DEVELOPMENTS IN THE LAW
INTERSECTIONS IN HEALTHCARE AND LEGAL RIGHTS

INTRODUCTION

Americans have no universal, legal right to healthcare.[1] The federal Constitution guarantees a right to speak without government intrusion, but no platform from which to be heard,[2] the right to privacy in one's home, but no home to begin with,[3] and the right to life absent due process, but no affirmative right to life-saving care.[4] Put reductively, at the federal level, Americans have no positive right to anything.[5] Or, at least, so prevailing interpretations go.[6] So, Americans have no positive, universal, constitutional right to healthcare. Of course, the law does not deal only in individual, constitutional rights. The fact that the law does not straightforwardly ensure healthcare access does not mean it is not intimately entangled with such access. The Chapters that follow demonstrate as much. But, at the same time, one cannot fully understand the relationship between law and health in America, and the intersections between healthcare and legal rights, without keeping in mind this foundational truth: Americans have no legal right to healthcare. The Chapters to come discuss developments in the law that exist because of, and are shaped by, this underlying fact.

Keeping in mind what the law doesn't do, this Developments Issue will look to what it does. The law, where healthcare and public health are concerned, does a lot. First, the law recognizes rights that closely implicate one's health. On the federal level, many of these spring from substantive due process protections. For example, the Supreme Court has been willing to recognize rights to privacy,[7] a limited right to bodily autonomy,[8] and some right to freedom in child-rearing,[9] all of which intersect with health and healthcare in one way or another. Even though these rights usually cannot ensure meaningful, affirmative access,[10] they can provide legal footholds for talking about healthcare and

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[1] *See* Amanda Mull, *What It Means for Health Care to Be a Human Right*, THE ATLANTIC (June 26, 2019, 12:11 PM), https://www.theatlantic.com/health/archive/2019/06/health-care-human-right/592357 [https://perma.cc/774L-FL9Y].

[2] *See* U.S. CONST. amend. I.

[3] *See* U.S. CONST. amend. IV.

[4] *See* U.S. CONST. amend. V; U.S. CONST. amend. XIV, § 1.

[5] *See* Jackson v. City of Joliet, 715 F.2d 1200, 1203 (7th Cir. 1983) ("[T]he Constitution is a charter of negative rather than positive liberties.").

[6] *See* EMILY ZACKIN, LOOKING FOR RIGHTS IN ALL THE WRONG PLACES: WHY STATE CONSTITUTIONS CONTAIN AMERICA'S POSITIVE RIGHTS 2 (2013).

[7] *See* Griswold v. Connecticut, 381 U.S. 479, 482–86 (1965).

[8] *See* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 857 (1992).

[9] *See, e.g.*, Troxel v. Granville, 530 U.S. 57, 66 (2000).

[10] *See* Katherine L. Record, *Litigating the ACA: Securing the Right to Health Within a Framework of Negative Rights*, 38 AM. J.L. & MED. 537, 540–42 (2012).

the law. Privacy may entitle a patient to the sole counsel of their doctor.[11] Autonomy may similarly guard against government intrusion into key healthcare decisions that go to the way we order our lives, or arrange our affairs.[12] Some of the Court's decisions, strung together, suggest some right for individuals to decide when and how to have a family,[13] and some right of parents to make decisions for and about their children, including their children's health.[14]

Then, there are well-established constitutional rights with less substantive health-based overlap. For example, the Equal Protection Clause provides for equal protection under the law,[15] so the law gives it content. When the law touches health, public health, and healthcare, and classifies people as it does, the Equal Protection Clause enters the stage. This is especially likely to happen as several suspect classes — race and sex, at least — loop in layered biological, social, and cultural considerations.[16] These classes, race especially, also tend to correlate with health outcomes.[17] Structural racism (in partnership with the law) brings about differences in quality of care, access to care, and exposures and stresses that undermine baseline health status.[18] Other broad restrictions on government power factor in as well, including the Eighth Amendment prohibition on cruel and unusual punishment.[19] It is not that all punishments need necessarily concern the body, but that many ultimately do. Through incarceration, the state puts itself in total control of the bodies in its custody, but, theoretically, standards of decency dictate how that control can be exercised.[20] In these ways, we parse some of our society's most abstract values and commitments on intensely physical planes.

