Episode: *Ethics Talk: What Do MLPs Offer Undocumented Patients?*

Guest: Lynette Martins, MBE, LLM
Host: Tim Hoff
Transcript: Cheryl Green

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[mellow theme music]

[00:00:04] TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. Long-time listeners will know that we've talked about what good health care for undocumented patients looks like before. Our January 2021 issue considered the nature and scope of clinicians' obligations to support and care for undocumented immigrants, refugees, and asylees. There's much that clinicians can do to help ease the burdens on undocumented patients and make health care spaces more accessible to them. They can distribute brochures, invite patients to share their experiences, and direct and connect those who need them to resources.

As the demands of patients' socially, culturally, and politically situated health needs grow increasingly complex, clinicians can also partner with attorneys to help respond with care to the fuller spectrum of patients' legal needs. Many patients who are undocumented, for example, experience health vulnerabilities that call for legal advice, help petitioning a court, legal representation in administrative proceedings, or other kinds of legal referrals or advocacy.

Medical-legal partnerships are key interprofessional collaborations that address patients' extra-clinical needs. The growth of medical-legal partnerships expands opportunities to identify and respond to legal determinants of health for undocumented patients. Joining us to discuss the roles of MLPs for undocumented patients is legal researcher and consultant Lynette Martins. Lynette, thank you so much for being on the podcast. [music fades]

LYNETTE MARTINS: Thank you so much for having me. I'm delighted to be here.

[00:01:48] HOFF: Previous articles in the Journal, as I will have just mentioned in the narration that's not yet recorded at the time of this interview, have outlined what good health care for undocumented patients looks like. Interested listeners can check out the article titled *Good Sanctuary Doctoring for Undocumented Patients*, as well as our full January 2019 issue on *Health Care for Undocumented Immigrants*, which will be linked in the show notes. So let's start there. What does good legal care for undocumented patients require?

MARTINS: Yeah, this is such a great place to start, and I think it places us in an area in which we can kind of think about law and medicine as having synergies, right? So, usually, there might be some hesitance on behalf of some medical professionals in

terms of medical malpractice. And in that context, right, there's this sort of hesitance to interact with the legal team. But I want to say that in the medical-legal partnerships, this brings us into an area of synergy in which we have similar goals, intentions, and also requirements in order to achieve the overarching goals for our client-patients. And so, you might imagine, and if you're reading through Mark's and his co-author's paper, we're going to, some of the same characteristics are mirrored.

So, for instance, really establishing this level of trust through dialogue and providing reassurance. And if there's something that goes outside of the scope of what you would be or consider your area of expertise, you provide some access to other resources. And really beyond that, it would just be having this firm understanding of what immigration law is substantively, but also, I think at the heart of it—and really, I think this also mirrors the medical side—is being this legal champion for the best interests of your patient. And I would actually say, and I think this is sort of the consensus of being, arguing in the best interests of your community writ large. So, those are some of the commonalities, I think, that are exemplified in both the medical and legal side.

[00:04:09] HOFF: So, what are some of the unique legal needs of undocumented patients specifically that better access to legal services might help address?

MARTINS: Yeah, this is something that's so critical. So, here in the United States, undocumented immigrants are excluded, for instance, from federally-funded health benefits and programs. And even though there are some that are covered through some state programs, there's just a huge amount of variability. Aside from that, aside from health programs, I think you want to think about employment and compensation and how, through what mechanism they're employed, how are they compensated? Who's compensating them? What housing do they have access to? These are all falling under the broad, overarching social determinants of health that I think we'll probably talk a little bit more later on. But I think these are critical areas to understand when you're thinking about patients and clients moving between the clinical care and also their unmet legal needs that might be actually unique to this particular population.

I think just as a sort of an emphasis here, most MLPs won't have the resources in terms of immigration law expertise to be able to provide the level of service and care that would be required for these particular patient-clients. So I think it becomes a very specialized and unique area that not only captures this particular population, but obviously overlaps onto areas, other areas of care, for instance, cancer care, chronic disease care, and some subspecialties like palliative as well. So, you can see how further complex providing care for these particular patients can often be.

[00:06:08] HOFF: Hmm. And why is it that many MLPs don't have that expertise? Is it a lack of training or a lack of funding or interest in young legal professionals? What seems to be the source?

