

Standards in Medical-Legal Partnerships

August 2024, Volume 26, Number 8: E591-664

From the Editor

- Medical-Legal Partnerships and the Future of Health Care 593
Jin K. Park

Case and Commentary

- How Is Access to Legal Resources and Advocacy Foundational to Health Justice? 596
Yael Zakai Cannon, JD

- What Should Clinicians in Organizations Without Established MLP Programs Do
When Their Patients Need Lawyers to Meet Their Health Needs? 605
Dinushika Mohottige, MD, MPH, Karina Albistegui Adler, JD, Allison Charney, JD,
and Lilia Cervantes, MD, MSc

- How Should MLP Clinicians and Attorneys Help Veterans Secure Disability Benefits
When Health Records Documentation Is Insufficient? 616
Cynthia Geppert, MD, PhD, DPS, MA, MPH, MSB, MSJ, HEC-C

AMA Code Says

- AMA *Code of Medical Ethics'* Opinions Related to Medical-Legal Partnerships 622
Annika Penzer

State of the Art and Science

- How Should We Measure Effectiveness of Medical-Legal Partnerships? 626
Prashasti Bhatnagar, JD, MPH, Deborah F. Perry, PhD, and Margaret E. Greer, MS

Policy Forum

- How Should a Medical-Legal Partnership Address Unique Needs of People With
Criminal Legal System Involvement? 634
Lisa B. Puglisi, MD and James Bhandary-Alexander, JD

Why MLP Legal Care Should Be Financed as Health Care 640
William M. Sage, MD, JD and Keegan D. Warren, JD, LLM

Medicine and Society

What Are Epidemiological Foundations for Integrating Legal Services Into Health
Care Settings? 648
Adrienne W. Henize, JD and Andrew F. Beck, MD, MPH

Can Medical-Legal Partnerships Do More to Advance Reproductive Justice After
Dobbs? 655
Medha Devanagondi Makhoul, JD and Natasha Rappazzo

Podcast

What Do MLPs Offer Undocumented Patients?: An Interview With Lynette Martins



AMA Journal of Ethics®

August 2024, Volume 26, Number 8: E593-595

FROM THE EDITOR

Medical-Legal Partnerships and the Future of Health Care

Jin K. Park

Medical legal partnerships (MLPs) are interprofessional collaborations between medical and legal professionals designed with the goal of identifying patients' health-harming legal and social needs. The pressing need for such collaborative endeavors is highlighted by the broader pattern of health status in the United States. According to some estimates, **access to health care** services accounts for 10% to 20% of modifiable health outcomes.¹ As is now well-known, health status is influenced by broader social and economic factors—the so-called structural determinants of health (SDoH)—apart from individual behavioral or genetic risk factors. Indeed, physicians now increasingly insist upon the social nature of disease, such that those seeking to systematically understand the drivers of poor health are expected to account for the fact that “disease is always generated, experienced, defined, and ameliorated within a social world.”² Of course, SDoH matter because they adversely impact not only our health, but also genuine human flourishing in a variety of ways.³ As Michael Marmot has written: “so intimate is the connection between our set of social arrangements and health that we can use the degree of health inequalities to tell us about social progress in meeting basic human needs.”⁴ While this close connection between health and human flourishing is now widely understood, an important tension remains: how to balance health care provision with prevention and with broader goals of social justice.⁵

Similar questions have long-occupied legal academics and practitioners. As a general proposition, the law has often shaped our understanding of what fundamental forms of social support we may expect from one another—particularly with regard to our health.^{6,7,8} As legal scholars have argued, the law has been a crucial determinant of health in a variety of circumstances and has often been the setting in which health-promoting social reforms have been made.⁹ And, as Lawrence Gostin and Lindsay Wiley demonstrate in their landmark contribution, *Public Health Law: Power, Duty, Restraint*, many of the significant public health interventions in the 20th century—vaccinations, workplace protections, food and safety regulations, and child welfare—relied fundamentally on obligations generated by the law.¹⁰ It is in these cases that the law has been called upon to help resolve fundamental tensions between population health and well-being, on one hand, and personal liberty and other pro-social goals, on the other. As novel methodologies are brought to bear to systematically study the impact of the law on population health over time¹¹—in particular, the role of law *itself* in determining health outcomes—the potential of the **law to promote health** will continue to be central.

Far from being just a bridge between the 2 professions of law and medicine, MLPs have been proposed as a crucial hinge by which shared concerns may be addressed constructively.^{12,13,14} Since at least 1993, when pediatricians and lawyers worked together at the Boston Medical Center to construct one of the first MLPs, the MLP model has been replicated across the country,¹⁵ generating significant interest and attention for its potential to address SDoH. However, the unique ability of MLPs to identify and address many health-harming social and legal needs means that the MLP model has—often for good reason—come to encompass an increasingly diverse set of interventions.¹⁶

Contributions to this issue seek to answer several fundamental questions that must be addressed if MLPs are to gain a broader foothold in health care delivery. First, there are questions about *value*—what fundamental normative goals and priorities are MLPs best suited to fulfill? Next, there are questions about *scope*—can we expand the scope of services and activities MLPs are engaged in apart from the well-known I-HELP™ (income and insurance, housing and utilities, education and employment, **legal status**, personal and family stability) model?¹⁶ Relatedly, are there particular domains in which MLPs have been uniquely demonstrated to be effective? Lastly, there are questions about *evidence*—what kinds of evidence are necessary to evaluate the efficacy of various MLP programs? While these questions are by no means exhaustive of the many issues in which the current theme issue intervenes, the issue helps to put forward a diverse set of perspectives on these questions and seeks to set the agenda for MLP research and practice going forward.

References

1. Magnan S. Social determinants of health 101 for health care: five plus five. National Academy of Medicine. October 9, 2017. Accessed October 5, 2023. <https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/>
2. Jones DS, Podolsky SH, Greene JA. The burden of disease and the changing task of medicine. *N Engl J Med*. 2012;366(25):2333-2338.
3. Wilson J. Not so special after all? Daniels and the social determinants of health. *J Med Ethics*. 2009;35(1):3-6.
4. Marmot M. Foreword. In: Venkatapuram S. *Health Justice: An Argument from the Capabilities Approach*. Wiley; 2011:ix-x.
5. Glied S, D'Aunno T. Health systems and social services—a bridge too far? *JAMA Health Forum*. 2023;4(8):e233445.
6. *National Federation of Independent Business v Sebelius*, 567 US 519 (2012).
7. *Graham v Richardson*, 403 US 365 (1971).
8. Fuse Brown EC, Lawrence MB, McCuskey EY, Wiley LF. Social solidarity in health care, American-style. *J Law Med Ethics*. 2020;48(3):411-428.
9. Benfer EA. Health justice: a framework (and call to action) for the elimination of health inequity and social injustice. *Am Univ Law Rev*. 2015;65(2):275-351.
10. Gostin LO, Wiley LF. *Public Health Law: Power, Duty, Restraint*. 3rd ed. University of California Press; 2016.
11. Wagenaar AC, Pacula RL, Burris S, eds. *Legal Epidemiology: Theory and Methods*. 2nd ed. Wiley; 2023.
12. Healton EB, Treanor WM, DeGioia JJ, Girard VW. Training future health justice leaders—a role for medical-legal partnerships. *N Engl J Med*. 2021;384(20):1879-1881.

13. Zuckerman B, Sandel M, Lawton E, Morton S. Medical-legal partnerships: transforming health care. *Lancet*. 2008;372(9650):1615-1617.
14. Teitelbaum J, Lawton E. The roots and branches of the medical-legal partnership approach to health: from collegiality to civil rights to health equity. *Yale J Health Policy Law Ethics*. 2017;17(2):343-377.
15. Lawton E. A history of the medical-legal partnership movement. *Community Health Forum*. 2014;(Fall/Winter):12-13. Accessed March 6, 2024. <https://medical-legalpartnership.org/wp-content/uploads/2015/01/NACHC-Magazine-A-History-of-the-Medical-Legal-Partnership-Movement.pdf>
16. Regenstein M, Trott J, Williamson A, Theiss J. Addressing social determinants of health through medical-legal partnerships. *Health Aff (Millwood)*. 2018;37(3):378-385.

Jin K. Park is a MD/JD candidate at Harvard Medical School in Boston, Massachusetts, and Yale Law School in New Haven, Connecticut. His research interests focus on legal and political determinants of health.

Citation

AMA J Ethics. 2024;26(8):E593-595.

DOI

10.1001/amajethics.2024.593.

Conflict of Interest Disclosure

Author disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Is Access to Legal Resources and Advocacy Foundational to Health Justice?

Yael Zakai Cannon, JD

Abstract

Health justice as a movement incorporates research about how to more effectively leverage law, policy, and institutions to dismantle inequitable power distributions and accompanying patterns of marginalization that are root causes of health inequity. Legal advocacy is key to health justice because it addresses patients' health-harming legal needs in housing, public benefits, employment, education, immigration, domestic violence, and other areas of law. In medical-legal partnerships, lawyers and clinicians are uniquely positioned to jointly identify and remove legal barriers to patients' health, advocate for structural reform, and build community power.

Case

JM is 29 years of age and presents in distress to a municipal emergency department with an acute asthma exacerbation for the third time this month. JM is admitted and seen by a hospitalist, Dr H, who learns from JM that he is living in an apartment with mold and fears being evicted after falling behind on rent. Dr H is concerned that JM will continue to experience severe asthma exacerbations and overall poor health if he remains in substandard and unstable housing.

Commentary

Dr H is rightfully concerned about JM's health. Exposure to mold in homes has been linked to increased incidence and severity of asthma.^{1,2,3} If JM were to be evicted, his health would be further at risk, as eviction has been linked to myriad health conditions.⁴ Indeed, even the threat of eviction has been shown to harm health.⁵ On her own, Dr H lacks the tools in her toolbox to address JM's substandard housing conditions or prevent his eviction. JM is experiencing health-harming legal needs and requires legal advocacy both to ensure that his landlord remediates the mold in his home in accordance with the local housing code and to prevent his eviction.^{6,7}

Each year, millions of Americans—and disproportionately people with low-income and people of color—have unmet legal needs related to housing and many other areas of law, such as public benefits, employment, education, immigration, child custody, domestic violence, and disability discrimination.^{8,9,10} Legal problems in all of these

areas harm health and are associated with socioeconomic and racial health disparities.^{8,11,12} For example, illegal **substandard housing** conditions, like those experienced by JM, are a root cause of asthma prevalence and severity,^{2,3} and high asthma rates disproportionately burden people of color and households with low income.¹³ Despite the urgency of such issues, many people with low income fail to obtain legal assistance because they do not recognize their problems as legal in nature and face barriers to accessing legal services.^{14,15} Without legal help, the health of patients like JM can worsen.^{8,14}

Health justice as a movement incorporates research on how to effectively leverage law, policy, and institutions to dismantle inequitable power distributions and the accompanying patterns of marginalization that serve as root causes of health disparities.^{16,17} While health equity has been defined as all people having a fair and equal opportunity to achieve health and well-being, the term *justice* centers the potential for law to facilitate health equity.¹⁸ Because many unmet socio-legal needs harm health and drive inequity, access to justice—or access to adequate legal information, advice, and advocacy—is therefore foundational to health justice. Medical-legal partnerships (MLPs) embed lawyers in health care settings to train health care partners to screen patients for social needs and refer them for legal services.^{12,18} This article argues that MLPs offer a promising approach for effectuating health justice by bringing lawyers onto the treatment team to remove legal barriers to health, advocate for structural reform, and build community power.

Health Justice and Medical-Legal Partnerships

Health justice begins with an examination of how law and policy have created and perpetuated health inequity, including how broader patterns of discrimination and marginalization, such as structural racism, impact health.^{6,16,19} The health justice framework recognizes that the disproportionate burden of health problems experienced by certain populations is “made, not born.”²⁰ Indeed, a growing body of research recognizes that “[m]edical care is estimated to account for only 10-20 percent of the modifiable contributors to healthy outcomes for a population,” and the other 80% to 90% are known as the social determinants of health, or the conditions in which people live, eat, work, learn, and age.²¹ Health justice underscores that these conditions are not just social but political and structural determinants of health, with roots in law and policy that drive health disparities.^{22,23}

These conditions often present in patients as health-harming legal needs. Housing codes requiring that rental housing be free of hazards like mold and landlord-tenant laws protecting renters from unjust evictions are examples of laws that can impact health.¹ Problems with the substance, implementation, and enforcement of such laws can drive health disparities when they result in people from racially minoritized and socioeconomically marginalized populations, such as JM, disproportionately experiencing unhealthy and unstable housing.¹ For instance, redlining and restrictive covenants relegated many people of color across the country to neighborhoods with substandard housing conditions, reinforcing racialized poverty and making stable and affordable housing inaccessible for many people of color.¹⁰ When landlords do not adhere to housing codes designed to ensure tenants’ safe and habitable conditions, the health of tenants from those minoritized and marginalized communities is harmed.¹ Indeed, “health justice is ... economic justice, racial justice, housing justice, and other forms of justice that necessitate access to legal resources to address unmet legal needs.”¹⁴ Health justice requires radical action by cross-sector partners to address these

inequities; it requires resolving health-harming legal needs facing individuals, transforming systems that drive health disparities, and building the power of affected communities to drive the health justice agenda.^{20,24}

By embedding lawyers in health care teams, medical-legal partnerships offer a different model of health care that leverages interprofessional collaborations to tackle the social and structural determinants at the root of health injustice and thereby offer a different and promising model of access to justice. In a traditional legal services model, a person may not realize they have a legal issue with a legal remedy until there is a crisis, such as receipt of an eviction notice. That person must then seek out and obtain legal assistance. Many individuals do not identify their problems as legal in nature, face barriers to locating and accessing legal services, perceive the process as overwhelming and time intensive, and lack comfort with legal services.^{12,14,15}

MLPs lower such barriers to legal assistance by capitalizing on patients' presence in the health care setting and their relationships with their health care practitioners to engender trust in the legal team.¹⁴ In MLPs, clinicians proactively screen for and help patients recognize potential legal needs, refer patients to a legal team, and advocate collaboratively with attorneys and legal navigators to address health-harming legal needs.^{11,12,14} A 2020 study found that MLPs reduce obstacles to legal assistance by creating a straightforward, affordable, and trustworthy access point.¹⁵ These partnerships can also facilitate more transformative change, as they offer opportunities for interprofessional teams to engage in structural reform efforts through patients-to-policy advocacy and community power building.^{14,15}

Identifying and Addressing Health-Harming Legal Needs

In an MLP, Dr H would be trained by a lawyer to screen for and identify legal needs so that she could recognize JM's substandard housing conditions and eviction concern as potential legal issues and refer JM to an attorney.^{12,25,26} That attorney could advocate for mold remediation through a letter to the landlord or litigation, and Dr H could assist by providing medical records or court testimony documenting the impacts of mold on JM's respiratory health and the urgent need for mold remediation.^{12,27} Moreover, JM's MLP attorney could advocate for emergency rental assistance or rent abatement and assert his rights under landlord-tenant laws, such as those requiring landlords to provide safe and habitable housing free of mold, in order to prevent his eviction, avoid the resulting health harms, and ensure he has stable and healthy housing.^{28,29} Such collaborative MLP advocacy to remedy substandard housing conditions has been directly linked to improved asthma and respiratory health.³⁰

Access to justice is critical in many other types of matters implicating health besides housing. For example, lawyers can assist patients in asserting their rights to family and sick leave and workplace accommodations,³¹ which can help people remain employed and prevent health harms—and racial disparities—associated with unemployment, including increased risk of hospitalization.^{32,33} For pediatric patients, attorneys can advocate for necessary special education services and fight illegal exclusionary discipline,^{34,35,36} keeping students in school and reducing their risk of health outcomes associated with low educational attainment, such as chronic disease and lower life expectancy.^{37,38,39} For survivors of intimate partner violence, lawyers can obtain divorce, custody, and protective orders.⁴⁰ Data indicate that legal representation reduces recurrence of domestic violence, protecting the safety and health of survivors.⁴¹ Similarly, immigrants with legal representation experience greater likelihood of success

at all stages of immigration proceedings,^{42,43} with numerous health-promoting benefits, such as greater access to health care and employment.^{44,45,46} MLPs therefore provide an innovative approach for effectuating health justice that goes well beyond traditional health law.

The National Center for Medical-Legal Partnership developed the I-HELP™ framework for helping health care and legal partners identify and understand such health-harming legal needs in the categories of income, housing and utilities, education and employment, legal status, and personal and family stability.²⁵ MLPs are expanding beyond these areas by, for example, engaging physicians with public defenders and law school clinics to advocate for compassionate release from incarceration of people with serious health conditions.^{18,47} Research shows the benefits of MLP legal advocacy, including improved health and reduced stress for patients, as well as return on investment for hospitals and health care systems.^{26,29}

Advocacy for Structural Reform

Health justice requires more than legal advocacy to leverage laws already on the books, such as housing codes; it also requires structural reform of laws, policies, and systems that drive health inequity.¹⁶ MLPs use a “patients-to-policy” approach to pursue this type of transformative change.

Using this approach, MLP partners listen to their patients’ concerns and draw on their patient-focused advocacy to identify broader systemic gaps and problems with the law and engage in policy advocacy to address those problems.^{48,49} A **patients-to-policy approach** allows MLPs to build on their individual-level advocacy by surfacing the health harms that result from current legal structures and pursuing broader reforms to improve community health and health equity. This advocacy can take different forms. For example, attorneys can advocate for law reform by preparing health care team members, as well as patients, to provide written or oral testimony before local, state, and federal lawmakers at legislative hearings in order to share their firsthand knowledge of how the law impacts health and drives disparities.^{6,14,49} In JM’s case, beyond protecting JM’s individual rights, Dr H and her MLP partners might employ such a patients-to-policy approach to identify gaps in the city’s housing code and inspections system. They could use that knowledge to advocate with municipal or state legislators for systemic reform, such as housing code changes to require proactive mold screenings in rental units. The MLP could also advocate for other transformative policy changes, such as significant increases to housing voucher programs, a universal basic income program, and homeownership initiatives for low-income tenants, all of which could benefit JM and promote broader health equity.

Community Power Building

Health justice also requires intentionally building power for both individuals and communities experiencing health inequities.^{16,50,51} MLPs offer a unique model for fulfilling this important health justice objective.

MLP scholars have called upon MLPs to more vigorously embrace antiracist, intersectional, and power-building approaches^{12,52,53} to ensure they “are not merely creating repeat clients but rather increasing the collective power of marginalized communities and dismantling racial injustice that legal (and medical) systems have perpetuated.”¹⁴ Consistent with their holistic and patient-centered orientation, MLP partners can help patients build their power by educating them about their rights and

providing them with tools and resources to aid in future self-advocacy.⁵⁴ For example, an MLP could work closely with JM to help him understand his rights to safe, healthy housing and how to document and pursue remediation of substandard housing conditions by his landlord if they recur. MLPs can also **build community power** by facilitating patient engagement with policy makers in accordance with the patients-to-policy approach, such as by helping JM testify before legislators about his lived experience and the need for stricter housing code enforcement and greater access to affordable housing. Furthermore, MLPs can connect patients like JM with grassroots movements, such as tenant cooperatives, which can provide patients with greater solidarity and power. Attorneys, physicians, and other health professionals can also become resource allies, lending their expertise and support to those organizations and engaging in community-based participatory research and other collaborative efforts to help affected communities identify their needs and lead the development and implementation of the health justice agenda.^{55,56}

Call to Action

Hospitals, health care systems, and government entities should seek opportunities to develop and expand medical-legal partnerships that can address health-harming legal needs, pursue structural reform, and promote community power, all of which advance health justice. In particular, more universities and teaching hospitals should develop academic MLPs (A-MLPs) that engage students in MLP learning and advocacy and conduct MLP research. Given universities' research missions, A-MLPs are well-positioned to study both connections among law, health, and equity and the efficacy of MLP approaches to inform best practices. Furthermore, A-MLPs can train the next generation of law, medical, nursing, and other students to practice differently in ways that intentionally promote health justice, thereby contributing to the transformation of the health care and legal systems. Through curated preprofessional interdisciplinary learning environments during their formative years of professional development, students can learn to practice with an understanding of how health and justice intertwine and to intentionally partner across disciplines to foster health equity.⁵⁷ A-MLPs are uniquely positioned to teach future lawyers, doctors, and other health care professionals early in their careers how to advance health justice by collaboratively addressing the health-harming legal needs of individual patients like JM, advocating for structural reform, and building community power.^{57,58,59}

References

1. Cannon Y. Injustice is an underlying condition. *Univ PA J Law Public Aff.* 2020;6(2):201-266.
2. Mészáros D, Burgess J, Walters EH, et al. Domestic airborne pollutants and asthma and respiratory symptoms in middle age. *Respirology.* 2014;19(3):411-418.
3. Hagemolen of ten Have W, van den Berg NJ, van der Palen J, van Aalderen WM, Bindels PJ. Residential exposure to mould and dampness is associated with adverse respiratory health. *Clin Exp Allergy.* 2007;37(12):1827-1832.
4. Hoke MK, Boen CE. The health impacts of eviction: evidence from the national longitudinal study of adolescent to adult health. *Soc Sci Med.* 2021;273:113742.
5. Benfer EA, Vlahov D, Long MY, et al. Eviction, health inequity, and the spread of COVID-19: housing policy as a primary pandemic mitigation strategy. *J Urban Health.* 2021;98(1):1-12.

