



Seton Hall University School of Law
Health Law Forum

Health Law Outlook



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Health Care Reform's Forgotten Youth

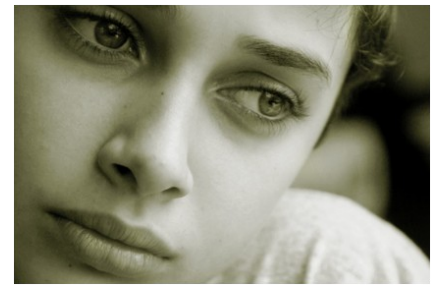
The Need to Expand Health Coverage for Youth Aging Out of Foster Care

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Following much political debate and discussion, the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act were signed into law in March of this year.¹ One of the chief aims of the health care reform was to increase insurance coverage across the country. Young

people have been a group of particular concern, with one in three 19 to 34-year-olds currently uninsured, and forty-seven percent of this population having gone without insurance in the past.² One way PPACA addresses this disparity is through a provision that allows dependents under the age of twenty-six to remain on their parents' insurance plan. Moreover, PPACA's coverage extension includes subgroups within this age range that traditionally are not eligible for coverage under their parents' health care insurance. For example, the coverage mandate includes dependents who no longer live with their parents, who are not listed as dependents



on a parent's tax return, who are not students, and who are married.³ The breadth of this reform mandate highlights the policy concern behind extending coverage to this age group.

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The Genetic Information Nondiscrimination Act

Examining Its Impact on Unintended Consequences Minority Communities and Criminal Justice

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In May of 2008, Congress passed The Genetic Information Nondiscrimination Act of 2008 (GINA). Heralded by its supporters as the first civil rights act of the 21st century, GINA, P.L. 110-233, prohibits United States insurance companies and employers from discriminating on the basis of genetic information. GINA took effect on November 21, 2009, and is meant to advance the field of genetic research by alleviating public fear that health insurers or employers might use DNA information to discriminate.¹ The implementation of GINA may face many legal, social, and ethical challenges. This article will focus on GINA's potential impact on minority communities in the U.S. and, specifically, how it might affect minorities in the criminal justice system.

GINA states that “many genetic conditions and disorders are associated with particular racial and ethnic groups and gender” and that “Congress clearly has a compelling public interest in relieving

the fear of discrimination and in prohibiting its actual practice in employment and health insurance.”² The employment provision of GINA amends Title VII of the Civil Rights Act of 1964 (Title VII) which originally prohibited employment discrimination based on race, color, religion, sex, or national origin.³ GINA strengthens Title VII by prohibiting genetic discrimination in employment decisions including hiring, firing, job placement, and promotions.⁴ GINA's impact, on minority communities, however, will be hard to predict, and its power to protect genetic information must be challenged before it can be evaluated.⁵

The field of genetics research is regarded with wariness and mistrust among many racial and ethnic minority groups.⁶ Vulnerable groups have historically been subjected to human rights offenses in the name of scientific research. In the Tuskegee syphilis study, which took place between 1932 and 1972, the U.S. Public Health Service conducted an experiment on 339 African American men who were infected with syphilis.⁷ Even at the time of the Tuskegee study -- eighty years before the enactment of GINA -- the notion of *genetic determinism*, or the idea that genes are solely responsible for behavioral and physical characteristics, was a topic of debate. The study was conducted in order to

support the hypothesis that Caucasians experienced more neurological complications from syphilis, whereas African Americans were more prone to cardiovascular damage.⁸ The subjects of the study, who were mostly illiterate sharecroppers, were not informed about the disease they were suffering from and were denied available treatment.⁹ By the end of the experiment, numerous men and their families died from syphilis and its related complications. Since then, perceived genetic differences among races have been proven scientifically unfounded. Much of society, however, still treats race as a genetically unique health indicator.¹⁰

Genetic information challenges traditional conceptions of health, disease, and medical abnormalities. For a long time, lactose intolerance was thought to be a genetically abnormal state.¹¹ Research in different populations, however, revealed that the ability to metabolize lactose was the result of mutations that were under strong selective pressure in countries where domestication of animals led to increased dairy consumption.¹² Thus, disease susceptibility is not always dictated by genetic traits, but rather by an interaction between genes and environment.

Although environment clearly plays a significant role in health status, the view

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Are Children Safe at School?

An Evaluation of H.R. 4247

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*"The grainy video shows a fourteen-year-old boy being dragged on his hands and knees down a hall and then pushed into a dark room. In the process, his father says, his finger was slammed in the door and broken. Surveillance video reveals dark spots on the wall of the seclusion room that the family's attorney says are blood. [The boy's father] says his son has autism and is nonverbal. The teenager couldn't complain about the treatment...."*¹

Cedric, age twelve, was in foster care because his parents had neglected him, and physically and emotionally abused him and his siblings. Their parents had underfed and withheld food from them. When the foster parent enrolled Cedric at the school, she informed the administration that withholding food was traumatic for him. Because he had "stopped working" at 11:00 one morning, Cedric was placed on delayed lunch. By 2:30 p.m., he still had not been allowed to eat and got up to leave the classroom. Cedric refused to sit in his chair. The teacher then forced Cedric into his chair but was unable

to restrain him, so the teacher "put him face down [on the floor] and sat on him." He struggled and repeatedly told the teacher he couldn't breathe. A short time later he stopped speaking and moving. When Cedric was placed back into his chair, he "slumped over and slipped onto the floor." Paramedics were called, but were unable to revive Cedric. This scene was witnessed by Cedric's classmates.²

On March 3, 2010, the U.S. House of Representatives approved H.R. 4247, The Keeping All Students Safe Act ("the Act"), to protect children from "inappropriate" uses of restraint and seclusion in school.³ The legislation was developed in part as a result of a report issued in 2009 by the Government Accounting Office (GAO) that uncovered evidence that hundreds of children had been "traumatized or physically harmed" as the result of being restrained or secluded.⁴ The bill passed by a vote of 262 to 153,⁵ with the opposition primarily arguing that the legislation was a "federal intrusion into school affairs traditionally overseen by state and local authorities."⁶

Currently, there are no federal regulations that relate to restraints and seclusions in public and private schools,⁷ and state laws and regulations on this topic "vary widely."⁸ Despite the concern of the bill's opposition, nineteen states have no laws or regulations related to restraints and seclusions in schools, seven states address only restraints (not seclusions), and only eight states "specifically prohibit the use of ... restraints that impede a child's abil-



