

TEACHING HEALTH LAW FROM A SOCIAL-ECOLOGICAL PERSPECTIVE

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I started teaching health law relatively recently—in the fall of 2010, just after the Affordable Care Act (“ACA”) was enacted, but before much of it had been implemented. This timing has been a blessing because I started with a fresh slate rather than adding the ACA on top of a previously developed course. It has also been a curse, but ultimately I appreciate that I started teaching the course at a time when the ACA was under constant threat. The ever-evolving nature of health law means that health law teachers must always bear in mind a goal that applies to all teaching: we must prepare students for the challenges they will face over the coming half-century without knowing exactly what those challenges will look like. Knowledge of current health law statutes, regulations, and case law serves primarily as the medium in which we practice skills together in the classroom.

I. SOME PRELIMINARIES

With the twin goals of building knowledge and honing skills, I designed my survey course around a series of in-class exercises that occupy about three-quarters of our time in class. Students work in groups of two to four to generate client advice, judicial memos, and guidance for state and federal lawmakers. In most cases, we work through these exercises after doing background reading and reviewing a basic outline of the key issues together as a class. While students work through the exercises, I circulate among the groups and dialogue with them about their process and ideas. Rather than having groups report back to the class in any formal way, I wrap up each exercise by calling on particular students to share specific insights with the group or to engage in a role-playing exercise. I encourage, but do not require, students to draft written responses to the in-class exercise prompts as part of their preparation for the final exam, which is modeled on the exercises.

My course is designed to meet the needs of dabblers who are curious about health law but don’t expect to practice in the area. It also functions as an

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introduction for beginning experts—those who know they are interested in practicing health law and will take several additional specialized courses. I am fortunate to work with a stellar group of health law practitioners from the Washington D.C. community who teach more than a dozen specialized health law courses as part-time faculty at American University. We have a large student body, and about fifteen percent of students express an interest in practicing health law. My course has been taught for four credits, though I am experimenting with a more intensive three-credit version in the spring 2017 semester. I typically have between twenty and forty students in the class.

My course is designed primarily for law students who have completed courses in torts, contracts, and constitutional law. Most of the students in my course are in the first semester of their second year of law school (constitutional law is a required first-year course), joined by a handful of third-year students and typically two or three lawyers (many of whom trained at foreign law schools) who are taking the course as LL.M. students. Few of my students have completed a course in administrative law, though many of them are taking administrative law concurrently with the health law survey course.

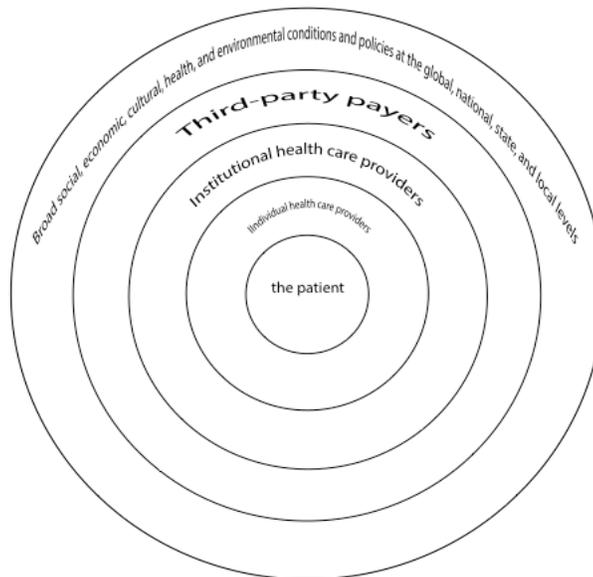
II. THE SOCIAL-ECOLOGICAL MODEL AS A BLUEPRINT FOR THE HEALTH LAW SURVEY COURSE

With all of that in mind, the first year I taught the course I set out to identify some organizing themes. I'm a visual thinker, so I started with what my students now refer to as the "bullseye." I draw it on the white board the first day and come back to it each time we transition from one major topic to the next. It is loosely based on the social-ecological model of health that drives my scholarly work in public health law, but with an emphasis on the health care sector.

