

Health Law’s Coherence Anxiety

THEODORE W. RUGER*

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INTRODUCTION

By now, anyone asking whether academic health law suffers from a “law of the horse”¹ problem risks beating a dead one. For more than a decade, versions of the question have been commonplace in law journals and faculty lounges. What does the quip mean as applied to health law? In its most simplistic form, it connotes doubts about whether the set of legal rules surrounding the provision and financing of health care is at all unique and thus worthy of specialized scholarship and teaching in American law schools. A more subtle and persistent form of the question goes to the overarching thematic unity and coherence of health law as a scholarly field. Responding to these intellectual challenges has become a cottage industry among the nation’s leading health law scholars, who have effectively answered the first critique about the uniqueness of various health law doctrines,² but continue to struggle with the second one about overall

* Professor, University of Pennsylvania Law School. © 2008, Theodore W. Ruger. I thank Jennifer Prah Ruger and numerous participants in a Petrie-Flom Center workshop at Harvard Law School for comments on an earlier draft of this Essay.

1. Frank Easterbrook popularized this phrase when he applied it to cyberlaw. See Frank H. Easterbrook, *Cyberspace and the Law of the Horse*, 1996 U. CHI. LEGAL F. 207, 207, 208 (explaining that a primary meaning of the phrase is “that the best way to learn the law applicable to specialized endeavors is to study general rules”).

2. See, e.g., Einer R. Elhauge, *Can Health Law Become a Coherent Field of Law?*, 41 WAKE FOREST L. REV. 365, 368–69 (2006) (describing the distinctive legal relations that health law constructs and governs); Mark A. Hall, *The Legal and Historical Foundations of Patients as Medical Consumers*, 96 GEO. L.J. 583 (2008) (noting the salient differences between consumer law generally and as applied to medical relationships).

theoretical coherence. This debate carries meaningful stakes, both for the future direction and impact of health law scholarship as well as its ultimate status and representation within the legal academy.

This brief Essay is another piece in the growing body of literature about these questions that is fast becoming an identifiable subfield in its own right.³ As health law has emerged as an increasingly important subject in twenty-first-century American life, the amount of scholarly output on health law topics has proliferated. At the same time, however, many leading health law scholars continue to decry the “identifiable patholog[ies]”⁴ of the field, including its apparent lack of a “unifying principle or animating concern”⁵ to give the field theoretical coherence. Many of these same scholars have endeavored to discern within health law—or impose upon it—such unifying principles.⁶ Adhering to the conventions of this genre, I will later briefly describe a few of my own suggestions for generalized ways of thinking about health law that may be useful in understanding the field.

Rather than reflexively jump into this coherence pursuit, however, I want to first pause to explore—and to a certain extent resist—the normative preference for a particular kind of field theorization that drives the chase. Jack Balkin has suggested in a different context that “instead of asking whether the law has the property of coherence, we must begin by asking how judgments of coherence and incoherence come about.”⁷ If we take Balkin’s question seriously with respect to health law’s present coherence anxiety, we find that the field is being measured against an intellectual schema for field definition that is decidedly stacked against it—one that prioritizes sparse conceptual reductionism, singularity of legal form, internalist logic, historical determinism, and institutional centralization as the touchstones of coherence.⁸ The roots of this orthodox

3. For a representative, if underinclusive, set of this literature, see generally, for example, *id.* (applying a comparative paradigm methodology to health care law); Symposium, *The Field of Health Law: Its Past and Future*, 14 HEALTH MATRIX 1 (2004); Mark A. Hall, *The History and Future of Health Care Law: An Essentialist View*, 41 WAKE FOREST L. REV. 347, 362–63 (2006) (concluding that “health care law is an academic sub-discipline that inquires how law should and does take account of the special features of medicine and treatment relationships”); Peter D. Jacobsen, *Health Law 2005: An Agenda*, 33 J.L. MED. & ETHICS 725 (2005) (claiming that the legal framework governing health law is dominated by market forces). See also the contribution of Richard Epstein in this Symposium: Richard A. Epstein, *The Erosion of Individual Autonomy in Medical Decisionmaking: Of the FDA and IRBs*, 96 GEO. L.J. 559 (2008).

4. Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449, 1452 (1994).

5. Mark A. Hall, *Law, Medicine and Trust*, 55 STAN. L. REV. 463, 464 (2002).

6. See, e.g., *id.* at 466 (applying the concept of therapeutic jurisprudence to health care law); see also Lawrence O. Gostin, *A Theory and Definition of Public Health Law*, 10 J. HEALTH CARE L. & POL. 1, 12 (2007) (offering “a definition of public health law” comprised of “several core values”).

7. J.M. Balkin, *Understanding Legal Understanding: The Legal Subject and the Problem of Legal Coherence*, 103 YALE L.J. 105, 107 (1993).

8. I explain these factors in more detail in Part I, *infra*. I do not claim that all of these attributes must be present for a field to be presumed “coherent” under the standard account—they are cumulative factors rather than absolute prerequisites. So, for instance, a field is often thought to be coherent if it can be reduced to one or a few core principles. It is more coherent if it centers on internal legal

conception are as old as Langdell's legal science and have displayed remarkable durability through the twentieth century even as scholarship in more established fields moves in alternative directions.

I will elaborate on these specific features of the currently prevailing field coherence paradigm in a later section. But the main point is that this particular conceptual framework is itself a construction of the legal academy and one that need not—and ought not—be applied hegemonically. Though it may be a useful intellectual default rule for assessing emerging fields, it is hardly the only theoretical frame from which to approach and study a given area of law. Recent scholarship in more mature fields has pointedly rejected many of the standard tenets of this framework in favor of more complex and multifaceted modes of analysis, usually to the benefit of our greater understanding.⁹

In my view, it is time to similarly deemphasize this quest for a singular coherence in health law, at least the kind of “coherence” that takes as its *sine qua non* the discovery of a handful of core internal principles to unify the field of law. Health law flunks most of the classical attributes of field coherence. It is a mishmash of various legal forms, applied by divergent and often colliding institutions, and has developed much more often through external pressures and even historical accidents than from any determinate internal evolution or refinement. Yet is it hardly the only legal field that possesses these centrifugal features (the postmodern conception of constitutional law is another). And it would be surprising if all legal subjects fit the same off-the-rack model of coherence. Joseph Raz has observed that “while it is possible that some legal systems display considerable coherence, there surely cannot be a general reason to suppose that they all do.”¹⁰ In a heterogeneous legal culture like the United States', it should not surprise us if some fields display greater classical coherence than others.

But this possible lack of a central core does not mean that health law lacks essential, or special, attributes worthy of study; nor does it mean that the field lacks an identifiable structure and architecture. Moving away from the conventional coherence paradigm need not resort to a focus only on minutely particularized analysis of given cases and doctrines. To say that health law is messy is not the same as saying it is random; to say it is multifaceted and difficult to center on a parsimonious internal core is not the same as saying it defies all abstraction and generalization. Health law is a legal field shaped dramatically by external dynamics: the surrounding political and economic climate, interest group pressure from various organized actors, and institutional change and interaction

principles rather than external institutional structures; and better still if it reflects a certain purity of legal form. A different form of perceived coherence is available for fields that center on a specific legal institution, such as a single court (think constitutional law) or framework statutes (labor law, environmental law).

9. See Parts I and II, *infra*, for a discussion of some of these developments in constitutional law and tort law scholarship.

10. Joseph Raz, *The Relevance of Coherence*, 72 B.U. L. REV. 273, 283 (1992).

among the bodies that apply and shape the law. Because I am most interested in the pliability of health law over time, and its development in relation to these external stimuli, I am generally skeptical that a single animating principle of internal logic, or a small set of such ideas, can be found to knit together the disparate strands of the field. I will return to these thoughts later in the Essay and suggest a few frames of historical and institutional analysis that appear to have special relevance for understanding the development of health law rules. In sum, some of the very features of health law that distance it from the classical coherence paradigm—its mix of various legal forms, its institutional multiplicity, its permeability to external historical development and political pressure—are themselves generalizable features that are worthy of future examination from a theoretical and empirical perspective.

