

# THE YALE LAW JOURNAL

## COMMENT

### The “M” in MLP: A Proposal for Expanding the Roles of Clinicians in Medical-Legal Partnerships

Medical-legal partnerships (MLPs) are a promising innovation in the delivery of legal services. Usually located in health care facilities, MLPs connect medical patients with lawyers in order to “detect, address and prevent health-harming social conditions” that medicine alone cannot treat.<sup>1</sup> There is no single MLP model—organizations vary considerably by client base and clinical setting.<sup>2</sup> Some MLPs work with medical providers that serve the general public, such as hospitals and community health clinics,<sup>3</sup> while others work with special populations, such as children, veterans, elderly people, and cancer sufferers.<sup>4</sup>

- 
1. *The MLP Response*, NAT’L CTR. FOR MED.-LEGAL PARTNERSHIP, <http://medical-legal-partnership.org/mlp-response> [<http://perma.cc/8L99-ADXH>]; see also Marcia M. Boumil, Debbie F. Freitas & Cristina F. Freitas, *Multidisciplinary Representation of Patients: The Potential for Ethical Issues and Professional Duty Conflicts in the Medical-Legal Partnership Model*, 13 J. HEALTH CARE L. & POL’Y 107, 108 (2010) (explaining the basic structure and purpose of the MLP model).
  2. See Ellen M. Lawton & Megan Sandel, *Medical-Legal Partnerships: Collaborating To Transform Healthcare for Vulnerable Patients—A Symposium Introduction and Overview*, 35 J. LEGAL MED. 1, 3 (2014) (“One of the finest attributes of the MLP model is its relative flexibility . . .”); Amy Killelea, Note, *Collaborative Lawyering Meets Collaborative Doctoring: How a Multidisciplinary Partnership for HIV/AIDS Services Can Improve Outcomes for the Marginalized Sick*, 16 GEO. J. POVERTY L. & POL’Y 413, 420-22 (2009) (describing four prototypical models for MLP collaboration); *The Medical-Legal Partnership Toolkit: Phase I: Laying the Groundwork*, NAT’L CTR. FOR MED.-LEGAL PARTNERSHIP 9 (Mar. 2015), [hereinafter *MLP Toolkit*] <http://www.medical-legalpartnership.org/wp-content/uploads/2014/03/MLP-Toolkit-Phase-I-FINAL-FILLABLE.pdf> [<http://perma.cc/2NJ9-CD5C>] (characterizing various MLP models using a spectrum that ranges from referral networks to fully integrated MLPs).
  3. *Partnerships Across the U.S.*, NAT’L CTR. FOR MED.-LEGAL PARTNERSHIP (June 24, 2016), <http://medical-legalpartnership.org/partnerships> [<http://perma.cc/7B24-BNHF>].
  4. See Boumil et al., *supra* note 1, at 108-09; *Partnerships Across the U.S.*, *supra* note 3.

Some patients encounter MLPs while seeking treatment for acute physical illnesses or emergencies, while others see their clinicians frequently for rehabilitation or mental health treatment.<sup>5</sup> Most MLPs primarily serve low-income patients, who are particularly vulnerable to economic, social, and environmental determinants of health.<sup>6</sup> MLPs have been established in 294 health care institutions across forty-one states, and the model is continuing to evolve.<sup>7</sup>

There is a growing literature on the economic and social impacts of MLPs,<sup>8</sup> and a significant body of scholarship discussing medical practitioners' roles in spotting legal needs and referring their patients to the legal side of the MLP.<sup>9</sup> However, scholars have paid relatively little attention to clinician involvement after referral.<sup>10</sup> Analysis by the academy, and by organizations like the National Center for Medical-Legal Partnership (NCMLP),<sup>11</sup> has mainly focused on clinicians as gatekeepers for the legal side of the MLP and, to a lesser extent, as sources of corroborating evidence during formal legal proceedings.<sup>12</sup> Although

- 
5. See Megan Sandel et al., *The MLP Vital Sign: Assessing and Managing Legal Needs in the Healthcare Setting*, 35 J. LEGAL MED. 41, 50 (2014) (describing an MLP in a pediatric emergency department); Kelly Burdette Mendonca, *San Francisco VA Health Care System: Medical Legal Partnership Helps Senior Veterans*, U.S. DEP'T VETERANS AFF. (Feb. 22, 2016), [http://www.sanfrancisco.va.gov/SANFRANCISCO/features/Medical\\_Legal\\_Partnership.asp](http://www.sanfrancisco.va.gov/SANFRANCISCO/features/Medical_Legal_Partnership.asp) [<http://perma.cc/YP84-GZAR>] (describing an MLP at a geriatric practice).
  6. See Boumil et al., *supra* note 1, at 111; Sandel et al., *supra* note 5, at 50 (“Depending on the partnering legal entity, eligibility for services can range up to 200% of the [federal poverty level] . . .”).
  7. NAT'L CTR. FOR MED.-LEGAL PARTNERSHIP, <http://medical-legalpartnership.org> [<http://perma.cc/LZX4-QZVK>].
  8. See, e.g., Laura K. Abel & Susan Vignola, *Economic and Other Benefits Associated with the Provision of Civil Legal Aid*, 9 SEATTLE J. SOC. JUST. 139, 140 (2010) (finding that MLPs “improve clients’ health and generate revenue for hospitals”); Bharath Krishnamurthy et al., *What We Know and Need To Know About Medical-Legal Partnership*, 67 S.C. L. REV. 377, 382 (2016) (noting that “[a]lthough the effects of the MLP approach have been relatively untested, some pilot studies have provided enough preliminary evidence to demonstrate the need for an evaluation of MLP on a larger scale”). For a detailed survey of the literature on the impacts of MLPs up to 2012, see Tishra Beeson, Brittany Dawn McAllister & Marsha Regenstein, *Making the Case for Medical-Legal Partnerships: A Review of the Evidence*, NAT'L CTR. FOR MED.-LEGAL PARTNERSHIP (Feb. 2013), <http://medical-legalpartnership.org/wp-content/uploads/2014/03/Medical-Legal-Partnership-Literature-Review-February-2013.pdf> [<http://perma.cc/TU7J-J5BR>]. For a curated selection of the literature on the impact of MLPs, see *Measuring Impact*, NAT'L CTR. FOR MED.-LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/resources/measures> [<http://perma.cc/9CMV-NJXB>], specifically the section titled “Data on the Impact of Medical-Legal Partnership.”
  9. See *infra* notes 36-44 and accompanying text.
  10. See *infra* Part II.
  11. NAT'L CTR. FOR MED.-LEGAL PARTNERSHIP, *supra* note 7.
  12. See *infra* notes 45-51 and accompanying text.

