

All Care is Health Care: How Healthcare-Legal Partnerships Are Challenging the Biomedical
Paradigm¹

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All Care is Health Care: How Healthcare-Legal Partnerships Are Challenging the Biomedical Paradigm

This project comprehensively examines how healthcare-legal partnerships (HLPs) are challenging the biomedical paradigm. I explore this in clinics through rich semi-structured interviews with HLP advocates (social workers, healthcare administrators, nurses, lawyers, and physicians) and focus groups with patients. In this paper, I will highlight the ways in which on-site legal services in clinics help in breaking down barriers that limit access to care and thus reduce anxiety and stress in patients. I will also argue that while helpful, HLPs continue to operate under a neoliberal biomedical model-based health care system and hence, do not provide a comprehensive solution to the complex health needs of patients. Health issues are not just legal issues; they are social issues that need to be addressed using a structural care approach.

Keywords: health equity, healthcare-legal partnerships, structural care, structural competency

Doesn't the Constitution guarantee each and every citizen the right to life, liberty, and the pursuit of happiness? And the government cannot infringe upon those rights, correct? Why is the Social Security Administration infringing upon my very right to live [then]? It's 18 below zero, with a wind-chill of negative 25, so I am not equipped to survive out there [as a homeless person].

Elijah Jackson shakes his head in disbelief and almost chuckles. This is the first time he has taken a breath; he expressed his story in a rushed manner after staying quiet for almost twenty minutes of the focus group. He takes off his cap and bows his head, showing bald patches on his dark-skinned scalp from hazardous working environments and chemical burns. A middle-aged African American, Elijah has battled through homelessness, suicidal ideation, and clinical depression in the last six years because his social security benefits were abruptly cut. He credits his survival to God, his resilience, and the support offered through legal aid at St. Paul Clinic. His feelings of frustration and anger—visible through his raised voice and energetic moving of both hands—slowly transform into feelings of gratitude to be alive. He looks up at the ceiling as if to thank God and places his hands on the roundtable as he continues to share his story.

Elijah goes on to explain his most recent legal interaction. “I came to [see] my doctor for a bacterial infection in my foot that made it difficult to walk.” The bacterial infection was caused by an unclean carpet in his house, for which the landlord was unwilling to take responsibility. On sharing this with the physician, Sarah Parker, the on-site legal attorney, became involved in the process and helped in getting the carpet clean at no cost to Elijah.

I felt stressed and helpless to retaliate against a protected class – I didn't know what to do. But Sarah, she wrote a letter and she got it done. It was helpful in fixing my bacterial infection, but also, I suffer from clinical depression and anxiety, so this [help of holding the landlord accountable] was very beneficial.

Elijah's story perfectly encapsulates why healthcare-legal partnerships are invaluable. Conceptually, these partnerships highlight how health care needs are intertwined with social needs (such as housing, food, etc.) and operationalize this by adding lawyers to the healthcare team. As

is evident in Elijah's case, having on-site legal support in health clinics helps in providing immediate support to patients in fixing barriers that limit access to quality care. Given Elijah's low socioeconomic status, he would not have been able to fix a housing situation detrimental to his physical and mental health without the help of free legal services.

Health and illness for many years have been conceptualized as private life events; you suffer and heal on individual levels. While illness can feel like an entirely personal process, social factors such as where you live, breathe, learn, work, and grow govern which groups experience which illnesses with what consequences. The social determinants of health broadly include political, social, and economic factors, whose distribution impacts both individual and community health. Several studies show that social determinants of health such as education, race/ethnicity, sexual orientation, socioeconomic status, income, and neighborhood conditions, exacerbate poor health outcomes and drive health inequities (Brennan Ramirez, Baker, and Metzler 2008; Minnesota Department of Health 2014; Tyler 2011). For instance, infant mortality rates increase as the mother's level of education decreases. African Americans are sixteen times more likely to get HIV/AIDS than white, non-Hispanic persons, and are more likely to die of breast cancer. The American Indian, Hispanic/Latino, and African American communities are plagued with the highest rates of obesity. Low socioeconomic status is associated with an increased risk for many diseases, including diabetes, chronic respiratory diseases, and cardiovascular diseases. The rising problem of homelessness disproportionately impacts communities of color (42% of those who experience homelessness are African American) and leads to several mental illnesses and substance abuse. Lower-income and minority communities are less likely to have access to grocery stores with a variety of healthy foods (Brennan Ramirez et al. 2008; Minnesota Department of Health 2014; Tyler 2011).

Despite growing evidence showing that unmet social needs directly translate into poor health (Robert Wood Johnson Foundation 2011; WHO 2008), creating major health disparities, our health care system continues to operate under a strict biomedical model (Atkins et al 2014). A critical component of this model is the “clinical gaze.” In the words of Foucault (1975), clinical gaze can be defined as adopting a “myopic view” that focuses on the organ or the lesion instead of the person suffering. The clinical gaze is both an instrument and product of biomedical culture, wherein physicians place more value on their own “objective” observations and biotechnical testing rather than accepting narratives provided by the patient themselves (Konner 1987).

A biomedical model thrives in a neoliberal society such as the United States, wherein health is not a right, but a private commodity. Similar to neoliberalism, this model builds upon principles of individualism. It perpetuates neoliberal ideologies, wherein patients are supposed to embrace the concepts of self-interest and self-discipline. Health is seen as an individual responsibility; regardless of the political, economic, social, and structural forces, individuals are held accountable for the health choices they make (McGregor 2001). Such individualization of health often shifts the blame of living in under-resourced communities and suffering from illnesses onto patients from marginalized communities. Seth Holmes (2013) explains the characteristics of patient blaming and clinical gaze in *Fresh Fruit, Broken Bodies* by narrating the experiences of Abelino, a migrant farm laborer who suffers from knee pain. Abelino’s knee pain in a biomedical space is stripped of any social, political, economic and structural meanings; the role of structural forces such as international economic policies and his status as an undocumented Triqui man, both of which render him at the bottom of the labor market, are invalidated. By placing more emphasis on radiological studies, such as X-rays and MRI, and on the “objective” and “real” truth, the physician—in a biomedical space—diminishes Abelino’s descriptions of his social and employment history, and his bodily experiences. As explained in the book, the overemphasis on biotechnical testing and “science” invalidates the experiences and narratives presented by the

patients, and leads to the formation of stereotypes such as, “Mexicans don’t comply/understand” and “Mexicans are hard to work with.” Other examples include physicians placing the blame on individuals suffering from obesity due to their overreliance on fast foods, rather than recognizing the role of poverty, homelessness, food insecurity, and other social conditions in making those choices; and shaming patients suffering from diabetes or hypertension for not going on regular walks without taking into consideration neighborhood danger or lack of access to parks and other recreational spots (Metzl and Hansen 2014). The emphasis on biomedicine in clinical settings strives to further streamline health care services such that physicians focus only on fixing the biological ailment; other social, political, or economic problems faced by the patients (that irrefutably have an impact on the health) should be “fixed” by other disciplines. Separate divisions or “specializations” in fields of social work, law, mental health, public health, dental health, and so on, create rigid and inaccessible structures which prevent interdisciplinary action and intervention, thereby leaving patients high and dry (McGregor 2001).

