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ARTICLE

Celebrating 70 Years of Health Law at BU

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Abstract

This essay celebrates the BU Health Law Program upon its 70th anniversary, offering reflections on the founders of the program, Fran Miller, George Annas, and Wendy Mariner ("FGW," endearingly), and their contributions to the field.

Current faculty offer reflections, including: Several speak to scholarly research, including Elizabeth McCuskey on health care finance, Aziza Ahmed on human rights, Dionne Lomax on antitrust, Christopher Robertson on trust, and Kathy Zeiler on the marketplace. Other contributors speak to the student experience, with Dianne McCarthy on mentorship, Laura Stephens on demanding excellence, Michael Ulrich on teaching, and Larry Vernaglia on merging law and public health. On FGW's broader impacts, Nicole Huberfeld speaks to the translation of research to reach new audiences, and Kevin Outterson writes about FGW's pivotal roles in establishing the health law field and the institutions that now define it.

Together these pieces testify to the astounding contributions of these scholar-teacher-leaders across many domains and dimensions of health law. While their contributions are countless and immeasurable, these reflections offer a start.

Keywords: public health; health care finance; human rights; antitrust; Affordable Care Act; health law

Scholarship

Healthcare Finance by Elizabeth McCuskey

Health policy and scholarship have coalesced around deep critiques of the role of health care finance in public health outcomes, interrogating money and power in medicine from an array of perspectives and theoretical grounds.[1] The depth, vibrancy, and humanity of this critique was not inevitable. Wendy, Fran, and George have set us on this path and led the way. Their prescience at the dawn of the managed care era, combined with their vigilance and their unflinching clarity, have been a ballast to health law scholarship during the age of economic theory.

Wendy's body of work on health insurance put private insurance squarely in the cross-hairs of public health[2] and has never let up. Recognizing that "[h]ealth reform debates in the United States are typically

[1]"Celebrating 70 Years of Health Law at BU" is edited by Christopher Robertson, with special thanks to Matthew Snyder, Leona Hansen, Camille Cummings, and Rachel Varon.

[2]*See, e.g.*, Wendy K. Mariner, *Problems with Employer-Provided Health Insurance — The Employee Retirement Income Security Act and Health Care Reform*, 327 New Eng. J. Med. 1682 (1992); Wendy K. Mariner, *Liability for Managed Care Decisions: The Employee Retirement Income Security Act (ERISA) and the Uneven Playing Field*, 86 Am. J. Pub. Health 863 (1996).

conducted using the language of insurance,"[3] Wendy has translated the Patient Protection and Affordable Care Act (ACA), ERISA, and managed care for public health policymakers — as well as for lawyers — and curated the conversation about private insurance in public health. She has led by example, encouraging searching inquiry into the public health implications surrounding health care reform efforts, as well as interrogating the very nature of health insurance.[4]

Fran has implored health law scholarship to "follow the money" toward the sources of dysfunction that demand our attention.[5] Her leadership has kept the human impact of money in medicine at the forefront, reminding scholars more than two decades ago that "[p]atients' legal and ethical rights … are little more than rhetoric when the resources needed to implement them are elusive … . [and] when the medical[] and … pharmaceutical communities give lip service to their legitimacy but fail to acknowledge responsibility for the economic and social ramifications of trying to fulfil them."[6]

Nearly a decade before that, George and Fran wrote about the connections among medical technology, informed consent, and money, explaining that "the content and the style of imparting medical information can profoundly affect a country's total health expenditures" and drain resources that could instead go toward universal coverage.[7]

In his individual capacity, George has likewise trained bioethics and public health scholars to grapple with the economic and financial realities that force us into tragic choices about the rationing and distribution of care.[8] His powerful critiques of individualism and market-based distribution of medicine put medical literature in conversation with public health and human rights ethics.[9]

Human Rights and Health by Aziza Ahmed

Early in the AIDS crisis, when there was an enormous amount of fear about human immunodeficiency virus and its spread, governments frequently responded to the epidemic in ways that stigmatized and targeted particular populations, often undermining a more effective public health response. In this moment, a new group of scholars, including George Annas, began to raise concerns about human rights in the public health response.

A very early example of Annas's intervention into this space had to do with the detainment of Haitian migrants in Guantanamo Bay, Cuba, as an HIV containment strategy. As conditions in Guantanamo Bay revealed themselves to be crowded, and issues with health care rampant, human rights advocates began to sound the alarm.[10] The camp was closed in July 1993.[11] George Annas helped draw attention to this issue when, a month after the camp's closure, he wrote in the *New England Journal of Medicine* about the

[3]Wendy K. Mariner, *Health Reform: What's Insurance Got to Do with It? Recognizing Health Insurance as a Separate Species of Insurance*, 36 Am. J.L. & Med. 436, 436 (2010).

[4]*See, e.g.*, Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 Conn. Ins. L.J. 199 (2008); Wendy K. Mariner, *Health Insurance is Dead; Long Live Health Insurance*, 40 Am. J.L. & Med. 195 (2014).

