

# Teaching Health Law

## Teaching Health Law

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**Keywords:** Teaching, Health Law, Classroom, Equity

**Abstract:** This column will be the first in a series exploring innovative ways to teach concepts and ideas in health law across a wide variety of classrooms, schools, and curriculums.

As the new editor of the Teaching Health Law column, it is my honor to (re)introduce you to the column that began almost twenty years ago with Charity Scott<sup>1</sup> as the inaugural editor. *JLME* is bringing the column back after a period of dormancy. As before, the column will be written for and by those teaching health law, and it will run four times a year. In the past, contributing authors have come from a variety of disciplines and settings, bringing a diversity of experiences and perspectives. Yet all have shared the common goal of striving for teaching excellence. Many have been full-time professors who can spend significant time on innovative pedagogical methods they are willing to share with others. Some have been full-time practicing attorneys and adjunct professors, with incredibly rich experience that informs their teaching goals and methods.<sup>2</sup> Contributors have come from law, medical, and public health schools, and we welcome all those who can further the reach of the support this column provides.

While this column depends on the contributions of many different people, I want to take a moment to honor Charity and the role she played in shaping the column's goals and direction. Under Charity's guidance,

I believe the column has made three crucial contributions, which form the principles that will guide me as editor going forward.

### Guiding Principles

#### *Valuing Teaching*

The Teaching Health Law column elevated issues related to teaching to keep them on par with and connected to our scholarly discourse around health law and policy developments. Many academic conferences focus overwhelmingly on research, and many schools continue to place out-sized emphasis on professors' scholarly development. Through this column, and through her involvement in organizing the Jay Healey Teaching Session every year since 2005, Charity was instrumental in helping ASLME to become known as a place for getting much-needed support for teaching, and for facilitating stimulating and edifying conversations about teaching with others who prioritize this aspect of our profession. These opportunities also reinforce the mutually constitutive relationship between teaching and research, especially in an area like health law, which is continually and rapidly evolving in response to everchanging legal, scientific, political, social, technological, and economic forces.

#### *Valuing the Whole Person*

Charity's influence can also be seen in the holistic approach this column took toward teaching. Of course, prior articles have delved into perennial questions about balancing scope and breadth of coverage, developing effective assessments, integrating skills and doctrine, and working across disciplines and schools to encourage interdisciplinary teaching and collaborative learning. But in a space where professors and stu-

### About This Column

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dents have long been advised to try to detach the personal from the professional, and to approach the law “objectively,” this column was notable for integrating consideration of the whole person. It acknowledged those personal aspects of the teacher or student’s identity that may not be able to be easily detached from learning, and it went even further to challenge us to consider how creating space for the personal in the classroom might even enhance learning.<sup>3</sup> This was consistent with Charity’s emphasis on the

this column, I was struck by how many of the topics, struggles, and pieces of advice shared remain relevant today, and seem even more important in light of a dramatically shifting scientific, cultural, and legal landscape.

With these principles in mind, my goal is for this column to once again serve as a conduit for our community to engage one another in wide-ranging topics relating to teaching health law. The last decade has seen dramatic change in the technological, cultural, political, and legal landscapes, and I

the creation of new consumer protections intended to address existing inequality. This includes the broadening of antidiscrimination protections to prevent sex, bans on discriminatory benefit design in insurance, and the ACA’s elimination of narrow eligibility categories as barriers to Medicaid — barriers that not only produce racially discriminatory effects, but also reinforce notions of deservingness rooted in stereotyping based on race, ethnicity, gender, disability, and socioeconomic status.

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well-being of students and teachers as important values in their own right,<sup>4</sup> and which the pandemic has helped us understand as inextricably linked to questions of teaching efficacy.

#### *Valuing Community*

Finally, this column, along with the Jay Healey Teaching Session at the annual ASLME Health Law Professors Conference, sought to create a safe space for professors at all levels to share their experiences — their joys and fears, their successes and how they learned from experiments that did not work as well. An important goal was to support new teachers (and teachers new to health law), as well as to encourage a spirit of on-going learning and development for teachers at all stages of their career. Charity helped to accomplish this by facilitating honest, stimulating, and affirming conversations that transcended any one conference or moment in time. In fact, in reviewing prior articles from

am eager to learn about any issues or questions you’d like addressed. Please reach out to me if you have an idea for a column you’d like to write, or if there is a topic you’d like us to cover. In the spirit of helping to spark the creative juices, I use the rest of this column to offer my thoughts on one important trend that has captured our collective attention, has salience for virtually any topic or area covered in a health law course, and presents interesting opportunities, challenges, and questions for health law teachers: the movement to “center equity” in health law and policy.