I. HEALTH LAW SCHOLARSHIP AND THE CLASSICAL COHERENCE PARADIGM

Before fully embracing such questions, however, health law scholarship must get out from under the shadow of the conventional field-coherence paradigm, which threatens to follow the field like a gloomy rain cloud even as it moves in interesting new directions (the Peanuts cartoon characters are the best metaphorical exemplars here). No one has expressed the perceived incoherence of health law more comprehensively than many of the nation's leading health law scholars themselves, and their words form a key part of the following analysis. But these doubts do not arise from thin air—most of the perceived shortcomings of health law can be distilled, classified, and fit within a much longer intellectual tradition embodied in the more generalized coherence impulse of the twentieth-century legal academy at large. The following pages aim to break apart the bundle of attributes that comprise the conventional measure of field coherence against which health law is said to be deficient. Like other intellectual conventions, it is one that was adopted by many legal scholars over the past century, and as such is subject to debate and revision. Though perhaps a useful paradigm in general terms, no feature of the classical coherence account is inevitable, unassailable, or without a viable alternative conception. Health law's poor fit with this traditional account virtually compels reassessment and revision of the paradigm as applied to this field.

I should make clear that, for the purposes of this Essay, I am responding to a conception of "coherence" in the legal academy that is substantially more specific and stylized than the general dictionary definition of that term (of course all scholarly communication ought to be "coherent" in the thin sense that it meets basic norms of intelligibility and organization). Nor do I aim to explore the more nuanced philosophical distinction between epistemic coherence and constitutive coherence that Raz and others have written about.¹¹ The concept I describe here is a particular trade usage in the legal academy and one which

11. *See id.* at 275.

impacts both the creation of health law scholarship and its reception by readers in the relevant scholarly communities. This particular coherence account is comprised of a bundle of presumptive attributes, and it is possible to break up the standard account into several component parts. Not all of these are required for a field to be considered coherent; though a field that lacks most or all of these will rarely be perceived as such. In turn, these are: (1) a reductionist focus on internal logic; (2) a focus on essential legal form; (3) an emphasis on linear historical development; and (4) a high level of institutional specification and centralization. I will describe each of these in a bit more detail below. A general point throughout this discussion is that each of these attributes reflects a particular analytical choice—on most of these dimensions alternative framing conceptions are available, and in other legal areas are becoming increasingly prevalent in recent years. Scholarship in many more established fields has moved away from many of the terms of this conventional paradigm even as it appears to continue to hold sway for many coherence accounts of health law.

A. THE PREFERENCE FOR REDUCTIONIST EXPLANATION

First, the standard coherence impulse in the legal academy carries with it a distinct push for parsimony, if not singularity, in explanation of a given area of law. This reductionist impulse dates at least to the Langdellian reformulation of American law that took place in the late nineteenth century. Embodying this intellectual style, Langdell maintained that “the number of fundamental legal doctrines is much less than is commonly supposed.”¹² Arthur Corbin reflected a similar style when he wrote that the study of law entailed more than mere knowledge of legal phenomena, but also that legal thinkers “must try to reduce those principles into a logical and harmonious system.”¹³

This attitude remains important today. The historian Neal Duxbury, in a longitudinal review of American legal thought, finds persistent evidence of an “obsession with singularity in the search for foundations” that remained entrenched through the twentieth century.¹⁴ He concludes that “[t]his propensity for explanation by reduction has been a primary feature of American jurisprudence” since Langdell’s time.¹⁵ This intellectual style favors frames of analysis that are powerfully reductionist in character, and which purport to explain a vast array of legal materials with the use of one or a few core conceptual building blocks. As any legal academic will recognize, the resulting dynamic in certain

12. C.C. LANGDELL, A SELECTION OF CASES ON THE LAW OF CONTRACTS vi (Lawbook Exchange, Ltd. 1999) (1871).

13. Arthur L. Corbin, *Yale and the New Science of Jurisprudence*, 21 CASE & COMMENT 953, 954 (1915), reprinted in 2 THE HISTORY OF LEGAL EDUCATION IN THE UNITED STATES 667, 668 (Steve Sheppard ed., 1999) [hereinafter HISTORY OF LEGAL EDUCATION].

14. Neil Duxbury, *Faith in Reason: The Process Tradition in American Jurisprudence*, 15 CARDOZO L. REV. 601, 601–02 (1993).

15. *Id.* at 601.

areas of legal scholarship is a kind of *Name That Tune*¹⁶ intellectual tournament: “You can theorize the field in x ideas? Well, I can do it in $x-1$.”

This preference for singularity in explanation is reflected in more nuanced fashion in the internal status hierarchy in many law schools, where more prestige is traditionally bestowed on those fields regarded as having strong jurisprudential parsimony (contract, tort) rather than fields centered on important social or economic relationships but with a high level of heterodoxy in legal forms and theoretical foundations (family law, health law). And as is manifested by the anxiety expressed by many health law scholars, the intellectual pressure to achieve singular coherence is felt most acutely by newer fields aspiring to more established, if not canonical, status.

This is not the place for a full assessment of this singularity impulse or its general desirability as a frame for legal analysis. There is no question that such a style has had, and continues to have, dramatic potential for explanation and illumination in many areas of legal thought. Well known examples include Oliver Wendell Holmes Jr.’s influential vision of framing the law of torts around the fundamental negligence principle,¹⁷ or more recently the elegant typology of liability rules and property rules explained by Calabresi and Melamed in their *One View of the Cathedral* article.¹⁸ In its origins over a century ago and in its current persistence, the academic preference for elegant and sparse theoretical coherence reflects a worthy intellectual goal of discernment and illumination, while at the same time representing a self-interested status move by a legal academy seeking to differentiate itself from the lawyerly mode of particularized case analysis and reach a rough parity with other academic disciplines in the university.

The paradigm’s impact on the nation’s leading health law scholars is evident, and is exemplified in the words of Mark Hall, who describes a quest for “an organizing principle that not only makes the disparate parts of health care law cohere, but also distinguishes health care law from other bodies of integrated legal thought.”¹⁹ This is given causal significance in the standard account: health law is undertheorized, or is messy, *because* general principles have not yet been unearthed and agreed upon. As Hall puts it, the “conceptual disarray” of health law “exists *because*, unlike other areas of law, *no unifying principle* or

16. Viewers of TV game shows in the pre-Idol era may recall this program (airing in various incarnations in the 1950s, 1970s and 1980s) as a contest where points were awarded for naming a song after hearing only the first few notes. For detail on the show’s history, see Curt Alliaume, *Name That Tune*, <http://www.curtalliaume.com/ntt.html> (last visited Aug. 23, 2007).

17. See Thomas C. Grey, *Accidental Torts*, 54 VAND. L. REV. 1225, 1268 (2001) (describing Holmes’s decision to “emphasize the centrality of negligence to torts,” and stating that “[t]his focusing of tort law upon objective negligence was his most important innovation”).

18. See generally Guido Calabresi & A. Douglas Melamed, *Property Rules, Liability Rules, and Inalienability: One View of the Cathedral*, 85 HARV. L. REV. 1089, 1089 (1972) (presenting an approach to unify property law and tort law through “a concept of ‘entitlements’ which are protected by property, liability, or inalienability rules”).

19. Hall, *supra* note 5, at 465.

animating concern *has yet been identified* for the law of health care delivery.”²⁰ In this framework the cure for the malaise is the imposition of some grand unifying theme, the discovery of which is a central test of the field.

B. THE PREFERENCE FOR TYPOLOGICAL DISTINCTIONS BASED ON PURE LEGAL FORM

There is a second feature of this singularity impulse that is more specific, but so overwhelmingly accepted that it bears some explanation and historical discussion. For much of the past century the legal academy has displayed an intellectual preference for fields that cohere around distillate legal forms rather than other kinds of conceptual building blocks. Hence the foundational dichotomy between tort and contract, the distinct status of criminal law, and the occasionally uncertain conceptual status of property, which sits rather uneasily in a typology hinging on distinctions in legal form.²¹ So entrenched is this focus on legal difference that we largely take this for granted, though, as I explain in the next few pages, there is a story of historical contingency that lies behind this central organizational choice.

