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PUBLIC HEALTH LEGAL SERVICES: A NEW VISION

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Introduction[±]

The role of legal services in achieving important public health goals has emerged as a new and powerful idea in recent years, one that is beginning to transform several settled understandings. For providers of legal services to vulnerable individuals, this

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[±] To assist readers of printed versions of this article, all citations with URLs appear with hyperlinks to those sites at <http://www.bc.edu/phlsdocs>.

emerging vision raises intriguing questions about best practices and institutional funding. For public health officials, it suggests a new tool to add to the traditional armamentarium of vaccine, sanitation, community education, population studies, and the like. And for those concerned about revitalizing liberalism, it provides an example in praxis.

We call this emerging vision “public health legal services.” The phrase encompasses those legal services provided by private sector attorneys to low-income persons that advance the public’s health. For example, assume an asthmatic child with multiple emergency room admissions. Each time the child is stabilized she returns home to a mold-infested home that triggers the next emergency episode. An attorney who compels the landlord to abate the mold is exercising individual rights on behalf of the child. She is also improving the child’s health. If several such actions within the same community result in similar improvements, such outcomes might be aggregated and evaluated using traditional public health metrics. Such studies could document the public health value of such actions as surely as studies of vaccine effectiveness or improved sanitation. And if such legal services not only improved access to justice but public health, should not that change the public debate about the value of legal services?

If this emerging vision of legal services’ capacity to engage social determinants of health is as rich as we suspect, it deserves both a careful depiction and an honest critique. We focus in this Article upon its implications primarily for legal services providers, but, because we suppose it also advances the mission of public health, we will explore this contention as well.

This conception of public health legal services departs from the commonplace understanding about public health law as concerned with the exercise of the state’s public health power. Rather, it extends that understanding to include the exercise of individual rights by private lawyers that *also* advances the public’s health. Just as it was once discovered that communities need access to health information, clean water, inoculation, and regulation of hazardous activities and products as part of a comprehensive scheme for promoting and achieving health, so too the emerging vision suggests that community health promotion also requires affordable access to effective legal information and assistance.

The first exemplars of this vision were legal services for HIV-positive persons and for pediatric patients. Since then similar experiences with oncology, asthma care, and other patients have deepened this understanding. From the perspective of legal service providers for the poor, this emerging vision offers both exciting opportunity and considerable discomfort. The prevailing legal services delivery models in the United States operate on a nearly pure market-driven format. In sharp contrast to the medical world, insurance coverage plays virtually no part in the allocation of legal services in our country. Lawyers and law firms sell their services. For those who cannot afford them, public and charitable private agencies, along with private lawyers offering *pro bono*

services, offer a patchwork of coverage which, all observers agree, fails to come close to meeting the need.¹

The idea of public health legal services offers a rich and powerful incentive for public and private agencies to increase those free and subsidized services. At the same time, the legal services necessary from a public health perspective may not be the ones currently emphasized by providers. Those providers, usually nonprofit legal entities, most often operate on a legal emergency-room model, offering the most assistance to those persons who are the most vulnerable and face the most extreme crises. The services offered therefore tend to be litigation-oriented, and tend to be retrospective, responding to past critical events, rather than prospective, offering preventive care to avoid crises in the future. The vision of public health legal services in many ways favors the latter over the former, and therefore calls upon providers to rethink their customary resource allocation models, and may call for painful, short-term choices between the new model and the always urgent demand for litigation and crisis-driven legal work. This Article engages that tension in an effort to understand it, if not resolve it.

This Article will proceed as follows. In Part I we will describe how public health legal services may legitimately be understood as a new tool of public health. In the parts that follow we will lay out our argument that they may be viewed as a new model for the delivery of legal services. Part II will review the historical development of providing legal services to the poor, particularly the emergency-room flavor of most current schemes, to permit a more focused contrast with the newer vision of public health legal services. Part III will describe the parallel innovations in Los Angeles and Boston, and later in New York, that have made concrete the working notion of public health legal services. Part IV will consider the challenges of public health legal services in practice and explore questions for further research.

I) Public Health Legal Services as a New Tool of Public Health

This Article describes an emerging conception that is both a new model for delivering legal services to the poor and a new tool for advancing public health. In this part, we develop our assertion that it is a new tool for public health.

A) Introduction and Definition

Can counseling clients, filing briefs, researching law, taking depositions and engaging in litigation be fairly paired with identifying pathogens, compiling statistics, assessing interventions and educating communities as skills that advance the public's health? To explore this question, we begin with a landmark report of the Institute of Medicine from 1988, which identified public health's mission as fulfilling "society's

¹ See, e.g., DEBORAH L. RHODE, ACCESS TO JUSTICE 3 (2004); Gary Blasi, *How Much Access? How Much Justice?*, 73 FORDHAM L. REV. 865, 879 (2004); Alan W. Houseman, *Civil Legal Assistance for the Twenty-First Century: Achieving Equal Justice for All*, 17 YALE L. & POL'Y REV. 369, 402 (1998).

interest in assuring conditions in which people can be healthy.”² According to that Report, an “organized community effort” by “private organizations and individuals as well as by public agencies” would accomplish this mission through the application of “scientific and technical knowledge to prevent disease and promote health.”³ In the Institute’s terms, then, can we rightly think of the application of attorneys’ technical knowledge as preventing disease and promoting health? To answer this question we must answer two predicate questions. Can law be thought of as central to public health? And, if so, can direct legal services be thought of as contributing to “society’s interest in assuring conditions in which people can be healthy”?

Those two questions invite a working definition of public health legal services. Two innovative legal services programs, one in Los Angeles and the other in Boston,⁴ emerged about the same time and share the same understanding: that client health outcomes achieved through the exercise of legal rights benefit communities as certainly

² INSTITUTE OF MEDICINE, *THE FUTURE OF PUBLIC HEALTH* 7 (1988). Public health practice is predicated on identifying health problems through assessment, policy development to solve identified local and national health problems, and assurance of all populations receiving access to appropriate and cost-effective care as a function of government. See Public Health Practice Council, *What Is Public Health Practice?*, http://www.cdc.gov/od/ocphp/PHPCouncil/Docs/Meetings/03_15_2007/Handouts/Definition%20of%20PH%20Practice.doc (last visited Mar. 1, 2007).

Public health practice’s first focus is always prevention, though that may take several forms. http://www.fhea.com/CertificationCols/level_prevention.htm (last visited Aug. 19, 2007):

- (1) Primary prevention interventions are “those provided to individuals to prevent the onset of a targeted condition,” such as vaccines against diseases and counseling that promotes the use of seatbelts and bicycle helmets. U.S. PREVENTIVE SERV. TASK FORCE, *GUIDE TO CLINICAL PREVENTIVE SERVICES* (2nd ed.) xli (1996), available at <http://www.ahrq.gov/clinic/cpsix.htm> (last visited Aug. 16, 2007).
- (2) Secondary prevention is interventions to “identify and treat asymptomatic persons who have already developed risk factors or preclinical disease but in whom the condition is not clinically apparent,” and is focused upon identifying people who are in the early stages of a common disease, even patients who are asymptomatic, and in diseases that have a significant risk for negative outcome without treatment. *Id.*
- (3) Tertiary prevention involves the care of established disease, with attempts made to restore to highest function, minimize the disease’s negative effects, and prevent complications related to it.

Public health’s programs are based on data and evidence, developed over time, with an emphasis on collective rather than individual benefit. Because public health emphasizes the long view in evaluating the efficacy of interventions, this often means an investment of substantial resources without necessarily an immediate return but one with significant benefit over time. Fluoridation of the water is an example of this long-term perspective. An example of public health’s focus on community rather than individual well-being is the infectious disease patient who is quarantined to prevent new cases but receives no direct benefit herself for being isolated. Public health agencies use outcome data to evaluate the success of their programs.

³ *Id.*

⁴ For a description of these programs, see Part III *infra*.

as other health outcomes and should be valued as such. These two programs developed on opposite coasts, in different types of legal practices, with different orientations, using different nomenclatures, addressing different client groups, with no direct cross-fertilization. Yet their shared qualities suggest a common rubric, which we describe as follows:

Public health legal services. Those legal services provided by private sector attorneys⁵ to low-income persons the outcomes of which, when aggregated and evaluated using traditional public health measures, advance the public's health as they protect individual rights.

Note that this definition focuses on the efforts of private lawyers serving low-income clients providing services that have an aggregate public health benefit. While neither of those limitations is categorically necessary,⁶ each serves the purposes of this Article and its mission. The conception of public health legal services that this Article explores involves the work of *pro bono* and subsidized lawyers assisting clients who cannot afford private counsel. That public service itself accomplishes critical public health goals, or so this Article will assert.

B) Can Law Be Thought of as Central to Public Health?

We consider two competing narratives to answer the question whether law is central or peripheral to public health. The first is the standard version of public health's history, in which a biomedical model emerged in the late nineteenth century, leaving law to deal with such marginal matters as regulation and licensing. The second is an emerging revisionist version in which law is indeed central.

The noted public health historian Daniel Fox describes the standard version as being "a progression from marginally useful policy, made mainly by civil servants learned in law, to effective policy, made by persons trained in disciplines that rely chiefly on [the] biomedical and behavioral science" that followed the late nineteenth century's "revolutionary advances in epidemiology and bacteriology."⁷ In the resulting biomedical model of public health, lawyers became mere technicians who assisted scientists to implement their programs, drafting state regulations to monitor tuberculosis cases, for

⁵ By "private sector attorneys," we intend to distinguish government lawyers whose employment role is to advance the public health. The private sector attorneys whose work we address here include legal services and public interest lawyers, and law firm lawyers offering *pro bono* legal assistance. See *infra* notes 35-37.

⁶ Michael L. Pates, Director, American Bar Association's Center for Human Rights, and of the ABA's AIDS Coordination Project, notes that this definition could be broadened, for example, to include legal services to middle-class clients with Medicare claims. (Private communication to authors.) Extending his reasoning, the concept could also include the advice from the largest New York law firm to wealthy clients seeking experimental treatments for cancer. As the text explains, the goals of this Article suggest a more modest definition for now.

⁷ Daniel M. Fox, *The Professions of Public Health*, 91 AM. J. PUB. HEALTH 1362, 1362 (2001).

example, or license new laboratory tests.⁸ Law's marginal place in this version was exacerbated by the traditional antipathy between lawyers and physicians.⁹ The absence of public health legislation and case law beginning in the 1930s would in this version be evidence in support of law's peripheral role. Indeed, the power of the biomedical model was so compelling that by the 1970s many experts believed there would never again be another major infectious disease outbreak in the United States.¹⁰

By contrast, the revisionist version of public health's history, according to Fox, holds that "law has for 500 years been an essential discipline of public health."¹¹

Revisionism begins with accounts of the 16th and 17th centuries, when the countries of Western and Northern Europe experienced . . . a "profound transformation—really a revolution [in] political attitudes and practices" that included the creation of a "new elite" who inaugurated the "reign of the expert professional." These experts, lawyers as well as physicians, wrote public health statutes that embraced a "fundamentally optimistic belief that proper knowledge will help overcome the most inexorable aspect of human existence, its fragility in the face of nature." The authors of public health legislation addressing both the control of persons with infectious diseases and the regulation of the environment shared a "universal belief in [the] ability [of science] to improve the quality of life." The advance of science since the 19th century reinforced this belief; it did not initiate it. . . .

"Public health is everywhere and always contingent," [Christopher]

⁸ *Id.*

⁹ *Id.* at 1363. Fox writes:

The personal experience of many contemporary public health practitioners reinforces the subordinate role accorded to law and lawyers by these historians. Lawyers and physicians often have tense relationships. Members of the 2 professions frequently disagree about the definition of appropriate evidence, the value of adversarial proceedings, and the social utility of due process. Officials at all levels of government frequently experience lawyers as sources of delay and rarely as sources of assistance. Moreover, most officials who become targets of lawyers for individual plaintiffs or classes of plaintiffs discover that the formal clients of attorneys general and agency counsel are governing boards and governors rather than individual public employees. . . .

¹⁰ A typical public health school infectious disease control case study would have been a typhus outbreak in a rural village in some developing part of the world. Its characteristics would have included a discrete outbreak in an isolated setting among the general population of a known pathogen transmitted casually and causing illness quickly, vulnerable both to treatment and control through prompt, aggressive intervention. Key goals would be to contain the outbreak, identify the pathogen, and deliver effective medical services. *See, e.g.*, <http://medind.nic.in/maa/t06/i4/maat06i4p342.pdf>; <http://www.lapublichealth.org/acd/reports/spclrpts/spcrpt05/OutbreakMurineTyphus05.pdf>.

¹¹ Fox, *supra* note 7, at 1363.

Hamlin insists, employing a word used by social scientists who employ historical methods to suggest the interrelatedness, complexity, and unexpected consequences of any past event. Because public health policy is contingent, scientific or technical advances have never been its sole determinants. . . .

The new historiography . . . justifies the reconception of which professions contribute to public health practice In the new conception, [it] is the result of ongoing sociopolitical negotiations that involve experts in a variety of disciplines¹²

AIDS is a strong proof text in support of the revisionist version.¹³ AIDS marked the end of the biomedical model's hegemony, for it could provide no quick fix.¹⁴ These

¹² *Id.* at 1363-4 (internal cites omitted) (quoting CHRISTOPHER HAMLIN, PUBLIC HEALTH AND SOCIAL JUSTICE IN THE AGE OF CHADWICK: BRITAIN, 1800–1854 341 (1998)).

¹³ And indeed, the revisionists Fox cites all write after AIDS's discovery in 1981, most long after. See Fox, *supra* note 7, at 1363-64 (citing MARC RAEFF, THE WELL-ORDERED POLICE STATE: SOCIAL AND INSTITUTIONAL CHANGE THROUGH LAW IN THE GERMANIES AND RUSSIA, 1600–1800 120, 257 (1983); PETER BALDWIN, CONTAGION AND THE STATE IN EUROPE, 1830–1930 529 (1999); HAMLIN, *supra* note 12, at 52; Elizabeth Fee & Dorothy Porter, *Public Health, Preventive Medicine and Professionalization: England and America in the 19th Century*, in MEDICINE IN SOCIETY: HISTORICAL ESSAYS 249–276, 261 (Andrew Wear, ed. 1992); Elizabeth Fee & Roy M. Acheson, *Introduction*, in A HISTORY OF EDUCATION IN PUBLIC HEALTH: HEALTH THAT MOCKS THE DOCTORS' RULES 1–14 (Elizabeth Fee & Roy M. Acheson eds. 1991); NANCY TOMES, THE GOSPEL OF GERMS: MEN, WOMEN AND THE MICROBE IN AMERICAN LIFE 240–41 (1998); EVELYNN MAXINE HAMMONDS, CHILDHOOD'S DEADLY SCOURGE: THE CAMPAIGN TO CONTROL DIPHTHERIA IN NEW YORK CITY, 1880–1930 (1999)).

¹⁴ Indeed, twenty-seven years after the discovery of AIDS there is still no vaccine or cure. This is not to say that the biomedical model was of no value. Investigators from the U.S. Centers for Disease Control (now the U.S. Centers for Disease Control and Prevention) (CDC) used classic biomedical techniques to conclude just seventeen months after AIDS's discovery that it was likely caused by an unknown bloodborne pathogen. See CDC, *Acquired Immune Deficiency Syndrome (AIDS): Precautions for Clinical and Laboratory Staffs*, 31 MORBIDITY & MORTALITY WKLY. REP. 577 (Nov. 5, 1982). See also CDC, *Pneumocystis Pneumonia—Los Angeles*, 30 MORBIDITY & MORTALITY WKLY. REP. 250 (June 5, 1981), reprinted at 45 MORBIDITY & MORTALITY WKLY. REP. 729 (Aug. 30, 1996). The next month, the CDC published evidence that strengthened the bloodborne hypothesis, of an infant blood transfusion recipient who may have developed AIDS from a donor later diagnosed with AIDS. CDC, *Possible Transfusion-Associated Acquired Immune Deficiency Syndrome (AIDS)—California*, 31 MORBIDITY & MORTALITY WKLY. REP. 652 (Dec. 10, 1982). And the following May—less than twenty-four months after the first AIDS case reports—the French announced that they had isolated the virus, eventually named HIV (“human immunodeficiency virus”). F. Barre-Sinoussi, J. C. Chermann, F. Rey, M. T. Nugeyre, S. Chamaret, J. Gruest, C. Dautuet, C. Axler-Blin, F. Vezinet-Brun, C. Rouzioux, W. Rozenbaum & L. Montagnier, *Isolation of a T-lymphotropic Retrovirus from a Patient at Risk for Acquired Immune Deficiency Syndrome (AIDS)*, 220 SCIENCE 868 (1983). See also Lawrence K. Altman, *Federal Official Says He Believes Cause of AIDS Has Been Found*, N.Y. TIMES, Apr. 22, 1984, §1, at 1 (referring in part to the report contained in the preceding citation). And see, http://nobelprize.org/nobel_prizes/medicine/laureates/2008, (last visited Jan. 8, 2009) (describing the conferral of one-half the Nobel Prize in Physiology or Medicine 2008 upon French researchers Françoise Barre-Sinoussi and Luc Montagnier for their discovery).

This impressive biomedical achievement was either unpersuasive or overlooked by a young attorney in the Office of the White House Legal Counsel, for three years later, in a memorandum to White

unexpected limits of the biomedical model belied the standard version's account of public health's history as a linear "progression from marginally useful policy, made mainly by civil servants learned in law, to effective policy" based on science.¹⁵

It also restored law's centrality to public health. AIDS occurred within culturally contested terrain¹⁶ involving complex social determinants of health. It first affected already highly stigmatized groups—gay men, injection drug users, and hemophiliacs. Halting its spread required specific, morally contentious interventions—screened blood, condoms, and clean needles.¹⁷ Even as conservative a body as President Reagan's AIDS Commission concluded that law was essential to confronting such challenges.

House legal counsel Fred Fielding concerning the president's briefing materials for a forthcoming news conference, now-Chief Justice of the United States Supreme Court John G. Roberts advised:

The AIDS briefing points consider the dispute over admitting AIDS-afflicted children into the public schools. The third bullet item contains the statement that "as far as our best scientists have been able to determine, AIDS virus is not transmitted through casual or routine contact." I do not think we should have the President taking a position on a disputed scientific issue of this sort. He has no way of knowing the underlying validity of the scientific "conclusion," which has been attacked by numerous commentators. I would not like to see the President reassuring the public on this point, only to find out he was wrong later. There is much to commend the view that we should assume AIDS can be transmitted through casual or routine contact, as is true with many viruses, until it is demonstrated that it cannot be, and no scientist has said AIDS definitely cannot be so transmitted.

John G. Roberts & Deborah K. Owen, Office of the White House Legal Counsel, Memorandum for Fred F. Fielding Re: Domestic Briefing Materials for Press Conference 1 (Sept. 13, 1985), *available at* <http://www.bc.edu/phlsdocs> (last visited XXXX). *And see* Todd S. Purdum & John S. Broder, *Nominee's Early Files Show Many Cautions for Top Officials, Including Reagan*, N.Y. TIMES, Aug. 19, 2005, at A12 (reporting the disclosure of the memorandum in the preceding citation during Roberts's confirmation hearings). *See also* AIDS AND THE LAW (David W. Webber, ed., 4th ed. 2008) 3-87, note 311; scholars and practitioners should note that Webber provides is the single most comprehensive historical account of U.S. HIV/AIDS legal issues. *And see* Alito discussion, *infra* note 18.

¹⁵ Fox, *supra* note 7, at 1362.

