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# HEALTH LAW AT FIFTY YEARS: A LOOK BACK

*Arnold J. Rosoff*<sup>†</sup>

**EVERY FIELD HAS ITS POINT OF VIEW.** Seen from the perspective of one field, the same scene, the same world, looks different than when seen from another field's vantage point. When I start my principal Health Law course, in which many of the students are studying to be health professionals or health care managers, I commonly tell them that whether or not they care to learn about the law *per se*, they will find it interesting and worthwhile to look at the health care field from the perspective of the legal system. "It looks a lot different from this side of the fence," I often tell them; and whatever else we may differ on in the course of the term, I suspect they come away convinced of that little bit of truth.

Law is a response to society's felt needs. Legislation is enacted to deal with problems the society is facing, or expects soon to face. Likewise, courts deciding cases look beyond the situations and interests of the individuals in the particular litigation and try to reach decisions that will also constitute good public policy. Consequently, studying both legislation and adjudication in a particular field is a way of seeing what problems society is facing – or feels it is facing – in that area and what it regards as workable solutions.

The study of health law offers a look at health care and its role in our society as seen through the lens of the law. The picture it reveals is interesting and varied. Over the fifty years that have passed since the Law-Medicine Center was established at Case Western Reserve University, the health care system in this country has taken many twists and turns, as have the needs, perceptions, predilections, and approaches of society with regard to health care. This essay looks at the evolution of health law as a reflection of the most significant of these developments.

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## I. THE EVOLUTION OF HEALTH LAW

The starting point for what has become the vast field of health law was “forensic medicine,” the application of medicine in the courtroom for criminal cases and civil tort litigation, especially personal injury and medical malpractice cases. The field was variously called “medical law,” “law and medicine,” or “legal medicine.”<sup>1</sup> Although forensic medicine has various components, the one most aligned with our modern-day perceptions of health law is medical malpractice. The intersection of law and medicine was primarily in the courtroom – or in preparation for the courtroom. In terms of the “iron triangle” of the health care system—the interplay among quality, access, and cost<sup>2</sup>—the emphasis clearly was on achieving and maintaining quality of care. Throughout the first half of the twentieth century, most of the action in the emerging field of health law was in this sector. The concern with quality of care has not gone away, but it has been joined by concern for other problems in the healthcare system, particularly the other two points of the triangle, access and cost. Thus, it takes its place in a broader firmament of societal concerns, and the term “medical law” gives way to the broader term of “health care law,” or just “health law.”

Starting after World War II, access to health care joined quality of care on the nation’s list of health care-related concerns. Problems of disparity in access to health services related to race, age, socioeconomic status, and geography increasingly captured public attention and spurred corrective measures. The Hill-Burton legislation,<sup>3</sup> passed in 1945, created a federal-state partnership to assess the need and provide financial support for hospital development to deal with demand pent up during the Depression and War years. The focus of that law and its various amendments shifted over time to reflect a changing view of where the greatest needs lay. Ultimately, national concern over access, particularly of the elderly and the poor, culminated in the passage of Medicare and Medicaid in the mid-1960s, a development that has fundamentally changed the face of American healthcare and,

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<sup>1</sup> The last term is still reflected in the name of one of the principal organizations in the field, the American College of Legal Medicine (ACLM). Another of its major organizations, the American Society of Law, Medicine and Ethics, was formerly known as the American Society of Law and Medicine.

<sup>2</sup> WILLIAM L. KISSICK, *MEDICINE’S DILEMMAS: INFINITE NEEDS VERSUS FINITE RESOURCES* 2-3 (1994) (“But in what I call the iron triangle of health care . . . access, quality, and cost containment have equal angles, representing identical priorities, and an expansion of any one angle compromises one or both of the other two.”).

<sup>3</sup> Construction and Modernization of Hospitals and Other Medical Facilities, The Public Health and Welfare (Hill-Burton) Act, 42 U.S.C. § 291 (2000).

with it, the face of health law. The demand for health services that these federal programs created, and the reorientation of the healthcare system that they set in motion, fueled a cost-inflation spiral that has continued to the present day, bringing Cost to the fore as the driving problem in health care. Much of health law, as we now know it, is a response, direct or indirect, to these cost pressures. As society's concerns have expanded from quality, to access, to cost, and finally to trying to maintain an appropriate balance among these three forces, the development of health law has mirrored this evolution with a shift in its regulatory focus.