Figure 1: The Social-Ecological Model of Health



Figure 2: A Social-Ecological Model of Health Care



Many colleagues (most influentially for me, Elizabeth Weeks Leonard, Nicole Huberfeld, and Kevin Outterson when they introduced their newly published health law case book¹ while it was still a work in progress) rightly point out that after the ACA, health law is no longer driven by private law. Nonetheless, I find private law is a great entry point for my students, most of whom are fresh off a first year curriculum that is heavy on torts and contracts. Medical malpractice law occupies an ever-smaller proportion of my course, but I find it to be a helpful starting point because it allows us to focus on the interaction between an individual health care provider and patient—something all my students have experienced first-hand.

My approach to the health law survey class is heavily influenced by the population-level focus of my work as a public health law scholar. So why do I put the individual patient at the center of the bullseye? Why do I start with individualistic, relational health care encounters? Because those encounters are what virtually everyone thinks of when they think about health. It works well to meet students where they are and then gradually widen the lens to encompass other factors and a broader conception of health. And, after all, at the root of public health's focus on collective needs and social justice is respect for the dignity of individual people.

III. HEALTH CARE AND INDIVIDUAL AUTONOMY

I start the course with informed consent and the ways in which civil liability is used as a tool to shape (and, initially at least, bring into being) discussion between doctor and patient about medical treatment. This is an intensely relational discussion, focused on the particular values a specific patient brings to the table and the particular assumptions, biases, and fears that influence a specific doctor. Immediately, however, I raise questions about other stakeholders outside the doctor-patient dyad. What about the hospital's obligations? What considerations might it want the doctor and patient to take into account? What about the third-party payer and others who are within the same risk pool who will share the cost of premium increases as health care expenditures rise? Should the doctor share information about the relative cost of various treatment options? Do we expect the doctor to even know about the relative cost?

Our discussion of the role cost considerations should play in doctor-patient decision-making leads us to consider the interests of the public as a whole with regard to other aspects of treatment. Should doctors discuss issues like antibiotic resistance or the need for a patient's sexual partner or other contacts to seek medical attention? How far do these obligations extend? When students

1. NICOLE HUBERFELD, ELIZABETH WEEKS & KEVIN OUTTERSON, *THE LAW OF AMERICAN HEALTH CARE* (2017).

push back against the idea that health care providers should consider anything but the needs of the patient, I sometimes ask them whether doctors should advise parents in a community with high vaccination rates to free-ride on herd immunity provided by others rather than have their children vaccinated, undertaking a minimal—but real—risk. My goal, influenced by Wendy Parmet’s excellent chapter on health care law in her book on viewing law (writ large) through a population health lens,² is to encourage students to see the full range of interests at stake in decisions about medical treatment. This gradual widening of our lens provides a perfect introduction to the bullseye and allows me to introduce the public—and not merely the aggregation of individual patient interests—as a health law stakeholder, something I am also exploring in my scholarly work.³

IV. HEALTH CARE QUALITY

After a couple of additional class sessions on issues that primarily concern patient autonomy (including end of life decision-making and health information privacy—we don’t spend much time on these topics, so I urge students to take the excellent bioethics and privacy courses offered by my adjunct faculty colleagues), we move on to health care quality. *Helling v. Carey*, in which a judge ignored the customary reasonable doctor standard of care and instead used a form of cost-benefit analysis to find that failure to administer a simple and seemingly cost-free puff test to detect glaucoma could amount to malpractice even though all expert witnesses involved agreed that it was not common practice among ophthalmologists to perform the test on low-risk patients, is an excellent cautionary tale to start with.⁴ I use *Vaughn v. Menlove* (in which the defendant farmer argued that he did his personal best and should not be punished for lacking “the highest order of intelligence”) in a similar fashion in my torts class.⁵ The glaucoma test also provides nice opportunity to raise the cascade of interventions (in a context that’s slightly less personal for me than labor and delivery) before addressing all the messy details of high-intervention childbirth using the Furrow casebook’s To Monitor or Not problem.⁶ To Monitor or Not is one of my favorite client advising problems, prompting students to think about how to engage their client in a

2. WENDY E. PARMET, POPULATIONS, PUBLIC HEALTH, AND THE LAW 191–218 (2009).

3. Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J.L. & PUB. POL’Y 47 (2014); Lindsay F. Wiley, *From Patient Rights to Health Justice: Securing the Public’s Interest in Affordable, High-Quality Health Care*, 37 CARDOZO L. REV. 833 (2016).

