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Recommended Citation
Available at: http://ir.lawnet.fordham.edu/flr/vol70/iss3/2
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INTRODUCTION

Following the recommendations of trusted resources, at around the eighth month of my wife’s pregnancy with our first child, my wife and I began to search for a pediatrician. Being relatively new to south Florida, we did not know the names of any pediatricians off hand. Thus, as many would, we turned to “word of mouth.” Fortunately, we were quite enamored with my wife’s obstetrician/gynecologist (“OB/GYN”) and were pleased when he recommended two pediatricians for us to consider. The first (“Physician A”) had just moved his practice from California to Florida, and shared an office building with and was a member of the same hospital district as our OB/GYN. The second (“Physician B”) was the pediatrician that our OB/GYN took his own children to. Additionally, my wife was able to obtain a third recommendation (“Physician C”) for a pediatrician that two persons from my wife’s workplace took their children to and were pleased with.

Again following the guidance of trusted resources, and armed with a long list of suggested questions to ask, my wife and I scheduled interviews with each of the three recommended physicians. I also confirmed that each of the physicians was a member of the Health Maintenance Organization (“HMO”) that we subscribe to, so that the insurer would pay for care provided by these pediatricians. In addition, prior to attending the interviews, I looked up each doctor’s Florida Practitioner Profile on the Internet. Pursuant to a state statute, beginning July 1, 1999, the Florida Department of Health was

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3. See Karlsrud, supra note 1, at 96.
required to compile a "practitioner profile" for all physicians seeking an initial license to practice medicine in the state or renewal of an existing license. Among the information that must be included in such practitioner profiles are: 1) the names of and dates of attendance at each medical school the practitioner attended; 2) the name of each location at which the practitioner has privileges; 3) the address from which the practitioner will primarily conduct his or her practice; 4) any specialty board certifications; 5) the year that the physician began practicing medicine; 6) any medical school faculty appointments; 7) any convictions or pleas of nolo contendre for any criminal offense; and 8) any disciplinary action taken against the practitioner within the past ten years by any medical licensing board, specialty board, or medical practice organization (including resignation or non-renewal of staff membership or privileges at any hospital, HMO, clinic, or similar organization). Additionally, the profile must contain information regarding the physician's compliance with state law requirements for demonstrating financial responsibility, such as obtaining a minimally required amount of professional liability insurance. The profile also must contain information regarding any professional liability action within the past ten years which involved a payment of more than $5000. Finally, practitioners may choose to include in their profiles information regarding committee memberships, professional or community service awards, publications, and languages spoken other than English.

Prior to meeting with any of the three physicians, and prior to checking their physician profiles, it seemed that Physician B was the leading candidate to become our daughter's pediatrician. What could be a stronger positive factor than the fact that our own respected OB/GYN takes his kids to that doctor? However, checking Physician B's profile revealed some troubling information. First, Physician B's profile revealed two malpractice settlements, in 1993 and 1996 for $250,000 and $225,000 respectively. Second, Physician B received a suspension from the Florida Department of Health in 1994, though the penalty was stayed in that instance. By contrast, the profiles of the other two physicians under consideration revealed no disciplinary action or malpractice payments. In other respects, for example

6. Id.; see also id. ch. 456.039.
7. Id. ch. 456.039(1)(a)1-8.
8. See id. chs. 456.041(4), 458.320.
9. Id. ch. 456.041(4). The statute dictates that any information regarding professional liability actions be accompanied by the following language: "Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the practitioner. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred." Id.
10. See id. ch. 456.039(5).
medical education, practice experience, and board certifications, the three physicians appeared comparable.\textsuperscript{11}

This article will reflect closely on the positive or negative role that physician profiles might play in the physician selection process, and, more importantly for present purposes, try to determine whether similar "lawyer profiles" would be a positive or negative step in helping middle-income persons to find appropriate legal representation.

Following this introduction, this article will examine the difficulties middle-income persons encounter in trying to find appropriate legal representation, and will relate those difficulties to similar difficulties encountered by persons seeking medical treatment.\textsuperscript{12} Next, the article will discuss the recent wave of state physician profile legislation,\textsuperscript{13} including both the underlying conditions that led to the adoption of such legislation\textsuperscript{14} and the arguments that have been advanced both in favor of and in opposition to physician profile legislation.\textsuperscript{15} Then, the article will apply the discussion of physician profile legislation to the legal practice context\textsuperscript{16} in order to consider whether similar "lawyer profiles" are likely to appear in the near future\textsuperscript{17} and whether, regardless of their imminence, such profiles would be valuable to middle-income persons who are seeking legal representation.\textsuperscript{18} The article postulates that, while the underlying conditions that led to the adoption of physician profile legislation are not sufficiently present in the legal practice context to make the development of publicly accessible lawyer profiles likely in the near future,\textsuperscript{19} such profiles would, in fact, be of value to prospective consumers of legal services.\textsuperscript{20} Therefore, the article continues to consider what information should be included,\textsuperscript{21} and what information excluded,\textsuperscript{22} from lawyer profiles.

\textsuperscript{11} To find out how the rest of our pediatrician selection process went, how the above-described information factored into our final decision, and what that decision was, see infra Conclusion.
\textsuperscript{12} See infra Part I.
\textsuperscript{13} See infra Part II.
\textsuperscript{14} See infra Part II.A.
\textsuperscript{15} See infra Part II.B.
\textsuperscript{16} See infra Part III.
\textsuperscript{17} See infra Part III.A.
\textsuperscript{18} See infra Part III.B.
\textsuperscript{19} See infra Part III.A.
\textsuperscript{20} See infra Part III.B.
\textsuperscript{21} See infra Part III.C.1.
\textsuperscript{22} See infra Part III.C.2.
I. WHY IT'S EVEN HARDER FOR THE AVERAGE PERSON TO FIND A LAWYER THAN IT IS TO FIND A DOCTOR

The problem of how middle-income persons go about finding an appropriate lawyer for their legal needs has been much discussed. The consensus seems to be that there is no clear or easy way for a person to find an appropriate lawyer for his or her particular legal needs. According to a recent survey conducted on behalf of Martindale-Hubbell, "[m]ore than one-fourth of Americans admit that the inability to compare information about different attorneys (28%) and being intimidated or confused by the whole process (27%) of choosing a lawyer would limit their ability to research their options." Another fifth (20%) claim their ability to research options for choosing a lawyer is limited by lack of resources and information.

The Martindale-Hubbell survey concluded that the most common source people turn to in their quest to find appropriate legal representation is the views of family members and friends. A full three-quarters of those surveyed (75%) indicated that they would rely on family and friends to be their first resource when trying to find a lawyer. However, reliance on word of mouth may be particularly problematic in conjunction with the selection of professional services. The predominant view of the delivery of professional services in America over the past century has been that of the "Professionalism Paradigm." One of the fundamental conditions underlying the


26. Yankelovich, Lawyers in America: How We Choose Them, Use Them, and Sometimes Lose Them 26 (December 2000) (unpublished manuscript, on file with author) [hereinafter Lawyers in America]. The survey, based on interviews with 1001 adults chosen through random-digit dialing, was conducted by Yankelovich on behalf of Kaplow Communications and Lawyers.com, the Internet division of Martindale-Hubbell. See Lawyers in America, supra, at 3.

27. Id.

28. Id. at 8.

29. Id. at 24.

“bargain”\(^{31}\) that is the essence of the Professionalism Paradigm is the fact that the delivery of professional services involves the application of “esoteric knowledge,”\(^{32}\) of the kind which requires years of specialized education and training to acquire.\(^{33}\) The recipients of professional services lack the specialized knowledge necessary to evaluate the quality of services they receive.\(^{34}\) Therefore, client or patient recommendations based upon personal experiences with particular professionals may be misleading.

The problems with word-of-mouth recommendations may be even more acute in the legal context than in the medical context.\(^{35}\) This is because most Americans are in regular contact with at least one physician.\(^{36}\) Indeed, the increasing number of people who receive their medical care through some sort of managed care plan\(^{37}\) are

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\(^{31}\) Pearce, supra note 30, at 1238. Pearce describes the Professionalism Paradigm in terms of a bargain between the profession and society: The profession agrees to use its specialized knowledge and skills for the benefit of its clients (or patients) and the public at large, and society, in turn, agrees to grant to the profession an exclusive right to practice the profession, free from government, and to some extent, market control. \(\text{Id.}\) at 1239-40.

\(^{32}\) \(\text{Id.}\) at 1239. The other two fundamental conditions that Pearce identifies as underlying the Professionalism Paradigm are altruism, the notion that the profession will place its clients’ and the public’s interest ahead of its own financial and other self-interests, and autonomy in the form of self-regulation by the profession. \(\text{Id.}\) at 1239-40.

\(^{33}\) For example, doctors must complete at least four years of medical school training and a year-long internship, and pass three parts of the national licensing examination, before they are considered minimally qualified to practice medicine in any of the 50 states. See In Re Boston Medical Center Corporation, No. 1-RC-20574, 1999 WL 1076118, at *1-3, *16, *33 (N.L.R.B. Nov. 26, 1999) (discussing medical education in the context of holding that medical interns, residents, and fellows are “employees” for purposes of the National Labor Relations Act). Similarly, lawyers must graduate from an accredited law school and pass a state bar examination to be eligible to practice law. See, e.g., Geoffrey C. Hazard, Jr. et al., The Law and Ethics of Lawyering 870 (3d ed. 1999).


\(^{35}\) See Morton, supra note 23, at 284-85, 284 n.3 (describing reliance on word of mouth to find an attorney as “anachronistic”).

\(^{36}\) According to the Martindale-Hubbell survey, 77% of Americans indicated that they had hired a primary care physician. See Lawyers in America, supra note 26, at 16.

\(^{37}\) A simple definition describes managed care as “any system of health coverage in which the entity responsible for paying for covered services exercises control over the manner in which those services are delivered.” William M. Sage, Regulating Through Information: Disclosure Laws and American Health Care, 99 Colum. L. Rev. 1701, 1704 n.5 (1999) [hereinafter Sage, Regulating Through Information]. As of early 1998, 165 million Americans received some form of managed medical care. See Timothy S. Hall, Third-Party Payor Conflicts of Interest in Managed Care: A Proposal
usually required by the plan to have a primary care physician, who serves essentially as a gatekeeper for all of the medical services received under the plan. Thus, at least the primary care physician can offer an "expert" opinion with regard to referrals for doctors to perform specialty care. Indeed, it is just such a referral that my wife and I sought in our search for a pediatrician.

By contrast, most persons are not in regular contact with an attorney who plays a role analogous to that of the primary care physician. Suggestions have been made that persons engage in periodic "legal checkups" along the lines of annual physical exams. While preventive lawyering of this type might make sense for business or other entity clients, it seems implausible in the current context where most of the existing legal needs of middle-income individuals

for Regulation Based on the Model Rules of Professional Conduct, 29 Seton Hall L. Rev. 95, 100 (1998).

38. See Barry R. Furrow, Managed Care Organizations and Patient Injury: Rethinking Liability, 31 Ga. L. Rev. 419, 444, 482-84 (1997); Sage, Regulating Through Information, supra note 37, at 1746 n.154.

39. Of course, this arrangement does not resolve the difficulty a person might have in selecting a primary care physician. But see infra notes 54-55 and accompanying text (discussing the trend of intermediary institutions such as managed care plans to provide information to consumers to help them select a primary care physician). Moreover, as Sage points out, a primary care physician's competence in making referrals may differ from that physician's competence as a practitioner. Sage, Regulating Through Information, supra note 37, at 1746 n.154. Additionally, the primary care physician may have certain financial or other conflicting interests that may cause referrals to be made for reasons other than the merit of the referred-to doctor. Cf. Hall, supra note 37, at 104 (describing "withholds"—accounts set aside by managed care organizations to pay for specialty care, where part or all of any surplus in the account is paid to the primary care physician who provided fewer referrals than the allotted amount was set aside to cover).

40. See supra text accompanying notes 1-3.

41. However, the Martindale Hubbell survey indicated that 68% of those surveyed had hired a lawyer at some point in their lives. See Lawyers in America, supra note 26, at 22. Moreover, of those surveyed who had previously hired a lawyer, 52% claimed to have a "family lawyer" who handled all their affairs. Id. at 41. Nonetheless, this means that only a little more than a third of those surveyed claimed to have such a family lawyer.

