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Introduction

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WHAT IS HEALTH LAW?

As a distinct field of study and practice, health law is still relatively new, and its boundaries continue to be contested. As recently as 2006, Einer Elhague questioned whether health law could "become a coherent field of law."[1] The fact that Elhague's musings appeared in a symposium dedicated to the idea that the "once vibrant . . . and fresh" subject of health law was haunted by a "specter of exhaustion" indicates the contested nature of the "field-ness" of this field.[2] Its boundaries are even more hotly disputed. Is health law limited to the relationships among health care professionals, patients, the institutions where they meet, and the payers who finance their encounters? Or does it also encompass legal issues related to public health and the social determinants of health, which social epidemiology demonstrates[3] play an even greater role than health care in shaping outcomes?[4] As feminist health law scholars, we "view health law as an inherently . . . expansive field."[5] For the purposes of this volume, however, and in light of the potential for other areas – such as poverty law, housing law, and employment law – to generate Feminist Judgments

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[1] Einer R. Elhague, *Can Health Law Become a Coherent Field of Law?*, 41 WAKE FOREST L. REV. 365, 365 (2006).

[2] Mark Hall, Carl Schneider et al., *Rethinking Health Law: Introduction*, 41 WAKE FOREST L. REV. 341 (2006).

[3] *See* Lisa F. Berkman & Ichiro Kawachi, *A Historical Framework for Social Epidemiology: Social Determinants of Population Health*, *in* SOCIAL EPIDEMIOLOGY 1, 2 (Lisa F. Berkman, Ichio Kawachi et al., eds., 2nd ed. 2014).

[4] *See* Rachel Rebouche & Scott Burris, *The Social Determinants of Health*, *in* OXFORD HANDBOOK OF U.S. HEALTH LAW 1097–1112 (I. Glenn Cohen, Allison K. Hoffman et al., eds., 2017).

[5] Seema Mohapatra & Lindsay F. Wiley, *Feminist Perspectives in Health Law*, 47 J. L. MED. & ETHICS 103, 103 (2020).

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books of their own, we have narrowed our focus to more traditional health law topics. Nonetheless, we view the insights of social epidemiology regarding the influence of social, economic, and environmental factors on health as "an invitation to engage with the rich literature of critical legal theories that view law as an expression of social power."[6]

This book is part of a broader movement to engage critical perspectives – including feminist legal theory, critical race theory, critical disability studies, LatCrit, ClassCrit, queer theory, and more – in health law and policy debates. As we argued in an article we wrote at the inception of this book project:

> [e]xamples of how health laws and policies have reflected and reinforced white male patriarchy abound, including the conceptualization of decisions about reproductive health as exceptions to general principles protecting bodily and decisional autonomy, restrictions on the practice of midwifery and nursing that privileged the professionalization of medical practice, and the notion that public measures to support access to health care and healthy living conditions must be justified by exceptional circumstances against a background norm of personal responsibility.[7]

Health law is a dynamic field ripe for the application of feminist perspectives. From a field dominated by private, common-law governance of relationships among patients, providers, and payers, health care has rapidly become one of the most heavily regulated sectors of the economy. Health care financing is transitioning away from its traditional commitment to actuarial fairness toward a commitment to mutual aid. The health care system's growing reliance on collective financing raises thorny questions about which community members to include and which conditions to cover. Health law scholarship is also in the midst of a renaissance. A growing number of professors and researchers are offering deep commentary on four competing rationales: *professional autonomy* (in which the law shields physicians' decisions from outside meddling), *patient autonomy* (in which the law empowers the individual choices of some, but not all, patients with regard to some, but not all, health care decisions), *market power* (in which the law privileges economic analysis of the central problems of health care quality, cost, and access), and the emerging perspective of *health justice* (in which the law centers social concerns that represent more than the mere aggregation of individual patient interests). Feminist legal theory and critical race feminism provide crucial but underexplored frameworks for assessing and enriching

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[6] *Id.*

[7] *Id.*

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these competing rationales at a time when litigants are calling on judges to craft resolutions to disputes that will reverberate for generations.

