Preface

The Content and Organization of This Book

As this book passes its half-century anniversary, we pause to reflect on the remarkable metamorphosis of health care law from a subspecialty of tort law, to a mushrooming academic and practice field whose tentacles reach into myriad scholarly disciplines and areas of substantive law. This book's eight prior editions reflect important stages in this evolutionary growth. Health care law originated as a separate field of professional practice and academic inquiry during the 1960s, when this book was first published. Under the somewhat grandiose label of "medical jurisprudence," the primary focus at first was on medical proof in all kinds of criminal and civil litigation, on medical malpractice actions against physicians, and on public health regulation. The principal concern was how traditional bodies of legal doctrine and practice—such as criminal, tort, and evidence law—should apply in medical settings.

During the 1970s, bioethics became a major additional area of concern as a consequence of the right to die movement spawned by the *Quinlan* case, and the focus on individual autonomy contained in the informed consent doctrine and the landmark decision on reproductive decisionmaking in Roe v. Wade. Law courses during this and earlier periods were taught under the heading of "law and medicine."

In the 1980s, economic and regulatory topics formed the third component of health care law, as exemplified by the increasing application of antitrust laws to the health care industry and the growing body of legal disputes under

Medicare and Medicaid. This newer dimension accelerated its growth into the 1990s with the spread of HMOs and other managed care organizations, which propelled various corporate and contractual restructurings. These newer topics found their way into courses described as "health law."

New developments present continuing challenges to each of these areas of health care law and ethics. Biotechnology, consumer-driven health care, and bioterrorism are examples of emerging issues that receive increased attention in the previous edition. Currently, there is an explosion of interest in health care public policy, coinciding with Affordable Care Act, whose importance reverberates throughout the field yet whose survival remains uncertain.

This path of development has resulted in an academic discipline defined more by an accretion of topics drawn from historical events than by a systematic conceptual organization of issues. Each of the four major branches—malpractice, bioethics, public health, and financing/regulation—stands apart from the others and is thought to be dominated by a distinct theme. The principal concern of malpractice law is quality of care; bioethics is concerned with individual autonomy; public health poses the rights of patients against the state; and the primary focus of financing and regulatory law is access to care and the cost of care. As a consequence, health care law has yet to become a truly integrated and cohesive discipline.[1] It is too much the creature of history and not of systematic and conceptual organization.

Our major ambition in this book is to improve this state of disarray. This field has reached a stage of maturity that calls for stepping back and rethinking how all of its parts best fit together as a conceptual whole. In our view that conceptual whole is best organized according to the fundamental structural relationships that give rise to health care law. These relationships are:

1. The patient/physician relationship, which encompasses the duty to treat, confidentiality, informed consent, and malpractice
2. State oversight of doctors and patients, which encompasses the right to die, reproductive rights, physician licensure, and public health
3. The institutions that surround the treatment relationship, encompassing public and private insurance, hospitals and HMOs, and more complex transactions and organizational forms

We develop the traditional themes of quality, ethics, access, and cost throughout each of these three divisions. We also address cutting-edge and controversial topics such as health care reform, genetics, managed care, and rationing, but not as discrete topics; instead, we integrate these developments within a more permanent, overarching organizational structure, which is capable of absorbing unanticipated new developments as they occur.

1. This disarray is reflected by the ongoing confusion over competing names for the field. Although "law and medicine" and "health care law" appear to signify the same topic, the first term is understood to mean older style malpractice subject matter, and the second term is used to refer to newer economic and regulatory issues. Paradoxically, whereas "health care law" and "health law" might be thought to signify somewhat different fields—the latter is not restricted to medical treatment and therefore encompassing public health issues—in fact they are taken to mean the same thing.

In deciding which topics to present in each section and in what depth, our basic guide has been to focus on the essential attributes of the medical enterprise that make it uniquely important or difficult in the legal domain. Health care law is about the delivery of an extremely important, very expensive, and highly specialized professional service. If it were otherwise, this book would likely not exist. Some lawyers and scholars maintain that there is no unifying concept or set of ideas for health care law; instead, it is merely a disparate collection of legal doctrines and public policy responses, connected only by the happenstance that they involve doctors and hospitals in some way—much as if one had a course on the law of green things or the law of Tuesdays. It would be far more satisfying to find one or more organizing principles that explain not only what makes the disparate parts of health care law cohere, but also why that coherence distinguishes health care law from other bodies of integrated legal thought and professional practice.