#### A. Organization and Financing of Health Care

As the focus of Health Law has gradually turned toward cost concerns, the last fifty years have also seen a dramatic shift in the approaches used to achieve society's cost-containment objectives. From an early position that was essentially *laissez faire* in terms of cost controls, the system at first moved increasingly toward command-and-control regulation. States and the federal government created all manner of regulatory programs and agencies trying first one approach and then another to get a handle on health care cost escalation. To name but a few, the regulatory initiatives included: utilization review (retrospective, prospective, and concurrent), hospital rate regulation, vigorous control of insurance and health plan rates, and Certificate of Need (CON), played out on both the state and federal level. State and federal regulators sought more and more power to control health care decision-making until, by the end of the 1970s, public sentiment had turned sharply against larger and more intrusive government bureaucracies, not just in health care but in all sectors of the national economy. This shift was reflected in the voters' rejection of a second term for President Jimmy Carter and the election of conservative champion Ronald Reagan, who campaigned upon a promise to "get the government off of our backs."<sup>4</sup>

#### B. The Turn toward Competition

On the health care front, Congress was not disposed to move further in the direction of traditional command-and-control regulation; but the cost problem was still pressing. To contain costs, the govern-

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<sup>4</sup> PBS, *Debating Our Destiny: The Second Presidential Debate*, pt. iv, (Ronald Reagan, Remarks during the Second Presidential Debate (October 28, 1980)), available at <http://www.pbs.org/newshour/debatingourdestiny/80debates/cart4.html> (last visited Dec. 3, 2003).

ment turned to new strategies intended to harness competitive market forces and to use financial incentives instead of direct controls. In October of 1983, the federal government implemented a prospective payment system for hospital services, paying hospitals by the case on the basis of DRGs, or Diagnosis-Related Groups.<sup>5</sup> At about this time, Health Maintenance Organizations (HMOs) and other forms of managed care organizations (MCOs) began to come into their own,<sup>6</sup> using a wide array of methods to tie compensation of health care providers and institutions to their attempts to reduce and control utilization of high-cost services. This move from fee-for-service (FFS) medicine to a prospective payment system (PPS) had a profound effect, one still being felt today, changing our concerns about quality of care. Instead of the earlier concern that quality might be compromised by doctors ordering and performing unnecessary services (wasteful and unneeded tests, surgeries, hospitalizations, etc.), the concern began to be that doctors and health plans would skimp on needed services. Whereas under FFS, providers fattened their financial bottom line by providing more care, under PPS, the opposite was likely to be the case. Both the reality and the public perception that skimping was taking place, or would take place, had its inevitable impact on health law.

### C. Managed Care “Backlash” and ERISA

This situation persists today. MCOs are widely seen as cold-hearted entities, too strongly focused on protecting their bottom line – and their shareholders’ return on investment in the case of for-profit entities – at the expense of their members’ health interests. This perception has spawned countless pieces of remedial legislation, both federal and state, some enacted and some not, and an equally uncountable number of lawsuits charging inadequate care. Much of this litigation has been met with interference from ERISA, the Employee Retirement Income Security Act of 1974,<sup>7</sup> which has blocked and/or distorted claims against health plans because of its sweeping preemption of state law. This conflict between ERISA and development of legal accountability of health plans has, in turn, generated a mountain of scholarly commentary and calls for legislative and/or judicial recti-

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<sup>5</sup> See 42 U.S.C. § 1395ww(d)(7) (2000). See generally BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 694-98 (4th ed. 2001) (outlining the development and application of DRGs).

<sup>6</sup> Congress had taken a major step to stimulate HMO development with the passage of federal assistance legislation in 1973, the Health Maintenance Organization Assistance Act of 1973, 42 U.S.C. § 300e-9 (2000), but despite this endorsement, HMO growth moved slowly throughout the 1970s.

