed to the insured, who is her client, defense counsel typically have a close relationship with the insurance company and a financial interest in serving the company’s interests.\textsuperscript{376} Lawyers who do insurance defense work often receive a substantial percentage or even all of their work from an insurer with whom they have an ongoing relationship. Indeed, some insurers choose to handle defense of insureds with their own employees—salaried, in-house counsel.\textsuperscript{377} This de facto exception to the prohibition on corporate legal service providers has been approved against ethical challenges by the majority of courts that have faced the issue.\textsuperscript{378}

The circumstance of the insurance defense counsel is, therefore, not unlike the hypothetical circumstance of a lawyer employed by a corporate legal service provider (or a doctor employed by an MCO). She has an ethical duty of loyalty to the client and a duty to exercise her independent professional judgment in the service of the client’s best interests, despite possibly conflicting duties to her corporate

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\textit{payment of premiums to provide the insured: 1) indemnity up to policy limits against liability incurred for covered conduct and 2) defense against claims of such liability. Policies typically but not always give the company the right to choose defense counsel and to control the defense. A run-of-the-mill case—one in which the alleged liability is clearly covered within the policy limit and the insured’s interest in the defense is solely economic—will proceed without conflict. The insurance company is, in effect, the true party in interest. Only the insurance company’s money is at stake in the litigation, and the insured is content to have the insurance company conduct the defense as it sees fit.}
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Not uncommonly, however, the interests of the insurer and the insured diverge for one or more reasons, including: 1) the complaint alleges some conduct that is covered and some that is not covered; 2) the plaintiff seeks damages beyond the amount covered by the policy; or 3) the insured has non-economic reasons for avoiding any apparent admission of negligence or wrongdoing… Choices in the conduct of the defense may, therefore, benefit one at the expense of the other.

George C. Harris et al., Navigating the Insurance Triangle, ch. 3. at TM-1, in Litigation Ethics: Course Materials for Continuing Legal Education (John Q. Barrett & Bruce A. Green eds., 2000). Particularly if the insurer is obligated to provide a defense to the insured without regard to the cost of that defense, the insurer will be interested in controlling the costs of defense whereas the insured will prefer that the defense lawyer do everything possible on her behalf.

376. See Mallen & Smith, supra note 368, § 29.3, at 215 (“The attorney’s relationship with the insurer usually is ongoing, supported by a financial interest in future assignments and, like other long-term relationships, sometimes strengthened by real friendship.”).

377. See Ronald E. Mallen & Jeffrey M. Smith, Legal Malpractice § 28.5, at 498 (4th ed. 1996) (“There has been a noticeable increase by insurers in the use of salaried counsel to defend their insureds.”).

378. Courts in nine of eleven states that have faced this issue have found it permissible for insurers to defend insureds with in-house counsel. See, e.g., Cincinnati Ins. Co. v. Wills, 717 N.E.2d 151, 155 (Ind. 1999) (“[A]torneys who are employees of insurance companies do not necessarily trigger an impermissible conflict … when they appear as counsel to defend claims against the companies’ policyholders.”); see also Petition of Youngblood, 895 S.W.2d 322 (Tenn. 1995) (finding it is not a per se ethical violation for in-house insurance company counsel to represent policyholders).
employer or financial incentives to do less than all for the client. We choose, however, not to prohibit this arrangement but to regulate it for a simple reason: if we did not allow insurance for the costs of defense, few tort defendants would be able to afford a lawyer. Living with the ethical tension created by the "insurance triangle" of lawyer-client-insurance company is preferable to the alternative: no professional representation for tort defendants.\textsuperscript{379}

As could be the case in a regime of corporate legal service providers, this ethical tension is regulated in part by ethical rules that guide the lawyer's conduct and, most significantly, by liability rules that compensate clients whose interests are not protected and deter insurance companies from disregarding those interests. While most courts have regarded the insurance company as a "dual client,"\textsuperscript{380} the prevailing general principle is that when the interests of the insurer and insured diverge, the lawyer's paramount duty is to the "primary" client, the insured.\textsuperscript{381} Similarly, a lawyer employed by a corporate service provider would still owe a paramount duty of loyalty to the client.