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Zoning Laws

A Potential Local Government Tool for Decreasing Childhood Obesity in Low-Income Areas

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Childhood Obesity as a Significant Problem and Fast Food as a Major Contributor

Childhood obesity is a serious problem that requires immediate attention. Some researchers estimate the prevalence of overweight and obesity among six-to-eleven-year-olds to be approximately twenty percent.¹ Obese and overweight children are more likely to become obese as adults; approximately eighty percent of children who were overweight at age ten to fifteen were obese at age twenty-five.² An estimated 400,000 people die per year due to complications of physical inactivity and

poor diet such as diabetes, stroke, heart disease, high blood pressure, and certain cancers.³ Further, overweight and obesity in adults costs America \$98-129 billion each year in national health care expenditures.⁴ With more children becoming obese as adults, these numbers will only rise. The epidemic has perplexed health care professionals who have been unable to successfully help a majority of families change their unhealthy behaviors, suggesting that the problem lies not with the individuals, but in the obesogenic environment created by society. As a result, many children today are not expected to outlive their parents.⁵

While physical activity plays a major role in childhood obesity, another major part of this problem is the increased caloric intake in children's diets.⁶ Fast food in particular has been implicated

as a major threat to the children's health.⁷ Research highlights three main reasons why this is so: larger portion sizes, high density of calories, and the frequency with which American children patronize fast food restaurants.⁸ This frequency is largely affected by the fact that the number of fast food restaurants in the nation has dramatically increased, from 72,850 restaurants in the 1970s to over 280,000 in recent years.⁹

However, the prevalence of fast food restaurants near schools is particularly problematic since children have access to them before and after school. A 2005 study found that fast food restaurants were clustering near schools in Chicago; fast food restaurants were three to four times more prevalent around schools than other parts of Chicago.¹⁰

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Violence from a Legal Perspective

Child Abuse & Mandatory Reporting Laws

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Mandatory reporting laws exist for many issues, including elder abuse, injuries from weapons and crimes, domestic violence, driving impairment, drunk driving, child abuse, and gunshot wounds.¹ While all states have mandatory reporting laws for child abuse, not all states have mandatory reporting laws for other issues like gunshot wound victims.² The laws for child abuse reporting, which have been argued to be ineffective in promoting safety, “pit concerns of patient and community safety against desires to maintain patient-physician confidentiality.”³ Therefore, some mandatory reporting laws are controversial because of their efficacy as well as their effect on the doctor-patient relationship.

“SOME MANDATORY REPORTING LAWS ARE CONTROVERSIAL BECAUSE OF THEIR EFFICACY AS WELL AS THEIR EFFECT ON THE DOCTOR-PATIENT RELATIONSHIP.”

The process of reporting child abuse has certainly changed over the years. Mandatory reporting of suspected child abuse began after medical professionals recognized a condition called battered child syndrome.⁴ As early as the 1940s, but primarily during the 1950s, physicians noticed that childhood traumas could have been intentionally inflicted.⁵ An article in the *Journal of the American Medical Association*, which analyzed 302 abused children from seventy-one hospitals, coined the term “battered child syndrome” and was “influential in stimulating federal policy regarding the reporting of child abuse.”⁶

This landmark study and the escalating concern about child abuse in the early 1960s led to a 1962 conference sponsored by the United States Chil-

dren’s Bureau. The conference resulted in a proposal to institute mandatory reporting laws and introduce battered child syndrome as a medical condition that would require the same level of reporting as communicable diseases.⁷ Since children are a vulnerable population who are not able to advocate or report for themselves, mandatory reporting laws were established to provide a safeguard from the subjective judgment of medical professionals.⁸ As a result, states began establishing mandatory child abuse reporting laws and by 1967, every state had separately passed one.⁹ Still, most physicians and other professionals who are “mandated to report” suspected child abuse “have not received training in identifying and reporting child maltreatment during their formal education.”¹⁰ Thus, although the reporting laws exist, more needs to be done to train medical professionals to ensure that the laws are implemented effectively.

Physicians face two difficulties when identifying child abuse. First, it is usually difficult to determine abuse because the physical and behavioral history with regards to suspected abuse can be vague, inaccurate or unavailable to the physician.¹¹ In addition, the physicians’ account of the history can lack important details. Second, although it is important to recognize abuse to prevent further risk to the child, physicians must be cautious when reporting suspected abuse. A physician could cause a family substantial stress if he or she misdiagnoses an unintentional injury as abuse.¹² Therefore, when determining whether a case should be reported, physicians are presented with the problem of identifying suspected abuse while also being careful not to misdiagnose an unintentional injury.

State Laws: Physicians as Mandated Reporters

Anytime a physician suspects that abuse or neglect was the cause of an injury, the physician is legally mandated to report to their state’s child protective services.¹³ The required language and details



of reports vary by state; however, most laws are quite vague in their mandates. Arguments have been made that the statutes should contain more specificity instead of vague phrases like “causes to believe,” “reasonable cause to believe,” “known or suspected abuse” and “reasonable suspicion” that a child may have been abused.¹⁴ In New Jersey, the law does not explicitly specify who is mandated to report, but does state that reporting is required when anyone “has reasonable cause to believe that a child has been subjected to abuse.”¹⁵ New Jersey’s law is similar to New York’s and other states’ laws, which “mandate that physicians report to child protective services if they have ‘reasonable cause to suspect,’” but like other states, “reasonable cause is not defined.”¹⁶ As a result, one study of over 1200 pediatricians in Pennsylvania found that there was “significant variability in how pediatricians interpret reasonable suspicion.”¹⁷ Since the laws are not explicit, doctors, who lack legal expertise, have difficulty interpreting and complying with the requirements of the law.

Others, however, argue that the laws are intentionally vague to promote and facilitate reporting.¹⁸ Unfortunately, this is not the case. “The lack of a definition of ‘reasonable suspicion’ is one reason that child abuse is underreported... giving clearer definition to the term would help to ground mandated reporters, provide for more equitable treatment and set standards for accountability.”¹⁹ The vague language of the law therefore seems to be discouraging, rather than encouraging, the reporting of suspected abuse.

