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RETHINKING HEALTH LAW

INTRODUCTION

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A specter haunts health law, the specter of exhaustion. Our field was once vibrant with new issues and fresh ideas. Today, scholarship routinely recycles old proposals about recurring problems. The dominant paradigms—patient autonomy and market theory—have largely done their work and run their course. And while new perspectives are struggling to be born,[1] they are tentative and incomplete.

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1. *See, e.g.*, Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247 (2004); Roger Dworkin, *Getting What We Should from Doctors: Rethinking Patient Autonomy and the Doctor-Patient Relationship*, 13 HEALTH MATRIX 235 (2003); Mark A. Hall, *Trust, Law and Medicine*, 55 STAN. L. REV. 463 (2003); Mark Hall & Carl Schneider, *Where Is the "There" in Health Law? Can It Become a Coherent Field?*, 14 HEALTH MATRIX 101 (2004); Peter D. Jacobson, *Health Law 2005: An Agenda*, 33 J. L. MED. & ETHICS 725 (2005); Rand Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155 (2004); William Sage, *Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597 (2003); Carl Schneider, *Benumbed*, 34 HASTINGS CENTER REP. 9 (2004); Lois Shepherd, *Face to Face: A Call for Radical Responsibility in Place of Compassion*, 77 ST. JOHN'S L. REV. 445 (1993).

The time has come to rethink health law's paradigms broadly and boldly. To that end, we asked a small group of leading health law scholars and other academics[2] to join us at Wake Forest University in December 2005 to reflect on three questions:

- Does health law have a core set of concerns?
- What new paradigms can best help us reconceive health law?
- How can health law accommodate the special psychological, emotional, and moral aspects of its subject?

This symposium publishes the results of that discussion. Some of the articles and essays address our three questions at the broadest level. Others tackle more specific issues in health law in a way that suggests the merits of newer paradigms and better methods.

It is easy to forget but crucial to remember that the central purpose of health care law is to improve the lives of patients. Our conference prospectus therefore proposed a "patient-centered" approach to reconceptualizing the field. Under that rubric, lines of inquiry that are now underdeveloped might profitably be pursued. We offered three possibilities: *a relational perspective*, *patient-centered professionalism*, and *patient-centered empiricism*. While none of the symposium articles proposes a comprehensive patient-centered health law, most of the articles offer promising insights into the concept.

Mark Hall offers an "essentialist" definition of health care law that emphasizes the centrality of the patient. He hopes that making the patient central would force the law to acknowledge and accommodate crucial features of the medical arena, such as the social and psychological realities of treatment encounters and the essential ingredients of medical practice and professionalism.[3] "Sometimes," Hall writes, "it matters fundamentally, even profoundly, that a legal matter involves physicians caring for patients, rather than providers servicing generic consumers."[4] On this view, health care law should develop doctrines specific to its subject by rethinking itself as a law of relationships with the patient at the center. This *relational perspective* would not treat medicine as a business like any other. It would not automatically apply doctrines from other fields of law. It would instead require that medical encounters be seen in the context of the parties' interactions

2. In addition to those who wrote articles for this symposium, workshop attendees included Gregg Bloche, Eric Cassell, Rebecca Dresser, Russell Korobkin, and Bill Sage.

3. Mark A. Hall, *The History and Future of Health Care Law: An Essentialist View*, 41 WAKE FOREST L. REV. 347, 357-62 (2006).

4. *Id.* at 361.

with each other and their relationships with providers, facilities, insurers, employers, and family members.[5]

Einer Elhauge endorses a different relational perspective on health care. He agrees that "we might think of modern health law as being about a . . . complex web of relations that affect our health."[6] But he fears that Hall's focus on the vulnerability of the patient, the professionalism of caregivers, and the trust between patient and caregiver would return us to the era of blind trust in professional self-regulation.[7] He prefers a *comparative analytic method* that uses interdisciplinary insights to craft the best accommodations of four competing and often contradictory paradigms—the moral, professional, market, and political.[8]

Roger Dworkin applies such an approach in his article on medical malpractice.[9] In designing a medical malpractice system that maximizes "institutional competencies," he takes on the challenging task of assessing ways to integrate morality, professionalism, market forces, and politics.[10]

