

WHEN AND WHY LAWYERS ARE THE PROBLEM

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Whenever you got business trouble, the best thing to do is to get a lawyer. Then you got more problems, but at least you got a lawyer.¹

INTRODUCTION

There have always been bad lawyers—and even good lawyers can give what turns out to be bad advice—at least when judged, as they always are, in hindsight.² So what’s new or, if not new, different about the current state of affairs? The prospectus for the Clifford Symposium suggested that the problem is that, instead of the “classical arrangement, in which the private practitioner renders legal advice to those who retain him or her for specific matters,” there is now a “wide variety of other approaches . . . [that have] made the delivery of legal services more responsive to client needs . . . [but] have also exposed both lawyers and clients to new pressures that may jeopardize the quality of the advice delivered.”³

There is no question that there have been profound changes in the lawyer-client relationship over the past several decades, as competition has made the delivery of legal services more responsive to consumers’ wants and needs. I am considerably more skeptical about the claim that these changes have jeopardized the quality of legal advice. What counts as “quality” legal advice depends greatly on one’s prior assumptions about the expected scope and nature of the representation—and those assumptions are contingent upon a host of factors, including willingness to pay. It is one thing to complain *ex post* about

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1. WorkingHumor.com, Humorous Quotes Attributed to Chico Marx, http://workinghumor.com/quotes/chico_marx.shtml (last visited Jan. 19, 2008).

2. I have addressed the issues raised in this Article in previous works, including David A. Hyman, *Professional Responsibility, Legal Malpractice, and the Eternal Triangle: Will Lawyers or Insurers Call the Shots?*, 4 *CONN. INS. L.J.* 353 (1997) [hereinafter Hyman, *Professional Responsibility*]; and David A. Hyman & Charles Silver, *And Such Small Portions: Limited Performance Agreements and the Cost/Quality/Access Trade-Off*, 11 *GEO. J. LEGAL ETHICS* 959 (1998). Much of the analysis in Parts II and III is drawn from those articles. See *infra* notes 8–31 and accompanying text.

3. The Thirteenth Annual Clifford Symposium on Tort Law and Social Policy, Symposium Packet, Introduction by Prof. Stephan Landsman (2007) (on file with the DePaul Law Review).

conflicts of interest and inadequacies in the advice that has been provided—and there will always be experts in professional responsibility available to opine how the professionally dictated standard would have prevented the problem. It is quite another thing to establish that consumers are willing *ex ante* to pay for the costs of those professionally dictated standards of care.

Stated differently, complaints about “new pressures that may jeopardize the quality of the advice delivered” are a long way from proving that the old way of doing things involved sensible default rules—let alone efficient mandatory minimum rules. Yet it has historically been a short step from complaints about “new pressures that may jeopardize the quality of the advice delivered” to various forms of regulation designed to insulate the profession and professionals from those pressures—with the costs of such protections borne by consumers. Both the legal and medical professions have been conspicuous offenders in this regard—except that the legal profession has succeeded in insulating more of its actions from antitrust scrutiny.

Part II explores how the medical profession has dealt with these issues.⁴ Part III catalogs a few recent episodes involving the legal profession that show the same tendencies.⁵ Part IV turns to the more subtle and less frequent issue: when lawyers *qua* lawyers are the problem.⁶ Part V concludes.⁷

II. PROFESSIONAL REGULATION: YOU'RE NEVER ALONE WHEN YOU'RE SCHIZOPHRENIC

Professional regulation is routinely analyzed on an ahistorical, profession-specific basis. This approach is deeply problematic; seeing how common issues (the scope and degree of deference to professional authority, deciding whether ethics rules are defaults or mandatory minimums, the extent of continuing education and monitoring of competence) have been handled over time and across professions helps demonstrate the contingent nature and mutability of the boundaries that are set and the bargains that are made. A longer and broader view also provides a welcome dose of humility for those considering the merits and demerits of both the old and new rules, because it shows the *ad hoc* (if not outright schizophrenic) nature of past rules and the likely compromises that will be seen in future rules. This broader perspective also makes it clear that one should view com-

4. *See infra* notes 8–23 and accompanying text.

5. *See infra* notes 24–31 and accompanying text.

6. *See infra* notes 32–49 and accompanying text.

7. *See infra* notes 50–52 and accompanying text.