#### **Centering Equity**

In just a little over a decade, we have seen a tremendous expansion in our public consciousness about health inequity. The Affordable Care Act (ACA), and its implementing regulations, certainly helped catalyze this through its expansion of public and private insurance access, including

Who can forget the pictures of engaged citizens showing up to town halls to challenge political leaders opposed to the ACA’s passage, or the protests by people with disabilities in Congress demanding health care reform, with protesters in wheelchairs being carried out when they refused to leave? In some states, grass roots movements among minority and underserved communities helped secure Medicaid expansion despite state politicians’ resistance. And the high-profile regulatory and judicial battles over women’s access to prescription contraception helped spotlight tensions between gender equity goals and religious liberty exemptions — a conflict that has expanded to include gender affirming care and HIV prevention.

Of course, one can’t talk about this evolving focus on inequity without acknowledging the impact of the COVID-19 pandemic. The pandemic, and our response to it, rendered vis-

ible long-standing forms of inequality and their devastating effects on health. For example, COVID-19 shone a light on hospitals' use of crisis standards for resource allocation in ways that explicitly or implicitly devalued the lives of people with disabilities. It also exposed how outdated and unnecessary regulatory burdens impeded access to reproductive care needed by women and other pregnant patients.

But top of mind for most is how the pandemic helped to raise the public's consciousness about the role of structural racism in producing stark health disparities. The racial disparities in COVID-19 outcomes are well known by now — those identifying as American Indian/Alaska Native, Black, or Latina/o/x have suffered much higher rates of COVID-19 hospitalizations and deaths compared to white individuals.<sup>5</sup> Such disparities should not have been surprising in light of the structural inequity in employment, housing, and health care that has long resulted in disproportionately greater exposure to harm and greater barriers to care.<sup>6</sup> In the case of COVID-19, for example, minority workers were disproportionately represented in industries at the greatest risk of infections, like the meat packing and restaurant industries, without being supplied adequate protective equipment.<sup>7</sup> They were also disproportionately represented among those without employment protections like paid sick leave, making it difficult for them to follow public health guidance for their own protection, as well as the protection of their families and co-workers. For those needing care, a combination of residential segregation and the dearth of health care resources in minority communities made access to COVID testing and high-quality treatment more difficult.

The unpredictability of the disease, combined with the unprecedented shutdown of much of the economy, created an atmosphere of sustained public attention to the various forms of inequality throughout society that have serious consequences for physical and mental health. The murder of George Floyd was a particularly dev-

astating and compelling example of this broader inequity; but heightened citizen action in an era of flourishing social media meant that the public had instantaneous and unfiltered access to a constant stream of video accounts and testimonials about the many ways that racism was devastating Black lives. The George Floyd murder became a window into a more critical examination of the inequality embedded in every sector of society, as well as a warning of the consequences of failing to adequately attend to this problem.

This period of consciousness-raising also had a transformative effect on our public discourse. The dominant framing of discussions around equity have historically been couched in the language of "health disparities" and have been largely focused on the role of insurance, socio-economic status, or patients' individual behavior as causes. Comparatively little attention had been given to scholarly work highlighting the role of structural racism; indeed, some researchers report having been actively discouraged from focusing on racism or from even using the word. When racism in health care had been discussed, it was typically understood as involving an individual act, like a denial of care, motivated by animus or bias. Considered rare in modern times, many books reference discrimination as useful historical context for explaining early civil rights law.

But the last few years have brought a growing recognition of the connection between health disparities and the unequal structures and systems through which health and health care are shaped, as well as a greater understanding that structural racism does not depend on individuals acting with the intent to harm or disfavor a particular racial group. Racism, like other forms of structural inequality, includes a complex array of social structures, interpersonal interactions, and beliefs by which the group in power categorizes people into socially constructed "races" or other categories through which the non-dominant groups are disempowered, devalued, and denied equal access to resources. Structural racism "can per-

sist in governmental and institutional policies in the absence of individual actors who are explicitly racially prejudiced."<sup>8</sup> This transformation in our rhetoric and understanding presents both opportunities and challenges for teaching health law.

