



6-30-2022

Lawyers as Caregivers

Paula Schaefer
paula.schaefer@tennessee.edu

Follow this and additional works at: <https://commons.stmarytx.edu/lmej>



Part of the [Law and Psychology Commons](#), [Law and Society Commons](#), [Legal Ethics and Professional Responsibility Commons](#), [Legal Profession Commons](#), [Legal Remedies Commons](#), and the [Medicine and Health Sciences Commons](#)

Recommended Citation

Paula Schaefer, *Lawyers as Caregivers*, 12 ST. MARY'S J. ON LEGAL MALPRACTICE & ETHICS 330 (2022).
Available at: <https://commons.stmarytx.edu/lmej/vol12/iss2/4>

This Article is brought to you for free and open access by the St. Mary's Law Journals at Digital Commons at St. Mary's University. It has been accepted for inclusion in St. Mary's Journal on Legal Malpractice & Ethics by an authorized editor of Digital Commons at St. Mary's University. For more information, please contact sfowler@stmarytx.edu.

ARTICLE

Paula Schaefer

Lawyers as Caregivers

Abstract. This Article argues that clients—much like patients in a healthcare setting—need their lawyers to be caregivers. The Article opens by developing a definition of caregiving in medicine and law. It then turns to five key components of caregiving in medicine, explaining the substantial research that this care is crucial for patient satisfaction, trust, and healing. Medical educators have drawn on this research to better prepare medical professionals to be excellent caregivers. The Article then explores the evidence that an attorney’s clients have the same needs and suffer similar harm when attorneys fail to meet these needs. Next, the Article turns to the question of how law schools can better prepare students for the caregiving aspect of client representation. Finally, the Article concludes with thoughts on why an embrace of caregiving can separate good lawyers from great lawyers.

Author. Associate Dean for Academic Affairs and Art Stolnitz Professor of Law, University of Tennessee College of Law. Thank you to Emily Gould and Jordan Franklin for research assistance and to the editors of the *St. Mary’s Journal on Legal Malpractice & Ethics*. I appreciate the feedback and suggestions I received from participants in two discussion groups at the Southeast Association of Law Schools annual conference in 2021. Finally, I want to thank my many, many healthcare providers from my 2020 hospital stay, including Paul Becker, Sudarshan Doddabele, Marcia Lyons, James Ogradowski, Fantashia O’Neal, and Azamit Seyoum.

ARTICLE CONTENTS

I.	Introduction.....	332
II.	What Is Caregiving and Who Needs It?.....	334
III.	Common Aspects of Caregiving in Medicine and Law	338
	A. Promptly Responding to the Call.....	338
	B. Making a Connection with Kindness, Positivity, Active Listening, Touch, and Humor.....	341
	C. Understanding that Some Conversations Call for Less Honesty	347
	D. Moving Beyond Bias and Stereotypes and Towards Respect.....	351
	E. Taking Confidentiality Seriously.....	356
IV.	Teaching Caregiving in Law School.....	363
	A. Navigating the Politics	363
	B. Making It Personal.....	365
	C. Integrating Client Caregiving Topics into Current Courses	368
V.	Conclusion	371

“It is of course true . . . that all of the great physicians have been those men and women who are not only well versed in the hard-core physiopathology of their time, but are equally at ease . . . with the human heart in conflict.”¹

I. INTRODUCTION

On June 22, 2020, I went into cardiac arrest when I had a pulmonary embolism following knee surgery. I spent the next five weeks in the hospital. During the first ten days, I used a ventilator and was not aware of what was happening. By the time I was awake and somewhat coherent, I could not stand, much less walk. In the weeks that followed, I was completely dependent on a team of caregivers—doctors, nurses, certified nursing assistants, and physical and occupational therapists.

I am indebted to all of them for saving my life and putting me on the road to recovery. They accomplished that not only through medicine, but also through caregiving. Of course, medicine was a piece of what saved me, but it was not the only thing or even the most important thing. Technical knowledge and skill were necessary to remove blood clots from my lungs, but I survived because of the care I was provided in the weeks that followed. From responding when I hit the call button to telling me they were optimistic about my recovery, my medical providers showed me care every moment of the day. And that care was a real, tangible contributor to my recovery.

During my time in the hospital, I was acutely aware of and grateful for the care I received—and frustrated on the occasions when it fell short. I remember thinking on numerous occasions: “It takes a special person to do this work.” It was not their knowledge of science or the human body that I marveled at, but their ability to support me and guide me through an experience that made me feel vulnerable and scared.

Because I teach and write about attorney ethics, and because I had a lot of time on my hands, I spent some time in the hospital thinking about lawyers as caregivers. Specifically, I found myself comparing the caregiving aspects of the legal and medical professions. I thought about whether the professions provide analogous forms of care and whether that care is as important for clients as it is for patients. After I left the hospital, I began reading the literature on caregiving in medicine—from studies on the

1. AUGUSTUS A. WHITE III, SEEING PATIENTS UNCONSCIOUS BIAS IN HEALTH CARE 229–30 (Harvard Univ. Press 2011).

effectiveness of placebos² to books and articles on the impact of bias on patient care.³ In most areas, the medical profession is at least twenty years ahead of the legal profession in thinking about the impact of care on outcomes. I could see the potential relevance of this medical research to lawyers and legal educators.

This Article explores the role of a lawyer as a caregiver. Following this Introduction, Part II develops the definition of caregiving and explains the need for it by patients and clients. The resulting definition of caregiving is this: actions taken by a medical or legal professional to address the needs of a patient or client beyond the medical or legal concern. A number of legal scholars have been teaching, researching, and writing about caregiving in the practice of law for years. This discussion provides a broad overview of that scholarship and situates this Article in relation to those important predecessors.

Part III is the heart of this Article and where I hope to contribute something new to lawyers' understanding of how to fulfill client care needs. This discussion explores five key components of caregiving. In discussing each component, I consider why patients have this need and, when applicable, what the field of medicine has done to improve care. From there, I address the substantial evidence indicating that an attorney's clients have the same needs. I include examples from cases, news articles, and legal scholarship demonstrating the negative consequences for clients who are not provided each aspect of care. Each sub-part of this discussion closes with thoughts on what lawyers can learn from medical providers through research in the healthcare field.

Next, Part IV turns to the question of how law schools can better prepare students for the caregiving aspect of client representation. This section starts with a discussion of how to navigate the political issues involved in integrating caregiving into the curriculum. Then, I turn to why and how legal educators should make the issue of caregiving personal for students. This Part ends with specific suggestions as to where caregiving concepts can be incorporated into the current law school curriculum. Finally, Part V concludes with thoughts on why an embrace of caregiving can separate good lawyers from great lawyers.

2. See *infra* notes 55–97 and accompanying text (examining the effectiveness of placebos in health studies and how the use of placebos can be used in the lawyer–client relationship).

3. See *infra* notes 134–46 and accompanying text (discussing the history of racial and gender bias in patient care and how medical experts have responded to the issue to reduce said bias).

I share an uncomfortable amount of personal information in this Article. My purpose is to reveal how vulnerable I felt and how crucial it was that my healthcare professionals provided care with empathy, kindness, respect, responsiveness, and assurance of confidentiality. The research reveals that when professionals—whether in medicine or law—satisfy these needs for care, it makes all the difference in the life of the patient or client.

II. WHAT IS CAREGIVING AND WHO NEEDS IT?

The definitions of caregiving and caregivers often reference healthcare providers and patients. According to one source, a caregiver is “a person who tends to the needs or concerns of a person with short- or long-term limitations due to illness, injury or disability.”⁴ Another provides that a caregiver is “a person who provides direct care (as for children, elderly people, or the chronically ill).”⁵ Similarly, another definition of caregiving is “the practice of providing care for a vulnerable neighbo[r] or relative[.]”⁶ The term “care” has many meanings, but the one relevant here is “an attention to detail or the supervision and protection of something.”⁷

Consistent with these definitions, this Article uses the term “caregiving” in the healthcare context to mean the actions taken by a medical professional to address the needs of a patient beyond the medical concern. Part III of this Article makes the case that caregiving includes: (1) promptly responding to requests or needs; (2) creating a connection through kindness and empathy; (3) showing compassion and using judgment in talking about a possibly difficult future; (4) demonstrating respect for patients irrespective of race, gender, or minoritized status; and (5) signaling a commitment to protect confidences.⁸ Medical research demonstrates that these aspects of care are important for patient satisfaction, trust, and healing.⁹ Based on that

4. *What is a Caregiver?*, JOHNS HOPKINS MED., https://www.hopkinsmedicine.org/about/community_health/johns-hopkins-bayview/services/called_to_care/what_is_a_caregiver.html [<https://perma.cc/2PE3-CQZD>].

5. *Caregiver*, MERRIAM-WEBSTER.COM, <https://www.merriam-webster.com/dictionary/caregiver> [<https://perma.cc/JHG5-G8RH>].

6. *Caregiving*, COLLINS ENG. DICTIONARY (12th ed. 2014), <https://www.thefreedictionary.com/caregiving> [<https://perma.cc/DM39-VWDM>].

7. *Care*, DICTIONARY.COM, <https://www.dictionary.com/browse/care> [<https://perma.cc/7P-VW-UTKE>].

8. See *infra* Part III (providing an in-depth analysis of how aspects of caregiving can improve the lives and morale of patients).

9. See, e.g., *infra* notes 52–55 and accompanying text (emphasizing the benefits of positive relations between doctors and their patients).

research, medical schools have developed courses aimed at improving the delivery of care to patients.¹⁰

The dictionary definitions of caregiving or caregiver do not reference lawyers meeting the non-legal, but related needs of their clients. But clients and patients have common qualities that suggest they have a shared need for care. The lawyer–client relationship is a fiduciary relationship in which the lawyer agrees to act on the client’s behalf.¹¹ It is a relationship of trust and confidence.¹² Like the patient relies on the doctor to use training to treat an injury or illness, the client relies on a lawyer to use legal training to address a legal problem.¹³ And just as non-medical but related needs arise in the doctor–patient relationship, non-legal but related needs will arise in the attorney–client relationship. Accordingly, when this Article uses the term caregiving in reference to lawyers, it means actions taken by a legal professional to address the needs of a client beyond the legal concern. Whether clients and patients have the same caregiving needs is the subject of Part III.

10. See WHITE, *supra* note 1, at 230 (discussing medical school class aimed at helping future doctors gain self-awareness and learn to recognize and eliminate bias in interactions with patients); see also Helen R. Winefield & Anna Chur-Hansen, *Evaluating the Outcome of Communication Skill Teaching for Entry-Level Medical Students: Does Knowledge of Empathy Increase?*, 34 MED. EDUC. 90, 91–92 (2000) (describing a method for teaching the empathetic response to medical students); Dinah Wisenberg Brin, *Standardized Patients Teach Skills and Empathy*, ASS’N AM. MED. COLLS. (Nov. 27, 2017), <https://www.aamc.org/news-insights/standardized-patients-teach-skills-and-empathy> [https://perma.cc/5Y68-3MHG] (discussing the widespread use of simulated patients in medical school education “as a means to help medical students learn how to grapple with sensitive issues”); see also *infra* notes 143–144 and accompanying text (addressing medical school accreditation standards requiring education on bias in patient care).

11. RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 16 (AM. L. INST. 2000) (describing lawyer’s duties to the client); see *id.* at cmt. b (explaining how the lawyer is a fiduciary); see also *Alexander v. Inman*, 974 S.W.2d 689, 693–94 (Tenn. 1998) (“The relationship of attorney and client is ‘extremely delicate and fiduciary’; therefore, attorneys must deal with their clients in utmost good faith.”).

12. See, e.g., *Accident & Inj. Med. Specialists, P.C. v. Mintz*, 279 P.3d 658, 663 (Colo. 2012) (citing *Olsen & Brown v. City of Englewood*, 889 P.2d 673, 675 (Colo. 1995)) (“The attorney–client relationship is distinctly a fiduciary relationship arising as a matter of law and founded upon a special trust and confidence.”).

13. RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 16(2) (AM. L. INST. 2000) (“[A] lawyer must, in matters within the scope of the representation: . . . act with reasonable competence and diligence”); *id.* § 52 (“[A] lawyer who owes a duty of care must exercise the competence and diligence normally exercised by lawyers in similar circumstances.”); *id.* at § 16 cmt. b (“*Rationale.* A lawyer is a fiduciary, that is, a person to whom another person’s affairs are entrusted in circumstances that often make it difficult or undesirable for that other person to supervise closely the performance of the fiduciary. Assurances of the lawyer’s competence, diligence, and loyalty are therefore vital.” (emphasis added)).

Though they may not use the term caregiving, numerous legal scholars have recognized the need for caregiving in the attorney–client relationship.¹⁴ The following discussion is not intended to be exhaustive but includes some important examples.¹⁵ Since the late 1970s, client-centered lawyering has been the dominant teaching model in clinical legal education.¹⁶ A client-centered approach is commonly associated with minimizing the lawyer’s impact on client decision-making and emphasizes the importance of understanding “clients’ perspectives, emotions and values.”¹⁷ Susan Brooks and Robert Madden developed the relational lawyering framework¹⁸ which recognizes the importance of “cultural, emotional, and interpersonal dimensions” of lawyers’ work.¹⁹ The book *Building on Best Practices: Transforming Legal Education in a Changing World* explained the importance of teaching law students empathy and relational skills.²⁰ The therapeutic jurisprudence framework recognizes the role of law (including practices and techniques of lawyers) in a client’s psychological wellbeing.²¹ And a robust body of scholarship on cross-cultural lawyering explains lawyers’ need to develop cross-cultural competence in order to effectively represent clients.²²

14. I do not mean to suggest that the word “caregiving” needs to be used in describing these aspects of the attorney–client relationship. In fact, in teaching law students about these issues, it would likely be more effective not to use the word caregiving. See *infra* Part IV.A (explaining how the term “caregiving” is interpreted in the medical field and legal field).

