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Panel Discussion: A Conversation on Health and Law

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A CONVERSATION ON HEALTH AND LAW

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COLLEGE) AND JANET CALVO**, CITY UNIVERSITY OF NEW YORK
SCHOOL OF LAW, PROFESSOR OF LAW
NOVEMBER 7, 2008

*Moderated by Ruthann Robson***, City University of New York,
Distinguished Professor and Professor of Law*

PROFESSOR RUTHANN ROBSON: Good morning. Thank you for joining us today for our Conversation on Health Law and Policy. We are pleased to have with us Professors Janet Calvo and Nicholas Freudenberg. Please keep in mind that the goal for today is to encourage a free-wielding conversation between Professors Calvo and Freudenberg, which I will moderate by posing some general questions. Questions have been submitted ahead of time by a number of law students and those have been taken into consideration in shaping the questions asked. Both Professors Calvo and Freudenberg have seen some of those questions ahead of time. We thank you both for being here today.

Janet Calvo has been on the faculty of the City University of New York (“CUNY”) School of Law since 1985. She is a professor of Health Law and Immigration Law. Most of her scholarship involves the intersection of the two—health law and immigration. It has involved immigration policy in terms of immigrant healthcare.¹ Professor Calvo’s scholarship has also focused on the constitutional idiosyncrasies of immigration policy and the rights of undocumented persons.² Prior to joining the faculty of CUNY School of Law, Professor Calvo practiced as an attorney and litigated a number of important cases. She is also a professor of Pre-trial Civil Practice.

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¹ Janet M. Calvo, *The Consequences of Restricted Healthcare Access for Immigrants: Lessons From Medicaid and SCHIP*, 17 ANNALS HEALTH L. 175 (2008).

² See, e.g., Janet Calvo, *A Decade of Spouse-Based Immigration Laws: Coverture’s Diminishment*, 24 N. ILL. U. L. REV. 153 (2004).

Public Health at Hunter College. He has published widely on the health and social consequences of incarceration, effective city living, HIV and AIDS, and combating corporate practices that damage public health.³ He is an activist who has and continues to work across various sectors, including working with community groups and with government entities seeking to optimize health. He is also the founder of the website “Corporations and Health Watch,”⁴ which provides information on the impact of corporate practices on population health, with the goal of effective strategies to change those practices.

Welcome and thank you again to both of you for being here. I would like to begin the conversation by really considering health as a right. During the recent presidential debates, the question of whether healthcare was a right or a responsibility was posed to both candidates. Senator McCain answered that healthcare is a responsibility while President-Elect Obama answered that it is a right. We know who won but it seems that healthcare as a right is starkly contrasted to healthcare as a responsibility and I would like to explore that difference further. So, first, I would like to ask whether you believe that it is health that is a right, or is it healthcare that is a right? What are the differences between naming healthcare or health as a right and what does a right really mean in terms of legal rights and public health rights? Is health or healthcare a constitutional right that would be enforceable through litigation in the courts or a kind of social right—something that we recognize as an important goal of social policy, but something that cannot be litigated?

PROFESSOR JANET CALVO: Well, I will start, but first, I would like to take a little detour. I want to say to all the law students that submitted questions that those questions were great. As a law professor, it was terrific to see the thoughtfulness of those questions. I would also like to thank Professor Robson for organizing today’s conversation and for the opportunity she has given to you to open your minds and really contemplate these issues. It is wonderful. Thank you also to Nick for being here today. We are so excited to have you.

PROFESSOR NICHOLAS FREUDENBERG: It is a thrill to be here. I am so excited to be here today and to be talking about

³ Julie Graves Krishnaswami, *Nicholas Freudenberg: A Selected Bibliography to Accompany a Conversation on Health and Law*, 12 N.Y. CITY. L. REV. 55 (2009).

⁴ Corporations and Health Watch, <http://www.corporationsandhealth.org/index.php> (last visited Mar. 30, 2009).

health and healthcare rights in the Constitution. It is a different conversation than I am used to, but what better time to discuss such a deep and profound issue.

PROFESSOR JANET CALVO: I would like to start with the legal issues and then I would like to hear Nick's thoughts about these notions. There is a difference between a right to health and a right to healthcare. The international community has conceptualized the right to health and has created documents that establish a right to health.⁵ Other countries incorporate those norms into their constitutional adjudication.⁶ It would behoove the United States to consider those international norms in creating its own solutions for ensuring health. Some lawyers are working to get the United States to accept, ratify, and incorporate into the domestic law international norms of the right to health. Pushing on that field would be a very good thing for lawyers to do. A special commission of the United Nations responsible for the international right to health recently released a report and its standards are very developed.⁷ Other nations have already considered and helped shaped the meaning of "health" and the standards governments must meet in order to fulfill the right to health.

The right to healthcare is a subset of the right to health. The international community speaks of respecting, protecting, fulfilling the right to health. The right to healthcare is part of the fulfillment obligation. However, another part of the fulfillment obligation is undertaking public health objectives, such as providing clean water or appropriate sanitation systems.⁸ That is not, perhaps, as great a problem in the United States. Though, I was recently in Florida working on the election, and in the urban sprawl of Miami, there are many people that cannot drink the water coming from their taps. It proves that we still have a long way to go in this country as well.

⁵ See Lesley Stone & Lawrence O. Gostin, *Using Human Rights to Combat the HIV/AIDS Pandemic*, 31 HUMAN RIGHTS 2 (Fall 2004); Benjamin Mason Meier, *The Highest Attainable Standard: Advancing a Collective Human Right to Public Health*, 37 COLUM. HUM. RTS. L. REV. 101 (2005); Alicia Ely Yamin, *Not Just a Tragedy: Access to Medications as a Right Under International Law*, 21 B.U. INT'L L.J. 325 (2003); Eleanor D. Kinney, *The International Human Right to Health: What Does This Mean for Our Nation and Our World?*, 34 IND. L. REV. 1457 (2000–2001).

⁶ S. AFR. CONST. 1996.

⁷ Ms. Kyung-wha Kang, United Nations Deputy High Commissioner for Human Rights, *The Right to Health: Health and Human Rights from the United Nations perspective*, Address Before the World Medical Association General Assembly (Oct. 16, 2008).

⁸ LAWRENCE O. GOSTIN, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* (2d ed. 2008).