¹⁶ *See, e.g.*, David I. Schulman, *AIDS Discrimination: Its Nature, Meaning and Function*, 12 NOVA L. REV. 1113 (1988), *available at* <http://www.bc.edu/phlsdocs> (last visited XXXX). Schulman writes:

AIDS is like a stain on a microscopic slide, highlighting pre-existing chronic social problems the way a stain brings into sharp relief the characteristics of certain organisms. For those resistant to confronting such problems—drug abuse or inequitable health care delivery, for example—there is a temptation to attribute them to AIDS, as if our resolution of these issues had been effective until AIDS destroyed our social stability.

Id. at 1113.

¹⁷ The predominant transmission route—certain sexual behaviors—could have affected heterosexuals in the United States first, as it has in Africa. It is one of AIDS's many ironies that the high visibility of the gay community's suffering is what finally humanized gay and lesbian people in the eyes of many others, an unspeakably high price to have to pay for one's own dignity. *See, e.g.*, JOHN-MANUEL ANDRIOTE, VICTORY DEFERRED: HOW AIDS CHANGED GAY LIFE IN AMERICA (1999).

HIV-related discrimination is impairing this nation's ability to limit the spread of the epidemic. Crucial to this effort are epidemiological studies to track the epidemic as well as the education, testing, and counseling of those who have been exposed to the virus. [However, p]ublic health officials will not be able to gain the confidence and cooperation of infected individuals or those at high risk for infection if such individuals fear that they will be unable to retain their jobs and their housing, and that they will be unable to obtain the medical and support services they need because of discrimination based on a positive HIV antibody test.¹⁸

¹⁸ REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC 119 (1988). See also *School Board of Nassau County, Florida v. Arline*, 480 U.S. 273 (1987) (regarding the applicability of the Rehabilitation Act of 1973 to tuberculosis and other contagious diseases).

Allowing discrimination based on the contagious effects of a physical impairment would be inconsistent with the basic purpose of [the Rehabilitation Act of 1973], which is to ensure that handicapped individuals are not denied jobs or other benefits because of the prejudiced attitudes or the ignorance of others. . . . Congress acknowledged that society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment. Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness. Even those who suffer or have recovered from such noninfectious diseases as epilepsy or cancer have faced discrimination based on the irrational fear that they might be contagious. The Act is carefully structured to replace such reflexive reactions to actual or perceived handicaps with actions based on reasoned and medically sound judgments. . . . The fact that some persons who have contagious diseases may pose a serious health threat to others under certain circumstances does not justify excluding from the coverage of the Act all persons with actual or perceived contagious diseases. Such exclusion would mean that those accused of being contagious would never have the opportunity to have their condition evaluated in light of medical evidence and a determination made as to whether they were "otherwise qualified." *Rather, they would be vulnerable to discrimination on the basis of mythology—precisely the type of injury Congress sought to prevent.*

Id. at 284-85 (emphasis added; internal cites omitted). It warrants noting that *Arline* was issued despite the best advice of yet another future member of the Court. See Roberts discussion *supra* note 14. During Samuel Alito's confirmation hearings as an associate justice of the Supreme Court, The Washington Post reported that he "helped write a[n] opinion that employers could legally fire AIDS victims because of a 'fear of contagion, whether reasonable or not,' because discrimination based on insufficient medical knowledge was not prohibited by federal laws protecting the disabled." Peter Barker, *Alito Nomination Sets Stage for Ideological Battle; Bush's Court Pick is Appeals Judge with Record of Conservative Rulings*, WASH. POST, Nov. 1, 2005, at A01. See Charles J. Cooper, Assistant Attorney General, Office of Legal Counsel, U.S. Department of Justice, Memorandum for Ronald E. Robertson, General Counsel, HHS, Re: Application of Section 504 of the Rehabilitation Act to Persons with AIDS, AIDS-Related Complex, or Infection with the AIDS Virus (June 20, 1986), available at <http://www.bc.edu/phlsdocs> (last visited XXX). That opinion, issued by Attorney General Edwin Meese, has been called "odious" by at least one commentator. LAWRENCE O. GOSTIN, *THE AIDS PANDEMIC: COMPLACENCY, INJUSTICE, AND UNFULFILLED EXPECTATIONS* xxv (2004). Following *Arline*, Attorney General Richard Thornburgh revoked the opinion. See Douglas W. Kmiec, Acting Assistant Attorney General, Office of Legal Counsel, U.S. Department of Justice, Memorandum for Arthur B. Culvahouse, Jr., Counsel to the President, Re: Application of Section 504 of the Rehabilitation Act to HIV-infected Individuals (Sept. 27, 1988),

Thus, AIDS demonstrates the revisionists' claim that public health needs law's capacity to absorb cultural tension and mediate norms and values.¹⁹ This Article claims²⁰ that it is precisely law's capacity to engage some of the most complex and contentious social determinants of health that makes the vision of public health legal services so powerful.

C) Can Direct Legal Services Also Be Considered Central to Public Health?

The preceding has made the case that law can be thought of as central to public health. But what kind of law? Daniel Fox wrote of the pioneering work of Lawrence Gostin, Anthony Moulton and Gene Matthews when presenting the arguments in favor of public health law.²¹ But the work of those scholars concerns what is normative, the authority of the state to ensure health. Can public health law also include the authority of individuals acting through direct legal services to ensure their own health and the health of their communities? Can public health legal services be considered a field of public health law?

They can for two reasons. First, they reduce public health's boundary anxiety. As Gostin notes,

Scholars and practitioners have long been conflicted about the "reach" or domain of public health. Some prefer a narrow focus on the proximal risk

available at <http://www.bc.edu/phlsdocs> (last visited XXXX). *And see*, WEBBER, *supra* note 14, at 3-87 – 3-88.

¹⁹ For an example of law's engagement with the social determinants of another devastating global health problem, see Ruth Roemer, Allyn Taylor & Jean Lariviere, *Origins of the WHO Framework Convention on Tobacco Control*, 95 AMER. J. PUB. HEALTH 936 (2005) (regarding the efforts of lawyers to persuade the World Health Organization to adopt the first global health treaty on tobacco control). *See also* ALLAN M. BRANDT, *THE CIGARETTE CENTURY: THE RISE, FALL, AND DEADLY PERSISTENCE OF THE PRODUCT THAT DEFINED AMERICA* 319-445 (2007).

²⁰ *See especially, infra* Part IV.

²¹ *See* Fox, *supra* note 7, at 1362. Fox explains:

Gostin's commentary [in the same issue of the journal in which Fox writes] (and the book on which it is based—*Public Health Law: Power, Duty, Restraint*) makes the first sustained argument since the early 19th century that law is an essential tool to protect and promote the public's health. The new public health law program of the Centers for Disease Control and Prevention (CDC), described by Moulton and Matthews [in the same issue], is a pioneering program, because it identifies laws as interventions to prevent disease rather than as technical requirements imposed on public health officers who are applying the results of biomedical science.

Id. (describing Lawrence O. Gostin, *Public Health Law Reform*, 91 AM. J. PUB. HEALTH 1365 (2001); Anthony D. Moulton & Gene W. Matthews, *Strengthening the Legal Foundation for Public Health Practice: A Framework for Action*, 91 AM. J. PUB. HEALTH 1369 (2001)).

factors for injury and disease...[such as] identify[ing] risks or harms and interven[ing] to prevent or ameliorate them[,]. . . exercising discrete powers such as surveillance, infectious disease controls (e.g., screening, vaccination, partner notification, and quarantine), and sanitary measures (e.g., safe food and drinking water).

Others prefer a broad focus on the societal, cultural, and economic foundations of health...[such as] the underlying conditions that are associated with poor health...[through an interest] in the equitable distribution of social and economic resources because social status, race, and wealth are important determinants of health. . . . The problem with an expansive view is that public health—as a field, as a mandate—becomes limitless, as almost everything human beings undertake affects public health.²²

Public health legal services only address those social determinants about which society has already reached consensus, that is, ones based on a justiciable claim. Thus, they help establish common ground between public health minimalists and maximalists.

Second, they effectuate health and human rights. The leading founder of this newly emerging public health field was the late Jonathan Mann, the first director of the World Health Organization's Global Programme on AIDS.²³ Like most public health practitioners of his generation, Mann had been trained to believe in the hegemony of the biomedical model. Thus, he was initially puzzled by political leaders' resistance to the compelling data he presented about AIDS in their countries. He eventually understood, however, that his training had failed to prepare him to account for how certain diseases—like AIDS—might occur within a volatile social field that created resistance to such data. Public health, he and his colleagues concluded, must account for this volatile social field as well:

The heated, intense dialogue between public health and human rights has been one of the most important and unanticipated outcomes of the first decade of the AIDS pandemic. Discrimination has been identified as both counterproductive for public health program effectiveness and as a major underlying cause of ill health worldwide. It is reasonable to speak of a “revolution” in thinking about health through its inextricable connection with human rights. . . . [A]s the challenges of AIDS and other major public health problems of the future involve behavior—individual and

²² Lawrence O. Gostin, *Public Health, Ethics, and Human Rights: A Tribute to the Late Jonathan Mann*, 29 J. L. MED. & ETHICS 121, 122-23 (2001) (internal citations omitted) [hereinafter Gostin, *Tribute to Mann*].

²³ *Id.* at 121.

collective—the value of incorporating human rights norms within public health practice will increase.²⁴

Health and human rights, however, focuses upon the establishment of norms and structures,²⁵ not upon their effectuation.²⁶ But affording individuals rights is not enough. Once afforded, they must be realized:

To enhance health effectively, human rights must also work from a bottom up, or exercise, perspective. . . . [T]he question [that] must be answered... [is] once enacted, what will individuals and communities do with these rights that make a difference in their health? How will they exercise such rights . . . Will they even know about such rights, let alone...have access to legal services or administrative agencies that will enforce [them]?²⁷

As Paul Farmer observes:

[W]e can recognize . . . human rights abuses But what, precisely, is to be done? . . . Passing more human rights legislation is not a sufficient response to . . . human rights challenges As the Haitians say, “Laws are made of paper; bayonets are made of steel.”²⁸

²⁴ JONATHAN M. MANN, DANIEL J.M. TARANTOLA & THOMAS W. NETTER, A GLOBAL REPORT: AIDS IN THE WORLD 537 (1992).

²⁵ See generally Jonathan M. Mann, Lawrence Gostin, Sofia Gruskin, Troyen Brennan, Zita Lazzarini & Harvey Fineberg, *Health and Human Rights*, 1 J. HEALTH & HUM. RTS. 7 (1994) reprinted in HEALTH AND HUMAN RIGHTS: A READER 7 (Jonathan M. Mann, Sofia Gruskin, Michael A. Grodin & George J. Annas eds. 1999). See, also, CHRIS BEYRER & H.F. PIZER, PUBLIC HEALTH & HUMAN RIGHTS: EVIDENCE-BASED APPROACHES (2007). And see, e.g., Scott Burris, *Introduction: Merging Law, Human Rights and Social Epidemiology*, 30 J.L. MED. & ETHICS 498 (2002) (being the introduction to Symposium, *Health, Law, & Human Rights: Exploring the Connection*, 30 J.L. MED. & ETHICS 487 (2002)); Gerald M. Oppenheimer, Ronald Bayer & James Colgrove, *Health and Human Rights: Old Wine in New Bottles?*, 30 J.L. MED. & ETHICS 522 (2002); Helen Watchirs, *Review of Methodologies Measuring Human Rights Implementations*, 30 J.L. MED. & ETHICS 716 (2002); Eileen O’Keefe & Alex Scott-Samuel, *Human Rights and Wrongs: Could Health Impact Assessment Help?*, 30 J.L. MED. & ETHICS 734 (2002).

²⁶ Gostin, for example, notes that “[a]ffording individuals their rights can be a powerful public health strategy, freeing them from physical or emotional abuse, social stigma, and economic dependence.” Gostin, *Tribute to Mann*, *supra* note 22, at 128.

²⁷ David I. Schulman & R. Bradley Sears, HIV Legal Checkups: New Tool For Improving Community Health Through Human Rights 1 (workshop syllabus), *Health, Law and Human Rights: Exploring the Connections* (Phila., PA) (Sept. 30, 2001) (being a conference sponsored by the American Society for Law, Medicine & Ethics et al.), available at <http://www.bc.edu/phlsdocs> (last visited XXXX).

²⁸ PAUL FARMER, PATHOLOGIES OF POWER: HEALTH, HUMAN RIGHTS, AND THE NEW WAR ON THE POOR 235 (2003).

With all due respect to Farmer, law is not just made of paper. It also contains steel, as when public health legal services compel a landlord to abate the mold in an asthmatic child's home, forbids an employer from firing an employee living with HIV, ensures that a woman with metastatic breast cancer gets insurance coverage, or forces the Social Security administration to provide promised benefits. Public health legal services effectuate the norms of health and human rights in the lives of subjects active in their own health. They are the critical effectuating *infrastructure* to the health and human rights *superstructure* so vital to public health's future.

II) Traditional Legal Services and *Pro Bono* Delivery Models

The model of public health legal services developed in this Article envisages private lawyers offering free or subsidized legal assistance to low-income clients, and by doing so, achieving palpable public health benefits.²⁹ Part I situated that conception within the public health understandings. This Part further situates the model by describing the conventional and historical views of provision of legal services to the poor. Understanding that landscape is essential to an appreciation of the tensions arising from a commitment to public health legal services. The latter enterprise might call for a strategy for using poverty lawyers and their resources that is markedly different from the strategies which have dominated poverty law culture over the past decades.

The history within the United States of delivering legal services to those who cannot afford it has been dominated by two competing principles—one focused on achieving access to justice for all comers, and the other focused on enhancing the political power of the disadvantaged.³⁰ The public health conception of legal services delivery developed in this Article differs from, but complements, both of those themes. This Part will describe briefly, as an important backdrop to the advancement of a public health legal services blueprint, the historical underpinnings of legal aid and *pro bono* in the American legal system. Later, Part IV will rely on the understandings developed here to compare the alternative vision of lawyers representing disadvantaged populations, one expressly related to the conception of public health, with those traditional understandings.

A) The Challenge of Scarcity

²⁹ See *supra* text accompanying notes 21-28.

³⁰ See Richard Abel, *Law Without Politics: Legal Aid Under Advanced Capitalism*, 32 UCLA L. REV. 474, 487 (1985); Mark Feldman, *Political Lessons: Legal Services for the Poor*, 83 GEO. L.J. 1529, 1569-82 (1995); Mark Spiegel, *The Boston Legal Aid Society: 1900-1925*, 9 MASS. LEGAL HIST. 17 (2003).

The American legal profession is structured as a market system.³¹ With few exceptions,³² lawyers sell their time, effort and expertise to the highest bidders.³³ This arrangement obviously contrasts with that of the United States health care delivery system, which funds its services largely, although certainly not exclusively, through public or private medical insurance.³⁴ An individual who encounters an important legal need but who cannot afford the cost of a private lawyer (and who cannot persuade a private lawyer to take her case on a contingent fee basis) has essentially three options available to her.³⁵ If she meets the program's eligibility criteria, she may qualify for free

³¹ However, the legal profession's system may not accurately be labeled a "free market" system, because of the limitations on fees imposed by the state regulatory schemes. *See, e.g.*, AMERICAN BAR ASSOCIATION, MODEL RULES OF PROFESSIONAL CONDUCT, R. 1.5 (2003) [hereinafter MODEL RULES] (lawyers may not charge an "unreasonable fee"). *See also* Jeffrey W. Stempel, *Embracing Descent: The Bankruptcy of a Business Paradigm for Conceptualizing and Regulating the Legal Profession*, 27 FLA. ST. U. L. REV. 25 (1999) (resisting a market-driven conception of the legal profession).

³² Some legal services are covered by personal insurance policies, which pay for a lawyer to defend the policyholder. *See* Blanca Fromm, Comment, *Bringing Settlement Out of the Shadows: Information about Settlement in an Age of Confidentiality*, 48 UCLA L. REV. 663, 675 (2001) (describing such policies and their limits). The market for "legal expenses insurance" in the United States is far less vibrant than in Western Europe. *See, e.g.*, Anthony Heyes, Neil Rickman & Dionisia Tzavara, *Legal Expenses Insurance, Risk Aversion and Litigation*, 24 INT'L REV. L. & ECON. 107 (2004); Neil Rickman & Alastair Gray, *The Role of Legal Expenses Insurance in Securing Access to the Market for Legal Services*, in REFORM OF CIVIL PROCEDURE: ESSAYS ON "ACCESS TO JUSTICE" 305, 321-22 (A.A.S. Zuckerman & Ross Cameron eds. 1995). Some employers and organizations offer "prepaid legal services," which operates as a form of legal services insurance. *See, e.g.*, Michael Z. Green, *Ethical Incentives for Employers in Adopting Legal Service Plans to Handle Employment Disputes*, 44 BRANDEIS L.J. 395 (2006); Judith L. Maute, *Pre-paid and Group Legal Services: Thirty Years After the Storm*, 70 FORDHAM L. REV. 915, 935 (2001) ("[e]mployer-paid [legal service] programs cover 7.6 million Americans, with Hyatt Legal Plans and the United Auto Workers being the largest providers"); ABA Comm. on Ethics and Prof'l Responsibility, Formal Op. 87-355 (1987) (accepting lawyer's participation in for-profit prepaid legal services plan).

³³ The prevalence of contingent fee retainer agreements in certain types of legal work, most notably plaintiffs' tort liability litigation, does not undermine the assertion in the text. Lawyers who earn a living through contingent fees are charging their clients, sometimes handsomely so, by retaining a percentage of the successful clients' recovery. *See, e.g.*, A.B.A. Tort Trial & Ins. Practice Section Task Force on Contingent Fees, *Contingent Fees in Mass Tort Litigation*, 42 TORT TRIAL & INS. PRAC. L.J. 105 (2006).

³⁴ *See generally* The Kaiser Family Foundation, *Health Care Costs: A Primer* (Aug. 8, 2007), <http://www.kff.org/insurance/7670.cfm> (last visited Sept. 15, 2008).

³⁵ Not surprisingly, the distinct options identified here in fact might be drawn with more nuances. For instance, an emerging movement within the legal profession describes "unbundled legal services," in which a consumer/client pays for limited and usually discrete items of legal assistance, and otherwise represents herself. For a description of that development, *see, e.g.*, Forrest Mosten, *Unbundling Legal Services, A Key Component in the Future of Access to Justice*, 57 OR. ST. B. BULL. 9 (1997); Robert E. Hirshon, *The Importance of Unbundling Legal Services*, 40 FAM. CT. REV. 13 (2002); Mary Helen McNeal, *Redefining Attorney-Client Roles: Unbundling and Moderate-Income Elderly Clients*, 32 WAKE FOREST L. REV. 295, 339 (1997) ("discrete-task representation may be a practical alternative for providing legal assistance to the moderate-income elderly"). In addition, new models of representation are developing which employ the services of lay advocates instead of lawyers as a reasonable substitute for high-priced legal services. Those models, over the visceral and strenuous opposition of the organized bar, are growing in number and in acceptance. *See, e.g.*, Deborah Rhode, *The Delivery of Legal Services by Non-Lawyers*, 4 GEO. J. LEGAL ETHICS 209 (1990).

legal services through an established legal aid organization.³⁶ Alternatively, she may locate a private lawyer willing to represent free of charge, on a *pro bono publico* basis.³⁷ Or, lastly, she may represent herself.³⁸

Most individuals who cannot afford a lawyer proceed without one, and represent themselves.³⁹ The primary reason for that fact is that the free services available through legal aid organizations and *pro bono* providers cannot come close to meeting the demand for them.⁴⁰ Lawyers representing the poor therefore face a serious *scarcity* problem.⁴¹ That scarcity challenge is intensified, and dramatically so, if one includes in the population of those in need all of the middle and lower-middle class families who, while typically not eligible for free or subsidized legal services, in fact have a great deal of difficulty affording the services of a private lawyer.⁴²

³⁶ Legal aid organizations tend to be nonprofit entities funded by the federal Legal Services Corporation, see Legal Services Corporation Act of 1974, Pub. L. No. 93-355, 88 Stat. 378 (codified at 42 U.S.C. 2996 (2000)); <http://www.lsc.gov/laws/act.php> (last visited Apr. 13, 2008), or a comparable state legal assistance program, see, e.g. M.G.L.A. Pt. III, T. I, Ch. 221A (creating the Massachusetts Legal Assistance Corporation). Many private nonprofit organizations operate in a similar fashion without public funding.