42. See, e.g., Gary Bellow & Jean Charn, Paths Not Yet Taken: Some Comments On Feldman's Critique of Legal Services Practice, 83 Geo. L.J. 1633, 1659 app. II (1995) (suggesting "legal check ups" for legal services recipients); Louis M. Brown, The Practice of Preventive Law, 35 Am. Judicature Soc'y 45 (1951) (advocating "preventive law" along the lines of "preventive medicine"); Forrest S. Mosten, Unbundling of Legal Services and the Family Lawyer, 28 Fam. L.Q. 421, 445-46 (1994) (advocating asymptomatic "legal wellness" checkups). Apparently, members of the American Association of Retired Persons ("AARP") Legal Services Network have begun providing "Legal Checkup seminars" at various locations throughout the country. See AARP Legal Services Network, at http://www.aarp.org/lsn/checkup.html (last visited Oct. 15, 2001); see also Wayne Moore & Monica Kolasa, AARP's Legal Services Network: Expanding Legal Services to the Middle Class, 32 Wake Forest L. Rev. 503, 533 (1997). However, such group presentations seem a far cry from the individual examinations one would expect to receive from a physician.
For a number of years, a variety of prepaid legal services plans that may function in similar ways to health insurance, thereby providing access to lawyers for common legal needs for clients, have also been in existence. However, under such plans members do not receive a "primary care lawyer" who functions similarly to a primary care physician in a managed health care plan. Rather, prepaid legal services plan members are referred by the plan to particular lawyers affiliated with the plan to handle discreet legal problems. Generally, in a given calendar year, the plan will pay for a certain number of hours of legal services provided by its affiliated lawyers for the types of services covered under the plan. Members do not receive routine legal checkups or anything resembling the type of preventive care that is the cornerstone of managed health care plans. Moreover, even though there has been an increase in activity regarding prepaid legal services plans in the past few years, the percentage of persons being served by such plans is not yet significant enough to have much of an overall impact in improving the way people choose attorneys.

Presently, the number and variety of arrangements for delivering managed health care are staggering. While some managed care plans employ physicians directly, an increasing number of plans

43. According to a survey conducted by the American Bar Association ("ABA"), 61% of the situations faced by moderate income households that could be addressed by the civil justice system are not brought to any part of the justice system. See ABA Consortium on Legal Services and the Public, Legal Needs and Civil Justice: A Survey of Americans—Major Findings from the Comprehensive Legal Needs Study 24 (1994).


46. See, e.g., Jim Ellshoff, Pre-Paid Legal Coverage Now Offered in Montana, 25 Mont. Law. 31, 35 (Dec. 1999) (setting forth number of hours of legal services provided by Montana Prepaid Legal Services plan in exchange for monthly $16 premium).

47. Heid & Misulovin, supra note 44, at 342-43 (describing range of legal services covered by various prepaid legal services plans).


51. See Hall, supra note 37, at 101-02, 101 n.22 (citing Jeffrey F. Chase-Lubitz, The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care
contract with loose collections of practitioners or physician networks to provide medical services to the plan’s members.\textsuperscript{52} In turn, for the most part it is employers, pension plans, or government entities that contract with the managed care plans to provide medical services to their employees or recipients of public benefits.\textsuperscript{53} Institutional entities which facilitate the provision of medical services from physicians to patients—including health maintenance organizations, physician provider networks, insurance companies, employers, pension plans, and government entities—may have both economic incentives and legal obligations to provide information to patients that will be helpful to them in selecting physicians.\textsuperscript{54} For example, in his detailed analysis of medical disclosure laws, Professor William Sage describes the plethora of information that New York law requires be provided to him regarding the doctors, hospitals, and treatments available to him as a member of the health plan offered by his employer, Columbia University Law School.\textsuperscript{55}

By contrast, to the extent that there are intermediary institutions involved in the delivery of legal services, they lack similar incentives or legal obligations to provide information to potential clients that will aid them in their selection of an attorney. As pointed out above, prepaid legal services plans remain relatively marginal.\textsuperscript{56} Moreover, given that most such plans have opted for a referral network structure rather than a primary care provider structure, it is not clear that the plans have much of an incentive to provide extensive information regarding available attorneys. Indeed, the best known group legal services plan is that offered by the AARP.\textsuperscript{57} However, a visit to the AARP’s Web site does not provide any specific information beyond the name, contact information, and areas of practice of the listed

\textit{Industry}, 40 Vand. L. Rev. 445, 446 & n.8 (1987)).


53. As of 1998, 76\% of Americans with health insurance received that coverage through their employment. Sage, \textit{Regulating Through Information}, supra note 37, at 1720 & n.46 (citing Medicare Payment Advisory Commission, Health Care Spending and the Medicare Program: A Data Book 19 (1998)). Another 16\% received insurance from government sources (mostly Medicaid), and 8\% purchased their own health insurance. \textit{Id}. at 1720. Virtually all Americans over the age of 65 are eligible for Medicare. \textit{Id}. at 1720 n.46. Of course, approximately one-sixth of the American population lacks any health insurance coverage. \textit{Id}. at 1703, 1815 & n.430.

54. See \textit{id}. at 1737-38.

55. \textit{Id}. at 1704.

56. See supra notes 44-49 and accompanying text. \textit{But see} Heid & Misulovin, supra note 44, at 336-40 (pointing to an increasing number of employers providing prepaid legal services plans to employees as a fringe benefit, and predicting further growth in the future). Heid and Misulovin do not discuss what, if any, information is provided by employers to employees regarding the individual lawyers participating in the plans. Heid & Misulovin, supra note 44.

57. See Moore & Kolasa, supra note 42, at 503.
Moreover, in instances where government is an intermediary to providing legal services directly to individuals, such as in legal services and public defender programs, the client rarely has a choice of attorneys, so providing background information about the attorneys for purposes of attorney selection is beside the point.

According to the Martindale-Hubbell survey, after consulting family and friends, the favored secondary resource in finding a lawyer is the yellow pages. Of course, beyond areas of practice there is little substantive information in the yellow pages that would assist a person in selecting an appropriate attorney. Individuals also turn to other forms of advertising as a secondary source in their search for a lawyer. Yet, while there has been a proliferation of advertising by lawyers following the United States Supreme Court’s decision in *Bates v. State Bar of Arizona*, such advertising, whether it takes the form of late-night television commercials or direct mailings, provides little information that would be of use to persons in finding appropriate and competent representation.

Attorney directories offer little more in the way of useful information. While directories such as Martindale-Hubbell do provide basic background information on attorneys—such as when and where they graduated from law school, bar admissions, and fields of practice—such sources do not provide information that might reflect poorly upon the listed attorneys, such as disciplinary actions, malpractice payments, or criminal convictions. Given that most

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59. Lawyers in America, *supra* note 26, at 8, 25 (stating that 50% of those surveyed indicated that they would check the yellow pages as a secondary resource in looking for an attorney).

60. According to the Martindale-Hubbell survey, 33% of those surveyed would refer to television, radio, or print advertisements as a secondary resource to help them to find a lawyer. See *id.* at 25.

61. 433 U.S. 350 (1977). In *Bates*, the Court held that truthful advertising by attorneys is a form of constitutionally protected speech, and that blanket bans on such advertising are unconstitutional. *Id.* at 382-83. In a series of cases subsequent to *Bates*, the Court has generally upheld particular attorney advertising practices against regulatory efforts by state bar authorities. See generally Morton, *supra* note 23, at 311-13.


63. Morton, *supra* note 23, at 299. Martindale-Hubbell does offer its own quality rating system based upon oral or written reviews by other attorneys. See, e.g., I The Martindale-Hubbell Law Directory xv-xvi (2001). Lawyers receive both a “legal ability rating” and a “general recommendation” rating. *Id.* In the former category,
directories rely on voluntary submissions by attorneys, it is hard to see how they would survive if they included such adverse information.

Another manner in which consumers of legal services seek attorneys is through lawyer referral services. The typical lawyer referral service is operated on a not-for-profit basis by a local bar association, although increasingly for-profit lawyer referral services have come into being. Typically, a person looking for a lawyer contacts the referral service and self-identifies the problem area. The potential client is then referred to the next lawyer in line who has expressed a willingness to take cases in the problem area identified by the client. Referral services rarely require the attorney to demonstrate any particular expertise or experience in a problem area in order to receive referrals in that area. Usually only active membership in the bar in good standing, and perhaps a certain amount of malpractice insurance coverage, is required of the participating lawyers in the referral service. Additionally, no effort is made to match particular attorney competencies or characteristics to those of the potential client or case. Additionally, the referral lawyers can receive a “C” (fair to high); “B” (high to very high) or an “A” (very high to preeminent). In the latter category, lawyers can receive a “V” rating (“very high”). Taken together, the highest rating that an attorney can receive is an “AV” rating. However, Martindale-Hubbell does not make any direct claim that “AV” rated lawyers are superior to other attorneys, and no study to date has supported such a claim. To the contrary, at least one study has suggested that “AV” rated lawyers are no less likely to be sued for malpractice than other lawyers. See Manuel R. Ramos, Legal Malpractice: No Lawyer or Client Is Safe, 47 Fla. L. Rev. 1, 38-39 (1995), [hereinafter Ramos, No Lawyer or Client Is Safe].

64. Morton, supra note 23, at 301.
65. Id.; see also Model Rules of Prof’l Conduct R. 7.2 cmt. 6 (1983) (approving payment of charges to join not-for-profit lawyer referral services).
66. Morton, supra note 23, at 302; see also Rules Regulating Fla. Bar 4-7.11 (providing for for-profit lawyer referral services).
67. This procedure is somewhat troubling, given that prospective clients are often poorly situated to diagnose their own legal problems. See supra notes 30-34 and accompanying text. Moreover, personnel who work for the referral service, even if lawyers themselves, are likely to lump client problems into pre-existing categories of cases, without full consideration of the details of the clients’ problem or the appropriateness of such categorizations. See, e.g., Lucie E. White, Subordination, Rhetorical Survival Skills, and Sunday Shoes: Notes on the Hearing of Mrs. G., 38 Buff. L. Rev. 1 (1990).
68. In this regard, lawyer referral services work similarly to the English “taxi” system as it relates to barristers’ services. See Deborah L. Rhode, In the Interests of Justice: Reforming the Legal Profession 60 & n.23 (2000).
69. Morton, supra note 23, at 301.
70. Id. A notable exception is the AARP’s Lawyer Referral Network, which, from its inception, required participating lawyers to have a minimum of four years of practice experience, devote at least 20% of their practice to the type of cases for which referrals will be offered, and carry a minimum threshold amount of malpractice insurance. See Moore & Kolasa, supra note 42, at 539.
71. Morton, supra note 23, at 301.
72. Id. at 301-03.
service does not provide any information about the referred lawyer of the type that would be contained in a physician profile.\textsuperscript{73}

Increased development of the Internet has opened up a variety of additional options for persons seeking attorneys.\textsuperscript{74} Of course, much of the information available to potential consumers of legal services over the Internet is fundamentally the same as that available via traditional resources,\textsuperscript{75} only delivered through a different medium. For example, lawyers advertise over the Internet, attorney directories are available on-line,\textsuperscript{76} and both for-profit and not-for-profit attorney referral services operate on-line. The same limitations each of these sources present in helping persons find appropriate legal representation apply equally in the on-line environment and the traditional "bricks and mortar" world. The Internet has also produced non-traditional means of obtaining legal services. For example, consumers may receive legal advice or other forms of less-than-full-service legal representation over the Internet.\textsuperscript{77} However, in such contexts, the client is likely to know even less about the person providing the legal services than in the traditional context where at least a face-to-face meeting is involved. Furthermore, while such developments may ultimately go a long way toward providing more affordable and readily available legal assistance to persons of modest means,\textsuperscript{78} they are not likely to do so by making it easier for individuals to find specific providers of legal services best suited to their particular legal needs.

\textsuperscript{73} See id. Cf. supra notes 4-10 and accompanying text (discussing the relatively extensive requirements of Florida's physician profiles).