We believe those organizing principles can, in part, be found in the phenomenology of what it is to be ill and to be a healer of illness. These two human realities are permanent and essential features that distinguish this field from all other commercial and social arenas. They permeate all parts of health care law, giving it its distinctive quality and altering how generic legal doctrine and conventional theories of government respond to its problems and issues. Health care law might still be worth studying even without these unique attributes of medical encounters, but it is much more engaging and coherent because of them. It is these attributes that give rise to an interrelated set of principles that justify classifying health care law as a coherent and integrated academic and professional discipline. Elaborating this perspective, see Mark A. Hall, The History and Future of Health Care Law: An Essentialist View, 41 Wake Forest L. Rev. 347 (2006).[2]

Accordingly, we stress the essential attributes of medical encounters throughout these materials by incorporating insights from other academic disciplines and theoretical perspectives. Behavioral disciplines such as psychology, sociology, and anthropology help to illuminate the nature of medical knowledge and the lived experience of illness, dependency, and trust as they occur in real-life medical encounters. Findings from health services research published in the health policy literature create a stronger empirical and theoretical base

2. For additional discussion of the overall content of health care law and approaches to teaching and understanding it, see Clark Havighurst, American Health Care and the Law: We Need to Talk!, 19(4) Health Aff. 84 (July 2000); William M. Sage, Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy, 96 Geo. L. J. 497-522 (2008); Theodore W. Ruger, Health Law's Coherence Anxiety, 96 Geo. L. J. 625-648 (2008); Wendy Mariner, Toward an Architecture of Health Law, 35 Am. J. L. & Med. 67 (2009); M. Gregg Bloche, the Emergent Logic of Health Law, 82 S. Cal. L. Rev. 389-480 (2009); Andrew Fichter, The Law of Doctoring: A Study of the Codification of Medical Professionalism, 19 Health Matrix 317-385 (2009); Sandra Johnson, Regulating Physician Behavior: Taking Doctors' "Bad Law" Claims Seriously, 53 St. Louis U. L. J. 973 (2009); Maxwell Mehlman, Can Law Save Medicine?, 36 J. Leg. Med. 121 (2015); Teaching Health Law, J. L. Med. & Ethics (recurring column); Symposium, Teaching Health Law , 61 St. Louis U. L. J. 371 (2017); Symposium, Jurisprudence and the Body, 63 Syracuse L. Rev. 327 (2013) Symposium, 19 Ann. Health L. 1 (2010); Symposium, Patient-Centered Law and Ethics, 45 Wake Forest L. Rev. 1429 (2010); Symposium, Rethinking Health Law, 41 Wake Forest L. Rev. 341 (2006); Symposium, The Field of Health Law: Its Past and Future, 14 Health Matrix 1 (2004); William J. Curran, Titles in the Medicolegal Field: A Proposal for Reform, 1 Am. J. L. & Med. 1 (1975).

for exploring health care law, one that better exposes its broad social impact. Analytical disciplines, such as economics and moral and political theory, create the foundation for understanding developments in financing, regulation, and bioethics. And, the perspectives of feminist, communitarian, and critical race theory demonstrate the limitations of conventional analytical models and help us understand how health care law must evolve to accommodate viewpoints and concerns that have been excluded in the past.

Course Coverage

Clearly, it is not possible (or, if possible, not desirable) to cover the entirety of this book in a single course. The course coverage offered at different schools varies widely according to the curricular structure at each school and each teacher's interest and expertise. Accordingly, we have organized this book in a manner that lends itself to compartmentalization for use in a number of different courses, taught both in law schools and in schools of medicine, public health, and health care administration. The following are the most common sequences and groupings. Many courses contain a combination of several of these:

Malpractice	Chapters 2, 3, and 4
Bioethics	Chapters 3, 5, 6, and 7
Public Health	Chapter 8, and portions of Chapters 3 and 7
Health Care Finance and Regulation	Chapters 2, 9, and 10

In the first chapter, we have collected background and introductory readings that are relevant in a number of places throughout the book.