In an effort to combat the health disparities that disproportionately impact racial and ethnic minorities (Minnesota Departments of Health 2014), clinics, while operating under the same biomedical models, have implemented cultural competency frameworks to realize the role of culture on health. These frameworks include interpreter services, recruitment and retention policies, training, coordinating with traditional healers, use of community health workers, culturally competent health promotion, the inclusion of family/community members, immersion into another culture, and administrative and organizational accommodations (Brach and Fraserirector 2000). While well-intentioned, these frameworks shift the blame for illnesses from the individual patient to the culture of the individual. Cultural competency frameworks, while helpful in acknowledging the role of culture in health, are inherently reductionist. They treat culture as monolithic, place blame on a patient’s culture, emphasize cultural differences, and neglect structural power imbalances. Lastly, they fail to recognize biomedicine as a cultural system

itself—all of which essentially drive health disparities (Kleinman and Benson 2006; Lee and Farrell 2006).

Through this framework, physicians are exposed to homogenized, static and packaged ideas of culture, which are used in estimating patient behavior, preference or response in the clinic, thereby diminishing health care inequality. By making the definition of culture static and synonymous with ethnicity, nationality, and language, the framework thus becomes a series of “do's and don'ts” that define how to treat a patient of a given ethnic background and stereotype groups such as “Mexicans believe this,” “Chinese believe this,” and so forth (Kleinman and Benson 2006). As Helena Hansen recalls from her cultural competency training during medical school in her interview with Perez (2015), the structure of cultural competency reinforced racial stereotyping. Medical students were trained to prescribe red tablets to Chinese patients since they liked the color red, and to let all members of Mexican families into the exam room since Mexicans value family. These are but a few examples of how cultural competency models guide the provider to come with pre-determined ideas about certain cultures and patients, therefore silencing the patient voice, their social realities, and individual differences. Highlighting the pitfalls of such frameworks, Jonathan Metzl and Helena Hansen (2014) emphasize the need to move away from cultural competency frameworks to focus on the social realities of the patients. Introducing structural competency models as the replacement, Metzl and Hansen strive to operationalize social determinants of health into the delivery of care in order to effectively address and fix these disparities. These models include training healthcare professionals with structural awareness and humility, that is, understanding how social and economic inequities impact the lives and consequently, the health of patients. They explain, “Stigma and cultural conflict in health-care settings needs be understood as the sequelae of a host of financial, legal, governmental, and ultimately ethical decisions with which medicine must engage politically if it wishes to help its patients clinically” (Metzl and Hansen 2014:2).

As is evident through the social determinants of health, the social realities of patients severely impact their health; hence, it is important that physicians are trained to not only understand the social context in which their patients are living, but also implement that into the delivery of care. Stepping outside of the rigid bounds of a biomedical model, it is extremely vital to engage the different stakeholders in health including lawyers, social workers, mental health professionals, and oral health clinicians in order to collectively and structurally address the needs of the patients.

This structural focus in health care is also prevalent in human rights culture and theory. The Universal Declaration of Human Rights, declared in 1948, emphasized that everyone has the right to a “standard of living adequate for health and well-being of himself and his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, or other lack of livelihood in circumstances beyond his control” (Wronka 2017:16). However, it did not mandate a legal obligation for countries to follow the declaration.

Based on Immanuel Kant’s principle stating that each of us has a worth or a dignity that must be respected, we broadly understand moral rights as negative rights and positive rights. In a neoliberal society such as the United States, “negative rights”—rights to life, liberty, and the pursuit of happiness—are the only legitimate rights as they do not impose an obligation on others to provide you with something (individualism). These rights are called negative rights because such rights impose a “negative” duty on people—the duty not to interfere with an individual’s activities in a certain area. On the other hand, positive rights (or commonly known as welfare rights) are “positive” in that they seek “positive” assistance from others in ensuring proper human well-being for all, such as securing an education, access to health care services, and food (Andre and Velasquez 1990). Health falls into the category of positive rights, whose pursuit is looked at as infringing upon the rights of other people. In other words, ensuring universal access to health

care would translate into levying a tax, which neoliberals argue would provide “unearned” goods to those who do not deserve it and be an “intolerable burden” (Bradley 2010).

The rigid demarcation of “positive” and “negative” rights, however, is flawed: human rights are inherently interdependent and indivisible. For instance, negative rights protect equal individual opportunity. However, it is important to realize that individuals have different levels of opportunity based on their health status; illness impairs the typical functioning of humans, and thus restricts the range of opportunity. Whether it is a chronic illness such as muscular dystrophy that places physical limits on the individuals or a mental illness such as Down Syndrome that hampers the cognitive development of individuals, it is evident that illnesses place additional barriers, thereby limiting the range of opportunities. Hence, in order to provide equal opportunity to individuals, it is vital to provide health care to restore, as closely as possible, normal functioning. In this way, if there is an obligation to protect individual opportunity, promoting and restoring health is a key component in fulfilling that obligation (Bradley 2010).

A Medical-Legal Partnership, or Healthcare-Legal Partnership (HLP), is a new model of care that has a clear structural focus; it integrates the social determinants of health and works towards bridging the gaps in health care by contextualizing health issues as legal issues. Since barriers such as food insecurity, income insecurity, lack of healthcare insurance, poor housing conditions, lack of education, and lack of personal stability can be legal issues, adding a lawyer to the healthcare team can allow for effective and quality care for patients (Atkins et al 2014; Beeson, McAllister, and Regenstein 2013; Huston, Zinn, and Leal-Castanon 2011; Murphy et al 2015). As is evident in Elijah’s case, medical care that does not include social realities in the medical plan is counterproductive; he was going to have that bacterial infection regardless of the medication unless the carpet was changed. Having on-site legal support in health clinics helps in providing immediate support to patients in fixing barriers that limit access to quality care. Sarah, as a lawyer,

had the power and resources to intervene and hold the landlord accountable, consequently making living conditions better for Elijah.

HLPs strive to provide access to health as a right by ensuring access to other social rights, such as affordable housing, insurance, and so on. They provide on-site legal assistance to patients in the form of consultations, brief advice, and direct legal representation. Patients are connected with on-site attorneys after being screened for unmet legal needs by trained clinicians. These partnerships deal with a varied range of legal issues including housing, food insecurity, disability, immigration, health care access, and income maintenance. Contrary to traditional health care systems, wherein physicians refer patients to seek legal support without considering social factors such as availability of transportation, or only focus on “fixing” the illness through medicine, this collaboration and on-site representation provide sustainable and holistic health care services to patients.

HLPs are extremely powerful as they hold the potential to effectuate policy change at federal, state, and local levels to improve the health and well-being of populations. Witnessing the intertwined relationship of health and legal issues through patient cases provides lawyers the agency to highlight the important and often missing voices of patients, and hence, pioneer advocacy initiatives for health care access, safe housing, and other social rights that have an impact on health. For instance, HLPs in Cleveland helped resolve some immigration barriers for survivors of domestic violence and other crimes by advocating for the passage of U visas, which offer protection to victims of crime and domestic violence by allowing them to stay in the US. Other examples include improved disability eligibility requirements, safe affordable housing, and fuel assistance programs (Tyler 2011).

