ARTICLES & ESSAYS

THE HISTORY AND FUTURE OF HEALTH CARE LAW: AN ESSENTIALIST VIEW

*Mark A. Hall**

I. A THUMBNAIL INTELLECTUAL HISTORY OF ACADEMIC HEALTH LAW

This symposium was organized to consider the scope, content, and future direction of health law. One's view on these questions necessarily depends on who is asking and for what purposes. Legal practitioners will have a very different view of the field, for instance, than lawmakers and other public policy analysts.[1] I approach this inquiry from the perspective of a legal academic by considering how the subject is taught in law schools and conceived by the community of health law scholars, as reflected in leading casebooks[2] and in academic commentary about the field. What one quickly observes is

* Fred D. and Elizabeth L. Turnage Professor of Law, Wake Forest University. Work on this Article was supported in part by a grant from the Robert Wood Johnson Foundation, under its Investigator Awards in Health Policy Research program. The Article benefited from comments by participants in the December 2005 workshop, "Rethinking Health Law," at Wake Forest University School of Law and in a faculty colloquium at the University of Pennsylvania Law School.

1. This diversity of perspectives is reflected, for instance, in the various approaches to these questions presented in a symposium last year in *Health Matrix*, which asked contributors to reflect on the past, present, and future of health law. Symposium, *The Field of Health Law: Its Past and Future*, 14 HEALTH MATRIX 1 (2004). *See also* Peter D. Jacobson, *Health Law 2005: An Agenda*, 33 J.L. MED. & ETHICS 725 (2005).

2. Despite my conflict of interest, I examine mainly William Curran's casebooks, on several of which I am a coauthor, because they span the longest time and the largest number of topics. I also focus on the casebook by Furrow and colleagues because it is the one that has been most widely used over the past decade and a half, and it too covers the full breadth of the field. Other casebooks also deserve close attention, but this Article is not meant to be a casebook survey, and these others have existed in only one or two editions or focus on only portions of the field.

a dramatic transformation of the field over a generation.

As a legal academic field, most observers[3] date the beginning of health law with William Curran's 1960 publication of the first casebook.[4] Its content reveals a vastly different sense of the field than what prevails now. The original casebook was devoted almost entirely—eighty-three percent—to forensic medicine.[5] The rest dealt with public health, the regulation of medical practice, and liability.[6] This reflects roughly the composition of the medical discipline known at the time as "medical jurisprudence."[7] Medical jurisprudence was established in European medical schools centuries ago as the study of various medical issues relevant to the legal system, such as forensic medicine (pathology, cause of injury, etc.), toxicology, abortion, and the determination of insanity.[8] In the

3. Arnold J. Rosoff, *Health Law at Fifty Years: A Look Back*, 14 HEALTH MATRIX 197, 205 (2004); Marcella Bernard, *The Father of Health Law*, HARV. PUB. HEALTH REV. (1997), *available at* http://www.hsph.harvard.edu/review/william_curran.shtml; Robert McG. Thomas Jr., *William J. Curran, 71, Dies; Developed Health Law Field*, N.Y. TIMES, Sept. 25, 1996, at B10 ("If Mr. Curran was not the father of modern health law, he was more than a midwife . . . . [H]e virtually invented the field itself.").

Historical research suggests that John Ordronaux, LL.B., M.D., was the first law faculty member fully dedicated to health law. He held a chair in medical jurisprudence as a professor at Columbia Law School for roughly forty years, beginning in 1861. In 1874, the University of Pennsylvania appointed John J. Reese, a forensic toxicologist at its medical school, to a chair of medical jurisprudence in its law department, but he submitted his resignation a year later due to lack of student interest. The offer was initially refused for twelve years, during which he remained in a "largely symbolic professorship, . . . teaching few or no law students." JAMES C. MOHR, DOCTORS AND THE LAW: MEDICAL JURISPRUDENCE IN NINETEENTH-CENTURY AMERICA 120-22, 239-41 (1993).

4. WILLIAM J. CURRAN, LAW AND MEDICINE: TEXT AND SOURCE MATERIALS ON MEDICO-LEGAL PROBLEMS (1960). I have found only one earlier published teaching text written primarily for law students rather than practitioners. ELMER D. BROTHERS, MEDICAL JURISPRUDENCE: A STATEMENT OF THE LAW OF FORENSIC MEDICINE (1914). The author of this earlier text was a practicing lawyer in Chicago who lectured at John Marshall Law School. The 276-page book consisted of the following topics in these proportions: evidence and procedure, 20%; forensics, 17%; fiduciary relationship, 25%; malpractice, 26%; and regulation, 12%. *Id.*

5. *See infra* App.

6. The few pages on insurance addressed a new program for the military, now known as TriCare (previously CHAMPUS). CURRAN, *supra* note 4, at 755-60. The regulation pages mainly addressed hospitals. *Id.* at 744-55. Remarkably, malpractice liability was virtually absent from the first edition.

7. *See generally* BROTHERS, *supra* note 4 (providing an overview of the discipline of "Medical Jurisprudence").