the NCMLP envisions clinician engagement “at all levels” of a fully integrated MLP,<sup>13</sup> the organization has provided relatively little guidance on the clinician’s role at any stage other than the referral process.<sup>14</sup> This Comment takes a first step toward exploring new roles for clinicians at MLPs.

I argue that the period immediately after a doctor has identified a legal need is particularly worthy of further study and experimentation, especially in MLPs with more potential legal clients than their attorneys can represent. At under-resourced MLPs, not all patients’ legal needs are pressing enough to make it past the intake process that lawyers use to prioritize clients.<sup>15</sup> Even some patients with urgent legal needs may face long wait times after referral from the medical side of the MLP. A clinician’s referral, then, initiates the process by which a patient may come to access a lawyer, but also exposes the patient to a bottleneck that may delay or preclude his access to services, allowing his nascent legal issue to develop into a larger problem.

Drawing on my experience at an MLP that provides legal services to veterans,<sup>16</sup> this Comment proposes that MLPs should begin expanding the clinician’s role in resolving early-stage legal issues that do not yet require a lawyer’s services. Such an approach would facilitate the goal of “preventive law[ying]” by helping to treat patients’ nascent legal needs before they become more urgent.<sup>17</sup> It would also further clinicians’ professional goals by helping to address legal needs before they threaten patients’ health.<sup>18</sup> Part I introduces the basic characteristics of the MLP model. Part II describes the literature on the clinician’s role as a member of the MLP team. Part III argues that MLPs should ex-

---

13. See *MLP Toolkit*, *supra* note 2, at 9.

14. For example, resources for setting up MLPs and training physicians tend to focus on the referral process, if they discuss physicians at all. See, e.g., *MLP Toolkit*, *supra* note 2, at 8-10, 15-16 (outlining how to set up an MLP without providing content for either medical or legal training); *Training Partners and Students*, NAT’L CTR. FOR MED.-LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/resources/training> [<http://perma.cc/9PRV-FFY2>] (offering only one video curriculum and one chart, both on social determinants of health, as training for front-line health care providers and medical residents).

15. See D. James Greiner, *What We Know and Need To Know About Outreach and Intake by Legal Services Providers*, 67 S.C. L. REV. 287, 287-88 (2016) (stating that, through the intake process, legal services providers “choose their clients” and “choose what services those clients receive”).

16. From September 2015 to June 2016, I worked as an intern at the Connecticut Veterans Legal Center (CVLC). Many of the ideas in this Comment derive from that experience, but they do not represent the views of the organization or any of its staff members. See CONN. VETERANS LEGAL CTR. (CVLC), <http://ctveteranslegal.org> [<http://perma.cc/WCW3-VYPG>].

17. See, e.g., Lynn Hallarman et al., *Blueprint for Success: Translating Innovations from the Field of Palliative Medicine to the Medical-Legal Partnership*, 35 J. LEGAL MED. 179, 187 (2014).

18. See, e.g., Mallory Curran, *Preventive Law: Interdisciplinary Lessons from Medical-Legal Partnership*, 38 N.Y.U. REV. L. & SOC. CHANGE 595, 602-03 (2014).

periment with expanding the clinician's role, relying on clinicians' expertise for early-stage conflict resolution rather than only referrals and corroboration. Part IV outlines a model program that demonstrates how this insight would translate into practice. Part V ends by considering ways to reframe the division of labor between clinicians and lawyers at MLPs in light of state bar restrictions on the unauthorized practice of law.<sup>19</sup>

### I. WHAT IS AN MLP?

MLPs are joint ventures between medical providers and civil legal aid organizations.<sup>20</sup> Members of both professions and their clients benefit from this type of collaboration, as many social, financial, and environmental causes of poor health "are amenable to civil legal solutions,"<sup>21</sup> and "health institutions . . . serve as an excellent entry point to civil legal aid."<sup>22</sup> MLPs help patients with legal needs involving their income (e.g., private employment issues and/or government benefits), housing and utilities (e.g., rent subsidies and living conditions), education and employment (e.g., specialized education services and workplace rights), legal status (e.g., veteran discharge status and criminal/credit histories), and personal and family stability (e.g., custody and guardianship).<sup>23</sup> On the legal side, a lawyer's representation of an MLP client may involve giving legal advice, writing a letter on the client's behalf, filing forms with a government agency, or providing full-blown legal representation in front of a tribunal.<sup>24</sup> On the medical side, MLP clinicians are doctors, nurses, community health workers, or mental health practitioners, and they treat everything from acute conditions to chronic mental illness.<sup>25</sup>