\textsuperscript{74} Thirty-four percent of the persons surveyed on behalf of Martindale-Hubbell indicated that they would use the Internet as a secondary resource in searching for a lawyer. Lawyers in America, supra note 26, at 25. As one would imagine, there are significant age-based differences in persons' willingness to turn to the Internet as a resource. Thus, 52\% of those aged twenty-six to twenty-nine were found likely to search the Internet as a secondary resource when looking for a lawyer, whereas, only 15\% of those fifty-two years of age or older were likely to turn to the Internet for assistance. Id. at 55.

\textsuperscript{75} See supra notes 59-73 and accompanying text.

\textsuperscript{76} See supra note 25.

\textsuperscript{77} See Richard Zorza, Re-conceptualizing the Relationship Between Legal Ethics and Technological Innovation in Legal Practice: From Threat to Opportunity, 67 Fordham L. Rev. 2659, 2663 \& n.16 (1999). In addition to providing some information to help persons to find lawyers, the Internet has also made available a tremendous amount of raw legal information that may make it easier for persons to represent themselves, rather than seeking the services of a lawyer. See id. at 2663-64, 2668-69. Interactive forms, pleadings, and other legal documents may further facilitate self-representation. Id. at 2668-69. For a more detailed discussion of the issues presented by self-representation in family law cases, see Steven Berenson, A Family Law Residency Program?: A Modest Proposal in Response to the Challenge Presented by Self-Represented Litigants In Family Court, 32 Rutgers L.J. (forthcoming December 2001).

\textsuperscript{78} See Zorza, supra note 77.
In light of the above discussion, it appears that there is ample need for additional sources of information valuable to middle-income persons selecting an attorney. Perhaps "lawyer profiles," along the lines of the physician profiles that have begun to appear in numerous states around the country, could serve that purpose.

II. PHYSICIAN PROFILES

Massachusetts was the first state to adopt physician profile legislation.79 In 1996, Massachusetts established a toll-free telephone number from which consumers of health care services could obtain certain information about Massachusetts health care providers.80 Four categories of data were provided by the Massachusetts hotline. The first was factual practitioner data, including personal information about the provider, educational and professional background, as well as any awards, honors, or specialty training or certifications.81 The next category of data included the practitioner's malpractice claims history.82 The hotline disclosed payments relating to claims of malpractice. However, rather than disclosing the specific amount of the payment, the hotline identified whether the payment was above average, below average, or average.83 The hotline also contained a disclaimer stating that malpractice payments may be unrelated to professional competence, and information regarding the percentage of practitioners in a particular specialty area who have made malpractice payments.84 The third category of information provided by the Massachusetts hotline pertained to licensing board and hospital disciplinary actions.85 The final category of information available through the Massachusetts hotline included information regarding criminal misdemeanor and felony convictions.86 The information disclosed included all criminal convictions, not only those directly related to the delivery of medical services.87 The Massachusetts hotline also excluded categories of arguably relevant information,

80. Id. at 975. For a history of the legislation creating the Massachusetts hotline, see id. at 975-76.
81. Id. at 976.
82. Id. at 977.
83. Stewart, supra note 79, at 977. The statute did not specify the method the Massachusetts Board of Registration in Medicine should use to determine the "average" claims payment. Id. at 978. The Board has apparently chosen to compare malpractice payments made by physicians within a given specialty in order to determine average, above average, and below average claims payments. See http://www.massmedboard.org/malpractice.htm (last visited Oct. 15, 2001).
84. Stewart, supra note 79, at 977.
85. Id. at 981.
86. Id. at 987.
87. Stewart, supra note 79, at 987.
including information relating to malpractice or disciplinary claims filed but not resolved, information relating to substance abuse by the provider, and provider-specific outcome data.\textsuperscript{88} Massachusetts' physician profiles became available over the Internet in May 1997.\textsuperscript{89}

Following the lead of Massachusetts and Florida, approximately two dozen states have provided for some form of publicly accessible physician profiles.\textsuperscript{90} There is a great deal of variety in the information that is included in state physician profiles. Information that may be included ranges from the doctor's demographic and educational background, licenses, and certifications, to malpractice suits, state licensing, or peer review disciplinary actions, and criminal convictions.\textsuperscript{91} Massachusetts and Florida represent one end of the continuum, providing the widest range of information about each practitioner. In fact, Massachusetts and Florida are presently the only states that include information relating to malpractice actions in their physician profiles. California represents an intermediate position, providing disciplinary but not malpractice information about profiled physicians.\textsuperscript{92} New York is the latest major state to approve on-line physician profiles.\textsuperscript{93}

\textbf{A. Conditions Underlying the Movement Toward Physician Profiles}

A number of conditions paved the way for the adoption of physician profile legislation. These included the development of informed consent doctrine, the "crises" in medical malpractice and peer review, and the creation of the National Practitioner Data Bank. Each of these conditions is discussed below.\textsuperscript{94}

1. The Development of Informed Consent Doctrine

Public acknowledgment that patients or other consumers of health care services might make worthwhile use of information relating to the background, performance, or practices of their health care

\textsuperscript{88} Stewart, supra note 79, at 988.
\textsuperscript{90} Kristen Hallam, Physicians Caught in the Web; Thanks to Internet, Doc Disciplinary Data Now Just a Mouse Click Away, Mod. Healthcare, Sept. 4, 2000, at 30.
\textsuperscript{92} Patricia Simms, It's Still Not Easy to Get Data on Doctors; There's Some Information Online, But It's Pretty Sketchy, Wis. St. J., Mar. 11, 2001, at A1.
\textsuperscript{94} See infra Parts II.A.1-II.A.4.
providers is a relatively recent phenomenon. Historically, the flow of information in the physician-patient relationship, as was the case with regard to other types of professional relationships, was governed by the "Professionalism Paradigm." Under this model, because patients lack the training and sophistication necessary to comprehend the esoteric knowledge involved in the practice of medicine, there is little to be gained by efforts on the part of doctors to educate patients or to provide explanations regarding the medical issues or treatment alternatives implicated by the patients' situations. For similar reasons, there was thought to be little to be gained from significant patient input regarding the course of treatment to be undertaken by the physician.

Though the possession of esoteric knowledge continues to be one of the hallmarks of medical practice, recent decades have seen inroads made into the view that doctors are able to use this knowledge in a manner that results in certain, non-contingent, and consistent judgments regarding preferred courses of treatment in the cases of particular patients. Rather, evidence has developed that doctors make highly contingent, prudential judgments regarding the appropriate course of treatment in particular circumstances. In such an environment, it has come to be believed that patients' autonomy interests require that they be educated and informed, and have input regarding the treatment choices and alternatives available to their medical practitioners. Similarly, it has come to be believed that patient input can have salutary effects on the quality of treatment decision making in the context of medical uncertainty. Indeed, this trend has been evidenced in areas of medical law including informed consent, discipline and malpractice, and peer review.

The law of informed consent has its origins in the common law tort of battery, and the notion that persons have an absolute right of control over the physical integrity of their bodies. However, at least in theory, the doctrine has expanded into a broader right of participation by patients in medical decision making. Some have

95. See supra notes 30-34 and accompanying text.
97. This view is consistent with Kuhn's broader conclusion that scientific knowledge is in fact no less contingent, and no more immutable, than knowledge in the social sciences, which were traditionally considered to result in a softer form of "truth" than "hard science." See generally Kuhn, supra note 30.
99. Id. at 48. In practice, doctors have resisted the substantially increased burdens of communication placed upon them by the evolving standard. See generally Jay Katz.
even argued for a broadening of the right of informed consent to a protected interest in patient choice. A more restricted contention that has been made, yet one that is more directly germane to this paper, is that the right of informed consent includes a right on the part of the patient to information concerning the doctor's background and performance record. Physician profiles arguably satisfy the requirements of this expanded conception of informed consent by providing patients with relevant background information regarding their doctors.

2. The "Crisis" in Medical Malpractice

The historical veneer of medical certainty was also undermined by a series of disclosures during the 1980s revealing a much greater incidence of medical negligence than had previously been acknowledged publicly. Though discussions of medical malpractice "crises" were longstanding, there was, in fact, a great increase in medical malpractice litigation during the '80s. From 1975 to 1986, the number of malpractice claims per 100 physicians increased more than 10% per year. Indeed, more medical malpractice cases were filed between 1977 and 1987 than in the previous history of American tort law. Naturally, this great expansion led to a corresponding increase in the cost of premiums paid for medical malpractice insurance. While there was much controversy surrounding the above discussed figures, and a great deal of dispute over whether, in fact, a "crisis" in


101. See Twerski & Cohen, supra note 99. But see Sage, Regulating Through Information, supra note 37, at 1750 n.172 (citing cases refusing to hold doctors liable for failure to disclose physician specific information); Kate Sievert Cook, Casenote, Albany Urology Clinic, P.C. v. Cleveland: Why You Should Always Ask Your Urologist if He Is a Cocaine Addict, 52 Mercer L. Rev. 1159 (2001).

102. See Health Care Quality Improvement Act of 1986, 42 U.S.C.A. § 11101(1) (1994) ("The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.")


105. Id. (citing P. Huber, The Legal Revolution and its Consequences 9 (1988)).

106. Id. at 412.
malpractice existed, there was, at a minimum, a public perception at this time that "something needed to be done" about adverse medical results relating to physician negligence.

There is more recent evidence that medical errors continue to occur at an alarming rate. In a 1999 report, the National Academy of Sciences' Institute of Medicine ("IOM") estimated that between 44,000 and 98,000 American hospital patients die each year due to medical errors. This report has further intensified efforts toward increased disclosure to medical patients. For example, the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") subsequently enacted a rule requiring hospitals to tell patients when they have been the victims of medical errors. Advancement of physician profile legislation has also been spurred by release of the IOM report.

3. Ineffective Peer Review

Paralleling the mid-1980s "crisis" in medical malpractice was a perceived crisis in peer review of medical practitioners. Peer review is the process by which doctors monitor and review the work of their colleagues. Peer review typically takes place in a hospital setting and consists of physicians on the hospital's peer review committee reviewing their colleagues on the hospital's staff. Peer review is thought to have the potential to be a particularly effective means of monitoring the quality of medical services, as the reviewing physicians work side by side with the physicians under review.

However, a number of factors are considered to have inhibited peer review from reaching its full potential. First, doctors are reluctant to pass judgment on their colleagues. Second, reviewers are reluctant to impose strict sanctions, given the devastating effect suspension or withdrawal of hospital privileges might have on the practice of a colleague. Also, peer reviewers are generally not compensated for their often time consuming work. Finally, in the past, members of

107. Id. at 430.
108. To Err is Human: Building a Safer Medical System 1 (Linda T. Kohn et al. eds., 1999). This estimate is based on empirical studies conducted in Colorado, Utah, and New York. Id. at 1 & nn.2-3.
109. See Robert Davis, Hospital Mistakes Must Be Disclosed; Accreditation at Risk if Patients Aren't Told, USA Today, June 28, 2001, at 1A.
110. Adler, supra note 96, at 696.
111. Id.
113. Adler, supra note 96, at 697.
114. Id.
115. Id.
LAWYER PROFILES?

peer review committees were often sued under a variety of theories by doctors subject to adverse peer review determinations.\textsuperscript{116} Moreover, where states passed legislation providing immunity for physicians involved in the peer review process, physicians denied hospital privileges took to attacking the peer review process on antitrust grounds.\textsuperscript{117}

Another major problem relating to peer review that was perceived in the mid-1980s concerned the lack of communication and cooperation between licensing authorities for medical practitioners across state lines, as well as a perceived lack of communication among peer review authorities. For example, it was perceived that a medical practitioner who lost his or her license to practice in one state as the result of incompetence, might simply move across the state line and receive a new license to practice medicine in the new state, without regard to any prior misfeasance.\textsuperscript{118} It was similarly thought that doctors could avoid the harsh results of adverse peer review determinations simply by seeking admitting or practice privileges at other institutions.

4. The National Practitioner Data Bank

In order to address the problems of migratory incompetent doctors and ineffective peer review, in 1986 Congress enacted the Health Care Quality Improvement Act ("HCQIA"),\textsuperscript{119} which "was designed both to provide for effective peer review and interstate monitoring of incompetent physicians, and to grant qualified immunity from damages for those who participate in peer review activities."\textsuperscript{120} Among other provisions, the HCQIA provided for the establishment of a National Practitioner Data Bank ("NPDB"), which was designed to provide a clearinghouse for information regarding licensing, disciplinary action, and peer review regarding all medical practitioners.