8. MOHR, *supra* note 3, at 3-4; Emil F. Frey, *Medicolegal History: A Review of Significant Publications and Educational Developments*, 10 LAW MED. &

nineteenth century, the focus in America expanded to include aspects of liability and regulatory law that were relevant to a physician's professional practice, such as malpractice and licensure.[9] By the middle of the nineteenth century, many U.S. medical schools had one or more faculty members, and oftentimes departments, devoted to medical jurisprudence.[10]

A century later, it appears that Professor Curran's primary aim was to convey to law students a sense of the field as it had been developed by physicians. Curran's primary academic appointments were in schools of medicine and public health.[11] In an article four years before his casebook, he and a physician colleague described their Harvard Law School seminar as one that addressed the same topics covered by Curran's casebook using a series of physician lecturers and a grab-bag of demonstrative and experiential techniques.[12] His students visited a hospital and mental institution, attended an autopsy, and viewed a presentation of typical courtroom exhibits such as x-rays, medical photographs, and laboratory test results.[13] This is hardly the stuff of a new academic legal field. It is descriptive, practical, entertaining, not very systematic, and almost entirely atheoretic.

From these humble beginnings, the field began to expand in scope and interest. The 1970 second edition of Curran's casebook, which was coauthored with Donald Shapiro, shows only a modest shift in its foci, but for the first time bioethics topics appeared, accounting for ten percent of the coverage.[14] Despite this expansion,

---

HEALTH CARE 56, 56 (1982). I was fascinated to discover recently that Thomas Percival initially entitled his seminal 1801 book on medical ethics "medical jurisprudence" because half the work is devoted to legal topics such as competency to make a will, abortion and infanticide, and forensic medicine. *See* THOMAS PERCIVAL, MEDICAL ETHICS: OR, A CODE OF INSTITUTES AND PRECEPTS, ADAPTED TO THE PROFESSIONAL CONDUCT OF PHYSICIANS AND SURGEONS 34-35 (The Classics of Medicine Library 1985) (1803).

9. *See, e.g.*, leading treatises such as JOHN J. ELWELL, A MEDICO-LEGAL TREATISE ON MALPRACTICE AND MEDICAL EVIDENCE, COMPRISING THE ELEMENTS OF MEDICAL JURISPRUDENCE (Fred B. Rothman & Co. 1996) (1866); JOHN ORDRONAUX, THE JURISPRUDENCE OF MEDICINE IN ITS RELATIONS TO THE LAW OF CONTRACTS, TORTS, AND EVIDENCE (Arno Press 1973) (1869). For a thorough history of the field, see MOHR, *supra* note 3. Frey, *supra* note 8, provides a good bibliographic survey of the primary publications in medical jurisprudence.

10. MOHR, *supra* note 3, at 39-41.

11. *See supra* note 3.

12. *See* William J. Curran & Robert H. Hamlin, *The Medico-Legal Problems Seminar at Harvard Law School*, 8 J. LEGAL EDUC. 499, 500-01 (1956).

13. *Id*. at 501.

14. WILLIAM J. CURRAN & E. DONALD SHAPIRO, LAW, MEDICINE, AND FORENSIC SCIENCE (2d ed. 1970). Remarkably, Medicare and Medicaid, enacted four years earlier, were not covered at all, but malpractice liability, which was

the coverage was still a hodgepodge of topics reflecting how physicians encountered the legal system, for instance, by providing expert testimony, coping with increasing regulation, and modifying the definition of death to accommodate more organ donation.[15] There were no organizing principles, no real analytical coherence that one might call a sub-discipline of law, and a glaring neglect of most of the policy themes that now dominate health law.

A sense of the field as we know it today did not begin to emerge until the 1980s. As reflected in Curran and Shapiro's 1982 third edition,[16] traditional topics still prevailed, but regulatory, economic, and ethics topics accounted for almost half the coverage.[17] This evolution continued through the 1990 fourth edition, in which David Kaye and I joined as junior coauthors,[18] and the 1998 fifth edition, for which I took the lead,[19] so that, currently, in the 2003 sixth edition,[20] the topics that dominated the first Curran edition—forensic evidence and public health—now account for less than fifteen percent of the coverage, and the newer topics account for about seventy percent.[21] Malpractice liability has remained consistently at about sixteen to eighteen percent through all the editions after the first.[22] A similar distribution exists in the casebook and treatise published by West, but with even less attention to the original topics and even more on regulatory and corporate law topics.[23]

---

virtually absent from the first edition, leapt to the second largest topic area—nineteen percent—in the second edition. *See infra* App.

15. CURRAN & SHAPIRO, *supra* note 14; *see also* Walter Wadlington, *Some Reflections on Teaching Law and Medicine in Law School Since the 60's*, 14 HEALTH MATRIX 231, 232-33 (2004) (listing the topics covered by law and medicine in 1977 as malpractice, forensic medicine, regulation, and a collection of bioethics topics).

16. WILLIAM J. CURRAN & E. DONALD SHAPIRO, LAW, MEDICINE, AND FORENSIC SCIENCE (3d ed. 1982). *See* George J. Annas, *Health Law at the Turn of the Century: From White Dwarf to Red Giant*, 21 CONN. L. REV. 551, 552 n.4 (1989) (confirming that Curran's 1982 edition was, at the time, the "basic text for the standard Law and Medicine course"). A more modern scope is also reflected in WALTER WADLINGTON ET AL., CASES AND MATERIALS ON LAW AND MEDICINE (1980).