(“Child Abuse Reporting Laws,” Continued on page 6)

‘Forgotten Youth,’ Continued

Unfortunately, there is a subgroup of this population that has even lower coverage statistics, and will see no benefit from the reforms: youth aging out of foster care.* Only thirty-three percent of children who age out of foster care have health insurance.⁴ The number of youth encompassed by this statistic is not as small as one might imagine – as of 2009, there were 89,401 children in foster care aged sixteen and above.⁵ To compound this, youth in foster care at this advanced age are more likely to be placed in group home settings and to have a less of a chance of being reunified with their biological families, and thereby less of an opportunity to take advantage of the new PPACA provisions.⁶ Although progress has been made in the past ten years to improve the transition out of foster care for this group, health care coverage lags far behind

the level afforded to young adults in the health care reform law. Given the intent behind – and priority placed upon – the extension of parental insurance coverage to children up to age twenty-six, a renewed effort is needed to ensure that the reform’s policy objectives are also applied to the vulnerable population of youth aging out of foster care. Progress can be made by extending Medicaid coverage age limits in existing state programs and improving independent living skills programs.

When children are taken into foster care, their medical needs are covered under the Medicaid program.⁷ Both states and the federal government have enacted programs aimed at creating a smooth transition between Medicaid coverage as a youth in foster care and health care coverage as a young adult, sometimes using multiple tools to reach this goal. One of the most widely recognized examples is the Chafee option, which is contained in

the 1999 Foster Care Independence Act (FICA) and allows states to extend Medicaid coverage for youth who are still in foster care on their eighteenth birthday.⁸

“ALTHOUGH PROGRESS HAS BEEN MADE IN THE PAST TEN YEARS TO IMPROVE THE TRANSITION OUT OF FOSTER CARE FOR THIS GROUP, HEALTH CARE COVERAGE LAGS FAR BEHIND THE LEVEL AFFORDED TO YOUNG ADULTS IN THE HEALTH CARE REFORM LAW”

However, decisions about how to extend coverage to children aging out are made on a state-by-state basis, and the Chafee option has not been implemented in all fifty states.⁹

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* As used here, “aging out” refers to the process of leaving foster care and transitioning to independent adulthood. The age requirements and programs to facilitate this process vary by state.

‘Child Abuse Reporting Laws,’ Continued

While one part of the New York law is similar to New Jersey (that professionals are required to report “when they have *reasonable cause* to suspect that a child coming before them in their professional or official capacity is an abused or maltreated child”), there is an additional component to the New York law that requires reporting even if the reporter does not actually see the child.²⁰ The law states that reporting is required when “the parent, guardian, custodian, or other person legally responsible for the child comes before the reporter and states from personal knowledge facts, conditions, or circumstances that, if correct, would render the child an abused or maltreated child.”²¹ In addition, the New York law contains a long list of mandated reporters. The list includes virtually all medical professionals, including physicians, nurses, residents, interns,

hospital personnel, and emergency medical technicians.²² The state laws are therefore generally similar in their language, although some differences do exist as to who is considered a mandated reporter in each state.

“THEORETICALLY, THE LAW IS SUPPOSED TO REMOVE CONFUSION FROM THE PHYSICIAN’S MIND REGARDING WHAT TO REPORT AND NOT TO REPORT, AND STUDIES SHOW THAT IT IS ACHIEVING THIS GOAL.”

The new state laws do not regard communications between patients and physicians regarding child abuse to be privileged. According to Dr. Malkeet Gupta, “notions of confidentiality and

informed consent are not an issue.”²³ The physician’s legal duty to report any information indicating suspected abuse supersedes doctor-patient confidentiality. Some doctors find this law helpful as it allows them to “facilitate discussion of the possibility of abuse with the patient’s family.”²⁴ Theoretically, the law is supposed to remove confusion from the physician’s mind regarding what to report and not to report, and studies show that it is achieving this goal. In fact, “the legal mandate to report most strongly correlated with the physician’s decision to report suspected maltreatment.”²⁵

Forty-six states have criminal penalties for physicians who fail to report cases of child abuse if the physician had “known” or “should have known” about the abuse.²⁶ According to the Children’s Bureau of the United States Department

(‘Child Abuse Reporting Laws,’ Continued on page 7)

‘GINA’s Impact,’ Continued

of *genetic exceptionalism* employed by GINA emphasizes the singularity of genetic information. Since genetic information may be used to link a person to a certain group or heritage, it has the potential to change society’s conception of culture and history.¹³ In particular, genetic information may pose consequences for groups, such as Native Americans, who have certain rights based upon their heritage. Advocates for these groups are apprehensive about the consequences that revealing their genetic information may have on their ancestral protections and rights.¹⁴

On the other hand, the prohibition against genetic testing of employees may have unintended negative consequences for minorities in a wide setting of employment and insurance situations. Minority communities in the United States suffer disproportionately from illnesses such as cancer, cardiovascular disease, HIV infection, diabetes, and obesity.¹⁵ While these trends are greatly determined by environmental and structural factors, the notion of genetic exceptionalism supports the misconception that genes are largely indicative of traits such as race and health status.¹⁶ Since prevalence of disease-related genes often varies by ethnicity, it is possible that groups that are merely *perceived* to share similar undesirable genetic information will suffer from discrimination.¹⁷ Employers may rely on stereotyping to associate minority individuals with poor health status. Since most employers do not want to hire unhealthy workers, they may simply assume

the worst and not risk hiring employees who they perceive as being genetically different.

Further, some employees may take a “guilty until proven innocent” approach and feel obliged to provide their genetic information voluntarily in order to prove that they are healthy.¹⁸ In these situations, those who do not provide their genetic information may be discriminated against. Therefore, minorities who are reluctant to submit to genetic testing based on their prior experience with racial profiling may be inadvertently penalized for not being tested. Thus, GINA’s provisions may unintentionally facilitate discrimination by employers and health insurance providers, or create *disparate impact* discrimination. Disparate impact discrimination takes place where an employer does not act in an overtly discriminatory manner but may be engaging in hiring or employment practices that, while facially neutral, are actually discriminatory in operation.¹⁹

In order for minority communities to participate in genetic testing, it is crucial that they are educated about the potential risks and benefits of genetic testing and the limitations of GINA’s protections. Specifically, while GINA protects decisions based on genetic information in health insurance and employment settings, it does not cover long-term care insurance, life insurance, or disability insurance settings.²⁰ These insurance settings, along with others, may require individuals to



provide their DNA for genetic testing. Under current U.S. protocols for law enforcement and DNA banking, the availability of genetic information obtained through avenues other than health insurance and employment markets may put minority communities in danger of being disproportionately wrongfully convicted.²¹ Thus, members of minority communities must be fully informed and cautious before submitting their genetic information in any context.