Three general categories of information must be reported to the NPDB: medical malpractice payments, licensing actions, and adverse actions by health care entities.\textsuperscript{121} Any payment made to a complaining person as a result of a medical malpractice claim must be reported to the NPDB, whether made by an individual or an insurance

\textsuperscript{116} Id. at 698. Such theories include defamation, denial of due process, and tortious interference with business relations. Id.

\textsuperscript{117} Id.

\textsuperscript{118} Id. at 692.

\textsuperscript{119} See supra note 102; see also 42 U.S.C.A. § 11101 (1994).

\textsuperscript{120} Ruth E. Flynn, Demand for Public Access to the National Practitioner Data Bank: Consumers Sound Their Own Death Cry, 18 Hamline J. Pub. L. & Pol'y 251, 251-52 (1996) (quoting Austin v. McNamara, 979 F.2d 728, 733 (9th Cir. 1992)).

\textsuperscript{121} Ryzen, supra note 104, at 416.
company.\textsuperscript{122} There is no minimum threshold that must be met in order to trigger the reporting requirement.\textsuperscript{123} Any disciplinary actions taken by state medical boards must also be reported to the NPDB, if they relate to "professional competence or professional conduct."\textsuperscript{124} Such actions include "license revocations, suspensions, censures, reprimands, probation, and voluntary surrenders."\textsuperscript{125} Finally, health care entities that engage in professional review activities must report actions that adversely affect a physician's clinical privileges for a period of more than thirty days, when such actions arise out of the peer review process and are based upon the physician's professional competence or professional conduct.\textsuperscript{126}

From its inception, information contained in the NPDB has not been available to the public.\textsuperscript{127} Such secrecy was justified on grounds that opening up the data bank's records to public scrutiny would defeat the Act's primary purpose of increasing the involvement in and reliability of peer review activities.\textsuperscript{128} Despite this fact, numerous proposals have been made since the Act's inception to provide public access to some or all of the information contained in the data bank.\textsuperscript{129} Most recently, Congressman Thomas Bliley of Virginia proposed legislation to open up the data bank.\textsuperscript{130} None of the proposals to make the information contained in the data bank available to the public have been successful, and it does not appear that granting public access is likely to be approved anytime soon.\textsuperscript{131} Nonetheless, the very existence of a single source containing the wealth of information thought to be relevant to issues of physician choice, along with the efforts to open up the data bank, seem to have created a momentum that has helped pave the way for state physician profiles.\textsuperscript{132} Indeed, many of the same entities and organizations that have had their efforts to provide access to the data bank thwarted at the federal level have found success in obtaining access to similar information through efforts at the state legislative level.\textsuperscript{133}

\textsuperscript{122} Id. (citing 45 C.F.R. 60.7 (1991)).
\textsuperscript{123} Id.
\textsuperscript{124} Id. at 417 (citing 45 C.F.R. 60.8 (1991)).
\textsuperscript{125} Id.
\textsuperscript{126} Id. at 418 (citing 45 C.F.R. 60.9 (1991)).
\textsuperscript{127} Flynn, supra note 120, at 252.
\textsuperscript{128} Id. at 253.
\textsuperscript{131} Pape, supra note 129, at 982.
\textsuperscript{132} Id. at 983; see also Ryzen, supra note 104, at 455.
\textsuperscript{133} Note that subsequent to the development of the data bank, a number of
B. Arguments For and Against Physician Profiles

Numerous arguments have been made both in favor of and against providing public access to physician profiles. These arguments can be grouped into four general categories. The first category of arguments relates to consumer sovereignty and autonomy. The second category focuses on the impact of physician profiles on medical practice. A third category focuses on physicians’ privacy interests. A final category of arguments focuses on the costs and logistical challenges involved in compiling and maintaining accurate physician profiles. A discussion of these arguments follows. ¹³⁴

1. Consumer Sovereignty and Autonomy

The most basic argument in favor of physician profiles focuses on patients as consumers of medical services. Proponents of the consumer protection perspective regard the purchase and sale of medical services in the same manner as any other consumer transaction.¹³⁵ Within that framework, it is argued that the more information consumers have, the more efficient purchasing decisions they will make. Thus, the more information about the providers of medical services that is available to consumers, the better. Also, consistent with the above discussion of the informed consent doctrine,³¹ proponents of public access to physician profiles argue that the information contained in such profiles is germane to patient decision making regarding the appropriate course of medical treatment to be given by a particular provider. Providing such information serves patients’ autonomy interests.

Opponents of physician profiles, on the other hand, argue that rather than providing valuable information that will help consumers in selecting a physician, physician profiles are likely to have the opposite effect. In particular, such opponents focus on the confusing nature of private sources, including both non-profit advocacy groups and for-profit business entities, established a variety of databases that are available to the public, either for free or for a fee, containing information similar to that contained in the data bank. See, e.g., Public Citizen Group, 20,125 Questionable Doctors Disciplined by State and Federal Governments (2000); The American Board of Medical Specialties, http://www.abms.org (last visited Oct. 15, 2001); American Medical Association, AMA Physician Select, http://www.ama-assn.org/aps/amahg.htm (last visited Oct. 15, 2001); HealthGrades, Physician Profiles, http://www.healthgrades.com (last visited Oct. 15, 2001); Search Pointe, http://www.searchpointe.com (last visited Oct. 15, 2001); see also FSMB Report, supra note 91, at 4; Jeff Sturgeon, Here’s How to Check Out a Physician, Roanoke Times & World News, Feb. 11, 2001, at 2.

¹³² Infra Parts II.B.1-II.B.4.
¹³⁵ See, e.g., Emanuel & Emanuel, supra note 96, at 156.
¹³⁶ See supra Part II.A.1; see also Lawrence Smarr, A Comparative Assessment of the PIAA Data Sharing Project and the National Practitioner Data Bank: Policy, Purpose and Application, 60 Law & Contemp. Probs. 59, 66-72 (1997).
malpractice and disciplinary information contained in physician profiles. Indeed, a number of commentators have argued that the presentation of the limited amount of information regarding malpractice judgments and settlements that is made available to members of the public through physician profiles is so likely to be misleading that it would be better if such information were not provided at all.137

As discussed above, data banks vary in terms of their reporting requirements for malpractice payments—some do not require reporting of such payments at all, others require reporting of all malpractice payments regardless how small, and others only of payments above a certain threshold amount.138 In the latter case, it is argued that payments below the threshold amount reflect only the “nuisance value” of the claim,139 and therefore, do not provide any reliable indication that the payer has in fact committed medical malpractice. It has also been argued that even larger settlements are a poor indication that malpractice has actually occurred.140 It is also contended that past malpractice claims may be poor predictors of future claims.141 It has been further argued that rather than evidencing physician incompetence, malpractice claims are most directly influenced by medical specialty and geographic location. For example, 73% of all OB/GYNs have been sued at least once.142 However, according to 1991 data, while the average obstetrician had

137. Flynn, supra note 120, at 276.
138. See supra text accompanying notes 91-93.
139. The term “nuisance value” refers to those costs that would have to be incurred to dispose of even the most baseless claim of malpractice. See Ryzen, supra note 104, at 430. Such costs might include attorneys fees, expert witness fees, and the like.
140. Ryzen, supra note 104, at 431; Flynn, supra note 120, at 277. At least one study concluded that the likelihood of malpractice litigation being pursued is more greatly influenced by the doctor’s interpersonal skills than by the technical quality of the services provided. Flynn, supra note 120, at 277 (citing 6 Health News Daily, Nov. 23, 1994, at 227 (citing studies by Gerald Hickson, M.D., et al.)); see also Randall R. Bovbjerg & Kenneth R. Petronis, The Relationship Between Physicians’ Malpractice Claims History and Later Claims: Does the Past Predict the Future?, 272 JAMA 1421 (1994) (concluding that previous claims, regardless of whether they resulted in payments or not, are indicative of physicians with troubled relationships with their patients). For a description of the Bovbjerg and Petronis study, see Stewart, supra note 79, at 979-81.
141. Ryzen, supra note 104, at 432 (citing Rolph, et al., Malpractice Claims Data as a Quality Improvement Tool II: Is Targeting Effective?, 266 JAMA 2093 (1991)). But see Bovbjerg & Petronis, supra note 140, at 1425 (concluding that a history of prior malpractice claims is strongly predictive of a likelihood of future claims against a practitioner).
been sued three times, the average New York State obstetrician had been sued eight times.\textsuperscript{143}

Similar arguments have been made regarding the misleading nature of and inconsistency among disciplinary actions taken by medical licensing boards.\textsuperscript{144} More particularly, it may be difficult for consumers to determine the appropriate amount of weight to attach to disciplinary sanctions without knowledge of the frequency or severity of similar sanctions in the relevant jurisdiction. For example, the most active state medical board in the country, among states with more than 2000 practicing physicians, appears to be that of Kentucky, which reported approximately 8.23 disciplinary actions per 1000 physicians in the year 2000.\textsuperscript{145} The least active board was that of Idaho, with only 1.43 actions per 1000 physicians.\textsuperscript{146} In between these extremes, there is a great deal of variability in state medical board disciplinary activity.

Finally, the malpractice and disciplinary information contained in physician profiles may be presented in a manner that deprives it of much of its informational value. Most state physician profiles do not contain any information relating to the facts or circumstances of the disciplinary or malpractice action. Rather, all that is usually reported is the outcome (e.g., $10,000 settlement, six-month suspension, etc.) It is argued that consumers can take little away from a report of the outcome of disciplinary or malpractice proceedings without knowing anything about the facts of the underlying matter.\textsuperscript{147}

One way that proponents of practitioner profiles have attempted to address some of the opposing arguments discussed above is by advocating for disclaimer language to be included in the practitioner profile along with any information relating to malpractice payments. As mentioned earlier, such language must be included in Florida’s

\textsuperscript{143} Ryzen, supra note 104, at 430 (citing Gastel, Medical Malpractice Insurance Information Institute, New York, Nov. 1991).

\textsuperscript{144} Stewart, supra note 79, at 985. The Hickson study, supra note 140, was unable to document a correlation between prior disciplinary action and quality of subsequent care.

\textsuperscript{145} This figure represents the FSMB's Composite Action Index ("CAI") for 2000. See Federation of State Medical Boards, Summary of 2000 Board Actions (Apr. 6, 2001), http://www.fsmb.org/PDFFiles2001SBA.pdf (on file with the Fordham Law Review). The CAI, in turn, represents the arithmetic mean of four other state activity ratios: 1) total actions divided by total licensed physicians; 2) total actions divided by practicing in-state physicians; 3) total prejudicial actions divided by total licensed physicians; and 4) total prejudicial actions divided by practicing in-state physicians. \textit{Id}. A prejudicial action includes any loss or restriction of a license or license privilege or any penalty or reprimand to an individual physician. \textit{Id}. The CAI is purported to be a useful way to measure a state board's disciplinary activity over time. However, since the CAI is not claimed to be reliable in jurisdictions with less than 2000 practicing physicians, \textit{Id}., those figures are not referred to in the above discussion.

\textsuperscript{146} \textit{Id}.

\textsuperscript{147} Stewart, supra note 79, at 985-86.
Massachusetts requires a disclaimer of even greater detail than the Florida disclaimer. Additionally, some have suggested including information regarding malpractice-payment frequency in certain specialty practice fields. One can certainly question the impact that such boilerplate disclaimer language is likely to have on the readers of practitioner profiles. Indeed, such disclaimers seem about as likely to be effective as jury instructions to disregard prior testimony. Nonetheless, for the proponents of practitioner profiles, the possibly misleading quality of malpractice payment and disciplinary information is outweighed by the marginal benefit to consumers that such information provides in making decisions regarding medical practitioners.

2. Impact on Medical Practice

Proponents of physician profiles contend that practitioners are likely to be more careful and practice more proficiently if they are aware that adverse consequences, whether in terms of discipline or malpractice, are likely to be made readily accessible to prospective patients. Ultimately, market forces may drive incompetent practitioners out of business, if consumers are aware of, and therefore hold such practitioners accountable for, unacceptable performance and results.