17. *See infra* App.

18. WILLIAM J. CURRAN, MARK A. HALL & DAVID H. KAYE, HEALTH CARE LAW, FORENSIC SCIENCE, AND PUBLIC POLICY (4th ed. 1990).

19. WILLIAM J. CURRAN, MARK A. HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, HEALTH CARE LAW AND ETHICS (5th ed. 1998).

20. MARK A. HALL, MARY ANN BOBINSKI & DAVID ORENTLICHER, HEALTH CARE LAW AND ETHICS (6th ed. 2003).

21. *See infra* App.

22. *See infra* App.

23. *See infra* App.

It is fair to say that Professor Curran was more of a follower than a leader through this evolution.[24] His primary contributions to the field will be remembered as a founder and as a leader in forensic medicine and public health, but his organizing view of health law was defined mainly by what legal topics most interested the medical community. The legal academics who led the ascendance of the newer topics and themes[25] include, in alphabetical order: Clark Havighurst at Duke University in finance and regulation,[26] Jay Katz at Yale University in bioethics,[27] and Ed Sparer at the University of Pennsylvania in patients' rights and access.[28] If there were a Mount Rushmore of modern health law, it might well consist of Curran, Havighurst, Katz, and Sparer. Their work and intellectual influence embody the four corners of malpractice liability, bioethics, insurance financing, and corporate organization and regulation.

Still, it is striking how different these four individuals are in their intellectual outlook and public policy interests. Indeed, it is difficult to imagine a group of intellectual leaders who have less in common than these four. One is reminded of the ancient parable from India of the blind men and the elephant. Each man believes the elephant is something completely different depending on what

24. For a review of the field's development similar to this Article, see Timothy Stoltzfus Jost, *The Uses of* The Social Transformation of American Medicine*: The Case of Law*, 29 J. HEALTH POL. POL'Y & L. 799 (2004).

25. No single person stands out as a leader in the subfield of malpractice, but beginning in the 1980s, casebook coverage of malpractice shows a notable shift in emphasis from purely doctrinal tort issues to public policy considerations reflected in the current debate over medical malpractice crisis and reform. Arthur Southwick deserves special mention, however, because of his focus on hospital institutional liability and responsibility. *See generally* ARTHUR F. SOUTHWICK, THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION (1978).

26. Professor Havighurst's focus on federal regulation and economic policy issues arose from his work in the 1970s under a series of grants from and projects with various federal agencies. For an autobiographical essay, see Clark C. Havighurst, *I've Seen Enough! My Life and Times in Health Care Law and Policy*, 14 HEALTH MATRIX 107 (2004).

27. *See generally* JAY KATZ, EXPERIMENTATION WITH HUMAN BEINGS: THE AUTHORITY OF THE INVESTIGATOR, SUBJECT, PROFESSIONS, AND STATE IN THE HUMAN EXPERIMENTATION PROCESS (1972) (developing a classic set of teaching materials with the assistance of Alexander Morgan Capron and Eleanor Swift Glass). For his explanation of goals and themes, see Jay Katz, *Reflections on Teaching Law and Medicine*, 25 HOUS. L. REV. 475 (1988).

28. Professor Sparer spearheaded the Health Law Project, which focused on patient advocacy, and greatly influenced several students or researchers who became prominent health law scholars, including Rand Rosenblatt at Rutgers-Camden, and Sylvia Law at New York University. Rosoff, *supra* note 3, at 210-11; Elizabeth M. Schneider, *Ed Sparer's Legacy*, 60 BROOK. L. REV. 1, 2 (1994).

part he happens to touch—tusk, tail, ear, or trunk—yet the parts are all undeniably connected to the same beast, which is made up of each of these parts but is considerably larger and different than the sum of the parts. These four founders did not collaborate or otherwise convene to shape and direct the field, nor does the work of any one or two of them embody the entire scope of the field. Instead, the field evolved more organically to form a collective sense of what it is and is about.

The modern view of the field is first seen clearly in the 1987 edition of Furrow and his colleagues' casebook.[29] Marking a clear break from the past, this casebook was the first to use the now prevailing title "Health Law." It was quickly followed by two new casebooks from other leading academics: Havighurst, later joined by Blumstein and Brennan, and Annas, Law, Rosenblatt, and Wing.[30] These two casebooks had an even stronger public policy focus with sharply contrasting political ideologies. These intellectual currents converged to form a huge stream of academic activity. Numerous health law programs, specialty journals, and new law professors (myself included) entered and expanded the field in the 1980s and 1990s. The protean, molten field solidified to take the shape we now know, consisting mainly of malpractice liability, bioethics, insurance financing, and corporate regulation. The original topic of forensic medicine was cast aside, becoming a specialized aspect of scientific evidence and criminal law.[31] Only the status of public health law remains uncertain.[32]

More important than settling on this range of topics is agreement on the dominant public policy themes. Clearly expressed

29. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS (1987).