As is frequently also the case at civil legal aid organizations, MLPs are often outmatched by the needs of their client base.<sup>26</sup> The average low-income house-

---

19. MODEL RULES OF PROF'L CONDUCT r. 5.5 (AM. BAR ASS'N 1983).

20. See Krishnamurthy et al., *supra* note 8, at 377.

21. *Id.* at 378; see also James Teufel et al., *Legal Aid Inequities Predict Health Disparities*, 38 *HAMLINE L. REV.* 329, 355 (2015) ("A growing body of evidence supports that legal representation results in improved health outcomes.").

22. Krishnamurthy et al., *supra* note 8, at 377.

23. *How Civil Legal Aid Helps Health Care Address SDOH*, NAT'L CTR. FOR MED.-LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh> [<http://perma.cc/Q4E6-2V4U>]. Some MLPs also handle minor criminal issues. *Id.*

24. *Id.* (listing civil legal aid interventions in the forms described above).

25. See Krishnamurthy et al., *supra* note 8, at 381.

26. See Sandel et al., *supra* note 5, at 46 ("Because the prevalence of legal needs is so high and the resources are so few, access to legal assistance is often limited, and resources are

hold has up to three legal needs per year, but less than one in five legal needs are handled with the help of a lawyer.<sup>27</sup> Individuals who have significant contact with some component of the health care system tend to have extensive unmet legal needs as well.<sup>28</sup> For example, they may need help applying for government assistance, such as Medicaid or disability benefits; they may have difficulty obtaining or keeping their housing, whether owned or rented, due to physical or mental illness; or they may have health-related work disruptions that make it harder for them to meet their financial obligations.<sup>29</sup> MLPs can help patients manage these burdens, but they often lack the funding and attorney resources necessary to carry out their mission to the fullest extent.<sup>30</sup>

Within MLPs, clinicians act as gatekeepers for patients with legal needs. Organizations differ, but MLPs generally employ some sort of formal or informal procedure that allows clinicians to refer patients to the legal side of the partnership.<sup>31</sup> After this initial referral, legal staff may contact the patient in order to conduct additional screening based on income and other eligibility factors.<sup>32</sup> Once the legal side has enough information from the patient, the MLP determines whether the patient has a bona fide legal issue, and if so, whether the MLP's lawyers have the capacity and expertise to take on the patient as a

---

stretched too thin . . . Greater Boston Legal Services estimates that it turns away three out of every five clients due to a lack of resources.”); *Understanding the Civil Legal Aid and Health Care Landscapes*, NAT'L CTR. FOR MED.-LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/resources/landscapes> [<http://perma.cc/87LH-E8K6>] (“Civil legal aid is historically underresourced, poorly coordinated and frequently disconnected from other community resources.”).

27. *Documenting the Justice Gap in America: The Current Unmet Civil Legal Needs of Low-Income Americans*, LEGAL SERVS. CORP. 13 (2009), <http://www.americanbar.org/content/dam/aba/migrated/marketresearch/PublicDocuments/JusticeGaInAmerica2009.authcheckdam.pdf> [<http://perma.cc/ETP5-XM5V>].
28. See Krishnamurthy et al., *supra* note 8, at 378 (citing studies that document the prevalence of unmet health-harming civil legal needs in health center patients); Sandel et al., *supra* note 5, at 46 (“National data show that health centers serve more than 22 million patients in the United States . . . . In excess of 70% of [these] patients live below the federal poverty level . . .”).
29. See Hallarman et al., *supra* note 17, at 187; Killelea, *supra* note 2, at 430.
30. See *supra* notes 26-28.
31. See Emily A. Benfer, *Educating the Next Generation of Health Leaders: Medical-Legal Partnership and Interprofessional Graduate Education*, 35 J. LEGAL MED. 113, 126 (2014) (describing different referral approaches); Boumil et al., *supra* note 1, at 110; see also *Screening Patients*, NAT'L CTR. FOR MED.-LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/resources/screening> [<http://perma.cc/CV7P-X5NA>] (offering a customizable legal needs screening tool for download).
32. See, e.g., Sandel et al., *supra* note 5, at 50 (“Depending on the partnering legal entity, eligibility for services can range up to 200% of the [federal poverty level] and can be restricted to certain citizenship statuses.”).

client.<sup>33</sup> Like other civil legal aid organizations, MLPs with heavy caseloads and limited resources for new clients prioritize new intakes according to certain criteria, a system known as “triage.”<sup>34</sup> One MLP administrator has referred to this reality as “practic[ing] in the legal equivalent of the emergency room.”<sup>35</sup>

## II. EXISTING LITERATURE ON THE CLINICIAN’S ROLE

As in all legal services organizations, lawyers in MLPs determine which potential clients receive services. However, it is the clinician who is largely responsible for deciding which patients make it into the pool of referrals. Since the referral process is such a vital component of the clinician’s role, it is not surprising that efforts to help clinicians spot legal needs have received the most attention in the literature on the medical side of MLPs.<sup>36</sup> To prepare clinicians for their role in the referral process, the NCMLP advocates for MLPs to train medical providers on social determinants of health.<sup>37</sup>

Many MLPs have heeded the NCMLP’s recommendations. For example, some MLPs use legal needs screening tools, such as oral or written questionnaires and exam room posters, to create a systematic way of spotting a patient’s legal issues on the medical side of the MLP.<sup>38</sup> Others rely on training sessions to raise awareness about legal needs that might arise in a clinician’s patient population<sup>39</sup>—one MLP, the Health Justice Project in Chicago, Illinois, esti-

---

33. See Benfer, *supra* note 31, at 126-27 (describing an approach where medical providers identify a legal or social determinant of health during an exam and then refer the patient to further intake processes); Greiner, *supra* note 15, at 287-88 (emphasizing that the intake process allows legal services providers to select both clients and legal matters).