However, opponents of physician profiles argue that providing public access to physician profiles will adversely impact medical practice. First, some argue that physicians will unduly practice "defensive medicine" in order to avoid any incidents that might ultimately lead to reportable information. Second, others argue that physicians are more likely to litigate cases that formerly would have settled, in order to avoid public disclosure of the settlement. Additionally, some argue that the availability to plaintiffs' lawyers of information regarding previous malpractice claims will result in an increase in the number of claims filed. Obviously, doctors spending more time in courtrooms or working on the defense of medical

148. See supra note 9.
149. See Stewart, supra note 79, at 983 n.170, for the text of the Massachusetts disclaimer.
150. See, e.g., Miller, supra note 34, at 130; Pape, supra note 129, at 1027.
151. See FSMB Report, supra note 91, at 7-8; Miller, supra note 34, at 129-30; Ryzen, supra note 104, at 457.
152. See Adler, supra note 96, at 740; Stewart, supra note 79, at 973.
154. Pape, supra note 129, at 989-90; Ryzen, supra note 104, at 434; Flynn, supra note 120, at 275-76.
155. See Ryzen, supra note 104, at 456 & n.238.
malpractice litigation will not have a salutary effect on the delivery of medical services to patients.

Third, some argue that public access to physician profiles will harm the peer review process, which, as discussed above, many view as being an important factor in improving medical practice. The peer review process depends, at least in part, on the self-reporting of data by the physicians subject to review. However, physicians may be reluctant to provide all of the information necessary for effective peer review if they are concerned that the information may become publicly available as part of their physician profiles. Additionally, it has been argued that hospitals have decreased the incidence of disciplinary action affecting hospital privileges so as to avoid having to report such data to the NPDB. Finally, doctors may be even more reluctant to take adverse action with regard to their peers if the results of the peer review action will be available to the public.

In response, it can be noted that physicians already practice "defensive medicine," have done so since at least the increase in malpractice litigation in the 1980s described above, and are likely to continue to do so in the future, with or without practitioner profiles. And while it may be too early to draw any grand conclusions, it does not appear that the states that have already instituted practitioner profiles have witnessed an increase in malpractice litigation activity. For example, the Executive Director of Massachusetts' Board of

156. See supra text accompanying note 112; see also Pape, supra note 129, at 990.
158. Id. at 990.
159. Sage, Regulating Through Information, supra note 37, at 1795 n.353 (citing Laura-Mae Baldwin, Hospital Peer Review and the National Practitioner Data Bank: Clinical Privileges Action Reports, 282 JAMA 349 (1999)). Additionally, Sage contends that some managed care physicians insisted on having "no cause" termination provisions inserted in their employment contracts in order to prevent incurring reportable terminations from managed care panels. Id. (citing Alice G. Gosfield, Presentation to the American Medical Association (Feb. 1993)). Apparently, deals are also worked out with HMOs on a case-by-case basis to allow doctors to resign from a health plan rather than incur reportable discipline. See Robert Pear, Inept Physicians Are Rarely Listed as Law Requires, N.Y. Times, May 29, 2001, at A1.

Even more troubling is a recent report by the Inspector General of the Department of Health and Human Services demonstrating extremely low levels of compliance with the HCQIA's reporting requirements by both HMOs and hospitals, even where discipline is imposed. See Department of Health and Human Services, Office of Inspector General, Managed Care Organization Nonreporting to the National Practitioner Data Bank: A Signal for Broader Concern (May 2001). According to the report, from 1990-99, HMOs reported a total of only 715 adverse actions to the NPDB, and 84% of HMOs reported no adverse actions at all. Id. at 1. Hospital reporting is not much better—as of the year 2000, 60% of hospitals had never reported an adverse action to the NPDB. Id. at 2.
160. See Flynn, supra note 120, at 275.
161. Supra Part II.A.2.
Registration in Medicine testified before Congress that rather than leading to an increase in frivolous malpractice claims, the Massachusetts rate for malpractice payments actually decreased by 12.4% since establishment of the profiles, more than twice the rate of decrease nationally. Nor does there appear to have been an adverse effect on peer review activities from existing practitioner profile legislation. Indeed, the manager of the Florida Department of Health's practitioner regulation program similarly testified before Congress as to an absence of any negative consequences resulting from implementation of Florida's practitioner profile program.

3. Physician Privacy

Opponents of physician profiles have argued that public access to physician profiles results in a violation of the physicians' privacy rights. To the extent that profiles include information that might be highly embarrassing to physicians, such as criminal convictions, this argument has strength. Also, given that professional disciplinary actions have been viewed as having a "quasi-criminal" status, thus implicating heightened due process concerns, it is clear why physicians are reluctant to make the results of disciplinary proceedings available to the public.

Nonetheless, it is the case that most information contained in physician profiles was already available to the public before the enactment of physician profile legislation. For example, most disciplinary actions by state medical boards are matters of public record, as are most criminal records. The outcomes of malpractice cases are also generally available to the public. Additionally, as pointed out above, a number of groups collect and disseminate information about physicians, ranging from Public Citizen to the American Medical Association. Of course, consumers were previously required to visit multiple sources in order to collect all of

164. Id. (prepared testimony of Gloria Crawford Henderson, Director, Division of Medical Quality Assurance, Florida Department of Health).
165. See Pape, supra note 129, at 992; Stewart, supra note 79, at 963.
167. See Stewart, supra note 79, at 963-64.
168. Flynn, supra note 120, at 270.
169. Id. at 271.
170. Id. at 270-71.
the information available through physician profiles, and many of the 
sources may have been difficult for average persons to access.\textsuperscript{171} 
However, given that most of the information contained in practitioner 
profiles was already public, it is hard to see how the marginal decrease 
in physician privacy caused by practitioner profiles outweighs the 
increase in convenience to consumers created by collection of such 
data in a single, easily accessible place.

4. Costs and Logistical Difficulties

Some opponents of physician profiles have based their opposition 
on the high costs involved in collecting and maintaining the relevant 
data.\textsuperscript{172} Moreover, it is argued that such costs are not justified given 
that, as pointed out above,\textsuperscript{173} the information contained in practitioner 
profiles was already widely available through other sources.\textsuperscript{174} 
However, practitioner profiles seem to be wildly popular with 
consumers. In September 2000, the Director of Florida’s Division of 
Medical Quality Assurance testified before Congress that Florida’s 
physician profile Web site had averaged more than 15,000 “hits” per 
month.\textsuperscript{175} And in the first three-and-a-half years of Massachusetts’ 
practitioner program, 4.9 million profiles were requested.\textsuperscript{176} 
Given such popularity, and the number of states that have moved to 
implement some sort of publicly accessible practitioner profile 
program, it seems that most believe that incurring the costs necessary 
to make the information contained in practitioner profiles easily and 
conveniently accessible to consumers is justified.

Additionally, questions have been raised about the quality of data 
contained in physician data banks.\textsuperscript{177} Obviously, the usefulness of the 
information provided to consumers in physician profiles is dependent 
upon the accuracy, completeness, and timeliness of the information

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\textsuperscript{171} See supra text accompanying notes 168-170; see also Stewart, supra note 79, at 964. 
\textsuperscript{172} See Stewart, supra note 79, at 989. 
\textsuperscript{173} See supra text accompanying notes 168-170. 
\textsuperscript{174} See Stewart, supra note 79, at 989. 
\textsuperscript{175} See Public Access to the National Practitioner Data Bank: Hearings Before the 
House Commerce Comm., 106th Cong. (Sept. 20, 2000) (prepared testimony of Gloria 
Crawford Henderson, Director, Division of Medical Quality Assurance, Florida 
Department of Health). 
\textsuperscript{176} Public Access to the National Practitioner Data Bank: Hearings Before the 
House Commerce Comm., 106th Cong. (Mar. 1, 2000) (prepared testimony of Nancy 
Achin Sullivan, Executive Director, Massachusetts Board of Registration in 
Medicine). 
\textsuperscript{177} See, e.g., Department of Health and Human Services, Office of the Inspector 
General, Managed Care Organization Nonreporting to the National Practitioner Data 
Bank: A Signal for Broader Concern (2001); General Accounting Office, National 
Practitioner Data Bank: Major Improvements Are Needed to Enhance Data Bank’s 
Reliability (2000); Pape, supra note 129, at 1018.
\end{flushleft}
provided.\textsuperscript{178} However, there is a good deal of variability in the quality of the data used to compile physician profiles.\textsuperscript{179} Concerns have even been raised about the completeness and quality of data contained in the NPDB.\textsuperscript{180}

It seems clear that standards regarding the quality and integrity of data are an essential component of physician profiles.\textsuperscript{181} In Florida, the information contained in physician profiles is based largely upon self-reported data from doctors seeking initial medical licenses or extensions thereof.\textsuperscript{182} Therefore, it seems that the threat of under-reporting of negative information is greater than the threat of false positives.\textsuperscript{183} And while there are penalties to be applied to doctors who fail to report information required to be reported by the profiles legislation,\textsuperscript{184} there are also procedures available for doctors to correct what they claim to be inaccurate information contained in their profiles.\textsuperscript{185} The NPDB has even more involved procedures for doctors to file grievances to correct perceived inaccuracies in their records.\textsuperscript{186}

\section*{C. The Prognosis for Physician Profiles}

Given the fact that half the states have adopted some form of publicly accessible physician profiles\textsuperscript{187} and more seem likely to follow suit, it seems clear that the responses to the above-described arguments against publicly accessible physician profiles\textsuperscript{188} have carried the day, and that physician profiles are here to stay. Moreover, as stated above,\textsuperscript{189} physician profiles appear to be extremely popular with the public. Nonetheless, it is probably too early to draw any grand conclusions regarding the success or failure of providing public access

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{178} See Pape, supra note 129, at 1018.
\item \textsuperscript{179} Id. at 1013-14, 1018.
\item \textsuperscript{180} See supra text accompanying note 177.
\item \textsuperscript{181} See Pape, supra note 129, at 1004-08 (discussing "fair information practices" for physician data banks).
\item \textsuperscript{182} Fla. Stat. ch. 456.039 (2001).
\item \textsuperscript{183} A fingerprint check run of all new applicants for medical licenses since 1997 and all applicants for renewals since 2000 revealed sixteen doctors who failed to report criminal convictions as required by Florida's profile legislation. \textit{Check Reveals Criminal Past of 2000 M.D.s}, Miami Herald, June 12, 2001, at 7B.
\item \textsuperscript{184} See Fla. Stat. ch. 456.039(3)(a), (b). Among other penalties, the state medical board may deny a license application or revoke an existing license for failure to provide required information, or issue fines of up to $50 for each day the required information is not provided. \textit{Id.}
\item \textsuperscript{185} See Fla. Stat. ch. 456.041(7). A copy of the profile must be provided to the doctor at least thirty days before publication. The doctor then has thirty days to correct any errors. \textit{Id}
\item \textsuperscript{186} See Pape, supra note 129, at 1020 & nn. 294-96 (citing 45 C.F.R. 60.11(a)(2), 60.14 (1996)).
\item \textsuperscript{187} See supra text accompanying note 90.
\item \textsuperscript{188} Supra Part II.B.
\item \textsuperscript{189} See supra text accompanying notes 175-176.
\end{itemize}
\end{footnotesize}
to state physician profiles. Indeed, it does not appear that any comprehensive studies have been undertaken of the initiatives that have been implemented to date. However, as pointed out above, anecdotal evidence seems favorable to physician profiles.

III. IS THE TIME RIPE FOR LAWYER PROFILES

No state presently offers lawyer profiles along the lines of the physician profiles discussed above. However, given the popularity of physician profiles and the momentum in favor of state physician profile legislation, it is worth asking whether the time is ripe for lawyer profiles.

A. Underlying Conditions

While some of the conditions discussed above that led to the adoption of physician profiles might apply equally to the legal context, there are significant differences that suggest that the time is not yet ripe for lawyer profiles. For example, the doctrine of informed consent is not nearly as developed in the legal practice context as it is in the medical context. Additionally, there is no present consensus that there is a legal malpractice crisis. Also, peer review has not been deemed to be as central to effective legal practice as it is to medical practice. Finally, the National Discipline Data Bank is much less developed than the NPDB.