30. GEORGE J. ANNAS ET AL., AMERICAN HEALTH LAW (1990); CLARK C. HAVIGHURST, HEALTH CARE LAW AND POLICY: READINGS, NOTES, AND QUESTIONS (1988). The Annas book is no longer in print. It was succeeded by two separate casebooks, with expanded teams of authors: RAND E. ROSENBLATT, SYLVIA A. LAW & SARA ROSENBAUM, LAW AND THE AMERICAN HEALTH CARE SYSTEM (1997); KENNETH R. WING, MICHAEL S. JACOBS & PATRICIA C. KUSZLER, THE LAW AND AMERICAN HEALTH CARE (1998).

31. Also, topics covered by mental health law never merged with the rest of the field, and so it remains essentially an orphaned subtopic. Additionally, there are other strands not fully accounted for here, such as food and drug law and intellectual property law as it applies to biotechnology.

32. Public health was absent from almost all of the new casebooks of the 1980s, except for Curran's, but made a resurgence with the AIDS epidemic and is now also covered extensively in LAWRENCE O. GOSTIN ET AL., LAW, SCIENCE AND MEDICINE 440-618 (3d ed. 2005); HALL, BOBINSKI & ORENTLICHER, *supra* note 20, at 786-884. Still, its concerns are distinctly different than the rest of the field, in part because it is not at all restricted to medical care delivery.

first by Furrow, Johnson, Jost, and Schwartz,[33] the main concerns of health law are usually grouped and summarized as quality, autonomy, access, and cost.[34] Large disagreements exist about the proper emphasis on any one of these themes, or how best to pursue them through the law, but all of these core focal points of public policy remain front and center in health law scholarship.

An alternative thematic structure is to emphasize the *relationships* in health care between and among patients, physicians, institutions, and government. This relational structure was first developed by the American Society of Law and Medicine Task Force on Health Law Curricula in 1985, and it was used to organize the 1998 edition of Curran's casebook, which I led.[35] This structure does not differ fundamentally, however, from the standard conception. It retains the same basic content areas and policy themes, covering liability, ethics, financing, and regulation and emphasizing quality, autonomy, access, and cost.[36]

In a nutshell,[37] health law in the United States coalesced

33. FURROW ET AL., *supra* note 29, at xviii-xix. *See also* Robert L. Schwartz, *Where is Health Law Going?: Follow the Money*, 14 HEALTH MATRIX 219, 220 (2004).

34. Rand E. Rosenblatt, *Conceptualizing Health Law for Teaching Purposes: The Social Justice Perspective*, 38 J. LEGAL EDUC. 489, 490-91 (1988) ("[H]ealth law courses appear to be organizing themselves around three broad subdivisions: (1) access to care; (2) quality of care; and (3) financing and cost containment."). Einer Elhauge describes a similar division in health law among market, professional, moral and political paradigms. Einer Elhauge, *Can Health Law Become a Coherent Field of Law?*, 41 WAKE FOREST L. REV. 365 (2006) [hereinafter Elhauge, *Health Law—Coherent Field*]; Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449, 1452-53 (1994) [hereinafter Elhauge, *Allocating Morally*]. Bill Sage speaks in terms of industrialization, consumerism, and social solidarity. William M. Sage, *Unfinished Business: How Litigation Relates To Health Care Regulation*, 28 J. HEALTH POL. POL'Y & L. 387 (2003). Others articulate somewhat different competing paradigms of professionalism, regulation, markets, institutions, social justice, or participatory democracy. *See* GOSTIN ET AL., *supra* note 32, at 621; Clark C. Havighurst, *The Professional Paradigm of Medical Care: Obstacle to Decentralization*, 30 JURIMETRICS J. 415, 419 (1990); Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155, 155 (2004).

35. *See* CURRAN, HALL, BOBINSKI & ORENTLICHER, *supra* note 19, at xxx; *see also* FURROW ET AL., *supra* note 29, at xvii; Am. Soc'y Law and Med., *Health Law and Professional Education: The Report of the Task Force on Health Law Curricula of the American Society of Law and Medicine*, 63 U. DET. L. REV. 245, 252 (1985).

36. Thus, the basic contents of the current Aspen and West casebooks are essentially the same, even though the Aspen book uses the relationship structure.

37. *See, e.g.*, MARK A. HALL ET AL., HEALTH CARE LAW AND ETHICS IN A NUTSHELL (2d ed. 1999).

intellectually and academically roughly twenty-five years ago as the doctrinal and public policy study of law that applies to the health care industry.[38] As such, the field continues to expand and evolve to follow changes in the industry and shifts in public policy. The 1990s emphasized new topics, such as genetics and managed care, and in the 2000s, we are confronting consumer-driven health care and issues relating to pharmaceuticals. Health law has been able to absorb these topics within the existing structure and set of primary policy concerns. This suggests that the field has matured in fairly short order into a sub-discipline with some degree of permanence and intellectual coherence.

II. DISSATISFACTIONS WITH HEALTH LAW

Still, many health law scholars remain dissatisfied with the state of the field.[39] What existed for centuries as a field defined by physicians' encounters with courts is now defined in essentially the same fashion, only much more broadly, as the judicial, legislative, market, and regulatory systems' encounter with all facets of the health care industry. The field is much richer and more sophisticated than its origins, but it is still a hodgepodge. Each of the four major branches stands apart from the others and is thought to be dominated by distinct themes. Confusion exists over whether and how various other topics fit into the field, such as public health law, food and drug regulation, and intellectual property issues.