MARTINS: So, yes, a combination of all of those. But I would say primarily it's the funding stream. So, immigration MLPs are not particularly common. And if you look at the breadth of and the scope of practice of some of the other MLPs, this is probably the

one that has the least number that are existent. Though I could, I mean, there are so many new MLPs that are being established, so that's a footnote for that particular fact. But I think that it's primarily the funding stream and difficulty in securing, procuring funds to be able to financially sustain this type of program, which, as you can imagine, coordination of care between legal and medical services is often very difficult and challenging.

[00:07:09] HOFF: Hmm. I guess I'm realizing I don't really fully understand how MLPs are established. Are they all subject to that federal oversight of how funds are used, or is there a group of private MLPs who don't accept federal funding so that they can avoid those kind of restrictions on which services they can offer to whom? How does that all work?

MARTINS: Yeah, absolutely. So I think that the, I think the simple response to that is just there are funds that can be accessed through federal mechanisms. And so, that becomes a more accessible mode of financial accessibility. The second thing is some, you asked about if there are some private streams of revenue or if there are other alternative models, and certainly there are. For instance, law firms that will do some either pro bono work or very motivated individuals who want, in a firm, that are particularly compelled to provide legal aid services for a particular population, and so they become affiliated with that particular population in a medical facility and then have this coordination of care with them. And I'm thinking about some services like palliative care, where the provision of health care is wide ranging and in itself involves sort of this coordination of care around several different areas. But yeah, it absolutely does not have to be through one stream of funding, but it just ends up being that that's the most accessible one in terms of availability.

[00:08:54] HOFF: Hmm. Final follow-up for this initial question, I promise.

BOTH: [chuckle]

HOFF: You've mentioned briefly the social determinants of health with which many of our listeners will be familiar. Is there a helpful distinction in the legal community between social determinants of health on one hand and legal determinants of health on the other? Or does that distinction mostly collapse, given the influence that legally determined circumstances of a person's life, like whether they're legally eligible for housing or medical care, given the influence those things have on some of the traditionally identified social determinants of health?

MARTINS: Yeah, I think there, I mean, there.... Let's just define each one and see if there's some overlap there. I think when you think about social determinants of health, there are income, for instance, housing, education, access to employment, food insecurity. Those types of things are what we would fall under this framework of social determinants of health. Legal determinants of health is usually used to describe when a law actually impacts health. And so, you can think of several instances in which a law is implemented, and then as such, health is either positively or negatively impacted. And

so, I think you can start to see sort of the differentiation between the two, which I think are pretty distinct.

[00:10:18] HOFF: Hmm. Yeah, that's interesting and helpful. Thank you for laying out the distinction. Like I said, we can move on now to our next question.

For some patients, the legal and medical needs that they have do overlap quite directly. For instance, refugees seeking asylum status must participate in an interview in which they state why they seek asylum. Some research suggests that these interviews can be retraumatizing, because refugees can be asked about some very specific details about their experiences. Good mental health professional support during these interviews can be helpful. What are some other examples of when health professionals can support undocumented patients in legal proceedings?

MARTINS: Yeah, I think this is a, really, this comes back to sort of the original approach that Mark talks about in his paper, which is really this establishing of trust and rapport with your patient-client, providing constant reassurance in so many, for not only the distress of their legal, their unmet legal needs, which is occurring in real time, but also, a reassurance of privacy and confidentiality: that your medical provider is on your side, and they will not become someone who will either divulge private, protected health information to anybody, particularly law enforcement, unless they're, footnote to that, unless there is particular exclusions, like if there's some firmly held belief that this person has committed a crime, so on and so forth. So I think access, this continuity of care, like, what is my plan of care going to look like? Am I going to have that? Am I going to still continue to see you? Those are things that are sort of looming, I think, questions for persons who are encountering this process. Will I have access to the medication that I need? This is particularly the case for people who have chronic diseases that require the constant medication for there to be able to mitigate against their disease.

And I think finally, and certainly not in any order, but sort of sustaining, I think, health care professionals can provide that sort of network of care and resources that's so critical in this environment. So, for instance, I'm thinking of social workers or clergy or people of faith that might be consistent with the patient-client and seeking out community health workers as well. That might be critical components of this continuity of care. So I think establishing trust, keeping that rapport, if possible, reassurance in moments of distress. And I think providing those resources, those critical things would be, I think, really necessary from the health care professional and the legal one alike.