15. See generally J. Kim Wright & Dolly M. Garlo, *Law as a Healing Profession: New Trends Are Expanding Choices in Law Practice*, 63 OR. ST. B. BULL. 9 (2003) (providing additional examples).

16. Katherine R. Kruse, *Fortress in the Sand: The Plural Values of Client-Centered Representation*, 12 CLINICAL L. REV. 369, 369–71 (2006).

17. *Id.* at 378.

18. Susan L. Brooks, *Mindful Engagement and Relational Lawyering*, 48 SW. L. REV. 267, 268 (2019) (describing the origins of the relational lawyering framework and pedagogy).

19. *Id.*

20. Larry O. Natt Gantt II & Benjamin V. Madison III, *Teaching Knowledge, Skills and Values of Professional Identity Formation*, in BUILDING ON BEST PRACTICES: TRANSFORMING LEGAL EDUCATION IN A CHANGING WORLD 253, 261 (Deborah Maranville et al. eds., 2015), <https://ssrn.com/abstract=2637499> [<https://perma.cc/JG2C-6KEG>] (addressing the importance of teaching law students empathy, ethical sensitivity, and other relational skills).

21. David B. Wexler, *The DNA of Therapeutic Jurisprudence* 3 (Ariz. Legal Stud. Discussion Paper No. 20–43, 2020), <https://ssrn.com/abstract=3731574> [<https://perma.cc/Z85K-3ZYV>] (discussing therapeutic jurisprudence, as well as therapeutic design and therapeutic application of the law).

22. See Shahrokh Falati, *The Makings of a Culturally Savvy Lawyer: Novel Approaches for Teaching and Assessing Cross-Cultural Skills in Law School*, 49 J.L. & EDUC. 627, 628 (2020) (reviewing the “various stages of cultural competency”); Annette Demers, *Cultural Competence and the Legal Profession: An Annotated Bibliography of Materials Published Between 2000 and 2011*, 39 INT’L J. LEGAL INFO. 22, 23 (2011)

A couple of things are noteworthy about the legal scholarship that emphasizes the caregiving obligations of lawyers. Clinicians have been the primary authors of this scholarship²³ and have applied this work in their legal clinics, which mainly represent underserved communities.²⁴ Much of this scholarship has focused on the care needs of these communities,²⁵ perhaps suggesting by omission that other clients do not have the same needs for caregiving.

In some ways, the discussion in this Article is narrower in focus than these predecessors in legal scholarship. Part III focuses on whether clients need the same categories of caregiving as patients and considers what lawyers can learn about the provision of care from healthcare providers and medical research.²⁶ As such, this is a narrower focus than articulating a framework for conceptualizing lawyering, such as relational lawyering or client-centered lawyering. But in other ways, this Article addresses a broader audience of clients and lawyers than prior scholarship. All clients and patients—regardless of age, wealth, race, gender, or ability—are vulnerable.²⁷ Vulnerability is inherent in unequal relationships when one party relies on the other for help, like the attorney–client or doctor–patient

(emphasizing the importance of “cultural competence”); Carwina Weng, *Multicultural Lawyering: Teaching Psychology to Develop Cultural Self-Awareness*, 11 CLINICAL L. REV. 369, 369 (2005) (demonstrating the importance of self-awareness in the formula for “multicultural competence”); Susan Bryant, *The Five Habits: Building on Cross Cultural Competence in Lawyers*, 8 CLINICAL L. REV. 33, 35 (2001) (developing “the Habits” to assist lawyers in cross-cultural competency).

23. See, e.g., *supra* notes 20, 22, 24, 28, 194, 202 and accompanying text (referencing the scholarship that clinicians authored regarding caregiving in the law).

24. See, e.g., Kruse, *supra* note 16, at 384 (explaining for clinicians, teaching lawyering skills is inseparable from instilling a commitment to addressing poverty and social justice issues and that the “client-centered approach offered a pedagogical opportunity to explore these social justice values” within client representation in the clinic).

25. See Shannon Gleeson, *Legal Status and Client Satisfaction: The Case of Low-Wage Immigrant Workers*, 46 LAW & SOC. INQUIRY 364, 365 (2021) (describing the needs of impoverished clients “with less human, social, and cultural capital”); Peter Margulies, *The Lawyer as Caregiver: Child Client’s Competence in Context*, 64 FORDHAM L. REV. 1473, 1475–78 (1996) (describing the lawyer’s role as caregiver for the child client); Theresa Glennon, *Lawyers and Caring: Building an Ethics of Care into Professional Responsibility*, 43 HASTINGS L. J. 1175, 1175 (1992) (defining the ethic of care to mean that lawyers’ “professional lives are connected to the lives of those who live in poverty”).

26. See *infra* Part III (detailing the similarities between the doctor–patient relationship and the attorney–client relationship).

27. It may be tempting to dismiss the caregiving needs of organizational clients. But even when a client is an organization, humans make decisions for it and those humans need caregiving. See, e.g., *infra* note 157 (providing an example of an organizational client and how it relates to caregiving).

relationship.²⁸ The following discussion addresses how this vulnerability translates into caregiving needs for all patients and clients.

III. COMMON ASPECTS OF CAREGIVING IN MEDICINE AND LAW

A. Promptly Responding to the Call

During my weeks in the hospital, I was unable to stand without substantial help. I was entirely dependent on a nurse (or certified nurse's nursing assistant) responding when I pushed a call button. If my assigned nurse or nursing assistant could not get there immediately, she or he could respond through a speaker and ask if I could wait a few minutes. Sometimes, though, I received no response at all when I pushed the call button. I would grow anxious and upset as I waited ten, fifteen, twenty minutes or more. I felt helpless. This waiting was my single biggest frustration as a patient. It is the only thing I complained about on my patient care survey when I was discharged from the hospital.

Difficulty communicating with—or receiving an inadequate response from—a healthcare provider tops patients' lists of frustrations about healthcare.²⁹ Patients' vulnerability and helplessness is one reason communication roadblocks are so maddening for them.³⁰ A patient in need

28. Tina Sideris, *From Post-Traumatic Stress Disorder to Absolute Dependence in an Intensive Care Unit: Reflections on a Clinical Account*, 45 MED HUMANITIES 37, 43 (2019) (“Power is implicated in our dependence on another to meet our needs, and, indeed in our meeting of the other’s needs.”); Lloyd B. Snyder, *Teaching Students How to Practice Law: A Simulation Course in Pretrial Practice*, 45 J. LEGAL EDUC. 513, 520 (1995) (explaining the “vulnerability clients feel when they place their futures in a lawyer’s hands”).

29. See Lisa Skär & Siv Söderberg, *Patient Complaints Regarding Healthcare Encounters and Communication*, 5 NURSING OPEN 224, 225 (2018) (identifying most patient complaints as centering around “communication and interaction” with healthcare providers); Ashlyn Frassinelli, *5 Common Patient Complaints in Healthcare*, ISSUETRAK (2021), <https://www.issuetrak.com/blog/5-common-patient-complaints-in-healthcare/> [<https://perma.cc/HXM9-PZNS>] (describing lack of communication and dismissiveness as one of five common patient complaints); *Patients' Top Complaint? It Isn't Doctors or Nurses, Study Finds*, ADVISORY BD. (Apr. 28, 2016), <https://www.advisory.com/daily-briefing/2016/04/28/top-patient-complaints> [<https://perma.cc/V7WD-TUM7>] (describing a study in the Journal of Medical Practice Management which found that only 4% of negative online reviews relate to medical treatment, while 53% relate to communication).

30. Nathalie Martin, *The Virtue of Vulnerability*, 48 SW. L. REV. 367, 375 (2019) (citing research which showed that patients sued doctors who “deserted them or were otherwise unavailable” to them as well as those who devalued or failed to consider patient views and who delivered information poorly); Sideris, *supra* note 28, at 42, quoting a former ICU patient as explaining the experience in the ICU:

You know, it made me feel helpless, and powerless. It's hard to describe. You feel, what can I say, you feel hurt and you could easily start to cry. Yes and then I thought oh please let someone come; don't let a person who is so dependent wait so long. That is important, right?

of medical advice or assistance who cannot help herself is at the mercy of the healthcare provider.³¹ This was at the heart of my frustration in waiting on nurses or nursing assistants to help me with a bedpan.³² Having a need that the patient cannot satisfy himself or herself that he or she must rely upon someone else to fulfill, when that person is not responsive to the patient's needs, results in an angry and frustrated patient.

Another reason for communication frustration can be that the patient reasonably expected some action or answer from the healthcare provider that the patient has not received.³³ It could be writing a prescription, talking to another healthcare provider to coordinate care, providing a promised diagnosis, or resolving inconsistent care instructions.³⁴ When this stressful wait is met with silence, the patient sometimes decides to reach out in order to nudge the healthcare provider to do the job the healthcare provider has failed to do.³⁵ So in this case, the patient is not only helpless in solving the medical issue, but also has to remind the doctor to satisfy the caregiving obligation. Feeling neglected on such an important issue can result in anger, a loss of trust, and complaints.

Like a healthcare provider, an attorney must also respond promptly to a client's call. A lawyer, as the client's agent, has a legal duty to communicate information about the representation to the client, including complying with the client's request for information.³⁶ That communication duty is also embodied in attorney professional conduct rules. Model Rule of Professional Conduct 1.4 addresses an attorney's ethical obligation of

Id. (quoting José G.M. Hofhuis et. al, *Experiences of Critically Ill Patients in the ICU*, 300 INTENSIVE & CRITICAL CARE NURSING 308 (2008)).

31. Skär & Söderberg, *supra* note 29, at 225 (explaining patient complaints about communication with healthcare professionals include receiving inadequate information from the healthcare provider and not being included in decisions about treatment).

32. *See supra* introduction to Part III.A (detailing my experience with doctors and medical workers).

33. *E.g.*, Janine W.Y. Kee et al., *Communication Skills in Patient-Doctor Interactions: Learning from Patient Complaints*, 4 HEALTH PROS. EDUC. 97, 101 (2018) (describing patient complaints about receiving inadequate information or poor-quality information from their healthcare providers).

34. *Id.* (discussing a patient's complaint about conflicting instructions from doctor and nurse about whether a procedure was needed).

35. *Id.* (describing the patient's decision to approach the doctor about inconsistent instructions provided by the doctor and a nurse; and instead of clarifying the situation, the doctor used an unfriendly tone, tried to determine the identity of the nurse, and seemingly blamed the patient for not taking notes).

36. RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 20 (AM. L. INST. 2000).

communication.³⁷ Among the rule's requirements, part (a)(3) requires that the lawyer keep the client reasonably informed and (a)(4) requires that an attorney promptly respond to a client's reasonable request for information.³⁸ Comment 4 to the rule encourages a lawyer to communicate information to the client, to respond when the client asks for information, and if the lawyer cannot provide the information immediately, let the client know when a response can be expected.³⁹

Like a helpless patient, a vulnerable client's frustration grows when a lawyer does not respond to a call for information or help.⁴⁰ This is because clients are entirely dependent on the lawyer, as gatekeeper of information, to respond to this need. And just like a frustrated patient completing an exit survey, clients complain when their lawyers fail to communicate. The most frequent complaint made against lawyers with disciplinary authorities is neglect and lack of communication.⁴¹ For example, the most frequent complaint against Tennessee attorneys in the most recent reporting year was "neglect or failure to communicate."⁴² This failure amounted to 45% of the total filed complaints. In second place, 11% of complaints were for a lawyer's "improper communication."⁴³

There can be numerous reasons for lapses in communication—by healthcare providers and lawyers alike⁴⁴—but there is one that is particularly worthy of attention here: lack of empathy.⁴⁵ Research reveals that empathy

37. MODEL RULES OF PROF'L CONDUCT R. 1.4 (AM. BAR ASS'N 2021).

38. *Id.*

39. *Id.* at cmt. 4.

40. See, e.g., David S. Dolowitz & Jamila Abou-Bakr, *Attorney-Client Relations in Divorce Cases: The Intersection of Ethics and Malpractice in Family Law*, 31 J. AM. ACAD. MATRIM. LAW. 345, 357 (2019) (discussing the unique challenges of poor client communications in the family law context).

41. Jennifer Gerarda Brown & Liana G.T. Wolf, *The Paradox and Promise of Restorative Attorney Discipline*, 12 NEV. L.J. 253, 259–60 (2012) (citing statistics from states reflecting lack of communication and neglect topping the list of client complaints).

42. TENN. BD. PRO. RESP., 39TH ANN. DISCIPLINE REP. FISCAL YEAR JULY 1, 2019–JUNE 30, 2020, at 5 (2020), <https://docs.tbpr.org/pub/bpr-annual-report-fy%2019-20.pdf> [<https://perma.cc/737S-PCNK>].

43. *Id.*

44. Being overextended and procrastination are other major contributors that professionals should be aware of and work to control. See MODEL RULES OF PROF'L CONDUCT R. 1.3 cmt. 2 (AM. BAR ASS'N 2021) (discussing the lawyer's need to control his workload so that all matters can be handled competently); see also *id.* at cmt. 3 (explaining that a lawyer's procrastination can cause unreasonable delay, needless anxiety, and a loss of trust).

