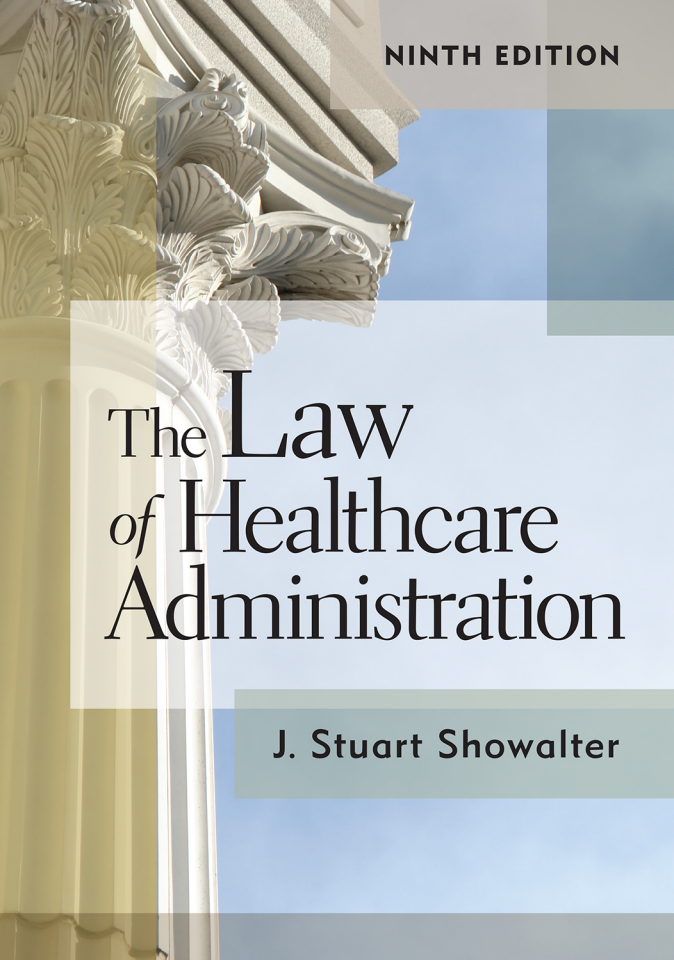




NINTH EDITION

The Law *of* Healthcare Administration

J. Stuart Showalter

The Law *of* Healthcare Administration

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PREFACE

Overview

The ninth edition of *The Law of Healthcare Administration* continues to offer a thorough treatment of health law in the United States, doing so in plain language for nonlawyers. It begins with a history of law and medicine, moves to a description of how—despite various reform efforts—the US healthcare “system” came to be so fragmented, and then presents specific issues that affect healthcare leaders on a daily basis (e.g., contracts, torts, taxation, antitrust law, regulatory compliance) and—a major addition to the book—human resources (HR) law.

An Entire Chapter on Human Resources

Numerous instructors have asked for a chapter on human resource issues; thus, a new chapter responds to this request. It discusses the distinction between “employee” and “independent contractor,” defines other categories of workers, and goes to considerable length to present civil rights law and various nondiscrimination issues. The chapter also includes a section on labor law—the National Labor Relations Act and the Taft-Harley Act, union organizing, collective bargaining, fair and unfair labor practices, and more. Three judicial decisions with HR-related implications are found in *The Court Decides*.

The chapter is described more fully under the chapter contents heading on page xvi.

Other Highlights of the Ninth Edition

Discussions of the history of law and the history of medicine have been pared down and combined; they now constitute chapter 1. This is followed by a century’s worth of attempted healthcare reform efforts culminating with passage of the Affordable Care Act (ACA) in 2010 and subsequent (unsuccessful) attempts to “repeal and replace” it.

End-of-life topics have been updated to include new “death with dignity” laws in some states, one state’s adoption of “physician aid in dying” through judicial decision, and the latest on the Physician Orders for Life-Sustaining Treatment (POLST) paradigm.

Throughout the book I have updated citations, added current web addresses, and made editorial changes to minimize (or at least clarify) legal jargon. Like the editions before it, the ninth edition is a practical text for students and educators in health administration, public health, nursing, and similar programs or disciplines.

Chapter Contents

Chapter 1: A Brief History of Law and Medicine

“A page of history is worth a volume of logic,” so this chapter compares the histories of the two disciplines. In part 1, it presents the history of law, its sources, the relationships among the three branches of government, the basic structure of the federal and state court systems, and some basics of legal procedure in civil cases. In part 2, we read about the history of medicine through the ages and the advent of “modern medicine” a mere century or so ago. Viewed in this light, we see that twenty-first-century healthcare is a newborn.

Chapter 2: Access to Healthcare: Rights and Responsibilities

This chapter discusses the structure of the US healthcare “system” and points out that it is not a *system* at all in the true sense of the word. Instead, it is a conglomeration of different types of providers and payers resulting in serious inequalities of coverage.

In response to numerous requests, the chapter outlines the various US government healthcare systems and agencies (e.g., Public Health Service, Indian Health Service, Veterans Administration healthcare), and describes their relationship with the state and private sectors. It describes numerous health policy efforts from the Vaccine Act of 1813, to Medicare and Medicaid, to President Clinton’s reform proposal, to the ACA. The legal challenges to the ACA are discussed in detail, including the landmark cases of *NFIB v. Sebelius* and *King v. Burwell*.

A presentation of traditional principles of access to care follows the section on healthcare reform efforts. These principles include the right to care, rules regarding admission and discharge, the government’s duty to pay in some cases, involuntary commitment of the mentally ill, and utilization review. Appendices show the various federal health insurance programs, the history of health reform efforts, and details on implementation of the ACA.

Chapter 3: The Organization and Management of a Corporate Healthcare Institution

This chapter reviews some basic concepts of corporation law, including a corporation’s “personhood,” its ability to shield owners from personal

liability, the foundations and limitations of corporate power, and the duties of a corporation's governing board. The concept of piercing the corporate veil and the various reasons for and methods of restructuring a healthcare corporation are also explored. Attention is also given to hospital–physician joint ventures and their potential for renewal as a result of the effects of the ACA and other factors in the healthcare environment.

Chapter 4: Human Resources Law

As mentioned earlier, this chapter is brand-new to the text. It describes how employment law affects the healthcare organization, identifies the major employment statutes and case law principles, points out the most significant areas of contention, and enables students to know when to consult employment law experts. Major topics include categories of workers in the workplace, antidiscrimination statutes, and labor law issues.

Chapter 5: Contracts and Intentional Torts

This chapter addresses the essential elements of a valid contract—competent parties, “meeting of the minds,” consideration, and legality of purpose—and the importance of contract law in the relationships between patients and their physicians and between patients and hospitals. The chapter also briefly discusses issues related to workers’ compensation and intentional tort, pointing out that both can affect physician–patient and hospital–patient relationships.

Chapter 6: Negligence

This chapter outlines the four basic elements of proof in a tort case, the ways the standard of care can be proven, and the concept of causation. It addresses *respondeat superior* (vicarious liability), the “school rule,” *res ipsa loquitur*, defenses to malpractice suits, and alternatives to the tort system.

Chapter 7: Liability of the Healthcare Institution

This chapter shows that the law has come a long way in recent years as it relates to healthcare organizations: The shift from charitable immunity to application of respondeat superior in the healthcare setting is one example. The demise of the “captain-of-the-ship” and “borrowed-servant” doctrines is another. These notions have now expanded to the point that the independent contractor defense seems no longer viable in the healthcare field. The chapter also addresses the rise of managed care in the 1980s and 1990s, the conflicts that sometimes arise between advancing patient welfare and reducing healthcare costs, and the phenomenon of Employee Retirement Income Security Act preemption providing immunity for some managed care organizations.

Chapter 8: Medical Staff Privileges and Peer Review

This chapter focuses on decisions about medical staff privileges. It points out that management and the medical staff are responsible for the credentialing process and may recommend physician applicants (including doctors of osteopathy, dentistry, podiatry, and chiropractic, as well as other physicians, depending on state law). The ultimate responsibility for appointing a competent medical staff lies with the hospital governing board, however. The chapter also addresses issues related to the peer review and quality assurance functions, both of which are efforts to monitor the quality of care. It concludes with some thoughts about accountable care organizations, complementary and alternative medicine practices, and integrative healthcare.

Chapter 9: Health Information Management

The title of this chapter reflects a belief that the term *medical records* is passé because information about a person's health (or payment for health-related services) can be maintained in many types of media other than paper. Regardless of the form in which it is maintained, health information must be accurate and its confidentiality must be ensured. This chapter reviews the various ways in which health information is properly used, such as for documentation of treatment, for accurate billing, and as evidence in legal forums. It also discusses the Health Insurance Portability and Accountability Act and other state and federal laws that govern the protection of health information. It outlines circumstances in which third parties may legitimately access individuals' health information with and without patient consent, and it points out the pitfalls that one can encounter when that information is improperly disclosed inadvertently or through "hacking" by cyberthieves.

Chapter 10: Emergency Care

This chapter reviews the common-law rule that individuals have no duty to provide emergency care and the rule's numerous exceptions, both judicial and statutory. It provides considerable detail on the federal Emergency Medical Treatment and Labor Act, which currently sets the standard for emergency department personnel's review of patients' conditions, and presents examples of liability for failure to meet those standards. The chapter concludes with a brief discussion of Good Samaritan statutes, which are probably unnecessary but have afforded some medical personnel a measure of emotional comfort.