6. Cannon Y. Unmet legal needs as health injustice. *Univ Richmond Law Rev.* 2022;56(3):801-877.
7. Trott J, Regenstein M. Screening for health-harming legal needs. National Center for Medical-Legal Partnership; 2016. Accessed August 7, 2023. <https://medical-legalpartnership.org/wp-content/uploads/2016/12/Screening-for-Health-Harming-Legal-Needs.pdf>
8. Cannon Y. Closing the health justice gap: access to justice in furtherance of health equity. *Columbia Human Rights Law Rev.* 2021;53(2):517-581.
9. The justice gap: executive summary. Legal Services Corporation. Accessed September 29, 2023. <https://justicegap.lsc.gov/resource/executive-summary>
10. Foster S, Cannon Y, Bloche G. Health justice is racial justice: a legal action agenda for health disparities. *Health Affairs Forefront.* July 2, 2020. Accessed September 22, 2023. <https://www.healthaffairs.org/doi/10.1377/hblog20200701.242395>
11. Kessler L, Cannon Y, Tuchinda N, et al. Co-creating a legal check-up in a school-based health center serving low-income adolescents. *Prog Community Health Partnersh.* 2021;15(2):203-216.
12. Benfer EA, Bhandary-Alexander J, Cannon Y, Makhlof M, Pierson-Brown T. Setting the health justice agenda: addressing health inequity & injustice in the post-pandemic clinic. *Clin Law Rev.* 2021;28(1):45-84.
13. Perez MF, Coutinho MT. An overview of health disparities in asthma. *Yale J Biol Med.* 2021;94(3):497-507.
14. Cannon YZ. Medical-legal partnership as a model for access to justice. *Stanford Law Rev Online.* 2023;75:73-88.
15. 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.
16. Wiley LF, Yearby R, Clark BR, Mohapatra S. Introduction: what is health justice? *J Law Med Ethics.* 2022;50(4):636-640.
17. Benfer EA, Wiley LF. Health justice strategies to combat COVID-19: protecting vulnerable communities during a pandemic. *Health Affairs Forefront.* March 19, 2020. Accessed September 25, 2023. <https://www.healthaffairs.org/doi/10.1377/hblog20200319.757883/full>
18. Cannon YZ, Johnson V. Advancing racial justice through civil and criminal academic medical-legal partnerships. *Clin Law Rev.* 2023;30(1):29-63.
19. Wiley LF. Health law as social justice. *Cornell J Law Public Policy.* 2014;24(1):47-105.
20. Harris AP, Pamukcu A. The civil rights of health: a new approach to challenging structural inequality. *UCLA Law Rev.* 2020;67(4):758-832.
21. Magnan S. Social determinants of health 101 for health care: five plus five. National Academy of Medicine; 2017. Accessed March 13, 2024. <https://nam.edu/wp-content/uploads/2017/10/Social-Determinants-of-Health-101.pdf>
22. Yearby R. The social determinants of health, health disparities, and health justice. *J Law Med Ethics.* 2022;50(4):641-649.
23. Dawes DE. *The Political Determinants of Health.* Johns Hopkins University Press; 2020.
24. Pierson-Brown T. It's not irony, it's interest convergence: a CRT perspective on racism as public health crisis statements. *J Law Med Ethics.* 2022;50(4):693-702.

25. How legal services help the health care system address social needs. National Center for Medical-Legal Partnership. Accessed September 29, 2023. <https://medical-legalpartnership.org/response/i-help>
26. Tobin Tyler E. Medical-legal partnership in primary care: moving upstream in the clinic. *Am J Lifestyle Med.* 2019;13(3):282-291.
27. Musumeci M. Augmenting advocacy: giving voice to the medical-legal partnership model in Medicaid proceedings and beyond. *Univ Mich J Law Reform.* 2011;44(4):857-900.
28. Gold AE. No home for justice: how eviction perpetuates health inequity among low-income and minority tenants. *Georget J Poverty Law Policy.* 2016;24(1):59-86.
29. Krishnamurthy B, Hagins S, Lawton E, Sandel M. What we know and need to know about medical-legal partnership. *S C Law Rev.* 2016;67(2):377-388.
30. O'Sullivan MM, Brandfield J, Hoskote SS, et al. Environmental improvements brought by the legal interventions in the homes of poorly controlled inner-city adult asthmatic patients: a proof-of-concept study. *J Asthma.* 2012;49(9):911-917.
31. Griffin F. Improving health outcomes and lowering costs: attorneys as proactive, paid providers treating social determinants of health. *Rutgers Univ Law Rev.* 2019;71(3):795-841.
32. Hergenrather KC, Zeglin RJ, McGuire-Kuletz M, Rhodes SD. Employment as a social determinant of health: a systematic review of longitudinal studies exploring the relationship between employment status and physical health. *Rehabil Res Policy Educ.* 2015;29(1):2-26.
33. Williams J, Wilson V. Black workers endure persistent racial disparities in employment outcomes. Economic Policy Institute. August 27, 2019. Accessed September 25, 2023. <https://www.epi.org/publication/labor-day-2019-racial-disparities-in-employment>
34. Black DW. Reforming school discipline. *Northwest Univ Law Rev.* 2016;111(1):1-74.
35. González T, Etow A, De La Vega C. Health equity, school discipline reform, and restorative justice. *J Law Med Ethics.* 2019;47(suppl 2):47-50.
36. Bonuck K, Hill LA. Special education disparities are social determinants of health: a role for medical-legal partnerships. *Prog Community Health Partnersh.* 2020;14(2):251-257.
37. González T, Etow A, De La Vega C. School discipline is a public health crisis. *Bill of Health.* October 6, 2020. Accessed September 25, 2023. <https://blog.petrieflom.law.harvard.edu/2020/10/06/school-discipline-is-a-public-health-crisis>
38. Wu YT, Daskalopoulou C, Muniz Terrera G, et al; ATHLOS consortium. Education and wealth inequalities in healthy ageing in eight harmonised cohorts in the ATHLOS consortium: a population-based study. *Lancet Public Health.* 2020;5(7):e386-e394.
39. Cannon Y, Tuchinda N. Critical perspectives to advance educational equity and health justice. *J Law Med Ethics.* 2022;50(4):776-790.
40. How legal aid helps domestic violence survivors. Legal Services Corporation. Accessed September 25, 2023. <https://www.lsc.gov/our-impact/publications/other-publications-and-reports/how-legal-aid-helps-domestic-violence>
41. Abel LK. Economic benefits of civil legal aid. National Center for Access to Justice, Cardozo Law School; 2012. Accessed September 25, 2023.

<https://ncforaj.files.wordpress.com/2012/09/final-economic-benefits-of-legal-aid-9-5-2012.pdf>

42. Taylor Poppe ES, Rachlinski JJ. Do lawyers matter? The effect of legal representation in civil disputes. *Pepperdine Law Rev.* 2016;43(4):881-944.
43. Eagly IV, Shafer S. A national study of access to counsel in immigration court. *Univ PA Law Rev.* 2015;164(1):1-91.
44. Makhlof MD. Health justice for immigrants. *Univ PA J Law Pub Aff.* 2019;4(2):235-311.
45. Gelatt J. Immigration status and the healthcare access and health of children of immigrants. *Soc Sci Q.* 2016;97(3):540-554.
46. Prentice JC, Pebley AR, Sastry N. Immigration status and health insurance coverage: who gains? Who loses? *Am J Public Health.* 2005;95(1):109-116.
47. Vanjani R, Martino S, Reiger SF, et al. Physician-public defender collaboration—a new medical-legal partnership. *N Engl J Med.* 2020;383(21):2083-2086.
48. Sandel M, Hansen M, Kahn R, et al. Medical-legal partnerships: transforming primary care by addressing the legal needs of vulnerable populations. *Health Aff (Millwood).* 2010;29(9):1697-1705.
49. Marple K, Dexter E. Keeping children safe from lead poisoning. National Center for Medical-Legal Partnership; 2018. Accessed March 13, 2024. <https://medical-legalpartnership.org/wp-content/uploads/2018/04/Keeping-Children-Safe-from-Lead-Poisoning.pdf>
50. Benfer EA, Mohapatra S, Wiley LF, Yearby R. Health justice strategies to combat the pandemic: eliminating discrimination, poverty, and health disparities during and after COVID-19. *Yale J Health Policy Law Ethics.* 2020;19(3):122-171.
51. Galarneau C, Smith PT. Respect for communities in health justice. *J Law Med Ethics.* 2022;50(4):650-655.
52. Makhlof MD. Towards racial justice: the role of medical-legal partnerships. *J Law Med Ethics.* 2022;50(1):117-123.
53. Shek D. Centering race at the medical-legal partnership in Hawai'i. *Univ Miami Race Soc Justice Law Rev.* 2019;10(1):109-146.
54. Cannon Y. Equipping the next generation of health justice leaders. *Bill of Health.* September 20, 2021. Accessed September 29, 2023. <https://perma.cc/WC44-9VMT>
55. Tobin-Tyler E. Aligning public health, health care, law and policy: medical-legal partnership as a multilevel response to the social determinants of health. *J Health Biomed Law.* 2012;8(2):211-247.
56. Valverde JR. Preparing tomorrow's lawyers to tackle twenty-first century health and social justice issues. *Denver Law Rev.* 2018;95(3):539-591.
57. Girard VW, Cannon YZ, Perry DF, Moore ES. Leveraging academic-medical legal partnerships to advance health justice. *J Law Med Ethics.* 2023;51(4):798-809.
58. Tobin-Tyler E. Allies not adversaries: teaching collaboration to the next generation of doctors and lawyers to address social inequality. *J Health Care Law Policy.* 2008;11(2):249-294.
59. Mitchell LK, Watson MK, Silva A, Simpson JL. An interprofessional antiracist curriculum is paramount to addressing racial health inequities. *J Law Med Ethics.* 2022;50(1):109-116.

Yael Zakai Cannon, JD is an associate professor of law at Georgetown University Law Center in Washington, DC. She also serves as director of the medical-legal partnership Health Justice Alliance Law Clinic and as a faculty fellow at the Georgetown University Center for Social Justice Research, Teaching, and Service. She received a JD from

Stanford Law School and a BA in history and in African American Studies from the University of Maryland. Her research interests focus on the potential for law to promote health equity, well-being, and justice for children and families.

Editor's Note

The case to which this commentary is a response was developed by the editorial staff.

Citation

AMA J Ethics. 2024;26(8):E596-604.

DOI

10.1001/amajethics.2024.596.

Acknowledgements

Thank you to Georgetown University's Law and Medical Centers for their support of the Health Justice Alliance; to Vicki Girard, Marta Beresin, Eileen Moore, Ana Caskin, Deborah Perry, and Lisa Kessler for their collaboration in leading the Georgetown University Health Justice Alliance; to Deborah Perry and Robert Hopkirk for their thoughtful feedback; and to Julia Byrne and Arielle Fried for their research assistance.

Conflict of Interest Disclosure

Author disclosed no conflicts of interest.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

What Should Clinicians in Organizations Without Established MLP Programs Do When Their Patients Need Lawyers to Meet Their Health Needs?

Dinushika Mohottige, MD, MPH, Karina Albistegui Adler, JD, Allison Charney, JD, and Lilia Cervantes, MD, MSc

Abstract

Undocumented people in the United States face innumerable legal and structural barriers to health and health care services, including for kidney failure. Their experiences vary across states and regions due to wide variation in insurance coverage and unreliable access to health-promoting resources, including medical-legal partnerships. This commentary on a case canvasses key policy about structural and legal determinants of health for undocumented persons.

Case

In the emergency department (ED) of a large, urban academic health center near the US-Mexico border, Dr B encounters GG, who presents with severe fatigue, headache, dysuria (painful urination), and aching joints. After GG is stabilized, metabolic tests reveal that GG has kidney failure. Dr B refers GG immediately for emergency dialysis and then routine dialysis follow-up. However, due to GG's immigration status, the state's Medicaid program does not reimburse for routine dialysis, only for emergency dialysis.

Three weeks later, Dr B gets called back to the ED because GG is back with severe life-threatening symptoms (hyperkalemia, confusion, and hypoxia from pulmonary edema) due to lack of routine dialysis. Dr B is morally distressed and outraged that he has had to witness GG's symptoms become life-threatening due to the state Medicaid program's lack of coverage for optimal kidney care (eg, routine dialysis).

Dr B thinks, "My patient needs a lawyer," and wonders what to do.

Commentary

Clinicians' moral distress stemming from their inability to provide optimal care for individuals like GG and questions regarding how to improve care for undocumented individuals have generated critical national discourse, investigation, and equity-enhancing policy reform related to caring for undocumented people with kidney disease. Over 2 decades of studies have documented the extensive, multilevel harm and financial cost associated with emergency-only dialysis for individuals with kidney

failure.^{1,2,3,4,5,6,7} Compared to individuals receiving routine hemodialysis, those who rely on emergency dialysis experience an almost 5-fold greater hazard of 1-year mortality⁸ and a 14-fold greater hazard of 5-year mortality.⁹ Patients and their caregivers describe substantial morbidity and symptoms related to emergency dialysis treatments, including death anxiety and caregiver stress related to finances, care navigation, and emotional distress, which have multigenerational impacts.^{4,6,10} Primary care clinicians and emergency medicine and nephrology specialists also describe substantial moral distress related to providing emergency-only dialysis: witnessing suffering among individuals who have inadequate treatments, needing to balance ethics and laws, and experiencing discordance with principles of ethics that underlie medical training.^{4,9,11,12,13}

Calls for evidence-based analyses to assess the cost effectiveness of and outcomes associated with a shift from emergency-only to routine **dialysis for undocumented immigrants** have been answered with rigorous qualitative and quantitative studies spanning a decade.¹⁴ Some studies demonstrate the morbidity, mortality, social, and economic benefits of comprehensive kidney care options, including transplantation.¹⁴ Other studies report reduction in mortality, emergency department visits, hospitalizations, and length of stay with routine dialysis compared to emergency-only dialysis.^{8,9} In a study of individuals who transitioned from emergency to routine dialysis in Colorado, patients reported significant improvement in quality of life and multiple symptoms, including anxiety, depression, pain, and dyspnea.¹⁵ In Colorado, emergency dialysis expenditures for undocumented immigrants averaged over \$20 000 per person per month from 2017 until 2019, when a policy change that included kidney failure as a qualifying condition for **emergency Medicaid** (EM) went into effect, lowering routine dialysis expenditures for undocumented immigrants to an average of \$5574 per person per month in 2021 and saving the state nearly \$15 000 per person per month.⁵ A cohort study from California demonstrated that kidney transplant outcomes among undocumented immigrants were not inferior to those of US residents,¹⁶ thereby debunking myths regarding risk of kidney transplantation among undocumented individuals, who account for a substantially greater proportion of kidney donors (8% to 10%) than recipients (1%).^{17,18,19}

In light of these findings, we provide a roadmap for clinician empowerment and action, which begins with a broadened understanding of the legal and regulatory context in which undocumented individuals like GG receive kidney care. We also describe policies that have been leveraged to ensure more comprehensive care for undocumented individuals and opportunities to enhance care through policy advocacy and structurally competent practice.

Recognizing the Legal and Regulatory Context

Providing optimal care for GG and other undocumented immigrants requires **recognizing the barriers** they face in receiving high-quality care and the patchwork of legal environments and state-specific policies that shape the landscape in which health care is delivered. Each of these factors exerts a unique influence on undocumented individuals' health and sociopolitical experiences and their health care resources—from primary care to subspecialty care, including dialysis for kidney failure.^{1,2,13,20,21,22,23,24,25} The Personal Responsibility and Work Opportunity Act of 1996 (PWORA) is cited along with numerous associated restrictive federal policies as a foundational structural barrier for undocumented individuals due to explicit provisions restricting such individuals from accessing federal benefits, including health care programs and assistance programs such as Medicaid and Medicare.^{25,26,27}

Post-PWORA, several states took steps to maintain certain undocumented individuals' eligibility for health benefits through a court-created eligibility category known as Permanently Residing Under Color of Law (PRUCOL). Those states include New York, California, Connecticut, Hawaii, Illinois, Massachusetts, and Virginia.²⁸ Although benefits vary by state, many offer comprehensive health insurance coverage that mimics Medicaid. For instance, in New York, certain undocumented individuals may be designated as PRUCOL under the state's health code for the purpose of health insurance eligibility.²⁹ Not to be confused with a lawful immigration status, PRUCOL designation does, for many, confer long-term eligibility for means-tested benefits (ie, adjusted based on gross income), such as state Medicaid. In short, the patchwork of legal environments and state-specific policies provides an impetus for policy makers, advocates, and health care practitioners to consider state and federal policies that can provide overarching protections for individuals regardless of the states in which they reside.^{21,22,24,25}

Leveraging EMTALA and Emergency Medicaid

Despite challenges posed by PWORA and other restrictive policies, legal precedent exists to ensure that undocumented immigrants in the United States have access to critical emergency care.^{7,8,13,29} The 1986 Emergency Medical Treatment and Labor Act (EMTALA) is a key legal provision by which hospitals are required to screen, stabilize, and treat patients found to have an emergency, regardless of immigration status. EM, which reimburses treatment of emergency medical conditions for individuals who are uninsured and excluded from regular Medicaid due to immigration status, also offers a critical lever to expand coverage for undocumented individuals. However, the Centers for Medicare and Medicaid Services (CMS), as affirmed by the Office of the Inspector General, allows states to determine the level of reimbursement and qualification for emergency medical services.^{5,27} Therefore, CMS' deference to states' interpretations of emergency medical conditions and services under EM gives clinician advocates and policy makers a critical policy lever for expanding access to health care for undocumented immigrants.²⁷ EM supplements to state budgets have been described as critical subsidies for promoting innovation in undocumented immigrant health insurance coverage and overall population and public health.²⁷ For instance, Medicaid policy in California offers a path to kidney transplantation for undocumented immigrants via Medi-Cal, which provides immune suppression coverage for individuals who meet specific criteria.^{1,16} California's passage of Senate Bill 104 in 2019 extended eligibility for full-scope Medi-Cal benefits to undocumented youth aged 19 to 25 years regardless of PRUCOL status (with a further extension to adults aged 50 years and older in 2022 and to adults of any age in 2024),^{23,30} and other states have similarly leveraged Medicaid as a path to expand transplant access.³¹ Dr B could consider the state-specific coverage restrictions that exist for GG and work with local and national organizations to advocate for state-specific Medicaid and other policy changes that would expand coverage for routine hemodialysis, potentially further supporting Colorado's demonstration of the overall economic and health benefits of this approach.

Enhance Policy Awareness

Improving care for GG also requires organizational and individual action to recognize—and to advocate against—threats to equity-enhancing policies or programs related to immigration. One salient example is threats to the Deferred Action for Childhood Arrivals (DACA) program, created by an executive order in 2012, which protects eligible undocumented immigrants who were brought to the United States as children from deportation and grants work authorization.³² Multiple studies demonstrate positive

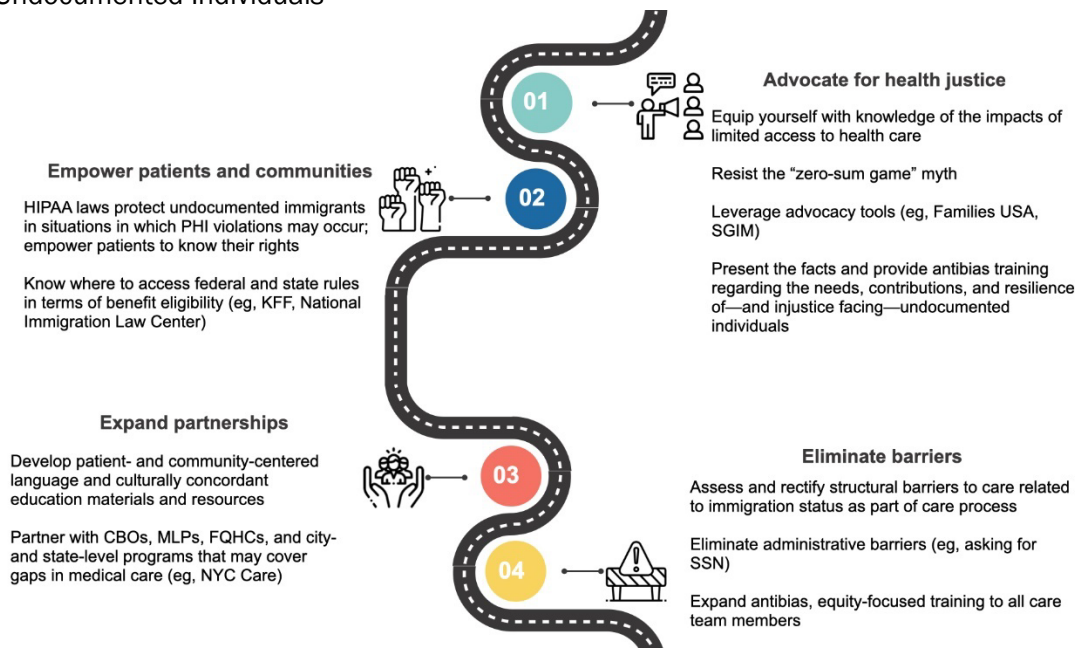
short-term outcomes for DACA recipients, including decreased delays in health care utilization and improved self-reported mental health outcomes.^{32,33} However, ongoing threats to DACA (eg, *Texas v United States*, in which the federal Fifth Circuit Court of Appeals ruled that DACA is unlawful and barred new applicants³⁴) and newer, evolving state-level restrictions (eg, SB 1718 in Florida, which requires Medicaid-accepting hospitals in Florida to inquire about immigration status³⁵) are examples of policies that cause profound social, health-related, and economic harm due to delayed presentations for care and subsequent costs to individuals and health systems.