It is possible to regard this substantive cacophony as a strength of the field.[40] Health law is more diverse and inclusive as a consequence. It attracts a broad array of scholars who pursue a fascinating range of topics with insights from multiple disciplines. Students are drawn to its courses in droves, and its academic

38. *Accord* James F. Blumstein, *Health Care Law and Policy: Whence and Whither?*, 14 HEALTH MATRIX 35, 35-36 (2004) (stressing the public policy dimension of health law); Barry R. Furrow, *From the Doctor to the System: The New Demands of Health Law*, 14 HEALTH MATRIX 67, 67 (2004) ("Health law is the legal domain that addresses the health care industry in all of its component parts."); Clark C. Havighurst, *Health Care As a Laboratory for the Study of Law and Policy*, 38 J. LEGAL EDUC. 499, 499 (1988) ("[T]he common denominator that best unifies the study of health care law is the health care industry itself."). Notice, this is considerably different than how European civil law systems regard health law, where the field is split into public law and private law components. In the U.S., the public and private dimensions cut across the four substantive areas of concern.

39. *See generally* Am. Soc'y Law and Med., *supra* note 35; Elhauge, *Allocating Morally*, *supra* note 34.

40. *See, e.g.*, Annas, *supra* note 16, at 552; Alexander Morgan Capron, *A 'Bioethics' Approach to Teaching Health Law*, 38 J. LEGAL EDUC. 505, 506 (1988).

conferences can be fascinating intellectual mélanges. But another consequence of this Tower of Babel is that health law has yet to become a truly integrated and cohesive discipline. As George Annas has quipped, it is hard to explain why health law is more than just another "law and a banana" field.[41] Consider also the views of these other health law scholars:

> The law governing American health care arises from an unruly mix of state and federal agencies and from a jumble of statutes and common-law doctrines conceived, in the main, without medical care in mind. . . . [J]udges tended to pursue doctrinal integrity within disparate areas of law. . . . [As a result,] [t]he law of health care provision is a chaotic, dysfunctional patchwork.[42]

> Health law policy suffers from an identifiable pathology. . . . [H]ealth care law borrows haphazardly from other fields of law, each of which has its own internally coherent conceptual logic, but which in combination results in an incoherent legal framework and perverse incentive structures. In other words, health care law has not—at least not yet—established itself to be a field of law with its own coherent conceptual logic, as opposed to a collection of issues and cases from other legal fields connected only by the happenstance that they all involve patients and health care providers.[43]

> This path of development has resulted in an academic discipline defined more by an accretion of topics drawn from historical events than by a systematic conceptual organization of issues. . . . [Some claim that] it is merely a disparate collection of legal doctrines and public policy responses, connected only by the happenstance that they involve doctors and hospitals in some way—much as if one had a course on the law of green things or the law of Tuesdays.[44]

> Although there are also many statutes, regulations, and legal rules that apply exclusively to the provision and financing of health care, they affect so many different matters, emanate

41. Annas, *supra* note 16, at 553. For a similar claim relating to cyberlaw, see Frank H. Easterbrook, *Cyberspace and the Law of the Horse*, 1996 U. CHI. LEGAL F. 207, 207-08 (1996).

42. M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247, 249-50, 321 (2003) (footnote omitted).

43. Elhauge, *Allocating Morally*, *supra* note 34, at 1452.

44. HALL, BOBINSKI & ORENTLICHER, *supra* note 20, at xxx-xxxi.

> from such diverse sources, and are so uncoordinated, inconsistent, and incomplete that they fail to constitute a coherent legal regime that can be studied as an integrated whole.[45]

> [Is health law] a special or unique field or something that should be celebrated as such? I think not. . . . There just is not enough that is unitary here. There is no severable body of principles, or even a set of issues, defined by either circumstances or type of controversy. . . . The truth of the matter is that I do not think there is much out there that deserves to be called health law, let alone a whole field of it.[46]

Some health law scholars resist the nihilism that the Emperor of Health Law is wearing no clothes.[47] The genesis of this symposium was a shared interest in whether it is possible to find greater conceptual coherence in the field. Is health law truly a legal academic sub-*discipline*, meaning that there is a core substantive focus for the field and a core set of methods of inquiry? If so, what are they, and how do the parts of the field relate to each other? By framing the inquiry this way, I do not mean to impose undue rigor on how the field is constructed. All the pieces do not need to fit into a tidy whole for health law to be regarded as a legitimate intellectual field, nor does health law have to be organized by theory or overarching principle. Perhaps health law, by its nature, eschews theorizing and systemization. But even if health law is not organized by theory or abstract principle, still, is there any method of inquiry, core set of questions, or a collection of mid-level principles that would give health law some disciplinary focus? The octopus of health law can have many long and winding tentacles, but it is not an organic whole unless they connect at a center. Family law is concerned with rights and obligations arising from intimate relationships, environmental law is built around a set of core statutes, and intellectual property law applies general property principles to intangible constructs. But what is the body of the health law octopus? I will venture some tentative thoughts of my own.