³⁷ See MODEL RULES, *supra* note 31, at R. 1.6 (encouraging all lawyers to offer at least 50 hours per year in free *pro bono* services to those who cannot afford representation). “Pro bono has . . . emerged as the dominant means of dispensing free representation to poor and underserved clients, eclipsing state-sponsored legal services and other nongovernmental mechanisms in importance.” Scott L. Cummings, *The Politics of Pro Bono*, 52 UCLA L. REV. 1, 1 (2004).

³⁸ See, e.g., Deborah Rhode, *Access to Justice: Connecting Principles to Practice*, 17 GEO. J. LEGAL ETHICS 369, 399-404 (2004) [hereinafter Rhode, *Access to Justice*]; Russell Engler, *And Justice for All—Including the Unrepresented Poor: Revisiting the Roles of Judges, Mediators, and Clerks*, 67 FORDHAM L. REV. 1987, 1988, 2022 (1999).

³⁹ See Brenda Star Adams, “Unbundled Legal Services”: A Solution to the Problems Caused by Pro Se Litigation in Massachusetts’s Civil Courts, 40 NEW ENG. L. REV. 303, 304 (2005); Russell Engler, *Out of Sight and Out of Line: The Need for Regulation of Lawyers’ Negotiations with Unrepresented Poor Persons*, 85 CAL. L. REV. 79 (1997); Alicia M. Farley, Current Development 2006-2007, *An Important Piece of the Bundle: How Limited Appearances Can Provide an Ethically Sound Way to Increase Access to Justice for Pro Se Litigants*, 20 GEO. J. LEGAL ETHICS 563 (2007).

⁴⁰ See Legal Services Corporation, *Documenting the Justice Gap in America: The Current Unmet Civil Legal Needs of Low-Income Americans* (2005), <http://www.lsc.gov/JusticeGap.pdf> (last visited Sept. 15, 2008).

⁴¹ See, e.g., Gary Bellow & Jeanne Charn, *Paths Not Yet Taken: Some Comments on Feldman’s Critique of Legal Services Practice*, 83 GEO. L.J. 1633 (1995); Paul R. Tremblay, *Toward a Community-Based Ethic of Legal Services Practice*, 37 UCLA L. REV. 1101 (1990).

⁴² See, e.g., James P. George, *Access to Justice, Costs, and Legal Aid*, 54 AM. J. COMP. L. 293, 312 (2006) (“economic studies often criticize attorney compensation as one problem in both the cost of legal services, and its unavailability to the middle class client”); George C. Harris & Derek F. Foran, *The Ethics of Middle-Class Access to Legal Services and What We Can Learn from the Medical Profession’s Shift to a Corporate Paradigm*, 70 FORDHAM L. REV. 775, 790-95 (2001) (reviewing studies showing that the cost of legal assistance prevents consumers from using lawyers.); John T. Nockleby, *Access to Justice: The Economics of Civil Justice*, 39 LOY. L.A. L. REV. 683, 684 (2006).

Lawyers and programs providing low-cost or free assistance to poor⁴³ individuals must confront that scarcity in their resource allocation decisions. Because they cannot serve all, they must decide whom to serve, and how. In doing so, they are also deciding ineluctably whom not to serve, and why. A rich debate has therefore ensued about the proper role of legal services to the poor, whether through organized legal assistance programs or through privately offered *pro bono* representation.

B) Access to Justice or Political Empowerment

The earliest programs of free legal assistance in the U.S. represented a combination of charitable *noblesse oblige* and public spirited commitment to justice.⁴⁴ The elite law firm lawyers leading those efforts “believed in the possibility of reconciling private interest and public virtue via making legal rights ‘*certain* and procedurally *effective*.’”⁴⁵ The commitment to “certain” and “effective” opportunity to the protection of legal rights has remained, ever since, a hallmark of the efforts to provide assistance to the poor.⁴⁶ From that sentiment has evolved the most common justification of free legal services—to provide “access to justice.”⁴⁷

The access commitment may be contrasted with a different commitment, one that would call for a different utilization of available resources, dedicated to broader impact work and political mobilization. But before we address that competing principle, the contours of the access idea deserve some attention.

⁴³ For clarity’s sake, we will use the word “poor” in this Part to refer to those persons who cannot afford private counsel, and therefore look to *pro bono* lawyers and legal aid organizations for assistance. We recognize that not all of those persons might qualify as “poor” under prevailing governmental guidelines related to the poverty line, but for our purposes here they may be considered poor.

⁴⁴ Spiegel, *supra* note 30, at 20. Spiegel describes the first organized legal aid organization as a German immigrant aid association in New York City in 1876. *Id.* at 20. He notes that the more prominent programs following that aid association, the Chicago Legal Aid Society, the New York Legal Aid Society, and the Boston Legal Aid Society, were the product of elite corporate lawyers hoping to achieve an ideal of access to justice. *Id.* at 21. *See also* David Luban, *The Noblesse Oblige Tradition in the Practice of Law*, 41 VAND. L. REV. 717 (1988).

⁴⁵ Spiegel, *supra* note 44, at 20 (quoting Robert Gordon, *The Ideal and the Actual in the Law: Fantasies and Practices of New York City Lawyers, 1870-1910*, in THE NEW HIGH PRIESTS: LAWYERS IN POST-CIVIL WAR AMERICA 51, 54-57 (Gerard W. Gawalt ed., 1984) (emphasis in original)).

⁴⁶ *See* RHODE, *supra* note 1, at 62 (describing the emergence of legal aid as a public responsibility).

⁴⁷ *See id.*; Bruce A. Boyer, *Justice, Access to the Courts, and the Right to Free Counsel for Indigent Parents: The Continuing Scourge of Lassiter v. Department of Social Services of Durham*, 36 LOY. U. CHI. L.J. 363 (2005); Deborah J. Cantrell, *Justice for Interests of the Poor: The Problem of Navigating the System without Counsel*, 70 FORDHAM L. REV. 1573, 1573-74 (2002).

A moment's reflection shows that the "access to justice" precept, standing alone, is quite question-begging. Because free lawyers cannot provide access to justice for all comers, the lawyers must make value judgments (or some kind of judgments) about who gets access and who does not. While some commentators have suggested a queuing, first-come, first-served approach,⁴⁸ that allocation model is not a sensible one.⁴⁹ A far more rational allocation scheme, and the one seemingly employed by most subsidized provider organizations, involves a weighted *triage* process.⁵⁰ Shaped, in part, by the moral philosophers' analysis of battlefield triage in the medical context,⁵¹ the legal services triage arrangement tends to privilege immediacy and protection from more serious harms over less urgent matters.⁵² It also tends to privilege broader scopes over narrower scopes. Thus, a legal matter that might offer relief to hundreds of similarly situated individuals will have greater value than one which offers significant relief to one person.⁵³

Two important insights emerge from that triage posture connected to the access to justice principle. First, a battlefield triage model will nearly always privilege crises—a *post hoc* response to tragedy. In the medical world, this model would resemble the emergency room. It therefore necessarily deemphasizes preventive care—the *ex ante* consideration of avoiding the crises in the first place. Second, because the triage process requires the making of value judgments about relative harms and benefits, and because it privileges broader scopes and wider remedies, that engagement inevitably acquires a political tinge, whether intended or not. The lawyers⁵⁴ seeking to employ a program's

⁴⁸ Marshall J. Breger, *Legal Aid for the Poor: A Conceptual Analysis*, 60 N.C. L. REV. 281, 353-354 (1982); Marie A. Failing, *Litigating against Poverty: Legal Services and Group Representation*, 45 OHIO ST. L.J. 1, 18 (1984). See also Edward J. Hoort, *Equal Access to Justice vs. Alleviation of Poverty*, Legal Services of Eastern Michigan at <http://www.lsem-mi.org/pdf/access2justice.pdf> (noting that communities have limited resources that can only reach a certain number of individuals).

⁴⁹ See, e.g., DAVID LUBAN, *LAWYERS AND JUSTICE* 309 (1988) (suggesting that a lottery or a queue would give equal opportunity to a woman facing court-sanctioned sterilization as a woman in dispute with Montgomery Ward over the store's failure to honor her clothes dryer warranty). Luban borrows from H.L.A. Hart's critique of utilitarianism to observe that "[a] lottery . . . treats every potential client with equal concern and respect only by treating every potential client with no concern and respect." *Id.* (quoting H.L.A. Hart, *Between Utility and Rights*, 79 COLUM. L. REV. 828, 830 (1979)).

⁵⁰ See Paul R. Tremblay, *Acting "A Very Moral Type of God": Triage among Poor Clients*, 67 FORDHAM L. REV. 2475 (1999) [hereinafter Tremblay, *Triage among Poor Clients*]; Judith L. Maute, *Changing Conceptions of Lawyers' Pro Bono Responsibilities: From Chance Noblesse Oblige to Stated Expectations*, 77 TUL. L. REV. 91, 94 (2002) ("Emergency triage is the only practical option to manage the overwhelming demand.").

⁵¹ See Tremblay, *Triage among Poor Clients*, *supra* note 49.

⁵² *Id.*

⁵³ *Id.* See also Troy E. Elder, *Poor Clients, Informed Consent, and the Ethics of Rejection*, 20 GEO. J. LEGAL ETHICS 989, 993-1002 (2007).

⁵⁴ The discussion will assume, for the sake of simplicity, that the lawyers offering the legal services through a community-based program will make the triage allocation decisions. In fact, that assumption is

scarce resources to maximize the efficiency and benefit for clients will frequently focus on powerful opponents, and will often challenge entrenched interests. The result will usually be a backlash from the powerful opponents and entrenched interests. The political tenor of legal services practice has been a common complaint from conservative commentators, and the triage model encourages the criticism. We review those criticisms in more depth below.⁵⁵

While the commitment to equal or broad access to justice for individuals is the most common motivating ideology for lawyers and programs offering legal services to the poor,⁵⁶ it is hardly the only one. Many observers have disagreed with the proposition that the role of legal services is to provide access to courts and similar institutions, or to protect the rights of individual persons.⁵⁷ That proposition, the critics argue, assumes that the systems of justice are fundamentally fair, and that all that poor persons need to obtain justice is comparable representation within that system.⁵⁸ The access to justice model overlooks the deep political disadvantages endured by the poor, and the inherent biases within the existing institutions favoring those with economic clout. A more effective role for lawyers serving the poor, those observers would suggest, must include strategies for mobilizing communities and altering the political balance of power.⁵⁹

This critical view played an important role in the early years of the federally-funded legal services movement.⁶⁰ The Office for Economic Opportunity (OEO), the precursor to the Legal Services Corporation (LSC) established during President Lyndon Johnson's administration in 1965, included such community-building aspirations.⁶¹ Those aspirations were controversial, and were eliminated from the agenda of the LSC, which was established to replace the OEO in 1974. They remain, however, a dominant

subject to serious debate within the poverty law literature. *See, e.g.*, Anthony Alfieri, *Impoverished Practices*, 81 GEO L.J. 2567, 2576 (1993).

⁵⁵ *See infra* text accompanying notes 68-78.

⁵⁶ *See, e.g.*, Abel, *supra* note 30, at 479-81 (describing and criticizing the traditional view of access to lawyers).

⁵⁷ *See* Failing, *supra* note 47, at 36-37.

⁵⁸ *See* Blasi, *supra* note 1, at 877-79.

⁵⁹ *See* Tomiko Brown-Nagin, *Elites, Social Movements, and the Law: The Case of Affirmative Action*, 105 COLUM. L. REV. 1436, 1438 (2005) (making the point in the context of affirmative action); Edgar Cahn, *Reinventing Poverty Law*, 103 YALE L.J. 2133 (1994); Edgar Cahn, *Co-Producing Justice: The New Imperative*, 5 U.D.C. L. REV. 105, 106 (2000).

⁶⁰ Marc Feldman, *Political Lessons: Legal Services for the Poor*, 83 GEO. L.J. 1529, 1558 (1985); Alan Houseman, *Civil Legal Assistance for Low-Income Persons: Looking Back and Looking Forward*, 24 FORDHAM INT'L L.J. 1214, 1218 (2002).

⁶¹ *Id.*

commitment among the theorists of poverty law practice today.⁶² To employ a blunt generalization, there are two alternative visions of what we might call the empowerment perspective. The first, the more conservative of the two, is sometimes labeled “impact work.”⁶³ Under this stance, lawyers for the poor use their skills within courts and legislatures to effect widespread change within the existing institutions, by filing class action lawsuits and “test” cases, and by organizing well-coordinated legislative campaigns. Lawyers working in this mode choose their clients carefully and selectively to find the most appropriate representative for the story and sentiments they wish to portray.⁶⁴ These lawyers strive to change the day-to-day lives of the poor and working class by creating laws and establishing precedents favorable to those populations, just as lawyers and lobbyists for the wealthy do all the time. They would defend their work as the most efficient and effective use of the scarce resources available to them, achieving far more benefit through that strategy than representing individuals ever could accomplish.

The second vision within the empowerment perspective departs from impact work, and focuses instead on building community.⁶⁵ It adopts what a leading proponent calls a “rebellious” stance for lawyers, rejecting the “regnant” stance represented by both the access to justice model and the impact work model.⁶⁶ These “community lawyers” possess far less faith in the likelihood of existing institutions to balance power or to achieve long-lasting change.⁶⁷ They argue that little sustained and effective change has come from courts or from legislatures unaccompanied by grass-roots mobilization.⁶⁸ They are also skeptical of strategies that privilege the role of lawyers over the role of lay persons and community members.⁶⁹

⁶² See Louise Trubek & Jennifer Farnham, *Social Justice Collaboratives: Multidisciplinary Practices for People*, 7 CLINICAL L. REV. 227 (2000); Lucie White, *Facing South: Lawyering for Poor Communities in the Twenty-first Century*, 25 FORDHAM URB. L.J. 813 (1998).

⁶³ See Sameer M. Ashar, *Public Interest Lawyers and Resistance Movements*, 95 CAL. L. REV. 1879, 1917-18 (2007); Elder, *supra* note 52, at 993; Kevin Johnson, *Lawyering for Social Change: What's a Lawyer to Do?*, 5 MICH. J. RACE & L. 201, 220 (Fall 1999).

⁶⁴ Johnson, *supra* note 60, at 220-21.

⁶⁵ See, e.g., Ascanio Piomelli, *Appreciating Collaborative Lawyering*, 6 CLINICAL L. REV. 427 (2000); Shauna Marshall, *Mission Impossible?: Ethical Community Lawyering*, 7 CLINICAL L. REV. 147 (2000)

⁶⁶ GERALD LÓPEZ, *REBELLIOUS LAWYERING: ONE CHICANO'S VISION OF PROGRESSIVE LAW PRACTICE* (1992).

⁶⁷ Piomelli, *supra* note 62, at 438-40.

⁶⁸ See Brown-Nagin, *supra* note 57, at 1522-25; Thelton Henderson, *Social Change, Judicial Activism, and the Public Interest Lawyer*, 12 WASH. U. J. L. & POL'Y 33, 41 (2003).

⁶⁹ Alfieri, *supra* note 53; White, *supra* note 59, at 823-25; LÓPEZ, *supra* note 66, at 330.

While the community lawyering conviction has considerable support within the academy and among commentators, it remains far less prevalent in practice within organized programs offering legal assistance to the poor, for perhaps not surprising reasons.⁷⁰ Those organizations instead continue to struggle with the tension between individual access to justice strategies and the commitment to impact work and test cases.⁷¹ That struggle is informed, sometimes definitively so, by the political implications of the resulting work. To that topic we now turn.

C) Political Attacks on Poverty Law Strategies

From its inception, legal services work has been the subject of intense criticism, most often from political conservatives who view its proponents as pursuing a “left-wing agenda.”⁷² The more that the providers of legal assistance to the poor depart from a pedestrian, unfocused, individual access to justice delivery model, the more political pressure those providers must endure.⁷³

As noted above, the OEO program, with its commitment to community development and client power, lost its political support in Congress, and was replaced during the Nixon administration by the more access-oriented LSC.⁷⁴ Even the LSC became the focus of political opposition, and in 1981 President Reagan proposed the full de-funding of LSC, but Congress compromised by reducing, not eliminating, the

⁷⁰ There are many reasons for this reality. Some of those reasons relate to expertise and comfort levels. The lawyers who work for legal assistance programs and who volunteer their *pro bono* time simply know how to work within the existing institutions far better than they know how to “build community.” See David Dominguez, *Community Lawyering*, 17 UTAH B.J. 31, 32 (2004). The community building work is also necessarily more illusory and speculative, and its successes or failures harder to measure and define. In a world dominated by scarcity and competing demands for available resources, it is difficult at the street level to allocate many of those resources to such seemingly risky campaigns. See Tremblay, *Triage Among Poor Clients*, *supra* note 49, at 2512.

⁷¹ See Robert Bickel, *Limited Legal Services: Is It Worth It?*, 39 COLUM. J.L. & SOC. PROBS. 331, 364 (2006). See also Kenneth W. Mentor and Richard D. Schwartz, *A Tale of Two Offices: Adaptation Strategies of Selected LSC Agencies*, 21 JUST. SYS. J. 143, 164 (2000).

⁷² J. C. Kilwein, *The Decline of the Legal Services Corporation: “It’s Ideological, Stupid!”* in THE TRANSFORMATION OF LEGAL AID: COMPARATIVE AND HISTORICAL STUDIES 61 (Francis Regan, Alan Paterson, Tamara Goerliely & Don Fleming eds. 1999).

⁷³ See, e.g., Matthew Diller, *Lawyering for Poor Communities in the Twenty-First Century*, 25 FORDHAM URB. L.J. 673, 673-74 (1998)(describing Congressional restrictions aimed to limit or prohibit legal services work not aimed at single-client, ordinary cases); William P. Quigley, *The Demise of Law Reform and the Triumph of Legal Aid: Congress and the Legal Services Corporation from the 1960s to the 1990s*, 17 ST. LOUIS U. PUB. L. REV. 241, 241 (1998) (describing the Legal Services Corporation restrictions on legal services practice).

⁷⁴ See ALAN HOUSEMAN & LINDA PERLE, SECURING EQUAL JUSTICE FOR ALL: A BRIEF HISTORY OF CIVIL LEGAL ASSISTANCE IN THE UNITED STATES 27-29 (2003) [hereinafter SECURING JUSTICE FOR ALL].

agency's budget.⁷⁵ In the 1990s, a Republican Congress further reduced LSC funding and imposed sweeping and wide-ranging restrictions on the work that LSC-funded programs could perform.⁷⁶ Congress did so because of "the conviction of many Republicans in Congress that legal aid lawyers promote a left-wing agenda through lobbying and litigation."⁷⁷ The restrictions prevented LSC-funded lawyers from engaging in most legislative advocacy, representing undocumented persons, challenging welfare laws, and accepting court-awarded attorney's fees.⁷⁸ The United States Supreme Court and lower courts have invalidated a couple of the restrictions,⁷⁹ but most remain in place. Opponents of legal services have also challenged states' use of Interest on Lawyers' Trust Account (IOLTA) funds to support those programs, but the opponents ultimately lost that campaign in the United States Supreme Court.⁸⁰

Today, conservative organizations such as the National Legal and Policy Center (NLPC),⁸¹ the Heritage Foundation,⁸² and the Conservative Caucus Foundation⁸³

⁷⁵ *Id.*; Henry Rose, *Retrospective on Justice and the Poor in the United States in the Twentieth Century*, 36 LOY. U. CHI. L.J. 591, 597 (2005).

