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Setting the Health Justice Agenda: Addressing Health Inequity and Injustice in the Post-Pandemic Clinic

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SETTING THE HEALTH JUSTICE AGENDA: ADDRESSING HEALTH INEQUITY & INJUSTICE IN THE POST-PANDEMIC CLINIC

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The COVID-19 pandemic surfaced and deepened entrenched pre-existing health injustice in the United States. Racialized, marginalized, poor, and hyper-exploited populations suffered disproportionately negative outcomes due to the pandemic. The structures that generate and sustain health inequity in the United States—including in access to justice, housing, health care, employment, and education—have produced predictably disparate results. The authors, law school clinicians and professors involved with medical-legal partnerships, discuss the lessons learned by employing a health justice framework in teaching students to address issues of health inequity during the pandemic. The goal of health justice is to eliminate health disparities that are linked to structural causes like subordination, discrimination, and poverty. This Article suggests six maxims for law school clinics to advance health justice, centering on themes of transdisciplinary collaboration, upstream interventions, adaptability, racial justice, systemic advocacy, and community-based strategies. The discussion draws on analyses of the scholarly literature on medical-legal partnerships and examples from the authors' clinics. These maxims for health justice are particularly relevant during a global public health emergency, but they also transcend the current moment by contributing to the long-running cross-clinic dialogue about teaching and designing clinics for social justice.

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INTRODUCTION

One of the goals of clinical legal pedagogy is to teach students about the lawyer's role in ensuring both access to, and the quality of, justice for low-income and historically marginalized populations.¹ The COVID-19 pandemic illustrated how—for far too many—justice is inaccessible, inequity is rapidly increasing, and health justice is out of reach. Historically marginalized groups and low-income populations experienced disproportionate infection and mortality rates from COVID-19, as well as the highest rates of unemployment, barriers to health care access, food insecurity, and extreme eviction risk during the pandemic. These disparities stem from the social determinants of health (SDOH). SDOH “encompass[] the full set of social conditions in which people live and work,”² and drive health inequity for people living in poverty, people of color, and other historically marginalized groups. Structural determinants of health, including the political and legal systems in which discrimination can become embedded, influence poor health outcomes.³ It is upon the legal profession to uncover how the law, laden with bias and discrimination, can operate as a vehicle of subordination, creating barriers to opportunity, long-term hardship, and poor health. No other profession bears more responsibility for the role of law in lifting or oppressing members of society. The pandemic-related increase in the need for legal services highlighted the urgency of not only providing the next generation of lawyers with foundational lawyering skills, but also imbuing them with a sense of

¹ Jane Aiken, *Striving to Teach “Justice, Fairness, and Morality”*, 4 CLIN. L. REV. 1, 9 (1997); see also Stephen Wizner & Jane Aiken, *Teaching and Doing: The Role of Law School Clinics in Enhancing Access to Justice*, 73 FORDHAM L. REV. 997, 998 (2004); Philip Schrag, *Constructing a Clinic*, 3 CLIN. L. REV. 175 (1996).

² COMM’N ON THE SOC. DETERMINANTS OF HEALTH, WORLD HEALTH ORG., A CONCEPTUAL FRAMEWORK FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 9 (2010), https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf; see also Centers for Disease Control and Prevention, About Social Determinants of Health, <https://www.cdc.gov/socialdeterminants/about.html> (defining social determinants of health as the “conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes”); Emily A. Benfer, Seema Mohapatra, Lindsay F. Wiley & Ruqaiyah Yearby, *Health Justice Strategies to Combat the Pandemic: Eliminating Discrimination, Poverty, and Health Disparities During and After COVID-19*, 19 YALE J. HEALTH POL’Y, L. & ETHICS 122, 126 (2020) (“The social determinants of health are subdivided into ‘structural determinants’ and ‘intermediary determinants.’ Structural determinants of health are ‘social and political mechanisms that generate, configure and maintain social hierarchies’ and organizations and institutions that can impact behavior. Structural determinants (discrimination, poverty, and other forms of subordination, as well as the political and legal systems in which subordination is embedded), impact the intermediary determinants of health. The intermediary determinants include material and environmental circumstances, such as health care, housing, and employment conditions.”).

³ See COMM’N ON THE SOC. DETERMINANTS OF HEALTH, *supra* note 2.

legal stewardship. In this way, the pandemic underscored the need for clinical legal education to adopt strategies that both increase lawyering skills and directly address the structural determinants at the root of the justice crisis.

Health justice is the eradication of social injustice and health inequity caused by discrimination and poverty. The health justice framework provides a model for training students to recognize the structural and intermediary determinants of health at the root of their clients' hardship, and to actively work with the community to address barriers to health equity and social justice. The framework centers on engaging, elevating, and increasing the power of historically marginalized populations to address structural and systemic barriers to health, as well as to compel the adoption of rights, protections, and supports necessary to the achievement of health justice.⁴ In the law clinic setting, health justice offers a holistic, interprofessional, and proactive approach to addressing social injustice. It teaches students to investigate the roots of their clients' legal crises and to identify leverage points to shift the deeply connected health disparities and injustices that plague marginalized communities. A holistic understanding of social injustice and health inequity prepares students to seize those opportunities to develop proactive—rather than reactive—legal interventions to address potential health crises. While we have used the health justice framework to conceptualize and explain the work of medical-legal partnerships (MLPs) in this Article, the framework can be adapted to any law school clinic setting.

This Article arose from a discussion among five law school clinicians and law professors who have over four decades of combined experience designing and working in MLPs to address health-harming legal needs for low-income and historically marginalized patients. The Article provides our reflections on the successes and challenges of the

⁴ At times, this Article uses the term “empowerment” or alternative phrasing, such as here, where we describe the aim of health justice to “elevate the power” of historically marginalized communities. The concept of “empowerment” is open to critique because it contemplates the idea of a favored group granting power to another. “[T]here is a fundamental paradox in the idea of people empowering people because the very institutional structure that puts one group in a position to empower others also works to undermine the act of empowerment.” Judith Gruber & Edison J. Trickett, *Can We Empower Others? The Paradox of Governing of an Alternative Public School*, 15 AM. J. COMMUNITY PSYCH. 353 (1987). The health justice framework seeks the outcome of empowerment (and should not contemplate the idea of an outside actor bestowing power). See, e.g., Angela Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. REV. 758, 806 (2020). (“[H]ealth justice . . . calls for subordinated communities to speak and advocate for themselves. Embracing social movements as equal partners . . . acknowledges the internal limitations of public health and law. Moreover, allowing marginalized groups an equal voice empowers them against the possibility of abusive alliances of public health and law.”).

MLP model for promoting health justice during the COVID-19 pandemic. It also memorializes our identification of key principles that, we think, could and should be adopted across all clinics, regardless of subject matter, to advance social justice and health equity and enhance student learning. Part I provides an overview of the relationship between structural injustice and pandemic-related health impacts. It then explains how individual-level responses to these crises have largely failed to protect the populations that are widely considered marginalized in U.S. society. Finally, it describes the role of legal interventions in combatting health inequity. Part II introduces the health justice framework, showing how MLPs have used it to address “wicked problems” at the intersection of law, health, race, and poverty. Part III proposes maxims for law clinics in general to adopt to advance health justice, drawn from the authors’ experiences over the past eighteen months.

We believe that the health justice framework and our reflections can be useful to all clinicians because of the relationship between unmet legal needs and poor health: When clinics intervene to help clients address financial or food insecurity, unstable or unsafe housing, employment discrimination, inadequate educational supports, immigration issues, and interpersonal or community violence, criminal justice issues, among other legal needs, we address health justice. Because we are all, ultimately, affecting the SDOH and the structures that direct health outcomes, this framework provides helpful insights to clinicians working across a range of legal issues. Amid the global COVID-19 pandemic, the link between health equity and access to justice is clearer and more salient than ever before.

I. RACIAL HEALTH INEQUITY AND SOCIAL INJUSTICE: THE AMERICAN CRISIS AND STATUS QUO

A. *The Toll of Discrimination, Poverty, and Poor Health on Historically Marginalized Groups*

The lower a person’s socioeconomic status, the greater the risk of suffering from chronic diseases, including heart disease, pulmonary disease, and diabetes—all of which increase the risk of COVID-19 complications and mortality.⁵ The events of 2020 illuminated how discrimination and poverty prevent historically marginalized groups from equitable access to resources and necessities—such as housing, em-

⁵ Emily A. Benfer, David Vlahov, Marissa Long, Evan Walker-Wells, J.L. Pottenger, Jr., Gregg Gonsalves & Danya E. Keene, *Eviction, Health Inequity, and the Spread of COVID-19: Housing Policy as a Primary Pandemic Mitigation Strategy*, 98 J. URB. HEALTH 1, 4 (2021).

ployment, food, education, healthcare, or employment—and continued to do so throughout the pandemic. Leading into the pandemic, Black and Latinx⁶ people experienced poverty at more than twice the rate of whites.⁷

Before the pandemic, Black Americans were twice as likely to be unemployed as whites, and people of color were more likely to have jobs that do not provide a living wage.⁸ Only 10% of white Americans experienced hunger, compared to up to 21.5% of households of color.⁹ Also, many people of color and low-income people disproportionately live in neighborhoods with limited access to affordable nutritious food.¹⁰ For example, only 8% of Black Americans have a grocery store within their census tract.¹¹ Housing precarity and eviction affects Black renter households at the highest rates of any racial group and has long-term negative implications for health.¹²

SDOH like poverty, limited access to clean air and water, and substandard living conditions have driven larger proportions of people of color to develop comorbidities, like asthma or hypertension.¹³ Communities of color have long had higher rates of high blood pressure, asthma, diabetes, and obesity, and other chronic health condi-

⁶ This Article uses the terms “Black,” “Black American,” and “African American” interchangeably and capitalizes the term “Black.” See Kimberlé Williams Crenshaw, *Race, Reform, and Retrenchment: Transformation and Legitimation in Antidiscrimination Law*, 101 HARV. L. REV. 1331, 1332 n.2 (1988) (“I shall use ‘African-American’ and ‘Black’ interchangeably. When using ‘Black,’ I shall use an upper-case ‘B’ to reflect my view that Blacks, like Asians, Latinos, and other ‘minorities,’ constitute a specific cultural group and, as such, require denotation as a proper noun.”). Where we cite to the data or to the descriptions of others, we use the terms employed by those authors for accuracy.

⁷ In 2018, 10% of white Americans were in poverty, compared to 21% of Blacks and 18% of Latinos. JESSICA SEMEGA, MELISSA KOLLAR, JOHN CREAMER, & ABINASH MOHANTY, U.S. CENSUS BUREAU, *INCOME AND POVERTY IN THE UNITED STATES: 2018* 13 (2019), <https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-266.pdf>.

⁸ Margot Nitschke, Alliance to End Hunger, *Hunger is a Racial Equity Issue* (July 2017) https://alliancetoendhunger.org/wp-content/uploads/2017/07/Factsheet_Alliance-To-End-Hunger_HUNGER-IS-A-RACIAL-EQUITY-ISSUE_071917.pdf; see also Yael Cannon, *Injustice is an Underlying Condition*, 6 U. PA. J.L. & PUB. AFF. 201, 223 (2020).

⁹ Nitschke, *supra* note 8.

¹⁰ Cannon, *supra* note 8, at 223 (citing ELIZABETH TOBIN-TYLER & JOEL B. TEITELBAUM, *ESSENTIALS OF HEALTH JUSTICE: A PRIMER* 70 (2019)).

¹¹ Nitschke, *supra* note 8.

¹² Peter Hepburn, Renee Louis & Matthew Desmond, *Racial and Gender Disparities Among Evicted Americans*, 7 SOCIO. SCI. 649, 652 (2020); Gracie Himmelstein & Matthew Desmond, *Eviction and Health: A Vicious Cycle Exacerbated By a Pandemic*, Health Affairs Health Pol’y Brief (Apr. 2021).

¹³ See generally Emily A. Benfer & Allyson E. Gold, *There’s No Place Like Home: Reshaping Community Interventions and Policies to Eliminate Environmental Hazards and Improve Population Health for Low-Income and Minority Communities*, 11 HARV. L. & POL’Y REV. S1 (2017).

tions, along with lower rates of life expectancy.¹⁴ The available state-level data on racial disparities underscores these national disparities.¹⁵ While many racial health disparities cross socioeconomic boundaries, the public health literature recognizes that people of color who are also lower-income face a “double burden” that compounds health impacts as a result of the stressors associated with both racism and poverty.¹⁶

The pandemic exacerbated these conditions: the highest rates of excess COVID-19 morbidity and mortality, unemployment, food insecurity, and eviction in the United States occurred among Black, Latinx, Native, and low-income people.¹⁷ These disparities can be explained by structural and intermediary determinants of health. Structural determinants of health include structural, institutional, and interpersonal discrimination that influence the laws and policies dictating access to the intermediary determinants of health, such as material and environmental circumstances.¹⁸ For example, barriers to employment, housing, education or health care, among other intermediary determinants of health, can be traced to the “longstanding underlying social, economic, and health inequities that stem from structural and systemic barriers across sectors. . . .”¹⁹ SDOH have made it more difficult for many low-income people of color to comply with the CDC pandemic protocol, such as social distancing and self-quarantine due to low-wage essential worker duties, lack of sick leave, lack of child care during school closures, overcrowded housing, and reliance on public transportation.²⁰ Against this backdrop of pandemic-related social determinants combined with longstanding socioeconomic and health conditions that existed before the pandemic, Native American, Latinx, and Black American communities experienced higher rates of infection, hospitalization, intensive care treatment, and

¹⁴ Cannon, *supra* note 8, at 203-204, 223-224.