45. Jennifer K. Robbenolt & Jean R. Sternlight, *Behavioral Legal Ethics*, 45 ARIZ. ST. L.J. 1107, 1144 (2013) (discussing powerful professionals and the associated lack of empathy); Kee et al., *supra*

can be especially challenging for professionals like doctors and lawyers.⁴⁶ Jennifer Robbennolt and Jean Sternlight explain that members of high status professions tend to see themselves as more powerful than others,⁴⁷ and powerful people “tend to be less likely to take the perspective or feel the emotions” of others and are even challenged in accurately identifying others’ emotions.⁴⁸ Robbennolt and Sternlight conclude: “[F]or lawyers, such difficulties in reading others may result in a failure to attend to the needs of clients and lead to ethical violations such as failure to communicate.”⁴⁹

B. *Making a Connection with Kindness, Positivity, Active Listening, Touch, and Humor*

I believe my healthcare providers helped my recovery by the way they connected with me. I use the word “connected” to encompass offering small acts of kindness, sharing a laugh or a touch outside the context of a medical procedure, and taking time to listen. My orthopedist once snuck in to see me at a hospital where he did not have privileges, not to treat me, but to tell me he had been following my recovery. At a time when I did not fully comprehend everything that was wrong, I remember another doctor optimistically telling me: “We expect you to make a full recovery.” My physical therapist and her intern told me again and again that I could do the things that felt impossible. My favorite intensive care unit (ICU) nurse shared stories of her family, food, and travel, and asked me questions about my family and life outside of the hospital. There are countless other examples of small and daily ways my healthcare providers connected with me. They drew art on my bandage, took me outside to see the sky, showed me pictures of their kids and pets (and looked at mine), washed my hair, told me jokes, discussed Friends reruns and HGTV episodes (that ran on a continuous loop in my room), and once even let my sons in to see me despite stringent COVID-19 visitor rules.

Empirical studies have found a correlation between a positive patient–doctor connection and better outcomes for patients.⁵⁰ Such connections are made when doctors communicate with empathy, kindness, and

note 33, at 101 (describing research on patient complaints about junior doctors’ communication and the theme of “lack of empathy” that emerged).

46. Robbennolt & Sternlight, *supra* note 45, at 1144.

47. *Id.* at 1143.

48. *Id.* at 1144.

49. *Id.*

50. Johan Verhulst et al., *The Medical Alliance: From Placebo Response to Alliance Effect*, 201 J. NERVOUS & MENTAL DISEASE 546, 547 (2013) (describing benefits of a “positive physician-patient relationship”).

interpersonal warmth.⁵¹ Positive connections between patient and doctor have been found to result in higher patient satisfaction,⁵² reduced risk of litigation,⁵³ “and improved adherence with treatment.”⁵⁴

Perhaps most impressive, a positive interpersonal connection between doctor and patient correlates with improved health results in the context of placebo studies.⁵⁵ Those positive health outcomes and placebo research are the focus of the following discussion. While placebos and health outcomes may seem to have little in common with the lawyer–client relationship, this research actually holds a great deal of promise for clients navigating the legal system.

Traditionally, placebos have been used in double-blind studies to determine if a new medication is more effective than a placebo.⁵⁶ In these studies, the placebo has been viewed as the equivalent of “no treatment.”⁵⁷ But in the past two decades, researchers have begun studying the effectiveness of placebos themselves.⁵⁸ This research illuminates the real, positive physiological response that can be triggered by some combination of doctor, patient, and placebo.⁵⁹ Placebos have been found to be effective in treating subjective symptoms⁶⁰ such as pain and disturbed bowel function associated with irritable bowel syndrome (IBS),⁶¹ hot flashes in

51. *Id.*

52. *Id.*

53. *Id.*; see also Martin, *supra* note 30, at 375 (quoting Beth Huntington & Nettie Kuhn, *Communication Gaffes: A Root Cause of Malpractice Claims*, 16 BAYLOR U. MED. CTR. PROC. 157, 157 (2017)) (“[S]imply put, patients do not sue doctors they like and trust.”).

54. Verhulst, *supra* note 50, at 547.

55. Cara Feinberg, *The Placebo Phenomenon: An Ingenious Researcher Finds the Real Ingredients of ‘Fake’ Medicine*, HARV. MAG., Jan.–Feb. 2013, at 3; Verhulst, *supra* note 50, at 547; Ted J. Kaptchuk et al., *Components of Placebo Effect: Randomised Controlled Trial in Patients with Irritable Bowel Syndrome*, BMJ, Apr. 2008, at 1.

56. Verhulst, *supra* note 50, at 547.

57. *Id.*

58. Ted J. Kaptchuk & Franklin G. Miller, *Open Label Placebo: Can Honestly Prescribed Placebos Evoke Meaningful Therapeutic Benefits?*, BMJ, Oct. 2018, at 1.

59. Feinberg, *supra* note 55, at 3.

60. Kaptchuk & Miller, *supra* note 58, at 1. Open-label placebos are not thought to change the underlying pathophysiology, but rather the manifestation of symptoms. Researchers note that placebos will not shrink tumors or treat malaria or high cholesterol, but they may effectively address symptoms like pain, hot flushes, and nausea. *Id.* at 2.

61. Kaptchuk et al., *supra* note 55, at 1; Sarah Ballou et al., *Open-Label Versus Double-Blind Placebo Treatment in Irritable Bowel Syndrome: Study Protocol for a Randomized Controlled Trial*, TRIALS, May 25, 2017, at 1, <https://trialsjournal.biomedcentral.com/articles/10.1186/s13063-017-1964-x> [<https://perma.cc/KE3T-722Y>].

menopausal women,⁶² chronic low back pain,⁶³ and fatigue in cancer patients.⁶⁴

In an IBS placebo study published in 2008 (2008 IBS Placebo Study), researchers divided IBS patients into three groups: (1) a waitlist group that received no treatment; (2) a group that received placebo acupuncture but only “limited interaction” with a doctor; and (3) a group that received placebo acupuncture and an “augmented” patient–doctor interaction.⁶⁵ Both the limited interaction and augmented groups received six identical placebo acupuncture treatments.⁶⁶ In the second phase of the experiment, some patients in the two treatment groups received actual acupuncture, while others continued to receive sham acupuncture.⁶⁷ All participants knew they might receive either placebo or real acupuncture, but no one knew which they received throughout the experiment.⁶⁸

In the limited interaction group, the practitioners spent less than five minutes with each patient and explained that in this “scientific study,” they had been “instructed not to converse with patients.”⁶⁹ In contrast, the augmented group’s initial visit lasted forty-five minutes.⁷⁰ The practitioners followed a script that required them to discuss four content areas related to IBS and engage in five behaviors: (1) being warm and friendly; (2) engaging in active listening; (3) expressing empathy, like “I can understand how difficult IBS must be for you”; (4) engaging in “[twenty] seconds of thoughtful silence” as if pondering the treatment plan while taking the patient’s pulse; and (5) expressing confidence and positive expectations, like

62. Yiqi Pan et al., *Open-Label Placebos for Menopausal Hot Flashes: A Randomized Controlled Trial*, NATURE RSCH. SCI. REPS., Nov. 18, 2020, at 1, <https://www.nature.com/articles/s41598-020-77255-z> [<https://perma.cc/4LTV-KLSZ>]. In the text, I use the more common terminology in the United States, hot “flashes.”

63. Cláudia Carvalho et al., *Open-Label Placebo Treatment in Chronic Low Back Pain: A Randomized Controlled Trial*, 157 PAIN J. ONLINE 2766, 2766 (2016), <https://pubmed.ncbi.nlm.nih.gov/27755279/> [<https://perma.cc/B2RJ-DAUC>].

64. Eric S. Zhou et al., *Open-Label Placebo Reduces Fatigue in Cancer Survivors: A Randomized Trial*, 27 SUPPORTIVE CARE IN CANCER 2179, 2179 (2018), <https://pubmed.ncbi.nlm.nih.gov/30298411/> [<https://perma.cc/A9Z9-BQQD>].

65. Kaptchuk, et al., *supra* note 55, at 2–3.

66. *Id.* at 3.

67. *Id.* at 2.

68. *Id.* at 3–4 (explaining “dummy acupuncture” was used because there is evidence of its high placebo effects, making it indistinguishable from real acupuncture); *id.* at 4 (explaining how participants were told they had a 50% chance of receiving genuine acupuncture and that it was a “placebo-controlled study,” but were not told the purpose was to study placebo efficacy).

69. *Id.* at 3 (internal quotation marks omitted).

70. *Id.*

“I have had much positive experience treating IBS and look forward to demonstrating that acupuncture is a valuable treatment in this trial.”⁷¹

The researchers found the augmented group had the best outcomes in all four measures of the study: global improvement, adequate relief, symptom severity, and quality of life.⁷² The limited interaction group experienced the second most effective relief, followed by the waitlist group.⁷³ The outcomes of the augmented group were “not only statistically significant but also clearly clinically significant in the management of irritable bowel syndrome.”⁷⁴ Researchers noted that the percentage of augmented group patients reporting adequate relief (over 60%) was comparable with that found in clinical trials of current IBS drugs.⁷⁵

In recent years, open-label placebo (OLP) studies have considered whether placebo treatment can be effective even if researchers tell patients they are receiving a placebo.⁷⁶ In typical OLP studies, physicians assign patients to one of two groups: a placebo group or an existing treatment group.⁷⁷ They tell participants that placebos are often an effective treatment for their condition, the placebo response is automatic, that it is okay not to believe, and that taking the pills is critical.⁷⁸ The doctors frame the issue with the phrase, “let’s see what happens.”⁷⁹ Consistently, in study after study, patients in the OLP group report substantially more positive health effects than the existing treatment group.⁸⁰

An acupuncturist with a degree in Chinese medicine, Ted Kaptchuk is one of the world’s leading placebo researchers and a faculty member at

71. *Id.* (internal quotation marks omitted).

72. *Id.* at 5 tbl.2.

73. *Id.*

74. *Id.* at 6.

75. *Id.*

76. *E.g.*, Ted J. Kaptchuk, *Open-Label Placebo: Reflections on a Research Agenda*, 61 PERSPS. BIOLOGY & MED. 311, 312 (2018) (positing, based on initial research, that deception is not necessary for placebos to be effective).

77. *Id.* at 315.

78. *Id.* at 316.

79. *Id.* (internal quotation marks omitted); *see also* Kaptchuk & Miller, *supra* note 58, at 1 (“The dialogue [with study participants] emphasized, ‘let’s see what happens.’”).

80. *See* Kaptchuk, *supra* note 76, at 316–18 (addressing outcomes in studies involving IBS, chronic lower back pain, cancer-related fatigue, allergic rhinitis, and migraines and concluding “the consistency and magnitude of symptomatic relief across these several studies, involving a diverse set of medica[] conditions and implemented in different hospitals in the United States and Europe, suggest that a real therapeutic benefit may be produced by the OLP intervention”).

Harvard School of Medicine.⁸¹ Kaptchuk recognizes that continued study is necessary to fully understand the power of placebo, but he has some ideas based on the studies he and his colleagues have conducted.⁸² Contrary to some theories, Kaptchuk does not think the patient's "expectation" is the key to the placebo effect.⁸³ Study patients have generally not had positive results with previous treatments, deny positive expectations, and are given realistic treatment prospects.⁸⁴ Further, Kaptchuk explains that the clinical evidence is inconsistent with expectation theory.⁸⁵ Kaptchuk thinks one of the keys is hope.⁸⁶ He notes that study participants with chronic conditions often report their feelings of hope.⁸⁷ He describes their hope as a "tragic optimism"⁸⁸ and "a combination of opposites, balancing despair with an openness to a different future"⁸⁹ that leads to them "to seek treatment even from a counterintuitive intervention."⁹⁰ He explains that hope is not a "magic bullet," but "a posture that encourages and cognitively mimics neurological mechanisms of placebo to happen."⁹¹

Significant to caregiving, Kaptchuk also has theories about the importance of the doctor–patient relationship on the effectiveness of placebos.⁹² Kaptchuk notes that in his OLP studies, both patient groups (those who will and will not receive the placebo) have the same supportive interaction before being assigned to their group.⁹³ He concludes that this suggests "supportive interaction alone is not sufficient for producing placebo effects in the context of such trials."⁹⁴ Nonetheless, he

81. Feinberg, *supra* note 55, at 37.

82. Kaptchuk, *supra* note 76, at 312 ("The OLP agenda is in its infancy, and where it will lead is unclear.").

83. Kaptchuk & Miller, *supra* note 58, at 2 (explaining how participants were frustrated by multiple unsuccessful treatments and described the OLP study as crazy and denied positive expectations).

84. *See* Kaptchuk, *supra* note 76, at 319 (criticizing expectation theory and contrasting it with his approach to OLP studies, which runs directly counter to the traditional understanding); Kaptchuk & Miller, *supra* note 58, at 2 ("Most of the participants in the main trials of open label placebo . . . experienced refractory symptoms and were frustrated by multiple unsuccessful treatments.").

85. Kaptchuk, *supra* note 76, at 319–20.

86. *Id.* at 321.

87. *Id.* at 314, 321.

88. Kaptchuk & Miller, *supra* note 58, at 2 (internal quotation marks omitted).

89. Kaptchuk, *supra* note 76, at 321.

90. Kaptchuk & Miller, *supra* note 58, at 2.

91. Kaptchuk, *supra* note 76, at 321.

92. *Id.* at 323–24.

93. *Id.* at 323.

94. *Id.* at 324.

acknowledges that the doctor–patient interaction “that lead to trust and rapport may interact with OLP.”⁹⁵ He notes that ritualized behaviors, including warmth, empathy, and attention, as well as touch and interaction in a healing space, may be significant.⁹⁶ Finally, Kaptchuk states two of his suspicions about doctor care and OLP: “an uninterested physician could negate” the placebo benefits, and taking “placebo pills independent of any patient–clinician relationship would reduce the effectiveness of OLP.”⁹⁷

The importance of this research for the attorney–client relationship may not be immediately apparent. After all, a client has a legal problem, which placebo pills certainly cannot cure. But just like the patient’s physiological condition (which also cannot be cured by a placebo),⁹⁸ the client’s legal challenge is just one of the client’s needs. Clients often feel anxiety, stress, fear, and helplessness.⁹⁹ The placebo research suggests that a lawyer’s empathy, kindness, touch, encouragement, and humor—in other words, connectedness to the client—may positively impact these issues.¹⁰⁰

The 2008 IBS Placebo Study provides a helpful guide for lawyers. The scripted interactions in the augmented placebo group lead to measurably better outcomes for those patients.¹⁰¹ The difference was the doctor’s connection, created by spending time with the patient, being warm, actively listening, showing empathy, touching the patient, and expressing positive expectations.¹⁰² Lawyers can follow this same script, which may result in the same positive outcomes for clients.