⁷⁶ See Liza Q. Wirtz, *The Ethical Bar and the LSC: Wrestling with Restrictions on Federally Funded Legal Services*, 59 VAND. L. REV. 971, 1015 (2006); David Luban, *Taking Out the Adversary: The Assault on Progressive, Public-Interest Lawyers*, 91 CAL. L. REV. 209, (2003); David S. Udell, *The Legal Services Restrictions: Lawyers in Florida, New York, Virginia, and Oregon Describe the Costs*, 17 YALE L. & POL'Y REV. 337 (1998).

⁷⁷ Robert Pear, *As Welfare Overhaul Looms, Legal Aid for Poor Dwindles*, N. Y. TIMES, Sept. 5, 1995, at A1.

⁷⁸ Luban, *supra* note 72; Note, *Constitutional Law—Congress Imposes Restrictions on Use of Funds by the Legal Services Corporation: Omnibus Consolidated Rescissions and Appropriations Act of 1996*, Pub. L. No. 104-134, 110 Stat. 1321, 110 HARV. L. REV. 1346, 1347 (1997).

⁷⁹ See *Legal Services Corporation v. Velasquez*, 531 U.S. 533 (2001) (invalidating on First Amendment grounds restrictions on the right of LSC-funded legal-services lawyers to challenge existing welfare law under limited circumstances); *Dobbins v. Legal Services Corporation*, 356 F. Supp. 2d 267 (E.D.N.Y. 2005) (invalidating certain restrictions imposed on LSC grantees regarding use of non-LSC funds).

⁸⁰ *Washington Legal Foundation v. Legal Foundation of Washington*, 536 U.S. 903 (2002).

⁸¹ See "The Legal Services Corporation Is Still Ignoring Congressionally Mandated Reforms—And Misusing Taxpayers' Money," Statement by Kenneth Boehm to the U.S. House Committee on Appropriations Subcommittee on the Departments of Commerce, Justice, and State, the Judiciary and Related Agencies, Apr. 9, 2004, available at <http://www.nlpc.org/pdfs/BoehmTestimony4904.pdf>; "Thwarting the Will of Congress: How the Legal Services Corporation Evaded, Diluted, and Ignored Reform," Testimony before the Subcommittee on Commercial and Administrative Law of the Committee on the Judiciary House of Representatives, by Kenneth Boehm, Feb. 28, 2002, available at <http://www.nlpc.org/view.asp?action=viewArticle&aid=225>.

⁸² See Kenneth Boehm & Peter Flaherty, *Why the Legal Services Corporation Must Be Abolished*, <http://www.heritage.org/Research/LegalIssues/BG1057.cfm> (last visited Oct. 19, 2008).

⁸³ See "Abolish the Legal Services Corporation" <http://www.conservativeusa.org/lsc.htm>.

continue their attacks on the LSC and on state legal assistance programs. As long as its proponents frame its mission as a class-based struggle, the campaign for legal assistance to the poor will endure such condemnation from powerful and entrenched interests. An important question considered later is whether that mission might be described and framed differently, in such a way that its political opponents may appreciate better the aims of the movement—to achieve healthier communities and neighborhoods.

III) The Emergence of Public Health Legal Services: Los Angeles, Boston and New York City

The tradition and history of legal services described in Part II grew out of a liberal vision of justice that has been consistently opposed by conservatives and, more recently, sharply interrogated by the radical left.⁸⁴ The programs described in this Part, by contrast, emerged beneath the radar of that ferocious debate and were thus able to develop indigenously. The Los Angeles and Boston programs developed on opposite coasts, in different types of legal practices, with different orientations and nomenclatures, addressing different client groups, with no direct cross-fertilization, the Los Angeles program resulting from local government policies,⁸⁵ the Boston program from leadership within the medical community.⁸⁶

Yet they emerged about the same time and shared the conviction that health outcomes achieved through the exercise of legal rights should be valued as carefully by public health, using the same outcome measures, as other health outcomes, and that such valuations result in a very different discussion about the importance of legal services and early access to legal intervention. Interestingly, they also emerged as research was establishing the importance of social determinants of health.⁸⁷ Since these programs

⁸⁴ Critics of conventional legal services delivery models fault those approaches for failing to account for the political implications of offering expert, professional assistance to communities which lack effective power. See, e.g., LÓPEZ, *supra* note 66, (1992); Thomas Hilbink, *The Profession, the Grassroots, and the Elite: Lawyering for Civil Rights in the Direct Action Era*, in CAUSE LAWYERING AND SOCIAL MOVEMENTS (Austin Sarat & Stuart A. Scheingold eds. 2006) (describing tensions between grassroots activists and law reform proponents); Anthony V. Alfieri, *Reconstructive Poverty Law Practice: Learning Lessons of Client Narrative*, 100 YALE L.J. 2107, 2123-2130 (1991) (poverty lawyers silence their clients); Sameer M. Ashar, *Symposium: Race, Economic Justice, and Community Lawyering in the New Century: Public Interest Lawyers and Resistance Movements*, 95 CAL. L. REV. 1879, 1917-18 (2007) (describing the tensions between activism and lawyering); Feldman, *supra* note 30; Lucie E. White, *To Learn and to Teach: Lessons from Driefontein on Lawyering and Power*, 1988 WIS. L. REV. 699, 767-68 (stressing the importance of organizing over technical lawyering).

⁸⁵ See text accompanying notes 90-116 *infra*.

⁸⁶ See text accompanying notes 117-144 *infra*.

⁸⁷ SOCIAL DETERMINANTS OF HEALTH (Michael Marmot & Richard Wilkinson eds. 1999). See also Michael Marmot, *Social Determinants of Health Inequalities*, 365 LANCET 1099 (2005); Nancy E. Adler & Katherine Newman, *Socioeconomic Disparities in Health: Pathways and Policies*, 34 HEALTH AFF. 21, 60 (2002); Steven H. Woolf et al., *The Rising Prevalence of Severe Poverty in America: A Growing Threat to Public Health*, 31 AM. J. PREVENTIVE MED. 332 (2006). And see, SOCIAL INJUSTICE AND PUBLIC HEALTH

frame many social determinants in terms of unmet legal need, they broaden public health's array of intervention strategies.⁸⁸ Thus, law's capacity to engage some of the most complex and contentious social determinants of health makes the vision of public health legal services particularly intriguing not just to advocates for legal services but for public health.⁸⁹

A) Los Angeles

City government was the driving force in Los Angeles in the development of what this Article proposes to call public health legal services.⁹⁰ But while it was the driving force, it was not the only force. City leaders worked with an array of partners, steering rather than doing all the rowing itself.⁹¹

1) In the Beginning: The Nation's First AIDS Anti-discrimination Law

In June 1985, the Los Angeles City Council held hearings on the nature and extent of AIDS discrimination.⁹² The next month, movie star Rock Hudson's confirmation of the rumors of his AIDS diagnosis created the first global AIDS moment, and with it a political window of opportunity for the Council to enact the world's first

(Barry S. Levy & Victor W. Sidel eds. 2006). The World Health Organization Commission on Social Determinants of Health identifies unemployment, unsafe workplaces, urban slums, globalization and lack of access to health systems as non-medical determinants of disease. *See* INTERIM STATEMENT OF THE COMMISSION ON SOCIAL DETERMINANTS OF HEALTH (2007) at http://www.who.int/social_determinants/resources/interim_statement/en/index.html (last visited Mar. 1, 2008).

⁸⁸ Barry Zuckerman, Ellen Lawton & Samantha Morton, *From Principle to Practice: Moving from Human Rights to Legal Rights to Ensure Child Health*, 92 ARCH. DISEASE IN CHILDHOOD 100 (2007).

⁸⁹ There is at least one additional program that shares many of the insights and elements discussed in this section, the Berkeley Community Law Center's HIV/AIDS Law Project and its participation in the Family Care Network of Alameda County, California, and we here wish to acknowledge the leadership and importance of that program. *See generally*, Jeffrey Selbin & Mark Del Monte, *A Waiting Room of Their Own: The Family Care Network as a Model for Providing Gender-Specific Legal Services to Women with HIV*, 5 DUKE J. GENDER L. & POL'Y 103 (1998). Our adoption of the heuristic of the emergence of public health legal services in Los Angeles, Boston and New York is meant to construct a narrative, not a history. Any historian will be indebted to Selbin and Del Monte not only for their description and interrogation of the Berkeley program, but also to their very helpful placement of it within the history of HIV legal services.

⁹⁰ *See* text accompanying notes 90-116 *infra*.

⁹¹ The description of government steering rather than rowing is taken from DAVID OSBORNE & TED GAEBLER, *REINVENTING GOVERNMENT: HOW THE ENTREPRENEURIAL SPIRIT IS TRANSFORMING THE PUBLIC SECTOR* 25 (1992).

⁹² PUBLIC HEALTH, HUMAN RESOURCES AND SENIOR CITIZENS COMMITTEE, REPORT TO THE LOS ANGELES CITY COUNCIL (Aug. 13, 1985) (Los Angeles City Council File Number 85-0869-S1), *available at* <http://www.bc.edu/phlsdocs> (last visited XXX).

AIDS anti-discrimination law⁹³ to both acclaim and opprobrium.⁹⁴ Los Angeles's vision of civil rights partnering with public health in an epidemic was new,⁹⁵ for law historically had been a mechanism for scapegoating and blame.⁹⁶

The city drew on two factors. The first was the strength of the biomedical model of infectious disease. While AIDS was new and frightening, its cause had already been identified more than two years before.⁹⁷ Thus, there was no scientific excuse to treat people with AIDS like pariahs.⁹⁸ The second was the rich individual rights legacy that

⁹³ L.A. MUN. CODE Sections 45.80 *et seq.* (adopted Aug. 14, 1985).

⁹⁴ *See, e.g.*, Editorial, *The Only Weapons Against AIDS*, N.Y. TIMES, Aug. 18, 1985, §4, at 18. *But see, e.g.*, John Wolf, Letter to the Editor, *City's AIDS Ordinance*, L.A. TIMES, Aug. 26, 1985, §2, at 4 (“These people should be discriminated against. I'm not going to . . . eat in a cafe where they may be handling my food. They should be quarantined . . .”).

⁹⁵ It was especially new for Los Angeles, which had had no public health department since 1964. In the first half of the twentieth century, the city's public health department had delivered a wide array of such biomedical services as vital statistics, communicable disease control, milk inspections, harbor rodent control, and mosquito abatement pursuant to a grant of authority by the state. CAL CONST. art. 11, §7. But in 1964, it closed its department and contracted with Los Angeles County for services following a failed attempt to overturn a state law that taxed city residents twice for public health services, once to support the city's department and a second time to support a county department that provided no city services. TERREE A. BOWERS, CHIEF DEPUTY CITY ATTORNEY, OFFICE OF THE LOS ANGELES CITY ATTORNEY, REPORT TO THE ARTS, PARKS, HEALTH AND AGING COMMITTEE OF THE LOS ANGELES CITY COUNCIL RE: DRAFT ORDINANCE AMENDING LOS ANGELES MUNICIPAL CODE TO AUTHORIZE COUNTY ENFORCEMENT OF COMMERCIAL SEX VENUE ORDINANCE WITHIN THE CITY AND DRAFT PROVISION AMENDING CITY-COUNTY PUBLIC HEALTH AGREEMENT OF 1964 TO EXEMPT CITY FROM LIABILITY FOR THE COSTS OF COURT TIME FOR THE ENFORCEMENT THEREOF 2 (Feb. 28, 2005) (Council File No. 04-2229), *available at* http://clkrep.lacity.org/onlinedocs/2004/04-2229_rpt_atty.pdf (last visited XXX).

⁹⁶ *See, e.g.*, WILLIAM H. MCNEILL, PLAGUES AND PEOPLE (1976).

⁹⁷ *See supra* note 14 and accompanying text.

⁹⁸ *See, e.g.*, William F. Buckley, Op-Ed., *Crucial Steps in Combating the AIDS Epidemic: Identify All the Carriers*, N.Y. TIMES, Mar. 18, 1986, at A27 (proposing to tattoo infected gay men on the buttocks and infected injection drug users on the upper forearm). Curiously, as of February 13, 2008, the Buckley op-ed was unavailable on either The New York Times's website or on Lexis-. An inquiry to The New York Times's public editor regarding its absence had received no reply as of Apr. 22, 2008. As of that date, however, it is available on Westlaw. *See also* F.V. Scott, *Playing Politics with Death: Radical Homosexuals and the AIDS Epidemic*, PASSPORT MAGAZINE, June 1985, at 2; Derald Skinner, *From the Editor*, PASSPORT MAGAZINE, June 1985, at 2 (“With no hope of a cure in the foreseeable future, the alternatives are quarantine for those infected or potential *contamination and eventual eradication of the remainder of the population.*”) (emphasis added); *see generally*, GENE ANTONIO, THE AIDS COVER-UP? THE REAL AND ALARMING FACTS ABOUT AIDS (1986). According to a confidential disclosure to one of the authors, Reagan White House domestic policy advisor Gary Bauer considered the Antonio book his policy “bible.” Bauer is credited with single-handedly blocking the Presidential AIDS Commission's recommendation that the President enact federal AIDS anti-discrimination protections on the grounds that it would be a “foot in the door toward a national gay rights bill.” Fred Barnes, *Last Call*, THE NEW REPUBLIC, Oct. 10, 1988, at 10. REPORT OF THE PRESIDENTIAL COMMISSION, *supra* note 18, at 121 (recommending the issuance of an executive order); *id.* at 121 (recommending a “strong anti-discrimination message . . . be a part of all national HIV . . . materials”); *id.* at 123 (recommending the inclusion of people with HIV as people with disabilities covered by the anti-discrimination provisions of Section 504 of the

had emerged in the prior decades. Due process, equal protection and civil rights laws that required the majority to respect the dignity and liberty of minorities served as a second bulwark against the primitive human impulse to stigmatize and blame people with AIDS.

Los Angeles combined both these elements to emphasize that discrimination posed “a substantial threat” not just to those against whom it was directed, but also to the “health, safety and welfare of the [entire] community.”⁹⁹ By 1987, the City Attorney’s Office had concluded that the ordinance even had public health value in preventing HIV transmission, since compliance with the law required a working knowledge of HIV’s

Rehabilitation Act of 1973); *see also* Marlene Cimon, *Reagan Likely to Defer Action on AIDS Policy*, L.A. TIMES, Aug. 1, 1988, §1, at 1; *Reagan Proposal Responding to Report Excludes Anti-Discrimination Support*, AIDS POL’Y & L., Aug. 10, 1998, at 1. For a thoughtful discussion of the effect of the epidemic on gays and lesbians, *see* ANDRIOTE, *supra* note 17.

⁹⁹ *See* § 45.80, *supra* note 89.

AIDS was first recognized in 1981 by the Federal Center for Disease Control based on the study of a pattern of unusual illnesses among young, single men reported by the medical center associated with UCLA within our City. . . . AIDS in the opinion of the scientific and medical community is caused by a virus . . . which attacks and cripples the body’s immune system . . . leaving [it] vulnerable to opportunistic infections. . . . [A] person afflicted with AIDS suffers a variety of virus and/or fungus-caused illnesses which debilitate the body resulting in a high mortality rate within three years after diagnosis. . . . [T]he spread of the virus has occurred through the exchange of bodily fluids, i.e. blood, blood by-products, or semen, between individuals. . . . [N]o evidence exists to indicate the spread of the virus by casual contact. . . . [M]edical studies of family groups in which one or more persons have been diagnosed with AIDS show no spread of the virus other than through sexual intimacy or through the exchange of blood [T]he virus can thrive only in favorable conditions, and cannot exist for a significant period of time outside the body, and can be protected against by the application of regular practices of hygiene, such as the use of chlorine in swimming pools or spas and the use of household bleach when washing garments or cleaning contaminated surfaces. . . . [T]he public health danger represented by the virus and its subsequent manifestation as AIDS is caused by the lengthy incubation period during which period an apparently healthy individual may spread the disease to other persons through the exchange of blood, blood by-products, or semen. . . .

Id.

For a discussion of the first years of Los Angeles’s enforcement of the new law, *see* Schulman, *supra* note 16, at 1125-1129, 1133-1134; David I. Schulman, *AIDS, The Law and Society: Fact vs. Fear*, LOS ANG. LA WY., Sept. 1988, at 18. For a thoughtful discussion of the educative function of the new law, *see* Robert Roden, *Educating Through the Law: The Los Angeles AIDS Discrimination Ordinance*, 33 UCLA L. REV. 1410 (1986). For a discussion of the challenge of AIDS discrimination at this time generally, *see* John Heilman, *AIDS Discrimination*, LOS ANG. LA WY., June 1986, at 26. For a report of another jurisdiction’s early examination of the problem of AIDS discrimination, *see* REPORT OF THE METROPOLITAN HUMAN RELATIONS COMMISSION [MULTNOMAH COUNTY, OREGON], AIDS AND DISCRIMINATION: A LOCAL GOVERNMENT RESPONSE (1988) (by Claire Levine & Marsha Spellman). For a present-day example of the importance of combating AIDS discrimination to improve health outcomes, *see* RALF JÜRGENS & JONATHAN COHEN, HUMAN RIGHTS AND HIV/AIDS: NOW MORE THAN EVER 7 (2007). All sources except Roden *available at* <http://www.bc.edu/phlsdocs> (last visited Sept. 13, 2008).

modes of transmission.¹⁰⁰ In 1991, the California Court of Appeals affirmed the public health value of such ordinances in rejecting a civil rights preemption challenge to Contra Costa County's ordinance on the grounds that it also advanced public health.¹⁰¹

¹⁰⁰ David I. Schulman, Mitchell Karp & Norman Nickens, *Municipal AIDS Discrimination Laws as Public Health Education Tools for Preventing HIV Transmission*, 3RD INT'L AIDS CONF. (Session F.5.6) (abstract) (Washington, D.C.) (June 5, 1987). (Karp and Nickens were AIDS discrimination attorneys with the New York City Commission on Human Rights and the San Francisco Human Rights Commission, respectively.) Washington, D.C. attorney Robert E. Stein made a similar observation in his report to the U.S. Department of Health and Human Services on the mediation strategies of these three pioneering AIDS discrimination units. ROBERT E. STEIN, *THE SETTLEMENT OF AIDS DISPUTES: A REPORT FOR THE NATIONAL CENTER FOR HEALTH SERVICES RESEARCH* iii (1987) (Grant No. HS-005597-01), available at <http://www.bc.edu/phlsdocs> (last visited XXXX):

As the number of people with AIDS or [HIV] increases, failure to resolve [AIDS legal disputes] will contribute to the cost of care, and equally important to the quality of care they will receive. . . . [AIDS] dispute resolution must be considered an integral part of the delivery of health care. [Emphasis added.]

