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Toward an Architecture of Health Law

Wendy K. Mariner
Boston University School of Law

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Wendy K. Mariner[†]

INTRODUCTION

In 1894, John Drinkwater, the befuddled, searching architect in John Crowley's compelling fantasy, *Little, Big*, built his own home, Edgewood, "as a kind of compound illustration" of Victorian architectural styles.[1] Rounding each corner, the visitor sees a different façade and interior – Italianate villa, Tudor manor house, neo-classical, country cottage – complete in itself, its attachment to the others invisible from a single perspective.

Reading a small flurry of articles from the past few years attempting to describe the field of health law,[2] one feels like a visitor to Edgewood. The different perspectives are pleasing in themselves, without necessarily revealing the whole. This essay examines what I call the "architecture" of the health law field. By this I mean, without pressing the metaphor too far, the framework of beams and studs in which interior spaces can be designed, furnished and accessorized in different ways.

This essay addresses three primary questions. First, what is an academic field of law? Second, is health law such a field? Lastly, if it is, how can or should it be portrayed? The first question may have no answer. There are no hard and fast rules for constituting an academic field of law, as explained below in Part IV. Scholars, like practicing lawyers, fashion their own spheres of expertise in response to practical need. This means that health law can

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[†] Professor of Health Law, Bioethics & Human Rights, Boston University School of Public Health; Professor of Law, Boston University School of Law; Professor of Socio-Medical Sciences and Community Medicine, Boston University School of Medicine; Co-Director, Regulatory Knowledge and Research Ethics, BU-BRIDGE Clinical and Translational Science Institute, Boston University. My thanks to Fran Miller, George Annas, and William Sage for encouragement and suggestions in preparing this essay.

[1] JOHN CROWLEY, LITTLE, BIG 32 (Harper Perennial ed. 2006).

[2] *See generally* George J. Annas, *Health Law at the Turn of the Century: From White Dwarf to Red Giant*, 21 CONN. L. REV. 551 (1989) [hereinafter *White Dwarf*]; M. Gregg Bloche, *The Invention of Health Law*, 91 CALIF. L. REV. 247 (2003); Henry T. Greeley, *Some Thoughts on Academic Health Law*, 41 WAKE FOREST L. REV. 391 (2006); Mark A. Hall, *The History and Future of Health Law: An Essentialist View*, 41 WAKE FOREST L. REV. 347 (2006) [hereinafter *Essentialist View*]; Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155 (2004); S. Sandy Sandbar et al., *Legal Medicine and Health Law Education*, *in* LEGAL MEDICINE 3 (S. Sandy Sandbar et al. eds., 7th ed. 2007); Walter Wadlington, *Some Reflections on Teaching Law and Medicine in Law School Since the '60s*, 14 HEALTH MATRIX 231 (2004).

qualify as a distinct field of law for several different reasons, summarized in Part V. Therefore, I begin with the third question. After describing the challenges of doing so, I suggest a conceptual framework for describing the field. It is not a theory, nor a set of normative standards, but a description – an architecture, if you will. The framework offers a blueprint for identifying the principles worthy of consideration in identifying and analyzing legal issues affecting health, while also allowing room for debating the normative values that might govern particular sub-specialities or doctrines.

I. DESCRIBING HEALTH LAW: THE CHALLENGES

Viewing the health law field as a whole, and as separate from other fields of law, encounters two major challenges: (1) the range of legal issues the field covers; and (2) the fact that many doctrines formerly unique to medicine have given way to more general principles from other legal domains.

The first challenge is surely the sheer breadth of doctrines that potentially apply to health issues. These include aspects of administrative, antitrust, constitutional, contract, corporate, criminal, environmental, food and drug, intellectual property, insurance, international, labor/employment, property, taxation, and tort law. At first, it may seem impossible to master all the law that could be relevant to health issues. Judge Frank Easterbrook's concern about dilettantism has some bite here.[3] Lawyers who know too little about the fields they try to join together – especially non-legal fields – risk errors of fact or judgment. The concern is that familiarity with only small segments of another field can deteriorate into doctrinal dabbling, distorting more general principles. But this may say less about the legitimacy of the health law field than the degree of difficulty in mastering it. One cannot profess expertise in health law without a solid grounding in the principles that are brought to bear on health issues, and their underlying rationales.

A possible response to the breadth problem is the practice of sub-specialization, whereby scholars and practicing lawyers become familiar with the scope of the field, but develop expertise in a particular area. This is already common practice not only in health law, but also in other more traditional legal domains, such as constitutional law, where experts on the First Amendment may profess little knowledge of the negative commerce clause. Thus, the breadth problem is not necessarily an impediment to classification as an independent field of law.

The second challenge in describing the boundaries of health law is that the doctrines and principles grounded in other legal domains have come to apply to health problems with less and less special adaptation to the particular circumstances of the medical profession or the physician-patient relationship.[4] Doctrines look less like unique rules for health than relatively straightforward applications of principles of contract, tort, administrative law,

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[3] Frank H. Easterbrook, *Cyberspace and the Law of the Horse*, 1996 U. CHI. LEGAL F. 207, 207-08 (1996) (mocking "law and . . ." courses dedicated to a particular subject matter as dilettantism, analogous to "Law of the Horse.").

[4] *See* Darian M. Ibrahim & D. Gordon Smith, *Entrepreneurs on Horseback: Reflections on the Organization of Law*, 50 ARIZ. L. REV. 71, 76 (2008) (arguing that "a new field of legal study is justified when a discrete factual setting generates the need for distinctive legal solutions.").

or insurance, for example. This dilution of special rules followed health law's transformation from a narrow field of medical jurisprudence to the broader field encompassing professional, financial and civic relationships among patients, government, health providers, and financing institutions. The most obvious example is the doctrine of informed consent, which applies principles of autonomy and self-determination to decisions about medical treatment and recognizes that physicians have no special prerogative to make these decisions for their patients.[5] George Annas and other health law scholars have advocated for patients' rights to make their own decisions about medical care, to be treated with dignity and in privacy in hospitals, and to have access to medical records of their treatment, among other rights individuals enjoy outside medical facilities.[6]

Judicial and statutory recognition of patient rights was not only a victory for patients' rights advocates, but also a response to changes in the science and practice of medicine.[7] Other sets of rules once thought foreign to the medical profession, such as antitrust law, began to govern physicians and health care organizations in more or less the same manner that they applied to commercial businesses.[8] Tort, contract and insurance principles are also increasingly brought to bear on health-related relationships with little alteration from their commercial origins.[9] To be sure, many of these principles and doctrines are modified somewhat to suit the particular circumstances of health problems.[10] Nonetheless, what is striking about health law doctrines today is how much less they diverge from the standards imported directly from other legal domains than they did a half-century ago.

Paradoxically, as health law gained acceptance as a distinct specialty, the legal principles governing much of its subject matter loosened their parochial ties to medicine as the rationale for singular rules. The convergence of principles and doctrines as applied in the health law field with the principles and doctrines as applied in their fields of origin poses a dilemma for defining the boundaries of health law. On one hand, this convergence can be seen as welcome recognition of particular needs of patients, professionals or organizations in the health field. On the other hand, to the extent that principles are not distinctive, there may be less justification for claiming a unique field of health law.

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[5] Jay Katz, The Silent World of Doctor and Patient (1984). *See generally* Ruth R. Faden et al., A History and Theory of Informed Consent (1986).

[6] *See generally* George J. Annas, The Rights of Patients (3d ed. 2004).

[7] Wendy K. Mariner, *Informed Consent in the Post-Modern Era*, 13 L. & Soc. Inquiry 385, 393 (1988).