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plaints by professionals about how competition will adversely affect consumers with considerable skepticism, because self-interest has a distinct tendency to skew such assessments.⁸

I focus on the medical profession, because it is analogous to the legal profession in a number of ways, including the degree of expertise and prestige of those involved and the extent to which competition has reshaped the terrain in recent years. For much of its history, the medical profession operated as a classic cottage industry, and professional ethics focused on the “traditional rules prohibiting doctors indulgence in the three A’s: adultery, alcoholism, and, worst of all, advertising.”⁹ As this aphorism suggests, opposition to competition in its myriad forms was a core principle of organized medicine:

[O]utbreaks of . . . competition were ruthlessly suppressed, with the result that the hegemony of the dominant ideology was seldom challenged. Under the banners of “medical science,” “quality of care,” and “professional prerogative,” the medical profession was able to repel most attacks along its borders, to force many of its antagonists into alliances, and to confine other would-be invaders to narrow enclaves.¹⁰

The basic position of the American Medical Association (AMA) on health matters was that all involved had to accept “the private physician’s monopoly control of the medical market and complete authority over all aspects of medical institutions.”¹¹ This fundamental precept was manifested in various ways. For example, beginning in 1927, the AMA took the position that a contract to deliver medical services required a reasonable degree of free choice of physicians.¹² The AMA repeatedly affirmed this position over the following fifty years until it was determined to constitute a restraint of trade.¹³ Al-

8. David B. Wilkins, *Partner, Shmartner!* EEOC v. Sidley Austin Brown & Wood, 120 HARV. L. REV. 1264, 1275 (2007):

Far too many trees have been killed in defense of an understanding of professionalism that treats the well-being of lawyers as the primary good to be protected. And, as Professor Richard Abel has so ably demonstrated, many if not most of the restrictions that the profession has erected against the unauthorized practice of law in the name of the public interest are far more protective of lawyers’ income and status than they are of the public.

Id.; see also *Coleman v. Comm’r*, 791 F.2d 68, 69 (7th Cir. 1986) (“Some people believe with great fervor preposterous things that just happen to coincide with their self-interest.”).

9. Stephen G. Potts, *Looking for the Exit Door: Killing and Caring in Modern Medicine*, 25 HOUS. L. REV. 493, 493 (1988).

10. Clark C. Havighurst & Nancy M.P. King, *Private Credentialing of Health Care Personnel: An Antitrust Perspective—Part Two*, 9 AM. J.L. & MED. 263, 291 (1983).

11. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 300 (1982).

12. *In re Am. Med. Ass’n*, 94 F.T.C. 701 (1979), *enforced*, 638 F.2d 443 (2d Cir. 1980), *aff’d*, 455 U.S. 676 (1982) (equally divided court).

13. See *id.*

though the AMA's position appeared innocuous, it essentially prevented "a group of doctors from offering care to patients at any lower price than their colleagues. In the name of free choice, it effectively eliminated the possibility of competition and the right to patients to choose among competing physician groups."¹⁴ By effectively precluding selective contracting, the ethical rule crippled insurers in their negotiations with providers and helped maintain healthcare as a cottage industry built on a foundation of fee-for-service reimbursement.¹⁵

In like fashion, the AMA and its local societies adopted ethical rules that prohibited salaried practice and prepaid medical care.¹⁶ Physicians who entered into such arrangements and those who consulted with them were expelled—foreclosing access to local hospitals and cross-coverage. After one of the most bitter battles in the history of modern American medicine, the Supreme Court held that the AMA and a local medical society had violated the Sherman Act.¹⁷ Despite this success, opposition to alternative delivery models continues, albeit at a lower level of intensity.

Although organized medicine suffered defeats in these cases, the larger framework of laws and practices reflected medical dominance of institutional arrangements.¹⁸ Health Maintenance Organizations operated quite successfully in some parts of the country and developed their own institutional ethic, but the paradigmatic doctor practiced alone or in a small group. Prohibitions on corporate practice remained on the books; compensation was based almost exclusively on piecework; all microallocation decisions were made by physicians; and tax-subsidized private insurance and public underwriting of care for the elderly—Medicare—and the poor—Medicaid—encouraged the near-complete insulation of patients from cost. Not surprisingly, there were dramatic, system-wide financial consequences, because every incentive pointed toward increased consumption—including the medical profession's ethic of absolute fidelity to patients, which blossomed when watered by an artesian well of money.