[5]*See, e.g.*, Frances H. Miller, *Foreword: Following the Money*, 36 Am. J.L. & Med. 288 (2010); Rights and Resources (Frances H. Miller ed., 2003); *see also, e.g.*, Wendy H. Mariner, *Whither Private Health Insurance Now?*, Health Affs.: Health Affs. Forefront (Jan. 12, 2018), https://www.healthaffairs.org/content/forefront/whither-private-health-insurance-now ("Follow the Money").

[6]Frances H. Miller, *Introduction: Patient Rights and Health Care Resources: Two Sides of an Irregular Coin*, *in* Rights and Resources, *supra* note 5, at xi.

[7]George J. Annas & Frances H. Miller, *The Empire of Death: How Culture and Economics Affect Informed Consent in the U.S., the U.K., and Japan*, 20 Am. J.L. & Med. 357, 359 (1994).

[8]*See, e.g.*, George J. Annas, Some Choice: Law, Medicine, and the Market (1998).

[9]*See, e.g.*, Charles J. Dougherty, *Some Choice: Law, Medicine, and the Market*, 340 New Eng. J. Med. 1445 (1998) (book review); James J. Pattee, *Some Choice: Law, Medicine, and the Market*, 282 JAMA 96 (1998) (book review).

[10]*See, e.g.*, Mary B.W. Tabor, *Judge Orders the Release of Haitians*, N.Y. Times (June 9, 1993), https://www.nytimes.com/1993/06/09/nyregion/judge-orders-the-release-of-haitians.html.

[11]*See id.*

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many legal issues at stake in the detainment of Haitian migrants in Guantanamo, including the medical care concerns, First Amendment rights, and due process issues implicated by their detention.[12]

His work drawing attention to the issue contributed to the formation of a broader scholarly and activist field of study and work — health and human rights. The key book in this field, *Health and Human Rights*, was written in 1999 and co-edited by George Annas along with Jonathan Mann, Sofia Gruskin, and Michael Grodin.[13] This sub-field in health law has had enormous influence in shaping the types of debates that occur at the intersection of law and public health, raising key questions of how we ought to think about civil rights, civil liberties, and human rights in the response to long-term public health problems, as well as how to formulate a correct response to public health crises.

Antitrust by Dionne Lomax

The health care industry has undergone significant transformations, driven by changes in both market dynamics and regulatory frameworks. Initially, the industry operated under a fee-for-service model, which rewarded providers for the quantity rather than the quality of care, contributing to rising costs.[14] The emergence of Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and other managed care models in the late twentieth century marked a shift toward cost control and efficiency.[15] This era saw increased collaboration among health care providers, including mergers and joint ventures designed to integrate care delivery and reduce expenses.[16] However, these changes also prompted greater scrutiny from antitrust regulators, who aimed to prevent anticompetitive practices while promoting innovation and competition within the health care sector.[17]

Antitrust has been a scholarly research interest for Professor Miller, who saw its non-obvious relations to topics as diverse as the national resident match program and certificates of need.[18] Professor Mariner situated antitrust in the fundamental structural and moral features of the health law system.[19]

The evolution of antitrust compliance in the health care sector has become increasingly complex, reflecting a dramatic shift from the regulatory environment of twenty-five years ago. Previously, health care providers operated within a more lenient framework, utilizing mechanisms like the messenger model to avoid price-fixing allegations[20] and relying on the federal Health Care Guidelines to assess anticompetitive risks.[21] Hospitals and physician groups could pursue mergers and acquisitions with fewer regulatory concerns, often leveraging defenses such as the failing firm doctrine to justify consolidations that might otherwise be seen as anticompetitive.[22] However, today's landscape is vastly different. The withdrawal of the Health Care Guidelines has removed clear compliance benchmarks,

[12]George J. Annas, *Detention of HIV-Positive Haitians at Guantanamo--Human Rights and Medical Care*, 329 New Eng. J. Med. 589, 589 (1993).

[13]*See* Health and Human Rights: A Reader (Jonathan Mann et al. eds., 1st ed. 1999).

[14]*See* Cong. Rsch. Serv., Health Insurance: A Primer 16 (2015), https://crsreports.congress.gov/product/pdf/RL/RL32237.

[15]*Id.*

[16]*See* Yevgeniy Feyman & Jonathan Hartley, *The Perils of Hospital Consolidation*, Nat'l Affs., Summer 2016, at 53, 54–59.

[17]*See* David Dranove & Andrew Sfekas, *The Revolution in Health Care Antitrust: New Methods and Provocative Implications*, 87 Milbank Q. 607, 609–15 (2009).

[18]*See* Frances H. Miller & Thomas L. Greaney, *The National Resident Matching Program and Antitrust Law*, 289 JAMA 913 (2003); Frances H. Miller, *Antitrust and Certificate of Need: Health Systems Agencies, the Planning Act, and Regulatory Capture*, 68 Geo. L.J. 873 (1979).