[8] *See generally* Group Life & Health Insurance Co. v. Royal Drug Co., Inc., 440 U.S. 205 (1979) (applying Sherman Act to Blue Cross); Jefferson Parish Hospital District No. 2 v. Hyde, 466 U.S. 2 (1984) (applying Sherman Act to insurer). *See also*, Utah County v. Intermountain Health Care, Inc., 709 P.2d 265 (Utah 1985) (revoking hospital's state tax exemption).

[9] *See generally* Aetna Health Inc. v. Davila, 542 U.S. 200 (2004) (liability for health insurance coverage denials under ERISA and state common law); American Manufacturers Mutual Insurance Company v. Sullivan, 526 U.S. 40 (1999) (insurers handling state worker compensation programs are not state actors for purposes of the 14th Amendment); Darling v. Charleston Community Memorial Hospital, 33 Ill.2d 326, 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946 (1966) (applying corporate liability for negligence to hospital).

[10] *See generally* Alberts v. Devine, 395 Mass. 59 (1985) (physician's duty of confidentiality).

II. DESCRIBING THE ARCHITECTURE OF HEALTH LAW

Despite these challenges, the persistence and growth of health law as a *de facto* legal specialty still argues for its acceptance as a field of law. This is not to say that health law unequivocally meets the definition of a field of law; rather, as I describe in Part IV, there is no authoritative definition that must be met. Health law qualifies because people practice it, and there is little to gain by academic debates over whether what they do is a field or not. Furthermore, as I argue in Part V, the absence of an overarching theory of health law is no impediment to becoming a field of law.

Nevertheless, if health law is a field, one should know what it includes. Ideally, health law should be described in a manner that gathers all the disparate legal doctrines into a comprehensible whole with observable commonalities, but without necessarily forcing it to adopt any normative goal. This requires accepting the applied nature of the field. The subject matter to which the law applies retains its singular importance. The reason we struggle with definitions is that what brings the different legal domains into play is the subject matter – health. As the Task Force on Health Law Curricula noted, "a description of health law cannot be viewed as merely the sum of its component bodies of law . . . . The content of health law emerges only in the application of these various bodies of law to the domain of the health professions."[11] Today, I would replace "the domain of the health professions" with "social structures that affect health."

Health is the *subject* of law, but it is not the *goal* of law. Most fundamentally, health law adopts and adapts principles from other legal domains to protect the value of health within a framework of justice and the rule of law. Thus, it is not simply the rote application of contract doctrine to an agreement between entities that happen to be in the health field, but an interpretation of whether and how that doctrine ought to be modified both to achieve the goal of contract law and to recognize the value of health. In this very broad sense, health law has dual normative goals: justice and protection of health.

The sense in which I use the concept of goals here is not to impose a requirement that the law must achieve specific normative ends. Rather, it recognizes that justice or the rule of law has its own goals and values.[12] In one sense, most applied fields have dual goals. The difference between health law and "law and the horse" is that the latter need not ascribe any particular value to the horse, whereas health law does value health, but not as a sole end in itself. This type of goal works best, and perhaps only works where it expresses a very broad and highly abstract value, like keeping promises or protecting health. Imposed on more granular circumstances, a value becomes outcome determinative and often counterproductive.[13] A value-driven legal structure

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[11] 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 DET. L. REV. 245, 254-55 (1985) [hereinafter *Task Force*].

[12] *See generally* Joseph Raz, *The Rule of Law and Its Virtue*, *in* LIBERTY AND THE RULE OF LAW 3 (1979); BRIAN Z. TAMANAHA, ON THE RULE OF LAW: HISTORY, POLITICS, THEORY (2004); THE RULE OF LAW: IDEAL OR IDEOLOGY? (Allan C. Hutchinson & Patrick J. Monahan, eds., 1987).

[13] *See generally* BRIAN Z. TAMANAHA, LAW AS A MEANS TO AN END: THREAT TO THE RULE OF LAW (2006).

would convert a description of a field into a normative prescription for particular outcomes. If we knew what outcomes we wanted, why worry about the values of law? Laws would become merely a tool for achieving other ends. Just as not every contract need uphold the value of keeping promises, not every law need value health over other goods. For this reason, health law, like other applied fields, recognizes the importance of weighing the goals of law or justice equally with the value of protecting health.

The value of health is an essential consideration, but not necessarily controlling in any particular setting or circumstance. Lawyers need to think carefully about when a legal principle is controlling and when the health concern is controlling. It is one thing to contextualize the application of legal principles in specific circumstances.[14] It is quite another to subordinate general legal principles to the possibly self-interested goals of a particular industry or profession, no matter how congenial. This in no way precludes adapting principles to account for special obligations owed by physicians to patients by reason of a person's status as a patient and the physician's status as physician, for example. But that informs doctrinal development. It should not impose an overarching goal for law itself, not even in the health law field.

At the same time, it is not enough to apply existing bodies of law to health issues. The very attempt at application challenges the meaning of the principles being applied.[15] Recognizing the consequences of legal principles in the health context yields important insights into how we think about the relationship between individuals and government, as well as individual and social responsibility for health risks.[16] Health law analyses are transforming the way we think about the body, personal information, and property.[17] The interpretation of some laws related to health can affect the distribution of wealth and the allocation of resources. The application of health law principles has blurred the lines between medicine and public health, disease and health, and what it means to be a citizen, a consumer and a patient.[18] These and countless other applications reveal the importance of both law and health and the iterative process of interpreting their mutual influence.

International law has already developed a conceptual framework for an architecture of the health law field in terms that recognize both the value of justice and the value of health. Looking at international conceptions of a field has the advantage of permitting comparative analysis of particular problems

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[14] *See generally* Catherine MacKinnon, Feminism Unmodified: Discourses on Life and Law (1987); Brian Tamanaha, Realistic Socio-Legal Theory: Pragmatism and a Social Theory of Law (Oxford 1997); Mary L. Dudziak, Freedom is Not Enough: The Opening Up of the American Workplace (2006).

[15] *See, e.g.*, Adam Wagstaff, *Social Health Insurance Reexamined* 20 (World Bank Policy Research Working Paper No. 4111, 2007); Lawrence Lessig, *The Law of the Horse: What Cyberlaw Might Teach*, 113 Harv. L. Rev. 501, 502 (1999).

[16] *See generally* Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 Conn. Ins. L. J. 199 (2008).

[17] *See, e.g.*, Maxwell J. Mehlman, Wondergenes: Genetic Enhancement and the Future of Society (Indiana University Press) 84-86 (2003); Ruth Fletcher et al., *Legal Embodiment: Analysing the Body of Healthcare Law*, 16 Med. L. Rev. 321, 324-331 (2008).

[18] *See, e.g.*, Eleanor D. Kinney, Protecting American Health Care Consumers 9-10 (2002); Wendy K. Mariner, *Standards of Care and Standard Form Contracts: Distinguishing Patient Rights and Consumer Rights in Managed Care*, 15 J. Contemp. Health L. & Pol'y 1, 3-4 (1998).

and laws across jurisdictional boundaries. It offers a common language for communicating with scholars and lawyers in other countries. In today's world, health is a global issue, and laws affecting health reach across national boundaries in many ways.[19] For this reason alone, awareness of the treatment of health in international covenants and documents may become an important part of teaching and practice.

One need not have any interest in international or comparative law, however, to recognize parallels between laws governing health and health care in the United States and the conceptual framework for rights and obligations used in international covenants.