In 1989, the U.S. Public Health Service also studied the Los Angeles, New York and San Francisco programs, along with subsequent programs established in the Philadelphia Department of Public Health and the Washington State Department of Social & Health Services, in order to develop best practices for federal AIDS anti-discrimination efforts, which were then presented at a three-day training conference for federal, state and local civil rights and public health officials. U.S. PUBLIC HEALTH SERVICE [hereinafter PHS], *FIVE STATE/LOCAL APPROACHES FOR PREVENTING AND RESOLVING HIV-RELATED DISCRIMINATION* (2 vols.) (1989) (Contract Number 282-88-0021; Delivery Order Number 1); PHS, *COMMON ELEMENTS OF HIV-RELATED DISCRIMINATION PROGRAMS: GUIDANCE FOR STATE AND LOCAL OFFICIALS* (Dec. 6, 1989) (Contract Number 282-88-0021; Delivery Order Number 2); *HIV-RELATED DISCRIMINATION PREVENTION AND RESOLUTION: A PUBLIC HEALTH SERVICE INVITATIONAL WORKSHOP* (Dec. 6-8, 1989) (Bethesda, MD); see also Anne M. Guthrie, Liese Sherwood-Fabre, Richard J. Steele, Stephanie E. Karsten, Betty F. Lorenz, & Jami L. Ritter, *State/Local Strategies to Prevent and Resolve HIV-Related Discrimination: Five Case Studies*, 5TH INT'L AIDS CONF. 5:959 (Abstract No. M.F.P.13) (Montreal, Canada) (June 4-9, 1989) (being an abstract of the preceding PHS reports, available at <http://www.aegis.com/conferences/iac/1989/MFP13.html> (last visited XXXX)); *HHS Secretary Calls for State-Mandated AIDS Training for Health Workers, Educators*, BNA [Bureau of National Affairs] WASH. INSIDER, Dec. 11, 1989 (reporting on Health and Human Services Secretary Louis W. Sullivan's call at the conference for "education [to be] the 'number one weapon' against AIDS discrimination," and "state-mandated AIDS training for health professionals . . . and other public servants . . ."). See also PHS, *DEVELOPMENT OF AN ANALYTICAL APPROACH TO DETERMINING THE COST TO SOCIETY OF HIV-RELATED DISCRIMINATION* (May 30, 1990); and see, L. Fishback, A. Guthrie, L. Lewin, J. Needleman & B. Barnow, *An Analytic Approach to Determining the Costs to Society of HIV-Related Discrimination*, 6TH INT'L AIDS CONF. 6:337 (Abstract No. Th.D.847) (San Francisco, CA) (June 20-23, 1990) (being an abstract of the preceding U.S. Public Health Service report), available at <http://www.aegis.com/conferences/iac/1990/ThD847.html> (last visited XXXX). Schulman et al., STEIN, and the PHS reports and Dec. '89 conference material available at <http://www.bc.edu/phlsdocs> (last visited XXXX).

¹⁰¹ *Citizens for Uniform Laws v. County of Contra Costa*, 233 Cal. App. 3d 1468, 1470 (1991) ("a county may adopt an ordinance prohibiting discrimination against those who undergo health testing which discloses an infectious disease, for the public health purpose of encouraging citizens to be tested without fear of discrimination in order to learn of the presence of the disease and prevent its transmission" [Emphasis added]).

2) Connecting HIV Legal Services to Public Health.

The city's next step was to guide the development of a relationship between local HIV legal services programs and public health, a two-part undertaking. The first was an arduous, multi-year collaboration with a range of partners to foment the development of a single, county-wide HIV legal services delivery program based on the best practices of poverty legal services programs. The city and the ACLU began by persuading the region's largest AIDS services provider to fund a UCLA law school study to identify the inadequacies of the existing fragmented HIV legal services system.¹⁰² The city and its partners then persuaded the AIDS program to hire the former executive director of one of the leading local poverty legal services programs as an independent consultant to conduct a needs assessment and make recommendations for improvements based on legal services' best practices.¹⁰³ They then spearheaded efforts to use the needs assessment and recommendations to persuade the county commission that allocated federal HIV monies to quadruple the allocation to HIV legal services to make possible the creation of the recommended single county-wide system.¹⁰⁴ Two key arguments to persuading the commission that are now recognizable as proto-public health legal services recommendations were that HIV legal staff members in the envisioned new program could be likened to social workers with teeth, and that HIV legal services were actually a component of health care.¹⁰⁵

¹⁰² Gary L. Blasi, *The Legal Service Delivery System for People Affected By AIDS in Los Angeles County: Problems and Opportunities for Leadership* (Jan. 31, 1994), *available at* <http://www.bc.edu/phlsdocs> (last visited Sept. 13, 2008).

¹⁰³ An effort she called the HIV Legal Services Delivery Project for Los Angeles County [hereinafter HLSDP]. Katharine Krause, *Proposal for Developing a Plan to Improve and Coordinate HIV Legal Services in Los Angeles County* (June 13, 1994); Katharine Krause, *Assessment of the Legal Needs of People Living with HIV and AIDS in Los Angeles County* (May 1, 1995); HLSDP, *Report, Recommendation and Action Plan for the Improvement of HIV Legal Services Delivery in Los Angeles County* (Dec. 1995), all *available at* <http://www.bc.edu/phlsdocs> (last visited Sept. 13, 2008). Krause was particularly influential in her emphasis upon the principled, vital need to always make the highest and best use of resources when services were underfunded. Krause, *Assessment, supra* at vii - viii.

¹⁰⁴ HLSDP, *Memorandum to Priorities and Planning Committee, Los Angeles County Commission on HIV Health Re: Legal Needs Presentation* (July 18, 1996); HLSDP, *Memorandum to Los Angeles County Commission on HIV Health Services Re: Legal Services Funding Needs* (Aug. 12, 1996), *available at* <http://www.bc.edu/phlsdocs> (last visited Sept. 13, 2008).

¹⁰⁵ *See* HLSDP, *Priorities and Planning supra* note 101, at 1-2:

HIV legal services are an essential and undervalued element of the continuum of HIV care. They are essential because they are the means by which a person living with HIV can secure the other elements in that continuum. They are undervalued because they are not as tangible as medical care, housing or public benefits. . . . Legal services are so critical to people living with HIV and AIDS because they are the way in which other vital services are secured. Effective legal assistance can enable the person living with HIV to:

- Keep his job secure, retaining income and health benefits, instead of starting on a downward financial spiral;

The second part arose from the City Attorney's Office's AIDS anti-discrimination enforcement work. Staff noticed that virtually every case they investigated began with an unnecessary disclosure of the complainant's HIV status. For instance, the complainant might have shared his status with his landlord in the mistaken belief that she had a right to know, and the disclosure led to harassment and eviction. Borrowing the concept of prevention from public health, the City Attorney's Office concluded that if complainants could be counseled about their right to keep their status private *before* such disclosures, most discrimination could be prevented altogether. By 1993, the office was calling this idea an "HIV legal checkup."¹⁰⁶ HIV-positive people needed legal counseling as soon as possible after learning their test results on the importance of disclosing their status only to those who had a legal need to know, thus preventing discrimination in employment, housing, and public accommodation. However, the City lacked the resources to implement such services.

3) Further Innovation by the HIV Legal Checkup Project

That changed in 1996 when Brad Sears¹⁰⁷ sought ideas for creating an HIV law practice. Sears expanded the City Attorney's Office's HIV legal checkup concept from its initial core discrimination prevention conception into a comprehensive client intake strategy for addressing the full range of HIV legal issues. These issues included: denial of benefits, tenant rights, immigration, family law, and debtor-creditor conflicts. Key to Sears's expansion was the same core insight as the original conception—reaching clients *before* they had legal problems.

Sears launched the HIV Legal Checkup Project with grant funding in the spring of 1997 as part of the new county-wide HIV legal services agency, HALSA.¹⁰⁸ Law students supervised by attorneys performed the checkups, ensuring a steady stream of volunteers. The checkup's comprehensiveness meant that, on average, one to two incipient legal problems were identified before they became crises. The checkup's client education component empowered many to resolve such problems themselves. Those

-
- Get an experimental therapy covered by her health insurance rather than be forced to rely upon what is most "cost effective" for the insurer;
 - Get adequate dental or medical services, instead of being denied care because of fear and ignorance; or
 - Get medical and financial benefits that were initially denied, instead of being stopped by a daunting administrative appeals process.

¹⁰⁶ See, e.g., *In the Field*, AIDS POL'Y & L., Apr. 16, 1993, at 6.

¹⁰⁷ Now a professor at UCLA School of Law and Director of the Williams Institute on Sexual Orientation Law and Public Policy.

¹⁰⁸ The HIV & AIDS Legal Services Alliance for Los Angeles County [hereinafter HALSA]. For the history of HALSA's formation, see *supra* notes 101 to 104 and accompanying text.

requiring professional intervention required less HALSA attorney time than had they presented in crisis mode, preserving HALSA resources to serve more clients. The checkups also improved later HALSA services because clients often identified newly-emerging needs more quickly, at an earlier stage in the problem's development, because of the checkup's education component, and called HALSA more promptly, because checkup clients associated HALSA with their positive experience with checkup. The checkup intake database also served as a de facto ongoing needs assessment instrument for HALSA's director to identify newly-emerging client needs, such as immigration or tax relief.¹⁰⁹

4) Partnering with the CDC and the American Bar Association

In November 2000, the City's Attorney Office continued this linkage of legal services to health outcomes in a letter to the CDC proposing an HIV legal checkup strategy for encouraging more people to come forward to be tested.

[I]f counseling and testing programs promptly and consistently refer newly diagnosed HIV positive persons for . . . checkups that counsel them to protect their privacy by not disclosing their status to their employers or landlords . . . *more people would voluntarily come forward to be tested because a major source of discrimination would be abated.*¹¹⁰

¹⁰⁹ See generally HALSA, Legal Needs Assessment (1998) (excerpt); HALSA, HIV Legal Checkup Project Volunteer Advocate Training Manual (2000) (excerpt); *Proposal Seeks to Extend "Legal Checkups" Nationwide: Early Intervention Seeks to Avert Bias in Jobs, Housing*, AIDS POL'Y & L., Feb. 16, 2001, at 1; *What Is a "Legal Checkup"?*, *id.* at 6; *"Checkup" Looks at Client's Current, Future Legal Needs*, *id.* at 7; *Priorities in Legal Checkup*, *id.*; *Legal Checkups: A Sample Form*, *id.* at 8; Schulman & Sears, *supra* note 27; David I. Schulman, HIV Legal Checkups: Implications and Opportunities (plenary presentation outline), HIV/AIDS Law and Practice: From "Nuts & Bolts" to "Cutting Edge" (May 17, 2002) (Chicago, IL) (being a conference sponsored by the American Bar Association); David I. Schulman, *Making a Difference with HIV Legal Checkups*, 31 HUM. RTS., Fall 2004, at 18 ; Margarita R. Guzmán, *Youth, HIV/AIDS, and Advice on Disclosure*, YOUNG LAWY., Feb. 2006, at 3 ; ABA, HIV Legal Checkup: Answering the Call (2005) (Young Lawyers Division) (2005-6 national public service project handbook). HALSA, Legal Needs Assessment; HALSA, HIV Legal Checkup; Schulman, HIV Legal Checkups; and ABA, HIV Legal Checkup, available at <http://www.bc.edu/phlsdocs> (last visited Sept. 13, 2008).

Sears has continued to make important contributions to the conception this Article calls public health legal services. See John-Manuel Andriote & R. Bradley Sears, *The Role of Legal Services in Ensuring Access to Health Care for People with HIV/AIDS*, in HRSA, DIRECTIONS IN HIV SERVICE DELIVERY & CARE -- A POLICY BRIEF, NO. 4: REDUCING BARRIERS TO CARE 13 (Caitlin Ryan, ed. 2000). See also John-Manuel Andriote & R. Bradley Sears, *Ensuring Access to Health Care for People with HIV/AIDS: The Role of Legal Services (A Ryan White CARE Act Policy Study)* (Apr. 2000) (being the unpublished manuscript summarized in the preceding citation); BRAD SEARS & DEBORAH HO, WILLIAMS INST. SEX'L ORIENT. L. & PUB. POL., UCLA SCHL. L., HIV DISCRIMINATION IN HEALTH CARE SERVICES IN LOS ANGELES COUNTY: THE RESULTS OF THREE TESTING STUDIES (Dec. 2006). All documents available at <http://www.bc.edu/phlsdocs> (last visited Sept. 13, 2008).

¹¹⁰ David I. Schulman, Deputy City Attorney, Office of the Los Angeles City Attorney, Letter to U.S. Centers for Disease Control and Prevention Re: Public Comments, 10/17/00 Draft Revised Guidelines for HIV Counseling, Testing and Referral 3 (Nov. 26, 2000), available at <http://www.bc.edu/phlsdocs> (last visited Sept. 13, 2008).

By coincidence, the next month the CDC, itself, published a report linking the fear of stigma and discrimination to the reluctance of persons to be tested for HIV.¹¹¹ The following November, the CDC adopted the city's recommendation,¹¹² perhaps the first time the agency had recognized the public health role of private attorneys. The next spring, the American Bar Association (ABA) invited the City Attorney's Office to discuss the implications of the CDC's action at the first national HIV legal services providers conference,¹¹³ and later committed to train private sector attorneys to provide the counseling nationwide.¹¹⁴

¹¹¹ CDC, *HIV-Related Knowledge and Stigma, United States*, 2000, 49 MORBIDITY & MORTALITY WKLY. REP. 1062 (Dec. 1, 2000), available at <http://www.cdc.gov/mmwr/PDF/wk/mm4947.pdf> (last visited Sept. 13, 2008).

An essential component of efforts to prevent new human immunodeficiency virus (HIV) infections in the United States is the use of voluntary HIV counseling and testing by persons at risk for HIV, especially members of underserved populations. . . . *The stigmatization of persons infected with HIV and the groups most affected by HIV*, including men who have sex with men and illicit drug users, is a barrier to testing.

Id. (emphasis added) (internal citations omitted).

¹¹² CDC, *Revised Guidelines for HIV Counseling, Testing, and Referral*, 50 MORBIDITY & MORTALITY WKLY. REP. 37 (Nov. 9, 2001), available at www.cdc.gov/mmwr/PDF/rr/rr5019.pdf (last visited Sept. 13, 2008) [hereinafter CDC, *Revised Guidelines*].

¹¹³ See Schulman, HIV Legal Checkups *supra* note 109. And two months later, the Bush Administration's AIDS czar endorsed the concept. Scott H. Evertz, Director, White House Office of National AIDS Policy, Letter to Los Angeles City Attorney Rockard Delgadillo (July 19, 2002), available at <http://www.bc.edu/phlsdocs> (last visited Sept. 13, 2008).

¹¹⁴ The ABA's largest division, the Young Lawyers Division, initiated the undertaking--entitled "Answering the Call," as in lawyers answering the call of the CDC to help slow the spread of HIV--as its public service project for 2005-2006. YLD developed training materials that included a DVD, written materials and an award-winning web-based Continuing Legal Education audio-training. See, e.g. *supra* note 106, ABA (2005). The ABA's AIDS Coordinating Committee has continued to maintain the project at <http://www.abanet.org/AIDS/answerthecall/home.html> (last visited Sept. 13, 2008). The ABA also cited the CDC guideline as a key reason for Congress not to reduce federal monies supporting HIV legal services. Robert D. Evans, Director, ABA Governmental Affairs Office, Letter to Chairman, U.S. Senate Committee on Health, Education, Labor and Pensions United States Senate et al. Re: Legal Services and Ryan White CARE Act Reauthorization (May 9, 2006), available at <http://www.bc.edu/phlsdocs> (last visited Sept. 13, 2008). The letter also pointed out the health importance of HIV legal services generally.

[M]edical and legal services providers report that virtually everyone living with HIV/AIDS encounters legal problems associated with his or her health status, and that many cannot afford the legal representation they need to fight for their rights to continue working, maintain access to healthcare, or ensure their confidentiality. These types of assistance include navigating the public-benefits bureaucracy; maintaining private health insurance; help with debtor-creditor concerns; advice on probate, family support, and arranging for the proper care of dependents; and, of course, preserving housing and employment in the event of discrimination. Legal assistance in these and other areas helps ensure that "Core Medical Services," including drug treatment regimens, are

5) More Partnering at Home

In June 2006, Los Angeles County asked the city to assist in drafting the first HIV legal services standard to express the emerging understanding that HIV legal services have public health value. The final standard noted that

[f]rom a public health perspective HIV legal services help slow the spread of HIV by combating discrimination and, thus, encouraging more people to come forward to be tested. From an individual rights perspective, HIV legal services help ensure a client's sense of dignity and self-worth by providing legal assistance to people living with HIV and AIDS on a range of issues. From an individual wellness perspective, they help ensure that a client has access to the care, services and benefits to which he or she is entitled.¹¹⁵

6) Conceptualizing Public Health Legal Services with Boston, New York and the ABA

The city's most recent effort has involved expanding the concept of HIV legal checkups into the concept of public health legal services. In March 2003, the city's Disability Commission determined that the legal checkup concept might be of great benefit to other disabled persons. The Commission director and the City Attorney's Office met with researchers at UCLA's public health and law schools to explore studying legal checkup outcomes and best practices, and with other public interest law programs to discuss pilot legal checkup projects beginning with one for persons newly-diagnosed with cancer. In May 2006, when the City Attorney's Office learned of Medical-Legal Partnership | Boston, and New York City's LegalHealth, it conceived the concept of public health legal services to describe all these programs and introduced the term that November at a meeting of ABA stakeholders to which representatives from the City Attorney's Office and the Boston and New York City programs were invited to discuss the linkage of legal services to health outcomes.¹¹⁶

provided and followed consistently.

Id. at 2. The ABA also urged the CDC to incorporate the guideline into its pre-test counseling revisions. Shelley D. Hayes, Chair, & Richard T. Andrias, Immediate Past Chair, ABA AIDS Coordinating Committee, Letter to Bernard M. Branson, Associate Director for Laboratory Diagnostics, Division of HIV/AIDS Prevention, National Center for HIV, STD & TB Prevention, U.S. Centers for Disease Control & Prevention Re: Proposed Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings 3 (Aug. 22, 2006), *available at* <http://www.bc.edu/phlsdocs> (last visited Sept. 13, 2008).

¹¹⁵ LOS ANGELES COUNTY COMM. ON HIV, STANDARDS OF CARE: LEGAL SERVICES 4 (Jan. 13, 2006), *available at* <http://www.bc.edu/phlsdocs> (last visited Sept. 13, 2008).

¹¹⁶ The ABA's AIDS Coordinating Committee (chaired by Shelley D. Hayes of Washington, D.C.) hosted the meeting, which was also attended by leaders and staff of the ABA's Section of Individual Rights and Responsibilities, Health Law Section, and Standing Committee on Pro Bono and Public

B. Boston Medical Center's Medical-Legal Partnership | Boston

Medical-Legal Partnership | Boston -(MLP | Boston)¹¹⁷ was founded in 1993 out of a pediatrician's frustration in confronting the health impacts of poverty on children.¹¹⁸ Dr. Barry Zuckerman, Chief of Pediatrics at Boston Medical Center (BMC), realized that as a doctor treating vulnerable children he did not have the skills or tools to address many of the problems that contributed to or caused the health problems prevalent in his clinic, such as substandard housing that exacerbated asthma, lack of food stamps for food insecure families, and utility shut-offs during the cold winter months. Dr. Zuckerman felt powerless to help his patients until he learned that many of the problems he saw had legal remedies. He took the unusual step of hiring a legal services lawyer to train his staff and work directly with patient-families to ensure that their basic needs—for food, housing, health care, safety and education—were met.¹¹⁹

MLP | Boston's groundbreaking innovation was to create a medical-legal partnership with a committed vision of shifting legal resources to a prevention model.¹²⁰ It is not surprising that medical-legal partnership would flourish in the pediatric setting: pediatricians are uniquely situated to intervene when children's basic needs are not being met, because children are seen regularly in the pediatric setting, especially in the first five years of life. These ongoing visits lead to the development of trusting relationships between pediatric providers and families. In pediatrics, the ethos of preventive medicine is well-accepted, and lends itself particularly well to identifying non-medical determinants of child health, since families are encouraged to seek out preventive care.¹²¹

Services.