Chapter 11: Consent for Treatment and Withholding Consent

This chapter explores the difference between consent and informed consent and outlines the minimum requirements for the latter. It also considers consent issues in emergency situations and such thorny issues as the right to die (i.e., refusal to consent to life-sustaining treatment), consent for patients

who are not competent to make choices for themselves, and physicians' role in helping terminally ill patients end their lives legally. The chapter ends with discussion of various methods of documenting and enforcing patients' end-of-life preferences—including living wills and durable powers of attorney—and discusses “death with dignity” laws that allow physicians to help certain terminal patients to end their own lives. The landmark Montana case permitting physician aid in dying in the absence of statute is presented in *The Court Decides*. The appendix compares advance directives to Physician Order for Life-Sustaining Treatment forms.

Chapter 12: Taxation of Healthcare Institutions

This chapter addresses the taxation of healthcare organizations, which are primarily not-for-profit corporations. All tax-exempt organizations are not-for-profit, but not all not-for-profits are tax exempt. The standards for income and property tax exemption are also discussed, as are the occasions in which some income of a tax-exempt organization may be taxable. The chapter raises the question of what it means to be a charity and what implications that designation may have under federal and state law. It closes with a review of a 2010 decision that, if followed by other states, augurs rough sailing ahead for not-for-profit hospitals' property tax exemptions, especially if the ACA continues to decrease the number of uninsured Americans.

Chapter 13: Competition and Antitrust Law

This chapter reviews the basic concepts of antitrust law, including laws against restraints of trade, monopolization, and price discrimination. It distinguishes among the various per se violations and shows how cases that do not fit one of those categories are decided on the basis of a rule-of-reason analysis. Exemptions from the antitrust laws include implied repeal, state action, Noerr-Pennington, and the business of insurance doctrines. This chapter reviews the factors used in defining the appropriate market for individual cases, and it concludes with a discussion of what to expect in the coming years, especially now that the ACA is being implemented. A significant US Supreme Court decision from North Carolina has been added to *The Court Decides*, and other cases (from Ohio and Idaho) are also discussed.

Chapter 14: Issues of Reproduction and Birth

This chapter reviews many of the sensitive and contentious legal questions surrounding reproduction. These include sterilization, wrongful life, wrongful birth, surrogate parenting, in vitro fertilization (IVF), stem cell research, and abortion. The hospital's role in reproduction issues is discussed, including whether the hospital can be required to provide such services and whether government programs will pay for the procedures if the hospital does provide

them. The chapter also points out that stem cell research will continue to be an issue, and it points out that it may only be a matter of time before abortion shows up again on the Supreme Court's docket.

Chapter 15: Fraud Laws and Corporate Compliance

This chapter addresses one of the most salient issues in healthcare today: the prevention of fraud and abuse in governmental healthcare programs. The major fraud laws are reviewed, as are the aggressive enforcement activities of federal and state regulators; the severe monetary and criminal penalties that can be imposed for violations of these laws are emphasized. The chapter also discusses some of the changes to the fraud laws occasioned by the passage of the ACA, and it reviews the basics of a proper corporate compliance program, an essential preventive measure and a valuable resource for a wide range of legal and ethical issues.

Instructor Resources

This book's Instructor Resources include a test bank; PowerPoint presentation; and an updated instructor's manual with chapter overviews, answers to end-of-chapter discussion questions, and answers to end-of-case discussion questions.

For the most up-to-date information about this book and its Instructor Resources, go to ache.org/HAP and browse for the book's title, author name, or order code (24031).

This book's Instructor Resources are available to instructors who adopt this book for use in their course. For access information, please e-mail hapbooks@ache.org.

ACKNOWLEDGMENTS

Rare are the authors who are not beholden to others for the success of their work. In my case, gratitude extends back more than two decades to the late professor Arthur F. Southwick of the University of Michigan. It was he who authored *The Law of Hospital and Health Care Administration* (1978), the landmark text, published by Health Administration Press (HAP), from which this book descends.

I used the second edition of the book while teaching at Washington University School of Medicine, and I collected a set of companion cases that HAP published as a supplement. Upon Professor Southwick's death in 1997, the editors approached me to update the text. Thus my name first appears on the third edition, known then as *Southwick's The Law of Healthcare Administration* (1999).

In addition to Professor Southwick—whom I never met, unfortunately—I am grateful to the many staff and editors of HAP who have assisted me for nearly 25 years. The list includes Andrew Baumann, Helen-Joy Bechtle, Jane Cayalag, Janet Davis, Cepheus Edmondson, Rob Fromberg, Marisa Jackson, Scott Miller, Betsy Perez, Theresa Rothschadl, Jennifer Seibert, James Slate, and Chris Underdown. These dedicated individuals have reconfirmed the old adage, “There is no such thing as good writing; there is only good rewriting [and proofreading, layout, cover design, marketing, etc.].”

For this new edition of the book I am especially indebted to my copyeditor, Theresa Rothschadl. I also thank Joseph Topinka, Sallie Thieme Sanford, G. Roger King, Martha “Marty” Knutson, and Jeff Sconyers for their professional advice on human resources issues; Susan and Rick Jackson on human resources and other subjects; and Peter Korchnak, Amy Vandembroucke, Lonny Shavelson, Bob Uslander, Jeff Levine, Kathryn Tucker, and Amy Harris Lavan on death with dignity and aid in dying. Without the assistance of these fine professionals, this text would not be as good as it is. Any remaining errors or omissions, of course, are mine.

A BRIEF HISTORY OF LAW AND MEDICINE

A page of history is worth a volume of logic.

—Justice Oliver Wendell Holmes Jr.
(*New York Trust Co. v. Eisner*, 256 U.S. 345, 349 [1921])

Law is ancient; medicine is a newborn. A bit of history will help put these two disciplines in perspective.

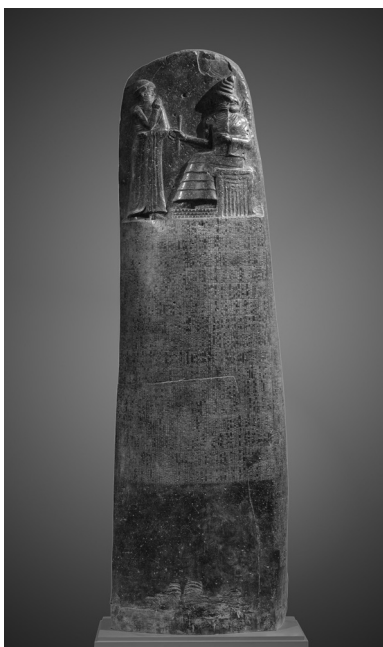
What follows in this first chapter is historical synthesis, neither the product of primary research nor drawn from any one or even a few secondary sources. It is, instead, a collection of harmonious facts, opinions, and sentiments drawn from varied perspectives, review of the literature, and the author's personal experience. It is intended to give the reader a feel for what some might call the “crossroads” of law and medicine and to set the stage for a thoughtful overview of the law and healthcare administration.

PART 1: THE HISTORY OF LAW

After reading part 1 of this chapter, you will

- understand that law comes from four basic sources,
- know that no one branch of government is meant to be more powerful than another,
- understand the legal citation system and certain key terms, and
- be familiar with basic aspects of legal procedure.

It is reasonable to assume that laws—rules for human interaction—have existed in some form since the first sentient beings roamed the earth. The oldest known *written* laws were proclaimed nearly four millennia ago by King Hammurabi of Babylon. They were inscribed on an eight-foot-tall black stela (stone pillar), lost for centuries but rediscovered in 1901 (see exhibit 1.1). Dubbed the “Code of Hammurabi,” it is an example of *lex talionis* (the “law of retaliation”), under

EXHIBIT 1.1**Code of
Hammurabi**

which a person who injures another is to be given a specific punishment appropriate for the crime.

For example, in Hammurabi's realm, adultery and theft were punishable by death, a slave who disobeyed his master lost an ear (the ear being an ancient symbol of obedience), and a surgeon who caused injury had his hand amputated. This latter provision may have been the first version of malpractice law known to humankind.

In addition to these harsh “eye for an eye, tooth for a tooth” standards, the code contained rules for everyday social and commercial affairs—sale and lease of property, maintenance of lands, commercial transactions (contracts, credit, debt, banking), marriage and divorce, estates and inheritance, and criminal procedure. As a result of Ham-

murabi's reputation as a lawgiver, depictions of him can be found in several US government buildings, including the US Capitol and the Supreme Court.

In later centuries, other concepts helped law to evolve. Aristotle spoke of *natural law*—the idea that there exists a body of moral principles common to all persons and recognizable by reason alone—as distinct from *positive law* (formal legal enactments).¹ In *Leviathan*, an important work of seventeenth-century thought, Thomas Hobbes described law as a “social contract” between the individual and the state in which people agree to obey certain standards in return for peace and security. Without that implicit agreement and adherence to law, Hobbes famously wrote, mankind would be in a constant state of war and life would be “solitary, poor, nasty, brutish, and short.”

These and other schools of thought—including utilitarianism, strict constructionism, and libertarianism—have influenced the US legal system over the centuries. One can of course study law by merely reading statutes and judicial decisions, but it helps to be aware of some of these philosophies because they lie at the root of American **common law**.

common law

The body of law based on custom and judicial precedents, as distinct from statutory law; its historical roots are the traditional laws of England that developed over many centuries and were carried over to the American colonies and thus the United States.