Carl Schneider uses the law of bioethics to explore the argument for a patient-centered health law.[11] He argues that the contemporary law of bioethics has foundered on its preoccupation with the autonomy principle and suggests that the policies that law has instituted have, on empirical examination, apparently failed substantially. He notes that the agenda of bioethics has been set by the intellectual interests and ideological preferences of bioethics and asks what the agenda would be like were it set by patients. He suggests that they would want bioethics to address issues that (1) affect many people and (2) are susceptible to solution, and he proposes rationing and the undertreatment of pain as examples of such issues.[12]

Lois Shepherd and Carol Heimer explore a different strand of patient-centered health law, one that develops what might be called *patient-centered professionalism.*[13] They seek to revise and revivify the professionalism paradigm in a way that emphasizes the needs, wants, and experiences of patients. They wish to supplement patients' rights by encouraging providers to discern and deliver

5. *Id.* at 357-62; s*ee also* Hall & Schneider, *supra* note 1.

6. Einer Elhauge, *Can Health Law Become a Coherent Field of Law?*, 41 WAKE FOREST L. REV. 365, 370 (2006).

7. *Id.* at 375-77.

8. *Id.* at 379-90.

9. Roger B. Dworkin, *The Process Paradigm: Rethinking Medical Malpractice*, 41 WAKE FOREST L. REV. 509 (2006).

10. *Id.* at 509-36.

11. Carl E. Schneider, *After Autonomy*, 41 WAKE FOREST L. REV. 411 (2006).

12. *Id.* at 411-44.

13. Carol A. Heimer, *Responsibility in Health Care: Spanning the Boundary Between Law and Medicine*, 41 WAKE FOREST L. REV. 465 (2006); Lois Shepherd, *Assuming Responsibility*, 41 WAKE FOREST L. REV. 445 (2006); *see also* Jacobson, *supra* note 1.

what patients truly want and need. They ask, for example, whether there are any principles of paternalistic professionalism (like "beneficence") that can be salvaged and renovated, whether fiduciary principles of law should be more directly and forcefully applied to the provider-patient relationship, and whether ethical theories of conduct (such as virtue ethics or the ethics of care) might usefully inform professional duties.

In this vein, Shepherd wants to rethink responsibilities for patient health. She urges that we consider not simply the duties of professionals, but also those of insurers, governments, family members, the individual patient, and others.[14] Some such entities may assume heightened responsibilities for patients' health—for example, because they have voluntarily created expectations, because they have given patients reason to trust them, because they have received a license from the state, or because patients have become dependent on them. Heimer asks how the law—viewed broadly to include institutional guidelines and "other kinds of 'rules' that form the penumbra of law"—can produce "responsible and responsive health care," a goal that requires both that professionals be morally competent and that social incentives encourage them to assume responsibility for patients' welfare.[15]

Finally, several of the symposium articles and essays illustrate or advocate *patient-centered empiricism*. They argue that health care law and policy need to attend more closely to what actually happens to patients and to how public policy initiatives actually affect patients. Such inquiries often suggest new problems that have been overlooked, old problems that are less troublesome than had been thought, and programs that make sense in principle but fail in practice. For instance, Timothy Jost examines the entire system of health care laws and regulation from an evidence-based perspective that asks how well several ideological approaches actually advance their policy objectives.[16] He concludes that, "for real reform to happen, we will need a unified and coordinated framework of health care law based on a coherent and evidence-based understanding of the fundamental problems that plague our health care system and of how a health care system should be constructed so as to overcome these problems."[17]

As Hank Greely observes,[18] the risk of proposing new paradigms is that one may succumb to the desire to make one's favored paradigm dominant. Then, academic time and effort are frittered

14. Shepherd, *supra* note 13, at 445-61.

15. Heimer, *supra* note 13, at 465-507.

16. Timothy S. Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 537-618 (2006).

17. *Id.* at 539.

18. Henry T. Greely, *Some Thoughts on Academic Health Law*, 41 WAKE FOREST L. REV. 391 (2006).

away arguing about which paradigm should prevail. That's the last thing we would wish upon ourselves, and our field. Instead, we search for new approaches that will energize health law scholarship, even if this energy diverges into multiple paradigms that further fragment the field. Health law scholarship, like any useful human enterprise, is messy and cannot be driven solely by logic and argument. To thrive it needs to be fertilized with new ideas that create ecologic diversity, which is what we hope this symposium provides. If we are even partly successful, then we embrace Greely's closing sentiment that all of "our contributions can be both real and important. We should get back to them. There is work to be done."[19]

19. *Id.* at 409.