45. Havighurst, *supra* note 38, at 499.

46. Ken Wing, *Letter to the Editors of Health Matrix*, 14 HEALTH MATRIX 237, 237-38, 242 (2004).

47. I allude, of course, to Hans Christian Anderson's fable, "The Emperor's New Clothes." HANS CHRISTIAN ANDERSON, *The Emperor's New Clothes*, *in* XVII TALES (Charles Elliot ed., P.F. Collier & Son 1909-1914) (1837), *available at* http://www.bartleby.com/17/3/3.html.

III. COMPARATIVE INSTITUTIONAL ANALYSIS

One appealing response to the chaotic patchwork of health law's topics and themes is to regard it as an intellectual field defined more by method than by substance—that method being some version of comparative institutional analysis.[48] This is a method of inquiry that strives for a value-neutral reflection on which of several competing institutional, social, or theoretical approaches is best suited to the problem at hand. Competing approaches might include, for instance, market, regulatory, or professional self-regulatory mechanisms, or judicial, legislative, or administrative lawmaking. Comparative analysis asks whether one approach is superior, or less inferior, to the others according to a pragmatic assessment of how well its general features fit a particular issue or range of issues.[49] I admire (and have employed) this approach to health law, which fits well with its varied public policy terrain. But, this general legal process method is not at all unique to health law. It is a broader jurisprudential or analytical method that is suitable for any legal arena, and its general application to health law is fundamentally no different than in any other field.

Comparative institutional analysis is important, however, because it forces us to consider that many of medicine's particular institutions are unique, and those that are not often operate differently than in other social and economic arenas. Yet, this does not mean that comparative analysis defines the field. Instead, it is a lens that focuses attention on the distinctive attributes that alter how general legal, economic, and social systems function in this field. Comparative analysis leads us to realize that health law might be substantively different from other bodies of law. If so, then health law is defined at least in part by these substantive differences and not just by the method that identifies these differences.

IV. ESSENTIALISM IN HEALTH CARE LAW

For a body of substantive law to emerge as a distinctive field of intellectual inquiry, it must be more than just an assortment of rules that results from applying other bodies of substantive law to a

48. Different examples in health law can be found in MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS *passim* (1997); Roger B. Dworkin, *Bioethics? The Law and Biomedical Advance*, 14 HEALTH MATRIX 43, 46-47 (2004); Elhauge, *Health Law—Coherent Field*, *supra* note 34, *passim*; Elhauge, *Allocating Morally*, *supra* note 34, *passim*.

49. *See generally* Edward L. Rubin, *The New Legal Process, the Synthesis of Discourse, and the Microanalysis of Institutions*, 109 HARV. L. REV. 1393 (1996).

particular economic sector or human activity. Such a field is not intellectually distinctive unless there are one or more attributes of the economic or social enterprise in question that make it uniquely important or difficult in the legal domain. Surely medicine has such characteristics. Medical law is about the delivery of an extremely important, very expensive, and highly specialized professional service provided in situations of tremendous personal vulnerability. To focus on why these characteristics are uniquely important, I propose an *essentialist* approach to our inquiry: what are the essential features of health care delivery that distinguish its legal issues from those of other related fields? After some thought, six possibilities come to mind:

- the experience of being a *patient*—illness, vulnerability, suffering, and in need of care;
- the *professionalism* of health care providers—professing a higher ethic, submitting to a social compact, and engaging in a learned practice;
- the *treatment relationship* between patients and providers, consisting of very large measures of trust, dependency, authority, and caring;
- the existential *stakes* of medical care—death, disability, and the essence of being human;
- the nature of *medical practice*, especially its uncertainty, complexity, and technology;
- the *high cost* of care and *wide variability* of need, which necessitate public or private insurance that fundamentally alters medical economics.

Observe that, in framing the inquiry this way, I have narrowed our focus to medicine, rather than to health broadly conceived and affected. Perhaps this is not necessary, but it is helpful in building the base of an essentialist view. We begin by asking what is central to the primary enterprise before considering possible extensions from this base into other arenas, such as mental health, public health, environmental health, or social, economic, and political conditions writ large.

Beginning, then, with medical care, each of the six features I have listed is a *sine qua non* of medicine, and medicine uniquely combines all of them at once. This is why they are essential to defining what health *care* law is and is about. They permeate all parts of health care law, giving it its distinctive quality and altering how generic legal doctrine and conventional theories of government and markets respond to its problems and issues. Some aspects of these features exist in other areas of law. Although only health care law, by definition, addresses *patients* as such, other legal fields also focus on various human conditions of suffering, need, and debilitation that constitute being a patient. Other legal fields also address special professional ethical obligations, entail sensitive relationships, involve life and death stakes and high costs, or relate to a complex and uncertain body of expertise. But only health care law entails all of these features. Moreover, these features are essential and universal, not collateral or contingent. And, they each obviously raise unique, interesting, and difficult legal issues, especially when they occur in various combinations. Other themes and concerns in health care law come and go and necessarily are filtered through these permanent features.[50] These core features give the field its interdisciplinary complexity and its rich array of doctrinal and theoretical approaches.