<sup>7</sup> 29 U.S.C. § 1144 (2000).

fication of the impasse.<sup>8</sup> In recent years, it has also led to a set of cases decided by the Supreme Court, trying once again—as the Court has tried on numerous previous occasions—to properly delineate the scope of ERISA preemption in the health care field.<sup>9</sup>

#### D. Antitrust

The movement that began in the 1970s of viewing health care as an industry rather than as a profession and focusing on unleashing competitive forces, also had the effect of spawning a torrent of antitrust litigation. The suits began with the Supreme Court's landmark 1975 decision in *Goldfarb v. Virginia State Bar*,<sup>10</sup> which declared that the "learned professions," principally law and medicine, were not exempt from antitrust laws. All sorts of arrangements, combinations, preferences, and activities that had become commonplace in the health care field over the years now were called into question as a matter of antitrust law and policy. What makes this era of health law development so intriguing is that antitrust was an area of law that had grown and developed outside of and apart from the health care system and then was brought into it all at once. Principles that had been formed and tested in other realms now were suddenly applied in the health-care field, often with unpredictable and catastrophic results.<sup>11</sup> The effect was rather like a dam bursting. Sometimes the law develops in a slow and gradual way; at other times opposing forces are brought together suddenly and cataclysmically. The era that *Goldfarb* began was of the latter type.

#### E. Patients' Rights

The last fifty years have also brought dramatic changes in the conceptualization and practical treatment of patients' rights. It is hard

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<sup>8</sup> For a brief but representative listing of this substantial body of literature, see FURROW ET AL., *supra* note 5, at 346-49.

<sup>9</sup> See, e.g., *Pegram v. Herdrich*, 530 U.S. 211, 236-37 (2000) (holding that mixed eligibility and treatment decisions are not fiduciary decisions within the scope of ERISA); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (holding that an Illinois statute, as applied to health benefits from an HMO under contract with an employee welfare benefit plan, was not preempted by ERISA), *overruled in part by* *Ky. Ass'n of Health Plans, Inc. v. Miller*, 123 S. Ct. 1471 (2003); *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 123 S.Ct. 1471 (2003) (holding that Kentucky's "any willing provider" laws were not pre-empted by ERISA).

<sup>10</sup> 421 U.S. 773, 779, 792-93 (1975).

<sup>11</sup> See, e.g., Arnold J. Rosoff, *Antitrust Law and the Health Care Industry: New Warriors into an Old Battle*, 23 ST. LOUIS U. L.J. 446 (1979) (exploring the interface of antitrust and health law and calling for a comprehensive synthesis of policy in these fields).

to believe that it has been almost half a century since "informed consent" was first introduced into the health care lexicon<sup>12</sup> and added to the growing firmament of patients' rights doctrines and concepts. Most of the patients' rights movement has been oriented toward recognizing and assuring individual autonomy, the right to choose for one's self in matters related to health care. The traditional deference to professional authority had run its course in this country, and many saw the necessity for shifting power in the physician-patient relationship to the patient's side. As with other changes in the health care system, this shift is amply reflected in the law. It is reflected, for example, in the landmark informed consent decision of *Canterbury v. Spence*,<sup>13</sup> replacing the doctor-based standard for disclosure of information with a patient-based standard measured by the patient's needs and desire to know. Even though the *Canterbury* ruling has been adopted in fewer than half of the states, this case and its progeny are emblematic of much of the change that has occurred in physician-patient relationships in this country in the past quarter-century. It has done as much as any one case could to regrade the terrain on which those relationships are played out.

#### F. The Right of Privacy

Naturally, one cannot discuss the ascendance of patients' rights without acknowledging the ever-controversial 1973 abortion ruling, *Roe v. Wade*,<sup>14</sup> which recognized a constitutionally protected *right of privacy*, defined broadly to mean a right of individual self-determination with regard to matters intimately affecting one's personal health and personhood. The *Roe v. Wade* ruling has figured in countless other cases, in all jurisdictions and at all levels, following and applying its core principle to other situations, some close to the original, others farther afield, as well as some cases refusing to extend the *Roe* principle to other situations. See, for example, *United States v. Rutherford*,<sup>15</sup> which refused to apply *Roe v. Wade's* protection of

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<sup>12</sup> The doctrine is generally said to have started with the California decision of *Salgo v. Leland Stanford Jr. Univ. Bd. of Tr.*, 317 P.2d 170, 181 (Cal. Dist. Ct. App. 1957), where the court determined a doctor has a duty disclose any facts that are necessary to the patient's decision about consenting to treatment.

<sup>13</sup> 464 F.2d 772, 780-88 (D.C. Cir. 1972) (discussing the nature and evolution of the informed consent doctrine).

<sup>14</sup> 410 U.S. 113, 152-56 (1973).