First, an understanding of inequality as rooted in the structure and systems of health care delivery and finance means that we can no longer relegate discussion of identity-based inequity to traditionally siloed coverage of antidiscrimination law. Increasingly, discussions of access, quality, and cost that span many different aspects of our system are viewed as incomplete without a consideration of equity. Consider the role that racial, ethnic, gender, and class stereotyping has played in the foundational design of our welfare-based support systems, including Medicaid — especially in decisions about which people should be excluded and how much flexibility states should have in program design.<sup>9</sup> We continue to see this playing out in modern debates about Medicaid expansion. A focus on equity through the narrow lens of antidiscrimination law obscures these more subtle yet pervasive forms of structural inequity.

Public health is another area rife with examples of the persistence of problematic or discredited policies or practices that disproportionately harm racial or ethnic minorities, women, and LGBTQ individuals, despite civil rights protections. For example, every level of government has targeted populations engaging in certain behaviors, like illicit drug use or sex work, for punitive interventions in the name of public health, based on perceptions of dangerousness and assumptions that such individuals cannot be trusted to make healthy decisions. There has been increasing advocacy by public health practitioners and researchers disavowing such punitive approaches in favor of more supportive efforts to promoting health, such as facilitating individuals' awareness of and access to essential health care and social supports. Nonetheless, certain communities continue to be targeted for such punitive and harmful government inter-

vention, especially certain racial and ethnic minorities, pregnant women, and those with mental health conditions. Knowledge about the experiences of these communities is crucial to understanding the mistrust and other challenges that may impede ongoing public health efforts, as well as for helping students think critically about the role of courts as a check on liberty-infringing action.

Perhaps the strongest indicator of the significance of this recent move to center equity is the fact that we are seeing greater attention to equity throughout health care topics where we haven't seen this focus before. This includes laws governing various forms of health care financing, such as ERISA, non-profit law, and the regulation of value-based payments.

There is also greater scrutiny of many forms of quality regulation. One of the most dramatic examples of this is what has occurred in the wake of *Dobbs v. Jackson Women's Health Organization*.<sup>10</sup> By eliminating the longstanding constitutional protection for abortion access, *Dobbs* unleashed an overwhelming number of new state abortion bans and other regulations that have significant implications for women and other individuals capable of pregnancy, especially those experiencing overlapping forms of subordination linked to economic instability or discrimination. The regulatory effects of *Dobbs* directly or indirectly intersect with many areas routinely covered in courses relating to the law of health-care delivery and finance: FDA regulation; HIPAA; health facility regulation; professional discipline and scope of practice laws; ERISA pre-emption; insurance design; and yes, antidiscrimination law.

A second implication of the movement to center equity in health relates to *how* we center equity in our teaching. Centering equity in health law requires centering the experiences of the affected populations. Sometimes the implications of a particular policy or practice may be obvious, as in the explicit use of race-based calculations in medical decision-making that can lead to unnecessary and risky Caesarian sections, or delay referrals for

medically necessary care. Such uses of race have persisted for years but are coming under increasing scrutiny.<sup>11</sup>

In many cases, however, it will not be immediately clear to students how structural inequity is operating. Centering equity may require presenting a richer picture of a patient's or community's experience to make the inequality visible. I've found a few techniques helpful when I attempt this in my health law survey. I do not assume that students have the relevant knowledge about the medical, legal, or social issues that shape health and health care for certain communities. Where valuable, I incorporate historical and contemporary resources that give students a first-hand look at the various social determinants of health embedded within and beyond the health care delivery and financing systems that contribute to the unequal distribution of burdens and benefits throughout society. I also try to keep populations that have been marginalized, excluded, or harmed by our existing systems at the forefront of class discussion throughout the entire course. My goal is to enable students to gain a more complete understanding of the health care system through a number of different perspectives and experiences.