I also think that we all have to work to make these rights enforceable through litigation. It is going to take some work, but it is possible. For example, the New York State Constitution has a provision, Article 17, which requires that the state provide for the needy.⁹ It also has a provision that imposes upon the state an obligation to promote the public health.¹⁰ Other states have those kinds of provisions. In litigation, focusing in on the state constitution in adjudication is a very promising area. Incorporating the international norms into constitutional adjudication is a hard road, but it is still possible. The development of health as an accepted and important right in our own constitutional adjudication will be difficult, but there are more conceptual openings now than there were before.¹¹

PROFESSOR NICHOLAS FREUDENBERG: I would first like to clarify the distinction between health and healthcare. I will be speaking from my perspective as a public health researcher and professional and as an advocate. I think that my perspective is different from a legal perspective—overlapping, but different. In public health, we spend a lot of time distinguishing between health and healthcare. Health is really the physical, emotional, mental, and social well being of an individual, a community, or a population.

In public health, we are particularly concerned with populations. The thinking in public health, as it has developed over the past 200 years, is that the fundamental influences on health—the fundamental determinants of health—are social conditions. It is the food we eat, the air we breathe, the education we receive, our working conditions, our housing conditions, our social structures, and the connections between people. The influences are involved and numerous. I think that if we want to assure the health of an individual or a population, we then need to look at that complex range of factors. I agree with Professor Calvo that healthcare is a component of that. However, the thinking in public health is that healthcare is actually a fairly modest determinant of health as compared to underlying living conditions. If one looks at the great improvements in public health in the last century or so—the first part of the 20th century—most of them came about because of improvements in water and sanitation and housing and nutrition.¹²

⁹ N.Y. CONST. art. 17, § 1; *see also* Aliessa v. Novello, 754 N.E.2d 1085 (N.Y. 2001).

¹⁰ N.Y. CONST. art. 17, § 3.

¹¹ Martha F. Davis, *The Spirit of Our Times: State Constitutions and International Human Rights*, 30 N.Y.U. REV. L. & SOC. CHANGE 359 (2006).

¹² John B. McKinlay & Sonja M. McKinlay, *The Questionable Contribution of Medical*

The development of medical care in the middle and later part of the 20th century made a fairly modest contribution.¹³ Longevity increased and mortality decreased precipitously; however, then the increase and decrease becomes much flatter. Advances have not continued to be made. I think we need to look at health and the social influences on health to determine what it would take to have a healthier population.

I think to say that there is a right to health—which I believe is a social and human right—and a right to healthcare requires that we think more about what that means because there is no way that government or society can guarantee that everybody is in good health. There are too many influences. The random variation of genetics or what one can inherit from one's parents is not something that is controllable by public policy or the law. I think what we mean when we say that people have a right to health is that they have a right to achieve their full potential. What we want is a legal and social framework that gives people the right to achieve their potential and to become full members of society regardless of their genetic constitutions.

I think there is an obligation on the part of society to make healthcare available for people. I do a lot of work in jails and prisons.¹⁴ In a perverse sense, prisoners are the only people in this country with the right to healthcare because of the Eighth Amendment.¹⁵ The notion that it is illegal—unconstitutional—to deprive people of medical care is maybe a floor that could help us move forward. However, I think fundamentally, the right to health and the right to healthcare is something that will be decided in the political and social arena. There will be some very sharp debates about that in the next few weeks and months and years. I think that if a right to healthcare is to be won, it will be won in the political arena, not in the courts.

PROFESSOR JANET CALVO: I think that it is true that the real action is in the legislative area. However, I think that considering constitutional notions of what is fundamentally fair—of what promotes equality—must be brought into that discussion. Al-

Measures to the Decline of Mortality in the United States in the Twentieth Century, 55:3 MILBANK MEMORIAL FUND Q. HEALTH & SOC'Y 405-28 (Summer 1977).

¹³ J.B. McKinlay, S.M. McKinlay & R. Beaglehole, *A Review of the Evidence Concerning the Impact of Medical Measures on Recent Mortality and Morbidity in the United States*, 19:2 INT'L J. HEALTH SERVICES 181-208 (1989).

¹⁴ See Krishnaswami, *supra* note 3.

¹⁵ *Estelle v. Gamble*, 429 U.S. 97, 103 (1976) (affirming that prisoners have an Eighth Amendment right to adequate healthcare).

though the action will come from the legislature, constitutional notions must be considered because, without considering such notions, reform just becomes political trading. I think it is our obligation as lawyers to ensure that the fundamental constitutional concepts that underlie the notion of democracy be brought into the dialogue.

PROFESSOR NICHOLAS FREUDENBERG: I agree with you completely, but I would add that when I say political, I do not only mean legislative. I think there are ethical and moral questions that need to be debated widely, including in courtrooms; but not only in courtrooms—in the public. If we are going to be successful in making health and healthcare a right in this country, we must mobilize broad cross-sections of people.¹⁶ To my mind, the question that I think a lot of what this election was about is what we want from our government—what we expect of individuals. I think that as we look at the last forty years or so, there has been a fundamental shift in the country in the wrong direction about what is regarded as a market responsibility and what is regarded as a public responsibility. If we are going to make progress on making health and healthcare right, that is the debate, the political debate that we need to engage in.

PROFESSOR JANET CALVO: I think you are right about that. For example, the law and economics people—those folks coming out of the University of Chicago; their notion was of the freedom to contract.¹⁷ Their notion of contract in society was that in permitting an absolute freedom to contract, individuals' self-interest would promote the good of all. Well, that did not work in the financial world, so I do not see how they think it is going to work in the health world.

PROFESSOR NICHOLAS FREUDENBERG: We have seen that it has not worked.

PROFESSOR JANET CALVO: Yes.

PROFESSOR NICHOLAS FREUDENBERG: There are 45 million people without health insurance in the United States—maybe

¹⁶ See Alicia Ely Yamin, *The Right to Health Under International Law and Its Relevance to the United States*, 95 AMERICAN JOURNAL OF PUBLIC HEALTH 1156 (July 2005); Jean Carmalt & Sarah Zaidi, *The Right to Health in the United States of America: What Does It Mean?*, <http://www.upliftinternational.org/> (follow "Health & Human Rts" hyperlink, then follow "The Right to Health in the US: What Does It Mean?" hyperlink) (last visited Mar. 30, 2009).

¹⁷ See, e.g., RICHARD EPSTEIN ET AL., *THE FALL AND RISE OF FREEDOM OF CONTRACT* (F. Buckley ed., Duke University Press 1999).

50 million.¹⁸

PROFESSOR JANET CALVO: Right.