The international language commonly used to discuss laws concerning health and health care was inspired by the Committee on Economic, Social and Cultural Rights of the United Nations Economic and Social Council (ECOSOC), in particular its authoritative interpretation of Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR): "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[20] Article 12 sets forth a comprehensive, aspirational statement of what has come to be called the international human right to health, itself derived from the Universal Declaration of Human Rights. [21] The ECOSOC Committee recognized that the "right to health is not to be understood as a

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[19] *See* Economic Policy Comm., European Comm'n, The Impact of Aging on Public Expenditure: Projections for the EU25 Member States on Pensions, Health Care, Long-Term Care, Education and Unemployment Transfers 2004-2050 5 (2006), http://ec.europa.eu/economy_finance/epc/documents/2006/ageingreport_en.pdf; Obijiofor Aginam, Global Health Governance: International Law and Public Health in a Divided World 70 (2005); European Observatory on Health Sys. & Policies, Social Health Insurance Systems in Western Europe 4 (Richard B. Saltman et al. eds., 2004), http://www.euro.who.int/document/E84968.pdf.

[20] International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200 (XXI), Preamble, U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (Dec. 16, 1966) [hereinafter *ICESCR*], *available at* http://www.unhchr.ch/html/menu3/b/a_cescr.htm.

[21] The Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. GAOR, 3d Sess., 1st plen. Mtg., U.N. Doc. A/810 (Dec. 12, 1948), *available at* http://www.un.org/Overview/rights.html. The International Bill of Rights consists of The Universal Declaration of Human Rights, *id.*, the *ICESCR*, *supra* note 20, and the International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), at 52, U.N. GAOR, 21st Sess., Supp. No. 16 (1966), *available at* http://www.unhchr.ch/html/menu3/b/a_ccpr.htm. Article 25(1) of the Universal Declaration of Human Rights states: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." Other articles specify related rights and the universality of all the rights described in the Declaration. For example, Article 1 states: "All human beings are born free and equal in dignity and rights." Article 2 states: "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status." Article 5 states: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment." Article 9 states: "No one shall be subjected to arbitrary arrest, detention or exile." Article 12 states: "No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation." The Universal Declaration of Human Rights, *supra*.

right to be healthy," something no one can guarantee.[22] Rather, the Committee describes steps that signatory States Parties are expected to take, subject to their respective resources and other constraints on feasibility. Although the Committee contemplates that each country will adopt legislation or take other action to promote health, the precise nature of such actions remains subject to interpretation and, in practice, they are implemented differently and to varying degrees by each country.[23]

General Comment No. 14 makes clear that, like all human rights, "[t]he right to health [in ICESCR Article 12] contains both freedoms and entitlements."[24] States Parties must not interfere with personal freedoms, and they must provide, to the extent feasible, the care and protection necessary to protect the health of everyone in their populations. These obligations are described as the duty to "respect, protect, and fulfill" the right to health:

> (1) *respect* individual human rights and personal freedoms;
> (2) *protect* people from harm from external sources or third parties; and
> (3) *fulfill* the health needs of the population.[25]

International Health Framework	**United States Health Laws**
Respect	**Individual Rights**
• Liberty • Privacy • Nondiscrimination	• Liberty, informed consent • Privacy, confidentiality • Nondiscrimination • Access to emergency care
Protect	**Health and Safety Regulation**

• Safety and quality standards
  ○ Food, medical products
  ○ Health professionals, facilities
  ○ Workplace and environment
• Nondiscrimination
  ○ Access to care
  ○ Access to information
	• Health, safety and quality standards
	  ○ Food, medical products
	  ○ Health professionals, facilities
	  ○ Workplace and environment
	  Insurance
	• Nondiscrimination
	  ○ Access to care
	  ○ Access to information
	• Marketing standards
	  ○ Consumer disclosure
	  ○ Antitrust
	  ○ Anti-fraud, abuse

Fulfill	**Service and Benefit Programs**
• Ensure provision of care • Ensure health living conditions • Promote research • Provide education • Promote education	• Direct service programs • Financing benefits, services • Conduct, support research • Support public and professional education • Provide information

[22] U.N. Econ. & Soc. Council [ECOSOC], Sub-Comm. on Econ., Soc., and Cultural Rights, *Report on the Twenty-Second, Twenty-Third and Twenty-Fourth Sessions*, Annex IV, ¶ 8, U.N. Doc. E/2001/22-E/C.12/2000/21 (2001) [hereinafter *General Comment*].

[23] Eleanor D. Kinney, *The International Right to Health: What Does This Mean for Our Nation and World?*, 34 IND. L. REV. 1457, 1467 (2001).

[24] *General Comment*, *supra* note 22.

[25] *Id.* at Annex IV, ¶ 33.

These three obligations provide an organizational structure for categorizing laws affecting health in any country. The parallels between types of law relevant to protecting individual rights, regulating private entities, and government provision or financing of services are striking, at least to this observer.[26] The table above illustrates how laws affecting health in the United States fall rather naturally into these categories. (The left hand column lists illustrative topic areas within the categories of respect, protection and fulfillment; the right hand column lists topics incorporated into Americans laws.) If we think about this structure architecturally, the three categories might represent three sections of the house, each with its particular framework.

Virtually all federal, state and local laws defining the rights and duties of private individuals and organizations, as well as those creating public programs and benefits, can be classified according to one of the three categories. Because the classification is based on the target of the law, some subjects can overlap categories.[27] For example, in the international framework, prohibitions against certain forms of discrimination are found in both the first and second categories: the State has an obligation not to discriminate against individuals as part of its duty to respect the right to health and a further obligation to ensure that third parties do not discriminate as part of its duty to protect the right to health. This separation has the advantage of distinguishing between laws that assign responsibility directly to government and laws that impose obligations on private entities.

The duty to respect the right to health requires the State to "refrain from interfering directly or indirectly with the enjoyment of the right to health."[28] This means that the State may not deny equal access to health services or health information, or initiate or enforce discriminatory practices. It also requires States to refrain from "applying coercive medical treatments," meaning that States must respect individuals' freedom to choose the type of care they receive and to refuse care they do not want.[29] The duty of respect can be best understood as a duty of noninterference with basic human rights like liberty, privacy, dignity and freedom from arbitrary discrimination in the health context, so that individuals are neither denied access to care nor treated unfairly within any health setting. Indeed, it is generally believed to confirm that such fundamental rights must be respected in the health context. Such respect often takes the form of positive law protecting specific rights,

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[26] Wendy K. Mariner, *Law and Public Health: Beyond Emergency Preparedness*, 38 J. HEALTH L. 247, 250 (2005) (noting parallels); Wendy K. Mariner, *Public Health and Law: Past and Future Vision*, 28 J. HEALTH POL., POL'Y & L. 525, 536-37 (2003) (same).

[27] Comment 14 from the twenty-second session distinguishes the three obligations primarily in terms of whether the State or third parties are providing or interfering with access to health services. *General Comment*, *supra* note 22, Annex IV, at ¶ 33. For example, Comment 14 mentions an obligation to refrain from marketing unsafe drugs as part of the duty to respect the right to health and the similar duty to control the marketing of medical equipment and medicines by third parties as part of the duty to protect the right to health, thereby accounting for countries with either public or private systems. *Id.* at ¶¶ 34, 35.

[28] *Id.* at ¶ 33.

[29] *Id.* at ¶¶ 34, 35.

such as the right to informed consent to medical care.[30] In the United States, the duty of respect can be seen in laws forbidding interference with individual rights, such as laws requiring informed consent to medical care and research and prohibiting invasions of privacy and discrimination in access to care.