This last point can easily be obscured. Healthcare, public health, and medicine all involve complex science. Determinations in this field

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[11] *See Casey*, 505 U.S. at 883–84 (plurality opinion).

[12] *See* Caitlin E. Borgmann, *The Constitutionality of Government-Imposed Bodily Intrusions*, 2014 U. ILL. L. REV. 1059, 1066–68.

[13] *See* Moore v. City of East Cleveland, 431 U.S. 494, 503–06 (1977).

[14] *See* Pierce v. Soc'y of Sisters, 268 U.S. 510, 534–35 (1925); Meyer v. Nebraska, 262 U.S. 390, 399 (1923); Parham v. J.R., 442 U.S. 584, 603–05 (1979) (recognizing "parents' authority to decide what is best for the[ir] child" in the medical context, *id.* at 604).

[15] U.S. CONST. amend. XIV, § 1.

[16] *See* Katherine M. Franke, *The Central Mistake of Sex Discrimination Law: The Disaggregation of Sex from Gender*, 144 U. PA. L. REV. 1, 2–6 (1995); Audrey Smedley & Brian D. Smedley, *Race as Biology Is Fiction, Racism as a Social Problem Is Real: Anthropological and Historical Perspectives on the Social Construction of Race*, 60 AM. PSYCH. 16, 16 (2005).

[17] *See* Vickie M. Mays, Susan D. Cochran & Namdi W. Barnes, *Race, Race-Based Discrimination, and Health Outcomes Among African Americans*, 58 ANN. REV. PSYCH. 201, 202–03 (2007).

[18] *See* Gilbert C. Gee & Chandra L. Ford, *Structural Racism and Health Inequities: Old Issues, New Directions*, 8 DU BOIS REV. 115, 117–18 (2011).

[19] *See* U.S. CONST. amend. VIII.

[20] *See* Rhodes v. Chapman, 452 U.S. 337, 346–48 (1981).

are the stuff of experts. Yet science only gets us so far. Scientific conclusions do not convert themselves into policies, regulations, or legal standards. For one, science is rarely certain or completely determinate. Even if it were, there is an intermediate step where somebody needs to take that science, mix it with other values, and produce an end result.[21] Healthcare and the law surrounding it, then, are unavoidably value-laden. The question is, who gets to have what say in discerning these values: Doctors? Scientists? Bureaucrats? Families? Politicians? The courts? And what of the individuals and communities whose bodies are on the line? Those are the people who are harmed when law ignores science, or distorts it, weaponizes it, or perhaps pursues one vision of it to the exclusion of all others. As you read each Chapter of this Developments Issue, notice specifically *whose* bodies are on the line. Whose bodies are inviolable, whose are not. Whose are temples and whose are battlefields.

Because the intersection of healthcare and legal rights is bound up not just in science and law, but in values, the Chapters in this issue track developments in all three. To that end, this Introduction would be remiss to ignore the pandemic that is still raging at the time of drafting and will almost certainly continue beyond the time of publication.[22] But COVID-19 has not necessarily changed the way laws work in this area so much as it has laid these workings bare. Americans have spent the pandemic collectively wrestling with what to do about developing scientific realities, competing interests, conflicting freedoms, and inequitable outcomes.[23] Each of the Chapters that follow does the same thing.

Chapter I starts by looking at developments in state legislatures across the country as bills banning gender-affirming care for transgender youth, and criminalizing the provision of such care, proliferate. In doing so, the Chapter reviews a clear scientific consensus that says access to some form of gender-affirming care for transgender youth is not only desirable, but medically necessary. A conservative backlash to increased transgender visibility, these bills advance a protectionist narrative that flies in the face of scientific evidence. As the Chapter argues, the use of protectionist rhetoric to justify anti-trans policies itself represents a development, as conservative groups move away from villainizing trans youth as dangerous predators — a strategy that has largely failed — to instead advancing policies of erasure in the name of feigned compassion. In part because this new crop of bills is so divorced

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[21] *See, e.g.*, Cary Coglianese & Gary E. Marchant, *Shifting Sands: The Limits of Science in Setting Risk Standards*, 152 U. PA. L. REV. 1255, 1262–83 (2004).