14. STARR, *supra* note 11, at 300.

15. See Charles D. Weller, "Free Choice" as a Restraint of Trade in American Health Care Delivery and Insurance, 69 IOWA L. REV. 1351, 1364–67 (1984).

16. See *id.* at 1364–72.

17. *Am. Med. Assoc. v. United States*, 317 U.S. 519, 536 (1943) ("[The AMA] represented physicians who desired that they and all others should practice independently on a fee for service basis, where whatever arrangement for payment each had was a matter that lay between him and his patient in each individual case of service or treatment.").

18. See generally Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431 (1988).

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The unleashing of price—and, to a lesser extent, quality—competition over the past several decades has transformed the medical marketplace. The overwhelming majority of the population is in some form of managed care, although the merits of that organizational arrangement remain in considerable dispute. Fee-for-service medicine has not been replaced, but hybrid compensation arrangements have become much more prevalent. Instead of simply trusting individual physicians to “do the right thing,” there has been a substantial increase in monitoring and public reporting of quality measures. Direct financial incentives for higher-quality care (payment for performance or “P4P”) has become official government policy. Physicians now practice in an environment that was inconceivable only two decades ago.

The ethical rules of the medical profession have slowly evolved in response to these developments. The patient-centered ethic, which reached its zenith under unrestricted fee-for-service practice, remains the centerpiece of professional self-definition, but it has been significantly tempered by considerations of the societal interests at stake. Cost-effectiveness and cost-benefit analyses routinely appear in the medical literature. Bedside rationing is seriously discussed, and physicians and physician groups have accepted contracts that tie their salaries to the cost and quality of the care they render.

To be sure, physicians have not simply acceded to these developments. They have formed unions; engaged in collusive anti-competitive conduct; created “astroturf” campaigns targeting specific managed care practices; used disciplinary proceedings against medical directors of managed care organizations; and done everything in their power to create a managed care backlash. Although some of these efforts were successful, there has still been a sea change in the organizational structure and incentive arrangements under which doctors and other healthcare institutions operate.

At present, matters appear to have stabilized, but *détente* is not the same thing as a lasting peace. Even modest financing or delivery-side innovations can prompt controversy and a renewed debate over first principles. The opening of a “Botox-on-the-go” storefront office in Manhattan prompted a heated response from the usual suspects making the usual arguments.¹⁹ More sweeping delivery-side initiatives,

19. Natasha Singer, *The Little Botox Shop Around the Corner*, N.Y. TIMES, Apr. 19, 2007, at G3:

Some doctors who specialize in administering such injections contended that convenience and pricing are inappropriate criteria for choosing a cosmetic medical provider. . . . [T]he American Society for Aesthetic Plastic Surgery, the American

such as the opening of outpatient nurse practitioner-staffed clinics in retail outlets, have prompted heated denunciations and condemnation from professional societies, including the AMA and the American Academy of Pediatrics.²⁰ For anyone with a sense of history, the bill of particulars is déjà vu all over again:

Physicians, however, express concern about the quality of care and the potential impact on their businesses. . . .

The effect of this specialized care delivery model on traditional primary care practices may be to remove some patients and services from the doctor's office, leaving a sicker population behind. Some practitioners will see this as "cream skimming" and a threat to their revenue, particularly if they rely on income from short appointments for simple cases to subsidize the cost of more time-consuming appointments for more complex cases.²¹

Even modest attempts to disseminate truthful information on price and quality can trigger opposition—and the mobilization of pliable state agencies to do the dirty work.²² To summarize, the medical profession has used every tool at its disposal to resist the forces of competition. Although they have advanced these positions under the flag of protecting patients, it is no accident that their positions neatly coincide with the protection of physicians' incomes, prerogatives, and control of the means of production.²³ Part III turns to the analogous dynamics that have marked the legal profession's efforts to resist competitive forces.

Academy of Facial Plastic and Reconstructive Surgery, and the American Society for Dermatologic Surgery will start a campaign Friday, called the Physicians Coalition for Injectable Safety, to promote the idea that only board certified surgeons and dermatologists can guarantee cosmetic expertise.

Id.

20. See Bruce Japsen, *Doctors, Retailers Square Off: AMA to Seek Probe of In-Store Clinics*, CHI. TRIB., June 26, 2007, sec. 3, at 1; Jay E. Berkelhamer, *Retail Health Clinics Are a Return to an Earlier Form of Medical Care*, WALL ST. J., May 19-20, 2007, at A7 (noting the American Academy of Pediatrics' opposition to retail clinics because they undermine continuity of care).