In addition to demonstrating the relevance of feminist perspectives, this volume also highlights the continued importance of courts in the health law realm. Over the last decade, sweeping health policy reforms have drawn students' and researchers' attention to legislatures and regulators, pulling focus away from the field's common-law roots. As these reforms mature, however, judges and courts are again taking center stage, setting up the next decade as a crucial period for court judgments with massive implications for health, feminism, and social justice on issues such as Medicaid eligibility, access to reproductive health care, and protections for people with preexisting conditions. By reflecting on how the courts of the past could have shaped the development of today's health law, we hope that students, researchers, and advocates will gain a new perspective on current and future disputes before the courts.

WHAT IS A FEMINIST JUDGMENT?

Following the model of the *Feminist Judgments* series, the purpose of this book is to broaden to health law the inquiry that the original volume (*Feminist Judgments: Rewritten Opinions of the United States Supreme Court*) began. Other books in the series have focused on tax law, family law, trusts and estates, employment discrimination law, tort law, and reproductive justice. The original volume showed that feminist perspectives could have changed the development of American constitutional law if justices had applied them in important Supreme Court cases. This health law volume demonstrates how feminist theories and methods can transform law in a field where paternalism, individualism, gender stereotypes, and tensions over the public-private divide shape judicial decisions about health care.

Each chapter focuses on a single court decision. The decisions concern patient autonomy, informed consent, medical and nursing malpractice, the relationships among health care professionals and the institutions where they work, communications between health care providers and the patients they serve, end-of-life care, reproductive health care, biomedical research, ownership of human tissues and cells, the influence of religious directives on health care standards, health care discrimination, equitable access to long-term care in nursing homes, equitable access to community-based alternatives, private health insurance, Medicaid coverage, the Affordable Care Act, and more.

Each chapter begins with a commentary from a scholar who puts the case in historical context, summarizes the original opinion, discusses what makes

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the rewritten opinion feminist, and describes how a feminist approach might have altered subsequent developments in health law. The feminist judgments take the form of rewritten majority opinions, concurrences, and dissents. The opinion authors are scholars who inhabit the role of a judge deciding the case. They rely exclusively on the factual record, precedents, and scientific understanding available at the time of the original decision to show how a judge with a feminist perspective could have adjudicated the matter differently. The commentaries and rewritten opinions are presented by separate authors, which fosters an inherently collaborative approach to each case. Collaboration does not always result in consensus; sometimes, the opinion author and the commentary author may disagree about what a feminist approach to the case should be. Nonetheless, the iterative process – whereby feminist judgment authors and commentary authors read and responded to each other's drafts – enriches the analysis of both halves of each chapter in this volume.

The selection process for the health law cases presented in this volume was also collaborative. We began by putting together a list of health law cases that implicate gender, culled from our own teaching, knowledge, and scholarship. Many of the cases feature prominently in the major health law textbooks and casebooks used by undergraduate, law, and health sciences students across the country. We reflected on the health law field: its breadth; the central tensions it concretizes; and the implications of gender, misogyny, patriarchy, feminism, and intersectionality for its core rationales. We assembled a distinguished and diverse advisory panel to evaluate the cases that we were considering and recommend additional cases. Emily Benfer, Marie Boyd, Erin Fuse Brown, Kathy Cerminara, Brietta Clark, Abbe Gluck, Allison Hoffman, Nicole Huberfeld, Lisa Ikemoto, Craig Konnoth, Daniela Kraiem, Dayna Bowen Matthew, Elizabeth McCuskey, Wendy Parmet, Jessica Roberts, Nadia Sawicki, Stacey Tovino, Elizabeth Weeks, Leslie Wolf, and Ruqaiijah Yearby all served as advisers. Some of these scholars later agreed to serve as opinion or commentary authors.

Some of the cases we selected for this volume do not have an explicit or obvious connection to gender, but we felt that there was a feminist aspect of the case that needed to be brought to the forefront. For example, the *Schloendorff v. Society of New York Hospitals* case is cited in almost every health law text as being the first to articulate the principle of "informed consent." We include it here for that proposition but also for its heavily gendered analysis of the relationship between nursing and medicine and the implications of that analysis for patient autonomy and quality of care. Another example is *National Federation of Independent Business v. Sebelius*, a

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Supreme Court case that upheld the individual mandate of the Affordable Care Act but struck down its expansion of Medicaid eligibility, which Congress designed to be mandatory for the states. Although gender implications are not apparent on the surface of this case, the effect of leaving Medicaid expansion to state discretion is disproportionately borne by people capable of becoming pregnant[8] who live in low-income households. They have a greater-than-average need for health care while also being called on to bear the burdens of caring for other family members in need. Moreover, the shift from actuarial fairness to mutual aid and from personal responsibility to collective responsibility for health that was on trial in the case is ripe for examination from feminist perspectives that emphasize shared vulnerability and a public ethic of care.