1. Informed Consent

A number of commentators have argued for incorporation of the medical concept of informed consent into the practice of law. Yet while attorneys have long had an ethical obligation to communicate with their clients regarding the objectives of legal representation and the means to be used to achieve those objectives, a formal concept of informed consent has not heretofore been a required component of the everyday practice of lawyers in most jurisdictions. However, just as the “doctor knows best” approach to medical practice has been

190. See supra text accompanying notes 162-163.
192. See, e.g., Model Rules of Prof'l Conduct R. 1.2(a) (1998) (“A lawyer shall abide by a client's decisions concerning the objectives of representation ... and shall consult with the client as to the means by which they are to be pursued.”); 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.”) Ethical Consideration 7-8 of the predecessor Model Code of Professional Responsibility stated that a lawyer “should exert his best efforts to insure that decisions of his client are made only after the client has been informed of relevant considerations.” Model Code of Prof'l Responsibility EC 7-8 (1969).
undermined in recent decades, so too has the belief in the certainty and immutability of lawyers' decision making. Part of the reason for this trend lies in the consumer protection movement, as well as the decrease in respect for authority generally in the post-Vietnam War and Watergate eras. Also, the triumph of Legal Realism has caused a loss of faith in the autonomy of law as a discipline.

Additionally, the lack of incorporation of a formal concept of informed consent in legal practice may be about to change. As part of the ABA's Ethics 2000 project, the commission charged with reviewing the Model Rules of Professional Conduct recommended adding the concept of "informed consent" in various places throughout the rules where consent of the client is required. Should the Commission's proposed revisions be adopted by the ABA House of Delegates, and subsequently incorporated into various state adaptations of the Model Rules, the result might be a strong movement toward incorporation of the concept of informed consent into legal practice. However, none of the proposed changes would

193. See supra Part II.A.1.
194. See Cramton, supra note 23, at 607.
195. Id. at 607-08. The Legal Realist movement, beginning in the 1920s, challenged the existing notion that immutable legal rules could be deduced from prior case decisions, and then applied in future cases to yield determinate results. See Joseph William Singer, Legal Realism Now, 76 Cal. L. Rev. 467, 469 (1988) (reviewing Laura Kalman, Legal Realism at Yale, 1927-1960 (1986)). Rather, the Legal Realists contended that decisions in cases are both fact specific, and functions of existing social conditions, and therefore, are much less determinate than previously assumed. Id.
197. The Commission proposed adding the following definition of "informed consent" to the Rules: "the agreement... to a proposed course of conduct after the lawyer has communicated adequate information and explanation about the material risks of and reasonably available alternatives to the proposed course of conduct." Model Rules of Prof'l Conduct R. 1.0 (Proposed Rule 2001), http://abanet.org/cpr/e2k-rule10.html (on file with the Fordham Law Review).
199. Specific instances where the proposed rules would require informed consent of the client include: agreements between attorney and client to limit the scope or objectives of representation, see R. 1.2(c) (Proposed Rule 2001), http://www.abanet.org/cpr/e2k-rule12.html (on file with the Fordham Law Review); waivers of confidentiality by the client, see R. 1.6(a) (Proposed Rule 2001), http://www.abanet.org/cpr/e2k-rule16.html (on file with the Fordham Law Review); and waivers of concurrent conflicts of interest, see R. 1.7(b) (Proposed Rule 2001), http://www.
LAWYER PROFILES?

directly reach so far as to require a lawyer to provide information regarding the lawyer's background, disciplinary, or malpractice record, as part of the duty of informed consent. This fact, along with the lesser development of the concept of informed consent in the legal context as compared to the medical context, suggests that the push toward publicly accessible profiles will not yet be as strong in law as it is in medicine.

2. Legal Malpractice

To date, lawyers have not experienced an influx of professional liability actions of the magnitude that has effected the medical profession. For example, an empirical study comparing doctors and lawyers in Detroit, Michigan, and Columbus, Ohio, in the mid-1980s showed that while 68% of the doctors in Detroit and 49% of the doctors in Columbus had been sued for malpractice, only 20% of the lawyers in Detroit and 18% of the lawyers in Columbus had been similarly sued.

Nonetheless, there has been a growth in malpractice litigation against attorneys in recent years, and some predict that that growth

abanet.org/cpr/e2k-rule17.html (on file with the Fordham Law Review).

201. The Commission recommended no change to Model Rule 1.1, which merely requires that a lawyer be "competent" to undertake representation on a particular legal matter. The Rule, in turn, defines competent representation as requiring "the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation." Model Rules of Prof'l Conduct R. 1.1 (2001). Moreover, the Comment to the Rule indicates that even if a lawyer is not competent to undertake the representation at the outset, the lawyer can nonetheless undertake the matter if the lawyer can become competent through "necessary study" or "reasonable preparation." R. 1.1 cmts. 2, 4. It is hard to see how this Rule could be interpreted properly to require attorneys to disclose facts about their background, experience, or disciplinary or malpractice record prior to taking on a particular case. While an attorney's fiduciary duties to a client might require more in the way of disclosure, such duties are not likely to arise until after the formation of an attorney-client relationship. See, e.g., Tante v. Herring, 453 S.E.2d 686 (Ga. 1994). However, it is prior to the decision whether to engage a particular attorney that the prospective client stands to benefit most from the disclosure of such information.


203. See Peters, et al., supra note 103, at 608.

204. Rhode, supra note 68, at 165. Rhode attributes this growth to failure of disciplinary processes to provide effective consumer remedies, consumer activism, a
will magnify in the near future. Of course, a growth in malpractice litigation does not prove that there has in fact been an increase in attorney malpractice. Indeed, a recent study conducted by the ABA regarding legal malpractice claims found that nearly 68% of the malpractice claims filed resulted in no payment at all to the claimant, and only a little more than 1% of the cases resulted in a judgment for the plaintiff. Previous ABA studies resulted in similar findings. Moreover, anecdotal evidence presented to the ABA in its study of malpractice claims in the years 1990-95 indicated that, to the extent there was growth in the frequency and/or severity of malpractice claims during that period, such growth was small, gradual, and inconsistent across jurisdictions. No evidence presented in the more recent study appears to contradict that trend. In any event, until there is a widespread public perception of a “crisis” in legal malpractice, along the lines of the medical malpractice “crisis” that was perceived in the 1980s, it seems unlikely that this factor will fuel a significant movement toward publicly accessible lawyer profiles.

search for “deep pockets” following financial scandals, and an increase in the number of lawyers specializing in malpractice work. Id. 205. Schumann & Herlihy, supra note 202. More particularly, Schumann and Herlihy predict a tremendous growth in legal malpractice litigation in Texas due to 1) a decline in the professional collegiality that made lawyers reluctant to sue other lawyers; 2) increased difficulty in recovering from traditional defendant groups due to changes in Texas law; 3) rising numbers of inexperienced and unmentored lawyers; 4) a likely decline in the Texas business cycle; and 5) acceptance of novel theories of liability including breach of fiduciary duty and liability without privity. Id. at 148-50.

206. ABA Standing Committee on Lawyer’s Professional Liability, Profile of Legal Malpractice Claims 1996-1999 (2001) [hereinafter Legal Malpractice Claims 1996-1999]. Note that the methodology used in the ABA study involved questioning malpractice insurers. Id. at 1. Therefore, the study does not address malpractice by lawyers who do not carry malpractice insurance. In a similar earlier study, the ABA estimated that between 30% and 50% of lawyers carry no malpractice insurance. ABA Standing Committee on Lawyers’ Professional Liability, Legal Malpractice Claims in the 1990s, at 5 (1996) [hereinafter Legal Malpractice Claims in the 1990s].

207. More specifically, 53.73% of the claims were abandoned without payment and 14.03% resulted in judgments for the defendant. Legal Malpractice Claims, 1996-1999, supra note 206, at 10.

208. Id.

209. The ABA’s study for the years 1990-95 found that more than 56% of the malpractice claims filed resulted in no payment at all to the claimant, and only 0.25% resulted in plaintiff’s judgments. Legal Malpractice Claims in the 1990s, supra note 206, at 12. In its study of the years 1983-85, the ABA found that 68.36% of the claims resulted in no payment to the claimant, and only 1.14% of the claims resulted in plaintiff’s judgments. Legal Malpractice Claims, 1996-1999, supra note 206, at 10.

210. Legal Malpractice Claims in the 1990s, supra note 206, at 20.

3. Peer Review

The development of peer review systems for assessing the quality of legal services lags far behind the development of such systems in other professions, such as medicine and accounting. In his article regarding quality assurance in medical care, Avedis Donabedian identifies three categories of criteria that medical professionals use to make assessments of the quality of medical care: structure, process, and outcome. Structural criteria identify information about the qualifications of service providers and the place where their services are offered. Process criteria focus on what is done for the client or patient, while outcome criteria focus on results obtained. Because outcomes (such as morbidity) are relatively easy to measure, initial quality assurance techniques in the medical profession focused on outcome measures. However, over time, sophisticated structural and process measures have been developed in the medical field. A similar progression has taken place in the development of sophisticated quality assurance measures in the accounting and engineering professions.

By contrast, the development of outcome, structure, and process performance measures in the legal field has been ad hoc, haphazard, and isolated. Although the Internet and other electronic databases have made outcome data regarding legal proceedings much more readily available, few comprehensive studies of the results of legal representation have been conducted. Structure and process measures have been implemented to a limited degree in practice contexts involving public funding. For example, efforts to monitor the utilization of federal funds in the federal legal services program resulted in the publication of the ABA Standards for Providers of Civil Legal Services to the Poor. Similar concerns on the criminal

215. Donabedian, supra note 213.
216. Martyn, Peer Review, supra note 212, at 297 (citing Donabedian, supra note 213, at 411).
217. Id.
218. Id.
219. Id.
220. Id.
221. Id. at 298.
222. Id. at 298-99.
223. Id. at 299.
224. Id. at 300.
225. Id. at 301.
side led to the enactment of the ABA Standards for Criminal Justice. Some large law firms have made some efforts to develop systems for evaluating lawyer performance. However, such efforts have been quite limited. Malpractice insurers have also started to get into the business of evaluating lawyer competence in an effort to hold the line on malpractice premiums.

Perhaps the most concerted effort to instill a widespread peer review component in law was undertaken by the American Law Institute-American Bar Association ("ALI-ABA") Committee on Continuing Professional Education, which published a Discussion Draft of a Model Peer Review System in 1980. The draft included both structural and process measures of competent legal practice. Of course, the legal profession's primary code of ethics, the ABA's Model Rules of Professional Conduct, articulates a standard of competence that all attorneys are required to maintain. Additionally, the report of the ABA's McCrate Committee sets forth specific skills that must be possessed by attorneys in order to practice competently. Despite these efforts, uniform quality assurance standards, as well as a comprehensive peer review system, have not been implemented in the legal profession, and the above-described efforts do not seem to have had much impact on the day-to-day practice of law in this country.

Arguably, because the present system of lawyer disciplinary regulation is made up of lawyers policing other lawyers, current disciplinary systems represent a form of peer review. Moreover, to the extent that lawyer disciplinary systems can be conceived of as a form of peer review, they have historically suffered from some of the same problems that have plagued the medical peer review process. In 1967, the ABA created a Special Committee on Evaluation of Disciplinary Enforcement, under the direction of retired U.S. Supreme Court Justice Thomas Clark, to review what were believed to be serious shortcomings in then-current lawyer disciplinary systems.

226. Id. at 300.
227. Id. at 301-02.
228. Id.; see also Robert E. O'Malley, Preventing Legal Malpractice in Large Law Firms, 20 U. Tol. L. Rev. 325 (1989). Robert E. O'Malley served as Loss Prevention Counsel to the Attorneys' Liability Assurance Society, Inc. Id.
230. See Martyn, Peer Review, supra note 212, at 302.
231. But see supra note 201.
Indeed, the Clark Committee concluded that the state of attorney disciplinary systems represented a "scandalous situation that requires the immediate attention of the profession."

One of the major problems identified by the Clark Committee was a lack of adequate reciprocity between state disciplinary authorities, such that attorneys disbarred in one jurisdiction were being permitted to practice law after relocating to a different jurisdiction. As noted above, similar criticisms were made of the medical peer review system prior to enactment of the HCQIA.