The legal status and categories of undocumented immigrants add complexity to the structural barriers facing undocumented individuals—including their eligibility for asylum status and other immigration status designations, which impacts their care trajectories and eligibility for state-specific benefits, including transplantation.²⁷ Increasingly, restrictive border policies have ripple effects in immigrant communities, including by limiting an individual's ability to seek asylum at the border or apply for asylum once inside the United States.³⁶ Undocumented individuals also live in diverse communities with pro- or anti-immigrant climates. For instance, in some California counties, investigators found mismatches between community needs and state services and resources, as well as resistance of local law enforcement agencies and policy makers to the state's inclusive policy goals.³⁷ Clinicians like Dr B and organizations should remain vigilant about threats to these inclusive policies and ensure that patients, their caregivers, advocates, and community organizations are empowered with referrals to speak with attorneys if such policies are violated.

Protect and Expand Care Opportunities

To enhance the care of GG and other undocumented immigrants, clinicians and health care systems should be empowered with information about policy advocacy and resources that enhance equitable care (see Figure). Despite broad limitations in access to care, undocumented individuals can access limited primary care and medications through federally qualified health centers in the United States, which may have established partnership agreements with medical centers for referral and consultation (eg, nephrology subspecialty care).^{38,39} When available, medical-legal partnerships (MLPs) may enable clinicians to tackle immigration issues and address legal determinants of health, thereby improving the health and social well-being of undocumented individuals while helping them navigate resources for transportation and housing, for example.^{40,41,42,43,44,45} Finally, clinicians and organizations can demonstrate support for policies that broadly provide health care coverage to all individuals residing in the United States, including those that lift exclusions of immigrants from federal policies as well as those that offer states flexibility to tailor Medicaid for expanded coverage. One example of such legislation is the Health Equity and Access Under the Law for Immigrant Families Act of 2023,⁴⁶ which would remove barriers to health care insurance, including documented immigrants' 5-year waiting period for eligibility for Medicaid, the Children's Health Insurance Program, and access to the Affordable Care Act marketplace and Medicare.

Figure. Strategies for Leveraging Reform Roadblocks to Equitable Care for Undocumented Individuals



Abbreviations: CBOs, community-based organizations; HIPAA, Health Insurance Portability and Accountability Act; KFF, Kaiser Family Foundation; MLPs, medical-legal partnerships; SGIM, Society of General Internal Medicine.

Structurally Competent Care

One key practice that can be employed by all clinicians to improve care for GG and other undocumented immigrants is to operationalize structural competency and address structural violence, which describes social arrangements that harm individuals and populations, including their health.⁴⁷ Undocumented immigrants, due to marginalization across multiple domains (eg, race, skin color, gender, religion, sexual orientation), experience structural vulnerability and violence in the form of policy constraints (eg, immigration status), which may restrict their access to health-promoting resources, including **comprehensive kidney care**.

Antidotes to this structural violence that can be implemented at the level of a clinical encounter include utilization of structural vulnerability assessment tools to enhance clinician capacity to screen, evaluate, and mitigate the structural barriers (eg, anti-immigration policies, xenophobia) that confer substantial health risk.^{48,49,50} Clinicians and multidisciplinary care teams should also receive training regarding categories of immigration status that impact care and specific resources available for advocacy. Accordingly, traditional structural vulnerability tools, which assess environments, food access, social networks, legal concerns, education, and experience of discrimination, could be expanded to encompass the unique challenges faced by many undocumented individuals in accessing care (see Figure). These challenges include legal barriers and external constraints, such as transportation barriers, lack of linguistically and culturally tailored services, discrimination due to immigration status (eg, social security number or citizenship status required as a precursor to provision of care), complex systems that prohibit access to or produce substantial barriers to care (eg, complex care navigation, digital divide), fear of deportation and presumption of deportability by clinicians due to shifting political landscapes, financial constraints and stolen or lost wages, and stigma.^{13,21,22,24,25,38,43,47,51} Ideally, clinicians should couple these efforts with

administrative changes in their practices (see Figure), including ensuring that intake forms do not request information (eg, social security numbers) that would restrict access to care and working to establish relationships with MLPs and community-based organizations with expertise in navigating care journeys and mitigating the unique barriers facing undocumented individuals.

Beyond the clinic, **addressing structural violence** and achieving health equity in the United States necessitate a justice-focused approach to policy reform, including advocacy, community power-building, expanded partnerships, and the elimination of administrative barriers (see Figure). Evidence abounds on the profound harm of anti-immigration policies that restrict access to comprehensive health care, including kidney replacement therapy options.^{38,52} As clinicians and organizations navigate advocacy for patients like GG, they should be prepared to resist the “zero-sum game” myth, which has created innumerable barriers to health-promoting policy solutions by obscuring the collective harm of structural inequities that burden immigrant communities and by preventing coalition building across minoritized and marginalized groups who are made to perceive that “available resources” have fixed dimensions.⁵³

Critical to success are sustained multisector efforts (eg, community health worker, MLP, and navigator programs that aid immigrants in enrolling for benefits) to address the multilevel sociopolitical barriers facing undocumented individuals, along with resistance to policies that erode trust and harm health (eg, reversal of public charge rules) and the need for education on policy advances (see Table). Through our collective efforts as individuals and members of health care organizations, we can contribute to the ideal: a ripple effect of equity-enhancing policy advocacy and optimal health care provision for all.

Table. State-Level Legislative Actions^a to Extend Affordable Health Care Coverage to Income-Eligible Residents, Regardless of Immigration Status^b

Policy expansion	Population target	States involved
As of June 2024, 12 states and DC provide comprehensive state-funded coverage to income-eligible children regardless of immigration status.	Income-eligible children	CA, CT, IL, MA, ME, NJ, NY, OR, RI, UT, VT, WA
State-funded Medicaid for all adults regardless of immigration status.	All income-eligible adults 19 years and older	CA ^c
As of June 2024, 22 states and DC provide coverage from conception to end of pregnancy regardless of immigration status.	Income-eligible pregnant people	AR, CA, CT, IL, LA, ME, MD, MA, MI, MN, MO, NE, NY, OK, OR, RI, SD, TN, TX, VA, WA, WI
State-funded Medicaid coverage for individuals 65 years and older regardless of immigration status	Income-eligible individuals 65 years and older	NY ^d
Uses state funds to offer private health insurance with premium subsidies regardless of immigration status	Individuals with incomes up to 300% of the federal poverty level	CO ^d

Abbreviations: AR, Arkansas; CA, California; CHIP, Children’s Health Insurance Program; CO, Colorado; CT, Connecticut; DC, District of Columbia; IL, Illinois; LA, Louisiana; MD, Maryland; MA, Massachusetts; ME, Maine; MI, Michigan; MN, Minnesota; MO, Missouri; NE, Nebraska; NJ, New Jersey; NY, New York; OK, Oklahoma; OR, Oregon; RI, Rhode Island; SD, South Dakota; TN, Tennessee; TX, Texas; UT, Utah; VA, Virginia; VT, Vermont; WA, Washington; WI, Wisconsin.

^a Legislative actions refer to those using state-only funds or seeking waivers under the Patient Protection and Affordable Care Act.

^b Pillai et al,³⁰ Public Health Law Center.⁵⁴

^c Provided state-funded Medicaid for young adults aged 19 to 25 years from January 2020, adults 50 years and older from May 2022, and adults aged 26 to 49 years regardless of immigration status from January 2024.

^d Since 2023.

References

1. Rizzolo K, Dubey M, Feldman KE, Powe NR, Cervantes L. Access to kidney care for undocumented immigrants across the United States. *Ann Intern Med.* 2023;176(6):877-879.
2. Cassidy D, Rizzolo K, Powe NR, Cervantes L. Beyond state borders: transforming dialysis care for undocumented immigrants. *Nat Rev Nephrol.* 2023;19(9):539-540.
3. Cervantes L, Mundo W, Powe NR. The status of provision of standard outpatient dialysis for US undocumented immigrants with ESKD. *Clin J Am Soc Nephrol.* 2019;14(8):1258-1260.
4. Cervantes L, Carr AL, Welles CC, et al. The experience of primary caregivers of undocumented immigrants with end-stage kidney disease that rely on emergency-only hemodialysis. *J Gen Intern Med.* 2020;35(8):2389-2397.
5. Cervantes L, Rizzolo K, Tummalapalli SL, Powe NR. Economic impact of a change in Medicaid coverage policy for dialysis care of undocumented immigrants. *J Am Soc Nephrol.* 2023;34(7):1132-1134.
6. Rizzolo K, Novick TK, Cervantes L. Dialysis care for undocumented immigrants with kidney failure in the COVID-19 era: public health implications and policy recommendations. *Am J Kidney Dis.* 2020;76(2):255-257.
7. Raghavan R. Caring for undocumented immigrants with kidney disease. *Am J Kidney Dis.* 2018;71(4):488-494.
8. Nguyen OK, Vazquez MA, Charles L, et al. Association of scheduled vs emergency-only dialysis with health outcomes and costs in undocumented immigrants with end-stage renal disease. *JAMA Intern Med.* 2019;179(2):175-183.
9. Cervantes L, Tuot D, Raghavan R, et al. Association of emergency-only vs standard hemodialysis with mortality and health care use among undocumented immigrants with end-stage renal disease. *JAMA Intern Med.* 2018;178(2):188-195.
10. Cervantes L, Fischer S, Berlinger N, et al. The illness experience of undocumented immigrants with end-stage renal disease. *JAMA Intern Med.* 2017;177(4):529-535.
11. Cervantes L, Richardson S, Raghavan R, et al. Clinicians' perspectives on providing emergency-only hemodialysis to undocumented immigrants: a qualitative study. *Ann Intern Med.* 2018;169(2):78-86.
12. Jawed A, Moe SM, Anderson M, et al. High moral distress in clinicians involved in the care of undocumented immigrants needing dialysis in the United States. *Health Equity.* 2021;5(1):484-492.
13. Brenner JM, Blutinger E, Ricke B, Vearrier L, Kluesner NH, Moskop JC. Ethical issues in the access to emergency care for undocumented immigrants. *J Am Coll Emerg Physicians Open.* 2021;2(3):e12461.
14. Straube BM. Reform of the US healthcare system: care of undocumented individuals with ESRD. *Am J Kidney Dis.* 2009;53(6):921-924.
15. Cervantes L, Tong A, Camacho C, Collings A, Powe NR. Patient-reported outcomes and experiences in the transition of undocumented patients from emergency to scheduled hemodialysis. *Kidney Int.* 2021;99(1):198-207.
16. Eguchi N, Tantisattamo E, Chung D, et al. Outcomes among undocumented immigrant kidney transplant recipients in California. *JAMA Netw Open.* 2023;6(2):e2254660.

17. Gely YI, Esqueda-Medina M, Johnson TJ, et al. Experiences with kidney transplant among undocumented immigrants in Illinois: a qualitative study. *Kidney Med.* 2023;5(6):100644.
18. Lange-Maia BS, Johnson TJ, Gely YI, Ansell DA, Cmunt JK, Lynch EB. End stage kidney disease in non-citizen patients: epidemiology, treatment, and an update to policy in Illinois. *J Immigr Minor Health.* 2022;24(6):1557-1563.
19. Cervantes L, Rizzolo K, Klassen D. Organ procurement and transplant equity among US residents: the 5% guideline. *Am J Kidney Dis.* 2022;80(1):139-142.
20. Rizzolo K, Cervantes L. Barriers and solutions to kidney transplantation for the undocumented Latinx community with kidney failure. *Clin J Am Soc Nephrol.* 2021;16(10):1587-1589.
21. Fabi R, Cervantes L. Undocumented immigrants and COVID-19: a call for federally funded health care. *JAMA Health Forum.* 2021;2(9):e212252.
22. Fernández A, Rodríguez RA. Undocumented immigrants and access to health care. *JAMA Intern Med.* 2017;177(4):536-537.
23. Zuckerman S, Waidmann TA, Lawton E. Undocumented immigrants, left out of health reform, likely to continue to grow as share of the uninsured. *Health Aff (Millwood).* 2011;30(10):1997-2004.
24. Grubbs V. Undocumented immigrants and kidney transplant: costs and controversy. *Health Aff (Millwood).* 2014;33(2):332-335.
25. Kullgren JT. Restrictions on undocumented immigrants' access to health services: the public health implications of welfare reform. *Am J Public Health.* 2003;93(10):1630-1633.
26. Kaushal N, Kaestner R. Welfare reform and health insurance of immigrants. *Health Serv Res.* 2005;40(3):697-721.
27. Park JK, Reyes-Becerra C, Makhlof MD. State flexibility in emergency Medicaid to care for uninsured noncitizens. *JAMA Health Forum.* 2023;4(7):e231997.
28. Sacco S, Saxena S. Permanently residing under color of law: a practitioner's guide to an ambiguous doctrine. *CUNY Law Rev.* 2020;23(2):364-433.
29. *Aliessa v Novello*, 96 NY2d 418 (2001).
30. Pillai A, Pillai D, Artiga S. State health coverage for immigrants and implications for coverage and care. Kaiser Family Foundation. May 1, 2024. Updated June 20, 2024. Accessed June 24, 2024. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/>
31. Simpson HM, Bock A, Cervantes L. Policy in clinical practice: emergency Medicaid and access to allogeneic stem cell transplant for undocumented immigrants. *J Hosp Med.* 2022;17(1):50-53.
32. Giuntella O, Lonsky J. The effects of DACA on health insurance, access to care, and health outcomes. *J Health Econ.* 2020;72:102320.
33. Pourat N, Davis AC, Chen X, Vrungos S, Kominski GF. In California, primary care continuity was associated with reduced emergency department use and fewer hospitalizations. *Health Aff (Millwood).* 2015;34(7):1113-1120.
34. Park JK, Yale-Loehr S, Kaur G. DACA, public health, and immigrant restrictions on healthcare in the United States. *Lancet Reg Health Am.* 2023;21:100493.
35. Immigration, S 1718, Reg Sess (Fla 2023). Accessed April 4, 2024. <https://www.flsenate.gov/Session/Bill/2023/1718>
36. Centers for Medicare and Medicaid Services. Medicare Program; End-Stage Renal Disease Prospective Payment System, payment for renal dialysis services furnished to individuals with acute kidney injury, End-Stage Renal Disease Quality Incentive Program, Durable Medical Equipment, Prosthetics, Orthotics

and Supplies (DMEPOS) Competitive Bidding Program (CBP) and fee schedule amounts, and technical amendments to correct existing regulations related to the CBP for certain DMEPOS; final rule. *Fed Regist*. 2018;83(220):56922-57073. Accessed June 25, 2024. <https://www.govinfo.gov/content/pkg/FR-2018-11-14/pdf/2018-24238.pdf>

37. Young MT, Tafolla S, Perez-Lua FM. Caught between a well-intentioned state and a hostile federal system: local implementation of inclusive immigrant policies. *Milbank Q*. 2023;101(4):1348-1374.
38. Sommers BD. Stuck between health and immigration reform—care for undocumented immigrants. *N Engl J Med*. 2013;369(7):593-595.
39. Doshi M, Lopez WD, Mesa H, et al. Barriers and facilitators to healthcare and social services among undocumented Latino(a)/Latinx immigrant clients: perspectives from frontline service providers in Southeast Michigan. *PLoS One*. 2020;15(6):e0233839.
40. Regenstein M, Trott J, Williamson A, Theiss J. Addressing social determinants of health through medical-legal partnerships. *Health Aff (Millwood)*. 2018;37(3):378-385.
41. Murphy C. Making the case for medical-legal partnerships: an updated review of the evidence. National Center for Medical-Legal Partnership; 2020. Accessed April 4, 2024. <https://medical-legalpartnership.org/wp-content/uploads/2020/10/MLP-Literature-Review-2013-2020.pdf>
42. Murphy JS, Lawton EM, Sandel M. Legal care as part of health care: the benefits of medical-legal partnership. *Pediatr Clin North Am*. 2015;62(5):1263-1271.
43. Sandel M, Hansen M, Kahn R, et al. Medical-legal partnerships: transforming primary care by addressing the legal needs of vulnerable populations. *Health Aff (Millwood)*. 2010;29(9):1697-1705.
44. Cohen E, Fullerton DF, Retkin R, et al. Medical-legal partnership: collaborating with lawyers to identify and address health disparities. *J Gen Intern Med*. 2010;25(suppl 2):S136-S139.
45. League A, Donato KM, Sheth N, et al. A systematic review of medical-legal partnerships serving immigrant communities in the United States. *J Immigr Minor Health*. 2021;23(1):163-174.
46. HEAL for Immigrant Families Act, S 2646, 118th Cong (2023-2024). Accessed April 4, 2024. <https://www.congress.gov/bill/118th-congress/senate-bill/2646/titles?s=1&r=92#:~:text=A%20bill%20to%20expand%20access,coverage%2C%20and%20for%20other%20purposes>
47. Page-Reeves J, Regino L, Schleder T. Policy implications of structural violence and syndemic dynamics: a lens for addressing Latinx immigrant diabetes health disparities. *Curr Diab Rep*. 2022;22(3):137-145.
48. Bourgois P, Holmes SM, Sue K, Quesada J. Structural vulnerability: operationalizing the concept to address health disparities in clinical care. *Acad Med*. 2017;92(3):299-307.
49. Metz J, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. *Soc Sci Med*. 2014;103:126-133.
50. Neff J, Holmes SM, Knight KR, et al. Structural competency: curriculum for medical students, residents, and interprofessional teams on the structural factors that produce health disparities. *MedEdPORTAL*. 2020;16:10888.
51. Galvan T, Lill S, Garcini LM. Another brick in the wall: healthcare access difficulties and their implications for undocumented Latino/a immigrants. *J Immigr Minor Health*. 2021;23(5):885-894.

52. Straube BM. The imperatives for change in the US health care payment and delivery systems are clear. *Adv Chronic Kidney Dis*. 2008;15(1):7-9.
53. Long S, Littlecott HJ, Eccles GL, et al. Testing the zero-sum game hypothesis: an examination of school health policy and practice and inequalities in educational outcomes. *Lancet*. 2017;390:S60.
54. Public Health Law Center. Executive summary: expanding health care access to all through state law. Public Health Law Center; 2023. Accessed March 6, 2024. <https://www.publichealthlawcenter.org/sites/default/files/resources/Health-Care-For-All-Summary.pdf>

Dinushika Mohottige, MD, MPH is an assistant professor in the Institute of Health Equity Research at the Icahn School of Medicine and the Barbara T. Murphy Division of Nephrology at Mount Sinai in New York City. She received a BA in public policy and a health policy certificate from Duke University, where she was a Robertson Scholar, and then earned an MPH in health behavior and health education from the Gillings School of Global Public Health and a medical degree from the School of Medicine at the University of North Carolina at Chapel Hill. She completed her residency in internal medicine and was chief resident at Duke University, where she also received nephrology training. She engages in patient and community-centered, inequity-focused research on the impact of socio-structural factors and racialized medicine on kidney health and kidney transplantation.

Karina Albistegui Adler, JD is a co-director of health justice at New York Lawyers for the Public Interest, where she has developed campaigns aimed at increasing access to health care and organ transplantation for undocumented and low-income individuals in New York. Her approach is rooted in community-centered perspectives and enriched by a lifetime of lived immigrant experiences. Karina obtained her BA from Sarah Lawrence College and her JD from the City University of New York School of Law.

Allison Charney, JD is the executive director of the Mount Sinai Medical Legal Partnership (MSMLP) in New York City. She is also a founding co-chair of the MSMLP board of directors. She joined MSMLP in her current role after 13 years as a partner in 2 top-tier law firms representing clients in litigation and regulatory matters. She received a BA from Brandeis University and a JD from Emory University School of Law.

Lilia Cervantes, MD, MSc is a professor in the Department of Medicine and the director of immigrant health at the University of Colorado Anschutz Medical Campus (CU-Anschutz) in Aurora. Dr Cervantes completed her bachelor's degree at the University of Colorado Boulder and her doctor of medicine degree, residency in internal medicine, and master of science degree in clinical science at CU-Anschutz. Funded by the Robert Wood Johnson Foundation, the Doris Duke Foundation, and the National Institutes of Health, Dr Cervantes has conducted studies to understand the social challenges and perspectives of Latinx individuals with kidney disease and, in partnership with a community advisory panel, translated her findings to develop and test community-based interventions.

Editor's Note

The case to which this commentary is a response was developed by the editorial staff.

Citation

AMA J Ethics. 2024;26(8):E605-615.

DOI

10.1001/amajethics.2024.605.

Acknowledgements

This work was supported by National Human Genome Research Institute award HG010248 and National Institute of Diabetes and Digestive and Kidney Diseases award DK137259 (Dr Mohottige).

Conflict of Interest Disclosure

Dr Mohottige reported being a member of the ESRD National Coordinating Center Health Equity Taskforce, National Kidney Foundation Health Equity Advisory Committee, National Kidney Foundation Transplant Advisory Committee, NKF-GNY Medical Advisory Board, and *Healio Nephrology News & Issues* Editorial Advisory Board. The coauthors disclosed no conflicts of interest.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.



