

2004

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### Recommended Citation

Mark A. Hall and Carl E. Schneider, *Where Is the "There" in Health Law - Can It Become a Coherent Field*, 14 Health Matrix 101 (2004)  
Available at: <https://scholarlycommons.law.case.edu/healthmatrix/vol14/iss1/9>

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# WHERE IS THE “THERE” IN HEALTH LAW? CAN IT BECOME A COHERENT FIELD?

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**GERTRUDE STEIN COMPLAINED OF OAKLAND**, “There is no there there.”<sup>1</sup> Churchill complained of his pudding that “it has no theme.”<sup>2</sup> And everybody complains of health law that it lacks an organizing principle. Health law scholars bemoan the “pathologies” of health law<sup>3</sup> and its contradictory and competing “paradigms”<sup>4</sup> which form a “chaotic, dysfunctional patchwork.”<sup>5</sup>

But it should not surprise us that any field which grows by accretion lacks a unifying idea or animating concern. And health law certainly grew by accretion. It began in the 1960s, when the Law-

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<sup>1</sup> GERTRUDE STEIN, *EVERYBODY’S AUTOBIOGRAPHY* 289 (Cooper Square Publishers 1976) (1937).

<sup>2</sup> Conversation between Winston Churchill and a waiter at the Savoy Hotel, in LORD HOME, *THE WAY THE WIND BLOWS: AN AUTOBIOGRAPHY* 217 (1976).

<sup>3</sup> Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449, 1452 (1994) (arguing that health law suffers from the pathology of applying its four different paradigms inconsistently).

<sup>4</sup> Various discussions on health law’s different intellectual paradigms can be found in TASK FORCE ON HEALTH LAW CURRICULA, AMERICAN SOCIETY OF LAW AND MEDICINE, *HEALTH LAW AND PROFESSIONAL EDUCATION* (1985) (outlining a comprehensive framework and organization of the field); George J. Annas, *Health Law at the Turn of the Century: From White Dwarf to Red Giant*, 21 CONN. L. REV. 551 (1989) (proposing an paradigm for health law focused on social justice, bioethics, and public health); M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 249 (2003) (arguing that health law is both chaotic and unruly); Elhauge, *supra* note 3; Clark C. Havighurst, *The Professional Paradigm of Medical Care: Obstacle to Decentralization*, 30 JURIMETRICS J. 415 (1990) (criticizing the professional paradigm); Rand E. Rosenblatt, *Conceptualizing Health Law for Teaching Purposes: The Social Justice Perspective*, 38 J. LEGAL EDUC. 489 (1988) (summarizing different approaches to health law); Susan M. Wolf, *Shifting Paradigms in Bioethics and Health Law: The Rise of a New Pragmatism*, 20 AM. J.L. & MED. 395, 408–14 (1994) (analyzing the shifting paradigms in health law and critiquing economic rationality as an organizing principle).

<sup>5</sup> Bloche, *supra* note 4, at 321.

Medicine Center was established, concerned with medical proof in litigation, physicians' malpractice, and public-health regulation. During the 1970s, bioethics was taken into the fold. And in the 1980s, economic and regulatory topics gained prominence in the field.

Health law, then, is more the creature of history than of systematic and conceptual organization. It looks hardly more cohesive than a "law of horses." As Judge Easterbrook once quipped about cyberlaw: "Lots of cases deal with sales of horses; others deal with people kicked by horses; still more deal with the licensing and racing of horses, or with the care veterinarians give to horses, or with prizes at horse shows. Any effort to collect these strands into a course on 'The Law of the Horse' is doomed to be shallow and to miss unifying principles."<sup>6</sup>

This is not to say that there have been *no* attempts to give health law the dignity of an explaining principle. Medical law has in recent years entertained two competing paradigms – the patients' rights approach and the law and economics approach. The patients' rights approach at heart hopes that medicine can be regulated by endowing patients with rights of autonomy to which medical professionals and institutions must defer. The law and economics approach at heart hopes that medicine can be regulated in the market, by consumers making purchasing decisions that discipline medical institutions.

Both these approaches have their merits. Not least, both have helped temper the tendency of medicine to exalt its guild interests and have helped put the patient at the center of the law's concerns. Nevertheless, there is today discontent with both paradigms. Few people suppose that markets can solve all problems, and many people doubt that the medical marketplace can ever work really well. Furthermore, the law and economics paradigm offends the political sensibilities of many scholars who write in the area. The patients' rights view has enamored academics, but today even many academics are beginning to feel that that view is bumping against the point of diminishing returns. In addition, while both the patients' rights and the law and economics approaches put the patient at the center of their universe, they imagine a patient who does not exist. The patients' rights approach imagines patients vigorously exercising and protecting their autonomy in order to pursue unique "life plans." The law and economics approach imagines consumers making purchasing decisions based on a well-developed understanding of what they want and what the mar-

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<sup>6</sup> Frank H. Easterbrook, *Cyberspace and the Law of the Horse*, U. CHI. LEGAL F., 1996, at 207.

kets offer. Crucially, however, real patients are little like either of these stick figures.

We suspect there is no grand organizing principle for medical law because there cannot be. Medical law deals with medical activities in too many settings and must borrow from too many areas of law. Nevertheless, we believe medical law can adopt a more useful analytical perspective, one that tends to distinguish it from other areas of law. We propose an analytical framework that views health care law as a law of relational webs rather than a law of transactions.