Genetic testing has transformed the way the U.S. justice system balances a reasonable expectation of privacy with the interest of protecting society. In the current criminal justice system, citizens are protected from random searches and seizures under the Fourth Amendment.²² Still, searches and seizures are justified if there is probable cause to believe that a person has committed a crime. In some states, this justification is applied to the collection and genotyping of DNA samples from all suspects who are arrested, or “booked.”²³ Numerous advocates, how-

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‘Child Abuse Reporting Laws,’ Continued

of Health and Human Services, the penalties for failing to report can include fines from

\$100 to \$5000 and jail time ranging from ten days to five years. Many advocates of



the law state that it has been a great incentive, encouraging physicians and other medical professionals to report; one could argue that without such a law, reporting may be forgotten in the midst of all the extra demands placed on physicians. Hence, the legal consequences resulting from a failure to report have certainly encouraged medical profes-

sionals to report.

National Efforts

In addition to state laws, Congress passed the Child Abuse Prevention and Treatment Act in 1974, which created

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'GINA's Impact,' Continued

ever, argue that collecting DNA from people who are merely suspects constitutes an unlawful search and seizure under the Fourth Amendment.²⁴ Further, under the guise of protecting society, DNA collection could progress from being mandatory only for convicted criminals, to being required of all arrested suspects and job applicants.²⁵

Under Title II of GINA, an employer is prohibited from requesting genetic information, even absent the intent to discriminate.²⁶ Therefore, if there is no clear statutory exception, employers are prohibited from requesting DNA samples even for criminal background checks. However, if GINA is not properly enforced, the collection and banking of genetic information could result in serious civil rights violations. For example, if employees were required to submit their DNA profiles for pre-employment screening against criminal databases, it would be possible for people to become criminal suspects absent just cause. Further, if employers were allowed to request background checks at their discretion, employees who have DNA on file immediately may be linked to crimes even though there may be multiple unidentified DNA gathered at the crime scene.²⁷

On the other hand, if employers stored DNA samples and only genotyped them when needed for forensic purposes, they would face the daunting challenge of storing and maintaining confidentiality of sensitive personal information.²⁸ Since it is logistically difficult to run a DNA identification program, employers might turn to law enforcement agencies to perform criminal background screening for potential employees. This has severe implications for those who have their genetic information revealed. People who have DNA on file with government agencies are immediately linked to a DNA database of criminal offenders, and become a part of the state DNA search dragnet.²⁹ Even after acquittal or clearance, these individuals' profiles are subject to regular database searches that look for genetic matches associated with DNA collected from crime scenes.³⁰ If

GINA is not properly implemented, job applicants who would be required to submit their DNA are perpetually at risk for being linked to and stigmatized for crimes simply because their DNA is on file.

Consequently, for people with higher arrest rates by law enforcement personnel, increased DNA collection has the potential to create serious civil rights infringements.³¹ This poses a serious potential problem for Hispanic and African American minority communities, who are arrested more often than other groups in the U.S.³²

In August 2009, the University of Akron (UA) in Ohio provoked strong criticism when it started requesting fingerprints and DNA samples from all potential employees for the purpose of performing federal criminal background checks.³³ Traditionally, standard criminal record policies for civilian employees do not require the collection of genetic information.³⁴ The U.S. military collects DNA samples from all personnel, but only genotypes them to identify individuals missing in action or to identify remains.³⁵ Under GINA, forensic laboratory personnel are required to voluntarily submit their DNA, but the data is held in a separate database and only matched against crime scene profiles in cases of possible contamination.³⁶ None of these agencies, however, screen DNA profiles against criminal databases as part of security background check protocol.³⁷ Upon learning of the UA policy, the American Civil Liberties Union expressed anger over the idea that employers might consider themselves "entitled to [prospective employees] most private, personal genetic information."³⁸

After gaining much negative press, the faculty senate of UA revised its rule to require only certain job applicants at the university to submit DNA for criminal background checks. These applicants included those applying for jobs as university employees with access to valuable equipment, student living quarters, and faculty offices.³⁹ While the criminal background check process was designed to increase overall institutional security, it focused heavily on security and house-keeping personnel. Since these employees

"GENETIC TESTING HAS TRANSFORMED THE WAY THE U.S. JUSTICE SYSTEM BALANCES A REASONABLE EXPECTATION OF PRIVACY WITH THE INTEREST OF PROTECTING SOCIETY. "

were more likely to come from minority groups or groups with low socioeconomic status, this requirement could be *de facto* discriminatory against groups that have traditionally been targeted by the criminal justice system.⁴⁰ Although some law enforcement officials believe that "DNA is blind to race," the system itself has shown that justice is not blind; class discrimination, stereotyping, and racial profiling have influenced the conviction and arrest process of minority individuals.⁴¹ Thus, the current policy of DNA storage and dragnet searching disproportionately affects vulnerable groups that are already subject to discrimination.⁴² If GINA accomplishes its objective of increasing the prevalence of genetic testing, it will be critical to protect minority communities by closely regulating testing and ensuring the confidentiality of genetic information.