AMA Journal of Ethics®

August 2024, Volume 26, Number 8: E616-621

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

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

Cynthia Geppert, MD, PhD, DPS, MA, MPH, MSB, MSJ, HEC-C

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.

The American Medical Association designates this journal-based CME activity for a maximum of 1 AMA PRA Category 1 Credit™ available through the AMA Ed Hub™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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.

Cynthia Geppert, MD, PhD, DPS, MA, MPH, MSB, MSJ, HEC-C is a senior ethicist and legal liaison at the VA's National Center for Ethics in Health Care and a consultation-liaison psychiatrist at the New Mexico Veterans Affairs Health Care System.

Editor's Note

The case to which this commentary is a response was developed by the editorial staff.

Citation

AMA J Ethics. 2024;26(8):E616-621.

DOI

10.1001/amajethics.2024.616.

Acknowledgements

The author would like to thank Anita Tarzian RN, PhD for her invaluable assistance with the article.

Conflict of Interest Disclosure

Author disclosed no conflicts of interest.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

Copyright 2024 American Medical Association. All rights reserved.
ISSN 2376-6980



AMA Journal of Ethics®

August 2024, Volume 26, Number 8: E622-625

AMA CODE SAYS

AMA Code of Medical Ethics' Opinions Related to Medical-Legal Partnerships

Annika Penzer

Abstract

This article considers AMA *Code of Medical Ethics*' opinions relevant to medical-legal partnerships.

Legal Support for Patients

Roughly 60% of a person's health is determined by a range of social factors that might include legal status, family stability, education, employment, housing, income, and health insurance.¹ With these factors largely outside of clinicians' control, it is crucial that patients have access to additional resources that offer legal support. Medical-legal partnerships (MLPs)—collaborations between lawyers and physicians—aim to provide this critical support. MLPs embed **lawyers in health care settings** and allow clinicians and patients to address some of the confounding socio-legal variables that may negatively impact health.¹ When treating vulnerable populations, physicians often cannot meet patients' needs to the fullest extent possible without support from external, nonmedical resources. MLPs render that external support internal, increasing the ease with which clinicians can holistically support their patients. Studies indicate that patients with easy access to legal support are admitted to the hospital less frequently, exhibit more positive health behaviors, have more stable housing, experience better mental health, have lower out-of-pocket health care costs, and have more access to financial resources.² Although the American Medical Association (AMA) *Code of Medical Ethics* does not directly address the topic of MLPs, several opinions offer guidance to clinicians who are considering the role of MLPs in their practice.

Collaborative Care

One of the central pillars of MLPs is collaboration, since patients have more continuity of care when specialists from various professional backgrounds join forces. For example, lawyers and clinicians joining in common cause helps “disrupt the cycle of returning people to unhealthy conditions” that often result in rehospitalization.¹ Indeed, through their roles in MLPs, lawyers are an “important part of the health care workforce” and are deemed part of the “health care team.”³ Opinion 10.8, “Collaborative Care,” highlights the value of supporting collaboration in health care settings. Opinion 10.8 states:

As leaders within health care institutions, physicians individually and collectively should:

- (a) Advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills.
- (b) Encourage their institutions to identify and constructively address barriers to effective collaboration.⁴

Although there are some state standards for how MLPs should operate,^{5,6} there is no universal consensus. Opinion 10.8 suggests that clinicians should encourage their institutions to provide the tools and training necessary for fostering a collaborative environment in the service of patient care. As such, the AMA Code may be interpreted as encouraging institutional support for professional collaborations, such as MLPs, in health care settings.

Inequity in Health Care

MLPs assist “patient populations with a range of health-harming social and legal needs” that are often associated with and viewed as social determinants of health.⁷ The AMA Code offers guidance on reducing disparities in health care and addressing financial barriers to accessing care—2 goals that align closely with those of MLPs.² Opinion 8.5, “Disparities in Health Care,”⁸ speaks to the need for physicians to **promote equity** in service of reducing disparities. To fulfill this obligation, Opinion 8.5 states that physicians should:

- (a) Provide care that meets patient needs and respects patient preferences....
- (e) Encourage shared decision making.
- (f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients’ health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.⁸

MLPs’ purpose to better support the whole patient aligns with Opinion 8.5.

Opinion 11.1.4, “Financial Barriers to Health Care Access,”⁹ addresses how clinicians should **mitigate financial barriers** to accessing care among their patients. Considering the responsibility to ensure that patients can access the care they need regardless of their financial means, Opinion 11.1.4 states that physicians should:

- (a) take steps to promote access to care for individual patients, such as providing pro bono care in their office or through freestanding facilities or government programs that provide health care for the poor, or, when permissible, waiving insurance copayments in individual cases of hardship. Physicians in the poorest communities should be able to turn for assistance to colleagues in more prosperous communities.
- (b) help patients obtain needed care through public or charitable programs when patients cannot do so themselves.⁹

Legal professionals in medical settings can play a significant role in assisting with these responsibilities. With targeted education for physicians and direct tools for addressing immigration, housing, financial and other barriers to care, lawyers can help medical professionals fulfill their responsibilities to ensure access to health care for all.

Safe Discharge

Opinion 1.1.8, “Physician Responsibilities for Safe Patient Discharge from Health Care Facilities,”¹⁰ emphasizes the importance of responsible discharge to safe environments that are conducive to healing. Opinion 1.1.8 states that physicians should “[c]ollaborate with those health care professionals and others who can facilitate a patient discharge to establish that a plan is in place for medically needed care that considers the patient’s particular needs and preferences.”¹⁰

Many patients may need support from socio-legal resources to ensure that the environment they return to after a hospital stay will foster their continued well-being. The National Center for Medical-Legal Partnership states: “[u]sing legal expertise and services, the health care system can disrupt the cycle of returning people to the unhealthy conditions that would otherwise bring them right back to the clinic or hospital.”¹ Accordingly, the AMA Code supports a role for entities like MLPs that can help physicians meet their responsibilities for safe discharge.

Conclusion

While the AMA Code does not provide a direct perspective on physician participation in MLPs, MLPs can help physicians carry out the responsibilities and principles articulated in Opinions 10.8, 8.5, 11.1.4, and 1.1.8.

References

1. The need. National Center for Medical-Legal Partnership. Accessed September 13, 2023. <https://medical-legalpartnership.org/need/>
2. Impact. National Center for Medical-Legal Partnership. Accessed April 24, 2024. <https://medical-legalpartnership.org/impact/>
3. The response. National Center for Medical-Legal Partnership. Accessed April 25, 2024. <https://medical-legalpartnership.org/response/#:~:text=At%20these%20medical%2Dlegal%20partnerships,just%20like%20any%20other%20specialist>
4. American Medical Association. Opinion 10.8 Collaborative care. *Code of Medical Ethics*. Accessed April 29, 2024. <https://code-medical-ethics.ama-assn.org/ethics-opinions/collaborative-care>
5. Recommended standards and guidelines for medical-legal partnerships in Texas. Texas Medical-Legal Partnership Coalition. Accessed April 25, 2024. <https://www.txmlpc.org/membership/operational-guidelines#:~:text=MLPs%20should%20provide%20a%20range,community%20engagement%2C%20and%20systemic%20advocacy>
6. Georgia Department of Community Health. Standards for medical-legal partnerships that serve income eligible individuals and families pursuant to OCGA §31-2-4. Georgia Department of Community Health; 2014. Accessed April 25, 2024. <https://dch.georgia.gov/document/publication/standards-medical-legal-partnerships-10-2017pdf/download>
7. Tobin-Tyler E, Teitelbaum JB. Medical-legal partnership: a powerful tool for public health and health justice. *Public Health Rep*. 2019;134(2):201-205.
8. American Medical Association. Opinion 8.5 Disparities in health care. *Code of Medical Ethics*. Accessed April 29, 2024. <https://code-medical-ethics.ama-assn.org/ethics-opinions/disparities-health-care>
9. American Medical Association. Opinion 11.1.4 Financial barriers to health care access. *Code of Medical Ethics*. Accessed April 29, 2024. <https://code-medical-ethics.ama-assn.org/ethics-opinions/financial-barriers-health-care-access>
10. American Medical Association. Opinion 1.1.8 Physician responsibilities for safe patient discharge from health care facilities. *Code of Medical Ethics*. Accessed April 25, 2024. <https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-responsibilities-safe-patient-discharge-health-care-facilities>

Annika Penzer is an undergraduate student at Stanford University in Stanford, California, studying philosophy and human biology. In the summer of 2023, she was an intern for the Council on Ethical and Judicial Affairs at the American Medical Association in

Chicago, Illinois, and has been involved with biomedical ethics research at New York University, Stanford University, and the Icahn School of Medicine at Mount Sinai.

Citation

AMA J Ethics. 2024;26(8):E622-625.

DOI

10.1001/amajethics.2024.622.

Conflict of Interest Disclosure

Author disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

Copyright 2024 American Medical Association. All rights reserved.
ISSN 2376-6980

STATE OF THE ART AND SCIENCE: PEER-REVIEWED ARTICLE

How Should We Measure Effectiveness of Medical-Legal Partnerships?

Prashasti Bhatnagar, JD, MPH, Deborah F. Perry, PhD, and Margaret E. Greer, MS

Abstract

Medical-legal partnerships (MLPs) try to mitigate health inequity by uniting legal and health professionals to respond to legal determinants of patients' health. While there is a long tradition of "patients-to-policy" work in MLPs, the current empirical evidence base has evaluated MLP effectiveness by assessing benefits to individual patients, clinicians, and hospital and legal systems. This article calls for future research to measure how community power, which includes shifting power to impacted communities to develop and lead equity-focused agendas, is built as both a process and an outcome of MLPs.

Value of MLPs

Medical-legal partnerships (MLPs) are innovative collaborations between clinicians and lawyers to address "health-harming legal needs" (HHLNs) in health care settings.^{1,2} Utility shutoffs, poor or unsafe housing conditions, and denial of health insurance can impact physical health through exposure to harmful materials, such as lead and asbestos, as well as mental health, and require legal assistance. Generally, MLPs work to address HHLNs through direct legal representation and advocacy.^{1,2,3,4}

There is evidence that MLPs have a positive impact at the individual and institutional levels in the form of improved health outcomes, fewer emergency room visits, reduced hospital costs,^{5,6,7,8} and increased access to legal services,^{5,6,7} or "access to justice."⁹ One unique aspect of MLPs is the commitment to aggregating the lessons learned from individual client representation in the service of advocating for policy-level changes in programs, laws, and regulations—an approach often referred to as "patients-to-policy" work.⁹ Descriptive studies of the role that MLPs have played in shifting policy using clients' lived experiences are available in law review articles^{9,10,11} and on the National Center for Medical-Legal Partnership's website.⁶

Nevertheless, scholars and practitioners face practical challenges in building an evidence base that is aligned with the full range of processes and health justice outcomes that MLPs can promote, and the current approach to MLP evaluation concentrates power within the same hospital and legal systems that play an active role

in creating and perpetuating health inequities.^{12,13,14,15,16,17} Therefore, we need a significant paradigm shift in MLP research to advance our understanding of the full scope of the MLP model. MLPs should be evaluated on the basis of how they operationalize the values and principles underlying health justice—that is, on the extent to which their patients-to-policy work shifts power toward impacted communities to set, influence, and implement health equity agendas and thereby contribute to structural change.

In this article, we provide a brief description of the limitations of the current MLP evidence base and outline a health justice approach for MLP research and evaluation. In particular, we highlight the role of academic MLPs in advancing the conceptualization and measurement of community power as a process and outcome of MLP work.

Current State of MLP Evidence

Most of the empirical evidence on MLP effectiveness focuses on patient- and hospital-level outcomes. On the patient level, pilot studies—many of which use self-report to measure outcomes—show that MLPs can lower patient stress, increase patient access to financial resources, improve overall patient health, and increase patients' sense of empowerment.^{5,6,7,18,19,20,21,22,23} Moreover, MLPs have demonstrated increased system-wide screening for legal needs and access to legal services for patients,^{5,6,24,25,26,27,28,29} reduced health care spending, and increased return on investment for hospital systems.^{30,31,32}

Very few randomized control trials (RCTs) evaluating the efficacy of MLPs exist. Although RCTs are often considered the gold standard for evaluating clinical interventions, a 2021 systematic review of experimental studies of MLPs identified only 6 such studies.³³ Some authors have argued that, given significant evidence of benefits associated with MLPs, it is difficult to “establish equipoise, a central ethical principle of randomized control trials, which holds that a subject may be enrolled in a RCT only if there is true uncertainty about which of the trial arms is most likely to benefit the patient.”³⁴ Moreover, ethical reasons require the exclusion of people with complex, immediate, or serious legal needs from the study designs, which could yield a limited understanding and narrow evaluation of MLPs.³⁵

While an argument can be made for continuing to gather evidence of the effects of MLPs on patients, clinicians, and systems, the momentum carrying the health justice movement toward radical structural reform calls on all of us to rethink our current research and evaluation approaches. Structural racism is deeply embedded within US health and legal systems, from segregation of care to who and what the law chooses to protect and exploit.^{12,13,14,15,16,17} Thus, centering the effectiveness of MLPs on benefits to hospital or legal systems that play an active role in perpetuating health inequities—or maintaining the status quo—does little to unsettle power dynamics driving health inequities. As legal scholar Dina Shek notes: “creating perpetual clients within a traditional legal services model does little to change the power dynamics for vulnerable community members and hinders fully engaged citizenship.”¹¹

Building and Measuring Community Power

Public health scholars have increasingly highlighted the need for structural interventions that shift power toward minoritized communities in order to pursue health justice.^{15,16,17,36,37} In 2 2023 articles, Heller et al build upon existing theories of power—for example, the “three faces of power” theory (introduced by social theorist Steven

Lukes) and the “four domains of power” theory (introduced by Black Feminist sociologist Patricia Hill Collins)—and offer key questions to consider for recognizing, analyzing, and shifting power within the context of public health interventions.^{17,38} In particular, Heller et al call for developing public health actions that “grow power within marginalized communities to influence decisions, build the infrastructure necessary to set an equity-focused agenda, and change the narrative.”¹⁷ This concept of **community power** has been defined by Pastor et al:

Community power is the ability of communities most impacted by structural inequity to develop, sustain and grow an organized base of people who act together through democratic structures to set agendas, shift public discourse, influence who makes decisions, and cultivate ongoing relationships of mutual accountability with decision makers that change systems and advance health equity.³⁹

To address the root causes of health inequities, MLP researchers should consider the extent to which MLPs’ patient-to-policy work challenges existing power structures and pushes for structural change. As Pastor et al emphasize, we must “think beyond policy wins and ... consider changes in the broader institutional and community contexts that facilitate conditions for an equitable society.”⁴⁰ Within the MLP context, the first author (P.B.) explains that the existing patient-to-policy approach concentrates power among lawyers and health care partners to identify the problem and propose remedies.¹⁵ Building community power requires a shift in this approach to instead follow the leadership of directly impacted communities, who have always been at the forefront of justice movements. Using advocacy and organizing efforts led by agricultural workers as a case study, the first author proposes movement lawyering, which Hung defines as “lawyering that supports and advances social movements, defined as the building and exercise of collective power, led by the most directly impacted, to achieve systemic institutional and cultural change,”⁴¹ as a model that MLPs can adopt to move beyond the existing patients-to-policy approach and build community power.¹⁵

Role of MLPs

The leadership of community members in designing and implementing evaluation protocols allows communities to not only challenge the existing power dynamics and imbalance, which drive health inequities, but also create space for developing a shared language and goals, which is important for ensuring sustainability of justice efforts. Academic MLPs (A-MLPs) are uniquely positioned to answer this call to action and center community power within MLP research and evaluation.^{42,43} A-MLPs are those that have a university-based partner as one of the main collaborators (often a law or medical school). This specific type of MLP focuses on “1) educating pre-professional learners, 2) intentionally creating interprofessional learning environments, and 3) contributing to the evidence base for the MLP model as a health equity intervention.”⁴²

Due to their university affiliation, A-MLPs often have access to the research infrastructure necessary to evaluate the activities and outcomes of MLPs.⁴² As the focus shifts to measuring whether and how MLPs build community power, A-MLPs can offer access to stable funding, trained researchers and staff, and physical space to local grassroots and movement organizations to co-create evaluation protocols using community-led methodologies and data collection practices, including listening circles.⁴⁴ With A-MLP organizational support and community-led evaluation efforts, grassroots and movement organizations can measure power as both a strategy and an outcome based on the specific needs of the communities.

Additionally, A-MLPs' focus on interdisciplinary and interprofessional education^{10,42,45,46} can further strengthen the capacity of grassroots and movement organizations to lead MLP research and assessments. In particular, A-MLPs can integrate community-led sessions on the exploitative history of research and on community practices for data collection, analysis, and dissemination to build trust and accountability.^{47,48,49} A-MLPs can also train pre-professional learners alongside community members in power-building strategies, including advocacy and grassroots lobbying, coalition and movement building, campaign development, impact litigation, and research and policy analysis.⁵⁰

The method for measuring community power will vary based on the specific needs and goals of different communities. Thus, it is essential to facilitate community-driven processes for developing and implementing evaluation protocols instead of using a one-size-fits-all approach. Additionally, the focus on building community power, which challenges the concentration of power in the status quo, will help ensure that these academic partnerships do not reinforce or reify **structural racism**. Initiatives like the Association of American Medical Colleges Collaborative for Health Equity: Act, Research, Generate Evidence,⁵¹ the Praxis Project,⁴⁴ and the Lead Local research project⁴⁰ highlight the importance of community-led research and evaluation, as well as offering concrete examples of how to center, build, and measure community power for health justice. The next evolution of MLP research and evaluation needs to adopt a similar structural approach of building community power.

Conclusion

This article offers a new paradigm for MLP research and evaluation. Currently, MLP research and evaluation determine effectiveness based on benefits to individual patients, clinicians, and hospitals. In doing so, the existing model maintains power within the same hospital and legal systems that perpetuate health inequities. To advance health justice, MLPs—together with the leadership of impacted communities—should build, measure, and evaluate community power as a variable. A-MLPs are uniquely positioned to center community power within MLP research and evaluation by leveraging their educational and research resources in collaboration with grassroots and movement organizations.

References

1. Cannon Y. Closing the health justice gap: access to justice in furtherance of health equity. *Columbia Hum Rights Law Rev.* 2022;53(2):517-581.
2. Teitelbaum J, Lawton E. The roots and branches of the medical-legal partnership approach to health: from collegiality to civil rights to health equity. *Yale J Health Policy Law Ethics.* 2017;17(2):343-377.
3. Makhlouf MD. Towards racial justice: the role of medical-legal partnerships. *J Law Med Ethics.* 2022;50(1):117-123.
4. The partnerships. National Center for Medical-Legal Partnership. Accessed September 6, 2023. <https://medical-legalpartnership.org/partnerships/>
5. Medical-legal partnerships. County Health Rankings and Roadmaps. Updated January 25, 2019. Accessed September 7, 2023. <https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/medical-legal-partnerships>
6. Impact. National Center for Medical-Legal Partnership. Accessed September 7, 2023. <https://medical-legalpartnership.org/impact/>

7. Weintraub D, Rodgers MA, Botcheva L, et al. Pilot study of medical-legal partnership to address social and legal needs of patients. *J Health Care Poor Underserved*. 2010;21(2)(suppl):157-168.
8. Tobin Tyler E, Lawton E, Conroy K, Sandel M, Zuckerman BS, eds. *Poverty, Health and Law: Readings and Cases for Medical-Legal Partnership*. Carolina Academic Press; 2011.
9. Cannon YZ. Medical-legal partnership as a model for access to justice. *Stanford Law Rev Online*. 2023;75:73-88.
10. Benfer E, Bhandary-Alexander J, Cannon Y, Makhlof M, Pierson-Brown T. Setting the health justice agenda: addressing health inequity and injustice in the post-pandemic clinic. *Clin Law Rev*. 2021;28(1):45-84.
11. Shek D. Centering race at the medical-legal partnership in Hawai'i. *Univ Miami Race Soc Justice Law Rev*. 2019;10(1):109-146.
12. Yearby R, Clark B, Figueroa JF. Structural racism in historical and modern US health care policy. *Health Aff (Millwood)*. 2022;41(2):187-194.
13. Marquez DR, Lever H, eds. Segregation in health care. *AMA J Ethics*. 2023;25(1, theme issue):E1-E87.
14. Garber J. How hospital segregation contributes to racial health disparities. Lown Institute. August 6, 2020. Accessed September 7, 2023. <https://lowninstitute.org/how-hospital-segregation-contributes-to-racial-health-disparities/>
15. Bhatnagar P. Medical-legal partnerships and legal regimes: a health justice perspective. *J Law Med Ethics*. Forthcoming 2024.
16. Yearby R. Structural racism and health disparities: reconfiguring the social determinants of health framework to include the root cause. *J Law Med Ethics*. 2020;48(3):518-526.
17. Heller JC, Fleming PJ, Petteway RJ, Givens M, Pollack Porter KM. Power up: a call for public health to recognize, analyze, and shift the balance in power relations to advance health and racial equity. *Am J Public Health*. 2023;113(10):1079-1082.
18. Ryan AM, Kutob RM, Suther E, Hansen M, Sandel M. Pilot study of impact of medical-legal partnership services on patients' perceived stress and wellbeing. *J Health Care Poor Underserved*. 2012;23(4):1536-1546.
19. Rosen Valverde JN, Backstrand J, Hills L, Tanuos H. Medical-legal partnership impact on parents' perceived stress: a pilot study. *Behav Med*. 2019;45(1):70-77.
20. 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.
21. Bhatnagar P. All care is health care: how healthcare-legal partnerships are challenging the biomedical paradigm. Bachelor's thesis. University of Minnesota; 2018. Accessed September 7, 2023. https://conservancy.umn.edu/bitstream/handle/11299/201930/bhatnagar_prashasti_summa%20thesis.pdf?sequence=1&isAllowed=y
22. Klein MD, Beck AF, Henize AW, Parrish DS, Fink EE, Kahn RS. Doctors and lawyers collaborating to HeLP children—outcomes from a successful partnership between professions. *J Health Care Poor Underserved*. 2013;24(3):1063-1073.
23. Pettignano R, Bliss LR, Caley SB, McLaren S. Can access to a medical-legal partnership benefit patients with asthma who live in an urban community? *J Health Care Poor Underserved*. 2013;24(2):706-717.