PROFESSOR NICHOLAS FREUDENBERG: The United States has some of the worst health indicators among industrial nations.¹⁹ Maybe a quarter of our healthcare budget goes to administration and profit.²⁰ It has not worked.

PROFESSOR JANET CALVO: It has not worked. Healthcare is not a commodity like stock or a car. It has not worked. What worries me, and I would like to know Nick what you think about this, is that even the Democratic plan—the Obama plan—is not universal healthcare. It is still fundamentally based on the notion of contracting—choosing. I am going to choose this health insurance, and then, if I do not like that one, I can choose this other health insurance. The only additional guarantee that he proposes is a mandate for children.²¹ What do you think of that? What do you think about that approach to healthcare reform? Do you think it's going to work? Obviously, it is better than what we have now. But what is virtue of reform without achieving a universal healthcare system?

PROFESSOR NICHOLAS FREUDENBERG: I believe that the solution to our healthcare problem is a national health plan—universal coverage with a public responsibility to ensure that coverage and public oversight. You well know that we are at the bottom of the list of world nations in making that decision. I think that there is a pretty strong ideological commitment on the part of Obama supporters and the Democratic Party for incremental, rather than sweeping change. I think that is the lesson they drew from the Clinton plan,²² even though that was not the lesson I drew. I think that the failure to articulate a clear rationale and the decision to try and enlist, rather than challenge, the prerogatives of the insurance

¹⁸ UNITED STATES CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2007 (August 2008), *available at* <http://www.census.gov/prod/2008pubs/p60-235.pdf>.

¹⁹ Press Release, The Commonwealth Fund, New Study: U.S. Ranks Last Among Other Industrialized Nations On Preventable Deaths (January 8, 2008), http://www.commonwealthfund.org/usr_doc/Nolte_PressRelease_1-3-08.pdf?section=4059 (last visited Mar. 3, 2009).

²⁰ National Health Expenditures Accounts: Definitions, Sources, and Methods, 2007, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/dsm-07.pdf>; *see* Tables on National Health Expenditures 1960-2007, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>.

²¹ Barack Obama and Joe Biden's Plan to Lower Healthcare Costs and Ensure Affordable, Accessible Health Coverage for All, <http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf>.

²² Health Security Act of 1993, H.R. 3600, 103d Cong. (1st Sess. 1993).

and pharmaceutical industry is what destroyed the Clinton plan. I think unless the economic crisis forces the new administration and Congress to completely rethink the system, then what we are going to get in these next four years is incremental change.

I think what we need to look for is establishing some principles of the kind we were talking about that will move us in the right direction. Some people are talking about Medicare for all—providing what is currently provided under Medicare and expanding that to children and then to adults. I think that is a better strategy than some others. However, I do not think it is likely that the new administration will advocate for a national health plan. I am not sure the forces advocating for that are strong enough yet to put that on the agenda in the first place.

PROFESSOR RUTHANN ROBSON: What do you see as the obstacles to creating a national healthcare plan, especially in terms of corporations asserting their rights?

PROFESSOR JANET CALVO: Corporate entities have challenged similar kinds of health programs. The city of San Francisco, for example, tried to have a similar kind of system—what they call a “Pay or Play.”²³ It means that employers have to provide health insurance. However, if the employers do not provide health insurance, they have to pay into a public system. That is essentially what Obama is suggesting—a payroll deduction.²⁴ Employers of a certain size have to either provide health insurance to their employees, or they have to pay into a system. These plans have been challenged by the corporate entities that have to pay into the systems. They challenge it constitutionally. They say that their constitutional rights are violated, especially procedurally. Then they also challenge it under ERISA (Employee Retirement Income Security Act),²⁵ which is a federal statute. ERISA has been an impediment to local healthcare reform because it places restrictions upon state healthcare systems.²⁶ One thing that should happen is that states should be allowed more freedom in creating their healthcare systems. The limitations of ERISA should be diminished.

²³ Golden Gate Restaurant Association v. San Francisco, 2009 WL 605320 (9th Cir. 2009).

²⁴ The Agenda: Healthcare, http://www.whitehouse.gov/agenda/health_care/ (last visited Mar. 3, 2009).

²⁵ Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in sections of 29 U.S.C.).

²⁶ Nicholas Freudenberg et al., *Public Health Campaigns to Change Industry Practice That Damages Public Health: An Analysis of 12 Case Studies*, HEALTH EDUC. BEHAV. (Dec. 12, 2007) (ePub Ahead of Print as doi:10.1177/1090198107301330), available at <http://heb.sagepub.com/cgi/rapidpdf/1090198107301330v1.pdf>.

As an aside, I am personally very troubled by this part of constitutional rights law. I cannot believe that we have jurisprudence that recognizes the constitutional rights of corporations as if they were individuals.²⁷ It is just a perversion. It does not add up. It is a complete perversion of our system—in a number of ways. It is a perversion in the sense that the purpose of constitutional rights is to protect the natural individual from the overwhelming power of the state, particularly to protect minorities, and to protect the people from huge power. Some of these corporations are bigger than the government entities that are trying to regulate them. We have multinational corporations and we have big national corporations. These corporations are asserting constitutional rights as if they were just you and I. It offends me, and it upsets me that the United States Supreme Court accepts that notion.²⁸ This notion permits corporations to assert that their constitutional rights are impeded by the government striving to impose healthcare reform. I wonder if the corporations are going to challenge the “Pay or Play” system that Obama proposes like they challenged the city of San Francisco. This notion, of constitutional rights of corporations, is also applied when individuals attempt to utilize the law against corporations that have wronged them and the public, especially with respect to punitive damages.²⁹ It is offensive.

PROFESSOR NICHOLAS FREUDENBERG: I would like to get back to the question that started this exchange, and then return to the question of what obstructs a broader notion of the right to healthcare and a national health plan.

I think it comes back to something I mentioned before, which is the philosophical and ideological discussion in this country about the role of government in markets. I think there is a very deep-seated belief on the part of people with power and authority that markets are the solution, and that government is the problem. This is a relatively recent shift, certainly originating in the 1980's with President Reagan. It really was a deliberate effort by corporate America and global corporations to create a climate to let them do what they want. I think that, to some extent, the recent

²⁷ See Jess M. Krannich, *The Corporate “Person”: A New Analytical Approach to a Flawed Method of Constitutional Interpretation*, 37 LOYOLA U. CHI. L.J. 61 (2005); Carl J. Meyer, *Personalizing the Impersonal: Corporations and the Bill of Rights*, 41 HASTINGS L.J. 577 (1990).