After narrowing down our list of cases, we issued a public call for authors. We invited prospective authors to indicate the cases they were interested in working on and how they would approach the task of rewriting the judgment from a feminist perspective (for opinions) or the feminist methods or themes they would highlight (for commentaries). After selecting authors and soliciting abstracts, we held a workshop hosted by Indiana University Robert H. McKinney School of Law in December 2018, which most of our authors attended. The workshop provided an opportunity to discuss the application of feminist theories and methods to the cases included in the volume and to workshop chapter abstracts. We did not provide any restrictions or specific instructions about what qualifies as "feminist." Authors have taken their opinions and commentaries in exciting, creative directions, within the rules of the project: As with the original *Feminist Judgments* volume, the rewritten health law opinions in this book rely on the same factual record and precedents that bound the original court at the time of the opinion.

The opinion authors bring feminist perspectives to bear on their analysis of the facts of the cases and the relevant laws and precedents in force at the time of the original decision. In addition to applying feminist legal theories, many of the rewritten opinions featured in this volume use distinctively feminist methods. In particular, several opinions feature storytelling that centers the lived experience of the litigants and other affected individuals. One of the underlying claims of this volume is that judicial experiences, perspectives, and reasoning processes affect even seemingly objective questions, like whether a

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[8] We use the term *woman* to include anyone who identifies and experiences life as a woman. We also use terms such as *pregnant people* and *people capable of becoming pregnant* to include people who do not identify as women. *See* Chase Strangio, *Can Reproductive Trans Bodies Exist?*, 19 CUNY L. Rev. 223, 230–232 (2016).

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requested benefit is covered by the terms of a health insurance policy or whether a physician's conduct comports with customary practice. The rewritten opinions in this book demonstrate that incorporating feminist theories and methods into the adjudication of health law disputes generates more equitable, responsive, and fully informed judicial decision-making.

A ROAD MAP FOR THE BOOK

To guide the reader, we provide a brief overview of the chapters included in this volume, highlighting cross-cutting doctrinal and theoretical themes. The text in this section draws heavily from abstracts originally submitted by the authors whose work is featured in this book. We present the cases in chronological order, rather than siloing them by feminist or health law themes. Taken together, these rewritten opinions form a kind of alternate history of what health law could have been – and could still become in the future.

We begin with *Schloendorff v. Society of New York Hospitals*,[9] a 1914 New York Court of Appeals decision frequently cited as the foundational case establishing a patient's common-law right to bodily autonomy. But Judge Benjamin Cardozo's assertion that "every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages"[10] was mere dicta. In affirming a directed verdict for the hospital where the plaintiff's uterus was removed without her consent, Cardozo infantalized a night nurse and deemed her awareness of the patient's objection to surgery insufficient to put the hospital on notice that an independent-contractor surgeon was planning a non-consensual hysterectomy. In her feminist judgment, Professor Kelly Dineen – who worked for several years as a practicing nurse and earned a doctoral degree in health care ethics prior to joining the legal academy – unearths a treasure trove of contemporaneous sources that establish the nursing function as an independent basis for duties to patients for which the hospital may be held vicariously liable. By authoring a dissent, rather than rewriting the majority opinion, Dineen creates space to directly confront Cardozo's mischaracterization of the relationships among and responsibilities of nurses, physicians, and hospitals with regard to patient care. In her commentary, Professor Danielle Pelfrey Duryea – whose scholarly interests include interprofessional education as well as gender, race, and critical

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[9] 105 N.E. 92 (N.Y. 1914).
[10] *Id.* at 93.

theory – situates Cardozo's derision of nurses and Dineen's restoration of the nursing function as a distinct basis for liability within the emergence of "modern nursing" as a devalued feminine counterpart to masculine, valorized "modern medicine" in the second half of the nineteenth century.