The obligation to protect requires affirmative action to ensure that third parties—essentially private entities – also do not interfere with the right to health. Where private parties provide goods and services, the State is expected regulate their activities by legislation, contract or other means. This includes ensuring that health professionals meet appropriate quality and competence standards, that food, medicines and health-related products are manufactured and marketed safely, and that industry does not pollute the water, air or soil.[31] It also requires legislation or other action to prevent third parties from limiting access to care, such as family planning and pre- and post-natal care, as well as accurate health information. It is important to note, however, that the international framework does not prescribe any substantive or structural requirements for positive law. Apart from the general notion that laws should not imperil health or violate human rights, countries are free to develop many different approaches to protecting health.

United States laws that set health and safety standards fall easily within this category. They include professional and facility licensure laws, laws setting environmental standards, safety and health standards for workplaces, product standards and other laws intended to reduce health risks arising from products or the social or working environment. This is a broad category crossing a variety of legal fields, from administrative law to products liability. It includes anything that prevents the conduct of business in a way that could harm the health of patients, customers, workers or the general public. Sanitary standards for conducting businesses that can harbor and spread disease have existed since colonial times, applying to animal slaughtering operations, mortuaries, and milk pasteurization, for example.[32] More modern examples include standards for clinical and research facilities, standards for manufacturing food, drugs, medical devices and cosmetics, and even inspecting restaurants. Laws requiring licensure of health professionals, hospitals and other medical facilities are intended to ensure that those who are granted the privilege of providing care have at least a minimal level of competence and skill. Laws regulating health insurance set standards at least believed to promote access to care and prevent certain forms of discrimination. A huge number of national, state and local agencies, from the federal Food and Drug Administration to the local septic system inspection office, have been created to administer these regulatory systems.[33] The common law also provides standards intended to protect health, as found in

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[30] *See* World Health Org., Patients' Rights, http://www.who.int/genomics/public/patientrights/en/ (last visited Feb. 19, 2009) (collection of international and national documents on patient rights).

[31] *General Comment*, *supra* note 22 at ¶¶ 35, 51. The General Comment also mentions the obligation to refrain from marketing unsafe drugs and polluting the environment as part of the duty to respect. *See id.* at ¶ 34.

[32] *See generally* William J. Novak, The People's Welfare: Law and Regulation in Nineteenth-Century America 14-15 (1996).

[33] *See generally* Kenneth R. Wing, The Law and the Public's Health (6th ed. 2004).

negligence law, products liability and even contract and insurance law applicable to health insurance. This category might also include laws that prohibit the sale of illicit drugs like heroin and marijuana, or the sale of cigarettes and alcohol to minors, and laws that authorize the involuntary detention of people who are likely to transmit contagious diseases to others and people who are likely to harm others because of mental illness.

The obligation to fulfill requires countries to ensure that adequate health care is provided to the entire population, whether by public or private programs or a mixture of the two.[34] Recognizing the social determinants of health, it also requires that everyone have equal access to safe food and water, basic sanitation, and adequate housing and living conditions. Ensuring care also includes providing for appropriate training for medical professionals and ensuring that a sufficient supply of hospitals and other health facilities accessible is to everyone in the country. Assisting individuals to enjoy the right to health includes fostering research and disseminating information to the public. Satisfying these duties entails enacting legislation, adopting regulatory measures or providing funding to develop affirmative programs.[35] Here again, however, there is no substantive requirement for any particular approach. States may provide direct health services to all or some people in their countries, require third parties such as employers or insurers to pay for care, contract with third parties to offer care, or use a combination of approaches.

The duty to fulfill can be seen in American laws that affirmatively create benefit programs – offering health care, services or information that individuals are free to accept or refuse. This includes a vast array of public programs to purify the water supply, organize disaster relief, provide medical care such as Medicare and Medicaid as well as state programs for those without health insurance, and fund public and private health programs like family planning clinics, child nutrition programs, substance abuse treatment centers, and refugee care facilities. It also includes public support for biomedical research and public information programs. The number and type of laws creating government programs in the fulfillment category has risen dramatically since the mid-twentieth century.

Visualizing health laws as falling within these three categories has several virtues. First, it pays needed attention to the relationship between human health and respect for human rights.[36] It embraces both the value of justice and the value of health. The ICESCR recognizes, in Article 4, that in order to protect people in the enjoyment of the right to health, some limits on individual rights may be required, but "the State may subject such rights only to such limitations as are determined by law only in so far as this may be compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society."[37] This is intended to warn countries against using the right to health as a pretext for depriving

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[34] *See General Comment*, *supra* note 22, at ¶ 36.

[35] *See id.* at ¶ 37.

[36] *See* Sophia Gruskin & Daniel Tarantola, *Health and Human Rights*, in PERSPECTIVES ON HEALTH AND HUMAN RIGHTS 3, 3 (Sophia Gruskin et al. eds., 2005) (describing the recognition of the synergistic relationship between health and human rights).

[37] *ICESCR*, *supra* note 20, art. 4.

people of other human rights.[38] Any limitation on freedom must be justified by its genuine contribution to preserving other freedoms and entitlements. In this way, basic human rights provide a boundary constraint for the choices of positive law that are permitted to protect health and fulfill health needs. This constraint guards against allowing the value of health to override the rule of law.

Another advantage of this framework is that it includes all aspects of the health field: personal relationships, financial relationships, federal-state jurisdiction, contractual relationships, rights and responsibilities, and institutional structures. While health and healing may be the objectives of people who provide medical care and those who finance and regulate those services, there is much more to making health or healing possible. The range of social and environmental factors that affect health are often as or more important than medical care.[39] The field of health continues to expand as more is learned about what affects health, especially socioeconomic factors, such as the distribution of income and wealth, political inequality, education, employment, housing, and the environment (known as the social determinants of health), as well as individual genetics, travel and migration, and climate change.[40] Laws governing those factors should not be ignored.[41] If institutional licensure and antitrust are included because they affect the way health care is made available, occupational and environmental factors that may affect health should be considered as well.[42] They may solve problems that seem intractable when viewed as medical or health care problems alone. Adopting this broader vision is consistent with the history of health law, which has developed and expanded in response to advances in science and changes in the social institutions that affect health and medical care.

Finally, and most importantly, although the framework acknowledges the relevance of many different factors affecting health, it does not prescribe any particular legal structure or set of doctrines. The overall question is how to organize social institutions (including rights and duties) to protect health and treat illness without jeopardizing essential human rights like autonomy and dignity. Answers to this question will necessarily embody normative values.

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[38] *Id.* at art. 5.

[39] *See generally* COMM'N ON SOC. DETERMINANTS OF HEALTH, WORLD HEALTH ORG., FINAL REPORT: CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH (2008), http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf.

[40] *See generally* WHY ARE SOME PEOPLE HEALTHY AND OTHERS NOT? THE DETERMINANTS OF HEALTH OF POPULATIONS (Roger G. Evans et al. eds., 1994); ICHIRO KAWACHI ET AL., INCOME INEQUALITY AND HEALTH: A READER (1999); WORLD HEALTH ORG., SOCIAL DETERMINANTS OF HEALTH (Michael Marmot & R.G. Wilkerson eds., 2003), http://www.euro.who.int/document/e81384.pdf; Nancy E. Adler et al., *Socioeconomic Status and Health: The Challenge of the Gradient*, 49 AM. PSYCHOLOGIST 15 (1994); Adam Wagstaff & Eddy van Doorslaer, *Income Inequality and Health: What Does the Literature Tell Us?*, 21 ANN. REV. PUB. HEALTH 543 (2000).