²⁸ *E.g.*, Philip Morris USA v. Williams, 549 U.S. 346 (2007); Michael L. Rustad, *The Uncert-Worthiness of the Court’s Unmaking of Punitive Damages*, 2 CHARLESTON L. REV. 459 (2008).

²⁹ *E.g.*, Philip Morris USA, 549 U.S. 346.

failure of many corporations is a symptom of that view. What gives me ground for modest optimism is that the recent collapse of the financial and investment industries has led to an openness to discussion—the realization that what some people call “market fundamentalism”³⁰ or “super capitalism,”³¹ is not working. Certainly, people in the developing world have said it was not working for them for a long time, but now it is also not working for us here in New York City, the richest city in the world.

I think we have an opening. We need advocates, lawyers, and public health professionals to talk about these issues—talk about what we want. What we want for our children. What we want for our communities. How are we going to get what we want in a political system where corporations hold the dominant voice? If we are not going to get it, then what do we need to change?

In the public health field, I think that what we are seeing recently is that the health of populations is being determined by decisions made in corporate boardrooms and corporate offices of the food, automobile, pharmaceutical, tobacco, and alcohol industries. Those are the public health decision makers because their products have the greatest effect on our health. If we want to achieve international health goals, if we want to reduce disparities in health, we are going to have to change that.

That change requires both a broad political and legal discussion, but it also requires some very specific discussions. For example, if we expose our children to 20,000 advertisements-a-year, the majority of which are food advertisements and almost 100% of the food advertisements are for unhealthy food, then it is not surprising that we are in the midst of an obesity epidemic. If we want to change that, then we are going to need to do something about those advertisements and enforce a public responsibility to protect children. I think by raising public debates around that and proposing legislative and legal solutions, we begin to make change. I do not think there is going to be a single transformative change. I think we are looking for a tipping point where we see, as America did in earlier periods, at the end of the Depression, in the 1920's maybe, a different balance between market and government.

PROFESSOR RUTHANN ROBSON: How, then, can one go

³⁰ Joseph Stiglitz, *Redefining the Role of the State: Joseph Stiglitz on Building a Post-Washington Consensus*, 2:3 WORLD ECON. J. 45-86, available at http://www2.gsb.columbia.edu/faculty/jstiglitz/download/2001_World_Economics.pdf.

³¹ ROBERT REICH, *SUPERCAPITALISM: THE TRANSFORMATION OF BUSINESS, DEMOCRACY AND EVERYDAY LIFE* (Knopf 2007).

about resolving the broader equality issues? You talked about access and those sorts of things. But you also talked about obesity, and that is also a problem in terms of class, in terms of race. How do you get at those problems?

PROFESSOR NICHOLAS FREUDENBERG: Again, I see it as a moral and ethical social issue. I think the success of the right³² for so long was its ability to engage people in moral and philosophical questions. I disagreed with its points, but I think it was able to engage with people in ways that we were not.³³ I think we need to learn how to do that, and I think we now have an opening. I think racial, gender, and socio-economic targeting of populations to get them to buy products that will make them fat, sick, and die early is offensive.

It ought to be unacceptable. If we could move that to a legal framework, that would be a further step in rectifying the problem. I think people are open to that. I think people are open to the notion that targeting African American communities with tobacco and alcohol advertisements, for which there is a big empirical body of literature showing that that is the case,³⁴ is offensive. It is un-American, and, therefore, we ought to find ways to stop it. I think, again—politically, morally, and legally.

PROFESSOR JANET CALVO: I am thinking about how the legal analysis fits in. I think that you are right that the broader moral, philosophical arguments have to be made, but there is also the question, when it comes to the law, of the chicken and the egg. Can the legal system push society beyond what it is ready for? Or is society ready for something and then it just takes the legal system to recognize it? I think it is complicated.

I do not think a legal system can push a society to a place where it is not going to go; but I think the legal system can pick up on some of those moral and philosophical discussions and push us forward in a variety of ways. For example, the litigation against the tobacco companies brought out their racketeering and misrepresentation and fraud to the public. The litigation against them was

³² Conservatives.

³³ Progressives.

³⁴ See, e.g., S.A. Grier & S.K. Kumanyika, *The Context for Choice: Health Implications of Targeted Food and Beverage Marketing to African Americans*, 98:9 AM. J. PUB. HEALTH 1616-29 (2008); M.L. Alaniz & C. Wilkes, *Pro-Drinking Messages and Message Environments for Young Adults: The Case of Alcohol Industry Advertising in African American, Latino, and Native American Communities*, 19:4 J. PUB. HEALTH POL'Y 447-72 (1998); B.A. Primack, J.E. Bost, S.R. Land & M.J. Fine, *Volume of Tobacco Advertising in African American Markets: Systematic Review and Meta-Analysis*, 122:5 PUB. HEALTH REP. 607-15 (2007).

very hard, but the persistence of litigators against the tobacco companies forced, through the discovery process, the revelation of the degree of their heinous deception.³⁵ That then helped the public dialogue. I think that is an example of the legal system's role.

PROFESSOR NICHOLAS FREUDENBERG: Exactly. I see it as a dialogue with each contributing to the other. I think the fight against tobacco by the tobacco advocacy lawyers was just remarkable and set some precedents and examples that we now need to apply to the food industry, particularly fast food and junk food and to the pharmaceutical industry in order to deal with the major determinants of illness and health. But I also think there was the environmental movement, the reframing of the tobacco issue from whether individuals have an individual obligation to smoke or quit smoking to the recognition that we all have the right to breath clean air. That reframing set the stage for making those legal arguments. It is the combination of a determined group of litigators *and* a social movement that brings about change. That is what we all should be hoping for it. I hope that the legal community will contribute to the health community's agenda of changing our healthcare system.

PROFESSOR RUTHANN ROBSON: I would like to discuss the individual rights aspects of these issues. Suppose, an organization on campus or the government put up signs directing that people "Take the stairs," "Don't eat junk food," etc. How would you respond to my being in a bad mood and saying it is my individual right to take the elevator? I am offended by those signs. I have a right to walk or not walk. I am tired of you, government, telling me about what I should be doing.