[19]*See* Wendy K. Mariner, *Toward an Architecture of Health Law*, 35 Am. J.L. & Med. 67, 87 (2009); Wendy K. Mariner, *Market Theory and Moral Theory in Health Policy*, 4 Theoretical Med. 143 (1983).

[20]*See* Jeffrey L. Harrison, *The Messenger Model: Don't Ask, Don't Tell?*, 71 Antitrust L.J. 1017, 1017–19 (2004).

[21]*See* Richard M. Steuer, *Counseling Without Case Law*, 63 Antitrust L.J. 823, 836, 838, 849 (1995) (referring, with respect to several types of arrangements, to the Health Care Guidelines as instructive of the Department of Justice's and Federal Trade Commission's stance on certain transactions).

[22]*See* Marianela López-Galdos, *Comparing the US & EU Failing Firm Defense: Reflections from an Economic Perspective*, 28 Loy. Consumer L. Rev. 297, 298–301 (2016).

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forcing providers to navigate antitrust laws based on case law and past regulatory actions alone.[23] Moreover, certain employment practices have come under increased scrutiny, with courts and agencies imposing oversight on non-compete clauses and no-poach agreements.[24] Any misstep now carries not only civil but also potential criminal liabilities,[25] underscoring the importance of a robust, proactive compliance strategy.

To effectively navigate this challenging environment, health care entities must implement comprehensive antitrust compliance programs that are tailored to their specific operations. These programs should include thorough training, regular audits, and risk assessments, fostering a culture of compliance across the organization. Moreover, it is crucial to maintain detailed documentation of all compliance efforts to ensure continuity and demonstrate effectiveness to regulators. By taking these proactive steps, health care organizations can better protect themselves against antitrust risks, ensuring they remain compliant in an increasingly regulated market.

Trust by Christopher Robertson

Trust is a critical part of health care, since patients are deeply vulnerable, with their health and wealth dependent on the expertise and care of their physicians, nurses, and health care institutions. Where trust is lacking, numerous health outcomes suffer, such as delays in seeking health care, lapses in screening for cancer, and refusals to get vaccines.[26] Furthermore, distrust drives health disparities for minoritized racial and ethnic populations.[27]

Surveys show that Americans trust doctors (84%) and nurses (85%) much more than government agencies (56%), pharmaceutical companies (34%), or health insurance companies (33%).[28] But U.S. doctors still lag behind their counterparts elsewhere in the world.[29]

In a 2001 article in the *Boston University Law Review*, Fran Miller noted, "Many patients suspect that self-interested physicians will either deny them care because they earn more money by doing less for their patients, or will persuade them to undergo unnecessary—even sometimes dangerous—therapy … . All this is a far cry from the Norman Rockwell stereotype of the kindly old family physician and his grateful patients of fifty years ago."[30]

Miller focused on the context of clinical trials for new drugs and devices. As Miller noted, there are a wide range of ethical problems and principles for human subjects research, but Miller specifically called

[23]*See* Lauren Norris Donahue & Brian J. Smith, *FTC Joins DOJ in Withdrawing from Long-Standing Health Care Antitrust Policy Statements*, K&L Gates: Hub (July 25, 2023), https://www.klgates.com/FTC-Joins-DOJ-in-Withdrawing-from-Long-Standing-Health-Care-Antitrust-Policy-Statements-7-25-2023.

[24]*See* J. Mark Gidley et al., *White & Case Global Non-Compete Resource Center (NCRC)*, White & Case (Oct. 21, 2024), https://www.whitecase.com/insight-tool/white-case-global-non-compete-resource-center-ncrc (describing, among other things, a renewed effort by the Federal Trade Commission to stop enforcement of non-competes); Stephen A. Miller & Nathan J. Larkin, *DOJ Continues Crackdown on No-Poach Agreements*, Cozen O'Connor (Feb. 2, 2022), https://www.cozen.com/news-resources/publications/2022/doj-s-crackdown-on-no-poach-agreements-continues.

[25]*See The Antitrust Laws*, Fed. Trade Comm'n, https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/antitrust-laws (last visited Nov. 16, 2024).

[26]*See, e.g.*, Christopher Tarver Robertson, *Biased Advice*, 60 Emory L.J. 653 (2010); Susannah L. Rose et al., *Patient Responses to Physician Disclosures of Industry Conflicts of Interest: A Randomized Field Experiment*, 166 Organizational Behav. & Hum. Decision Processes 27 (2021).

[27]*See, e.g.*, Chanita Hughes Halbert et al., *Racial Differences in Trust in Health Care Providers*, 166 Archives Internal Med. 896 (2006); Christopher T. Robertson et al., *Diverse Patients' Attitudes Towards Artificial Intelligence (AI) in Diagnosis*, PLOS Digital Health, May 2023, at 1, https://doi.org/10.1371/journal.pdig.0000237.