Anglo-American Common Law

Anglo-American law can be traced back more than a millennium to when the Anglo-Saxon inhabitants of what was to become England tried to centralize their various kingships to ward off enemies and maintain peace. In the

process, they started a legal system that would eventually prevail throughout England, hence the name *the common law*. That system included certain concepts that are familiar today: writs (court orders); the offices of sheriff, bailiff, and mayor; taxation; complex legal record keeping; the use of sworn testimony; and *stare decisis* (respect for legal precedent).

The common law grew with the further cohesion of the country following the conquest of England by Duke William of Normandy (“William the Conqueror,” 1028–1087) in 1066. Under King Henry II (1133–1189), tribunals such as the King’s Court and circuit courts were added, and the decisions of those bodies became part of the common law. Also part of the common law are the Magna Carta (1215), the Habeas Corpus Act (1679), the Petition of Right (1628), and the English Bill of Rights (1689). These instruments describe certain basic concepts—the authority of the sovereign (monarch or state), freedom of speech, limitations on the use of martial law, the separation of judicial and legislative powers, and recognition that statutes are not the sole basis of law—that applied to colonial America and remain woven through the fabric of US law to this day.

At its most basic level, the purpose of any legal system is to prevent anarchy and provide an alternative to personal revenge as a method of resolving disputes, as Hobbes feared. Considering the size and complexity of the United States, the litigious temperament of our people, and the wide range of possible disputes, our legal system is remarkably successful in achieving its purpose. It has its shortcomings, to be sure, but at least it stands as a bulwark against vigilante justice and blood feuds.

The law permeates today’s healthcare field because the US medical system is perhaps the most heavily regulated enterprise in the world. It is subject not only to the legal principles that affect all businesses (everything from antitrust to zoning) but also to myriad provisions peculiar to healthcare. For these reasons, students of healthcare administration need to become familiar with the law and legal system. Almost every decision and action taken by healthcare personnel has legal implications, and all such decisions and actions are explicitly or implicitly based on some legal standard. Furthermore, students must understand basic legal principles well enough to recognize when professional legal advice is needed. The main purpose of this book is to help you and your organization stay out of trouble.

Definition of Law

In its broadest sense, **law** is a system of principles and rules devised by organized society or groups in society to set norms for human conduct. Societies and groups must have standards of behavior and means to enforce those

law

A system of standards to govern the conduct of people in an organization, community, society, or nation.

standards; otherwise, they devolve into vigilantism. The purpose of law, therefore, is to prevent conflict among individuals and between government and its subjects. When conflicts occur, legal institutions and doctrines supply the means of resolving the disputes.

Because law is concerned with human behavior, it is not an exact science. Indeed, “it depends” is a law instructor’s most frequent answer to students’ questions. This response is frustrating for both the students and the instructor, but it is honest. The law provides only general guidance; it is not an exact blueprint for living. Its application varies according to the circumstances of the case. However, this inherent ambiguity is actually a strength, because it allows for adaptation to new circumstances. Legal rigidity would inhibit initiative, stunt the growth of social institutions, and ultimately result in decay.

Viewed in proper light, law is a landscape painting that captures the beliefs of a society at a certain moment in time. However, it is not static; it is a work in progress, a constantly changing piece of art—a hologram, perhaps—that moves with society. Most often it moves at a glacial pace—slowly and quietly, the land shifting slightly beneath it. At other times, it moves seismically, as was the case in 2010 with the passage of a legislative temblor known as the **Affordable Care Act (ACA)**, or “Obamacare.”² Despite outcries from some segments of the political spectrum and many attempts to repeal it, the US Supreme Court has held provisions of the ACA to be constitutional. Most of the ACA’s reforms took effect in 2014, and the aftershocks will be felt for years. Until the dust settles completely, we will not know how much the act has altered the legal topography.

Affordable Care Act (ACA)

The health reform law enacted by Congress in 2010; full name: Patient Protection and Affordable Care Act, Pub. L. No. 111-148. The ACA will be discussed more fully in chapter 2.

Types and Sources of Law

Law can be classified in various ways. One of the most common is to distinguish between public law and private law. *Public law* concerns the government and its relations with individuals and businesses. *Private law* refers to the rules and principles that define and regulate rights and duties among persons. These categories overlap, but they are useful in illustrating Anglo-American legal doctrine.

Private law comprises the law of contracts, property, and tort, all of which usually concern relationships between private parties. It also includes, for example, such social contracts as canon law in the Catholic Church and the regulations of a homeowners’ association. Public law, on the other hand, regulates and enforces rights in which the government has an interest (e.g., labor relations, taxation, antitrust, environmental regulation, criminal prosecution). The principal sources of public law are as follows:

- Written constitutions (both state and federal)
- Statutes enacted by a legislative body (federal, state, local)
- Administrative law
- Judicial decisions

Constitutions

The US Constitution is aptly called the “supreme law of the land” because it sets standards against which all other laws are judged. Other sources of law must be consistent with the Constitution.

The Constitution is a grant of power from the states to the federal government (see Legal Brief). All powers not granted to the federal government in the Constitution are reserved by the individual states. This grant of power to the federal government is both express and implied. For example, the Constitution expressly authorizes the US Congress to levy and collect taxes, borrow and coin money, declare war, raise and support armies, and regulate interstate commerce. Congress may also enact laws that are “necessary and proper” to carry out these express powers. Thus, the power to coin money includes the implied power to design US currency, and the power to regulate interstate commerce embraces the power to pass antidiscrimination legislation, such as the Civil Rights Act of 1964.

The main body of the Constitution establishes, defines, and limits the power of the three branches of the federal government:

1. The legislature (Congress) has the power to enact statutes.
2. The executive branch has the power to enforce the laws.
3. The judiciary has the power to interpret the laws.

Each branch plays a different role, and their interaction is governed by a system of “checks and balances” designed to maintain a measure of parity among them (see exhibit 1.2). Specifically, the president can nominate federal judges and high-ranking government officials, but the Senate must confirm those nominations. Congress can remove high-ranking federal personnel (including judges and the president) through the impeachment and trial process. The president can veto a congressional bill, but Congress can override a veto by a two-thirds vote of each chamber. The judiciary can declare a law or

Legal Brief

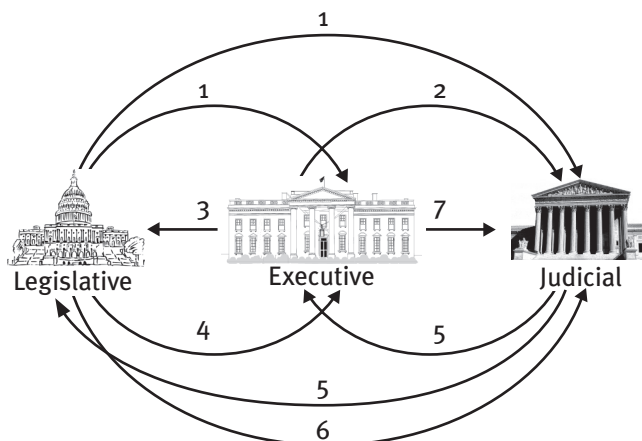


The United States is not a union; it is a federation (from the Latin word *foedus*, meaning “covenant”) of 50 self-governing states that have ceded some of their sovereignty to the central (federal) government to promote the welfare of all.

EXHIBIT 1.2**Checks and Balances**

1. Impeach and convict; confirm or block permanent appointments
2. Appoint judges
3. Approve or veto legislation
4. Draft legislation; override vetoes

5. Interpret laws and regulations
6. Establish court system; amend laws to cure defects
7. Appoint judges; change regulations to cure defects



regulation invalid, at which point Congress can amend the law or the executive branch can change the regulation to cure the defect.

Twenty-seven amendments follow the main body of the Constitution. The first ten are known as the Bill of Rights, and they were ratified in 1791, just two years after the Constitution took effect (see Legal Brief). Among the rights secured by the Bill of Rights are

- freedom of religion, speech, and press;
- the rights of assembly and petition;
- the right to bear arms;
- protection against unreasonable searches and seizures;
- rights in criminal and civil cases (e.g., jury trial, self-incrimination); and
- the right to substantive and procedural **due process of law**.

due process of law
Fair treatment through the normal judicial system.

Of the 17 other amendments, two cancelled each other: the Eighteenth, which established Prohibition, and the Twenty-First, which repealed the Eighteenth. Thus, as of this writing, only 15 substantive changes have been made to the basic structure of US government since 1791.

In addition to the US Constitution, each state has its own constitution. A state's constitution is the supreme law of the particular state, but it is subordinate to the federal Constitution. State and federal constitutions

are similar, although state constitutions are more detailed and cover such matters as the financing of public works and the organization of local governments.

Statutes

Statutes are positive law enacted by a legislative body. Because our federal system is imbricate with national, state, and local jurisdictions, the legislative body may be the US Congress, a state legislature, or a deliberative assembly of local government such as a county or city council (in which case the law is known as an “ordinance”). Enactments by any of these bodies can apply to healthcare organizations. For example, hospitals must comply with federal statutes such as the Civil Rights Act of 1964 and the Hill-Burton Act, which prohibit discrimination at patient admission. Most states and a number of large cities have also enacted antidiscrimination statutes.