21. Richard Bohmer, *The Rise of In-Store Clinics—Threat or Opportunity?*, 356 NEW ENG. J. MED. 765, 765, 767 (2007).

22. See, e.g., Anthony Ramirez, *Attorney General Objects to Insurer's Ranking of Doctors by Cost and Quality*, N.Y. TIMES, July 14, 2007, at B3 (discussing New York State Attorney General's threat to insurance companies for adopting and preparing to publicize systems for ranking physicians based on cost and quality of services they provide).

23. Such strategies are not unique to health care. Cf. Nat'l Soc'y of Prof'l Engineers v. United States, 435 U.S. 679, 693 (1978) (striking down ethical prohibitions on competitive bidding that were defended on the grounds that because "bidding on engineering services is inherently imprecise, [competition] would lead to deceptively low bids, and would thereby tempt individual engineers to do inferior work with consequent risk to public safety and health").

III. HOW HAS THE LEGAL PROFESSION DEALT WITH COMPETITION?

The legal profession has dealt with competition in much the same way as the medical profession: vigorous resistance whenever possible and grudging retreat or détente when absolutely necessary. As in the medical context, the issue is invariably framed in terms of the importance of protecting consumers by ensuring that only high-quality legal services are available. Consider the tenor of the Minority Report in the American Bar Association's Report on Nonlawyer Activity in Law-Related Situations:

[T]he report does not sufficiently emphasize that the protection of the public should be an essential factor in any proposal to increase access. We disavow any inference that may be taken to the effect that access to justice is the paramount goal to be served, or that in doubtful cases, the access goal should be given greater weight than the goal of the protection of the public from the harm that may befall them at the hands of unskilled or unethical providers. In our judgment, the prospect of incompetent representation casts a long shadow over the doorway of access. . . . To help assure maximum access, nonlawyer provision of certain legal services should be encouraged and nurtured. But once the door of access is opened wider, we must anticipate the dangers to the public that could lurk in the darkness behind that door.²⁴

As this excerpt suggests, lawyers routinely respond to competition by emphasizing the risks to vulnerable consumers. However, as Professor Rhode observed, “the main danger lurking in the shadows is the bar's own interest in restricting competition.”²⁵

Given this dynamic, it is not all that surprising that “much of the specific content of former and current professional self-regulation falls neatly within the economist's catalog of anticompetitive practices: entry restrictions that protect incumbents against new competition; market-division strategies that limit the competition of lawyers with one another, and restraints on price and service.”²⁶ As Professor Gellhorn noted in an article bearing the understated title *The Abuse of Occupational Licensing*, “[o]nly the credulous can conclude that licensure is in the main intended to protect the public rather than those who have

24. Ernest Y. Sevier & Raymond J. Werner, *Minority Report*, in COMMISSION ON NONLAWYER PRACTICE, AMERICAN BAR ASSOCIATION, *NONLAWYER ACTIVITY IN LAW-RELATED SITUATIONS: A REPORT WITH RECOMMENDATIONS* 163–65 (1995).

25. Deborah L. Rhode, *Professionalism in Perspective: Alternative Approaches to Nonlawyer Practice*, 22 N.Y.U. REV. L. & SOC. CHANGE 701, 706 (1996).

26. Roger C. Cramton, *Delivery of Legal Services to Ordinary Americans*, 44 CASE W. RES. L. REV. 531, 551–52 (1994).

been licensed or, perhaps in some instances, those who do the licensing.”²⁷

Those who doubt that this is a fair description of how the organized bar has dealt with competition should consider the confrontations over the use of staff counsel and fixed fee arrangements in insurance defense,²⁸ the unbundling of legal services,²⁹ partnerships between lawyers and nonlawyers,³⁰ and the ongoing fight over whether lawyers need to be involved in real estate closings and refinancings.³¹ If you’re still prepared to believe that professional self-regulation is all about protecting the public, I’ve got a bridge in Brooklyn that you’ll want to take a look at.

IV. WHEN AND WHY LAWYERS *QUA* LAWYERS ARE THE PROBLEM

As this brief tour of the regulation of the medical and legal professions suggests, the most recent complaints about “new pressures that may jeopardize the quality of the advice delivered” are mostly about the resistance of incumbent providers to the impact of market forces and competition. But it does not follow that lawyers *qua* lawyers cannot be part of the problem.