Nearly two decades after the Clark Committee issued its report, the ABA convened another Commission on Evaluation of Disciplinary Enforcement, this time under the direction of Robert McKay (the "McKay Commission"). The McKay Commission concluded that many of the worst problems in disciplinary enforcement identified by the Clark Committee had been corrected. For example, with regard to the Clark Committee's finding of inadequate provisions for reciprocal discipline, the McKay Commission noted that the subsequently drafted and widely adopted ABA Model Rules for Lawyer Disciplinary Enforcement contain a provision providing for a presumption that identical discipline will be imposed in each jurisdiction in which an attorney is licensed, based upon the imposition of discipline in the first jurisdiction. Nonetheless, the McKay Commission made numerous recommendations for further improvement of attorney disciplinary systems.

Among these recommendations, the McKay Commission found the lack of public access to attorney disciplinary proceedings to be a major source of distrust of the profession.

Unlike the widespread adoption of the recommendations from the Clark Committee's Report, the recommendations of the McKay

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234. Id. at 722 (quoting American Bar Association Special Committee on Evaluation of Disciplinary Enforcement, Problems and Recommendations in Disciplinary Enforcement (1970)).
235. Id.
236. See supra Part II.A.3.
237. Powell, supra note 233, at 709 & n.2.
239. Id. at 113-14 (citing ABA Model Rules for Lawyer Disciplinary Enforcement, Rule 22 (1971)).
240. Id. at 1-86.
241. Id. at 33-34; see also DeGraw & Burton, supra note 62, at 393.
242. McKay Commission Report, supra note 238, at xiv-xv; see also Leslie C. Levin,
Commission have not led to dramatic actual changes in attorney disciplinary systems. Scholars still offer a variety of critiques of attorney disciplinary enforcement systems. Most of these lie beyond the scope of this article. However, criticisms of the lack of public access to attorney disciplinary proceedings are relevant to the extent that middle-income persons seeking legal representation would find information relating to such proceedings useful in their attorney selection process. Indeed, from the perspective of middle-income persons seeking information that would be relevant to them in the selection of an attorney, present attorney disciplinary systems leave much to be desired and have improved little since the McKay Commission wrote its report. As of 1992, in twenty-eight states, disciplinary complaints against a lawyer did not become public until the equivalent of a finding of probable cause was made and the matter was referred to the state supreme court for the initiation of formal proceedings. In twenty states, disciplinary proceedings remained confidential until sanctions were imposed.

Presently, in only three states will the existence of a complaint be disclosed in the absence of a finding of probable cause. Oregon is currently the only state whose lawyer disciplinary process is open to the public at all stages of the proceedings. Florida and West Virginia's disciplinary records are open to the public when a charge is filed or a complaint is dismissed. The McKay Commission recommended that other states adopt Oregon's open system, but to date, no other states have completely followed suit.

Even to the extent that the results of attorney disciplinary processes are "open" to public examination, they are rarely made available to the public in a format that would be characterized as easily accessible or comprehensible. For example, some jurisdictions publish the names of disciplined attorneys without any description of the conduct that led to the sanction, while other jurisdictions provide descriptions of sanctionable conduct but withhold the names of the sanctioned attorneys. Moreover, even jurisdictions that do provide detailed

244. Morton, supra note 23, at 304-05. This is the procedure that is recommended in the ABA’s Model Rules for Lawyer Disciplinary Enforcement. Id. at 305 & n.110 (citing Model Rule 16(B)).
245. Id. at 305.
246. Rhode, supra note 68, at 161.
248. Id. at 578-79.
249. See Powell, supra note 233, at 730.
250. See DeGraw & Burton, supra note 62, at 358.
accounts of conduct resulting in discipline and identify offending attorneys, are likely to publish this information in sources primarily aimed at providers, not consumers, of legal services, such as bar journals or lawyer newspapers. Additionally, most disciplinary systems still provide for private reprimands and other forms of non-public discipline. It seems quite possible that public impatience with the secretive nature of attorney disciplinary systems might eventually lead to a push toward lawyer profiles. However, despite the McKay Commission's findings, it does not appear that public dissatisfaction with lawyer disciplinary processes has yet risen to a level adequate to spur a new round of major changes.

4. National Discipline Data Bank

The ABA Center for Professional Responsibility does maintain a National Discipline Data Bank ("NDDB"), which is intended to be a clearinghouse of information relating to public discipline of lawyers by state and federal courts and federal administrative agencies. As was the case with the NPDB, the NDDB was intended to facilitate interstate sharing of disciplinary information. And, for reasons similar to those relating to the NPDB, public access to the NDDB is severely restricted. However, unlike the NPDB, consumers can, for a fee, receive access to current-year information regarding disciplinary action against a lawyer from the NDDB. Given that the ABA is a private rather than a governmental entity, reporting to the NDDB is voluntary. Thus, the NDDB is seen as being a much less comprehensive data source than the NPDB. Perhaps this fact, along with the private status of the ABA, has prevented widespread calls for opening up the NDDB to the public free of charge. Correspondingly, the existence of the NDDB does not seem to have created any momentum toward the creation of publicly accessible lawyer profiles.

B. Arguments For and Against Lawyer Profiles

In light of the above discussion, it does not appear that the time is ripe for a movement toward lawyer profiles. Nonetheless, it is worth reviewing the arguments that have been made for and against physician profiles, to see if they apply similarly in the legal practice context.

251. Id. at 355 & nn.9-10; see also Morton, supra note 23, at 307.
254. See id.; see also supra Part II.A.4 (discussing the NPDB).
255. See Morton, supra note 23, at 306-07.
256. Id.
1. Consumer Sovereignty and Autonomy

The consumer sovereignty and autonomy arguments in favor of publicly accessible professional profiles are similar in the legal context to those in the medical context. As consumers of legal services, potential clients will better be able to find appropriate legal representation the more they know about potential providers of such services. Professor Linda Morton cites to a survey of consumers of legal services, in which the participants indicated that the two qualities they most sought in an attorney were integrity and quality. Morton contends that making information available to consumers regarding disciplinary and malpractice actions against attorneys might provide consumers with information that they value in the attorney selection process. In the Martindale-Hubbell survey, 81% of the respondents indicated a desire for a resource where they could look up lawyers and their credentials. Three out of five (62%) indicated that they would like access to legal resources on the Internet.

Increasing information available to consumers of legal services regarding their attorneys might also serve the autonomy interests of such consumers. Morton argues that the more information that consumers of legal services have regarding attorneys, the more likely such consumers are to take an active role in the litigation of their cases. Further, Morton points to evidence that increased client participation in their legal representation leads to the delivery of higher quality legal services.

However, just as in the medical context, arguments have been made that providing certain information to consumers of legal services, particularly information relating to lawyers' malpractice and disciplinary records, will not help consumers to make informed decisions, but rather will mislead and confuse such consumers. As in the medical context, perhaps the answer is to provide more information to consumers rather than less. Disclaimer language can be included in lawyer profiles regarding the weight that should be given to disciplinary and malpractice information, and statistics can be provided regarding the frequency and severity of disciplinary and malpractice activities in the relevant jurisdiction and/or specialty practice area.

257. Id. at 287 (citing Robert E. Smith & Tiffany S. Meyer, Attorney Advertising: A Consumer Perspective, J. Marketing 56, 60 (Spring 1980)).
258. Id. at 288.
259. Lawyers in America, supra note 26, at 29.
260. Id. at 30.
262. Id. at 291 (citing Douglas Rosenthal, Lawyer and Client: Who's In Charge? (1974)).
263. See, e.g., Pennex, supra note 247, at 577.
2. Impact on Legal Practice

One might also raise questions regarding the impact that lawyer profiles might have on the practice of law. Recall that the argument has been made that physician profiles will have a negative impact on medical practice, and will further exacerbate the practice of "defensive medicine." However, it does not appear to be the case that the development of legal malpractice standards has had an adverse effect on the practice of law, or has resulted in the practice of "defensive law." To the contrary, it appears that many of the precautions taken by lawyers to avoid legal malpractice, such as calendaring systems and conflicts checks, have had a salutary impact on the practice of law. Therefore, it seems unlikely that furthering public access to the results of malpractice actions will reverse this trend.

The argument has been made that opening disciplinary procedures up to public scrutiny would render such proceedings less effective, as witnesses and complainants would not be willing to come forward, out of fear of reprisal. However, the public nature of Oregon's lawyer disciplinary system does not appear to have had a negative impact on the system's effectiveness. To the contrary, the system is generally viewed as a great success.

In addition, Morton contends that making public information regarding disciplinary and malpractice actions against attorneys will ultimately improve the poor public image of lawyers. While Morton acknowledges that the initial disclosure of the volume of complaints against lawyers might have a negative effect on the profession's image, she believes that in the long run such disclosure would cause lawyers to improve their practices to avoid the embarrassment that is likely to result from such disclosure. Moreover, Morton further contends that the public will appreciate replacement of the bar's current degree

264. See supra text accompanying note 153.
266. Id. at 140. The recent ABA report regarding legal malpractice claims shows that claims based on administrative errors, such as missing a court date, decreased by 5% since 1995. Legal Malpractice Claims 1996-1999, supra note 206, at 11. Such claims are presently at their lowest recorded level. Id.
267. See Pennex, supra note 247, at 576.
271. Id. at 292-93.
of reticence to "come clean" with regard to current levels of consumer dissatisfaction with a new approach of openness. 272

3. Lawyer Privacy

The privacy arguments raised against physician profiles apply with equal force in the legal context. Similarly however, these arguments also seem to be outweighed by the increase in convenience to consumers that would be provided by lawyer profiles. As was the case with doctors, most of the information that would be contained in lawyer profiles is already available to the public, albeit through diverse and sometimes difficult to access sources. For example, most state bars will provide attorney disciplinary information to inquiring consumers. 273 Information regarding legal malpractice judgments and settlements is available through a variety of sources. And, of course, most criminal records are available to the public. As argued above, the marginal reduction in lawyer privacy that would result from collecting such information in a single, easily accessible source is greatly outweighed by the benefit that would be provided to consumers from the creation of such a source. 274

4. Costs and Logistical Difficulties

The costs of creating lawyer profiles might even be greater than those associated with the creation of physician profiles. This is because while there were already numerous, comprehensive data sources to draw upon in creating physician profiles, as pointed out above, the existing sources of information regarding lawyers are less thorough and comprehensive. 275 Nonetheless, given the popularity of physician profiles, it is safe to assume that lawyer profiles would be equally popular with the public, therefore warranting the costs that might be involved in creating and maintaining lawyer profiles.

Similar concerns regarding data quality and database maintenance would arise in the context of lawyer profiles as are present with regard to physician profiles. Standards and protocols for data collection and maintenance would be an absolute necessity. Nevertheless, many of the lessons that are being learned with regard to data management in the physician profile context will be applicable to lawyer profiles in

272. Id. at 292.
273. See, e.g., Morton, supra note 23, at 307-08 (discussing California Bar's disciplinary information "hotline"); Pennex, supra note 247, at 572-73 (stating that Michigan disciplinary proceedings are available to public after formal process has issued).
274. See supra Part III.B.3.
275. See supra Part III.A.4.
276. See Morton, supra note 23, at 306.
the future, resulting in more comprehensive, reliable, and accurate profiles.

C. The Prognosis for Lawyer Profiles

As pointed out above, because the underlying conditions that paved the way for physician profiles do not appear to be present to the same degree in the legal context, it seems unlikely that publicly accessible lawyer profiles will become a reality in the near future. Nonetheless, given the above conclusion that the arguments for publicly accessible lawyer profiles generally outweigh those against such profiles, it is worth considering what information should or should not be included in lawyer profiles. The following are suggestions for categories of information that should be included and excluded.

1. Information That Should Be Included in Lawyer Profiles

a. Demographic Information

The inclusion of basic demographic information about the practitioner would seem to be both important to consumer decision making and relatively unobjectionable. Information that would be included in this category would be the name and business address of the practitioner, colleges and law schools attended, dates of attendance and degrees received.

b. Licensing and Certification Information

Basic license information should also be included in lawyer profiles, such as all state bar admissions, admission dates, and bar numbers. Specialty certifications should be included in a manner consistent with the state bar's ethics rule regarding advertising such certifications. Courts before which an attorney is specially admitted to practice should also be included.