¹⁵ See, e.g., Racial Data Dashboard, COVID Tracking Project, <https://bit.ly/2QvDF1t> (showing disproportionately higher rates of infection and death for non-whites relative to percentage of population by state).

¹⁶ Cannon, *supra* note 8, at 212 (citing Edith Chen, Andrew D. Martin & Karen A. Matthews, *Understanding Health Disparities: The Role of Race and Socioeconomic Status in Children's Health*, 96 AM. J. PUB. HEALTH 702, 702 (2006)).

¹⁷ Emily A. Benfer & Lindsay F. Wiley, *Health Justice Strategies to Combat COVID-19: Protecting Vulnerable Communities During a Pandemic*, HEALTH AFFAIRS BLOG (Mar. 19, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200319.757883/full/>.

¹⁸ Benfer et al., *supra* note 2, at 126.

¹⁹ Samantha Artiga, Bradley Corallo & Olivia Pham, *Racial Disparities in COVID-19: Key Findings from Available Data and Analysis*, KAISER FAMILY FOUND. (Aug. 17, 2020), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-covid-19-key-findings-available-data-analysis/>.

²⁰ Cannon, *supra* note 8, at 204.

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mortality.²¹

In light of pre-pandemic disparities, it was entirely predictable that people living in poverty, people of color, people with disabilities, LGBTQIA people, and other marginalized groups would bear the brunt of the collective crises plaguing society, including the COVID-19 pandemic, police violence, economic recession, climate disasters, and voter suppression.²² It is also foreseeable that, without interventions, these traumas will be repeated and will result in perpetual deterioration of health and well-being, as well as long-term economic and housing instability. This fact, long recognized by scholars and activists, has reached a level of public consciousness and discourse unknown for a generation, and presents an opportunity for clinical legal education to address these “wicked problems” to scale.

B. Health Inequity as a “Wicked Problem”

Health inequity refers to the systematic differences in health status between populations. This inequity results from differences in the distribution of health resources between demographic groups which lead to unfair and avoidable differences in health outcomes.²³ Health inequity is a complex social phenomenon that can be categorized as a wicked problem.

The wicked problem paradigm provides a theoretical framework for defining problems and developing innovative strategies for disrupting challenges anchored in complexity.²⁴ Wicked problems have several characteristics.²⁵ They straddle disciplinary boundaries, mak-

²¹ *Id.* at 214-215.

²² Benfer et al., *supra* note 2, at 126.

²³ NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE, COMMUNITIES IN ACTION: PATHWAYS TO HEALTH EQUITY 99 (Alina Baciú, Yamrot Negussie, Amy Geller, and James N. Weinstein, eds., 2017).

²⁴ There are those who would argue that the wicked problem frame creates more questions than it provides answers. “Questions also emerge as to whether the notion of wicked problems offers any new insights on how to tackle wicked problems in policy practice.” Catrien J.A.M. Termeer, Art Dewulf & Robbert Biesbroek, *A Critical Assessment of the Wicked Problem Concept: Relevance and Usefulness for Policy Science and Practice*, 38 POL’Y & SOC’Y 167, 169 (2019). *But see* Claes Andersson & Petter Törnberg, *Wickedness and the Anatomy of Complexity*, 95 FUTURES 118, 118-138 (2018) (arguing that the qualities of wicked problems are also the reasons why we struggle to, “predict, prevent and deal with them. They are also seen as key to the development of a new generation of approaches to understanding and tackling these problems.”).

²⁵ *See* Horst W. J. Rittel & Melvin M. Webber, *Dilemmas in a General Theory of Planning*, 4 POL’Y SCIENCES 155, 160-167 (1973). The authors, credited with coining the term, identified ten characteristics of a wicked problem. They distinguish wicked problems from “problems in the natural sciences, which are definable and separable and may have solutions that are findable.” *See also* Termeer et al., *supra* note 24, at 167-168 (framing wicked problems as those that “transcend the borders of traditional policy domains, involve a wide variety of actors across different scale levels and resist our attempts to solve them”); Judith

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ing them difficult to define in isolation from other interconnected concerns. They have multiple root causes and operate at varying levels of scale, making it difficult to inventory all their implications. Wicked problems are persistent and resist true resolution; indeed, they are “reinvented and refurbished, just as solutions are refreshed and recycled.”²⁶

The problem of health inequity is “wicked” according to these terms.²⁷ The reach of health inequity extends from the health care sector to housing markets, public school districts, environmental concerns, employment, and beyond. Thus, the full consequences of health inequity are unknowable, and cannot be narrowly defined as simply a problem attributable to a lack of access to health insurance, housing instability, low educational attainment, or poor air quality. Health inequity is chronic, rooted in myriad social ills; it is the downstream result of historic and current injustices at the interpersonal, community, and national level. Anchored in systemic poverty and discrimination, health inequity resists superficial solutions. The interconnectedness of SDOH and the structural barriers to power and resources that was both spotlighted and compounded during the pandemic is only the most recent face of health inequity. The health disparities tallied since March 2020 represent both a health inequity crisis and the status quo.

Attempts to address health inequity must respond to its “wicked” qualities. Legal interventions that fail to account for the power and relational dynamics that have sustained health inequities over time and across demographic groups risk accelerating, if not further entrenching, their oppressive consequences. Efforts to upend the racial and social injustice at the core of health inequity must involve more than direct representation. Legal advocacy strategies must also target structural and intermediary health determinants, including economic and socially discriminatory institutions and the laws and policies they effectuate. The framework of the wicked problem anchors the position that efforts to disrupt health-related disparities require interdisciplinary collaboration, public leadership, and creative strategies that target – in tandem – the needs of individuals, communities, and whole

Welch Wegner, *Reframing Legal Education's Wicked Problems*, 61 RUTGERS L. REV. 867, 871 (2009) (defining a “wicked problem” as one that occurs “when the factors affecting possible resolution are difficult to recognize, contradictory, and changing; the problem is embedded in a complex system with many unclear interdependencies, and possible solutions cannot readily be selected from competing alternatives”).

²⁶ Brian W. Head, *Problem Definition and the Policy Process: Wicked Problems*, OXFORD RESEARCH ENCYCLOPEDIA OF POLITICS (2017).

²⁷ “The adjective ‘wicked’ was initially supposed to describe ‘the mischievous and even evil quality of these problems, where proposed “solutions” often turn out to be worse than the symptom.’” Termeer et al., *supra* note 24, at 168 (citing C. West Churchman, *Wicked Problems*. 13 MGMT. SCI. B-141 (1967)).

populations.²⁸

C. The Role of Legal Intervention

In light of the social injustice and health inequity precipitated by the pandemic, it is critical to examine the role of law and legal education in mitigating and addressing the SDOH that exacerbate harm among historically marginalized groups.²⁹ People living in poverty experience adverse health outcomes directly related to socioeconomic status and their environment at higher rates than peers with higher income levels.³⁰ Old, inadequate, and unaffordable housing and substandard housing conditions often lead to negative health effects.³¹ At the same time, socioeconomic status can impact a patient's adherence to medical treatment.³² For example, an individual who is unable to afford an electric bill will be unable to refrigerate medication or use medical equipment requiring electricity. The majority of these poor health indicators can be traced, in part, to unresolved civil legal needs, such as food insecurity due to unlawful public benefit denials, which are common among low-income populations or lack of social supports during the pandemic that forced families to stretch food budgets.

During the pandemic, our clinics represented many clients whose legal issues constituted barriers to health and exemplified the “wicked” nature of health inequity. For example, the Georgetown Health Justice Alliance Law Clinic represented a family experiencing food insecurity due to pandemic-related unemployment. They lived in a rental unit with a rodent infestation and pervasive mold, which threatened the health of the entire family and, especially, that of a child with asthma. Because schools were closed, these substandard housing conditions posed an even greater chronic health threat.³³ When their landlord refused to repair the hazardous conditions, the family spent their food budget on repairs.³⁴ They feared eviction and

²⁸ Rittel & Webber, *supra* note 25, at 159.

²⁹ NAT CTR. FOR MED.-LEGAL PARTNERSHIP, UTILITY ACCESS AND HEALTH: A MEDICAL-LEGAL PARTNERSHIP PATIENTS-TO-POLICY CASE STUDY (June 2010), <http://cca-ct.org/Utility%20Access%20and%20Health%20An%20MLPPatients-to-Policy%20Case%20Study.pdf>.

³⁰ Emily A. Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice*, 65 AM. U. L. REV. 278, 350 (2015).

³¹ *Id.* at 292-99.

³² NAT CTR. FOR MED.-LEGAL PARTNERSHIP, *supra* note 29.

³³ “Being forced to stay inside a home with substandard housing conditions like mold or rodents can exacerbate respiratory and other illnesses that function as underlying conditions that make people more at risk for serious COVID complications.” Cannon, *supra* note 8, at 250.

³⁴ This phenomenon of the difficult choices low-income families can face as to which critical necessities to spend money on is sometimes known as “heat or eat.” *Id.* at 220.

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retaliation from their landlord. The children struggled to access remote schooling without reliable internet access. Each of these challenges carried severe consequences for the family's health, due in large part to unresolved civil legal needs and the absence of legal protections and social supports.

These themes—heightened income and food insecurity, the amplified impact of poor housing conditions, the threat of eviction, and the educational challenges and inequities—were commonplace among those living in poverty, and the clients of law clinics throughout the pandemic.³⁵ This is due in great part to structural determinants of health, such as laws and policies, which are a substantial source of health-harming issues among low-income populations and historically marginalized groups who are clinic clients.

II. MEDICAL-LEGAL PARTNERSHIP CLINICS IN PURSUIT OF HEALTH JUSTICE

By virtue of their structure and pedagogical goals, interdisciplinary and interprofessional clinical legal education programs, such as MLP clinics, are uniquely positioned to address social problems and ensure that everyone has “a fair and just opportunity to be healthy.” MLPs address the interconnected issues implicit in systemic health inequity and train law students—as complex “wicked” problem solvers—to respond to these concerns in individual lives and on a societal level. They also exemplify how other clinics can incorporate health justice principles to achieve client and pedagogical goals.

A. *Employing the Health Justice Framework to Address Wicked Problems*

The health justice framework³⁶ is designed to leverage law and

³⁵ These challenges have been documented nationally among communities of color and low-income communities during the pandemic. *See generally* Cannon, *supra* note 8.

³⁶ Health justice is a growing field that has been defined and written about in numerous social justice contexts. *See, e.g.*, Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J. L. & PUB. POL'Y 47, 47 (2014); Benfer, *supra* note 30; Lindsay F. Wiley, *From Patient Rights to Health Justice*, 37 CARDOZO L. REV. 833 (2016); Lindsay F. Wiley, *Applying the Health Justice Framework to Diabetes as a Community-Managed Social Phenomenon*, 16 HOUS. J. HEALTH L. & POL'Y 191 (2016); Lindsay F. Wiley, *Tobacco Denormalization, Anti-Healthism, and Health Justice*, 18 MARQ. BENEFITS & SOC. WELFARE L. REV. 203 (2017); Tobin-Tyler & Teitelbaum, *supra* note 10, at 15; Medha D. Makhlouf, *Health Justice for Immigrants*, 4 U. PA. J.L. & PUB. AFF. 235 (2019); Yael Cannon, *The Kids Are Not Alright: Leveraging Existing Health Law to Attack the Opioid Crisis Upstream*, 71 FLA. L. REV. 765 (2019); Emily A. Benfer, Emily Coffey, Allyson E. Gold, Mona Hanna-Attisha, Bruce Lanphear, Helen Y. Li, Ruth Ann Norton, David Rosner, Kate Walz, *Health Justice Strategies to Eradicate Lead Poisoning: An Urgent Call to Action to Safeguard Future Generations*, 19 YALE J. HEALTH POL'Y L. & ETHICS 146 (2020); Matthew B. Lawrence, *Against the “Safety Net,”* 72 FLA. L. REV. 49 (2020); Harris & Pamukcu,

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policy to “eliminate health disparities caused by discrimination and poverty and empower historically marginalized communities.”³⁷ A focus on the concept of “justice” adds to the public health framework of health “equity” by centering the critical role of law and policy in facilitating health disparities and in pursuing their elimination.³⁸ To achieve these goals, the framework offers three foundational principles:³⁹ *First*, legal and policy interventions must address the structural determinants of health inequities. *Second*, interventions must be accompanied by supports and protections that address inequities in the SDOH. *Third*, low-income communities and communities of color must be engaged and must have the opportunity to be leaders in the development, implementation, enforcement and evaluation of laws, policies, or other interventions aimed at achieving health equity and social justice. By necessity, employing the health justice framework requires lawyers to identify 1) sources of structural determinants of poor health (e.g., subordination, discrimination, and poverty), 2) the laws, policies, processes, budgets, and enforcement mechanisms that operate as vehicles of subordination and perpetuate harm, and 3) the resulting material and environmental circumstances that result in poor health outcomes and barriers to opportunity for historically marginalized groups.