Although there is obviously considerable individual variation, law tends to attract people with—and legal training tends to accentuate—certain distinctive characteristics and personality traits. David Mais-

27. Walter Gellhorn, *The Abuse of Occupational Licensing*, 44 U. CHI. L. REV. 6, 25 (1976); accord Jonathan R. Macey & Geoffrey P. Miller, *An Economic Analysis of Conflict of Interest Regulation*, 82 IOWA L. REV. 965, 966 (1997) (noting that the organized bar can use rules of legal ethics to “enhance its profits . . . by limiting the supply of legal services available in the marketplace”).

28. See Charles Silver, *Flat Fees and Staff Attorneys: Unnecessary Casualties in the Continuing Battle over the Law Governing Insurance Defense Lawyers*, 4 CONN. INS. L.J. 205, 221–22, 243–44 (1997).

29. See Hyman, *Professional Responsibility*, *supra* note 2, at 395.

30. See Larry E. Ribstein, *Ethical Rules, Agency Costs, and Law Firm Structure*, 84 VA. L. REV. 1707, 1721 (1998). Professor Ribstein elaborated on the issue as follows:

If we had true multi-disciplinary firms, which were capable of delivering one-stop finance, accounting and legal advice and guidance, maybe this would change. But outside legal advice now can come only from firms that are controlled by lawyers. Not that firms would necessarily be better if they were controlled by any other single profession. But what if the firm could be controlled by capitalist owners interested only in profits? Then we might see structures better designed to fit *clients’* needs.

Posting of Larry Ribstein to Ideoblog, <http://www.ideoblog.org/> (Apr. 5, 2007, 5:52 AM) (emphasis in original).

31. See Fed. Trade Comm’n, *Competition in the Real Estate Marketplace*, Advocacy Letters, <http://www.ftc.gov/bc/realestate/outreach/letters.htm> (last visited Jan. 19, 2008); George C. Leef, ‘UPL’ *Lawyer Welfare Revisited*, 25 REG. 8, 8–9 (2003), available at <http://www.cato.org/pubs/regulation/regv25n4/v25n4-noted.pdf>.

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ter, a consultant specializing in advising professional services firms, holds up a mirror to the profession in his regular column in *American Lawyer*:

[L]awyers are professional skeptics: They are selected, trained, and hired to be pessimistic and to spot flaws. To protect their clients, they place the worst possible construction on the outcome of any idea or proposal, and on the motives, intentions, and likely behaviors of those they are dealing with. . . .

In their legal training, lawyers are encouraged to be dispassionate. They have been schooled to leave their personal feelings at home. . . .

As many researchers have shown, lawyers score very low in the areas of intimacy skills and sociability. . . .

When lawyers reason with each other, the primary objectives are not necessarily logic, consistency, reasonableness, or fairness. In their professional practice, whether in trial or deal-making, many lawyers are more frequently rewarded for persuasiveness, rhetoric, verbal agility, and point scoring. . . .

Lawyers also have a strange view of the concept of risk. In any other business, an idea that was likely to work much of the time would be eagerly explored. This is not necessarily the case with lawyers. If one partner says, "This works in the vast majority of cases," you can be sure that another will say, "Maybe, but I can construct a hypothetical scenario where it will fail to work. That makes it risky." Probabilities do not seem to influence the discussion, only possibilities. There is no greater condemnation in legal discourse than to describe something as risky. Contracts, deals, and court cases must be bulletproof, not risky.³²

How do these traits play out in issues that arise at the interface of law and medicine? I focus on two examples: disclosure/communication after an adverse event and a tragic case involving end-of-life care.

*A. What Should Doctors Say to Their Patients after
Something Bad Happens?*

Anyone who has ever seen a TV show involving lawyers knows their standard advice on dealing with the police. Don't say anything, no matter what. Don't explain. Don't justify. Don't rationalize. Opening your mouth can only make things worse. Just ask any criminal defense lawyer and you'll get chapter and verse on the subject.³³

32. David Maister, *The Trouble With Lawyers*, AM. LAWYER, Apr. 2006, at 97, 99–100.

33. See Some Advice From Your Public Defender, <http://www.craigslist.org/about/best/sfo/70300494.html> (last visited Jan. 19, 2008) ("You have the right to remain silent. So SHUT THE FUCK UP."); Nat'l Lawyers Guild: L.A. Chapter, Dealing With the Police: General Guidelines for Activists, http://www.nlg-la.org/Dealing_with_Police.pdf (last visited Jan. 19, 2008); Baum & Assocs., When the Police Come Knocking . . . , <http://www.baumlaw.com/info.html> (last visited Jan. 19, 2008); Law Office of Kevin R. Churchill, Why You Shouldn't Talk to Police, <http://www>