While there is salient literature available on why such partnerships are important and on the benefits of investing in HLPs, there is limited literature available on their impact on patient health outcomes. Much of the data that evaluates HLP service quality is often preliminary in nature

with no existing common measures of quality, outcomes, and so on. The study conducted by Zuckerman et al (2004) is one of the few studies that mention outcomes of HLPs. It highlights the outcomes of providing legal aid in terms of housing subsidies obtained and benefits granted; however, there is little translation available about what these outcomes mean from a clinical and population health perspective (Beeson et al. 2013).

Furthermore, patient voices are completely absent from the literature. There are no studies that provide a patient narrative around the impacts of HLPs on health outcomes. Moreover, there is a dearth of literature on the limits of using legal aid services to effectively advance health equity (Beeson et al. 2013).

This project evaluates the impacts and challenges of HLPs in two rural and two urban neighborhood clinics in Minnesota through interviews with HLP advocates (lawyers, physicians, healthcare-administrators, nurses, and social workers) and focus groups with patients. In this paper, I will highlight the ways in which on-site legal services in clinics help in bridging the barriers that limit access to care, reducing anxiety and stress in patients. I will also argue that while helpful, HLPs continue to operate under a neoliberal biomedical model-based health care system, and hence, do not provide a comprehensive solution to the complex health needs of patients. Health issues are not just legal issues; they are social issues that need to be addressed using a structural care approach.

I am defining structural care approach as a three-pronged strategy of contextualizing health issues as social issues. The key facets—each of which is a precondition for the other—include: (1) operationalizing structural competency as defined by Metzl and Hansen (2014) in medical education to focus on the structural barriers faced by patients, and to address these issues and patients themselves with humility, (2) engaging different key stakeholders in health by establishing on-site partnerships for social care such as food shelves, housing, pharmacy, and so forth, and (3) having lawyers as patient advocates in this restructured healthcare team, wherein they pioneer

advocacy initiatives based on patient stories to break systemic barriers to health care such as lack of affordable housing, healthy food supplies, and so forth.

METHODS

The central question of my study is: How do HLPs challenge the biomedical paradigm? In what ways do they not?

To answer this question, I employed a two-pronged approach: focus groups with patients and semi-structured interviews with HLP advocates. A combination of these qualitative methods provided me with rich, in-depth narratives from patients and HLP advocates alike on the impacts and challenges of HLPs. Specifically, the focus groups explored how and if legal services have helped produce positive health outcomes in patients, while the interviews focused on where these partnerships succeed and fail.

Initially, I had intended to focus on one neighborhood clinic in Minneapolis to understand how its HLP operates and if it benefits the involved stakeholders (patients and HLP advocates). However, I struggled immensely with access in this pursuit; clinics denied my request because of not being able to take the responsibility of supervising an undergraduate student. It was in this process of being rejected that I learned about the Upper Midwest Healthcare Legal Partnership Learning Collaborative, comprised of HLP advocates. After receiving an approval from the Institutional Review Board at the University of Minnesota, I introduced my study in one of the collaborative's scheduled meetings and was able to gain access to clinic staff and patients. Furthermore, clinic staff helped me recruit patients for the focus groups through phone calls and recruitment flyers available in Somali, Hmong, Arabic, Spanish, and English.

In total, I conducted eighteen semi-structured interviews with HLP advocates between October 2017 and January 2018. Of these eighteen, four identified as males and fourteen identified as females. They had a range of working experience within their current position, with some

individuals new to the position (about one year) and others having as many as forty years of experience. Four of these interviews were in-person; the remaining fourteen were conducted over the phone.

To explore patient perspectives on the experience of HLPs, I conducted three focus groups in clinics in Minneapolis, Mankato, and St. Paul between January 2018 and February 2018. In total, fourteen patients shared their stories: two identifying as male, and twelve identifying as female. In terms of race, four individuals identified as white, eight identified as African American, one identified as Burmese, and one identified as Mexican. All the names of clinics, patients, and HLP advocates have been changed to maintain confidentiality.

Even though the sample size is small and thus not fully representative, my study provides important and unheard patient narratives, along with thoughtful conversations with HLP advocates from varying disciplines. Since the movement for HLPs is relatively new, all of these in-depth, rich, and vulnerable personal stories of the most important stakeholders in health are extremely vital. Moreover, as the results show, patients and HLP advocates also share how their experiences are not unique, but instead are experienced by many of their community members.

Coding and Analysis

I followed a systematic process to code and analyze the rich discussions captured through interviews and focus groups. A digital recorder was used to record all of my conversations with participants, which were transcribed by me as verbatim as possible. Data for this study was coded using ATLAS.ti to sort and generate quotes from interview transcripts based on my pre-created codebook consisting of fourteen codes such as advocacy work, white privilege, holistic care, structural care, inaccessibility, legal issues, pro-HLP, and so on. Several of the interview passages were assigned to different codes based on the description of the codes. See Appendix A for the codes with their appropriate descriptions.

LEGAL CARE IS HEALTH CARE: BREAKING DOWN BARRIERS

St. Paul Clinic was the site for my third focus group and I walked in having no expectations. I had already conducted two separate focus groups at Minneapolis Clinic and Mankato Law Center with very low participation rates. Even though recruitment showed immense promise with about twenty to twenty-five participants showing a keen interest in sharing their stories, only two individuals showed up to the focus groups each time. The conference room at St. Paul Clinic was medium in size with a capacity to fit about ten to twelve participants. The black chairs with no armrest or support were set up around a roundtable with minimal space between them. It was 1:15 pm, fifteen minutes after the focus group was supposed to start, and only two participants had shown up—this was typical. I started to introduce myself, why I was here and transitioned into explaining the consent forms. At 1:30 pm, I was pleasantly surprised as four more participants, talking amongst each other enthusiastically, entered and found spaces in the room. The room was suddenly filled with energy, conversations, and voices. I had to speak loudly to try to get the attention of the people and as I got to the point, two more individuals entered the room. We were already about forty minutes behind schedule, but I tried not to think about it. Even though the chairs were uncomfortable, individuals in the room were very forthcoming in sharing their most intimate details with each other, requiring no probing from me whatsoever. Unlike other focus groups, I was just another participant as the room continued to fill with loud voices, sometimes talking over each other.

Aung Khun whispers something in Burmese to her interpreter as Elijah is talking, preparing for her turn. Her wrinkled skin and sunken eyes gave away her age as she slouched into her chair with one hand placed on her left cheek, expressionless. Mr. Ma starts speaking on her behalf in English and her eyes are fixated on me. Mr. Ma, with a smile on his face, summarizes Aung's journey at St. Paul Clinic. A low-income middle-aged woman, she runs a house consisting of three children with no other familial support. A diabetes diagnosis—which includes consistent insulin

dosages, expensive prescription drugs, and a strict diet to follow—and a rejected social security benefits application only made things more stressful.

A couple years ago, she [became a] diabetes patient and then, [started] taking a lot of medications and insulin too, so she wanted to apply [for] supplemental security income. She tried [to apply] by herself first, but they denied her. She was frustrated and upset because she doesn't have money and she needs to support her kids and like others here, she also has these [health] problems. That's why she told the doctor she wants to apply for the supplemental security income, so they [connected her with] Sarah Parker [the attorney on site]. Finally, she made it, she got the \$1500 check in last month. That's why she [hopes that] everybody can work with Sarah, so she can help everybody with their troubles.