Judges face the task of interpreting statutes. Interpretation is especially difficult when the wording of a statute is ambiguous, as it usually is. To clarify statutes, the courts have developed several *rules of construction*, which in some states are themselves the subject of a separate statute. Regardless of their source, the rules are designed to help judges ascertain the intent of the legislature. Common rules of construction include the following:

- Interpretation of a statute’s meaning must be consistent with the intent of the legislature.
- Interpretation of a statute’s meaning must give effect to all its provisions.
- If a statute’s meaning is unclear, its purpose, the result to be attained, legislative history, and the consequences of one interpretation over another must all be considered.

Legal Brief



Read literally, the Bill of Rights applies only to the federal government. However, the Supreme Court has held that most of the rights set forth in those ten amendments also apply to the states because of the Fourteenth Amendment, Section 1 of which reads in part:

No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person . . . the equal protection of the laws.

Because the Bill of Rights and the Fourteenth Amendment apply only to the federal and state governments, purely private discrimination is not a constitutional violation. Plaintiffs in civil rights cases, therefore, need to prove that “state action” was a factor. *Simkins v. Moses H. Cone Mem. Hosp.* is an example.³ Decided in 1963, it involved racial discrimination against African American physicians by two private hospitals. The hospitals justified their actions because of “separate but equal” language in the Hill-Burton Act (a 1946 law that provided federal financial assistance to improve the nation’s healthcare facilities). However, a federal appeals court struck down the discriminatory provisions and found that state and federal involvement through Hill-Burton amounted to “state action” and was thus illegal.

Judicial interpretation, whether it involves constitutions or statutes, is the pulse of the law. A prominent example appears later in this chapter in the discussion of *Erie R. R. Co. v. Tompkins*, a case in which the meaning of a venerable federal statute was at issue. In chapter 12, the section on taxation of real estate discusses numerous cases concerning the meaning of “exclusive use” of a piece of property for charitable purposes. These cases are just a few of the many examples of judicial interpretation that permeate this text. Readers should be alert for others, and try to discern the different philosophies of judicial interpretation that the cases’ outcomes represent.

Administrative Law

Administrative law is the type of public law that deals with the rules of government agencies. According to one scholar, “Administrative law . . . determines the organization, powers, and duties of administrative authorities.”⁴ Administrative law has greater scope and significance than is sometimes realized. In fact, administrative law is the source of much of the substantive law that directly affects the rights and duties of individuals and businesses and their relation to governmental authority (see the discussion of federal healthcare privacy regulations in chapter 9).

The executive branch of government carries out (administers, implements) the law as enacted by the legislature and interpreted by the courts. However, the executive branch also makes law (through administrative regulations) and exercises a considerable amount of quasi-judicial (court-like) power. The term *administrative government* means all departments of the executive branch and all governmental agencies created for specific public purposes.

Administrative agencies exist at all levels of government: local, state, and federal. Well-known federal agencies that affect healthcare are the National Labor Relations Board, Federal Trade Commission, Centers for Medicare & Medicaid Services, and Food and Drug Administration. At the state level, there are boards of professional licensure, Medicaid agencies, workers’ compensation commissions, zoning boards, and numerous other agencies whose rules affect healthcare organizations.

Legislative bodies delegate lawmaking and judicial powers to administrative government as necessary to implement statutory requirements; the resulting rules and regulations have the force of law, subject to the provisions of the Constitution and statutes. The Food and Drug Administration, for example, has the power to make rules controlling the manufacturing, marketing, and advertising of foods, drugs, cosmetics, and medical devices. Similarly, state Medicaid agencies make rules governing eligibility for Medicaid benefits and receipt of funds by participating providers.

The amount of delegated legislation increased tremendously during the twentieth century, especially after World War II. The reason for this

increase is clear: Economic and social conditions inevitably change as societies become more complicated. Legislatures cannot directly provide the detailed rules necessary to govern every particular subject. Delegation of rulemaking authority puts this responsibility in the hands of experts, but the enabling legislation will stipulate the standards to be followed by an administrative agency when it writes the regulations. Such rules must be consistent with their underlying legislation and the Constitution.

Judicial Decisions

The third major source of law is the judicial decision. All legislation, whether federal or state, must be consistent with the US Constitution. The power to legislate is, therefore, limited by constitutional doctrines, and the federal courts have the power to declare an act of Congress or of a state legislature unconstitutional.⁵ Judicial decisions are subordinate to the Constitution and to statutes as long as the statutes are constitutional. Despite this subordinate role, however, judicial decisions are the primary domain of private law, and private law—especially the law of contracts and torts—traditionally has had the most influence on healthcare and thus is of particular interest to healthcare administrators.

Common law—judicial decisions based on tradition, custom, and precedent—produced at least two important concepts that endure today: *writ* and *stare decisis*. A writ is a court order directing the recipient to appear before the court or to perform, or cease performing, a certain act.

The doctrine of **stare decisis**—the concept of precedent—requires that courts look to past disputes involving similar facts and principles and determine the outcome of the current case on the basis of the earlier precedents as much as possible. This practice engenders a general stability in the Anglo-American legal system (see Legal Brief).

Consider, for example, the opening sentence of the 1992 abortion decision, *Planned Parenthood of S.E. Pennsylvania v. Casey*. The case involved the question of whether to uphold or overturn the precedent set in *Roe v. Wade*, the landmark abortion decision of 1973. Justice Sandra Day O'Connor's opinion in the *Casey* case sums up *stare decisis* in nine words: “Liberty finds no refuge in a jurisprudence of doubt” (see The Court Decides at the end of this chapter).

Stare decisis applies downward, but not horizontally. An Ohio trial court, for example, is bound by the decisions of Ohio's Supreme Court and the US Supreme Court but not by the decisions of other Ohio trial courts or out-of-state

stare decisis

Latin for “to stand by a decision.” It is the principle that a court must respect precedents (decisions of higher courts) in legal decision-making on cases with similar facts.

Legal Brief



Use of precedent distinguishes common-law jurisdictions from code-based civil law systems, which traditionally rely on comprehensive collections of rules. The civil law system is the basis for the law in Europe, Central and South America, Japan, Quebec, and (because of its French heritage) the state of Louisiana.

courts. Courts in one state may, but are not required to, examine judicial decisions of other states for guidance, especially if the issue is new to the state. Similarly, a federal trial court is bound by the decisions of the Supreme Court and the appellate court of its circuit but not by the decisions of other appellate or district courts.

The doctrine of *stare decisis* should not be confused with a related concept—*res judicata*, which literally means “a thing or issue settled by judgment.” (In Latin, the word *res* means “thing.”) In practical terms, once a legal dispute has been resolved in court and all appeals have been exhausted, *res judicata* prohibits the same parties from later bringing suit regarding the same matters.

The Court System

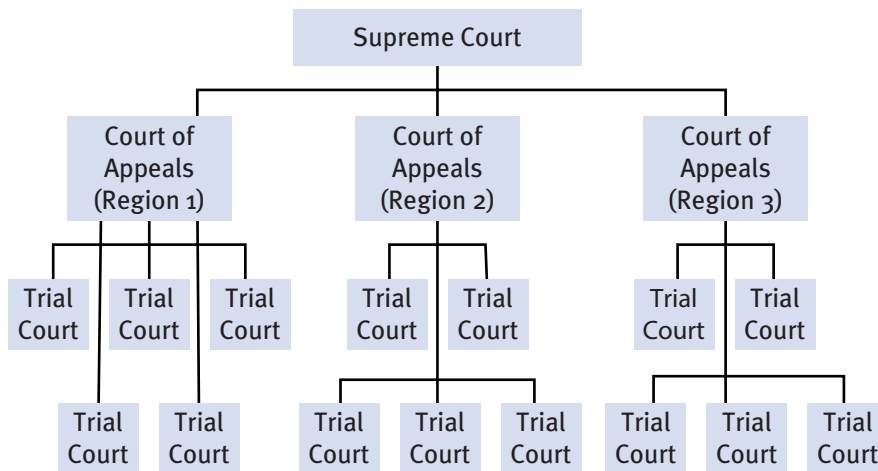
In a perfect world, we would not need courts and lawyers. This idea may have inspired Shakespeare’s famous line in *Henry VI*, “The first thing we do, let’s kill all the lawyers.”⁶ At the time—the sixteenth century—resentment against lawyers ran high in England. Shakespeare was perhaps engaging in a little lawyer bashing, and his intention may have been to express his indictment of a corrupt system. On the other hand, the remark may have been a compliment; the character who utters the famous words was an insurgent who would not want skillful lawyers around to uphold law and order. Or maybe the Bard was just trying to get a laugh out of the audience. Regardless of one’s interpretation of the play, we do not live in a utopia, so we need courts and lawyers.

There are more than 50 court systems in the United States. In addition to the state and federal courts, there are courts for the District of Columbia, the Virgin Islands, Guam, the Northern Mariana Islands, and Puerto Rico. The large number of court systems makes the study of US law complicated, but the decentralized nature of federalism adds strength and vitality. As various courts adopt different approaches to a novel issue, the states become a testing ground on which a preferred solution eventually becomes apparent.

State Courts

The federal courts and the court systems of most states use a three-tier structure comprising the trial courts, the intermediate courts of appeal, and a supreme court (see exhibit 1.3). In a state court system, the lowest tier—the trial courts—is often divided into *courts of limited jurisdiction* and *courts of general jurisdiction*. Typically, the courts of limited jurisdiction hear only specific types of cases, such as criminal trials involving lesser crimes (e.g., misdemeanors, traffic violations) or civil cases involving disputes of a certain

EXHIBIT 1.3
Model of a
Typical Three-
Tier Court
Structure



amount (e.g., in small claims court, lawyers are not allowed and complex legal procedures are relaxed). State courts of general jurisdiction hear more serious criminal cases involving felonies and civil cases involving larger sums of money.