While doctors in these placebo studies also provide a sugar pill (or fake acupuncture) to patients, it seems that lawyers have something just as valuable to offer. Like the OLP study doctors, lawyers can encourage their clients to hope their anxiety and worries will decrease during the

95. *Id.*

96. *Id.*

97. *Id.*

98. *See supra* note 60 and accompanying text (explaining open-label placebos are not believed to alter underlying pathophysiology).

99. *See, e.g.,* Barbara Glesner Fines & Cathy Madsen, *Caring Too Little, Caring Too Much: Competence and the Family Law Attorney*, 75 UMKC L. REV. 965, 979 (2007) (noting the impact of clients’ fear, anger, and vulnerability on the representation and the need for lawyers to make connections through empathetic listening).

100. *See supra* notes 72–75, 80, 96–97 and accompanying text (describing positive results in placebo studies following supportive doctor interaction plus a placebo).

101. *See supra* notes 71–75 and accompanying text (describing outcomes of augmented treatment).

102. *See supra* note 71 and accompanying text (listing various empathetic behaviors which medical practitioners engaged in).

representation.¹⁰³ Similar to the doctors in the 2008 IBS Placebo Study, attorneys can encourage their clients to expect good things from the representation.¹⁰⁴ So, an attorney could say, “You do not need to worry about this legal problem so much anymore. I think it will help you navigate this [litigation, divorce, negotiation, etc.] if you let me take on this burden for you. I will let you know when there are things you need to know or worry about. A lot of my clients think it helps to hand off their worries to me.”¹⁰⁵ This interaction is akin to the placebo studies: the lawyer makes a positive connection and offers something—although not in a pill form—that may relieve the client’s physical and emotional manifestations of a legal problem.¹⁰⁶

C. *Understanding that Some Conversations Call for Less Honesty*

My kidneys failed after I went into cardiac arrest. While I was in the hospital, I spent at least twelve hours a week connected to a dialysis machine. My feet were incredibly swollen and got worse if I did not keep them elevated for most of the day. I had a lot of questions about what to expect in the weeks and months ahead. Two of my nephrologists—both competent from a medical standpoint—answered my questions in very different ways. One told me that some patients never fully recovered from a kidney failure like mine and described what some of those patients experience when they leave the hospital. The other doctor told me that most people who suffer acute kidney failure experience a complete recovery. He told me he had every reason to think I would have a full recovery.

103. See *supra* notes 78–79 and accompanying text (describing what patients are told about the possible effectiveness of placebo treatment in OLP studies); see also *supra* notes 86–91 and accompanying text (describing the role of hope in placebo studies).

104. See *supra* note 71 and accompanying text (referencing positive expectation language).

105. Even doctors who do not use placebos in their care subscribe to the view that making a positive connection can work like a placebo. Orthopedic Surgeon Augustus White III, explains that much like “giving [] patients a placebo” he tried to “stimulat[e] [the patient’s] perception” that they would get better by conveying his optimism, his commitment to them, his desire for their progress, and his conviction “that this attitude made a difference.” WHITE, *supra* note 1, at 229.

106. Unlike Kaptchuk, I theorize that the human connection is substantially more important than the placebo pill in the OLP studies. To say that the placebo and non-placebo groups had identical doctor interactions but enjoyed different results misses one of the key points of the interaction. The doctor followed through with a promise of pills (that he told the patient might provide relief) with one group but not with the other. The lack of follow-through for the non-placebo group—rather than the actual sugar pill itself—is likely a significant difference. In other words, both groups did not have an identical human interaction. Both were told “there is something more I may be able to give you that will help your condition,” but only one group received it.

Maybe because I am a pessimist, I believed the worst-case-scenario-doctor. I was disheartened by the bleak picture he painted. I spent a lot of time thinking about what my life would be like if I had to make time for outpatient dialysis. I wondered how I could possibly teach if my feet ballooned after a few minutes of standing.

I think both doctors possessed the same medical information but presented it to me in different ways. The doctor who gave me the worst-case scenario may have thought it would be dishonest not to tell me what may lie ahead. After all, that was my question. In his mind, it may not have felt like an option to provide less information; that may be the way he approaches lots of issues in his life. Or maybe he tends to be a bit of a pessimist, while the other doctor may be more of an optimist.

Was the worst-case scenario doctor an inferior caregiver—or just a different type of caregiver? Are there principles that should guide doctors and lawyers in these conversations? Is it possible that patients and clients actually want and need something less than total honesty?

Duke professor of psychology and behavioral economics Dan Ariely is an expert on dishonesty.¹⁰⁷ Among his books is *The Honest Truth About Dishonesty: How We Lie to Everyone—Especially Ourselves*.¹⁰⁸ Ariely became interested in studying deception and self-deception due to his experience as a patient with burns over 70% of his body.¹⁰⁹ And he has continued to think about the role of deception and self-deception throughout his recovery.¹¹⁰ Ariely explains that patients with burns over 30% of their bodies are at serious risk of losing their lives, but his doctors did not tell him about his risk of death or the long painful road to recovery.¹¹¹ He ultimately saw the value of some dishonesty, explaining that while dishonesty is “corrosive and destructive[,] . . . we don’t want to eliminate it completely.”¹¹² Ariely believes that the question about dishonesty is about “dosage and under what conditions,” concluding the doctors did the right thing by not telling him “exactly the truth.”¹¹³

107. Dan Ariely, DUKE'S FUQUA SCH. OF BUS., <https://www.fuqua.duke.edu/faculty/dan-ariely> [<https://perma.cc/AZ3L-2B25>].

108. DAN ARIELY, *THE (HONEST) TRUTH ABOUT DISHONESTY: HOW WE LIE TO EVERYONE—ESPECIALLY OURSELVES* (2012).

109. The Hidden Brain, *Everybody Lies, and That's Not Always a Bad Thing*, NPR (Apr. 9, 2018, 9:01 PM), www.npr.org/transcripts/599930273 [<https://perma.cc/NT7W-FGTQ>].

110. *Id.*

111. *Id.*

112. *Id.*

113. *Id.*

Lawyers have a legal and ethical obligation to be truthful in their dealings with clients.¹¹⁴ One key aspect of a lawyer's fiduciary duty of loyalty is the duty to deal honestly with a client.¹¹⁵ Model Rule 8.4(c) provides that it is professional misconduct to engage in conduct involving dishonesty.¹¹⁶ Further, it is implicit in Model Rule 1.4, addressing communication with clients, that a lawyer must communicate information to a client honestly.¹¹⁷ This rule requires a lawyer to communicate necessary information for the client to provide informed consent (when informed consent is required by the Rules).¹¹⁸ Additionally, it provides that "[a] lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation."¹¹⁹ Lawyers face serious consequences for lying to clients, ranging from civil liability¹²⁰ to professional discipline.¹²¹

In light of this, it may be difficult for lawyers to accept that they should sometimes take a nuanced approach to honesty with their clients.¹²² But just like doctors, they should. Professional rules governing attorney conduct recognize that there are situations when lawyers must exercise judgment about honesty. Comment 7 to Model Rule 1.4 provides that there may be

114. Of course, a lawyer also has a duty of honesty in dealings with non-clients, too. *See* MODEL RULES OF PROF'L CONDUCT R. 4.1 (AM. BAR ASS'N 2021) (prohibiting lawyers from making false statements of material fact or law to a third party); *id.* at R.7.1 (barring false and misleading communications about a lawyer's services); *id.* at R.8.4(c) (providing it is misconduct for lawyers to "engage in conduct involving dishonesty"). The discussion in this part, though, focuses on honesty in client interactions.

115. RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS, § 16(3) (AM. L. INST. 2000) (noting the lawyer's duty to "deal honestly with the client").

116. MODEL RULES OF PROF'L CONDUCT R. 8.4(c).

117. *Id.* at R. 1.4.

118. *Id.* at R. 1.4(a)(1). Model Rule 1.0(e) defines "informed consent" as agreement to a course of conduct "after the lawyer has communicated adequate information and explanation about the material risks" and available alternatives. *Id.* at R. 1.0(e).

119. *Id.* at R. 1.4(b).

120. *E.g.*, Lisa G. Lerman, *Lying to Clients*, 138 U. PA. L. REV. 659, 696–98 (1990) (citing numerous cases where clients successfully brought malpractice claims against lawyers based on lies ranging from billing fraud to falsely claiming the lawyer had obtained a divorce on the client's behalf).

121. *See* Disciplinary COUN. v. Burchinal, 170 N.E.3d 855, 861 (Ohio 2021) (disbarring attorney for misconduct including lying to clients about work attorney had not completed); Bd. of Prof'l. Resp. v. Mathey, 480 P.3d 1184, 1193 (Wyo. 2021) (disbarring attorney for misconduct including violating Rules 1.4 and 8.4(c) by repeatedly lying to the client about case status, settlement checks, and a default judgment).

122. A nuanced approach can be especially difficult for professionals who are rigid in their thinking. It will be even more challenging for such a person to feel comfortable navigating an issue that he or she previously saw in black and white terms.

circumstances when a lawyer is justified in withholding information from a client.¹²³ One example provided is a situation when a client is “likely to react imprudently to an immediate communication.”¹²⁴ The comment contrasts withholding information that would harm the client (acceptable) with situations where withholding information is in the interest of the lawyer or a third party (unjustified).¹²⁵

Some basic principles flow from the foregoing discussion about honesty in a professional relationship. First, both doctors and lawyers should recognize that safety is critical. If the disclosure of information will likely harm the patient or client, the professional should refrain from making or at least delaying that disclosure. Ariely admits that when he was hospitalized with severe burns, he may not have been able to handle it if a doctor told him the difficult future he likely faced.¹²⁶ Professional conduct rules make this same point: the risk of harm may justify non-disclosure or at least a delay in disclosure.¹²⁷

Second, caregivers must recognize that patients or clients do not need all information. Undoubtedly, truthful information is necessary for their decision-making.¹²⁸ If professionals provide clients or patients with false or incomplete information, they will not be able to make informed decisions.¹²⁹ So honesty in the area of decision-making is not up for debate.

123. MODEL RULES OF PROF'L CONDUCT R. 1.4, cmt. 7.

124. *Id.*

125. *See id.* (“[A] lawyer might withhold a psychiatric diagnosis of a client when the examining psychiatrist indicates that disclosure would harm the client.”).

126. *See* The Hidden Brain, *supra* note 109 (“And I can tell you that sometimes I think about my experience in the hospital—not just with deception, but with pain and with medications and with placebo and with lack of control and so on—as kind of a magnifying glass on all kinds of things in life, and including in deception. And I—I don’t think I could have taken the physicians telling me exactly—exactly the truth.”).

127. MODEL RULES OF PROF'L CONDUCT R. 1.4, cmt. 7.

128. *See id.* at R. 1.4(a) (requiring lawyer to notify client of any decision when informed consent is required under applicable rules); *see also id.* at R 1.0(e) (defining “informed consent” to require the lawyer to communicate “adequate information and explanation about the material risks of and reasonably available alternatives to the proposed course of conduct”); *id.* at R 1.4(b) (“A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.”); Mark Spiegel, *Lawyering and Client Decisionmaking: Informed Consent and the Legal Profession*, 128 U. PA. L. REV. 41, 44–49 (1979) (describing the history of informed consent in healthcare and concluding “[t]he doctrine of informed consent, then, combines the patient’s right to make a decision with a requirement that the physician provide sufficient information to make the exercise of that right meaningful”).

129. MODEL RULES OF PROF'L CONDUCT R. 1.4, cmt. 5 (“The guiding principle [in explaining a matter to a client] is that the lawyer should fulfill reasonable client expectations for information

In contrast, if the information is provided so that the patient or client knows what they might anticipate in the future,¹³⁰ the professional should proceed with more caution and possibly less brutal honesty. It is unnecessary to speculate about every possible adverse outcome. Doing so can unnecessarily take away a patient or client's hope and optimism and create needless anxiety.¹³¹

Finally, non-disclosure does not have to be forever. A delay in disclosure may be appropriate until there is a better time to share the information.¹³² That may be a time when previous bad news has had a chance to sink in, when the patient or client is less distraught, or when further support is in place.¹³³ Making this judgment call is more difficult than a black and white rule to always disclose everything immediately, but acting in the best interests of the patient or client often requires judgment and not simplicity.

D. *Moving Beyond Bias and Stereotypes and Towards Respect*

Several months after leaving the ICU, I returned to drop off a note for one of my nurses. The country was still in the thick of the pandemic, and I was surprised when I was allowed to walk to the nurse's station in the ICU. I explained to a nurse at the desk that I wanted to drop off a card for a nurse who had cared for me the previous summer. I saw her face light up as it registered that she knew me. She said, "I remember you. You are a lawyer. And your ex-husband was here every day." She then called over some other nurses and reminded them of who I was. They gushed about how well I seemed to be doing and talked about how rough things had been for me when I was in the ICU.

Even though I was on a ventilator during much of the time I was in the ICU, these nurses felt they knew me beyond my illness. I know that they saw a nice looking, neatly dressed Caucasian man in his 40s show up and sit by my bed every day. Word must have spread that he was my ex-husband. They learned I was a lawyer. I suppose someone asked my ex-husband about what I did for a living. Maybe they asked him other questions about me. Even though I could not speak for myself during much of this time, they showed respect for me as a person. I was more than just a non-communicative patient attached to machinery.

consistent with the duty to act in the client's best interests, and the client's overall requirements as to the character of the representation.").