PROFESSOR NICHOLAS FREUDENBERG: Yes, I think that is a fair statement. I am a co-chair and one of the founders of the CUNY Campaign against Diabetes.³⁶ Let me digress for just a moment and then respond to your question. We created, about two and a half years ago, the CUNY Campaign against Diabetes, because we were tremendously concerned about the epidemics of obesity and diabetes, here in New York City and the country as a

³⁵ Tobacco Products Liability Project, <http://tobacco.neu.edu/> (last visited Mar. 30, 2009); Jean Macchiaroli Eggen, *The Synergy of Toxic Tort Law and Public Health: Lessons From a Century of Cigarettes*, 41 CONN. L. REV. 561 (2008); Jean C. O'Connor et al., *Preemption of Local Smoke-Free Air Ordinances: The Implications of Judicial Opinions for Meeting National Health Objectives*, 36 J.L. MED. & ETHICS 403 (2008).

³⁶ Campaign Against Diabetes – The City University of New York, <http://web.cuny.edu/academics/centers-and-institutes/urban-health/campaign-against-diabetes.html> (last visited Mar. 3, 2009).

whole. The diabetes mortality rate has almost doubled despite other improvements in public health.³⁷ That rate of increase usually does not happen.

The increase in diabetes deaths is driving greater disparities among New Yorkers. Not only are the death rates for diabetes going up for Whites, Blacks, Latinos, Asians, really for every group, but they are going up faster for African Americans and Latinos. We are seeing increasing death rates, and we are seeing them increase widely. A couple years ago, some researchers predicted that if these trends continue, our children and grandchildren will have shorter life spans than we do because the trends of obesity and diabetes are reversing a century of public health progress.³⁸ That is the back drop for why we care about diabetes in a big city. But, going to your question, I think it is a good example, because in order to reverse obesity, it is necessary but not sufficient for individuals to make changes because individuals make their choices about behavior in a social context.

We are doing a bunch of other things around how this institution, CUNY, is taking on these issues. We have had students from about six different campuses doing a survey of all twenty-three food services on the CUNY campuses around the city. What we have found, with some variation, is that the food services are pretty mediocre. The one on my campus, Hunter's Brookdale College, was one of the worst. It was much easier to buy unhealthy food than healthy food. We actually had students put together a market basket from the cafeterias that were healthier and less healthy. What they found was that the unhealthy food was cheaper, was prepared more quickly, and was more prominently displayed. An institution has an obligation to make healthy food more available.

We have an obligation to remind people, but of course it is still one's personal choice. But I think the social imperative is that the healthy choice should be the easy choice. It should be the default option.

It is because of the corporate onslaught in making unhealthy—high fat, high sodium, high sugar—food available everywhere, and available cheaper than healthy food, that we have an obesity epidemic. If we are going to reverse that epidemic, if we

³⁷ "The death rate from diabetes rose by 71% between 1990 and 2003." Press Release, New York City Department of Health and Mental Hygiene, *New Diabetes Report Documents Devastating Effects in New York City* (July 27, 2007), available at <http://www.nyc.gov/html/doh/html/pr2007/pr060-07.shtml>.

³⁸ S.J. Olshansky, et al., *A Potential Decline in Life Expectancy in the United States in the 21st Century*, 352:11 *NEW ENG. J. MED.* 1138-45 (Mar. 2005).

are going to reverse that widening gap in death rates, then we are going to have to take on the food industry. So those signs, directing people to behave in different ways, are a little part of it. If that were all we were doing, shame on us. But we are trying to take some institutional context as well.

PROFESSOR JANET CALVO: I think that people sometimes see public health measures as being imposed by an arm of the government and as restricting individual choice. I do not think they have to be seen that way. I think that if one knew the background of the restrictions, one could see that the government is not merely telling people to walk but is instead concerned that our health in the future not be limited. I think it makes it easier if there is public education about the details. There was a lawsuit a number of years ago brought against the fast food industry.³⁹ However, it was brought too early. It was too early because the public had not yet been educated about it. The proponents of the lawsuit had not pulled together the scientific material, and that lawsuit was just trashed by the public and by lawyers. "How dare you sue McDonald's?" they asked. "People make the choice to eat those hamburgers." "They are fat because they are fat." "It is personal discipline." This was the reaction to that lawsuit. The lawsuit was a little too early because the public dialogue had not yet moved sufficiently.

PROFESSOR NICHOLAS FREUDENBERG: But it also contributed to that dialogue, and I think it was followed by "Supersize Me."⁴⁰ I think that film did make a change to public consciousness. A lot of people complain about individual rights and worry that the state is depriving us of our pleasures. I am always upset and offended by those arguments because the real culprits are the corporations. The culprit is McDonald's, who spends 653 million dollars-a-year trying to get our kids to eat happy meals. The real culprit is Coca-Cola. If parents were engaged in practices aiming to shorten children's lives, that would put them at risk, they would be arrested for child abuse. The vast amount of trying to persuade people to change health habits is done not by public health authorities, but by corporations. The average kid between the ages of two and seventeen spends more time watching advertisements for unhealthy food than he or she will getting a college degree.⁴¹ What

³⁹ Jonathan Wald, *McDonald's Obesity Suit Tossed*, CABLE NEWS NETWORK (Feb. 17, 2003), <http://money.cnn.com/2003/01/22/news/companies/mcdonalds/>.

⁴⁰ *SUPERSIZE ME* (Kathbir Pictures 2004).

⁴¹ WALTER GANTZ, PH.D. ET AL., THE HENRY J. KAISER FAMILY FOUNDATION, *FOOD FOR THOUGHT: TELEVISION FOOD ADVERTISING TO CHILDREN IN THE UNITED STATES 3* (2007) (finding that the average child between the ages of two and seven is exposed

does that say about our social values and our choices that we allow that to happen?

PROFESSOR JANET CALVO: Corporations, in addition to constitutional rights, have great power over the legislative process. They use their individual rights to resist regulation. One thing that contributes to what you are talking about now is the subsidies for corn. A lot of food is high in fat and high in corn syrup. We have a society that heavily subsidizes corn and does not subsidize healthier foods and that undermines our health.⁴²

PROFESSOR NICHOLAS FREUDENBERG: Exactly. I think that is an example of where there is great promise for law folks and public health folks to work together. I think we are not going to make advances unless we level the playing field with campaign finance reform, lobbying reform and much tighter rules for the “revolving door”—people going from industry to government. I think working together to get advocates the same access to the political process that corporations now have is a very important strategy. Public health folks often overlook that. We assume that we just need to get out pamphlets or put media messages on television rather than change the political process.