[28]ABIM Foundation, Nat'l Op. Rsch. Ctr., Surveys of Trust in the U.S. Health Care System 8 (2021), https://www.norc.org/content/dam/norc-org/pdfs/20210520_NORC_ABIM_Foundation_Trust%20in%20Healthcare_Part%201.pdf

[29]*See* Robert J. Blendon et al., *Public Trust in Physicians — U.S. Medicine in International Perspective*, 371 New Eng. J. Med. 1570, 1570–72 (2014).

[30]Frances H. Miller, *Trusting Doctors: Tricky Business When It Comes to Clinical Research*, 81 B.U. L. Rev. 423, 423–24 (2001).

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out the reigning discourse of the time, which evinced a "complete failure to address conflicts of personal interest between clinical investigator and research subject."[31] As Miller explained, these personal interests are not always financial, and "[e]ven the best-intentioned clinical investigators face temptation to skew study designs to insure that meaningful results will be forthcoming."[32] Miller also called out the extant policies that permitted scientific investigators to proceed without even disclosing their conflicts of interests to human subjects, as long as the institution "managed" the conflicts.[33] Miller exclaimed, "This is an astonishingly loose standard."[34]

Miller's prescient article was published years before the Institute of Medicine issued its landmark report, *Conflict of Interest in Medical Research, Education, and Practice*, and a decade before Congress would pass the Physician Payments Sunshine Act as part of the Affordable Care Act.[35] Law and ethics have continued to make progress in other aspects of clinical research and health care, but the fundamental problems of conflicts of interest remain trenchant.[36] Study after study shows that physicians follow the money. My own work in this vein is inspired by Miller's prescience, wisdom, and candor.

Market Imperfections by Kathy Zeiler

Remarkable advances in medical technology driven largely by economic competition and profit seeking have made it possible to cure the once-incurable, lengthen the human lifespan, and entirely eradicate diseases. These advances have also generated complicated social questions. For example, how should society allocate medical goods and services in the face of resource constraints? Separately, how might efforts to maximize profits, coupled with pervasive market imperfections, negatively affect medical resource allocation and create conflicts of interests between providers and patients and between health care insurers and enrollees? And, to circle back, how might such conflicts exacerbate resource constraints?

Professor Wendy Mariner contributed important insights to our understanding of these complex, intersecting issues. In four articles published in the mid-1990s, when the Clinton administration was attempting to reform U.S. health care and health insurance systems, she illuminated several key issues that eventually drove the design of the ACA. The first article summarized the basic provisions of the proposed reform and explained the mechanisms by which Congress might restrict coverage, reminding us that Congress has the constitutional authority to deny coverage of certain goods and services given that we have no constitutional right to health care.[37]

The allocation of scarce health care resources has generated some of our most heated debates since the advent of medical care. After the failure of the Health Security Act, Professor Mariner, in another article, offered a plausible theory to explain why Americans so vehemently oppose health care rationing.[38] While Americans might be in favor of reducing overall spending, they chafe at the thought

[31] *Id.* at 436.
[32] *Id.* at 437.
[33] *See id.* at 439.
[34] *Id.*
[35] *See* Comm. on Conflict of Int. in Med. Rsch., Educ., & Prac., Inst. of Med., Conflict of Interest in Medical Research, Education, and Practice (Bernard Lo & Marilyn J. Field eds., 2009); Elizabeth Richardson, Health Policy Brief: The Physician Payments Sunshine Act (2014), https://www.healthaffairs.org/content/briefs/physician-payments-sunshine-act.
[36] *See* Christopher T. Robertson et al., *Effect of Financial Relationships on the Behaviors of Health Care Professionals: A Review of the Evidence*, 40 J.L. Med. & Ethics 452 (2012).
[37] *See* Wendy K. Mariner, *Patients' Rights to Care Under Clinton's Health Security Act: The Structure of Reform*, 84 Am. J. Pub. Health 1330, 1330–33 (1994).
[38] *See* Wendy K. Mariner, *Rationing Health Care and the Need for Credible Scarcity: Why Americans Can't Say No*, 85 Am. J. Pub. Health 1439 (1995).

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of anyone, especially private insurers, restricting access to their individual health care, especially care that might extend life.[39] She argued the only way to get Americans to accept rationing is to artificially restrict supply of health care covered not only by public programs but also by private insurance plans.[40] Once people believe that health care is scarce, then the government can act to equitably allocate supply among private and public plans, ensure that all plans distribute care equitably, and implement equitable criteria for rationing.[41]

Professor Mariner's theory likely explains why the ACA avoided new forms of rationing. While Congress took some small steps towards reducing the total cost of care — for example, by changing Medicare payment rules to encourage provider quality improvements that would lead to lower overall costs[42] — it did not impose artificial restrictions on the supply of care financed through public and private channels. This suggests that buy-in on rationing might be trickier than Professor Mariner supposed. Americans might be so opposed to rationing that they will not tolerate government aims to impose overall supply restrictions, the first step in Professor Mariner's four-step proposal for a more equitable distribution of health care. Resistance to rationing pushes the United States toward alternative methods to contain costs, perhaps the next frontier in health care reform.