The implications of GINA on minority communities will only be seen as it is implemented and court decisions are made. Therefore, it will be important for employees, consumers, and advocates to document cases of discrimination for policymakers to review, analyze and remedy. If these precautions are taken, GINA has the potential to improve personalized genetic medicine, and speed progress towards a system of health care that is safe, effective, affordable, and equitable for all Americans. ✧

'H.R. 4247,' Continued

ity to breathe.”⁹

The Act has the potential to reduce the possibility of trauma and physical harm to children while under the care of their school. The purpose of the Act is articulated as follows:

to prevent and reduce the use of physical restraint and seclusion in schools, ensure the safety of... students and school personnel... ensure that physical restraint and seclusion are imposed... only when a student's behavior poses an imminent danger of physical injury to the student, school personnel, or others, and assist [s]tates... in establishing policies and procedures... and collecting and analyzing data.¹⁰

“School personnel [would] be prohibited from imposing... mechanical restraints[,], chemical restraints[,], physical restraints[,], or any] aversive behavioral interventions that compromise health and safety.”¹¹ In addition, “less restrictive techniques” need to be considered, the student being restrained or secluded must be continually monitored, and the school personnel imposing these techniques must be trained and certified by a state approved program.¹²

According to congressional testimony provided by Greg Kutz, the Managing Director of Forensic Audits and Special Investigations at GAO, children were subjected to restraint or seclusion at a higher rate than adults, despite the greater risk of injury.¹³ Some have suggested that these techniques can be used to effectuate improved student behavior, but there is no evidence to support this theory.¹⁴ In contrast, the mental health community has raised concerns that the use of physical restraints may cause psychological harm by “triggering reactions related to prior trauma.”¹⁵

The term “restraint” can be used to describe three different forms of re-

straining techniques: ambulatory, mechanical, and chemical.¹⁶ “Ambulatory,” restraints, also known as physical restraints, have been used to control children with “emotional disturbances” since the 1950s.¹⁷ Today, strict guidelines govern most medical, psychiatric and law enforcement applications of physical restraints.¹⁸ In public schools, physical restraints are used to allow a “child in crisis an opportunity to gain control.”¹⁹ The Public Health Service Act defines physical restraint as “a personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs or head freely.”²⁰ This is not a “benign form of behavior control” and some believe that “there is no such thing as a safe restraint.”²¹ Restraints can result in death by “positional asphyxia,” a “compromise of respiratory function.”²² This can occur when “a child is face down on the floor because the child must breathe against the weight of their body, or when seated, if the restraint is restricting chest or abdominal movement.”²³

A mechanical restraint is defined as the “use of devices as a means of restricting a [student’s] freedom of movement.”²⁴ The term describes a variety of devices or objects used to restrict the movement of

“ THE ACT HAS THE POTENTIAL TO REDUCE THE POSSIBILITY OF TRAUMA AND PHYSICAL HARM TO CHILDREN WHILE UNDER THE CARE OF THEIR SCHOOL. ”

children including tape, handcuffs, bungee cords and therapeutic chairs.²⁵

Chemical restraints use medication as a means to control a child’s behavior.²⁶ An argument can be made that this type of restraint is more widespread, given the increase in physicians outside of the school system prescribing medications to control behavioral symptoms in children that are viewed as disruptive.²⁷ Although prescribed with the best interests of the

patient in mind, some types of psychological medications have physiological risks.²⁸ Neuroleptic (antipsychotic) medications have been found to increase the risk of sudden death by 2.39 times and anti-depressants can “increase the heart’s QT interval* which is frequently associated with sudden death.”²⁹ The combination of chemical and physical or mechanical restraints can be dangerous as well.³⁰ A number of medications “inhibit the body’s cooling mechanisms which can lead to heat exhaustion or stroke during the prolonged exertion of a restraint.”³¹

Seclusion is defined in the Public Service Health Act as “a means of behavior control technique involving locked isolation,” not including “time-out.”³² A multitude of negative emotions have been found to result from confining and isolating children, including “feelings of



anger, anxiety... humiliation, abandonment... [and] despair.”³³ These reactions can be “escalated” in children who have been exposed to prior violence or abuse.³⁴ Some alleged incidents describe

(‘H.R.4247,’ Continued on page 13)

*The time between the beginning of the Q wave and the end of the T wave in the heart’s electrical cycle.

'Zoning Laws,' Continued

"SINCE LOW INCOME AREAS ARE ASSOCIATED WITH HIGHER OBESITY RATES, IT IS MORE IMPORTANT THAN EVER -- FOR THESE AREAS IN PARTICULAR -- TO INCREASE OPPORTUNITIES TO ACCESS HEALTHY FOODS."

Another contributing factor to the frequency of fast food consumption by American children is the decreased prevalence of alternatives, including supermarkets, which tend to offer healthier options.¹¹ This issue is further complicated by socioeconomic factors. One study found that wealthier neighborhoods had more than three times as many supermarkets as lower income areas.¹² Since low income areas are associated with higher obesity rates, it is more important than ever -- for these areas in particular -- to increase opportunities to access healthy foods.¹³

Zoning Laws and Their Potential Uses

One potential way to improve low-income children's diets is to facilitate behavior change by expanding opportunities for children to eat healthier foods and limiting their access to fast foods. Local governments have considered accomplishing this through zoning laws.¹⁴ Zoning laws allow local governments to implement regulations that control, among other things, the uses of buildings and lots. Three types of zoning have been considered to combat obesity: conditional, incentive, and performance zoning.¹⁵ Conditional zoning stipulates the rezoning of a piece of land for a different purpose upon a condition. For example, a municipality might rezone a residential lot for commercial development with the condition that supermarkets are given exclusivity to development.¹⁶ Incentive zoning, on the other hand, allows a developer who would otherwise have to comply with a certain condition to develop without that condition if certain

public benefits not required by the zoning ordinance are provided. Removing compliance obligations in exchange for a certain condition might provide incentives for developers to build stores, such as supermarkets, which offer healthier items for the public's benefit.¹⁷ Finally, performance zoning sets specific standards for anyone using the zoned land. In this type of zoning it is possible for a local government to allow fast food restaurants to build on a lot provided that the restaurants offer a certain number of healthy options.¹⁸



While initiatives involving all three types of zoning have been proposed, no local government has actually implemented any type of zoning restriction to limit unhealthy, fast food for the purpose of combating obesity. Certain towns, such as Concord, Massachusetts have used zoning restrictions to ban fast food restaurants, but only for aesthetic purposes.¹⁹

Concerns about Zoning for Obesity and Why Zoning Can Work

Zoning restrictions aimed at combating childhood obesity have been attacked for several reasons.²⁰ First, it has been postulated that lawmakers will run into administrative issues in defining fast food. Second, many citizens and lawmakers believe that it is improper to restrict the freedom to choose what type of food to eat, finding these laws paternalistic.²¹ Third, because of the unpopularity associ-

ated with limiting citizens' freedom, administrations are hesitant to take on a project which will potentially affect their popularity. Finally, some have suggested that there are constitutional challenges to this type of law.²²

The administrative problems associated with defining fast food have been successfully overcome in many towns throughout the country. For example, the town of Concord, Massachusetts defined fast food restaurants as restaurants

whose principal business is the sale of foods or beverages in a ready-to-consume state, for consumption within the building or off-premises, and whose principal method of operation includes: (1) sale of foods and beverages in paper, plastic or other disposable containers; or (2) service of food and beverages directly to consumer in a vehicle.²³

Carefully worded statutes like these have, so far, evaded administration problems.