34. See, e.g., Curran, *supra* note 18, at 603 (“[W]e are so flooded with potential clients that our triage frequently excludes those who aren’t already in a legal crisis.”); Greiner, *supra* note 15, at 288 (“When demand for services outstrips supply to such an extent that traditional attorney-client relationships can be offered only to a small fraction of eligible individuals, then choice, rationing, and triage are inevitable.”).

35. Curran, *supra* note 18, at 603.

36. See *infra* notes 37-44.

37. *Training Partners and Students*, *supra* note 14.

38. See Benfer, *supra* note 31, at 123; Krishnamurthy et al., *supra* note 8, at 381; Sandel et al., *supra* note 5, at 46 (“[I]t is imperative that legal needs are actively screened for, especially as most patients’ needs go unresolved.”).

39. See, e.g., Benfer, *supra* note 31, at 148; Stewart B. Fleishman et al., *The Attorney as the Newest Member of the Cancer Treatment Team*, 24 J. CLINICAL ONCOLOGY 2123, 2124 (2006); Melissa D. Klein et al., *Doctors and Lawyers Collaborating To HeLP Children—Outcomes from a Successful Partnership Between Professions*, 24 J. HEALTH CARE FOR POOR & UNDERSERVED 1063, 1065 (2013); Krishnamurthy et al., *supra* note 8, at 382 (“Training for front-line health workers focuses more on connecting common social determinants of health with clinical conditions that can be impacted by the MLP intervention.”); Jennifer K. O’Toole et al., *Resident Confi-*

mates that it has trained “in excess of 200 health professionals, including nurses, doctors, and physician assistants, in the identification of legal and social determinants of health.”<sup>40</sup> Reaching even further back into the pipeline, the NCMLP and a number of MLPs have advocated for and implemented training programs for medical students and residents.<sup>41</sup> Some of these programs foster early collaboration by offering joint courses that bring together students from the fields of law, medicine, social work, and/or public health.<sup>42</sup> Finally, some MLPs have experimented with new ways to communicate referrals between the medical side and the legal side.<sup>43</sup> The Health Justice Project emphasizes integrating the MLP into the health provider’s electronic medical record system to make legal referrals “in the same way a referral to a specialist—such as ‘oncology’—is made.”<sup>44</sup>

Though the referral process dominates the literature on the medical side of MLPs, a subset of the literature assesses the best ways to involve physicians in later stages of formal legal proceedings. Written statements from clinicians can corroborate patients’ claims for government assistance in connection with such issues as asylum status,<sup>45</sup> relief from a utility shut-off,<sup>46</sup> or service-connected compensation for military veterans.<sup>47</sup> MLPs serving these patients have tried to make clinicians more comfortable in advocacy roles. For instance, the PhilaKids

---

*dence Addressing Social History: Is It Influenced by Availability of Social and Legal Resources?*, 51 CLINICAL PEDIATRICS 625, 626 (2012); Stacey-Rae Simcox, *Lightening the VA’s Rucksack: A Proposal for Higher Education Medical-Legal Partnerships To Assist the VA in Efficiently and Accurately Granting Veterans Disability Compensation*, 25 CORNELL J.L. & PUB. POL’Y 141, 173-74 (2015); Daniel R. Taylor et al., *Keeping the Heat on for Children’s Health: A Successful Medical-Legal Partnership Initiative To Prevent Utility Shutoffs in Vulnerable Children*, 26 J. HEALTH CARE FOR POOR & UNDERSERVED 676, 679 (2015); Elizabeth Tobin Tyler, *Allies Not Adversaries: Teaching Collaboration to the Next Generation of Doctors and Lawyers To Address Social Inequality*, 11 J. HEALTH CARE L. & POL’Y 249, 278-79 (2008) (describing the Rhode Island Medical-Legal Partnership for Children, which provides “training for doctors, nurses, social workers and other health care providers on how to identify common legal issues encountered in medical settings”); Jeanette Zelfhof & Sara J. Fulton, *MFY Legal Services’ Mental Health-Legal Partnership*, 44 CLEARINGHOUSE REV. J. POVERTY L. & POL’Y 535, 538 (2011).

40. Benfer, *supra* note 31, at 148.

41. See, e.g., Melissa D. Klein et al., *Training in Social Determinants of Health in Primary Care: Does It Change Resident Behavior?*, 11 ACAD. PEDIATRICS 387, 387-88 (2011); O’Toole et al., *supra* note 39, at 630-31; *Training Partners and Students*, *supra* note 14.