This emphasis on clear distinctions in legal form erects a daunting, perhaps insurmountable barrier to health law scholarship in its efforts to meet the prevailing coherence standard. Indeed, the fact that health law lacks a tight focus around a particular legal form is often cited as evidence of its incoherence. Clark Havinghurst has argued that health law rules “emanate from such diverse sources, and are so uncoordinated, inconsistent, and incomplete that they fail to constitute a coherent legal regime that can be studied as an integrated whole.”²² Likewise, Gregg Bloche has described the field as “a jumble of statutes and common-law doctrines”²³ that, in the main, constitutes “a chaotic, dysfunctional patchwork.”²⁴ In the view of Einer Elhauge, health law suffers from “an identifiable pathology” due to its haphazard borrowing from other fields, resulting in an “incoherent legal framework.”²⁵

As descriptors, these accounts are unquestionably correct: health law does embrace a wide variety of legal forms. But the normative judgment about incoherence that flows from that fact is derivative of the antecedent organizational choice at issue here: the decision to classify law by its essential legal forms. Although familiar, even orthodox, today, this mode of organizing law by pure legal form was but one of many contenders for predominance in the formative era of the late nineteenth century. Its ultimate adoption was histori-

20. *Id.* at 464 (emphasis added).

21. See, e.g., Henry E. Smith, *Intellectual Property as Property: Delineating Entitlements in Information*, 116 YALE L. J. 1742, 1755–56 & nn. 33–37 (2007) (describing the realist critique of conventional conception of property).

22. Clark C. Havinghurst, *Health Care as a Laboratory for the Study of Law and Policy*, 38 J. LEGAL EDUC. 499, 499 (1988).

23. M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247, 250 (2003).

24. *Id.* at 321.

25. Elhauge, *supra* note 4, at 1452.

cally contested. An alternative typology focusing on “primary rights” was available in the earlier era, and would have, if even partially adopted, created a markedly more receptive intellectual climate for the flourishing of fields like health law and family law that center on fundamental interests or transactions as opposed to idealized legal forms. I will briefly recount this episode of contested intellectual history, returning at the end of this Essay to some suggestions about how health law scholarship might draw on some insights from the largely forgotten primary rights approach.

At the middle of the 1800s, American legal thought was in an unusually protean state of flux, generated in large part by the mid-century reforms of pleading and other procedural devices that aimed to modernize and systematize legal procedure.²⁶ This reformative regularization and separation of procedure created a conceptual problem for theorists of the substantive law. In the pre-modern period, substantive rights and procedural remedies were coupled together in specific pairings, such as trover, conversion, or trespass. But with procedure unified and made separate from the underlying interests, the substantive law floated untethered from these traditional procedural forms. A new classification typology was needed to make sense of the substantive areas of law in their own right. The challenge was, of course, also a unique opportunity for pathbreaking legal thought, a rare “opening given to legal theory by procedural innovation.”²⁷

These conditions coalesced to produce, in the decades from roughly the 1860s through the 1880s, an unusually wide-ranging debate about how best to organize the substance of the law.²⁸ A full analysis of this intellectual ferment is far beyond the scope of this Essay; for my purposes here it suffices to summarize a basic boundary line that came to characterize two competing schools of thought on the question. One of these, heavily influenced by Roman law, focused on clear distinctions in the legal forms themselves, breaking the law into component parts such as tort, contract, criminal law, and (perhaps) constitutional law.²⁹ An alternative classification approach was expressed in a leading treatise by John Norton Pomeroy.³⁰ Pomeroy’s emphasis was on classifying law not by legal form but by primary right or interest.³¹ In broad strokes coupled

26. For the historical analysis in the next few paragraphs I rely heavily on Grey, *supra* note 17, *Accidental Torts*, 54 VAND. L. REV. 1225 (2001). Prior to this era, the substantive forms of law were linked closely to particular procedural forms, such that the pleading itself gave a certain classification to the law. *See id.* at 1230–31. Beginning with New York in 1848, however, many legislatures in common law jurisdictions sought to unify and modernize civil procedure, permitting litigants to simply plead their particular legal claim in relatively straightforward fashion. *See id.* at 1231.

27. *Id.* at 1232.

28. On the classification impulse generally in this era, see Howard Schweber, *Before Langdell: The Roots of American Legal Science*, in 2 HISTORY OF LEGAL EDUCATION, *supra* note 13, at 606, 631 (describing the “emphasis on taxonomy as the goal of scientific inquiry”).

29. *See* Grey, *supra* note 17, at 1233, 1235.

30. *See generally* JOHN NORTON POMEROY, AN INTRODUCTION TO MUNICIPAL LAW 358–537 (1864). “Municipal” law here meant the law of a given nation as opposed to international law.

31. *See generally id.*

with more detailed analysis, he aimed to create a typology of substantive interests, each protected by a collection of legal rules.

In general terms, Pomeroy divided these legal interests into three broad categories.³² The first two are familiar to modern readers—contractual rights and property.³³ A third category, however, dealt with a wide range of “personal rights” that to a modern eye appear to be a disparate collection of interests protected by a jumble of legal forms.³⁴ In Pomeroy’s typology, the primary rights were classified first, and the legal forms to protect those rights overlaid on this initial typology.³⁵ So, for instance, Pomeroy identifies bodily integrity as a foundational primary interest,³⁶ and then discusses in detail a variety of legal protections that from a formal point of view are quite distinct.³⁷ Bodily integrity is protected, in his scheme, by tort rules such as trespass to the person, criminal law rules against assault, privileges such as self-defense, and constitutional rules such as the Eighth Amendment’s prohibition on cruel and unusual punishments.³⁸ Though contract and property were themselves forms of “primary” interests in Pomeroy’s scheme, tort law was conceptually deemphasized as a mere enforcement device—and one that did not create its own underlying substantive interests.³⁹ We know now, of course, that Pomeroy’s classification lost the intellectual debate over a century ago. Today’s legal canon, reflected in the mandatory first-year courses and in the shape and division of legal scholarship generally, is organized primarily around differences in forms of law rather than upon legal protections for primary substantive interests.

The adoption of a classification scheme hinging on legal form, rather than some version of a primary rights approach, carried with it dramatic implications for the development of American legal scholarship. These implications vary in severity for different fields of law, as certain disciplines would have thrived under either approach. For instance, contract law was a prominent part of all of the new classifications that emerged in the nineteenth century.⁴⁰ It fit well with both a “legal forms” approach and a “primary rights” typology because contracts could be characterized as either an underlying substantive right or an enforcement regime, or both.⁴¹ Likewise, real property law was featured under both classificatory schemes, for reasons related as much to historical importance and path dependence as any clear conceptual unity. Indeed, modern property scholars have noted that the field fits uneasily within the modern typology of

32. Grey, *supra* note 17, at 1253.

33. *Id.*

34. *See id.*

35. *See id.* at 1253–56.

36. *See POMEROY, supra* note 30, at 368–69.

37. *See* Grey, *supra* note 17, at 1254.

38. *See POMEROY, supra* note 30, at 368–69; Grey, *supra* note 17, at 1254–55.

39. *See* Grey, *supra* note 17, at 1254–55.

