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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should MLP Clinicians and Attorneys Help Veterans Secure Disability Benefits When Health Records Documentation Is Insufficient?

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Abstract

This case commentary considers unique features of medical-legal partnerships (MLPs) in the Veterans Health Administration that may potentially mediate and minimize ethical tensions that may arise in MLP collaborations involving diagnosing and documenting disability.

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Case

AB is 55 years old, unhoused, self-employed, divorced and has no children. He is unable to work due to a back injury sustained during his job as a contractor 2 years ago that limits his functional ability. He is currently living in his van and on alternating nights at a local shelter. A staff member at the shelter advises AB to file a claim for social security disability insurance (SSDI) benefits. AB tells the staffer he tried but found the application so complicated he gave up. The staff member then remembers that AB is a veteran and connects him to a new medical-legal partnership (MLP) housed on the grounds of the local Veterans Health Administration (VHA) medical center. At the VHA MLP, AB is fortunate to meet an attorney with considerable experience in a community MLP, JD, who arranges for AB to see Dr C, a new primary care physician in the VHA MLP. JD explains to Dr C that to file an SSDI claim, AB must be able to demonstrate that he has been unable to work for the last year due to his back injury.[1]

Preparing for her first visit with AB, Dr C learns that AB has an existing VHA electronic health record (EHR): AB served in the army as a mechanic during Operation Iraqi Freedom. AB's health record shows that, after being discharged from the military, he was seen at a VHA medical center in another city for symptoms of posttraumatic stress disorder (PTSD) and suicidal ideation. AB attended a few appointments but then moved across the country and never reestablished care in the VHA system or in the community. After examining AB, Dr C tells JD she has "no question that AB's back injury would likely qualify for SSDI," and she also thought his PTSD would meet diagnostic criteria, yet she does not believe there is currently adequate evidence to support either claim. She wants to help AB get the benefits he deserves but worries about compromising her professional integrity by engaging in questionable documentation practices. JD

reassures her they both have the same goal—not to manipulate the health record but to get AB the care he needs and deserves. They meet to discuss their options and consider next steps.

Commentary

The collaboration of attorneys and clinicians working under the auspices of VHA MLPs can streamline the process of obtaining health care, benefits, and social services for veterans who, like AB, find the bureaucratic process required to file for either SSDI or VHA benefits overwhelming. However, like Dr C, clinicians may experience an ethical tension between their desire to help unhoused veterans like AB and their professional obligation to provide accurate and complete medical documentation. The attorney Jesselyn Friley expresses a view frequently found in older literature on MLPs that there is an intrinsic conflict between the ethical orientations of law and medicine:

> [Physicians] are bounded by codes of professional ethics that emphasize independent judgment and honesty. Meanwhile, lawyers are also bounded by ethics rules that compel them to advocate for their clients as vigorously as they can. The interaction between these tenets of medical and legal ethics can be a source of conflict in MLPs. For instance, a lawyer may push a physician to tailor his treatment notes to match legal standards. In making such a request, the lawyer is fulfilling his obligation to secure the best outcome for his client. But, in going along with the request, the physician may have to compromise his ethical duty of professional independence.[2]

Clinicians also seem to presume there is an irreconcilable tension between what Lomas and Berman call "diagnosing for administrative purposes" and diagnosing for therapeutic ones. They write: "Thus, any physician who performs diagnostic examinations for administrative purposes cannot escape the ethical conflict between his natural and trained therapeutic role and tendencies and the divergent social expectations of claimants and adjudicators."[3] This quotation might imply that the zealous advocacy for their client that is an ethical obligation of attorneys is fundamentally incompatible with clinicians' commitment to honesty and integrity in diagnosis and documentation. Dr C's unstated assumption in the case scenario is that she must either falsify the medical record or leave AB helpless and hurting. This commentary will argue that this traditional view (ie, that there is an inherent conflict of interest when lawyers and clinicians collaborate to obtain disability benefits for patient-clients) is based on a false dichotomy. The commentary will further suggest that there are distinctive features of MLPs within the VHA that enable their attorneys and clinicians to approach the disability diagnostic-and-documentation dilemma from a broad and mutual commitment to ameliorating the adverse impact of social determinants of health.