<sup>15</sup> 442 U.S. 544, 544 (1979) (ignoring the District Court's alternative conclusion that cancer patients' privacy interests had been infringed since that conclusion was not addressed by the Court of Appeals).

personal choice to overcome the FDA's prohibition of Laetrile as a cancer treatment even for end-stage patients seemingly without any other hope of arresting their fatal disease, and *Bowers v. Hardwick*,<sup>16</sup> which refused to apply the constitutional right of privacy to invalidate a state's anti-sodomy laws.

### G. The Borders of Life

Patients' rights are particularly sensitive at the borders of life, an area that has been tremendously affected by medical technology over the past fifty years. The dramatic advances in medicine's ability to prolong life—or some semblance of life—in the very young, the old, and those with very serious conditions caused by illness and accident have raised highly troubling questions about the quality of life and, in fact, about the very question of what *is* life. One can scarcely begin to count the legal contests that these difficult situations have spawned, starting with the landmark *Quinlan* case<sup>17</sup> and continuing through a staggering variety of factual combinations and permutations: comatose patients;<sup>18</sup> incompetent patients, both formerly competent<sup>19</sup> and never competent;<sup>20</sup> terminally ill patients and those who, although severely compromised, were not facing imminent death.<sup>21</sup> It is difficult to imagine a comprehensive health law text nowadays that would not have a substantial section devoted to these topics, although they received scant attention a generation ago.

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<sup>16</sup> 478 U.S. 186, 190-91 (1986), *overruled by* Lawrence v. Texas, 123 S. Ct. 2472 (2003).

<sup>17</sup> *In re Quinlan*, 355 A.2d 647, 671 (N.J. 1976) (holding that the guardian of a woman in a persistent comatose state could withdraw life-sustaining treatment).

<sup>18</sup> See, e.g., *Cruzan v. Dir., Mo. Dep't. of Health*, 497 U.S. 261, 265 (1990) (allowing the State to require clear and convincing evidence of patient's wishes to not live in a permanent vegetative state before removing life-sustaining treatment).

<sup>19</sup> See, e.g., *In re Conroy*, 486 A.2d 1209, 1231-37 (N.J. 1985) (permitting the withdrawal of life-sustaining treatment from an elderly nursing-home resident who had developed mental impairments due to old age, by meeting court created factors and standards).

<sup>20</sup> See, e.g., *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 435 (Mass. 1977) (stating that the right of a competent person to decide the course of medical treatment is equally due to an incompetent person where there is no sufficient State interest to the contrary).

<sup>21</sup> *Bouvia v. Super. Ct. of Los Angeles County*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986) (holding that the right to privacy "encompasses a virtually absolute right to refuse medical treatment," thereby permitting a quadriplegic patient in constant pain and confined to a hospital bed to refuse medical treatment).



## H. Creating and Shaping Life – A Brave New World

Technology has also blossomed in the areas of assisted reproduction and of genomics, spurred in large part by the Human Genome Project and related research efforts. Here too, as in the previous section, there have been more cases than can readily be tallied involving in vitro fertilization and the ownership of embryos,<sup>22</sup> surrogate parenting,<sup>23</sup> and the handling of maternal-fetal conflicts.<sup>24</sup> Closely related are the cases on the patentability of “life”<sup>25</sup> and rights relating to the genetic components of life.<sup>26</sup> As a society, we are just on the threshold of an unknown universe of scientific discovery and possibility. Likewise, the issues of law and bioethics that we are about to encounter are inchoate and unpredictable. Stem cell research, cloning, manipulation of the very essence of life—these developments will not only raise profound moral and philosophical questions, but legal issues as well.

## II. FELLOW TRAVELERS ALONG THE WAY

As health law stands on the threshold of untold new frontiers, a mature field that has survived childhood and adolescence and is ready for adult challenges, it is fitting that we reflect, at least briefly, on those who helped bring us to this point. Let us take a moment to remember comrades who made much of this journey at our side but are no longer here with us. For many of us, they were not just our colleagues; they were our teachers, our mentors, indeed our “parents.” We owe them a debt beyond measure.

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<sup>22</sup> See, e.g., *Davis v. Davis*, 842 S.W.2d 588, 597 (Tenn. 1992) (holding that embryos were neither persons nor property, but were due special respect for their interim status of potential human life).