PROFESSOR JANET CALVO: I think that we must remain aware, however, that there are some serious constitutional questions about the power of government to curtail the rights of individuals. I think that power has been used by some officials abusively. For example, New York passed very restrictive legislation to deal with multi-drug resistant tuberculosis. Its effect was to incarcerate those who allegedly refused treatment.⁴³ Another example occurred in Arizona where a person infected with tuberculosis was required to wear a face mask.⁴⁴ When the man did not do so, he was put into a public health incarceration facility—essentially a jail.⁴⁵ Instead of educating him better about wearing the face mask and what he was supposed to do, they incarcerated him in a jail. Another example is a case from California where a Laotian woman

to more than 30 hours of food advertising annually 34% of which is for candy and snacks, 28% of which is for cereal, and 10 percent of which is for fast food).

⁴² MICHAEL POLLAN, *THE OMNIVORE'S DILEMMA* (Penguin Press 2006).

⁴³ NEW YORK CITY DEPARTMENT OF HEALTH & MENTAL HYGIENE, BUREAU OF TUBERCULOSIS CONTROL, *TB AND THE LAW 9* (2007), available at <http://nyc.gov/html/doh/downloads/pdf/tb/tb-law.pdf>.

⁴⁴ Robert Knox, *Arizona TB Patient Jailed as a Public Health Menace*, NATIONAL PUBLIC RADIO (June 11, 2007), <http://www.npr.org/templates/story/story.php?storyId=10874970>

⁴⁵ *Id.*

had multi-drug resistant tuberculosis.⁴⁶ Her English was not very strong. She asked multiple times for a translator and requested that someone find her son to come and tell her what she was supposed to do. She could not understand. The government wound up incarcerating her. She ultimately won a million dollar judgment for a denial of her liberty rights.⁴⁷ Another case is one from Georgia where health officials held a young Mexican man who had multi-drug resistant tuberculosis.⁴⁸ The first thing they did was call Immigration and Naturalization Services (“INS”) to see if he was an undocumented immigrant. In these cases, presumptions harmed the ill victims. Do you have any insights into this?

PROFESSOR NICHOLAS FREUDENBERG: I have also done a little work on tuberculosis and was working in the New York City jails in the late 1980s and early 1990s when there was a resurgence of tuberculosis here in New York City. Some colleagues of mine did a study at Riker’s Island, documenting that every day an inmate spent at Riker’s increased his or her chance of contracting tuberculosis.⁴⁹ The jail was actually an incubator for the epidemic. I think that is a very clear example of government doing exactly the wrong thing—ending up contributing to a public health problem rather than fulfilling its obligation to protect people. It is an example, as is the Phoenix case, of what happens when people are not thinking through what the consequences are of their actions.

Another example involves a case brought in Alabama by the National Prison Project American Civil Liberties Union in which I was an expert witness.⁵⁰ The practice in Alabama was that it was one of the few states to have mandatory HIV testing for everyone admitted to its state prison system. It would test people and then a corrections officer would come and notify people of the result and saying, “Hey buddy, you’ve got AIDS.” They would take that person and put them in a segregated unit. None of the officers wanted to work there because they were afraid of getting infected themselves. So they essentially abandoned that unit. The doctors

⁴⁶ Hilary Abramson, *From Sickbed to Jail, for Lack of Medical Interpretating*, NEW AMERICAN MEDIA (May 30, 2006), http://news.newamericamedia.org/news/view_article.html?article_id=d3ca2c4c273f4956a50d8b359a9c142c.

⁴⁷ *Id.*

⁴⁸ Associated Press, *Teen Jailed in GA after Refusing TB Treatment* (Aug. 27, 2007), <http://msnbc.msn.com/id/20467662> (last visited Mar. 30, 2009).

⁴⁹ E.Y. Bellin, D.D. Fletcher & S.M. Safyer, *Association of Tuberculosis Infection with Increased Time in or Admission to the New York City Jail System*, 269:17 J. AM. MED. ASS’N 2228-31 (May 5, 1993).

⁵⁰ *Onisha v. Hopper*, 126 F.3d 1323 (11th Cir. 1997), cert. denied, 120 S.Ct. 931 (2000).

the prison hired to provide those inmates medical services would examine them from a few feet away. Because the guards did not go into that unit and because they were locked up twenty-four hours-a-day, a lot of the inmates were having sex with each other, further contributing to the spread of infectious diseases.

The National Prison Project brought a lawsuit against the Alabama Correctional System for these conditions. We lost, although the conditions improved significantly. I think again, that is an example of the powers of the state to isolate and segregate being used not to achieve its stated objective of improving public health. The remedy we were seeking was comprehensive AIDS education for everybody. Segregating people was giving false assurance to a variety of people. I do believe that the state has the responsibility to protect public health. It is a responsibility of the state, and I am not opposed to a state using its police powers to live up to that responsibility.

I would say that identifying someone with tuberculosis and setting up a way for that person to get treatment if he or she is not doing so, does fall within the state's police powers. But the reality is that there are, in 99 out of 100 cases, opportunities to do that without getting to that last resort, and that government has an obligation—an affirmative obligation—to try all those other remedies first, and to exhaust them. In New York City, the way we did reverse the resurgence of tuberculosis was to institute directly observed therapy where a health worker would go and actually deliver medication and watch people take it.⁵¹ The devil is in the details of how to do that—whether you do it in a coercive way or you do it in a way that provides incentives. The New York City program was some mix of those things. I find fault with some elements of it. But they offered people food. They offered them help in finding housing, and they observed them taking the medicine. I think in almost all cases, it is possible not to use coercion.

I think the last case you [Professor Janet Calvo] mentioned illustrates something. We talked earlier about what the right to healthcare means. I certainly think it means getting healthcare in a language you can understand and in a manner that demonstrates respect for one's culture. To turn that into legislation and create legal rights is pretty complex—doable, but complex. There are in fact both community struggles and legal struggles here in New York, and you know about them more than I do—to get the right

⁵¹ T.R. Frieden, P.I. Fujiwara, R.M. Washko & M.A. Hamburg, *Tuberculosis in New York City—Turning the Tide*, 333:4 NEW ENG. J. MED. 229–33 (1995).

to a translator, to ensure it is not enough just to get in a room with a doctor, if that person speaks a different language. I think it illustrates how tough it is going to be to make that right to healthcare a reality.

PROFESSOR JANET CALVO: I think it is important for people to understand that there are fundamentals of constitutional law that affect how we talk about these issues within the legal community. Even if the state does have power—police power—it really needs to use that police power in very limited situations and try everything else it can before it does so. A lot of what I see is cases getting to litigation unnecessarily because people are actually trying to do what are good for their health. Occasionally, there is someone who just says, “I’m not doing it because I don’t want to.” But that is so rare. Most of these folks are trying. They do not want to be sick. They do not want to make other people sick. They are trying and the punishment by the state comes down too fast.