Second, some have accused zoning restrictions of curtailing the freedom of individuals to choose what types of food to eat. While this accusation seems valid on its face, it ignores the full context of the situation. The reality for some lower socioeconomic areas is that the choices are already limited to, and saturated by, fast food restaurants and bodega stores.²⁴ By limiting the amount of fast food restaurants in an area or forcing a fast food restaurant to offer a certain number of healthy alternatives, a local government can expand children's access to healthier food. For these areas, zoning restrictions would not limit choices, but expand them, provided governments ensure that healthy alternatives take the place of fast food restaurants.

Third, administrations have been hesitant to adopt this type of policy because of potential effects on their approval ratings. Administrations will, however, likely face similar battles with alternative solutions to the obesity epidemic. Though it is possible that this type of law

('Zoning Laws,' Continued on page 11)

‘Zoning Laws,’ Continued

will be unpopular at the outset, doing nothing to increase low-income children’s opportunities to develop healthy behaviors and live a healthy life is irresponsible. Weighed against the alternatives, such as a tax on unhealthy foods, zoning restrictions are less controversial.²⁵

Finally, zoning for obesity has been met with resistance concerning constitutional challenges. While it is true that constitutional challenges may be raised, it is likely that with careful wording, these laws will pass constitutionality tests.²⁶ States have the authority to regulate their citizens in the interest of the public’s health, safety, morals, and welfare.²⁷ Using this concept, known as police power, states are given authority to enact zoning laws.²⁸

Much, and sometimes all, of this power to create zoning laws is delegated to local governments.²⁹ The ability of the states and local governments to enact laws in the interest of public health rests in a decision by the Supreme Court in *Jacobson v. Massachusetts*.³⁰ In *Jacobson*, the Supreme Court upheld a Massachusetts law that required individuals to be vaccinated in the interest of public health. Further, *Jacobson* set a standard of review for state public health legislation: a court can only overturn a public health statute if that statute “has no real relation to [public

health], or is, beyond all question, a plain, palpable invasion of rights secured by the fundamental law.”³¹

A state’s ability to enact zoning laws in the interest of public health was confirmed in *Village of Euclid v. Ambler Realty*.³² In *Village of Euclid*, the Supreme Court upheld a municipality’s cumulative zoning laws which required the separation of residential, commercial, and industrial areas from each other for the purpose of reducing risk of fires, traffic accidents, and nervous disorders.³³ The Supreme Court extended *Jacobson*’s standard of review in *Village of Euclid*, indicating that state public health laws were irreversible unless they were “clearly arbitrary and unreasonable, having no substantial relation to the public health, safety, morals, or general welfare.”³⁴

Since restricting unhealthy food in fast food restaurants is different from either requiring vaccinations or imposing zoning restrictions to avoid fires, traffic accidents, and nervous disorders, local governments must ensure that zoning laws that restrict fast food restaurants in the interest of the public health meet the *Village of Euclid* standard. Some might argue that restricting unhealthy food from fast food restaurants is per se arbitrary since unhealthy food can also be bought at supermarkets or other stores. The strongest argument against this lies in the research; people living in neighborhoods with supermarkets



have been found to consume more fruits and vegetables.³⁵ Conversely, studies have shown a positive correlation between eating fast food and higher fat intake, body-mass index, and overweight status.³⁶ Further, these associations between fast food and unhealthy status were independent of other factors, such as television viewing or physical activity, suggesting that a large portion of the obesity problem is solely related to fast food consumption.³⁷

Conclusion

Childhood obesity is an expansive and expensive problem that can lead to serious health consequences. Conditional, incentive, and performance zoning laws provide just a few ways in which local governments, particularly in lower socioeconomic areas, can improve children’s access to healthier foods. Although there may be some resistance and potential legal challenges, if carefully written, it is likely that these zoning restrictions will ultimately survive these challenges. ☼

‘Forgotten Youth,’ Continued

Where the Chafee option has been implemented, Medicaid coverage is only extended until the age of twenty-one¹⁰ — five years less than the PPACA coverage allows for youth in more traditional homes. States have also extended Medicaid coverage to youth who have aged out through other existing options, including: (1) “§1115 waivers,” which allow states to, in effect, expand Medicaid eligibility to other groups, and (2) the medically needy category, which helps cover those who may not meet Medicaid income requirements.¹¹ Still, while the

provisions in the 2010 reform allow for coverage of children with traditional parental relationships until the age of twenty-six on a national level, the various state programs extend coverage for youth aging out, at most, until the age of twenty-one.¹² These state levels should be standardized and similarly increased to twenty-six for children without the benefit of a traditional home life.

Particularly in times of recession, fiscal concerns can make the extension of Medicaid unpopular, despite society’s moral obligation to assist children who have had

limited care and support. However, PPACA allows for matched Medicaid funding by the federal government,¹³ which could provide a welcome contribution to state budgets where, for example, a state looked to extend the Chafee option to age twenty-six. Additionally, research shows that the Chafee option is affordable, ranging from \$110 to \$350 per month for each covered youth in states surveyed¹⁴ (the nationwide average payment per Medicaid enrollee per month in 2007 was \$480.25).¹⁵

(‘Forgotten Youth,’ Continued on page 12)

‘Forgotten Youth,’ Continued

Unfortunately, an increase in age limits would solve only a portion of the problem. The bigger picture for youth aging out of foster care shows a struggle to gain general independent living skills, and specifically those skills necessary to navigate the available options in the health care system. A true solution needs not only to standardize the state-by-state gaps in coverage, but also to reinforce current laws related to independent living support. In 1999, FICA’s amendments to Title IV-E of the Social Security Act gave states more funding and greater flexibility to provide independent living support and training to youth aging out of foster care.¹⁶

The nation’s state and local governments, with financial support from the federal government, should offer an extensive program of education, training, employment, and financial support for young adults leaving foster care, with participation in such programs beginning several years before high school graduation and continuing, as needed, until the young adults emancipated from foster care establish independence or reach 21

years of age.¹⁷

The effectiveness of this provision’s implementation is difficult to survey, as there are essentially fifty different applications across the fifty states. Still, some emerging studies show there is much room for improvement. A review of the classroom-based life skills training program in Los Angeles County looked at concrete measures of the “transition to adulthood,” such as a high school diploma or equivalent, employment status, housing, delinquency, pregnancy and ability to obtain documents such as social security cards and bank accounts.¹⁸ The study found “no significant impacts” on the progress of those foster youth in the life skills program as compared to those in the control groups.¹⁹ This does not paint an optimistic picture regarding the ability of aging out youth to navigate the health care system.