In practice, health justice lawyering prompts the student or lawyer to move beyond a traditional attorney-client relationship, and to identify and address the underlying policies and conditions that created the harm. In the traditional attorney-client setting, the client self-identifies the need for an attorney, often at a point of crisis, and seeks assistance. For example, a family may be facing eviction after reporting conditions violations, or due to a reduction in household wages, making it impossible for them to afford their home. The lawyer’s immediate role is to appeal the eviction, perhaps raising retaliation or conditions claims, or to reach an equitable settlement that allows the family time to move. Health justice pushes advocates to dissect the root causes of the client’s despair. For example, laws and policies that favor landlords in the eviction system in the state may have made it easier for the landlord to file an unchecked retaliatory eviction. State preemption laws may have prohibited local government from adopting rent caps or inclusionary zoning policies that would have made housing more affordable for the family. The legacy of historically discriminatory laws and policies may have led to the family’s inability to

supra note 4, at 758.

³⁷ Benfer et al., *supra* note 2, at 136.

³⁸ Cannon, *supra* note 8, at 207.

³⁹ Benfer et al., *supra* note 2, at 137-141.

build a sufficient safety net for emergencies. The lack of organization among tenants may have silenced the client's voice as well as any attempts to compel policy makers to provide legal protections, financial supports, and accommodations. Evictions filed against people of color often implicate interpersonal, systemic, and structural forms of racial discrimination.

In addition to meeting the client's immediate needs, then, health justice requires advocates to explore and understand the connections between these injustices, health disparities, and the structural racism that drives them,⁴⁰ to elevate and empower affected communities, engage in community-based work to listen to the needs of the impacted community members, and to collaborate with interdisciplinary partners in addressing both the individual and systemic drivers of these inequities. It requires advocates to educate, partner with, and work to amplify the power of historically marginalized communities in order to reform laws and policies and secure legal protections and financial supports, including through the enforcement of existing laws to their fullest extent and through upstream mechanisms whenever possible.⁴¹ It also requires structural remediation to correct and prevent discrimination and poverty. These are the types of responses required of post-pandemic law school clinics and 21st century lawyers.

B. Medical-Legal Partnership

The MLP is a service delivery model that integrates lawyers into the health care team and implements health justice by addressing those SDOH that have legal remedies, known as health-harming legal needs.⁴² In the MLP model, legal professionals (e.g., attorneys, paralegals, supervised law students) are embedded into the health care team and work in collaboration with health care providers (e.g., physicians, nurses, physician assistants, medical students, residents, social workers) and the patient in order to identify and treat social and legal issues that negatively impact health and that cannot be resolved through medical care alone.⁴³ When embedded as specialists in a health care setting, legal professionals can directly resolve specific problems for individual patients, while also helping clinical and non-clinical staff navigate systemic and policy barriers and transforming institutional practices. Because the medical team conducts screenings,

⁴⁰ Cannon, *supra* note 8, at 208.

⁴¹ *Id.* at 218.

⁴² Edward B. Heaton et al., *Training Future Health Justice Leaders – A Role for Medical-Legal Partnerships*, 384 NEW ENG. J. MED. 1879, 1880 (2021).

⁴³ NAT'L CTR. FOR MED.-LEGAL PARTNERSHIP, <https://medical-legalpartnership.org> (last visited Apr. 21, 2021).

legal issues are often identified earlier in the timeline of crisis and before the patient becomes aware of the legal nexus. The interdisciplinary nature of the model uniquely situates MLPs to address the structural problems at the root of community health inequities, including local and state policies. Using legal expertise and services, the health care system can disrupt the cycle of poor health and improve patient health.

The model was born out of necessity and by virtue of interprofessional collaboration. In the 1990s, physicians at Boston Medical Center were seeing many pediatric asthma patients with acute asthma needs at emergency room visits, despite standard medical treatment.⁴⁴ After exploring further with the patients' guardians, they learned that many of their patients were living in substandard housing conditions, where mold, rodents, and other asthma triggers were preventing their patients from recovering.⁴⁵ Previously, parents tried to advocate with their landlords for those conditions to be remediated, but without success.⁴⁶ The physicians realized they needed an attorney on their team who could seek enforcement of housing and other rights implicating the health and safety of children and their families.⁴⁷

The model quickly received widespread support from the legal and medical fields. The American Bar Association and the American Academy of Pediatrics passed resolutions encouraging and promoting the development of MLPs among their memberships to "identify and resolve diverse legal issues that affect patients' health and well-being."⁴⁸ Both the U.S. Veterans Administration and the U.S. Health Services & Resources Administration have prioritized and incentivized MLP development among grantees.⁴⁹ Over the last decade, MLPs across the United States have nearly tripled, increasing from 82 partnerships serving over 160 hospitals and health centers in 37 states in 2009 to over 450 in 49 states and the District of Columbia in 2019.⁵⁰

⁴⁴ Barry Zuckerman, Megan Sandel, Lauren Smith & Ellen Lawton, *Why Pediatricians Need Lawyers to Keep Children Healthy*, 114 PEDIATRICS 224, 224 (2004).

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.* at 224-25.

⁴⁸ Benjamin Gitterman & Megan Sandel, *Resolution: Medical-Legal Partnership: Promoting Child Health through Preventative Law*, AMERICAN ACADEMY OF PEDIATRICS (Dec. 11, 2007), <https://medical-legalpartnership.org/wp-content/uploads/2014/02/American-Academy-of-Pediatrics-MLP-Resolution.pdf>.

⁴⁹ HRSA Recognizes Civil Legal Aid as "Enabling Services," *Allows Health Centers to Use Funding for MLP*, NAT'L CTR. FOR MED.-LEGAL PARTNERSHIP (OCT. 27, 2014), <https://medical-legalpartnership.org/enabling-services> (last visited Apr. 21, 2021); *Advancing Civil Legal Aid and Medical-Legal Partnerships in VA Medical Centers*, NAT'L CTR. FOR MED.-LEGAL PARTNERSHIP (May 3, 2019), <https://medical-legalpartnership.org/wp-content/uploads/2019/06/Advancing-Civil-Legal-Aid-and-MLP-in-VAMCs.pdf>.

⁵⁰ *Hundreds of the Nation's Leading Health Organizations Integrate Patient-Centered*

Nationally, the legal partners include 170 legal aid agencies and 58 law schools.⁵¹ The medical partners include health centers, children's hospitals, Veterans Administration medical centers, safety net hospitals, and community clinics.⁵²

MLPs work with a diverse array of patient populations, such as veterans, children, elders, and people with certain medical conditions like diabetes or cancer.⁵³ They target a panoply of legal issues that implicate health, including housing, public benefits, access to health care, disability, family, domestic violence, education, and immigration law.⁵⁴ In a MLP, health care providers screen patients for legal needs and refer them to lawyers for advocacy to address health-harming situations through a variety of legal interventions.⁵⁵ They also aim to transform health care practices to treat not only medical, but also social and legal issues that affect a person's health and well-being.⁵⁶ Moreover, using a "patients-to-policy approach," MLPs endeavor to improve population health, by using health and legal tools in combination to address systemic social problems that harm the health and well-being of a population.⁵⁷

MLP law school clinics are an increasingly important part of the growing MLP movement. These MLP clinics engage law students in this important interprofessional collaboration and holistic legal advocacy, integrating law students into healthcare teams at partner medical schools, hospitals, and other health centers. Academic MLPs "educate and train aspiring lawyers, doctors, nurses, social workers, case managers, and other health professionals to identify and understand people's health-harming legal needs, to collaborate with professionals in

Legal Services Into Their Care Delivery to Address Their Communities' Health-Related Social Needs, NAT'L CTR. FOR MED.-LEGAL PARTNERSHIP, <https://medical-legalpartnership.org/partnerships/> (last visited Apr. 21, 2021); Jack Karp, *Virus Turns Up Pressure On Medical-Legal Partnerships*, LAW360 (July 19, 2020, 8:02 PM), <https://www.law360.com/articles/1293163/virus-turns-up-pressure-on-medical-legal-partnerships>.

⁵¹ NAT'L CTR. FOR MED.-LEGAL PARTNERSHIP, *supra* note 50.

⁵² *Id.*

⁵³ MARSHA REGENSTEIN, JENNIFER TROTT & ALANNA WILLIAMSON, *THE STATE OF THE MEDICAL-LEGAL PARTNERSHIP FIELD: FINDINGS FROM THE 2016 NATIONAL CENTER FOR MEDICAL-LEGAL PARTNERSHIP SURVEYS 11-12* (2017), <https://medical-legalpartnership.org/wp-content/uploads/2017/07/2016-MLP-Survey-Report.pdf>.

⁵⁴ Kate Marple, *Chart: How Legal Services Help the HealthCare System Address Social Needs*, NAT'L CTR. FOR MED.-LEGAL PARTNERSHIP (Jan. 21, 2015), <https://medical-legalpartnership.org/mlp-resources/messaging-chart/>.

⁵⁵ Jennifer Trott & Marsha Regenstein, *Screening For Health-Harming Legal Needs*, NAT'L CTR. FOR MED.-LEGAL PARTNERSHIP (2016), <https://medical-legalpartnership.org/wp-content/uploads/2016/12/Screening-for-Health-Harming-Legal-Needs.pdf>; Elizabeth Tobin Tyler, *Medical-Legal Partnership in Primary Care: Moving Upstream in the Clinic*, 13 AM. J. LIFESTYLE MED. 282, 284 (2017).

⁵⁶ Tobin Tyler, *supra* note 55, at 284.

⁵⁷ *Id.*

various disciplines to address these needs, and to use their collective expertise to transform the systems that prevent people from achieving optimal health and well-being.”⁵⁸

MLPs embedded in law school clinics have been achieving important results for decades. For example, in the 1990s, physicians at the University of New Mexico reached out to faculty at the law school to develop a partnership engaging law students in family law and child welfare advocacy on behalf of high needs patient families. In 2007, the Health Law Partnership (HeLP) Legal Services Clinic at Georgia State Law School was launched in partnership with Morehouse and Emory Universities’ Schools of Medicine to bring law clinic students together with public health, social work, and bioethics students to advocate around access to health care and public benefits, consumer, housing, and education law needs for patients.⁵⁹

The last several years have seen tremendous growth in the development and expansion of MLP law school clinics, including the law schools at Georgetown, Penn State, the University of Pittsburgh, Yale, and Wake Forest, where the authors of this Article teach, among others. At least 58 law schools are now engaged in some way in MLP work.⁶⁰ Through interprofessional learning environments and advocacy teams, MLP clinic students “gain input from their same and different discipline peers while exploring patterns in the problems their clients face and the conditions in which they live. As a result, they learn to draw connections between individual client concerns and larger societal/structural concerns.”⁶¹ Although MLP law clinics use different methods to foster interdisciplinary and holistic health and legal advocacy, common approaches include rotations for medical, social work, public health, or students of other health disciplines into law clinics; interdisciplinary case advocacy and team meetings; case rounds, simulations, and team-based projects with interdisciplinary teams; cross-disciplinary legislative advocacy projects; collaborative presentations to community groups; and integration of medical and other students and providers into law clinic seminars and exercises.⁶²

⁵⁸ Edward B. Heaton et al., *supra* note 42, at 1880.

⁵⁹ See Georgia State University, Health Law Partnership Legal Services Clinic, <https://law.gsu.edu/student-experience/experiential-learning/clinics/health-law-partnership-legal-services-clinic/>.

⁶⁰ NAT’L CTR. FOR MED.-LEGAL PARTNERSHIP, *supra* note 50.

⁶¹ Jennifer Rosen Valverde, *Preparing Tomorrow’s Lawyers to Tackle Twenty-First Century Health and Social Justice Issues*, 95 DENV. L. REV. 539, 578 (2018).

⁶² *Id.* at 577; see also GEORGETOWN UNIV. HEALTH JUSTICE ALLIANCE, <https://www.law.georgetown.edu/health-justice-alliance/about-us/> (last visited Apr. 28, 2021); Emily A. Benfer, Abbe R. Gluck & Katherine L. Kraschel, *Medical-Legal Partnership: Lessons from Five Diverse MLPs in New Haven, Connecticut*, 46 J. L. MED. & ETHICS 602–09 (2018); Vicki W. Girard et al., *Defining the Academic Medical-Legal Partnership and its*

In training students to diagnose and tackle problems holistically and to collaborate interprofessionally, academic MLPs (including MLP law clinics) “present great promise for health and legal institution transformation by influencing and changing the way providers in both realms are trained from the beginning, before they even take on their first patient or client.”⁶³ They also present an ideal vehicle for addressing the wicked problems facing society during and after the pandemic.