The next tier in most states is the intermediate appellate courts. They hear appeals from the trial courts. In exercising their jurisdiction, appellate courts are usually limited to the evidence from the trial court and to interpreting questions of law, not questions of fact.

The highest tier in the state court system is a state supreme court. This court hears appeals from the intermediate appellate courts—or from trial courts if the state does not have intermediate courts—and, like the trial courts, the supreme court has limited jurisdiction and hears only certain types of cases. (Texas and Oklahoma are a little different: each has two separate highest courts, one for civil and the other for criminal cases.) The high court is also charged with administrative duties, such as adopting rules of procedure and disciplining attorneys.

The states are not uniform in naming the various courts. A trial court of general jurisdiction, for example, may be called a circuit, superior, common pleas, or county court. New York is unique in that its trial court is known as the “supreme court,” so named because it has essentially unlimited jurisdiction in civil and criminal cases. New York’s intermediate appellate court, then, is the “Supreme Court Appellate Division.”

In most states, the highest court is named the supreme court, but in Maine and Massachusetts the high court is styled the “Supreme Judicial Court,” and in New York, Maryland, and the District of Columbia, the highest court is called the “Court of Appeals.” In West Virginia the highest court is the “Supreme Court of Appeals.”

Federal Courts

US District Courts

The structure of the federal court system is similar to that of the state courts. At its bottom tier, federal district (trial) courts hear nearly all categories of cases, including criminal matters arising under federal statutes and civil cases between parties from different states or based on federal law. There are 94 district courts—at least one in each state plus one each in the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and the Northern Mariana Islands. Each district also has a US bankruptcy court, which is a unit of the district court. The federal courts (beginning with the district courts) have exclusive jurisdiction over certain kinds of cases, such as violations of federal antitrust or securities laws, **admiralty**, bankruptcy, and issues related to the Employee Retirement Income Security Act.

admiralty

The system of law that applies to accidents and injuries at sea, maritime commerce, alleged violations of rules of the sea over shipping lanes and rights of way, and crimes aboard a ship.

Federal and state courts have *concurrent* jurisdiction in cases arising under the US Constitution or under any federal statute that does not confer exclusive jurisdiction to the federal court system. A federal district court may hear suits based on state law in which a citizen of one state sues a citizen of another state if the amount in dispute is more than \$75,000.⁷ These suits are called *diversity of citizenship* cases. A prime example is *Erie R. R. Co. v. Tompkins*.⁸ In this famous case, Tompkins, a citizen of Pennsylvania, was injured by a passing train while walking along the Erie Railroad's right-of-way in that state. He sued the railroad for negligence in a New York federal court, asserting diversity jurisdiction. The railroad was a New York corporation, but the accident occurred in Pennsylvania, and the railroad pointed out that Tompkins was trespassing on its property. Under Pennsylvania's court decisions, trespassers could not recover for their injuries. Tompkins countered that because there was no state statute on the subject, only common-law precedents, the railroad could be held liable in federal court as a matter of "general law." At issue was how to interpret this section of the Federal Judiciary Act: "The laws of the several States, except where the Constitution, treaties, or statutes of the United States otherwise require or provide, shall be regarded as rules of decision in trials at common law, in the courts of the United States, in cases where they apply."⁹

An 1842 case, *Swift v. Tyson*, had concluded that this language applied only to a state's *statutes*, not its common law.¹⁰ Because of that precedent, the lower courts held for Mr. Tompkins. The Supreme Court disagreed, however, citing various plaintiffs' use of diversity jurisdiction and the *Swift* doctrine to circumvent an unfavorable state law. Thus, the court overturned the precedent set by *Swift*, stating:

Except in matters governed by the Federal Constitution or by acts of Congress, the law to be applied in any case is the law of the state. And whether the law of the state shall be declared by its Legislature in a statute or by its highest court in a

decision is not a matter of federal concern. There is no federal general common law. Congress has no power to declare substantive rules of common law applicable in a state whether they be local in their nature or “general,” be they commercial law or a part of the law of torts. And no clause in the Constitution purports to confer such a power upon the federal courts.

Tompkins thus stands as an example of how precedents can evolve over time based on experience and the changing needs of society. Note that claims involving federal statutes and the US Constitution may also be tried in state court, depending on the situation.

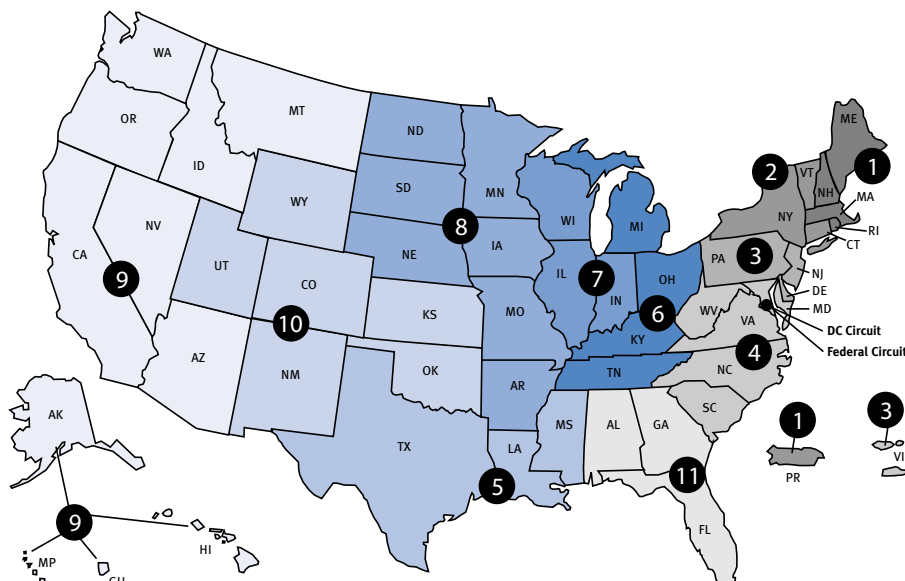
US Courts of Appeals

There are 13 US Courts of Appeals. The 94 judicial districts (trial courts) are organized into 12 geographically defined “circuits,” and the Court of Appeals of each circuit hears cases from the district courts located in its respective region. The thirteenth such court is the US Court of Appeals for the Federal Circuit, which has subject matter responsibilities rather than oversight of a given region. This court hears appeals in specialized cases, such as those involving patent laws or specific statutes assigned to it by Congress (see exhibit 1.4).¹¹

US Supreme Court

At the highest level of the federal court system is the US Supreme Court. The Supreme Court hears appeals of cases involving federal statutes, treaties, or the US Constitution from the US courts of appeals and from the highest state

EXHIBIT 1.4
Map of US
Courts of
Appeals



writ of certiorari

An order from a higher court to a lower court, requesting that the record of a case be sent up for review.

courts. In most cases litigants have no absolute right to have their case heard by the Supreme Court. Instead, they must petition for a **writ of certiorari**—an order to the lower court requiring that the case be sent up for the high court’s review—and must persuade at least four of the nine justices that the issue merits their attention. The Supreme Court normally decides only about 150 cases per year from the 8,000–10,000 “cert petitions” it receives.

In the words of Chief Justice William H. Taft, the justices see their function as “expounding and stabilizing principles of law for the benefit of the country, passing upon constitutional questions, [and] to preserve uniformity of decision among the intermediate courts of appeal.”¹² As a result, the Supreme Court grants certiorari only in cases that present questions of extraordinary legal or social significance or when the federal courts of appeals have differed in deciding cases involving the same legal issue. Because the court has considerable discretion in which cases it chooses to hear, lower courts decide most of the important legal issues.

The Constitution vests the judicial power of the United States “in one supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish” (Article III, Section 1). Unlike state judges, federal judges are given lifetime appointments and can be removed only by impeachment and conviction. Congress may create additional courts and may redefine the jurisdiction of all tribunals below the Supreme Court level. Over the years, Congress has complemented the district courts and the courts of appeals with several federal courts that have specialized functions—for example, the US Federal Claims Court (which hears certain contract claims brought against the government), the US Court of International Trade, the US Tax Court, and the US Court of Appeals for the Armed Forces.

Alternatives to the Court System

There are two popular options for resolving disputes outside of the court system. The first is to resort to the quasi-judicial power of an administrative agency or tribunal. (Workers’ compensation commissions are a familiar example.) Administrative bodies settle far more disputes today than do the judicial courts, and administrative agencies usually have the statutory responsibility and power to enforce their own decisions (which courts do not have). Thus, the agency that wrote the regulations often brings the initial proceeding, hears the case, and decides the dispute as well. The Federal Trade Commission, for example, is empowered to compel an alleged offender to cease and desist from practicing unfair methods of competition under the commission’s regulations.

Statutes prescribe the powers of administrative bodies. The role of ordinary courts is generally limited to preventing administrative authorities from exceeding their powers and to granting remedies to individuals who have been

injured by wrongful administrative action. Sometimes statutes grant the right of appeal of an adverse administrative decision to a judicial court.