42. See, e.g., Benfer, *supra* note 31, at 122-23; Tobin Tyler, *supra* note 39, at 252.

43. See, e.g., Klein et al., *supra* note 39, at 1066.

44. Benfer, *supra* note 31, at 126.

45. See Sabrineh Ardalan, *Constructive or Counterproductive?: Benefits and Challenges of Integrating Mental Health Professionals into Asylum Representation*, 30 GEO. IMMIGR. L.J. 1, 4-5 (2015).

46. See Taylor et al., *supra* note 39, at 678-79.

47. See Simcox, *supra* note 39, at 166.

MLP in Philadelphia, Pennsylvania, sought to increase clinician support for an energy insecurity program that required medical testimony to prevent utility shut-offs.<sup>48</sup> To further this goal, PhilaKids brought in “[a]n outside legal expert in utility law” to assuage clinicians’ concerns about “the idea of personal responsibility for outstanding utility bills,” “enabling continued debt forgiveness,” and “assumptions of faulty budgetary priorities . . . [among] families.”<sup>49</sup> An MLP for veterans at William and Mary Law School in Williamsburg, Virginia, took a different approach to improving the quality of physician testimony: it had graduate students in psychology evaluate veterans for mental health conditions and traumatic brain injuries with the Department of Veterans Affairs’ service connection standards in mind.<sup>50</sup> The subject of obtaining and improving formal clinician testimony, in the form of affidavits, exhibits, or live witness testimony, has received some attention,<sup>51</sup> but there is room for further exploration.

The period between referral and formal proceedings has rarely been assessed as an opportunity for clinicians to help address a patient’s legal needs.<sup>52</sup> Traditionally, the referral from the medical side is seen as passing off the patient to the legal side.<sup>53</sup> However, during this period, treating the patient’s nascent legal needs may fall within the purview of both the medical side and the legal side of the MLP.<sup>54</sup> This is especially true if the patient has not made it through the legal side’s intake or triage system yet, if the need does not yet involve formal legal proceedings, and if the clinician continues to see the patient on a regular basis.

A number of MLPs have had clinicians take a more active role in addressing the patient’s legal issues at this early stage. At the Health Education and Legal Assistance Project: Medical-Legal Partnership in Chester, Pennsylvania, clinicians have the opportunity to informally consult the MLP’s lawyers about spe-

---

48. See Taylor et al., *supra* note 39, at 679.

49. *Id.*

50. See Simcox, *supra* note 39, at 175-76, 179-80.

51. See, e.g., Ardalan, *supra* note 45, at 5; Spencer Rand, *Hearing Stories Already Told: Successfully Incorporating Third Party Professionals into the Attorney-Client Relationship*, 80 TENN. L. REV. 1, 2 (2012); Simcox, *supra* note 39.

52. See *infra* notes 55-58 and accompanying text. At the time of publication, these articles were the only articles in the NCMLP’s comprehensive database of academic papers that discussed this time period. See *Research*, NAT’L CTR. FOR MED.-LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/resources/academic-articles> [<http://perma.cc/ZE34-BN4C>].

53. See *supra* notes 37-44 and accompanying text.

54. See Charity Scott, *Doctors as Advocates, Lawyers as Healers*, 29 HAMLINE J. PUB. L. & POL’Y 331, 346-50 (2008).



cific patients or general legal topics.<sup>55</sup> Through these consultations, the clinicians sometimes gain enough information to “provide direct support to clients without the attorney having to retain formal representation.”<sup>56</sup> Similarly, lawyers at MFY Legal Services in New York City “regularly provide[] advocacy help to health care professionals as a first step” in resolving landlord-tenant issues, “especially when a patient’s housing provider is resistant to the patient returning” after inpatient mental health treatment.<sup>57</sup> Often, this informal advocacy resolves landlord-tenant issues “much more quickly than litigation,” and helps the patient have a smoother transition back to the community.<sup>58</sup> Though other MLPs have undoubtedly implemented other versions of these practices, they have not received much attention in the literature.

### III. EXPANDING THE CLINICIAN’S ROLE

I argue that the period after a doctor has identified a legal need is worthy of further study and experimentation. As far as it is possible to tell from the literature,<sup>59</sup> and from my experience working at an MLP, most MLPs seem not to be adjusting the traditional division of labor between clinicians and lawyers. Once a clinician identifies a legal need, responsibility for addressing the need usually shifts to the legal side of the MLP,<sup>60</sup> and the clinician only reappears later if needed for corroborating testimony in more formal legal advocacy.<sup>61</sup> At least two MLPs have altered this division of labor informally and reported positive, if anecdotal, results.<sup>62</sup> Building off of these anecdotes and my own experience at a veterans MLP, I argue that MLPs should think carefully about formally expanding the clinician’s role beyond spotting legal issues to include taking affirmative steps towards resolving those problems at their early stages.

There are several reasons to think that an expanded role for clinicians would further the MLP’s mission and improve services for patients. Most importantly, altering the division of labor between clinicians and lawyers would help resource-constrained MLPs prevent nascent legal issues from developing

---

55. Daniel Atkins et al., *Medical-Legal Partnership and Healthy Start: Integrating Civil Legal Aid Services into Public Health Advocacy*, 35 J. LEGAL MED. 195, 205 (2014).

56. *Id.* at 206.

57. Zelhof & Fulton, *supra* note 39, at 539.

58. *Id.*

59. *See supra* Part II.

60. *See, e.g., supra* notes 36-44 and accompanying text (discussing the literature on the referral process as the clinician’s primary role in the MLP).

61. *See supra* notes 45-51 and accompanying text.