With Sarah Parker's help, Aung was able to repeal her decision and receive a check of \$1500 to support her family and her health. The importance of that check was visible in the tears falling from Aung's eyes. Unable to speak English, she communicated her gratitude by extending her wrinkled lines through a soft smile, never moving her eyes away from mine. The loud simultaneous claps by participants after sharing success stories signified solidarity. All of them share similar lived experiences when it comes to accessing health care services and/or legal support at the clinic—lived experiences of running through homeless shelters as fiercely and quickly as the winds in Minnesota, of navigating life on limited income and resources. Every one of the patients who participated in the focus group was on Medical Assistance (representative of Sarah's overall patient/client population). The tears shed while articulating stories signify the importance of these partnerships. All eight participants unequivocally stated that having Sarah present on-site to provide immediate support was instrumental in accessing quality care and that without this support, they would not know where to go and what to do.

I felt the same sentiment and energy as I spoke with HLP advocates. I met with Sarah Parker on a typical snowy Tuesday in Minnesota—consisting of negative 20-degree wind chill and delayed public transit. Setting an appointment with Sarah had been challenging, with several email exchanges, but she found thirty minutes to spare in the morning and I took it. St. Paul Clinic is conveniently located three blocks away from the light rail station; the three-block walk, however,

was anything but convenient. In the middle of what felt like a momentous snow trek, I found myself staring at a pile of snow that was almost as tall as I was and clearly had not been shoveled in a while. I finally found the clinic, tucked away in the corner of a street in such a way that I could have easily walked past it if it weren't for my slow and careful walking.

I entered St. Paul Clinic to a foggy welcome sign which had different languages on it. Cleaning my glasses did not provide any sense of clarity, however. There were what seemed to be two haphazard lines consisting of patients trying to either get checked in or get a new appointment. I walked towards the waiting room of the clinic—same as the lobby—and stood awkwardly processing that I was almost ten minutes late to my interview. The receptionist sent me up one floor, which is when I noticed that the clinic, consumed by the loud voices and large crowds, was not so small after all. Sarah, with one hand opening the staff door and the other holding the phone to her ears, was patiently waiting for me. Fortunately (or unfortunately), the snow storm meant that her day had drastically opened up as many patients did not show up for their appointments.

Sarah's office was the complete opposite of her personality. An incredibly small corner office, its empty walls were painted with a melancholy off-white hue. Her desk was neatly organized with pamphlets about her services in different languages with a couple scattered visiting cards. Sarah grabbed a seat near her computer and picked up a piece of paper from her desk—she had printed out the questions we were going to talk about and had scribbled some tiny, messy notes all over the page. Sarah has been working at St. Paul Clinic for the past year; the clinic received a grant to establish their HLP and Sarah is a part of that pilot.

Despite a general shyness that I gathered from what seemed to be some rehearsed answers, she clearly exhibits passion and love for her patients and for ensuring a system that works for them. As Elijah articulated, “She is very compassionate, very accommodating, very caring. She goes above and beyond her job always.” In addition to supporting patients with their legal issues, she spends a significant amount of her time facilitating trainings for social workers, physicians, and

other healthcare professionals in the clinic on how legal issues manifest themselves within health, how to screen patients effectively, and the latest legal changes/policies (ex: immigration). In every answer, regardless of the question, she cleverly and passionately included how her being on site has made all the difference, as though I were the funder evaluating the partnership's efficacy.

A lot of barriers have been broken down because I am on site and able to help clients. So, for example - the transportation. The clients are there for medical appointments already and they can usually stay for a short period of time to speak with me. Same thing with the phone conversations [using] the interpreters - when they are able to meet with me in person, I am able to tell them "you can call, this is my phone" and I physically show them the phone. It's right there in my office - "this is the number to get to this phone. Call me and let me know your name and I will get an interpreter online for us." Physically being there on site helps me reach patients who don't know what legal services are or don't think they need legal services - because my presence encourages the providers to ask more questions and offer those services that they might not have offered otherwise - probably 50% less likely that they would have accessed our services. My presence has made a huge difference.

In many ways, Sarah's answers effortlessly expand on the stories of her patients—Elijah, Aung, and other participants—who described how they were able to address their health needs because of legal services. Sarah confirms how her patients have barriers in the form of transportation, language, and financial status. Having a lawyer as part of the healthcare team helps in bridging those barriers by providing on-site, free-of-cost legal services.

Ashley Pratt was of the same opinion—lawyers are able to break down several barriers, thereby making health care possible for patients. Ashley is the founder and executive director of Cancer Foundation, a non-profit organization that specifically caters to cancer patients and helps in making their care affordable, accessible, and possible by providing legal representation. Ashley and I met each other unusually; she heard about me through one of the lawyers I had interviewed before. She reached out and expressed her interest in my project, wishing to meet with me. Our first meeting was informal and focused on my story. We met at a loud coffee shop, full of college students, where she bought my coffee for me. A tall, white lady probably in her 50s, she reached the coffee place before me and was waiting in a high chair with a big smile on her face. Despite

this being our first meeting, she gave me a warm hug and made it seem like meeting at coffee shops was our tradition. As we sat down and went through the stereotypical introductions of names, titles, and so forth, she started probing enthusiastically and asked questions regarding my project: why I was doing it, how I was doing it, and what's my "story." I felt obligated to share how my intersectional identity as an international student of color has made it extremely difficult to understand the payment structures of health care delivery systems; hence, accessing quality care is always beyond distressing—which is also what brings me into this project of navigating the relationship between legal and health issues. We chatted about my life and some random topics here and there for a good thirty minutes and left the coffee place with a set date for a formal interview—this time with her as the interviewee.

When I called Ashley, I could picture her tucking little strands of her long blonde hair behind her ears, as she repeatedly did in our meeting, conveying her enthusiasm. This interview was different from all my other interviews; it was not with someone housed within a health clinic and part of an established HLP. Even though Cancer Foundation does not have an established connection with a specific cancer clinic due to funding issues, they are available to clients through referrals from oncology social workers, their cancer help hotline, and through their legal clinic at Spirit House (a recovery place that provides free accommodation to cancer patients and their caregivers). The client dynamics at Cancer Foundation were inherently different from those at neighborhood clinics in terms of healthcare insurance; they are low-income individuals who are either on private insurance or insurance through an employer, with only a very small proportion on Medical Assistance. Despite the differences in the demographics and the different ways in which I phrased my questions, Ashley always reinforced how having lawyers on healthcare teams is essential to quality care.

I think that there are clients who come to us with just a whole bunch of worries. I mean, they are dealing with lots of different legal issues because of the seriousness of their health crisis. So, I think getting help, based on what they tell us, is a *huge* help for them in terms

of reducing stress and just getting some answers. For some of our clients, legal care has made their health care possible. We have had clients who have needed a bone marrow transplant and their perfect donor is the sibling back in their old country, but they have been blocked from coming here to donate. So, we have been able to [work with] lawyers who can get us the red tape and get the sibling here. It's been hugely helpful to the folks who need the help.