24. Regenstein M, Trott J, Williamson A. The state of the medical-legal partnership field: findings from the 2016 National Center for Medical-Legal Partnership surveys. National Center for Medical-Legal Partnership; 2017. Accessed February 6, 2024. <https://medical-legalpartnership.org/wp-content/uploads/2017/07/2016-MLP-Survey-Report.pdf>
25. Murphy C. Making the case for medical-legal partnerships: an updated review of the evidence, 2013-2020. National Center for Medical-Legal Partnership; 2020. Accessed February 6, 2024. <https://medical-legalpartnership.org/wp-content/uploads/2020/10/MLP-Literature-Review-2013-2020.pdf>
26. Nerlinger AL, Alberti PM, Gilbert AL, et al. Evaluating the efficacy of medical-legal partnerships that address social determinants of health. *Prog Community Health Partnersh.* 2021;15(2):255-264.
27. Martinez O, Boles J, Muñoz-Laboy M, et al. Bridging health disparity gaps through the use of medical legal partnerships in patient care: a systematic review. *J Law Med Ethics.* 2017;45(2):260-273.
28. Hernández D. “Extra oomph”: addressing housing disparities through medical legal partnership interventions. *Housing Stud.* 2016;31(7):871-890.
29. Sege R, Preer G, Morton SJ, et al. Medical-legal strategies to improve infant health care: a randomized trial. *Pediatrics.* 2015;136(1):97-106.
30. Martin J, Martin A, Schultz C, Sandel M. Embedding civil legal aid services in care for high-utilizing patients using medical-legal partnership. *Health Affairs Forefront.* April 22, 2015. Accessed February 6, 2024. <https://www.healthaffairs.org/content/forefront/embedding-civil-legal-aid-services-care-high-utilizing-patients-using-medical-legal>
31. Teufel JA, Werner D, Goffinet D, Thorne W, Brown SL, Gettinger L. Rural medical-legal partnership and advocacy: a three-year follow-up study. *J Health Care Poor Underserved.* 2012;23(2):705-714.
32. Rodabaugh KJ, Hammond M, Myszka D, Sandel M. A medical-legal partnership as a component of a palliative care model. *J Palliat Med.* 2010;13(1):15-18.
33. John J, Murphy T, Zientek E, et al. Efficacy of medical legal partnerships to address health harming legal needs: a systematic review of experimental studies in the field. Research Square; 2022. Accessed July 17, 2024. <https://assets-eu.researchsquare.com/files/rs-1625222/v1/a7e9c7e2-414d-4538-b868-af0af3984331.pdf?c=1671086680>
34. Sauaia A, Santos G, Scanlon M, Farley T, Dean P. Improving health outcomes in vulnerable populations: the medical-legal partnership—Colorado’s experience. *J Health Care Poor Underserved.* 2022;33(2):580-589.
35. Liaw W, Northrup TF, Stotts AL, et al. Medical-legal partnership effects on mental health, health care use, and quality of life in primary care: a randomized clinical trial. *J Am Board Fam Med.* 2023;36(3):414-424.
36. Wiley LF, Yearby R. Symposium conclusion: Health Justice: Engaging Critical Perspectives in Health Law and Policy. *Bill of Health.* October 22, 2021. Accessed September 7, 2023. <http://blog.petrieflom.law.harvard.edu/2021/10/22/symposium-conclusion-health-justice/>
37. Harris AP, Pamukcu A. The civil rights of health: a new approach to challenging structural inequality. *UCLA Law Rev.* 2020;67:758-832.
38. Heller JC, Little OM, Faust V, et al. Theory in action: public health and community power building for health equity. *J Public Health Manag Pract.* 2023;29(1):33-38.

39. Pastor M, Ito J, Wander M. *Leading Locally: A Community Power-Building Approach to Structural Change*. USC Dornsife Equity Research Institute; 2020. Accessed February 6, 2024. https://static1.squarespace.com/static/5ee2c6c3c085f746bd33f80e/t/5f98a9a4cd172a172549dcce/1603840428427/Leading_Locally_FULL_Report_web.pdf
40. USC Dornsife Equity Research Institute (ERI). Lead local. USC Dornsife. Accessed September 18, 2023. <https://dornsife.usc.edu/eri/publications/lead-local-reports/>
41. Hung B. Movement lawyering as rebellious lawyering: advocating with humility, love and courage. *Clin Law Rev*. 2017;23(2):663-669.
42. Girard VW, Perry DF, Kessler LP, Cannon Y, Bhatnagar P, Roth J. The academic medical-legal partnership: training the next generation of health and legal professionals to work together to advance health justice. Georgetown University Health Justice Alliance; National Center for Medical Legal Partnership; 2022. Accessed February 6, 2024. <https://medical-legalpartnership.org/download/academic-mlp-report/?wpdmdl=7562&refresh=6679e26bb8e151719263851>
43. Girard VW, Cannon Y, Perry DF, Moore ES. Leveraging academic medical-legal partnerships to advance health justice. *J Law Med Ethics*. 2024;51:798-809.
44. Building community power for health, justice, and racial equity. Praxis Project. Accessed September 18, 2023. <https://www.thepraxisproject.org/building-power>
45. Girard VW, Moore ES, Kessler LP, Perry D, Cannon Y. An interprofessional approach to teaching advocacy skills: lessons from an academic medical-legal partnership. *J Leg Med*. 2020;40(2):265-278.
46. Cannon Y. Equipping the next generation of health justice leaders. *Bill of Health*. September 20, 2021. Accessed September 7, 2023. <https://blog.petrieflom.law.harvard.edu/2021/09/20/health-justice-leaders/>
47. Brown LT, Bachelder A, Gomez MB, Sherrell A, Bryan I. The rise of anchor institutions and the threat to community health: protecting community wealth, building community power. *Kalfou*. 2016;3(1):10.15367/kf.v3/1.88.
48. Garcia NM, López N, Vélez VN. QuantCrit: rectifying quantitative methods through critical race theory. *Race Ethn Educ*. 2018;21(2):149-157.
49. Smith LT. *Decolonizing Methodologies: Research and Indigenous Peoples*. 2nd ed. Zed Books; 2012.
50. USC Program for Environmental and Regional Equity. Power-Building Ecosystem Framework. USC Dornsife; 2020. Accessed February 6, 2024. https://dornsife.usc.edu/eri/wp-content/uploads/sites/41/2023/01/2020_Power_Building_Ecosystem_Framework_v3.pdf
51. AAMC CHARGE. Association of American Medical Colleges. Accessed September 7, 2023. <https://www.aamchealthjustice.org/get-involved/aamc-charge>

Prashasti Bhatnagar, JD, MPH is a law-public health postdoctoral scholar at the Kirwan Institute for the Study of Race and Ethnicity at The Ohio State University in Columbus. She is also a PhD student at the University of California, Los Angeles, and a board director for the Midwest Immigration Bond Fund. As a public health attorney, she focuses on exploring and implementing community-led interventions rooted in health justice, carceral and border abolition, and liberation.

Deborah F. Perry, PhD is a research professor of pediatrics and the director of research and evaluation for the Georgetown University Health Justice Alliance in Washington, DC. As a public health researcher, she engages community partners to co-create rigorous evaluations and elevate community voices through mixed methods studies. Her work focuses on maternal and child health populations in urban communities of color in and around Washington DC, where she has lived and worked for more than 30 years.

Margaret E. Greer, MS is a third-year medical student at the Georgetown University School of Medicine in Washington, DC. After starting medical school, she joined the Health Justice Scholar Track and is involved with work focusing on advocacy and value-based care. She completed a master's in pharmacology at Georgetown University and helped co-lead a COVID testing clinic at Bread for the City.

Citation

AMA J Ethics. 2024;26(8):E626-633.

DOI

10.1001/amajethics.2024.626.

Acknowledgements

We extend our deepest gratitude to Vicki Girard, Yael Cannon, Lisa Kessler, and Eileen Moore for their leadership of the Georgetown University Health Justice Alliance and the Health Justice Scholars track at the Georgetown University School of Medicine. We also sincerely thank Vicki, Yael, and Lisa for their thoughtful edits and feedback on this manuscript.

Conflict of Interest Disclosure

Authors disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

POLICY FORUM: PEER-REVIEWED ARTICLE

How Should a Medical-Legal Partnership Address Unique Needs of People With Criminal Legal System Involvement?

Lisa B. Puglisi, MD and James Bhandary-Alexander, JD

Abstract

Medical-legal partnerships (MLPs) are well suited to address health-harming legal needs associated with the collateral consequences of mass incarceration in the United States, such as those that limit access to food, housing, employment, and family reunification postrelease. MLP innovations seek to expand the current model to address patients' criminal, as well as postrelease, civil legal needs by including community health workers and some patients as legal partners and creating coalitions to promote local and state policy change. Overall, this article explains how these MLP innovations can support rights of people returning to communities after incarceration and can be leveraged to mitigate criminal legal system involvement.

Early MLPs in Health Care

Initiated in 1993, medical-legal partnership (MLP) is an innovation in the delivery of health care that interweaves the skills of health and law professionals to tackle structural barriers to health by addressing legal issues, such as those related to poor housing conditions and immigration, which interfere with health and well-being.^{1,2,3} In so doing, MLPs aim to create change at the individual, health system, and policy level. Recently, **the scope of MLPs** has expanded from the civil legal needs of typically minoritized patients to the criminal and civil legal needs of people with histories of incarceration.⁴

On any given day in 2021, the criminal legal system in the United States detained almost 1.9 million people; in that year, almost 7 million people were jailed and close to 4 million were on probation or parole.^{5,6,7} Incarceration has a disproportionate impact on Black and Latinx people, with the imprisonment rate for Black men at the end of 2021 being more than 5 times that for White men.⁵ People who are incarcerated also have a high prevalence of many chronic physical and mental health conditions. As of 2016, more than quarter of people in state prisons had been diagnosed with major depressive disorder,⁸ almost half had a substance use disorder,⁹ and almost half reported ever having a chronic health condition.¹⁰ The so-called collateral consequences of criminal legal system involvement, which refers to the system of sanctions that people who have a criminal record face—including barriers to food access, housing, and employment—

have been found to contribute to perceived stress after release from incarceration.¹¹ Given that MLPs have been shown to strengthen patients' financial security by aiding in the procurement of public benefits¹² and stable housing,¹³ MLPs are well-positioned to help tackle the collateral consequences of incarceration that drive poor health.

Based on our experiences over the past decade running an MLP that serves people returning to the community after incarceration, we reflect on lessons learned and on innovations developed to adapt the model to the needs of the people we serve. We will first describe the setting of our practice, and then we will describe innovations with a focus on legal assistance and policy-reforming strategies.

Setting

Serving people returning to their communities from incarceration, the Transitions Clinic program in New Haven (TC-NH), Connecticut, is one of 48 primary care programs in the Transitions Clinic Network that address health needs such as diabetes, hypertension, hepatitis C treatment, and office-based treatment of substance use disorders (eg, alcohol and opioid use disorders).¹⁴ At the crux of each program are **community health workers** (CHWs) who have themselves been previously incarcerated and are embedded within the primary care teams to build trust with patients, engage them in their primary care, and address their social determinants of health.¹⁵ CHWs undergo a yearlong training developed by the Transitions Clinic Network that covers issues such as the broad range of collateral consequences of incarceration, advocating for patients with law enforcement while maintaining privacy, and conducting effective outreach.

The TC-NH program was started in 2010 and is based at a federally qualified health center. Patients have typically been released from a correctional facility within the preceding 6 months and have at least one chronic health condition or are over the age of 50. Most often patients are referred directly from the prison system or are identified by the CHW through community outreach to local halfway houses and social service providers. The MLP component of TC-NH started in 2014 and is a collaboration between the Transitions Clinic program and the Solomon Center at Yale Law School, which identifies law students interested in the MLP, oversees their training and legal work, and provides credit for their coursework. The law students are directly overseen by a physician while in clinic and by their legal supervisor at the Solomon Center.¹⁶

Legal Assistance

Needs-based innovations. We began our program with a focus on addressing civil legal needs, such as family issues and debt that people face after incarceration. Tackling a targeted need for a specific population is common in MLPs, and doing so can help clinicians match patients' needs to MLP skill sets. A civil legal needs screener is conducted for all new patients, of which we see on average 4 per week. From an internal survey, initially we found that 62% of people had at least one identifiable civil legal need, with needs related to public benefits (45%), family matters (15%), housing and utilities (13.0%), and employment (9%) being most common. However, over time there was increasing interest from patients in addressing criminal legal needs, such as police interactions and helping to resolve outstanding warrants. They saw these things as sometimes more immediately pressing and as impacting every aspect of their lives, including their health. Thus, by providing space for patients to not only complete a civil legal needs screener, but also ask about other outstanding concerns, we have gleaned data that provided an opportunity for our program to serve the full breadth of patients' needs. This approach requires some degree of flexibility from the MLP lawyer and a

willingness to adapt service delivery to changes in the needs of the patient population, such as by engaging public defenders and judges to advocate for revocation of outstanding warrants, when possible.¹⁷

Although CHWs could bolster most MLP programs, they have not specifically been described as core components of MLPs in the literature.¹⁷ Our program CHWs are integral to the functioning of the MLP. The legal team works directly with the CHW to build trust with patients and reach those who don't have phones or are limited by restrictions imposed by halfway houses. CHWs, who have built relationships with halfway house staff, help patients collect records that the legal team needs, ensure open channels of communication, and identify broader issues that they hear about repeatedly. Given that the CHWs spend roughly half of their time in the community, they extend the reach of the MLP beyond traditional clinic walls and into the community.

Strengths-based innovations. While typical lawyer-client interactions can be passive or transactional, our work has demonstrated opportunities for challenging this conceptualization. Leveling the power dynamic can be especially important and productive when working with clients who are themselves quite knowledgeable about the law and have extensive experience working in law libraries in prison as “jail house lawyers,” advocating for their own release and that of others. In our experience, knowledgeable clients provide an opportunity for lawyers to adapt their role by more actively engaging patients in their legal complaints—identifying and providing necessary documentation, understanding the history of the issue at hand, developing litigation, identifying priorities for legislative advocacy, and designing a more sophisticated advocacy plan. Anecdotally, our patients have shared that they enjoyed working so closely with a lawyer—some have voiced that this was their first positive experience with any agent of the criminal legal system. Additionally, our law students have come to **see their clients as partners** in addressing their needs. In the case of one patient whose life is severely restricted by being on the sex registry in Connecticut for a crime he took a plea deal on many years before the registry was established, the law students are pursuing his litigation idea of promoting a lack of due process hearing for people with convictions that predate the enactment of the statute that established the registry.

Policy Change Strategies

MLP scholars have conceptualized a “patients-to-policy” approach to advocacy, whereby recurring patient problems presented in the clinic serve as a natural springboard for identifying policy advocacy priorities. We have taken up this approach and built on it. This approach has led us, for example, to identify the lack of proper identification among our patients as a barrier to transitioning to the community. But rather than simply raising this issue to legislators, we used the MLP legal team, which had special experience in state-level advocacy, to build and lead a statewide coalition to advocate for the provision of state identification to all people leaving incarceration. This effort incorporated the personal stories of and relationships between our staff and justice-impacted clients to create a public narrative around patients’ need for identification, which led other organizations that recognized the gravity of the issue to participate. These coalition partners included people who were previously incarcerated and community advocates, faith leaders, and labor unions. In spring 2023, our coalition successfully convinced legislators to pass a bill requiring the Department of Corrections to issue proper state identification to all people leaving incarceration. The governor signed the bill on June 28, 2023,¹⁸ and we continue to intervene in the executive branch conversation regarding its effective implementation.

We also have used the MLP legal team to advocate for the policy priorities of the Transitions Clinic, such as the need for sustainable state funding of the work of CHWs in Connecticut, by participating in traditional advocacy with state officials and by utilizing a “bargaining-for-the-common-good” framework, in which unions that have the right to bargain use contract fights as an opportunity to organize with community partners around a set of demands that benefit not only the bargaining unit, but also the wider community.¹⁹ Using this framework, our coalition allies put the need for Transitions Clinic funding into the state labor negotiating process as a union demand. The coalition organized for state funding of CHWs led to another success, as the legislature passed an amended bill requiring the Connecticut Department of Social Services to apply for a waiver that would allow clinics like Transitions to bill Medicaid for CHW work.²⁰ By engaging in coalitions and using a bargaining-for-the-common-good approach, we are experimenting with moving not just from patients to policy, but from patients to **policy to power**, thereby building collective capacity to achieve policy goals relevant to patient health through our MLP.

In summary, the legal needs that people experience after incarceration are nuanced, and many intersect with their health. MLPs present an opportunity for health systems to rise to the challenge of meaningfully impacting the life and well-being of people who have often been left out of traditional systems of care. By leveling power differentials and instigating new positive interactions with the medical system and legal system for people who have historically been marginalized by both, they can have a positive impact even beyond the clinic doors.

References

1. Zuckerman B, Sandel M, Lawton E, Morton S. Medical-legal partnerships: transforming health care. *Lancet*. 2008;372(9650):1615-1617.
2. Beck AF, Klein MD, Schaffzin JK, Tallent V, Gillam M, Kahn RS. Identifying and treating a substandard housing cluster using a medical-legal partnership. *Pediatrics*. 2012;130(5):831-838.
3. Ramos AK, Deal A, Quintero SA, Wilson FA. Immigrant-focused medical legal partnerships: a practical innovation to improve immigrant health and social well-being. *Prog Community Health Partnersh*. 2023;17(1):135-143.
4. Benfer EA, Gluck AR, Kraschel KL. Medical-legal partnership: lessons from five diverse MLPs in New Haven, Connecticut. *J Law Med Ethics*. 2018;46(3):602-609.
5. Carson EA; Bureau of Justice Statistics. Prisoners in 2021—statistical tables. US Department of Justice; 2022. Accessed March 12, 2024. <https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/p21st.pdf>
6. Zeng Z; Bureau of Justice Statistics. Jail inmates in 2021—statistical tables. US Department of Justice; 2022. Accessed March 12, 2024. <https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/ji21st.pdf>
7. Kaeble D; Bureau of Justice Statistics. Probation and parole in the United States, 2021. US Department of Justice; 2023. Accessed March 12, 2024. <https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/ppus21.pdf>
8. Maruschak LM, Bronson J; Bureau of Justice Statistics. Indicators of mental health problems reported by prisoners. US Department of Justice; 2021. Accessed April 26, 2024. <https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/imhprpspi16st.pdf>

9. Maruschak LM, Bronson J, Alper M; Bureau of Justice Statistics. Alcohol and drug use and treatment reported by prisoners. US Department of Justice; 2021. Accessed March 12, 2024.
<https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/adutrpspi16st.pdf>
10. Maruschak LM, Bronson J, Alper M; Bureau of Justice Statistics. Medical problems reported by prisoners: survey of prison inmates, 2016. US Department of Justices; 2021. Accessed March 12, 2024.
<https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/mprpspi16st.pdf>
11. Lu B, Thomas K, Feder S, Bhandary-Alexander J, Aminawung J, Puglisi LB. The association between civil legal needs after incarceration, psychosocial stress, and cardiovascular disease risk factors. *J Law Med Ethics*. 2023;51(4):856-864.
12. Weintraub D, Rodgers MA, Botcheva L, et al. Pilot study of medical-legal partnership to address social and legal needs of patients. *J Health Care Poor Underserved*. 2010;21(2)(suppl):157-168.
13. 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.
14. Transitions Clinic Network sites. Transitions Clinic. Accessed April 26, 2024.
<https://transitionsclinic.org/locations/>
15. Shavit S, Aminawung JA, Birnbaum N, et al. Transitions Clinic Network: challenges and lessons in primary care for people released from prison. *Health Aff (Millwood)*. 2017;36(6):1006-1015.
16. Vanjani R, Martino S, Reiger SF, et al. Physician-public defender collaboration—a new medical-legal partnership. *N Engl J Med*. 2020;383(21):2083-2086.
17. Tobin-Tyler E, Teitelbaum JB. Medical-legal partnership: a powerful tool for public health and health justice. *Public Health Rep*. 2019;134(2):201-205.
18. An Act Concerning the Issuance of an Identity Card or Motor Vehicle Operator's License to a Person Being Discharged From a Correctional Facility, H 6875, Gen Assemb, Reg Sess (Conn 2023).
19. McCartin JA. Bargaining for the common good. *Dissent*. 2016;63(2):128-135.
20. Govala K, Carlesso J. Medicaid reimbursement for community health workers gets OK. *Connecticut Mirror*. June 7, 2023. Accessed April 26, 2024.
<https://ctmirror.org/2023/06/07/house-oks-medicaid-reimbursement-for-community-health-workers/>

Lisa B. Puglisi, MD is an associate professor at the Yale School of Medicine in New Haven, Connecticut, where she is also the director of education for the SEICHE Center for Health and Justice. She practices internal medicine and addiction medicine in her primary care practice, where she co-directs a medical-legal partnership. Her research, clinical, and education program development focus on improving the health and well-being of people impacted by mass incarceration.