Next, we turn to *Reynolds v. McNichols*,[11] a 1973 opinion from the Tenth Circuit Court of Appeals. Although the plaintiff was never convicted of prostitution, she was held, examined, and involuntarily treated for sexually transmitted infections under the city of Denver's "hold and treat" ordinance several times between 1970 and 1972, in the absence of a confirmed diagnosis of any infection. The Tenth Circuit rejected her due process and equal protection challenges to the ordinance, noting that the "fact that the plaintiff was a prostitute is of crucial significance" and concluding there was no sex discrimination, even though the city did not detain the plaintiff's male clients. In her feminist rewrite of the majority opinion, Professor Wendy Parmet, a public health and constitutional law scholar, questions the health officials' assumptions that female sex workers are "the primary source of venereal disease" and that the city can only protect the public's health by forcibly treating them. Parmet relies on precedents invalidating discriminatory public health interventions, prohibiting discrimination on the basis of sex, and protecting the rights to choose abortion and contraception. She holds that the application of the ordinance to the plaintiff was discriminatory and that, under the circumstances, the defendants' forced treatment of the plaintiff violated her right to privacy and their failure to obtain a warrant before forcing her to submit to a medical examination or remain in detention violated the Fourth Amendment's prohibition on unreasonable searches. In her commentary on *Reynolds*, Professor Aziza Ahmed, a legal historian and health law scholar, situates the case in terms of historical responses to sex work under the banner of public health.

Conservatorship of Valerie N.[12] is the next case in this volume. The original 1985 opinion from the California Supreme Court concerned an "adult developmentally disabled daughter," whose parents wished to have her surgically sterilized because she was (according to the parents) sexually aggressive toward men and other forms of contraception either made her "ill" or were not feasible for her.[13] Although the California Supreme Court held that California law did not authorize the sterilization of Valerie and, therefore, the trial court had properly denied the parents' petition, the case is

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[11] 488 F.2d 1378 (10th Cir. 1973).
[12] 707 P.2d 760 (Cal. 1985) (en banc).
[13] *Id.* at 762.

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nonetheless ripe for a feminist rewrite. Professor Doriane Lambelet Coleman's feminist rewrite corrects the original opinion's failure to center Valerie's own desires for physical intimacy and perhaps sexual liberty. Coleman – whose interdisciplinary scholarship focuses on women, medicine, and sex – demonstrates how feminism requires attention not only to women's issues in general but also to the woman herself, and not only to childbearing (or not) but also to sexuality separate from its procreative aspects. Professors Cynthia Soohoo and Sofia Yakren's commentary situates the case in terms of how sexism and ableism shape attitudes toward sexuality, reproduction, and health care decision-making powers of women with disabilities. It also discusses the evolving understanding of capacity to make medical treatment decisions and alternatives to traditional surrogate decision-making. Soohoo and Yakren are colleagues at the City University of New York Law School, where Soohoo codirects the Human Rights and Gender Justice Clinic and Yakren teaches disability law, among other subjects.

In the following chapter, we turn to *Bouvia v. Superior Court*,[14] a California state court decision from 1985 in which a twenty-eight-year-old quadriplegic woman sought to have a feeding tube removed and to refuse any further lifesaving measures. The original opinion held that a competent adult – male or female – has the right to refuse life-sustaining treatment. The original decision's description of "the ignominy, embarrassment, humiliation and dehumanizing aspects created by her helplessness"[15] prompts this chapter's authors to question whether the original court supported Bouvia's decision because of her right to choose or because the justices believed the life of a woman who was no longer capable of performing the roles traditionally expected of her was not, in fact, worth living. Professor Barry Furrow – one of the founding coauthors of a health law casebook in which *Bouvia* is prominently featured – proffers a poetic feminist rewrite focusing on the factors that were important to Bouvia, rather than her inability to perform the roles that concerned the original court. Furrow also considers whether recognizing an autonomy "right" in this case ignores the larger issue of lack of resources to support disabled people, which led Bouvia to seek a court order to end her life after multiple failed attempts to access the care she needed in a non-institutional setting. Professor Joan Krause's commentary discusses how the original opinion simply noted without comment the county's "fruitless" efforts to find Bouvia an apartment with live-in or visiting nurse assistance or identify other options. Krause, whose scholarly work focuses on health law and

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[14] 225 Cal. Rptr. 297 (Cal. Ct. App. 1986).
[15] *Id.* at 305.

women and the law, illuminates the original court's decision to focus on the principle of personal autonomy to resolve this dispute – and thus to ignore any broader public responsibilities to the disabled community.