¹¹⁷ For a description of this program's operations and some ethical issues it encounters, see Pamela Tames, Paul R. Tremblay, Thuy Wagner, Ellen Lawton & Lauren Smith, *The Lawyer Is In: Why Some Doctors Are Prescribing Legal Remedies for Their Patients, and How the Legal Profession Can Support This Effort*, 12 B.U. PUB. INT. L. J. 505 (2003). See also CONSORTIUM ON LEGAL SERVICES AND THE PUBLIC, AGENDA FOR ACCESS: THE AMERICAN PEOPLE AND CIVIL JUSTICE (1996).

¹¹⁸ In 1993, the organization was known as the Family Advocacy Program (FAP). FAP changed its name to Medical-Legal Partnership for Children in 2006, and then bifurcated and expanded its national and local activities, resulting in the formation, in January 2009, of the National Center for Medical-Legal Partnership and Medical-Legal Partnership | Boston. Both programs remain part of Boston Medical Center's Department of Pediatrics. See <http://www.medical-legalpartnership.org> (last visited Mar. 22, 2009).

¹¹⁹ See MOMENTS IN LEADERSHIP: CASE STUDIES IN PUBLIC HEALTH POLICY AND PRACTICE (Barbara DeBuono et al. eds. 2007).

¹²⁰ See Ellen M. Lawton, *Medical-Legal Partnerships: From Surgery to Prevention?*, J. MANAG. INFO. EXCH. 37 (Spring 2007) [hereinafter Lawton, *Surgery to Prevention*].

¹²¹ See Barry Zuckerman, Megan Sandel, Lauren Smith & Ellen Lawton, *Why Pediatricians Need Lawyers to Keep Children Healthy*, 11 PEDIATRICS 224 (2004).

Nevertheless, while pediatricians are usually taught to consider the family and social context of their patients, they often do not have the specific knowledge or resources to intervene effectively in these arenas.¹²² Pediatricians' training and experience is generally limited to addressing the biological causes of illness. As a result, they are reluctant to ask families about housing conditions, violence, or access to adequate food, since they are unsure what to do with the response. Thus, pediatricians and other health care providers often find themselves in the difficult situation of recognizing the effect of social factors on the health of their vulnerable young patients, while feeling helpless to address them.¹²³ Indeed, even highly skilled social workers do not have the training to address complicated questions about family eligibility for public benefits, especially where there is an immigration component.

Children with poorly managed physical and mental health conditions miss school, fall behind their classmates, and experience preventable health consequences. Their illness affects their family wellbeing because repeated emergency room visits, doctor's office visits, and hospitalizations place their low-income parents' low wage jobs at risk.¹²⁴ As it turns out, legal advocacy is the best medicine for the social determinants of health.¹²⁵ For lawyers, it presented an opportunity to change the way legal services are typically delivered, away from crisis-generated litigation toward *preventive law*.¹²⁶

MLP | Boston developed a series of core components to ensure the success and integration of legal services anchored in the clinical setting.

1) Training and Education of Front-Line Healthcare Staff on Basic Legal Needs Issues

Training and curricula developed by MLP | Boston staff empower frontline health care staff persons to screen, identify and triage legal problems, since they know they have the back-up of consultation with legal staff. Doctors, because of their position of trust, are well-positioned to screen patients through regular contact and in a position of trust. Lawyers are able to bring a new type of expertise to the healthcare setting, so patients will be treated more holistically than in a typical medical exam room and they will be

¹²² *Id.*

¹²³ Kevin Fiscella & Ronald Epstein, *So Much To Do, So Little Time: Care for the Socially Disadvantaged and the 15-minute Visit*, 168 ARCH. INT. MED. 17, 1843-1852 (Sept. 2008).

¹²⁴ See Steven Parker, S. W. Greer & Barry Zuckerman, *Double Jeopardy: The Impact of Poverty on Early Child Development*, PEDIATRIC CLINICS OF NORTH AMERICA 1227 (1988); Lauren A. Smith et al., *Implications of Welfare Reform for Child Health: Emerging Challenges for Clinical Practice and Policy*, 106 PEDIATRICS 1117 (2000).

¹²⁵ See Zuckerman, Sandel, Smith & Lawton *supra* note 120, at 224.

¹²⁶ See Thomas Barton & Samantha Morton, *Advancing the Practice of Preventive Law and Medicine* (unpublished draft, on file with authors).

seen earlier than in a traditional legal services office.¹²⁷ In 2007, MLP | Boston staff did over eighty trainings of medical, legal or public health staff in the metropolitan Boston area.

2) Direct Legal Assistance to Patient-Families on a Broad Range of Legal Issues

What began with a single lawyer working at the hospital has morphed into a team of nine lawyers and paralegals working to ensure families' basic needs—for food, housing and safety and stability—are met, and serving an estimated 1500 families in 2007, with approximately 3,000 legal matters. MLP | Boston is a weekly presence on-site at BMC and at six affiliated community health centers, providing intake clinics and case consultations. MLP | Boston relies on a robust network of *pro bono* partners from Boston-area law firms to increase the direct legal service it provides to patient families. Starting in 2006, four local law firms “adopted” health centers. Attorneys from the law firms Day Pitney LLP, Foley Hoag LLP, Holland & Knight LLP, and Ropes & Gray staff and directly handle the cases generated at intake clinics at the health centers. This unique approach to *pro bono* service delivery has energized a new generation of lawyers seeking innovative ways to have an impact with their legal skills; by coming into the clinical site, the *pro bono* attorneys have an opportunity to partner with skilled health care professionals as part of a team, eliminating the sometimes isolating work of *pro bono* advocacy and bolstering their knowledge about a broad range of topics.

3) Systemic Advocacy

In achieving the first two goals of a medical-legal partnership, training and direct service, often patterns emerge of legal problems that require more than individual solutions. Examples include families repeatedly presenting similar complaints about landlords who violate state or local sanitary or housing code laws, and food stamp application rules that are routinely violated by government agency workers. While laws exist on the books to protect patients in these situations, they are not adequately enforced. While lawyers can help individual patients, clearly more patients can be served by addressing changes to the systems that enforce or implement the laws.

Two examples from MLP | Boston are a collaboration called “Breathe Easy at Home” and a food stamp clinic collaboration with the Massachusetts Department of Transitional Assistance (DTA), the state’s welfare department. The Breathe Easy at Home program¹²⁸ is designed to improve access and communication between medical homes for children with asthma, public health agencies and housing agencies within the

¹²⁷ Chén Kenyon, Megan Sandel et al., *Revisiting the Social History for Child Health*, 120 PEDIATRICS 734 (2007).

¹²⁸ For a description of the Breathe Easy at Home program, see Monisha Cherayil, Denise Oliveira, Megan Sandel & Ellen Tohn, *Lawyers and Doctors Partner for Healthy Housing*, CLEARINGHOUSE REV. J. POVERTY L. & POL’Y 65 (2005).

City of Boston. This collaborative effort among several agencies, including the City's Inspectional Services Department's Housing Inspection Division, MLP | Boston, the Boston Public Health Commission, the Boston Urban Asthma Coalition, the Bowdoin Street Neighborhood Health Center, and the Asthma Regional Council of New England, was developed to ensure that housing code inspections, where warranted, are performed quickly and any follow up inspections are performed to make sure substandard conditions are resolved.

Through a shared website, doctors, nurses, or other health professionals can refer patients with asthma for housing inspections if they suspect substandard housing conditions may be triggering a child's asthma in his or her home. Triggers such as the presence of cockroaches, mice, mold, or moisture problems can cause serious issues for some children with asthma. This innovative program tracks children through the inspection, violation preparation, reinspections, and housing court systems, to improve communication between medical, public health and housing in hope of reducing these conditions to make children healthier.

The Food Stamp Clinic at Boston Medical Center began as a separate clinic from the weekly legal intake clinic because of the prevalence of food stamp issues in families seen and referred. After years of notoriety as having one of the worst food stamp program participation rates in the country, Massachusetts made impressive gains during 2005 and 2006. However, thousands of low income families and low-wage working households remain unserved.¹²⁹ At BMC, the MLP | Boston staff and volunteers regularly address violations in implementation of the program, such as improper deductions, refusing translation services, and requiring immigration documentation when unwarranted. As a result of MLP | Boston advocacy, the Food Stamp Clinic recouped thousand of dollars in food stamp benefits for families each month. Each case that MLP | Boston handles gives the referring health care provider a window into administrative agency decision-making and applications, and empowers them to take further action on behalf of their patient-families, should their application be denied. MLP | Boston became an efficient broker between DTA and the patient-families in BMC's pediatric clinic, leveraging institutional resources like interpreter services and the on-site food pantry. In recognition of this inter-institutional efficiency that accrues first and foremost to the patient, the Massachusetts DTA, in January 2008, began stationing case workers weekly at BMC's pediatric clinic to handle food stamp intake, thereby providing crucial access to needy families and preventing public health legal problems, such as hunger, before they occur.¹³⁰

¹²⁹ Food Research and Action Center, STATE OF THE STATES: 2007 -- A PROFILE OF FOOD & NUTRITION Programs across the Nation (June 2007), *available at* http://www.frac.org/Press_Release/06.04.07.html (last visited Nov. 13, 2008).

¹³⁰ See <http://www.medical-legalpartnership.org/sites/default/files/page/Grid.pdf> (last visited: April 23, 2009) and http://mass.gov/?pageID=pressreleases&agId=Eeohhs2&prModName=eohhspressrelease&prFile=080207_dta_satellite_offices.xml (last visited Nov. 13, 2008).

4) Feedback Loop with Medical Staff

While issues of confidentiality and functionality initially created concern in both the medical and legal communities, it is essential to have legal services integrated into the medical care delivery system as seamlessly as possible. Part of the integration is having clear feedback to the referring health care provider at the initiation of a case, updates on case progress and timely notification of closing a case, all without violating legal ethics.¹³¹ Often, medical providers do not need much of the details of legal cases, but simply want to know a family was seen, that the lawyer is working with the family and that the case has had a resolution.¹³²

In educating medical providers about working with lawyers, it is important to emphasize the different rules governing lawyers, such as not being mandated reporters of child abuse and neglect, and the privileges and confidentiality duties that are afforded the lawyer-client interactions. These rules and duties are easily explained, and often with proper releases and limited disclosure can assure the different needs and requirements of both professions to work well together for a common goal of public health.

5) National Expansion

In 2005, after a decade of providing informal assistance to programs looking to replicate the Boston model, MLP | Boston received major national foundation support to launch a national office aimed at providing funding and technical assistance to developing partnership sites. The National Center for Medical-Legal Partnerships (NCMLP) answers weekly requests for materials and in-depth technical assistance, makes an average of three site visits per month, and hosts an annual conference. In its first round of funding, NCMLP provided \$25,000 seed grants totaling \$400,000 to partnership sites. This strategic investment leveraged \$3.2 million dollars in outside funding, benefiting 20 medical-legal partnerships.

As medical-legal partnership gains momentum, NCMLP continues to find innovative ways to strengthen its practice. Burgeoning regional collaborations in New England, California, Virginia, and Ohio represent the next phase of medical-legal partnership growth. The national network now includes over eighty partnerships serving over 180 health care sites in thirty-six states; medical-legal partnerships served over 10,000 clients in 2008. These programs exist in rural and urban settings, in hospitals and community health centers, and are based in a range of medical specialties—pediatrics, family medicine, geriatrics, and most recently, prisoner re-entry programs. While each partnership is structured differently, programmatic success is dependent upon strong buy-in from medical partners. To help facilitate this, a core focus of NCMLP is to provide

¹³¹ For a discussion of these tensions and how NCMLP seeks to resolve them, see Tames et al., *supra* note 116, at 507.

¹³² *Id.* at 510.

regular trainings for front-line healthcare providers. Having legal staff present on-site at the medical institution where patients are seen is also crucial. This not only removes traditional barriers to obtaining legal assistance and increases the likelihood that families will receive the information they need,¹³³ but also encourages regular dialogue between partners.¹³⁴

In building a national network of pediatric, family medicine and internal medicine sites, NCMLP has established its message that there is more involved in maintaining good health than what a doctor alone is able to provide, and a checkup or a chronic care visit has to include making sure patients' basic needs are met.¹³⁵ The practices of medicine and law, particularly for low-income families, cannot exist separate from one another. We must recognize the correlations between hunger, housing and health as well as the negative impact that a delay in access to the legal system can have on a patient's well-being.

The proven strengths of these partnerships are now earning national recognition.¹³⁶ In August 2007, the ABA passed a resolution in favor of medical-legal partnerships, encouraging their development and praising their holistic approach to health and advancement of preventive law.¹³⁷ The medical world is also taking note. In July 2007, MLP | Boston received the American Hospital Association's NOVA Award for innovations in community health and in October 2008, *The Lancet* published a commentary by NCMLP, "Medical-Legal Partnership: Transforming Health Care."¹³⁸ Indeed, in January 2008, the Robert Wood Johnson Foundation, the largest health care foundation in the U.S., launched a commission specifically focused on strategies to address the social determinants of health.¹³⁹

6) Research & Evaluation

The central question that drives any discussion about medical-legal partnership is this: Does legal intervention improve health outcomes? On an intuitive level, we sense

¹³³ *Id.* at 517.

¹³⁴ 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 (2008).

¹³⁵ See Kenyon et al., *supra* note 126, at 734-35.

¹³⁶ See Tames et al., *supra* note 116, at 507.

¹³⁷ American Bar Association, Health Law Section, Report to the House of Delegates, Recommendations (Aug. 2007), available at http://www.abanet.org/AIDS/docs/ABA_MLP_ResolutionAug2007adopted.doc.

¹³⁸ Barry Zuckerman, Megan Sandel, Ellen Lawton, & Samantha Morton, *Medical-Legal Partnerships: Transforming Healthcare*, 372 LANCET 1615 (2008), full text available at <http://www.bc.edu/phlsdocs> (last visited XXX), published version available at [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(08\)61670-0/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)61670-0/fulltext)

¹³⁹ See <http://www.rwjf.org>.

that it must be true because too many legal aid attorneys have seen families thrive and succeed after legal intervention, especially when closely pegged to physical health, such as housing condition cases. But is there any data to support this suspicion? The thinking is, of course, that if we could *prove* that legal interventions improve health, then perhaps legal services might be resourced and regarded in the same way as the health care system—and viewed as an important basic service that, if done preventively, can save communities and systems money. Medical-legal partnerships struggle with the contours of this research question.

NCMLP's analysis and approach has been to focus on the short-term and intermediate impacts of its activities in order to measure its impact.¹⁴⁰ By demonstrating increased access to basic needs like food, housing, education, etc., it can link the access to improved health outcomes that are already well-established. For example, the health impacts of homelessness are well-studied and documented, but there is a research gap in the effectiveness of legal intervention on preventing and shortening periods of homelessness, which is well documented to be detrimental to long term child health outcomes. Acceptance of the medical-legal partnership model into the healthcare mainstream occurs where researchers can explain with the support of data how legal services delivered in the clinical setting complements traditional medical care and enhances the lives of families.

NCMLP has conducted a series of evaluation research studies in partnership with MLP | Boston, including: (1) a series of formative, but not in-depth, focus groups of clients to create a framework for concept mapping; (2) concept mapping; (3) comparison of seventy two qualitative interviews examining how families with access to medical-legal partnership services deal with their housing issues, compared with families who do not have access to medical-legal partnership; and (4) comparison site study between BMC and two clinical sites with medical legal partnerships and two other clinical sites to examine whether the presence of an on-site legal program increases the likelihood that a family's legal needs will be identified and addressed. Some health and well-being indicators will also be examined over the study's follow-up period, though that study is ongoing and results are unavailable at this time.

The Concept Map was developed as a process of engaging program stakeholders to identify the range of outcomes or benefits resulting from medical-legal collaboration. Researchers conducted two focus groups, one in English and one in Spanish, with former MLP | Boston clients, to develop initial questions about outcomes they identified as important to their interaction with MLP | Boston staff.

The mapping process with lawyers and doctors involved in medical legal partnerships across the country resulted in identifying six domains of outcomes that

¹⁴⁰ See Ellen Lawton, Robyn Riseberg, Gavriela Bogin-Farber, Rachael Knight, Jonathan Cohen & Chi-Cheng Huang, *Disparities in Health, Disparities in Law: The Global Potential of Individual Advocacy*, in HEALTH CAPITAL AND SUSTAINABLE SOCIOECONOMIC DEVELOPMENT (Patricia Cholewka & Mitra M. Motlagh, eds. 2008).

medical and legal partners cite as important outcomes for medical-legal partnerships. Those domains are: (1) Family Empowerment Through Legal Assistance; (2) Enhanced Family Health and Well-being; (3) Enhanced Child Health and Well-being; (4) Improved Access to Legal Assistance; (5) Medical-Legal Collaboration; and (6) Improved Provider Capacity to Address Social Determinants of Health. These domains form the framework for devising outcome and process measures nationally for medical-legal partnerships.¹⁴¹

The seventy-two in-depth qualitative comparison interviews revealed the following highlights:

- ✓ MLP | Boston patient-families felt more empowered to access the services they needed than patient-families at other health centers. Overall MLP | Boston patient-families were better, more skilled advocates.
- ✓ MLP | Boston patient-families were more likely to acknowledge they had a problem when speaking with their doctors. Patients seen at health centers without MLP | Boston legal clinics were more likely to feel that if a doctor could not help them with a problem, they would not be willing to disclose that there was a problem.
- ✓ MLP | Boston patient-families were more likely to get what they needed with less work. MLP | Boston patient-families employed more effective strategies to solve legal problems than patient-families seen at other health centers, such as calling Boston's housing code enforcement agency services versus using Raid to handle a cockroach infestation.

Lastly, another core strategy for medical-legal partnership evaluation and research is the needs assessment for legal services. The purpose of this effort is to quantify the prevalence and nature of legal needs in a particular clinical population, to identify the resources or services sought and utilized in response to those legal needs, and to characterize possible barriers to the receipt of legal assistance.¹⁴²

In 2007, NCMLP conducted one of the first studies to assess the legal needs of a hospital-based population (that of Boston Medical Center) in which factors that may affect access to or utilization of legal assistance are also measured. Families were surveyed about 12 basic needs that ranged from safety, affordability and stability of housing, to food, health care, educational services, child care services, and income

¹⁴¹ See Lawton, *Surgery to Prevention*, *supra* note 119, at 38.

¹⁴² David Keller, Nathan Jones, Judith A. Savageau & Suzanne B. Cashman, *Development of a Brief Questionnaire to Identify Families in Need of Legal Advocacy to Improve Child Health*, 8 *AMBULATORY PEDIATRICS* 4:266 (July-Aug. 2008).

generally. Preliminary data from that study¹⁴³ indicate that the most commonly cited concerns were related to finances: having enough money to pay for basic expenses, such as housing, utilities and food. Families also frequently reported concerns about their children's safety when at school. Over 94% of families reported facing or experiencing at least one concern within the last month; 67% reported experiencing concerns related to at least five of the 12 basic needs. At least 21% of families reported that at least one child in the household has a physical or mental condition that interferes with daily activities. Nearly half (48.7%) of families reported that within the past year they had received a letter from a utility company threatening to shut off utilities; 23% actually experienced a shut-off in the past year; and 25% of families reported that they had used a cooking stove to heat their home in the past year, because they could not afford their bills. Over 36% of families said that they had either reduced the size of their meals or had skipped meals because they did not have enough money for food.¹⁴⁴ Many families reported that their concerns were both persistent (77% reported that the issues had been a concern for at least six months) and severe (85% described their concerns as "somewhat serious" or "very serious"). This preliminary study confirms the striking depth of need for legal assistance among the hospital-based population.