James Bhandary-Alexander, JD is the legal director of the medical-legal partnership at the Solomon Center for Health Law and Policy at Yale Law School and at the SEICHE Center for Health and Justice at the Yale School of Medicine in New Haven, Connecticut. He is also a clinical lecturer and associate research scholar at Yale University.

Citation

AMA J Ethics. 2024;26(8):E634-639.

DOI

10.1001/amajethics.2024.634.

Conflict of Interest Disclosure

Authors disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.



AMA Journal of Ethics®

August 2024, Volume 26, Number 8: E640-647

POLICY FORUM: PEER-REVIEWED ARTICLE

Why MLP Legal Care Should Be Financed as Health Care

William M. Sage, MD, JD and Keegan D. Warren, JD, LLM

Abstract

Medical-legal partnership (MLP) integrates the unique expertise of lawyers into collaborative clinical environments. MLP teams meet the needs of individual patients while also detecting structural problems at the root of health inequities and advancing solutions at the institutional, community, and system levels. Yet MLPs today operate in limited settings and survive on scant budgets. Expanding their impact requires secure funding. Financing MLPs as health care can do the following: (1) help address inequity at the point of care; (2) enable expert diagnosis and treatment of nonmedical drivers of health; (3) enhance team-based practice in health care organizations; (4) offer another way for clinicians to participate in advocacy; and (5) bolster a broader movement to increase access to justice.

The American Medical Association designates this journal-based CME activity for a maximum of 1 AMA PRA Category 1 Credit™ available through the AMA Ed Hub™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Medical-Legal Partnership Needs Funding

Medical-legal partnership (MLP) is an established, successful, yet underappreciated approach to care delivery that uses legal expertise to bridge the gap between America's enormous investment in medicine and the payoff of that investment in individual and population health. MLP addresses health-harming legal needs connected to nonmedical drivers of health (NMDOH). These are often summarized through the I-HELP™ acronym: income and insurance, housing and utilities, education and employment, legal status, and personal and family stability.¹ Beyond solving acute problems, MLP prioritizes moving from patients to policy by translating patterns of need into institutional, community, and system change.²

Because it does not command sufficient public attention or resources, MLP tends to operate in particular environments and generally survives on shoestring budgets.³ Rather than offering general coverage of MLP through Medicaid or Medicare, federal policy targets specific clinical enterprises, including federally qualified health centers (FQHCs), nonprofit hospitals, and **Department of Veterans Affairs facilities**. Each setting has unique characteristics that demonstrate commitment to addressing NMDOH by incorporating legal interventions into the delivery of care.

Taken together, however, these federal programs convey what we consider a key insight for future MLP policy: that legal needs and social needs are inextricable from each other and from clinical interventions at the point of service. In our view, lawyers' expertise must be integrated into care delivery for the health care system to achieve consensus goals of increasing access to care, remediating avoidable health disparities, and improving the population's health. Achieving these goals requires consistent funding through public investment.

Although MLP financing could take various forms, coding and reimbursing health-promoting legal services based on clinical indications and impact embedded in electronic health records is most straightforward.⁴ For example, substandard living conditions are classified as a habitability matter by housing attorneys, who document in structured, electronic fields the unhealthy home environment and the interventions employed to force a landlord to improve the situation. In combination with a clinical diagnosis, such as asthma, and a clinical outcome, such as **reduced incidence of asthma attacks**, the legal interventions enhance the value proposition of medical services and align with new screening and billing standards for NMDOH in primary care practices and emergency departments.^{5,6}

Why MLPs Are Important

Recognizing the remediation of health-harming legal needs as part of clinical care would meet the moment in several important ways. First, it reinforces other efforts to achieve health equity by strengthening the connection between community and clinical settings for individuals and families as well as for populations. Second, by configuring legal assistance as clinical revenue generation through an adjustment of coding and claims rather than as a benefit expansion, it favors the integrated provision of MLP services over less measurably effective "referral out" models, in which legal needs are only loosely connected to patient well-being.⁷

Third, by bringing physicians, nurses, lawyers, social workers, and others together in pursuit of shared goals, funding MLP as clinical care helps accelerate interprofessional training and team-based practice, which adds a positive dimension to potentially concerning trends toward physician employment within large organizations. Fourth, MLP's incorporation of legal advocacy tools and training in clinical settings fosters a greater sense of agency and control in the postpandemic health care workforce, which struggles with burnout and moral injury.⁸ Finally, funding MLP makes overall civil legal aid (ie, access to justice for those who cannot afford it) more financially secure by linking it conceptually and operationally to medical care that has broad-based public endorsement.⁹

Health Plans and Health Coverage

The Centers for Medicare and Medicaid Services (CMS) has acknowledged the value of legal expertise in expanding access to insurance, including through its Connecting Kids to Coverage outreach and enrollment initiative.^{10,11} However, there is no statutory mandate for health plan coverage of legal services, whether through private insurance or under Medicare or Medicaid. Moreover, despite recent attention to NMDOH, CMS does not expressly identify health-harming legal needs or state that legal care to address them is part of health care. Nonetheless, some Medicaid managed care organizations have elected to finance legal care using administrative dollars, which are subject to competing priorities, or through state-based Section 1115 waivers if permitted.¹² To bolster arguments for sustained Medicaid support, researchers have

recommended that MLP activities be framed by health plans as “case management,” “care management and coordination,” or “value-added services.”¹³

Expanding health plan coverage—the most straightforward way to fund MLPs—requires consistency in coding and measuring legal care. Fortunately, MLP legal professionals already gather an extensive social history from patients to assess their health-harming legal needs. This process yields information important to medical decision-making that otherwise may be hard for a clinician to obtain and share as structured data. In many cases, the associated complexity and risk also will justify higher-level Current Procedural Terminology codes for the clinician’s services. Similarly, MLP legal care data enables more accurate recording of the Z codes that already exist in the *International Statistical Classification of Diseases and Related Health Problems* structure for documenting health-related social needs.¹⁴ Anyone can “diagnose” using these codes, and many are similar to the problem codes that MLP legal teams routinely employ in legal recordkeeping. In addition to inputting Z59.1 (inadequate housing) for asthma,¹⁴ the MLP legal team would document the type of housing, which is critical for both choosing the correct acute intervention and advocating for better population-level policies. Having lawyers and physicians work together on Z code strategy would also help align the MLP model of care with established claims verification and payment processes.

Delivery System Funding of MLPs

In contrast to the embryonic state of MLP in laws governing health coverage, committed support for legal services is evident in the regulation of FQHCs, nonprofit hospitals, and Department of Veterans Affairs facilities.

Health centers. The Public Health Service (PHS) Act defines a “health center” as an entity that provides primary health services to medically underserved areas or populations.¹⁵ Comprehensive primary care, specialty care and behavioral health care, education of patients and the community, and—discussed in more detail below—case management services and enabling services comprise the “primary health services” that are required for designation as an FQHC. Additional health services, including to alleviate unhealthy conditions in the living, built, and natural environments, may be provided directly or by contract.

Enabling services expressly include patient-facing legal services.¹⁶ Although the recognition of legal services as enabling services by the Health Resources and Services Administration (HRSA) was not explicit until 2014, the agency takes the position that MLP “was always part of enabling services.”¹⁷ For example, lawyers enable care when they appeal a reduction in home health hours, empower a domestic violence survivor to receive services, or alleviate financial stressors that inhibit a person’s ability to obtain treatment.

Case management also explicitly encompasses legal services.¹⁶ The PHS Act includes within case management services “establishing eligibility for and gaining access to federal, state, and local programs that provide or financially support the provision of medical, social, housing, educational, or other related services.”¹⁵ For example, legal services may be necessary to assert due process rights when a person is wrongfully denied Medicaid, loses their Section 8 housing voucher, or seeks accommodations at school for a medical condition.

Because the work of MLP is expressly within the HRSA's definition of required primary health services, FQHCs may use their federal funding to develop and maintain MLPs, counting incidents of contracted legal care in their HRSA-approved scope on Form 5A.¹⁶ HRSA has made awards specifically for MLP as a primary health service since at least 2015, including a September 2023 initiative targeting disparities in perinatal health.¹⁸ HRSA regulation of FQHCs aligns with MLP's core premise: that meeting legal needs is integral to the delivery of quality care.

Nonprofit hospitals. To maintain federal tax exemption as a charitable organization under Internal Revenue Code §501(c)(3), nonprofit hospitals must provide “community benefit,” and the Patient Protection and Affordable Care Act of 2010 (ACA) requires them to conduct a periodic community health needs assessment (CHNA) and to adopt an implementation strategy for meeting identified needs.¹⁹ Community health needs include “the need to address financial and other barriers to accessing care, to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community.”²⁰ Beyond CHNAs, MLP helps hospitals meet requirements related to NMDOH and health equity in their own licensure and accreditation standards and in standards governing the health plans that pay them.

Without MLP legal expertise, hospitals may miss critical drivers of community health.^{21,22} The American Hospital Association (AHA) comprehensively surveys its members annually and includes questions about hospital collaboration with legal services organizations.²³ A research study based on the 2020 survey found that the roughly 55% of hospitals reporting a relationship with a legal services organization were more likely to have lower health care costs and utilization.²⁴ The AHA recommends “engaging or consulting legal organizations to take part in developing a community health needs assessment, to help identify interconnections or linkages between health outcomes and legal assistance and potential community-level interventions.”²⁵

Veterans Affairs' outpatient clinics and medical centers. The Veterans Health Administration (VHA) provides for the care and treatment of military veterans and is the nation's largest integrated health care system.²⁶ Studies have shown positive correlations between MLP and veteran physical and mental health.^{27,28} Several VHA system-wide directives emphasize the importance of civil legal services to the health of veterans, such as Directive 1510, which permits in-kind space donation to MLPs or similar organizations for training VA medical staff and providing legal care to patients.²⁹

Interdisciplinary and Community Engagement

Pursuing a more visible, financially sustainable role for MLP has ethical as well as clinical significance, as health care professionals, policy makers, and the public confront new challenges involving equity, opportunity, and trust in health care. When MLP began decades ago, the expectation was that physicians' clinical knowledge and authority would help lawyers do their jobs better. Recent MLP experience suggests that, particularly in integrated delivery models associated with academic health centers and law schools, lawyers training physicians to operate the levers of social change through analysis and advocacy is an equally meaningful interprofessional transfer of knowledge.³⁰

Few major infrastructure changes are necessary for most health care entities to integrate MLP lawyers into the delivery of care. Mirroring clinical practice, legal service

delivery includes well-developed systems to track and share social diagnoses, interventions, and outcomes, thereby forming an **information base for collaboration**, evaluation, and payment. No expensive referral platform is needed, and best practices exist for prioritizing patients' needs and pursuing both individual and population health strategies to meet them.^{31,32}

We do not argue for medicalizing legal drivers of health or transferring responsibility for addressing them to hospitals and health professionals.³³ Control over legal interventions that supplement clinicians' biomedical perspective should remain with MLPs and other community-based legal services entities that have demonstrated their expertise, experience, and trustworthiness.³⁴ Health care organizations should be an active, creative, but generally deferential partner.

At scale, MLP can also help the nation's legal aid lawyers improve their overall effectiveness at achieving justice. In 2020, the American Academy of Arts and Sciences endorsed MLP and similar collaborations between legal and health professionals as the most important step in closing the "justice gap" in American society that contributes to health inequity.³⁵

Finally, unlike most other forms of social support, legal services follow a model of professional control and client centeredness that is sufficiently similar to medical services as to be intuitive to the health professions. As members of the health care workforce contend with feelings of powerlessness to serve patients and society in accordance with their ethical beliefs, engagement with lawyering skills through MLP can help chart a productive interdisciplinary path forward. Many steps can help move MLP in this direction, but in our view the most important is for policy makers to accept MLP services as a form of clinical care and fund them accordingly.

References

1. Marple K. Framing legal care as health care. National Center for Medical-Legal Partnership; 2015. Accessed February 6, 2024. <https://medical-legalpartnership.org/wp-content/uploads/2015/01/Framing-Legal-Care-as-Health-Care-Messaging-Guide.pdf>
2. Tobin Tyler E. Medical-legal partnership in primary care: moving upstream in the clinic. *Am J Lifestyle Med*. 2017;13(3):282-291.
3. Baños J, Trott J, Regenstein M. Environmental scan of medical-legal partnerships in health centers. National Center for Medical-Legal Partnership; 2023. Accessed January 22, 2024. https://medical-legalpartnership.org/wp-content/uploads/2023/08/Environmental-Scan_Final.pdf
4. Sage W, Warren K. Swimming together upstream: how to align MLP services with US healthcare delivery. *J Law Med Ethics*. 2023;51(4):786-797.
5. CPT® evaluation and management (E/M) code and guideline changes. American Medical Association; 2022. Accessed September 23, 2023. <https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf>
6. Beck AF, Henize AW, Qiu T, et al. Reductions in hospitalizations among children referred to a primary care-based medical-legal partnership. *Health Aff (Millwood)*. 2022;41(3):341-349.
7. National Center for Medical-Legal Partnership. The Medical-Legal Partnership Toolkit—phase I: laying the groundwork. National Center for Medical-Legal Partnership; 2015. Accessed February 6, 2024. [https://www.medical-](https://www.medical-legalpartnership.org/wp-content/uploads/2015/01/MLP-Toolkit-Phase-I-Laying-the-Groundwork.pdf)

legalpartnership.org/wp-content/uploads/2014/03/MLP-Toolkit-Phase-I-FINAL-FILLABLE.pdf

8. Sage WM, Tiase VL. Risk, responsibility, resilience, respect: COVID-19 and the protection of health care workers. In: Cohen IG, Gluck AR, Kraschel KL, Shachar C, eds. *COVID-19 and the Law: Disruption, Impact, and Legacy*. Cambridge University Press; 2023:42-57.
9. Cannon Y. Medical-legal partnership as a model for access to justice. *Stanford Law Rev.* 2023;75(1):73-88.
10. Tobin Tyler E. Improving outreach and enrollment efforts in health centers through medical-legal partnership. National Association of Community Health Centers; 2017. Accessed April 22, 2024. <https://medical-legalpartnership.org/wp-content/uploads/2017/08/O-E-MLP-Feb-2017-Issue-Brief-FINAL.docx.pdf>
11. Outreach and enrollment grants. InsureKidsNow.gov. Accessed October 4, 2023. <https://www.insurekidsnow.gov/campaign-information/outreach-enrollment-grants/index.html>
12. Trott J, Peterson A, Regenstein M. Financing medical-legal partnerships: view from the field. National Center for Medical Legal Partnership; 2019. Medical-Legal Partnership Fundamentals Issue Brief 2. Accessed February 6, 2024. <https://medical-legalpartnership.org/wp-content/uploads/2019/04/Financing-MLPs-View-from-the-Field.pdf>
13. Mann C. Tapping into Medicaid financing streams strategies for medical-legal partnerships. National Center for Medical-Legal Partnership webinar. June 10, 2019. Accessed September 23, 2023. <https://www.youtube.com/watch?v=bOdgNuldTQk>
14. ICD-10-CM codes lookup. American Association of Colleges of Pharmacy. Accessed March 28, 2024. <https://www.aapc.com/codes/icd-10-codes-range/>
15. Health Centers, 42 USC §254b (2024).
16. HRSA Health Center Program. Service descriptors for Form 5A: services provided. Bureau of Primary Health Care. Accessed September 23, 2023. <https://bphc.hrsa.gov/sites/default/files/bphc/compliance/form-5a-service-descriptors.pdf>
17. Legal aid is now an enabling service for health centers [2015 MLP summit]. National Center for Medical-Legal Partnership. May 18, 2015. Accessed September 23, 2023. https://youtu.be/_jltVJvyw0
18. Healthy Start Initiative: Eliminating Disparities in Perinatal Health. Health Resources and Services Administration. September 22, 2023. Accessed February 6, 2024. <https://www.hrsa.gov/grants/find-funding/HRSA-24-033>
19. Rosenbaum S, Byrnes M, Hurt N. Community benefit and the ACA: a brief history and update. George Washington University Milken Institute School of Public Health. Accessed September 26, 2023. https://nchh.org/resource-library/HCF_CBACA%20overview.pdf
20. Internal Revenue Service. Additional requirements for charitable hospitals; community health needs assessments for charitable hospitals; requirement of a section 4959 excise tax return and time for filing the return; final regulations. *Fed Regist.* 2014;79(250):78954-79016.
21. Theiss J, Regenstein M. Facing the need: screening practices for the social determinants of health. *J Law Med Ethics.* 2017;45(3):431-441.
22. Crossley M, Tobin Tyler E, Herbst JL. Tax-exempt hospitals and community health under the Affordable Care Act: identifying and addressing unmet legal needs as social determinants of health. *Public Health Rep.* 2016;131(1):195-199.

23. AHA data resources. AHA Data and Insights. Accessed September 23, 2023. <https://www.ahadata.com/aha-data-resources>
24. Hamadi HY, Zhao M, Park S, et al. Improving health and addressing social determinants of health through hospital partnerships. *Popul Health Manag.* 2023;26(2):121-127.
25. American Hospital Association. Improving health equity through medical-legal partnerships. American Hospital Association; 2020. Accessed September 23, 2023. <https://www.aha.org/system/files/media/file/2020/11/aha-medical-legal-partnerships-1120-final.pdf>
26. Veterans Health Administration. US Department of Veterans Affairs. Updated April 2, 2024. Accessed March 28, 2024. <https://www.va.gov/health/>
27. Trott J, Lattimore K. Medical-legal partnerships for veterans: assisting veterans and service members with legal needs during VA transitions. National Center for Medical-Legal Partnership; 2020. Accessed March 26, 2024. <https://medical-legalpartnership.org/wp-content/uploads/2020/10/BWF-VA-Transitions-Issue-Brief-FINAL.pdf>
28. 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.
29. Veterans Health Administration. VHA directive 1510: veterans legal referral process. US Department of Veterans Affairs; 2021. Accessed February 6, 2024. https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=9450
30. Marple K, Curran M, Lawton E, Rahajason D. Types of training that help meet patients' needs and strengthen the health care and legal workforces. National Center for Medical-Legal Partnership; 2020. Accessed January 22, 2024. <https://medical-legalpartnership.org/download/tool-types-of-trainings/>
31. Theiss J, Sandel M, Teitelbaum J, Marple K. Applying the medical-legal partnership approach to population health, pain points and payment reform. National Center for Medical-Legal Partnership; 2016. Accessed February 6, 2024. <https://medical-legalpartnership.org/wp-content/uploads/2016/10/Applying-the-MLP-Approach-to-Population-Health-October-2016.pdf>
32. Marple K, Curran M, Lawton E, Rahajason D. Bringing lawyers onto the health center care team to promote patient and community health. National Center for Medical-Legal Partnership; 2020. Accessed February 6, 2024. <https://medical-legalpartnership.org/wp-content/uploads/2020/10/Health-Center-MLP-Toolkit-FINAL.pdf>
33. Sage WM, Laurin JE. If you would not criminalize poverty, do not medicalize it. *J Law Med Ethics*. 2018;46(3):573-581.
34. Glied S, D'Aunno T. Health systems and social services—a bridge too far? *JAMA Health Forum*. 2023;4(8):e233445.
35. Frazier KC, Levi JG, Minow ML, et al. *Civil Justice for All: A Report and Recommendations From the Making Justice Accessible Initiative*. American Academy of Arts and Sciences; 2020. Accessed October 3, 2023. https://www.amacad.org/sites/default/files/publication/downloads/2020-Civil-Justice-for-All_0.pdf

William M. Sage, MD, JD is a professor at the Texas A&M University School of Medicine and Texas A&M University School of Law. He is also a professor (by courtesy) of government and public service at Texas A&M's Bush School of Government and Public Service as well as the founding faculty director of the university's Institute for Healthcare

Access. He holds an undergraduate degree from Harvard College and medical and law degrees from Stanford University.

Keegan D. Warren, JD, LLM is the executive director of the Institute for Healthcare Access at Texas A&M University in Fort Worth. She has over a decade of experience in the integration of medical and social services through medical-legal partnerships. Warren earned an LLM degree in health law and policy from Southern Illinois University, a JD degree from the University of Texas, and a BA degree in Spanish, international relations, and Latin American studies from the University of Arkansas.

Citation

AMA J Ethics. 2024;26(8):E640-647.

DOI

10.1001/amajethics.2024.640.

Conflict of Interest Disclosure

Authors disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.



AMA Journal of Ethics®

August 2024, Volume 26, Number 8: E648-654

MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

What Are Epidemiological Foundations for Integrating Legal Services Into Health Care Settings?

Adrienne W. Henize, JD and Andrew F. Beck, MD, MPH

Abstract

Medical-legal partnerships vary widely in how they are structured and use data to inform service delivery. Epidemiological data on certain chronic conditions' prevalence, the incidence of potentially preventable morbidity, and health-harming legal factors also influence approaches to care. This article draws on a pediatric example of how data-driven medical care complements data-driven legal care. This article also considers medical and public health ethical frameworks to guide protected information sharing, promote optimal service delivery, and achieve the best possible medical-legal outcomes.