62. *See supra* notes 55-58 and accompanying text.

into larger problems that require full-blown legal representation. The intake and triage systems used by MLPs typically prioritize patients with the most severe and developed legal issues and ration legal services in a way that does not fulfill their potential to effectuate “preventive law.”<sup>63</sup> Once a patient’s legal issue is sufficiently urgent to make it past the triage stage, his representation is likely to require more attorney time than it would have required earlier. There is an analogy here to the value of preventive care in medicine: earlier intervention in a potential or developing medical condition is likely to result in lower-cost and lower-risk solutions than would have been achieved if the condition had been allowed to fully develop.<sup>64</sup> Similarly, prevention in the legal context would likely reduce the amount of attorney time required to serve a client by reducing the likelihood of litigation, and the amount of medical care required to undo the damage caused by that client’s health-harming legal needs.<sup>65</sup>

The clinician who spots a nascent legal issue is in the best position to take preventive action for several reasons. At this stage, the clinician is already familiar with the patient’s health history, current treatment, and potential legal needs. As the person with the most information about a patient, the clinician is best placed to help the patient resolve the issue, either before referring to the MLP or while waiting for the legal side to finish intake and triage. This process avoids unnecessary delay as information is repeated from clinician to intake administrator to lawyer. Repeating a story—especially one involving a burgeoning dispute with a landlord or family member—can also be frustrating and sometimes painful for a patient.<sup>66</sup> Having the clinician take the first steps reduces the emotional costs<sup>67</sup> and the time costs of passing information to the legal side of the MLP.<sup>68</sup>

---

63. See Curran, *supra* note 18, at 603; Hallarman et al., *supra* note 17, at 187 (“The legal system is not structured to promote ‘preventive law,’ especially for low-income or otherwise vulnerable people . . .”); Tobin Tyler, *supra* note 39, at 254 (“Lawyers, particularly legal services lawyers, often despair that they come to a problem long after any legal solution can make a meaningful difference in a client’s life.”).

64. See Hallarman et al., *supra* note 17, at 186-87; *cf.* Krishnamurthy et al., *supra* note 8, at 385 (“A helpful analogy likens surgery to litigation—both call for the intensive, yet inefficient, allocation of resources focused on a single individual.”).

65. See Hallarman et al., *supra* note 17, at 186-87.

66. See Rand, *supra* note 51, at 2 (“Although attorneys use a variety of techniques to understand client stories, few take advantage of other professionals who are already hearing the clients’ stories.”).

67. See Ardalan, *supra* note 45, at 7-8.

68. As a general matter, the strategy of shifting work from the legal side to the medical side may also reduce monetary costs for MLPs for the simple reason that some patients’ health insurance will cover certain types of visits with certain clinicians. The legal side of an MLP typically has no such opportunities for third-party payment.

Finally, addressing early-stage legal issues can further the clinician's professional goals with respect to the patient.<sup>69</sup> Especially in practices that involve long-term treatment, clinicians often engage with their patients' life circumstances in order to effectively treat their mental and physical health conditions.<sup>70</sup> Often, early-stage dispute resolution is less about the law than about managing interpersonal issues—something that social workers, counselors, and therapists help their patients with every day. Patients often have to learn or relearn important life skills with the help of their clinicians after an illness or injury. Empowering patients to resolve problems on their own, without a formal advocate, especially when issues are not so far along that they require a lawyer, thus fits with the overall mission of a clinician's work. In other cases, early-stage legal assistance can involve securing government benefits or safe living conditions, both of which have immediate impacts on patients' health.<sup>71</sup> This both raises the overall quality of health care delivery and reduces the long-term burden on health care providers.

There are, of course, limits to the type and quantity of work on nascent legal issues that MLPs can assign to clinicians. Some legal issues should go to the legal side in the first instance, despite the delay and inefficiencies associated with referral, either because they are particularly risky and time-sensitive (e.g., when a patient has already received an eviction notice) or because they are beyond the expertise of the clinician (e.g., when a patient raises a civil issue that stems from criminal proceedings). Additionally, new responsibilities should fit as well as possible within the clinician's existing work style and substance—the pace of an emergency room physician's work is unlikely to accommodate greater responsibilities within an MLP. Finally, MLPs must not run afoul of state rules prohibiting lawyers from aiding nonlawyers in the unauthorized practice of law.<sup>72</sup> The model program below attempts to work through these issues.

---

69. See Scott, *supra* note 54, at 346-48. This paragraph also draws heavily on my experience at CVLC.

70. See, for example, the Department of Veterans Affairs' Supportive Services for Veteran Families program, which provides grants to clinics and other organizations that assist veterans in accessing a number of supportive services. *Homeless Veterans*, U.S. DEP'T VETERANS AFF., [http://www.va.gov/homeless/ssvf/index.asp?page=/home/general\\_program\\_info\\_regs](http://www.va.gov/homeless/ssvf/index.asp?page=/home/general_program_info_regs) [<http://perma.cc/A3K6-2B6K>] (describing the program); *Supportive Services*, U.S. DEP'T VETERANS AFF., [http://www.va.gov/homeless/ssvf/index.asp?page=/official\\_guide/supportive\\_services](http://www.va.gov/homeless/ssvf/index.asp?page=/official_guide/supportive_services) [<http://perma.cc/CLY9-GXZH>] (listing services provided by the program, including assistance with employment, money management, child care, and more).

71. See *How Civil Legal Aid Helps Health Care Address SDOH*, *supra* note 23 (listing health impacts of civil legal aid under the column titled "Impact of Civil Legal Aid Intervention on Health/Health Care").