In addition to scarce resource allocation, policy makers have been grappling with how to remedy conflicts of interest in health care markets. The simple story is that profit motives are behind conflicts. When we look deeper, however, we see that conflicts are possible only when health care providers and insurers possess more information than patients about the patients' ailments, medical treatment options, and the factors that produce positive and negative outcomes following particular treatments.[43] This raises a key question: can we harness the power of competition, a major driver of innovation, while sufficiently attending to the information asymmetries that misalign the interests of patients and their providers and insurers?

In two articles, Professor Mariner provided a framework for thinking about market imperfections that might compel government protection of patients and enrollees. In the first, she illuminated important differences between business ethics and medical ethics and explained why we should be pessimistic that the forces of competition will align the interests of managed care organizations (MCOs) and enrollees.[44] She further clarified the problem's root causes. First, MCOs are designed to manage care, including denying care that was not promised as part of the exchange.[45] Second, enrollee choice over contract terms is limited, and determining what exactly is promised through the agreed-upon contract terms is quite difficult for enrollees.[46] In the second article, Professor Mariner zeroed in on inefficiencies that arise when insurers promise to cover "necessary care."[47]

These sorts of insights, along with others in the literature, might explain a number of ACA provisions. For example, private health plans are required to spend a certain percentage of premiums on enrollee care,[48] which dampens their incentive to skimp on necessary care after enrollees pay premiums. If the

[39] *See id.* at 1442–43.

[40] *See id.* at 1443–44.

[41] *See id.*

[42] *See* Melinda Abrams et al., Commonwealth Fund, The Affordable Care Act's Payment and Delivery System Reforms: A Progress Report at Five Years 6–7 (2015), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2015_may_1816_abrams_aca_reforms_delivery_payment_rb.pdf.

[43] *See* David K. Leonard et al., *Institutional Solutions to the Asymmetric Information Problem in Health and Development Services for the Poor*, 48 World Dev. 71, 71 (2013).

[44] Wendy K. Mariner, *Business vs. Medical Ethics: Conflicting Standards for Managed Care*, 23 J.L. Med. & Ethics 236 (1995).

[45] *See id.* at 237–40.

[46] *See id.* at 240–41.

[47] Wendy K. Mariner, *Patients' Rights After Health Care Reform: Who Decides What Is Medically Necessary?*, 84 Am. J. Pub. Health 1515 (1994).

[48] *See* Jared Ortaliza & Cynthia Cox, *2024 Medical Loss Ratio Rebates*, Kaiser Fam. Found. (June 5, 2024), https://www.kff.org/private-insurance/issue-brief/medical-loss-ratio-rebates/.

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minimum spending requirement is not met, the plan must return the unspent amount to enrollees.[49] The ACA also requires quick coverage decisions and reviews of those decisions in cases where time is of the essence.[50] The foresight to include such provisions requires a deep understanding of the relevant concerns, and we have Professor Mariner to thank for clarifying why Congress needed to keep patient protection top of mind when drafting the ACA.

The Student Experience

Mentorship by Dianne McCarthy

When I first met Professor Fran Miller, I had no idea of the roles she would play in my life — mentor, professor, friend, encourager, advocate. Since we first met, Fran has helped me shape and realize things I could never have imagined.

It was 1995, and I was in search of my next professional adventure. For the last fifteen years, I had worked in community mental health, first as a clinical social worker and then a health care administrator, providing services to our neighbors who suffer from serious and persistent mental illness. In the mid-90s, funding for community services was terminated or severely curtailed. Seeing the shuttering of services I helped to build, I looked to the next phase of my career. On a whim, I applied to law school – what else was a girl to do?

Enter Professor Fran Miller, my mentor and guide throughout my legal career. I vividly remember sitting in Fran's office, in awe of this delightful, funny, inspiring woman. As I told her of my plans to go to Suffolk at night (so I could continue to work full time), she immediately responded that I would do no such thing. I would attend BU Law. Note, I had not yet been accepted to BU Law School — that small detail would not get in the way of Fran's plans for me! I received my acceptance letter shortly thereafter.

Surprisingly, I did well and in my second year began my search for a law firm. I went to Fran — she was at that time searching for a firm to provide consulting services and had met and very much liked Dave Szabo and Neil Motenko at Nutter McClennen & Fish. So, I went to Nutter and worked for Dave! After a few years, knowing law firm life was not for me and that my long-term goal was to return to my roots of health care service, I began my search for in-house positions. I once again went to Fran — she had a good friend and colleague, Mark Waxman, who had just left Foley & Lardner in California to serve as General Counsel to what was then Caregroup (now, after several iterations, Beth Israel Lahey Health). I went to work for Mark! When Mark left Caregroup to return to private practice, I … went to Fran. Fran was then on the board of Joslin Diabetes Center, and they were looking for a general counsel. You get the picture … I went to Joslin as General Counsel.