130. See, e.g., Linda F. Smith, *Medical Paradigms for Counseling: Giving Clients Bad News*, 4 CLINICAL L. REV. 391, 417–18 (1998) (providing a framework for delivering bad news to clients).

131. *Id.*

132. MODEL RULES OF PROF'L CONDUCT, R. 1.4, cmt. 7.

133. Smith, *supra* note 130, at 417–18.

I know that some patients may not enjoy the respect I felt. Some patients do not have a family member (or ex-husband) at their bedside to speak on their behalf and humanize them. More troubling, other patients may be the victim of negative assumptions based on the color of their skin or another aspect of their identity learned through a chart or a family member. Those assumptions may result in deficient patient care.

A growing body of medical research recognizes that healthcare provider bias against people of color, women, and other minoritized groups negatively impacts patient care for members of those groups.¹³⁴ Even after controlling for socio-economic factors (which might result in differential care related to insurance coverage), studies reflect that minority populations receive inferior treatment in every field of medicine.¹³⁵ One study has revealed that Black patients receive different cardiac treatment and are more likely to be referred to doctors still in training while non-Black patients in similar circumstances are referred to specialists.¹³⁶ Another study revealed that Black patients with painful long bone fractures were less likely to receive opioids and other analgesics.¹³⁷ Still other research reflects that Black and Hispanic women experience racial discrimination while receiving reproductive services, and that these women and their infants suffer a two to four times greater mortality rate at birth.¹³⁸ A 2018 study found that a

134. INSTITUTE OF MEDICINE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 37, 123 (Brian D. Smedley et al. eds., 2003) [hereinafter INSTITUTE OF MEDICINE]; William J. Hall et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review*, 105 AM. J. PUB. HEALTH 60, 60 (2015) (explaining that attitudes and behaviors of health care providers contribute to disparities in health care access, quality, and outcomes for people of color in the United States).

135. WHITE, *supra* note 1, at 194–95.

136. *Id.* at 211–13.

137. *Id.* at 212–13. Orthopedic Surgeon Augustus White III discusses why the unequal care for African American patients with long bone breaks is so disturbing. *Id.* at 215.

A bone break is about as simple and straightforward as an injury can get. It has no relation to culture or language or unhealthy lifestyle, or whether African Americans might be adverse to some kinds of treatments. It simply must be fixed, and the considerable pain of it has to be addressed. Broken bones and analgesia are an ideal case to test whether the health-care delivery system is functioning in an egalitarian way, as we expect it to. And the health-care delivery system failed that test miserably.

Id.

138. Katy B. Kozhimannil et al., *Racial and Ethnic Diversity in the Nursing Workforce: A Focus on Maternity Care*, 22 POL'Y, POL. & NURSING PRAC. 170, 171–72 (2021).

majority of minority women described their prenatal care as disrespectful and stressful.¹³⁹

In the early 2000s, medical educators felt a sense of urgency in addressing these issues of bias.¹⁴⁰ Two things propelled change in medical education. The first was the 2003 book *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*.¹⁴¹ The book contained numerous studies, including some described in the preceding paragraph, uncovering that minorities receive inferior medical treatment across all areas of practice.¹⁴² The second was medical school accreditation standards, specifically Liaison Committee on Medical Education (LCME) Directives 21 and 22, which required an examination of culture and bias in the provision of medical care.¹⁴³ Today, LCME Standard 7.6 requires medical schools to provide a curriculum that provides opportunities to recognize and address biases in self, others, and the health care delivery process.¹⁴⁴

Medical educators have been innovative in responding to the need to address bias in patient care. For example, Dr. Dan Goodenough developed a course on self-awareness for Harvard medical students based on his study of “how conscious and unconscious attitudes—biases, prejudice, and stereotyping—contribute to treatment errors and health-care disparities.”¹⁴⁵ In another example, Dr. Augustus White III suggested that an internal newsletter (distributed to Harvard medical, dental, and public

139. *Id.* at 172 (citing M.R. McLemore et al., *Health Care Experiences of Pregnant, Birthing and Postnatal Women of Color at Risk for Preterm Birth*, 201 SOC. SCI. & MED., 127–35 (2018), <https://www.sciencedirect.com/science/article/abs/pii/S0277953618300698?via%3Dihub> [<https://perma.cc/2ADL-SS7HJ>]).

140. WHITE, *supra* note 1, at 258 (“With the scope of the racial, ethnic, gender, and other biases and their destructive consequences revealing themselves more or more clearly, I was also feeling a sense of urgency. . . . [T]his was not some kind of diffuse, intractable problem that we could only hope might improve over time. We knew then—in 2001 and 2002—as we still know today, that [patients are receiving unequal treatment based on biases].”).

141. INSTITUTE OF MEDICINE, *supra* note 134. The book was the result of a charge from Congress to the Institute of Medicine to study disparities in healthcare. *Id.* at 3.

142. *Id.* at 5–12 (summarizing evidence of healthcare disparities found).

143. Directive 21 provided that “[f]aculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.” WHITE, *supra* note 1, at 258. Directive 22 stated, “[m]edical students must learn to recognize and appropriately address gender and cultural biases in themselves and others, and in the process of health care delivery.” *Id.*

144. LCME, FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL, STANDARDS FOR ACCREDITATION OF MEDICAL EDUCATION PROGRAMS LEADING TO THE MD DEGREE 10 (2020), <https://lcme.org/publications/> [<https://perma.cc/RT8G-SYQE>].

145. WHITE, *supra* note 1, at 205.

health students) start publishing anonymous reports of incidents involving prejudice, along with commentary—usually by a faculty member—addressing the prejudice and its impact on care.¹⁴⁶ Medical researchers point to evidence that mindfulness training could help reduce the impact of implicit bias on patient care.¹⁴⁷

Unquestionably, attorney–client interactions—just like any human interactions—can be negatively impacted by explicit and implicit bias. Nonetheless, most legal scholarship does not focus on bias in the attorney–client relationship.¹⁴⁸ Instead, legal scholarship primarily focuses on bias against clients by participants in the legal system (such as by judges, juries, opposing attorneys)¹⁴⁹ and bias within the legal profession.¹⁵⁰ The

146. *Id.* at 207–08. For example, an incident report involving jokes among residents about gay and obese patients was shared, along with a response from a psychology professor explaining why such conduct is especially troubling in future physicians. *Id.* at 208.

147. Diana J. Burgess et al., *Mindfulness Practice: A Promising Approach to Reducing the Effects of Clinician Implicit Bias on Patients*, 100 PATIENT EDUC. & COUNSELING 372, 372–73 (2017) (explaining evidence suggesting that mindfulness training reduces the likelihood that implicit biases will be activated, increases awareness of and ability to control responses to activated biases, increases self-compassion and compassion toward patients, and reduces internal sources of cognitive load that lead to activation of bias).

148. One important exception is in the area of criminal defense lawyers; the impact of their implicit bias on clients has been examined in legal scholarship. *See generally* Walter I. Goncalves, Jr., *Narrative, Culture, and Individuation: A Criminal Defense Lawyer's Race-Conscious Approach to Reduce Implicit Bias for Latinxs*, 18 SEATTLE J. SOC. JUST. 333, 334 (2020) (noting “[t]hese systemic racial inequities coexist with and are heightened by the behavior of defense attorneys, prosecutors, judges, jurors, and probation and pre-trial service officers through implicit racial bias and racial stereotyping”); L. Song Richardson & Phillip Atiba Goff, *Implicit Racial Bias in Public Defender Triage*, 122 YALE L. J. 2626, 2626 (2013); Jonathan A. Rapping, *Implicitly Unjust: How Defenders Can Affect Systemic Racist Assumptions*, 16 N.Y.U. J. LEGIS. & PUB. POL’Y 999, 999 (2013).

149. *See* Irene Oritseyinmi Joe, *Regulating Implicit Bias in the Federal Criminal Process*, 108 CAL. L. REV. 965, 965–66 (2020) (discussing the role the Federal Judiciary’s bias may play in the criminal process); Melissa L. Breger, *Making the Invisible Visible: Exploring Implicit Bias, Judicial Diversity, and the Bench Trial*, 53 U. RICH. L. REV. 1039, 1039 (2019); Mikah K. Thompson, *Bias on Trial: Toward an Open Discussion of Racial Stereotypes in the Courtroom*, 2018 MICH. ST. L. REV. 1243, 1244 (2018); L. Song Richardson, *Systemic Triage: Implicit Racial Bias in the Criminal Courtroom*, 126 YALE L. J. 862, 864 (2017); Mark W. Bennett, *Implicit Racial Bias in Sentencing*, 126 YALE L. J. F. 391, 394 (2017); Justin D. Levinson et al., *Judging Implicit Bias: A National Empirical Study of Judicial Stereotypes*, 69 FLA. L. REV. 63, 63 (2017); Jerry Kang et al., *Implicit Bias in the Courtroom*, 59 UCLA L. REV. 1124, 1124 (2012); Fatma E. Marouf, *Implicit Bias and Immigration Courts*, 45 NEW ENG. L. REV. 417, 417 (2011); Jeffrey Rachlinski et al., *Does Unconscious Racial Bias Affect Trial Judges?*, 84 NOTRE DAME L. REV. 1195, 1196–97 (2009).

150. *See* Michele Benedetto Neitz, *Pulling Back the Curtain: Implicit Bias in the Law School Dean Search Process*, 49 SETON HALL L. REV. 629, 631 (2019) (discussing how bias can impact even legal education); Justin D. Levinson & Danielle Young, *Implicit Gender Bias in the Legal Profession: An Empirical Study*, 18 DUKE J. GENDER L. & POL’Y 1, 4 (2010) (considering “implicit bias based theories of gender inequality in the legal profession and detail[ing] [an] empirical study”); Anne D. Gordon, *Better than Our*

American Bar Association provides numerous resources to lawyers concerning implicit bias, but the focus there is the criminal justice system¹⁵¹ and law firms and other legal employers,¹⁵² and not implicit bias in the attorney–client relationship.

In 2021, the American Bar Association proposed a change to law school accreditation standards that would require law schools to provide training in bias, cross-cultural competency, and racism.¹⁵³ This change will require law schools to address a critical need—helping students see the negative impact bias can have on their ability to represent clients. According to Andrea Curcio’s research, there is a need. She reports that law students believe that their legal training makes them “less susceptible than others . . . to having, or acting upon, stereotypes or biases.”¹⁵⁴

Hand-in-hand with learning about implicit biases and stereotypes, professional students should be taught the importance of respecting their clients and patients.¹⁵⁵ Respect can be a powerful antidote to bias. It can flow from seeing the client as an individual with specific needs rather than as a stereotype associated with race, gender, or some other identity.¹⁵⁶

Biases: Using Psychological Research to Inform Our Approach to Inclusive, Effective Feedback, 27 CLINICAL L. REV. 195, 197 (2021) (“Clinicians are uniquely situated to be able to create either a supportive or hostile environment in our classrooms, given our intensive personal interactions with our students.”).

151. *Implicit Bias Videos and Toolkit*, AM. BAR ASS’N, <https://www.americanbar.org/groups/diversity/resources/implicit-bias/> [<https://perma.cc/6DUV-DESA>] (providing video and toolkit materials for judges, prosecutors, and public defenders); *Fighting Implicit Bias*, AM. BAR ASS’N, https://www.americanbar.org/groups/judicial/committees/fighting_implicit_bias/ [<https://perma.cc/G8BK-DVL3>]; see also *Implicit Bias Initiative*, AM. BAR ASS’N, <https://www.americanbar.org/groups/litigation/initiatives/task-force-implicit-bias/> [<https://perma.cc/J877-ZRMC>] (providing a general overview of implicit bias).

152. *Bias Interrupters Project—You Can’t Change What You Can’t See: Interrupting Racial and Gender Bias in the Legal Profession*, AM. BAR ASS’N, https://www.americanbar.org/groups/diversity/women/initiatives_awards/bias-interrupters/ [<https://perma.cc/BD6V-SSVS>].

153. Memorandum from Scott Bales, ABA Council Chair, & William Adams, ABA Managing Dir. Accreditation & Legal Educ., to Interested Persons & Entities, ABA (May 25, 2021) [hereinafter ABA Memorandum] (regarding ABA Standards—Matter for Notice and Comment—Standards 205, 206, 303, 507, and 508).

154. Andrea A. Curcio, *Addressing Barriers to Cultural Sensibility Learning: Lessons from Social Cognition Theory*, 15 NEV. L.J. 537, 540 (2015) (footnote omitted).

155. See, e.g., Skär & Söderberg, *supra* note 29, at 227 (describing “not being met with respect, not being understood and not being welcomed to the healthcare setting” as a patient complaint about interactions with healthcare providers).

156. WHITE, *supra* note 1, at 268 (explaining that individuation—focusing on the patient as an individual rather than categorizing the patient—is an important tool for overcoming bias); Aastha Madaan, *Cultural Competency and the Practice of Law in the 21st Century*, AM. BAR ASS’N: PROB. & PROP.

It can also result from the professional appreciating and internalizing the fact that the client (or patient)—and not the lawyer (or doctor)—is in charge.¹⁵⁷ Teaching lawyers to be respectful of clients has been an important aspect of client-centered lawyering and relational lawyering.¹⁵⁸

E. *Taking Confidentiality Seriously*

When I asked a nurse if there were any COVID-19 patients on my floor, she refused to tell me, citing patient confidentiality. When another nurse took a snapshot of an ugly wound on my wrist (caused by a strong drug in an IV line), I joked, “You must have the least popular Instagram account ever.” She responded with a very serious explanation of how all patient wound photos are private and protected by HIPAA. In another instance, a physical therapist realized that her sister was my former student. When I later asked if she had shared something we discussed with her sister—something I had wanted her to share—she told me she had not because she did not want to reveal my identity as a patient. As I practiced using my walker in the hallways of the hospital, I passed multiple bulletin board reminders of confidentiality obligations under HIPAA.