The second alternative method for dispute resolution is **arbitration**, which is often faster, less complicated, more confidential, and less costly than a lawsuit. Arbitration involves submission of a dispute for decision by a third person or a panel of experts outside the judicial process. When the parties to a dispute voluntarily agree to have their differences resolved by an arbitrator or by a panel and to be bound by the decision, arbitration becomes a viable alternative to the court system. Statutory law in most states favors voluntary, binding arbitration and frequently provides that an agreement to arbitrate is enforceable by the courts.¹³ Arbitration is different from *mediation*, in which a third party—the mediator—simply attempts to persuade adverse parties to agree to settle their differences. The mediator has no power to require a settlement.

arbitration

An extrajudicial hearing sometimes used in medical liability cases to avoid a court trial and conducted by a person or a panel of people who are not necessarily judges.

Legal Procedure

Substantive law is the type of law that creates and defines rights and duties. Most of this book is devoted to substantive law as it relates to healthcare providers. *Procedural law*, as the term implies, provides the specific processes for enforcing and protecting rights granted by substantive law. The branch of procedural law discussed in this section is law relating to trial of a case.

Commencement of Legal Action: The Complaint

To begin a lawsuit (an *action*), a claimant (the *plaintiff*) files a complaint against another party (the *defendant*). The complaint states the nature of the plaintiff's injury or claim and the amount of damages or other remedy sought from the defendant. (The complaint and other papers subsequently filed in court are *pleadings*.) A copy of the complaint, along with a summons, is then served on the defendant. The summons advises the defendant that he must answer the complaint or take other action within a limited time (e.g., 30 days) and that the plaintiff will be granted judgment by default if the defendant fails to act.

The Defendant's Response: The Answer

In response to the summons, a defendant files an answer to the complaint, admitting to, denying, or pleading ignorance to each allegation. The defendant may also file a complaint against the plaintiff (a *countersuit* or *counterclaim*) or against a third-party defendant whom the original defendant believes is wholly or partially responsible for the plaintiff's alleged injuries.

At this stage in the proceeding, the defendant may ask the court to dismiss the plaintiff's complaint if the court lacks jurisdiction, a judgment has already been made on the same matter, or the plaintiff's complaint failed to state a legal claim. Although the terminology differs from state to state,

the motion to dismiss is usually called a *motion for summary judgment* or a *demurrer*. If the court grants the motion to dismiss, the judgment is final and the plaintiff can appeal the decision immediately.

Discovery

In rare cases, the court's decision quickly follows the complaint and answer stages. Usually, however, especially in urban areas, several months elapse between commencement of the action and trial. During this time, each party engages in *litigation*, or *discovery*, in an attempt to determine the facts and strength of the other party's case.

Discovery is a valuable device that can be used, for example, to identify prospective defendants or witnesses or to uncover other important evidence. For example, in one hospital case, a patient had fallen on the way to the washroom and fractured a hip.¹⁴ During discovery, the hospital was required to disclose the identity of the nurse who had directed the patient to the washroom instead of giving bedside attention.

During the discovery phase, parties may use any or all of the following five methods to discover the strength of the other party's case:

1. *Deposition*. Sworn testimony given under oath before a court reporter and in the presence of attorneys for each side; transcripts of the testimony may be used as evidence in court.
2. *Written interrogatories*. Written questions, the answers to which are sworn to and may be used as evidence; interrogatories are somewhat less effective than oral depositions because there is little opportunity to ask follow-up questions.
3. *Subpoena duces tecum*. A request requiring documents, such as medical records, as evidence for the case; special rules govern the handing over of healthcare records because of the sensitivity of those documents.
4. *Physical or mental examination of a party*. Used when the physical or mental condition of a party to the lawsuit is in dispute and good cause for the examination is shown.
5. *Request for admission of facts*. A request that the opposing party admit certain facts; once a fact has been admitted, the parties save the time and expense of proving it in open court and thus may simplify the case.

Only relevant facts and matters that are not privileged or confidential may be solicited through these methods.

The Trial

A trial begins with the selection of a jury if either party has requested a jury trial. After jury selection, each attorney makes an opening statement

subpoena duces tecum

A court order, issued at the request of one of the parties to a suit, that asks a witness to bring to court or to a deposition any relevant documents under the witness's control.

that explains matters to be proven during the trial. The plaintiff then calls witnesses and presents other evidence, and the defense attorney is given an opportunity to cross-examine each of the witnesses. After the evidence is in, a party may ask the court for a **directed verdict**. Judges will grant such a motion if the jury, viewing the facts most favorably to the other party, could not reasonably return a verdict in that other party's favor. The motion can be made by the defendant after the plaintiff has presented all their evidence, or by either party after both parties have made their respective cases.

If the judge denies the motion, she gives instructions to the jury concerning applicable law, and the jury retires to deliberate until it reaches a verdict. Many times, after the jury has reached its decision, the losing party asks the court for a “judgment notwithstanding the verdict”—also known as **judgment NOV**, an abbreviation for the Latin term *non obstante veredicto*—and a new trial. The motion is granted if the judge decides that the verdict is clearly not supported by the evidence.

A related concept is a **summary judgment**, which can be issued by the judge before trial if the factual issues are undisputed or are so one-sided that they need not be tried. A motion for summary judgment will be supported by declarations under oath and evidence adduced during the discovery phase. If granted, the summary judgment concludes the case as to that set of facts.

The judge and the jury play key roles in the trial. The judge has the dominant role, deciding whether evidence is admissible and instructing the jury on the law before deliberation begins. The judge also has the power to take the case away from the jury by means of a directed verdict or a judgment notwithstanding the verdict. The role of the jury is thus limited to deciding the facts and determining whether the plaintiff has proven the allegations by a preponderance of the evidence.

Because the jury's role is to decide the facts, the impartiality of the jury is of utmost importance. If there is evidence that a jury member might have been biased, many courts overturn the verdict. In cases tried without a jury, the judge assumes the jury's fact-finding role. (Because either a judge or the jury can perform this function, it is often referred to as that of the “trier of fact.”)

Appeal and Collection

The next stage in litigation is often an appeal. For various reasons (e.g., satisfaction with the verdict, a party's unwillingness to incur additional expenses), not all cases go to an appellate court.

The party who appeals the case (the losing party in the trial court) is usually the *appellant*, and the other party is the *appellee*. When reading appellate court decisions, one must not assume that the first name in the case heading is the plaintiff's because many appellate courts reverse the order of the names when the case is appealed (see exhibit 1.5). The appellate court's

directed verdict

An order from the judge for the jury to issue a particular verdict if no reasonable person could reach a decision to the contrary based on the evidence presented.

judgment NOV (non obstante veredicto)

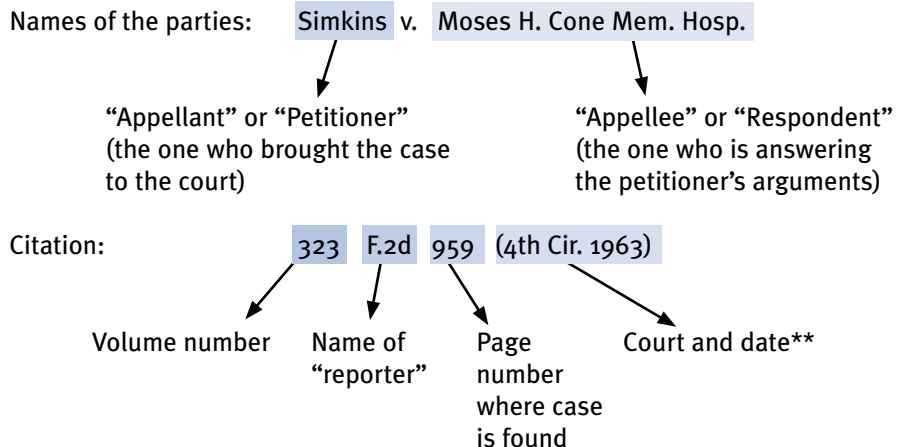
A verdict “notwithstanding the verdict” entered by the court when a jury's verdict is clearly unsupported by the evidence.

summary judgment

An order by a court finding in favor of one party against the other without a trial; it is issued if the judge finds that there is no “genuine issue of material fact” left to be determined and the moving party is “entitled to judgment as a matter of law” (Rule 56, Federal Rules of Civil Procedure).

EXHIBIT 1.5**Legal Citation System**

The legal system uses a unique citation method.* The citation in the *Simkins v. Moses H. Cone Mem. Hosp.* case is a good example. Its heading efficiently conveys a sizable amount of information, as follows:



The *reporter* is the publication in which the decision is documented. Supreme Court decisions are published in the *U.S. Reports* (abbreviated *U.S.*). Federal appellate decisions, such as the *Simkins* case decision, are published in the *Federal Reporter* (abbreviated as *F.*, *F.2d*, or *F.3d*).

Many federal and most state trial court decisions are not published formally; however, if a federal trial court decision is published, it will appear in the *Federal Supplement* (*F. Supp.* or *F. Supp. 2d*). In case names at the trial court level, the name given first is that of the person who initiated the action (the plaintiff), and the other is the one against whom the case is brought (the defendant). Thus, for example, in *Smith v. Jones*, Smith would be the plaintiff and Jones, the defendant. If the defendant loses in the trial court, the names are sometimes reversed on appeal to show the appellant (former defendant) first. Thus, in the previous example, if Jones loses at the trial court, the appellate decision might read *Jones v. Smith*. A caption that reads something like *State v. Jones* is most likely a criminal prosecution.