The connection is so clear that it has passed into common parlance: to “lawyer up” is slang for “to stop answering questions during a police interrogation, and request a lawyer.”³⁴

Not surprisingly, defense lawyers and in-house counsel have brought the same strategies and mindset to bear in dealing with medical malpractice. When something bad happens, the standard legal advice is “never apologize and say as little as possible.” In general, healthcare providers have deferred to this advice.

This is clearly an example of lawyers acting like lawyers, but why is that a problem? Ignore for the moment that the advice is inconsistent with the ethical obligations of hospitals and physicians to disclose such information to injured patients. Instead, focus on the reality that the “don’t say anything” strategy results in patient dissatisfaction and appears to actually increase the probability of a malpractice lawsuit.³⁵ The lawyerly strategy has also triggered a backlash: several states now *require* hospitals to disclose serious, unanticipated outcomes to patients; grassroots organizations are promoting apology; some malpractice insurers and healthcare institutions are experimenting with greater disclosure; and many states have passed laws encouraging apologies.³⁶

To be sure, it is an open question whether healthcare providers would behave differently if they did not receive advice from their lawyers. People do not like to acknowledge their mistakes. Providers might also believe that being more forthcoming will increase the number of claimants and the direct costs they will bear as a result of their malpractice.³⁷ Thus, it is possible that the “advice of counsel” defense may have simply given physicians license to do something they would have done anyway. It remains to be seen how the apology movement

colorado-criminal-lawyer.com/police/evidence.html (last visited Jan. 19, 2008). It’s not just American lawyers. *See, e.g.*, Pub. Legal Educ. Ass’n of Saskatchewan, Talking to Police: Why You Need a Lawyer (2005), <http://www.plea.org/newyj/resources/talkpolice.pdf>. *See also* Richard Abel, *General Damages are Incoherent, Incalculable, Incommensurable, and Inegalitarian (But Otherwise a Great Idea)*, 55 DEPAUL L. REV. 253, 264 n.75 (2006) (“The Automobile Association of America gives every insured instructions about what to do ‘if you have an accident’: ‘Do not admit responsibility for or discuss the circumstances of the accident with anyone other than the police or an authorized Auto Club claims representative.’” (emphasis in original)).

34. Urban Dictionary, Lawyer Up, <http://www.urbandictionary.com/define.php?term=lawyer+up> (last visited Jan. 19, 2008).

35. *See, e.g.*, David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 944 (2005).

36. *See* Sorry Works! Coalition, <http://www.sorryworks.net/newsletter20070308.phtml> (last visited Jan. 19, 2008).

37. *See* David M. Studdert et al., *Disclosure Of Medical Injury To Patients: An Improbable Risk Management Strategy*, 26 HEALTH AFF. 215, 215–20 (2007).

will turn out, but the preferred solution of many lawyers to malpractice exemplifies how lawyers can become the problem, instead of the solution.

B. *The Linares Case*

My second example of the problems that can arise at the interface of law and medicine is a train-wreck of a case, where the crash was triggered by the actions of a single risk-averse lawyer.³⁸ On August 2, 1988, Samuel Linares, a young child, swallowed a balloon and stopped breathing. He was hospitalized at Rush-Presbyterian St. Luke's hospital in Chicago for eight months, during which the physicians concluded that he was in a persistent vegetative state and would never recover. In response to multiple requests from Samuel's parents, the doctors agreed that it was appropriate to remove the respirator that was keeping Samuel alive.³⁹ However, the hospital's general counsel, Max Brown, advised the physicians "not to remove the life support for the Linares child. 'There is an absence in the law,' Mr. Brown said. 'I told the medical staff there was a possibility they would face criminal charges. I can't speculate with the careers of doctors and nurses.'"⁴⁰ Brown advised Mr. Linares, a twenty-three-year-old laborer, that he should seek a court order authorizing the removal of the respirator. The hospital had taken the same steps in a similar, contemporaneous case where the parents disagreed on whether treatment should be discontinued. Obtaining a court order in that case is reported to have cost \$40,000. Linares made about \$300 per week. The medical bills for his son were estimated to total \$200,000.