III. SETTING THE AGENDA: MAXIMS FOR ACHIEVING HEALTH JUSTICE

Throughout the pandemic, MLP clinics worked in collaboration with health care providers and the hardest hit communities to respond to stark and rapidly expanding health inequity and social injustice. The increased demand, compounding nature of client crises, and urgency of the need tested the MLP and clinical teaching models, revealing both their benefits and opportunities for growth. While the lessons from the pandemic are ongoing and will require constant reflection and evaluation to extract, it is clear to us that the following maxims are critical to contributing to urgently needed social change, meeting client needs and achieving client goals, and training the next generation of attorneys to be stewards of justice:

- 1) *Transdisciplinary and Interprofessional Collaboration Perfects Problem Definition and Solution Ideation*
- 2) *Upstream Interventions Prevent the Greatest Amount of Harm in Individual Client Advocacy*
- 3) *Adaptable Interventions Best Address an Evolving Problem and Meet Stakeholders’ Changing Needs*
- 4) *A Racial Justice Focus Must Anchor Clinical Practice*
- 5) *Systemic Advocacy Achieves Health Justice*
- 6) *Community-Based Interventions Increase the Power of Affected Populations*

We acknowledge that these maxims may require resources that are not yet available to implement, or may be challenging or take years of planning to implement. Nevertheless, we hope that they provide readers with new and useful perspectives on the possibilities for

Role in Training the Next Generation of Health & Legal Professionals to Work Together to Advance Health Justice (on file with authors); Valverde, *supra* note 61, at 577.

⁶³ Yael Cannon, *A Mental Health Checkup for Children at the Doctor’s Office: Lessons from the Medical-Legal Partnership Movement to Fulfill Medicaid’s Promise*, 17 *YALE J. HEALTH POL’Y, L. & ETHICS* 253, 287 (2017); *see also* TOBIN-TYLER & TEITELBAUM, *supra* note 10, at 139 (“One of the key features of MLPs is their ability to bring together and train health care, public health, legal, and social service providers to understand health-harming needs through a structural and legal lens.”).

clinic design. We also humbly acknowledge the limits of our own understanding of this topic: While we believe that these reflections may prove useful to others, we also write in the hopes of furthering dialogue with the larger clinical community about clinic design in pursuit of social justice. After all, confronting wicked problems requires an evolving and flexible solution. We offer these maxims as a proposed but ever adapting agenda for clinics to achieve the health justice so urgently needed in this moment and beyond.

A. Transdisciplinary and Interprofessional Collaboration Perfects Problem Definition and Solution Ideation

Many law school clinics aim to improve students' problem-solving capacity.⁶⁴ In the pandemic and post-pandemic setting, teaching students to identify the pervasive challenges posed by wicked problems can help students see the whole interconnected and evolving system of problems in which their clients' issues are situated. It can also underscore why individual-level responses are often inadequate on their own to solving wicked problems. Interprofessional and transdisciplinary collaboration is critical to fully defining the wicked problems affecting historically marginalized groups in the aftermath of the pandemic. It can provide a clearer picture of wicked problems, which make it "less apparent where and how we should intervene even if we do happen to know what aims we seek."⁶⁵ Transdisciplinary collaboration is also paramount to solving wicked problems, in part, because of the many traits it fosters, including responsiveness, exploration, collective learning, and resilience.⁶⁶ These traits embody key components of wicked-problem solving: innovative strategies, systems-informed hypotheses, and engagement at a variety of leverage points within the structures that perpetuate the harm.

The challenges that face historically marginalized communities are severe, complex, and multifaceted, and they cannot be resolved without also examining the overlapping systems and the legal, economic, social, historical, and political implications of the issues at hand. Yet students providing legal assistance to individual clients in a traditional legal setting rarely learn about the structural or intermediary determinants of health—let alone the linked societal contexts—of the problem they seek to solve; nor do they learn how to identify partners who could assist them in approaching the issue in a holistic and

⁶⁴ See Schrag, *supra* note 1, at 180.

⁶⁵ Rittel & Webber, *supra* note 25, at 159. The authors are credited with coining the term "wicked problem."

⁶⁶ *Id.*

expeditious way.⁶⁷ As Richard Neumann and Donald Schön write, “Effective lawyers do not practice law. They solve problems, using law as one among many professional tools.”⁶⁸

Collaboration across disciplines allows students the opportunity to transcend professional boundaries and disciplinary silos that limited earlier responses and to engage in multi-dimensional analysis.⁶⁹ By partnering across disciplines, clinics can increase innovation and effective problem identification and solving.⁷⁰ For students, interprofessional collaboration enhances perspective, awareness, teamwork and collaboration skills, creative problem-solving, and leadership experience.⁷¹ In addition, they gain an appreciation and respect for the role of other professions in achieving their clients’ goals. Most importantly, they can be more effective in addressing the compounded issues their clients face.

Collaboration is a strength of the MLP Clinic model. In this setting, law students practice on interprofessional teams that may include students or practitioners from the fields of law, social work, public health or medicine. This level of interprofessional and interdisciplinary collaboration is a vital aspect of examining the whole patient or client, and it expands the team’s ability to identify creative solutions to legal issues and SDOH affecting low-income populations. “MLPs offer an ideal forum through which to support cross-education and highlight how law is about more than ‘liability’ (and its avoidance), with an explicit goal for MLPs’ work being the advancement of patient care through interdisciplinary teamwork.”⁷²

Similarly, because of the complex and intertwined nature of social injustice, all law school clinics can and should collaborate across

⁶⁷ See Linda Morton et al., *Teaching Interdisciplinary Collaboration: Theory, Practice, and Assessment*, 13 QUINNIPIAC HEALTH L.J. 175, 176 (2010); Gary L. Harbaugh, *Assumptions of Interprofessional Collaboration: Interrelatedness and Wholeness*, in INTERPROFESSIONAL CARE AND COLLABORATIVE PRACTICE 11, 19-20 (R. Michael Casto et al. eds., 1994).

⁶⁸ Richard K. Neumann Jr. & Donald Schön, *The Reflective Practitioner, and The Comparative Failures of Legal Education*, 6 CLIN. L. REV. 401, 405 (2000).

⁶⁹ See Emily A. Benfer, *Educating the Next Generation of Health Leaders: Medical-Legal Partnership and Interprofessional Graduate Education*, 35 J. LEGAL MED. 113, 113-48 (2014).

⁷⁰ See Elizabeth Tobin Tyler, *Allies Not Adversaries: Teaching Collaboration to the Next Generation of Doctors and Lawyers to Address Social Inequality*, 11 J. HEALTH CARE L. & POL’Y 249, 274 (2008); Laura R. Bronstein, *Index of Interdisciplinary Collaboration*, 26 SOC. WORK RES. 113, 114 (2002)

⁷¹ See Benfer, *supra* note 69.

⁷² Elizabeth Tobin Tyler, Lauren Taylor Anderson, Leah Rappaport, Anuj Kumar Shah, Deborah L. Edberg & Edward G. Paul, *Medical-Legal Partnership in Medical Education: Pathways and Opportunities*, 35 J. LEGAL MED. 149, 149-177 (2014); Tobin Tyler, *supra* note 70, at 271-73; see also Amy T. Campbell, *Teaching Law in Medical Schools: First Reflect*, 40 J. L. MED. & ETHICS 301, 305 (2012).

legal issues. For example, during the pandemic the Georgetown Law Center criminal justice clinics collaborated with the school's MLP clinic medical partners to obtain compassionate early release for clients. The medical partners were able to define the health threats that the clients would face during the pandemic if forced to remain imprisoned and unable to socially distance.⁷³ Overwhelmingly, the evidence demonstrates that interprofessional teams improve health outcomes of both patients and communities.⁷⁴ Collaboration across disciplines is paramount given our post-pandemic reality, especially as clinical legal education programs seek to further social justice and health equity.

B. Upstream Interventions Prevent the Greatest Amount of Harm in Individual Client Advocacy

Families of means can often access legal advice proactively and even preventively at certain critical junctures in their lives: prior to marriage or divorce; or in advance of the birth of a child or the end of life, for example.⁷⁵ They have the resources to anticipate, plan for, and prevent legal issues. However, low-income individuals do not typically have such opportunities. Instead, people with limited resources may never access an attorney to assist them with legal needs, either because they do not recognize their issues as being legal in nature, or because there are not enough attorneys (or law clinic students) providing free or low-cost legal assistance to address the unmet needs.⁷⁶ With this preexisting "justice gap" that has only been exacerbated during the pandemic,⁷⁷ those who provide free legal services are recognizing that there is more unmet need than ever.⁷⁸ Even before the pandemic, legal services providers were often forced to limit case acceptances to those with situations categorized as emergencies, making

⁷³ Georgetown Univ. Law Center, *For Georgetown Law's Criminal Clinics, A Banner Year for Compassionate Release Wins*, <https://www.law.georgetown.edu/experiential-learning/clinics/a-banner-year-for-compassionate-release-wins/>.

⁷⁴ WORLD HEALTH ORG., *FRAMEWORK FOR ACTION ON INTERPROFESSIONAL EDUCATION & COLLABORATIVE PRACTICE 7* (2010), <https://www.who.int/publications/i/item/framework-for-action-on-interprofessional-education-collaborative-practice>.

⁷⁵ Samantha Morton, *Legal Information and Rights Education as Element of Care: A Promising Health Justice Strategy*, HEALTH AFF. BLOG (Jun. 7, 2021), <https://www.healthaffairs.org/doi/10.1377/hblog20210603.174251/full/>.

⁷⁶ LEGAL SERVS. CORP., *THE JUSTICE GAP: MEASURING THE UNMET CIVIL LEGAL NEEDS OF LOW-INCOME AMERICANS* 8, 36 (2017), <https://www.lsc.gov/sites/default/files/images/TheJusticeGap-FullReport.pdf>.

⁷⁷ AM. ACAD. OF ARTS AND SCIENCES, *CIVIL JUSTICE FOR ALL 1-3* (2020), https://www.amacad.org/sites/default/files/publication/downloads/2020-Civil-Justice-for-All_0.pdf. ("According to one recent study, low-income Americans received adequate legal attention in only 14 percent of the problems they reported.")

⁷⁸ *Id.* at 2-3

legal services the “legal emergency room for the poor.”⁷⁹ When low-income people do access legal information and representation, it is often in the face of crisis.⁸⁰ Once problems have escalated into crises, they become more inextricable, more wicked, more harmful, and more challenging to solve.

This model of downstream, crisis lawyering is also driven by the way most people access free or low-cost legal assistance. Some people may be eligible for a court-appointed attorney once a crisis, like an arrest or removal of children into foster care, has already transpired. Otherwise, an indigent person must typically first recognize that the problem is in fact a legal issue with which an attorney may be able to help, obtain information on how to access free or low-cost legal assistance for that issue, and then reach out affirmatively to that law office by phone or make their way in person to a law office or courthouse.⁸¹ Some low-income clients meet their attorney a few minutes before a hearing in which they may be facing very high stakes, such as the loss of their home or their child.

These challenges to accessing legal advice and representation mean that low-income people who do obtain legal assistance often do so at the point at which their situation has escalated and the harm has proliferated. Indeed, “it is an axiom of civil legal aid service provision that by the time clients realize that they have a legal problem, it is likely so far along that prevention is impossible.”⁸² When there are delays in accessing legal assistance and situations escalate, “a family whose custody matter could have been resolved had they had legal help may end in violence between the parents, families facing mortgage foreclosure or illegal evictions may lose their home and have to rely on the assistance of the shelter system and an individual denied Unemployment Compensation will not have money to buy food or

⁷⁹ Hearing Before the S. Judiciary Comm., 2013 Leg., 5-9 (Pa. 2013) (written statement of Rhodia D. Thomas, Executive Director of MidPenn Legal Services), <https://www.pubintlaw.org/wp-content/uploads/2013/07/Witness-list-and-testimony-May-7-Hearing-FI-NAL.pdf> (hereafter cited as “Written Statement of Rhodia D. Thomas”).

⁸⁰ Morton, *supra* note 75.

⁸¹ Barry Zuckerman, Megan Sandel, Ellen Lawton, Samantha Morton., *Medical-Legal Partnerships: Transforming Healthcare*, 372 LANCET 1615, 1616 (2008), <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2808%2961670-0>. In discussing the advantages of the MLP model, the authors write, “For many vulnerable patients, accessing stand-alone legal services offices can be a challenge, from a lack of transportation and time to patients not recognising their problems as having legal solutions. Even more importantly, this strategy increases the likelihood that patients will receive the help they need before a deprivation of basic needs leads to a crisis.” *Id.*

⁸² Ellen Lawton, *Integrating Healthcare and Legal Services to Optimise Health and Justice for Vulnerable Populations: The Global Opportunity*, in THE LAW OF THE FUTURE AND THE FUTURE OF LAW: VOLUME II 73, 78 (Sam Muller et al. eds., 2012).

pay a mortgage thereby leading to even more dire consequences.”⁸³ Legal interventions at this late stage often come after clients and their families have experienced harm in areas that are well-documented drivers of poor health and racial and socioeconomic health disparities, such as domestic violence, loss of employment, eviction, homelessness, and food insecurity.⁸⁴ The justice gap and the current typical model of downstream lawyering therefore has significant implications for health justice.