State appellate decisions can be found in the National Reporter System created by the West Publishing Company (now part of Thomson West) and in official reporters published by some states. The National Reporters are grouped regionally (see exhibit 1.4) and contain the decisions of the courts of nearby states—for example:

Northeastern Reporter (N.E., N.E.2d)
Southern Reporter (So., So. 2d)
Pacific Reporter (P., P. 2d)

A designation of *2d* or *3d* indicates that a publisher began a new numbering sequence (called a new “series”) at a certain point, beginning with volume 1 of the later series. For example, “N.E.2d” reads as “Northeastern Reporter, second series,” and cases therein would be cited as “1 N.E.2d” plus the page number.

* These conventions vary slightly in some states’ official reports, but they generally hold throughout the country.

** Court designation is not necessary if implicit in the name of the reporter in which the case is published.

function is limited to a review of the law applied in the case; it accepts the facts as determined by the trier of fact. In its review, the appellate court may affirm the trial court decision, modify or reverse the decision, or reverse it and remand the case for a new trial.

The final stage of the litigation process is collection of the judgment. The most common methods of collection are execution and garnishment. A *writ of execution* entitles the plaintiff to have a local official seize the defendant's property and to have that property sold to satisfy the judgment. A *garnishment* is an order to a third person who is indebted to the defendant to pay the debt directly to the plaintiff to satisfy the judgment. Often, the third party is the defendant's employer, who, depending on local laws, may be ordered to pay a certain percentage of the defendant's wages directly to the plaintiff.

Discussion Questions for Part 1

1. Why is some knowledge of the history of law important to understanding the law more fully?
2. What are the four sources of law in the United States?
3. Describe the three branches of government and the role of each, including the system of checks and balances.
4. What is the hierarchy among the sources of law in the federal government?
5. What is the system for citing judicial opinions?
6. What are due process and stare decisis, and why are they important?
7. Describe the structure of the federal judicial system.



The Court Decides

Planned Parenthood of S.E. Pennsylvania v. Casey 505 U.S. 833 (1992)

O'Connor, Justice

Liberty finds no refuge in a jurisprudence of doubt. Yet 19 years after our holding that the Constitution protects a woman's right to terminate her pregnancy in its early stages, that definition of liberty is still questioned. . . .

[T]he Court's legitimacy depends on making legally principled decisions under circumstances in which their principled character is sufficiently plausible to be accepted by the Nation. . . . The Court is not asked to [overrule prior decisions] very often. . . . But when the Court does [so], its decision requires an equally rare precedential force to counter the inevitable efforts to overturn it and to thwart its implementation. Some of those efforts may be mere unprincipled emotional reactions; others may proceed from principles worthy of profound respect. But whatever the premises of opposition may be, only the most convincing justification under accepted standards of precedent could suffice to demonstrate that a later decision overruling the first was anything but a surrender to political pressure, and an unjustified repudiation of the principle on which the Court staked its authority in the first instance. So to overrule under fire in the absence of the most compelling reason to reexamine a watershed decision would subvert the Court's legitimacy beyond any serious question. . . .

The promise of constancy, once given, binds its maker for as long as the power to

stand by the decision survives and the understanding of the issue has not changed so fundamentally as to render the commitment obsolete. From the obligation of this promise this Court cannot and should not assume any exemption when duty requires it to decide a case in conformance with the Constitution. A willing breach of it would be nothing less than a breach of faith, and no Court that broke its faith with the people could sensibly expect credit for principle in the decision by which it did that. . . .

The Court's duty in the present case is clear. In 1973, it confronted the already divisive issue of governmental power to limit personal choice to undergo abortion, for which it provided a new resolution based on the due process guaranteed by the Fourteenth Amendment. Whether or not a new social consensus is developing on that issue, its divisiveness is no less today than it was in 1973, and pressure to overrule the decision, like pressure to retain it, has grown only more intense. A decision to overrule *Roe's* essential holding under the existing circumstances would address error, if error there was, at the cost of both profound and unnecessary damage to the Court's legitimacy, and to the Nation's commitment to the rule of law. It is therefore imperative to adhere to the essence of *Roe's* original decision, and we do so today. ■

Discussion Questions

1. What is the significance of the first sentence in this excerpt?
2. In your opinion, is this defense of the principle of stare decisis persuasive?
3. If you were attempting to get this case overruled, what arguments might you make to counter this position?



PART 2: THE HISTORY OF MEDICINE

After reading part 2 of this chapter, you will

- have a greater appreciation for the evolution of medicine over the millennia,
- understand that “modern Medicine” is a recent phenomenon, and
- recognize that the structure of today’s US health system is the result of compromises made over the course of decades.

If it helps to know some history when studying the US legal system, the same can be said about healthcare. Without some background, we may be in danger of concluding that our health system is timeless and ineluctable. It is neither. It was not predestined, and surely no creator would have designed it thusly on a tabula rasa. Let us, therefore, review some history of how our health system came to be the peculiar creature it is.¹⁵

Appendix 1.1 at the end of this chapter is a detailed timeline of the history of medicine from the pharaohs to the present. If that history were displayed on a 24-hour clock with the pharaohs at 12:01 a.m. and the present being 11:59 p.m., we would see that “modern medicine” is only about an hour old. What came before the modern era?

The Pharaohs and Babylonians

For eons, medicine consisted primarily of mysticism and spiritual belief systems. Various ancient cultures had some understanding of good dietary habits and the pharmacological effects of certain plants, such as tobacco and peyote, but they had little knowledge of natural disease processes. They usually relied on shamans to invoke what they believed to be the healing powers of the spirit world. It should be noted that, in fact, this approach is not extinct in the contemporary world. Forms of shamanism persist in various indigenous cultures today, including, among others, those of some Native Americans, the Hmong of Southeast Asia (see *Shamanism: The Ancient Meets the Modern*), certain African tribes, and a few mestizo (mixed-race) peoples in Central and South America.

The ancient Egyptians were relatively advanced in terms of medical knowledge.¹⁶ They were familiar with anatomy (perhaps because of their embalming practices), were aware of the connection between pulse and the heart, could diagnose and treat a few diseases, and were adept at simple surgery and orthopedics. Magic and mysticism were prevalent nevertheless, and

Shamanism: The Ancient Meets the Modern

A particularly striking example of the contrast between scientific medicine and traditional beliefs is found in Anne Fadiman's *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* (Farrar, Strauss, and Giroux 1997). The book tells the story of an epileptic Hmong child in California whose parents' strong belief in shamanistic animism led to a "collision of cultures," as the book's subtitle puts it. Even though it covers events that occurred in the late twentieth century, the book describes what medicine in ancient times must have been like in many places.

some of their medical practices were ineffective—even harmful.¹⁷ In any event, what useful knowledge they amassed was not communicated widely, perhaps because of their use of hieroglyphic writing, which was not deciphered in the Western world until the early 1800s.

The ancient Babylonians introduced the concepts of diagnosis and prognosis, wrote prescriptions, used logic and observation to advance medical knowledge, and even published a diagnostic handbook around 1050 BCE.¹⁸ Like their Egyptian counterparts, however, Babylonian physicians did not spread their science widely, and when patients were not cured by the basic medicine of the day, exorcism and similar techniques were the only remaining options.

Hippocrates, Galen, and 2000 Years of Medical Practice

Being ignorant of the concepts and practices developed in Egypt and the Middle East, Greek and Roman physicians such as Hippocrates (ca. 460–370 BCE) and Claudius Galenus ("Galen," ca. 131–201 CE) practiced *humoralism*, the belief that the body consisted of four basic substances ("humors") that determined one's state of health. Under this theory, an imbalance in the four humors was said to be the cause of disease and disability. The four humors and their corresponding attributes are summarized in exhibit 1.6.

This theory dominated Western medical practice for more than two millennia, during which time practices such as bloodletting, purging, administration of emetics, and application of poultices were common. These treatments were largely ineffective and, like bloodletting, often did more

EXHIBIT 1.6

Humoralism
and the Four
Humors

Humor	Organ	Personal Characteristic	Disposition
Blood	Liver	Sanguine	Courage, amorousness
Yellow bile	Gallbladder	Choleric	Anger, bad temper
Black bile	Spleen	Melancholic	Depression, irritability, sleeplessness
Phlegm	Brain and lungs	Phlegmatic	Peacefulness and calm

harm than good. For example, several twentieth-century scholars surmise that President George Washington, who died in December 1799 at age 84, succumbed to acute inflammatory edema of the larynx (and resultant suffocation) secondary to a septic sore throat. His condition was probably aggravated by the removal of up to half his blood volume in the hours before his death.¹⁹

Medicine finally began to advance in the early nineteenth century, but physicians—given their ignorance of etiology, pathology, and similar disciplines—often had little to offer a patient besides comfort, compassion, and concern, as illustrated in the famous Victorian era painting *The Doctor*, shown in exhibit 1.7. In time, however, a few seminal developments started the process that gradually led to what we can call “modern medicine.”

Anesthesia

One of these occurred in 1846 when John C. Warren, MD (1778–1856), and dentist William T. G. Morton (1819–1868) performed the first significant public demonstration of anesthesia at Massachusetts General Hospital. Using diethyl ether, and with Morton as his anesthetist, Dr. Warren removed a tumor from a patient’s jaw. After the patient, Gilbert Abbott, awoke and reported that he had felt no pain, Warren proudly announced to the audience of physicians and medical students, “Gentlemen, this is no humbug.”²⁰ The



EXHIBIT 1.7

The Doctor,
Sir Luke Fildes
(1891)

Source: Used with the permission of the Tate Gallery, London.