[41] *See generally* Barry Zuckerman et al., *Why Pediatricians Need Lawyers to Keep Children Healthy*, 114 PEDIATRICS 224 (2004); Steven H. Woolf et al., *The Health Impact of Resolving Racial Disparities: An Analysis of US Mortality Data*, 94 AM. J. PUB. HEALTH 2078 (2004).

[42] *See* A. J. McMichael et al., *Global Environmental Change and Health: Impacts, Inequalities, and the Health Sector*, 336 BRIT. MED. J. 191, 193 (2008) (arguing that "the greater public health preventative challenge lies is stopping the process of climate change.").

But the framework does not answer the "how" question itself. Instead, it leaves each country free to analyze the merits of specific choices for positive laws in each category. It is here that more specific debates take place about the justifiable objectives of particular laws and the merits of particular means to achieve them, from employer mandates to compulsory immunization.

The international framework thus offers an architectural blueprint for constructing health laws. Figure A, depicted at the end of this article, offers a rough illustration. The obligation to respect can be seen as the foundation for two more stories, one protecting and the other fulfilling health needs. Laws protecting basic human rights, such as autonomy and privacy, frame the structure, creating boundary constraints as well as structural beams projecting through all the floors. Within each story are multiple rooms, furnished with relevant legal domains overlaying topic areas, as illustrated at the end of this article in Figure B. Debates over particular laws contribute to the discussion of how to furnish the rooms. Should government provide particular services directly, fund private entities to do so, require private organizations to provide services, or adopt some or all of these options? Which legal principles should govern? A few antiques may fit some rooms perfectly, while new pieces may be required in others. Some bits of furniture may need reupholstering to suit the room. The iterative process of adapting doctrine to suit the circumstances continues here.

This vision of health law is less eccentric than the house of Edgewood, with its idiosyncratic, mismatched sections. The international framework offers an integrated, external architecture for housing the field of health law. In contrast to Edgewood, health law's idiosyncrasies are inside, in the rich variation of its interior spaces. There is even room for considering international and comparative law. Importantly, by consolidating all types of law that affect health, it reminds us that there are many ways to solve health problems and that we should consider all the alternatives before automatically adopting a particular approach.

III. WHAT IS A FIELD OF LAW ANYWAY?

The foregoing description explicitly recognizes, as do most observers, that health law is an applied field.[43] To many, this confers an advantage and a rich opportunity to consolidate legal education in a way that mirrors actual practice.[44] Some academic traditionalists, however, would not count an applied field as a "field of law."[45] This begs the question of why other generally accepted areas of study or practice should qualify as fields of law. By what standards and criteria, and for what purpose, is any particular area thought to qualify as a substantive field?[46] This question turns out to be quite difficult to

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[43] *White Dwarf*, *supra* note 2, at 552-3; Sandbar, *supra* note 2, at 6.

[44] *White Dwarf*, *supra* note 2, at 567-8.

[45] Easterbrook, *supra* note 3, at 207-08.

[46] Almost all recent articles examining applied fields of law refer to Easterbrook's essay on cyberlaw. *Id.* *See also* Hall, *supra* note 2, at 355; Greely, *supra* note 2, at 404-05; Lessig, *supra* note 15, at 501. Easterbrook's essay itself did not offer a definition for a field of law, apart from referencing an admonition that "'Law and . . .' courses should be limited to subjects that could illuminate the entire law." Easterbrook, *supra* note 3, at 207.

answer. The literature is notable for the absence of an epistemology or *meta* theory for positively defining the essential characteristics of a "field of law."[47]

One possible answer, which may be the most accurate, is that separate fields have become accepted as a matter of historical accident or practical need. If longevity counts, one might take note that Blackstone's *Commentaries* includes a chapter entitled "Of Offences Against the Public Health, and the Public Police or Economy," dealing primarily with plague.[48] Treatises on medical jurisprudence also date from the 19th century,[49] including works by John Ordronaux, who taught on the law faculties of Boston University and Columbia University.[50]

It might be argued that a field cannot be defined simply by the subject matter to which it applies. And yet many are defined in that manner, and they have ample precedent. Nineteenth century legal scholarship includes treatises on the law of highways,[51] the law of railways,[52] the law of telegraphs,[53] and the law of building associations, which may be an ancestor of banking and mutual insurance law.[54]

Legal texts summarizing the law in 18th and 19th century America contain somewhat different lists of fields of law (sometimes called subjects or

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[47] Authors describe particular fields in different terms, often without specifying independent criteria. *See, e.g.*, W. Cole Durham Jr., *Revivifying the Field of Law and Religion*, 57 Emory L. J. 1411, 1411 (2008); Brian Leiter, *The End of Empire: Dworkin and Jurisprudence in the 21st Century*, 36 Rutgers L. J. 165, 165 (2004) (taking "stock of the field of law and philosophy"); Lessig, *supra* note 15, at 502; Jacqueline Lipton, *A Framework for Information Law and Policy*, 82 Or. L. Rev. 695, 700 (2003) (arguing for a new field of "information law" that focuses on information, in contrast to cyberlaw, which the author argues focuses instead on the technology).

[48] William Blackstone, Commentaries on the Laws of England: In Four Books 161 (London, A. Strahan for T. Cadell and W. Davies 1803). *See also* Thomas F. Gordon, A Digest of the Laws of the United States 553 (Philadelphia, printed for the author 1827) (including the chapter "Of Quarantines and Health Laws"). *See generally* Bertram Jacobs, A Manual of Public Health Law (1912); LeRoy Parker & Robert H. Worthington, The Law of Public Health and Safety (Albany, M. Bender 1892).

[49] *See* J. H. Balfour Browne, The Medical Jurisprudence of Insanity (London, J. & A. Churchill 1871); James C. Mohr, Doctors and the Law: Medical Jurisprudence in Nineteenth Century America (1993); John Ordronaux, Jurisprudence of Medicine in its Relation to the Law of Contracts, Torts, and Evidence (Philadelphia, T. & J.W. Johnson 1869); Isaac Ray, A Treatise on the Medical Jurisprudence of Insanity (Boston, Little, Brown, & Co. 1838). *See also* Sandbar, *supra* note 2, at 2 (briefly describing the history of medical jurisprudence in the United States).

[50] John Ordronaux, The Jurisprudence of Medicine in its Relations to the Law of Contracts, Torts, and Evidence (The Lawbook Exch., Ltd. 2006) (1869). *See also* Obituary Notes, January 21, 1908, N. Y. Times, http://query.nytimes.com/mem/archive-free/pdf?_r=1&res=9E0DE0DD113EE033A25752C2A9679C946997D6CF (detailing Ordronaux's teaching career at Columbia, Dartmouth, University of Vermont, and Boston University).

[51] Joseph K. Angell & Thomas Durfee, A Treatise on the Law of Highways; (Boston, Little, Brown, & Co. 1857).

[52] Isaac F. Redfield, Practical Treatise upon The Law of Railways. (Boston, Little, Brown, & Co. 1858) (Chief Justice of Vermont).

[53] William L. Scott & Milton P. Jarnagin, A Treatise upon the Law of Telegraphs; (Boston, Little, Brown, & Co.1868).

[54] G. A. Endlich, The Law of Building Associations: Being a Treatise upon the Principles of Law Applicable to Mutual and Co-operative Building, Homestead, Saving, Accumulating, Loan and Fund Associations, Benefit Building Societies, & c., in the United States (Jersey City, Frederick D. Linn & Co. Law Publishers and Booksellers 1882).

divisions) than their later counterparts. Nonetheless, many are described by the subjects to which the law described applies.