[00:13:27] HOFF: Can you expand briefly on that hesitancy you mentioned of some patients to interact with health care professionals at all because of how closely some medical professionals work with some law enforcement? What are some of the ways that legal professionals can help address that hesitancy or other concerns about repercussions for those seeking legal help?

MARTINS: Yeah, I think this one can be a little bit thorny, mostly because some legal professionals can sort of project themselves as lawyers, right? Like, they are actually at

entities such as USCIS or any government areas that, departments, that you would assume undocumented individuals might be located at and try to prey on them. So there are some predatory individuals that try to solicit you under the guise that they are legal counsel.

So I think we, you know, there has to be some reassurance that there's some credibility, first of all, that you are someone who is credentialed in order to proceed with this particular case. I think a lot of it comes through word of mouth. If you are someone or you are an entity, a legal professional in the community, a lot of times, it is through the community that you work with, through the organizations that you are familiar with and you're integrated with in your local community that other entities or undocumented individuals will come to you to seek out this legal counsel. So I think it's really critical for you to have this presence in the community that signals to people that you are a champion for this legal cause and for immigrants writ large, and that that is something that I think becomes the signal for others to be able to say, okay, this is someone I can trust and really call upon in this particular circumstance.

[00:15:32] HOFF: Hmm. Yeah. It sounds like the methods that legal professionals might use to build trust overlap with those that health professionals might use. Which actually leads us well into this next question on cross-training. So, training legal professionals in some health care concepts and training health professionals in some legal concepts can improve both legal professionals' and health professionals' capacity to respond with care to the full spectrum of needs of undocumented patients. So what are a few of the key cross-training topics in legal-medical interprofessional education?

MARTINS: Yeah, so, I recently stumbled upon some training that a, not a medical professional, but an ethicist that does teach a medical ethics class actually invites her medical students into court with her. She is a lawyer ethicist, and she provides that kind of training for them. And I thought that was wonderful because they see another side of their patient who might be on the cusp of eviction or having some other issues with perhaps trying to get compensated appropriately for their services through whatever amount of employment that they were engaged in. So I think this just provides this other level of information for clinicians that I think is so important to be able to understand holistically what is happening and also being able to, on the medical side, being able to advocate one way or the other. So, I think starting from this health justice framework, we can kind of see this significant overlap that both professions in training would require.

[00:17:22] And I think legal professionals should be able to, in this particular instance, to provide some level of education and knowledge and information sharing on, especially on policy changes when there's so much uncertainty. Just by way of example, the public charge rule that had become an issue, I believe, in the prior administration around 2019, this was something that there was quite a bit of uncertainty circulating around. And just in summary for what the public charge rule really was concerned about was, are you going to be a burden—not my words—on the federal government as a result of your immigration status? And as a result, a lot of undocumented, particularly immigrants, were not accessing health care for fear of being either deported or reported for their

undocumented status, and as a result of that, being deported. So, lots of uncertainties surrounded that. Lots of misinformation and disinformation swirled around as well, as a result. And I think legal professionals more informed about this and on the substantive version of the law would be able to better guide health care professionals to say, well, no, this is what it really means. And I think having that level of knowledge and awareness and being able to communicate that to health professionals is really critical.

Providing these legal services and education in this environment is just testament to the fact that in this sort of vulnerability, that this setting is an effective way to help identify patients and help these patients access benefits and services that they would just not ordinarily be able to or have been excluded from. So I think just sort of thinking about coming back to the social determinants of health and what might a legal professional think through, there are some sort of mnemonics that are used to help us to remember what areas and domains that might be relevant to cover when you're screening, diagnosing, and referring patient-clients with unmet legal needs to these legal services as part of their medical plan.

[00:20:06] So, for instance, it's "I HELP" is one example. The I is income, H is housing, E is employment, L is legal status, and P is personal stability. And that actually just means end-of-life care planning or advance directives, guardianship, those types of things. So I think these are areas that certainly, legal professionals can help, but I also think that there's some ability for cross-training and lots of information sharing. And there's this robust discussion about just how much information should be shared between the medical team and the legal team just to be compliant with the, not only HIPAA, but also the state and local privacy laws. So, I think that's also a big area in need of definite boundaries and for the medical and legal team to understand the confines of how much information they're permitted to share and just how much would actually be helpful for the patient's best interest. And I think in both areas, that's really what you're focused on, right? This concept of the best interest of your patient-client and how best to achieve that using all the tools that you have been trained for, maybe not all, but most of the tools that you've been trained for.