4. *Helling v. Carey*, 519 P.2d 981, 983 (Wash. 1974).

5. *Vaughn v. Menlove* (1837) 132 Eng. Rep. 490, 492; 3 Bing. (N.C.) 468, 471 (C.P.).

6. BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY S. JOST & ROBERT L. SCHWARTZ, *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* (7th ed. 2013).

dialogue about competing concerns and how to navigate the nuances of the standard of care for malpractice.

After a few classes on physician malpractice and hospital liability with liberal use of client counseling problems (*Creating a Shield*, in the *Furrow* book,⁷ is another favorite), we transition to market-based regulatory approaches to improving health care quality. I assign lengthy excerpts from the Pennsylvania MCARE Act⁸ and Joint Commission guidelines⁹ for students to work through in the context of client advising scenarios. After introducing a series of cases and sample state scope of practice laws, we spend significant time on a client advising problem in which a group of doctors, influenced by Medicare payment incentives (spoilers!), wishes to rely more heavily on nurses and lay patient care coordinators. When we reflect on those exercises, I like to linger on a discussion of the goals of reporting regimes, disciplinary actions, and scope of practice laws and how well suited (relative to malpractice liability and other alternatives) they are for their purported purposes. This also sets up a nice discussion of the relative strengths of primary care physicians, specialists, nurses, and other health care professionals and lay support staff from the perspective of patient advocates, payers, and the public.

V. HEALTH CARE COSTS AND ACCESS

We begin the unit on costs and access, which makes up about one-half of the course, by focusing on the obligations of health care providers to care for patients, starting with the formation and termination of the treatment relationship and common law obligations of continuing care. We then transition to EMTALA,¹⁰ focusing on the distinctions between the statute's obligations and the common law framework that predated it. This structure allows us to explore broader ideas about the pros and cons of common law versus regulatory approaches while also considering the distinction between ethical obligations and legal obligations.

My favorite thing about teaching EMTALA is that it naturally prompts a discussion about the mutual aid approach to health care financing. What does it mean to require hospitals to provide uncompensated care? If the costs are passed along to all patients and payers, then we are talking about a form of mutual aid, but a hidden form. An excellent article by Nicole Huberfeld and Jessica Roberts¹¹ has given me fresh fodder for this discussion, which

7. *Id.* at 431–32.

8. 40 PA. CONS. STAT. §§ 1303.101–1303.1115 (2002).

9. THE JOINT COMMISSION, <https://www.jointcommission.org> [<https://perma.cc/8U57-U6PZ>].

10. 42 U.S.C. § 1395dd (2012).

11. Nicole Huberfeld & Jessica L. Roberts, *Health Care and the Myth of Self Reliance*, 57 B.C.L. REV. 1 (2016).

previews all of the different ways that we collectively bear health care costs and the wide ranging implications of which health care costs should spur mutual aid. And this discussion naturally leads to consideration of why policymakers prioritize (often expensive) rescue care over (often less expensive) preventive care.

At this point, I cannot resist sharing the upstream/downstream parable—in many ways the foundational myth of public health—with my students. For those who don't have it seared into their brains like I do, the idea is that there is a village next to a river. One day, the villagers notice bodies floating by. The immediately rush into the water, risking their own lives to fish out the victims and resuscitate them. The steady flow of victims never lets up and the villagers are so occupied by the valiant effort to rescue them that it doesn't occur to anyone to travel upstream and figure out what's pushing people in.

Finally, after much anticipation, we expand our focus to discuss third party payers. I assign Deborah Stone's seminal article¹² on mutual aid and actuarial fairness (one of very few secondary sources I assign), which reinforces the ideas we have generated on our own in the previous class on EMTALA. We begin with coverage disputes between individuals and private insurance companies. I warn students that coverage disputes will be a unifying theme from here on out and that they should pay close attention to how different an individual's options for recourse are depending on whether they have private insurance covered by ERISA, private insurance that falls outside ERISA, Medicare, or Medicaid. My left-leaning students are sometimes surprised to hear me express sympathy for health insurance companies who refuse to cover services that patients and their doctors say they need. It takes some effort, but not much, to encourage them to see how coverage of expensive services that turn out to be unnecessary (e.g., high-dose chemotherapy with autologous bone marrow transplant for breast cancer) is an outcome to be avoided. And not only because the costs are spread to others.