277. See supra Part III.A.
278. See supra Part III.B.
279. See, e.g., FSMB Report, supra note 91, at 5; Miller, supra note 34, at 128-29; Pape, supra note 129, at 1022; Stewart, supra note 79, at 976-77.
280. See, e.g., FSMB Report, supra note 91, at 5-6.
c. Malpractice Payments

Malpractice payments above mere "nuisance value" should be included in lawyer profiles. While the exact figure that corresponds to the nuisance value of a case may be difficult to determine with certainty, and may vary from jurisdiction to jurisdiction, a fair number to consider would be $5000. Disclaimer information should be provided regarding the types of cases that generate the highest proportion of malpractice claims, in order to provide some context for the malpractice payment information. Similarly, language should be included highlighting the lack of an established correlation between malpractice payments and actual substandard practice. Moreover, malpractice payments should be excluded from lawyer profiles after a ten-year period, as any informational value contained in such payments is likely to dissipate over that period of time.

The lawyer profile should include the actual amount of each malpractice payment made above the $5000 threshold, as is currently the practice with regard to Florida's physician profiles, as opposed to Massachusetts' practice of merely listing the number of payments in its "above average," "average," or "below average" categories, or the FSMB's recommendation of simply listing the number of malpractice judgments and settlements above threshold amounts. While providing specific numbers admittedly may add little to consumers' information, the categorization schemes that have been adopted seem too vague to have any informational value to consumers at all, and seem to be too great a concession to the opponents of providing any malpractice payment information at all.

d. Information Regarding Malpractice Insurance

Surprisingly, Oregon is the only state that actually requires lawyers to obtain malpractice insurance. While an eventual move toward mandatory malpractice insurance would seem to be warranted, in the interim it seems appropriate to provide consumers with

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282. See supra note 139.
283. In fact, according to the ABA's recent study, Legal Malpractice Claims 1996-1999, supra note 206, at 13, more than 80% of the malpractice claims reported were resolved for defense costs of $5000 or less. Additionally, the amount of indemnity payment was $10,000 or less in 83.43% of the cases. Id. at 15.
284. See supra text accompanying note 9.
285. See supra note 83 and accompanying text.
286. FSMB Report, supra note 91, at 7-8.
287. Rhode, supra note 68, at 167.
288. Id. at 168; see also Leubsdorf, supra note 265, at 155-56; Sahl, supra note 268, at 103.
information regarding whether or not the attorney who they are considering retaining carries malpractice insurance.

e. Disciplinary Information

Certainly, all public disciplinary information regarding an attorney should be included in the attorney's profile. Additionally, and perhaps most controversially, information regarding the number of all complaints filed with disciplinary authorities against an attorney should also be included. Of course, the argument will be made that disclosure of complaints for which no basis was ultimately found will unfairly harm the reputations of attorneys. However, there is evidence, at least in the medical context, that complaints against practitioners, at a minimum, demonstrate troubled relationships between the practitioners and their clients. This would be valuable information for consumers to have. Moreover, only a small percentage of dissatisfied clients actually file complaints against their lawyers. Therefore, it is likely that complaint figures understate the degree of dissatisfaction with particular attorneys. Profiles should also include the number of listed complaints that were dismissed without findings of probable cause.

As stated above, it does not appear that attorneys' reputations have been unduly damaged by the availability of this type of information in Oregon. Additionally, at least some complaints against attorneys are initiated by other attorneys, judges, or other legal professionals under the profession's self-reporting requirements. While attorneys sometimes file complaints against other attorneys for improper purposes, such as to gain an advantage in litigation, the self-reporting requirement also adds at least a small additional peer-review component to the disciplinary process. As pointed out above, the McKay Commission concluded that the secrecy of the present attorney disciplinary system was a primary cause of the lack of public confidence in that system and, as a result, a major factor in dissatisfaction with the profession generally. Attorney profiles offer an opportunity to provide the kind of public access to disciplinary information that the McKay Commission called for a decade ago.

289. See Pennex, supra note 247, at 576; Sahl, supra note 268, at 111.
290. Stewart, supra note 79, at 977.
291. See Rhode, supra note 68, at 159-60.
292. Supra text accompanying notes 268-69.
293. See Model Rules of Prof'l Conduct R. 8.3(a) (2001).
294. See supra notes 233-52 and accompanying text.
295. See supra text accompanying note 241.
296. Id.
297. See McKay Commission Report, supra note 238, at 34.
f. Criminal Convictions

Information should be included in lawyer profiles regarding criminal convictions. Although such information raises privacy concerns of the type discussed above, given that criminal conviction information is generally available to the public, and given the likelihood that consumers would strongly desire the inclusion of such information and might well decline to associate with lawyers previously convicted of crimes, the benefit of including such information outweighs the potential harms.

However, questions remain as to whether there should be limits on the information provided based upon the offense involved or the age of the conviction. For example, some would argue that only crimes related to the practice of law should be included. However, lawyers can be professionally disciplined for a broad range of criminal conduct that calls into question the lawyer’s “honesty, trustworthiness or fitness as a lawyer,” and lawyers are often denied admission to practice based upon prior criminal activity. Moreover, it seems likely that at least some consumers would find a lawyer’s criminal record to be relevant to a decision whether to retain that lawyer, regardless of the nature of the conviction or how long ago it took place.

With regard to physician profiles, the FSMB recommends the inclusion of all felony convictions, and any misdemeanor convictions “involving offenses against the person, offenses of moral turpitude, offenses involving the use of drugs or alcohol and violations of public health and safety codes.” The FSMB would not place any time limit on the date of the conviction, and would require reporting of convictions following guilty and no-contest pleas, as well as convictions following adjudicatory proceedings. These recommendations seem balanced and sensible and are adopted here.

g. Optional Information

Lawyers should be given the option of including a variety of information in their profiles. Such information should include restrictions or limitations on the types of cases the practitioners are

298. See supra Parts II.B.3., III.B.3.
299. See, e.g., FSMB Report, supra note 91, at 6-7.
300. See, e.g., Miller, supra note 34, at 132.
303. See, e.g., Miller, supra note 34, at 133.
304. FSMB Report, supra note 91, at 7.
305. Id.
willing to handle. Lawyers should also be permitted to state their office hours and proficiency in languages other than English.

Inclusion of information such as publications authored, awards received, committee memberships held, and community service activities performed seems relatively innocuous but of marginal benefit to consumers. There must be some limits on the amount of information that can be contained in profiles, so that the profiles remain manageable for both consumers and administrators of profiles. Such information may also prove difficult to verify for profile administrators. Thus, inclusion of such information should be determined by states on a case-by-case basis.

2. Information That Should Be Excluded from Lawyer Profiles

The following categories of information should be explicitly excluded from lawyer profiles.

a. Malpractice Claims for Which No Payment is Made

In cases where a malpractice claim is resolved without even a "nuisance" payment to the claimant, or with a court judgment for the defendant, a presumption should arise that the claim was without merit. Therefore, in such instances, information relating to the claim should not be included in lawyer profiles. The damage to the lawyer's reputation that would result from inclusion of information regarding frivolous claims greatly outweighs any benefit to consumers that might result from inclusion of such information.

b. Criminal Charges Not Resulting in Conviction

For similar reasons why malpractice claims not resulting in payment should be excluded, criminal charges that do not result in conviction should be excluded from lawyer profiles.

c. Chemical Dependency/Substance Abuse Problems

Finally, information relating to evidence of chemical dependency or substance abuse on the part of the practitioner should also be excluded from lawyer profiles. It is certain that consumers would like to have reliable evidence of substance abuse by a practitioner in

308. See, e.g., Miller, supra note 34, at 134 (discussing issue in medical context); Stewart, supra note 79, at 988 (same).
309. Miller, supra note 34, at 134.
310. Id.
determining whether to retain that lawyer. However, there is reason to believe that disclosure of this type deters substance abusers from seeking the help they need to address their addictions. Ultimately, consumers will benefit more from substance abusers getting the help they need, than they will from disclosure of past evidence of abuse. To the extent that previous substance abuse actually had a significant effect on the lawyer's practice, it is likely that the abuse will be reflected in disciplinary information or criminal convictions that will be included in lawyer profiles. Moreover, in the absence of such concrete effects, it is likely that information relating to substance abuse will be difficult to substantiate and subject to dispute. Therefore, isolated evidence of chemical dependency or substance abuse should not be included in lawyer profiles.

**CONCLUSION**

When we left the story of our search for a pediatrician, my wife and I were about to conduct interviews with each of the three prospective candidates. Pediatrician A was eliminated from our consideration relatively quickly, because his hospital admitting privileges were at a facility that was too far from our home to be practical. Our interview with Physician C went very well. My wife and I found Physician C to be personable, extremely energetic, enthusiastic, and similar to us in age and outlook. Moreover, Physician C had recently become a mother herself, so it seemed that her knowledge of the issues that we would face would likely be of a more recent, intimate, and personal kind than would be the case with regard to the other candidates. These facts, combined with the favorable references described above, made Physician C seem like the best choice.

On the other hand, Physician B, a more experienced practitioner, seemed a bit tired and jaded in our interview. Of course, this could have been due to any number of non-recurrent and unknown (at least to us) factors, not the least of which may have been that our interview took place at the end of what might have been a long day. Nonetheless, the less than scintillating interview, combined with the troubling malpractice and disciplinary information contained in Physician B's profile, caused us to place Physician B second in our initial ranking.

However, another series of developments occurred between our initial ranking of physicians and our daughter's birth, and our

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311. *Accord* Rules Regulating the Fla. Bar 3-7.1(o) (stating that the reason for the inadmissibility in disciplinary proceedings of evidence that the attorney has sought drug or alcohol treatment is to encourage attorneys to seek such treatment without fear of negative consequences).

312. *See supra* Introduction.
subsequent final decision regarding her pediatrician. One of my wife’s colleagues, who was due to deliver around the same time as my wife, gave birth to a son six weeks prematurely. As a result, the boy had a number of serious, though not life-threatening, health problems. My wife’s colleague had selected Physician C to be her son’s pediatrician. However, after a few visits, my wife’s colleague was particularly unhappy with the service that she and her son had received from Physician C’s office. Moreover, Physician C’s office seemed ill-equipped to handle the special medical needs of the prematurely born boy. In fact, Physician C’s office eventually referred my wife’s colleague and her son to Physician B, on grounds that his office would be better able to handle the boy’s special medical needs.

Not surprisingly, this development led to a change of course for my wife and me. While we were hopeful that our child would be born without special medical needs, we wanted a pediatrician who was well equipped to deal with such an unfortunate development should it transpire. Therefore, despite a less than stellar practitioner profile and a less than scintillating interview, my wife and I changed our chosen pediatrician back to Physician B.

Fast forward nearly a year. My wife and I have been extremely pleased with the service that we have received from Physician B and his office (and my wife’s colleague’s son is doing very well, too). So what does this tell us about physician, and perhaps even lawyer profiles? Of course, it’s hard to say, and it would be foolish to draw grand conclusions from a single anecdote. Given that I am a lawyer who has had some professional experience with both legal and medical malpractice cases, opponents of profiles might attribute to my wife and me an above-average knowledge of the frequency of medical malpractice and disciplinary actions and of the relatively low predictive value that can be placed upon three undescribed blemishes on an apparently otherwise spotless practice record. Thus, they might go on, we were much more willing and better able to discount the negative information contained in Physician B’s practitioner profile than the average consumer would be.

However, we did place significant weight on Physician B’s disciplinary and malpractice record. Yet in the end, that record turned out to be just one part of what was a relatively complex, multi-factored analysis. I believe that most consumers would treat this information in a similar manner, as one factor to consider, rather than being absolutely determinative. On balance, we were very glad to have Physician B’s practitioner profile at our disposal, and I believe that most non-lawyers would feel the same way, even if their analyses of the information might be somewhat different from ours.

Moreover, I know that if lawyer profiles were available, and I were looking to hire a lawyer, I’d check them out as well. And I can’t
imagine why a non-lawyer looking to hire a lawyer would feel any differently. Therefore, even if the time for lawyer profiles isn’t this moment, that time should be coming relatively soon.