PROFESSOR NICHOLAS FREUDENBERG: But can I ask you [Professor Janet Calvo] about another example? I agree with you. We should not confuse bad public health practice with public health practice. But I wondered where you stand on immunization and vaccination, which is another area of health law that is the subject of debate. The public health view is that immunizations are among the most effective ways of controlling disease, and that mandatory immunization is credited with saving lives, saving money, improving population health. There are some people who do not believe in immunizations. There are some medical exemptions.

There is a biological principle positing that if a certain proportion of the population is not vaccinated, then the risk is an epidemic, especially in our heterogeneous society where some people have not been immunized from childhood from other countries. If we get above that proportion that chooses not to be vaccinated for cultural, religious, or other reasons, we risk re-exposing the population to an epidemic. What do you [Professor Janet Calvo] think about this and how do you think constitutional arguments affect the issue?

PROFESSOR JANET CALVO: That is a very hard one. But I think that, looking objectively, certain mandates are required. That falls within the police powers of the state.⁵²

⁵² *Gibbons v. Ogden*, 22 U.S. 1 (1824); *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 1 (1905).

PROFESSOR NICHOLAS FREUDENBERG: Small pox vaccination?

PROFESSOR JANET CALVO: Yes, small pox vaccination, for example. But I think there must be some kind of process that allows people to explain why they do not want to be vaccinated and if the reason is legitimate, then an exception must be made.

PROFESSOR NICHOLAS FREUDENBERG: What if a third of the population believes that their God tells them it is wrong to vaccinate their children?

PROFESSOR JANET CALVO: Freedom of religion is then very problematic. There is a balancing that is triggered when freedom of religion is involved.⁵³ It is a difficult legal issue.⁵⁴

PROFESSOR NICHOLAS FREUDENBERG: It is not theoretical. There are religious communities where no one has been immunized, and there have been outbreaks of disease at expense of the person involved.

PROFESSOR RUTHANN ROBSON: I think one thing that is interesting is considering the reasons given and whether those reasons are legitimate under the Constitution. Freedom of religion is in the Constitution⁵⁵ so when the reason for refusing a vaccination is framed as a religious reason, it is given more credence, and religious exemption is usually granted. However, if someone gives a political or medical reason that does not really hold up. For example, if a parent reasons that one in seven zillion children die from a particular vaccination and decides he or she does not want his or her child exposed to it, health authorities would normally say, "Okay, fine, but then you cannot enroll your child in school," or something to that effect. I think that judging those reasons is interesting in terms of the Constitution.

PROFESSOR JANET CALVO: Right. And I also think that ultimately even religion can be trumped, for example, some people sacrifice animals as part of their religions; yet, the government can control that for public health reasons.⁵⁶ I think that in those situations, a sophisticated understanding of public health is important and, therefore, public health education is very important. The public health authorities have to be willing to really explain and

⁵³ See, e.g., *Sherbert v. Verner* 374 U.S. 398 (1963).

⁵⁴ Ross D. Silverman, *No More Kidding Around: Restructuring Non-Medical Childhood Immunization Exemptions to Ensure Public Health Protection*, 12 ANNALS HEALTH L. 277 (2003).

⁵⁵ U.S. CONST. amend. I.

⁵⁶ See, e.g., *Church of Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520 (1993).

support their interests. I think they could prove the herd immunity concept. However, I think lawyers are careful about protecting the individual's interests and demand proof that the interest of the state is really legitimate in order to trump individual liberty interests.

PROFESSOR NICHOLAS FREUDENBERG: I guess having grown up in this society and seeing the ways that government uses its authority, I certainly see why. But again, it comes back to some of our earlier discussions and the notion that individualism and individual rights both protect against abuses of power by the state, but also works as an ideology promoted by corporations. I think our concern for individuals at the expense of the collective—at the expense of society—is the problem. Individuals saying they can smoke because they want to; saying they do not have to wear a motorcycle helmet because they do not want to. It is a social problem. It is a public health problem. I do not know exactly how one would work those problems out other than by looking at the particulars.

PROFESSOR JANET CALVO: If it makes you feel any better, the courts often allow infringement upon individual rights. The courts often find some legitimate state interest when individuals object to its actions.⁵⁷ It is inappropriate in some cases because the state has not proven what it needs to, and that is a problem.

PROFESSOR RUTHANN ROBSON: One thing that we have not discussed so far, though I think the themes have been alluded to, is how you both see mental health fitting into this overall.

PROFESSOR NICHOLAS FREUDENBERG: Well, just to illustrate, more than 50% of all prison and jail inmates have some sort of mental health or drug problem.⁵⁸ As a result of the de-institutionalization—the moving of people out of mental hospitals that began in the 1950s and continues to this day—the largest mental hospitals in the country right now are Rikers Island, a few miles from here, and the Los Angeles County Jail. We now have more mentally ill people in this country in jails than in mental hospitals. Another example, to return to our healthcare discussion, is a bill recently passed by Congress which requires insurance companies to cover mental health services comparable to the physical health services they cover.⁵⁹ It is a very weak law, but I guess a modest step

⁵⁷ *Jacobson*, 197 U.S. 1.

⁵⁸ THE UNITED STATES DEPARTMENT OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT: MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006).

⁵⁹ The Renewable Energy and Job Creation Act of 2008, H.R. 6049, 110th Cong. (2d Sess. 2008).

in the right direction.

PROFESSOR JANET CALVO: When I graduated from college, my first job was working with the Connecticut Department of Mental Health. What they were trying to do at the time was de-institutionalize patients of three huge mental health hospitals. The worst one was in Fairfield County—the wealthiest county in Connecticut.⁶⁰ The whole thrust was to de-institutionalize people and get them into community-based mental health programs. However, there was a non-acceptance of people who were struggling with mental health problems. The community-based programs were not sufficiently developed and it led to mentally ill people from state mental institutions being without treatment in urban areas like Hartford and New York City. You are right about how the jails are now the mental health institutions and they are just as bad as, and even worse than mental health hospitals. I just do not know how we handle it. What do we do? Mental health issues are so important. Do you have any notions of how society should be dealing with this responsibly?