Upstream identification of legal issues and legal interventions, in which individuals get connected to an attorney or law clinic student for advice or representation before they are deep into a crisis, is a strength of the MLP clinic model. This approach allows for preventive legal advocacy to preserve health and well-being, or restore it quickly, before an individual or family is in crisis. Prior to and during the pandemic, MLPs deployed a critical upstream approach that involves a) legal teams training health care providers to understand and spot legal issues in a changing legal landscape; b) health care teams screening for and identifying legal issues when they interact with patients; and c) providers referring patients for legal care.⁸⁵

Upstream intervention begins with training members of the health care team to understand and recognize legal issues that a patient or caregiver may be facing. Penn State Dickinson Law’s MLP Clinic provided ongoing education to its medical partners during the pandemic, focused on the implementation of the 2019 “public charge” rule—a new, punitive immigration policy that has deterred noncitizens and their family members from enrolling in health-promoting public benefits.⁸⁶ The rule was proposed in 2018, finalized in 2019, implemented beginning in February 2020 (just as the administration began publicly recognizing the threat of a COVID-19 outbreak in the United States), and ultimately rescinded in March 2021. Health care providers as well as patients were understandably confused about the implications of the public charge rule during that period, especially because the rule was variably enforced due to court challenges and the pandemic. Education of health care providers about the changing le-

⁸³ Written statement of Rhodia D. Thomas, *supra* note 79.

⁸⁴ See generally, Cannon, *supra* note 8, at 223; *How Legal Services Help the Healthcare System Address Social Needs*, NAT’L CENTER FOR MEDICAL-LEGAL PARTNERSHIP (2015), <https://medical-legalpartnership.org/response/i-help/> (last visited Jul. 8, 2021); U.S. Dep’t of Health & Human Services, Office of Disease Prevention and Health Promotion, *Social Determinants of Health*, HEALTHY PEOPLE 2030, <https://health.gov/healthypeople/objectives-and-data/social-determinants-health> (last visited Jul. 8, 2021).

⁸⁵ Karp, *supra* note 50.

⁸⁶ Medha D. Makhoul & Jasmine Sandhu, *Immigrants and Interdependence: How the COVID-19 Pandemic Exposes the Folly of the New Public Charge Rule*, 115 NW. U. L. REV. ONLINE 146 (2020).

gal landscape was critical to identifying and addressing patients' legal needs. Frontline providers used this type of updated knowledge and leveraged the MLP model to screen for and identify legal needs. In turn, MLP practitioners could identify patterns in referrals and inform policy makers and other providers and agencies serving the same communities of patients' experiences and urgent needs during the pandemic.

Upstream intervention continues with helping individuals realize they have a legal issue. When patients come to see a health care provider who is participating in an MLP, in addition to a physical or mental health assessment, they also get a "legal check-up."⁸⁷ At the Georgetown University Health Justice Alliance Law Clinic, the inter-professional team developed a legal check-up for adolescents who see a health care provider at the MedStar Georgetown School Health Center at Anacostia High School, which serves a student body that is nearly 100% African American and has a very high percentage of low-income families.⁸⁸ The legal check-up can help families of the clinic's patients to identify unmet legal needs that could be harming their health and well-being. If not for this partnership and its screening approach, issues like poor housing conditions, utility shut-offs, a threat by a landlord of eviction, a reduction in food stamps, or termination of Medicaid might never have been recognized by these families as legal issues with legal remedies.⁸⁹

Upstream interventions culminate in the prompt referral of patients with identified legal issues to an MLP's team of lawyers and law students, who can provide legal advice, a brief service, warm hand-off referrals, or full legal representation to resolve the issue. For example,

⁸⁷ Valverde, *supra* note 61, at 550-57; Dennis P. Stolle et al., *Integrating Preventive Law and Therapeutic Jurisprudence: A Law and Psychology Based Approach to Lawyering*, 34 CAL. W.L. REV. 15, 27 (1997).

⁸⁸ Lisa Kessler, Yael Cannon, Nicole Tuchinda, Ana Caskin, Christina Balz Ndjatou, Vicki W. Girard, & Deborah F. Perry, *Co-creating a Legal Check-up in a School-based Health Center Serving Low-income Adolescents*, 15 PROGRESS IN COMMUNITY HEALTH PARTNERSHIPS: RESEARCH, EDUCATION, AND ACTION 203, 204 (2021).

⁸⁹ MLP legal teams often continue to screen for legal issues even after the patient has been referred by the health care team and/or during the course of representation in order to holistically assess for additional health-harming legal needs. For example, law students at the Georgetown University Health Justice Alliance Law Clinic work with each client during the semester to conduct a "public benefits check-up," regardless of the legal issue with which the client presents, considering how legal needs in this area could be affecting food and income insecurity. As with other MLPs, the law students are frequently evaluating and re-evaluating the clients' needs holistically and in partnership with them to identify unmet needs as early as possible, seeking "updates on a client's life events and other areas of client need and purpose, examining not only the legal risks but also the client's 'total welfare' including well-being." Valverde, *supra* note 61, at 552; *see also* Stolle et al., *supra* note 87, at 16-17 (1997).

in response to a legal screening that identifies housing-related concerns, a patient may share with a health care provider that she hadn't paid rent because she was using that money to pay for repairs of poor housing conditions that her landlord refused to fix, including mold and rodents that were affecting her children's asthma. She notes her landlord also threatened her with eviction for failing to pay rent. Following that legal screening, the health care provider can help the patient understand that she may have a legal issue that an attorney could help with—even though she hasn't been served with eviction papers at this point—and refer the patient to a legal partner. That legal partner could assert the patient's rights, including any defenses, and work to *prevent* the eviction. This represents a far more upstream approach to legal interventions than the status quo, in which many legal services organizations are unable to represent tenants until they have been served with an eviction summons.

The MLP Clinic at Penn State Dickinson Law has worked collaboratively with health care providers to identify and refer cases at an earlier stage, with providers intervening at the Medicaid application stage in certain cases involving noncitizens' access to health care. For example, Emergency Medicaid is a reimbursement mechanism for states that provide care and services related to "emergency medical conditions" for uninsured noncitizens who do not qualify for Medicaid. The Clinic's recent clients include patients suffering from treatable conditions causing blindness, extreme tooth pain, hypoglycemia, and suicidal ideation. Because approval of Emergency Medicaid for these conditions is not guaranteed and any delay in treatment would threaten these patients' lives or livelihoods, the Clinic has worked with health care providers to assemble the strongest possible Emergency Medicaid applications for such clients in order to avoid the delays associated with the public benefits appeal and fair hearing process. Such upstream legal advocacy can help to ensure health justice for noncitizens by leveraging the law to improve their health and well-being and reduce disparities.

The upstream advocacy approach utilized by MLP clinics was especially useful during the pandemic. The connection to a provider who frequently interacted with at-risk populations enabled MLPs to engage in upstream and preventive advocacy before and throughout the pandemic. COVID forced many law clinics and legal services organizations to close their physical offices,⁹⁰ and access to legal services became more limited. However, throughout the pandemic, MLP

⁹⁰ See, e.g., Legal Aid Society of the District of Columbia, *How to Get Legal Help During the COVID-19 Outbreak*, MAKING JUSTICE REAL BLOG (Mar. 13, 2020), <https://www.makingjusticereal.org/how-to-get-legal-help-during-the-covid-19-outbreak>.

health care providers continued to interact with their patients through telehealth and in-person visits and connected patients to legal care through a more preventive, upstream model of civil legal advocacy. As health care providers were able to continue their interactions with patients, their understanding of the changing legal landscape was critical to them being able to identify legal issues upstream and connect people with legal care during the pandemic. MLP law clinics worked to arm their health care partners with this important and ever-evolving information. For example, as eviction moratoriums unfolded, enhanced benefits programs (including food stamps and unemployment relief) were established, educational inequities deepened, and employment protections changed shape, the Georgetown University Health Justice Alliance Law Clinic created and regularly updated materials and conducted trainings to educate physicians and other providers about the changing legal landscape affecting their patients' rights.⁹¹ Ultimately, an upstream approach allows communities double-burdened by virtue of race and socioeconomic status to identify legal issues that serve as SDOH and to do so in a timelier way to prevent crises that further marginalize them and that drive health disparities.

Law school clinics across practice areas can engage in upstream preventative practice, by collaborating with interprofessional community-based partners that have trusted relationships and frequent contact with members of at-risk populations.⁹² Just as the moment of interaction with health care can be a gateway to legal care, interactions with other community-based partners can provide entry points for upstream identification of legal issues and clients.⁹³ Attorneys and law students can train those partners to understand and identify legal

⁹¹ Georgetown Univ. Medical Center, *Health Justice Alliance Responds to COVID-19*, (May 19, 2020), <https://gumc.georgetown.edu/gumc-stories/health-justice-alliance-responds-to-covid-19/>.

⁹² Ellen Lawton, *Integrating Healthcare and Legal Services to Optimise Health and Justice for Vulnerable Populations: The Global Opportunity*, in *THE LAW OF THE FUTURE AND THE FUTURE OF LAW: VOLUME II* 73, 78 (Sam Muller et al. eds., 2012).

⁹³ See generally Daniel Atkins, Shannon Mace Heller, Elena Debartolo, Megan Sandel, *Medical-Legal Partnership and Healthy Start: Integrating Civil Legal Aid Services into Public Health Advocacy*, 35 J. LEG. MED. 195 (2014); Johnna S. Murphy, Ellen M. Lawton & Megan Sandel, *Legal Care as Part of Health Care: The Benefits of Medical-Legal Partnership*, 62 PEDIATR. CLIN. NORTH AM. 1263–71 (2015); TOBIN-TYLER & TEITELBAUM, *supra* note 10; Scott Burris, *Law in a Social Determinants Strategy: A Public Health Law Research Perspective*, 126 PUBLIC HEALTH REP. 22 (2011); Ellen M. Lawton & Megan Sandel, *Investing In Legal Prevention: Connecting Access to Civil Justice and Healthcare Through Medical-Legal Partnership*, 35 J. LEG. MED. 29 (2014); *Medical-Legal Partnerships, COUNTY HEALTH RANKINGS & ROADMAPS* (Jan. 25, 2019), <https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/medical-legal-partnerships>; Marsha Regenstein et al., *Commentary, Addressing Social Determinants Of Health Through Medical-Legal Partnerships*, 37 HEALTH AFFAIRS 378 (2018).

issues.⁹⁴ Formalized screening tools or more informal screening mechanisms can be used by non-legal partners who work closely with affected communities to identify legal needs that can harm health and well-being.⁹⁵ Indeed, the ABA Commission on the Future of Legal Services has emphasized the benefits of using legal check-ups to improve access to legal services more broadly:⁹⁶ “Legal checkups are an underused resource to help solve individuals’ problems and expand access to legal services,” will “help to inform people of their legal needs and to identify needed legal assistance,” as well as serve as “prophylactic measures” to prevent legal problems from arising.⁹⁷ By regularly screening for legal issues among the individuals they serve, community-based partners can help recognize legal issues before the point of severe crisis, thus preventing or mitigating harmful health impacts.

Law clinics can go beyond screening and referral-based partnerships to collaborate with community-based, non-attorney partners in exploring the social and structural context surrounding client problems. Through upstream lawyering, clinic students learn to spot legal problems that may otherwise be missed or overlooked and can identify future potential legal risks that could have significant implications for health and drive health disparities.⁹⁸ Law clinics can purposefully explore the connections between their legal interventions and the upstream impacts on health, as legal advocacy “can have preventive and remedial impact in crisis situations such as threatened eviction, loss of income, threatened employment termination, family breakdown, and chronic stressors such as inadequate benefits, inappropriate social housing, or domestic violence.”⁹⁹

Clinical pedagogy and practice should deploy an upstream approach. This not only prepares the clinic to respond during a national or community-wide trauma, but also prepares students to set the goal of lawyering as prevention, and to see their work as an opportunity to

⁹⁴ *How Legal Services Help the Healthcare System Address Social Needs*, NAT’L CTR FOR MED.-LEGAL PARTNERSHIP, <https://medical-legalpartnership.org/response/i-help/> (last visited Jul. 8, 2021)

⁹⁵ Kessler et al., *supra* note 88, at 216.

⁹⁶ ABA COMM’N ON THE FUTURE OF LEGAL SERVS., REPORT ON THE FUTURE OF LEGAL SERVICES IN THE UNITED STATES 1, 6, 43 (2016) (hereafter cited as “ABA Report”) (“Recommendation 4: Individuals should have regular legal checkups, and the ABA should create guidelines for lawyers, bar associations, and others who develop and administer such checkups.”); *see also* Valverde, *supra* note 61, at 550–57.

⁹⁷ ABA Report, *supra* note 96, at 1, 6, 43–45; *see also* Valverde, *supra* note 61, at 550–57.