Lack of health care coverage is a systemic problem that indirectly impacts the whole of society, but it is directly felt by foster youth, particularly as they are at a higher risk of experiencing ongoing medical and mental health problems when

compared to other youth.²⁰ In 2014, most individuals will be required to obtain basic health insurance coverage or pay a fee, as mandated by PPACA.²¹ While many young adults aging out may be eligible for an exemption from the fee penalty based on their income levels, this will not improve their health care coverage. Despite the high priority of this age group in the politics of health care reform, it is only through the combined reform of health care coverage age limits in state programs and improvements in independent living programs, including a greater focus on health insurance options within those programs, that these youth will see any improved access to health care. ☼



‘Child Abuse Reporting Laws,’ Continued

the National Center for Child Abuse and Neglect (NCCAN) to “support state and local efforts to prevent and treat child abuse and neglect.”²⁷ NCCAN was charged with defining child abuse and neglect, a definition that continues to expand.²⁸ NCCAN “was developed by legislation stimulated by the battered child syndrome, but as politicians and statutes were explicated, other conditions—such as physical neglect, emotional neglect, and sexual abuse—were added to the definition of a more inclusive problem called child abuse and neglect—later to be relabeled child maltreatment.”²⁹ The “expansion of definitions has also led to increased reporting,” perhaps because “much of what is now called abuse was once considered to be appropriate

discipline.”³⁰ In summation, progress has been made as physicians are now informed of their duty to report. Still laws need to be more specific (for example, providing more concrete factors for determining suspected abuse) so that physicians and health care professionals know the appropriate steps that need to be taken to report suspected abuse. More specificity in the reporting laws will not only help protect the safety of the abused child, but will also help protect the physician and health care facility from violating the applicable state laws.

Mandatory reporting laws exist to protect vulnerable populations such as child abuse victims. However, the laws are only effective if physicians are aware of the laws and know how to respond

when faced with suspected abuse. The legal mandate was designed to facilitate proactive reporting and remove confusion about when reporting is required. When deciding whether to report, physicians need to balance concerns of suspected abuse with concerns of improperly diagnosing an unintentional injury. In the future, mandatory reporting laws should be written with more specificity to provide health care professionals with clear directives on how to properly report suspected abuse, thereby minimizing the possibility of inaccurate reporting. ☼

'H.R. 4247,' Continued

children being isolated in closets, restrooms and small boxes.³⁵

Several factors helped bring this issue to light.³⁶ Increases in the integration of students with emotional and behavioral problems in public school environments are occurring alongside heightened attention to school violence and teacher shortages.³⁷ The Individuals with Disabilities Education Act (IDEA) "established the principle of serving children with special needs in the least restrictive environment."³⁸ Students are now being integrated within the public education system regardless of their level of disability, and the restraint procedures formerly restricted to hospitals and institutions are now being employed in a classroom setting.³⁹

Over the years, numerous lawsuits regarding the use of restraints on children have been filed against school districts by parents and advocacy groups.⁴⁰ Plaintiffs pose arguments that restraint is a violation of the Eighth (prohibition against cruel and unusual punishment) and Fourteenth

Amendment (due process) rights, as well as a violation of the Civil Rights of Institutionalized Persons Act (CRIPA), though the latter is used less often.⁴¹ The U.S. District Court, Middle District of Alabama, examined this issue in *Wyatt v. King* in 1992.⁴² The court stated that "staff working with individuals with mental illness required specific training regarding interventions" and that the "training should include... psychotherapeutic interventions."⁴³ Findings have shown that "intensive staff training at schools has reduced assaultive incidences by eighty percent with a seventy-seven percent reduction in disruptive incidents."⁴⁴ After instituting a staff training program at a mental health facility, Pennsylvania and Delaware saw a ninety percent decrease in the use of physical restraint.⁴⁵ Staff were instructed in crisis management and prevention procedures, as well as methods to determine when and how to go about a physical restraint.⁴⁶

Although it is likely not a legislative priority, it is hopeful that the recent atten-

tion to health care will assist in bringing this issue to the forefront of the congressional agenda. The lack of federal law and patchwork of state regulations do a disservice not only to students, but teachers as well. The integration of special needs students into public and private school systems provides a host of benefits to those students, their classmates and their instructors. Still, without the necessary training and instruction, an ill-managed conflict can end with traumatic and tragic consequences. For the benefits of IDEA and the integration it promotes to be positively realized, public and private schools will need to be given better tools and instruction to manage children with more individualized needs. It is possible that H.R. 4247 will be instrumental in realizing these ideals. ☼

The Health Law Forum &

Health Law Outlook

would like to thank the following:

**Interim V. Provost Kathleen
Boozang**

**Professor Carl Coleman
Helen Cummings
Denise Pinney**

**Sharon Carone
Gina Fondetta
Dorothea Harris**

The SHU Law Copy Center

And the Members of

The Health Law Outlook

The Health Law Forum

The Student Bar Association

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53. See CONCORD BYLAWS, *supra* note 19 (Stating the definition used by Concord, MA to ban fast food restaurants).
54. Jason P. Block et al., *Fast Food, Race/Ethnicity, and Income: A Geographic Analysis*, 27 AM. J. PREVENTIVE MED. 211–217 (2004).
55. See Catlin, *supra* note 20, at 1096.
56. Allyson C. Spacht, *The Zoning Diet: Using Restrictive Zoning to Shrink American Waistlines*, 85 NOTRE DAME L. REV. 391, 391–403 (2009) (discussing constitutional challenges to zoning restrictions).
57. *Id.*
58. *Id.*
59. *Id.*
60. Jacobson v. Massachusetts, 197 U.S. 11, 12 (1905).
61. *Id.*
62. Village of Euclid v. Ambler Realty, 272 U.S. 365 (1926).
63. *Id.*
64. *Id.*
65. See *Environment*, *supra* note 11.
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67. See Jeffrey, *supra* note 36.