Through all of these interactions and more, I knew that my personal medical information would not be revealed to anyone. That information ran the gamut from the small things—vital signs, for example—to the big things, like my medical diagnoses and prognosis. It included embarrassing things (that I refuse to list even now) and seemingly innocuous things, like identifying me by name as a patient. It is critical to note that even the disclosures of seemingly innocuous information—like a patient’s name—may be anything but harmless. For a host of reasons, my siblings decided not to share my condition with my mother. If my identity had not been safely guarded by all of my caregivers, that might have compromised a decision that was important to my family.

Protecting the confidentiality of medical information is understood to be essential for patient care.¹⁵⁹ In 1996, “[t]he Health Insurance Portability

MAG., Mar. 1, 2017, at 2–3 (explaining the need for lawyers to appreciate client individuality and focus on client needs).

157. For example, the lawyer for Luzerne County, Pennsylvania showed a lack of respect for his client—who acts through a council—when the lawyer not only failed to consult the council about an important decision in the case but also defended the lack of consultation by telling reporters, “[i]t was a decision by me, the owner of the firm that was assigned with the task of winning the lawsuit and defending Luzerne County.” Paula Schaefer, *Who Gets to Decide—Attorney or Client?*, 49 *DICTIONARY* 13, 13 (2021). Unsurprisingly, this lack of respect for and deference to the client resulted in anger, hurt feelings, and the end of the county’s relationship with the lawyer and his firm. *Id.*

158. See *supra* notes 16–20 and accompanying text (outlining the history and practices of client-centered lawyering and relational lawyering).

159. See Jessica De Bord et al., *Confidentiality*, UW MED. DEP’T BIOETHICS & HUMANS., <https://depts.washington.edu/bhdept/ethics-medicine/bioethics-topics/detail/58> [https://perma.

and Accountability Act [] (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information.”¹⁶⁰ To do this, HHS published the Privacy Rule, which established national standards for the protection of certain health information, and the Security Rule, which “establish[ed] a national set of security standards for protecting certain health information [being] held or transferred in [an] electronic form.”¹⁶¹ The Privacy Rule and the Security Rule apply to “health plans, health care clearinghouses, and to any health care provider who transmits health information in electronic form in connection with transactions for which the Secretary of HHS has adopted standards under HIPAA (the ‘covered entities’).”¹⁶²

HIPAA violations by health care professionals can result in civil and criminal penalties.¹⁶³ A civil penalty can range from \$100 to \$50,000 depending on the type of violation.¹⁶⁴ There are annual maximums for these penalties, and can go as high as \$1.5 million for willful neglect without correction.¹⁶⁵ Criminal penalties can range in price from \$50,000 to \$250,000 depending on the severity of the violation.¹⁶⁶ Criminal penalties can include prison time that could range from up to one to ten years.¹⁶⁷

cc/G3PZ-5JHW] (“Creating a trusting environment by respecting patient privacy encourages the patient to seek care and to be as honest as possible during the course of a health care visit. . . . It may also increase the patient’s willingness to seek care.”); *Patient Confidentiality in Healthcare*, MARYVILLE UNIV., <https://online.maryville.edu/blog/patient-confidentiality/> [<https://perma.cc/9ENL-2SCS>] (“Patients are more likely to disclose health information if they trust their healthcare practitioners. Trust-based physician-patient relationships can lead to better interactions and higher-quality health visits. Healthcare professionals who take their privacy obligations seriously, and who take the time to clearly explain confidentiality rules, are more likely to have patients who report their symptoms honestly.”).

160. *Summary of the HIPAA Security Rule*, HHS, <https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html> [<https://perma.cc/WR8U-RU38>].

161. *Id.*

162. *Summary of the HIPAA Privacy Rule*, HHS, <https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf> [<https://perma.cc/6A45-GKNA>].

163. *HIPAA Violations & Enforcement*, AM. MED. ASS’N, <https://www.ama-assn.org/practice-management/hipaa/hipaa-violations-enforcement> [<https://perma.cc/3PBE-B6MP>].

164. *Id.*

165. *Id.*

166. *Id.* The levels of severity are knowingly disclosing information, committing offenses under false pretenses, or committing offenses with the intent to sell, transfer, or use health information for commercial advantage, personal gain, or malicious harm. *Id.*

167. *Id.*

HIPAA requires periodic trainings, and although “periodic” is not defined, most organizations train all employees annually.¹⁶⁸ Training is mandatory for anyone who encounters protected health information (PHI).¹⁶⁹ There is no specified length of time for a HIPAA training, but the trainings usually include an overview of HIPAA, why it’s important, how to safeguard PHI, preventing HIPAA violations, consequences of HIPAA violations, updates to HIPAA, etc.¹⁷⁰ Health care providers are “required to post their entire notice” on HIPAA in a “clear and prominent location” at their facility.¹⁷¹

Similarly, lawyers have a legal obligation to protect confidential client information. As a fiduciary, a lawyer must protect client confidences.¹⁷² And like other attorney fiduciary duties, the lawyer’s duty of confidentiality is embodied in attorney professional conduct rules.¹⁷³ Model Rule 1.6(a) provides that absent client permission¹⁷⁴ or a listed an exception,¹⁷⁵ a lawyer “shall not reveal information relating to the representation of the client.”¹⁷⁶ The obligation of confidentiality is broader than the attorney–client privilege, which only protects information shared between attorney and client, in confidence, for the purpose of giving or receiving legal advice.¹⁷⁷ Accordingly, although such information is not *privileged*, the duty

168. 7 *Common Questions Regarding OSHA and HIPAA Training Requirements for Dental and Medical Offices*, MEDSAFE (Dec. 16, 2015), <https://www.medsafe.com/blog/compliance-topics/7-common-questions-regarding-osha-and-hipaa-training-requirements-for-dental-and-medical-offices> [https://perma.cc/JS64-TT6E].

169. *Id.* Those that encounter PHI include “doctors, dentists, nurses, receptionists, and part-time employees/interns.” *Id.*

170. *HIPAA Training Requirements*, HIPAA J., <https://www.hipajournal.com/hipaa-training-requirements/> [https://perma.cc/6KPN-3VNE].

171. *FAQ*, HHS (Dec. 20, 2002), <https://www.hhs.gov/hipaa/for-professionals/faq/341/are-health-care-providers-required-to-post-their-entire-notice-at-their-facility/index.html> [https://perma.cc/3BU5-5D5R].

172. RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 16(3), 49 (AM. L. INST. 2000).

173. Paula Schaefer, *A Primer on Professionalism for Doctrinal Professors*, 81 TENN. L. REV. 277, 288 (2014).

174. MODEL RULES OF PROF'L CONDUCT R. 1.6(a) (AM. BAR ASS'N 2021).

175. *Id.* at R. 1.6(b).

176. *Id.* at R. 1.6(a).

177. *See id.* at R. 1.6 cmt. 20 (“The duty of confidentiality continues after the client-lawyer relationship has terminated.”).

of confidentiality prevents lawyers from revealing information related to the client's representation even if it is information that has been revealed in a courtroom or court filing, information obtained from someone other than the client, or client information learned when a third party was present.¹⁷⁸

Law students and lawyers are taught about the duty of confidentiality. Every accredited U.S. law school teaches attorney professional responsibility, which includes discussion of the duty of confidentiality.¹⁷⁹ Forty-six states have a professional responsibility continuing legal education (CLE) requirement, which encompasses discussion of ethical duties such as the duty of confidentiality.¹⁸⁰

Despite this, anyone who has practiced law knows that lawyers do not take the obligation of confidentiality very seriously.¹⁸¹ Lawyers frequently tell war stories about their clients' matters, typically being careful not to disclose privileged information, but still disclosing confidential information.¹⁸² They regularly tell their spouses, romantic partners, friends, and families about their cases and other client matters.¹⁸³ They talk about confidential information in public places, within earshot of others who do

178. MODEL RULES OF PROF'L CONDUCT R. 1.6 cmt. 3.

179. AM. BAR ASS'N, ABA STANDARDS AND RULES OF PROCEDURE FOR APPROVAL OF LAW SCHOOLS 2020–2021, Standard 303(a)(1) (2020) (providing that schools must require students to satisfactorily complete a professional responsibility course of at least two credits in the curriculum), https://www.americanbar.org/content/dam/aba/administrative/legal_education_and_admissions_to_the_bar/standards/2020-2021/2020-21-aba-standards-and-rules-chapter3.pdf [<https://perma.cc/2V5V-UTHS>].

180. *Minimum CLE Hours by State*, LORMAN, <https://www.lorman.com/Minimum-CLE-Hours-by-State> [<https://perma.cc/XAQ8-Z25L>].

181. See generally David F. Chavkin, *Why Doesn't Anyone Care about Confidentiality? (And, What Message Does That Send to New Lawyers?)*, 25 GEO. J. LEGAL ETHICS 239, 241 (2012) (discussing settings in which lawyers regularly violate the duty of confidentiality); Paula Schaefer, *Why Don't My Students Believe Me When I Tell Them About an Attorney's Confidentiality Obligation?*, 44 DICTA 21 (Nov. 2017).

182. Roy D. Simon Jr., NY Rules of Prof. Conduct § 1.6:48, (Dec. 2021) (explaining that “lawyers talk all the time about matters they are handling,” and while lawyers “usually” shield client identity, lawyers take a risk of breaching fiduciary duty and violating Rule 1.6 each time they discuss client matters).

183. Chavkin, *supra* note 181, at 241 (discussing how lawyers violate confidentiality as a social device, such as to answer the question “[h]ow was your day, dear?”). Oddly, comments to the conflict of interest professional conduct rule assume that such inter-family disclosure of confidential information takes place. See MODEL RULES OF PROF'L CONDUCT R. 1.7 cmt. 11 (explaining that when lawyers on opposing sides of a matter are related “there may be a significant risk that client confidences will be revealed”).

not have a right to know.¹⁸⁴ Some even write books in which they disclose confidential client information.¹⁸⁵

There are numerous examples of how these disclosures harm clients and result in adverse consequences for lawyers. In a high profile case, J.K. Rowling's solicitor told a friend (who told a reporter, who wrote a story) that Rowling was secretly writing books under the pen name Robert Galbraith.¹⁸⁶ In less widely publicized cases, lawyers have harmed their clients and faced discipline for revealing confidential information in response to negative online reviews,¹⁸⁷ in blog posts,¹⁸⁸ and in conversations with others.¹⁸⁹ In one case, an attorney was disciplined for threatening her own client that she would reveal confidential information to authorities if the client did not pay past-due legal fees.¹⁹⁰

184. Kenneth P. Vogel, *Isn't That the Trump Lawyer? A Reporter's Accidental Scoop*, N.Y. TIMES (Sept. 19, 2017), <https://www.nytimes.com/2017/09/19/us/politics/isnt-that-the-trump-lawyer-a-reporters-accidental-scoop.html> [<https://perma.cc/A6HM-N4L3>] (overhearing and reporting on a discussion between two lawyers, Ty Cobb and John Dowd, about the Russia investigation).

185. See, e.g., MICHAEL COHEN, *DISLOYAL: A MEMOIR: THE TRUE STORY OF THE FORMER PERSONAL ATTORNEY TO PRESIDENT DONALD J. TRUMP* (Skyhorse 2020) (detailing Michael Cohen's perspective of representing former President Donald J. Trump). The broad definition of confidentiality encompasses information (privileged or not) related to the representation of a client, absent the client's consent to disclosure. The consequences for such a breach could be an ethics complaint for breach of Rule 1.6 and a suit for breach of the fiduciary duty of loyalty.

186. Daisy Wyatt, *How JK Rowling was revealed as the true author behind the Robert Galbraith novels*, THE INDEPENDENT (Oct. 16, 2015), <https://www.independent.co.uk/arts-entertainment/books/features/how-jk-rowling-was-revealed-as-the-true-author-behind-the-robert-galbraith-novels-a6696576.html> [<https://perma.cc/2H58-6C9V>] (quoting Rowling as saying she had been "yearning to go back to the beginning of a writing career in this new genre, to work without hype or expectation and to receive totally unvarnished feedback"). The law firm paid an undisclosed amount to settle the matter and the attorney faced professional discipline.

187. See *In re* Conduct of Conry, 491 P.3d 42, 45 (Or. 2021) (en banc) (reprimanding an attorney publicly for disclosing confidential client information in response to negative online review); *People v. Isaac*, 470 P.3d 837, 838 (Colo. O.P.D.J. 2016) (suspending an attorney for six months for posting confidential information in response to two negative client reviews); *In re* Skinner, 758 S.E.2d 788 (Ga. 2014) (reprimanding an attorney for revealing confidential information in response to negative reviews posted online by the client).

188. *In re* Disciplinary Proceedings Against Peshek, 798 N.W.2d 879, 880 (Wis. 2011) (imposing identical, reciprocal 60-day suspension against an attorney—licensed in Wisconsin and Illinois—who disclosed client confidences in blog posts).

189. *In re* Anonymous, 932 N.E.2d 671, 672–73 (Ind. 2010) (reprimanding an attorney for revealing to a friend that client had filed for divorce); *Elkind v. Bennett*, 958 So. 2d 1088, 1090 (Fla. Dist. Ct. App. 2007) (describing how a client sued lawyer for malpractice when the client was fired after lawyer's disclosure of confidential information in a letter to client's employer).

190. *In re* a Member of the State Bar of Arizona, Rachel L. Yosha, Bar No. 011780, Respondent, 2017 WL 9480270, at *2 (Ariz. Disp. Com. Oct. 23, 2017).