The subject of our next chapter is *Moore v. Regents of University of California*,[16] a California Supreme Court case from 1990 adjudicating the claims of a patient whose tissues were used to produce a patented immortal cell line. Though Moore consented to several procedures between 1976 and 1983, his physician did not inform him that his cells were valuable to the physician's research and economic interests. The original opinion recognized Moore's claims for breach of fiduciary duty and informed consent but rejected his claim for conversion (a tort claim for theft) because recognizing such a claim would "hinder research by restricting access to the necessary raw materials."[17] In her feminist judgment for the majority, Professor Lisa Ikemoto, a scholar whose work highlights how biomedical technology interacts with race and gender, illuminates the role of informed consent in transforming the doctor-patient relationship from one that is paternalistic to one premised on patient rights. Her account recognizes the role of the women's health movement in achieving that transformation. In recognizing the plaintiff's property-based tort claim, she also discusses how the grievance Moore is expressing is about exploitation, by an industry – the biotechnology industry – based on commercializing cells and tissues. In her commentary, Professor Jessica Roberts, whose scholarship focuses on people's legal interests in their genetic data, highlights that courts have recently become more receptive to recognizing robust legal rights for individuals who provide tissue and data for research purposes. Roberts notes that if *Moore* had adopted a feminist approach, this development would have arrived much sooner.

In the next chapter, we turn to *Linton v. Commissioner of Health & Environment*,[18] a 1965 case from the Sixth Circuit Court of Appeals that grappled with disparate-impact racial discrimination in a state Medicaid program. The Tennessee Medicaid program covered the skilled nursing facility care that the *Linton* plaintiffs required, but the state allowed nursing facilities accepting Medicaid payments to "certify" a limited number of beds for Medicaid patients (for whom the facilities typically received lower reimbursement rates). The plaintiffs sued on behalf of adversely affected Medicaid patients, arguing that the limited bed policy violated the federal Medicaid statute and had a disparate impact on black Medicaid recipients in violation of

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[16] 793 P.2d 479 (Cal. 1990).
[17] *Id.* at 494.
[18] 65 F.3d 508 (6th Cir. 1995).

Title VI of the Civil Rights Act. In the original opinion upholding the remedial plan adopted by the lower court, the Sixth Circuit Court of Appeals failed to adequately address the petitioning facilities' challenge to the district court's factual finding of disparate impact. The original opinion sidestepped the issue, asserting that it was of no consequence whether the legal predicate for the remedial plan was a disparate-impact violation of Title VI or the less controversial violation of the federal Medicaid statute. Professor Gwendolyn Majette, whose scholarship focuses on access to health care, offers a feminist opinion concurring in the judgment that corrects the Sixth Circuit's failure to address the Title VI issue. Majette provides a fuller, more comprehensive analysis that addresses the intersection of gender, race, class, and age. Professor Ruqaiijah Yearby, who has written extensively on racism as a social determinant of health, provides the commentary. Yearby explores whether the opinion in *Linton* could have done more to ensure that the unique harms experienced by patients because of their race would be fully addressed in the remedial plan.

It may surprise some readers to see *Olmstead v. L.C.*[19] in a health lawbook. The 1999 Supreme Court case was pivotal for disability rights but it specifically concerned discrimination within a state Medicaid program. The plaintiffs were women with intellectual disabilities and mental health diagnoses whose physicians concluded that they could be cared for appropriately in a community setting but they remained institutionalized because the state Medicaid program failed to place them in a community care program. The Supreme Court held that the Americans with Disabilities Act (ADA) prohibits states from unnecessarily institutionalizing disabled people as a condition of receipt of publicly assisted medical care. The original opinion requires states to provide community-based treatment for persons with mental disabilities when the state's treatment professionals determine that such placement is appropriate, the affected individuals do not oppose such treatment, and the state can reasonably accommodate the placement. Professor Becka Rich, whose scholarly interests include bioethics and disability law, proffers a rewritten opinion for the majority that differs from the original opinion in its explicit rejection of the defendants' arguments that the costs of community care limit their obligations under the ADA. Rich's feminist judgment indicates that the courts will hold states to task for taking full advantage of the flexibility and funding provided by Medicaid to support their compliance with the integration mandate of the ADA. In his commentary, Professor Doron Dorfman, a scholar of

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[19] 527 U.S. 581 (1999).