<sup>23</sup> See, e.g., *In re Baby M*, 537 A.2d 1227, 1246-49 (N.J. 1988) (ruling that a surrogate contract in which compensation was proffered and parental rights were terminated was a violation of public policy).

<sup>24</sup> See, e.g., *In re A.C.*, 573 A.2d 1235, 1237 (D.C. 1990) (en banc) (holding that substituted judgment of the patient’s wishes should be applied to determine treatment for a dying, incompetent, pregnant patient).

<sup>25</sup> See *Diamond v. Chakrabarty*, 447 U.S. 303 (1980) (holding that living microorganisms, genetically engineered by humans, are patentable).

<sup>26</sup> *Moore v. Regents of Univ. of Cal.*, 793 P.2d 479 (Cal. 1990) (en banc) (permitting a claim for breach of disclosure duty where plaintiff’s cells were used for research without permission, but denying plaintiff’s conversion claim because of plaintiff’s lack of continuing ownership interest in the excised cells).

## A. William J. Curran

Perhaps the person most widely regarded as a parent of the field of health law is William Curran, who has been called “the father of Health Law”<sup>27</sup> and who was one of the field’s leading and most visible figures for over three decades. Bill Curran began his pioneering work in the late 1950s, and in the early 1960s developed and directed the Law-Medicine Research Institute at Boston University. Most of his career was spent at Harvard University, where he served on both its medical and public health faculties. He founded and directed the Program in Law and Public Health at Harvard Public Health School and, in that role, mentored untold numbers of lawyers who went on to make their careers in health law, many of whom have become leaders of the field.

The author or co-author of a virtual mountain of articles, chapters, and other publications on various aspects of health law, Curran is probably most broadly known for his periodic essays in the *New England Journal of Medicine*, published under the title of *Law-Medicine Notes*. He contributed nearly 200 of these over a quarter-century, from 1964-1988, and, through them, was the voice of health law for much of the U.S. medical community.<sup>28</sup> Curran is also known as co-author of one of most widely used texts in the field, *Law, Medicine, and Forensic Science*,<sup>29</sup> the name of which reflects the early orientation of the field. Acknowledging the field’s expansion, the book was recast in 1990 as *Health Care Law, Forensic Science, and Public Policy*, with two new authors, Mark Hall and David Kaye replacing Donald Shapiro, Curran’s co-author for the first three editions.<sup>30</sup>

For decades, Bill Curran was in the foreground wherever important and ground-breaking work was being done in health law. For example, he was the lawyer-member of the 1968 Harvard Ad Hoc Committee that developed the criteria for brain death and was influential in the 1970s in the development of the NIH rules regulating human subjects research. Not just a player on the domestic scene,

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<sup>27</sup> Marcella Bernard, *William Curran: The Father of Health Law*, HARV. PUB. HEALTH REV., Oct.-Nov. 1998, at [http://www.hsph.harvard.edu/review/william\\_curran.shtml](http://www.hsph.harvard.edu/review/william_curran.shtml) [hereinafter *William Curran*]

<sup>28</sup> *Id.*

<sup>29</sup> WILLIAM J. CURRAN & E. DONALD SHAPIRO, *LAW, MEDICINE, AND FORENSIC SCIENCE* (3d ed. 1982). The first edition was published by Curran in 1960 under the title “Law and Medicine: Text and Source Materials on Medico-Legal Problems.” The second edition was published in 1970 under the current title and co-authored by Shapiro.

<sup>30</sup> WILLIAM J. CURRAN, MARK A. HALL & DAVID H. KAYE, *HEALTH CARE LAW, FORENSIC SCIENCE, AND PUBLIC POLICY* (4th ed. 1990).

Curran was at the forefront of international Health Law and was the first director of the Harvard University-World Health Organization International Collaborating Center for Health Legislation. He played a lead role in fostering international cooperation to check the spread of HIV/AIDS when it emerged as a global health concern in the 1980s. Routinely called on to help draft legislation to address health law issues, he did much of this work in his home state. In 1996, soon after his death, the *New York Times* wrote that, “[i]n Massachusetts, whose laws became models for national and international legislation, he left his fingerprints on so many statutes dealing with issues like psychiatric commitments, qualifications of physician’s assistants, minimum professional standards for medical examiners, patient’s rights, and drug addiction rehabilitation, that the state’s health and medical laws could be called the Curran code.”<sup>31</sup>