The VHA's MLP Program

The US Department of Veterans Affairs (VA) is an agency of the federal government that provides benefits, health care, and cemetery services to eligible veterans. The VHA is the largest integrated health care system in the country.[4] It is also the largest health care agency in the nation that serves as a safety net for low-income and disabled patients like AB.[5] While the VHA and the Veterans Benefits Administration provide a rich array of social services for eligible veterans, the Office of General Counsel at the VA relies on pro bono services to provide direct assistance to veterans in civil matters.[6] Hence, until the introduction of MLPs in the VA in 2009, veterans were dependent on pro bono and other forms of community legal aid for assistance with civil legal matters.[7] Yet a 2022 survey found that legal concerns were among 5 of the top 10 unmet needs reported by unhoused veterans like AB.[8] The VHA published a directive establishing policy for legal

referral processes in 2021,[9] and, as of June 2024, there were 43 VA MLPs.[10] The MLPs are usually located on VHA campuses, and MLP lawyers train VHA clinicians like Dr C to screen veterans for legal concerns and then refer them to the MLP staff for legal assistance. A study of 4 VHA MLPs found VHA benefits and housing, family, and consumer needs to be the most common concerns and that 8% of the participants were, like AB, seeking social security or other forms of public benefits.[11]

Mediating Ethical Tensions

In this case, JD and Dr C agree on 3 key points, and that agreement will form the shared basis for their work with AB. First, AB likely meets SSDI criteria for PTSD and a back injury. Second, there is currently insufficient documentation to establish the level of evidential support required. Third, and most importantly, their primary and mutual goal is to obtain that requisite information to file a successful claim. For veterans who had received a total disability rating from the VA during FY 2000 to 2006, PTSD was the most common diagnosis for which those veterans sought DI,[12] and the diagnosis also is correlated with being unhoused,[1] which matches AB's lived experience.

Further suppose that the MLP professionals quickly confirm that AB remains eligible for VHA care and get him enrolled at the local medical center. Dr C surmised at AB's initial appointment that the prior diagnosis of PTSD would likely qualify AB for additional VHA benefits, so JD and Dr C agree that they may be able to assemble an even stronger evidence file if they ask Dr S, the VHA psychologist in the primary care mental health integration program, to do a more comprehensive assessment of AB. Co-location of the program in primary care enables patients like AB to have the PTSD diagnosis confirmed the same day they see a mental health specialist.[13]

Having reviewed the literature, the VHA clinicians know that both SSDI and VHA benefits potentially enable veterans to obtain housing and improve their mental health and that, without this assistance, their mental health would likely deteriorate.[14] They recognize that the VHA health information will also help to substantiate AB's SSDI claim but that, even with this evidence, AB will still need to demonstrate the inability to work for 12 months to qualify for SSDI. The VHA clinicians contact their local program for homeless (ie, unhoused) veterans to see about housing for AB while JD helps AB complete the paperwork for additional VHA benefits and SSDI.

Overcoming Evidence Gaps

Fortunately, VHA practitioners may have several means of ethically closing the documentation gap that are not as accessible to many civilian clinicians: they have access to a comprehensive, longitudinal EHR.[15] The VHA EHR contains decades of data from all VHA episodes of care and, in some instances, from the US Department of Defense and even VHA-funded treatment in the community. The EHR also enables Drs C and S to submit all available documentation that is medically accurate such that JD can easily translate it into the legal language upon which the outcome of the claim may hinge.

In the past, VA clinicians may have been concerned about breaching patients' confidentiality or practicing outside their scope when asked to provide documentation for non-VA benefits. However, the VA has taken 2 administrative actions to facilitate information sharing that is relevant in the context of MLPs. Veterans are required to sign an authorization to release health information as a condition of being referred. The VHA has also issued a directive that instructs VA clinicians to complete many non-VA health-

related and social service forms on behalf of veterans as a means of honoring veteran autonomy and clinicians' beneficence-based obligations.[16]

JD and the clinicians recognize that even the VHA EHR cannot establish that AB's disabilities have prevented him from being gainfully employed for 12 months. Rather than resort to ethically problematic documentation processes, they can maximize the potential of the VHA MLP to improve AB's situation. The team has already begun to address the social determinants of health that have negatively affected AB's life. Enrollment in VHA care enables him to access housing through the VHA, to be referred for specialized PTSD treatment, to obtain treatment for his medical conditions, and perhaps, most crucially, to file for VHA benefits that have different criteria from SSDI.

Conclusion

An ethical conflict can emerge between an MLP attorney and a clinician if either is excessively or exclusively focused on the immediate instrumental view of obtaining SSDI monetary benefits, or what Lomas and Berman refer to as an "administrative diagnosis."[3] Although psychosocial assistance is urgently needed so that AB does not deteriorate further, SSDI is not sufficient to enable him to achieve recovery of his health and humanity. Together, AB and the MLP can work to access the wider scope of VHA services—that is, the "benefits of diagnosis"—that will in the long run improve AB's comprehensive well-being. Far from being contrary to their ethical duties as VHA clinicians, this activism fulfills the VHA's strategic priority to reduce the suicide rate among marginalized, underserved, unhoused veterans like AB.[17] Campbell and colleagues indicate that viewing MLPs through a bioethics lens, such as adopted in this commentary, can minimize the apparent conflict between law and medicine by demonstrating that both professions exercise a healing and an advocacy function.[18] Although this article has focused on the distinctive VHA context, recent publications suggest that community MLPs are also following a similar approach to the mediation of potential attorney-clinician ethical tensions related to the diagnosis and documentation of disabilities.[19,20]