⁹⁸ Valverde, *supra* note 61, at 552.

⁹⁹ Hazel Genn, *When Law is Good for Your Health: Mitigating the Social Determinants of Health through Access to Justice*, 72 CURRENT LEGAL PROBS. 159, 163 (2019).

not only provide access to justice, but also access to health and well-being. The prevention of legal crises through this upstream approach by any law clinic advances health justice because the legal crises that are averted are known to deeply harm the health and well-being of marginalized individuals and can mitigate health disparities affecting communities of color and under-resourced communities.

C. Adaptable Interventions Best Address an Evolving Problem and Meet Stakeholders' Changing Needs

The success of upstream approaches utilized by MLP clinics depends, in part, on the adaptability of interventions. This model has been tailored to serve a diverse set of patient populations—from children to immigrant communities to formerly incarcerated individuals to veterans—in a holistic manner.¹⁰⁰ Collaboration, screening, and referral are not rigid processes. These strategies can be executed in a variety of forms, relatively quickly, based on new information or circumstances. Clinics that strictly limit client services or opportunities for community engagement may find it challenging to leverage their knowledge and resources to meet legal needs that arise in tandem with a local or national crisis, like the pandemic. The use of adaptable interventions enables MLP clinics to address problems as they evolve, maintaining their capacity to meet needs in response to new information about the challenges facing a population of focus. Such nimble interventions are especially important in addressing wicked problems, given their tendency to transform, intensify, and refurbish over time in response to socio-environmental changes. The pandemic, by virtue of its sudden onset and drastic effect on every aspect of life, necessitated the use of adaptable interventions—and, so too does the achievement of health justice.

The implementation of COVID-19 safety protocols required the Health Law Clinic MLP at the University of Pittsburgh School of Law to find a new way to integrate legal needs screenings into the flow of an outpatient visit. Before the pandemic, law students were regularly onsite at the partner hospital, screening patients for health-harming legal needs. These screenings or “legal consults” were integrated into the routine of the outpatient appointment. Once a family consented to a legal needs screening, they could meet with the patient’s parent or guardian in a confidential space to conduct the screening, offer brief law-related information, and determine whether a full intake was needed. During the pandemic, the Clinic’s medical partner began seeing patients via “tele-medicine” in addition to keeping some tradi-

¹⁰⁰ See generally Benfer et al., *supra* note 62.

tional in-person appointments. In this hybrid forum, the patient, caregiver, physician, social worker, and any others critical to holistic care, participated in some combination of in-person or remote care. In every appointment, due to the new protocol, the law student completing the screening had to do so remotely, through Doximity or Teams. Breakout room functions allowed parties to be engaged or separated as appropriate and maintained patient-client confidentiality.

Adapting to this new process had its challenges. Students reported more meaningful interactions with patient caregivers when the medical appointment was in person, and the student was the only party engaging remotely, rather than when the patient was also dialing in. Clinic students had to coordinate with medical staff to remain connected to the patient and caregiver during the appointment. To design a new flow for outpatient visits, the Clinic needed to reestablish who all the parties to the visit were, what each party needed to accomplish during the visit, and the amount of time needed to complete that objective with the patient. At the same time, the existing collaborative relationship between the medical partner and the law school clinic supported the cycle of trial and error that ultimately resulted in the ongoing provision of legal services to patient families during the pandemic. Across the semesters in which our communities have been directly impacted by restrictive public health protocols, MLP clinics demonstrated the capacity to engage the iterative process necessary to adapt upstream intervention strategies to changing circumstances, determine the best way to provide legal services, and meet community needs.

Employing adaptable interventions is a strategy all law school clinics can adopt. From a pedagogical perspective, integrating adaptable interventions models the importance of creative problem solving for the next generation of legal advocates.¹⁰¹ The practice offers law students exposure to the reality that effective advocacy involves thinking outside the boxes of what worked in the past and generating alternate approaches for achieving desired outcomes. Students may increase their tolerance for the discomfort attendant to the trial and error process as they are encouraged to try out novel approaches.¹⁰²

¹⁰¹ Scholars have emphasized the importance of developing problem-solving capacities throughout legal education. See generally Stephen Nathanson, *Developing Legal Problem-Solving Skills*, 44 J. LEGAL EDUC. 215 (1994); Linda Morton, *Teaching Creative Problem Solving: A Paradigmatic Approach*, 34 CAL W. L. REV. 375 (1998); Alan M. Lerner, *Law and Lawyering in the Workplace: Building Better Lawyers by Teaching Students to Exercise Critical Judgment as Creative Problem Solvers*, 32 AKRON L. REV. 107 (1999); Raymond H. Brescia, *Creative Lawyering for Social Change*, 35 GA. ST. U. L. REV. 529 (2019).

¹⁰² See Schrag, *supra* note 1, at 184 (arguing that effective lawyers can, “(1) recognize those occasions when doing a task by the book is not likely to achieve satisfactory results,

Further, brainstorming modifications to existing tools and practice approaches can deepen interprofessional collaborative relationships. The values of adaptation, overcoming obstacles to change, and remaining open to new ways of working—exemplified in MLP clinics—can be cultivated across clinical programs.

D. A Racial Justice Focus Must Anchor Clinical Practice

COVID-19 emerged as a problem of both the crisis and the status quo due, in large part, to the racism that pervades the systems through which the SDOH are created and maintained. Scholars have well documented the enduring physical and mental health consequences of discrimination and institutional racism.¹⁰³ This relationship between the social construct of race and the biologic consequences of racism manifested during the pandemic as increased cases of infection, higher rates of hospitalization, and disproportionate deaths among persons of color.¹⁰⁴ One of the core tenets of the health justice framework is eliminating discrimination and poverty and other forms of subordination that operate as structural determinants of health that, in turn, restrict intermediary determinants of health, which include material and environmental circumstances.¹⁰⁵ In her incisive research, Professor Dina Shek identifies the failure to examine race and racism as a structural system undermining health and wellness as “the critical element missing from the MLP approach.”¹⁰⁶ Centering clinical practice on racial justice is a maxim that emerges from an acknowledged area of needed growth in the MLP movement and clinical teaching, generally.

Shek writes that, in the absence of an explicit racial justice focus, efforts to address social conditions having a negative impact on health “may actually serve to uphold and legitimize the structures that main-

(2) figure out a creative alternative, and (3) find the courage to deviate from the accepted norm of practice”).

¹⁰³ See David R. Williams, Jourdyn A. Lawrence, and Brigitte A. Davis, *Racism and Health: Evidence and Needed Research*, 40 ANN. REV. PUB. HEALTH 105, 105-125 (2019); Tony N. Brown, et al., “*Being Black and Feeling Blue*”: *The Mental Health Consequences of Racial Discrimination*, 2 RACE & SOC’Y 117, 117-131(2000); see also Emily Benfer, *supra* note 30, at n.34 (citing David R. Williams, *Discrimination and Health*, in 1 ENCYCLOPEDIA OF HEALTH & BEHAVIOR 254, 255-56 (Norman B. Anderson ed., 2004) and Clarence C. Gravlee, *How Race Becomes Biology: Embodiment of Social Inequality*, 139 AM. J. PHYSICAL ANTHROPOLOGY 47, 47-48 (2009)).

¹⁰⁴ See Centers for Disease Control and Prevention, *Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity*, <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html> (last visited Sept. 9, 2021).

¹⁰⁵ See Benfer, *supra* note 30, at 341-345.

¹⁰⁶ Dina Shek, *Centering Race at the Medical-Legal Partnership in Hawai’i*, 10 U. MIAMI RACE & SOC. JUST. L. REV. 109, 113 (2019).

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tain institutional racism.”¹⁰⁷ The default model of legal service provision uses a self-maintaining, hierarchical system. A client who seeks legal services is dependent upon the attorney for her knowledge and skill set in resolving a problem. This problem is resolved in a manner that strengthens the attorney’s knowledge and skills by virtue of the additional experience gained. The resolution reinforces the client’s dependence by keeping information and problem-solving tools in the hands of the attorney. This dynamic is underscored by the social messages of inferiority associated with having a marginalized identity. When considerations of race as a political factor remain accessory to the work of legal services organizations, the empowerment of communities of color, “will never be treated as a *necessary condition* for justice.”¹⁰⁸

Notwithstanding the broad justice mission for which MLP clinics stand, there are aspects of this clinical approach that challenge the model’s efforts to center anti-racism. One challenge comes from the fact that MLPs sit at the nexus of two professions that are grappling with their roles in perpetuating institutional racism. In legal education and across the medical profession, norms of practice are being critiqued, reevaluated, and updated to address latent and explicit biases. Historically, the field of medicine has been slow to acknowledge its complicity in the politics of race.¹⁰⁹ Racism as an upstream cause of health outcome disparities seemed to come into focus for a greater segment of the medical institution during the pandemic.¹¹⁰ In 2000, the human genome project resolved that there is no biological basis for classifying humans by race.¹¹¹

Yet, over the next several years, scholars such as Dorothy Roberts documented the harmful discriminatory practices that the medical profession continued to engage in under the presumption of race as a

¹⁰⁷ *Id.*

¹⁰⁸ *Id.* at 122.

¹⁰⁹ See Gilbert C. Gee & Chandra L. Ford, *Structural Racism and Health Inequalities: Old Issues, New Directions*, 8 DU BOIS REV. 115, 117 (2011) (arguing that “[t]he serious study of racism and health did not gain traction until the 1990s”).

¹¹⁰ In November 2020, the American Medical Association released a racial equity plan which identifies racism as, “an urgent public health threat.” See Kevin B. O’Reilly, *AMA: Racism is a Threat to Public Health*, AM. MED. ASSN. (Nov. 16, 2020), <https://www.ama-assn.org/delivering-care/health-equity/ama-racism-threat-public-health>.

¹¹¹ Patricia McCann-Mortimer, Martha Augoustinos & Amanda LeCouteur, ‘Race’ and the *Human Genome Project: Constructions of Scientific Legitimacy*, 15 DISCOURSE & SOC’Y 409 (2004). “At the public announcement of the completion of a draft map of the human genome in June 2000, Craig Venter, Head of Celera Genomics and chief private scientist involved with the Human Genome Project, claimed that ‘race’ was not a scientifically valid construct.” Cf. Richard C. Lewontin, *The Apportionment of Human Diversity*, 6 EVOLUTIONARY BIOLOGY 381 (1972) (indicating that scientists already understood that there was no biological basis for race-based distinctions).

biological reality.¹¹² It took until 2020, after a summer marked by Black Lives Matter-related protests, for the American Medical Association to adopt a new policy to “support ending the practice of using race as a proxy for biology or genetics in medical education, research and clinical practice” and to “recognize that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.”¹¹³ The social construction of race yields its share of discrimination within medical practices as well. Prejudicial narratives of race contribute to medical staff-members’ failure to believe the reported symptoms of patients of color,¹¹⁴ the withholding of pain medication from persons of color,¹¹⁵ and differences in the diagnosis and treatment of disease between black and white patients.¹¹⁶ This pattern contributes to the mistrust that many people of color feel toward doctors and hospitals.¹¹⁷ Many historically marginalized groups avoid care and are skep-

¹¹² See generally Dorothy E. Roberts, *What’s Wrong with Race-Based Medicine?* 12 MINN. J. OF L., SCI. & TECH. 1 (2011); see also Jonathan Kahn, *How a Drug Becomes ‘Ethnic’: Law, Commerce, and the Production of Racial Categories in Medicine*, 4 YALE J. HEALTH POL’Y, L. & ETHICS 1 (2004) (discussing a drug called BiDil and the framing of racial health disparities as biological in origin).

¹¹³ See Resolutions 10 and 11, in PROCEEDINGS OF THE AM. MED. ASSN., November 2020 Special Meeting of the House of Delegates, <https://www.ama-assn.org/house-delegates/special-meeting/proceedings-november-2020-special-meeting-house-delegates>.

¹¹⁴ “In the more than 200 stories of African-American mothers that ProPublica and NPR have collected over the past year, the feeling of being devalued and disrespected by medical providers was a constant theme.” Nina Martin & Renee Montange, *Nothing Protects Black Women From Dying in Pregnancy and Childbirth*, PRO PUBLICA (Dec. 7, 2017), <https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth>; see also P.R. Lochart, *What Serena Williams’s Scary Childbirth Story Says About Medical Treatment of Black Women*, VOX (Jan. 11, 2018, 4:40 PM) (observing that “black women can’t escape skepticism, even when the topics in question are their own bodies”), <https://www.vox.com/identities/2018/1/11/16879984/serena-williams-childbirth-scare-black-women>.

¹¹⁵ See Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt, & M. Norman Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PROCEEDINGS OF THE NAT’L ACADEMY OF SCIENCES OF THE UNITED STATES OF AMERICA 4296, 4296-4301 (2016) (providing “evidence that white laypeople and medical students and residents believe that the black body is biologically different—and in many cases, stronger—than the white body [and] . . . evidence that these beliefs are associated with racial bias in perceptions of others’ pain”); see also Alan Nelson, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, 94 J. NAT’L MED. ASS’N 666, 666-68 (2002).