The insurance industry has undertaken cost containment measures in the legal defense area directly parallel to those undertaken by MCOs. Just as MCOs attempt to control costs of treatment, many insurers employ some form of guidelines to control the conduct of the defense of insureds by outside counsel. An insurer may, for example, require advance approval for any substantial defense efforts, such as depositions, motions, legal research projects, or retention of expert witnesses.

In response to this practice, bar ethics committees have issued opinions holding that a lawyer's ethical duties to the client take  

\textsuperscript{379} We tolerate a similar ethical tension for the same reason in allowing advocacy groups to represent individual clients pro bono. As Professor Wolfram has explained, in discussing NAACP v. Button, 371 U.S. 415 (1963):

The strong ideological interest of an advocacy organization can plainly create a risk that the organization's lawyer will not represent sponsored clients with totally free and independent professional judgment. Nonetheless, if that risk is not incurred, no representation . . . would result. The Court apparently deems the latter less acceptable than the former. Wolfram, supra note 64, at 447.

\textsuperscript{380} Most, but not all, courts regard the insurance triangle as a circumstance of dual representation, with defense counsel owing attorney-client loyalties to the insurer as well as the insured. See Mallen & Smith, supra note 368, § 29.3; Douglas R. Richmond, Lost in the Eternal Triangle of Insurance Defense Ethics, 9 Geo. J. Legal Ethics, 475, 482 n.26 (1996).

\textsuperscript{381} See, e.g., Am. Cas. Co. v. O'Flaherty, 57 Cal. App. 4th 1070, 1076 (1997) (holding that insurer has a right as client to sue defense counsel for malpractice but only where there is no conflict between insurer and insured because "the attorney's primary loyalty must be to the insured it was retained to defend"); Siebert Oxidermo, Inc. v. Shields, 446 N.E.2d 332, 341 (Ind. 1983); Mallen & Smith, supra note 368, § 29.3, at 217 n.14 (discussing cases that held a lawyer's paramount duty is to the insured when interests between insured and insurer diverge).
precedence over her contractual duties to the insurance company. Reminiscent of medical ethics guidelines for physicians who operate in the managed care regime, a recent opinion of the ABA Ethics Committee held that "[a] lawyer must not permit compliance with 'guidelines' and other directives of an insurer relating to the lawyer's services to impair materially the lawyer's independent professional judgment in representing an insured."382 The propriety of insurer guidelines to insurance defense counsel has also been addressed in numerous recent state bar ethics opinions.383 An Indiana bar opinion, for example, held that "if the negotiated financial terms [of the contract between the insurance carrier and defense counsel] result in a material disincentive to perform those tasks which, in the lawyer's professional judgment, are not reasonable and necessary to the defense of the insured, such provisions are ethically unacceptable."384 While it found "no bright-line test as to the kinds of controls to which insurance defense counsel may agree," it referred counsel to an existing standard provided by Rule 5.4(c) and held that "[w]hen confronted by proposed guidelines which cannot be followed ethically," the lawyer must seek "an acceptable modification" or decline the representation.385 Other state ethics opinions have emphasized full disclosure to the insured of any limitations on representation.386


385. Id.

386. For example, see Virginia Leo 1723, which states: [T]he attorney/client relationship must remain free from undue influence from third parties, such as the insurance carrier... it is ethically impermissible for an attorney to agree to an insurance carrier's restrictions on the attorney's representation of the insured absent full disclosure and consent of the client at the outset of the representation and absent a determination that the client's rights will not be materially impaired by the restrictions.
Recent court opinions have also addressed the conflict between insurers’ attempts to control costs and lawyers’ ethical duties to clients. The Montana Supreme Court, in *In re Rules of Professional Conduct and Insurer Imposed Billing Rules and Procedures*, upheld the propriety of insurer billing guidelines in an action for declaratory relief brought by insurance defense counsel. The court held that guidelines requiring prior approval for defense activities such as scheduling depositions, conducting research, employing experts, and preparing motions, “fundamentally interfere[] with defense counsels’ exercise of their independent judgment, as required by [Model] Rule 1.8(f)” and that “defense counsel in Montana who submit to the requirement of prior approval violate their duties under the Rules of Professional Conduct to exercise their independent judgment and to give their undivided loyalty to insureds.” Similar principles could apply to the ethical duties of a lawyer employed by a corporate legal services provider, just as they apply to physicians employed by MCOs.