They already understand the basics of how a contract dispute against an insurer works, so we focus primarily on tort claims against managed care organizations. These cases provide a perfect opportunity to discuss the blending of financing with treatment decisions and other aspects of health care delivery. We focus on the three tools that characterize managed care—limited provider networks, primary care providers as gatekeepers, and utilization review—rather than being overly concerned with the plethora of labels that health plans use to market themselves. After looking at managed care from the perspective of tort liability, we shift to state and then federal regulation of the practices that define it. Like a mom ruining a perfectly good batch of mac and cheese with broccoli florets, I stuff a bit of ERISA preemption in among the

12. Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287 (1993).

state patient protection statutes, HIPAA portability provisions, and ACA underwriting reforms. In addition to several scenarios in which students are advocates for insureds against MCOs and vice versa, we do a lengthy problem focused on advising an employer working with an insurer to develop a wellness incentive program. Although this may seem like a relatively minor area of health law, I find that it does a good job of drawing out the nuances of “rational” health status-related discrimination, especially in a class where few if any students have had the experience of applying for direct-purchase insurance pre-ACA. It also gives me a chance to explicitly link our bullseye to the original social-ecological model, by way of contrasting it with the outmoded behavioral model on which the vast majority of wellness programs are based. I dislike the extent to which the Furrow book implies that wellness programs are representative of public health intervention. They are not.

With Medicare, I introduce the distinction between coverage (what a health plan covers) and eligibility (who a health plan covers), which everyone needs to grasp quickly before we dive into the weeds with Medicaid. Along with our discussion of the ACA’s tax penalties and subsidies, these topics allow us to explore the role of government in making decisions about coverage and eligibility. We also cover Medicare payment reforms in some detail, both so that students are well prepared to take a follow-up course on Fraud and Abuse, and because value- and quality-based payment models are giving providers a greater financial stake in patient outcomes and thus a growing interest in the social determinants of health operating upstream in their patient catchment areas. In the course of these discussions, we touch on how each of these programs bears evidence of policymakers’ reluctance to make decisions about health care coverage and payment in a transparent, accountable fashion that encourages public engagement and deliberation.

VI. PUSHING BEYOND HEALTH CARE

Ultimately, I only devote one class session to public health law—and not only because if I spend more time on it, evaluations will be full of admonitions that I focus too much on pet topics. I start with an overarching discussion of social disparities in health. We begin with a few cases on overt discrimination by health care providers. Students quickly see how inadequate current law is for the task of tackling implicit bias, which is far more widespread than overt discrimination. And then I really blow their minds by talking about how small a role health care plays in determining health outcomes compared to behaviors and environmental exposures and the social and economic conditions that influence them. This tees up our discussion of public health law, which might focus on drug-resistant tuberculosis, racial disparities in cervical cancer, or noncommunicable diseases related to poor nutrition and physical inactivity, depending on what I’m interested in at the time.

CONCLUDING THOUGHTS ON LAW AS A TOOL FOR PROMOTING POPULATION
HEALTH

I like to use this discussion of public health law to make a broader point that is implicit in the entire class, but rarely at the forefront, and one that goes hand in hand with the social-ecological model of health: that law can be used instrumentally and in an evidenced-based fashion to achieve particular goals. If the goal is to preserve the effectiveness of antibiotics or community immunity as public goods, there are legal tools for that. If the goal is to avoid iatrogenic injuries, then malpractice liability, market-based regulatory regimes, and information-based reporting requirements are all potential tools, each with its own advantages and limitations, for achieving that goal. If the goal is to ensure equitable access to health care, then tax penalties, subsidies, spending programs, and direct regulation of private insurers are tools for achieving that. Law itself is a determinant of health. If our laws promote equitable access to high-quality health care that respects human dignity, then population health will benefit. If our laws promote out of control spending on unnecessary and sometimes harmful medical interventions and indiscriminate use of antimicrobials, they will be to the detriment of public health.