¹¹⁶ For example, “Angiotensin-converting enzyme (ACE) inhibitors are considered less effective in Black patients than in White patients, and they might not be prescribed to Black patients with hypertension.” Jessica P. Cerdeña, Marie V. Plaisime, Jennifer Tsai, *From Race-Based to Race-Conscious Medicine: How Anti-Racist Uprisings Call Us to Act*, 396 LANCET 1125, 1125-28 (2020); see also Karon Gwyn et al, *Racial Differences in Diagnosis, Treatment, and Clinical Delays in a Population-Based Study of Patients with Newly Diagnosed Breast Carcinoma*, 15 CANCER 1595 (2004).

¹¹⁷ “Beliefs about physician mistrust among African American patients are reinforced through differential treatment in comparison with Whites.” Darcell P Scharff, Katherine J. Matthews, Pamela Jackson, Jonathan Hoffsuemmer, Emeobong Martin, & Dorothy Ed-

tical of the legitimacy of vaccination due to the legacy of forced sterilization and abusive experimentation on patients of color that continued well into the 2000s.¹¹⁸ Centering anti-racism is both crucial and challenging in this context.

With respect to legal education, the law school curriculum could do more to prepare students to speak to, critique, and engage matters of structural and systemic racism.¹¹⁹ It took the aftermath of the racist killings of Ahmaud Arbery, Breonna Taylor, and George Floyd in the spring of 2020 for law schools across the United States to publicly voice a commitment to anti-racism.¹²⁰ Scholars have written on the failure of law school curricula to acknowledge the social and political context in which law is ultimately practiced.¹²¹ Some have pointed out that law professors are not prepared to support students in discerning this context.¹²² As a result, “many law students may not have an understanding that the law has not always applied equally to people of

wards, *More Than Tuskegee: Understanding Mistrust About Research Participation*, 21 J. HEALTH CARE FOR THE POOR & UNDERSERVED 879 (2010).

¹¹⁸ See Lauren Bunch, *A Tale of Two Crises: Addressing Covid-19 Vaccine Hesitancy as Promoting Racial Justice*, 33 HEC FORUM 143–154 (2021); Manuel E. Jimenez, Zorimer Rivera-Núñez, Benjamin F. Crabtree, et al., *Black and Latinx Community Perspectives on COVID-19 Mitigation Behaviors, Testing, and Vaccines*, 4 JAMA NETWORK OPEN (2021); HARRIET A. WASHINGTON, *MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT* (2006).

¹¹⁹ A law professor at Howard University writes, “One would think that in teaching at one of the nation’s few historically Black law schools, discussions about racism and discrimination naturally flow from our curriculum. This is not the case. Criminal procedure and critical race theory classes are the exceptions to the absence of racial discussions.” Keesha Turner Roberts, *Law Schools Push to Require Anti-Racism Training and Courses*, 46 AM. BAR ASS’N HUMAN RIGHTS MAGAZINE (December 14, 2020), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/rbgs-impact-on-civil-rights/law-schools-push/.

¹²⁰ The American Association of Law Schools (AALS) Anti-Racist Clearinghouse hosts a repository of statements from U.S. Law Schools voicing their commitment to anti-racism. See AALS, *Law Deans Antiracist Clearinghouse Project*, <https://www.aals.org/about/publications/antiracist-clearinghouse/>.

¹²¹ See, e.g., Sharon L. Beckman & Paul R. Tremblay, *Foreword: The Way to Carnegie*, 32 B.C.J.L. & SOC. JUST. 215, 216 (2012) (arguing that “[t]he case method misses a great deal of the practice of law. . . . It erases the context of practice and, in doing so, fails to teach students to recognize and take account of the social, economic, and political forces constraining the choices of others”); L. Danielle Tully, *The Cultural (Re)Turn: The Case for Teaching Culturally Responsive Lawyering*, 16 STAN. J. CIV. RTS. & CIV. LIBERTIES 201, 206 (2020) (arguing that “first year courses . . . gloss over human context, both flattening and distorting the law’s development and its interpretation by focusing on black letter law to the exclusion of most everything else”).

¹²² “Be it affirmative action, Terry stops, freedom of expression, or discussions of disproportionate incarceration, these topics come up frequently within the law school curriculum. However, navigating these topics can seem like a minefield for most.” Erin C. Lain, *Racialized Interactions in the Law School Classroom: Pedagogical Approaches to Creating a Safe Learning Environment*, 67 J. LEGAL EDUC. 780, 781 (2018).

color.”¹²³ The dominant law school curriculum involves few opportunities to center the experiences and perspectives of persons of color.¹²⁴ Institutional racism within legal education and the medical profession creates a contextual challenge for MLP clinics wishing to center racial justice.

A further challenge, which should not be used as an excuse, can come from the location or practice area focus of some MLP clinics. Those serving a primarily low-income, white community, for example, may have a harder time centering a racial justice lens. Because the needs and concerns of the patient-client base of an MLP typically drive the policy advocacy in which a clinic engages, servicing Black, Indigenous, Latinx, and other communities of color directly can create a point of entry into advocacy centered on the struggle for racial justice that may not be readily available to MLPs in certain parts of the country. While clinical faculty are free to infuse their teaching with anti-racist pedagogy and opportunities to build students’ structural competence, the dictates of the clinic case load and the needs of clients may raise other policy priorities.

A racial justice model of legal services involves promoting practices that amplify the voices of persons of color, build power within communities of color, and seek structural change. Such emphasis shifts the dynamic in legal services from ensuring perpetual clients to promoting citizen engagement.¹²⁵ Naming racism is prerequisite to addressing racial disparities in health, education, employment, and economic segregation.”¹²⁶ The structure and pedagogy of an MLP clinic is well-suited to cultivating such discussion.¹²⁷

¹²³ Hannah Hayes, *Law Schools Vow to Address Structural Racism*, AM. BAR ASSN: PERSPECTIVES (Sept. 25, 2020), <https://www.americanbar.org/groups/diversity/women/publications/perspectives/2021/september/law-schools-vow-address-structural-racism/>.

¹²⁴ “The consequence of adopting this colorless mode is that when the discussion involves racial minorities, minority students are expected to stand apart from their history, their identity, and sometimes their own immediate circumstances and discuss issues without making reference to the reality that the ‘they’ or ‘them’ being discussed is from their perspective ‘we’ or ‘us.’” Kimberlé W. Crenshaw, *Foreword: Toward a Race-Conscious Pedagogy in Legal Education*, 11 NAT’L BLACK L.J. 1 (1989).

¹²⁵ Shek, *supra* note 106, at 125.

¹²⁶ Camara Phyllis Jones, *Confronting Institutionalized Racism*, 50 PHYLON 7, 18-20 (2003)

¹²⁷ For example, the Georgetown Health Justice Alliance Law Clinic introduced a new Health and Racial Justice project, through which students select a topic of interest connected to racial health disparities and examine the data and dimensions of those disparities, the role that law- and structural racism in law- has played in driving those disparities, and the opportunity for law and policy to mitigate those disparities and advance racial justice. The student groups identified readings, assigned materials for their classmates to read, and facilitated discussions and exercises to engage their peers in gaining a deeper understanding of the topic and exploring the role of law in the advancement of health and racial justice in the topic area they chose to explore.

In order to directly address racism as a SDOH, in addition to applying the health justice framework that centers on racial justice interventions, all law school clinics might consider deriving racial justice strategies based on the principles of critical race theory (CRT).¹²⁸ CRT is a movement “of activists and scholars engaged in studying and transforming the relationship among race, racism, and power.”¹²⁹ Public health scholars have adapted the CRT framework to develop a foundation for health disparities research.¹³⁰ Law school clinicians could, likewise, draw on the vocabulary and concepts of CRT to examine the challenges of addressing racial health disparities and the unintended consequences of a poverty-centric framing of non-profit legal advocacy.

Three immediately relevant, CRT-derived principles for MLPs and all clinics to consider adopting are race consciousness, centering in the margins, and praxis. In the public health context, race consciousness is the explicit acknowledgement of the role of racialization and racism in structuring health outcomes.¹³¹ Centering in the margins is the practice of “[m]aking the perspectives of socially marginalized groups, rather than those of people belonging to the dominant race or culture, the central axis around which discourse on a topic revolves.”¹³² Praxis is the iterative process of deploying knowledge derived through study and experience to take direct action.¹³³ Adopting these three principles, in addition to confronting the role law schools and partner organizations have played in contributing to the racial injustice our clients face, is an important step that clinics should consider as part of a health justice framework and agenda.

E. Engage in Systemic Advocacy to Achieve Health Justice

The pandemic underscored the need to train students to connect the needs of individual clients to the needs of the client community, which often requires moving beyond thinking about the client only as an individual, to thinking of the client as representative of a greater population facing barriers to health equity and social justice. Achiev-

¹²⁸ See, e.g., Medha D. Makhoul, *Towards Racial Justice: The Role of Medical-Legal Partnerships*, J. L. MED. & ETHICS (forthcoming 2022) (proposing ways for MLPs to begin incorporating racial justice principles into research and practice).

¹²⁹ RICHARD DELGADO & JEAN STEFANCIC, CRITICAL RACE THEORY: AN INTRODUCTION 3 (2017).

¹³⁰ See Chandra L. Ford & Collins O. Airhihenbuwa, *The Public Health Critical Race Methodology: Praxis for Antiracism Research*, 71 SOC. SCIENCE & MED. 1390 (2010).

¹³¹ Chandra L. Ford & Collins O. Airhihenbuwa, *Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis*, 100 AM. J. PUB. HEALTH S30-S35 (2010).

¹³² *Id.* at S31, tbl. 1.

¹³³ *Id.* at S31, tbl. 1.

ing health justice necessitates the incorporation of the views and experiences of clients into the analysis of structural and systemic problems and proposed solutions. For example, MLP clinic students may be among the first advocates to know which city landlords ignore health and safety regulations, how major employers evade medical and sick leave requirements, which local businesses refuse to reduce production in order to comply with pandemic social distancing rules, or how solitary confinement harms people even after a formal period of incarceration ends. They also bear witness to the pernicious health effects of systemic injustice on individual bodies, underscoring the urgency of a system-level response. MLPs that track referrals and outcomes in the Electronic Health Record are also able to identify patterns in referrals and clusters of specific SDOH in the community. As a result, MLPs and MLP clinic students are in a unique position to analyze and address structural and intermediary determinants of health in partnership with the affected community and from the vantage point of an interdisciplinary team.

While the legal remedy to a single client's needs might not be susceptible to formal legal aggregation through a class, or collective action, clinics can collaborate with their interprofessional teams and form or join coalitions to respond to the root causes of health inequity or to fill specialized roles in larger campaigns. For example, the Transitions Clinic at Yale was formed to prevent death and disability among people recently released from prison. Together, representatives of the legal and medical fields developed a nascent campaign to improve access to state IDs for those leaving incarceration. In isolation, either field's ability to intervene was limited. Together, the legal and medical practitioners, students, and patients cofounded the state-wide Justice Reinvestment Coalition, which advocates for divestment from carceral systems and investment in community care. The group assisted in the development of local bills to reduce barriers to employment for recently-incarcerated people. The lawyers and law students identified strategic options; the medical providers contributed the evidence base; and the patients experienced the real-world application of the intervention. Each member of the team is equal, and none is positioned as the only, or even primary, advocate.

Similarly, the Health Justice Project at Loyola University Chicago School of Law addressed the chronic lead poisoning of children in federally assisted housing. Providers impressed upon law students and policy makers the permanent harm lead poisoning wreaks on a child's brain and body and the legal team devised a policy strategy. Applying the interprofessional tenet of MLP, the team expanded to include practitioners from the fields of public health, science, sociology, civil

rights, children's rights, and housing, among others, to spearhead a national policy campaign designed to prevent the harm their individual clients experienced across the broader national population.¹³⁴ This interprofessional model of advocacy was replicated with law and public health students who worked on behalf of clients to successfully secure the passage of a federal law to eliminate carbon monoxide poisoning in federally assisted housing.¹³⁵

Systemic advocacy could begin with defining the problem from a health justice perspective. Students at Wake Forest University School of Law and School of Medicine collaborated to conduct a gap analysis to define the causes of health inequity. Students examined community health needs assessments, as well as the environmental, economic, and health conditions experienced by low-income population and communities of color, and the laws and policies that operated as SDOH. The analysis, coupled with community outreach and engagement, prompted the formation of a task force to address the barriers to health justice that the students identified. It also laid the foundation for the school's new MLP clinic.