40. *See id.*

41. *See id.* at 1233–34, 1242.

pure legal form.⁴²

For other fields, however, the choice of a typology based on legal form rather than primary rights had dramatic ramifications, which still resonate more than a century later. Health law and tort law represent two converse conceptual foils along this dimension, where the choice of classification scheme does much to make or break the field's perception as a "coherent" legal area. Health law coheres around certain key primary rights and relationships, but is extremely diverse and heterogeneous, even conflicting, in terms of the legal forms used to enforce values relating to those primary rights and relationships. Tort law is the opposite: disconnected from any specific primary right but—at least in the parsimonious negligence conception that Holmes and others came to emphasize—conceptually unified in terms of pure legal form. It is not hard to see how the choice of classification regime was freighted with huge stakes for the development of these and similar legal fields. Tort is all legal form, so that the decision to adopt a schema hinging on that differentiating variable was an essential precondition for its canonical status in the modern legal academy.⁴³

Health law, by contrast, is at its messiest—in other words, at its weakest from the point of view of the conventional coherence account—when viewed in terms of pure legal form. The interests and relationships that health law centers on are protected and regulated by a myriad of legal forms and institutions. As Carl Schneider and Mark Hall have written, "We suspect there is no grand

42. See, e.g., Edward L. Rubin, *Due Process and the Administrative State*, 72 CAL. L. REV. 1044, 1086 (1984) (describing property as "simply a label for whatever 'bundle of sticks' the individual has been granted"). The bundling conception of property has as much in common with Pomeroy's primary rights approach as it does the modern focus on ideal legal types. It is best viewed as a kind of holdover, part of the modern curriculum because of its ongoing importance, but more suited to a primary rights mode of analysis. Criminal law and constitutional law are harder cases, probably more featured under the currently prevailing focus on distinctions in legal form, though given their special nature such fields would have been important components even of a schema organizing the law under a primary rights framework.

43. The potential preeminence of some form of primary rights organizational framework in this period made the status of tort law clearly uncertain to contemporaneous participants in the debate. Holmes himself thought for a time that torts was "not a proper subject for a law book" because it "did not begin with a theory" and "has never worked one out." John Fabian Witt, *Contingency, Immanence, and Inevitability in the Law of Accidents*, 1 J. TORT L. 1, 6, 19 (2006) (quoting OLIVER WENDELL HOLMES, JR., *THE COMMON LAW* 77 (1881) and Oliver Wendell Holmes, Jr., *Book Review*, 5 AM. L. REV. 340 (1871) (reviewing C.G. ADDISON, *THE LAW OF TORTS* (1870))). For Holmes and other skeptics of tort law, the problem was that tort was purely remedial law, unconnected with any particular primary right and thus antecedent and subservient to all of them. See Grey, *supra* note 17, at 1241–42. Tort law was explicitly castigated because it was pure enforcement form, pliable enough to protect any interest and thus not robust enough to support a full theory in itself. Torts "had no distinctive primary subject matter," instead being "made up entirely of sanctioning rights . . . arising out of the violation of whatever primary rights . . . the law happened to protect." *Id.* at 1242. Of course, we know that the story doesn't end this way. Only a few years after he expressed his doubts about tort as a "proper" field of study, Holmes himself led the intellectual effort to theorize and promote tort alongside contract law, as the building blocks of the legal academic enterprise. Holmes did this by highlighting a particular form of tort law, the negligence action, and providing a complete theory and explanation that was satisfying to legal scholars and influential for judges and policymakers struggling with accident law for a newly industrializing United States. See *id.* at 1266–81.

organizing principle” for health law because it “borrow[s] from too many areas of law.”⁴⁴ Just to pick one of many low-hanging examples, in some state regimes patient confidentiality is protected by an extension of contract law, in others a breach is considered a tort, still others have statutory protections, and of course the federal Health Insurance Portability and Accountability Act (HIPAA) statute and subsequent administrative regulations govern this field as well.⁴⁵

This dynamic is said to reflect incoherence and inconsistency. The inconsistency point is certainly accurate (and will be further generalized in Part II below), but the incoherence judgment is a normative one that is dependent in large part on the analytic choice made over a century ago to prioritize distinctions in pure remedial form over classification of primary interests.

As Tom Grey puts it, however, “things need not have turned out this way.”⁴⁶ An alternative universe might be imagined where a primary interests classification approach prevailed, or at least persisted alongside the focus on pure legal form. It is not hard to imagine how health law—and similar fields like family law—would have fared differently and better under such an intellectual approach. Such fields often take as their center a set of primary interests and status relationships, but then struggle to describe and classify the legal responses that define and encircle such relationships. There is general agreement among health law scholars about some of these building blocks in the health law field: the right to bodily autonomy, the centrality of the physician-patient relationship, the unique dependencies that accompany the therapeutic transactions. To be sure, the contours and definitions and implications of these primary interests and relationships are debated, but no more so than ideas like negligence are in the tort field. The point is that there are central focal points of analysis available, but they inhere not in pure legal forms but rather in underlying primary interests. As I will discuss more below, that multiple institutions and legal forms vie for primacy in protecting and regulating such interests hardly denigrates the reality of such primary rights and relationships, but rather suggests something interesting about the contingency and elasticity of the legal forms themselves.

C. THE PREFERENCE FOR INSTITUTIONAL CENTRALITY

The discussion thus far has been about a standard notion of conceptual coherence—focused on a parsimonious typology of legal forms—that looms over health law scholarship even though it is a singularly poor fit. Two other elements of the prototypical field-coherence model relate to ideas of institutional specification and historical context, and here too health law’s particular

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

45. *Compare* Biddle v. Warren Gen. Hosp., 715 N.E.2d 518, 523 (Ohio 1999) (tort law remedy for breach of patient confidentiality), *with* Givens v. Mullikin *ex rel.* Estate of McElwaney, 75 S.W.3d 383, 407–08 (Tenn. 2002) (confidentiality protected by implied covenant in contractual relationship). *See generally* MARK A. HALL ET AL., MEDICAL LIABILITY AND TREATMENT RELATIONSHIPS 179–99 (2005).

46. *See* Grey, *supra* note 17, at 1284.

patterns of historical development and institutional allocation match poorly with the paradigmatic coherence variables.

First, a short point about institutional centralization and specification: Some fields in the legal academy share health law's disjointed internal framework but are able to cohere around a central institutional actor, textual foundation, or both. Constitutional law shares this lack of internal conceptual coherence, but traditionally, scholarship in the field has been able to achieve a kind of analytical centrality by close analysis of the predominant interpretive institution, the U.S. Supreme Court. That several of the important new ideas in constitutional law over the past half century have been floated in a recurring scholarly outlet entitled the "Supreme Court Foreword" illustrates in a literal fashion the way in which institutional focus can provide a field with an analytical center of gravity even where tight conceptual coherence is lacking.

Moreover, if we broaden the notion of foundational institutions to include framework texts and the agencies which implement them, we see this dynamic in other fields. This applies to constitutional law, of course, but also for fields not otherwise more integrated from a formal perspective than health law, like environmental law or labor law.⁴⁷ Finally, this idea of institutional centralization is not an exclusive requirement for field coherence—some established fields like torts or contracts that succeed in coherence around the pure conceptual forms described above can afford a high degree of institutional decentralization. Health law, of course, falls short on both measures: it lacks a tight parsimony of legal form, and it also is operationalized and contested across a dizzying array of federal, state, and private market regulatory actors and regimes. Barry Furrow has characterized this array of institutional actors as an "untidy morass of state and federal regulatory schemes" overlaid on the already "unruly domain" of health care delivery.⁴⁸ This institutional multiplicity clearly frustrates health law scholarship's fit within the classical coherence paradigm, but as I will suggest below is itself a generalizable feature of the field that itself offers rich ground for theoretical and empirical analysis.

D. THE PREFERENCE FOR HISTORICAL DETERMINISM

A final element that is often important in the conventional coherence account of field definition is a sense of orderly historical development or progress for a given field. Though hardly a universally shared attribute of modern legal thought, scholars seeking to define and regularize a new field of study have often sought to discern an orderly pattern of historical development of the relevant legal rules and institutions. John Fabian Witt has recently described this

47. On the development of labor law, see generally James Gray Pope, *Labor's Constitution of Freedom*, 106 YALE L.J. 941 (1997); on environmental law, see generally RICHARD J. LAZARUS, *THE MAKING OF ENVIRONMENTAL LAW* (2004).