References

1. Elder J. Connecting veterans to social security disability benefits: a key component in ending veteran homelessness. Substance Abuse and Mental Health Services Administration; 2014. Accessed January 31, 2024. https://www.va.gov/HOMELESS/ssvf/docs/Connecting_Veterans_to_Social_Security_Disability_Benefits_Sept2014.pdf
2. Friley J. Ethics of evidence: health care professionals in public benefits and immigration proceedings. *Yale J Health Policy Law Ethics*. 2017;17(2):327-342.
3. Lomas HD, Berman JD. Diagnosing for administrative purposes: some ethical problems. *Soc Sci Med.* 1983;17(4):241-244.
4. Veterans Health Administration: about VHA. US Department of Veterans Affairs. Updated November 8, 2023. Accessed March 10, 2024. https://www.va.gov/health/aboutvha.asp
5. Crowley R, Atiq O, Hilden D, Cooney TG; Health and Public Policy Committee of the American College of Physicians. Health care for our nation's veterans: a policy paper from the American College of Physicians. *Ann Intern Med*. 2021;174(11):1600-1602.
6. Office of General Counsel: legal help for veterans. US Department of Veterans Affairs. Updated July 18, 2023. Accessed March 10, 2024. https://www.va.gov/ogc/legalservices.asp

7. Theiss J, Trott J, Peterson A. Medical legal partnerships serving veterans: history, growth and progress. National Center for Medical Legal Partnership; 2019. Accessed March 10, 2024. https://medical-legalpartnership.org/wp-content/uploads/2019/05/MLPs-Serving-Veterans-History-Growth-and-Progress.pdf
8. Office of Public Affairs. Community homelessness assessment, local education and networking groups (CHALENG). US Department of Veterans Affairs; 2023. Accessed June 10, 2023. https://www.va.gov/HOMELESS/docs/CHALENG_2023_FACT_SHEET.pdf
9. Veterans Health Administration. VHA Directive 1510: veterans legal referral process. US Department of Veterans Affairs; 2021. Accessed January 31, 2024. https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=9450
10. Legal Services for Veterans Program. Medical legal partnerships and VA-affiliated legal clinics. US Department of Veterans Affairs; 2024. Accessed June 10, 2024. https://www.va.gov/HOMELESS/lsv/MLP_LC_List.pdf
11. Tsai J, Middleton M, Villegas J, et al. Medical-legal partnerships at Veterans Affairs medical centers improved housing and psychosocial outcomes for vets. *Health Aff (Millwood)*. 2017;36(12):2195-2203.
12. Muller LS, Early N, Ronca J. Veterans who apply for Social Security disabled workers benefits after receiving a Department of Veterans Affairs rating of "total disability" for service-connected ompairments: characteristics and outcomes. *Soc Secur Bull*. 2014;74(3):1-69.
13. Bohnert KM, Sripada RK, Mach J, McCarthy JF. Same-day integrated mental health care and PTSD diagnosis and treatment among VHA primary care patients with positive PTSD screens. *Psychiatr Serv.* 2016;67(1):94-100.
14. Montgomery AE, Blosnich JR, deRussy A, Richman JS, Dichter ME, True G. Association between services to address adverse social determinants of health and suicide mortality among veterans with indicators of housing instability, unemployment, and justice involvement. *Arch Suicide Res*. Published online August 11, 2023.
15. Perlin JB, Kolodner RM, Roswell RH. The Veterans Health Administration: quality, value, accountability, and information as transforming strategies for patient-centered care. *Am J Manag Care*. 2004;10(11, pt 2):828-836.
16. Veterans Health Administration. VHA Directive 1134(2): provision of medical statements and completion of forms by VA health care providers. US Department of Veterans Affairs; 2016. Updated May 11, 2020. Accessed January 31, 2024. https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=4300
17. US Department of Veterans Affairs. *Department of Veterans Affairs Fiscal Years 2022-28 Strategic Plan.* US Department of Veterans Affairs; 2022. Accessed January 31, 2024. https://department.va.gov/wp-content/uploads/2022/09/va-strategic-plan-2022-2028.pdf
18. Campbell AT, Sicklick J, Galowitz P, Retkin R, Fleishman SB. How bioethics can enrich medical-legal collaborations. *J Law Med Ethics.* 2010;38(4):847-862.
19. Keene DE, Murillo S, Benfer EA, Rosenthal A, Fenick AM. Reducing the justice gap and improving health through medical-legal partnerships. *J Leg Med.* 2020;40(2):229-245.
20. Johnson DY, Asay S, Keegan G, et al. US medical-legal partnerships to address health-harming legal needs: closing the health injustice gap. *J Gen Intern Med*. 2024;39(7):1204-1213.

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Editor's Note

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