In his 1868 text summarizing law, Joel Prentiss Bishop remarked, "the first thing to be noticed is, that the subjects run into and include one another."[55] For example, the law of evidence, although a recognized division in the law, pertained to the law of contracts, real property, personal property, torts, public wrongs, international public and private law, "and all the rest."[56] Bishop argued that discussions "aimed at ascertaining what is the true scientific division of the legal field . . . are like the endeavors to find the philosopher's stone, to square the circle . . . endeavors after what, in the nature of things, cannot be performed, because the thing itself does not exist."[57]

Many accepted fields of law exhibited blurred boundaries. Separate areas, such as the law of easements, the law of mortgages, the law of executory devises, and the law of estates eventually coalesced into the more general law of real property, while also touching on the law of contracts.[58] Each area has a feathering edge where overlap is inevitable. Prosser might have expressed the difficulty of setting firm boundaries when he wrote: "tort is a field which pervades the entire law, and is so interlocked at every point with property, contract and other accepted classifications that . . . the categories are quite arbitrary and there is no virtue in them."[59] Yet, Prosser also developed a separate field of agency.[60] Legal fields arise and fade away, expand and contract according to the problems and possibilities of contemporary society and commerce. So, the law of bills and notes has been overtaken by commercial transactions, which itself can be viewed as an aspect of contracts.

This phenomenon of running together yet remaining apart continues today. Compare the curriculum of almost any law school in 1950 with today's curriculum. Only a small proportion of subjects remain the same in name and content. Family law, for example, has absorbed the older law of marriage, with its reliance on distinctions between public and private spheres of responsibility, yet also feathers into principles of contract, tort, wills and trusts. Property law has borrowed from real and personal property. Subjects that today seem commonplace, like securities law and insurance law, would have surprised our ancestors, while others to which they paid studious attention, like admiralty, restitution, or maritime law, have a narrower audience. New fields arise and gain acceptance despite their initial strangeness. In 1868, Bishop encouraged his readers to study the U.S. Constitution because, "Here is a new field."

Some areas acquire their distinctiveness, despite belonging to a larger conceptual sphere. Intellectual property has carved out a specialty area within property law. But for practical experience, antitrust law might be an aspect of contracts. For that matter, many fields of law might be brought under the

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[55] Joel Prentiss Bishop, The First Book of the Law; Explaining the Nature, Sources, Books, and Practical Applications of Legal Science, and Methods of Study and Practice. § 321, at 219 (Boston, Little, Brown, & Co. 1868).

[56] *Id.* at 234.

[57] *Id.* at 220-221.

[58] *Id.* at 219.

[59] William J. Prosser, Handbook of the Law of Torts 2 (3d ed. 1964).

[60] *See* William Gregory, Gregory's Hornbook on the Law of Agency and Partnership 2 (2001).

umbrella of contracts. If we were to collapse all the categories of law that belong to contracts and torts, we would have two vast fields indeed. Yet that might only inspire continuing the subdivisions as subspecialties of contracts, with little substantive change in current teaching or practice.[61]

Bishop's refreshingly honest appraisal of the difficulty of separating one field from another did not dissuade him from recognizing divisions: "Still, as a matter of practical convenience, we may divide off the legal field in various ways, as may best suit the particular purpose of the division, or our tastes."[62] It thus appears that the division of legal principles into fields of law remains a function of the purpose for which division is useful. Or perhaps it's just a matter of taste.

Most treatises describing fields of law make no effort to define fields according to any independent criteria. Nonetheless, one can discern three possible approaches to defining a discrete field. The first is by subject matter, taking the history and tradition of rules and customs associated with a particular subject, like maritime trade and the sea.[63] The second centers on a statute or set of related documents.[64] A growing number of fields fall into this second category, including trademark, administrative, bankruptcy, tax, and environmental law, as well as constitutional law and international public law. The third, and apparently smallest category, is defined by the overall purpose of the laws associated with the field. Here, contract law may be the best example. As defined in Corbin's treatise, the purpose of contract law is "the realization of reasonable expectations that have been induced by the making of a promise."[65] One might expect that a similar purpose could be stated for other traditional and enduring fields, but legal goals are not easily found or stated.[66]

Fields of law appear to have grown up according to quite different principles of organization, principles that are neither mutually exclusive nor internally consistent. While some gather a variety of legal principles around a focal subject, others concentrate on a document that inspires interpretation. Some, like conflicts and evidence, seem more procedural than substantive. Surprisingly few are grounded in goals, conceptual principles or themes independent of the subject matter to which they apply. These may include

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[61] An analogy might be the specialty (and department) of medicine in medical schools, which includes many subspecialties, including cardiology, pulmonology, oncology, infectious diseases, and many others.

[62] Bishop, *supra* note 55, at § 327, 221.

[63] *See* Steven F. Friedell, Benedict on Admiralty § 1, at 1-2 (7th ed. 2005).

[64] *See* 1 Anne Gilson Lalonde et al., Gilson on Trademarks § 1.01[2], at 1-6 (Matthew Bender 2008).

[65] Arthur Linton Corbin, Corbin on Contracts, §1.1, at 1 (Matthew Bender 2008).

[66] *See* Prosser, *supra* at note 59, at 2-3 ("there is a central theme, or basis or idea, running through the cases of what are called torts, which, while difficult to put into words, does distinguish them in a greater or less degree from other types of cases."). Prosser nonetheless objected to attempts "to reduce the entire law of torts to a single broad principle . . . ." *Id.* at 4. Yet he did define it as "a body of law which is directed toward the compensation of individuals, rather than the public, for losses which they have suffered in respect of all their legally recognized interests, rather than one interest only, where the law considers that compensation is required . . . . The law of torts, then, is concerned with the allocation of losses arising out of human activities . . . ." *Id.* at 6.

conflict of laws, contracts, criminal law, property, and torts, although property and torts admittedly feather out into the cornucopia of other legal fields, too.

The lesson here is that no ultimate authority exists for defining a field of law. Defining a field by the subject matter around which legal principles are gathered has as credible a pedigree as any other approach. Complaints that "law and …" fields are necessarily illegitimate overstate the case. In the absence of any compelling argument for adherence to rigid boundaries, a field may be defined by its own practitioners for their purposes or tastes. The test of its validity lies in whether others accept it.

IV. ACCEPTING HEALTH LAW

The world of practicing lawyers has definitely accepted health law as a specialty. The public and private programs, activities, and businesses that finance, provide, and oversee health care account for more than 16 percent of the country's gross domestic product.[67] Expertise in laws governing the health sector is taken seriously for that reason alone. Today's law students are increasingly likely to encounter health law issues in their careers and certainly in their personal lives. The practice of law now includes substantial segments devoted to health-related issues. Moreover, the organizational structure of the practice of law has changed.[68] Larger firms offer specialty groups within a national general practice. The number of federal, state and local agencies involved with health-related issues increased dramatically in late 20th century, and lawyers have been welcomed at those agencies, as well as at hospitals, pharmaceutical companies, and advocacy organizations, to name only a few. Whatever one might think of the appropriate roles of graduate education and professional training, law schools need to train students for these careers.[69] Furthermore, those who teach health law must define their subject, if only to decide what to teach.[70] Students also need to know the general boundaries of the terrain to be covered.[71]

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[67] Aaron Caitlin et al., *National Health Spending in 2005: The Slowdown Continues*, 26 HEALTH AFFAIRS 142, 142 (2007); John A. Posal et al., *Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact*, 26 HEALTH AFF. w242, w242 (2007) (projecting 19.6% of GDP by 2016). *See also* Thomas M. Selden & Merrile Sing, *The Distribution of Public Spending for Health Care in the United States*, 27 HEALTH AFF. w349 (2008). For current statistics and the health care cost percentage of the gross domestic product, see DHHS, Centers for Medicare and Medicaid, Services, National Health Expenditure Data, http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage (last visited Mar. 18, 2009).