For an overview of principles, tips, and types of resources that I've found helpful, please feel free to review the PowerPoint I presented at the 2020 ASBH Conference, titled Centering Marginalized Populations in Bioethics & Health Law Courses: Principles & Strategies.<sup>12</sup> For a more in-depth example of how I have tried to center equity in my coverage of Medicare and Medicaid, you may want read *A Journey through the Healthcare Safety Net*.<sup>13</sup> In this essay, I explain how I supplement the casebook I use with several chapters from the book *Mama Might Be Better off Dead: The Failure of Health Care in Urban America*,<sup>14</sup> to introduce students to how some communities experience Medicaid and Medicare. Written by an investigative journalist, the book follows several members of a family living in an economically disadvantaged neighborhood of Chicago from

May 1989 to April 1990, chronicling their experiences with the health care system. It takes readers on a personal journey that touches almost every part of the health care safety net and exposes the many forces that have helped create an unequal health care system. For some students, reading about this family's experiences unsettles assumptions they may have about those who live in poverty or about how people navigate the health care system. Other students find the book validating, encouraging them to open up about their own experiences and the struggles their family and friends have faced. In either case, students' intimate view into the lives of this family causes them to become personally invested in the family's health and well-being and motivates them to dissect the complexities of our health care system, including access and financing rules that might otherwise seem tedious and impenetrable. Through this equity lens, students gain a better understanding of the access, quality, and cost concerns that remain relevant today, even with the ACA.

I will close this column with one other implication that the movement to center equity in health may have for teachers of health law. This focus on equity has sparked a renewed attention to and reclaiming of civil rights laws as a tool for addressing structural inequality. The dominant framing and coverage of civil rights law has focused on its limits — what private actors can't do; the high burden private actors face; and the downside of having to depend on underfunded government regulators whose priorities shift with changing administrations. But there is a never-ending battle over the meaning of civil rights law in every sector, including how capaciously or narrowly to define the scope of its power to combat existing inequity. This is particularly important in light of the growing scrutiny of governmental and private policies and practices in every sector.<sup>15</sup> In addition, researchers in the medical, public health, and health policy arenas are creating tools that can help entities better track and address inequity and take affirmative



steps to dismantle structural inequality in their system.

How, if at all, should this influence our teaching of antidiscrimination law? For those who have time to do a deeper dive into this area, this context creates a wonderful opportunity for students to better understand the power and limits of civil rights statutes, the extent to which antidiscrimination principles may be underutilized, and what kind of equity-based information or analysis might open up facially neutral policies to greater legal or public scrutiny. Although there are limits to what private actors can use the courts to do, regulators still have the power to scrutinize policies and practice having disparate effects. Even in private causes of action, there is an important question about the point at which the severity of discriminatory harm, along with evidence undermining the purported justification of such a harmful policy or practice, may be compelling enough of to raise an inference of disparate treatment that would support a private cause of action. In either case, the growing consciousness about structural discrimination and growing scrutiny of the harmful consequences of this inequity, means greater opportunity to use litigation and regulatory action to effect change — either through legal compulsion, or public shaming and citizen demands for accountability.

Admittedly, trying to balance breadth and depth of coverage in a complex and ever-expanding field like health law is difficult. This can make it challenging to effectively center equity throughout the myriad topics covered in a health law course. This is certainly the struggle I face

each year, as I am forced to make hard choices about what to include and what to leave out. That said, I offer the above ideas and accompanying resources as food for thought, for those who, like me, consider this a worthwhile struggle to pursue.

#### Note

The author has no conflicts to disclose.

#### References

1. Charity Scott was a Professor of Law and founding Director of the Center for Law, Health & Society at the Georgia State University College of Law, and co-founder of the Health Law Partnership (HeLP). She passed in March of this year.
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12. "Centering Marginalized Populations in Teaching," available at <<https://lmu.box.com/s/8yuix4k0xxx7zpxepvxp7jx47ut8jj>> (last visited Oct. 11, 2023).
13. B. R. Clark, "A Journey through the Health Care Safety Net," *St. Louis University Law Journal* 61 (2016).
14. L. Kaye Abraham, *Mama Might be Better Off Dead: The Failure of Health Care in Urban America* (1993).
15. One example is the Patient Reported Experience Measure of Obstetric Racism ("PREM-OB scale") — a tool designed to measure how racism impacts care during pregnancy, which will enable hospitals, researchers, and policymakers "to examine associations between overall birth experience, patient experiences of obstetric racism, and clinical data to improve policy and practice." V. Grubbs, *Researchers Seek Reproductive Justice for Black Women*, California Health Care Foundation, Sept. 25, 2020, available at <<https://www.chcf.org/blog/researchers-seek-reproductive-justice-black-women/#related-links-and-downloads>> (last visited Sept. 13, 2023).