The American Medical Association designates this journal-based CME activity for a maximum of 1 AMA PRA Category 1 Credit™ available through the [AMA Ed Hub™](#). Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Drawing on Data

Medical-legal partnerships (MLPs) address a range of social, economic, and environmental challenges by mitigating affronts to legal rights of patients and populations (eg, poor housing conditions, denial of appropriate public benefits, inadequate special education services). The effectiveness of such collaborations among medical, legal, public health, and other sectors is bolstered by the accrual and sharing of epidemiological data on health outcomes and on health-harming legal risks (eg, living in a community dense with housing code violations).¹ Here, we highlight the importance of providing data-driven medical care alongside legal care.

Cincinnati Child Health-Law Partnership

Our MLP, the Cincinnati Child Health-Law Partnership (Child HeLP), links Cincinnati Children's pediatric primary care centers and the Legal Aid Society of Greater Cincinnati.² The founding of Child HeLP in 2008 was formalized through a memorandum of understanding. Child HeLP currently encompasses 3 pediatric primary care centers serving roughly 30 000 children, the majority of whom are low income and insured by Medicaid. Attorneys and paralegals are on-site at the largest of these clinics.

At these centers, pediatric patients and their families are universally screened for social and legal risks (eg, housing instability, food insecurity) during clinic visits. Clinicians refer

patients for legal advocacy when risks are identified. At the same time, parents or guardians sign waivers enabling bidirectional sharing of patient- or family-level data by medical and legal partners. This agreement allows medical and legal partners to discuss pertinent information with one another. For example, the medical partner could relay to the legal partner that a child has a diagnosis like asthma, a condition known to be **influenced by housing conditions**.³ Following placement of the referral order by the medical team, legal aid attorneys or paralegals meet with the family (in person or via phone follow-up) to determine the optimal course of action. If there are questions or updates pertaining to the case, and upon case resolution, the legal partner shares information with the medical partner. The Child HeLP management team, comprising both medical and legal partners, closely tracks referral numbers, case types, and outcomes.^{1,4} This team also identifies opportunities for system-level advocacy (eg, influencing city- or state-level policy) that emerge from patterns recognizable in patient-level data.^{5,6}

Child HeLP relies on collaborative approaches to measurement and data sharing between organizations. Yet as protected patient- and population-level medical and legal information changes hands, very real ethical considerations emerge about how and when to share what data and with whom. In what follows, we ground our argument about the importance of data-driven medical and legal care in a recent case of multiple patients, all living in the same apartment complex with various housing concerns. We examine this case—and the cross-sector collaboration and data sharing that enabled its resolution—using both medical and public health ethical frameworks that show how care and data sharing can be extended from patient to population and then refocused on the patient.

A Case of Health-Harming Housing

In 2018, a Delaware limited-liability company acquired a 976-unit apartment complex in Cincinnati, and, after 4 years of disinvestment, widespread disrepair posed a serious threat to tenants' health. Tenants were living with water damage, mold, blocked sewer lines, hazardous wiring, and pest infestations. A fire in November 2022, followed by failure to routinely winterize plumbing, resulted in the flooding of dozens of units. Water was shut off multiple times during the winter. The City of Cincinnati issued orders to the owner to correct pervasive building, health, and fire code violations or risk legal action, but to no avail. Concurrently, tenants organized and voted to have the Legal Aid Society of Greater Cincinnati represent their interests. The City of Cincinnati Manager's Office and the Greater Cincinnati Homeless Coalition supported the development of a tenant association. A tenant leader created a Facebook Group for tenants to connect, share experiences, and get updates on meetings and legal proceedings.

Upon learning of the poor conditions, widely described in local media in late 2022, the Child HeLP management team sought to join the effort. At a patient level, the management team sought to proactively identify patients and their families living within the complex and offer Child HeLP referrals. Accordingly, Cincinnati Children's team members queried the electronic health record for pediatric primary care patients with an address within the apartment complex. Members of the clinical team then pursued outreach at clinic visits, by phone, or in person. When clinical team members made contact, they asked tenants if their children were sick, if they were experiencing poor unit conditions or knew of others who were, and offered to help them connect with the Legal Aid Society or the tenant association. If families requested a connection, then waivers were signed and referrals placed. Cincinnati Children's community health

workers and community engagement specialists also attended tenant association meetings to offer support and resources.

The city filed a public nuisance lawsuit against the owner in January 2023.⁷ The tenant association was allowed to join the city's suit as an interested party. In addition to supporting tenant-patients through existing referral pathways, the Child HeLP team supported the city's litigation with population-level epidemiological data. At a population level, the city and tenant association believed that being able to describe the health impact of housing conditions on children living in the complex would enhance the case for urgent remediation and legal action. After conferring with the Cincinnati Children's compliance and privacy officer, the MLP team deemed that the benefits of sharing deidentified data in the aggregate for population-level management outweighed the risks. The primary risk was that deidentification would be incomplete, enabling families (tenants) to see themselves in shared data and potentially provoking their discomfort and compromising their trust in the care team. Because this risk was deemed sufficiently small, the Cincinnati Children's team, in response to city requests and with tenant association guidance, tabulated how many children cared for at Cincinnati Children's lived in the complex, the number of pediatric hospitalizations and emergency department visits in the preceding 2 years, and the estimated prevalence of select chronic conditions sensitive to poor housing conditions (eg, asthma).

The analysis identified approximately 200 children who had more than 450 clinical encounters between May 2021 and April 2023. These encounters included more than 40 hospitalizations and 300 emergency department visits. The most common diagnosis codes attached to encounters were diseases of the respiratory system and injuries. Using comparative citywide data available from the Cincinnati Children's electronic health record system, we were able to quantitatively demonstrate that patients living in the complex had higher incidences of hospital admissions and emergency department visits and a higher prevalence of asthma than Cincinnati youth not living in the complex. These epidemiological data were paired with data emergent from housing inspections completed by city health and building department officials prior to a scheduled June 2023 trial in order to inform ongoing litigation.

A court hearing in June 2023, before the trial was set to begin, was requested by the mortgage lender that had filed a foreclosure case against the owner in May 2023 for defaulting on the lease. This hearing resulted in the establishment of new management via appointment of a receiver as temporary property manager to collect rents and oversee repairs. The trial was continued to allow the receiver to follow through on these responsibilities, and the case is currently ongoing. As such, it is too soon to measure the effect of the cross-sector data sharing partnership and litigation on patient- or population-level outcomes. That said, the initiation of tangible unit- and complex-level improvements holds promise for healthier living conditions and, in turn, healthier tenants.

Ethics and Medical-Legal Collaboration

Medical-legal data sharing allowed members of both the medical and the legal team to achieve more impact than they would have had alone. Nevertheless, the case of this unhealthy apartment complex—and those who call it home—provokes questions related to how we collaborate across sectors to optimize service delivery. Overlaying clinical with contextual data can promote more informed care for patients and more efficient recognition of risk patterns across, and actions for, populations.^{8,9} Yet privileged,

protected information should be shared with caution and in alignment with legal and ethical standards,^{10,11} especially as we move our focus from patient to population, apartment unit to complex, and back again.

The American Medical Association defines **core ethical principles** related to patient care, two of which are relevant here: (1) “a physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient”; and (2) “a physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.”¹² Pursuant to these principles, patient-level data are shared with consent when in the “best interests of the patient”—and deidentified population-level data are shared when consent is difficult to obtain but sharing is anticipated to benefit patients in the aggregate (eg, when hundreds of children live in a deteriorating, health-harming apartment complex).¹²

In our pediatric primary care centers, legal care is now delivered alongside medical care. Clinicians routinely ask patients about health-harming legal factors, such as adverse housing conditions. Many also identify the patient’s home community, gleaning insights that may prompt referral to Child HeLP.^{1,2} Should a family consent to a referral to Child HeLP, they sign the 2 aforementioned consents: one authorizes the sharing of protected health information with the Legal Aid Society of Greater Cincinnati, and the second allows the sharing of legal information with Cincinnati Children’s. These releases, developed under a memorandum of understanding between Cincinnati Children’s and the Legal Aid Society, are compliant with medical and legal requirements.¹⁰ They allow the medical team to communicate with the legal team about health challenges that may be influenced by the environment (eg, asthma) and the legal team to communicate with the medical team about the family’s legal rights and legal remedies that could affect medical outcomes. Legal advocates communicate with families about those rights as well. This approach is not unlike information sharing between primary care and subspecialty practitioners insofar as it remains patient centered and problem focused, but it expands the notion of what constitutes a subspecialty practitioner. Patient-level data sharing, with consent, facilitates effective mitigation of both medical and legal risk.^{2,4}

Public health ethics are similarly instructive for mitigating medical and legal risk, especially as population-level data is bidirectionally shared—clusters of respiratory disease are shared with legal (and public health) partners and clusters of substandard housing conditions with medical partners. Kass explicitly argues that “an appropriate, if not obligatory,” function of public health is to reduce social ills.¹³ As such, we believe it is an ethical requirement to act to mitigate harmful effects of certain situations (eg, a health-harming apartment complex). We also believe it is a duty to share data, to work across sectors to improve health and overcome injustice,¹⁴ and to ensure that those whose data are shared are guiding data uses in meaningful ways. Community “power,” epitomized by the tenant association’s data requests and advocacy, ensures that data and interventions are community centered, community shaped, and **community driven**.^{15,16} As clinicians and public health professionals consider their duty to act and the benefits of acting, they must acknowledge potential risks. True deidentification may not be possible when data emerge from small, insular populations.

Relatedly, the concept of a public health emergency, defined as “an occurrence or imminent threat of widespread or severe damage, injury, or loss of life or property

resulting from a natural phenomenon or human act,”¹⁷ can be instructive when confronted by an epidemic of substandard housing driven by the “human act” of property neglect. There are formal requirements for governmental agencies to pursue public health emergency declarations. Such declarations can lead to funding for public health action. They also can spur cross-sector data sharing. And evidence suggests that population-level, cross-sector data sharing can guide collaborative action during public health emergencies, no matter the pathogen.¹⁸

Conclusion

There is a strong epidemiological and ethical basis for cross-sector collaboration and data sharing. We suggest that patient-level data sharing, with appropriate guardrails, enables patient-level action that is more proactive and tailored to a specific harm (eg, legal advocacy to address a patient’s health-harming housing). We also suggest that population-level data sharing that minimizes the potential for identification of an individual and that is guided by the population in question enables population-level action that can more effectively target risk patterns that are otherwise invisible or easily ignored (eg, a cluster of public health-harming housing conditions). All of us clinicians collectively seek optimal service delivery and medical outcomes. We are most likely to achieve such optimization through collaboration—with consistent connections among clinical teams, legal advocates, municipal stakeholders, and, most importantly, affected community members.

References

1. Beck AF, Henize AW, Klein MD, Corley AMS, Fink EE, Kahn RS. A data-driven approach to optimizing medical-legal partnership performance and joint advocacy. *J Law Med Ethics*. 2023;51(4):880-888.
2. Klein MD, Beck AF, Henize AW, Parrish DS, Fink EE, Kahn RS. Doctors and lawyers collaborating to HeLP children—outcomes from a successful partnership between professions. *J Health Care Poor Underserved*. 2013;24(3):1063-1073.
3. O’Sullivan MM, Brandfield J, Hoskote SS, et al. Environmental improvements brought by the legal interventions in the homes of poorly controlled inner-city adult asthmatic patients: a proof-of-concept study. *J Asthma*. 2012;49(9):911-917.
4. Beck AF, Henize AW, Qiu T, et al. Reductions in hospitalizations among children referred to a primary care-based medical-legal partnership. *Health Aff (Millwood)*. 2022;41(3):341-349.
5. Beck AF, Huang B, Chundur R, Kahn RS. Housing code violation density associated with emergency department and hospital use by children with asthma. *Health Aff (Millwood)*. 2014;33(11):1993-2002.
6. Beck AF, Klein MD, Schaffzin JK, Tallent V, Gillam M, Kahn RS. Identifying and treating a substandard housing cluster using a medical-legal partnership. *Pediatrics*. 2012;130(5):831-838.
7. *City of Cincinnati and Cincinnati Board of Health v BRC Williamsburg Holdings, LLC and Dasmen Residential, LLC* (Hamilton CP, Ohio 2023). Accessed September 4, 2023. <https://www.cincinnati-oh.gov/sites/cityofcincinnati/assets/Williamsburg%20Complaint.pdf>
8. Beck AF, Sandel MT, Ryan PH, Kahn RS. Mapping neighborhood health geomarkers to clinical care decisions to promote equity in child health. *Health Aff (Millwood)*. 2017;36(6):999-1005.
9. Kaplan B. How should health data be used? *Camb Q Healthc Ethics*. 2016;25(2):312-329.

10. Health Insurance Portability and Accountability Act, Pub L No. 104-191, 100 Stat 2548 (1996).
11. Guidance regarding methods for de-identification of protected health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. US Department of Health and Human Services. Reviewed October 25, 2022. Accessed July 12, 2023. <https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html>
12. American Medical Association. Principles of medical ethics. *Code of Medical Ethics*. Revised June 2001. Accessed June 17, 2023. <https://code-medical-ethics.ama-assn.org/principles>
13. Kass NE. An ethics framework for public health. *Am J Public Health*. 2001;91(11):1776-1782.
14. Jones CM. The moral problem of health disparities. *Am J Public Health*. 2010;100(suppl 1):S47-S51.
15. Heller JC, Fleming PJ, Petteway RJ, Givens M, Pollack Porter KM. Power up: a call for public health to recognize, analyze, and shift the balance in power relations to advance health and racial equity. *Am J Public Health*. 2023;113(10):1079-1082.
16. Heller JC, Little OM, Faust V, et al. Theory in action: public health and community power building for health equity. *J Public Health Manag Pract*. 2023;29(1):33-38.
17. Haffajee R, Parmet WE, Mello MM. What is a public health “emergency”? *N Engl J Med*. 2014;371(11):986-988.
18. Hartley DM, Beck AF, Seid M, et al. Multi-sector situational awareness in the COVID-19 pandemic: the Southwest Ohio experience. In: Berube DM, ed. *Pandemic Communication and Resilience*. Springer Nature; 2021:265-278.

Adrienne W. Henize, JD is an associate professor of pediatrics. She is the program manager for the Cincinnati Child Health-Law Partnership and oversees several additional clinical-community partnerships central to Cincinnati Children’s Hospital’s commitment to the pursuit of health equity.

Andrew F. Beck, MD, MPH is a professor of pediatrics and a director of population health and health equity research and innovation. He serves on the management team for the Cincinnati Child Health-Law Partnership. He practices clinically as a primary care and hospitalist pediatrician.

Citation

AMA J Ethics. 2024;26(8):E648-654.

DOI

10.1001/amajethics.2024.648.

Acknowledgements

This work was supported in part by grant R01HS027996 from the Agency for Healthcare Research and Quality (Children's Hospital Medical Center; Dr Beck, primary investigator; A. W. Henize, co-investigator). We would like to thank Elizabeth Lanphier, PhD, MS, Robert S. Kahn, MD, MPH, Melissa D. Klein, MD, MEd, Elaine E. Fink, JD, John E. Schrider, JD, Nick DiNardo, JD, Virginia Tallent, JD, Mark Manning, JD, Shannon Price, JD, Stuart Taylor, MA, Joe Michael, PhD, and Aaron Flicker, MS for their thoughtful review of this manuscript and their contributions to the referenced case. We also thank the Child HeLP management team, the Cincinnati Children's primary care centers, and the City of Cincinnati Children and Families Cabinet for their ongoing commitment to the health and well-being of Cincinnati's youth.

Conflict of Interest Disclosure

Authors disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.



AMA Journal of Ethics®

August 2024, Volume 26, Number 8: E655-664

MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Can Medical-Legal Partnerships Do More to Advance Reproductive Justice After *Dobbs*?

Medha Devanagondi Makhoulf, JD and Natasha Rappazzo

Abstract

The medical-legal partnership (MLP) and reproductive justice (RJ) movements both seek to solve complex problems, serve diverse populations with intersectional challenges, and resolve community conditions that impact people's ability to reach their highest health potential. Yet MLPs have been overlooked as a strategy to advance reproductive health and justice. MLP has distinct advantages for advancing RJ, and many MLPs might already be doing RJ work without referring to it by name. By intentionally adopting an RJ strategy and explicitly addressing the unmet social and legal needs that limit people's ability to plan their reproductive futures, MLPs can better serve their clients and contribute to the movement to combat reproductive oppression.

Setback in Reproductive Health and Justice

In June 2022, the US Supreme Court issued its decision in *Dobbs v Jackson Women's Health*,¹ overruling the constitutional right to abortion founded in *Roe v Wade*² and radically transforming access to reproductive health care in the United States.^{1,2} As predicted, the decision has had disproportionate health impacts on people who face discrimination based on other axes of identity.³ These include Black, Indigenous, and people of color (BIPOC); people with lower incomes and fewer resources; noncitizens; minors; people with disabilities; and people with diverse sexual orientations and gender identities.⁴ *Dobbs* brought an end to nearly 50 years of abortion jurisprudence and standard medical practice.¹ One year after the decision, 26 states had banned or were likely to ban abortion, thus rolling back access to care for 15.4 million women of color in these states.⁵ These consequences explain how the *Dobbs* decision has set back advocacy for reproductive justice (RJ).

RJ encompasses "the complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women's human rights."⁶ These human rights include rights to "maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."⁷ The decision of whether or not to become a parent has broad implications for one's health, income, career, education, and relationships.

Medical-legal partnership (MLP) is not typically framed as an intervention for RJ. This article seeks to fill that gap. MLP is a model of collaboration and joint advocacy between lawyers and health care practitioners who seek to improve social conditions that affect health and well-being.⁸ Many social determinants of health, including sociopolitical and legal systems that perpetuate generational inequity, shape poor health outcomes and cannot be resolved through medical care alone.⁹ Among them are unaffordable and substandard housing, utility shutoffs, food insecurity, erroneous denials of public benefits, and inadequate funding for public schools. MLP is an effective means to address health and justice gaps, especially for BIPOC and in communities with lower incomes.^{10,11} The communities that are most likely to access and benefit from the services of MLPs are the very communities that are disproportionately impacted by laws and policies restricting access to sexual and reproductive health care.¹²

The community conditions that impact reproductive freedom are so broad that many MLPs may be doing RJ work without referring to it by name. This article describes the distinct advantages of MLPs for RJ advocacy and argues that intentionally adopting RJ practices can help MLPs better meet their clients' needs.

Reproductive Justice Framework

Roe framed the right to abortion as an individual's choice of whether or not to have a child, without consideration of the social determinants that impact such a choice.^{2,13} Following *Roe*, the mainstream reproductive rights movement adopted a single-issue approach by focusing its advocacy solely on abortion and birth control "at the expense of a broader agenda."¹⁴ This narrow approach and "choice" framework did not adequately recognize the ways in which racism, poverty, sterilization abuse, and other structures of subordination influence reproductive destinies, especially for people of color.^{13,14} In response, women of color advocated for a new, intersectional approach to reproductive rights that highlighted and challenged the **structural barriers** to reproductive freedom.¹⁵

The term *reproductive justice* was coined in 1994 by a group of Black women who saw the need to better articulate their realities in the movements for sexual and reproductive health.¹⁶ The RJ framework "analyzes how the ability of any woman [person] to determine her [their] own reproductive destiny is linked directly to the conditions in her [their] community—and these conditions are not just a matter of individual choice and access."⁶ RJ integrates multiple issues and diverse constituencies to highlight how intersectional forms of discrimination contribute to **reproductive oppression**.⁶ RJ differs from mainstream reproductive rights advocacy because it includes reproduction and parenting and links abortion to other community-centered concerns.⁶ It unites social justice movements in organized messaging and powerful grassroots coalitions.¹⁷

Like the movement for health justice, which is associated with MLP,⁹ RJ seeks to eliminate structural inequities, uplift individuals and communities, and secure collective power.¹⁸ However, engagement between RJ and health justice is limited, contributing to the public discourse on reproductive health that focuses on abortion exclusively instead of broader issues of protecting bodily autonomy, deciding whether or not to have a child, and parenting in safe and sustainable communities.¹⁹ Sexual and reproductive health exceptionalism, which "siloe[s] off reproductive and sexual health from other health care needs," is rooted in bias and stigma.²⁰ Greater alignment between health justice and RJ can build a more powerful and mainstream movement that better meets the needs of the most marginalized people, families, and communities.^{8,18}

How MLPs Advance Reproductive Justice

The MLP and RJ movements are aligned in several ways: they seek to solve complex social problems that “transcend the borders of traditional policy domains, involve a wide variety of actors across different scale levels and resist our attempts to solve them”²¹; they serve diverse populations with intersectional challenges⁸; and they highlight and resolve community conditions that impact people’s ability to reach their highest health potential by preventing legal and reproductive health crises, respectively. Because of these similarities, it is very likely that most MLPs are advancing RJ but have not framed their work in this way.

Linking RJ priorities to the types of services that MLPs provide reveals how MLPs help to advance RJ. In the literature on MLPs, I-HELP™ refers to advocacy relating to income and insurance, housing and utilities, education and employment, legal status, and personal and family stability.²² It is often cited to describe the legal domains in which MLPs operate. The chart below, adapted from the National Center for Medical-Legal Partnership,²² shows how MLPs can intervene to address unmet social and legal needs that limit reproductive freedom, thereby advancing RJ.