[00:21:34] HOFF: We'll wrap up with the focus of this month's issue, which is the lack of standardization of MLPs. On one hand, MLPs benefit from the regulatory flexibility to meet specific needs of patients and communities. But on the other hand, we ought to wonder whether and when oversight is needed to ensure safe, reliable practice when serving extremely vulnerable patient-clients. One challenge, for instance, is measuring MLPs' effectiveness and efficacy across the country. So, in what ways might MLPs and the patient-clients they serve benefit from standardization?

MARTINS: Yeah, this is the area that I've been most involved with and mostly just providing empirical evidence towards the effectiveness or efficacy of MLPs. I think there's much to say about this. I think just let me just state first, for those who may not know, that there are a variety of medical-legal partnerships across the United States, and some of them are general ones, in which case they just screen the general population, and they provide general legal services. But there are others that are more targeted toward specific populations, and these tend to predominate in areas where

there are more resources to provide such services. And by that, I mean, like we're talking about today, one that's targeted to a specific population, such as immigration or in this case, undocumented immigrants. There are others that are focused more on cancer patients. There are some that focus on palliative care, others that focus on reintegrating persons who were priorly incarcerated, right? So, I think it's important to sort of just have that basic understanding.

[00:23:29] The second thing to understand is in each of these, let's say, targeted MLPs, the population numbers are not as large as you would find in a general MLP. And so, what you might see is in a year of, let's say the cancer, let's say the breast cancer MLP, you might have about 30 patients. In your geriatric early-onset dementia MLP, you might have a similar caseload of 30 patients in a year. And so, if you're trying to establish, for the purposes of robust statistical analysis, establishing sort of a larger sample size, I think one benefit of standardizing MLPs would be to collaborate, do multi-site, collaborative trials, in a sense, to assess. So, Clinic A in Utah versus, added on to Clinic B in Philadelphia. Individually, they might have 35 or 40 patients, but collectively, their sample size might double or perhaps even more so triple and adding more credibility to their sample size. So, I think you can see the benefit through that lens of an empirical, from an empirical standpoint.

[00:24:56] And really what we're trying to say is that here's the evidence, and this is what we can attest to for intervention providing legal services in conjunction with this clinical care, provided this type of outcome, right? And either you have a metric associated with decreased stress or increased health outcome, particularly associated with whatever it is you're studying. So I think you can start to see where we're going with this in establishing more definitive lines for evidence that might better inform the setting for these MLPs, not only MLPs, but also patients, right? Because patients can also be, if you're thinking about sort of participatory and collaborative research, they can also better inform. And it could be like this iterative approach to, in essence, a quality improvement project, in which case you're just making the project better, and in essence better able to serve the patient-clients that are in your population. So, that's one aspect, I think, that would be, that comes to mind for me, because when I think about some of the population sizes for MLPs, they're very small, oftentimes, whereas you find the general MLPs to be quite large.

[00:26:29] But I also want to sort of highlight that the core, I would say the core functions of all MLPs are pretty standard, right? So they are, in essence, standardized. We all screen for unmet legal needs. We diagnose and then refer to the appropriate legal services. So I think there, what might need to happen is I think, and I foresee this sort of happening is, more sort of collaborative clinics that are smaller and perhaps newer, collaborating with more established clinics that have a larger sample size, have more integrated approaches and more evidence-based solutions and just more institutional knowledge and memory that they've acquired, and I would say wisdom. So I think that might start to happen as things progress. But I also want to just say that this is quite new. MLPs, even though sort of the kernels were there in their earlier days, I think as far as actual implementation on a policy level has only happened in the '90s. And so, I think it's really important to know that this is quite new, and I think the process is

constantly improving and getting better. [theme music returns] And I think the more resources that are being acquired will necessarily improve the programs that are being provided in whatever scope of practice that they are currently.

[00:28:13] HOFF: Lynette, thank you so much for your time and expertise on the podcast today.

MARTINS: Yeah, absolutely. Always happy to do so. Thanks, Tim.

HOFF: That's all for this episode of *Ethics Talk*. Thanks to Lynnette Martins for joining us. Music was by the Blue Dot Sessions. To read this month's full issue on *Standards in Medical-Legal Partnerships* for free, visit our site, journalofethics.org. For all of our latest news and updates, find us on social media @journalofethics, and we'll be back next month with an episode on *Non-Human Animal Research*. Talk to you then.