So, yes, with Fran always there for guidance and support, I did move around a bit, and I eventually finished out my career as General Counsel at the Center for Health Information and Analysis. Knowing that an idle retirement was not in my future, I … went to Fran.

Fran introduced me to Kevin Outterson. Over lunch at the original Eastern Standard, Kevin mentioned that the lawyers who were teaching Health Law Transactions were giving up the course — I expressed my interest, and, based on Fran's endorsement, he hired me.

Like many in the field, I always wanted to be Fran when I grew up. What better way to emulate my mentor and hero than to mentor others? With the support of the Law School and the amazing health law faculty, the Health Law Externship Program was re-invigorated and the BU Health Law Mentorship Program inaugurated, with the Class of 2022 being the first to experience the latter. With Fran on my shoulder, and in my heart, the Mentorship Program has grown to over forty mentees and mentors each

[49] *See id.*

[50] *See Appealing Health Plan Decisions*, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/indexappealinghealthplandecisions (last visited Nov. 17, 2024).

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year. In part due to its active programming, the Program has had success in assisting our health law students find jobs and enter the health law field.

Over the years, Fran and I have shared so many thoughts about our lives, our dreams, and our futures…and she has told me stories I cannot repeat and will never forget! Oh, and remind me to tell you of the time we went to NYC to bike all five boroughs in an afternoon. Needless to say, I can't wait for our next adventure together. Thank you, Professor Miller.

Demanding Excellence by Laura Stephens

I came to BU Law for its top-ranked Health Law Program, eager for a career as a hospital lawyer. In my second year, I bounded confidently into Fran's health law class, only to be caught off guard by how untrained my reasoning and powers of analysis were (despite my background in science). She never let me get away with anything — every imprecision she got from me was meticulously called out and corrected, albeit always with humor, cajoling, encouragement, and a bit of measured praise. Fran had the same effect on all the "health law kids" in the Law Tower. My third-year friend was the Editor-in-Chief of the *American Journal of Law and Medicine*, and I loved going with her to the journal office. I remember the excitement when the journal students would hear that Fran was on her way up to the office, usually with leftover pizza or donuts in one hand and a stack of newspapers in the other. "Did you all see the paper this morning? Can you believe what is happening in health care?" When we complained that we didn't have time to read the newspaper, she would say "You need to make the time. I read three papers every morning – the *New York Times*, the *Wall Street Journal*, and *The Boston Globe*. Good health lawyers are well-informed!" After asking the students what they were working on for the journal, she would leave us to become colleagues over the leftovers.

In all ways, and without any of us realizing it, Fran constantly modeled all of the attributes of an effective health care lawyer — excellence, deep preparation, uncompromising critical thinking, intellectual curiosity, enthusiasm, humor, and a genuine desire to "make things better." Many years into hospital law practice, especially after long days (and nights) on difficult cases, I still drew strength from all that she taught me (and of course her expectations), inside the classroom and out.

As a BU Law student, I didn't have the good fortune to take courses with George Annas and Wendy Mariner, but I have since depended heavily on their scholarship (along with Fran's) in my own teaching and writing. It is a privilege to be part of the Health Law Program that Fran, George, and Wendy created and stewarded, to carry on their teaching and scholarship, and to have the opportunity to honor and thank them in this volume.

Teaching by Michael Ulrich

Fran, George, and Wendy represent a rare breed in academia: people who are paid to teach and who actually care about teaching. Far too often, teaching takes a backseat to scholarship and service to a school. Students — those pesky kids sending all the emails about grades, but whose tuition dollars keep the lights on — can tell when professors think of teaching as a chore, an obligation they are forced to undertake to enable them to do what they really enjoy. But Fran, George, and Wendy genuinely care, and the joy they experience working with and teaching students is evident. Their passion for teaching has helped cultivate vibrant learning environments not only in their classrooms, but in their departments, schools, and the entire health law community.

Teaching is an art, a craft that takes consideration and effort. The needs and demands of the profession are constantly evolving and shifting from year to year, as are the laws, policies, and crises that our courses cover. Yet, the passion that Fran, George, and Wendy have demonstrated for their students has never dimmed. This dedication is reflected in the health law institutions they have built. For example, the annual Health Law Professors Conference, which these three pillars of the

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community helped start and build to its current expansive status, values and prioritizes teaching in parallel with scholarship. The Jay Healey Teaching Sessions that occur at each conference provide an opportunity to discuss constantly evolving challenges in education and explore innovative approaches to addressing them in a group setting. The ability to learn from some of the country's elite educators is truly an invaluable opportunity. And rather than praising the faculty member who received the most citations, had the most publications, or placed an article in the highest-ranked journal, the conference also devotes time to honoring the best of the best legal teachers with the Jay Healey Teaching Award. It should come as no surprise that Fran, George, and Wendy have all received this award.

We in the health law academy owe a great debt to these three, as they have inspired generations of not only brilliant scholars but also exceptional teachers. If we consider not only those that Fran, George, and Wendy taught directly but also the people who have learned from their health law disciples, it is not hyperbole to say that their educational imprint is immeasurable.