Ashley elaborated that a cancer diagnosis comes with a lot of stress, especially for those on low incomes. Cancer patients have to suddenly think about estate planning, transition out of their jobs, apply for benefits, figure out their cancer medical treatment plan, and so forth—all of which have immense financial implications. All of these factors are not medical in nature but heavily impact the medical care of cancer patients. Being low-income in this health crisis greatly limits access to care since cancer treatments are ridiculously expensive and, as Ashley explained, sometimes dependent on immigration status. Having a legal representative, free of charge, helps in mitigating this additional stress and anxiety, and makes health care accessible and possible.

LEGAL CARE IS HEALTH CARE: POSITIVE HEALTH OUTCOMES

The benefits of stress and anxiety reduction are not limited to the cancer patient population; overall, on-site legal services help in reducing stress and anxiety levels in low-income patients, who live harsh social realities. Debra Johnson, along with other patients, voiced this aptly: “stress literally kills you.”

Debra was one out of the two white participants in the focus group I conducted at Mankato Law Center. She entered the enormous conference room reserved for the focus group exactly at our scheduled time of 1:00 pm—I was still setting out the coffee, cookies, and consent forms. I was running a little behind on schedule because I had not anticipated how long it would take to find an Uber driver who would take me from Minneapolis to Mankato. Since I do not know how to drive and the “public transportation” options would take more than nine hours to reach, I was relying on the limited number of Ubers available. After two drivers canceled on me because of the

long trip, I finally managed to get to the destination. Debra's on-time arrival further threw me off because I did not expect participants to be on time, based on my previous focus group experiences.

Debra is an independent spirit; she entered the room with a sense of confidence and a warm smile, introducing herself before I could even say something. She started asking questions as I was arranging the room and it felt like the tables had been reversed, quite literally. She was immensely surprised when I told her that I came all the way from Minneapolis for this. She was completely aware of the lack of transportation prevalent in the communities of Mankato. "I can't imagine coming to this place without my car. It also helps that I live right around the corner. You cannot rely on any public transportation here – it is so limited," she said nonchalantly as if this was not a big deal at all.

Debra first used legal services when she came in for her dental appointment at Mankato Clinic. Mankato Clinic is home to several holistic partnerships such as on-site dental services, pharmacy, mental health services, and primary care. She remembers bringing up her property disputes and housing issues to one of the healthcare professionals during her visit, who then referred her to the Mankato Law Center. Prior to this, she did not even know about the Law Center; her face had a raised eyebrow and a confused grin as she tried to both explain and comprehend that these legal services were free of cost. While she did not receive legal care on site, she mentioned how that referral has been invaluable for her health—physically, emotionally, and mentally.

It was through the Mankato Clinic, the law part, that connected me with a lawyer down here [at Mankato Law Center]. And as far as my health, I have a lot of health issues. To have that stress taken away, I mean, it helps emotionally and mentally, absolutely – but also physically. One thing, I'm diabetic. I have high blood pressure. My spine is pretty much shot. I have disabilities and chronic pain. But you know, when I am feeling less stressed, I am able to relax more, which lowers my blood sugar, and if I am not all tensed, that helps my back. The stress is terrible for your health. So, this [help] has been very beneficial.

Debra nervously laughed as she explained the importance of legal services to me. Her nervous laughter was sometimes characteristic of her disbelief and frustration with the system, but she had accepted it nonetheless. Being low-income, she thought the words ‘legal services’ and ‘expensive’ were synonymous, and consequently, did not know where to go to seek services. Debra mentioned that having limited access to money and resources while navigating chronic illnesses is extremely stressful; it further manifests itself in the form of transportation barriers, financial barriers, and so forth—all of which prevent individuals from seeking quality care. Through the help provided at Mankato Law Center, she was able to navigate both her legal and health issues, which showed positive results in her health outcomes.

Debra is not alone in this realization. Brenda Lopez, a Spanish speaking immigrant in her mid-50s, shared how powerful and life-changing these services can be. Brenda was a part of my first focus group at Minneapolis Clinic. The convenient location of the clinic in the midst of several small ethnic businesses paints an apt picture of its overall patient population. Arriving a couple minutes late, Brenda greeted me with a slight nod and seated herself in one of the corner-most seats, exactly opposite Stella Jones, the only other participant who showed up for the focus group. The dynamics visible in the large conference room of the Minneapolis Clinic were starkly different from the overall vibe of the clinic; the room was well-organized and spacious, and the participants were quiet, speaking only when it was their “turn.” Brenda broke her silence for the first time, when James Carter, a third-year law student and a Spanish speaking interpreter, grabbed a seat and introduced himself in Spanish.

Brenda has been coming to the Minneapolis Clinic for the last four years. She consistently drives or takes the public transport—a commute of twenty to twenty-five minutes—to make use of the services available at the clinic such as dental, physical, and mental health services. “There’s nowhere else really that helps her the way that [Minneapolis Clinic] has helped and she has looked elsewhere but it’s the only place where she feels comfortable and the only place where she can get

what she can get,” James explained as Brenda continued to nod, playing with her golden-brown locks of hair. An immigrant, Brenda has one daughter and lives with a husband whom she wanted to divorce. She looked fiercely at me as James is translating for her; the tears falling from her eyes strongly suggest that she was in an abusive relationship. However, she was forced to cancel her divorce because of the unstable immigration status that made her dependent on her husband. James explained in a mellow voice that was almost hard to hear, “So, the divorce she wanted to go through was a while ago and [she] and her daughter had to go through therapy for a while. That was really hard.”

Navigating an abusive relationship with clinical depression and an unstable immigration status is overwhelming. Throughout her answers, Brenda maintained a soft smile along with a constant eye contact with me, as though to convey her gratitude for the legal services available to her. James interpreted for her and explained how the legal services through Minneapolis Clinic have been life-changing for her.

She was in a lot of pain before and the legal services have basically helped her adjust. She attempted suicide twice and through the help she got here, she is now in a good state. Even though there is still some pain, the help she has received [in terms of immigration and divorce] has helped her get to where she is now, reduced her stress, which is a lot better. She is not in therapy [anymore] but she still seeks help. Things are looking better for her.

Having access to legal services at her safe place, her long-term clinic, helped her figure out her immigration setbacks. Doing so gave her hope—hope to get a stable status so that she can live independently with her daughter; hope to *actually live* happily and freely. Brenda’s story is not exceptional—many other participants shared their stories of immigration, housing, child custody, and how having access to on-site free legal services at a place they trusted was essential to their well-being and survival. As Sarah, the on-site attorney at St. Paul Clinic, aptly summarized her patients’ experiences, “Obviously, we see a reduction in stress levels and protection from violence. Those are some *visible* benefits, but I know we are helping them with more than just that.”