A transactional perspective takes the atomistic view that each medical encounter is a discrete event rather than part of an on-going web of relationships. A relational web perspective, on the other hand, views medical encounters more holistically, as part of a larger context formed by the parties' interactions with each other and their relationships with other individuals and institutions. For example, informed consent law essentially requires separate consent for each component of service within an illness (invasive testing, surgery, pharmaceuticals, etc.). A relational perspective, on the other hand, views medical encounters more holistically, as part of a larger context formed by the parties' interactions. For example, the law recognizes patients' dependence by structuring the duty to treat around episodes of illness and preventing physicians from unilaterally dropping a sick patient without either the patient's permission or enough notice to give the patient time to find another doctor.

The transactional perspective grows out of the fact that medical law generally has not answered its basic questions by developing a set of doctrines specific to its subject. Rather, it has treated medicine as a business virtually like any other, and it has drawn its doctrines from the many fields of law that govern ordinary commercial affairs. But business law abstracts. It is disinclined to search out the particular aspects of each business that might make it different from other businesses and relies instead on generalizations about how all business works and should work. Law sometimes considers the ways medicine is a business that poses special problems, but other times it does not. And it rarely asks which approach is preferable. In short, medical law plucks from the web of life individual transactions and treats them as discrete events. But because medical law thus analyzes events in isolation from their context, it repeatedly misunderstands those events and assigns inappropriate legal consequences to them. Medical law thus condemns itself to operate at a fatal remove from reality.

All this becomes clearer when we understand the reality that a transactional approach ignores. First, real patients live their lives embedded in a web of relationships and personal histories that shape their thought and behavior in ways not easily incorporated by a trans-

actional model. Little in the lives of most people makes them the enthusiastic and skilled decision-makers that transactional law often imagines.<sup>7</sup> And insofar as patients think about themselves in medical contexts, they think—we suspect—primarily in non-transactional terms. They think that, at its heart, health care is about a relationship—the relationship between doctor and patient—that is in its essence and at its best not a legal relationship. Instead, it is a relationship which in some ways is damaged by being considered in transactional legal terms. In this way it resembles another institution generally apt for legal regulation: marriage, a relationship in which trust is crucial and personal relations are central.<sup>8</sup>

Second, real patients not only live in a web of relationships with their friends, families, and physicians that affect the way they act as rights-holders and as consumers. They also have web-like relationships with various medical institutions. Doctors organize into practice groups and refer patients to specialists and clinics. When patients are sicker, they enter hospitals and other complex parts of the health care enterprise. Furthermore, patients have increasingly elaborate financial and treatment relationships with health insurers. And, important decisions about insurance are frequently made through employers.

Unfortunately, the law tends to view each of these relationships as bilateral and one dimensional, rather than as part of a complex web of relationships. For instance, courts that adjudicate disputes over insurance coverage often fail to see that decisions about medical necessity for insurance purposes might also affect physicians' standard of care under liability law.<sup>9</sup> Also, because law operates at a level of abstraction, it ignores a good deal about the circumstances of medical personnel and institutions by assuming they respond in predictable ways to a narrow range of stimuli.

In sum, considering the psychological reality of treatment encounters and the complex structure of relationships among patients, physicians, facilities, insurers, employers, and many others, we need a law of relationships that accommodates the unique features of the medical arena, not a set of generic or abstract legal principles derived largely

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<sup>7</sup> See, e.g., CARL E. SCHNEIDER, *THE PRACTICE OF AUTONOMY: PATIENTS, DOCTORS, AND MEDICAL DECISIONS* (1998) (examining whether patients actually want the responsibility of making medical decisions for themselves and whether they have the ability to do so effectively).

<sup>8</sup> Mark A. Hall, *Law, Medicine and Trust*, 55 *STAN. L. REV.* 463, 477 (2002).

<sup>9</sup> See William M. Sage, *Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, *DUKE L.J.* (forthcoming 2004).

from commercial law or the law of individual rights. That law of relationships must be based on a view of the world as it actually is, of people and institutions as they actually are. Not least, that law must recognize the status of patients and the psychological and emotional vulnerabilities entailed in seeking medical care.

So what is to be done? Lawmakers need to be alert to the choice between transactional and relational perspectives in medical law. Examples of each can be found sporadically in judicial decisions, statutory and regulatory authorities, and academic commentary, but these choices are usually made without reflection. Therefore, no consistent pattern has emerged, and the choices are often ill advised (in both directions). In short, some areas may benefit from being less transactional, while others may need to remain primarily transactional, or become less relational. An analytical framework is needed to identify the important issues and provide conceptual tools for deliberation and resolution.

If lawmakers are to make wise choices about when to proceed transactionally and when to proceed relationally, they will need to understand better than they do how the world actually works. And crucially that will be possible only if scholars are willing to do what they have been promising to do since the legal realists—empirical research. Indeed, even if courts and legislatures persist in an implacably transactional approach, the malign effects of that approach will be considerably ameliorated if the nature of the transactions and the effects of legal regulation of them are better understood. Only in this way will medical-law scholars and lawmakers realize just how often the world works in unanticipated ways that keep law from achieving its purposes.

The search for a general theory of medical law is the search for a chimera. But scholars of medical law can usefully unite in a shared analytical framework—one that brings more rigor to the intuition that medicine differs in fundamental ways from other social and business arenas. Doing so will generate conceptual and empirical tools for deciding whether and when these special qualities should matter for the law and when they should not. In sum, we may find medical law's "there" not in grander principles but in a wiser method.