The successes of these system-level interventions are due, in part, to the fact that the credible voice of a health care provider can break through where attorneys and clients cannot; lawmakers, judges, and the public all tend to defer to a nurse's or a doctor's evaluation of need and the effects on health outcomes. Moreover, sometimes the advocacy strategies employed by social workers, nurses, community health workers, or doctors are more direct, more conscious of power relationships, and therefore more effective than legal strategies. The interprofessional advocacy may also result in quicker resolution than legal remedy, or relief obtained in legal venues, like courts and administrative agencies. At the core of the approach is the ability to work closely with affected communities and bring to the surface the experiences and challenges that inform interventions.¹³⁶

¹³⁴ This clinic, directed by Emily A. Benfer, received the 2018 Clinical Legal Education Award for Excellence in a Public Interest Project for an advocacy project that resulted in federal rulemaking by the U.S. Department of Housing and Urban Development and the 2015 Outstanding Medical-Legal Partnership Award from the National Center for Medical-Legal Partnership. Kate Marple and Erin Dexter, *Keeping Children Safe from Lead Poisoning*, National Center, for Medical-Legal Partnership, <https://medical-legalpartnership.org/mlp-resources/keeping-children-safe-from-lead-poisoning/> (describing the successful interprofessional collaboration and national lead poisoning prevention policy campaign that was inspired by two MLP clients' experience). Emily A. Benfer, *Contaminated Childhood: How the United States Failed to Prevent the Chronic Lead Poisoning of Low-Income Children and Communities of Color*, 41 HARV. ENV. L. REV. 493 (2017).

¹³⁵ Suzy Khimm, *Congress Passes Bill to Require Carbon Monoxide Alarms in Public Housing*, NBC (Dec. 22, 2020), <https://www.nbcnews.com/politics/congress/congress-passes-bill-require-carbon-monoxide-detectors-public-housing-n1251980>.

¹³⁶ Deborah Rhode, *The Public Interest: The Movement at Midlife*, 60 STAN. L. REV.

The legal and health care fields have both engaged in the response to health, racial, and economic injustice during the pandemic. However, neither the root structural or systemic causes, nor the appropriate solutions, can be realized in isolation.

The MLP clinic is uniquely situated for systemic intervention because it is designed to look at problems holistically, identify patterns in referrals, operate across disciplines, defer to the patient as most knowledgeable about the problem and reliability of any proposed solution, and seek upstream interventions. These attributes can be adopted by clinics across the law school setting to train the next generation of lawyers to be multidimensional wicked-problem solvers who engage in strategies to address structural determinants of health and the laws and policies they influence.

F. Community-Based Interventions Increase the Power of Affected Populations

The many advantages of MLP as a model of public interest practice that we have identified do not allow us to evade potentially problematic aspects of our relationship to the communities we serve, including viewing *people*, rather than systems, as a collection of problems in need of resolution, reproducing existing social hierarchies through professional dominance, and serving as a pressure relief valve for social agitation that otherwise could fuel organizing efforts. Scholars and community members identified these negative phenomena that persist in the relationships between public interest lawyers and their clients and communities, and have theorized, and implemented, models for change. Gerald Lopez's theory of "rebellious lawyering" provided a deep critique of traditional "regnant" practice,¹³⁷ and later "community lawyering,"¹³⁸ "law and organizing,"¹³⁹ and "movement

2027, 2046 (2008).

¹³⁷ Gerald P. López, *Reconceiving Civil Rights Practice: Seven Weeks in the Life of a Rebellious Collaboration*, 77 GEO. L.J. 1603, 1608 (1989) ("[T]hose operating in the rebellious idea of lawyering must situate their work in the lives and in the communities of the subordinated themselves, constantly re-evaluating the likely interaction between legal and 'non-legal' approaches to problems. They must know how to work with others in brainstorming, designing, and executing strategies aimed immediately at responding to particular problems and, more generally, at fighting social and political subordination. They must understand how to be part of, as well as how to build, coalitions, and not just for purposes of filing or 'proving up' a lawsuit. In short, the rebellious idea of lawyering demands that lawyers (and those with whom they work) nurture sensibilities and skills compatible with a collective fight for social change.").

¹³⁸ See, e.g., Charles Elessier, *Community Lawyering – The Role of Lawyers in the Social Justice Movement*, 14 LOY. J. PUB. INT. L. 375, 376 (2013) (community lawyering "has come to be used very broadly with a myriad of individual descriptions, strains and tendencies, each with their own pedigree. The most unifying feature seems to be a deep unease with the degree to which the representation of poor and working people has been individu-

lawyering”¹⁴⁰ engaged with and sparked new modes of community-based public interest law practice, such as The Community Justice Project,¹⁴¹ the law practice at the Workplace Project,¹⁴² and the Medical-Legal Partnership for Children in Hawaii.¹⁴³ All of these models maintain a place for lawyers and law students solving wicked problems like racism and poverty by practicing in a way that increases collective community power.¹⁴⁴

Public interest law practices that don’t address these issues run the risk of simply reproducing their own social position vis-à-vis their clients and the community in perpetuity, rather than changing underlying conditions or opening space for durable change.

MLPs and other clinics can creatively use their position to in-

alized, atomized, depoliticized and divorced from any leadership by real organized constituencies with their own substantive and political goals. It is accompanied by a realization that meaningful systemic change cannot result from this depoliticized and atomized approach. This has resulted in the search for a law practice that recognizes the centrality and leadership of the organized constituency in achieving meaningful change.”).

¹³⁹ See, e.g., Scott L. Cummings & Ingrid V. Eagly, *A Critical Reflection on Law and Organizing*, 48 UCLA L. REV. 443, 493-96 (2001) (“The law and organizing model privileges movement politics over law reform efforts and suggests that lawyers should facilitate community mobilization rather than practice in the conventional mode.”).

¹⁴⁰ See, e.g., Alexi Freeman & Lindsay Webb, *Yes, You Can Learn Movement Lawyering in Law School: Highlights from the Movement Law Lab at Denver Law School*, 5 HOW. HUM. & C.R. L. REV. 55, 57 (2020) (“Movement lawyers use their legal skills but are focused on and guided by the stated needs of impacted communities rather than on lawyer-led legal strategies; movement lawyers focus on shifting power rather than on policy change alone; movement lawyers work in service of, and in partnership with, social movements and do not pursue agendas that are contrary to or uninformed by the community’s stated needs.”).

¹⁴¹ See, e.g. Elesser, *supra* note 138 at 376.

¹⁴² See Jennifer Gordon, *We Make the Road by Walking: Immigrant Workers, the Workplace Project, and the Struggle for Social Change*, 30 HARV. C.R.-C.L. L. REV. 407, 443 (1995) (“in the context of limited resources, legal assistance should go to workers who want to be active participants in our programs, rather than to those who expect to be the passive recipients of a service. Second, once a worker is committed to fighting for better working conditions, problems must be addressed through a team approach. This approach necessarily involves as many workers from the affected workplace as possible, an organizer, and when necessary, a lawyer or supervised legal advocate.”).

¹⁴³ Shek, *supra* note 106 at 133) (“ First, all staff and law students read about rebellious lawyering (Gerald Lopez), racial justice (Camara Jones), and poverty (David Shipler), and learn about the history, culture, and politics of the communities we serve. Second, we regularly re-visit our community-centered praxis, critiquing our approaches to case management and client encounters, workshop planning, and policy engagement—seeking to tip the balance of skills, knowledge, and power back to affected communities. Much of our self-examination also occurs in dialogue with traditionally underserved and subordinated community members, including clients, colleagues, policy partners, and community ‘neighbors’ and friends. Finally, even as we may share some characteristics and experiences with our clients and partner communities, we examine and challenge our own privileges, including how we benefit from and may serve to perpetuate unequal systems.”).

¹⁴⁴ *Id.* at 133-137 (describing examples of how one MLP engages in rebellious lawyering practices).

crease the collective power of their clients' communities and should strive to build relationships with grassroots community institutions. Perhaps the best way for existing MLP programs to build these relationships is by identifying community campaigns addressing health justice, led by community organizations and grassroots groups, that already exist, and becoming involved as "resource allies."¹⁴⁵ Or, where those campaigns don't exist, MLP providers should work collaboratively with patients in order to identify community demands and conduct outreach to existing community organizations to determine whether and how a campaign to address those demands could be conceptualized and established. Although it is true that some MLPs are likely already able to drive campaigns themselves, they create more potential for durable change if they are done in coalition with clients and community.

For example, during the pandemic, the Haven MLP at Yale Law School supported a statewide coalitional campaign to improve access to the state Medicaid program by removing barriers based on immigration status. The MLP is situated in the student-run Haven Clinic, a collaborative, student-directed project that provides care to uninsured immigrants in Greater New Haven.¹⁴⁶ MLP students sit on the Haven Clinic advocacy committee, which was faced with determining whether to support the campaign, and if so, how best to do so. The students recognized the special contribution they had to make as an interdisciplinary team, in regular contact with the community that would benefit, and that included team members who had lived experience with the problem at hand. However, there were multiple proposals in front of the legislature, some more aggressive than others. The Haven MLP students considered both the policy and political options available, including information about what types of organizations championed which options. Ultimately the MLP students, and the Haven Clinic, chose to work with the coalition favoring the most aggressive proposal, which was most aligned with the demands of grassroots membership organizations from the immigrant community itself. They participated in online discussions and forums with community mem-

¹⁴⁵ E. Tammy Kim, *Lawyers as Resource Allies in Workers' Struggles for Social Change*, 13 N.Y. CITY L. REV 213 (2009) (resource allies "support community organizing through legal representation of members of external grassroots organizations" and in the case of MLPs, through holistic medical and legal care).

¹⁴⁶ Silvan Lebrun & Maria Fernanda Pacheca, *Organizations, Healthcare Providers Advocate to Expand Medicaid Eligibility to Undocumented Immigrants*, YALE DAILY NEWS (March 19, 2021), <https://yaledailynews.com/blog/2021/03/19/community-organizations-healthcare-providers-advocate-to-expand-medicaid-eligibility-to-undocumented-immigrants/>.

bers, testified in front of legislative committees,¹⁴⁷ contributed to a petition from medical providers,¹⁴⁸ and spoke at rallies and direct actions. At the end of the legislative session, a much more modest expansion of coverage to undocumented community members was signed into law.¹⁴⁹ But the coalition—and the relationships developed during the campaign—will endure into future legislative sessions.

MLP practitioners should, of course, also remain conscious of their obligation to respect the autonomy and agency of individual clients.¹⁵⁰ This is especially important when their clients are simultaneously clinic patients facing a range of important, personal decisions regarding their own health, which themselves require informed consent.

When law students and lawyers engage with the community in this way, it forces us to openly confront our own positions in the community, make tough advocacy choices, think through the small-p political effects of decisions, and put the MLP in a position to contribute to collective efforts to make durable change.

CONCLUSION

The COVID-19 pandemic accelerated health inequity and racial injustice in a tangible and unmistakable way. Across the country, historically marginalized, subordinated, and exploited people, many of whom were our clinic clients, have suffered job loss, COVID-19 infection and mortality, food and housing insecurity, and barriers to access to justice. Despite experience with past epidemics, which made the heightened risk entirely predictable, few preventive or protective measures were taken and, as a result, racial, health, and economic injustice can be expected to proliferate in the post-pandemic setting. The legal field has a special role to play in preventing this outcome by uncovering how the law operates as a vehicle of subordination, especially in times of crisis, and how it must change. The pandemic highlighted how certain MLP features can aid law school clinics in identifying injustice at the root of poor health, and can act to make

¹⁴⁷ See, e.g., Testimony of Rebeca Vergara Greeno, Executive Director of the Haven Free Clinic, <https://www.cga.ct.gov/2021/hsdata/tmy/2021SB-00956-R000311-Vergara%20Greeno,%20Rebeca,%20Executive%20Director-HAVEN%20Free%20Clinic-TMY.PDF> (last visited July 8, 2021).

¹⁴⁸ *Health Care Providers: Expand Husky to Undocumented Immigrants*, HUSKY FOR IMMIGRANTS COALITION, <https://husky4immigrants.medium.com/health-care-providers-expand-husky-to-undocumented-immigrants-62b78e8a5ef7> (last visited July 8, 2021).

¹⁴⁹ Jenna Carlesso, *Proposal Opening Husky to Undocumented Children in CT Wins Final Approval*, CT MIRROR (June 9, 2021), <https://ctmirror.org/2021/06/09/proposal-opening-husky-to-undocumented-children-in-connecticut-wins-final-approval/>.

¹⁵⁰ Robert D. Dinerstein, *Client-Centered Counseling: Reappraisal and Refinement*, 32 ARIZ. L. REV. 501 (1990) (describing the client-centeredness model and its critics).

law work to improve health for clients and community. However, this requires the legal profession to step up, accept responsibility, and act. Otherwise, we are witting bystanders to the cycle of despair.

In the post-pandemic law school clinic, we must acknowledge the role of law in lifting—or oppressing—members of society, and we must fulfill our obligation to train the next generation of lawyers to recognize the structural and intermediary determinants of health at the root of their clients' hardship. We must actively collaborate with the community and other disciplines to address barriers to health equity and to racial and social justice. This Article drew from the tested strengths of the MLP clinic model to offer maxims of health justice that can be adopted across clinics. At the core of the health justice agenda, we are called to teach our students to engage and elevate the power of our clients and other historically marginalized people, in the effort to address structural and systemic barriers and compel the adoption of rights, protections, and support. Ultimately, we must leverage every opportunity to address social and racial injustice and prepare our students to be stewards of equitable laws and policies focused on the achievement of health justice for all people.