[68] JOHN P. HEINZ ET AL., URBAN LAWYERS: THE NEW SOCIAL STRUCTURE OF THE BAR 1-9 (2005); Robert Nelson, *The AJD Project: The First National Longitudinal Study of Lawyer Careers*, 36 SW. U. L. REV. 355, 357-58 (2007) (reporting a shift from professional firms to large firms and organizations, both public and private, an increase in specialization and business representation among practicing lawyers, and "a very stark prestige hierarchy across fields of law.").

[69] *White Dwarf*, *supra* note 2, at 554.

[70] I confess to attempting the same thing when I began teaching health law. I initiated and chaired the Task Force on Health Law Curricula, which produced a report, "Health Law and Professional Education," for the American Society of Law and Medicine. *Task Force*, *supra* note 11. The Task Force was charged with developing not a theory, but an overview of the health law field, describing the objectives of teaching health law, and making recommendations for curriculum content. It was a practical report for faculty. However, it

With so many lawyers teaching and practicing what they call health law, it is hard to assert that no such field exists.[72] Defining it more elegantly and succinctly than I have tried to do in Part III above is both appealing and challenging.[73] Definitions tend to fall into two general categories: (1) definitions or descriptions based on topics or policy goals;[74] and (2) normative theories about the goals of health law in whole or in part.[75] Textbooks for teaching and practical treatises and manuals often use the first category, dividing the subject matter into subcategories familiar to practicing lawyers: subjects, such as liability, financing, corporate regulation, and bioethics; and policy goals, such as quality, cost, access, and autonomy. Alternatively, they divide it into structural components, such as international, governmental, institutional, and individual.

The topic-oriented approach has left some observers hungry for common legal themes to unite the components into more than a collection of health-related problems.[76] Some academics wish to endow the field with the higher credibility that law faculties accord to scholarship addressing legal theory.[77] The more ambitious souls have offered ideas toward constructing a theory of

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claimed, perhaps presumptuously, to present a conceptual model of health law as a working definition of the field, but cautioned that its report was highly preliminary and expected the field to evolve with the subject matter, as it indeed has.

[71] Wadlington, *supra* note 2, 160-64.

[72] "Law and Medicine" is one of the 20 chapters in 3 THE CAMBRIDGE HISTORY OF LAW IN AMERICA, THE TWENTIETH CENTURY AND AFTER (1920-) (Michael Grossberg & Christopher Tomlins eds., 2008).

[73] *See* discussion of challenges, *supra* Part II.

[74] CLARK C. HAVIGHURST, HEALTH CARE LAW AND POLICY: READINGS, NOTES, AND QUESTIONS 1 (1988). *See generally* GEORGE J. ANNAS ET AL., AMERICAN HEALTH LAW (1990); WILLIAM J. CURRAN & E. DONALD SHAPIRO, LAW, MEDICINE, AND FORENSIC SCIENCE (3d ed. 1982); BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS (6th ed. 2008); MARK HALL ET AL., THE LAW OF HEALTH CARE FINANCE AND ORGANIZATION (2d ed. 2008); MARK HALL ET AL., BIOETHICS AND PUBLIC HEALTH LAW (2d ed. 2008); MARK HALL ET AL., MEDICAL LIABILITY AND TREATMENT RELATIONSHIPS (2d ed. 2008); KENNETH R. WING, THE LAW AND AMERICAN HEALTH CARE (1998); RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM (1997); WALTER WADLINGTON ET AL., CASES AND MATERIALS ON LAW AND MEDICINE (1980).

[75] A third category, by far the largest although not discussed here, might be theories about the application of particular legal principles or doctrines to specific health issues to achieve normative goals, but which do not purport to describe or apply to the entire field of health law, however defined. *See generally* WENDY E. PARMET, POPULATIONS, PUBLIC HEALTH, AND THE LAW (2009) (arguing for imbuing certain constitutional law doctrines with what she calls the public health perspective, without purporting to define the field); Nan D. Hunter, *Managed Process, Due Care: Structures of Accountability in Health Care*, 6 YALE J. HEALTH POL'Y L. & ETHICS 93 (2006).

[76] *See, e.g.*, Einer R. Elhauge, *Can Health Law Become a Coherent Field of Law?*, 41 WAKE FOREST L. REV. 365, 365 (2006) ("health law, today, is not yet a coherent field of law."); Greeley, *supra* note 2, at 398; Mark A. Hall et al., *Rethinking Health Law: Introduction*, 41 WAKE FOREST LAW REVIEW 341, 341 (2006) (health law is haunted by a "specter of exhaustion"); Clark C. Havighurst, *Health Care as a Laboratory for the Study of Law and Policy*, 38 J. LEGAL EDUC. 499, 499 (1988) (noting that health law does not have "a discrete body of legal doctrine."); *White Dwarf*, *supra* note 2, at 555; Kenneth R. Wing, *Letter to the Editors of Health Matrix*, 14 HEALTH MATRIX 237, 238, 242 (2004) ("[t]here is no severable body of principles, or even a set of issues, defined by either circumstances or type of controversy . . . . I do not think that there is much out there that deserves to be called health law, let alone a whole field of it.").

[77] Greeley, *supra* note 2, at 402, 407.

health law,[78] efforts that have been regarded variously with enthusiasm and bemusement within the academy.[79] Given that law review articles are largely ignored outside the academy,[80] the audience for legal theory scholarship is limited. Where tenure standards favor theory over utility, however, junior faculty may have to find some strands of theory or at least doctrinal convergence in their topics. So faculty continue to look for the thematic threads that tie disparate health law issues together, much as scholars stitched together earlier groupings to posit a "law" of intellectual property or family law.[81] Normative theories respond to this aspiration.

Normative theories have focused on professional values,[82] economics,[83] and social goals, regulatory authority, and public expectations.[84] These may be seen as values that do or should influence legal doctrine applicable to problems in the health field or as goals for the law to achieve.

The special relationship between physicians and patients was a defining feature of medicine and law in its early days.[85] Both the values of the medical profession and its tradition of self-regulation offered a measure of distinctiveness to justify special rules for physicians and patients.[86] Today, however, professional self-regulation has been diminished – and tarnished[87] – so substantially that it no longer serves as a field-defining attribute.[88] Furthermore, professional self-regulation begs the question of whether the medical profession can be distinguished from the legal profession or any other for the purpose of crafting unique legal rights or responsibilities. More fundamentally, the very concept of profession has undergone intense questioning about whether it is possible to distinguish professions from other

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[78] Nan D. Hunter, *Risk Governance and Deliberative Democracy in Health Care*, 97 GEO. L.J. (forthcoming 2008); Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 465 (2002) [hereinafter *Trust*]; *Essentialist View*, *supra* note 2, at 357.

[79] Greeley, *supra* note 2, at 400; *White Dwarf*, *supra* note 2, at 553-54; Wing, *supra* note 76, at 237.

[80] Adam Liptak, *When Rendering Decisions, Judges Are Finding Law Reviews Irrelevant*, N.Y. TIMES, Mar. 19, 2007, at A8.

[81] *See generally* SAMUEL WILLISTON, THE LAW OF CONTRACTS (1922).

[82] *Essentialist View*, *supra* note 2, at 357-58 (discussing medicine, the relationship between physicians and patients, and the financing of medical care); *Trust*, *supra* note 78, at 469 (viewing the law pertaining to medical care through the lens of trust).