72. See, e.g., CAL. RULES OF PROF'L CONDUCT r. 1-300 (2016); see also *infra* Part V (discussing this issue in further depth).

#### IV. MODEL CLINICIAN INTEGRATION PROGRAM

This Part outlines a program that would expand the clinician's role in an MLP to include assisting patients with nascent legal issues.<sup>73</sup> The program would involve: (1) having clinicians conduct standardized screening for disputes, problems with government benefits, and other early signs of potential legal problems; (2) empowering clinicians to take a pre-enumerated set of actions in response to nascent legal issues, short of referral to the MLP or while waiting for the MLP to complete intake; and (3) having clinicians follow-up with the patient. Further details about each of these steps follow.

##### *A. Clinicians Screen All Patients for Early Signs of Potential Legal Issues*

A screening regime designed to help clinicians recognize early stage legal issues would be somewhat different from one designed to produce referrals to the legal side of the MLP. Serious legal issues, such as impending evictions, lawsuits, or denials of government benefits, are perhaps easier to spot in a questionnaire or interview than less serious ones. However, most serious legal issues can be predicted: difficulty making rent or complaints from a landlord lead to eviction notices; getting behind on utility bills leads to shut-offs; tensions with spouses or co-parents indicate that a marriage or a child support arrangement is not working. At regular intervals, clinicians should ask about these types of early indicators of legal trouble. For example, questions about whether a patient gets along with her landlord, feels safe in her home, or has any trouble paying rent and utility bills could help identify a burgeoning landlord-tenant issue. To uncover nascent family law or educational issues, a clinician could ask about a patient's relationship with his co-parent, his child support obligations, or his child's experience at school. Questions about a patient's relationship with her employer and coworkers might point to potential wage theft, workplace safety, or discrimination issues.

Though this list of possible questions may seem extensive, especially for MLPs that have already established a screening practice for more developed legal issues, the screening would be tailored to avoid taking over the clinician's time with the patient. The list of topics would narrow significantly depending on the MLP's client base and the patient's characteristics (family, income sources, etc.). Questions would be phrased for "yes" or "no" answers to save time. Patients could fill out a screening form ahead of time so that the clinician would know which topics to discuss further in person.

---

73. The impressions and ideas underlying this section were formed during and after my time at CVLC, with particular input from staff attorney Darren Pruslow.

*B. If a Patient Raises a Potential Legal Issue, the Clinician Takes Steps To Help Resolve It*

MLPs should empower clinicians to help patients resolve potential legal issues before they require the assistance of a lawyer. Social workers and mental health practitioners in particular are well equipped to offer assistance with patients' interpersonal disputes, to coach them on ways to communicate and advocate for themselves, and to help them proactively respond to problems. Possible strategies might involve talking through strategies for de-escalating a conflict, helping a patient write a letter explaining a grievance, or role-playing a difficult conversation with the clinician taking on the role of a landlord, employer, or co-parent.<sup>74</sup> A clinician could also suggest that a patient keep a diary and other records about the early stages of a dispute to ease the flow of information to the MLP's legal side in the event of a referral.

These actions would complement the work that many clinicians already do with their patients. Discussing a patient's responses to everyday situations can form a significant part of clinician interactions, especially when the patient is, for instance, a veteran with post-traumatic stress disorder or a patient with a newly diagnosed chronic illness. This more focused approach to working through interpersonal conflict and other day-to-day issues could help patients avoid more serious legal troubles that could threaten their health.

*C. Clinicians Follow Up with Patients About Potential Legal Issues*

Clinician follow-up is essential to helping resolve patients' conflicts and to utilizing both sides of the MLP effectively. If a nascent legal issue escalates despite the clinician's help, the clinician can refer the patient to lawyers within the MLP if she has not already done so. At this point, the patient is more likely to make it through triage and be taken on as a client, having exhausted dispute resolution strategies. Upon referral, the clinician will provide lawyers with a history of the issue and the steps that the patient has already taken to resolve it. Waiting to make the referral until this stage means that by the time the case reaches the legal side, the patient will have exhausted nonlegal dispute resolution options, and the clinician and patient together will have begun to create a record documenting the actions they have taken and the results they have achieved.

---

74. The literature on conflict resolution and clinical practice undoubtedly has excellent suggestions about helping patients resolve conflicts, but evaluating these suggestions is beyond the scope of this Comment.

**V. REFRAMING THE ROLES OF DOCTORS AND LAWYERS IN THE MLP**

MLPs seeking to alter the roles of their clinicians will have to stay within the legal profession's boundaries. Legal practice is strictly limited to individuals who have been admitted to the bar.<sup>75</sup> States regulate unauthorized practice by bringing suits against nonlawyers, and state bar associations discipline lawyers who assist others in unauthorized practice.<sup>76</sup> The essential question for MLPs, then, is what constitutes legal practice. Though the boundaries vary by state, a Florida Supreme Court decision<sup>77</sup> provides a typical set of permissible and impermissible activities for nonlawyers that has informed similar guidelines in other states.<sup>78</sup> That decision determined that a nonlawyer can sell printed material advising clients on courses of action, sell sample forms, and transcribe clients' responses, but cannot advise clients on remedies available, help them prepare forms by asking questions, or tell them where to file or how to present evidence.<sup>79</sup>

Following these principles, a clinician cannot help a patient prepare forms or legal filings, nor can she give advice on available legal procedures and remedies. However, she can help a patient avoid formal legal action by employing an entire menu of other conflict resolution strategies, as described above.<sup>80</sup> In order to avoid crossing these boundaries, MLPs seeking to change the responsibilities of lawyers and clinicians should ensure that all parties know the difference between assistance with a potential legal issue and unauthorized practice of law.