LEGAL CARE IS HEALTH CARE, BUT HEALTH CARE IS NOT JUST LEGAL CARE

The powerful stories of patients, well-supported by HLP advocates, highlight where HLPs succeed. They challenge the biomedical paradigm to consider lived social realities of patients and strive to operationalize that in a clinical setting. In other words, they stretch the bounds of holistic care models wherein clinicians look beyond mind, body, and spirit of patients; instead, they look at how social factors are impacting or limiting access to care for patients and negatively impacting their health status. But that is exactly the point: they only stretch the bounds of holistic care, they do not redefine those boundaries. As Tina Hughes, the on-site attorney at Minneapolis Clinic, put it, “on-site legal services are not the “silver bullet” by any means.”

Tina Hughes is different from all of my other lawyer interviewees; she is the liaison between Minneapolis Law Firm (a large law firm) and Minneapolis Clinic and has worked in this position for fifteen years. Thoughtful, understanding, and readily available: that is how patients, social workers, and physicians who have worked with Tina described her in my individual interviews with them. Elizabeth Jensen, the social worker at Minneapolis Clinic, elaborated, “I think Tina is such a great role model to others in that she's a lawyer, but she's also worked in the community a lot, so she understands the clients as well as what life in poverty [looks like] or what the barriers people are up against. She's really effective at bringing that back to her firm.” Tina’s passion for her work and for her patients is vividly visible as our thirty-minute interview lasted for more than an hour. She wholeheartedly believes that HLPs are the way to go, even though they do not provide comprehensive solutions to complex problems.

So, [there was a] woman that was homeless before but now she's got her criminal expungement and [thus] was able to get into some decent housing she could not [earlier]. Because of her mental illness, she could not go to a shelter because she couldn't be around other people - it was just too much for her and she was couch surfing with extended family. But her phone was stolen, any money she had was stolen. [Her extended family members] were heavy into drugs - that was a temptation for her. Last winter, when it was really cold out and she was homeless she was prostituting herself just to be off the street, so she wouldn't freeze to death. Now [after legal help, she looks] like a million bucks - I mean she was happy, she was healthy, she was put together. She has a place, she loves her daughter

and her granddaughter. Do I think that she'll never be homeless again? No, I think she will be. Same for my client today, they have their expungement off their eviction, so they have a clean record, but they're on a waiting list for public housing. So, the legal intervention helped remove one barrier but there is still a lot [to fix] before they can achieve their goal. But at least for this moment in time, being able to provide her legal services, case management services, psychiatric services, and then dental services has sort of helped her overall health be halfway decent.

Sarah Parker, the attorney at St. Paul Clinic, is of the same opinion—legal services provided in the clinic are extremely valuable, but at the same time, not comprehensive. She paused for a while before explaining that most of the legal issues she dealt with at the clinic were around housing: illegal rent increases, repair costs, eviction notices, and housing conditions. While it is easier to fix housing conditions and/or landlord-tenant issues, handling eviction notices gets a little trickier.

An example would be if you have an eviction on your record and there is a basis to have that eviction sealed from your record - that's a legal solution I could handle. And that could potentially help you find housing. But if there isn't a legal solution and you're being denied because of something that is properly on your record, then there's nothing a lawyer could specifically do. So, my services wouldn't comprehensively solve their issues. We do have a social worker, and she can, depending on the needs of the patient, give them resources for housing solutions - but even then, I don't think it's comprehensively helping the patient because we can't guarantee that they're going to find housing, unfortunately.

Sarah, like most other lawyers, is aware that in many ways legal services are an important but temporary solution to a complex systemic problem. In cases involving eviction that certainly have a detrimental impact on the health of patients, there is a limit to how much lawyers can assist and be helpful. Even after that initial help, it does not change or increase access to public and affordable housing.

Even though HLPs operate slightly differently within the context of cancer care, as Ashley explained, they follow a similar narrative when it comes to providing comprehensive care. Nancy Anderson chuckles when I ask her about the sustainability of legal services and if they are comprehensive. Nancy works alongside Ashley at Cancer Foundation as a lawyer. A short and shy woman, she also teaches a law class on the ways in which legal services can be implemented in health clinics.

Yeah, I mean sometimes it's just that the law is not going to be a remedy for their issue, and what we found almost universally is that people say to us, "well, thank you at least I know now, and I don't have to keep thinking about that and I can just focus on my health." So, there is value even when you know that something cannot be pursued and that what you want is not going to happen - but [there is] closure.

She pauses for a while, wiping the smile off her face when I push her to think about a specific example in which legal aid has not been a comprehensive solution.

One of the issues that people applying for social security benefits [face] is that even if they qualify, [which] means they have the diagnosis and they meet the other criteria, which is not making more than \$1700 gross per month, they are still approved on November 1st. They have to wait another five months before they get a check and that's their first check. So, they have five months where they are probably not able to make their mortgage, they may not be able to buy food and may not be able to pay rent - those are issues that we can't do anything about.

These conversations highlight that most lawyers, along with other HLP advocates, were able to articulate that while legal care is an important component of health care, health care is more than that; health issues are inherently social issues and in order to provide comprehensive care, those social issues need to be addressed. However, despite acknowledging the systemic barriers to health care that cannot be fixed through on-site legal aid, such as lack of affordable housing, fighting to get social security benefits, immigration, and so on, none of the HLPs are prioritizing any advocacy work to break those barriers. In other words, on-site lawyers, who have a unique position and access to powerful patient stories to potentially create systemic change, are not involved in advocacy work.

Energetic, enthusiastic, and ambitious: these are words I would attribute to William (Will) Thompson, the on-site attorney at Mankato Clinic. Even though our interview was over the phone, I could imagine the expressions on Will's face because of the way he spoke with passion and excitement. He genuinely believes that every patient should have the opportunity and access to seek legal services and works extremely hard to make a positive difference in patients' lives. Much like Sarah, Will was set to emphasize the importance of HLPs for patients regardless of the

question asked. He paused for a long time when I asked him about any advocacy initiatives pioneered by the HLP at Mankato Clinic.

As a healthcare-legal partnership, no. I think it would be a good idea, but I don't know if we have yet, just because all our partnerships are pretty new. We are like two years old now or three years old, I guess. So, I guess that's something that probably in the future, just because they have proven to be a successful access point for people.

Will's answer is not unique by any means. Similar answers were provided by all lawyers when probed about advocacy work as an HLP. While some lawyers blamed the newness of the partnership for not prioritizing such work, others highlighted the lack of funding, and hence, the unstable nature of said partnerships as the primary reason. As Nancy aptly summarized on behalf of all lawyers, "I'm sure you've heard plenty about this, but funding is *always* an issue."

In many ways, the lack of stable sources of funding is interrelated to the newness of partnerships. In our current medical system, HLPs cannot exist without sources of outside funding since these partnerships are not supported by state or federal sources. When there is no funding or the funding stops, it means that advocates have to find ways to start the partnerships afresh. These temporary sources of funding further translate into lawyers being pressed for time; they have to split their time between clinics and legal aid offices. They spend half of their weeks at the clinics, supporting patients with their legal concerns, and the other half working on cases at the legal aid offices. Additionally, taking money from a foundation comes with a price; it limits the definition of what advocacy can look like. If an HLP is funded by a foundation, the partnership has to be careful and strategic about how to align their advocacy initiatives with the values of the foundation. With this operating context, HLP advocates prefer to not risk their sources of funding, in order to ensure that they are still able to provide the important immediate support to patients. Between navigating the sustainability of the partnership and providing on-site legal care, lawyers feel unable to fully invest in and prioritize the advocacy work. As Sarah articulated: "I have to be honest. I am

not very involved in our advocacy portion. I would like to see the attorney be fully invested in the clinic, though, so the clinic has a full-time attorney there and that's their role.”