[22] *See* Hilary Brueck, Aria Bendix, Andrew Dunn & Skye Gould, *What Life in 2021 Will Look Like*, BUS. INSIDER (Dec. 23, 2020, 5:42 PM), https://www.businessinsider.com/2021-coronavirus-vaccine-timeline-return-to-normal-experts-weigh-in-2020-12 [https://perma.cc/WVS2-Z8NJ].

[23] *See* Ed Yong, *How the Pandemic Defeated America*, THE ATLANTIC (Aug. 4, 2020, 1:12 PM), https://www.theatlantic.com/magazine/archive/2020/09/coronavirus-american-failure/614191 [https://perma.cc/DL57-6T4R].

from medical realities, the bills prove to be arbitrary, and drip with animus. Under the Equal Protection Clause, this makes them constitutionally infirm. Further, this Chapter argues that by boxing out both parents and doctors from the decisionmaking process, these bans may violate recognized substantive due process rights as well.

Chapter II then charts developments in the law of religious exemptions, tracking the Supreme Court's increasingly narrow approach to a third-party harm principle. This Chapter argues that, normally, the Supreme Court has been willing to endorse religious exemptions to neutral laws of general applicability only when such exemptions did not impose burdens on third parties. In the past, nearly all kinds of third-party harms could militate against granting a religious exemption. This broader harm principle survived to some extent even in a post-RFRA world. However, as the makeup of the Court has evolved and its zeal for religious liberty as a particularly favored right has grown, the Court has simultaneously moved to shift the balance between religious liberty and third-party harm. At its most ambitious, the Court has suggested that only those singularly esteemed, constitutionally recognized interests can cut against religious exemptions. Having laid out this development in the case law, this Chapter uses the case study of religious exemptions to contraceptive mandates to outline how advocates might go about reframing harms in the language of the Supreme Court's preferred hierarchy. In the case of contraceptives and other healthcare-related harms, this means talking less about access to care, and more about the suspect classifications that mediate access.

Chapter III analyzes a different aspect of legal entanglement with reproductive choice — the regulation of pregnancy and pregnant people. Specifically, this Chapter describes the legal landscape that governs childbirth, focusing on tort law standards of care as well as the regulation of midwives as twin phenomena that work together to limit access to care options that fall outside of prevailing orthodoxy. Tort law liability standards incentivize doctors to insist on certain birthing procedures that take one approach to risk management between the fetus and pregnant person, crowding out legitimate alternatives a patient may prefer for medical, moral, or spiritual reasons. As healthcare providers bend to these incentives, a standard of care crystallizes that only reinforces certain practices and procedures as the norm. Where tort law limits the choices available to pregnant people in traditional medical settings, targeted legal regulation of midwives, often the only practitioners willing to pursue alternative visions of childbirth, prevent pregnant people from turning elsewhere for their preferred mode of care. Put together, Chapter III argues, these phenomena erect a legal infrastructure that regulates pregnancy especially harshly, and in doing so advances a fundamentally moral idea of fetal primacy under the guise of law and medicine.

Finally, Chapter IV looks at the extent to which CDC guidance on handling the COVID-19 pandemic in prisons and jails has influenced constitutional litigation challenging conditions of confinement. This Chapter first describes a pattern in cases challenging institutional responses to the pandemic under the Eighth and Fourteenth Amendments. In considering these claims, the Chapter argues, courts are affording undue deference to informal guidance published by the CDC, rather than taking ownership themselves over pressing constitutional questions with, quite literally, life-and-death stakes. After detailing this trend, the Chapter describes how this level of deference contravenes foundational principles in both administrative and constitutional law. Courts are supposed to defer to agency actions when they undergo considerable process and represent technical expertise. Neither is true of the CDC guidelines at issue. Rather, the CDC guidelines, instead of centering public health, seem to focus on traditional priorities of prison administration above anything else. Given this, Chapter IV argues that judicial deference to this agency action in particular both sacrifices a judicial backstop for enforcing constitutional rights, and hands this responsibility not to public health experts but to prison administrators themselves.