### B. Herbert A. Eastman

Herb Eastman, who died in 1995, ran clinical legal programs at Saint Louis University Law School and carried the torch of public interest law to his students. Eastman believed in combining education with activism in the pursuit of social justice. He also believed that people should be treated fairly and equally without regard to their color, background, or social status. In his teaching and his law practice, he was a role model for legal activism for the public good. He was also an advocate for the use of colorful and expressive language in the representation of social causes.<sup>32</sup> Jesse Goldner, his colleague at Saint Louis University, explained in a memorial statement that Herb believed “civil rights complaints should be written with the vibrant force found in journalistic and historical accounts of the events that form the basis of the lawsuits” to maximize their effect on lawmakers.<sup>33</sup> For a generation of students, he was the voice of public interest law.

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<sup>31</sup> *William Curran, supra* note 27 (citing Robert McG. Thomas, Jr., *William J. Curran, 71, Dies; Developed Health Law Field*, *N.Y. TIMES*, Sept. 25, 1996, at B10).

<sup>32</sup> *See, e.g.*, Herbert A. Eastman, *Speaking Truth to Power: The Language of Civil Rights Litigators*, 104 *YALE L.J.* 763 (1995) (discussing the failure of civil rights pleadings to adequately portray, through language, the reality of the abuses sought to be remedied).

<sup>33</sup> *See* Jesse A. Goldner, *Herbert A. Eastman: A Memorial Tribute*, 40 *ST. LOUIS U. L.J.* 305, 306 (1996).

### C. Dieter Giesen

An important aspect of our field's evolution is its growing internationalization. Health law has been developing not just in the United States but in countries all around the globe. Dieter Giesen was one of a small but growing group of academics committed to pulling together the evolving threads of law from different cultures and legal systems and trying to weave them into a coherent global fabric. Traveling frequently from his home in Berlin, Germany, Giesen visited, taught, and lectured around the world. An expert in family law and legal history, particularly English legal history, he is best known for his brilliance in comparative law studies and his encyclopedic treatise on comparative medical malpractice law.<sup>34</sup> Giesen was "a master of . . . two systems, common law and civil law. Few comparative lawyers have ever stood so solidly with both feet in both systems."<sup>35</sup> He has also been hailed as "the leading interpreter of German law to the common law world."<sup>36</sup> Dieter Giesen, who died in 1997, was a professor in the Free University of Berlin's Institute for International, Foreign and Comparative Law and Director of its Working Centre for International Studies in Medical Malpractice Law.

### D. Joseph M. (Jay) Healey

Jay Healey was the heart of health law to those who knew him—a large group because he was an extremely easy person to get to know. A gentle spirit who spent most of his career teaching at the University of Connecticut's medical, dental, and law schools, Jay was passionately devoted to the humanity of the health care field and took every opportunity to convey this belief and spirit to his students. He headed his medical school's Division of Humanistic Studies, and chaired its institutional review board; fitting posts for someone to whom concern for the rights and sensibilities of patients was so central. He drew no line between law and ethics and sought to convey to the health professionals he helped to train that doing right by patients was the right thing to do, whether required by law or not. Although Jay contributed his share to the health law literature, his focus and forte was teaching, where he saw himself measured not by his own achievement, but by what he could help others to do and become. His orientation and dedication in this regard are memorialized in the Jay Healey Distin-

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<sup>34</sup> DIETER GIESEN, *INTERNATIONAL MEDICAL MALPRACTICE LAW: A COMPARATIVE LAW STUDY OF CIVIL LIABILITY ARISING FROM MEDICAL CARE* (1988).

<sup>35</sup> Harry D. Krause, *Dedicatory Essay: Professor Dr. Dieter Giesen*, 12 J.

CONTEMP. HEALTH L. & POL'Y i, v (1995).

<sup>36</sup> *Id.*

guished Health Law Teacher Award, presented annually by the American Society of Law, Medicine and Ethics to an outstanding academic seen as carrying forward Jay's commitment to humanism in health care and his zeal for teaching.<sup>37</sup> Jay died well before his time in 1993 of pancreatic cancer; but his soul lives on in the memories of his students—now health lawyers, teachers, and health professionals around the country.