Public Health for Lawyers by Larry Vernaglia

Fifteen years or so ago, I offered a few remarks at BU School of Public Health about the value of a public health education to the delivery of professional legal services. My experiences studying under and working for Professors George Annas and Wendy Mariner clearly influenced me to appreciate the perspectives, values, and important considerations that pure legal training cannot always provide. Their teachings helped me fully appreciate the business, ethical, and human aspects of our work. So, I concluded that a formal public health education (of the type I was fortunate enough to receive at BUSPH from these fine scholars and others — like Leonard Glantz and Michael Grodin) added considerable value to a health law practitioner in the real world.

Then came the COVID-19 Pandemic.

We in the health care bar were confronted with challenges for which most lawyers generally had not been trained. But *we* had been taught in the Health Law program at BU SPH by George and Wendy, and in the Law School by Fran Miller. This was a time when medical ethics influenced so many choices clinicians and administrators were forced to make on the fly: making triage decisions (who gets the last special care bed and who doesn't?), expanding access in unexpected settings (like football fields), and using unproven technologies (use a garage-made ventilator and let practitioners use trash bags as personal protective devices?). These scholars didn't give us answers to these hard questions, but they taught us the formula and framework to reach the right decisions — blending legal and ethical principles in a cogent and unified approach to help the true front-liners make supportable and proper decisions. So, if I had to give that talk again, I would be far less theoretical and would certainly have some war stories to share!

Fran, Wendy, and George are three of the true greats in Health Law. Those of us fortunate enough to call them our teachers and friends will continue to carry their lessons throughout our legal careers.

Broader Impacts

Legacy by Danielle Pelfrey Duryea

To write briefly about Frances H. Miller as a teacher, observer, consulting expert, and scholar is to confront an impossibly wonderful task. As only the second woman to become a professor at Boston University School of Law (after Tamar Frankel in 1968), she unquestionably faced hurdles and doubters. I have heard her describe becoming an authority on modern FDA law and Medicaid as "being in the right place at the right time," but to peruse her many publications is to see her pioneering again and again:

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genetic information privacy,[51] electronic health records,[52] gene therapies,[53] clinician-researchers' conflicts of interest with their patient-subjects.[54] It is also to watch how, over and over, she connects seemingly disparate topics in health law. Her pragmatism sometimes belies the deftness with which she brings together the many strands of her knowledge.

Equally or more important, though, has been her influence on future practitioners. Because so many alumni have told me how much her food and drug law course influenced their professional goals, I think of it as the class that launched a thousand health law careers (at least). Though I have known Fran Miller personally only for these last five years, during which the pandemic prevented us from spending much time together in person, I too have felt the sun that radiates from her. Her curiosity about others, her generosity with expertise, and her warm camaraderie are a blessing to receive and a constant inspiration to act in the same spirit.

Translation by Nicole Huberfeld

The establishment of the field of health law owes much to this trio of BU's founding health law faculty. Each has too many firsts to name here, so examples will serve to underscore their pathbreaking careers. For example, Fran Miller was one of the first female faculty at BU Law in addition to being one of the very first law and medicine scholars. Wendy Mariner was one of the few legal scholars who studied not only 'law and medicine' but also the intersection of health care finance and constitutional law,[55] long pre-dating the Affordable Care Act litigation that led to *NFIB v. Sebelius* and forging a path for other scholars who study this cross-section with an eye toward equity. George Annas has been an especially prolific scholar, publishing more than twenty books with an unflinching take on patients' rights and bioethics in the law, calling out officials using patients' pain as a means to political ends,[56] and reminding scholars that real people's lives are at stake in all health-related litigation.[57]

Many would rightly focus on their abundant and pathbreaking legal scholarship, but just as important is how they prioritized what now is called "translational work" to make their legal scholarship and deep expertise accessible for others. A few examples will demonstrate their dedication to translation and dissemination. Fran shared her expertise in health law and trusts and estates law throughout her career by educating officials, including through serving as a consultant to the Clinton White House Task Force on Health Care Reform, by engaging with bar associations, and by serving community organizations and nonprofits.[58] Wendy has dedicated innumerable hours to the field of health law by serving as a leader of the American Bar Association and the Uniform Law Commission, as well as regularly publishing peer-reviewed publications in

[51]*See* Frances H. Miller & Philip A. Huvos, *Genetic Blueprints, Employer Cost-Cutting, and the Americans with Disabilities Act*, 46 Admin. L. Rev 369 (1994); Frances H. Miller, *Foreword: Phase II of the Genetics Revolution: Sophisticated Issues for Home and Abroad*, 28 Am. J.L. & Med. 145 (2002).

[52]*See* Frances H. Miller, *Health Care Information Technology and Informed Consent: Computers and the Doctor-Patient Relationship*, 31 Ind. L. Rev. 1019 (1998); Frances H. Miller, *Preface: Electronic Medical Information: Privacy, Liability and Quality Issues*, 25 Am. J.L. & Med. 191 (1999).