PROFESSOR NICHOLAS FREUDENBERG: I have some. I actually teach a course in urban health and we just did a section on mental health services. I think one thing is in our healthcare system, we need to make sure that the professionals, the nurses and doctors and social workers, have competencies in both physical health and mental health. Most people get most of their care from primary care practitioners, internists, pediatricians, OB GYN doctors, and from practitioners—nurse practitioners. For the most part, the training in physical health and mental health is totally separate. But physical and mental health problems happen in the same body. People go to the doctor wanting help. There is a very close connection between physical health problems and mental health problems. I think one thing to do is to better train our professionals, to set up reimbursement systems so that when you go to your healthcare provider, he or she is capable of dealing with both sets of problems. Sometimes that would require a referral.

I think the second issue is that we do a terrible job with prevention and early intervention. Schools are a great place to develop mental health services because you get early signs when kids are acting out or they are depressed or anxious. In a decent society, the school has a system for seeing the problem, the teacher or parent noticing a problem, and getting that kid into care. I think

⁶⁰ U.S. Department of Commerce Bureau of Economic Analysis, Regional Economic Accounts, www.bea.gov/regional/reis/scb.cfm (last visited Mar. 30, 2009).

beefing up our mental health services in schools and in daycare, and other places could lead to better mental health for the population. Then, I think thinking about prevention of mental illness and psychological problems. Having a safe place for your child for child care does a lot to relieve the kinds of anxiety and stresses and depressions that so many working parents face. That is a mental health issue. Having access to good child care is a mental health issue.

PROFESSOR JANET CALVO: I think those are terrific and I think that is great; but we still have a problem with people who are involuntarily detained because of their mental health issues, which I think people would be more willing to accept if the care that they got in those institutions was good care. However, often people are involuntarily detained because they are mentally ill, but then they do not receive treatment. They are just incarcerated.

PROFESSOR NICHOLAS FREUDENBERG: Because it is not a mental health system.

PROFESSOR JANET CALVO: Maybe they see a psychiatrist once and then they are drugged. They are forced to use drugs that may be adverse to them physically, and that may be another component of their problems. One of the things lawyers do, and some of our students have worked on this, is try to force the conditions to change in those institutions.⁶¹ It is very hard. There is law that mandates the government to provide treatment where it involuntarily detains a person in jail or in a mental institution⁶²; but people are still not getting the treatment they need.

PROFESSOR NICHOLAS FREUDENBERG: I think we can also look at the role of markets in this and how mental health is constructed and responded to in our society. Healthcare providers in general follow money rather than need. So if you live on the Upper East Side, it's not very hard to find mental health services, but if you live in Harlem, it is much harder. The pharmaceutical industry develops drugs for which there is a market and promotes those relentlessly within that market rather than where there is a social need. In the end, relying on market forces to solve our mental health problems will not work.

⁶¹ CUNY Law Students have, through the Health Law Concentration, worked with Mental Hygiene Legal Services and New York Lawyers for the Public Interest.

⁶² *Youngberg v. Romeo*, 457 U.S. 307 (1982) (holding that involuntarily committed residents have the right to reasonably safe confinement conditions, no unreasonable body restraints, and the habilitation they reasonably require); *Armstead v. Pingree*, 629 F. Supp. 273 (M.D. Fla. 1986). *See also* 56 C.J.S. Mental Health § 105.

PROFESSOR RUTHANN ROBSON: What would you tell law students about possibilities for change? What can they do?

PROFESSOR JANET CALVO: I think there are many things. First, I think that the dialogue we have had today, among public health scholars and legal scholars, is very important. Lawyers are used to working with expert witnesses but are not as used to collaborating with other professionals to come up with litigation or legislative advocacy strategies.

I also think that the recent election has opened a lot of opportunities for law students interested in health and healthcare reform. You can now work from within government for change. There will now be a Department of Justice that does not object to healthcare reform but, rather, helps promote it. You have an opportunity to go work for the state and local governments and insist they use their powers to promote health.

As far as litigation strategy, I would say make underlying constitutional claims. A lot of litigation gets resolved on statutory grounds and underlying constitutional claims are not made. However, the constitutional claims are like a Mack truck. They are like a big vehicle that can be driven through a case because once they are made, two things become relevant. Where constitutional due process and equal protection are invoked, fundamental notions of fairness and equality become relevant. These concepts then have to be considered in a case. Also the facts that go to those concepts have to be considered. Let me just give you one example of such a case. It was a case that a number of the CUNY law students worked on in the CUNY Law School clinic a number of years ago.⁶³ It involved access of non-citizens to Medicaid. One of the issues was the access of pregnant women to prenatal healthcare. It was a case that was originally resolved on statutory/regulatory grounds, but the constitutional claim was made.

Because the constitutional claim was made, public health data about the efficacy of prenatal healthcare and all the financial data about the fiscal advantage of prenatal healthcare were able to be brought into the case because they were relevant to the question of whether law was rational. Using the constitutional claim to bring in the facts made the judges much more informed and, therefore, more able to decide correctly on the statutory/regulatory grounds.⁶⁴ So I would say think about how what you are learning

⁶³ *Lewis v. Thompson*, 252 F.3d 567 (2d Cir. 2001).

⁶⁴ In 2000, the federal government made a motion to remove the injunction because the law had changed in 1996. The district court found that the new law was

in your Constitutional Law classes can be used to develop strategies to promote progressive agendas.

PROFESSOR NICHOLAS FREUDENBERG: I think our society needs smart, committed, passionate, well-trained lawyers like you all who can work in a variety of settings—as litigators to advance rights and enforce protections, to take on the industry, to win new ways of protecting those industries from harming people; as lawyers working in the law departments of public agencies; as members of city, state, and federal government working to protect the rights of your constituencies; as directors of non-profit organizations and advocacy organizations; and as practitioners, helping clients to win their rights to health and healthcare.

I think for you to fulfill those roles requires an understanding some of the issues that we have talked about today. We have just scratched the surface of many of these complex issues. I would just encourage you to pursue those interests, because the more you know, the better you will be able to both choose your role and then do it well.

PROFESSOR RUTHANN ROBSON: That concludes our discussion. Professors Freudenberg and Calvo will be available for questions following the panel. Thank you so much to both of you for being here today.

PROFESSOR JANET CALVO: Thank you.

PROFESSOR NICHOLAS FREUDENBERG: Thank you.

unconstitutional in denying prenatal healthcare to pregnant non-citizens and immediate Medicaid coverage to their newborn children. *Lewis v. Grinker*, 111 F. Supp. 2d 142 (E.D.N.Y. 2000). However, the Second Circuit held that the law was unconstitutional with respect to the newborn children, but constitutional with respect to the pregnant women. *Lewis*, 252 F.3d at 567.