Recent health law scholarship has recognized the importance of these features. I have advanced elsewhere that the core of what makes health law a distinctive intellectual field can be found in the phenomenology of what it is to be ill and to be a healer of illness.[51] Peter Jacobson criticizes courts for failing to consider the special importance of health care in ruling on contract and tort issues that affect health care policy.[52] Greg Bloche argues that health law should focus on the four substantive aims of health care, which are health promotion and restoration, rescue of those in dire need, support and comfort of patients, and personal dignity of patients.[53] Carl Schneider and I have proposed "an analytical framework that views health care law as a law of relational webs rather than a law

50. For instance, each of the four themes articulated by Professor Furrow and his colleagues in their 1987 casebook and the four paradigms articulated by Professor Elhauge arise from or relate directly to one or more of these essential features. *See generally* FURROW ET AL., *supra* note 29; Elhauge, *Health Law—Coherent Field*, *supra* note 34; Elhauge, *Allocating Morally*, *supra* note 34.

51. *See generally* Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463 (2002).

52. PETER D. JACOBSON, STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA 261-62 (2002).

53. Bloche, *supra* note 42, at 256, 299-309.

of transactions."[54] Lois Shepherd analyzes compassionate response to human suffering as a basis for legal obligations in medicine.[55] And recent work by Gail Agrawal,[56] Bill Sage, [57] Roger Dworkin,[58] and others[59] advances patient-centered versions of professionalism as antidotes to basing medical law and regulation on individual rights or undiluted market theory.

Each of us, in our distinctive voices, is driven by the conviction that generic legal doctrine does not adequately take account of certain essential features of medicine. Of course, any applied body of law should take some stock of its particular subject matter. Law and a banana[60] should consider the nature of bananas, after all. But this need to contextualize is much more compelling in health care law than in many or most other economic and social arenas. Therefore, we should think of health care law as a body of law that is "radically particularized," to use Carol Heimer's phrase,[61] meaning that it is deeply embedded in the particular attributes of medicine and treatment relationships. Therefore, it is a body of law whose defining characteristics include the special features of medicine.

This approach resonates broadly with Lon Fuller's approach to defining law or legality generally. In his jurisprudential debates with the legal positivists a half century ago, he argued for an "internal morality" of law consisting of eight constitutive elements that give law its legitimacy.[62] I propose a similar form of essentialism to explain why health care law is deeper than the simple positivist definition of all law that happens to apply to the

54. Mark A. Hall & Carl E. Schneider, *Where Is the "There" in Health Law? Can It Become a Coherent Field?*, 14 HEALTH MATRIX 101, 103 (2004).

55. Lois Shepherd, *Face To Face: A Call for Radical Responsibility in Place of Compassion*, 77 ST. JOHN'S L. REV. 445 *passim* (2003). *See generally* ERIC J. CASSELL, THE NATURE OF SUFFERING AND THE GOALS OF MEDICINE (1991).

56. Gail B. Agrawal, *Resuscitating Professionalism: Self-Regulation in the Medical Marketplace*, 66 MO. L. REV. 341 (2001).

57. William M. Sage, *Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597 (2003). Professor Sage's attention to professional norms and clinical realities is also an example of what has been called "therapeutic jurisprudence." For another recent example, see Kathy L. Cerminara, *Dealing with Dying: How Insurers Can Help Patients Seeking Last-Chance Therapies (Even When the Answer is "No")*, 15 HEALTH MATRIX 285 (2005).

58. *See* Dworkin, *supra* note 48.

59. *See, e.g.*, Peter D. Jacobson, *Health Law 2005: An Agenda*, 33 J.L. MED. & ETHICS 725, 735 (2005).

60. *See supra* note 41 and accompanying text.

61. Carol Heimer, *Responsibility in Health Care: Spanning the Boundary Between Law and Medicine*, 41 WAKE FOREST L. REV. 465 (2006).

62. LON L. FULLER, THE MORALITY OF LAW (rev. ed. 1969).

health care industry.[63] A similar "internal morality" framework has also been applied to medical ethics.[64] This approach bases clinical ethics on "the universal realities of the clinical encounter, i.e., healing, helping, caring, health,"[65] rather than on more generic, ad hoc, or socially contingent ethical principles. Under this essentialist approach, when ethics or law regards patients, it tends to regard them *as* patients, rather than as people who happen to be patients. And the same is true for people who are physicians and for services that are medical care. Sometimes, it matters fundamentally, even profoundly, that a legal matter involves physicians caring for patients, rather than providers servicing generic consumers. When this is so, general law becomes health care law.

In sum, the core of academic health care law consists of those aspects of law for which the unique features of medicine are central to the analysis or inquiry, rather than medicine simply being an incident of generic law's subject matter. Agreement on this point is all that is required in order to subscribe to my essentialist view. This view is not meant to be a boundary-drawing prescription of the field. Instead, it is only a focusing definition that identifies what is central to the field and what is more peripheral. Nor is it necessary to agree on what are all the special features of medicine, much less how and why they should matter in particular areas of law. Debating, disagreeing, and figuring this out is what health law scholarship does. Despite the many differences among health care law scholars, we are all engaged in the same enterprise at the core of the discipline of health care law if we frame the general inquiry in this substantive fashion.