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

dynamic in an intellectual history of tort law, labeling such determinist accounts “immanence” perspectives.⁴⁹ Such thinking has held important sway over leading accounts of tort law’s development. So, for instance, Wigmore could assert that one could “trace back in a continuous development . . . without a break, for at least two thousand years’ the evolution of the idea of tortious liability.”⁵⁰ In their most pointed form, these accounts adopt a preference for a kind of Weberian linearity in terms of the law’s rational development: law’s development is both linear and deontological. So for instance, Lord Mansfield maintained that the law “works itself pure” over time.⁵¹

Few modern scholars in health law or elsewhere would embrace anything close to Mansfield’s extreme conception of linear legal development and progress. But a milder version of this historicist impulse does prevail in the current academy, with negative normative implications for health law when it is compared with more venerable fields. Einer Elhauge has lamented the fact that health law’s major features developed by “happenstance.”⁵² Mark Hall and Carl Schneider attribute health law’s development as occasional “accretion” through history rather than a more systematic progress.⁵³ For health law scholars, history provides no help in supplying a systematic organizational meme on a field which is disorganized on the other dimensions described here.

It is hardly necessary or inevitable, however, to center analysis of a legal field on determinate historical development. The idea that law would display rational historical development over time is a contested analytic construct, and one that is waning in several more developed fields even as it looms large over health law scholarship. More mature fields are experiencing a new heterogeneity of approaches to history and other conceptual dimensions of field definition. John Witt has recently described current tort law scholarship as characterized by unprecedented debate over multiple conceptual dimensions of tort theory and history, including the presence or absence of any determinate development of the law over time.⁵⁴ Witt’s own work, and that of other leading scholars like Tom Grey, expressly rejects the determinist account of legal development in torts, finding instead a generally “accidental” pattern of development in tort in the past two centuries.⁵⁵ And for Witt and others, this unprecedented “diversity of outlook and approach,” is cause for intellectual celebration as scholars have “approach[e]d the topic from a far wider array of perspectives and on the basis of a dramatically more eclectic set of materials” than earlier generations.⁵⁶ Like

49. See Witt, *supra* note 43, at 4–6.

50. *Id.* at 6 (quoting John H. Wigmore, *Responsibility for Tortious Acts: Its History*, 7 HARV. L. REV. 315, 315 (1894)).

51. See *id.* at 7 (quoting *Omychund v. Barker*, (1744) 1 Atk. 21, 33; 26 Eng. Rep. 15, 23 (Ch.)).

52. Elhauge, *supra* note 2, at 365.

53. See Hall & Schneider, *supra* note 44, at 101–02.

54. See JOHN FABIAN WITT, *THE ACCIDENTAL REPUBLIC: CRIPPLED WORKINGMEN, DESTITUTE WIDOWS, AND THE REMAKING OF AMERICAN LAW* 8–9, 20–21 (2004).

55. *Id.* at 8–9; see Grey, *supra* note 17, at 1283–84.

56. Witt, *supra* note 43, at 1.

tort law, constitutional law scholarship has recently broadened dramatically in terms of the focal points of analysis and diversity of methodological approach. Long focused primarily on Supreme Court doctrine and constitutional text, scholars are now exploring the manner in which other institutional actors and the broader public contribute to framing and contesting constitutional meaning.⁵⁷ And the parsimonious focus on “original intent” that was prevalent in historical debates of the late twentieth century has largely been replaced by a longer and more complex view of constitutional development as taking place incrementally over a two-century span.⁵⁸

That these more established fields are diversifying and decentralizing even as health law scholarship struggles to fit within the more traditional coherence model suggests something about the gatekeeping function that the conventional paradigm serves within the hierarchy of the legal academy. Scholars in fields that attained canonical status in the bygone age of treatise-writing are afforded wide latitude to experiment with new approaches and interdisciplinary insights, and indeed are encouraged to do so. Parvenu fields like health law and family law, in contrast, are apparently held to a different standard, expected to conform to the more parsimonious conception of field coherence described here.⁵⁹ I do not mean to diminish this impulse altogether; clearly, in new areas of legal thought there ought to be some effort at field theorization and specification before wholesale deconstruction and decentralization occur.

However, if a neat analytical sparseness is taken as the exclusive ticket to admission in this internal status game, the deck is decidedly stacked against health law. As a field, health law is defined in large part by an unusual multiplicity of forms of law, ultimate goals, and historical roots. There are multiple (and often conflicting) values served by multiple (and often conflicting) legal forms, and implemented by multiple (and often conflicting) institutional actors. All of this would seem to compel a nuanced institutionalist and comparative perspective that is bound to frustrate a search for a singular internal logic to the field.

It may be that health law scholars will succeed in the near or distant future in overcoming this perceived coherence deficit even within the conceptual bounds of the classical coherence paradigm. Other fields, like tort and property, which

57. The literature on constitutionalism outside of the Supreme Court is now voluminous, and has generated its own secondary literature. *See, e.g.*, Doni Gewirtzman, *Glory Days: Popular Constitutionalism, Nostalgia, and the True Nature of Constitutional Culture*, 93 *Geo. L.J.* 897, 898–99 (2005).

58. Leading recent examples of work that employs a longer view of constitutional development include LARRY D. KRAMER, *THE PEOPLE THEMSELVES: POPULAR CONSTITUTIONALISM AND JUDICIAL REVIEW* (2004) and KEITH E. WHITTINGTON, *POLITICAL FOUNDATIONS OF JUDICIAL SUPREMACY: THE PRESIDENCY, THE SUPREME COURT, AND CONSTITUTIONAL LEADERSHIP IN U.S. HISTORY* (2007).

59. *See, e.g.*, John Dewar, *The Normal Chaos of Family Law*, 61 *Mod. L. Rev.* 467, 468 (1998) (contending that “many contemporary developments in family law can be characteri[z]ed as chaotic, contradictory or incoherent”); Carl E. Schneider, *The Next Step: Definition, Generalization, and Theory in American Family Law*, 18 *U. MICH. J.L. REFORM* 1039, 1040–41 (1985) (critiquing family law’s failure to generalize and asserting that “there is hardly any” theory in family law scholarship).

are now thought to be canonical and concisely theorized, were in earlier times regarded as just as unwieldy. But this result seems unlikely. The sheer variety of coherence suggestions in recent scholarship in a sense proves the point about how difficult health law is to parsimoniously theorize with a few core internal principles. Why try so hard, why fight against the nuanced multiplicity of legal forms, institutional actors, and ultimate ethical ends that characterize the provision and regulation of health care in the United States?

II. ALTERNATIVES TO THE STANDARD COHERENCE FRAMEWORK

As is obvious by now, my first normative suggestion for those working on health law questions is a negative one—scholars ought not strive too hard to shoehorn the unwieldy contours of health law within the neat edges of the standard field coherence paradigm. But the fact that health law may not cohere around an internal legal core need not mean that scholarship must address only disparate and minute particulars, avoiding other types of theoretical generalization. This messiness and complexity in legal form and institutional action is part of what makes health law important and unique, and provides fertile terrain for generalized study.

The conceptual difficulties that health law scholarship faces have already been described and are the reasons the field matches so poorly with the conventional coherence account. But these features are themselves core attributes of the field and worthy of careful examination, and perhaps, even of affirmative theoretical embrace. For instance, the fact that at bottom the field coheres not around reducible elements of legal form but rather around a set of primary interests and relationships protected by an inconsistent “jumble” of law, invites close theoretical inspection of those foundational interests themselves. That such interests are protected and mediated by multiple and occasionally conflicting institutions is a feature that itself is partially field-defining and opens up fruitful avenues for rich comparative analysis from both theoretical and empirical perspectives. Finally, the fact that health law is a “creature of history”—and a history that is contested, uncertain, and political in its development—ought to invigorate rather than demoralize scholarship, inviting the kind of complex interdisciplinary study of legal change that has lately brought fresh insight to the study of other fields such as constitutional law and torts.