The lesson of medical-legal partnership is simple: front-line health care providers offer a powerful voice that connects seemingly unrelated policies in areas such as affordable housing and energy costs with their often unrecognized health consequences. The rapid expansion of the model over the past few years now allows researchers and policymakers to learn much about how this collaboration can work in different settings and in different iterations. The testing grounds are in place, but the challenge remains to continue to ask the strategic questions and to gather the information required to answer those questions.

C) New York's LegalHealth

1) Mission and Operation

LegalHealth, a division of the New York Legal Assistance Group, was modeled after MLP | Boston. Soon after its inception in 2001, LegalHealth recognized that there was another population of vulnerable individuals needing assistance--adults with serious and chronic illness. While medical-legal partnerships between lawyers, doctors, and other healthcare professionals serving children had proven effective in combating selective socio-economic impediments to health, LegalHealth wanted to extend the reach

¹⁴³ MARK HANSEN & ELLEN LAWTON, BOSTON MED. CENTER, BETWEEN A ROCK AND A HARD PLACE: LEGAL NEEDS IN A PEDIATRIC EMERGENCY ROOM SETTING (Apr. 2008), available at <http://medical-legalpartnership.org>, last visited Mar. 22, 2009).

¹⁴⁴ *Id.*

of these partnerships to adults and soon became one of the few medical-legal partnerships serving adults as well as children in the nation.¹⁴⁵

Being diagnosed with a chronic or serious illness can be devastating, but coupled with legal problems that often spiral out of control post-diagnosis, an ill adult's life often becomes overwhelming. Individuals and families who are low-income and/or suffer from cultural or language barriers face especially difficult hurdles in managing their healthcare and meeting basic needs. The inability to access legal services for guidance with regard to healthcare coverage or benefits, and for basic needs such as habitable housing and adequate nutrition, can prevent vulnerable individuals from effectively managing their illnesses. This can lead to lack of compliance with their course of treatment, which negatively affects their quality of life. For these individuals and families, adequate knowledge of their legal rights and access to legal services can make an enormous difference in their lives and the outcomes of their particular situations.

Over the years LegalHealth has demonstrated that legal interventions can be effective in diminishing the stress that often accompanies a chronic illness and improving quality of life for underserved adult patients. LegalHealth has provided a model for comprehensive service delivery through on-site legal clinics at ambulatory and in-patient units at hospitals and community-based health organizations, and for providing innovative training programs for both medical professionals and patients. Currently, LegalHealth has alliances with fourteen public and private hospitals and ten community-based organizations serving chronically ill adults and children throughout New York City.¹⁴⁶ In 2007, LegalHealth assisted over 3,000 individuals.¹⁴⁷

Weekly half-day legal clinics are held on-site in partner medical institutions to address the legal issues connected to, or arising through, illness. Monthly intake is also held on-site at a host of community-based health organizations. This provides access to legal services in a setting where patients most frequently seek help. These clinics are conducted by staff attorneys who receive referrals from physicians, social workers and other medical professionals. LegalHealth's practice covers the areas of law most relevant to patients with serious health concerns and their families, including: assistance with benefits; private insurance coverage; immigration issues; debtor/creditor matters; employment-related matters; permanency and estate planning; advance directives; family law; and housing conditions. LegalHealth has also created a core training curriculum for physicians. Training sessions are held for health care workers at its 14 partner hospitals,

¹⁴⁵ See generally Randy Retkin, Julie Brandfield, Ellen Lawton, Barry Zuckerman & Deanna DeFrancesco, *Lawyers and Doctors Working Together -- A Formidable Team*, HEALTH LAWY., Oct. 2007, at 33, available at http://legalhealth.org/docs/lgh_lawyers_doctors_working_together.pdf; Stewart B. Fleishman, Randy Retkin, Julie Brandfield, & Victoria Braun, *The Attorney as the Newest Member of the Cancer Treatment Team*, 24 J. CLIN. ONCOL. 2123 (2006), available at <http://legalhealth.org/docs/jco.pdf>.

¹⁴⁶ <http://legalhealth.org/partnerships/partners.htm> (last visited Oct. 28, 2008); <http://legalhealth.org/partnerships/commOrg.htm> (last visited Oct. 28, 2008).

¹⁴⁷ <http://legalhealth.org/about/ourServices.htm> (last visited Oct. 28, 2008).

raising awareness of relevant legal situations that may affect their patients' health and well-being. Trained healthcare workers are able to make informed legal referrals and participate in advocacy on behalf of their patients.¹⁴⁸

Medical-legal collaborations for children have been a successful model in promoting child health and well-being,¹⁴⁹ and they have had an increasing national presence in the last ten years.¹⁵⁰ The success, in part, has been attributed to the public view that children are the responsibility of our society and a concomitant desire to take care of them. There is an unspoken presumption that adults do not need to be taken care of. Underserved adult patients, however, are a vulnerable population that is often too overwhelmed with health needs to manage the multitude of nonmedical needs required to keep their safety net of resources in place or to do other important planning. On their own, physicians do not have the time or resources to address the nonmedical needs of underserved adult patients. LegalHealth studies have shown that, without backup resources, the physicians prefer not to get involved in addressing the critical nonmedical needs of patients.¹⁵¹ After being introduced to LegalHealth's advocacy curriculum and direct service resources, physicians (i) had a greater awareness of their patients' legal needs, (ii) were more likely to make referrals for onsite legal assistance, (iii) were better equipped to assist their patients with needed forms and letters, and (iv) recognized the importance of their role in resolving their patients' nonmedical needs.

2) Empirical Research

LegalHealth and its healthcare partners have begun studying the effectiveness of these partnerships on health outcomes and quality of life for its clients/patients. One study evaluated the impact of its legal services on the lives of 51 of its clients with cancer. The results of that study showed that legal problems are a significant nonmedical problem for cancer patients that must be addressed to maintain quality of life during and after cancer treatment (78% percent of the survey clients reported that having cancer created their legal difficulties). The study showed that legal interventions had an impact on LegalHealth's clients in the following ways:

83% of the survey clients reported that legal services helped to reduce their worries and stress; 51% reported that legal services had a positive effect on their financial situation; 33% reported that legal services positively affected their family or loved ones; 23% of the survey clients reported that legal services helped them to maintain their treatment

¹⁴⁸ *Id.* See also <http://legalhealth.org/about/ourTrng.htm> (last visited Oct. 28, 2008).

¹⁴⁹ See Retkin et al., *supra* note at 34.

¹⁵⁰ See <http://www.mlpforchildren.org/OurMissionHistory.aspx> (last visited Oct. 28, 2008).

¹⁵¹ See Zuckerman, Sandel, Smith & Lawton, *supra* note 118, at 226.

regimens; and 22% reported that legal services helped them to keep medical appointments.¹⁵²

In 2006, LegalHealth worked with doctors from St. Luke's-Roosevelt Hospital on a study entitled *The Effect of Environmental Improvement brought about by Legal Interventions in Poorly Controlled Inner-City Asthmatics*.¹⁵³ The study found that patients who received legal intervention had significant improvements in asthma severity, cortico-steroid usage courses, and reduced emergency room visits as compared to the group of patients who did not receive legal intervention. It also concluded that, as a public health matter, the average cost of legal intervention is lower than the cost of one month of inhaled cortico-steroid and long-acting beta agonist (common asthmatic treatments for those patients), and less costly than other interventions done in studies of pediatric asthmatics.

LegalHealth has also studied the impact of medical-legal collaborations in relationship to physician education. It conducted a three-year study on behavioral and attitudinal impact of its training curriculum on the residents, attending physicians and faculty at four of its partner hospitals. From the data collected, LegalHealth identified the following changes in attitude and behavior:

- a 40% increase in pre-versus post-survey respondents making a legal referral in the last 6 months;
- a 37% increase in respondents who indicated that referrals had been recommended in precepting sessions;
- a 24% increase in respondents who agreed or strongly agreed that it is part of their job duties to make legal referrals;
- a 20% increase in respondents who indicated that they were able to assist their patients fill out forms for government benefits with an 11% increase in respondents who had affirmatively assisted their patients in obtaining government benefits in the past 6 months; and
- a 14% increase in respondents who were able to provide housing assistance.¹⁵⁴

The need to make legal services accessible to certain subsets of the underserved adult patient population has been recognized by others. For example, geriatric patient

¹⁵² RANDYE RETKIN, JULIE BRANDFIELD & CATHY BACICH, IMPACT OF LEGAL INTERVENTIONS ON CANCER SURVIVORS (Jan. 2007), available at <http://www.bc.edu/phlsdocs> (last visited XXXXX).

¹⁵³ Ariel Modrykamien, Luis Chug, Julie Brandfield, Lori Tartell, & Mary M. O'Sullivan, *A Retrospective Analysis of the Effect of Environmental Improvement Brought About by Legal Interventions in Poorly Controlled Inner-City Asthmatics*, 130 CHEST MEETING ABSTRACTS 83 (2006), available at <http://www.bc.edu/phlsdocs> (last visited XXXX).

¹⁵⁴ LEGALHEALTH, LANGELOTH FINAL REPORT OVERVIEW (Apr. 2008), available at <http://www.bc.edu/phlsdocs> (last visited XXXX).

groups receive legal services in the area of estate planning and guardianship issues.¹⁵⁵ Perhaps the most striking example of advocacy efforts on behalf of a patient group has been for people with HIV/AIDS whose legal needs have been recognized and funded since the early 1980's.¹⁵⁶ Both the New York State Department of Health and the CDC have recognized the critical role that lawyers play when a person is diagnosed with HIV/AIDS. In fact, the CDC recommends immediate referral to legal services based on a diagnosis of HIV/AIDS.¹⁵⁷

Legal interventions need to become part of the treatment matrix for individuals with serious and chronic illness and medical-legal partnerships such as LegalHealth's provide a model for service delivery and physician education that would benefit public health goals and serve as a model for "public health legal services." The problems that LegalHealth addresses are not unique to the poor and working poor New Yorkers served by that program. Hospitals and community health clinics around the country are beginning to recognize the need to provide legal services to vulnerable adults and children with chronic and serious illness and often call upon LegalHealth for replication strategies. Like the programs in Los Angeles and Boston, LegalHealth offers a model to others for demonstrating an effective medical-legal partnership, and in doing so strengthens the emerging conception of public health legal services.

IV. The Logistical and Experiential Implications of Public Health Legal Services for the Delivery of Legal Services

A) A Workable Collision of Health Care and Legal Services Providers

As described above in Part II, the established justifications for providing subsidized legal services rested on notions of due process rights and principles of fairness. In a nation dedicated to the rule of law, with long-standing commitments to procedural and substantive fairness, the specter of individuals suffering irreparable harm because of an inability to navigate the complex and sophisticated legal terrain was an intolerable one.¹⁵⁸ Proponents of at least minimal access to legal services relied on those

¹⁵⁵ See Karen Bassuk & Janet Lessem, *Collaboration of Social Workers and Attorneys in Geriatric Community Based Organizations*, 34 J. GERONTOL. SOC. WORK 93 (2001).

¹⁵⁶ Randy Retkin, Gary L. Stein & Barbara H. Draimin, *Attorneys and Social Workers Collaborating in HIV Care: Breaking New Ground*, 24 FORDHAM URB. L.J. 533 (1997).

¹⁵⁷ CDC, *Revised Guidelines*, *supra* note 107, at 37.

¹⁵⁸ See, e.g., Lon L. Fuller & John D. Randall, *Professional Responsibility: Report of the Joint Conference*, 44 A.B.A. J. 1159, 1162 (1958); Stephen L. Pepper, *The Lawyer's Amoral Ethical Role: A Defense, a Problem, and Some Possibilities*, 1986 AM. B. FOUND. RES. J. 613, 617 (1986).

fundamental, shared American values to defend society's obligation to make legal services available to all.¹⁵⁹

Until the developments described above in Part III, defenders of subsidized legal services did not include public health arguments as one of the justifications for the cost of free lawyers. Initially, the public health model for legal services delivery might seem only to augment existing models and justifications for providing legal help to those who cannot afford the market costs of that product. If the new public health legal services vision has merit, however, the defenders' assertions acquires an entirely new vector, for the goal of public health legal services as a legal services delivery model is to tie legal access and intervention to basic human needs in a health context. Doing so both demonstrates measurable, meaningful outcomes of legal intervention, and thus constructs a separate, additional argument for the value of legal access for the poor altogether, one based in wellness that is oriented towards addressing social determinants of health.

In the decades since the development of the modern legal services delivery system and priorities, a vast body of work relevant to the social determinants of health has emerged.¹⁶⁰ Considering the dramatic overlap in domains, priorities, and individuals to whom both areas are relevant, it was only a matter of time before the two bodies of work collided. Health care providers serving vulnerable populations—low-income families, people with chronic illness, the elderly and disabled—bear witness daily to the unrelenting impact of social determinants on patient health and well-being. When evaluating and treating patients, health care professionals frequently identify how inadequate food, housing, and community and individual safety; poor access to basic medications such as vaccines; or other unmet basic needs contribute solely or in part to preventable medical illness and poor health. Physicians are thus in a unique position to set in motion advocacy that ensures that the laws and policies protecting health are effectively implemented. It is this central notion—that lawyers have the skills to remedy the social determinants of health, while clinicians can address the biological determinants—that led to Boston's medical-legal partnership innovation.

It is also this simple innovation that demonstrates the mechanism for how the present legal services delivery system would be affected by a shift toward preventive law and the practice of public health legal services: it would introduce the front-line health care provider as part of the triage system for accessing limited legal aid resources. The rationale is simple. Health care providers are stakeholders invested in helping their patients who hold unique and relevant information that can increase triage acuity.

¹⁵⁹ See generally Simran Bindra & Pedram Ben-Cohen, *Public Civil Defenders: A Right to Counsel for Indigent Civil Defendants*, 10 GEO. J. ON POVERTY L. & POL'Y 1 (2003); Paul Marvy & Debra Gardner, *A Civil Right to Counsel for the Poor*, 32 HUM. RTS., Sum. 2005, at 8 ; see also Legal Services Corporation Mission Statement at www.lsc.gov/about/mission.php.

¹⁶⁰ See *supra* at note INSERT.

The clinical setting—where health care providers routinely screen patients for a variety of barriers to health—provides a virtually unrivaled opportunity for identifying legal violations that impair health, and to connect affected individuals and families with legal services to challenge those violations. Lawyers who are trained to address the underlying social conditions of poverty are the ideal partners for physicians seeking to uncouple the link between the biological and social origins of illness.

What is the cost to the legal services community of inviting this highly skilled, highly resourced, and highly valued partner to the service delivery system? The legal services community would have to commit to modeling its service delivery, and to a certain extent its priorities, on that of the clinical partners. Lawyers would then participate as part of the healthcare team, and not in a dyad with their clients. Lawyers would train and back up front-line clinicians to develop their triage instincts for the social determinants of health, and dispense small “doses” of legal information and consultation to a broad population of front-line staff.¹⁶¹ Training, especially of the next generation of health care providers (residents, medical students), would become a priority, and data and outcomes that are tracked would relate more closely to health and well-being than to potential legal or social justice outcomes.

Once the entry-point for access to legal services—currently the triage model as described in Part II—has been shifted to incorporate the healthcare professionals, the substantive services and priorities of the legal aid agency may (or may need to) shift in response to the sentinel view of the front-line health care providers. Whereas currently, most legal aid agencies rely on shelters, domestic violence advocates and other social service providers for referrals and shared triaging, embedding even a portion of the current legal delivery system within the clinical setting would mean that patients not yet connected to such legal need “first responders” might now be screened for legal advocacy and found eligible for legal services. In the new public health legal services system, then, the single mother of two children who has been diagnosed with stage 3 breast cancer could “jump the queue” ahead of equally deserving individuals struggling with housing eviction, discrimination and domestic violence. How might the privileging of the single mother’s case in the new system be justified? Because there would be a joint attack on the patient/client’s social determinants of health—medical *and* legal—that neither could construct alone. A case emanating from a clinical setting as distinct from a traditional legal case funneled to legal aid by a social service agency or hotline would bring two kinds of knowledgeable, respected, skilled professionals as partners to the patient while vastly reducing or even eliminating the need for time-intensive investigation by advocates to secure key supporting documentation and medical opinions.

The envisioned public health legal services system embedded within the medical services replaces the ad hoc nature of most existing legal services delivery intake system with health care providers already intimately familiar with screening, identification and priority-setting. What does the health care provider bring to the table, beyond early

¹⁶¹ See Tames et al., *supra* note 116, at 509-10.

access to vulnerable patients? A respected methodology and common capacity for evaluation, screening, identification and treatment of a broad range of human problems, from liver disease to depression. Front-line health care staff working with vulnerable populations also bring a unique understanding of the patient's needs and role that can benefit the traditionally "exclusive" attorney-client relationship. For example, in some cases, a joint consultation with the patient, the lawyer and the health care provider about a topic can be a supportive strategy for an overwhelmed, low-income single mother who is struggling to prioritize her response to legal and health needs.¹⁶² Or, for instance, a patient with HIV may be much less likely to be compliant with his antiretroviral therapy if he must worry about eviction, or having enough food. By meeting these basic needs, the HIV positive individual can be more compliant and prevent unnecessary opportunistic infections.

B) Political Implications of a Public Health Legal Services Rubric

The public health legal services conception also captures a more politically attractive stance for subsidizing legal services. Despite the commitments to due process and substantive fairness noted above, legal services for the poor has not been the most politically popular element of the welfare state.¹⁶³ Opponents from the right in particular find much to attack, and to attack with vigor.¹⁶⁴ Because poverty law programs cannot offer free lawyer time to all of the persons who need and request it, the programs historically have chosen the most critical cases and clients to serve.¹⁶⁵ Few, if any, such programs operate on a pure "access to justice" model; instead, program staff focus their efforts on those matters which will affect the most persons in the most significant way.¹⁶⁶ The decisions made by programs are sometimes (if not as often as the critics suggest¹⁶⁷) politically sensitive and inflammatory.¹⁶⁸

¹⁶² *Id.*

¹⁶³ See text accompanying notes [**INSERT**] *supra*.

¹⁶⁴ *Id.*

¹⁶⁵ Tremblay, *Triage Among Poor Clients*, *supra* note 49, at 2475.

¹⁶⁶ *Id.*; Robert Bickel, *Limited Legal Services: Is It Worth It?*, 39 COLUM. J.L. & SOC. PROBS. 331, 350 (2006).

¹⁶⁷ See, e.g., Anthony Alfieri, *Reconstructive Poverty Law Practice: Learning Lessons of Client Narrative*, 100 YALE L.J. 2107, 2122-23 (1991); Michelle S. Jacobs, *Full Legal Representation for the Poor: The Clash Between Lawyer Values and Client Worthiness*, 44 HOW. L.J. 257, 284 (2001); David A. Super, *The New Moralizers: Transforming the Conservative Legal Agenda*, 104 COLUM. L. REV. 2032, 2069 (2004).

¹⁶⁸ See Rhode, *Access to Justice*, *supra* note 38, at 1797; Mauricio Vivero, *From "Renegade" Agency to Institution of Justice: The Transformation of Legal Services Corporation*, 29 FORDHAM URB. L.J. 1323 (2002).