STRUCTURAL CARE: A NEW WAY OF LOOKING AT PATIENTS HOLISTICALLY

Funding HLPs would make on-site legal care sustainable and provide access to care, but without the advocacy piece, it will continue to be a band-aid solution to our neoliberal biomedical model-based health care system. Such a health care system will still drive individualization of health and work on the assumption that health operates outside of a social context. Such a health care system, therefore, will not support or provide adequate and comprehensive health care to underserved populations. It will fail to address the unequal dynamics between physicians and populations who bring distrust or vastly different backgrounds and experiences to the equation; of predominantly black patients feeling there is a lack of communication between patients and physicians, wherein physicians are not hearing them; of (undocumented) patients of color relying on social workers or community health workers to feel safe in accessing services from an inherently white, middle-class population of lawyers. These dynamics of distrust and disconnect are prevalent in my sample and hence, explain why despite an interest from patients in sharing their stories during recruitment, my focus groups ended up being small. In order to provide comprehensive care, our health care models need to center care around the lives of the whole person; it is essential to be cognizant of the impacts and roles of mind, body, spirit, and structural forces.

The Need for Structural Competency

Andrew Smith unintentionally but beautifully highlights the need for the first facet of structural care, that is operationalizing structural competency in medical education to train healthcare professionals with structural awareness and humility. An established family medicine physician at St. Cloud Clinic for the last eight years, Andrew has more than twenty years of

experience in rural medicine. He is devoted to bringing health care services to underserved areas in Minnesota. This dedication and love were noticeable in the way he talked about his alma mater, the University of Minnesota, Twin Cities in his enthusiastic voice. At St. Cloud Clinic, he is responsible for training future family medicine residents to deliver effective and quality care. Interestingly, he exhibits both white privilege in assuming that patients do not have the educational sophistication to understand their medical plans and a consciousness about the social barriers that prevent individuals from seeking and receiving care.

Certainly, from a physician's standpoint, you know [HLPs] do make a difference because a lot of these you know, what do you call these – social determinants of health, are challenging. I had somebody come in, who had diabetes and between the two of us, we can figure out if you can check your blood sugar these many times a day, take your insulin in this way, and organize your medication, and keep these types of things in mind as far as your diet, and till then, we can keep your diabetes well controlled. But when the person doesn't have the income or the coverage to get their insulin, then that doesn't help. And, even for some people, it's just, you know from an educational standpoint and they're just not educationally sophisticated enough to follow through with plans or really understand the importance of those plans. But, we can get a lawyer involved and they can do something.

I could hear a sense of sympathy and pity as he continued to paint his patients as the “helpless,” who were not able to take care of their well-being because of the lack of social resources, but mostly because of a lack of educational prowess to fully comprehend medication plans. Throughout his responses, he reaffirms his positionality as a physician who is not trained to identify social problems: “Unfortunately, that’s not a doctor thing. You don’t learn that in medical school.” This line of thinking thrives in a biomedical model, where low-income individuals are placed in monolithic boxes of lacking education; where physicians are trained to adopt a clinical gaze, stripping health issues from their social context and blaming patients for their health conditions.

A structural care approach, with this foundation of structural competency, would train future physicians and other healthcare professionals to fully recognize their privileges and seek to

understand the social world in which their patients are living. It would help in moving away from this narrative that patients are not educationally sophisticated to understand the importance of their plans, but instead explain how navigating homelessness and food insecurity, in addition to chronic illnesses, forces a ‘live-by-the-moment’ lifestyle; this lifestyle in itself propels patients to make certain decisions that might not allow room for follow-ups with clinics or following the medical plan.

Value of On-site Partnerships Beyond Health and Legal Services

The importance of the second key facet of structural care—establishing on-site partnerships beyond legal services—is rightly reinforced by Brenda Lopez’s story. As she communicates her feelings to James, I sense a hint of frustration for the first time; her once genuine smile feels a bit forced. Brenda does not make any eye contact with me as James explains on her behalf:

So, she suffers from migraines and she takes a really strong medicine [for it]. However, the [Minneapolis Clinic] didn’t have the medicine here so they recommended her to go to [another] hospital. Her problem was that there, they charged her a lot for the one injection. [This is why] there should be more partnerships and services in the clinic. You save money and effort by having it all in one place and you don’t have to have appointments here and there.

James looks at Brenda as if to confirm something. Brenda, hesitantly with a sheepish smile, starts speaking again.

Food shelves, clothing, other social resources would be helpful to people but if that is not possible, then at least have like lists [of places] where people could go to seek services like that. But overall, she says it's a hard question because she really likes the services here.

Brenda is not alone in feeling that on-site partnerships, similar to HLPs, are valuable as they break down financial barriers such as costs of transportation and make it convenient for patients to have all their appointments in one place. As described earlier, many of these patients are navigating their chronic health conditions in the presence of harsh social realities. For instance, Aung is a single mother who has to support three children in addition to taking care of her diabetes. Every

clinic visit, therefore, comes with an additional responsibility of ensuring that her children have a safe place to be and a person to supervise them while she is gone. Being low-income and on benefits without familial support means that she has to be strategic about which appointments to attend. Having such on-site partnerships thus helps in making an otherwise inaccessible health care system relatively easier to navigate as it recognizes the social realities of the patients. Making services convenient and in one place provides patients with the agency to prioritize their health as it fits into their own life schedule.

In addition to implementing structural and social forces into clinical care, these on-site partnerships serve as an effective bridge when on-site legal services are not comprehensive. Since health issues are not just legal issues, having social resources proves to be instrumental in providing some additional immediate support to patients—whether the issue is the social security benefits check not coming through or an eviction case not ending with a positive result. Sarah, the on-site attorney at St. Paul Clinic, expands on what Brenda and some other patients were communicating:

I wish there was a partnership, similar to the legal services partnership they have with me, with different housing providers. If there was such partnership with St. Paul Clinic and another non-profit, [we could] kind of funnel patients that are homeless but actively seeking housing to the non-profit. The non-profit can [then] specialize in helping them find [more permanent] housing. I think that might help break down some more barriers.

This sentiment of wanting more team-based partnerships, combining social, medical, and legal services, resonated with every physician, social worker, and lawyer I interviewed. Because health is not limited by the bounds of medicine alone or even law for that matter, it makes the most sense to involve all the stakeholders such as pharmacy services, dental services, food shelves, housing services, and so on in the care that is being delivered. It is vital to integrate the social determinants of health within the care models in order break down immediate barriers to care, thereby ensuring that all the needs of the patients are being met.

Changing the Biomedical Paradigm Through Advocacy and Action

Each patient story and every advocate's reflections emphatically showcase that on-site legal services, while extremely beneficial, are just not enough. In other words, there are systemic barriers to health care that cannot solely be fixed by on-site legal care, which directly translates into the inability to provide comprehensive care to patients. Building on the foundation of structural competency, and the move to involve and engage different stakeholders in healthcare teams, I argue that lawyers need to be permanent and full-time members of this restructured healthcare team, such that they can fully invest in the clinics and be advocates for their patients; advocates who highlight powerful patient stories to create systems that work for them.