The Linareses had scheduled an appointment with a lawyer on April 28, 1989 to discuss the matter. However, two days before their scheduled appointment, Mr. Linares walked into the intensive care unit of the hospital, pulled out a handgun, announced that he didn't want to hurt anyone, and ordered all medical personnel out of the room. He disconnected his son's respirator and held his son in his

38. See Steven H. Miles, *Taking Hostages: The Linares Case*, 19 HASTINGS CENTER REP. 4, 4 (1989); Dirk Johnson, *Questions of Law Live On After Father Helps Son Die*, N.Y. TIMES, May 7, 1989, at A26.

39. Johnson, *supra* note 38. "There was no ethical difference of opinion here," said Dr. Gilbert Goldman, the child's physician. "The physicians agreed that the child was in an irreversible coma and would not recover. There was no medical opposition to removing the ventilator." *Id.* The medical staff had also advised the Linares family "for months that Samuel's death was imminent." *Id.* Notwithstanding this unanimity of opinion, when Mr. Linares tried to disconnect his son from the respirator on a previous occasion, "hospital workers wrestled him to the floor," and "Mr. Linares was warned that he risked criminal charges if the boy died." *Id.*

40. *Id.*

arms while he died. He then surrendered to police. The attending physician for Samuel stated that “[t]here was no question that these were decent and concerned parents who cared very much for their child.”⁴¹

Cecil Partee, who had been appointed Cook County State’s Attorney a month earlier, said he would pursue “compassionate channels” in the case, but filed first degree murder charges, because “no one has the right to take the law into their own hands.”⁴² After the grand jury refused to indict Linares, he pled guilty to a misdemeanor charge of unlawful use of a weapon, and the judge sentenced him to a one-year conditional discharge.

Reeling from bad publicity over his unsuccessful attempt to indict Linares, Partee announced that a commission would develop guidelines for handling similar cases. He was voted out of office in the next election. Brown remains the general counsel of Rush, but judging by the dearth of litigation involving treatment-termination at Rush, he seems to have decided that the law is now sufficiently clear that treatment can be discontinued without resort to legal process.

To be sure, Brown was not representing the Linareses, and he owed them no duty of care or competence. If there was a bona fide risk of criminal liability, requiring judicial sign-off before disconnecting life-support was simply prudent—particularly given the previously mentioned dispute that unfolded over the treatment of a patient in the Rush ICU where the parents disagreed about the correct course of treatment. Yet there is simply no evidence that there was actually a bona fide risk other than Brown’s assertions. The parents and medical professionals agreed that it was appropriate to cease treatment. The attending physician had previously terminated treatment in numerous earlier cases.⁴³ The flood of commentary that followed these events was harshly critical of Brown’s position.⁴⁴ There is no evidence that Brown was acting in anything but the utmost good faith, but his risk aversion on behalf of his client and his preference for resolution

41. *Id.*

42. *Id.*

43. *Id.*

44. See, e.g., Norman Fost, *Do the Right Thing: Samuel Linares and Defensive Law*, 17 L. MED. & HEALTH CARE 330 (1989); John D. Lantos et al., *The Linares Affair*, 17 L. MED. & HEALTH CARE 308 (1989); Christine Mitchell, *On Heroes and Villains in the Linares Drama*, 17 L. MED. & HEALTH CARE 339 (1989); Lawrence J. Nelson & Ronald E. Cranford, *Legal Advice, Moral Paralysis and the Death of Samuel Linares*, 17 L. MED. & HEALTH CARE 316 (1989); Nancy A. Wynstra, *Role of In-House Counsel in Decisions about Withdrawal of Life Sustaining Treatment*, 17 L. MED. & HEALTH CARE 325 (1989). A response by Rush personnel may be found at Gilbert M. Goldman et al., *What Actually Happened: An Informed Review of the Linares Incident*, 17 L. MED. & HEALTH CARE 298 (1989).

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through legal process exemplifies how lawyers *qua* lawyers can be the problem.