The potential upsides of increasing clinician management of patients' legal issues may well call into question the rationale behind the current model of legal practice regulation. Outside of the MLP context, many scholars and practitioners have begun to push back on the traditional justifications for strict divisions between legal and nonlegal work.<sup>81</sup> The bar's limitations on nonlawyer

---

75. MODEL RULES OF PROF'L CONDUCT r. 5.5 (AM. BAR ASS'N 1983).

76. See, e.g., CAL. BUS. & PROF. CODE § 6126 (West 2003) (defining unauthorized practice of law as a misdemeanor); CAL. RULES OF PROF'L CONDUCT r. 1-300 (2016) (prohibiting the unauthorized practice of law); MASS. GEN. LAWS ch. 221, § 41 (2016) (authorizing punishment in the forms of fines and imprisonment for falsely representing oneself as an attorney).

77. Fla. Bar v. Brumbaugh, 355 So. 2d 1186, 1194 (Fla. 1978).

78. See, e.g., People v. Landlords Prof'l Servs., 264 Cal. Rptr. 548, 553 (Cal. Ct. App. 1989); Iowa Supreme Court Comm'n on Unauthorized Practice of Law v. Sturgeon, 635 N.W.2d 679, 683-85 (Iowa 2001); *In re Thompson*, 574 S.W.2d 365, 368 (Mo. 1978) (en banc).

79. *Brumbaugh*, 355 So. 2d at 1194.

80. See *supra* Section IV.B.

81. See, e.g., DEBORAH L. RHODE, ACCESS TO JUSTICE 92 (2004); CLIFFORD WINSTON ET AL., FIRST THING WE DO, LET'S DEREGULATE ALL THE LAWYERS 57-72 (2011); Derek A. Denckla,

practice were traditionally thought to protect consumers of legal services by ensuring high standards of quality and expertise and to protect vulnerable populations from people who misrepresent themselves as lawyers.<sup>82</sup> More cynical commentators trace these restrictions to lawyers' interest in protecting their professional monopoly on legal services and driving up their rates.<sup>83</sup> There are reasons to think that none of these justifications remain valid given the realities of today's market. From the consumer side, bar admission is a weak form of quality control and standard setting.<sup>84</sup> From the lawyer side, a monopoly on legal services orients the nature of the profession towards a certain kind of legal work while leaving a great deal of deadweight loss at the lower end of the market.<sup>85</sup>

At least so far, MLPs seem to have filled gaps in the supply of legal services without sacrificing quality or threatening the market for paid lawyers. The evidence will be even stronger if clinicians prove to be capable of handling the additional responsibilities that I have described above. As they evolve, MLPs may provide further evidence in favor of the argument that state bars should regulate rather than prohibit the practice of law by nonlawyers.<sup>86</sup> For now, I do not think MLPs need to go that far—they have room to expand the roles of clinicians without straying into the realm of true legal practice.

## CONCLUSION

MLPs should consider expanding clinicians' roles to include early assistance with nascent legal issues. This type of assistance can help conserve attorney

---

*Nonlawyers and the Unauthorized Practice of Law: An Overview of the Legal and Ethical Parameters*, 67 *FORDHAM L. REV.* 2581, 2581 (1999) ("This type of prohibition overwhelmingly affects people of limited means, who are unable to retain a lawyer based on an inability to pay fees or, in the case of a pro bono lawyer, based on the limited availability of free legal help.").

82. See, e.g., RHODE, *supra* note 81, at 82-83 (describing the legal profession's concern that nonlawyers will not "meet the competence and ethical standards established for licensed attorneys").
83. See, e.g., WINSTON ET AL., *supra* note 81, at 57-72 (examining how legal licensure requirements protect lawyers' earning premiums).
84. Denckla, *supra* note 81, at 2594 (noting that lawyers "may not be any more competent than a nonlawyer specialist in performing certain specific tasks" and that "lawyers have no exclusive claim to integrity despite the operation of disciplinary rules which ostensibly enforce good behavior").
85. *Id.* at 2598-99.
86. See, e.g., RHODE, *supra* note 81, at 92 (suggesting that "the goal should be to craft regulation that addresses legitimate ethical concerns without unduly restricting cross-professional collaboration"); WINSTON ET AL., *supra* note 83, at 83-94 (arguing that deregulating entry to the legal market "would generate benefits that greatly exceed any costs").

time and resources by resolving disputes before they escalate into conflicts that require legal representation. It can also further clinicians' objectives with respect to their patients' health. Although restrictions on the unauthorized practice of law set a boundary for the clinician's role, MLPs have room to expand this role without infringing on activities reserved for lawyers. My hope is that further innovation in this field will help lawyers and clinicians refine their roles to reflect the best that each profession has to offer.

JESSELYN FRILEY\*

---

\* Yale Law School, J.D. 2016. I would like to thank Margaret Middleton, Darren Pruslow, Millie VandenBroek, and the rest of the attorneys at Connecticut Veterans Legal Center for opening their doors to me and for inspiring this Comment. I am also grateful to Professor Abbe Gluck for her generous support and to Adrienne Lee and the *Yale Law Journal* staff for their thoughtful and helpful edits.