Elijah articulates the need for and importance of this third facet of structural care perfectly. As he continues to share his story and his frustrations with the health care system, everyone in the room is right there with him: teary-eyed, balancing a sense of helplessness with immense resilience and faith in God. He shares the pain his brothers and sisters have endured, the pain his neighbors have fought against, and the pain he feels being in this almost claustrophobic conference room. He takes his cap off once again as though feeling vulnerable, and says in a quivering voice:

So, I'm telling you, folks, even though we [are] tired, we [are] pissed, we can do it. I'm telling you...this is the last time that you [are] going [to] tell your story.

Elijah elaborates that while on-site legal services have been tremendously helpful, patients like him are in dire need of patient advocates, who have the power and ability to fight for their rights. On several occasions, he encourages the participants to share their stories in the focus group, hoping that I will be their advocate and share their realities with the world.

On-site lawyers are in a unique position where they have the power and ability to be patient advocates. They are the entry point for many struggling patients who are in pain not only because of their medical conditions but also because of their social realities. Despite being the most

important stakeholder in health care, patient voices are almost always missing—from research and from policies. HLPs have the potential to fill in this gap; lawyers in health clinics can use these powerful patient voices to highlight the interdependence of health care and social care, and thus effectuate federal, state, and/or local policy-level change to break systemic barriers to care. A fully invested lawyer in an HLP can ensure that it is indeed the last time a patient is sharing their story of pain and suffering.

If HLP advocates truly wish to help patients get access to social rights, the three facets of structural care need to work in conjunction. Structural competency as the foundation changes the culture of medical education by also including social contexts into the delivery of care. On-site social care partnerships further break this biomedical sphere by bringing in all key stakeholders who have an impact on health as members of the healthcare team. Having lawyers as patient advocates in this restructured team not only highlights the interdependence of social care and health care but also helps in breaking down systemic barriers to health care. As Will, the on-site attorney at Mankato Clinic articulated: “If we really want to meet all [patients’] needs, there’s got to be a way; it’s not just the medical or legal help.” I argue that a structural care approach in health clinics is that way; a way to provide comprehensive and sustainable care services to meet the needs of the patients.

CONCLUSION

HLPs show a lot of promise as they conceptually help patients get access to social rights such as housing, food, employment, and so on—all of which have an instrumental impact on their health. In our current model, the partnerships contextualize health issues as legal issues and break down barriers by providing on-site, free-of-cost legal services to most commonly, low-income patients, which further helps in reducing stress and anxiety. However, short-term and insufficient funding sources, lack of structural support and full responsibility from clinics, and overworked lawyers limit the partnerships’ scope to break systemic barriers, and hence, become a band-aid

solution to a complex problem. In other words, HLPs show how human rights—whether social, economic, or political—are interdependent, but are unable to provide comprehensive care because of the reasons mentioned above.

In order to truly change the biomedical paradigm, health issues need to be contextualized as social issues, wherein clinics employ a structural care approach that includes training healthcare professionals with structural awareness and humility, establishing on-site partnerships for social care, and making lawyers full-time members of the healthcare team. These facets of structural care, which include a mix of different disciplines within health care and not just a mixture of different services serving marginalized populations, are vital to providing comprehensive and sustainable care to all patients; care that incorporates the harsh social realities of patients like Elijah, Debra, Brenda, Aung and others at the center and does not let their powerful voices go unheard.

APPENDIX A: CODING AND ANALYSIS

Codes	Description
advocacy work	Any advocacy initiative led, pioneered, or supported by the healthcare-legal partnership.
holistic care	Any mention of the word “holistic” in reference to taking care of the whole patient.
inaccessibility: finances	Income status acting as a barrier to seek health care and/or legal services.
inaccessibility: language	Language barriers that prevent patients from seeking health care and/or legal services.
inaccessibility: transportation	Transportation (personal or public) acting as a barrier to seek health care and/or legal services.
inaccessibility: trust	Trust issues acting as a barrier to seek health care and/or legal services.
legal aid: helpful	Discussion about specific cases in which legal services have proved to play an important role in producing positive health outcomes.
legal aid: not comprehensive	Discussion about specific cases in which legal services have not been comprehensive in solving the needs of patients.
legal issues: benefits	Discussion of legal issues specific to benefits that impact patients (such as social security benefits, etc.).
legal issues: custody	Discussion of legal issues specific to custody that impact patients.
legal issues: housing	Discussion of legal issues specific to housing that impact patients (such as eviction, landlord/tenant issues, illegal rent increases, repair costs, etc.).
legal issues: immigration	Discussion of legal issues specific to immigration that impact the patients.
on-site vs off-site	Discussion about the importance of having legal services on-site instead of off-site.

Codes	Description
pro-HLP	Any mention of the importance of healthcare-legal partnerships irrespective of the question.
structural care	Any mention of wanting more on-site partnerships in reference to taking care of the whole patient.
white privilege	Any mention or hint of privilege in answers and/or body language of white participants.

APPENDIX B: INTERVIEW GUIDE**Focus group questions**

- 1) Demographic information: Gender, Age, Race/Ethnicity (visually observe)
- 2) How often do you visit this clinic?
 - a. What kinds of things do you come to the clinic for?
- 3) Can you tell us some barriers that limit you in receiving care?
- 4) Can you tell us about a time when you utilized legal services on site?
 - a. When was this and in regards to what?
 - b. What was the process like? Your experience?
- 5) How helpful have the legal services been in addressing your health needs?
 - a. In what ways have they been helpful?
 - b. In what ways were they not helpful?
- 6) How likely would you be to seek legal services if they weren't on site?
- 7) Why do you think on-site medical-legal partnerships work or don't work?
 - a. What can be improved? What are some challenges?

Semi-structured interview questions for professionals (health administrators, lawyers, physicians, social workers)

- 1) Can you tell me a little about what your job is and what a typical day entails?
 - a. What is your title?
 - b. How many days per week are you available for patients? The reason I am asking is to see the level of accessibility.
 - c. How long have you been here?
- 2) I am curious to know more about the makeup of your clients seeking these services
 - a. Racial/Ethnic makeup
 - b. Socioeconomic makeup
 - c. Age demographics
 - d. Gender/sexual orientation demographics: Female, Male, LGBTQ+
 - e. Type of healthcare insurance
- 3) Can you identify some of the barriers that affect your clients?
- 4) What kinds of legal issues are specific to these populations?
- 5) How helpful have the legal services been in addressing health needs of the people you serve?
 - a. Are they sustainable?
 - b. Do they bridge the barriers you identified?
 - c. What are barriers they can't address?
 - i. What do you think is the best way to address those barriers then?
- 6) (for lawyers) Have you engaged or led any policy or advocacy work?
- 7) How likely do you think patients would seek legal services if they weren't on site?
- 8) What has worked for you and what hasn't worked for you in your experiences? What would you like to see that isn't happening?
- 9) In your perspective, how would you imagine that all the needs of patients be met?
- 10) What have I not asked that I should? What have I not covered that is important to ask?

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