#### E. Henk Leenen

The first national society for health law in Europe was founded in 1967 in the Netherlands. One of the field's pioneers and architects was Henk Leenen, Professor of Social Medicine and Health Law at Amsterdam University. Leenen chaired the national association for many years and was senior editor of the *Dutch Journal of Health Law*. Having established himself early on as a champion of patients' rights with the publication of his 1978 book, *People's Rights in Health Care*, he soon became an outspoken advocate for the view, then regarded as radical, that the right to life only had meaning if a person had control over his or her life and, thus, the right to end it. Over the course of his career, Leenen fought for the passage of euthanasia legislation in the Netherlands. Although the Dutch courts had adopted a permissive attitude toward voluntary euthanasia some twenty years earlier, legislation supporting the practice was not enacted until April of 2002,<sup>38</sup> just months before Henk Leenen's death of lung cancer.

#### F. Nancy K. Rhoden

Another champion for the individual's right of self-determination in health care was Nancy Rhoden, a lawyer-ethicist, associate professor at Ohio State University, and professor at Carolina Law, University of North Carolina at Chapel Hill. Nancy's particular focus was reproductive rights and the care of pregnant women and infants. She agonized over the difficult question of whose interests and rights should prevail, those of the mother or the fetus, when these came into opposition in so-called "maternal-fetal conflicts." She ultimately came down on the side of the mother, favoring the interest of the patient who knew her own mind and, thus, best fit the concept of informed consent.<sup>39</sup> Nancy's approach to health law was characterized

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<sup>37</sup> Jay Healey is also memorialized in *Symposium Dedicated to Joseph "Jay" Healey*, 20 AM. J.L. & MED. 353 (1994).

<sup>38</sup> Obituary, *Hank Leenen*, 361 THE LANCET 1061 (2003).

<sup>39</sup> See Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951, 1952-53 (1986) (arguing that a

by a commitment to pursue first-hand exposure to the delivery of healthcare services, to learn by personal experience the pulls and tugs professionals felt as they faced the challenges of their profession. In this pursuit, she used a travel grant from the German Marshall Fund to spend a year observing the process of care in medical centers in the United States, Sweden, and Great Britain and used her insights from that experience to write an article on the care of seriously defective neonates.<sup>40</sup> Soon after that, a grant from the National Endowment for the Humanities and the National Science Foundation let her spend a year in the clinical setting at Albert Einstein College of Medicine and Montefiore Hospital in the Bronx, where she interviewed physicians and other professionals in the field of obstetrics. Building on this experience, she sought the help of colleagues to establish Perinatal Law and Ethics Rounds, a regularly scheduled educational conference designed to increase the sensitivity and understanding of those faced with the challenging decisions Nancy had illuminated in her writings.<sup>41</sup> Nancy Rhoden died in 1989. Her legacy is not just her insights into the field of perinatal care but also her commitment as an educator to learning by first-hand experience before endeavoring to teach others.

### G. Gene P. Schultz

Gene Schultz was drawn to the field of health law by his compassion for the suffering of others and a deep sense of personal mission. For many years, Gene taught criminal law as a member of the faculty of the Saint Louis University Law School. He practiced criminal law, wrote in that field, participated in the drafting of criminal legislation, and fought for the protection of criminal defendants' rights, and for the rights of minorities and the poor more generally. Then, in the 1980s, Gene, was touched deeply when friends and acquaintances were stricken with HIV/AIDS. Heeding the call of conscience, he took up the fight through the ACLU (American Civil Liberties Union) and the AALS (Association of American Law Schools) to outlaw discrimination on the basis of sexual orientation and AIDS. He was a national authority on AIDS and the law and co-author of a leading law

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woman should have the right to ultimately decide for or against a cesarean operation).

<sup>40</sup> See Nancy K. Rhoden, *Treating Baby Doe: The Ethics of Uncertainty*, HASTINGS CTR. REP., Aug. 1986, at 34 (discussing the ethical tension and medical uncertainty behind all Baby Doe (neonate) treatment decisions).