To summarize, both the legal and medical professions benefit from simple confidentiality rules: disclosures that fall outside of treatment/representation or some narrow exceptions are prohibited. Such broad rules are necessary to build trust and should be easy to implement. And yet lawyers have a much more lackadaisical approach to confidentiality than healthcare providers.¹⁹¹

Some differences between the professions may account for the different approaches and understanding these differences may help lawyers change. On the lawyer side, there is a public aspect to information that is subject to a duty of confidentiality. The lawyer's confidentiality obligation includes client information in publicly filed documents, revealed in open court, or discussed in interactions with opposing counsel.¹⁹² Although there is good reason for the lawyer's duty of confidentiality to encompass this information,¹⁹³ it is understandable that many lawyers do not think it deserves the same level of confidentiality as privileged information. As a result, there is a culture among lawyers of disclosing confidential client information.¹⁹⁴

191. That is not to say that medical providers never disclose confidential information in violation of HIPAA. See Charles Ornstein, *Doctors fire back at bad Yelp reviews—and reveal patients' information online*, WASH. POST (May 27, 2016), <https://www.washingtonpost.com/news/to-your-health/wp/2016/05/27/docs-fire-back-at-bad-yelp-reviews-and-reveal-patients-information-online/> [<https://perma.cc/EB29-3HCB>] (explaining after being burned by negative reviews, “doctors, dentists, chiropractors and massage therapists, among others, have divulged details of patients’ diagnosis, treatments and idiosyncrasies”); Alisa Chestler & Alexandria Murphy, *INSIGHT: Health Care Providers, Think Before You Yelp . . . and Other HIPAA Concerns*, BL (Jan. 3, 2020), <https://news.bloomberglaw.com/health-law-and-business/insight-health-care-providers-think-before-you-yelp-and-other-hipaa-concerns> [<https://perma.cc/27YQ-46YV>] (describing when a dental practice’s response to a Yelp review disclosed confidential patient information).

192. All the categories of information described here fall within the duty of confidentiality. See MODEL RULES OF PROF'L CONDUCT R. 1.6(a) (discussing a lawyer's broad duty to “not reveal information relating to the representation”); see also Iowa Sup. Ct. Att’y Disciplinary Bd. v. Marzen, 779 N.W.3d 757, 766 (Iowa 2010) (holding an attorney can violate the confidentiality obligation even if the information revealed is also available from public sources).

193. See, e.g., MODEL RULES OF PROF'L CONDUCT R. 1.6 cmt. 2 (explaining how the duty of confidentiality contributes to the development of trust). As the duty is defined, a client can expect that her attorney will not reveal the details of her divorce, DUI, or employment dispute even if the information was disclosed to carry out the litigation. After all, even if opposing counsel or a court reporter learned the information, this does not mean the whole world knows it or is entitled to hear it from the client's lawyer. See, e.g., *In re Anonymous*, 932 N.E.2d 671, 674 (Ind. 2010) (explaining there is “no exception allowing revelation of information relating to representation even if a diligent researcher could unearth it through public sources”).

194. As David Chavkin eloquently explains, it is not impractical for lawyers to abide by the duty of confidentiality, but they simply do not do so because of the “human tendency to gossip.” He asks,

On the medical provider side, reminders of the duty of confidentiality are pervasive and impossible to ignore. Medical offices post signs,¹⁹⁵ trainings are frequent,¹⁹⁶ and there are serious penalties for violating HIPAA laws.¹⁹⁷ Consequently, healthcare providers talk about the duty conversationally, seemingly as effortlessly as breathing.¹⁹⁸ In short, HIPAA has made the confidentiality obligation salient for healthcare providers in a way that it is not for the legal profession.

Lawyers could address their confidentiality problem by borrowing from healthcare providers to make the issue of confidentiality central to the

“Why couldn’t a lawyer answer the question ‘How was your day, honey?’ while respecting all information relating to the representation of a client?” Chavkin, *supra* note 181, at 263.

195. FAQ, *supra* note 171 (“Covered health care providers that maintain an office or other physical site where they provide health care directly to individuals are required to post their entire notice at the facility in a clear and prominent location.”); *Five Steps to HIPAA Compliance for a Doctor’s Office*, 24BY7SECURITY (Sept. 25, 2018), <https://blog.24by7security.com/five-steps-to-hipaa-compliance-for-a-doctors-office> [<https://perma.cc/263V-4MVM>] (stating providers must “[p]rint notice of privacy practices and place it in a common and clearly visible area in [the] office, so that patients are openly provided with the privacy laws and information that strives to keep their care confidential”).

196. *HIPAA Training Requirements*, HIPAA J., <https://www.hipaajournal.com/hipaa-training-requirements> [<https://perma.cc/8FFX-U8ZL>] (“HIPAA training is required ‘periodically[.]’ Most health care providers interpret ‘periodically’ as annually [It] should also be provided whenever there is a change in working practices or technology HIPAA training is [also] required for ‘each new member of the workforce within a reasonable period of time after the person joins the Covered Entity’s workforce’”); *Is HIPAA Training Required Annually?*, COMPLIANCE JUNCTION (Dec. 28, 2021), <https://www.compliancejunction.com/is-hipaa-training-required-annually> [<https://perma.cc/RWT3-MB6K>] (contending industry experts believe it is a best practice to provide refresher HIPAA training courses annually).

197. Four potential outcomes exist for HIPAA violations: (1) employer punishment; (2) termination of employment; (3) professional sanctions; or (4) criminal charges. Civil penalties are applicable when the individual knew or should have known that HIPAA rules were violated. Penalties begin at \$100 per violation but may rise to \$25,000 if there are multiple infractions of the same type. Criminal violations have a minimum fine of \$50,000 but may rise to \$250,000. Further, the individual may be required to pay restitution and may be sentenced to a term in jail. *What Happens if You Break HIPAA Rules?*, HIPAA J. (Nov. 3, 2021), <https://www.hipaajournal.com/what-happens-if-you-break-hipaa-rules> [<https://perma.cc/54PJ-TKLS>]; *HIPAA Violations & Enforcement*, AMA, <https://www.ama-assn.org/practice-management/hipaa/hipaa-violations-enforcement> [<https://perma.cc/DYN9-PR3P>].

198. Discussion of medical confidentiality and HIPAA is so pervasive that people tend to think the duty is more expansive than it actually is. See, e.g., Allyson Chiu, *Explaining HIPAA: No, it Doesn’t Ban Questions About Your Vaccination Status*, WASH. POST (May 22, 2021), https://www.washingtonpost.com/lifestyle/wellness/hipaa-vaccine-covid-privacy-violation/2021/05/22/f5f145ec-b9ad-11eb-a6b1-81296da0339b_story.html [<https://perma.cc/C9CY-UXHN>] (explaining HIPAA is commonly believed to broadly protect medical privacy when it actually only applies to covered providers and prevents their improper disclosure of medical information).

practice of law.¹⁹⁹ Law office leaders should model broad protection for client confidences by not talking about their cases with people (or within earshot of people) outside the firm.²⁰⁰ Lawyers should host in-house CLE and staff training on confidentiality so everyone in the office is on the same page about the breadth of the obligation. Although no regulation requires it, law offices could post signs in common areas, like break rooms, reminding everyone about the duty of confidentiality.²⁰¹ Lawyers could also make themselves more accountable to clients by giving notice of their confidentiality obligation, much like HIPAA notices provided to patients.

IV. TEACHING CAREGIVING IN LAW SCHOOL

*In The Doctor, Jack McKee is a skilled surgeon with a lousy bedside manner. It is only when McKee is diagnosed with throat cancer that he discovers how it feels to be a vulnerable, scared, and sometimes angry patient. McKee's experience as a patient changes him as a doctor and teacher. He assigns each of his surgical residents a hypothetical disease, a bed and backless gown, and a battery of tests. The unstated goal is that the residents' experience of being a patient will impact them the way it moved McKee: it will make them more caring doctors.*²⁰²

This Part discusses integrating caregiving into the law school curriculum. First, I provide some guidance for navigating the politics of a curriculum change. Second, I address how to accomplish it, arguing it is crucial to make caregiving topics personal for students. Finally, I address integration into the current law school curriculum.

A. Navigating the Politics

When Harvard School of Medicine recognized the need to address bias in the school's curriculum, it hired clinical psychologist Roxana Llerena-Quinn to work with faculty members on a solution.²⁰³ The school held

199. Lawyers, indeed, all people, often lose sight of the ethical dimension of an issue. See Ann E. Tenbrunsel & David M. Messick, *Ethical Fading: The Role of Self-Deception in Unethical Behavior*, 17 SOC. JUST. RSCH. 223, 224 (2004) (explaining ethical fading occurs when a person stops thinking of a decision as one that implicates ethical consequences).

200. Lawyers within a firm can discuss confidential information about firm clients without violating the duty of confidentiality. MODEL RULES OF PROF'L CONDUCT R. 1.6 cmt. 5.

201. Cf. Tigran Eldred, *Insights from Psychology: Teaching Behavioral Legal Ethics as a Core Element of Professional Responsibility*, 2016 MICH. ST. L. REV. 757, 799–800 (2016) (explaining lawyers can make ethics issues salient by keeping a framed quote about the importance of acting ethically at their desk).

202. THE DOCTOR (Touchstone Pictures 1991).

203. WHITE, *supra* note 1, at 265.

focus groups with students and faculty.²⁰⁴ The result was general agreement that multi-culturalism should be incorporated into the curriculum.²⁰⁵ Llerena-Quinn described the faculty reaction as composed of consensus, resistance, and avoidance, as in “This is wonderful, . . . but there’s no time in my course. Besides, a broken bone is a broken bone.”²⁰⁶

The suggestion that law schools should address caregiving topics may face similar resistance. Even if faculty members could be convinced that these topics should be taught, many will not view caregiving as important as the legal doctrine they are teaching. Another area of resistance—by law students and law professors—may be against the suggestion that lawyers need training to identify and combat bias.²⁰⁷ In a time when teaching critical race theory has been politicized,²⁰⁸ some are likely to express skepticism (or worse) about addressing bias in the law school classroom.

Legal educators who favor addressing issues of bias and other lawyer caregiving topics should be thoughtful about how they frame the issue. For starters, the word “caregiving” may be problematic. I use the word caregiving in this Article to draw a parallel with medical care, but using the word in the law school classroom or with colleagues may result in resistance. The concepts discussed here could be described as lawyering skills or aspects of the attorney–client relationship that result in client satisfaction and fewer complaints. That may not roll off the tongue, but it may be easier to gain buy-in with some students and faculty members.

In response to concerns that these topics are not as important as legal doctrine or are politically fraught, advocates should point to the research. If lawyers have the same results as medical providers, delivering the caregiving described in this Article will result in greater client satisfaction and trust, less client fear and anxiety, and fewer adverse outcomes for lawyers—like ethics complaints and lawsuits. Lawyers who can deliver in these areas are in demand by employers and clients alike.²⁰⁹ In short, helping students

204. *Id.*

205. *Id.*

206. *Id.*

207. *See infra* Part IV.B (arguing law students and professors may be reticent to accept training or responsibility for their own biases).

208. *See, e.g.*, Barbara Sprunt, *The Brewing Political Battle Over Critical Race Theory*, NPR (June 29, 2021), <https://www.npr.org/2021/06/02/1001055828/the-brewing-political-battle-over-critical-race-theory> [<https://perma.cc/3E8Y-XQGN>] (describing recent political attacks on critical race theory).

209. *See, e.g.*, Neil Hamilton, *The Gap Between the Foundational Competencies Clients and Legal Employers Need and the Learning Outcomes Law Schools Are Adopting*, 89 UMKC L. REV. 559, 564–66, 572

develop these skills prepares them to provide competent representation to their clients.

Beyond that, law school accreditation standards may soon provide another reason for teaching these topics. As noted earlier, the ABA is currently considering a proposal that would require law schools to teach students about “bias, cross-cultural competency, and racism.”²¹⁰ The ABA is also considering a standard that would require education in “[t]he development of professional identity.”²¹¹ The proposed standard explains it encompasses teaching students about “the special obligations lawyers have to their clients and society” and that “development of professional identity should involve an intentional exploration of . . . the values . . . [and] principles . . . foundational to successful legal practice.”²¹² The qualities of a caregiver fall within this explanation of professional identity formation. If these accreditation standards are adopted, it will provide another reason for addressing these topics.

B. *Making It Personal*

Two threads run throughout the caregiving discussion in Part III. The first is the patient/client experience of being vulnerable and dependent on the professional. The second is the doctor/lawyer’s need to be empathetic to fully meet patient/client needs. Without empathy, many future lawyers will fail to satisfy caregiving needs, including communicating, connecting with clients, showing respect, navigating hard topics, and maintaining clients’ confidences. If they do not understand why these things matter to clients, they will be less likely to fulfill these needs.

For some students, it may be enough to make these points through lectures and class discussions. But for students who have never been in a position of vulnerability (as a client or patient) and never had occasion to feel for a person in that position, it would be helpful to give them a taste of that experience. This is what the attending physician attempted while training residents in *The Doctor*,²¹³ described above. As a patient, he learned

(2021) (emphasizing “client service orientation”—which includes communication, relationship management, and emotional intelligence—as being very important for today’s clients and firms but not adequately addressed in law schools); *see also* Madaan, *supra* note 156, at 2–3 (explaining the need for cultural competency in the practice of law).

210. ABA Memorandum, *supra* note 153, at 6.

211. *Id.* at 7.

212. *Id.*

213. *THE DOCTOR* (Touchstone Pictures 1991).

what it meant to be vulnerable, and it made him a more caring doctor.²¹⁴ He could not give his residents that first-hand experience, so he simulated it by making them vulnerable.²¹⁵ In the real world, medical schools are putting students in the role of patients to help improve their empathy.²¹⁶

In law school, we have the opportunity to give students first-hand experiences developing empathy in simulation-based classes and classes that include role-play exercises.²¹⁷ Whether law students are the clients or actors are playing the clients, the experience will help them develop their caregiving skills (as lawyers) or feel what it is like to be on the receiving end of those skills (as clients).²¹⁸ Part of the evaluation of the exercise should consider how the lawyer met the client's needs (according to the client) in terms of communication, connection, and respect.