C. *Representativeness?*

How representative are these two examples? Not very, as it happens—because, in both instances, the law and the lawyers eventually accommodated themselves to external reality, rather than persisting in trying to force the opposite. Far too often, lawyers push legal norms on people who don't want them and have little use for them.⁴⁵ Within the field of healthcare, informed consent—that quintessential quasi-contractual creation of lawyers *qua* lawyers—exemplifies the problem:

[I]nformed consent is at worst a failure and at best a frustrating disappointment. The court assumed that patients hunger to make their own decisions and are thwarted by imperialistic doctors. But decades of evidence now establish that many patients feel no such hunger and that as patients become older and sicker any such hunger dwindles away. Even doctors who try earnestly and arduously are baffled when they attempt to equip patients to make intelligent medical decisions. Patients misunderstand even the most basic facts about treatments, do not remember what they are told, and do not analyze it accurately.⁴⁶

To summarize, far too many legislators and lawyers believe that “the keys to the courthouse” are “the keys to the kingdom” and that things go better with due process.⁴⁷ The result is laws and legal norms that “rest[] on demonstrably false assumptions about how human beings think and act.”⁴⁸ After the near-inevitable failure of these laws and legal norms to accomplish their intended objectives, “[w]hat remains is more regulations whose fatuity convinces their subjects that the law is ignorant, witless, and malign, something doctors are already all too willing to believe.”⁴⁹

V. CONCLUSION

There is no question that lawyers can be part of the solution, but they are sometimes the problem. How, then, should we differentiate

45. See Stewart Macauley, *Non-Contractual Relations in Business: A Preliminary Study*, 28 AM. SOC. REV. 55, 61 (1963) (“You don't read legalistic contract clauses at each other if you ever want to do business again. One doesn't run to lawyers if he wants to stay in business because one must behave decently.”); see also Carl E. Schneider & Lee E. Teitelbaum, *Life's Golden Tree: Empirical Scholarship and American Law*, 2006 UTAH L. REV. 53, 96.

46. Schneider & Teitelbaum, *supra* note 45, at 96.

47. David A. Hyman, *How Law Killed Ethics*, 34 PERSP. BIO. & MED. 134, 150 (1990). See also David A. Hyman, *Getting the Haves to Come Out Behind: Fixing the Distributive Injustices of American Health Care*, 69 LAW & CONTEMP. PROBS. 265 (Autumn 2006).

48. Schneider & Teitelbaum, *supra* note 45, at 97.

49. *Id.*

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garden-variety professional turf-protection and resistance to market forces—where doing nothing, other than enforcing the antitrust laws, is likely to be the optimal regulatory response—from issues where lawyers *qua* lawyers are the problem, where doing something more might be appropriate? To be sure, the situation is complicated by the usual difficulty of balancing Type I and Type II errors, coupled with the tendency of bootleggers to align themselves with Baptists.⁵⁰

There is no perfect solution to these problems, but better incentives for the delivery of the desired services—including the dismantling of regulations that unnecessarily impede competition and market entry—are an excellent place to start improving the status quo. Those who resist such steps are mostly concerned not with market failures, but with market successes:

It is ironic that just as a global network and automation are reducing the costs of contracting, and moving us closer to the world in which the Coase Theorem prevails, people promote more and more contract-defeating schemes. One is tempted to think that they are concerned not about market failures but about market successes—about the prospect that the sort of world people prefer when they vote their own pocketbooks will depart from the proposers' ideas of what people *ought* to prefer. Next thing you know, why, economic transactions between consenting adults will break out *right in public view!*⁵¹

Those who oppose more competitive markets for professional services invariably claim that their efforts are based on high moral principle and reflect the interests of consumers. They are wrong on both scores.⁵² Their efforts should be seen for what they are, instead of what they pretend them to be.

50. Bruce Yandle, *Bootleggers and Baptists in Retrospect*, 22 REG. 5, 5 (Fall 1999):

Durable social regulation evolves when it is demanded by both of two distinctly different groups. "Baptists" point to the moral high ground and give vital and vocal endorsement of laudable public benefits promised by a desired regulation. Baptists flourish when their moral message forms a visible foundation for political action. "Bootleggers" are much less visible but no less vital. Bootleggers, who expect to profit from the very regulatory restrictions desired by Baptists, grease the political machinery with some of their expected proceeds. They are simply in it for the money.

Id.

51. Frank H. Easterbrook, *Cyberspace Versus Property Law?*, 4 TEX. REV. L. & POL. 103, 111 (1999) (emphasis in original).

52. See Richard A. Posner, *Bad News*, N.Y. TIMES, July 31, 2005, sec. 7, at 1 ("[W]hen competition is intense, providers of a service are forced to give the consumer what he or she wants, not what they, as proud professionals, think the consumer should want, or more bluntly, what *they* want." (emphasis in original)) (book review).