PREFACE

THE CONTENT AND ORGANIZATION OF THIS BOOK

This book contains the materials from *Health Care Law and Ethics* (10th ed., 2024) that are focused on health care finance and regulation. As the larger casebook enters its seventh decade, 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 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, the focus on individual autonomy contained in the informed consent doctrine, and the landmark decision on reproductive rights 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."

Early twenty-first-century developments presented continuing challenges in each of these areas of health care law and ethics. Principally, the Affordable Care Act, whose importance reverberates throughout the field, ignited an explosion of interest in health care public policy, including issues of justice and equity. Biotechnology, consumer-driven health care, the opioid epidemic, gender identification, and bioterrorism are other examples of emergent issues that received increased attention in recent editions. As we approach this century's second quarter, legal and health policy repercussions from the catastrophic COVID-19 epidemic continue to loom large, and the Supreme Court's *Dobbs* decision reversing Roe v. Wade challenges a range of previous assumptions about foundational reproductive rights. At the same time, evolving social understandings regarding matters such as gender identification and structural racism, and fast-paced technical developments, such as artificial intelligence, pose new issues or call for reexamination of existing legal and policy norms.

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 field's 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 and increasingly also social justice; public health poses the rights of patients against the state; and the primary areas of focus of financing and regulatory law are 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.

Throughout various editions, our major ambition in this book has been 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 and justice, 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.

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

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 and patient care subject matter, and the second term is used to refer to newer economic, regulatory, and social issues. Paradoxically, whereas "health care law" and "health law" might be thought to signify somewhat different fields — with the latter not restricted to medical treatment and therefore encompassing public health issues — often these similar terms are taken to mean essentially the same thing.

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 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.

We intend that this book will continue to serve as both a teaching tool and an ongoing resource for conducting research in health care law. To that end, in addition to the bibliographic notes in each section, we have created a dedicated website to serve this book: health-law.org. It provides more extensive bibliographic sources, including a bibliography of resources and readings that relate to research in health care law generally. This website also extends the book's content with interesting background materials, updates of important events since publication, additional relevant topics that were excluded due to space constraints, and links to other online resources.

Acknowledgments

This manuscript could not have been prepared without the diligent help of those students and staff who assisted us over the past few years (Adithi Ayer, Nicolas Pena Brown, Elizabeth Bryan, Grace Connelly, Hayden Cresson, Alex Kremer, Ryan Mayhan, Connor Morgan, Maya Smith, Liv Staff, Lisa Walters, Andrew Thompson, and Tyler Yoo), and without the superhuman patience of our families (who, curiously, wish to remain anonymous). We also thank the following authors and publishers, who granted permission to use each of the excerpts of copyrighted material in these readings.

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July 2024