Bias is another area of law school training that needs to be personal and focused on the student. While the proposed law school accreditation standards suggest the *justice system* may be biased against clients,²¹⁹ law schools should endeavor to help students see their own capacity for harming clients with their biases.

Students—like all humans—doubt they have biases—explicit or implicit—or that they are influenced by them.²²⁰ Thus, anti-bias training is not particularly helpful unless students have the tools to understand themselves. A helpful place to begin is literature on the bias blind spot, which explains why we see biases in others but not ourselves.²²¹ With that

214. *Id.*

215. *Id.*

216. *E.g.*, Michael Wilkes et al., *Towards More Empathic Medical Students: A Medical Student Hospitalization Experience*, 36 MED. EDUC. 528, 529 (2002) (using simulations that put medical students in the role of patients to, among other goals, measure its effect on empathy).

217. *See, e.g.*, Snyder, *supra* note 28, at 520 (explaining a simulation used to teach pretrial practice).

218. *E.g.*, GANTT & MADISON, *supra* note 20, at 264–65 (explaining how practicing the skill of empathy, such as through role play, increases law students' capacity for empathetic reaction).

219. ABA Memorandum, *supra* note 153, at 7.

220. As noted earlier, surveyed law students report that they are not susceptible to the influence of bias. *See* Curcio, *supra* note 154, at 540 (“[L]aw students may believe that legal ‘objectivity’ and legal training in rational and analytical thinking makes lawyers less susceptible than others, and especially less susceptible than clients, to having, or acting upon, stereotypes or biases.”). This makes them no different from doctors and judges who believe the same thing. WHITE, *supra* note 1, at 269 (explaining when doctors are told about healthcare disparities based on bias, they report, “Not me”); Rachlinski et al., *supra* note 149, at 1225 (describing a study in which 97% of surveyed judges rated their ability to avoid prejudice in sentencing in the top half of judges).

221. Emily Pronin & Matthew B. Kugler, *Valuing Thoughts, Ignoring Behavior: The Introspection Illusion as a Source of the Bias Blind Spot*, 43 J. EXPERIMENTAL SOC. PSYCH. 1, 3 (2006); Emily Pronin et

background, students could be offered the opportunity to take an implicit association test (IAT)²²² on subjects including race, skin tone, age, sexuality, gender, disability, weight, and others.²²³ Upon completion of the test, the students are provided feedback on whether they have a strong, moderate, slight, little, or no automatic preference for one group over another (such as White over Black).²²⁴ Test takers are often skeptical of the IAT and its results,²²⁵ providing another reason to give background information on our inability to see biases in ourselves. The bias discussion must not only include information on how harmful biases can be but also provide tools for combatting biases in oneself.²²⁶

Courageous professors may facilitate the bias conversation by sharing their own IAT results and how they have worked to address their biases. When she is conducting anti-bias training for doctors, orthopedic surgeon Claudia O'Connor admits one of her own biases: she does not like to

al., *Objectivity in the Eye of the Beholder: Divergent Perceptions of Bias in Self Versus Others*, 111 PSYCH. REV. 781, (2004); Curcio, *supra* note 154, at 540.

222. See PROJECT IMPLICIT, www.implicit.harvard.edu [<https://perma.cc/32XK-TJ5L>] (offering IATs on a variety of different subjects).

223. *Id.*

224. After taking a test, the score is provided along with following explanation:

How does the IAT work?

The IAT measures associations between concepts (e.g., European Americans and African Americans) and evaluations (e.g., Good, Bad). People are quicker to respond when items that are more closely related in their mind share the same button. For example, an implicit preference for European Americans relative to African Americans means that you are faster to sort words when 'European Americans' and 'Good' share a button relative to when 'African Americans' and 'Good' share a button.

Studies that summarize data across many people find that the IAT predicts discrimination in hiring, education, healthcare, and law enforcement. However, taking an IAT once (like you just did) is not likely to predict your future behavior well.

Id.

225. When a person receives their IAT results, they are asked several questions about the IAT, one of which is "to what extent are you skeptical of the IAT score that you received?" *Id.* Some scholarship has provided a negative critique of the IAT. See, e.g., Klaus Fiedler et al., *Unresolved Problems with the "I", the "A", and the "T": A Logical and Psychometric Critique of the Implicit Association Test (IAT)*, 17 EUR. REV. SOC. PSYCH. 74, 100 (2006) (concluding the "five major problems" with IATs are "far from being solved"). It is helpful for professors to acknowledge these critiques as part of—but not the last word on—a discussion of implicit bias and the IAT.

226. For an excellent discussion of tools for de-biasing (focused on the law professor but helpful to anyone), see Gordon, *supra* note 150, at 226–36 (discussing anti-bias training programs, exposure to diversity, cultivating a growth mindset, mindfulness, and reducing cognitive fatigue).

operate on obese people.²²⁷ From there, she explains why it is important that she knows about it and what she must do to combat it.²²⁸ The classroom can provide a safe place for this self-exploration. As one doctor explains it, “The most difficult thing to realize is that yes, *you* may be the one doing it. *You* may be the one guilty of giving different care to people who don’t resemble you. . . . It’s hard to have that breakthrough where people realize that it *is* them.”²²⁹

C. Integrating Client Caregiving Topics into Current Courses

A stand-alone course that focuses on the lawyer–client relationship,²³⁰ professional identity formation,²³¹ or foundational lawyering skills²³² would be a good place to introduce topics related to lawyer caregiving. Ideally, students would take it early enough in their law school career so later courses could make use of the foundation it would provide.²³³

227. WHITE, *supra* note 1, at 242.

228. *Id.*

229. *Id.* at 242–43.

230. For example, University of St. Thomas School of Law requires second semester 1Ls to take the course “Serving Clients Well.” For the syllabus, see Ben Carpenter et al., *Serving Clients Well*, UNIV. OF ST. THOMAS SCH. OF L. (Jan. 2020), <https://www.stthomas.edu/media/hollorancenter/pdf/pddatabase/Serving-Clients-Well.pdf> [<https://perma.cc/9874-GRWW>] (sketching out the course goals, including a stated emphasis on developing “cross-cultural competency”).

231. For example, Loyola Law has a class called “Professional Identity Formation.” For the syllabus, see Josie M. Gough, *Professional Identity Formation*, LOY. UNIV. SCH. OF L., <https://www.stthomas.edu/media/hollorancenter/pdf/pddatabase/Professional-Identity-Formation.pdf> [<https://perma.cc/7453-6DNL>] (stating the course’s focus on “social justice and ethics” in the context of “develop[ing] [] a professional identity”). Similarly, Texas A&M University School of Law requires students to take a course called “Professional Identity.” For the syllabus, see Aric Short, *Professional Identity*, TEX. A&M UNIV. SCH. OF L. 1, 1 (Fall 2019), <https://www.stthomas.edu/media/hollorancenter/pdf/pddatabase/Professional-Identity-Course.pdf> [<https://perma.cc/J5KW-DLM8>] (laying out the course’s oft-ignored purpose of developing a professional identity while in law school).

232. For example, Gonzaga Law offers a class called “Litigation Skills and Professionalism Lab.” For the syllabus, see Patrick Fannin, *Litigation Skills and Professionalism Lab Syllabus*, GONZ. UNIV. SCH. OF L. 1, 2 (Fall 2018), <https://www.stthomas.edu/media/hollorancenter/pdf/pddatabase/Litigation-Skills—Professionalism-Lab—Transactional-Skills—Professionalism-Lab.pdf> [<https://perma.cc/K8C7-YV2B>] (focusing on the “ethical, moral[,] and professional considerations involved in civil litigation”).

233. The Thomas E. Holloran Center for Ethical Leadership in the Professions, at the University of St. Thomas School of Law, has cataloged forty-four law schools that require first-year law students to take a course focusing on professional formation or professional development. Rupa Bhandari & Jerry Organ, *Law School Professional Development Initiatives in the First Year*, HOLLORAN CTR. FOR ETHICAL LEADERSHIP IN THE PROS., <https://www.stthomas.edu/hollorancenter/>

Every law school addresses at least some caregiving topics (like communication and confidentiality) in professional responsibility courses. Professors teaching these courses could focus the discussion on the client's perspective and needs as they discuss cases and problems, such as involving a breach of confidentiality.²³⁴ Viewing these matters through the client's eyes might help future lawyers see how crucial confidentiality is and the harm done by wrongful disclosure.²³⁵

Two themes that run throughout professional responsibility courses are the lawyer's prospects of liability and discipline.²³⁶ In addressing both types of cases, professors should prompt students to identify problems in the attorney–client relationship that resulted in a breach of fiduciary duty, legal malpractice, or an ethics complaint. The cases often reveal a lawyer's neglectful communication,²³⁷ poor interpersonal skills or conduct reflecting a lack of respect for clients,²³⁸ or a disregard for client confidentiality.²³⁹

Finally, caregiving is already taught in legal clinics, where students have their first experience representing a client. It could be impactful for clinical professors to integrate lessons of medical caregiving into their teaching. For example, placebo research has demonstrated the importance of certain

learningoutcomesandprofessionaldevelopment/professionaldevelopmentdatabase [https://perma.cc/DB2B-BWY9].

234. David Chavkin places himself in the position of his clients, imagining whether they would authorize “cavalier” disclosure of the facts of their cases, provided “no identifying information was shared.” He believes clients would feel violated by such disclosure, yet many ethical experts conclude “it would be ethical even without disclosure to [] client[s].” Chavkin, *supra* note 181, at 263.

235. For example, when J.K. Rowling's lawyer disclosed confidential information about Rowling's penname, she issued a statement explaining her anger and loss of trust. Keith Gladdis, *JK Rowling and the Real-Life Whodunnit: Source of Leak Which Revealed Author Wrote Crime Novel Under Male Pseudonym Is . . . Solicitor from Her Own Law Firm*, DAILY MAIL (July 18, 2013) (internal quotation marks omitted), <https://www.dailymail.co.uk/news/article-2369111/JK-Rowling-Robert-Galbraith-leak-came-solicitor-OWN-law-firm.html> [https://perma.cc/4ULD-C8BC] (“To say that I am disappointed is an understatement. I had assumed that I could expect total confidentiality from Russells, a reputable professional firm, and I feel very angry that my trust turned out to be misplaced.”).

236. *See, e.g.*, CARL A. PIERCE ET AL., PROFESSIONAL RESPONSIBILITY IN THE LIFE OF THE LAWYER 4–5 (West Academic Publishing, 2d ed. 2015) (discussing the potential for a lawyer's breach of duty to result in civil liability or professional discipline).

237. *See, e.g., id.* at 245 (describing the client's frustration with the lawyer's lack of communication).

238. *See, e.g., id.* at 228 (contending the attorney made a practice of entering “nonrefundable retainer fee agreements” with clients and keeping the retainers post-termination).

239. *See, e.g., id.* at 315 (discussing an attorney who assured a client that anything he revealed would be kept confidential and then later revealed his statement to the authorities).

elements in the caregiver–patient interaction.²⁴⁰ Sharing the medical research and its implication for patient health might inspire students to be more purposeful in using warmth, active listening, touch, thoughtful silence, and optimism in their interactions with clients.²⁴¹

In the area of confidentiality, clinical faculty can borrow from the medical profession and create a culture of confidentiality in the clinic. This includes modeling respect for confidentiality, posting signs and giving other reminders of confidentiality in the clinic, and talking about the specific risks to confidentiality they have seen during their clinical practice.²⁴²

Legal clinics also provide an opportunity to build on students' understanding of cultural competence and the need to eliminate bias in the practice of law. Clinical students should be exposed to the research showing a connection between physician bias and substandard patient care,²⁴³ be asked to contemplate how the same issues might impact their clients, and develop a plan for addressing bias in their client interactions. Helping clinic students see the parallels between medical practice and the practice of law may help them to be more thoughtful about the impact of caregiving on future clients.

240. See *supra* notes 71–75 and accompanying text (discussing the effects of a study in which practitioners engaged in empathetic behaviors while communicating with patients).

241. *Id.*

242. See Eldred, *supra* note 201, at 799–802 (recounting efforts and strategies used to make law students consciously aware of ethical issues).

243. There is a wide body of literature supporting the proposition that physician bias creates disparities in health care outcomes. See, e.g., Alan Nelson, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, 94 J. NAT'L MED. ASS'N 666, 667 (2002) (“Bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers may contribute to racial and ethnic disparities in health care.”).

V. CONCLUSION

In his book, *Descartes' Error*, Antonio Demasio made an observation, which I used to open this Article: great physicians must understand not only medicine but also “the human heart in conflict.”²⁴⁴ In discussing the impact of racial bias on the practice of medicine, Augustus White builds on Demasio’s observation, explaining the disparities in healthcare for minority patients reflect a “disconnect between the physician and the heart and mind of his patient.”²⁴⁵

Demasio’s observation and White’s expansion apply equally to lawyers. Being a great lawyer means more than understanding the law or having the skills necessary to litigate a case or negotiate a transaction. It is just as important that lawyers understand how to care for their clients’ other needs. All clients—not just certain categories—are vulnerable. That is why they hired a lawyer. They need the assistance of a trained professional to solve their legal problem and help navigate the anxieties, fears, and trust issues that come with handing a problem to someone else. In this respect, the client’s needs are similar to the patient’s needs. Lawyers can learn to be better caregivers by studying the lessons of medical caregiving.

244. WHITE, *supra* note 1 and accompanying text.

245. WHITE, *supra* note 1, at 230.