Zoning Laws: A Potential Local Government Tool for Decreasing Childhood Obesity in Low-Income Areas

Student Contributors



Annie Collart is a first-year evening student at Seton Hall School of Law. She graduated from Marquette University in 2004 with a B.A. in German and History. She has volunteered for the past two years as a Court Appointed Special Advocate in Union County, NJ, advocating for children in foster care. Her work has focused on foster children facing severe medical challenges.



Cynthia Furmanek graduated from the University of California, Davis in June 2008 with a major in Neurobiology, Physiology, and Behavior. At Arizona State University, she continued her interest in science and health in the Physical Activity, Nutrition, and Wellness department. She graduated with a Master's in Science in June 2010 after completing her thesis on the effects of different types of exercise on postexercise hypotension. At Seton Hall, Cynthia plans to fuse her interests in exercise and health with her interest in law by pursuing a Health Law concentration.



Melody Hsiou is a first-year student at Seton Hall Law School. In 2008, she graduated from the University of California, Los Angeles, with a B.S. in Physiological Science and minor in Public Health. During her time at UCLA, she worked at the UCLA Medical Center as a research assistant and assistant grant editor. In 2010, she graduated from Columbia University's Mailman School of Public Health with an MPH in Sociomedical Sciences and Health Promotion. In 2009, she worked as a Health Literacy Advocate at Columbia's University Medical Center's Center for Community Health Partnerships, where she created a health resource library. She plans to pursue a Health Law concentration.



Stephanie Kozic is a first-year law student at Seton Hall University School of Law. She holds a B.M. in Music Theory and Composition from Westminster Choir College and an MSJ from Seton Hall University School of Law. Stephanie is currently a Quality Systems Analyst at Johnson & Johnson.



Brandon Lee Wolff is a first-year student at Seton Hall University School of Law. He graduated as a National McCabe Scholar from Swarthmore College in 2008 where he double majored in political science and sociology. He is the founder of the anti-violence organization SAVE R US (Students Against Violence Everywhere Are Us) which inspired his honors thesis in examining violence from a medical perspective. Since graduating, he worked as a Quality Assurance Supervisor for the United States Census Bureau. At Seton Hall, Brandon serves as a representative to the Student Bar Association and is a member of the Health Law Forum.

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Health Law Forum News

Student Health Law Conference

Newark, NJ—October 22, 2010

The American Society of Law, Medicine & Ethics and Seton Hall Law co-sponsored the Fourth Annual Student Health Law Conference on October 22, 2010. More than 200 participants from schools across the nation attended the conference, which exposed law students to the myriad career paths for attorneys in the health law field. The conference began with a presentation by Peter Leibold, Executive Vice President & Chief Executive Officer for the American Health Lawyer's Association, who provided an overview of his career path and the "hot" areas in the industry today. His remarks provided the future attorneys in attendance with invaluable advice.

Following the opening presentation, students attended a series of panels, each focusing on a different health law field. Panel topics ranged from Hospital & Health Care Management and Pharmaceutical & Medical Device Compliance to Government Enforcement and Health Information & Technology. Each panel was comprised of top attorneys in various health law fields who advised students on the countless possibilities of career paths. Panelists represented diverse employers, including Community Health Law Project, New Jersey Office of the Attorney General, the University of Medicine and Dentistry of New Jersey, the Food and Drug Administration, Saint Peter's University Hospital, and Gibbons P.C.

In each panel, health law attorneys discussed their experiences and career journeys, including the various positions they have held before finding their current place in the field. Students were then engaged in question and answer sessions where the panelists offered a broad range of valuable insight.

For instance, the Pharmaceutical & Medical Device Compliance Role panel featured Mark Petrille, Sunitha Ramamurthy, and Dr. Mark Bui. Mr. Petrille is the Director of Compliance for the Siemens Healthcare Sector in the United States, encompassing seven business units for which he is responsible for all activities relating to standards of conduct and ethical relationships. Ms. Ramamurthy is the Senior Director of Compliance, Commercial Operations at Eisai, Inc., where she is responsible for implementation of Eisai's compliance program to ensure adherence to laws and regulations. Lastly, Dr. Bui is the Associate Director for Global Regulatory Strategy in the oncology group at Bayer HealthCare Pharmaceuticals, where he works with pharmaceuticals and biologics in therapeutic areas. Together, the esteemed practitioners discussed the roles they play in the health law field and what their roles encompass. Also, they stressed the importance of a motivation to learn and an open-minded approach in considering the different fields of law.



Overall, the various panel discussions provided guidance for students and encouragement in the face of today's economy. The conference provided an excellent opportunity for participants to become exposed to the numerous fields of health law and to meet practicing health law attorneys. ☀

Blood Drive

Newark, NJ—September 15, 2010

This fall, the Health Law Forum hosted a blood drive, sponsored by the American Red Cross. A huge success, the blood drive had forty-three donors, saving up to 130 lives. The Forum hosted a competition between the first-year sections' students to see which would have the most donors. Section A came in first place and won a Dunkin Donuts breakfast, followed by Section D, then Section B, and lastly Section C. Fifteen students volunteered, including for table sitting prior to and registration on the day of the event. Please join us again when the Red Cross returns next semester for the spring blood drive. ☀

Health Law Forum News

About the Health Law Forum

The Health Law Forum is a student organization at Seton Hall Law School for those interested in health law.

The Health Law Forum hosts speakers, panel discussions, community service projects, and networking events throughout each academic year.

The Health Law Outlook (HLO), a subsidiary of the Health Law Forum for students interested in health policy, hosts regular round-table discussions about current topics in the healthcare field. Each semester, HLO presents healthcare issues using debate, brain-storming, presentation, and Socratic method formats. Many of the articles included in newsletters are the product of these meetings and discussion.

HLF 2010-2011 Executive Board:

Matthew McKennan (3L), President

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Health Law Outlook

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