[83] *See, e.g.*, CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH CARE REFORM 89-103 (1995); Elhauge, *supra* note 76, at 372.

[84] *See, e.g.*, Bloche, *supra* note 2, at 299-301; Rand E. Rosenblatt, *Conceptualizing Health Law for Teaching Purposes: The Social Justice Perspective*, 38 J. LEGAL EDUC. 489, 491-94 (1988).

[85] Barry R. Furrow, *From the Doctor to the System: The New Demands of Health Law*, 14 HEALTH MATRIX 67, 69 (2004).

[86] *See generally* WILLIAM J. CURRAN, LAW AND MEDICINE: TEXT AND SOURCE MATERIALS ON MEDICO-LEGAL PROBLEMS (1960) (describing earlier physician-centered doctrines on expert testimony, the locality rule, physician standards of disclosure, and confidentiality).

[87] *See, e.g.*, ROGER G. NOLL & BRUCE M. OWEN, THE POLITICAL ECONOMY OF DEREGULATION: INTEREST GROUPS IN THE REGULATORY PROCESS 155 (1983); Dion Casey, Note, *Agency Capture: The USDA's Struggle to Pass Food Safety Regulations*, 8 KAN. J. L. & PUB. POL'Y 142, 154-56 (1998).

[88] *See* Furrow, *supra* note 85, at 69-70 (describing the historical evolution in which "courts nipped and tucked the edges of the provider-patient relationship" and "judicially developed general legal and ethical principles governed the dyadic relationship of a sole practitioner and patient.").

commercial endeavors, and therefore whether professionals should be accorded different legal treatment by virtue of their calling alone.[89]

Law and medicine, not to mention the care delivery and financing institutions, have evolved so significantly that professionalism alone cannot offer thematic consistency across the entire range of issues within health law. The rise of hospitals and other health facilities, health insurance, and government agencies to regulate facilities, research, pharmaceuticals, and everything in between encouraged viewing the field as an industry amenable to economic analysis. Academic and perhaps political disagreements over law and economics approaches can tag the debate with a tinge of partisanship.

These conceptions of health law offer important perspectives on particular legal principles, but most seem too broad or too narrow, too subject-driven or too value-laden, to constitute an overarching normative goal for the field as a whole. They also carry the risk of legal instrumentalism – forcing law to achieve the goals of non-legal fields, like banking, insurance, or medicine.[90] Law can sometimes be a means to an end, but law has its own ends which should never be forfeited.[91]

For the most part, normative theories compete to resolve more specific issues within a field.[92] In this role, they sometimes reflect philosophical preferences for specific outcomes. It may be too much to expect any normative theory to embrace an entire field objectively. Certainly, no single theory has proved generally acceptable. This suggests that descriptions of the field should avoid normative stances.

Normative theories about health law have other disadvantages as a conceptual framework for a legal domain. Most normative theories limit their scope to medical care, typically excluding mental health, environmental health, public health, and social, economic and political conditions. Even thoughtful examinations that seek common themes across the spectrum of norms largely limit themselves to medical care and its financing.[93] Narrowing may be a practical necessity when organizing law school courses, but it fails to capture the growing interconnectedness of health issues today.

Mark Hall notes that one might regard health law "as an intellectual field defined more by method than by substance – that method being some version of comparative institutional analysis."[94] But, as he also correctly recognizes, comparing different theoretical approaches to analyzing an issue is a

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[89] *Compare*, P. Sieghart, *Professions as the Conscience of Society*, 11 J. Med. Ethics 117, 117-20 (1985) (positing that the rule of conduct in professional ethics is "the service of a noble cause," which differentiates true professions from other trades or occupations) *with* R. S. Downie, *Professional Ethics*, 12 J. Med. Ethics 64, 64 (1986) (challenging Sieghart's arguments and considering that "there is nothing to distinguish the professional from other occupations in terms of the criteria of self-interest and altruism.").

[90] *See* Lawrence O. Gostin, Public Health Law: Power, Duty, Restraint 4 (2008) (arguing that law should serve the goal of public health).

[91] *See* Wendy K. Mariner, *Law and Public Health: Beyond Emergency Preparedness*, 38 J. Health L. 247, 250 (2005).

[92] *See* Rand E. Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 Yale L. J. 243, 258-259 (1990).

[93] *See* Hunter, *supra* note 78, at 2.

[94] *Essentialist View*, *supra* note 2, at 357.

technique used in most legal domains.[95] Not being unique to health law, analysis cannot serve as a basis for distinguishing it from other fields. Nan Hunter proposes "risk governance" as a theoretical paradigm applicable to insurance and risk in medical care.[96] This approach has the value of recognizing law's central function as a risk allocation device. Yet because risk allocation it also a generic concept that pervades most legal fields – think of criminal law – it may serve best as a lens through which to view specific principles and doctrines, rather than as a defining attribute of health law.

These approaches have enriched our thinking about health law issues, but have not generated consensus. No single methodological approach, perspective or normative paradigm seems capable of encompassing the range of legal issues in the health field. They are best suited to interpreting principles and adapting doctrines and rules. Normative theories give us fresh perspectives on how to choose the right rule, for example whether direct government intervention or a standard for private entities to obey. In health law's architecture, they can direct us to one floor or another and guide how we design and furnish each room. They belong inside the house of health law, but they are too specific to construct its entire framework. In any event, there does not appear to be any satisfactory reason for making a normative theory a prerequisite to recognizing a field of law.

V. CONCLUSION

Health law is an eclectic and integrated translegal field, drawing on multiple domains of law to create an identifiable applied field of law. It applies and adapts existing law to protect health within the constraints of justice and human rights. Accomplishing this requires identifying all laws that affect health and evaluating their capacity to improve health without violating or impairing human rights. The international health framework provides a valuable, functional description of the health law field, because it encompasses virtually all the institutional and private structures and relationships needed to attend to people's health, as well as the range of legal doctrines available to address health concerns. The international health framework recognizes both the singular value of health to human beings and the impossibility of protecting, preserving or restoring health without legally sanctioned social institutions that respect human rights. It also encourages reflection on both the substantive and procedural contours of laws that might address health problems. It accomplishes this without imposing more specific normative goals on law itself. Viewing health law as a structure for making health the subject of law will, I hope, encourage continued examination and debate over the field's interior spaces.

At Edgewood, the house that Drinkwater built was home to generations of a family whose members exhibited beliefs in tradition, progress, literacy, laziness, nurturance, nonsense, and the occasional communion with faeries.

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[95] *Id.* at 356 (defining comparative institutional analysis, generally, as "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."). *See generally* INSTITUTIONS AND PUBLIC LAW: COMPARATIVE APPROACHES (Tom Ginsburg et al. eds., 2005).

[96] Hunter, *supra* note 78.

Today's house of health law accommodates an equally eclectic collection of scholars and practicing lawyers and promises many generations to come. Yet, unlike Edgewood, our home has changed, growing much larger and creating an increasingly cohesive external architecture from the values of justice and health. Inside, many different styles are still welcome.

Figure A.

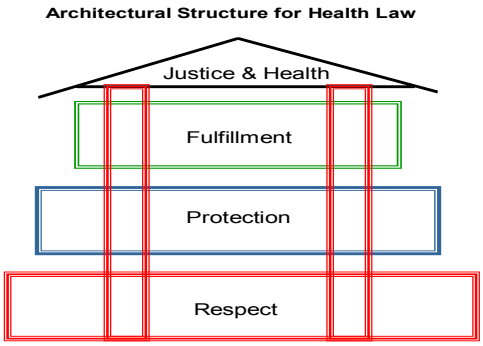

Figure B.