<sup>41</sup> For a full tribute to Nancy Rhoden, see Ruth Macklin, *Memorial Dedication for Nancy Rhoden*, 51 OHIO ST. L.J. 327 (1990) (noting Nancy Rhoden's multiple accomplishments in the field of bioethics).

school text on the subject.<sup>42</sup> He also served as co-counsel in the landmark case of *Weaver v. Reagen*,<sup>43</sup> which established the right of Medicaid-eligible persons with AIDS to reimbursement for the drug AZT.<sup>44</sup> In addition to his contributions to the cause of gay and lesbian rights as a lawyer, Gene was an active member of the National Gay and Lesbian Law Association and a compassionate mentor to gay students and faculty at Saint Louis University. He died in 1994 of complications related to AIDS.<sup>45</sup>

#### H. Arthur F. Southwick

Professor Arthur Southwick spent the bulk of his academic career, which spanned almost four decades, at the University of Michigan, where he had earned both his M.B.A. and his law degree. He taught business law and health law, focusing his attentions in the latter sphere on the business and organizational aspects of healthcare institutions. His textbook, *The Law of Hospital and Health Care Administration*, was a central fixture in the field's literature and the means by which countless numbers of hospital administrators learned about the laws that so significantly defined their field of practice. In turn, Art Southwick played a key role in developing that body of law, with his insightful writings analyzing the technical and practical aspects of hospital liability cases, such as the landmark *Darling v. Charleston Community Memorial Hospital*.<sup>46</sup> He passed away in 1997.

#### I. Edward V. Sparer

At the end of this alphabetical listing, but the first of this illustrious group to die and a true pioneer in health law was Edward Sparer. A feisty but beloved law professor at the University of Pennsylvania Law School, Sparer branched out from his core concern with poverty and civil rights law to fight for equal access and equity in health care. Another builder of institutions in the early days of health law, Sparer sought funds from the OEO (Office of Economic Opportunity) to found the Health Law Project at Penn in the 1970s. Through it, he promoted a combination of education and advocacy to improve the

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<sup>42</sup> See MICHAEL L. CLOSEN ET AL., *AIDS: CASES AND MATERIALS* (1989).

<sup>43</sup> 701 F. Supp. 717 (W.D. Mo. 1988), *aff'd*, 886 F.2d 194 (8th Cir. 1989).

<sup>44</sup> Jesse A. Goldner, *Gene P. Schultz: A Memorial Tribute*, 39 ST. LOUIS U. L.J. 3 (1994).

<sup>45</sup> See Goldner, *supra* note 44, at 1.

<sup>46</sup> 211 N.E.2d 253 (Ill. 1965) (finding a hospital liable for the negligent treatment leading to an amputation, and giving rise to the doctrine of "corporate negligence" of health care institutions).

status of the overlooked and underprivileged. The Health Law Project rallied support for various initiatives to bring health care to all and pursued Sparer's vision of equal treatment with a combination of compassion and combativeness. In addition to lobbying for legislation to expand health care benefits, it fought in the courts and the media to open the doors of health care institutions to the poor and assure that the nation would not tolerate the continuation of a dual-class system of care, with different standards of treatment for the haves and the have-nots.<sup>47</sup>

One casualty of that battle was Philadelphia General Hospital (PGH), an institution affiliated with Sparer's own home institution, the University of Pennsylvania. PGH was closed in part because of Sparer's persistent trumpeting of its failure to provide adequate health care to the local community and his campaign to improve that care, a campaign doomed by politics and purse strings. This crusade and other aspects of the Health Law Project's advocacy earned Sparer numerous opponents but few true enemies, for his sincerity and commitment to the cause of social justice were apparent to all. Ed Sparer died some 20 years ago, in 1983; but substantial numbers of his students and protégées still fill the ranks of health lawyers around the country, several of them leading academics who proudly carry his legacy forward.<sup>48</sup> That legacy has numerous dimensions but none more important than his dual commitments to learning by doing and to seeking access to good quality health care for all Americans.

### III. CONCLUSION

In both the variety and sweep of its elements and the diversity and richness of the women and men who are engaged in its work, Health Law is a vibrant and exciting area of the law. At fifty years—an arbitrary “age” with which to label a field that has had so many different points of beginning—it is fresh and new and shows no signs of slackening the pace of its development. Those of us who study and write and teach in this field are blessed by its wealth of opportunities and the importance of its mission.

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<sup>47</sup> For insight into Sparer's advocacy efforts and his underlying philosophy, see Rand E. Rosenblatt, *Equality, Entitlement, and National Health Care Reform: The Challenge of Managed Competition and Managed Care*, 60 BROOK. L. REV. 105, 105, 112-16 (1994).

<sup>48</sup> See Elizabeth M. Schneider, Foreword, *Ed Sparer's Legacy*, 60 BROOK. L. REV. 1 (1994).