Existing principles of liability law that govern the duties of insurance defense counsel and insurance companies to their insureds also provide a useful analogy for the role that liability could serve in correcting any encroachments by corporate legal service providers on the attorney-client relationship. Just as “the MCO made me do it” is no defense to medical malpractice, the claim that defense counsel was following the directives of the insurance company that engaged him is no defense to a legal malpractice action. Additionally, like MCOs with respect to physician negligence, insurance companies can be held vicariously liable in most jurisdictions for the negligence of defense counsel that they hire. Most significantly, just as MCOs

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387. 2 P.3d 806 (Mont. 2000). The case was vigorously defended by several major insurance companies and provoked numerous briefs by amici. See id. at 807.
Under no circumstances can [insurers’ outside counsel guidelines] be permitted to impede the attorney’s own professional judgment about how best to competently represent the insured. If the attorney’s representation is to be limited in any way that unreasonably interferes with the defense, it is the insured, not the insurer, who should make that decision.
*Id.* at 889 n.9; see also State Farm Mut. Auto. Ins. Co. v. Traver, 980 S.W.2d 625, 634 (Tex. 1998) (Gonzalez, J., concurring in part and dissenting in part) (“I am concerned that defense lawyers may be reluctant to resist cost-cutting measures that detrimentally affect the quality of the insured’s defense. There is a real risk that these efforts at cost containment compromise a lawyer’s autonomy and independent judgment on the best means for defending an insured.”).
390. See supra notes 296-97 and accompanying text.
owe duties directly to their subscribers, there is a well-developed body of case law establishing fiduciary duties owed by the insurance company directly to the insured. If an insurance company pursues its own interest in cost savings and resulting profit to the detriment of the insured, such as by unreasonably failing to settle a claim within policy limits, the insured can sue the company for "bad faith." The prospect of a bad faith action, which often includes a claim for punitive damages, is a powerful deterrent to any conduct by the insurer that compromises the insured's rights or interests. Corporate legal service providers, like insurers and MCOs, would owe fiduciary duties directly to those clients who sought their services. There is no reason why they would not be directly responsible for any breach of those duties that resulted in harm to the client.

In an ideal world, lawyers (and doctors and other professionals) would be free to employ their professional skill and training on behalf of clients to the fullest extent without cost constraints and without interference from non-professionals. We live, however, in a world of scarce resources and allocation decisions. The cost of uncompromising ethical rules, such as the current prohibition on non-lawyer ownership of legal service providers, may be a restraint of trade that prices legal services out of the range of low- and middle-income consumers. As the medical profession has learned, it may be necessary to live with the ethical tension of encroachments on professional autonomy in order to make professional services accessible to a wider class of society.

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1410-11 (11th Cir. 1984) (observing that vicarious liability is the majority rule); Smoot v. State Farm Mut. Auto. Ins. Co., 299 F.2d 525, 530 (5th Cir. 1962) ("Those whom the Insurer selects to execute its promises, whether attorneys, physicians, no less than company-employed adjusters, are its agents for whom it has the customary legal liability."); Pacific Employers Ins. Co. v. P.B. Hoidale Co., 789 F. Supp. 1117 (D. Kan. 1992); Continental Ins. Co. v. Bayless & Roberts, Inc., 608 P.2d 281 (Alaska 1980); Stumpf v. Continental Cas. Co., 794 P.2d 1228, 1232 (Or. Ct. App. 1990) ("[We] apply what appears to be the rule in the majority of jurisdictions: An insurer may be vicariously liable for the actions of its agents, including counsel that it hires to defend its insured."); But see Merritt v. Reserve Ins. Co., 110 Cal. Rptr. 511, 527 (Cal. Ct. App. 1973) ("[R]emedies for this negligence are found in an action against counsel for malpractice and not in a suit against counsel's employer to impose vicarious liability."); State Farm Mut. Auto Ins. Co. v. Traver, 980 S.W.2d 625, 629 (Tex. 1998) (holding that insurer may not be vicariously liable for malpractice of independent attorney whom it chooses to defend insured).

393. See generally Stephen S. Ashley, Bad Faith Actions: Liability and Damages (2d ed. 1997).