This focus on the substance of medicine (which Gregg Bloche

63. In explaining his differences with the legal positivists, Fuller emphasized that his account of law contains a richer "*social dimension*" that considers the context in which law arises and the interaction between lawgivers and citizens, *id.* at 193, just as I wish to stress the particular contexts of illness and treatment and the relationship between physician and patient.

64. *See generally* Howard Brody & Franklin G. Miller, *The Internal Morality of Medicine: Explication and Application to Managed Care*, 23 J. MED. & PHIL. 384 (1998).

65. Edmund D. Pellegrino, *Praxis as a Keystone for the Philosophy and Professional Ethics of Medicine: The Need for an Arch-Support*, *in* PHILOSOPHY OF MEDICINE AND BIOETHICS: A TWENTY-YEAR RETROSPECTIVE AND CRITICAL APPRAISAL 69, 76 (Ronald A. Carson & Chester R. Burns eds., 1997). *See generally* Edmund D. Pellegrino, *The Healing Relationship: The Architectonics of Clinical Medicine*, *in* THE CLINICAL ENCOUNTER: THE MORAL FABRIC OF THE PATIENT-PHYSICIAN RELATIONSHIP 153 (Earl E. Shelp ed., 1983); Edmund D. Pellegrino, *Toward a Reconstruction of Medical Morality: The Primacy of the Act of Profession and the Fact of Illness*, 4 J. MED. & PHIL. 32 (1979).

calls the search for "substantive coherence"[66]) is what differentiates an essentialist approach from a legal process approach. I agree with Einer Elhauge and others that comparative analysis offers the best analytical tool set for a broad range of health care law problems,[67] but such analysis is not truly health care law scholarship unless it also considers the features of medicine that distinguish it from other social and economic arenas. Taking account of those features is more distinctively health care law scholarship than is applying general tools of comparative analysis to subject matter that happens to include the health care industry.

V. CONCLUSION

So, to return finally to where I began: What is health law? First, I want to narrow the inquiry somewhat to ask "what is health *care* law," rather than a broader concept of health law that includes environmental and public health issues. Then, we must remember that the answer depends on who wants to know. For practicing lawyers, health care law is the set of legal questions raised by clients in, or affected by, the health care industry. For the public policy community, health care law consists of the legal drivers of the main policy concerns in health care financing and delivery, which are costs, quality, and access. And still different answers should be given to physicians, philosophers, or facility administrators. As for the legal academy, health care law has more coherence than simply the jumble of issues that others bring to the table. Instead, I propose something like the following: health care law is an academic sub-discipline that inquires how law should and does take account of

66. Bloche, *supra* note 42, at 301-02.

67. Elhauge, *Health Law—Coherent Field*, *supra* note 34, at 379-90. I disagree, however, with Elhauge's position that medicine's essential features are best understood in the first instance through comparative analysis. *Id.* Clearly, there is an interplay between which features are important and how they are and should be regarded by institutions and various modes of analysis, so debating which is primary or in the foreground is a bit of a chicken-and-egg debate. However, I do maintain that the potential importance of these essential features can be understood at a higher or more general level of analysis than one that focuses on specific health care institutions or paradigms. To that extent, these features define health care law apart from the use of comparative analysis. In contrast, when comparative analysis generalizes or abstracts, it becomes generic legal process analysis; therefore, it is not identified with health care law in particular until it considers these essential features.

Professor Elhauge has a stronger critique when he takes me to task for asserting these essential features without first explaining their potential legal significance. *Id*. at 380. Such work needs to be done, but awaits another (and longer) opportunity. For now, it should suffice that many of the contributors to this symposium themselves have stressed the legal significance of these features, as noted briefly in *supra* notes 54-59 and accompanying text.

the special features of medicine and treatment relationships. This simple yet profound conception emerges from the field's history and from its current direction, and it helps to focus future scholarship on the issues that are the most important and challenging.

APPENDIX: DISTRIBUTION OF TOPICS IN LEADING HEALTH LAW CASEBOOKS AND TREATISE

	Curran Editions						West	West
	1960	**1970**	**1982**	**1990**	**1998**	**2003**	**2004**	**Treatise**
Intro/Medical Science	41%	18%	9%	4%	5%	4%	1%	0%
Forensics/Evidence	42%	34%	25%	15%	1%	1%	1%	0%
Public Health	6%	13%	5%	11%	7%	8%	2%	0%
Malprac. Liability	1%	19%	17%	16%	17%	17%	16%	16%
Fiduciary Relationship*	0%	3%	10%	4%	12%	12%	14%	5%
Regulation/Corporate**	9%	3%	10%	14%	19%	15%	25%	44%
Insurance/Costs	1%	0%	4%	17%	14%	17%	16%	18%
Reproduction/Genetics	0%	5%	6%	7%	8%	10%	12%	7%
Right to Die	0%	1%	9%	9%	11%	11%	11%	9%
Organ Transplants***	0%	5%	5%	2%	5%	4%	3%	1%
Total Pages	809	1015	1110	1268	1437	1250	1555	994

*Fiduciary relationship issues include informed consent, the treatment relationship, duty to treat, and EMTALA.

**Regulation includes certificate of need laws and physician licensure.

***Organ transplantation includes the definition of death.