Anesthesia: A Brief History

Hanaoka Seishu (1760–1835), a Japanese surgeon, is said to have been the first person to perform surgery using general anesthesia when he treated a patient's breast cancer in 1804 (Masuru Izuo, *Medical History: Seishu Hanaoka and His Success in Breast Cancer Surgery Under General Anesthesia Two Hundred Years Ago*, 11 *BREAST CANCER* 319 [2004]. Accessed December 4, 2018, at <https://doi.org/10.1007/BFo2968037>). Because of the country's isolation, however, this development was unknown outside of Japan for many years. The American surgeon C. W. Long (1815–1878) used ether as an anesthetic in 1842 but did not publish his results until 1849 (C. Singer & E. A. Underwood, *A Short History of Medicine* at 343 [Oxford University Press 1962]). Morton and Warren were unaware of Long's success when they performed their operation in 1846.

era of painless surgery and dentistry had officially begun in the Western world (see *Anesthesia: A Brief History*).

Germ Theory and Vaccines

Anesthesia was followed in the 1860s by Louis Pasteur's (1822–1895) germ theory, the scientific proposition that infectious diseases are caused by microorganisms. Pasteur disproved the myth of spontaneous generation (the idea that living organisms can grow from nonliving matter); developed vaccines for rabies, cholera, and anthrax; and created a process (now known as *pasteurization*) to slow the growth of microbes in food. An earlier pioneer, the Hungarian physician Ignaz Philipp Semmelweis (1818–1865), had shown that the incidence of puerperal (childbed) fever could be reduced drastically with antiseptic technique and hand

washing in obstetrical clinics, but he was roundly ridiculed until Pasteur provided scientific proof of his theories.²¹

Antisepsis

In the 1860s, Joseph Lister (1827–1912) began to promote antiseptic surgery at the University of Glasgow, Scotland. Building on Pasteur's discoveries, and consistent with Semmelweis's beliefs, Lister treated instruments with a carbolic acid solution and required surgeons to wear clean gloves and wash their hands before and after operations. As a result of these new practices, he saw a profound drop in the number of wound infections. The results were published in a widely respected British medical journal in 1867,²² and Lister was later elected to the Royal College of Surgeons. Listerine mouthwash is named in his honor, as is the bacterial genus *Listeria*.

Based on these and other developments of the day, we can say that the era of modern medicine coincided roughly with the end of the US Civil War (see *The Late Nineteenth Century: The Gilded Age*). Given the progress made to that date, nursing and medical care were of better quality during that conflict than one might think. In particular, antiseptic techniques and anesthesia were not uncommon. Still, healthcare at the time was rudimentary by today's standards, and wartime casualties had a much greater chance of dying from infection and disease than from direct combat injuries.²³

The Nursing Profession

Coincident with medical advances came improvements in the practice of nursing. The primary meaning of *to nurse* is to feed at the breast or to suckle,²⁴ thus it is no coincidence that nursing was long considered solely “women’s work.” For centuries, much of nursing care was provided by women religious: Catholic nuns and women of other faiths. This gender bias was reinforced during wartime as men went off to do battle and women were left to care for the wounded. Even today, the nursing field is overwhelmingly female.

The first inklings that nursing is a profession with standards of its own arose during the Crimean War in the early 1850s, when Florence Nightingale (1820–1910) led a group of women to serve as nurses for English troops and began to bring true order to nursing services for the first time. In addition to dressing wounds and comforting casualties, she organized supplies, improved sanitation, attended to dietary needs, and addressed similar aspects of patient care of the time. In 1860, with generous public donations, Nightingale established the first official nurses’ training program, and her legacy lives on at the Florence Nightingale School of Nursing and Midwifery, a subdivision of King’s College London.²⁵ Because of her fame and her influential books *Notes on Hospitals* (1858) and *Notes on Nursing* (1859), Nightingale (“the lady with the lamp”) is generally regarded as the founder of modern nursing.

The US Civil War brought similar pressures for nursing services in this country, and the first US nursing schools opened during that conflict. According to one source, by the end of the nineteenth century, “somewhere between 400 to 800 schools of nursing were in operation in the country.”²⁶

As the need for nurses and nursing schools grew, nursing began to consider itself a profession, not a trade. It was inevitable that the field would seek to generate some professional associations (see What Is a Profession?). Thus, the late 1890s saw the creation of the American Society of Superintendents of Hospital Training Schools (now the National League for Nursing) and the Nurses Associated Alumnae of the United States (the forerunner of today’s American Nurses Association).

The Late Nineteenth Century: The Gilded Age

The final third of the nineteenth century saw rapid industrial development and increased economic growth in the United States and elsewhere. This period is known as the “Second Industrial Revolution” and, in America, the “Gilded Age.” Advances in medicine and other fields of applied science were comparable to those in heavy industries such as steel and railroads. (See, e.g., Ryan Engelman, *The Second Industrial Revolution, 1870–1914* [accessed December 7, 2018], at <http://ushistorys-cene.com/article/second-industrial-revolution>.)

What Is a Profession?

The *American Heritage Dictionary* defines a *profession* as “an occupation, such as law, medicine, or engineering, that requires considerable training and specialized study.” It could be said, whimsically, that a field is not truly a profession until it has one or more membership associations to represent it.

These national organizations were soon followed by state societies and associations, annual conventions, elections of officers, publication of professional materials and educational standards, and similar activities typical of most professional groups today. The nursing groups even developed the modern title “registered nurse” and lobbied successfully for enactment of nurse licensure statutes similar to those being passed to license physicians and other practitioners. The nurses’ lobbying successes were a “significant legislative accomplishment at a time when women held little political power.”²⁷

The demand for nurses increased dramatically, of course, during each of the two world wars in the twentieth century, and after World War II a debate arose about the best method of nurse training. Hospital-based nurse training programs (“diploma programs”) emphasized the practicalities of bedside care, while college-level “degree programs” were focused on more advanced types of nursing. A third avenue, community college-based “associate degree programs,” tried to split the difference. These distinctions continue today.

Emergence of Modern Hospitals and Medical Education

The ancestors of today’s hospitals were the almshouses of the Middle Ages. Those pits of misery and horror were used primarily to sequester the poor, the insane, and other unfortunate souls from “respectable society.” After all, effective treatment as we know it today was impossible, and recovery was more a matter of God’s will than of human intervention.

The picture began to change in the early nineteenth century, and after the US Civil War the transformation in this country was stunning. Professor Paul Starr characterized it thusly in his Pulitzer Prize-winning book, *The Social Transformation of American Medicine*:

Few institutions have undergone as radical a metamorphosis as have hospitals in their modern history. In developing from places of dreaded impurity and exiled human wreckage into awesome citadels of science and bureaucratic order, they acquired a new moral identity, as well as new purposes and patients of higher status. The hospital is perhaps distinctive among social organizations in having first been built primarily for the poor and only later entered in significant numbers and an entirely different state of mind by the more respectable classes. As its functions were transformed, it emerged, in a sense, from the underlife of society to become a regular part of accepted experience, still an occasion for anxiety but not horror.²⁸

One might dispute whether hospitals are, even today, citadels of “bureaucratic order,” but the overall thrust of Starr’s argument is correct: Once a place to segregate the contagious and dying “dregs of society,” the hospital as an institution rapidly gained prestige and honor when the medical profession as a whole emerged from its “dark ages” and moved from the late nineteenth

century into the twentieth. As Starr put it, “No longer [was a hospital] a well of sorrow and charity but a workplace for the production of health.”²⁹

As hospitals evolved and the body of medical knowledge grew, the need for improvements in medical education became self-evident. For centuries, medical education had placed little or no emphasis on science and research, and prior to the twentieth century it remained “highly variable and frequently inadequate.”³⁰ It was presented in one of three ways: through apprenticeships with local practitioners, in proprietary schools owned by other physicians, or at few universities that provided a combination of didactic and clinical training.

What few university-affiliated schools that existed taught diverse types of medicine, such as scientific, osteopathic, homeopathic, chiropractic, eclectic, physiomedical, botanical, and Thomsonian (which used herbs and application of various forms of heat). Because of the heterogeneity of educational experiences and the lack of standards for physician licensure, physicians in post-Civil War America varied tremendously in their medical knowledge, therapeutic philosophies, and aptitudes for healing the sick.³¹

Reform of this system began with influential college presidents such as Charles Eliot (1834–1909) at Harvard University and Daniel Coit Gilman (1831–1908) at Johns Hopkins University. The number of commercial medical schools dropped, training requirements for physicians increased from a few months after high school to three or more years, and programs placed more emphasis on science and research. According to Starr,

The new [medical education] system greatly increased the homogeneity and cohesiveness of the profession. The profession grew more uniform in its social composition. The high costs of medical education and more stringent requirements limited the entry of students from the lower and working classes. And deliberate policies of discrimination against Jews, women, and blacks promoted still greater social homogeneity. The opening of medicine to immigrants and women, which the competitive system of medical education allowed in the 1890s, was now reversed.³²

These effects undoubtedly contributed to the elite status with which US physicians have been viewed for most of the past century.

Physician education reform continued in 1904 when the American Medical Association (AMA) (established in 1847) created the Council on Medical Education and then supported the Carnegie Foundation’s *Bulletin Number Four* (also called the Flexner Report).³³ This document, issued in 1910, proposed new standards for medical schools and helped increase physicians’ professional stature.

In 1914, the AMA council set the first standards for hospital internship programs and identified the few hospitals that met them. Concurrent