Table. How Legal Services Help Health Care Address the Social Determinants of Health

Social determinants of health	Medical-legal partnership services	Advancement of reproductive justice
Income	<ul style="list-style-type: none"> Apply for and appeal denials of food assistance, cash assistance, disability benefits. 	<ul style="list-style-type: none"> SNAP benefits allow people—including pregnant, postpartum, and parenting individuals—to nourish themselves and their families. Income from other public benefits pays for necessities, such as the practical costs of reproductive health care and parenting.
Insurance	<ul style="list-style-type: none"> Apply for and appeal denials of health insurance. 	<ul style="list-style-type: none"> Health insurance covers reproductive health care services, including family planning, testing and treatment for STIs, pregnancy-related care, and, in some states, abortion.
Housing and utilities	<ul style="list-style-type: none"> Prevent evictions. Prevent utility shutoffs. Address unsafe housing conditions. 	<ul style="list-style-type: none"> Ensuring housing security can help improve birth and maternal health outcomes, especially for BIPOC, who are more likely to experience homelessness, and Black women, who are at highest risk for eviction.^{23,24} In addition, legal interventions can directly address poor conditions that pose health risks.²⁵
Education and employment	<ul style="list-style-type: none"> Enforce workplace rights, such as those guaranteed by the Pregnant Workers Fairness Act and the Family and Medical Leave Act. Obtain reasonable accommodations for people with disabilities. 	<ul style="list-style-type: none"> The ability to access accommodations or time off from work allows people with reproductive health-related needs to put their health first without risking their economic stability.
Legal status	<ul style="list-style-type: none"> Assist with immigration matters, such as applications for asylum, adjustment of status to lawful permanent resident, or naturalization. Provide advice on immigration status-based exclusions from public benefits. 	<ul style="list-style-type: none"> MLPs can assess the eligibility of undocumented mothers, who are less likely to access prenatal care due to their immigration status²⁶ and are more likely to experience pregnancy complications,²⁷ for emergency Medicaid to cover treatment of pregnancy-related conditions.

Personal and family stability

- Secure restraining orders for IPV.
- Secure adoption, custody, and guardianship for children.

- Restraining orders help make homes safer and decrease the likelihood of unintended pregnancy and perinatal harm. Those most at risk of experiencing IPV have a high risk of unintended pregnancy and negative reproductive health outcomes.²⁸ Pregnancy and the postpartum period are often dangerous times for people experiencing IPV; homicide is a leading cause of death, especially for Black women.²⁹
-

Adapted with permission from National Center for Medical-Legal Partnership.²²

Abbreviations: BIPOC, Black, Indigenous, and people of color; IPV, intimate partner violence; MLP, medical-legal partnership; SNAP, Supplemental Nutrition Assistance Program; STI, sexually transmitted infection.

Recognizing MLPs as a Tool for Reproductive Justice

Presently, there is unprecedented interest in combatting reproductive oppression.^{5,30} While inequities in abortion access existed long before *Dobbs*, the United States has seen **worsening maternal and infant health outcomes**, attacks on gender-affirming care,³¹ and growing maternal health care deserts in the year since the decision was issued.^{32,33} In the 26 states that had already banned or were likely to ban abortion 12 months after *Dobbs*,^{5,34} residents face unique barriers to reproductive freedom. As noted, these barriers often fall disproportionately on BIPOC and people with lower incomes.⁵

Yet the potential for MLPs to advance reproductive health and justice is underappreciated.^{35,36} There is a notable overlap in the communities that utilize MLP services and the communities that are most harmed by reproductive oppression.^{5,37} For example, the large majority of people who accessed legal aid services in 2021 were women, roughly a quarter of whom were aged 18 to 35 years³⁷; in June 2023, more than 36 million women of reproductive age lived in states that had banned or were likely to ban abortion.⁵ However, while 60% of MLPs served a “general population” in 2016, only 9% targeted pregnancy as a specific health condition for MLP intervention.³⁸ Screening for health-harming legal needs and directing legal services to pregnant patients would align more MLPs with RJ. In addition, nearly half of legal aid clients identify as Black, Hispanic of any race, or Native American,³⁹ and Black and Native American women are most likely to live in states that ban abortion, with Latinas being the largest group harmed by bans.⁵ Failing to recognize how intersecting identities and experiences may structurally disadvantage clients and impact their reproductive future neglects the holistic needs of clients and forgoes the power of MLPs to create change in lives, communities, and policies.

Recommendations and Conclusion

One of the advantages of MLPs as a tool for RJ is that the different strategies MLPs employ—direct representation, institutional change, and **policy advocacy**—provide several avenues of action for RJ.

Direct representation. On the individual client level, MLP staff can stay informed on issues impacting reproductive freedom in their community and build connections with local RJ organizations that may be better equipped to handle such issues when they arise among MLP patients-clients. For example, MLPs can work in tandem or in partnership with resource centers for people experiencing intimate partner violence. Additionally, expanding MLPs into abortion clinics or through collaboration with abortion funds (organizations that provide logistical and financial support to people seeking abortions)⁴⁰ creates opportunities for MLPs to work with pregnant, postpartum, and post-pregnancy clients who are facing significant social and economic challenges and

who otherwise may not find their way to a legal aid office.⁴¹ Lawyers and health care practitioners (ob-gyns, doulas, and others) can build relationships and partnerships with each other in order to reach specific populations with RJ-related legal needs.

MLP staff who work directly with patients-clients can take measures to acknowledge their sexual and reproductive needs. Incorporating RJ in MLP may be as simple as providing access to condoms in a medical or legal services waiting room, which may indicate that the medical or legal professional is comfortable discussing social and legal needs relating to sexual and reproductive health, thereby opening the door to patient-client-initiated conversations about those topics. MLP staff can also create processes for identifying compelling client stories and sharing them (with informed consent) with legislators or in op-eds for greater impact.

Attorneys can take further measures by counseling clients on the legality and availability of abortion care, over-the-counter birth control, and emergency contraception.⁴² It is worth noting that while MLPs funded by the Legal Services Corporation (LSC) are not permitted to help clients access abortion care, this restriction does not apply to other types of reproductive health care, such as contraceptives or sexually transmitted infections testing and treatment.⁴³ MLPs that do not receive LSC funding, such as MLPs in law school clinics or non-LSC affiliates of legal aid organizations, are not subject to these restrictions.

Institutional change. In an effort to create institutional change within health care systems, MLPs can educate health care practitioners on existing laws and policies related to sexual and reproductive health,⁸ perhaps in consultation with the health system's general counsel's office. Trainings may cover how to prepare for changes in the law on medication abortion and birth control,⁴⁴ current case law interpreting the legal definition of an emergency abortion,⁴⁵ or how patients can access doula coverage under Medicaid.⁴⁶

Policy advocacy. With respect to policy change, lawyers and health care practitioners—as stewards of power—are well-positioned to advocate for policies that make health care more equitable, accessible, effective, and affordable. For example, they can encourage state policy makers to adopt health-promoting options in federal programs, such as pregnancy-related Medicaid extensions.⁴⁷ Lawyers and health care professionals can also use their experience working with individual patient-clients and the specific health injustices those patients-clients encounter to inform the policy changes for which they advocate. In several contexts, MLPs have used this “patient-to-policy” strategy to successfully persuade policy makers to enact change.⁴⁸

Although there are MLPs advancing RJ by working in perinatal settings³⁶—and 9% of MLPs target pregnant individuals for MLP services, as reported in a 2016 survey³⁸—it is rare or unheard of for MLPs to explicitly make the connection between their work and RJ beyond perinatal care. Excluding certain components of sexual and reproductive health care, such as abortion and birth control, from the MLP space reflects and reproduces stigma, invites partisan divide into the legal-health space, and abandons communities who may need these essential services. When MLPs fail to consciously implement RJ practices or align their work with the RJ movement, they risk creating an environment where clients do not feel safe to express the full scope of their needs.⁴⁹

In the Supreme Court's opinion in *Dobbs*, the majority claimed that returning the "issue of abortion" to the states would allow the rule of law to prevail.¹ Instead, *Dobbs* created a geographic patchwork of laws regulating abortion as well as confusion among patients and clinicians about the permissibility of reproductive health care.^{50,51} As a movement founded on the principle that leveraging legal services in health care settings can address structural problems at the root of health inequities, MLPs can play a role in mitigating reproductive oppression compounded by *Dobbs*.⁵² The vision on which RJ was founded—reproductive freedom for all—is increasingly under attack, and MLPs can support the movement by adopting an intentional RJ strategy and explicitly addressing the unmet social and legal needs that limit people's ability to plan their reproductive futures.

References

1. *Dobbs v Jackson Women's Health Organization*, 142 S Ct 2228 (2022).
2. *Roe v Wade*, 410 US 113 (1973).
3. Human rights crisis: abortion in the United States after *Dobbs*. Human Rights Watch. April 18, 2023. Accessed September 23, 2023. https://www.hrw.org/news/2023/04/18/human-rights-crisis-abortion-united-states-after-dobbs#_Toc132207240
4. Fuentes L. Inequity in US abortion rights and access: the end of *Roe* is deepening existing divides. Guttmacher Institute. January 17, 2023. Accessed February 4, 2024. <https://www.guttmacher.org/2023/01/inequity-us-abortion-rights-and-access-end-roe-deepening-existing-divides>
5. Robbins KG, Goodman S, Klein J. State abortion bans harm more than 15 million women of color: *Dobbs* impact felt nationwide. National Partnership for Women and Families; 2023. Accessed September 23, 2023. <https://nationalpartnership.org/wp-content/uploads/2023/02/state-abortion-bans-harm-woc.pdf>
6. Ross L. What is reproductive justice? In: *Reproductive Justice Briefing Book: A Primer on Reproductive Justice and Social Change*. Pro-Choice Public Education Project; SisterSong Women of Color Reproductive Justice Collective; 2007. Accessed September 23, 2023. <https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fID=4051>
7. Ross L, Solinger R. *Reproductive Justice: An Introduction*. University of California Press; 2017.
8. Makhlouf M. Addressing racism through medical-legal partnerships. *Bill of Health*. September 24, 2020. Accessed September 23, 2023. <https://blog.petrieflom.law.harvard.edu/2020/09/24/addressing-racism-medical-legal-partnerships/>
9. Benfer E, Bhandary-Alexander J, Cannon Y, Makhlouf M, Pierson-Brown T. Setting the health justice agenda: addressing health inequity and injustice in the post-pandemic clinic. *Clin Law Rev*. 2021;28:45-84.
10. 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.
11. Cannon YZ. Medical-legal partnership as a model for access to justice. *Stanford Law Rev Online*. 2023;75:73-88.
12. Abrams Z. Abortion bans cause outsized harm for people of color. *Monitor on Psychology*. 2023;54(4):24. Accessed February 4, 2024. <https://www.apa.org/monitor/2023/06/abortion-bans-harm-people-of-color>

13. Murray M. Race-ing Roe: reproductive justice, racial justice, and the battle for *Roe v Wade*. *Harv Law Rev*. 2021;134(6):2025-2102.
14. Ziegler M. The price of privacy, 1973 to the present. *Harv J Law GenD*. 2014;37:285-329.
15. Murray M, Shaw K, Siegel RB, eds. *Reproductive Rights and Justice Stories*. Foundation Press/West Academic; 2019.
16. Onwuachi-Saunders C, Dang QP, Murray J. Reproductive rights, reproductive justice: redefining challenges to create optimal health for all women. *J Healthc Sci Humanit*. 2019;9(1):19-31.
17. About. Liberate Abortion Campaign. Accessed September 23, 2023. <https://www.liberateabortion.org/about>
18. Wiley LF, Yearby R, Clark BR, Mohapatra S. Introduction: what is health justice? *J Law Med Ethics*. 2022;50(4):636-640.
19. Rebouché R. Health justice meets reproductive justice. *Bill of Health*. September 28, 2021. Accessed September 23, 2023. <https://blog.petrieflom.law.harvard.edu/2021/09/28/reproductive-justice-health/>
20. Mainstreaming reproductive health. UCLA School of Law. Accessed September 23, 2023. <https://law.ucla.edu/academics/centers/center-reproductive-health-law-and-policy/mainstreaming-reproductive-health>
21. Termeer CJAM, Dewulf A, Biesbroek R. A critical assessment of the wicked problem concept: relevance and usefulness for policy science and practice. *Policy Soc*. 2019;38(2):167-179.
22. How legal services help the health care system address social needs. National Center for Medical-Legal Partnership. Accessed September 23, 2023. <https://medical-legalpartnership.org/response/i-help/>
23. Mhatre N. Moms and babies series: homelessness hurts moms and babies. National Partnership for Women and Families; National Birth Equity Collaboration; 2021. Accessed September 23, 2023. <https://nationalpartnership.org/wp-content/uploads/2023/02/homelessness-hurts-moms-and-babies.pdf>
24. Blumenthal C. The disproportionate burden of eviction on Black women. Center for American Progress. August 14, 2023. Updated August 29, 2023. Accessed February 4, 2024. <https://www.americanprogress.org/article/the-disproportionate-burden-of-eviction-on-black-women/#:~:text=Ashfaq%20Khan-,Black%20women%20are%20at%20greatest%20risk%20of%20eviction,United%20States%20are%20Black%20women>
25. Hernández D. “Extra oomph”: addressing housing disparities through medical legal partnership interventions. *Housing Stud*. 2016;31(7):871-890.
26. Fabi R. Why physicians should advocate for undocumented immigrants’ unimpeded access to prenatal care. *AMA J Ethics*. 2019;21(1):E93-E99.
27. Bhasin A. Moms and babies series: a systemic failure—immigrant moms and babies are being denied health care. National Partnership for Women and Families; National Birth Equity Collaboration; 2021. Accessed September 23, 2023. <https://nationalpartnership.org/wp-content/uploads/2023/04/immigrant-moms-and-babies-denied.pdf>
28. Hasstedt K, Rowan A. Understanding intimate partner violence as a sexual and reproductive health and rights issue in the United States. Guttmacher Institute. June 30, 2016. Accessed September 23, 2023. <https://www.guttmacher.org/gpr/2016/07/understanding-intimate-partner-violence-sexual-and-reproductive-health-and-rights-issue>

29. Lawn RB, Koenen KC. Homicide is a leading cause of death for pregnant women in US. *BMJ*. 2022;379:o2499.
30. Nash E, Guarnieri I. In the US midterm elections, resounding victories for abortion on state ballot measures. Guttmacher Institute. November 9, 2022. Accessed August 20, 2023. <https://www.guttmacher.org/2022/11/us-midterm-elections-resounding-victories-abortion-state-ballot-measures>
31. Reproductive rights include bodily autonomy for trans and intersex youth. National Women's Law Center. August 9, 2022. Accessed September 23, 2023. <https://nwlc.org/resource/reproductive-rights-include-bodily-autonomy-for-trans-and-intersex-youth/>
32. Baden K, Driver J. The state abortion policy landscape one year post-Roe. Guttmacher Institute. June 15, 2023. Accessed September 23, 2023. <https://www.guttmacher.org/2023/06/state-abortion-policy-landscape-one-year-post-roe>
33. Tu L. One year after *Dobbs*, abortion bans are harming reproductive care, ob-gyns say. *Scientific American*. June 23, 2023. Accessed September 23, 2023. <https://www.scientificamerican.com/article/one-year-after-dobbs-abortion-bans-are-harming-reproductive-care-ob-gyns-say1/>
34. After Roe fell: abortion laws by state. Center for Reproductive Rights. Accessed September 23, 2023. <https://reproductiverights.org/maps/abortion-laws-by-state/>
35. Mace S. Statement in response to *Dobbs v Jackson Women's Health Organization*. HELP MLP. June 27, 2022. Accessed September 24, 2023. <https://helpmlp.org/2022/06/27/statement-in-response-to-dobbs-v-jackson-womens-health-organization/>
36. Using legal services as part of a community strategy to improve maternal and child health: 2023 learning collaborative. National Center for Medical-Legal Partnership. March 1, 2023. Accessed September 24, 2023. <https://medical-legalpartnership.org/mlp-resources/maternal-health-learning-collab-2023/>
37. Legal Services Corporation. *By The Numbers: The Data Underlying Legal Aid Programs*. Legal Services Corporation; 2022. Accessed September 24, 2023. <https://lsc-live.app.box.com/s/e0ejxcp3lp4msvp77mvrzy9w0z354tf7>
38. Regenstein M, Trott J, Williamson A. The state of the medical-legal partnership: field findings from the 2016 National Center for Medical-Legal Partnership surveys. National Center for Medical-Legal Partnership; 2017. Accessed February 4, 2024. <https://medical-legalpartnership.org/wp-content/uploads/2017/07/2016-MLP-Survey-Report.pdf>
39. Shek D. Centering race at the medical-legal partnership in Hawai'i. *Miami Race Soc Justice Law Rev*. 2019;10(1):109-146.
40. Fast facts about abortion funds. National Network of Abortion Funds. Accessed March 19, 2024. <https://abortionfunds.org/abortion-funds-fast-facts/>
41. Rubin R. Medical-legal partnerships: how legal services can dramatically improve health outcomes, and the missed opportunity to help women seeking abortions. *Fam Court Rev*. 2019;57(4):569-582.
42. Richards M. The public, including women of childbearing age, are largely confused about the legality of medication abortion and emergency contraceptives in their states. Kaiser Family Foundation. February 1, 2023. Accessed September 24, 2023. <https://www.kff.org/womens-health-policy/press-release/the-public-including-women-of-childbearing-age-are-largely-confused-about-the-legality-of-medication-abortion-and-emergency-contraceptives-in-their-states/>

43. The Legal Services Corporation Act, 42 USC §2996f (b)(8) (2023).
44. Shetty N. Abortion medication minefield causing pharmacists confusion. *Bloomberg Law*. June 9, 2023. Accessed August 20, 2023. <https://news.bloomberglaw.com/us-law-week/abortion-medication-minefield-causes-confusion-for-pharmacists>
45. Rappazzo N. Emergency room to the courtroom: providing abortion care under EMTALA and state abortion laws. *Dickinson Law Rev.* 2023;128(1):325-358.
46. Chen A, Robles-Fradet A, Arega H. Building a successful program for Medi-Cal coverage for doula care: findings from a survey of doulas in California. National Health Law Program; 2020. Accessed August 20, 2023. <https://healthlaw.org/wp-content/uploads/2020/04/NHeLP-DoulaCare-Web-Format-final.pdf>
47. Rappazzo N, Chen A. Aligning pregnancy-related Medicaid coverage extensions and Medicaid doula coverage to improve maternal health. National Health Law Program. August 3, 2023. Accessed September 24, 2023. <https://healthlaw.org/resource/aligning-pregnancy-related-medicaid-coverage-extensions-and-medicaid-doula-coverage-to-improve-maternal-health/>
48. Tobin Tyler E. Aligning public health, health care, law and policy: medical-legal partnership as a multilevel response to the social determinants of health. *J Health Biomed Law.* 2012;8(2):211-247.
49. Glicksman E. Stigma's toll on sexual and reproductive health. *Hopkins Bloomberg Public Health*. October 17, 2022. Accessed August 20, 2023. <https://magazine.jhsph.edu/2022/stigmas-toll-sexual-and-reproductive-health>
50. Mattioli ML, Strandquest JK. Protection of health info post-“Dobbs”: providers and patients are stuck in the middle. *Legal Intelligencer*. June 30, 2023. Accessed September 24, 2023. <https://www.law.com/thelegalintelligencer/2023/06/30/protection-of-health-info-post-dobbs-providers-and-patients-are-stuck-in-the-middle/>
51. Nash E, Ephross P. State policy trends at midyear 2022: with Roe about to be overturned, some states double down on abortion restrictions. Guttmacher Institute. June 22, 2022. Accessed September 24, 2023. <https://www.guttmacher.org/article/2022/06/state-policy-trends-midyear-2022-roe-about-be-overturned-some-states-double-down>
52. New KFF national survey of OBGYNs finds Dobbs decision has made it harder to treat miscarriages and other pregnancy-related emergencies in affected states; in states with bans, half report patients who were unable to obtain an abortion they sought. News release. Kaiser Family Foundation; June 21, 2023. Accessed September 24, 2023. <https://www.kff.org/womens-health-policy/press-release/kff-national-survey-of-obgyns-finds-dobbs-decision-has-made-it-harder-to-treat-miscarriages-and-other-pregnancy-related-emergencies-in-states-with-bans/>

Medha Devanagondi Makhlof, JD is the Elsie de R. and Samuel P. Orlando Distinguished Professor and founding director of the Medical-Legal Partnership Clinic at Penn State Dickinson Law in Carlisle, Pennsylvania. Her research and teaching interests lie at the intersection of health law, immigrants' rights, and poverty law and policy.

Natasha Rappazzo is a JD candidate at Penn State Dickinson Law in Carlisle, Pennsylvania. They hold a BA degree in history and political science from Hofstra University. During law school, Natasha worked with the Center for Reproductive Rights,

the National Health Law Program and, prior to law school, was a community organizer for Planned Parenthood of Greater Texas.

Citation

AMA J Ethics. 2024;26(8):E655-664.

DOI

10.1001/amajethics.2024.655.

Conflict of Interest Disclosure

Authors disclosed no conflicts of interest.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.