To flesh out several of these suggestions in a little bit more detail, I will begin by returning to the discussion of the primary-interests approach that was raised in the last Part.⁶⁰ Although it lost the battle for orthodoxy over a century ago, an updated version of the primary-interests approach offers a much more suitable classification scheme for fields like health law and family law that center on foundational interests and relationships rather than pure legal forms. To a large extent many health law scholars already do center their analysis on underlying

60. *See supra* text accompanying note 30.

interests and relationships that exist in the health care setting, so my points here go as much to analytical emphasis and various follow-on implications as they do to any fundamental shift in focus.

Before exploring a few examples, it is worth pausing to make a simple but important clarification about the manner in which I am advancing the primary-interests framework here. My posture toward the rights and interests that might center various kinds of analysis in the field is fundamentally positivist, meaning that I am interested in the protection, modification, and contestation of various rights and interests as expressed in cases, statutes, and other forms of public and private law. This is not to say that the primary rights are nothing but the legal forms themselves—indeed, what interests me is the often imperfect and evolving fit between the underlying social and political conception of these rights and the legal modes employed to protect or limit them. But as objects of study for legal scholars, I am most interested in rights and interests as manifested in applications of the positive law. This interaction and legal change is protean and kinetic so that the shape and existence of the primary rights themselves necessarily expands and contracts over a fairly short period of time.

It is possible, of course, to take a very different posture toward the specification and normative advancement of primary rights in health. For instance, I regard Mark Hall's important work on trust and other "essential features" of medical care as describing a set of core attributes that are relatively static and distinct from (and perhaps antecedent to) the positive law that is the focus of my analysis here.⁶¹ Similarly, to the extent one can draw a meaningful distinction between descriptive and normative analysis, my framework here and in related works in progress is more descriptive. I am less interested in what the law ought to protect than a close analysis of what interacting legal institutions have operated to protect and how those protected interests have changed over time within the framework of American health law. The normative theoretical work about rights in health that scholars in various disciplines are engaged in is important and illuminating, but is not my central interest here.⁶²

I will briefly describe two different phenomena involving legal change and the interaction between various legal forms and the underlying interests that those forms operate to define, protect, and limit. The first example involves the evolution of the abortion right from *Roe v. Wade*⁶³ forward to the present day. Although the formal doctrine remains largely the same since *Roe*, the underly-

61. See Mark A. Hall, *The History and Future of Health Care Law: An Essentialist View*, 41 WAKE FOREST L. REV. 347, 358–59 (2006) (describing six essential features as the "*sine qua non* of medicine").

62. Examples abound here, and include, for example, Martha Nussbaum's prioritization of life, bodily health, and bodily integrity in her list of basic human capabilities, see MARTHA C. NUSSBAUM, *FRONTIERS OF JUSTICE: DISABILITY, NATIONALITY, SPECIES MEMBERSHIP* 76 (2006), and Jennifer Prah Ruger's application of Amartya Sen's capability approach to basic health allocational questions, see Jennifer Prah Ruger, *Health, Capability, and Justice: Toward a New Paradigm of Health Ethics, Policy and Law*, 15 CORNELL J.L. & PUB. POL'Y 403, 435–43 (2006).

63. 410 U.S. 113 (1973).

ing right has evolved dramatically from a relational right protective of physician and patient autonomy to an individualistic right held by the woman alone.⁶⁴ The shift in this underlying interest helps explain the Supreme Court's recent "partial birth" abortion decision,⁶⁵ and this general diminishment in the protection of physician autonomy can be traced across a range of the Court's decisions even beyond the abortion area. Because these cases operate across various fields of formal doctrine, recognition of the Court's diminished treatment of physician autonomy is possible only by focusing on that interest as a unit of analysis distinct from any particular doctrinal setting.

The second kind of legal development where a primary interests approach may offer insight is one commonplace in health law: when developing normative support for an emerging health-related right creates pressure for legal change. What follows are often rapid, multiple, and inconsistent legal responses, as political and legal institutions struggle to shift legal rules to respond to changes in the underlying normative culture. Examples include the late-twentieth-century development of a limited right to care in emergency situations, which was first operationalized in common law cases drawing on various theories,⁶⁶ and then formed the basis of an important federal statute (EMTALA).⁶⁷ This kind of dynamic recurs with unusual frequency in health law, and offers insight into law's permeability to external social and political pressure, and into the elasticity of existing doctrinal forms in accommodating normative change, and ultimately, into the imperfection of any one legal solution in mediating and settling controversial debates over health policy.

I will first return to the abortion context, however, which presents a different dynamic of significant change in the underlying primary interest that is masked to a great extent by a doctrinal framework that has remained relatively stable over time. As most health law scholars are aware (and most constitutional law scholars ignore), the Supreme Court's *Roe v. Wade* opinion was very much a health law case, emphasizing the medical nature of the abortion decision and the physician's professional role in that choice.⁶⁸ The most natural reading of the *Roe* majority opinion is as creating a relational right protecting the shared decisionmaking of patient and doctor. The *Roe* Court stated that:

[F]or the period of pregnancy prior to [the] "compelling" point, *the attending physician*, in consultation with his patient, *is free to determine*, without

64. See *infra* text accompanying notes 68–73.

65. *Gonzales v. Carhart*, 127 S. Ct. 1610 (2007).

66. Compare *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135, 140 (Del. 1961) (establishing a limited duty for hospitals to treat patients in "unmistakable emergenc[ies]" under a reliance theory), with *Guerrero v. Copper Queen Hosp.*, 537 P.2d 1329 (Ariz. 1975) (finding a duty to treat in emergencies as an implicit condition of state licensure).

67. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2000 & Supp. IV 2007). See generally David A. Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX 29 (1998) (describing the goals and history of EMTALA).

68. See *Roe v. Wade*, 410 U.S. 113, 163 (1973).

regulation by the State, that, *in his medical judgment*, the patient's pregnancy should be terminated. If that decision is reached, the judgment may be effectuated by an abortion free of interference by the State.⁶⁹

The *Roe* opinion also contained as support for its holding a lengthy discussion of the American Medical Association's changing official stance toward abortion.⁷⁰ As Nan Hunter has convincingly shown in her analysis of the internal Supreme Court memoranda preceding the *Roe* decision, the Court was internally divided on how to frame the underlying abortion right.⁷¹ Hunter describes the internal struggle between the Justices who favored a relational right inhering in both the physician and patient (Justices Blackmun and Douglas)⁷² and Justice Brennan who advocated a purely individual right in the woman.⁷³ Though *Roe* reflected judicial protection of the relational right, the decision's permanence on that dimension would be short-lived.

The Supreme Court's 1992 *Planned Parenthood v. Casey*⁷⁴ decision is rightly famous for its reaffirmation of the basic *Roe* holding and the doctrinal protection of the pre-viability abortion right (though it dispensed with *Roe*'s trimester framework).⁷⁵ However, a close reading of *Casey* with an eye to the underlying protection of physician discretion reveals a dramatically different posture than the *Roe* majority opinion. The *Casey* Court placed almost no independent weight on physician discretion or autonomy, upholding a variety of state regulations that were held to be ancillary to the basic right, such as a twenty-four-hour waiting period, an informed consent requirement, and a parental consent provision.⁷⁶ In so doing the Court deemphasized the independent constitutional status of the physician's professional role, stating that "[w]hatever constitutional status the doctor-patient relation may have as a general matter, in the present context it is derivative of the woman's position."⁷⁷ According to the Court, the physician-patient relation "does not underlie or override the two more general rights under which the abortion right is justified: the right to make family decisions and the right to physical autonomy," and so is entitled to no special "solicitude" so long as the woman's basic right is protected.⁷⁸ As to the physician's First Amendment right not to convey the state's required message, the Court made clear that it was of subsidiary importance and fair game for regulation, relevant "*only* as part of the practice of medicine, subject to reason-

69. *See id.* (emphasis added).

70. *See id.* at 141-44.