A dominant theme of the work traditionally performed by poverty law offices involves litigation on behalf of the “have-nots” against the “haves.”¹⁶⁹ Employees use legal services resources to challenge the conditions of employment and the wages and benefits offered to the workers.¹⁷⁰ Tenants oppose landlords’ eviction efforts, even those based on alleged lease violations (like drug use and violence¹⁷¹) and on non-payment of rent grounds.¹⁷² Welfare recipients litigate for themselves and others similarly situated for increased benefits and for fairer procedures for determining when the benefits will be paid or stopped.¹⁷³ Litigation and lobbying on behalf of undocumented individuals seek to improve the lot of those who entered the United States without proper papers.¹⁷⁴

That dominant, litigation-oriented foundation for the work traditionally performed by legal services organizations invites the critical reactions commonly observed to that work. Beleaguered employers, landlords, welfare agencies, and state and local governments criticize the lawyers who speak and act for their clients for their pursuit of a left-wing, political agenda.¹⁷⁵ They criticize the fact that the poor clients’ lawyers, who do not charge fees, are not constrained by the cost of litigation, creating an unfair and extortionate arrangement where the cost of private lawyers’ services for the other side make extended litigation impractical or impossible.¹⁷⁶ Critics therefore depict poverty

¹⁶⁹ See Marc Galanter, *Why the “Haves” Come Out Ahead: Speculations on the Limits of Legal Change*, 9 L. & SOC’Y REV. 95 (1974); Robert A. Katzmann, *The Legal Profession and the Unmet Needs of the Immigrant Poor*, 21 GEO. J. LEGAL ETHICS 3 (2008); Russell Engler, *Shaping a Context-Based Civil Gideon from the Dynamics of Social Change*, 15 TEMP. POL. & CIV. RTS. L. REV. 697 (2006) (Edward V. Sparer Symposium Civil Gideon: Creating a Constitutional Right to Counsel in the Civil Context).

¹⁷⁰ See, e.g., Martha M. Ertman, *Mapping The New Frontiers of Private Ordering: Afterword*, 49 ARIZ. L. REV. 695 (2007) (exploring private ordering in the employment context); Michael Z. Green, *Finding Lawyers for Employees In Discrimination Disputes as a Critical Prescription for Unions to Embrace Racial Justice*, 7 U. PA. J. LAB. & EMP. L. 55 (2004) (documenting the importance of legal services for employees); Susan Sturm, *Lawyers and the Practice of Workplace Equality*, 2002 WIS. L. REV. 277 (2002).

¹⁷¹ See, e.g., *Rucker v. Rucker*, 535 U.S. 125 (2002); *Boston Housing Authority v. Garcia*, 871 N.E.2d 1073 (Mass. 2007).

¹⁷² See, e.g., *Homesavers Council of Greenfield Gardens, Inc. v. Sanchez*, 874 N.E.2d 497 (Mass. App. 2007); *Larwrence v. Osuagwu*, 781 N.E.2d 50 (Mass. App. 2003).

¹⁷³ See Matthew Diller, *Form and Substance in the Privatization of Poverty Programs*, 49 UCLA L. REV. 1739, 1746 (2002); Matthew Diller, *The Revolution in Welfare Administration: Rules, Discretion, and Entrepreneurial Government*, 75 N.Y.U. L. REV. 1121, 1208 (2000); Lucy A. Williams, *The Ideology of Division: Behavior Modification Welfare Reform Proposals*, 102 YALE L. J. 719, 727, 736 (1992).

¹⁷⁴ See Daniel Kanstroom, *Deportation, Social Control, and Punishment: Some Thoughts About Hard Laws Making Bad Cases*, 113 HARV. L. REV. 1889 (2000); Daniel Kanstroom, *Deportation and Justice: A Constitutional Dialogue*, 41 B.C. L. REV. 771 (2000).

¹⁷⁵ See Raymond H. Brescia et al., *Who’s in Charge, Anyway? A Proposal for Community-Based Legal Services*, 25 FORDHAM URB. L.J. 831 (1998); Rhode, *Access to Justice*, *supra* note 38, at 1794.

¹⁷⁶ Laura K. Abel & Risa E. Kaufman, *Preserving Aliens’ And Migrant Workers’ Access To Civil Legal Services*, 5 U. PA. J. CONST. L. 491, 495 n.11 (2003) (describing claims of extortion); Rhode, *Access to Justice*, *supra* note 38, at 1791 (describing claims of frivolous litigation).

lawyers as troublemakers, extortionists, and left-wing ideologues.¹⁷⁷ The sting and resonance of those attacks likely have greater power among members of the middle class, many of whom cannot afford the kind of lawyer's time that poverty law programs offer to their more unfortunate constituents. There is evidence that many members of Congress, who decide the funding for the national Legal Services Corporation, which funds fifty-eight percent of all poverty legal services in the nation,¹⁷⁸ share at least some of these worries about the program.¹⁷⁹

Understanding legal services as a critical component of a public health system undercuts these criticisms and their power significantly. While provision of health care for those who cannot afford it is hardly uncontroversial,¹⁸⁰ its proponents are seldom vilified in the way that legal aid lawyers often are. Maintenance of public health goals also seems qualitatively different from, and subject to a more common and shared understanding than, litigation efforts intended to transfer wealth from certain segments of the population to other segments. If legal assistance for the poor were to come to be understood as a part of the objectives of pediatricians and primary care physicians seeing patients at a neighborhood community health center, its popular support, it seems, would solidify immeasurably. This transformed notion of the value of legal services might, in turn, provide practical evidence of what a revitalized liberalism might look like.

For instance, assume an agency with a million dollar budget that equally funds ten different services, with each service meeting only twenty-five percent of need. Assume that only six of the services met a rigorous definition of public health legal services. What if moderates and conservatives were willing to join with liberals to double the agency's budget, but only to fund the six public health legal services? The agency's budget would be two million dollars. Six of its services would each meet almost eighty-five percent of need while four would meet no need at all.¹⁸¹ That is a trade-off many

¹⁷⁷ See Boehm, *supra* note INSERT.

¹⁷⁸ LEGAL SERVICES CORPORATION, DOCUMENTING THE JUSTICE GAP IN AMERICA 18 (2005) (using 2002 figures about legal services lawyers in the United States, showing 58% funded by the LSC).

¹⁷⁹ See Wirtz, *supra* note 76; Luban, *supra* note 76 (describing Congressional restrictions aimed at discouraging the purported abuses by legal aid lawyers).

¹⁸⁰ See, e.g., Andrew Grossman, *Expansion of SCHIP not about Poor Children after All*, CHATTANOOGA TIMES FREE PRESS, Sept. 9, 2007, at F1; David Hogberg, *SCHIP Expansion: Socialized Medicine on the Installment Plan*, National Center for Public Policy Research, at <http://www.nationalcenter.org/NPA560.html>, Sept., 2007 (last visited Oct. 22, 2008); Devon Herrick & Matt Baumann, *SCHIP Expansion: Robin Hood in Reverse*, National Center For Policy Analysis, July 31, 2007, at <http://www.ncpa.org/pub/ba/ba589/> (last visited Oct. 22, 2008)(arguments made in the summer of 2007 by opponents of proposed federal legislation intended to expand the SCHIP program, which provides health care to needy children). For a description of the SCHIP program, see <http://www.ncsl.org/programs/health/chiphome.htm> (last visited Nov. 12, 2008).

¹⁸¹ A million dollar budget equally divided among ten services that each meets twenty-five percent of need allocates \$100,000 per service. A two million dollar budget divided equally among six services triples each

legal services directors might welcome, and which a revitalized liberalism might argue has qualitative not just quantitative meaning.

C) Prevention Contrasted with Triage

Seen in that light, a re-visioning of the goals and the understandings of legal services for the poor seems like altogether a good thing. And, for the reasons just described, it appears to be just that. But apart from the gains to be had in political and popular acceptance of this work, the re-visioning is liable to create thorny complications for the provision of a scarce resource to the many who lack it and need it. The new conception of public health legal services, if faithfully developed, may not flourish compatibly with many settled understandings of how poverty law has worked in this country for the past 30 years or more. As described above, the resource allocation schemes used by most legal services providers rely largely on notions of triage and focused case acceptance, with resources and attention aimed at those clients with the most critical and wide-ranging needs.¹⁸² A public health conception of legal services delivery may not support that focus at all.

Consider, as one example, the HIV Legal Checkup campaign described in Part III.¹⁸³ The thematic power of the HIV-LC campaign is in its application of *preventive* legal services as a component of *preventive* health care.¹⁸⁴ The HIV-LC protocol as developed by AIDS discrimination advocates¹⁸⁵ and promulgated by the CDC¹⁸⁶ envisions lawyers offering services to persons who are not yet in crisis, who may not yet have critical or emergent legal needs, with the express aim of educating them about their rights and encouraging them to pursue treatment.

Juxtapose that scheme with the daily existence of an overburdened street-level legal services program, facing hundreds of needy clients each week pleading for assistance with severe legal emergencies—lost child support, terminated welfare or health care benefits, kidnapped children, eviction or foreclosure notices, and so on. The prospective clients with those crises need lawyers to navigate the legal, administrative and regulatory systems in which their difficulties are embedded. The family court is a

service's funding, and thus triples the percent of need met, from twenty-five percent to 83.3%. Four hundred thousand dollars would need to be raised to replace the lost services.

¹⁸² Tremblay, *Community-Based Ethic*, *supra* note 41, at 1110-16.

¹⁸³ *See supra* text accompanying notes 105-106.

¹⁸⁴ *See, e.g.,* Andriote & Sears, *supra* note 106; Schulman, *supra* note 106; Dennis P. Stolle, *Advance Directives, AIDS, and Mental Health: TJ Preventive Law for the HIV-Positive Client*, 4 PSYCHOL. PUB. POL'Y & L. 854 (1998); *see also* CDC, *Revised Guidelines*, *supra* note 109.

¹⁸⁵ *See supra* notes 104-111 and accompanying text (describing the role of the LA City Attorney and the ABA in support of the HIV-LC protocols).

¹⁸⁶ *See* CDC, *Revised Guidelines*, *supra* note 109.

terribly complex terrain for a pro se litigant who has stopped receiving the child support she needs, or who risks losing custody of her children.¹⁸⁷ The state and federal welfare and Medicaid programs are terribly convoluted and Byzantine; without trained advocates, eligible recipients might forfeit their entitlement to essential benefits.¹⁸⁸ The courts overseeing evictions and foreclosures operate on rules of civil procedures that baffle first year law students at the nation's most prestigious law schools.¹⁸⁹ The clients facing those bureaucracies and establishments desperately need experienced, smart lawyers and paralegals. Without them, the clients are lost.

If the HIV-LC program were separate from, or an adjunct to, the bustling neighborhood legal services organization just envisioned, then one might imagine that the legal services program would help the clients in crisis and other lawyers, the HIV-LC lawyers, would provide the needed checkup assistance to persons who need education about their rights should they test positive for HIV. But that separation is a false vision. The lawyers are, in the grand scheme, all the same. For the most part,¹⁹⁰ each dollar of funding for HIV-LC is a dollar of funding not allocated to crisis management. Every hour spent on HIV-LC is an hour not spent on one of the clients in the waiting room, with the emergency case that needs lawyering help today.

This stark choice, then, will be a reality as public health legal conceptions collide with conventional legal services practice. One could describe that choice in such a way

¹⁸⁷ See Suzanne Reynolds, Catherine Harris & Ralph Peebles, *Back to the Future: An Empirical Study of Child Custody Outcomes*, 85 N.C. L. REV. 1629 (2007); Michael Millemann, *The State Due Process Justification for a Right to Counsel in Some Civil Cases*, 15 TEMP. POL. & CIV. RTS. L. REV. 733, 752 n. 147 (2006) (noting a court finding a limited right to counsel in child support matters); Naomi Stern, *Battered by the System: How Advocates Against Domestic Violence Have Improved Victims' Access to Child Support and TANF*, 14 HASTINGS WOMEN'S L.J. 47, 56-57 (2003).

¹⁸⁸ See Michael Millemann, *Mandatory Pro Bono in Civil Cases: A Partial Answer to the Right Question*, 49 MD. L. REV. 18, 26 (1990); Anthony Szczygiel, *Long Term Care Coverage: The Role of Advocacy*, 44 U. KAN. L. REV. 721, 757 (1996).

¹⁸⁹ See, e.g. Catherine F. Downing, James M. McCreight & Doris M. Rezza, *Termination of Residential Tenancies*, in 2 RESIDENTIAL AND COMMERCIAL LANDLORD-TENANT PRACTICE IN MASSACHUSETTS, Chapter 11 (2006), Westlaw cite at TPMII MA-CLE S-11-1 (describing the intricacies of eviction practice in Massachusetts); Ellen Yaroshefsky & Marilyn J. Flood, *Foreword to the Conference Report: The New York City Housing Court in the 21st Century: Can It Better Address the Problems Before It?*, 3 CARDOZO PUB. L. POL'Y & ETHICS J. 591, 593 (2006); see also William B. Hornblower, *The Independence of the Judiciary, the Safeguard of Free Institutions*, 22 YALE L.J. 1, 8 (1912) (describing the rules of civil procedure as "a complicated and voluminous practice Act of Brobdignagian proportions").

¹⁹⁰ There are some public sources of legal services funding which by virtue of their appropriation are earmarked for addressing discrete medical issues, and are not available for the clients in line in the legal aid waiting room. See, e.g., Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. No. 101-381, 104 Stat. 576 (codified at 42 U.S.C. §§ 300ff to 300ff-1). The existence of such earmarked programs does not undercut the observation in the text, because the lawyers funded by such programs are already engaged in public health legal services. This Article explores the expansion potential of the public health legal services concept to lawyers who have not traditionally engaged in that use of their time and resources.

to imply that the crises ought to trump the non-emergency needs of infected individuals. That rhetorical move, however, would be intellectually dishonest. As public health scholars and observers have long understood, the immediate needs of individuals today cannot serve automatically as such an ethical or policy trump, even if recognizing that conclusion means that some persons will not receive needed care.¹⁹¹

At the same time, it is similarly true that the long term needs of prevention care do not operate as a trump on the pleas of today's disaffected and suffering. Institutions such as the overburdened neighborhood legal services office must attend both to present crises and to prevention efforts to forestall future crises.¹⁹² If the latter efforts appear to require greater justification, it is because of what some observers have described as the "rescue mission" phenomenon—the widespread and understandable felt need to care for today's suffering.¹⁹³ Those greater justifications, though, likely exist.

The most straightforward justification for allocating scarce resources away from emergency treatment to preventive care like HIV-LC is a utilitarian one. It posits that greater investment in preventive care today, even at the cost of abandoning some crisis intervention today, is warranted by the long-term benefits achieved by the prevention efforts. This justification is a common one within public health circles.¹⁹⁴ The utilitarian argument, though, only works if it is *true*. It only works if available predictive evidence shows that investments in prevention today will in fact eliminate sufficient crises in the future to justify the investment. Clearly the medical-legal partnership proponents conclude that such a prediction is a sound one,¹⁹⁵ and the preliminary research data supports their optimism.¹⁹⁶ The empirical investigation needed to sustain that argument remains to be completed.

¹⁹¹ See, e.g., Charles C. Caldart & Nicholas A. Ashford, *Negotiation as a Means of Developing and Implementing Environmental and Occupational Health and Safety Policy*, 23 HARV. ENVTL. L. REV. 141, 185-86 (1999); Lawrence O. Gostin & Robert Archer, *The Duty of States to Assist Other States in Need: Ethics, Human Rights, and International Law*, 35 J. L. MED. & ETHICS 526, 530 (2007); John V. Jacobi, *Book Review*, 31 SETON HALL L. REV. 1089, 1090-91 (2001) (reviewing LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT (2000)).

¹⁹² See, e.g., Peter B. Edelman, *Toward a Comprehensive Antipoverty Strategy: Getting Beyond the Silver Bullet*, 81 GEO. L.J. 1697, 1734-1735 (1993); Paul R. Tremblay, *Rebellious Lawyering, Regnant Lawyering, and Street-Level Bureaucracy*, 43 HASTINGS L. J. 947, 950 (1992).

¹⁹³ See, e.g., TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (5th ed. 2001); RAANON GILLON, *PHILOSOPHICAL MEDICAL ETHICS* (2d ed. 2006).

¹⁹⁴ See, e.g., Caldart & Ashford, *supra* note 175, at 186; Richard J. Lazarus, *Environmental Law after Katrina: Reforming Environmental Law by Reforming Environmental Lawmaking*, 81 TUL. L. REV. 1019, 1034 (2007).

¹⁹⁵ See Barton & Morton, *supra* note 122.

¹⁹⁶ See *supra* notes 134-137 and accompanying text (describing research efforts by NCMLP); see also *supra* notes 141-143 (describing research efforts by LegalHealth).

V) Conclusion

Public health legal services are unique in bridging two already established, respected disciplines: legal aid and healthcare safety net providers. Given these two well-established agents of change, the opportunity to leverage already-existing networks and funding streams is unprecedented.

The rationale for public health legal services is simple: that health is substantially rooted in “upstream” social factors, such as housing, access to food and fuel, and availability of benefits. Public health has traditionally implemented prevention through tools that focus on long term benefit, such as fluoridating water to prevent cavities, or prioritize the collective over the individual, such as quarantining an individual. But in light of those very examples of prevention, public health legal services can often begin to address factors that could lead to disease if not addressed, such as the family getting food stamps that can prevent failure to thrive in children, or change the course of disease, such as removing mold from the home of an asthmatic.

Historically, providing legal services to the poor has been severely underfunded. In a world of limited resources, rationing of legal services remains essential. However, in allocating legal aid for the emergency situation only, such as the looming eviction, and not addressing the antecedents of the emergency, such as utility shut off or substandard conditions, the legal services community replicates the same inefficiencies as a medical system that only provides care in emergency rooms and hospitals. Medical history has shown that most health gains in the past fifty years have occurred when linkages were made between prevention and acute care. Similarly, the newer vision of public health legal services, with strongly preventive element linked to such vital acute legal services such as litigation might more effectively advance a liberal vision of justice.

Medical-legal partnership, in particular, recognizes how legal intervention can be the most effective treatment for many living and working conditions that influence health. Front-line healthcare providers are uniquely situated to triage and screen for social determinants of health that are particularly responsive to preventive legal interventions. In doing so, providers and lawyers not only stave off circumstances that contribute to more serious health issues or exacerbate existing disease, but can even move yet farther “upstream” to address care and benefits systems that improve health even more effectively.

Examples of public health legal services demonstrate this impact can be far reaching. MLP | Boston helps families address early signs of legal problems, such as food insecurity, utility shut off notices, and special education needs. While serving individual clients, MLP | Boston also provokes systemic change, such as when legal interventions result in food stamp workers appearing on site at the hospital to provide their public health service, eliminating the need for further legal interventions. In New York City, LegalHealth innovates to bring legal services to new patient populations, such as those living with cancer, to remove many of the social barriers that prevent compliance with complicated medical regimens essential to a cure. And programs

developed by the City of Los Angeles and its partners suggest that “legal checkups” can not only improve outcomes in diseases like HIV/AIDS by preventing the complex social determinant of health, discrimination, from arising, and thus affecting access to important services and opportunities, but can also even slow the spread of further disease by reducing the fear of those reluctant to be tested.

Public health legal services bring “steel” to laws that begin as mere paper.¹⁹⁷ They are the means by which basic human rights guaranteed by law, become guaranteed in fact. By effectuating health and human rights, they change the well-being of both people and populations. In so doing, public health legal services advance the public health mission envisioned by the Institute of Medicine of fulfilling “society's interest in assuring conditions in which people can be healthy.”¹⁹⁸

¹⁹⁷ See FARMER, *supra* note 28.

¹⁹⁸ See INSTITUTE OF MEDICINE, *supra* note 2.