[53]*See* Symposium, *Gene Therapy: Legal, Financial and Ethical Issues*, 4 B.U. J. Sci. & Tech. L. 3 (1998).

[54]*See* Miller, *supra* note 30.

[55]*See, e.g.*, Mariner, *supra* note 37.

[56]*See, e.g.*, Annas, *supra* note 8, at 88–97 (discussing the negative effect of the "War on Drugs" on medicinal use of marijuana).

[57]One measure of Annas' impact could be the "most cited" rankings. *See* Mark A. Hall & I. Glenn Cohen, *Most-Cited Health Law Scholars in Westlaw, 2016-2020*, Harvard L. Petrie-Flom Ctr.: Bill of Health (Oct. 12, 2021), https://blog.petrieflom.law.harvard.edu/2021/10/12/most-cited-health-law-scholars-3/ (placing George 10th in the list of most cited health law scholars).

[58]*See Frances H. Miller*, Bos. Univ. Sch. of L., https://www.bu.edu/law/files/2016/01/frances-miller.pdf (last visited Nov. 18, 2024).

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medical, public health, health policy, and allied health journals.[59] George has engaged in similar of activities, such as serving on the Massachusetts Board of Registration in Medicine and co-founding Global Lawyers & Physicians, an NGO that promotes health and human rights.[60] Additionally, for many years George provided regular contributions across numerous publications, including a law and bioethics feature in the *Hastings Center Report*, a column on Public Health and the Law in the *American Journal of Public Health*, and a regular feature in the *New England Journal of Medicine* called Legal Issues in Medicine, as well as writing books to help non-experts.[61] George and Wendy also co-authored many of these translational essays together,[62] as well as a casebook, *Public Health Law*, which has a fourth edition forthcoming.[63]

All of these different kinds of translational work have made highly complex subject matter accessible to non-legal experts, not just students, including the professionals whose lives are governed by health laws. Together, they forged a path that continues to be followed and should be valued for ahead-of-their-time understanding that the applicability of health law to real people's lives creates a special demand for the often-underappreciated translational work that they presciently prioritized.

Developing the Field by Kevin Outterson

George, Wendy, and Fran long served as professors, and the academy often judges such people by their scholarship. To be sure, they have acquitted themselves admirably on scholarship, as many here have attested. But I want to focus on another important aspect. These three people are much more than the sum of their writings; together they built a Health Law Program at Boston University that truly bridged the disciplines of public health and law, before anyone had a chance to tell them it was impossible.

The BU Health Law Program is an amazing achievement, but George, Wendy, and Fran also built institutions with impact far beyond our campus: the *Journal of Law, Medicine and Ethics*, the *American Journal of Law and Medicine*, the American Society of Law, Medicine & Ethics, and the Health Law Professors' Conference. All of these serve the larger academic community, and have actually created a community of scholarship based on friendship and respect that now embraces hundreds of health law scholars across the nation and beyond.

We can also take note of the choices they avoided, the things they said "no" to. They maintained independence in fields (FDA, ERISA, health insurance) where corporate money flowed. There was a time many decades ago when pain medicine companies and their charities offered grants to support increasing use of pain medications.[64] Likewise, after 9/11, some bioethicists argued for extraordinary government powers in times of "emergency," well-funded as part of the global health security agenda.[65] As academics, we have the truly remarkable gift of independence and academic freedom. George, Wendy, and Fran never sold off their birthright.

[59] *See Wendy Kathleen Mariner: Curriculum Vitae*, Bos. Univ. Sch. of L., https://www.bu.edu/law/files/2016/05/Mariner-Wendy.pdf (last visited Nov. 18, 2024).

[60] *See George J. Annas*, Bos. Univ. Sch. of L., https://www.bu.edu/law/files/2016/01/george-annas.pdf (last visited Nov. 18, 2024).

[61] *See id.*; *see also, e.g.*, George J. Annas, The Rights of Patients: The Authoritative ACLU Guide to the Rights of Patients (3d ed. 2004).

[62] *See, e.g.*, Wendy K. Mariner et al., *Reframing Federalism — The Affordable Care Act (and Broccoli) in the Supreme Court*, 367 New Eng. J. Med. 1154 (2012).

[63] Wendy K. Mariner et al., Public Health Law (3d ed. 2019).

[64] *See, e.g.*, Elizabeth Gourd, *American Pain Society Forced to Close due to Opioid Scandal*, 20 Lancet Oncology e350, e350 (2019).

[65] *See, e.g.*, George J. Annas, *Your Liberty or Your Life: Talking Point on Public Health Versus Civil Liberties*, 8 EMBO Reps. 1093, 1093 (2007) (discussing post-9/11 arguments for enhanced public health authority from other scholars).

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Conclusion

This essay reflects a chorus of BU faculty, a testament to the community that Fran, George, and Wendy have built. We are honored to carry the torch in the years that come, and we will continue to draw on their advice and contributions as we wish them the absolute best.

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