71. *See* Nan D. Hunter, *Justice Blackmun, Abortion, and the Myth of Medical Independence*, 72 BROOK. L. REV. 147, 177-88 (2006).

72. *See id.* at 177-81.

73. *See id.* at 181-84.

74. 505 U.S. 833 (1992).

75. *See id.* at 846, 873.

76. *See id.* at 880-887, 898.

77. *Id.* at 884.

78. *Id.*

able licensing and regulation by the State.”⁷⁹

Other developments since *Roe* confirm this shift in the nature of the underlying right even as the doctrinal test has changed little. A pair of cases that starkly illustrates the Court's uninterest in fostering physician autonomy as an independent constitutional norm is *Rust v. Sullivan*⁸⁰ and *Legal Services Corp. v. Velazquez*.⁸¹ The former case is famous (or infamous) among health law and constitutional scholars—it held that physicians do not have an absolute free speech right to counsel patients about abortion and that Congress may condition a physician's receipt of federal funds upon the doctor's inability to counsel patients about abortion options.⁸² The Court reasoned that the government through the so-called “gag rule” was not prohibiting speech but merely conditioning receipt of funds on the doctor's agreement not to speak about abortion, and that so doing transgressed neither the physician's nor the patient's constitutional right.⁸³

The Court reached a very different result in its more recent decision in *Legal Services Corp. v. Velazquez*,⁸⁴ a case most health law specialists may only vaguely recall because it involved a speech prohibition on lawyers, not doctors. But apart from the professional difference, the similarities are striking. The *Velazquez* case was a constitutional challenge to a federal statute that prohibited legal services attorneys who accepted public funding from endeavoring to “amend or otherwise challenge existing law.”⁸⁵ Legal services attorneys could represent their clients' case-specific interests but were precluded from arguing broader theories of invalidity or unconstitutionality.⁸⁶ In other words, lawyers could dispute the application or enforcement of laws to their clients, but were banned from raising facial constitutional objections to federal statutes. The plaintiff attorneys in *Velazquez* raised claims analogous to the physician in *Rust*: that the advocacy restriction infringed their client's right to representation and undermined their own professional autonomy.⁸⁷ In stark contrast to *Rust*, however, the Supreme Court agreed that the restrictions were unconstitutional and invalidated the federal restriction.⁸⁸ Justice Scalia dissented, arguing that there

79. *Id.* (emphasis added).

80. 500 U.S. 173 (1991).

81. 531 U.S. 533 (2001).

82. *See Rust*, 500 U.S. at 191–93.

83. *See id.* at 193–95.

84. 531 U.S. 533 (2001).

85. *Id.* at 538 (quoting Omnibus Consolidated Rescissions and Appropriations Act of 1996, Pub. L. No. 104-134, § 504(a)(16), 110 Stat. 1321).

86. *Id.*

87. *See id.* at 542 (noting that a lawyer “does not act ‘under color of state law’ because he ‘works under canons of professional responsibility that mandate his exercise of independent judgment on behalf of the client’ and because there is an ‘assumption that counsel will be free of state control’” (quoting *Polk County v. Dodson*, 454 U.S. 312, 321–22 (1981))); *see also* Brief for Respondents at 6, *Velazquez*, 531 U.S. 533 (Nos. 99-603, 99-960).

88. *See Velazquez*, 531 U.S. at 548–49.

was little in substance to distinguish the two cases.⁸⁹ His reasoning is persuasive, and raises the implication that the Court may show greater solicitude for the professional autonomy of lawyers than of doctors.

The lesson we can take from these abortion cases since *Roe* is that although the basic doctrinal protection for abortion has remained in place, the contours of the primary right protected by the doctrine changed quite a bit for many of the Justices. What was regarded at least partially as a relational right dependent on physician-patient decisional freedom became recast as a more exclusively independent individual right held by women alone. Understanding this shift in the nature of the underlying right helps explain the Supreme Court's controversial decision in last Term's "partial birth" abortion decision, *Gonzales v. Carhart*.⁹⁰ *Carhart* was striking in the degree to which it upheld a direct intrusion into physicians' choice of abortion procedure, even as it concluded that the ultimate abortion right would be unburdened because other procedures were available.⁹¹ The case thus stands at the endpoint of the progression described here, whereby the Court has essentially demedicalized the abortion right, removing any independent protection for physician discretion.

A focus on the Supreme Court's recent treatment of physician discretion in other contexts reveals a similar diminution of this underlying interest in its jurisprudence. In *Black & Decker Disability Plan v. Nord*, the Court rejected the traditional "treating physician rule," holding that ERISA does not require plan administrators in a disability application context to give special deference to the medical opinions of the applicant's treating physician.⁹² Similarly, in the 1998 Americans with Disabilities Act case of *Bragdon v. Abbott*, the Court ruled that a dentist was not free to refuse to treat an HIV-positive patient based upon his own good-faith medical judgment that a risk of transmission existed; instead the risk assessment must be based on objective scientific evidence of a threat.⁹³

The Supreme Court's diminishing solicitude for the traditional autonomy embraced in the physician-patient relationship was also evident in the recent case of *Gonzales v. Raich*,⁹⁴ a decision that is not considered a "health law" case at all precisely because the Court dismissed the role of treating physicians in California's medical marijuana regime. The Court flatly rejected an argument that the required participation of physicians reduced the potential for unlawful diversion, stating that "the fact that marijuana is used for personal medical purposes on the advice of a physician cannot itself serve as a distinguishing factor."⁹⁵ This judicial choice is not itself facially unreasonable, but it reflects how little of *Roe*'s deference to independent medical judgment remains in the

89. *See id.* at 552–57 (Scalia, J., dissenting).

90. 127 S. Ct. 1610 (2007).

91. *See id.* at 1637.

92. 538 U.S. 822, 825, 833–34 (2003).

93. 524 U.S. 624, 649–50.

94. 545 U.S. 1 (2005).

95. *Id.* at 27 (quotations omitted).

Court's current jurisprudence. And this diminishing trend appears to cut across cases in a number of different issue areas.

The foregoing pages offer a brief example of the manner in which focusing on a legal institution's treatment of a basic underlying interest (here, physician autonomy) may yield insight that narrow doctrinal analysis will not. But my analysis of that interest here is itself incomplete in its focus only on one institutional actor and its primary focus on one legal form (constitutional law). A more typical phenomenon in the health law context is where underlying normative pressure produces legal change that is institutionally decentralized and diverse in terms of legal form. One well-known example is the development in the latter part of the twentieth century of a basic right to medical treatment in an emergency. Prior to mid-century, the traditional "no-duty" rule had long exempted both physicians and hospitals from the obligation to care for new patients (paying or otherwise) absent any preexisting treatment relationship.⁹⁶ Beginning in the 1960s, however, a series of state courts began to adapt various common law doctrines to construct a limited right to receive care from emergency rooms. Some states extended new adaptations of a reliance theory, others treated private hospitals as quasi-public with corresponding duties at least in this limited area.⁹⁷ The doctrinal distinctions are not important here—what is important and recurring in health law is this phenomenon of legal change, whereby multiple institutions alter and apply existing legal forms to protect and define emerging primary interests.⁹⁸ In the case of the emergency treatment right as with other interests, this first-order legal response was itself criticized, modified, and extended by a different institutional actor in a different legal form—here the passage of a new federal statute, the Emergency Medical Treatment and Active Labor Act (EMTALA).⁹⁹ We can view this process of legal change as one in which the public and various legal and political actors gradually coalesced around a new conception of patient rights in emergency situations, and adapted a mix of existing and new legal institutions to protect this underlying right. That the legal means chosen and the implementing institutions vary dramatically suggests the benefits of a comparative approach; the incremental process by which law responds to pressure for change compels a nuanced historicist treatment.

96. See *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135, 138 (Del. 1961) (quoting several sources articulating this "no-duty" rule).

97. Compare *id.* at 140 (establishing a limited duty for hospitals to treat patients in "unmistakable emergenc[ies]" under a reliance theory), with *Manlove v. Wilmington Gen. Hosp.*, 169 A.2d 18, 18 (Del. Super. Ct. 1961) (holding that a "hospital is a quasi-public institution notwithstanding its private base, and is required, at all times, to render reasonable needed aid in instances where emergencies involving death or serious bodily impairment might reasonably exist"), and *Guerrero v. Copper Queen Hosp.*, 537 P.2d 1329 (Ariz. 1975) (finding a duty to treat in emergencies as an implicit condition of state licensure).

98. See generally Karen H. Rothenberg, *Who Cares? The Evolution of the Legal Duty To Provide Emergency Care*, 26 Hous. L. Rev. 21 (1989).

99. 42 U.S.C. § 1395dd (2000 & Supp. IV 2007).

Health law scholars will recognize this multimodal and incremental process of legal change as occurring with regularity across various other health-related areas. A similar story (though without a federal statute as the coda) could be told, for instance, with respect to the emergence of robust protection of patient informed consent, which was implemented through a diverse and inconsistent set of state doctrinal modifications, some sounding in tort, others in contract, others in extensions of the malpractice standard.¹⁰⁰ This multimodal dynamic of legal change, with its feature of seemingly haphazard borrowing from existing doctrinal areas, is one major driver of the incoherence critique that afflicts health law. But it is so frequently recurring in health law that it merits study and generalization as a key feature of the field.

Sensitivity to this recurring model of incremental and decentralized legal change suggests several lessons about the nature of law in this area. The first is its basic permeability to external normative change—the development and modification of extralegal preferences will produce reactive change in the legal system. This is hardly unique to health law, but may be intensified in this area for a few reasons. Abortion notwithstanding, health law is largely deconstitution-alized, meaning that legal change can occur without the blocking effect of either strong-form constitutional *stare decisis* or supermajority rules. Moreover, the relatively limited role of the federal government in many health areas enables change to develop outside of Congress, whose internal structures often operate to thwart majoritarian efforts for change. Third, the decentralized structure of health law might facilitate legal change because of slightly different regionalized preferences (for example, Oregon's assisted suicide law¹⁰¹) and/or because different political coalitions will be legislative or judicial winners in one jurisdiction but losers in another. This uneven public-choice dynamic might explain some of the perceived inconsistency between jurisdictions on various health law topics, but it also yields multiple pathways for policy experimentation and comparative analysis.

Beyond illustrating the close connection between law and broader society, the process of change in health law rules also demonstrates the remarkable pliability and elasticity of traditional legal doctrines in responding to such change. Because few health law areas are fully bureaucratized at the federal level, much recent policy innovation still operates at a state common law level and illustrates both the capability of judges to adapt common law forms to new problems as well as the ultimate limitations of such devices. To be sure, that some states first operationalized new conceptions of patient confidentiality or informed consent as tort law rules, and others extended contract doctrines to do so, is a mark of the kind of “incoherent” borrowing dynamic that is thought to plague the field.¹⁰² But beyond illustrating the normative force of those underlying

100. See cases cited *supra* note 45.

101. See Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.800–.825 (2005).

102. See cases cited *supra* note 45.

primary interests as drivers of legal change, this diversity of legal form also provides an illuminating glimpse into the instrumentalism and pliability of law—law serves ends, and sometimes different forms of law can be stretched to serve the same end (though in more or less optimal ways). The fact that these changes themselves tend to produce more modification, conflict, and occasionally statutory revising demonstrates something else about the imperfection of legal rules to perfectly enforce or mediate contested norms.

Finally, as Einer Elhauge and others have noted, the fact that health law entails basic rights and relationships that are protected by a variety of legal forms raises an unusual opportunity for a rich comparative analysis.¹⁰³ This is true both of the legal forms chosen (for example, statutory vs. common law solutions) as well as the legal institutions that apply and promulgate health law rules. It may be that health law is uniquely suited for decentralized and multifaceted institutional policymaking. Even regimes without constitutional imperatives for dual sovereignty have opted for decentralization in some key policy choices; for instance, recent reforms of the British National Health Service have given public bodies in Scotland, Wales, and Northern Ireland the authority to make different choices about coverage determinations and program design.¹⁰⁴ There are several possible conceptual foundations for such a proposition. Health policy choices are profoundly important, but have comparatively fewer obvious interstate externalities than other areas of environmental and economic regulation where uniform regulation is needed to solve a host of collective action and free rider problems. And the rapid shifts in technology, health industry organization, and the public's normative preferences about health argue in favor of the Brandeisian policy experimentation rationale for devolution of authority.

Of course, even in a regime with decentralized allocation of authority about health care, the federal government is involved and will continue to be more so. This leads to frequent vertical conflict over allocation of policy authority, which is occasionally overt in political discourse (witness various states' battles with President Bush in the recent SCHIP debate¹⁰⁵), but more often doctrinalized and applied through judicial preemption rules. Such institutional interaction and conflict figures prominently in recent preemption questions involving ERISA and FDA approval issues,¹⁰⁶ and will only intensify if the federal government's

103. See, e.g., Elhauge, *supra* note 2, at 379–82.

104. See A. Alvarez-Rosete et al., *Effect of Diverging Policy Across the NHS*, 331 BRIT. MED. J. 946, 946 (2005) (describing devolution of authority to local entities in Scotland, Wales, and Northern Ireland, with attendant “differences in emphasis of policy”).

105. See Sarah Kershaw, *8 States Plan To Press Bush on Health Bill*, N.Y. TIMES, Oct. 2, 2007 (describing lawsuits filed by eight states challenging the federal executive branch's administration of the State Children's Health Insurance Program, or “SCHIP”).

106. On ERISA preemption debates, see, e.g., Russell Korobkin, *The Failed Jurisprudence of Managed Care, and How To Fix It: Reinterpreting ERISA Preemption* 51 U.C.L.A. L. REV. 457 (2003) and Theodore W. Ruger, *The Supreme Court Federalizes Managed Care Liability*, 32 J.L. MED. & ETHICS 528 (2004). On recent FDA efforts to preempt state tort law, see Catherine M. Sharkey,

role in health care provision and regulation increases. The fact that multiple institutions and multiple sovereigns are involved in regulating overlapping areas of health policy is occasionally advanced as another “incoherent” feature of health law in the United States, but here too I think the judgment of incoherence is misplaced. As political scientist Stephen Skowronek has written about American governance more generally:

To synchronize the institutions of a polity or gear them to produce one coherent, overarching system would entail at the very least creating or recreating all of them simultaneously, and that is a task even the most radical revolution is unlikely to accomplish A genuinely institutional view of politics would adopt a multiple orders thesis. Its premise would be that any given polity is likely to be composed of very different and simultaneously operating institutional systems and it would identify the juxtaposition of these orders as the wellspring of change.¹⁰⁷

Skowronek’s insight about simultaneously operating institutions applies perfectly to the landscape of American health law, as does his suggestion to focus on institutional conflict and juxtaposition as levers of change. Like the related complexities of American health law discussed above, this institutional multiplicity ought to be regarded as an invitation to rich empirical and theoretical research rather than a badge of incoherence.

I will conclude with Joseph Raz’s conceptual caveat that there is “no reason to suppose that the law lives up to our preferences or values” as to a particular conception of coherence.¹⁰⁸ My sense as a newcomer to the field is that health law scholars as a group feel at least some intellectual pressure to live up to the traditional parsimonious idea of field coherence that prevailed through much of the twentieth century. Health law unquestionably falls short of many of the attributes of field coherence that comprise the conventional account, and in my view will continue to do so given the basic attributes of the field. But to say as much ought not to also implicate a normative judgment about the field’s intelligibility or ultimate status within the legal academy.

Preemption by Preamble: Federal Agencies and the Federalization of Tort Law, 56 DEPAUL L. REV. 227 (2007).

107. Stephen Skowronek, *Order and Change*, 28 POLITY 91, 94–95 (1995).

108. Raz, *supra* note 10, at 283.